Healthy! Capital Counties
Community Health Improvement Plan: Setting a Shared Course

December 15, 2012

Contents:

Applicable Jurisdictions:
       Clinton County
       Eaton County
       Ingham County

Steering Committee Members, Report Authors, and Project Funders:
Health Departments:
       Barry-Eaton District Health Department
       Mid-Michigan District Health Department
       Ingham County Health Department
Hospital Systems:
       Sparrow Health System
       McLaren Greater Lansing
       Eaton Rapids Medical Center
       Hayes Green Beach Memorial Hospital
Education:
       Michigan State University

Additional project funders include:
       McLaren Health Plan
       Physician's Health Plan of Mid-Michigan
       Ingham Health Plan Corporation
       National Association of County and City Health Officials
       The Robert Wood Johnson Foundation

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Community Advisory Committee Participant Organizations

BUSINESS COMMUNITY:
Capital Area Michigan Works
Peckham, Inc.
General Motors (Delta Plant)

FAITH COMMUNITY:
Action of Greater Lansing (Faith-based
Advocacy)

EDUCATION:
Michigan State University
Eaton Intermediate School District
Lansing School District
Clinton County Regional Educational Service
Agency

HOSPITALS and HEALTHCARE:
Extendicare
Sparrow Health System
Hayes Green Beach Memorial Hospital
McLaren Greater Lansing
Eaton Rapids Medical Center

HEALTH PLANS:
Ingham Health Plan
Physician's Health Plan of Mid-Michigan
McLaren Health Plan

PUBLIC HEALTH:
Barry-Eaton District Health Department
Mid-Michigan District Health Department
Ingham County Health Department
Michigan Department of Community Health
Clinton-Eaton-Ingham Community Mental
Health

LOCAL GOVERNMENT:
Eaton County Community Development and
Planning
Clinton County Board of Commissioners
Eaton County Board of Commissioners
Clinton County Parks
DeWitt Township
Bath Township

COALITIONS:
Capital Area Health Alliance
Clinton Building Stronger Communities Coalition
Power of We
Greater Lansing African American Health
Institute
Lansing Latino Health Alliance
Clinton County Great Start Collaborative
Ingham Substance Abuse Prevention Coalition
Michigan Disability Rights Coalition
Clinton-Eaton-Ingham Coordinated School
Health
Eaton County Substance Abuse Advisory Group
Clinton Substance Abuse Prevention Coalition

HEALTHCARE IMPROVEMENT:
Michigan Health and Hospital Association
MPRO (Michigan Quality Improvement in
Healthcare)
Michigan Public Health Institute
Great Lakes Health Information Exchange

HUMAN SERVICES:
Capital Area Community Services
Volunteers of America
Food Bank Council of Michigan
Tri-County Office on Aging
Ingham MSU Extension Service
The Safe Center (Domestic and Sexual Violence
Services)

LOCAL FUNDING ORGANIZATIONS:
Sparrow Foundation
Eaton County United Way
Capital Area United Way
Mid-South Substance Abuse Commission
Coordinating Agency

TRANSPORTATION:
Clinton Transit Authority

NEIGHBORHOOD ORGANIZATIONS:
Allen Neighborhood Center
Northwest Initiative (Lansing Neighborhood
Organization)

COMMUNITY MEMBER PARTICIPANTS:

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TIMELINE:
The Healthy! Capital Counties Project is a comprehensive community health assessment and improvement planning project.

Community Assessment Phase: July 2011 to June 2012

The assessment phase included the work in preparing the assessment infrastructure, securing funding and resources, establishing the Community Advisory Committee to oversee the work, collecting and analyzing data, and culminated in publishing a community health profile report.

Community Health Profile + Findings Report
This document (available at www.healthycapitalcounties.org) is a comprehensive community health profile and community health needs assessment for Clinton, Eaton, and Ingham Counties. It is a set of quantitative indicators and qualitative information on the factors affecting health, health behaviors, and health outcomes. The document was originally published on June 19, 2012, and a Findings document (summary) was added on August 2, 2012.

Transition Phase: June 2012 to August 2012

The transition phase included the work to transition from the community health assessment phase to the community health improvement phase. This included conducting the community dialogues and the prioritization of the health needs of the community.

Community Dialogues Report
The seven community dialogues conducted in June and July 2012 served as a 'bridge' between the Community Health Profile and the assessment or measurement phase, and the Community Health Improvement Plan. Participants considered the interconnectedness of health and the variables in the report through a series of representative 'stories', and made recommendations for action. The full report is available on www.healthycapitalcounties.org.

Community Health Improvement Planning "Setting a Shared Course" Phase: September 2012 to December 2012

This phase includes the work to develop a set of goals, objectives, possible strategies and measures to describe WHAT will happen to improve health around the priorities identified. In order to do this, we inventoried the current resources and interventions around each area, examined the root causes of each priority issue through fishbone diagramming, and a completed a search for evidence-based strategies that addressed the root causes we identified, and were not already being implemented.   We drafted CHIPs with goals, objectives, and potential strategies. We solicited a few volunteer reviewers for each priority issue from the Community Advisory Committee to make review the drafts and make recommendations for changes. Additional reviews were conducted by the members of the Steering Committee. This document represents the culmination of this work.

FUTURE: Community Health Improvement Planning "Coordinated Action" Phase: December 2013 to June 2013

This phase will include the following steps:

December 2012
- Develop *Selection and Partnership Tool*. This is a simplified checklist for organizations, agencies, and coalitions to communicate what they have an interest in taking the lead on, what they want to partner on, what they want to support in other ways, and what they don't see a role in.
- Distribute the draft goals, objectives, and recommended strategies to Community Advisory Committee members.

January 2013
- Distribute *Selection and Partnership Tool*. Possibly adapt to online survey using Google Docs and Forms.

February 2013
- Begin collecting responses to the *Selection and Partnership Tool*

March 2013
- Hospitals scheduled to have finalized their implementation strategies and received Board approval
- Community Advisory Committee reviews responses to *Selection and Partnership Tool.* Committee selects strategies for inclusion into the final CHIP.

April 2013
- Discussion and decision of organizational model and how to ensure coalition's ongoing capacity
- Community Advisory Committee reviews draft of Final CHIP

May 2013
- CHIP is finalized
- Selection of organizational model / ongoing coalition support

June 2013
- Yearly Implementation Planning begins (short-term tasks)

July 2013 to June 2013
- Implementation
- Monitoring and Evaluation

July 2014
- New Community Health Assessment and Improvement Planning Cycle begins; Community Health Profile and Needs Assessment scheduled for June 2015 (three years after June 2012)

Background

The primary stakeholders included those who sat on the project STEERING COMMITTEE. The Steering Committee consisted of representatives from each hospital system (Sparrow, McLaren Greater Lansing, Hayes Green Beach, and Eaton Rapids Medical Center) each health department's health officer (director) and a representative from Michigan State University's Office of Outreach and Engagement. The project has a larger, broader, COMMUNITY ADISORY COMMITTEE, which included representatives from agencies, community representatives, elected officials, organizations, health plans, and coalitions.

Data in the Healthy! Capital Counties project was pooled across the three counties, and stratified based on population density (persons per square mile) and median home value, both from the 2006-2010 American Community Survey (U.S. Census). The validity of this methodology was tested by analyzing groupings based on other measures. There was a high level of statistical agreement that the groupings we used (based on population density and median home value) matched groupings based on other measures. Additionally, these geographic groupings were validated with a focus group and the Advisory Committee.

The model we used for our assessment and improvement planning is from the Association for Community Health Improvement's Community Health Assessment Toolkit.
http://www.communityhlth.org/
We modified the model to align with the Public Health Accreditation Board's Standards and Measures 1.0 in relation to Community Health Assessment and Community Health Improvement Plans.
http://www.phaboard.org/accreditation-process/public-health-department-standards-and-measures/

Community Engagement

The development of this document was informed through significant engagement with the community. Initial suggestions for action based on information from the Community Health Profile was obtained through a community dialogue process. The Community Dialogues were held in seven locations across the region and suggestions for actions were collected from each participant, there were ninety-seven participants in total. The Community Dialogues are described in detail in a separate report, available at www.healthycapitalcounties.org.

All those who attended a focus group or participated in a community dialogue were invited to attend the Community Advisory Committee meetings, which enhanced participation from community members who are unaffiliated with a participating organization. The prioritization process occurred at the August 2nd Community Advisory Committee meeting.

On September 6, 2012, a series of back-to-back workshops were held to obtain needed information from community participants – this included an inventory of the current strategies employed in each of the priority issue areas, the root causes of each issue, and potential partners. In addition, volunteers were solicited who agreed to review the draft issue CHIPs that resulted. Staff then edited the drafts based on community member recommendations.

Prioritization Methodology

To narrow down the list of issues that surfaced as part of the Healthy! Capital Counties community health assessment report and the public dialogue sessions, we developed a prioritization matrix using the consensus criteria method. The consensus criteria method consists of three major steps:
1. Identifying the criteria to be considered when evaluating the issues;

2. Selecting weights for each criteria; and

3. Scoring each issue based upon the aforementioned criteria.

The four criteria selected to evaluate the issues for this process was:

a) Seriousness (how serious is the health issue);

b) Control (how much control do we have to affect the issue);

c) Capacity (what is our ability, as a community, to act on a particular issue); and

d) Catalytic (how much does this issue affect other health issues).

These criteria were preselected by the staff prior to the group prioritization process so that the group activity would not extend beyond the time scheduled. The group process was held on August 2nd 2012 at 3:00 pm in the Bath Community Center in Bath, Michigan during a regularly scheduled Healthy! Capital Counties Advisory Committee meeting. The meeting was attend by, not only the members of the Healthy! Capital Counties steering and advisory committees, but invitations were extended to all persons who participated in any focus group or community dialogue. During the group process, participants were asked to determine weights for each of the pre-selected criteria. Using the text polling program "Poll Everywhere," participants to identify which criteria was the most important to them. After the results were tallied, participants were asked to identify which of the remaining criteria the considered to be the most important. This line of questioning was continued until the list of criteria was ranked from most important to least important. Then each criterion was given a weight corresponding to its rank. The resulting weights were: Seriousness-4, Control-3, Catalytic-2, and Control-1. Individuals without a cell phone or without texting capabilities had their answers added manually.

After the prioritization weights were calculated, four separate prioritization worksheets were dispersed to the attendees, each with all of the issues listed on it (Obesity was added to the list that afternoon. The group felt that although its determinants were included in the list, it should be explicitly mentioned.). One worksheet asked attendees to choose three issues they felt we have the most Control over. On another, attendees were asked to choose three issues they felt were the most Serious. The third worksheet asked attendees to list the three issues they felt were the most Catalytic. The last worksheet asked attendee to list three issues they felt we had the greatest Capacity to address. The forms were collected, the responses for each issue were tallied, and that number was entered into an electronic prioritization matrix. This matrix took the number of votes for each issue's criteria and multiplied it by the weight of each criterion. For example, 5 votes for a criterion with a weight of 4 provide a score of 20 pts for that issue's criterion. The criteria for each issue were added together and the six issues with the largest sums were identified as strategic priority issues. These issues with the highest totals were: Access and Utilization of Community Resources, Access to Healthy Food, Access to Quality Healthcare, Health Education, Child Health, and Obesity.

These issues were examined along with the responses from the Community Dialogues to determine the final priority issues. In an effort to maintain the goals of the issues chosen at the prioritization meeting, some of the chosen priorities were merged with other categories. Health Education was folded into several categories and Access to Healthy Food was folded into the Obesity topic. As an end result, the final Strategic Priorities chosen after taking into account the information from the Community Dialogues and the prioritization meeting are:

a) Access to Quality Health Care,

b) Connection to Resources,

c) Obesity,

d) Child Health, and

e) Safety and Social Connection.

Healthy! Capital Counties Prioritization Matrix

	Seriousness 4 pts	Control 3 pts	Capacity 1 pts	Catalytic 2 pts	TOTALS
Access and Utilization of Community Resources	5 / 20	14 / 42	16 / 16	5 / 10	88
Access to Healthy Food	5 / 20	10 / 30	9 / 9	4 / 8	67
Access to Quality Healthcare	17 / 68	3 / 9	6 / 6	14 / 28	111
Safe and Connected Neighborhoods/ Communities (incl. Community Safety, Social Connection, Injury)	6 / 24	8 / 24	4 / 4	7 / 14	66
Overall Education Achievement (incl. behavior education, access to higher education, possibly school health)	3 / 12	3 / 9	1 / 1	7 / 14	36
Health Education	3 / 12	19 / 57	12 / 12	3 / 6	87
Mental health (incl. stress, depression, access)	8 / 32	1 / 3	3 / 3	3 / 6	44
Access to Physical Activity	0 / 0	9 / 27	7 / 7	3 / 6	40
Financial Stability (incl. Poverty and Income Distribution)	9 / 36	1 / 3	0 / 0	11 / 22	61
Housing Segregation	1 / 4	1 / 3	0 / 0	1 / 2	9
Housing Affordability	1 / 4	1 / 3	1 / 1	2 / 4	12
Environmental Quality	4 / 16	/ 0	2 / 2	1 / 2	20
Tobacco Use	1 / 4	9 / 27	8 / 8	2 / 4	43
Alcohol Use	2 / 8	2 / 6	1 / 1	1 / 2	17
Child Health (incl. School Health, preventable hospitalizations)	9 / 36	6 / 18	9 / 9	4 / 8	71
Maternal and Infant Health (incl. infant mortality)	2 / 8	/ 0	8 / 8	3 / 6	22
Quality of Life (feeling sick)	2 / 8	/ 0	/ 0	1 / 2	10
Premature Death (dying early)	1 / 4	/ 0	/ 0	/ 0	4
Chronic Disease (incl. cardiovascular and diabetes)	9 / 36	4 / 12	4 / 4	6 / 12	64
Obesity	10 / 40	4 / 12	5 / 5	10 / 20	77

Parts of the Community Health Improvement Plan:

SETTING A SHARED COURSE:

VISION
The vision of the Healthy! Capital Counties Community Health Improvement Process is that all people in Clinton, Eaton, and Ingham Counties live:
- In a physical, social, and cultural environment that supports health
- In a safe, vibrant, and prosperous community that provides many opportunities to contribute and thrive
- With minimal barriers and adequate resources to reach their full potential

PRIORITY STRATEGIC ISSUES
These are the fundamental **policy choices or critical challenges** that must be addressed in order for a community to achieve its vision. These are framed as questions to allow for a broad range of complementary strategies and ideas.

OBESITY
How can we create a community context where everyone can attain and maintain a healthy weight? How can we increase access to healthy foods and physical activity opportunities?
CONNECTION to RESOURCES
How can we promote awareness of and connections to community resources, programs, and supportive services? How can we identify and fill gaps in services and resources? How can we, as a community, assure that everyone has basic resources to live in good health?
ACCESS to QUALITY HEALTHCARE
How can we build a community system of care so that everyone has affordable, timely, and reliable access to high quality primary and specialty healthcare services in ambulatory and hospital settings?
SAFETY and SOCIAL CONNECTION (Social Determinant of Health)
How can we create safe neighborhoods or communities? How can we promote and support social connections?
CHILD HEALTH
How can we, as a community, assure every child grows up without preventable hospitalizations, with health education to establish good health behaviors, and in environments that support health?

GOALS Broad statement of what we hope to accomplish. Answer the questions posed as priority strategic issues.
Example: "Implement policies that support residents in achieving routine physical activity"

OBJECTIVES and RECOMMENDED STRATEGIES *How specifically will we accomplish our goal?*
Generate a variety of strategies. Resist pressures to settle for obvious or comfortable strategy. May be **programs**, designed to fix a particular issue, or they may be **policies**, designed to impact entire groups more distantly. Entities will be asked to identify which strategies they will take a role in implementing.

MEASURES   A way to demonstrate whether or not we have successfully implemented the strategy.

Parts of the Community Health Improvement Plan:

COORDINATED ACTION PHASE: (to be developed January 2013- June 2013)

SELECTED STRATEGIES

Based on the interest and willingness of partners to implement strategies, the Community Advisory Committee will *select* the strategies to implement. Additional strategies may be selected for capacity-building activities.

FINAL MEASURES

Measures that relate to each strategy that's been selected.

ACTION STEPS

Clearly describes how the strategy will be implemented.

CHAMPIONS or PARTNERS

Organizations, groups, coalitions, individuals, or other entities that will take on ***leadership*** to achieve the goals and objectives set forth in the Community Health Improvement Plan.

Safety and Social Connection

How can we create safe neighborhoods or communities?
How can we promote and support social connections?

This priority strategic issue is a **social determinant of health** – meaning that a feeling of safety and having social connections affects people's behavior, which in turn affects health outcomes. Safe neighborhoods and communities have less crime, violence, and accidental injury. People with more social connections are protected from poor health outcomes.

High levels of violent crime compromise physical safety and psychological well-being. Crime rates can also deter residents from pursuing healthy behaviors such as exercising out of doors. Additionally, some evidence indicates that increased stress levels may contribute to obesity prevalence, even after controlling diet and physical activity levels. According to Michigan Uniform Crime Report, the violent crime rate is highest in **urban areas**, with a rate nearly twice as high as Ingham County as a whole.

Focus group participants felt that unsafe neighborhoods are an issue in the urban areas of Ingham County, but not an issue for those living in Clinton, Eaton, or rural Ingham County. One man stated, *"I come from Eaton Rapids. I lived there almost my whole life and we basically left our doors open. Here, on the East side of Lansing, they have drive by shootings, and we're not used to so much violence."* A woman stated, *"Clinton County is really a blessing. I moved to St. Johns from Lansing… I live in the busiest area of St. Johns, and still feel safe."*

In contrast, accidental injury death rates are higher in **rural areas**. Participants in the root cause analysis felt that people driving unsafely on country roads and use of alcohol while driving contributed to safety issues in the rural areas.

It is important to provide individuals with knowledge, skills, and tools to make safe choices as well as facilitate social connectedness and community engagement across the lifespan. When we examined the root causes of lack of safety and social connection, participants felt that there is a lack of groups that build social connections as well as a lack of community building activities.

Suggested Actions from the Community Dialogues

on SAFETY…
- Acknowledge the relationship between community safety and health behaviors
- **Safety must be made a health priority** by state legislators, county commissioners, city councils, and local agencies
- There need to be **more resources**, such as an increased **police presence**, for the **enforcement of policies** aimed at preventing crime
- There must be support behind community efforts to make the community safer, such as **community watch groups**, (as long as these groups do not profile individuals, or take part in extreme neighborhood watch behaviors)
- Neighborhoods should be **walkable**, and the **creation of safe paths** should be encouraged.

on SOCIAL CONNECTION…
- **Building a sense of community** will have a positive impact on health by providing support and reducing stress
- Community members, particularly people in low-income areas, should **get to know their neighbors**, **help them** with parenting, and potentially provide them with financial assistance if they are struggling.
- Neighbors should also be encouraged to provide each other with extra fruits and vegetables if possible.
- Also, individuals should **share stories** and **teach each other** what they know about health, nutrition, and exercise in order to promote healthy behavior and shared ownership of health.
- **Neighborhood organizations** should focus on **reaching out to the community** by hosting **activities** in order to create social circles. Once these circles are formed, people can take part in **health-promoting group activities** such as group trips to the grocery store, or group exercise classes.
- Ingham Health Plan should include **support groups** in order to foster social connection.
- Individuals should be encouraged to **volunteer** when they see needs they would like to address, such as volunteering for a school system in need.
- People should also join **community groups and coalitions**, such as in Eaton Rapids, where a wide range of groups work to address the needs of the community.

Goal: Safety and Social Connection

Create safe neighborhoods and communities by decreasing crime, violence, and accidental injury, and promoting and supporting social connections.

Objective 1. Implement and strengthen policies and programs to enhance transportation safety.

Recommended strategies:

Rationale:

➔ Strengthen policies that reduce driving while drowsy or distracted (cell phone use, texting, etc)

Measure: the number of policies implemented to reduce distracted driving

Effective traffic safety policies and programs prevent motor vehicle related injuries and death.

➔ Pedestrian safety education – implement a pedestrian safety campaign in communities, develop education materials for outreach purposes, advocate for accessible crosswalks, etc.

Measure: the rate of pedestrian traffic injuries

Expanding the availability of, safety for, and access to a variety of transportation options and integrating health-enhancing choices into transportation policy has the potential to save lives by preventing chronic diseases, reducing and preventing motor-vehicle-related injury and deaths, improving environmental health, while stimulating economic development, and ensuring access for all people.

➔ Advocate to re-establish Michigan Motorcycle helmet law.

Measure: the adoption of a mandatory motorcycle helmet law

Data from the National Highway Traffic Safety Administration in 2008 showed that motorcyclists who do not use helmets are three times more likely to suffer a traumatic brain injury in a crash than those who are wearing helmets.

➔ Advocate for bicycle safety helmet laws.

Measure: the adoption of a bicycle safety helmet law

Supporters of helmet laws believe mandatory use of helmets can reduce brain injuries and fatalities among bikers.

➔ Enhanced enforcement of speeding

Measure: increased funding for enforcement of speeding violations

Speeding is one of the most prevalent factors contributing to traffic crashes. The economic cost to society of speeding-related crashes is estimated by NHTSA to be $40.4 billion per year. In 2008, speeding was a contributing factor in 31 percent of all fatal crashes, and 11,674 lives were lost in speeding-related crashes.

➔ Reduce alcohol-related traffic crashes through collaboration with area Substance Abuse Prevention Coalitions

Measure: a reduction in the alcohol-related traffic crash rates

Alcohol-related traffic crashes are more likely to be fatal than non-alcohol related crashes. Alcohol misuse can be impacted by reducing underage drinking and reshaping the social norms around alcohol consumption.

Objective 2. Support community and streetscape design that promotes safety and prevents injuries. Maintain conditions of sidewalks, adding sidewalks where they are needed, and removing snow in the winter so that pedestrians are not forced into the streets.

Recommended strategies:

Rationale:

➔ Separating traffic from pedestrians (speed bumps, roundabouts, road diets, etc.)

Communities and streets can be designed to reduce pedestrian, bicyclist, and vehicle occupant injuries. Road modifications can reduce the number of deaths and injuries.

Measure: adoption of traffic separation designs amongst master plans.

Many of these modifications can also increase levels of physical activity.

➔ Complete Streets policies (appears elsewhere)

<mark>*Please see OBESITY.*</mark>

➔ Safe Routes to School (appears elsewhere)

<mark>*Please see OBESITY.*</mark>

Objective 3. Strengthen policies and programs to prevent violence

Recommended strategies:

Rationale:

➔ Modifications to physical environment (windows that overlook sidewalks and parking lots)

Modifications to the physical environment can deter criminal behavior and enhance community safety laws.

Measure: number of municipalities requiring consideration of safety in building site plan review processes.

➔ Decrease the number of businesses selling alcohol and/or decrease alcohol outlet density through liquor control policies and advocacy

Decreasing the number of business selling alcohol has also been shown to reduce violent crime.

Measure: alcohol outlet counts and alcohol density rates

➔ Housing and economic development (reduce concentrated poverty)

Housing and economic development initiatives show promise in reducing rates of crime and violence.

Measure: increased funding to encourage housing and economic development

Education often results in higher incomes, on average, and more resources than a job that does not require education. Higher income often brings means less crimes being committed.

➔ Education initiatives (increase high school graduation rates)

Measure: increase in the percentage of students who graduate high school

Objective 4. Facilitate social connectedness and community engagement across the lifespan

Recommended strategies:

Rationale:

➔ Safe shared places for people to interact (parks, faith based and community organizations

Neighborhoods with high violence are thought to encourage isolation and therefore inhibit the social support needed to cope with stressful events. Additionally, exposure to chronic stress contributes to the increased prevalence of certain illnesses in neighborhoods with high levels of violence.

Measure: increase in knowledge of safe spaces through marketing

➔ Foster healthy relationships and positive mental health among community residents
i.e. implement programs that assist juveniles and adults who are re-entering their communities following incarceration that support their returning to work, school, and leading healthy lifestyles.

Some individuals need the support in order to get back into the 'real world' after being in trouble. Re-entering their communities with support reassures them that they are capable of achieving goals and not looked down upon like they may have felt in the past.

Measure: increase in the percentage of persons who receive support upon re-entry from institutional settings (mental health and substance

abuse treatment, jail, prison, etc)

➔ Increasing accessibility and employment opportunities for people with disabilities

Measure: increase in the percentage of disabled persons 18-64 who are employed

Those with disabilities can often work but don't have the resources to do so. By ensuring those with disabilities employment, they will gain a sense that they are needed and this in the long run will reduce crime and keep them off the streets.

➔ School-Based (Policy/Social Capital) Interventions to establish safe and socially connected schools.
http://www.cdc.gov/healthyyouth/adolescenthealth/pdf/connectedness.pdf

Measure: number of schools adopting interventions to increase school connectedness.

This intervention is aimed at increasing school connectedness for students. The goal is to increase positive behaviors and reduce harmful behaviors by students. Teacher involvement and peer groups are used. This is a school-based program/policy changes.

Objective 5. Provide individuals with knowledge, skills, and tools to make safe choices in safe places

Recommended strategies:

Rationale:

➔ School based programs to prevent violence (bullying, teen dating violence)
   o i.e. Bully-free schools evidence-based programs to change school environment along with discipline policies and practices

Measure: increase in the number of schools who are implementing evidence-based bullying prevention programs and policies

Education and skills-building programs can provide individuals and families with knowledge, skills, and tools to help them prevent violence and injuries.

➔ Social development strategies that teach children how to handle difficult situations
   o Michigan Model for Health Curriculum

Measure: increase in the number of schools implementing the Michigan Model for Health Curriculum, and increase in the fidelity with which schools are implementing the curriculum across all grades.

This will help to reduce crime in schools – it helps to teach children how to handle difficult situations without violence.

Having a good relationship with both parents helps to enhance child's development and have a positive influence on others.

➔ Parent and family skill based support programs that support positive family interactions
   Examples: 1.) The Nurturing Parenting Program - Family-based program that involves both parents and children in activities, focusing on building a positive regard for self and others. Several programs focus on specific age groups and racial populations.
   2.) Parents as Teachers - An international early childhood parent education and family support program designed to enhance child development and school achievement through parent education accessible to all families.

Measure: the percentage of parents who have attend a family skills based training program

➔ Workplace interventions (security systems and other safety procedures)

     o   Workplace anti-bullying policies and procedures

Measure: increase in the number of workplaces with model anti-bullying and violence prevention policies and procedures

➔ Early Warning, Timely Response: A Guide to Safe Schools offers research-based practices designed to assist school communities identify these warning signs early and develop prevention, intervention and crisis response plans.
http://cecp.air.org/guide/guide.pdf

Measure: increase in the percent of schools who have implemented research-based policies and practices to reduce school violence and emergency preparedness

➔ CASASTART (Striving Together to Achieve Rewarding Tomorrows), formerly known as Children at Risk, targets youth aged 11 to 13 in high-risk neighborhoods.
http://www.ojjdp.gov/mpg/CASASTART-MPGProgramDetail-692.aspx

Measure: the percentage of at-risk youth who participate in model violence prevention programming

Workplace interventions can reduce violence, bullying, and other negative behaviors.

Schools can implement research based policies and practices to reduce school violence and emergency preparedness.

Using case management, after-school activities, and law enforcement, the program attempts to decrease individual, family, and community risk factors while promoting positive behavior such as school performance and pro-social activities.

Child Health

How can we promote an environment that encourages and assures good health among children and adolescents?

How can our community assure every child grows up without preventable hospitalizations, with health education to establish good health behaviors, and in environments that support health?

This priority strategic issue is unique in that it focuses on a specific age group – children. This is strategic for a number of reasons. First, we know that the health trajectory of an entire life is established very early on in child development. The negative impact of poverty on the developing brain means that children who are deprived will later have worse health as adults, even if they practice good health behaviors. Eating and physical activity patterns are set very early in a child's life.

We also know that the places (homes, community settings, daycares, churches, schools, playgrounds, etc) that children live in have a significant impact on the health behaviors that children establish. Every child deserves to inhabit places that are healthy.

Children are a unique population in that they are constantly learning new information, skills, and expectations (norms) about ways of living that contribute to health (or not). Additionally, children (because their brain is still developing) are much likelier to be able to establish and sustain healthy behaviors based on education alone, than are adults. Children should all have the opportunity to participate in ongoing, scientifically proven, educational opportunities that establish positive health behaviors.

Upon reviewing the data, several of the indicators of concern addressed children 17 years old or less. During the community dialogues issues related to child health were repeatedly raised. Consequently, child health was listed as an issue in the prioritization process. The criteria used to determine the strategic priority issues were: Seriousness-4, Control-3, Catalytic-2, and Control-1. After several rounds of voting, the members of the Healthy! Capital Counties Advisory Committee ranked child health high in "seriousness" and "catalytic", and ranked health education high in "control". Combining child health and health education into a single area of focus allows us to implement actions which are strategic in improving health.

Suggested Actions from the Community Dialogues

- Provide youth with **in-depth health education**, both in **school** and in the **home**, before bad health habits form
- Health education in schools needs to promote **healthy eating, cooking**, as well as **physical activity** through walking programs.
- The school system should also provide information **on health care**, so that young people know what options are available to them.
- Many participants felt that education is a key factor in improving health and preventing adverse health outcomes.
- **Community education programs** focused on the major health issues in a specific community should be implemented in community centers.
- Communities should implement **family living classes** based on real-life scenarios in order to help families learn about health together.
- It is also important to provide health-related education to **physicians, school officials, and politicians** so that they can better serve the community.

Goal: Child Health

Promote an environment that encourages and assures good health among children and adolescents.

Objective 1. Reduce the number of preventable hospitalizations among children and adolescents.

Recommended strategies:

Rationale:

➔ Increase the proportion of children and adolescents who have had a wellness checkup in the past 12 months

http://www.chsaa.org/about/pdf/formBook/2012-2013Forms/01a_Physical.pdf

Measure: The proportion of children/adolescents with wellness checkups.

Increasing youth contact with medical professionals allows for better management of chronic conditions, identification of new conditions, and opportunities for clinical preventive services like immunizations and screenings.

➔ Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among children and adolescents

http://www.thecommunityguide.org/vaccines/universally/schools_childcare.html

http://www.thecommunityguide.org/vaccines/universally/homevisits.html
Measure: The vaccination rates among children and adolescents.

Vaccinations are one of the most cost-effective preventive interventions. Using best-practice policies, procedures, registries, and other efforts can help the tri-county maintain its high vaccination rates.

➔ Change school policy to include coordinated health-nutrition/fitness/chronic disease education

http://www.emc.cmich.edu/mm/default.htm

Measure: Number of new policies in schools for health nutrition, fitness, and chronic disease education.

Coordinated school health is a model that includes …

Research based curriculum intended to change the behavior of students regarding nutrition, physical activity, tobacco use and other risky behaviors.

➔ Institute asthma control programs and education for children

http://www.aafa.org/display.cfm?id=4&sub=79&cont=351

http://www.cdc.gov/asthma/interventions/openairway.htm

Measure: The number of asthma control programs in place/instances of asthma-related hospitalizations.

Children with asthma are some of the most likely to have a preventable hospitalization. Evidence-based coordinated asthma management can help to prevent hospitalizations.

By providing better navigation assistance for the services needed, they will be better able to receive care for their children and will be more likely to search for care .This will improve the health of children and reduce preventable hospitalizations.

➔ Institute a Pediatric Specialty Care hub for parents and physicians.

http://www.sparrow.org/News/Default.aspx?sid=1&nid=226&showBack=true&PageIndex=1

By increasing access to needed pediatric sub-specialty care services in the Capital Area, children with serious medical needs will be able to get needs addressed more quickly and closer to their residence.

Objective 2. Increase the proportion of children and adolescents practicing positive health behaviors.

Recommended strategies:

→ Increases the level of physical activity among children and adolescents through the establishment of model physical education programming.
http://www.epec4kids.com/

Measure: Percentage of children and adolescents with appropriate physical activity levels.

By increasing the amounts of physical activity that children and adolescents get, children will be healthier, and have healthier weights. There will be reduced cases of obesity.

→ Policy changes to adopt recommended nutrition standards in childcare settings and schools.

Measure: Number of new policies in schools and childcare settings addressing nutrition standards.

Change policies in schools or child care facilities to serve healthier foods and/or beverages (i.e. milk with lower fat content, no sugar sweetened beverages) in an effort to prevent childhood obesity. Example: *California Assembly Bill 2084 (regulates beverages serves in licensed childcare facilities)*

→ Increase the proportion of schools that offer nutritious foods and beverages outside of school meals

Measure: The proportion of schools with nutritious snacks/drinks.

Connect schools (k-12) to local farms or producers to provide healthier food options in school cafeterias. The goal is to get adolescents to consume healthier food and understand nutrition better, with an end goal of controlling obesity among youths.

→ Eliminate very low food security among children
• Increase enrollment and participation in the WIC program.
• Increase the number of summer food service program deliver sites.

http://miafterschool.org/program-quality/summer-food-service-program/

Measure: Number of children enrolled in food service programs/percentage of children with food insecurity.

Many children who are eligible for the WIC program are not enrolled or do not participate once enrolled. Identify and remove barriers to participation in populations with low enrollment and participation.

By providing healthy meals throughout the summer, children will be healthier and those with trouble finding food, will get free meals, ideally reducing food insecurity.

→ Increase the proportion of the Tri-County area's public and private schools that require daily physical education for all students

Measure: Percentage of schools with daily physical education for students.

By increasing physical activity and physical activity education in schools, students will get more exercise, be healthier and have lower levels of obesity.

→ Increase the proportion of children and adolescents who do not exceed recommended limits for screen time

Measure: Proportion of children/adolescents who exceed recommended limits for screen time (i.e. TV, video games).

The rationale behind this is by having children and adolescents limited in their screen time, the will be more active, less sedentary, and be less likely to suffer from obesity.

→ Require number of minutes of physical activity per day or by length of time in child care

Measure: Average number of minutes spent in physical activity by children in care.

Providing time for physical activity for children by care givers will allow them to be more active and stay at a healthier weight.

→ Decrease high risk behavior among adolescents
Such as expanding the Peer Assistance and Leadership program in all middle and high schools in the Capital Counties
http://www.eatonisd.org/schoolservices/instructionalservices/preventionprogramservices/youthprograms/peeras

Create peer-oriented youth programs in schools to create positive, supportive relationships. These programs will be used to promote health and healthy behaviors and work to prevent risky

Measure: The percentage of adolescents that engage in risky behaviors, BRFS survey.

behaviors in order to reduce risk and create overall safer and healthier students. (Health Ed., Parent Ed, Peer Assistance and Leadership)

Objective 3. Increase health-related self-efficacy among children and their caregivers

Recommended strategies:

Rationale:

➔ Improving the skills of caregivers in healthy eating and physical activity

http://www.healthysteps.org/

Measure: Number or percentage of caregivers adopting nutrition and physical activity policies.

Change policies to require certain nutrition and physical activity standards. The goal is to increase healthy eating and increase physical activity in children and reduce and prevent obesity. Nevada Senate Bill 27 (requires annual employee training include childhood obesity, nutrition and physical activity for licenses childcare providers)

➔ Increase early home visitation among high risk families

http://www.everychildsucceeds.org/

http://www.nursefamilypartnership.org

http://www.thecommunityguide.org/violence/home/homevisitation.html

Measure: Number of home visitations performed.

Provide visitations to high risk families involving nurse visits, workers, community peers to help reduce and prevent mother and childhood violence.

➔ Increase the proportion of children in poverty who participate in preschool programs designed to improve cognitive and social development

http://michheadstart.org/

Measure: the percentage of children in poverty in preschool programs for cognitive and social development.

Children who participate in a high quality preschool are more prepared to enter kindergarten, more likely to succeed academically, and earn higher incomes as adults.

Connection to Resources

How can we promote awareness of and connections to community resources, programs, and supportive services?
How can we identify and fill gaps in services and resources?
How can we, as a community, assure that everyone has basic resources to live in good health?

The Healthy! Capital Counties Community Health Profile and Needs Assessment presented a variety of serious and significant root causes of poor health outcomes that are challenging to address and control – and established the connection between differences in the exposure to these root causes to the differences in outcomes between different groups in different areas of the capital region. These included Income Inequality, Housing Segregation, Affordable Housing, Child Poverty, and others that demonstrated an unequal playing field.

During the Community Dialogues, a variety of stories were used to discuss these interconnected root causes and outcomes. Participants were encouraged to think critically about what would have prevented the poor health outcomes in the story.   Most of the participants expressed the notion that there were not usually easy answers to this question – that often, the root causes of the health problems stemmed from circumstances and situations that were in place decades in the past, and resulting from things outside of an individuals' control.

Throughout the seven community dialogues, one of the most frequent responses to the question "In order to have the biggest positive impact on the health of our community, what do you think we should focus on?" was the concept of Access to and Connection to Resources. Attendees felt people in the community did not have enough information about current resources or how to access them.

Because Connection to Resources was chosen in the Community Dialogues, it was provided as a choice for prioritization. Utilizing the prioritization matrix, Connection to Resources was one of the top responses from the advisory committee, ranking high in control and capacity.   When the committee later examined the root causes of poor connection to resources, the group identified that accessing resources is too hard due to lack of awareness of 211, people are isolated, there are a lack of basic needs and health resources, lack of connection of 211 to health activities, and many people feel excluded from participation in many programs and services due to a variety of barriers.

Suggested Actions from the Community Dialogues

- Neighborhood organizations should become more appealing to diverse groups of people, including youth, minorities, and people with and without children.
- A central resource or hub that contains information in plain English on available health resources, services, and help lines (i.e., a community clearing house) should be established.
- Information about how to become healthy and who to reach out to, should be printed in a widely distributed resource guide or pamphlet.
- Information on health resources and programs should be available at grocery stores, city hall, gas stations, libraries, churches, civic clubs, businesses, schools, food banks, shelters, and community centers. Health information could also be mailed directly to homes.
- In addition, health resources should be advertised on CATA buses and benches, as well as billboards.
- Grants should be made available to help health clinics offer more resources on healthy living.
- Provide resources to low-income individuals targeted at specific health issues such as teen pregnancy, parenting, and substance abuse.
- Social workers should distribute health information to isolated individuals who live in apartment complexes, who may not know where to go to access this information.

Promotion of 211:
- Many participants stated that 211, a database of health services and organizations, must be vigorously promoted since it is easy to access by phone, and provides information on a variety of health programs and resources.
- Organizations that provide health services should promote 211, and provide education on this resource.
- 211 should also be promoted by print, television, word of mouth, and faith-based groups.

Goal: Connection to Resources

Promote awareness of and connect individuals to community resources, find and fill gaps in services and resources, and ensure that everyone can access resources to live in good health.

Objective 1. Increase the number of individuals connected to traditional community resources (human services programs) via the 2-1-1 system.

Recommended strategies:

Rationale:

➔ Promote the Central Michigan 2-1-1 Information and Referral system, while concurrently increasing operational 2-1-1 funding to pay for staff to handle increased calls.

Measure: Number of calls that are able to be received by 2-1-1. Has it increased?

Many people, including those in need of help, are unaware of the 2-1-1 phone system, which provides 24 hour information and referral service. There is very little funding available to promote the 2-1-1 service – and if it is promoted, operational funds also need to be increased to handle additional calls.

➔ Improve the 2-1-1 calls per resident rate in Eaton and Clinton Counties

Measure: Monitor calls per resident in Eaton and Clinton counties to determine change in call rates.

While the call rate in Ingham County is fairly high, the call rates in Eaton and Clinton county are much lower than would be expected. Residents in Eaton and Clinton are less likely to be well-connected to helping resources.

➔ Promote the use of the 2-1-1 online service directory to ease demand for phone-based information and referral service.

Measure: The volume of calls regarding phone based information.

Funding limitations make increasing the number of 2-1-1 calls challenging. One solution may be to encourage the use of the 2-1-1 online directory, especially for human service professionals and persons with internet access.

➔ Promote the need for additional funding to operate the 2-1-1 service

Measure: increase in stable, ongoing funding source for 2-1-1.

It is difficult to identify funding to pay for a service that links people to other services. Providing more resources to 2-1-1, however, may allow for increased promotion and utilization, and improved health outcomes.

Objective 2. Reduce the gaps in services and resources and increase the utilization of services and resources.

Recommended strategies:

Rationale:

➔ Expanded the use of Community Health Workers in the Tri County area
www.countyhealthrankings.org/program/expand-use-community-health-workers-chw

Measure: Increase the number of CHW in the Tri-County area, measure how much they have increased from baseline.

Increasing the number of Community Health workers to provide increased opportunities to utilize preventive services. This plan has shown to result in improved birth outcomes and improved health behaviors for mothers/families.

➔ Increase the number of and the utilization of System Navigators and/or Patient Navigators
www.countyhealthrankings.org/program/systems-navigators-and-integration-eg-patient-navigators

Measure: Measure the increase in the number of system/patient navigators in use in the Tri-County area.

Increase the number of systems navigators and/or patient navigators to provide culturally sensitive assistance and guide patients through medical/support systems. Seeks to reduce disparities among those at risk.

Shown to increase preventive service use along with increased breast screenings and improved birth outcomes.

Health and social outcomes can be improved by supporting

➔ Provide Increased Support for Community Health workers
www.countyhealthrankings.org/program/expand-use-community-health-workers-chw

Measure: Count the increase in the number of CHW in the Tri-County area.

Community Health Aides for at-risk families. This would help by reducing barriers to service (lack of bus routes/transportation/scheduling issues/ability to pay). Identified those most at risk and focused on poor birth outcomes. This could be applied to the Tri-County area for reducing poor birth outcomes

➔ Improve referrals to adult education and language instruction programs for low-income patients.

Measure: improve the rate of referrals to education and language instruction programs.

Refer patients to adult education and English language instruction program to help enhance understand of health promotion and disease prevention

Objective 3. Improve the quality of existing resources and services

Recommended strategies:

Rationale:

➔ Utilize Referrers, i.e. No Wrong Door policies and other efforts

http://www.nowrongdoor.org.au/home.html

http://pathwayscourses.samhsa.gov/suicide_3_pg13.htm

Improve the treatment for individuals by properly identifying, assessing and providing treatment with the help of referrers (Referrers that work in mental health or primary care). The goals are to increase identification mental health issues by creating/increasing the ability to have dual diagnostic capabilities for mental health and primary care. (I.E. No Wrong Door). This could help increase the ability to diagnose mental health issues in the Tri County area.

Measure: Increase the number of referrals, or referrers used by primary care workers.

Objective 4. Promote positive social interactions and support healthy decisions

Recommended strategies:

Rationale:

➔ Promote Health behaviors through social media through a coordinated, comprehensive effort.

www.cdc.gov/socialmedia/tools/guidelines

www.cdc.gov/socialmedia/tools/guidelines/pdf/socialmediatoolkit_BM.pdf

Measure: Count the number of individuals following and interacting with the health information provided.

Using social media provides an easy way to reach many people in the workplace, and potentially outside of the workplace with health information and health advice. By using these methods to disperse health information, people will be better informed and be able to make better decisions.

Objective 5. Increase the connection of individuals with health promotion resources to encourage and enable individuals to achieve and maintain healthy lifestyles

Recommended strategies:

Rationale:

➔ Establish and promote health-related resources, services, and opportunities via the 2-1-1 service to include free or low-cost tobacco cessation, physical activity, healthy eating, and social connection opportunities and resources in local communities.

Measure: improvement in the number of health promotion items offered through the 211 service.

By connecting people more efficiently to 2-1-1 and its related health services, people will be able to make better choices regarding their health and will have more opportunities to access health resources.

➔ Engage primary care providers (and others in direct contact with individuals) in making referrals to 2-1-1 for these resources while using the evidence-based SBIRT model (Screening and Brief Intervention, Referral to Treatment).

Measures: Number of primary care providers and other care providers acting as a referrer for 2-1-1.

➔ Assure the 2-1-1 system has the capacity to establish, maintain, and update this additional service

Measure: increase in funding for 211 service to establish and maintain this service

➔ Establish new health promotion resources, services, and opportunities in local areas that lack these.

Measure: improvement in the number of health promotion resources, services opportunities in rural and urban underserved areas.

Obesity

How can we create a community context where everyone can attain and maintain a healthy weight?
How can we increase access to healthy foods and physical activity opportunities?
How can we prevent people from developing chronic diseases that are correlated with obesity such as hypertension, high cholesterol, stroke, heart disease, diabetes, kidney disease, and cancer?

Throughout the Community Health Assessment process, the issue of obesity was one of the most consistent and pervasive issues discussed. Obesity is a priority strategic issue for a number of reasons. First, it is connected with a vast number of poor health outcomes, including hypertension, high cholesterol, stroke, heart disease, diabetes, kidney disease, and cancer. It is one of the conditions which affects people throughout the lifespan. Obesity disparately affects some groups more than others – those who are African-American or Latino have higher rates of obesity, particularly adolescents. Those who live in urban low home price areas are most likely to live in a "food desert" – a place where it's difficult to easily access healthy foods, and are have worse rates of cardiovascular disease death. Those who live in rural areas are also at higher risk of dying from cardiovascular disease as well.

Focus group participants identified a need for increased access to healthy food, as well as neighborhoods and communities that support healthy physical activity. Participants also discussed how *easy* it was to access *unhealthy* food, and that makes making a healthy choice harder. Persons participating in the community dialogues also identified the issues of access to healthy food and physical activity opportunities.

Obesity ranked high in the prioritization due to its being ranked high in "seriousness" and "catalytic". Chronic disease also ranked highly. Since obesity is one of the main modifiable factors for chronic disease, it was incorporated within this priority strategic issue.

Community Advisory Committee members also identified the root causes of lack of access to healthy food and physical activities – these concepts are addressed in the proposed strategies.

Suggested Actions from the Community Dialogues

Access to Healthy Food:

- Improve access to nutritious food all year long via transportation to grocery stores, as well as food pantries.
- Meal centers should provide free healthy meals to children, seniors, and families in the community.
- Shopping assistants at farmers markets to help families shop for nutritious food.
- Offer and expand incentives to purchase healthy food, i.e. Double Up Food Bucks
- Cooking classes to prepare healthy food in inexpensive ways, without sacrificing flavor. School kitchens could potentially host.
- Reduce the amount of unhealthy food that is available for purchase. Policies that limit the number of fast food restaurants in a given community.
- Neighborhood food sources, including convenience stores, should utilize at least some of their shelf space for healthy foods.
- Mobile food trucks that deliver fresh, nutritious food to those in need on a weekly basis.
- Develop an alliance with farmers in the area to deliver fresh fruit and vegetables to urban, underserved areas.
- Schools should adopt healthy school nutrition programs
- Community gardens are an important way to bring families together, and encourage healthy eating. They may also encourage families to create their own gardening plots.
- It is important for community gardens to be accessible to all (esp. those with disabilities).
- In addition, incentives, resources, and coordinators should be provided for starting community gardens.
- Youth gardening programs

Access to Physical Activity:

- Participants felt that all community members should have access to safe, affordable, acceptable exercise options.
- Exercise classes in urban areas and small communities.
- Community wellness centers should provide free exercise classes on a regular basis, particularly in areas where it is unsafe to walk outside.
- People should be encouraged to take part in group exercise, and sports leagues.
- Exercise in the home should be encouraged.

Goal: Obesity

Create a community context where everyone can attain and maintain a healthy weight by increasing access to healthy foods and physical activity opportunities.

Objective 1. Increase access to healthy and affordable foods in communities.

Recommended strategies:

Rationale:

➜ Work with existing food outlets such as convenience stores, pharmacies, and fringe stores to improve the selection of fresh fruits and vegetables available for purchase, especially in low-income communities. Require stores accepting WIC benefits to carry selection of fresh produce. Explore the patterns of concentration of "food swamps" to determine overexposure of some areas to cheap high-calorie/high fat food choices.

People living in "food deserts" (areas where there is no place to buy fresh food) have difficulty buying fruits, vegetables, and other healthy foods. Increasing the availability of fruits and vegetables will offer healthy choices to patrons of small stores. Some evidence suggests, however, that over-exposure to "food swamps" (places with very high concentration of fast food and unhealthy food outlets) may also be a concern and need to be addressed through policy or practice changes.

Measure: decrease in the percent of census tracts that lack access to healthy food outlets (food deserts), decrease in the concentration of unhealthy food outlets (i.e. food swamps)

➜ Plan bus routes to connect low-income residents to fresh food

Some areas of the tri-county region are well connected through bus service to food stores – others are not. Increasing coverage to more low-income residents will reduce barriers to purchasing healthy foods.

Measure: decrease in the percentage of low income areas that lack bus service to grocery store.

➜ Improve access to Community Gardens, increase programs to learn to garden and safely preserve food, and support programs that provide tool loans, free seeds, and other gardening supplies.

Persons in urban areas often need space in a dedicated community garden; those living in rural areas need access to soil preparation services. Gardening allows people to eat more vegetables, and exposes them to a greater variety of produce.

Measure: Increase in the percentage of census tracts with a community garden

➜ Increase the number of farmers' markets and stands to accept government food assistance program payment (Michigan Bridge Card, EBT Stands, Project Fresh vouchers, etc.)

Farmer's markets and produce stands are less likely to accept food stamps (Electronic Benefits Transfer, SNAP) than traditional grocery stores. Additionally, this allows a greater percent of food assistance dollars to stay local to the area.

Measure: increase in the percentage of farmers' markets and produce stands with EBT card service.

➜ Increase the number of people served through Community Supported Agriculture (Farm Shares) and Urban Agriculture. Community Supported Agriculture farms allow people to purchase a "share" of the farm's yield; typically a season-long selection of vegetables and some fruit. Urban Agriculture farms reclaim land in urban areas to farm, and decrease the distance from farm to table in urban areas.

Programs that allow consumers to purchase directly from farms increase the consumption of locally-grown produce. They introduce participants to a wider variety of produce than is often available at the grocery store. Persons who are disabled or too busy to garden can also benefit from CSA farms.

Measure: increase in the total number of farm shares offered (sum of # shares in each CSA farm), increase in the number of Urban Farm sites

➜ Increase incentives to purchase healthy foods (discounts, Double Up Food Bucks)

By providing economic (monetary) incentives, people are encouraged to increase their purchase and consumption of healthy

Measure: increase in the percentage of healthy foods purchased through SNAP benefits

foods.

Some grocery store chains and health insurance companies are experimenting with programs to offer point-of-sale discounts or "money-back credits" to persons purchasing healthy food items.

The Double Up Food Bucks program offers SNAP (Food Stamps) recipients $2 for every $1 to spend on fruits and vegetables at participating Farmer's Markets. This program is privately grant funded. www.doubleupfoodbucks.org

Objective 2. Implement organizational and programmatic nutrition standards and policies, and improve the quality of foods served at worksites, organizations, and institutions.

Recommended strategies:

➔ More schools adopt recommended school food nutrition standards
http://michigan.gov/mdch/0,4612,7-132-2940_2955_2959_58773-261516--,00.html

Measure: increase in the percentage of schools adopting model school food nutrition standards and policies

➔ Other non-school food service institutions establish nutrition standards and policies

Measure: increase in the number of institutions establishing model policies

➔ Policy changes to adopt recommended nutrition standards in childcare settings

Measure: increase in the percentage of licensed childcare providers adopting model nutrition standards in childcare settings

➔ Work with local businesses to encourage ready access to fruits, vegetables and other healthy foods through the adoption of food procurement policies, farm-to-work programs, and worksite foodservice including food offered at meetings and events.

Measure: increase in the number of local businesses adopting model healthy food policies and practices.

Rationale:

The Michigan State Board of Education has adopted and recommended a set of Michigan Nutrition Standards (for schools) in 2011 to reduce childhood obesity and improve consumption of healthy foods. These standards are voluntary, but represent best practice in transforming the school environment to support healthy children.

Other institutions can also influence those that they serve by adopting recommended policies and practices to encourage consumption of healthy foods

Programs that combine health education for preschool children with policy change in the childcare setting show promise to influence healthy food choices before children enter K-12 schools. Research supports exposing children to a variety of fruits, vegetables, and whole grains throughout early childhood.

These strategies may include Farm-to-institution programs, discounting healthy food items, marking healthy food items with a healthy logo to encourage sales, merchandising healthy food items, or limiting the sales of non-nutritive foods, and policies that require healthy food choices at meetings and events.

Objective 3. Help people recognize and make healthy food and beverage choices

Recommended strategies:

➔ Point of Decision Prompts for Healthy Food Choices (calorie labeling, menu labeling, nutritional scoring systems)

Rationale:

Providing clear, concise, information can help consumers make more informed decisions when purchasing foods and beverages. Section 4205 of the Patient Protection and Affordable Care Act of 2010 requires restaurants and similar retail food establishments with 20 or more locations to list calorie content information for standard

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Measure: percent of food service establishments in compliance with the ACA's food calorie labeling regulations.	*menu items on restaurant menus and menu boards, including drive-through menu boards. Other nutrient information – total calories, fat, saturated fat, cholesterol, sodium, total carbohydrates, sugars, fiber and total protein – would have to be made available in writing upon request. The Act also requires vending machine operators who own or operate 20 or more vending machines to disclose calorie content for certain items.*
➔ Increase educational opportunities aimed at identifying, purchasing, storing, and preparing healthy foods	*Many people lack the skills and abilities to identify healthy foods, store properly, and routinely prepare them. A variety of evidence-based programs exist to meet this need, especially in SNAP (Food Stamp)-eligible persons. However, especially in rural areas, these programs are difficult to widely implement as transportation and participant time constraints are significant barriers.*
Measure: increase in the percent of SNAP households who have participated in a SNAP-Educational program in the past year.	

Objective 4.   Promote breastfeeding through policies and programs to increase the number of infants who breastfeed at birth and the proportion still breastfeeding at six months.

Recommended strategies: Rationale:

➔ Hospitals delivering babies adopt recommended policies and practices to support breastfeeding (i.e. Baby Friendly Hospital Initiative) http://www.babyfriendlyusa.org/eng/10steps.html	*For nearly all infants, breastfeeding is the best source of nutrition and immunologic protection, and also provides health benefits to mothers (faster weight loss, reduced risk of breast and ovarian cancers). Institutional changes in maternity care practices increase breastfeeding initiation and duration rates. Infants that are breastfed are less likely to become obese later in life – and the protection increases with each additional month of breastfeeding.*
Measure: increase in the percent of births that occur in facilities with Baby Friendly policies and procedures in place.	
➔ Increase the percent of worksites with Lactation Support policies and/or programs	*Support is important to help new mothers establish and continue breastfeeding as they return to work or school. Lactation policies that provide private space and flexible scheduling and that offer lactation management services and support (e.g. breastfeeding peer support programs) can make it easier for mothers to continue breastfeeding.*
Measure: increase the percent of worksites with model lactation support policies or programs	

Objective 5. Establish a coordinated, interconnected food policy system

➔ Support local food policy councils (Food Systems Workgroup, Eaton Good Food, Southern Clinton Food Policy Council, etc) to plan, and implement coordinated food systems policies.	*Food policy councils provide a network and forum for entities in various parts of the food system to communicate, plan, form new connections and develop innovative programs and policies.*
Measure: Food policy councils are regularly meeting and implementing policies that improve the food system.	

Objective 6. Encourage community design and development that supports physical activity.

➔ Increase the percent of municipalities that have enacted Complete Streets ordinances and/or policies. http://www.smartgrowthamerica.org/complete-streets	*Effective complete streets policies help communities routinely create safe and inviting road networks for everyone, including bicyclists, drivers, transit operators and users, and pedestrians of all ages and abilities.*
Measure: increase the percentage of municipalities that have adopted Complete Streets ordinances, increase the percentage of municipalities that have incorporated Complete Streets into their	

Master Plan.

➔ Increase the number of municipalities that utilize Health Impact Assessments

  http://www.cdc.gov/healthyplaces/hia.htm

Measure: increase in the percentage of municipalities that utilize health impact assessment in their site plan review processes.

HIA is a process that helps evaluate the potential health effects of a plan, project or policy before it is built or implemented. An HIA can provide recommendations to increase positive health outcomes and minimize adverse health outcomes. HIA brings potential public health impacts and considerations to the decision-making process for plans, projects, and policies that fall outside the traditional public health arenas, such as transportation and land use.

➔ Increase the number of municipalities incorporating active living concepts in their Master Planning process.

Measure: increase the percentage of municipalities that incorporate active living concepts into their Master Plan.

Similar to Complete Streets efforts, incorporating active living concepts such as walkability and bikability in the Master Planning process assures incremental improvements in local environments to support physical activity.

➔ Increase signage to encourage physical activity (paths, routes, etc)

Measure: Increase in the number of paths and physical activity routes that are appropriately signed.

Signs provide a cue that an activity is appropriate and encouraged.

➔ Increase opportunities for physical activity through infrastructure such as sidewalks, bike lanes, parks, paths and trails, adequate lighting, and playgrounds. Often, communities use non-motorized transportation plans to identify, plan, and obtain funding for these improvements.

Measure: increase in the percent of municipalities that have adopted a non-motorized transportation plan

People are more likely to use active forms of transportation and recreational facilities when they are prominent, safe, and located near their homes or places of employment. Connecting various destinations in a community provides additional opportunities for active transportation. Other dedicated public recreational facilities such as parks, playgrounds, and other resources should be maintained and/or developed in places with limited access to paid recreation resources. The Community Guide rates the evidence for creating or enhancing access to places forphysical activity and providing informational outreach as strong.

Objective 7. Promote and strengthen school and early learning policies and programs to increase physical activity

➔ Increase the number of schools adopting recommended physical activity policies and programs
http://www.epec4kids.com/

Measure: increase the percentage of schools adopting model policies and programming.

Schools that implement the recommended physical activity policies and programs reduce the incidence of childhood obesity and chronic disease in their students.

➔ Implement integrated, intensive, and comprehensive Elementary Children's Physical Activity and Nutrition Program
http://www.nhlbi.nih.gov/health/public/heart/obesity/wecan/

Measure: increase in the number of obese or overweight children who participate in a model program to reduce childhood obesity

For children that are already overweight, treatment options are very few; and even fewer options are research or evidence-based (to demonstrate effectiveness). The WECAN model is a promising approach to combine community, school, parents, and media partners.

➔ Policy changes to increase physical activity in childcare settings

Measure: increase in the percent of childcare settings with model

Policies to increase physical activity and decrease screen time in childcare settings can combine training with voluntary policy-making, or can mandate these changes through licensing rules.

physical activity policies.

➔ Implement intervention to reduce screen time in children.

http://www.thecommunityguide.org/obesity/behavioral.html

Measure: decrease in the amount of screen time reported by students

The Community Preventive Services Task Force recommends behavioral interventions aimed at reducing screen time based on sufficient evidence of effectiveness for reducing measured screen time and improving weight-related outcomes among children and adolescents and in a variety of settings. Obtaining stable, ongoing funding for programs such as these is often challenging.

Objective 8. Facilitate access to safe, accessible, and affordable places for physical activity by developing new places, and promoting and maintaining current places. Support workplace policies and programs that increase physical activity.

➔ Point of Decision Prompts for Physical Activity (take the stairs)

Measure: increase the number of point of decision prompts

This intervention involves using point of decision prompts to use stairs and also suggests enhancing the safety and comfort of taking the stairs to increase physical activity. This strategy should be combined with other strategies to have a measureable impact on physical activity levels.

➔ Shared Use Policies that open schools for community members physical activity

http://changelabsolutions.org/publications/model-JUAs-national

Measure: increase in the number of shared use policies in schools

One strategy for increasing opportunities for physical activity is to open school facilities during non-school hours. This strategy may be particularly effective in increasing physical activity levels of parents of school-age children. Rural areas without any other access to recreation facilities, and urban areas without access to free or low-cost facilities, may particularly benefit from this strategy.

➔ Implement evidence-based individually adapted behavior change programs (such as Worksite Wellness programs, i.e. Health Plus, which includes comprehensive check up)

http://www.cdc.gov/obesity/downloads/PA_2011_WEB.pdf

Measure: percentage of adults who have access to evidence-based behavioral change programs through their worksite or provided as a work benefit.

Few workers have access to an evidence-based worksite wellness program that demonstrates improved health outcomes. Programs should be combined with worksite policy and environmental changes to maximize impact.

➔ Implement low or no-cost physical activity programs such as sports or walking clubs with community, non-profit, and faith-based organizations

Social support interventions can serve as an important precursor to, or component of, other physical activity interventions that focus on environment and access. They are logical adjuncts to many other strategies because they provide ways for participants to identify barriers to physical activity and come up with solutions. They also can provide companionship and support to help group members achieve their goals.

Measure: increase in the number of persons who can be served through low-cost or no-cost physical activity programs

➔ Increase the number of worksites and organizations with comprehensive wellness policies informed by assessments
http://mihealthtools.org/work/
http://www.cdc.gov/healthycommunitiesprogram/tools/change/downloads.htm

Measure: increase the percentage of worksites that have

Worksites and organizations can utilize an assessment structure to help them identify strengths and weaknesses, as well as potential interventions to improve wellness at their organization.

Access to Quality Healthcare

How can we build a community system of care so that everyone has affordable, timely, and reliable access to high quality primary and specialty healthcare services in ambulatory and hospital settings?

The Capital Region of Michigan boasts a wide variety of organizations, government officials, health service providers, and safety net providers who have collaborated with a goal of 100% coverage and 100% access with 0% disparities. The Capital Area has instituted a wide range of progressive programs and policies over the past fifteen years that have resulted in many people obtaining access to health services that they otherwise would have been unable to access.

Continuing this legacy, the community identified "access to quality healthcare" as a priority strategic issue. Many persons felt that even though there are some healthcare services available to uninsured and Medicaid populations, the quality of services available is lower than that available for those with higher incomes or those with private insurance. Data from the Community Health Profile indicate that even though physicians are concentrated in Ingham County, people there are least likely to report that they have a primary care clinician -- a paradox that those who live in closest proximity to medical resources often have the most difficulty in obtaining access to them.

During the prioritization process, the participants ranked "access to quality healthcare" as high in "seriousness", "catalytic", and "control". Many felt empowered by past success in this area to continue to make improvements in this area.

Participants in the root cause analysis identified a variety of barriers to accessing healthcare, a number of reasons why people don't have insurance, and why some people don't have a primary care doctor. Strategies were recommended that address these root causes.

Suggested Actions from the Community Dialogues

- To improve health and quality of life, all individuals must have health insurance and access to affordable primary and specialty care, including dental health care.
- Free clinics should provide physical, mental, and nutrition services, as well as treatment for substance abuse; information about free clinics needs to be more widely distributed.
- Medical offices should have spec-trans applications in order to make it easier for patients who cannot use fixed transportation to get to their health appointments. There should also be increased bus routes, shuttle services, and bus passes to simplify transportation to and from medical offices.
- Other counties should adopt a program such as New Freedom through Clinton Transit, which provides transportation to frail & disabled individuals for health service appointments.
- People who live in rural communities, and teens who need reproductive health care, should have access to the health services they need. Family Planning should also become a focus, since teen pregnancies occur too often, and result in reduced options later in life.
- Healthcare providers should be given incentives to locate their practices in rural and inner-city areas, in order to reach members of the community whose health needs are sometimes ignored.
- Encourage doctors to accept more Medicaid patients, as well as individuals with low-income health plans.
- Home health visits as well as traveling/mobile health clinics to those in underserved areas.
- More support and funding behind community social work and Federally Qualified Health Centers. In Charlotte, participants felt as though there is little access to healthcare, and many people fall through the cracks.
- A community health program should be developed and supported by the health department and hospitals.
- Healthcare providers should go beyond providing medical services, but should also be a source of preventative information on health, nutrition, exercise, and valuable resources.
- Providers should be subsidized to provide quality care for all patients.

Goal: Access to Quality Healthcare

Increase access to affordable healthcare services, and improve the quality of healthcare services.

Objective 1. Increase the percentage of people with health insurance coverage

Recommended strategies:

➔ Develop and implement a coordinated plan to maximize the enrollment of newly eligible local persons into Medicaid and private insurance under Health Reform in 2014

Measure: establish a coordinated plan, increase the percentage of persons enrolled in Medicaid that are eligible

Rationale:

There is currently no shared strategy to address this issue across the tri-county area. A coordinated system with established lines of communication would result in more access to health insurance coverage than a fragmented, scattered approach.

Objective 2. Increase the percentage of people with a specific source of primary care

Recommended strategies:

➔ Expand Community Health Centers *(i.e. Federally Qualified Health Centers (FQHC), FQHC Look-alike Clinics, Charitable Care / Free Clinics)* to serve a greater number of people in Ingham County and establish new sites to serve those in Eaton and Clinton counties. http://www.countyhealthrankings.org/program/federally-qualified-health-centers-fqhcs

Measure: increase the numbers of people served through existing FQHC's, establish New Access Points for FQHCs in Clinton County and Eaton County.

Rationale:

Many people who are uninsured or with Medicaid have difficulty finding a primary care doctor. These types of clinics accept patients regardless of their ability to pay or insurance status. More safety net provider capacity is needed to serve the influx of new Medicaid patients and those that will continue to be uninsured.

There is strong evidence that Federally qualified health centers (FQHCs) increase access to primary care and improve health outcomes for their patients. By serving the uninsured, underinsured, and other vulnerable patients, FQHCs reduce disparities in access to care. Patients who receive most of their ambulatory care at community health centers have lower overall medical expenditures than those who receive care elsewhere. Investments in community health centers have been shown to reduce costs for local health care systems and provide economic benefits for surrounding communities.

➔ Increase the number of practicing primary care providers (Medical Doctors, Doctors of Osteopathic Medicine, Physician's Assistants, Nurse Practitioners)

Measure: improve the ratio of providers:population.

With the anticipated number of people entering the healthcare system in 2014, we will need additional providers. It may require the use of more mid-level providers such as Nurse Practitioners or Physician's Assistants.

➔ Increase the percent of practicing primary care providers (MD, DO, PA, NP) whose panel of patients with Medicaid matches the percent of the population with Medicaid. Payors may consider offering an incentive to providers who can demonstrate that they are doing their "fair share".

Measure: increase the mean or median percentage of patients served by providers who are Medicaid patients

Often, providers in private practice have only a small percentage of their patients who have Medicaid due to very low reimbursement rates and because these patients are more medically complex. Because providers will be offered a higher payment rate for Medicaid patients in 2013 and 2014, this is a good time to encourage providers to increase the percent of their patients with Medicaid.

➔ Increase the percent of primary care practices offering non-traditional hours for routine care

Many people work non-traditional schedules, lack paid sick time, have limited transportation options, or have family

Measure: Increase the percent of primary care practices offering non-traditional hours for routine care

obligations that make accessing medical care during traditional office hours difficult. This increases reliance on emergency room care for people both with and without insurance. People who are most likely to lack a specific source of primary care are also most likely to benefit from expanded office hours.

Objective 3. Increase utilization of clinical and community preventive services

Recommended strategies:

Rationale:

➔ Use payment and reimbursement mechanisms to encourage delivery of clinical preventive services *(i.e. payors reduce or eliminate cost-sharing for evidence- based clinical preventive services, payors actively increase utilization of recommended services through data analysis and outreach)* Clinical preventive services are things such as screenings, low-cost preventive medications like aspirin therapy, and immunizations. http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf

Making preventive services free at the point of care is critical to increasing their use, but is not sufficient. Delivery of clinical preventive services increases when providers can maximize reimbursements through billing systems, and be incentivized for providing evidence-based services with measurable treatment outcomes. (NPS)

Measure: improve the utilization of clinical preventive services by healthcare providers

➔ Support implementation of community-based preventive services and enhance linkages with primary care *(i.e. tobacco cessation quitline and asthma home environment intervention program linked to clinicians as referral points) One model is known as* **SBIRT** *(Screening, Brief Intervention, and Referral to Treatment) which utilizes clinicians and community resources to achieve better health outcomes that either can achieve alone.*

Clinical and community prevention efforts should be mutually reinforcing – people should receive appropriate preventive care in clinical settings (e.g., a clinician providing tobacco cessation counseling and medication) and also be supported by community-based resources (e.g. tobacco quitlines). Some preventive services can be delivered completely outside of traditional medical settings. (NPS)

http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf

http://www.integration.samhsa.gov/clinical-practice/sbirt

Measure: increase the number of healthcare providers trained to implement SBIRT or similar efforts.

➔ Implement evidence-based interventions to prevent Cardiovascular Disease and its complications (i.e. aspirin therapy, controlling high blood pressure, cholesterol reduction, smoking cessation services), and develop incentives and accountability mechanisms to broaden reach and increase utilization.

Healthcare quality can be enhanced to achieve maximum population impact in the area of cardiovascular disease prevention. All medical providers in ambulatory and hospital settings should consistently implement evidence-based preventive practices, and monitor and evaluate the results.

http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf

http://www.healthcare.gov/law/resources/reports/quality03212011a.html#s2-4

Measure: increase the percentage of patients that have received evidence-based preventive treatment

Objective 4. Enhance coordination and integration of clinical, behavioral, and complementary health services, and reduce barriers to accessing healthcare services.

Recommended strategies:

➔ Implement effective care coordination models (i.e. medical homes, community health workers).

Medical homes provide continuous, comprehensive, whole person primary care (NCQA – PCMH, PCPCC – PCMH). In this model of care, personal physicians and their teams coordinate care across the health care system, working with patients to address all their preventive, acute, and chronic health care needs, and arranging care with other qualified health professionals as needed. Medical homes offer enhanced access, including expanded hours and easy communication options for patients. They also practice evidence-based medicine, measure performance, and strive to improve care quality

http://www.countyhealthrankings.org/program/medical-homes

Community health workers (CHW) serve a variety of functions, including: providing outreach, education, referral and follow-up, case management, advocacy and home visiting services. CHW services are often targeted at women who are at high risk for poor birth outcomes,

http://www.countyhealthrankings.org/program/expand-use-community-health-workers-chw

Measure: reduction in the rate of preventable hospitalizations

➔ Implement Patient shared decision making models in primary care settings

Under a shared decision making (SDM) process, health care practitioners and patients work together to make joint decisions about a patient's care. SDM requires that patients be educated about and understand risks and benefits of their options. SDM is an important part of patient-centered care; education is often through the use of decision aids, such as pamphlets and videos.
http://www.countyhealthrankings.org/program/patient-shared-decision-making-sdm

Measure: increase number of physicians/providers trained to provide patient-shared-decision making

➔ Implement health systems navigation services (i.e. Promotora, Patient Navigators, Peer Coaches)

http://www.countyhealthrankings.org/program/systems-navigators-and-integration-eg-patient-navigators

Measure: increase the number of patients with access to a patient navigator or peer coach

Rationale:

There is strong evidence that medical homes improve health care quality. By proactively caring for patients, medical homes reduce preventable hospitalizations and emergency room visits.

Medical homes can increase continuity of care, evidence-based care, and patient or family participation. By increasing patient monitoring and non-urgent care, medical homes reduce duplicate services and emergency room visits.

Effects appear strongest for children with special health care needs and persons with chronic conditions such as diabetes or depression.

Medical homes reduce emergency visits for asthmatics. They may also reduce disparities in health outcomes. Some medical homes have been shown to improve access and preventive care, increase continuity of care, and reduce emergency room visits for low income persons.

There is strong evidence that Community Health Worker (CHW) interventions improve a variety of health outcomes and behaviors, and increase access to care, particularly among racial and ethnic minority women CHW models are a suggested strategy to promote healthy behaviors and connect underserved populations.

This strategy aims to reduce unnecessary medical interventions, improve compliance with treatment, and improve quality of medical care provided. There is strong evidence that patient shared decision making (SDM) using decision aids improves patients' knowledge of treatment options and increases their involvement in the decision making process.

Patient SDM using decision aids is a suggested strategy to control costs and may improve health outcomes.

Patient navigators provide culturally sensitive assistance and care-coordination, guiding patients through available medical, insurance, and social support systems. These programs seek to reduce racial, ethnic, and economic disparities in access to care and disease outcomes

SAMPLE ---- SAMPLE ---- SAMPLE ---- SAMPLE ---- SAMPLE

Selection and Partnership Tool

This tool will be distributed to organizations and persons participating in the Community Advisory Committee as well as additional potential partners. Responses will be collected and inventoried to help the committee in selection of the final strategies. It is anticipated that the community will not implement all of those recommended in the CHIP: Setting a Shared Course document – but rather a *selection* of those with significant interest and capacity. Additional strategies may be considered for development or capacity building, however.

In this sample, only one set of strategies is displayed – the full tool will include all recommended strategies.

Objective 1. Implement and strengthen policies and programs to enhance transportation safety.	Lead Organization	Partner Organization	Support	Not Applicable
Recommended strategies:				
➔ Strengthen policies that reduce driving while drowsy or distracted (cell phone use, texting, etc)				x
➔ Pedestrian safety education – implement a pedestrian safety campaign in communities, develop education materials for outreach purposes, advocate for accessible crosswalks, etc.				x
➔ Advocate to re-establish Michigan Motorcycle helmet law.	x			
➔ Advocate for bicycle safety helmet laws.			x	
➔ Enhanced enforcement of speeding				x
➔ Reduce alcohol-related traffic crashes through collaboration with area Substance Abuse Prevention Coalitions		x		

DEFINITIONS:

Lead Organization:
A lead organization takes a primary responsibility for implementing a particular strategy, which may include any of these: staff time, organizational resources, internal funding realignments, program development, starting and/or maintaining a multi-sectored coalition, developing collaborative partnerships, marketing/public relations efforts to increase the community's capacity to address the issue, or rigorous advocacy for policy changes.

Partner Organization:
Organizations are visible partners along with other entities in the community, and take on a significant role in accomplishing the strategy.

Support:
This category includes a variety of actions that indicate that the organization will support a strategy. Support may include willingness to serve on an existing coalition or workgroup, prioritizing local funding to encourage adoption of a strategy, or willingness to serve as an advocate on the issue in your own circle of influence.

Not Applicable:
Not related to my organization's mission/vision, or too far outside our scope.