Partnership for a Healthy Community
Board Meeting

August 26, 2021
1:00pm-2:30pm
Teams

AGENDA

1. **Approve 06/24/2021 meeting minutes** (Action) **(Pages 2-4)**

2. **Board Business**
   a. Board Members (Action)
   b. Cancer Chair Follow Up (Discussion)
   c. CHNA Next Steps (Discussion) **(Pages 5-7)**
      - MAPP Process Review **(Pages 8-36)**
      - Survey Distribution **(Pages 37-43)**
   d. Reproductive Health Update (Discussion) – *Michelle Compton*
   e. Substance Use Campaign Graphic (Action) – *Holly Bill*

3. **Committee Updates**
   a. Mental Health & Substance Use **(Page 44)**
   b. HEAL Presentation – *Kaitlyn Streitmatter & Shanita Wallace* **(Page 45)**
   c. Cancer
   d. Data Team **(Page 46)**

4. **Member Announcements**

Next Meeting:
Thursday, September 23, 2021
1:00pm-2:30pm
Teams

Partnership for a Healthy Community Board
Meeting Minutes
June 24, 2021

Members Present via Microsoft Teams:	Lisa Fuller	Chris Setti
	Larry Weinzimmer	Ann Campen
	Holly Bill	Amelia Boyd
	Beth Crider	Greg Eberle
	Jennifer Zammuto	Sally Gambacorta
	Monica Hendrickson	Kate Green
	Tricia Larson	
Others Present:	Amanda Smith	Amy Roberts

Approval of 05/27/2021 Meeting Minutes

Ms. Crider made a motion to approve the meeting minutes from the May 27, 2021 meeting. Motion was seconded by Mr. Weinzimmer. Motion carried (10,0).

Ms. Fuller entered the meeting at 1:03 pm.

Board Business

Diabetes Prevention Program – Page Add to Website Request

Ms. Bill met with the HEAL group and talked about the Diabetes Prevention Program and the team requested to have their own webpage under HealthHOI.org. Ms. Bill stated she is willing to help facilitate it and create it. It would be another addition under the Programs area. Ms. Bill also stated that a sub-committee she is on has also requested to have a page on the website for Trauma Informed Resources for Schools. There was some discussion as to where this information is stored, under the priorities or under programs. The Board did not have any objections for adding this information to the website in some fashion. Ms. Hendrickson suggested to use the same model that Illinois Tobacco and Mental Health have but to let the groups know that the website could be updated in the future and may look different.

CHNA/Survey Update

Ms. Fuller stated that a few weeks ago the Health Departments and the hospitals systems met to discuss expansion of the CHNA and gaps. Another meeting was held with Mr. Weinzimmer to look at the data differently and looking at other areas that are doing something similar. The team will be meeting again to meet next week to finalize Mr. Weinzimmer's contract and what their needs are. Ms. Hendrickson stated that possibly at the next meeting they will have Ms. Fox go over the MAPP process. Ms. Hendrickson also noted that they would like to know the timeline so that they can give feedback to all the agencies that support the data collection portion.

Ms. Larson left the meeting at 1:12 pm.

Ms. Green entered the meeting at 1:31 pm.

Cancer Board Representative

Ms. Fuller noted that the Partnership Board does not have a liaison or representative from the Cancer Priority Action Team to report out and that is a current need. The Cancer groups meets the 2nd Thursday of every month. Ms. Fuller asked if there is anyone interested in joining that committee. Ms. Bill and Mr. Eberle spoke of their experiences of being involved with their priority areas. Ms. Bill suggested moving Committee updates to the first part of the meeting to have a Cancer representative come on for an update, then they can leave the meeting. Short term, a Cancer representative can do the report out. Ms. Hendrickson did ask Board members to look at their schedules to see if they can be a representative for the Cancer group.

Committee Updates

Mental Health & Substance Use

Ms. Bill stated that their next meeting is on Monday. Ms. Fuller asked at the previous meeting if the sub-committee groups meeting was working. Ms. Bill stated that she asked the individual leads of the sub-committees if it is working and shared a chart of the responses. Ms. Bill stated it is working, as it's going faster, however, for some things they are still digging in data and in the planning stages. Mental Health First Aid has a cadre formed, but there haven't been a lot of trainings. School based social emotional training is just now taking off and they are working to find out what trauma informed means what they want the schools to do with that information. Suicide prevention is looking into data but are missing some data for Tazewell and Woodford. Ms. Bill suggested that the Partnership have an award for a school for being Trauma Responsive or something similar. All of the committees need extra help. Criminal Justice & Harm Reduction has great leaders but it's a large take-on and they need more help with digging into data. Technology enhanced classroom is going well and will pick back up in the fall. Mass media campaigns are requesting more help. Youth leadership programs can help to train peer educators in their school. The document will be sent out after the meeting. There was a discussion around team members doing this work pro-bono and what the financial side of this means. Ms. Crider discussed a grant they have received that could possibly pay for their time with the work that some of the sub-committees are doing. Ms. Hendrickson stated that they need to collect some return investment for the programs because the next part will be funding conversations.

Ms. Zammuto entered the meeting at 1:31 pm.

HEAL

Mr. Eberle stated that their last meeting they talked about the Catalyzing Communities Grant, which addresses equitable childhood obesity programs. The HEAL group would become the partner and they would have two representatives working with the organization. You can earn up to $25,000 in a two-year time span, which would offset 5 hours of work per week. Mr. Eberle stated at their last meeting they also talked about the Diabetes Prevention Program that Ms. Bill spoke of earlier in the meeting. They also talked about the HEAL newsletter that goes out quarterly by email. The HEAL food system partners were awarded additional funding for the next three years. Mr. Eberle reviewed their strategies and progress reports.

Cancer

No one was at the meeting to report for Cancer.

Data Committee

Ms. Smith provided the progress report in the agenda packet. They met and reviewed the

dashboards for each of the priority areas. The team has pulled different resources and have worked on the draft of the CHNA survey. They had a request from HEAL and they will be working to get more information to them. The Data Team would like continued discussion with the Board of what the role of their team is. Is the Data Team to proactively provide a repository of available data or provide data in response to objectives/strategies for the next CHNA? Ms. Hendrickson stated that the data team would prioritize more to support change otherwise they will be waiting for each cycle for the data markers. Ms. Fuller stated a regular reach out to the committees would be helpful to see what their needs are and where their gaps are. Ms. Smith noted there is a national standard to look at the return on investment for the Diabetes Prevention Program and it can be looked at in a small group.

Member Announcements

Ms. Hendrickson recognizes there a lot of newer individuals on the Partnership Board and Ms. Hendrickson is happy to sit down have an orientation with any Board Member, even older Board Members that would need a refresher. The dates available for an orientation are:

Tuesday, July 6 from 10:00-12:00
Wednesday, July 21 from 8:30-10:30
Wednesday, July 28 from 12:30-2:30

If you'd like to attend one of those please email Amy Roberts by the end of June 2nd to get put on the schedule.

Next Meeting: July 22, 2021
1:00-2:30
TBD

2022 Community Health Needs Assessment

Executive Summary:

For the 2022 Community Health Needs Assessment, the tri-county has determined to use the MAPP Assessment to meet the needs of identification of health priorities for Peoria, Tazewell and Woodford Counties. This assessment will be utilized to create the 2023-2025 Community Health Improvement Plan for the Partnership for a Healthy Community, the agreed upon collaborative working towards health improvement.

A MAPP Steering Committee will be created as an Ad-Hoc committee of the Partnership for Healthy Community (PFHC). The Steering Committee and any additional members will be charged with providing accountability for the Need Assessment (which includes the Status, Partners and Community Assessment) as well as initial review and prioritization of health concerns. The group will be representative but exclusive to health departments, healthcare, education, employment, housing, and social services.

The MAPP Assessment includes four assessments to be completed within the tri-county:

- **Community Status Assessment**- The Community Status Assessment largely aligns with MAPP's former Community Health Status Assessment and quantitatively describes the community, including demographics, health status, contributing factors (e.g., SDOH), health equity indicators, and across all these variables, existing inequities.
- **Community Partners Assessments**

  Health Equity Capacity: Assesses each partner's understanding and commitment to health equity and related concepts, their role in addressing inequities, and analysis of existing interventions, programs, and services across a spectrum of action including individual, organizational, systemic, and structural level.

  Community Engagement: Assesses each partner's relationship with, and relative power in, the community (e.g., history of allyship or mistrust); success in meeting community needs; and opportunities for the community to participate in shaping programs, services, or other activities designed to help them. These results can be used to transfer power to those historically excluded from decision making.

  - Assesses partner resources to meet community needs and how those resources are aligned to meet the needs of specific subpopulations. This data may inform decisions around funding and realigning resources to better meet the needs of those experiencing inequities.
  - Community Linkages: Assesses capacity to coordinate and align with other partners and stakeholders within the community system to improve overall quality, efficiency, and effectiveness of programs, services, and

interventions to address inequities. Also assesses how partners are building allies and networks with those holding power. These results may be used to identify gaps or opportunities to make improvements to the community system at large.

- Leadership: Assesses each partner's leadership support around both achieving equity as it relates to their mission and participation in the MAPP process. Results of this assessment may assist each partner to strengthen its position in the community to achieve its mission from an equity and CHI lens.

- **Community Context Assessment-** The Community Context Assessment builds on MAPP's former Community Themes and Strengths Assessment, digging deeper to understand the inequities identified in the Status Assessment, fill in data gaps, and explore the context of the community through the lens of those with lived experience. This assessment will be designed to move beyond perceived community needs and perpetuation of dependency on programs and services to understanding a community's strengths, assets, and culture, recognizing that all communities have a vibrancy that must be leveraged in community improvement. This assessment will also intersect with the Community Partners Assessment, highlighting how community members may work with partners to co-design and implement solutions.

Workplan and Scope

Assessment	Components	Leader/Writer	Approval Agencies	Completion Date	Total Cost for Tri-County
Community Status Assessment (Survey, Community Health, HCI)		Larry W – responsible for consolidating into single document	OSF, UPH, Carle-E, Hopedale, PCCHD, TCHD, WCHD, **PFHC**	3/1/2022	
	Community Survey Finalized	Larry W.	Partnership for a Health Community Board	8/13/2021	
	Community Survey Collection	N/A	Partnership for a Healthy Community membership	9/1/2021-10/15/2021	
	Community Survey Analysis + Demographics (National Targets) (Primary Data)	Larry W.	OSF, UPH, Carle-E, Hopedale, PCCHD, TCHD, WCHD	1/31/2022	

	includes analysis by geographic regions, race, age range, gender				
	Community Data (National targets) : Mortality, STI, Maternal/Child, Cancer, Housing, etc (King County Community Health Needs Assessment, 2021-2022)	PCCHD/UICOMP Epidemiologist	PCCHD, TCHD, WCHD, OSF, Carle-E, Hopedale, UnityPoint	1/31/2022	
	COMP Data Analysis (HCI) – National targets	Sally G/ Amanda S. Contract already exists (contract ends Dec 2021).	OSF, UPH, Carle-E, Hopedale, Heartland	1/31/2022 (takes about 3 months once data received)	
Community Partners Assessments					
A. Health Equity Capacity	Pending Pilot with NACCHO	UICOMP?	Partnership for a Health Community Board	February/ March 2022	
B. Community Engagement	Pending Pilot with NACCHO	LHD's	Partnership for a Health Community Board	February/ March 2022	
Community Context Assessment	Pending Pilot with NACCHO	Partnership Entities	Partnership for a Health Community Board	February/ March 2022	

MAPP Evolution Blueprint Executive Summary

November 2020

NACCHO
National Association of County & City Health Officials

EXECUTIVE SUMMARY

Acknowledgements 2
MAPP Over the Years 4
The Case for Evolving MAPP 5
The MAPP Evolution Process 7
MAPP Redesign: The Foundational Principles 8
Health Equity, Community Engagement, and MAPP 9
Community Engagement 12
Meeting Field Needs: MAPP Re-design Solutions 14
The Revised MAPP Phases 17
Phase 1: Build the CHI Foundation 17
Phase 2: Tell the Community Story 17
Phase 3: Continuously Improve the Community 18
The Revised MAPP Assessments 20
Community Status Assessment 20
Community Partners Assessment 21
Community Context Assessment 23
MAPP Evolution: What to Expect Next 24

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ACKNOWLEDGEMENTS

This report was produced with funding from the Centers for Disease Control & Prevention (CDC), Office of State, Tribal, Local, and Territorial Support, under grant number 5 NU8OT000306-03-00 and from the US Department of Health and Human Services, Health Resources and Services Administration (HRSA) under award number 6 UD3OA228920903. The contents of this resource are those of the authors and do not necessarily represent the official position of or endorsement by the CDC or HRSA.

This report was authored by Anna Clayton, Pooja Verma, and Sarah Weller Pegna, with contributions from Richard Hofrichter with the National Association of County and City Health Officials.

NACCHO would like to extend a special thank you to the following public health leaders who served on the MAPP Evolution Steering Committee and who guided and informed the contents of this document:

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Trish Harkness
Health IT and Systems Specialist
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Finally, NACCHO would like to thank all the individuals who contributed to the MAPP Evolution process and informed the development of this blueprint through surveys, focus groups, interviews, and document reviews.

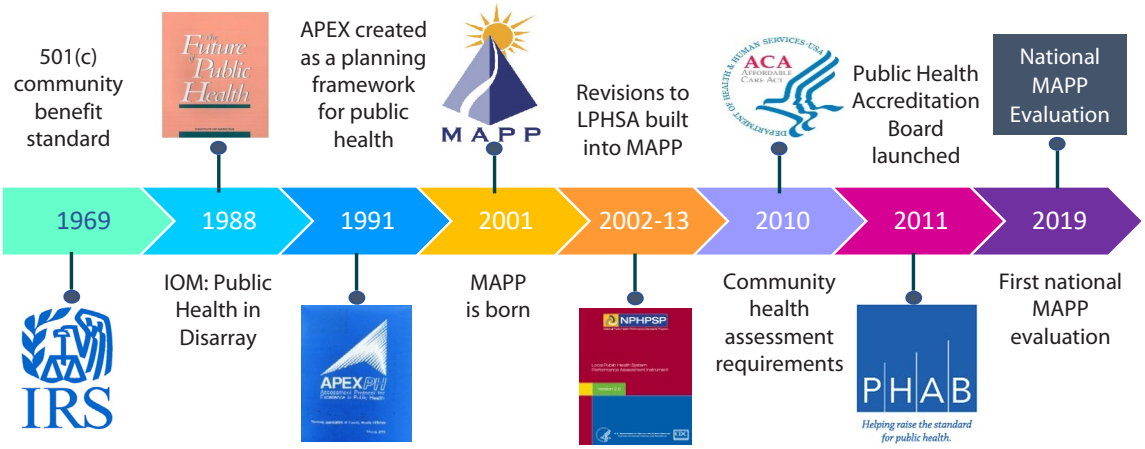
MAPP OVER THE YEARS

Developed in 2001, the National Association of County and City Health Officials (NACCHO's) Mobilizing for Action through Planning and Partnerships (MAPP) framework is now one of the most widely used and reputable community health improvement (CHI) frameworks in the field. MAPP provides a structure for communities to assess their most pressing population health issues and align resources across sectors for strategic action. It emphasizes the integral role of broad stakeholders and community engagement; the need for policy, systems, and environmental change (PSE) change; and alignment of community resources toward shared goals. The process results in a community health (needs) assessment (CH[N]A)[1] and a community health improvement plan (CHIP).

MAPP's creation was in response to a national imperative to shift from traditional program and organizational strategic planning to a community owned, systems thinking approach that considers the complex and evolving challenges faced uniquely by public health. Over the years, NACCHO, CDC, and HRSA have evolved MAPP to align with national strategies through

[1] The Public Health Accreditation Board (PHAB) requires health departments to complete a community health assessment (CHA) and the Internal Revenue Service (IRS) and the Health Resources and Services Administration (HRSA) requires non-profit hospitals and health centers, respectively, to complete a community health (needs) assessment CH[N]A. These terms are often used interchangeably. CH[N]A is used throughout this document to be inclusive of terminology used across sectors.

guidance on evolving CHI requirements across sectors[2,3,4]; integrating CDC's Local Public Health System Assessment (LPHSA); elevating MAPP as a foundation for health equity; and reinforcing national initiatives and frameworks such as the 10 Essential Public Health Services, Public Health Accreditation, and Healthy People. The first national evaluation of MAPP concluded in 2019, revealing that MAPP is effective at engaging in CHI processes, including initiating cross-sector partnerships, gathering community perspectives, meeting accreditation requirements, and raising awareness of health equity. However, it provided foundational evidence for the need further embed health equity and community engagement in MAPP, revise the framework to be more adaptable and responsive to community needs, facilitate sustained partner engagement, and offer more advanced training and guidance on this complex work.



THE CASE FOR EVOLVING MAPP

The public health field is credited with improving life expectancy through interventions such as sanitation, vaccinations, and food safety; however, not everyone has had the same opportunity to benefit. It is well documented that one's zip code is a greater predictor of health outcomes than genetic code, but it was not until the recent COVID-19 pandemic that the inextricable link between health inequities and social, economic, and political inequities resulting from centuries of structural racism and discrimination has gained widespread attention. Covid-19 mortality rates are more than twice as high in Black, Latinx, and Indigenous populations as in White populations, and the data reveal a strong overlay with socioeconomic status.[6,7] Inequities will continue to exacerbate as we face imminent public health threats if we do not align resources and mobilize communities to change the systems and structures that generated the inequities.

> **"[MAPP] is widely considered to be the 'gold standard' for conducting this kind of work. It has been used historically so there is a precedent and a general familiarity within the community." — MAPP Evaluation Respondent**

It is imperative that public health work with other sectors to move beyond traditional and more remedial health and human services to policy, systems, and environmental (PSE) change. White a health equity supplement was added to the MAPP framework in 2014, it was never an explicit foundational principle of MAPP and little guidance was offered to take action on the social determinants of health (SDOH) and much less on the root causes of health inequity. The evaluation revealed that most MAPP communities are still primarily focused on more traditional public health interventions with limited success in sustaining partnerships or engaging those most impacted by inequities.

Across the country, counties are declaring racism as a public health crisis, health departments and local government are establishing offices of health equity, and collaboration with community organizers is becoming more common.[8] With public health evolving to take a more active role in combatting health inequities, this MAPP redesign is perfectly timed to also coincide with the evolution of other national initiatives like the 10 Essential Public Health Services,[9] the PHAB Standards and Measures Version 2.0,[10] and Healthy People 2030,[11] which are all shifting to more explicitly focus on health equity.

THE MAPP EVOLUTION PROCESS

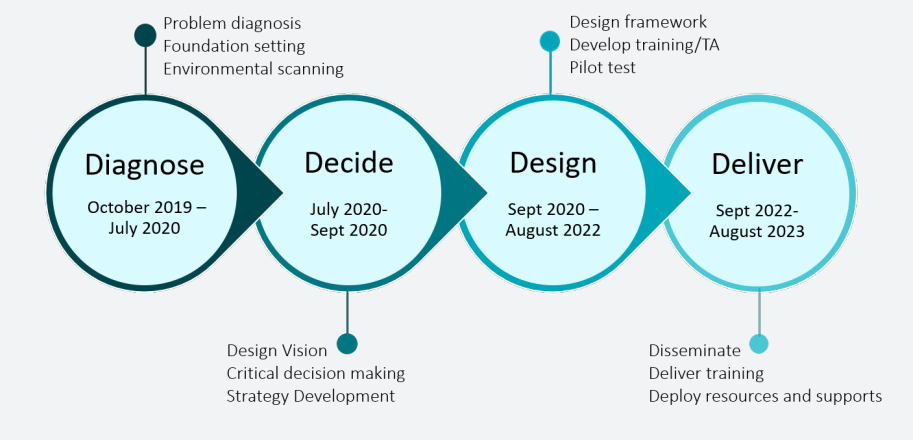
To address recommendations highlighted in the guidance, NACCHO is spearheading a MAPP evolution process through an exploration of field needs, promising practices, and expert guidance. To answer the questions **(see Table 1)**, NACCHO convened a 23-member, multi-disciplinary MAPP Evolution Steering Committee (MAPP ESC), which guided the process; facilitated focus groups and key informant interviews with diverse public health and healthcare practitioners and experts in health equity and CHI practice; and conducted an environmental scan of the literature and field strategies to inform the MAPP revisions.

MAPP Evolution Questions Fall 2019 – Fall 2020

- **What is the future vision for MAPP?**
- **How should health equity be more fully integrated into MAPP?**
- **What revisions to the MAPP phases and assessments are needed to advance community improvement?**
- **How can MAPP facilitate strategic partnership across sectors?**
- **How can MAPP better foster authentic community engagement?**
- **How can MAPP be adapted to meet needs of diverse jurisdictions and stakeholders?**

Moving from understanding the existing challenges and opportunities in the historical MAPP framework to the redesign and delivery of a revised MAPP framework grounded in evolving public health needs, **Figure 1** summarizes the four phases of the MAPP evolution process. NACCHO intends that by Fall 2023, this process will result in a complete MAPP framework redesign and enhanced training, technical assistance, and resources to better enable communities to improve population health through community health improvement.

Figure 1: MAPP Evolution Timeline*



*This anticipated timeline may change, based upon funding and the content development process.

The remainder of this document summarizes the work from the Diagnose and Decide phases, outlining proposed changes to the MAPP framework and next steps for the redesign. **The evolution timeline and all proposed revisions in this document are subject to change based on funding and practitioner feedback as NACCHO continues to engage stakeholders.**

MAPP REDESIGN: THE FOUNDATIONAL PRINCIPLES

Developed with the MAPP ESC and field input, this section proposes a set of foundational principles articulating the guiding values for the MAPP redesign and a vision for CHI as a community-led process to improve population health.

- **Equity.** Encourages shared exploration of the social injustices including structural racism, class oppression, and gender oppression, that create and perpetuate inequities. Mobilizes community action to address these injustices through transformative change to the structures and systems that perpetuate inequities and creates the opportunity for all to achieve optimal health.
- **Inclusion.** Fosters belonging and prevents othering by identifying and eliminating barriers to community participation and ensuring all stakeholders and community members, regardless of background or experience, can contribute to the MAPP process.
- **Trusted Relationships.** Builds connection and trust by honoring the knowledge, expertise, and voice of community members and stakeholders.
- **Community Power.** Actively builds community power to ensure those most impacted by the inequities and actions addressed through CHI are those that guide the process, make key decisions, and help drive action.

- **Strategic Collaboration and Alignment.** Creates a community-wide strategy that appropriately aligns the missions, goals, resources, and reach of cross-sectoral partners to improve community health and address inequities.
- **Data and Community Informed Action.** Identifies priorities, strategies, and action plans that are driven by the community's voice and grounded in community need as identified through timely qualitative and quantitative data.
- **Full Spectrum Actions.** Encourages community improvement through approaches ranging from provision of direct services to PSE and community power building for supportive communities that enable health and well-being for all.
- **Flexible.** Meets the real-time, evolving, and unique needs of diverse MAPP communities, organizations, and sectors through an adaptable framework.
- **Continuous.** Maintains continuous learning and improvement through iterative community assessment, planning, action, and evaluation cycles.

HEALTH EQUITY, COMMUNITY ENGAGEMENT, AND MAPP

The MAPP evaluation revealed that while MAPP communities are successfully engaging in a CH[N]A/CHIP processes that resulted in effective action to improve health, overall many of those communities did not make significant progress in acting on root causes of inequity through their CHI processes. A central question during the initial phases of MAPP Evolution was whether a health equity focus is appropriate for MAPP. Although communities acknowledged the barriers of MAPP through an equity lens such as limited funding, lack of concrete guidance, inconsistent understanding across partners, and political or regulatory barriers; overwhelmingly, the field supports full integration of health equity into MAPP with formal supports and guidance to facilitate success across diverse communities.

Health equity, or *"the state in which all people and populations have the opportunity to achieve optimal health,"* [12] is naturally aligned with the goal of improving population health which is defined by a shift from individual health behaviors and risk factors to examining the social and structural contexts that impact entire populations and lead to disparate distribution of outcomes.[13] A MAPP redesign focused on health equity provides the structure many communities need to act on inequities. A lack of shared understanding of health equity and related concepts prevents communities from moving upstream to address the root causes of inequity. NACCHO proposes a set of

definitions that will create a shared narrative and guide the MAPP redesign. As the field works to address inequities, scholarship is continuously evolving, thus these definitions are dynamic and subject to updates based on new knowledge.

- **Health inequities vs. Health disparities.** MAPP makes a distinction between health disparities which merely implies differences in outcomes across groups and health inequities which implies unfair and unjust differences. Health inequities are the *"preventable differences in the distribution of disease, and death that are systematic, patterned, unjust, and associated with imbalances in power and systems of oppression."*[14] To achieve health equity, communities must move beyond only treating and mitigating health disparities and also actively address the power imbalances and systems of oppression that create and perpetuate inequity.
- **Social Needs vs. Social Determinants of Health (SDOH).** There is widespread recognition that clinical care does not prevent illness and social factors like economic and housing stability must also be addressed. Social needs and SDOH are often conflated; while social needs are, the *"immediate needs of individuals in a community such as food, housing, transportation, or access to care,"* SDOH are the *"the community-wide conditions in which people are born, grow, live, work, learn, and age and the fundamental drivers of these conditions."* MAPP recognizes the importance of addressing social needs while also emphasizing cross-sectoral partnerships to collectively make systems and policy change to improve the SDOH.

- **Root causes of health inequity.** Similarly, SDOH are often used interchangeably with the root causes of health inequity, the *"underlying political, social, and economic systems that create imbalances in power and resources across groups to perpetuate inequities."*[15] Examples include systemic racism, class inequity, and other forms of oppression. Community improvement efforts that do not consider root causes of inequity will continue to mitigate symptoms of the larger problem.[16]
- **Power.** Power is *"the ability to control the processes of agenda setting, resource distribution, and decision-making, as well as to determine who is included and excluded from these processes."*[17] Power imbalances contribute to various forms of oppressions and are crucial to making the shift from mitigating inequities to actively confronting the root causes of health inequity through collective power building strategies.
- **Community power** is defined as *"the ability of communities most impacted by structural inequity to develop, sustain and grow an organized base of people who act together through democratic structures to set agendas, shift public discourse, influence who makes decisions, and cultivate ongoing relationships of mutual accountability with decision-makers that change systems and advance health equity."*[18]

Bringing together the themes identified through field input and best practices in achieving health equity, the following list of requirements will guide the integration of health equity into the new MAPP framework.

- **Health equity theory of social change:** MAPP's theory of change will transition health equity from concept to action by connecting the steps of CHI to the outcome of a more just and equitable society.
- **Shared exploration of health equity:** Foster collaborative exploration of health equity among partners and community to establish a shared language around how the same power imbalances that lead to racial inequities extend to inequities across class, culture, and gender, to offer more politically conservative or rural communities with tools to discuss equity with partners.
- **Broaden partnerships:** Strengthen guidance around expanding partnerships to include community organizers and those who are directly connected to building community trust and power and who are positioned to make policy, systems, and environmental (PSE) change.
- **Community engagement and building power:** Community engagement in MAPP will go beyond gathering community voice to creating a community-owned agenda by recognizing the role of power imbalances and developing community power.
- **Health equity data informed action:** Promote collection of health equity data and disaggregating to identify inequities across all communities to ensure targeted action.

- **Full-spectrum action**: Facilitate actions ranging from individual services to structural change and promote both transaction approaches which work from within existing structures to address issue-specific efforts, such as food insecurity or poverty relief[19,20,21], and transformational approaches which work across institutions to shift values and political will to permanently alter the way that systems and institutions operate, impacting multiple issues." [22,23,24]

Community Engagement

Any process like MAPP that is aimed at health equity must include community engagement as a cornerstone. There is a growing expectation across communities historically excluded from decision making that they should not only be engaged in decision making that directly impacts them, but also in designing solutions to improve their communities. In the absence of authentic community engagement, improvement efforts are less likely to meet actual needs, honor community identity, or leverage existing strengths and resources. If done without caution, attempts at community engagement may lead to harm by further perpetuating inequity, frustrating community members, squandering of resources that do not address actual needs, stigmatization, imposing trauma, and mistrust. While the case for community engagement is clear and has been communicated as a core tenet of MAPP, the actual practice remains unclear to practitioners. Historical MAPP training and resources did not clearly define community engagement and the MAPP evaluation revealed it as one of the most frequently requested areas for additional guidance.

> **"… participation without the redistribution of power is an empty and frustrating process for the powerless. It allows powerholders to claim that all sides were considered, but it makes it possible for only some of those sides to benefit. It maintains the status quo." — Sherry Arnstein**

The CDC defines **community engagement** as *"the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people."*[25] Community engagement efforts have been primarily focused on gathering input or one-way communication which infrequently translates to action. Authentic community engagement cannot happen without addressing power imbalances that have historically excluded marginalized communities and groups of people from decisioning making and control over programs, policies, and decisions that directly impact them.

Exercising community engagement must involve **community power building**, which is *"a set of strategies used by communities most impacted by structural inequity to develop, sustain and grow an organized base of people who act together through democratic structures to set agendas, shift public discourse, influence who makes decisions and cultivate ongoing relationships of mutual accountability with decision-makers that change systems and advance health equity.*[26]

To integrate community engagement more fully into MAPP, NACCHO is informally adopting Arnstein's Ladder of Citizen Control,[27] which defines community engagement efforts across a spectrum from non-participation to citizen power. MAPP guidance will provide a framework for assessing current levels of community engagement and offer concrete strategies for increasing the community's power to set its own agenda in the MAPP process.

Specific guidance will include community power building, cultivating community trust, honoring community culture, responsible and transparent use of data, and working with community organizing agencies for base building. This includes a set of diverse strategies to support community members to be in a relationship with one another; invest in each other's leadership; share a common identify shaped by similar experiences and an understanding of the root causes of their conditions; and to use their collective analysis to create solutions and strategize to achieve them.[28]

MEETING FIELD NEEDS: MAPP RE-DESIGN SOLUTIONS

Extensive field feedback on MAPP user needs was collected through both the MAPP evaluation and evolution process from multiple user groups with a focus on big city, rural and Tribal health departments, the healthcare sector, including hospital systems and health centers, and MAPP coordinators. These data were triangulated, and the following themes emerged describing limitations of MAPP and desired revisions to the framework. Field needs outlined in Figure 2 here were used to identify MAPP re-design solutions and drive the proposed revisions to MAPP phases and assessments.

Figure 2: MAPP Field Needs and Re-design Solutions

Field Needs	MAPP Re-design Solutions
Simplified Process *Simplified process to address issues with perceived complexity of the process. Specifically, all user groups highlighted the LPHSA as lengthy, redundant, and complex.*	• Reduced number of MAPP phases from six to three • New, more streamlined assessments (reduced from four to three) • LPHSA replaced with a simpler, more inclusive, and equity focused Community Partners Assessment
Adaptable Process *Adaptability to a community's unique needs based on resources, experience, and context.*	• Starting Point Assessment diagnosing CHI readiness across domains such as resources, partnerships, data infrastructure, and health equity. • Tailored pathways for CHI based on a community's starting point.
Flexible and Responsive Timeline *Due to requirements across sectors, communities repeat all six MAPP phases and four assessments every 3-5 years which leads to redundancy, burnout across partners, outdated information, depletion of resources, and delayed response to emerging needs. There is a need to shift from discrete 3-5 year CHI cycles to ongoing and continuous improvement.*	• Abandon discrete and repetitive MAPP cycles • Embed principles of continuous learning and improvement into the assessments which will be updated as data become available. • Integrate continuous quality improvement to make ongoing, small-scale improvements on long-range CHIP priorities.
Partner Engagement Guidance *Partnerships are foundational to MAPP, however; additional structure and guidance was most frequently requested throughout the MAPP evolution process to address challenges including the need for jargon-free communications, engaging non-traditional partners, and sustaining partnerships through the action cycle.*	• Explicit steps for trust building integrated throughout phases • A strategic collaboration and alignment tool will match partner resources and missions with CHI needs • Assessment of partnership strength and assets in Phase 1 to strategically guide partner engagement through Phases 2 and 3. • Jargon-free communication tools
Community Engagement Guidance *Community engagement has been central to MAPP, but the actual practice remains unclear to the field. Historical guidance did not push communities beyond soliciting input to transfer power over CHI to the community. MAPP users reported negative consequences such as frustration and mistrust as community input rarely translated to action.*	• Diagnose community engagement level at the onset and offer targeted strategies for building trust and citizen control over CHI will be integrated in each step • Power analyses tools • Example CHIP strategies and actions for transferring power to the community throughout CHI process • Emphasis on working with community organizers • Community engagement tools, templates, and in-depth training

Stronger Health Equity Integration *Very few MAPP communities reported upstream action and the field reported that MAPP guidance falls short of helping broad stakeholders develop a shared understanding of health equity, utilizing data to identify health inequities, and implementing concrete actions to address inequities.*	• Conditions for integrating health equity in the CHI process will be diagnosed at the onset and targeted strategies will be suggested for moving upstream in each assessment and phase • Baseline requirements for health equity will be built into the redesign with more guidance for communities ready to move further upstream • Strategy bank for achieving health equity • Health equity communication tools, facilitation guidance, and in-depth training
Detailed CHA Guidance *Guidance in conducting the CHA including around data collection and sharing, analysis, and presentation of findings. MAPP communities underscored the need for more flexibility in conducting the CHA based on available resources.*	• Tiered guidance around conducting the assessments with guidance and consideration around data methods with varying level of rigor to accommodate communities with limited resources • Guidance, tools, formal instruments, and templates for data collection, analysis, and presentation
Moving from Assessment to Action *Communities frequently described difficulty transitioning from assessment to action*	• Assessments will be updated on an ongoing basis instead of repeating across 3-5 year cycle, allowing for more time for action • Principles of continuous quality improvement will be embedded across all phases
Structure for Shared Measurement *Communities infrequently reported establishing shared measurement structures, with evaluation being one of the most frequently skipped steps of historical MAPP. Further, CHIP implementation often falls to the health department or a select few community partners.*	• Structures and tools for linking community indicators in the CHA to long and short-term outcomes, and process measures • Tools for delineating organizational specific metrics from shared metrics • Explicit guidance on a shared data dashboard
In-depth Training and Guidance Across Topics *More advanced training for experienced communities and in-depth trainings focused on skills building.*	• Comprehensive guides, formal instruments, and adaptable templates for conducting each phase • Revised MAPP 101 training and series of training on advanced topics including health equity, facilitation, CHAs, and community engagement

THE REVISED MAPP PHASES

NACCHO proposes shifting from a six phase MAPP process to three phases with more structured steps to address field challenges in integrating health equity into CHI processes, authentic community engagement, sustained partner engagement, and shifting from assessment to action and impact. **Figure 3** illustrates concepts from previous phases are being maintained but streamlined. The revised phases are summarized below:

Phase 1: Build the CHI Foundation

This phase sets the stage for the MAPP collaborative with a heavy emphasis and guidance around building strategic relationships with new and existing partners. This involves an analysis of the power and influence of various stakeholders to strategically develop the MAPP leadership structures and stakeholder engagement throughout the process. This will also involve cultivating a common understanding of the mission and vision of the MAPP collaborative and the foundational principles of MAPP, including health equity concepts. Further, this phase involves a formal "starting point" assessment of current CHI infrastructure across pre-defined domains to strategically scope the MAPP process based on readiness and resources, and to evaluate and improve the MAPP process and its impact on health equity over time.

Phase 2: Tell the Community Story

Formerly Phase 3: Conduct the MAPP Assessments, this phase results in a comprehensive, accurate, and timely community assessment of health and well-being. The revisions maintain the need for data and information from several perspectives including qualitative and quantitative. However, the revisions add a greater emphasis on understanding health inequities. This phase will also be more ongoing to ensure a more accurate picture of the community and more timely and responsive action. To streamline the assessments, *Forces of Change* from the historical framework have been integrated across all three revised MAPP assessments which are further detailed in the next section.

Figure 3: Alignment Across Revised and Historical MAPP Phases

Historical MAPP Framework	Revised MAPP Framework
Phase 1: Organize for Success Phase 2: Visioning	Phase 1: Build the CHI Foundation
Phase 3: Conduct the Assessments • Community Health Status • Local Public Health System • Community Themes and Strengths • Forces of Change	Phase 2: Tell the Community Story • Community Status • Community Partner • Community Context
Phase 4: Identify Strategic Issues Phase 5: Develop Goals & Strategies Phase 6: The Action Cycle	Phase 3: Continuously Improve the Community

Phase 3: Continuously Improve the Community

This phase incorporates ***Phases 4-6*** of the historical framework and maintains the emphasis on addressing upstream priorities but offers structured steps around taking health equity action through attention to both transactional and transformational approaches. With an emphasis on strategic partnerships for sustained action, this phase integrates power analyses and partner profiles to appropriately engage those partners best positioned to address inequity as it relates to each CHIP goal. This phase also employs methods of continuous quality improvement and rapid cycle improvement to promote sustained, data-driven action which allows for building an evidence base through small-scale improvements on existing strategies and small-scale testing on new, innovative strategies for health equity action. Further, this phase provides a framework for establishing a shared measurement structure across partners to monitor and evaluate short and long-term impact on CHIP priorities.

These phases are not final and will be subject to revisions based on broad field feedback and pilot testing. **Figure 4** below outlines in detail steps in each phase of the process.

Figure 4: The Revised MAPP Phases *(*indicates new step)*		
Phase 1: Build the CHI Foundation	**Phase 2: Tell the Community Story**	**Phase 3: Continuously Improve the Community**
Decide to Conduct MAPP 2.0 *Assess needs against MAPP 2.0 process and foundational principles.*	**Form the Assessment Design Team** *Recruit a team that represents the community and has expertise to coordinate the assessments.*	**Prioritize Issues for CHIP** *Prioritize top issues for the CHIP based on community voice, assets, impact potential, and other criteria.*
Lead Agency Conducts Initial power analysis * *Analyze stakeholder power and impact of CHI.*	**Design the Assessments** *Select priority indicators, identify methods, develop instruments, and ensure proper administration.*	**Conduct Power Analysis on Each Issue *** *Assess people and institutions that influence the issues to inform who to engage and how.*
Establish/Revisit CHI Leadership Structures *Identify CHI Core and Steering Committees*	**Conduct the Community Partners Assessment (*heavily revised)** *Assess partners to highlight opportunities to address health determinants and inequities.*	**Establish Priority Issue Sub-Committees** *Partners and community members self-identify for Priority Issue Sub-committees based on assets/skills/experience. Committee chairs join the CHI Leadership structures.*
Engage and Orient Leadership Committees *Onboard to establish baseline understanding of CHI, health equity, and community engagement.*	**Conduct the Community Status Assessment** *Quantitatively describe status of community.*	**Create Community Partner Profiles *** *Each partner completes a Partner Profile worksheet to demonstrate alignment of organizational mission, current work, priority issues, and community indicators.*
Define Community and Develop the CHI Mission * *Define the community and how each target population will benefit. Develop mission statement for the CHI coalition/collaborative.*	**Conduct the Community Context Assessment** *Explore lived experience and historical and structural context for inequities.*	**Develop Shared Goals and Long-Term Measures** *Sub-committees develop shared long-term goals for transformational change to achieve vision.*
Develop a Community Vision *Develop a long-range vision which imagines transformative change where all community members have the opportunity for health and well-being.*	**Present Data to Community and identify top issues** *Present data to the community and collectively select top issues.*	**Develop Strategies and Conduct (Racial) Equity Impact Assessment as Appropriate *** *Members identify new short-term, transactional strategies tailored to needs of specific populations.*

Conduct a Starting Point Assessment * *Diagnose community's CHI starting point across: QI on last cycle, partnerships, CHI infrastructure, community engagement, health equity, and leadership support.*	**Develop Issue Profiles through Root Cause Analysis *** *Discuss the findings and develop top Issue Profiles to identify root causes, community indicators and strategies to address them.*	**Continuous Quality Improvement Action Planning Cycles *heavily revised** *Modeling PDSA cycles, develop SMART objectives, action plans, and metrics to monitor progress and prepare for CQI.*
Identify CHI Infrastructure Scope and Develop CHI Plan *Scope and plan the CHI process and identify priorities to strengthen CHI infrastructure. Includes strategies to improve community engagement and move further upstream.*	**Disseminate Community Assessment Findings** *Develop and disseminate a Community Assessment Report to share findings.*	**Ongoing Monitoring and Evaluation of CHIP** *Develop centralized data dashboard to monitor CHIP and workgroup progress. All partners contribute to updating data. Evaluate CHIP implementation impact every 3-5 years.*
Coordinate CHI Infrastructure Workgroups * *Across phases workgroups will build and evaluate critical elements of CHI infrastructure such as data capacity, broadening funding and resources, evaluation, partner engagement, and health equity and community engagement.*		

THE REVISED MAPP ASSESSMENTS

Community Status Assessment

The Community Status Assessment largely aligns with MAPP's former Community Health Status Assessment and quantitatively describes the community, including demographics, health status, contributing factors (e.g., SDOH), health equity indicators, and across all these variables, existing inequities. Forces of change in the community are explored through a trend analysis of indicators over time to understand things like demographic shifts, unemployment rates, or insurance coverage. This foundational assessment also elucidates both data gaps and inequities that need to be further explored through additional assessments. Although this assessment is largely similar to the former version, specific changes being made include dropping the term "health" to emphasize the need to go beyond health indicators to understand contributing factors and root causes such as civic participation, predatory lending, and mass incarceration; tiered guidance for data collection methods with varying levels of rigor to meet communities where they are; a recommended list of indicators; and a compendium of secondary data sources. Informed by field feedback, NACCHO will offer guidance to adopt more ongoing and iterative assessment processes that are timely and build on, rather than repeat, past assessments. In cases where granular data are not available for sub-populations, particularly those that have been historically marginalized, guidance will be offered on how to gather data to better understand health status and its determinants through other assessments.

Community Partners Assessment

Replacing the LPHSA, the Community Partners Assessment provides structure for all community partners to look critically within their own systems and processes, reflect on their role in the community's health and well-being, and understand the degree to which they are addressing or perpetuating health inequities across a spectrum of action ranging from the individual to systemic and structural levels. It will offer an assessment instrument which, in contrast to the LPHSA, will be inclusive of but not be grounded in the 10 Essential Public Health Services to broaden its relevance to community partners outside health and human service sectors. This assessment includes the following domains:

- **Health Equity Capacity:** Assesses each partner's understanding and commitment to health equity and related concepts, their role in addressing inequities, and analysis of existing interventions, programs, and services across a spectrum of action including individual, organizational, systemic, and structural level. These results can be used to assist each partner in identifying opportunities to move upstream in their own work and identify gaps across the spectrum that may be addressed through the CHIP.
- **Community Engagement:** Assesses each partner's relationship with, and relative power in, the community (e.g., history of allyship or mistrust); success in meeting community needs; and opportunities for the community to participate in shaping programs, services, or other activities designed to help them. These results can be used to transfer power to those historically excluded from decision making.
- **Resources:** Assesses partner resources to meet community needs and how those resources are aligned to meet the needs of specific sub-populations. This data may inform decisions around funding and realigning resources to better meet the needs of those experiencing inequities.
- **Community Linkages:** Assesses capacity to coordinate and align with other partners and stakeholders within the community system to improve overall quality, efficiency, and effectiveness of programs, services, and interventions to address inequities. Also assesses how partners are building allies and networks with those holding power. These results may be used to identify gaps or opportunities to make improvements to the community system at large.
- **Leadership:** Assesses each partner's leadership support around both achieving equity as it relates to their mission and participation in the MAPP process. Results of this assessment may assist each partner to strengthen its position in the community to achieve its mission from an equity and CHI lens.

- **Workforce:** Each partner assesses whether their respective workforce is skilled, sufficient, and representative of community demographics to meet community needs and address inequities.
- **Policy Analysis:** Assesses each partner's internal organizational policies from an equity lens, and public policies which support or impede its ability to impact inequities in the community. These results can be used to identify concrete strategies for organizational, community, and public policy level change.
- **Data Access and Systems:** Inventories available assessments and data available across partners that may inform and contribute to the larger CHA; explores opportunities for data sharing and transparency across the community; and assesses each partner's data infrastructure for ongoing monitoring and evaluation to track its own impact on inequities and identify opportunities for shared measurement and evaluation in the CHI process.
- **Forces of Change:** Provides a structure for each partner to reflect on the forces of change (e.g., disease outbreaks/public health emergencies, political climate, market shifts, funding) impacting its work and future scenario planning to identify the specific set of uncertainties of what may happen in the future. These results may be used to plan for different realities to enhance adaptability and preparation for most effectively building community resilience.

Results of this assessment are designed to be compiled across all sectors and triangulated with the other two MAPP assessments to take a community-wide approach to address SDOH and root causes of inequity through the CHIP.

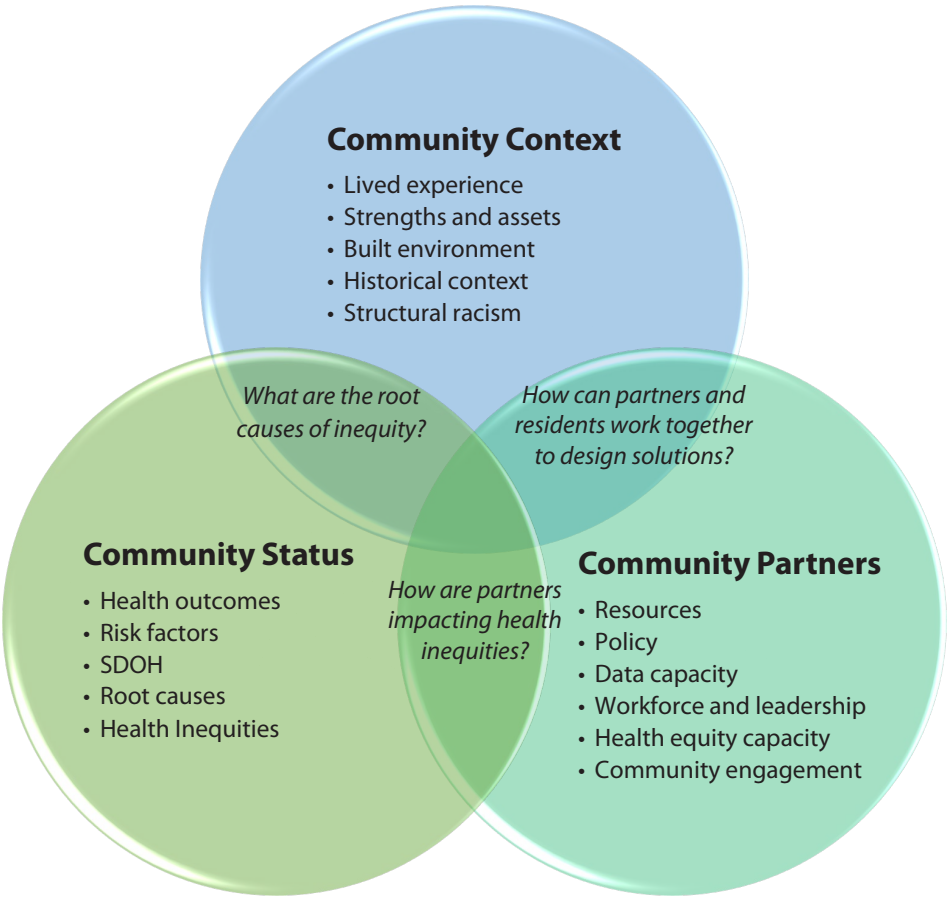
Community Context Assessment

A community context assessment provides rich perspectives and strengths-based data from those with lived experience, as well as a deep analysis of historical, systemic, and structural information which elucidate the root causes of inequity. The Community Context Assessment builds on MAPP's former Community Themes and Strengths Assessment, digging deeper to understand the inequities identified in the Status Assessment, fill in data gaps, and explore the context of the community through the lens of those with lived experience. This assessment will be designed to move beyond perceived community needs and perpetuation of dependency on programs and services to understanding a community's strengths, assets, and culture, recognizing that all communities have a vibrancy that must be leveraged in community improvement. This assessment will also intersect with the Community Partners Assessment, highlighting how community members may work with partners to co-design and implement solutions. Further, this assessment will explore historical policies, events, and other societal structures that have shaped the community and offer insight into what created the inequities in the first place. Specific domains assessed include:

- **Lived Experience:** The perceptions, insights, values, culture and priorities of those experiencing inequities
- **Community Member Strengths:** Strengths and assets possessed by community members (e.g., skills, education, job experience)
- **Built Environment:** Asset mapping of the built environment within neighborhoods experiencing the greatest inequities (e.g., public transit, complete streets, library)
- **Forces of Change:** Exploration of forces of change and how they impact communities through the lens of those with lived experience (e.g., factory closing, political climate)
- **Historical and Structural Oppression Analysis:** Research of the community's history to understand the institutional and structural root causes of inequities (e.g., redlining, segregation) and existing systems and policies that perpetuate the inequities.

All three assessments should not be viewed as discrete but interconnected, resulting in a more comprehensive picture of the community system that informs action in ***Phase 3: Continuously Improve the Community***. Examining data from each assessment will ensure that findings are not biased toward one perspective and protect against quantitative data overriding the voice of the community. Guidance will be provided in the MAPP redesign to assist communities in triangulating data to ensure data driven CHIP priorities.

Figure 5 visualizes the overlap across assessments and how elimination of any assessment would leave gaps in important insights needed for action.

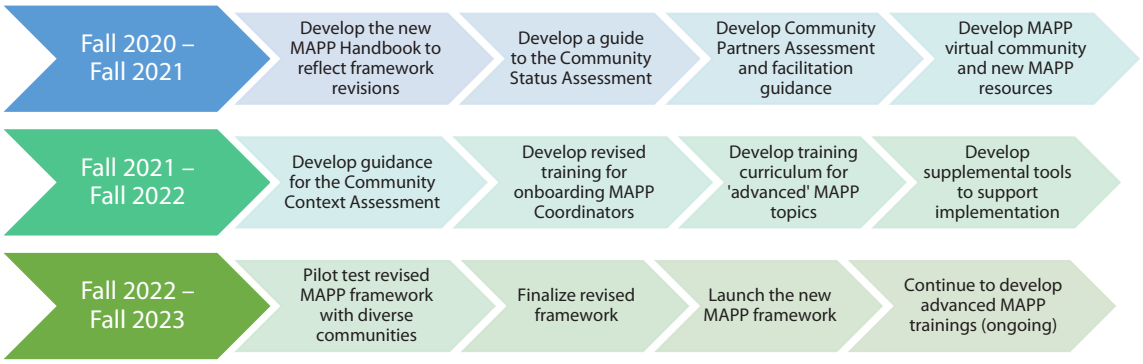


MAPP EVOLUTION: WHAT TO EXPECT NEXT

Through Fall 2022, NACCHO intends to engage the field in the Design phase of the MAPP evolution process, which will involve redesigning the MAPP phases and assessments as outlined above, along with trainings, resources, and supports to ensure the field is equipped for successful implementation. Following the design phase, NACCHO intends to pilot test the new framework between Fall 2022–Fall 2023 prior to its launch. A high-level summary of next steps is presented in **Figure 6.** As NACCHO progresses through the Design phase, it remains committed to providing ample opportunity to the field to give feedback, stay informed, and pilot test materials as they are developed. NACCHO encourages communities to move forward with their MAPP and CHI processes as the redesign is moving forward as this important work cannot be put on hold. Throughout the MAPP evolution process, NACCHO is committed to supporting communities in implementation of the current framework, offer

improvement opportunities through our learnings from MAPP evolution, and ongoing updates on progress as the revisions move forward. By Summer 2021, NACCHO intends to launch a MAPP Virtual Community to facilitate peer learning and support across communities.

Figure 6: MAPP Evolution Next Steps*



*This anticipated timeline may change, based upon funding and the content development process.

This action plan is based on the best knowledge NACCHO has to date of field needs and anticipated funding to redesign and deliver the framework. As NACCHO continues to collect field feedback and secure additional funding, specific timelines or products may shift over the years.

If you have questions or would like to inform the MAPP redesign, please e-mail NACCHO staff at pi@naccho.org.

REFERENCES

[1] Institute of Medicine. 1988. The Future of Public Health. Washington, DC: The National Academies Press. https://doi.org/10.17226/1091.

[2] Internal Revenue Service. Requirements for 501©(3) Hospitals Under the Affordable Care Act – Section 501(r). 2019. Accessed: https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r.

[3] Health Resources Services Administration: Health Center Program. Chapter 3: Needs Assessment. 2018. Accessed: https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-3.html.

[4] Public Health Accreditation Board. PHAB Standards and Measures Version 1.5. 2013. Accessed: http://www.phaboard.org/wp-content/uploads/SM-Version-1.5-Board-adopted-FINAL-01-24-2014.docx.pdf.

[5] Centers for Disease Control and Prevention. Local Public Health System Performance Assessment Instrument. 2013. Accessed: https://www.cdc.gov/od/ocphp/nphpsp/documents/07_110300%20Local%20Booklet.pdf.

[6] Price-Haywood EG, Burton J, Fort D, Seoane L. Hospitalization and mortality among black patients and white patients with Covid-19. N Engl J Med 2020;382:2534-2543.

[7] Hooper MW, Nápoles AM, Pérez-Stable EJ. COVID-19 and racial/ethnic disparities. JAMA Network. May 11, 2020. Access: https://jamanetwork.com/journals/jama/fullarticle/27660983.

[8] Human Impact Partners. Public Health Guidance for Organizing in the Time of COVID-19. 2020. Access: https://humanimpact.org/hipprojects/public-health-guidance-for-organizing-in-the-time-of-covid-19/?strategy=all.

[9] Public Health Innovation Center. Celebrating 25 Years and Launching the Revised 10 Essential Public Health Services. 2020. Access: https://phnci.org/national-frameworks/10-ephs.

[10] Public Health Accreditation Board. PHAB Standards and Measures Version 2.0. 2020. Access: https://phaboard.org/version-2-0/.

[11] U.S. Department of Health and Human Services. How has Healthy People Changed? 2020. Access: https://health.gov/healthypeople/about/how-has-healthy-people-changed.

[12] Jones, Camara. (2018). Toward the Science and Practice of Anti-Racism: Launching a National Campaign Against Racism, Ethnicity & Disease 28 (supplement 1): 231-234.

[13] Kindig D, Asada Y, Booske B. (2008). A population health framework for setting national and state health goals. JAMA, 299, 2081-2083.

[14] Whitehead, M. (1992). The concepts and principles of equity and health. International Journal of Health Services, 3, 429.

[15] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Washington (DC): National Academies Press (US); 2017 Jan 11.

[16] NACCHO. Roots of Health Inequity Webcourse. (ND). Unit 4: Root Causes. http://rootsofhealthinequity.org/.

[17] VeneKlasen, L, Miller V. (2002). A new weave of power, people & politics: The action guide for advocacy and citizen participation. Oklahoma city: World Neighbors, 2002. Accessed: http://intergroupresources.com/rc/RESOURCE%20CENTER/OWEN'S%20CATEGORIZATION%20OF%20RC/5%20-%20Primers%20&%20additional%20resources/5f-%20Power/dynamics%20of%20power.pdf.

[18] Lead Local. Lead Local Glossary. Retrieved October 20, 2020. Access: https://www.lead-local.org/glossary.

[19] Human Impact Partners. (2019). Changing internal practices to advance heath equity. Accessed: https://healthequityguide.org/wp-content/uploads/2019/10/HIP-RegV-PHTC-Webinar.pdf.

[20] Othering and Belonging Institute. (nd). Transactional vs. transformation change. Accessed: https://belonging.berkeley.edu/transactional-versus-transformative-change.

[21] Multnomah County Office of Diversity and Equity. (2014). Foundational assumptions of the equity and empowerment lens logic model. Accessed: https://multco.us/diversity-equity/equity-and-empowerment-lens.

[22] Human Impact Partners. (2019). Changing internal practices to advance heath equity. Accessed: https://healthequityguide.org/wp-content/uploads/2019/10/HIP-RegV-PHTC-Webinar.pdf.

[23] Othering and Belonging Institute. (nd). Transactional vs. transformation change. Accessed: https://belonging.berkeley.edu/transactional-versus-transformative-change.

[24] Multnomah County Office of Diversity and Equity. (2014). Foundational assumptions of the equity and empowerment lens logic model. Accessed: https://multco.us/diversity-equity/equity-and-empowerment-lens.

[25] Centers for Disease Control and Prevention. (1997). Principles of Community Engagement 2nd Edition.

[26] Lead Local. Lead Local Glossary. Retrieved October 20, 2020. Access. https://www.lead-local.org/glossary.

[27] Sherry R. Arnstein (1969) A Ladder Of Citizen Participation, Journal of the American Institute of Planners, 35:4, 216-224.

[28] Lead Local. Lead Local Glossary. Retrieved October 20, 2020. Access. https://www.lead-local.org/glossary.

The mission of the National Association of County and City Health Officials (NACCHO) is to improve the health of communities by strengthening and advocating for local health departments.

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2021 COMMUNITY HEALTH-NEEDS ASSESSMENT SURVEY

INSTRUCTIONS

We want to know how you view our community, and other factors that may impact your health. We are inviting you to participate in a research study about community health needs. Your opinions are important! This survey will take about 12 minutes to complete. All of your individual responses are confidential. We will use the survey results to better understand and address health needs in our community.

COMMUNITY PERCEPTIONS

1. What would you say are the three (3) biggest **HEALTH ISSUES** in our community?

- ☐ Aging issues, such as Alzheimer's disease, hearing loss, memory loss, arthritis, falls
- ☐ Cancer
- ☐ Chronic pain
- ☐ Dental health (including tooth pain)
- ☐ Diabetes
- ☐ Early sexual activity
- ☐ Heart disease/heart attack
- ☐ Mental health issues (including depression, anger)
- ☐ Obesity/overweight
- ☐ Sexually transmitted infections
- ☐ Viruses (including COVID-19)

2. What would you say are the three (3) most **UNHEALTHY BEHAVIORS** in our community?

- ☐ Angry behavior/violence
- ☐ Alcohol abuse
- ☐ Child abuse
- ☐ Domestic violence
- ☐ Drug abuse (illegal drugs)
- ☐ Drug abuse (legal drugs)
- ☐ Lack of exercise
- ☐ Poor eating habits
- ☐ Risky sexual behavior
- ☐ Smoking/vaping (tobacco use)

3. What would you say are the three (3) most important factors that would improve your **WELL-BEING**?

- ☐ Access to health services
- ☐ Affordable healthy housing
- ☐ Availability of child care
- ☐ Better school attendance
- ☐ Good public transportation
- ☐ Healthy food choices
- ☐ Job opportunities
- ☐ Less hatred & more social acceptance
- ☐ Less poverty
- ☐ Less violence
- ☐ Safer neighborhoods/schools

ACCESS TO CARE

The following questions ask about your own health and health choices. Remember, this survey will not be linked to you in any way.

Medical Care

1. When you get sick, where do you go? (Please choose only one answer).

- ☐ Clinic/Doctor's office
- ☐ Urgent Care Center
- ☐ Emergency Department
- ☐ Health Department
- ☐ I don't seek medical attention
- ☐ Other

If you don't seek medical attention, why not?

- ☐ Fear of Discrimination
- ☐ Lack of trust
- ☐ Cost
- ☐ I have experienced bias
- ☐ Do not need

2. In the last YEAR, was there a time when you needed medical care but were not able to get it?

- ☐ Yes (please answer #3)
- ☐ No (please go to #4: Prescription Medicine)

3. If you were not able to get medical care, why not? (Please choose all that apply).

☐ Didn't have health insurance.
☐ Too long to wait for appointment.
☐ Couldn't afford to pay my co-pay or deductible.
☐ Didn't have a way to get to the doctor.
☐ Fear of discrimination.
☐ Lack of trust.

Prescription Medicine

4. In the last YEAR, was there a time when you needed prescription medicine but were not able to get it?

☐ Yes (please answer #5)
☐ No (please go to #6: Dental Care)

5. If you were not able to get prescription medicine, why not? (Please choose all that apply).

☐ Didn't have health insurance.
☐ Pharmacy refused to take my insurance or Medicaid.
☐ Couldn't afford to pay my co-pay or deductible.
☐ Didn't have a way to get to the pharmacy.
☐ Fear of discrimination.
☐ Lack of trust.

Dental Care

6. In the last YEAR, was there a time when you needed dental care but were not able to get it?

☐ Yes (please answer #7)
☐ No (please go to #8: Mental-Health Counseling)

7. If you were not able to get dental care, why not? (Please choose all that apply).

☐ Didn't have dental insurance.
☐ The dentist refused my insurance/Medicaid
☐ Couldn't afford to pay my co-pay or deductible.
☐ Didn't have a way to get to the dentist.
☐ Fear of discrimination
☐ Lack of trust
☐ Not sure where to find available dentist

Mental-Health Counseling

8. In the last YEAR, was there a time when you needed mental-health counseling but could not get it?

☐ Yes (please answer #9)
☐ No (please go to next section – HEALTHY BEHAVIORS)

9. If you were not able to get mental-health counseling, why not? (Please choose all that apply).

☐ Didn't have insurance.
☐ The counselor refused to take insurance/Medicaid.
☐ Couldn't afford to pay my co-pay or deductible
☐ Embarrassment.
☐ Didn't have a way to get to a counselor.
☐ Cannot find counselor.
☐ Fear of discrimination
☐ Lack of trust.
☐ Long wait time

HEALTHY BEHAVIORS

The following questions ask about your own health and health choices. Remember, this survey will not be linked to you in any way.

Exercise

1. In the last WEEK how many times did you participate in exercise, (such as jogging, walking, weight-lifting, fitness classes) that lasted for at least 30 minutes?

☐ None (please answer #2) ☐ 1 – 2 times ☐ 3 - 5 times ☐ More than 5 times

2. If you answered "none" to the question about exercise, why didn't you exercise in the past week? (Please choose all that apply).

☐ Don't have any time to exercise.
☐ Don't like to exercise.
☐ Can't afford the fees to exercise.
☐ Don't have child care while I exercise.
☐ Don't have access to an exercise facility.
☐ Too tired.
☐ Safety issues

Healthy Eating

3. On a typical DAY, how many **servings/separate portions** of fruits and/or vegetables did you have? An example would be a banana (but not banana flavored pudding).

☐ None (please answer #4) ☐ 1 - 2 servings ☐ 3 - 5 servings ☐ More than 5 servings

4. If you answered "none" to the questions about fruits and vegetables, why didn't you eat fruits/vegetables? (Please choose all that apply).

☐ Don't have transportation to get fruits/vegetables
☐ Don't like fruits/vegetables
☐ It is not important to me
☐ Can't afford fruits/vegetables
☐ Don't know how to prepare fruits/vegetables
☐ Don't have a refrigerator/stove
☐ Don't know where to buy fruits/vegetables

5. Where is your primary source of food? (Please choose only one answer).

☐ Grocery store ☐ Fast food ☐ Gas station ☐ Food delivery program
☐ Food pantry ☐ Farm/garden ☐ Convenience store ☐ Other_____

6. Please check the box next to any of the health conditions that you have. (Please choose all that apply).
If you don't have any health conditions, please check the first box and go to question #8: Smoking.

☐ I do not have any health conditions ☐ Diabetes ☐ Mental-health conditions
☐ Allergy ☐ Heart problems ☐ Stroke
☐ Asthma/COPD ☐ Overweight
☐ Cancer ☐ Memory problems

7. If you identified any conditions in Question #6, how often do you follow an eating plan to manage your condition(s)?

☐ Never ☐ Sometimes ☐ Usually ☐ Always

Smoking

8. On a typical DAY, how many cigarettes do you smoke?

☐ None ☐ 1 - 4 ☐ 5 - 8 ☐ 9 - 12 ☐ More than 12

Vaping

9. On a typical DAY, how many times do you use electronic vaping?

☐ None ☐ 1 - 4 ☐ 5 - 8 ☐ 9 - 12 ☐ More than 12

GENERAL HEALTH

10. Where do you get most of your health information and how would you like to get health information in the future? (For example, do you get health information from your doctor, from the Internet, etc.). _____

11. Do you have a personal physician/doctor? ☐ Yes ☐ No

12. How many days a week do you or your family members go hungry?
☐ None ☐ 1–2 days ☐ 3-5 days ☐ More than 5 days

13. In the last 30 DAYS, how many days have you felt depressed, down, hopeless?
☐ None ☐ 1–2 days ☐ 3 – 5 days ☐ More than 5 days

14. In the last 30 DAYS, how often has your stress and/or anxiety stopped you from your normal daily activities?
☐ None ☐ 1–2 days ☐ 3 - 5 days ☐ More than 5 days

15. In the last YEAR have you talked with anyone about your mental health?
☐ Yes (please answer #16) ☐ No (please go to #17)

16. If you talked to anyone about your mental health, who was it?
☐ Doctor/nurse ☐ Counselor ☐ Family/friend ☐ Other _____

17. How often do you use prescription medications not prescribed to you or differently than how the doctor instructed on a typical DAY?
☐ None ☐ 1–2 times ☐ 3-5 times ☐ More than 5 times

18. How many alcoholic drinks do you have on a typical DAY?
☐ None ☐ 1–2 times ☐ 3-5 times ☐ More than 5 times

19. How often do you use marijaunia on a typical DAY?
☐ None ☐ 1–2 times ☐ 3-5 times ☐ More than 5 times

20. How often do you use substances such as inhalants, ecstasy, cocaine, meth or heroin on a typical DAY?
☐ None ☐ 1–2 times ☐ 3-5 times ☐ More than 5 times

21. Do you feel safe where you live? ☐ Yes ☐ No

22. In the past 5 years, have you had a:

Breast/mammography exam	☐ Yes	☐ No	☐ Not applicable
Prostate exam	☐ Yes	☐ No	☐ Not applicable
Colonoscopy/colorectal cancer screening	☐ Yes	☐ No	☐ Not applicable
Cervical cancer screening/pap smear	☐ Yes	☐ No	☐ Not applicable

Overall Health Ratings

21. My overall physical health is: ☐ Below average ☐ Average ☐ Above average
22. My overall mental health is: ☐ Below average ☐ Average ☐ Above average

INTERNET

1. Do you have Internet at home? For example, can you watch Youtube at home?

☐ Yes (please go to next section – BACKGROUND INFORMATION) ☐ No (please answer #2)

2. If don't have Internet, why not? ☐ Cost ☐ No available Internet provider ☐ I don't know how
☐ Data limits ☐ Poor Internet service ☐ No phone or computer

BACKGROUND INFORMATION

1. What county do you live in?

☐ xxx ☐ Other

2. What is your Zip Code? _____

3. What type of health insurance do you have? (Please choose all that apply).

☐ Medicare ☐ Medicaid/State insurance ☐ Commercial/Employer

☐ Don't have (Please answer #4)

4. If you answered "don't have" to the question about health insurance, why **don't** you have insurance? (Please choose all that apply).

☐ Can't afford health insurance ☐ Don't need health insurance
☐ Don't know how to get health insurance ☐ Other _____

5. What is your gender? ☐ Male ☐ Female ☐ Non-binary ☐ Transgender ☐ Prefer not to answer
☐ Other_____

6. What is your sexual orientation? ☐ Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual
☐ Queer ☐ Prefer not to answer ☐ Other _____

7. What is your age? ☐ Under 20 ☐ 21-35 ☐ 36-50 ☐ 51-65 ☐ Over 65

8. What is your racial or ethnic identification? (Please choose only one answer).

☐ White/Caucasian ☐ Black/African American ☐ Hispanic/LatinX
☐ Pacific Islander ☐ Native American ☐ Asian/South Asian
☐ Multiracial ☐ Other: _____

9. What is your highest level of education? (Please choose only one answer).

☐ Grade/Junior high school ☐ Some high school ☐ High school degree (or GED)
☐ Some college (no degree) ☐ Associate's degree ☐ Certificate/technical degree
☐ Bachelor's degree ☐ Graduate degree ☐ Other: _____

10. What was your household/total income last year, before taxes? (Please choose only one answer).

☐ Less than $20,000 ☐ $20,001 to $40,000 ☐ $40,001 to $60,000
☐ $60,001 to $80,000 ☐ $80,001 to $100,000 ☐ More than $100,000

11. During the COVID pandemic, how important have financial stimulus payments been to provide stability for your family, such as stimulus checks, SNAP benefits, unemployment benefits, loan/mortage deferment, eviction protections?
☐ Not important ☐ Neutral ☐ Very important

12. What is your housing status?

☐ Do not have ☐ Have housing, but worried about losing it ☐ Have housing, **NOT** worried about losing it

13. If you answered that you have housing, does your house have:
☐ leaking roof ☐ mold ☐ heat ☐ air conditiing
☐ running water ☐ rodents ☐ lead ☐ electicity ☐ Internet

14. How many people live with you? _____

15. How often do you communicate with people you care about and feel close to? (For example, talking, texting, meeting with friends/family?)
☐ less than once per week ☐ 1–2 times per week ☐ 3 - 5 times per week ☐ More than 5 times per week

16. Prior to the age of 18, which of the following did you experience (check all that apply):
☐ Emotional Abuse. ☐ Physical Abuse ☐ Sexual Abuse ☐ Mother treated violently
☐ Substance Use in household ☐ Mental Illness in household ☐ Parental Separation or Divorce
☐ Emotional Neglect ☐ Physical Neglect ☐ Incarcerated Household Member

Is there anything else you'd like to share about your own health goals or health issues in our community?

_____

Thank you very much for sharing your views with us!

PRIORITY ACTION TEAM PROGRESS REPORT: (MH/SU Committees)

Partnership for a Healthy Community

Priority Area	MH/SU Committees
Chair or Co-Chair	Holly Bill, Tim Bromley

Description

Mental Health and Substance Use Committees continue to meet as one committee currently.

Recap of Current Month

Priority Strategy Action Teams are continuing to work and show progress. The schedule has been revised to allow Action Teams to meet more often, with the larger committee meeting every other month now instead. The committee will continue to meet virtually with two in-person meetings at PCCHD twice each year; this was decided on by committee vote.

Please consider joining the larger meetings or Action Teams if you are interested. The schedule has been posted online.

Next Meeting: Monday, September 27, @ 9:00 am – Microsoft Teams

Plan for Upcoming Month

There is no August meeting for the larger committee, but all Action Teams are meeting. Please reach out if you would like more information about these meetings.

Goals	Goals: Reduce substance use to protect the health, safety, and quality of life for tri-county residents; Improve mental health among tri-county residents through preventive strategies and increased access to services

Objectives: Please refer to data dashboards

Activities

What? (C= Completed, NP= In progress, NS= Not started)	
Decide on virtual or in-person meeting dates at 7-19 steering committee	**C**
Update website with new dates and meeting locations (7/19)	**C**
Need to determine "award" name for schools who become 'trauma-responsive'	**IP**
Need to update website to include trauma-informed trainings	**NS**

Issues/challenges

The strategy committees (suicide, trauma-informed schools, high utilizers, Mental Health First Aid, mass media campaigns for teens, Narcan, etc) just need more help; small committees taking on a lot of work. If you are able to assist in any of the strategy committees please let co-chairs know so they can connect you with the appropriate person.

HEAL Team #4 Farm to Food Bank Proof of Concept Planning Project

PURPOSE: The path of farm-to-foodbank provides an opportunity to put healthier, more nutrient-dense local food products into the hands of needing populations by working with food bank frameworks that have already established direct connections to these populations.

GOAL 1: To support the local economy and local farmers through HEAL by establishing a procurement pipeline for fresh farm produce and protein sources.

GOAL 2: To establish a procurement strategy that supports both putting more dollars into the local farm economy by creating new avenues for distribution/logistics for local produce/proteins and provides real procurement solutions for food bank buyers who can put local produce into the hands of needing populations via existing frameworks.

OUR ASK: To provide thought leadership in Heal Team #4's project to financially support the planning and implementation process of the HEAL Farm to Food Bank initiative.

Estimated Cost for Planning: $50,000.00 - $75,000.00

PROPOSED PLANNING PROCESS:

1. Evaluate the Foodbank Marketplace by evaluating buying power, marketplace capacity, understand demand (budgets), and identify product input points (menus and uses).
2. Evaluate the Farmer/Producer Landscape to identify suppliers within the preferred product groups (grains, stable vegetable products, etc..) to evaluate pricing structure, supply volumes, and understand current logistics.
3. Evaluate Distribution Channels (existing, proposed, and hybrid) by designing operational procurement models for food banks and farmers.
4. Test the Feasibility of the proposed models by creating Financial mapping for each (capacity modeling, P&L, and budget feasibility).
5. Design Implementation Pilot for the food bank

TIME FRAME: 12 months

NEXT PHASE: Implementation

HEAL TEAM #4 MEMBERS:

Amy Fox, Tazewell County Health Department
Erin Meyer, Basil's Harvest
Monica Scheuer, Midwest Food Bank
Wayne Cannon, Peoria Area Food Bank
Kaitlyn Streitmatter, U of I Extension
Kathryn Bernstein, IL Public Health Institute

PRIORITY ACTION TEAM PROGRESS REPORT: DATA TEAM

Partnership for a Healthy Community

Priority Area	Data Team
Chair or Co-Chair	Amanda Smith

Description

The data team supports the Partnership for a Healthy Community in the development and administration of the Community Health Needs Assessment Survey and provides information and decision support for Priority Action Teams. Additionally, the data team discovers insights, shares knowledge and tracks performance and progress to assist in achieving the goals and objectives identified in the Community Health Improvement Plan.

Recap of Current Month

Continue to update dashboard
Preparation for administration of CHNA survey
Report built to electronically pull suicide attempt demographic data
Continued discussion of data team's role

Plan for Upcoming Month

Identify other data sources for youth obesity
Review EPIC SDOH (food insecurity) survey and validate with other organizations
Dive into suicide attempt demographic data
CHNA survey implementation

Goal	

Objectives

What?	By When?	Measure?

Activities

What? (C= Completed, NP= In progress, NS= Not started)	
Priority team data dashboards	**NP**
Administer CHNA survey	**NS**
Data resource guide	**NP**

Issues/challenges

Guidance/definition of data team's role