



# Community strategy and indicator toolkit: Maternal and infant health

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

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

## Priority outcome indicators

Desired outcome	Indicator name	Indicator description	Data source (lead agency)
Reduce preterm births	<b>Total preterm births</b> (#14)	Percent of live births that are preterm: <37 weeks gestation (Vital Stats, ODH)	Bureau of Vital Statistics (ODH)
	<b>Very preterm births</b> (#15)	Percent of live births that are very preterm: < 32 weeks gestation (Vital Stats, ODH)	Bureau of Vital Statistics (ODH)
Reduce low birth weight	<b>Low birth weight births</b> (#16)	Percent of births in which the newborn weighed <2,500 grams (Vital Stats, ODH)	Bureau of Vital Statistics (ODH)
Reduce infant mortality	<b>Infant mortality</b> (#17)	Rate of infant deaths per 1,000 live births (Vital Stats, ODH)	Bureau of Vital Statistics (ODH)
	<b>Neonatal infant mortality</b> (#18)	Rate of neonatal infant deaths per 1,000 live births (Vital Stats, ODH)	Bureau of Vital Statistics (ODH)
	<b>Post-neonatal infant mortality</b> (#19)	Rate of post-neonatal infant deaths per 1,000 live births (Vital Stats, ODH)	Bureau of Vital Statistics (ODH)

## Cross-cutting strategies and outcome indicators

### How were these strategies selected?

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

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

### Impact on disparities and inequities

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

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

## Social determinants of health: Strategies and outcome indicators

Strategy	Likely to decrease disparities	Indicator to measure impact of strategy (source)
<b>School-based health</b>		
<b>School-based health centers</b>	✓	Chronic absenteeism (ODE) (#23)
		Third grade reading (ODE) (#21)
		High school graduation (ODE) (#22)
<b>Early childhood supports</b>		
<b>Early childhood education (includes center-based early childhood education, preschool education programs and universal pre-kindergarten)</b>	✓	Kindergarten readiness (KRA, ODE) (#20)
		Preschool enrollment (ACS) (#24)
<b>Early childhood home visiting programs</b> See also: <b>Early childhood home visitation to prevent child maltreatment and specific evidence-based home visiting models supported by the Ohio Department of Health</b>	✓	Child abuse and neglect (JFS) (#87)
		Kindergarten readiness (KRA, ODE) (#20)
		Home visiting during infancy (OPAS) (#25)
<b>Affordable, quality housing</b>		
<b>Home improvement loans and grants</b> (see also: <b>housing rehabilitation loan and grant programs</b> )	✓	Adult depression (major depressive episodes) (priority outcome indicator) (NSDUH) (#3)
		Maternal depression or anxiety during pregnancy (OPAS) (#98)
		Postpartum depression (OPAS) (#99)
<b>Service-enriched housing</b> focusing on family health and tobacco cessation	✓	Severe housing problems (HUD via CHR) (#34)

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

Strategy	Likely to decrease disparities	Indicator to measure impact of strategy (source)
<b>Employment and income</b>		
<b>Earned income tax credits</b> (local option: outreach to increase uptake)	✓	Child poverty (ACS via CHR) (#29)
		Adult poverty (ACS) (#30)
		Household income before pregnancy (OPAS) (#32)
		Problems paying bills before pregnancy (OPAS) (#31)
		Maternal depression or anxiety during pregnancy (OPAS) (#98)
		Postpartum depression (OPAS) (#99)
		Low birth weight (priority outcome indicator) (VS) (#16)
Infant mortality (priority outcome indicator) (VS) (#17)		
<b>Employment programs, such as:</b>		
<b>Vocational training for adults</b>	✓	Household income (ACS via CHR) (#26)
		Unemployment (BLS and CPS via CHR) (#27)
		Labor force participation (BLS and CPS) (#28)
		Job loss before pregnancy (OPAS) (#33)
<b>Transitional jobs</b>	✓	Household income (ACS via CHR) (#26)
		Unemployment (BLS and CPS via CHR) (#27)
		Labor force participation (BLS and CPS) (#28)
		Job loss before pregnancy (OPAS) (#23)
<b>Local/regional built environment changes to support active living and social connectedness</b>		
<b>Community-scale urban design land use policies and Streetscape design (Complete Streets)</b>		Physical inactivity (no leisure time physical activity) (adult) (BRFSS via CHR) (#57)
		Insufficient physical activity (adult) (BRFSS) (#58)
		Physical inactivity (youth) (YRBSS) (#59)
<b>Bike and pedestrian master plans</b>		Physical inactivity (no leisure time physical activity) (adult) (BRFSS via CHR) (#57)
		Insufficient physical activity (adult) (BRFSS) (#58)
		Physical inactivity (youth) (YRBSS) (#59)
		Alternative commute modes (ACS) (#40)
		Driving alone to work (ACS via CHR) (#39)
<b>Green spaces and parks</b>	✓	Physical inactivity (no leisure time physical activity) (adult) (BRFSS via CHR) (#57)
		Insufficient physical activity (adult) (BRFSS) (#58)
		Physical inactivity (youth) (YRBSS) (#59)
		Access to exercise opportunities (Census via CHR) (#38)

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

Strategy	Likely to decrease disparities	Indicator to measure impact of strategy (source)
<b>Public building siting considerations</b> (such as location of school buildings)		Physical inactivity (no leisure time physical activity) (adult) (BRFSS via CHR) (#57)
		Insufficient physical activity (adult) (BRFSS) (#58)
		Physical inactivity (youth) (YRBSS) (#59)
<b>Smoke-free environments</b>		
<b>Smoke-free policies</b> (including maintenance of smoke-free workplace law and increased policy adoption for multi-unit housing, schools and other settings) (see also: <b>Smoke-free policies for indoor areas</b> , <b>smoke-free policies for outdoor areas</b> and <b>smoke-free policies for multi-unit housing</b> )	✓	Children exposed to secondhand smoke at home (NSCH) (#43)
		Adolescents exposed to secondhand smoke (OYTS) (#44)
		Adults exposed to secondhand smoke (home, car, public spaces, etc.) (BRFSS) (#45)
		Adults exposed to secondhand smoke at home (BRFSS) (#46)
		Tobacco-free policies enacted (ODH, in development) (#47)
		Adult smoking (BRFSS via CHR) (#68)
		Youth all-tobacco use (OYTS) (#69)

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

Strategy	Likely to decrease disparities	Indicator to measure impact of strategy (source)
<b>Breastfeeding</b>		
<b>Breastfeeding promotion programs</b>	✓	Breastfeeding information (OPAS) (#81)
		Ever breastfed (OPAS) (#82)
		Breastfed at 6 months (OPAS) (#83)
		Breastfed at discharge from hospital (VS) (#84)
		Exclusively breastfed at discharge from hospital (VS) (#85)
<b>Services to support healthy birth spacing</b>		
<b>Preconception education interventions</b> that provide information about the risks and benefits of behaviors that affect a woman's health before, during and after pregnancy (presented by medical providers, public health professionals, lay people or others with relevant education and training)		Preconception planning—birth control (OPAS) (#77)
		Preconception planning—health improvement (OPAS) (#78)
		Preconception planning—healthy weight (OPAS) (#79)
		Preconception planning—medical conditions (OPAS) (#80)
<b>Increase awareness of the full-range of efficacy-based contraceptive options including LARC</b>		Inter-pregnancy intervals (VS) (#75)
<b>School-based prevention programs and policies</b>		
<b>School-based health centers</b>	✓	Chronic absenteeism (ODE) (#23)
		Third grade reading (ODE) (#21)
		High school graduation (ODE) (#22)
<b>School-based physical activity programs and policies:</b>		
<b>Active recess</b> and policy adoption for minimum amounts of recess		Physical inactivity (youth) (YRBSS) (#59)
<b>Physically active classrooms</b>		Physical inactivity (youth) (YRBSS) (#59)
<b>School-based physical education</b> and <b>Enhanced school-based physical education</b>		Physical inactivity (youth) (YRBSS) (#59)
<b>Extracurricular activities for physical activity</b>		Physical inactivity (youth) (YRBSS) (#59)
<b>School-based nutrition programs and policies:</b>		
<b>School breakfast programs</b>	✓	Chronic absenteeism (ODE) (#23)
		Third grade reading (ODE) (#21)
		Food insecurity (CPS/BLS/ACS via CHR) (#49)
		Fruit consumption (youth) (YRBSS) (#53)
		Vegetable consumption (youth) (YRBSS) (#54)
<b>Competitive pricing for healthy food</b>		Fruit consumption (youth) (YRBSS) (#53)
		Vegetable consumption (youth) (YRBSS) (#54)
<b>School-based nutrition education programs</b>		Fruit consumption (youth) (YRBSS) (#53)
		Vegetable consumption (youth) (YRBSS) (#54)
<b>School fruit and vegetable gardens</b>		Fruit consumption (youth) (YRBSS) (#53)
		Vegetable consumption (youth) (YRBSS) (#54)
<b>Farm to school programs</b>		Fruit consumption (youth) (YRBSS) (#53)
		Vegetable consumption (youth) (YRBSS) (#54)

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

Strategy	Likely to decrease disparities	Indicator to measure impact of strategy (source)
<b>Community-based active living and healthy eating support</b>		
<b>Community healthy food access:</b>		
Community gardens		Vegetable consumption (adult) (BRFSS) (#52)
Healthy food initiatives in food banks	✓	Food insecurity (CPS/BLS/ACS via CHR) (#49)
		Fruit consumption (adult) (BRFSS) (#51)
		Vegetable consumption (adult) (BRFSS) (#52)
		Fruit consumption (youth) (YRBSS) (#53)
		Vegetable consumption (youth) (YRBSS) (#54)
Farmers' markets/stands		Fruit consumption (adult) (BRFSS) (#51)
	Vegetable consumption (adult) (BRFSS) (#52)	
	Fruit consumption (youth) (YRBSS) (#53)	
	Vegetable consumption (youth) (YRBSS) (#54)	
Healthy food in convenience stores	✓	Limited access to healthy foods (USDA via CHR) (#48)
		Fruit consumption (adult) (BRFSS) (#51)
		Vegetable consumption (adult) (BRFSS) (#52)
		Fruit consumption (youth) (YRBSS) (#53)
		Vegetable consumption (youth) (YRBSS) (#54)
Competitive pricing—fruit and vegetable incentive programs		Fruit consumption (adult) (BRFSS) (#51)
	Vegetable consumption (adult) (BRFSS) (#52)	
	Fruit consumption (youth) (YRBSS) (#53)	
	Vegetable consumption (youth) (YRBSS) (#54)	
WIC and senior farmers' market nutrition programs	✓	Fruit consumption (adult) (BRFSS) (#51)
		Vegetable consumption (adult) (BRFSS) (#52)
		Fruit and vegetable consumption among young children (TBD) (#55)
SNAP infrastructure at farmers' markets/EBT payment at farmers' markets		Fruit consumption (adult) (BRFSS) (#51)
	Vegetable consumption (adult) (BRFSS) (#52)	
	Fruit consumption (youth) (YRBSS) (#53)	
	Vegetable consumption (youth) (YRBSS) (#54)	
<b>Community physical activity programs:</b>		
Shared use (joint use agreements)	✓	Access to exercise opportunities (CHR) (#38)
		Physical inactivity (no leisure time physical activity) (adult) (BRFSS) (#57)
		Insufficient physical activity (adult) (BRFSS) (#58)
		Physical inactivity (youth) (YRBSS) (#59)
Community fitness programs		Access to exercise opportunities (CHR) (#38)
	Physical inactivity (no leisure time physical activity) (adult) (BRFSS) (#57)	
	Insufficient physical activity (adult) (BRFSS) (#58)	
Individually-adapted health behavior change programs		Physical inactivity (no leisure time physical activity) (adult) (BRFSS) (#57)
	Insufficient physical activity (adult) (BRFSS) (#58)	

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

Strategy	Likely to decrease disparities	Indicator to measure impact of strategy (source)
<b>Social support interventions for physical activity in community settings</b> (see also: <b>Community-based social support for physical activity</b> )		Physical inactivity (no leisure time physical activity) (adult) (BRFSS) (#57)
		Insufficient physical activity (adult) (BRFSS) (#58)
<b>Community-wide physical activity campaigns</b> (see also: <b>Community-wide physical activity campaigns</b> )		Physical inactivity (no leisure time physical activity) (adult) (BRFSS) (#57)
		Insufficient physical activity (adult) (BRFSS) (#58)
<b>Tobacco prevention and cessation</b>		
<b>Increasing the price of tobacco products (cigarette and/or other tobacco products tax)</b> (see also: <b>Tobacco pricing</b> )	✓	Adult smoking (BRFSS) (#68)
		Youth all-tobacco use (OYTS) (#69)
		Quit attempts (adults) (BRFSS) (#179)
		Smoking during pregnancy (VS) (#70)
		Maternal tobacco use (OPAS) (#71)
		Tobacco use before pregnancy (OPAS) (#72)
<b>Policies to decrease availability of tobacco products</b> (see also: <b>Tobacco access restrictions for minors</b> and <b>Minimum tobacco age laws</b> )		Youth all-tobacco use (OYTS) (#69)
		Access to tobacco products (Countertobacco.org) (#74)
		Smoking during pregnancy (VS) (#70)
		Maternal tobacco use (OPAS) (#71)
		Tobacco use before pregnancy (OPAS) (#72)
		Tobacco use in last 3 months of pregnancy (OPAS) (#73)
<b>Mass-reach communications</b>		Adult smoking (BRFSS) (#68)
		Youth all-tobacco use (OYTS) (#69)
		Quit attempts (adults) (BRFSS) (#179)
		Smoking during pregnancy (VS) (#70)
		Maternal tobacco use (OPAS) (#71)
		Tobacco use before pregnancy (OPAS) (#72)
<b>Links to cessation support</b> , including focus on helping parents of children with asthma to quit (see Healthcare system and access for strategies)		Smoking during pregnancy (VS) (#70)
		Maternal tobacco use (OPAS) (#71)
		Tobacco use before pregnancy (OPAS) (#72)
		Tobacco use in last 3 months of pregnancy (OPAS) (#73)

## Healthcare system and access: Strategies and outcome indicators

Strategy	Likely to decrease disparities	Indicator to measure impact of strategy (source)
<b>Medicaid modernization and increase access to coverage</b>		
<b>Health insurance enrollment and outreach</b>	✓	Uninsured adults (ACS and CHR) (#133) Uninsured children (ACS and CHR) (#134) Uninsured pregnant women (OPAS) (#157) Out-of-pocket spending (RWJF DataHub) (#135)
<b>Paying for value</b>		
Improve access to comprehensive primary care ( <b>Patient Centered Medical Homes</b> )	✓	Medical home, children (NSCH) (#136) Unable to see doctor due to cost (BRFSS) (#137) Without usual source of care (BRFSS) (#138) Potentially avoidable emergency department visits for Medicare (CWF) (#152) Prenatal care (VS) (#158) Provider visit prior to pregnancy (OPAS) (#159)
<b>Care coordination</b>		
<b>Community health workers</b> (including workers in community-based settings to address social determinants of health)	✓	Without usual source of care (BRFSS) (#138) Prenatal care (VS) (#158) Provider visit prior to pregnancy (OPAS) (#159) Preconception planning – birth control (OPAS) (#77) Preconception planning - health improvement (OPAS) (#78) Preconception planning - healthy weight (OPAS) (#79) Preconception planning – medical conditions (OPAS) (#80) Smoking in early pregnancy (OPAS) (#160) Smoking in late pregnancy (OPAS) (#161) Alcohol in early pregnancy (OPAS) (#162) Alcohol in late pregnancy (OPAS) (#163) Provider availability—Community Health Workers (TBD) (#146) Use of Community Health Workers (TBD) (#147)
<b>Pathways Community HUB model</b> (including community-based settings to address social determinants of health)	✓	Without usual source of care (BRFSS) (#138) Prenatal care (VS) (#158) Provider visit prior to pregnancy (OPAS) (#159) Preconception planning—birth control (OPAS) (#77) Preconception planning - health improvement (OPAS) (#78) Preconception planning - healthy weight (OPAS) (#79) Preconception planning – medical conditions (OPAS) (#80)



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

Strategy	Likely to decrease disparities	Indicator to measure impact of strategy (source)
<b>Standardized screening and evidence-based treatment services</b>		
<b>Progesterone treatment</b> (including screening for high-risk women)	✓	Preterm birth (VS) (#14)
<b>Provider counseling with patients about preconception health and reproductive life plans</b>	✓ (only reproductive life plans)	Preconception planning—birth control (OPAS) (#77)
		Preconception planning—health improvement (OPAS) (#78)
		Preconception planning—healthy weight (OPAS) (#79)
		Preconception planning—medical conditions (OPAS) (#80)
		Smoking in early pregnancy (OPAS) (#160)
		Smoking in late pregnancy (OPAS) (#161)
		Alcohol in early pregnancy (OPAS) (#162)
		Alcohol in late pregnancy (OPAS) (#163)
		Pre-pregnancy diabetes (OPAS) (#165)
		Pre-pregnancy high blood pressure or hypertension (OPAS) (#166)
<b>Comprehensive contraceptive options</b> (includes provider reimbursement, removing administrative and logistical barriers, unbundling payments to allow for immediate post-partum insertion of LARC)		Inter-pregnancy intervals (VS) (#75)
		Unintended pregnancy (OPAS) (#76)
<b>Increase breastfeeding support at birth facilities</b>	✓	Breastfeeding information (OPAS) (#81)
		Ever breastfed (OPAS) (#82)
		Breastfed at 6 months (OPAS) (#83)
		Breastfed at discharge from hospital (VS) (#84)
		Exclusively breastfed at discharge from hospital (VS) (#85)
		Breastfeeding support in hospitals (mPINC, CDC) (#168)
<b>Home visiting</b> (programs that begin prenatally)	✓	Home visiting during pregnancy (OPAS) (#169)
<b>Healthcare workforce to increase access to services</b>		
<b>Higher education financial incentives for health professionals serving underserved areas</b> (such as tuition reimbursement and loan repayment programs)	✓	Health professional shortage areas- primary care (HRSA) (#139)
		Provider availability- primary care physicians (AHRF/AMA via CHR) (#142)
		Provider availability- other primary care providers (AHRF/AMA via CHR) (#143)
		Provider availability- mental health providers (AHRF/AMA via CHR) (#144)
		Provider availability- dentists (AHRF/AMA via CHR) (#145)
<b>Cultural competence training for healthcare professionals</b>	✓	Cultural understanding and skills (TBD) (#150)

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

Strategy	Likely to decrease disparities	Indicator to measure impact of strategy (source)
<b>Health career recruitment for minority students</b> (can also include rural/Appalachian regions of the state and other underrepresented population groups)	✓	High school graduation rate for priority populations (ODE) (#148)
		Adult educational attainment for priority populations (ACS) (#149)
<b>Incorporate community health workers into health career recruitment for minority students and higher education financial incentives for health professionals serving underserved areas (including healthcare professions pipeline programs)</b>	✓	Health professional shortage areas- primary care (HRSA) (#139)
		Provider availability—Community Health Workers (TBD) (#146)
		Use of Community Health Workers (TBD) (#147)
<b>Educate providers on the value of integrating community health workers into a healthcare practice setting</b>	✓	Health professional shortage areas- primary care (HRSA) (#139)
		Provider availability—Community Health Workers (TBD) (#146)
		Use of Community Health Workers (TBD) (#147)
<b>Train primary care and women’s health care providers to provide patient counseling on the full-range of efficacy-based contraceptive options</b>		Preconception planning—birth control (OPAS) (#77)
<b>Infrastructure to collect accurate data about access, outcomes and disparities</b>		
Integrate public health data and healthcare system clinical data		Data not currently available—to be defined at community level
<b>Tobacco cessation services</b>		
Cessation services for pregnant women and people of childbearing age:		
<b>Expand access to evidence-based tobacco cessation treatments including individual, group and phone counseling (including Quitline) and cessation medications</b>		Smoking during pregnancy (VS) (#70)
		Tobacco before pregnancy (OPAS)(#72)
		Tobacco use in last 3 months of pregnancy (OPAS) (#73)
<b>Remove barriers that impede access to covered cessation treatments, such as cost sharing and prior authorization</b>		Smoking during pregnancy (VS) (#70)
		Tobacco before pregnancy (OPAS)(#72)
		Tobacco use in last 3 months of pregnancy (OPAS) (#73)
<b>Promote increased utilization of covered treatment benefits by tobacco users, including parents of children with asthma</b>		Smoking during pregnancy (VS)(#70)
		Tobacco before pregnancy (OPAS)(#72)
		Tobacco use in last 3 months of pregnancy (OPAS) (#73)

## Approaches to achieve health equity

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

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

## Resources for collaboration and community engagement

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

## Resources for collaboration and community engagement (cont.)

Resource	Description	Link
<b>Health Policy Institute of Ohio: Making the most of community health planning in Ohio: The role of hospitals and local health departments</b>	This policy brief describes community health planning requirements for local health departments and hospitals and identifies opportunities for increasing collaboration among various partners. The appendix includes a list of additional community health planning resources.	<a href="http://www.healthpolicyohio.org/wp-content/uploads/2016/03/PolicyBrief_CHAS_CHNAS_FINAL.pdf">http://www.healthpolicyohio.org/wp-content/uploads/2016/03/PolicyBrief_CHAS_CHNAS_FINAL.pdf</a> <a href="http://www.healthpolicyohio.org/making-the-most-of-community-health-planning/">http://www.healthpolicyohio.org/making-the-most-of-community-health-planning/</a>
<b>Hospital Council of Northwest Ohio (HCNO): HCNO approach to local collaboration in CHA and CHIP processes</b>	This brief document describes the approach HCNO has used in conducting collaborative assessments and plans with local health departments and hospitals in over 40 Ohio counties.	<a href="http://www.hcno.org/pdf/HCNO_Approach_to_Local_Collaboration_in_CHA_Improvement_Final_wLogo.pdf">http://www.hcno.org/pdf/HCNO_Approach_to_Local_Collaboration_in_CHA_Improvement_Final_wLogo.pdf</a>
<b>Local Initiatives Support Corporation (LISC): Resources for comprehensive community development</b>	Practitioner resources for engaging community members to drive neighborhood change.	<a href="http://www.instituteccd.org/resources/category/513">http://www.instituteccd.org/resources/category/513</a>
<b>M + R: Coalition Mapping Worksheet</b>	This tool (from M + R) can help identify new sources of support, resources, and perspectives.	<a href="http://www.countyhealthrankings.org/resources/practitioner%E2%80%99s-guide-advancing-health-equity">http://www.countyhealthrankings.org/resources/practitioner%E2%80%99s-guide-advancing-health-equity</a>
<b>M + R: Effective Recruitment of Coalition Members</b>	This tool (from M + R) helps you analyze “what’s in it for them?” when recruiting a new organization.	<a href="http://www.countyhealthrankings.org/resources/effective-recruitment-coalition-members">http://www.countyhealthrankings.org/resources/effective-recruitment-coalition-members</a>
<b>Missouri Foundation for Health’s Social Innovation for Missouri Project: Coalition Core Competencies Checklist</b>	This tool helps your team identify where your strengths are in the improvement process and where additional skills, knowledge, and/or resources may be needed.	<a href="http://www.countyhealthrankings.org/resources/coalition-core-competencies-checklist">http://www.countyhealthrankings.org/resources/coalition-core-competencies-checklist</a>
<b>NAACHO Resource Center: Engaging Partners, Stakeholders and Community Members</b>	This tool demonstrates how to engage community stakeholders from a variety of local sectors.	<a href="http://www.naccho.org/programs/public-health-infrastructure/community-health-assessment/resources">http://www.naccho.org/programs/public-health-infrastructure/community-health-assessment/resources</a>
<b>Northwestern University: Asset-based Community Development</b>	This organizations provides capacity-building training, worksheets and publications on community engagement, including a series of facilitation tools such as “Creating space for resident action and engagement” and “Tips for working with neighborhoods.”	<a href="http://www.abcdinstitute.org/toolkit/index.html">http://www.abcdinstitute.org/toolkit/index.html</a>
<b>National Quality Forum - Improving Population Health by Working with Communities – Action Guide</b>	The Action Guide is a framework to help multisector groups work together to improve population health by addressing 10 interrelated elements for success and using the related resources as needed. Like a “how-to” manual, the Action Guide is organized by these 10 elements and contains definitions, recommendations, practical examples, and a range of resources to help communities achieve their shared goals and make lasting improvements in population health.	<a href="http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&amp;ItemID=83002">http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&amp;ItemID=83002</a>

## Resources for collaboration and community engagement (cont.)

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

# Glossary

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

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

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

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

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

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

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

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

## Acronyms

**ACS** — American Community Survey

**AHRF** — Area Health Resources Files

**AMA** — American Medical Association

**BLS** — U.S. Bureau of Labor Statistics

**BRFSS** — Behavioral Risk Factor Surveillance System

**CDC** — Centers for Disease Control and Prevention

**CHR** — County Health Rankings

**CMS** — Centers for Medicare & Medicaid Services

**CPS** — Current Population Survey

**CWF** — Commonwealth Fund

**HRSA** — Health Resources and Services Administration

**HUD** — U.S. Department of Housing and Urban Development

**JFS** — Ohio Department of Job and Family Services

**KRA** — Ohio's Kindergarten Readiness Assessment

**LARC** — Long-acting reversible contraception

**mPINC** — Maternity Practices in Infant Nutrition and Care survey

**NSCH** — National Survey of Children's Health

**NSDUH** — National Survey on Drug Use and Health

**ODE** — Ohio Department of Education

**ODH** — Ohio Department of Health

**OPAS** — Ohio Pregnancy Assessment Survey

**OYTS** — Ohio Youth Tobacco Survey

**RWJF** — Robert Wood Johnson Foundation

**TBD** — To be determined

**USDA** — United States Department of Agriculture

**VS** — Vital Statistics

**WIC** — Supplemental Nutrition Program for Women, Infants, and Children

**YRBSS** — Youth Risk Behavior Surveillance System