Ascendant & Island County CHA Contract

Presented at CHAB

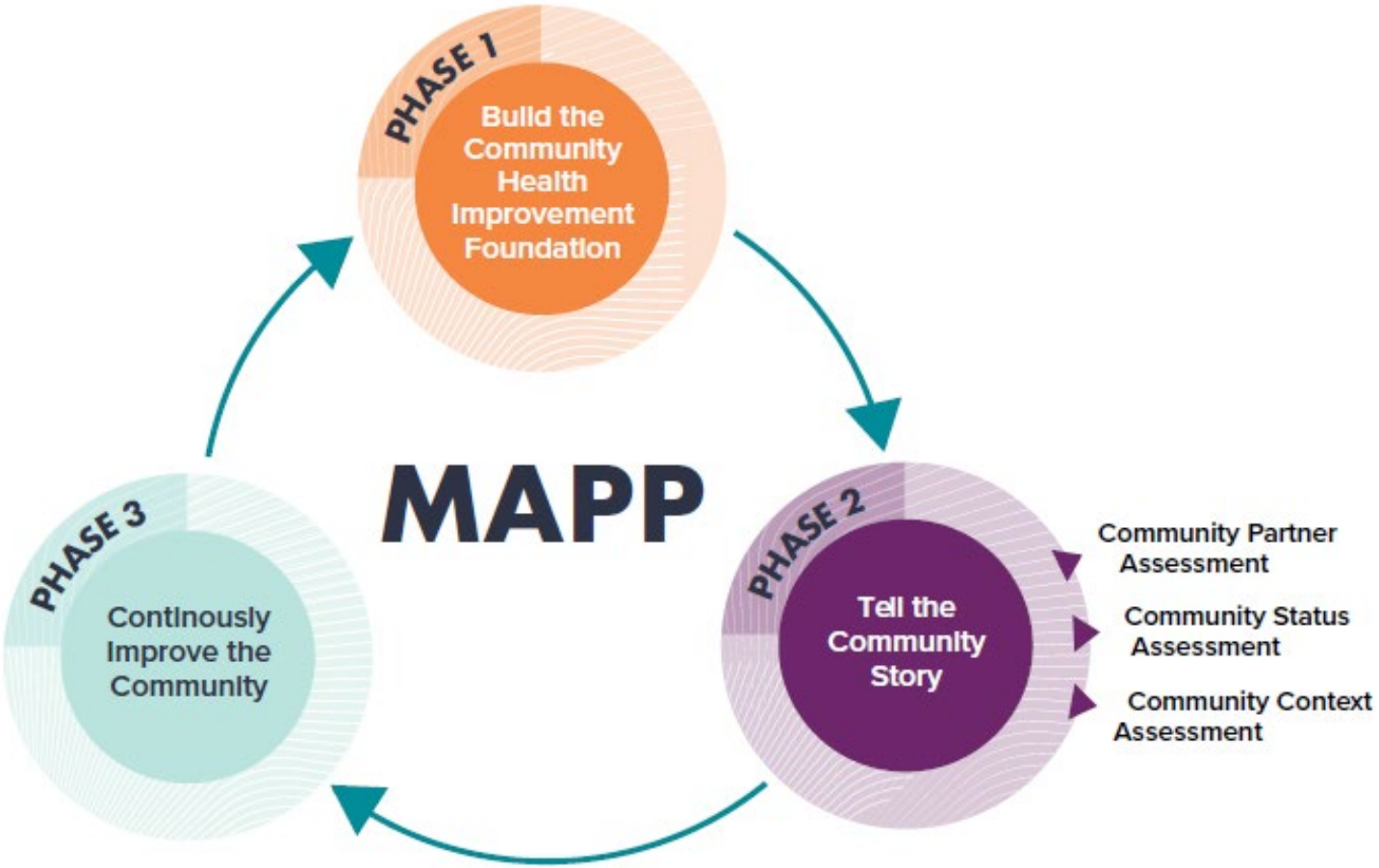
September 2023

Action Items

1. **Review materials:**
   - Community Partner List
   - Health Indicator List
   - Community Health Survey

2. **Come prepared to discuss the following questions:**
   - Who is missing from the Community Partner List?
   - Who should we prioritize from the Community Partner List?
   - What is missing from the Health Indicator List?
   - What do you think about the Community Survey?

If you'd prefer, or are unable to attend the meeting, you may also share your feedback using the Padlet discussion board: https://padlet.com/tlawson52/community-health-assessment-tools-feedback-ggtidbcsv15yieai


PHASE 1
Build the Community Health Improvement Foundation
MAPP
PHASE 2
Tell the Community Story
Community Partner Assessment
Community Status Assessment
Community Context Assessment
PHASE 3
Continously Improve the Community

Phase 1: Build the MAPP Structure

- Establish and support the success of our Community Health Advisory Board (CHAB)
- Advertise, recruit, and host the Community Health Assessment Team (CHAT)
- Solicit support and participation from Island County Public Health leadership

We will often refer to CHAB & Island County Public Health Leadership as the "Core Team" or "MAPP Core Team."

Phase 1: Build the CHIP Structure

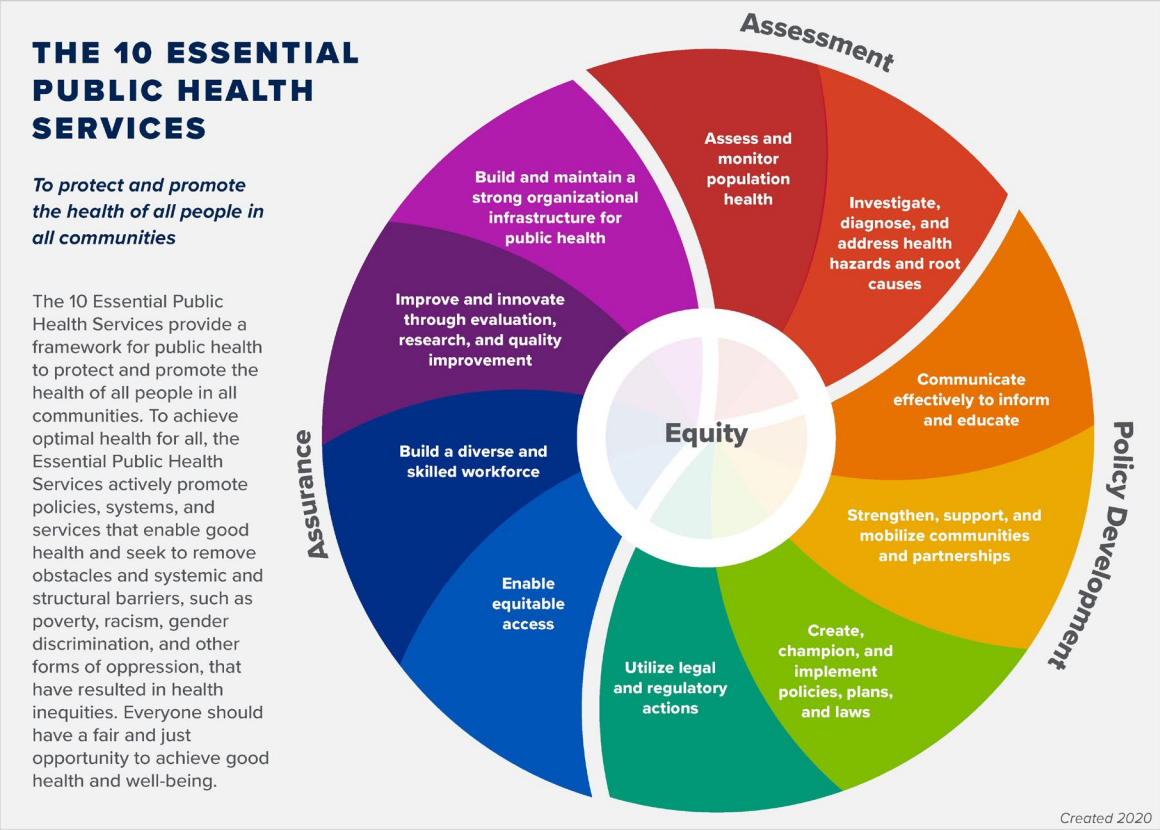
- Currently 13 CHAB members
- Hosted two (2) CHAT meetings to orient participants to the MAPP framework, as well as future and past Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP).
- Regular updates to Public Health Leadership via email and meetings, ongoing participation in CHAB/CHAT meetings
- Alignment with Comprehensive Plan Updates

Phase 2: Tell the Community Story

- Ascendant Healthcare Partners to support the completion of each of the assessments to help us Tell the Community Story
- CHAB and Public Health Leadership will act as the decision makers every step of the way
- CHAT will provide feedback and supporting outreach activities to engage our community

Community Partner Assessment

Partners from the county's local public health system will participate in a survey on their involvement in community health. The partners will convene to discuss the survey results as they apply to the Model Standard Activities which serve as quality indicators aligned with the 10-essential public health service areas.



Community Partner Assessment Goals

1. Describe why community partnerships are critical to community health improvement (CHI) and how to build or strengthen relationships with community partners and organizations.
2. Name the specific roles of each community partner to support the local public health system (LPHS) and engage communities experiencing inequities produced by systems.
3. Assess each MAPP partner's capacities, skills, and strengths to improve community health, health equity, and advance MAPP goals.
4. Document the landscape of MAPP community partners, including grassroots and community power-building organizations, to summarize collective strengths and opportunities for improvement.
5. Identify whom else to involve in MAPP and ways to improve community partnerships, engagement, and power-building.

Community Partner Assessment Deliverables

Deliverable	Person/Team Responsible	Timeline
Provide one link to CPA Partner Survey	Ascendant	Within 30 days of project start date
Collect at least 10 surveys	Core Team	Within 45 days of project start date
Facilitate Partner meeting(s) to discuss the CPA purpose, the survey results, and prioritize findings	Ascendant	Within 60 days of project start date
Provide written analysis of survey and meeting results	Ascendant	Within 30 days of partner meeting(s)

Partner List Discussion

Who is Missing?
Who Should We Prioritize?

Please note: We have points-of-contact for all the organizations listed.

Equity

Ensuring at least two (2) community/partner members or organizations that represent populations that are disproportionately affected by conditions that contribute to health risks or poorer health outcomes to participate in the survey and attend the meeting.

Partner List Discussion: Gaps

- Healthcare Partners
- South Whidbey Long Term Care
- Camano Childcare Partners
- Other Governmental Partners engage?
- Other Integrative Providers?
- Are there "sections" missing?

Equity

Ensuring at least two (2) community/partner members or organizations that represent populations that are disproportionately affected by conditions that contribute to health risks or poorer health outcomes to participate in the survey and attend the meeting.

Community Status Assessment

Informs MAPP and collects quantitative data on the status of your community such as demographics, health status, and health inequities. The CSA helps a community move "upstream" and identify inequities beyond health behaviors and outcomes, including their association with social determinants of health and systems of power, privilege, and oppression. The CSA is a community-driven assessment to help tell the community's story.

Community Status Assessment Questions

1. What does the status of your community look like, including health, socioeconomic, environmental, and quality-of-life outcomes?
2. What populations experience inequities across health, socioeconomic, environmental, and quality-of-life outcomes?
3. How do systems influence outcomes?

Community Status Assessment Deliverables

Deliverable	Person/Team Responsible	Timeline
Identify a Health Equity Liaison	Core Team	At kickoff meeting
Provide a minimum of 50 indicators	Ascendant	
Provide a link to community-wide survey	Ascendant	
Distribute collect at least 150 surveys	Core Team & CHAT	Within 70 days of project start date
Present and facilitate results to MAPP Core Team	Ascendant	
Provide written analysis of CSA	Ascendant	Within 30 days of survey close date

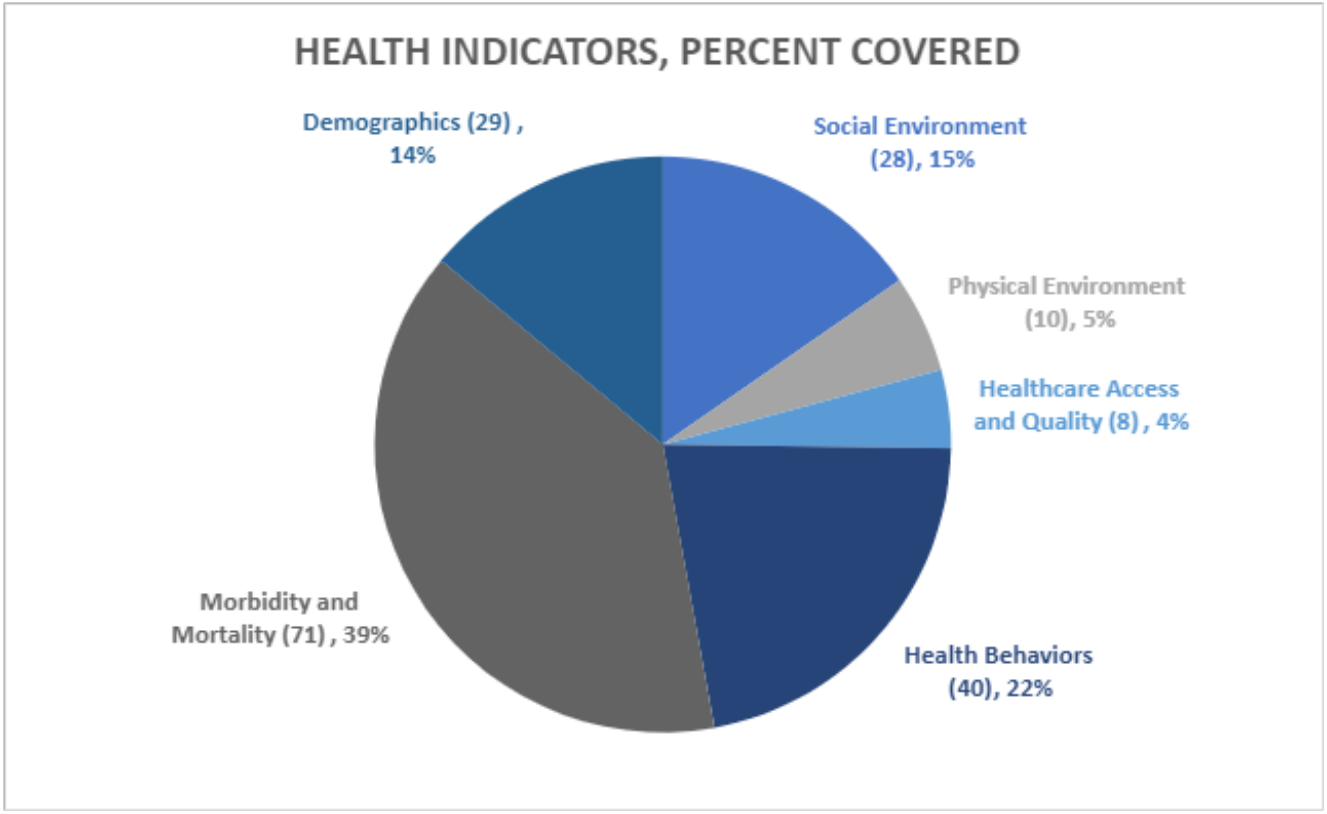
Health Indicator List: What is Missing?

Equity

Identify the vulnerable population(s) within the county: Under five years old, age 65 or over, disability, educational attainment (less than ninth grade), veteran population, immigrants, LGBTG+, African American, Hispanic, Asian, Native American.

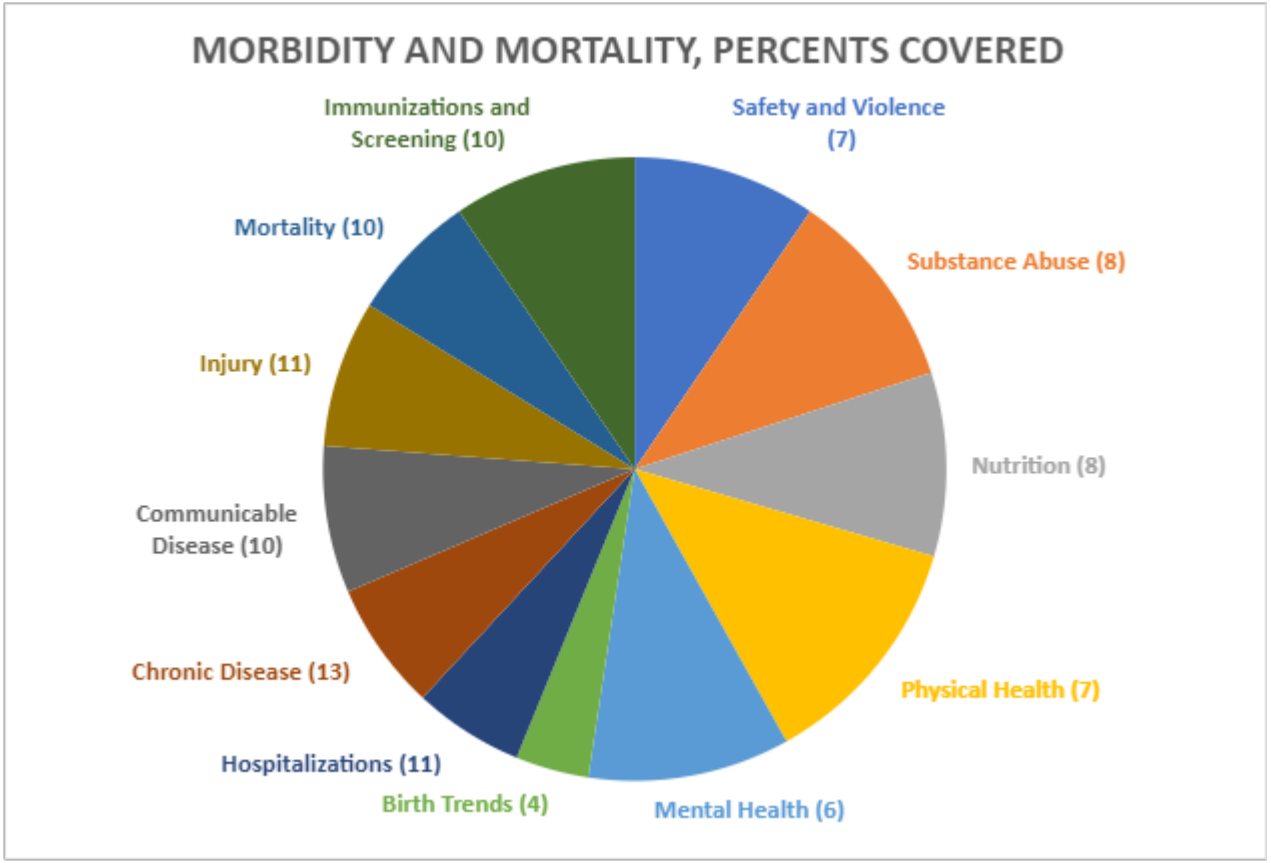
Provide supporting documentation from Washington Public Health Information Warehouse that provides details on vulnerable populations as well as any other supporting documentation requested by AHP.

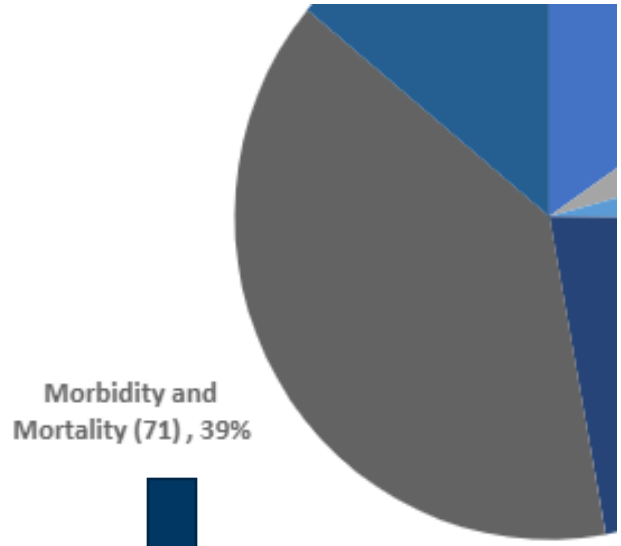
Health Indicator List: What is Missing?



Please note: The (#) represents the number of indicators in each section

Morbidity and Mortality as Indicators of Health Inequity





What is missing?

**Disaggregate whenever possible

Community Survey: What is Missing?

Equity

Identify the vulnerable population(s) within the county: Under five years old, age 65 or over, disability, educational attainment (less than ninth grade), veteran population, immigrants, LGBTG+, African American, Hispanic, Asian, Native American.

Once the vulnerable population is identified, the Health Equity Liaison is responsible for the distribution and collection of 50 completed surveys (all questions must be answered to be counted as a complete survey). The Liaison will scan all surveys to AHP.

Community Context Assessment

A qualitative tool to assess and collect data. It collects the insights, expertise, and views of people and communities affected by social systems to improve the functioning and impact of those systems. The CCA moves beyond interventions that rely on perceived community needs to understand a community's strengths, assets, and culture.

Community Context Assessment Questions

- What strengths and resources does the community have that support health and well-being?
- What current and historical forces of change locally, regionally, and globally shape political, economic, and social conditions for community members?
- What physical and cultural assets are in the built environment? How do those vary by neighborhood?
- What is the community doing to improve health outcomes? What solutions has the community identified to improve community health?

Community Context Assessment Deliverables

Deliverable	Person/Team Responsible	Timeline
Forces of Change Facilitated Group Discussion	Ascendant Core Team, CHAT, and community partners attend	
Present provide facilitation of results to Core Team	Ascendant	
Provide written analysis of assessment	Ascendant	Within 30 days of group discussion completion

Forces of Change Assessment Overview

How To Identify Forces of Change

Think about forces of change — outside of your control— that affect the local public health system and/or Island County.

1. What has occurred recently that may affect our local public health system or community?
2. What may occur in the future?
3. Are there any trends occurring that will have an impact? Describe the trends.
4. What forces are occurring locally? Regionally? Nationally? Globally?
5. What characteristics of our jurisdiction or state may pose an opportunity or threat?
6. What may occur or has occurred that may pose a barrier to achieving the shared vision?

Community Context Discussion

Given what we know about the Forces of Change Assessment, which community partners do we need to emphasize /highlight as essential participants?

- Social
- Economic
- Political
- Technological
- Environmental
- Scientific
- Legal
- Ethical

Equity

Ensuring at least two (2) community members or organizations that represent populations that are disproportionately affected by conditions that contribute to health risks or poorer health outcomes are in attendance.

Next Steps: Kickoff Meeting

September 21st from 12 PM – 1:30 PM
Virtual (meeting invitation will be sent out)

Agenda

- Presentation of the new MAPP 2.0 process
- Review your community indicators
- Finalize the community-wide survey

Requested Actions for CHAB

1. Participate in the Kickoff Meeting (if schedule allows)
2. Provide feedback on the community survey (due September 14th)
3. Sector representatives' network to solicit participation in CPA and CSA (hand out to be sent out)