Kent County

Photo courtesy of Experience Grand Rapids

2012 Community Health Improvement Plan

Prepared for Kent County

Submitted by the Michigan Public Health Institute

on behalf of *Kent County Working Together for a Healthier Tomorrow*

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Background

VISION & MISSION

The Kent County Community Health Improvement Plan (CHIP) was developed based on the results of a Community Health Needs Assessment (CHNA) conducted in collaboration with public health system partners in Kent County in 2011.

This effort, titled Kent County Working Together for a Healthier Tomorrow, is based on a broad definition of health, specifically the definition put forth by the World Health Organization: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Using this definition as a starting point, the following vision and mission were developed to guide the planning process in Kent County:

VISION

High quality of life, health, and well-being for all people in Kent County

MISSION

The people of Kent County are empowered to achieve lifelong physical, mental, and social well-being through:

- **Equal access to high quality, affordable healthcare;**
- **A coordinated system of care that is local, preventive, holistic, and patient centered; and**
- **An environment that supports healthy living for all.**

WORKING TOGETHER

Community engagement and collaborative participation were vital to the development of the Kent County CHIP. Using a systems approach, Kent County Working Together for a Healthier Tomorrow engaged a broad group of partners and stakeholders that represented the public health system. System partners served as members of several different groups, including:

- A Steering Committee that met frequently and guided the process,
- A broad-based Coalition that met at decision points throughout the process to provide review and input, and
- Several workgroups that were convened to complete specific tasks.

The following sectors were represented: health care, education, public health, mental health and substance abuse, food systems, law enforcement, foundations, parks and recreation, urban design, community planning, business and industry, volunteer and non-profit organizations, faith based organizations, and organizations known for serving historically underserved and understudied populations. A complete listing of community partners can be found in Appendix A.

ASSESSMENT PROCESS

Kent County's community health needs assessment (CHNA) process was designed based on a variety of tools and best practices, including the Association for Community Health Improvement's Community Health Assessment Toolkit and the National Association of County and City Health Official's Mobilizing for Action through Planning and Partnerships (MAPP) framework. The CHNA involved a systematic process of engaging community partners in the examination of indicators of population health, gathering input from community members, identifying key health issues, and selecting strategic priorities. For more information, the Kent County CHNA can be downloaded from: www.kentcountychna.org/pdfs/KentCoCHNA_Final.pdf.

SELECTING STRATEGIC PRIORITIES

In order to identify the five strategic priorities that provided the starting point for the development of the CHIP, Kent County Working Together for a Healthier Tomorrow went through an organized process of reviewing the CHNA data, understanding the input of community members, and reflecting on their own experiences as professionals in the public health community.

The identification of priorities began with a joint meeting of the two workgroups that had gathered and reviewed population data and community input data for the CHNA. Workgroup members evaluated findings in detail and engaged in a facilitated process designed to elicit workgroup members' feedback on what was observed in the data. As part of this process, individuals and small groups generated ideas about the most salient assessment findings, and, as a large group, clustered similar ideas about key findings. The workgroup used these clustered findings to develop a list of strategic health issues.

Through this joint workgroup process, Kent County Working Together for a Healthier Tomorrow identified 44 strategic health issues in 8 strategic areas. In order to identify priorities, the Coalition was asked to vote on strategic issues using a structured tool and process. Coalition members rated on a four point scale from a 'high priority' to 'not a priority' the degree to which each strategic issue aligned with each of the following categories:

- Linked to the vision and mission
- Data suggest a need to improve
- Important to community members
- Ability to make an impact

Mean scores were created for each strategic issue and the issues were ordered from highest priority to lowest priority.

The Steering Committee and Coalition each met on separate dates to review the findings of the voting process. The top strategic issues were closely related, and there was little variability in the top scores. In order to identify which of the top rated strategic issues would be addressed through the CHIP, the Steering Committee and the Coalition each identified how the priorities aligned with the mission, discussed existing assets and gaps in the community, and used a dot voting procedure to select the following five strategic priorities.

STRATEGIC PRIORITIES

1. **Increase the proportion of community members, including the uninsured and the working poor, who have access to affordable healthcare to promote equal access to high quality, affordable healthcare.**
2. **Increase the number of providers available that accept Medicaid or offer low-cost/free services to promote a coordinated system of care that is local, preventive, holistic, and patient centered.**
3. **Reduce disparities in adequacy of prenatal care to promote a coordinated system of care that is local, preventive, holistic, and patient centered.**
4. **Increase healthy eating by ensuring access to healthy foods to promote an environment that supports healthy living for all.**
5. **Reduce the disparity in health risk factors and protective factors between students to promote an environment that supports healthy living for all.**

IDENTIFYING STRATEGIES TO IMPROVE COMMUNITY HEALTH

Following the completion of the CHNA, five workgroups were convened to develop a plan to address each strategic priority. Each priority workgroup was led by co-chairs and included both partners who were involved in the development of the CHNA and new partners who were stakeholders in one of the five priority areas. The workgroups were tasked with:

- Reviewing CHNA data related to their priority area;
- Assessing the strengths and assets of the current service system for addressing the priority area;
- Identifying gaps and limitations of the current system; and
- Identifying evidence-based practices that build on community assets and address gaps.

This process began with a Mind Mapping session. Mind Mapping is a facilitated brainstorming process through which a group identifies and prioritizes themes and issues related to a specific topic. The priority workgroups completed Mind Maps through a facilitated planning meeting and were provided with copies of the Maps they created. (Mind Maps are included in Appendix B.) The planning process also included an online service system assessment completed by community partners in each priority area. The assessment gathered information about what community organizations are already doing to address each priority health issue, as well as potential gaps in services or opportunities to collaborate with existing initiatives without duplicating efforts. The Mind Maps and the assessment findings provided a starting point for exploring strengths and assets, as well as gaps and limitations of the current service system. Through this early work, partners recognized significant overlap in the first two priority areas and merged them into one group.

Based on the priority workgroups' assessment of data, current practices, and opportunities for improvement, each group developed goals, objectives, and strategies. In order to facilitate this process, the priority groups reviewed the CHNA data that were relevant to their priority area. They were also provided with a list of relevant evidence-based practices.

Once each group drafted goals, objectives, and strategies, they participated in a facilitated conversation to refine and align their plans. This process involved ensuring each goal was aligned with the priority area, each objective represented a clear measure of progress toward the goal, and each strategy was likely to lead to progress toward an objective. The following definitions were used to support the review and revision of goals, objectives, and strategies:

GOALS

Broad, brief statements that explain what you want to achieve in your community and provide focus or vision for planning

OBJECTIVES

Specific, measurable, achievable, relevant, and time-bound (SMART) statements that define progress toward a goal

STRATEGIES

Methods selected to achieve a goal or objective

Each workgroup carefully reviewed their goals, objectives, and strategies against these definitions. Additionally, workgroups were asked to review and prioritize their strategies against several criteria, including:

- The strategy is directly linked to an objective, a goal, and the priority area.
- There is evidence indicating the strategy is effective.
- The strategy reflects the needs, values, and preferences of the population.
- The strategy addresses a service, policy, or system gap.
- Resources are available or the will to pursue resources exists to implement the strategy.

Action plans were then developed for high priority strategies. Action planning began with the identification of an agency or agencies that could coordinate the implementation of each strategy. Once a coordinating agency was identified, the workgroups engaged in a facilitated process to develop *milestones* for the three year implementation period and *action steps* for the first 6-9 months of implementation. Initial action plans appear in Appendices C-F. Additional action plans will be developed throughout the implementation cycle under the leadership of coordinating agencies.

Table 1 provides an overview of the CHIP timeline and activities.

Table 1. Kent County Community Health Improvement Plan Timeline

Organize	**1/12**	**2/12**	**3/12**	**4/12**	**5/12**	**6/12**	**7/12**	**8/12**	**9/12**	**10/12**
Review findings of CHNA and discuss next steps for CHIP	X									
Identify co-chairs for each strategic priority in CHNA	X									
Identify agencies and coalitions addressing this priority		X								
Invite stakeholders to participate on a CHIP workgroup		X	X							
Gather & Review System Data	**1/12**	**2/12**	**3/12**	**4/12**	**5/12**	**6/12**	**7/12**	**8/12**	**9/12**	**10/12**
Develop and administer online system assessments			X	X						
Review assessment data				X	X					
Identify community assets and gaps in services				X	X					

Identify Strategies to Address Health Priorities & Gaps	**1/12**	**2/12**	**3/12**	**4/12**	**5/12**	**6/12**	**7/12**	**8/12**	**9/12**	**10/12**
Participate in facilitated Mind Mapping session		**X**	**X**							
Gather information on evidence-based practices			**X**	**X**	**X**	**X**	**X**			
Draft work plans which include goals, objectives, strategies, activities, and responsible partners				**X**	**X**	**X**	**X**			
Present strategies in each priority area to the Steering Committee and Coalition						**X**	**X**			
Develop Health Improvement Plan	**1/12**	**2/12**	**3/12**	**4/12**	**5/12**	**6/12**	**7/12**	**8/12**	**9/12**	**10/12**
Participate in facilitated process to finalize goals, objectives, and strategies								**X**	**X**	
Distribute goals, objectives, and strategies to partners to gather input									**X**	
Participate in facilitated process to develop action plans										**X**
Dstribute CHIP to partners for review, feedback and final edits										**X**
CHIP Launched!	**November 2012**									

ORGANIZATION & STRUCTURE OF THE CHIP

The next sections of this plan describe the goals, objectives, and strategies for each priority area: Access to Affordable Healthcare, Reduce Disparity in Adequacy of Prenatal Care, Ensure Access to Healthy Foods, Reduce Disparities in Youth Risk and Protective Factors. Each section includes relevant data from Kent County's CHNA describing the health status of community members, as well as reference to relevant state and national objectives and the evidence base underlying selected strategies. The plan also describes, in brief, evaluation activities, how to get involved, the partners who developed the plan, and appendices with community-developed action plans for priority strategies.

Access to Affordable Healthcare

Priority 1 - Increase the proportion of community members, including the uninsured and the working poor, who have access to affordable healthcare.

Priority 2 - Increase the number of providers available that accept Medicaid or offer low-cost/free services.[1]

THE PROBLEM

Access to routine medical care helps people prevent illness, identify health conditions, and treat health problems. Without access to preventive care, Kent County community members fail to get routine check-ups and health screenings that detect serious disease and ensure early treatment. The Michigan Behavioral Risk Factor Surveillance System Survey (BRFSS) asks several questions about access to healthcare. According to BRFSS findings, in Kent County:

- 13.6% of adults reported no healthcare access during the past 12 months.
  - The proportion increased for adults with less than a high school education (45.3%) and those lacking health insurance (54.9%).
- 10.7% of adults reported that they have no healthcare coverage.
  - These numbers increase to 16.9% for African Americans, 19.7% for adults with only a high school education, and 23.6% for adults with less than a high school education.

HP2020: Reduce the proportion of individuals who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines by 9%.

HP2020: Increase the proportion of persons with a usual primary care provider from 76.3% to 83.9%.

These results suggest that while access to healthcare in the county overall is a strength, there are substantial disparities between population groups. This extends to youth as well. According to Michigan Profile for Healthy Youth (MiPHY) findings:

- 52.4% of youth who received Ds/Fs in school received a checkup in the past 12 months, as compared with 71.1% of A/B students.

HP2020: Increase the proportion of adolescents who have had a wellness checkup in the past 12 months from 68.7% to 75.6%.

HP2020: Increase the proportion of children, adolescents, and adults who used the oral healthcare system in the past 12 months from 44.5% to 49.0%.

Access to dental care helps to ensure oral health, and it prevents serious diseases such as heart disease. Kent County has 65.3 licensed dentists per 100,000 people. The current supply of dentists to serve low-income patients is about 55% of what is needed in Grand Rapids and only 29% of what is needed countywide. Consequently, 65% of the children enrolled in Medicaid in the county are without regular dental care. According to BRFSS findings, approximately one-fourth of adults in Kent County had not seen a dentist in the previous 12 months and this proportion increased to nearly half for adults lacking health insurance.

[1] As noted above, Priority 1 and 2 decided to work in partnership due to similarities in the two priority areas and overlap in the partners engaged in the process.

Access to behavioral health care was also identified as a challenge by community members, although population-level data were unavailable. Based on focus group findings, Kent County community members with a behavioral health problem face unique access issues. For this sub-population, the inability to get an appointment with a psychiatrist or inability to pay for needed medications led to deterioration in health.

HP2020: Increase the proportion of adults with serious mental illness who receive treatment from 58.7% to 64.6%.

Focus group participants reported using alcohol and drugs to self-medicate, and, some discussed losing a loved one to suicide because the loved one was unable to get necessary behavioral health care.

Focus group and interview participants discussed healthcare access and quality overall, and reported that the quality of healthcare in Kent County is excellent, if you can afford it. Kent County community members identified area hospitals, clinics, specialty providers, and the local health department as providing excellent service and care. However, the quality of healthcare community members received was dependent on their ability to pay for services and providers. Some of the issues that community members faced include:

- Inability to afford preventive health care;
- Using the emergency department to address deteriorating health;
- Inability to access dental and mental health providers;
- Lack of availability of low-cost and free providers;
- Lack of providers who serve patients who are insured through Medicaid;
- Provider location, availability, transportation, language, literacy, and services for individuals with special needs;
- Lack of information about what providers accept Medicaid;
- Inability to qualify for Medicaid or afford private healthcare, and a lack of jobs that provide health insurance;
- Cost of prescription medications;
- Lack of coverage for dental or vision care;
- Lack of care coordination or continuity in care; and
- Experiences that were demeaning or discriminatory when accessing care.

THE PLAN

Based on these data and their service system assessment, the Priority 1 and 2 workgroup drafted goals, objectives, strategies, and action plans to address access to healthcare issues in Kent County. In doing so, the workgroup considered the following:

1. The Patient Affordability Act will increase the number of people eligible in the State of Michigan by 500,000.
2. Medicaid Expansion: States may expand Medicaid eligibility as early as January 1, 2011. Beginning on January 1, 2014, all children, parents, and childless adults who are not entitled to Medicare and who have family incomes up to 133 percent of the Federal Poverty Level will become eligible for Medicaid. Medicaid rates will be increased to Medicare parity for FY 2013 and 2014 but there are no expectations for continued parity beyond 2014.
3. Once people are in a managed care environment, trends demonstrate appropriate utilization of care.
4. The trend in health care is for physicians to be employed by the health system. Employed physicians may increase the trend for accepting Medicaid patients.
5. The primary volume of people needing assistance with accessing care is the underserved population.

Priority 1 and 2 Goals, Objectives, and Strategies appear in Table 2. Priority 1 and 2 Action Plans appear in Appendix C. Partners from Kent County hospitals and hospital systems are developing additional action plans that align with these strategies, which will be incorporated as they are completed. The data sources for tracking objectives appear in the footnotes. The evidence-base underlying the selected strategies appears in footnotes, where appropriate.

Table 2. Goals, Objectives, and Strategies to Improve Access to Healthcare.

GOALS	OBJECTIVES[2]	STRATEGIES
1. Ensure community members have access to primary and specialty healthcare.	O1. By October 1, 2015, decrease from 10% to 9% the percentage of adults who report that they have no healthcare access.	S1. Streamline and strengthen supports for enrollment in public insurance plans in Kent County, including Medicare, Medicaid, VA, and Disability.
	O2. By October 1, 2015, reduce the disparity in healthcare access among adults in Kent County: • Decrease from 16.9% to 15.2% the percentage of African American adults without health care access • Decrease from 23.6% to 21.2% the percentage of adults with less than a high school education without health care access.	S2. Increase the capacity of providers to accept patients with Medicaid.
	O3. By October 1, 2015, decrease from 8.4% to 7.6% the proportion of adults who report that they do not have someone they think of as their personal doctor or healthcare provider.	S3. Increase public and private support for basic health services for the under/uninsured community members of Kent County.
	O4. By October 1, 2015, reduce the disparity between students who received a check up in the past 12 months by increasing from 52.4% to 57.6% the percentage of students with Ds/Fs who received a checkup.	S4. Strengthen and expand comprehensive school-based health services, including primary care services where appropriate (i.e. school nurses, school-based health centers).[3]
2. Ensure community members have access to dental healthcare.	O5. By October 1, 2015, increase from 74.2% to 81.6% the proportion of adults who report having visited a dentist in the past 12 months.	S5. Streamline and strengthen supports for enrollment in public insurance plans in Kent County, including Medicare, Medicaid, VA, and Disability.
	O6. By October 1, 2015, reduce the disparity between adults who report having visited a dentist in the past 12 months by increasing from 40.7% to 44.8% the percentage of adults with less than a high school education who have visited a dentist.	S6. Increase public and private support for dental health services for the under/uninsured community members of Kent County.
		S7. Support the agenda of the Oral Health Coalition.[4]

[2] The BRFSS is the data source for objectives O1, O2, O3, O5, & O6. The MiPHY is the data source for objective O4. Vital Records is the data source for objective O9. Objectives O7 & O8 require identifying a data source.

[3] Angin, T., Naylor, K., & Kaplan, D. (1996). Comprehensive school-based health care: High school students' use of medical, mental health, and substance abuse services. *Pediatrics*, *97*, 318-30.

[4] The Kent County Oral Health Coalition's workplan appears in Appendix C.

3. Ensure community members have access to behavioral healthcare.	O7. By October 1, 2015, develop a set of data-driven priorities for improving access to behavioral health care services for Kent County community members.	S8. Expand and coordinate data collection efforts to ensure the behavioral health care needs of Kent County community members are understood and can be tracked over time.
	O8. By October 1, 2015, decrease by 10% the proportion of adults who report that they need behavioral health services who report that they do not have access to these services.	S9. Streamline and strengthen supports for enrollment in public insurance plans in Kent County, including Medicare, Medicaid, VA, and Disability.[5]
		S10. Increase public and private support for behavioral health services for the under/ uninsured community members of Kent County.[6]
		S11. Expand the number of behavioral health providers in Kent County who take Medicaid.
		S12. Increase the capacity of providers to offer telemental health services.[7,8]
4. Ensure appropriate, timely, well-coordinated access to a continuum of health and social services.	O9. By October 1, 2015, reduce ER visits for conditions that can be prevented through access to quality primary care by 10%.	S13. Explore the implementation a Kent County Community Healthcare Hub.[9]
	O10. By October 1, 2015, reduce preventable hospital stays from 168.4/10,000 to 160/10,000.	S14. Educate Kent County community members on how to access and utilize healthcare and other services for which they are eligible.

[5] Guide to Community Preventive Services. Mental health & mental illness: mental health benefits legislation. www.thecommunityguide.org/mentalhealth/benefitslegis.html.

[6] Guide to Community Preventive Services. Interventions to reduce depression among older adults: clinic-based depression care management. www.thecommunityguide.org/mentalhealth/depression-clinic.html.

[7] Simon, G., Ludman, E., Tutty, S., Operskalski, B., & Von Korff, M. (2004). Telephone psychotherapy and telephone care management for primary care patients starting antidepressant treatment: A randomized controlled trial. *Journal of the American Medical Association*, *292*, 935-42.

[8] Grady, B., Myers, K., & Nelson E. (2009). *Evidence-based practice for telemental health: American Telemedicine Association guidelines*. American Telemedicine Association Publication.

[9] Community Care Coordination Learning Network, Agency for Healthcare Research and Quality. (2010). *Connecting those at risk to care: a guide to building a community "HUB" to promote a system of collaboration, accountability, and improved outcomes*. AHRQ Publication No. 09(10)-0088. Rockville, MD.

Reduce Disparity in Adequacy of Prenatal Care

Priority 3 - Reduce disparities in adequacy of prenatal care.

THE PROBLEM

A healthy birth begins with a healthy pregnancy, and a healthy pregnancy is supported by adequate prenatal care. Adequacy of prenatal care can be measured by the Kotelchuck Index, which is recorded in Michigan birth records. This index incorporates how early moms enter prenatal care and the number of prenatal care visits they receive. The index categorizes adequacy of prenatal care as follows:

HP2020: Increase the proportion of pregnant females who received early and adequate prenatal care from 70.5% to 77.6%.

- Adequate Plus Prenatal Care - Prenatal care begun by the 4th month and 110% or more of recommended prenatal visits were received
- Adequate Prenatal Care - Prenatal care begun by the 4th month and 80% to 109% of recommended prenatal visits were received
- Intermediate Prenatal Care - Prenatal care begun by the 4th month and 50% to 79% of recommended prenatal visits were received
- Inadequate Prenatal Care - Prenatal care begun after the 4th month or less than 50% of recommended prenatal visits were received

While adequacy in prenatal care in Kent County is comparable to Michigan, substantial disparities exist. More specifically, in Kent County, a woman is more likely to receive inadequate prenatal care if she is African American, Hispanic/Latino, or Arab American. See Figure 1.

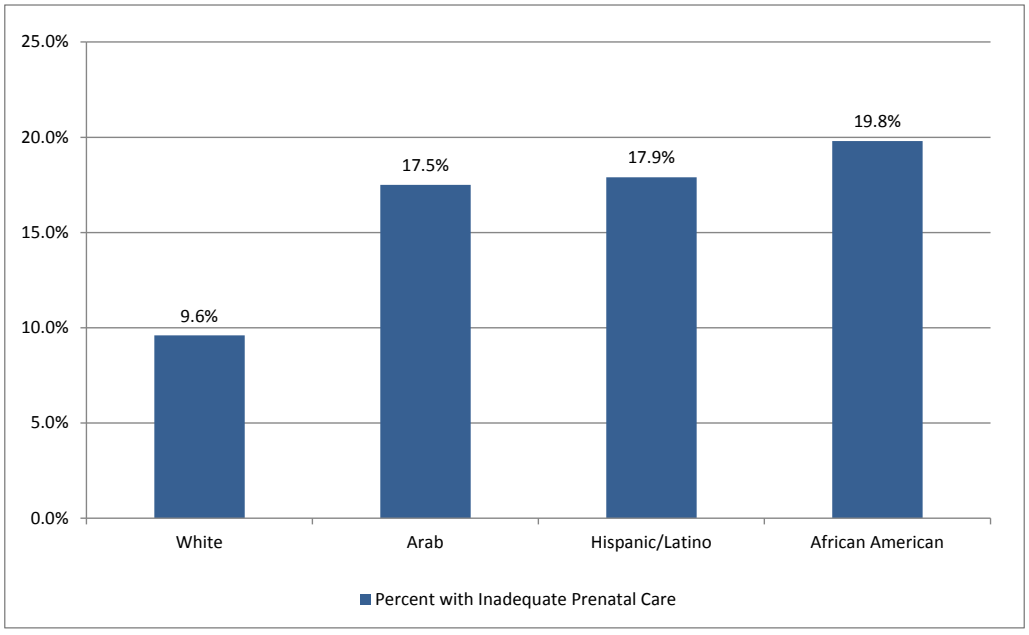

Figure 1. Percent of Births in Kent County with Inadequate Prenatal Care (Vital Records, 2009).

Beginning prenatal care in the first trimester is important to having a healthy birth, particularly because prenatal care providers can connect mothers to services that they might need early on to promote a healthy pregnancy. In Kent County, prenatal care is much less likely to begin early among younger mothers, and among mothers with a racial or ethnic background other than white. See Table 3.

HP2020: Increase the proportion of females delivering a live birth receiving prenatal care beginning in the first trimester from 70.8% to 77.9%.

Table 3. Percent of Births in Kent County with Prenatal Care Beginning in the 1st Trimester by Age and Race (Vital Records, 2009).

Age of Mother	All Races	White	African American	Arab	Hispanic/Latino
Less than 15	22.2%	25.0%	20.0%	N/A	N/A
15-19	54.7%	56.9%	51.8%	50.0%	48.2%
20-24	67.3%	70.0%	58.2%	77.8%	66.1%
25-29	78.0%	80.0%	65.0%	66.7%	67.5%
30-34	80.9%	82.3%	68.5%	55.6%	72.5%
35-39	78.9%	80.8%	57.4%	83.3%	67.5%
40 and Over	76.5%	78.7%	64.7%	33.3%	62.1%
Total	*74.1%*	*76.7%*	*59.8%*	*66.0%*	*64.8%*

Teens are more likely than adult women to receive late or no prenatal care, deliver pre-term, and deliver a baby at low birth weight. This is important to note because the teen pregnancy rate in Kent County (61.5/1,000) is higher than it is in Michigan overall (53.6/1,000).

The most tragic outcome that adequate prenatal care can help to prevent is the death of an infant. Findings from a study of fetal deaths in Kent County indicated that African American babies in Kent County are significantly more likely to die before their first birthday than babies of any other race or ethnicity. This study also found that African American and Hispanic/Latino mothers who lost a baby were more likely to have had late entry into prenatal care and to report fear, distrust, or dissatisfaction with the healthcare received.

The Michigan Department of Community Health is currently working to address infant mortality through the state's Infant Mortality Reduction Plan. The infant mortality rate in Michigan has not changed significantly in the past 10 years and remains higher than the U.S. rate. In 2010, the rate in the state was 7.1 infant deaths per 1,000 live births, which is higher than the U.S. rate of 6.1 infant deaths per 1,000 live births. Health disparities between races are notable. Michigan's African American infant mortality rate is approximately three times greater than the white, non-Hispanic rate. Likewise, the Hispanic, Native American, and Arabic populations in the state also have higher infant mortality rates. One key strategy the state described in its Infant Mortality Reduction Plan is a Regional Perinatal System. This system will establish coordinated perinatal care throughout the state in order to ensure pregnant women are receiving adequate prenatal care. Additionally, the state plans to expand home-visiting programs to support vulnerable women and infants, reduce unintended pregnancies, and weave the social determinants of health into all strategies for infant mortality reduction. Each of these strategies aligns well with those selected by Kent County.

HP2020: Increase the proportion of pregnancies that were intended from 51% to 56%.

Based on these data and their service system assessment, the Priority 3 workgroup drafted goals, objectives, strategies, and action plans to address the disparity in adequate prenatal care in Kent County.

Priority 3 Goals, Objectives, and Strategies appear in Table 4. Priority 3 Action Plans appear in Appendix D. The data source for tracking objectives appears in the footnotes. The evidence-base underlying the selected strategies appears in footnotes, where appropriate.

Table 4. Goals, Objectives, and Strategies to Reduce Disparities in Adequacy of Prenatal Care.

GOALS	OBJECTIVES[10]	STRATEGIES
1. Ensure all women receive prenatal care in the first trimester.	O1. By September 2015, increase from 75.7% to 79.5% the percent of women with a live birth in Kent County who received their first prenatal visit in their first trimester.	S1. Promote planning for pregnancy and recognizing pregnancy early.[11]
		S2. Implement a system for ensuring pregnant women presenting in the ED are scheduled an appointment with a prenatal care provider at discharge and referred to a home visiting or support program if eligible.
		S3. Ensure pregnant women have referral and navigation support to get their first prenatal appointment right away.
		S4. Promote OB provider adherence to ACOG guidelines pertaining to first trimester entry to prenatal care and acceptance of Medicaid "guarantee letter" as proof of insurance.
	O2. By September 2015, increase by 10% calls to 211 regarding prenatal care.	S5. Educate community on the availability of prenatal care resources, insurance eligibility, and other support services.
		S6. Identify funding for a coordinated "early and often" prenatal care messaging and a social marketing campaign.

[10] Vital records is the data source for O1, O3, & O4. Objective O2 requires identifying a data source.

[11] Community education and social marketing strategies to improve awareness of and access to prenatal care are recommended by the Centers for Disease Control and Prevention (S1, S5, S6). See Guide to Community Preventive Services. Guide to Community Preventive Services. Health communication & social marketing: health communication campaigns that include mass media and health-related product distribution. www.thecommunityguide.org/healthcommunication/campaigns.html.

2. Ensure all women receive an adequate number of prenatal care visits.	O3. By September 2015, increase from 78.4% to 82.3% the proportion of women with a live birth in Kent County who received adequate or adequate plus prenatal care.	S7. Increase the number of women who are served prenatally by home visiting programs that are evidence-based or promising practices.[12]
		S8. Ensure providers screen pregnant women for social determinants of health and provide referrals to appropriate resources and services.
3. Reduce disparities in the provision of prenatal care.	O4. By September 2015, reduce the disparity between African American and white women in Kent County in adequacy of prenatal care such that the percent of African American women who receive adequate prenatal care increases from 68.0% to 71.4%.	S9. Educate community members regarding the relationship between racism/ discrimination and poor birth outcomes.
		S10. Educate providers about the relationship between racism/discrimination and poor birth outcomes.
		S11. Ensure that processes for providing prenatal care are culturally competent.
		S12. Expand the models of prenatal care that are available within Kent County, such as Midwifery[13] care and Centering.[14]

[12] Paulsell, D., Avellar, S., Sama Martin, E., & Del Grosso, P. (2011). *Home Visiting Evidence of Effectiveness Review: Executive Summary.* Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Washington, DC.

[13] Gabay, M., & Wolfe, S. (1997). Nurse-midwifery. The beneficial alternative. *Public Health Reports*, *112*, 386-394.

[14] Walker, D., & Worrell, R. (2008). Promoting healthy pregnancies through perinatal groups: A comparison of Centering Pregnancy group prenatal care and childbirth education classes. *Journal of Perinatal Education*, *17*, 27-34.

Ensure Access to Healthy Foods

Priority 4 – Increase healthy eating by ensuring access to healthy foods.

THE PROBLEM

Healthy eating reduces the risk of obesity. Obesity can lead to a variety of poor health outcomes, including type 2 diabetes, cancer, coronary heart disease, and stroke. Moreover, insufficient nutrition puts adults and children at risk for illness and weakens the immune system. Children from birth to five years of age are especially vulnerable to nutritional deprivation, which negatively affects their ability to learn, grow, and fight infections.

Limited access to healthy foods and the relative availability of nutrient poor foods prevent many Kent County community members from maintaining a healthy diet. The existence of food deserts[14] within a community is one indicator of access to healthy foods. In Kent County there are 19,172 community members who live in a food desert.

A second indicator of access to healthy foods is 'food insecurity.' Food insecurity is calculated based on responses to a population survey conducted by the US Census. The rate is made up of three questions, including 1) are you worried your food will run out before you have money to buy more, 2) if the food you bought doesn't last, do you have money to buy more, and 3) can you afford to eat balanced meals. The food insecurity rate for Kent County is 15% overall, but households with children in Kent County experience a much higher food insecurity rate of 23%.

HP2020: Reduce household food insecurity from 14.6% to 6% and in doing so reduce hunger.

HP2020: Eliminate very low food security among children.

A third indicator of access to healthy foods is participation in income-based programs that provide food assistance. Compared to Michigan, a higher percentage of Kent County community members qualify for food assistance (SNAP) and over the past few years, the need for food assistance in Kent County has grown. The numbers of SNAP and WIC redemptions are increasing in Kent County, as is the number of students participating in the free and reduced lunch program.

HP2020: Increase the contribution of fruits to the diets of the population aged 2 and older.

HP2020: Increase the proportion of schools that do not sell or offer calorically sweetened beverages to students from 9.3% to 21.3%.

HP2020: Increase the proportion of school districts that require schools to make fruits or vegetables available whenever other food is offered or sold from 6.6% to 18.6%.

Two important indicators of healthy eating are the degree to which adults and children eat 5 or more servings of fruits and vegetables a day and the degree to which adults and children consume sugar sweetened beverages. The MiPHY (2010) includes questions about these indicators of healthy eating. In Kent County, 34.9% of students reported that they ate five or more servings per day of fruits and vegetables in the past seven days, and 32.1% of students indicated that they drank a can, bottle, or glass of soda or pop one or more times per day over the past seven days. Students who receive Ds/Fs are least likely to report adequate fruit and vegetable consumption and most likely to report drinking soda or pop on a daily basis.

[14] A food desert is defined as low-income census tract where a substantial share of residents have low access to a supermarket or large grocery store (Economic Research Service, USDA).

One poor health outcome associated with a lack of access to healthy food is obesity. According to BRFSS results, in Kent County, approximately 30% of adults are obese and another 35% are overweight. Adult males in Kent County are more likely than adult females to be overweight, and African American adults in Kent County are more likely than any other racial or ethnic group to be obese.

In addition, based on results from the MiPHY, one out of ten youth in Kent County are obese. Male youth in Kent County are more likely than female youth to be obese and American Indian, African American, and Hispanic students are more likely than other racial or ethnic group to be obese. Also, students who receive Ds/Fs in Kent County are more likely to be obese than students who receive As/Bs.

Obesity was clearly identified as a major health issue across the state in Michigan's state health assessment and state health improvement planning process. Nearly $3 billion in annual medical costs in Michigan are attributed to obesity. Currently, approximately 32% of Michigan's adult population is obese and another 35% is overweight. Additionally, approximately 52% of Michigan's adults achieve the recommended amounts of physical activity and 23% eat the recommend amount of fruits and vegetables. In fact, Michigan's state health improvement plan focuses on addressing obesity due to its high prevalence and serious consequences for every Michigan community. The plan aims to reduce the percentage of Michigan residents who are overweight or obese, and to increase the percentage of children and adults who achieve recommended levels of physical activity and eat the recommended amount of fruits and vegetables. The plan includes strategies for increasing sales of healthy foods in schools, increasing worksite wellness programs, and encouraging health care providers to offer counseling to reduce obesity. The strategies in the plan align with Healthy People 2020 objectives, as well as the strategies Kent County plans to carry out through this priority area.

MI SHIP: Increase the percentage of Michigan's youth and adults who eat the recommended amount of fruits and vegetables from 22.6% to 23.7% of adults and 19.6% to 20.6% of high school youth.

MI SHIP: Increase the percentage of Michigan's schools selling healthy foods from 26.7% to 28%.

MI SHIP: Decrease the percentage of high school students who drank soda or pop at least once a day from 27.6% to 26.2%.

MI SHIP: Increase the amount of food stamp sales at MI farmers markets from $705,969 to $824,624.

THE PLAN

Based on these data and their service system assessment, the Priority 4 workgroup drafted goals, objectives, strategies, and action plans to address increasing healthy eating by ensuring access to healthy foods in Kent County.

Priority 4 Goals, Objectives, and Strategies appear in Table 5. Priority 4 Action Plans appear in Appendix E. The data sources for tracking objectives appear in the footnotes. The evidence-base underlying the selected strategies appears in footnotes, where appropriate.

Table 5. Goals, Objectives, and Strategies to Increase Healthy Eating by Ensuring Access to Healthy Foods.

GOALS	OBJECTIVES[16]	STRATEGIES
1. Ensure healthy foods are available, accessible, and affordable.	O1. By September 30, 2015, reduce the overall food insecurity in Kent County from 15.2% to 14.2% and the food insecurity among children in Kent County from 23.2% to 22.2%.	S1. Increase the availability of healthy goods in corner stores and gas stations.[17,18]
		S2. Increase healthy foods options available in pantries.
	O2. By September 30, 2015, increase the average proportion of food assistance used to purchase fruits and vegetables by 5%.	S3. Market the enrollment in and use of SNAP benefits to purchase healthy foods at farmers' markets, mobile markets, large retail outlets and corner stores.[19,20]
2. Increase healthy eating within Kent County.	O3. By September 30, 2015, increase the number of adults eating five or more servings of fruits and vegetables per day by 5%.	S4. Implement a county-wide campaign to use a consistent message across agencies and at food outlets to promote healthier food choices.[21,22]
	O4. By September 30, 2015, increase the number of students eating five or more servings of fruits and vegetables per day from 34.9% to 36.6%.	S5. Implement strategies to encourage healthy choices at the point of purchase in schools.

[16] The US Household Food Security Module is the data source for objective O1. The data source for objective O4 is the Michigan Youth Risk Behavior Survey. Objectives O2 & O3 require identifying a data source.

[17] Several strategies (S1, S2, S3, & S5) are recommended in: Keener, D., Goodman, K., Lowry, A., Zaro, S., & Kettel Khan, L. (2009). *Recommended community strategies and measurements to prevent obesity in the United States: Implementation and measurement guide*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Atlanta, GA.

[18] Healthy Food Retailing PolicyLink. Equitable Development Toolkit. Available online at: www.policylink.org/site/c.lkIXLbMNJrE/b.5137405/k.6042/Healthy_Food_Retailing.htm.

[19] Leadership for Healthy Communities. (2009). Action Strategies toolkit: A guide for local and state leaders working to create healthy communities and prevent childhood obesity. Robert Wood Johnson Foundation, Princeton, NJ.

[20] Flournoy, R. (2011). Healthy Food, Healthy Communities: Promising strategies to improve access to fresh, healthy food and transform communities. PolicyLink, Oakland, CA.

[21] *Supplemental Nutrition Assistance Program (SNAP) at Farmers' Markets: A How-To Handbook*. Available online at: www.ams.usda.gov/AMSv1.0/getfile?dDocName=STELPRDC5085298.

[22] Guide to Community Preventive Services. *Health communication & social marketing: health communication campaigns that include mass media and health-related product distribution*. Available online at: www.thecommunityguide.org/healthcommunication/campaigns.html.

Reduce Disparities in Youth Risk and Protective Factors

Priority 5 – Reduce the disparity in health risk factors and protective factors between students.

THE PROBLEM

Risk factors are characteristics that increase the likelihood of poor health outcomes, whereas protective factors are characteristics that decrease the likelihood of poor health outcomes. By intervening to decrease risk factors and improve protective factors, poor health outcomes can be prevented. In Kent County, risk and protective factors are not equally distributed among student sub-populations. The MiPHY surveys students in the 7th, 9th, and 11th grade from schools across the State of Michigan that are willing to participate. Kent County's results for 2009/2010 school year highlight disparities in several areas:

- Tobacco & marijuana use is more common among boys;
- Prescription drug & alcohol use is more common among girls;
- Tobacco use is most common among white and American Indian students;
- Drug & alcohol use is more common among African American & Hispanic students;
- Having had sex is more common among African American and Hispanic/Latino students;
- Not wearing a seatbelt is more common among African American, Hispanic/Latino, and Asian Students; and
- Not wearing a bike helmet is more common among male, African American, Hispanic/Latino, and American Indian Students.

Disparities also exist among youth in Kent County related to perceptions of risk associated with substance abuse. Although 72.0% of students completing the MiPHY (2010) believed that regular alcohol use was a moderate or great risk, students receiving Ds/Fs, African American, and American Indian students were less likely to report alcohol use to be a moderate or great risk. Similarly, while 67.3% of students in the County reported regular marijuana use to be a moderate or great risk, male students, African American students, Hispanic students, and students receiving Ds/Fs were less likely to perceive regular marijuana use as risky. With regard to tobacco use, 84.5% of students reported regular cigarette use to be a moderate or great risk; however, fewer African American and Asian American students perceived cigarette smoking to be risky. As with all three of these items, students receiving Ds/Fs were least likely to perceive cigarette smoking as risky.

HP2020: Increase the proportion of adolescents perceiving great risk associated with alcohol abuse from 40.5% to 44.6%.

HP2020: Increase the proportion of adolescents perceiving great risk associated with smoking marijuana from 33.9% to 37.3%.

Community involvement and parental support can be important protective factors among youth. Kent County's 2009/2010 MiPHY results indicate that 88.8% of youth believed they have the opportunity to participate on sports teams, 61.5% reported scouting opportunities are available, 62.2% reported boys and girls clubs are available, 47.5% reported 4-H clubs are available, and 63.3% reported service clubs are available. However, students receiving Ds/Fs were less likely to report that they have positive opportunities to become involved in their community as compared with those receiving As/Bs. Hispanic and African American youth were also less likely to report opportunities for community involvement are available as compared with youth of other racial and ethnic backgrounds in the county.

HP2020: Increase the proportion of adolescents who participate in extracurricular and out-of-school activities from 82.5% to 90.8%.

Additionally, 47.1% of youth in Kent County indicated they know adults in their neighborhood they could talk about something important with, and 73.6% indicated they could ask their mom or dad for help with personal problems. However, African American, Hispanic, and Asian students were less likely to report that they know adults who they can talk to about something important or that they can go to their parents for help with personal problems, as were students with Ds/Fs.

HP2020: Increase the proportion of adolescents who have an adult in their lives with whom they can talk about serious problems from 75.7% to 83.3%.

By far, the most substantial disparities between groups of students was between students who receive Ds/Fs and students who receive As/Bs. Students receiving Ds/Fs were, on average, twice as likely as their peers to engage in health risk behaviors, and they were more likely to have felt hopeless, expressed suicidal ideation, or attempted suicide. See Figures 2 and 3.

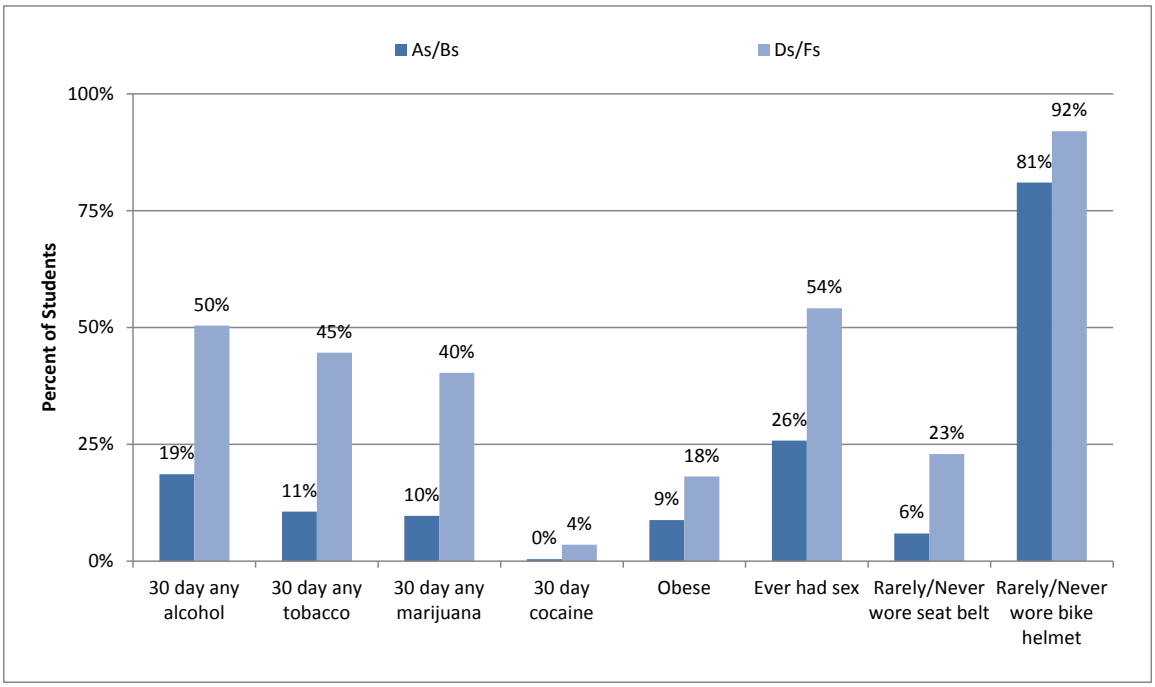

Figure 2. Disparities in risk factors between students receiving As/Bs and students receiving Ds/Fs.

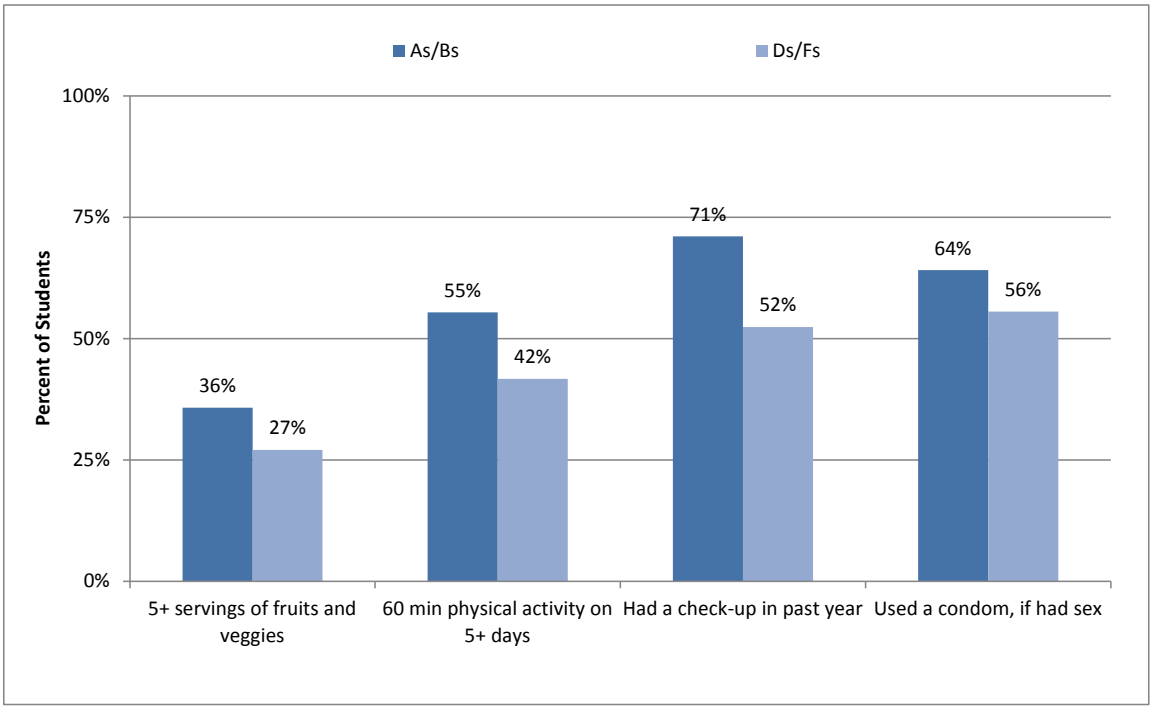

Figure 3. Disparities in protective factors between students receiving As/Bs and students receiving Ds/Fs.

When youth were asked in focus groups to talk about what prevents and promotes health for their age group, participants highlighted the differences in what youth are exposed to in different schools or parts of the community. They discussed differences in the quality of education provided in different districts, as well as the differences in opportunities at different schools. For instance, they talked about how some schools feel unsafe, whereas others seem very safe. These differences translated to how they felt about themselves and their peers.

Based on these data and their service system assessment, the Priority 5 workgroup drafted goals, objectives, strategies, and action plans to address decreasing disparities in health risk factors and protective factors between students in Kent County.

Priority 5 Goals, Objectives, and Strategies appear in Table 6. Priority 5 Action Plans appear in Appendix F. The data sources for tracking objectives appear in the footnotes. The evidence-base underlying the selected strategies appears in footnotes, where appropriate.

Table 6. Goals, Objectives, and Strategies to Reduce Disparities in Health Risk Factors and Protective Factors between Students.

GOALS	OBJECTIVES[23]	STRATEGIES
1. Coordinate and improve the collection of demographically representative data related to health risk and protective factors to identify current disparities.	O1. By Spring 2014, a demographically representative 20% of school districts in Kent County will complete the 2013-2014 cycle of the MiPHY.	S1. Identify and address barriers to MiPHY participation.
		S2. Create and administer a modified version of the MiPHY with elementary school students.
	O2. At least 4 school districts representative of the Kent County elementary age population will participate in the modified version of the MiPHY by Spring 2015.	S3. Engage CHNA partners and other partners in the development and implementation of a set of common core indicators.
	O3. By Fall 2015, youth serving agencies will implement a system of collecting and sharing a set of common core indicators of youth risk and protective factors.	S4. Establish a health-related Kent County Youth Advisory/Leadership Board.
2. Engage and empower youth to reduce disparities in risk and protective factors.	O4. By Spring 2015, the percentage of Kent County youth who are aware that they have chances to be involved in their community will increase from 63.3% to 64.4%.	S5. Expand mentoring programs for youth.[24]
	O5. By Spring 2015, increase the percentage of Kent County youth who believe that substance use is risky by 5%: • Regular cigarette smoking as a moderate or great risk will increase from 84.5% to 88.7%. • Alcohol use as a moderate or great risk will increase from 72.0% to 75.5%. • Marijuana as a moderate or great risk will increase from 67.3% to 70.7%.	S6. Develop and implement a social and mainstream media campaign to educate youth through youth created prevention messages.[25]
		S7. Market services and programs available to youth in Kent County.
	O6. By Spring 2015, the percentage of Kent County youth who believe that they can ask their mom or dad for help with personal problems will increase from 73.6% to 77.2%.	S8. Promote resources that support the development of parenting skills.[26]

[23] The MiPHY will be the data source for Objectives O1, O4, O5, O6, and O7. Objectives O2 & O3 require identifying a data source.

[24] DuBois, D., Holloway, B., Valentine, J., & Cooper, H. (2002). Effectiveness of mentoring programs for youth: A meta-analytic review. *American Journal of Community Psychology*, 30, 157-197.

[25] Guide to Community Preventive Services. *Health communication & social marketing: health communication campaigns that include mass media and health-related product distribution.* Available online at: www.thecommunityguide.org/healthcommunication/campaigns.html.

[26] Burrus, B., Leeks, K., Sipe, T., Dolina, S., Soler, R., Elder, R., Barrios, L., Greenspan, A., Fishbein, D., Lindegren, M., Achrekar, A., & Dittus, P. (2012). Person-to-person interventions targeted to parents and other caregivers to improve adolescent health: a Community Guide systematic review. *American Journal of Preventive Medicine*, 42, 316-26.

3. Ensure vulnerable youth have access to the services they need based on the risk factors they face in order to reduce disparities between youth.	O7. By Spring 2015, reduce the risk and protective factor disparities between youth in Kent County, including: • 5% reduction in the percent of male (14.7% to 14.0%), African American (14.4% to 12.7%), Hispanic/Latino (13.4% to 12.7%), and American Indian (16.0% to 15.2%) students who are obese. • 5% increase in seatbelt use among African American (13.7% to 13.0%), Hispanic/Latino (13.3% to 12.6%), and Asian (12.3% to 11.7%) students. • 5% increase in condom use among Hispanic/ Latino (47.4% to 49.8%) students who are sexually active. • An average 5% reduction in the disparities in risk factors between students who get Ds/Fs and students who get As/Bs.	S9. Advocate for expansion of comprehensive health education programs in all Kent County schools.[27]
		S10. Strengthen and expand the provision of comprehensive health services within the school system.[28]
		S11. Coordinate referral services to connect youth to the services they need based on their risk and protective factors.
		S12. Develop a health risk appraisal that can be completed as a self-assessment by youth that provides referrals to resources based on risk and protective factors.
		S13. Develop a health risk appraisal for providers that provides referrals for youth based on their risk and protective factors.

[27] Symons, C., Cinelli, B., James, T., & Groff, P. (1997). Bridging student health risks and academic achievement through comprehensive school health programs. *Journal of School Health*, 67, 220-227.

[28] Angin, T., Naylor, K., & Kaplan, D. (1996). Comprehensive school-based health care: High school students' use of medical, mental health, and substance abuse services. *Pediatrics*, 97, 318-30.

CHIP Evaluation

An evaluation of the implementation of this plan will be completed based on the objectives and outputs specified in the Action Plans provided in the appendices. Regular updates regarding the implementation of the plan and the achievement of milestones will be provided by the agency listed as the 'lead' in the action plan. Progress toward objectives will be tracked by the Kent County Health Department. The CHIP will be updated based on feedback from subcommittee members and system partners. Lessons learned from what has been done (what worked — what did not) will help guide future actions. Evaluation will also help to inform key decision makers and help determine whether the right strategies were implemented to achieve the intended goals and objectives.

Getting Involved

The Kent County CHIP is designed to engage any interested public health system partner in implementing strategies to improve community health. There are many ways to get involved, large and small, and the invitation to join this effort is open.

If you would like to learn more about how to connect with Kent County Working together for a Healthier Tomorrow, please contact:

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Acknowledgements

A special thanks to the priority workgroup co-chairs and members whose expertise, energy, and commitment transformed community health issues into a plan for action.

Priority 1 - Increase the proportion of community members, including the uninsured and working poor, who have access to affordable healthcare

Priority 2 - Increase the number of providers available that accept Medicaid or offer low-cost/free services

Priority 1 Co-Chairs
- Meg Tipton – Spectrum Health
- Mary Kay VanDriel – Value Health Partners

Priority 2 Co-Chairs
- Bradford Mathis – Saint Mary's Health Care
- Mishelle Bakewell – Metro Health

Workgroup Members
- Mark Witte – Network 180
- Maureen Kirkwood – First Steps
- Jan Hronek – Kent Health Plan

Priority 3 - Reduce disparities in adequacy of prenatal care

Co-Chairs
- Deanna Demory – Heart of West Michigan United Way
- Barb Hawkins Palmer – Kent County Health Department

Workgroup Members
- Brandi Alexander, Sue Toman – Family Futures
- Darlene VanOveren – Inter-Tribal Council
- David Lyman – Retired Physician
- Rebecca Velthouse – Booth Family Health Center
- Kathleen Neumann – Early Head Start
- Jessica Corwin – Spectrum Health
- Joann Gorby – Trinity Health
- Joann Hoganson, Mary Holt, Teresa Branson, Sue Sefton, Karyn Pelon, Denise Bryan, Cathy Raevsky – Kent County Health Department
- Matthew Van Zetten – Kent County Administration
- Minnie Morey – Asian American
- Leslie Hawkins – Great Start Collabortion
- Julie Sielawa – YMCA
- Sheila M. Putnam BSN – Priority Health
- Anh Tran, Ming Chiam, Maan Mang – Linguistics Liaison
- Bonnie Rencher – First Steps Welcome Home Baby
- Peggy Vander Meulen, Denise Evans – Strong Beginnings, Federal Healthy Start
- Mary Ziomkowski – GVSU Office of Vice Provost for Health
- Katie Penninga – Cherry Street Health Services
- Sara MacDonald – Kent County Fetal Infant Mortality Review
- Melisa Kuiper – Meridan Health Plan
- Susan Henning – Spectrum Health MOMS Program
- Rachel Fox – Arbor Circle
- Sherri Vainavicz – United Way 2-1-1
- Savator Seldon-Johnson – Kent County Department of Human Services
- Jennifer Raffo – MSU Medical School
- Adejoke Ayoola – Calvin College Dept. of Nursing
- Kimberly Muma – Grand Valley State University

Priority 4 - Increase healthy eating by ensuring access to healthy foods

Co-Chairs
- Sarah VanEerden – Kent County Health Department
- Deanna Demory & Linda Kiander – Heart of West Michigan United Way

Workgroup Members
- Cheryl Mulder – Spectrum Health NOW
- Christine Lentine – Kids Food Basket
- Mark Logan – Department of Human Services
- Jill Myer – Kent County Health Department
- Emma Rosauer – Access of West Michigan
- Bruce Schlenderer – Access of West Michigan
- Lisa Wideman – Senior Meals
- Kelly Hagmeyer – YMCA
- Sherri Vainavicz – United Way-211
- Amy Klinkoski – Grand Rapids Public Schools
- Sarah Portenga, RD – YMCA Dietitian
- Monica Smith – MSU Extension
- Terry Eudy – Grand Valley Health Plan
- Megan Murphy – First Steps
- Mark Lewis – Neighborhood Ventures
- David Schroeder – United Way
- Michael Merren – Food and Nutrition Coalition
- Jessica Corwin, RD – Spectrum Healthier Communities
- JoAnne Eakins – Ionia County Health Department
- Julie Orth, RD – Project Fit
- Susan Henning – Spectrum Health MOMS
- Barbara Grinwis – Oasis of Hope Center
- Carole Paine-McGovern – Kent Schools Services Network
- Jackie O'Connor – Area Agency on Aging of Western Michigan
- Melissa Kuiper – Meridian Health Plan
- Dave Miller – Heart of West MI United Way
- Gregory Dunn – Baxter Community Center
- Rachel Fox – Arbor Circle

Priority 5 - Reduce the disparity in health risk factors and protective factors between students

Co-Chairs
- Cheryl Blair – Kent Intermediate School District
- Brian Hartl – Kent County Health Department

Workgroup Members
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- Stephanie Painter, John Helmholdt – Grand Rapids Public Schools
- Enid Gaddis – Arbor Circle
- Sarah Gammans – Northview Public Schools
- Cheryl Blair – Kent Intermediate School District
- Jill Graybill – Spectrum Health Healthier Communities
- Tracy Malinowski, Michelle Johnson – Kent County Health Department
- Dion Charity – Northview Public Schools
- Denise Herbert – Network 180
- Paul Haan – Healthy Homes Coalition
- Lynn Heemstra – Our Community's Children
- Rachel Hood – West Michigan Environmental Action Council
- Deanna Demory – United Way
- Mary Hartfield – Girl Scouts Shore to Shore
- Minnie Morey – Asian American Center
- Gail Zandee – Calvin College
- Cathy Jordan – Wedgwood Christian Services
- Peggy Burns – Gerontology Network
- Terry Schweitzer – City of Kentwood
- Shannon Cohen – Kent County Prevention Coalition
- Julie Sielawa – YMCA
- Susan Sheppard – Arbor Circle
- Kalena Murphy, Johnny Adams, Shannon Wilson – Grand Rapids African American Health Institute
- Shannon Harris – Our Community's Children
- Stacy Stout – Hispanic Center

Appendix A: Community Partners

Steering Committee Members

Alliance for Health - Lody Zwarensteyn
Baxter Community Center - Sandy TenHoeve
Blue Cross Blue Shield – Cle Jackson
Cherry Street Health Services - Michael Reagan
Community Health Advisory Committee - Shana Shroll
Community Research Institute (GVSU) - John Risley
Family Futures - Candace Cowling
First Steps - Rebecca Fennell
Frey Foundation - Lynn Farrel
Grand Rapids African American Health Institute (GRAAHI) - Shannon Wilson
Healthy Homes Coalition – Paul Haan
Heart of West Michigan United Way - Deanna Demory
Ionia County Health Department - Lisa McCafferty
Kent County Correctional Facility - Randy Demory
Kent County Health Department - Barb Hawkins Palmer, Brian Hartl, Cheryl Clements, Cathy Raevsky, Bill Anstey, Jim Smedes, Dayna Porter, and Lisa LaPlante
Kent County Prevention Coalition - Denise Herbert
Kent Health Plan - Jan Hronek
Kent Intermediate School District - Cheryl Blair
Mary Free Bed - Randall Deneff
Metro Health Hospital - Mishelle Bakewell
Michigan Public Health Institute - Julia Heany and Lisa Gorman
Michigan State University - Jennifer Raffo and Tracy Thompson
Network180 - Mark Witte and Christopher Smith
Ottawa County Health Department - Marcia Knol
Our Community's Children - Lynn Heemstra
Pine Rest Christian Mental Health Services - Carol VanderWal
Planned Parenthood of West and Northern Michigan - Kathy Humphrey
Saint Mary's Health Care - Bradford Mathis
Spectrum Health Healthier Communities - Andre Pierre and Erin Inman
Spectrum Health - Meg Tipton
Steelcase Foundation - Susan Broman
Trinity Home Health Services - Denise Garman
Value Health Partners - Mary Kay VanDriel
Yo Peudo Program - Angel Rodriguez

Coalition Members

Access of West Michigan - Emma rosauer and Bruce Schlenderer
Alliance for Health - Lody Zwarensteyn
Arbor Circle - Rachel Fox, Susan Sheppard, Ruth Futierrez-VanBeek, and Enid Gaddis
Area Agency on Aging of Western Michigan - Jackie O' Connor and Barb Nelson
Area Agency on Aging of Western Michigan - Sandra Ghoston-Jones
Asian American Center - Minnie Morey
Baxter Community Center - Sandy Ten Hoeve and Gregory Dunn
Blue Cross Blue Shield of MI - Cle Jackson
Booth Family Health Center - Rebecca Velthouse
Calvin College Nursing Department - Gail Zandee
Catherine's Health Center - Karen Kaashoek
Cherry Street Health Services - Mike Reagan and Katherine Penninga
City of Kentwood - Terry Schweitzer
Community Health Advisory Committee - Shana Shroll
Community Representatives - Yvonne Woodward and Jean Parks
Community Research Institute (GVSU) - John Risley and Diane Gibbs
Essential Needs Task Force (ENTF) - Kent County - David Schroeder and Liz Genslet
Davenport University - Lori Pearl-Kraus
Department of Human Services - Savator Selden-Johnson
Early Head Start - Kathleen Neumann
Family Futures - Candace Cowling and Brandi Alexander
First Steps - Maureen Kirkwood, Rebekah Fennel, and Megan Murphy
Frey Foundation - Lynn Farrel
Friends of Grand Rapids Park - Steve Faber
Gerontology Network - Peggy Burns
Girl Scouts Shore to Shore - Mary Hartfield
Goodwill Industries of Greater Grand Rapids - Jill Wallace
Grand Rapids African American Health Institute (GRAAHI) - Shannon Wilson, Kalena Murphy, Johnny Adama
Grand Rapids Area Center for Ecumenism (GRACE) - Lisa Mitchell
Grand Rapids Area Coalition to End Homelessness - Janay Brower and Breanne McKee
Grand Rapids Area Health Ministry Consortium - Suzan Couzens
Grand Rapids Department of Parks and Recreation - Jay Steffen
Grand Rapids Planning Dept. - Suzanne Schulz
Grand Rapids Public Schools - Amy Klinkowski, Stephanie Painter, and John Helmholdt
Grand Valley Health Plan - Terry Eudy
Grand Valley State University - Jean Nagelkerk
Grand Valley State University Research Institute - Diane Gibbs
Great Start Collaboration - Leslie Hawkins
Guiding Light Mission - Stuart Ray
Healthy Homes Coalition - Paul Haan
Heart of West Michigan United Way - Deanna Demory, Cindy Mathis, Linda Kiander, and Dave Miller
Hispanic Center of Western Michigan - Stacy Stout
Ionia County Health Department - Dave Miller and JoAnne Eakins
Inter-Tribal Council of Michigan - Darlene VanOveren
Hispanic Center of Western Michigan - Victor Vasquez
Kent County Administration - Mathhew VanZetten
Kent County Correctional Facility - Randy Demory
Kent County Courts - Randy Demory
Kent County Department of Veterans Affairs - Carrie Jo Roy and Rich Goodrich
Kent County EMS - Damon Obiden
Kent County Family and Children's Coordinating Council - Matthew Van Zetten
Kent County Fetal Infant Mortality Review (FIMR) - Sarah MacDonald
Kent County Food and Nutrition Coalition - Michael Merren
Kent County Health Department - Chelsey Chmelar, Karyn Pelon, Teresa Branson, Mary Holt, Cathy Raevsky, Bill Anstey, Gail Brink, Mark Hall, Joann Hoganson, Adam London, Bobby Peacock, Lisa LaPlante, Shane Green, Jim Smedes, Barb Hawkins Palmer, Jill Myer, Sarah VanEerden, Brian Hartl, Tracy Malinowski, Michelle Johnson, and Dayna Porter
Kent County Healthy Homes Coalition - Paul Haan
Kent County Intermediate School District - Cheryl Blair
Kent County Medical Society - Patricia Dalton
Kent County Parks Department - Roger Sabine
Kent County Prevention Coalition - Denise Herbert and Shannon Cohen
Kent County School Nurses - Stephanie Painter
Kent Health Plan - Jan Hronek
Kent School Services Network (KSSN) - Carole Paine-McGovern
Kentwood City Planners - Terry Schweitzer
Kids Food Basket - Christine Lentine
Linguistics Liaison - Anh Tran
Lions Club - Kent County - Rick Stevens
Local First - Elissa Hillary
Mary Free Bed - Randall Deneff
Meijer - Julie Dykstra
Meridian Health Plan - Melissa Kuiper
Metro Health - Mishelle Bakewell
Michigan College of Optometry – Ferris State University - Mark Swan
Michigan Department of Community Health - Jessica Austin
Michigan Environmental Action Coalition (WMEAC) - Rachel Hood-West
Michigan Public Health Institute - Julia Heany and Lisa Gorman
Michigan State University - Tracy Thompson and Jennifer Raffo
Michigan State University College of Human Medicine - Jennifer Raffo
MSU Extension - Monica Smith
Neighborhood Ventures - Mark Lewis
Network180 - Mark Witte, Denise Herbert, and Christopher Smith
Northview Public Schools - Sarah Gammans and Dion Charity
Oasis of Hope - Barbara Grinwis
Our Community's Children - Lynn Heemstra, Shannon Harris
Pine Rest Christian Mental Health Services - Carol VanderWal and Carleen Crawford
Planned Parenthood of West and Northern Michigan - Kathy Humphrey
Project Fit - Julie Orth, RD
Priority Health - Kim Horn and Sheila M. Putnam, BSN
Retired Physician - David Lyman
Saint Mary's Health Care - Bradford Mathis and Amanda J. Echler
Senior Meals - Lisa Wideman
Spectrum Health - Meg Tipton
Spectrum Health Healthier Communities - Erin Inman, Andre Pierre, Jill Graybill, and Jessica Corwin, RD
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Spectrum Health NOW - Cheryl Mulder
Steelcase Foundation - Susan Broman
Strong Beginnings - Peggy Vander Meulen
The Rapid - Bill Kirk
Trinity Health - Joann Gorby
Trinity Home Health Services - Denise Garman
United Way - David Schroeder
United Way-211 - Sherri Vainavicz
Value Health Partners - Mary Kay VanDriel
Wedgewood Christian Services - Cathy Jordan
West Michigan Asian American Association, Inc. - Minnie Morey and Remi Kuklewski
West Michigan Regional Planning Commission - Dave Bee
West Michigan Strategic Alliance (WMSA) - Jessica Materson
YMCA of Greater Grand Rapids - Kelly Hagmeyer, Julie Sielawa, Sarah Portenga, RD

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Asian Community Center - Minnie Morey
Area Agency on Aging of Western Michigan - Barb Nelson
Calvin College Nursing Department - Gail Zandee
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Community Health Advisory Committee - Shana Shroll
Frey Foundation - Lynne Ferrell
Grand Rapids Area Center for Ecumenism (GRACE) - Lisa Mitchell
Grand Rapids Area Coalition to End Homelessness - Janay Brower and Breanne McKee
Grand Rapids Area Health Ministry Consortium - Suzan Couzens
Grand Rapids Department of Parks and Recreation - Jay Steffen
Goodwill Industries of Greater Grand Rapids - Jill Wallace
Healthy Homes Coalition - Paul Haan
Kent County Department of Veterans Affairs - Carrie Jo Roy
Kent County Health Department - Barb Hawkins Palmer, Brian Hartl, Cathy Raevsky, and Roger Sabine
Kent Health Plan - Jan Hronek
Lions Club – Kent County - Rick Stevens
Mary Free Bed - Randall Deneff
Meijer - Julie Dykstra
Metro Health Hospital - Mishelle Bakewell
Pine Rest Christian Mental Health Services - Carleen Crawford
Spectrum Health Healthier Communities - Diane Gibbs and Stephanie Painter
Steelcase Foundation - Susan Broman
The Rapid - Bill Kirk
Value Health Partners - Mary Kay VanDriel
West Michigan Environmental Action Council - Rachel Hood
West Michigan Strategic Alliance (WMSA) - Jessica Materson
YMCA of Greater Grand Rapids - Kelly Hagmeyer

Population Data Group

Area Agency on Aging of Western Michigan - Jackie O'Connor
Blue Cross Blue Shield - Cle Jackson
Cherry Street Health Services/ProAction Behavioral Health Mike Reagan
Community Research Institute (GVSU) - John Risley
Essential Needs Task Force (ENTF) - Kent County David Schroeder
Essential Needs Task Force (ENTF) - Kent County Liz Genlser
Family Futures - Candace Cowling
First Steps - Maureen Kirkwood
Friends of Grand Rapids Park - Steve Faber
Grand Rapids African American Health Institute (GRAAHI) - Shannon Wilson
Heart of West Michigan United Way - Deanna Demory
Kent County Correctional Facility - Randy Demory
Kent County EMS (KCEMS) - Damon Obiden
Kent County Fetal Infant Mortality Review (FIMR) - Sarah MacDonald
Kent County Health Department - Cathy Raevsky, Brian Hartl, Barb Hawkins Palmer, Dayna Porter
Kent County Medical Society - Patricia Dalton
Kent County Prevention Coalition (Network180) - Denise Herbert
Kent County Prevention Coalition - Wedgwood Christian Serv. - Shannon Cohen
Kentwood City Planners - Terry Schweitzer
Michigan State University - Tracy Thompson
Michigan State University - Jennifer Raffo
Oasis of Hope - Barbara Grinwis
Pine Rest Christian Mental Health Services - Carol VanderWal
Saint Mary's Health Care - Bradford Mathis and Amanda J. Echler
Spectrum Health Healthier Communities - Andre Pierre and Erin Inman
Trinity Home Health Services - Denise Garman
West Michigan Regional Planning Commission - Dave Bee
West Michigan Strategic Alliance (WMSA) - Greg Northrup
YMCA of Greater Grand Rapids - Kelly Hagmeyer

MPHI Staff

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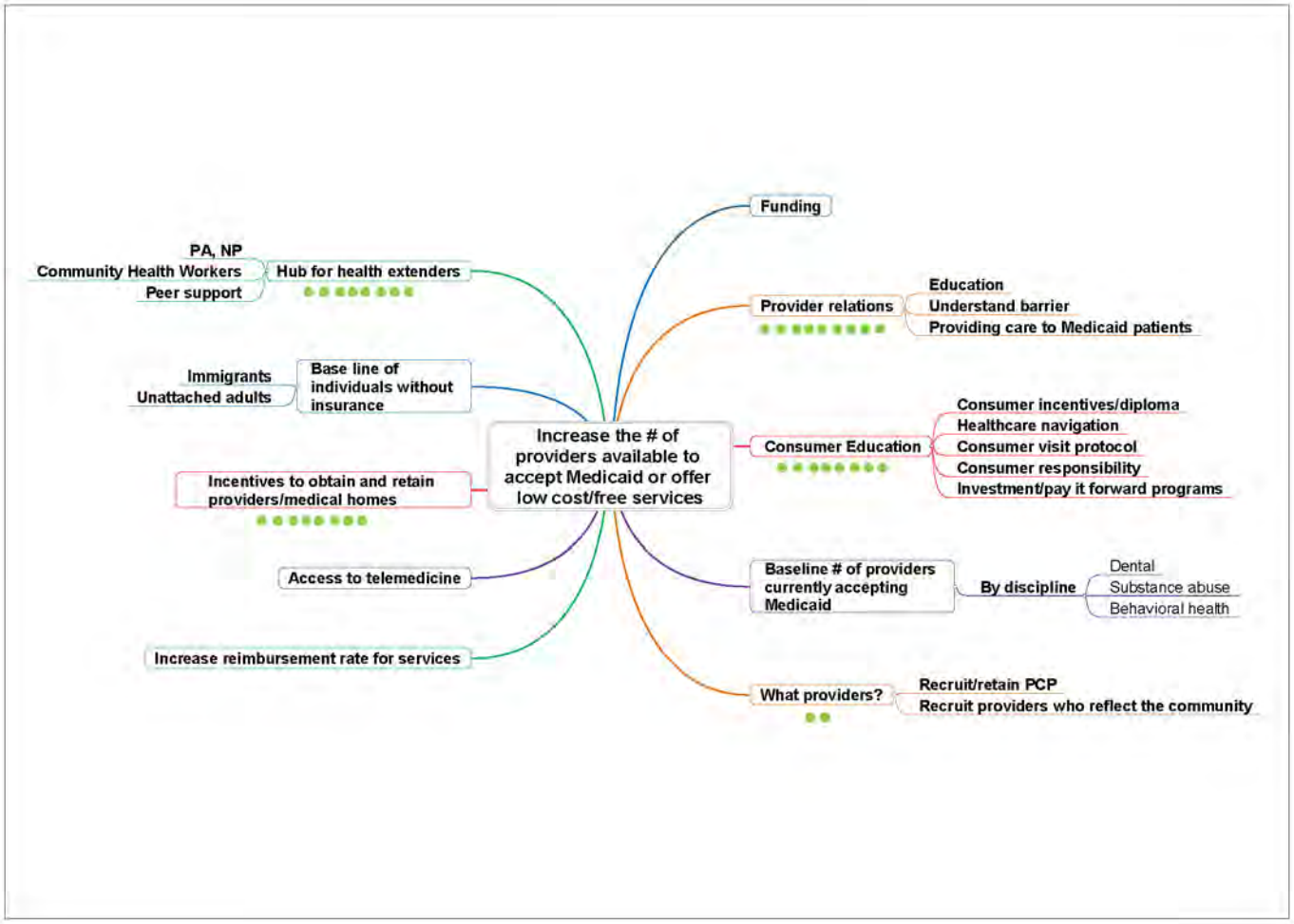
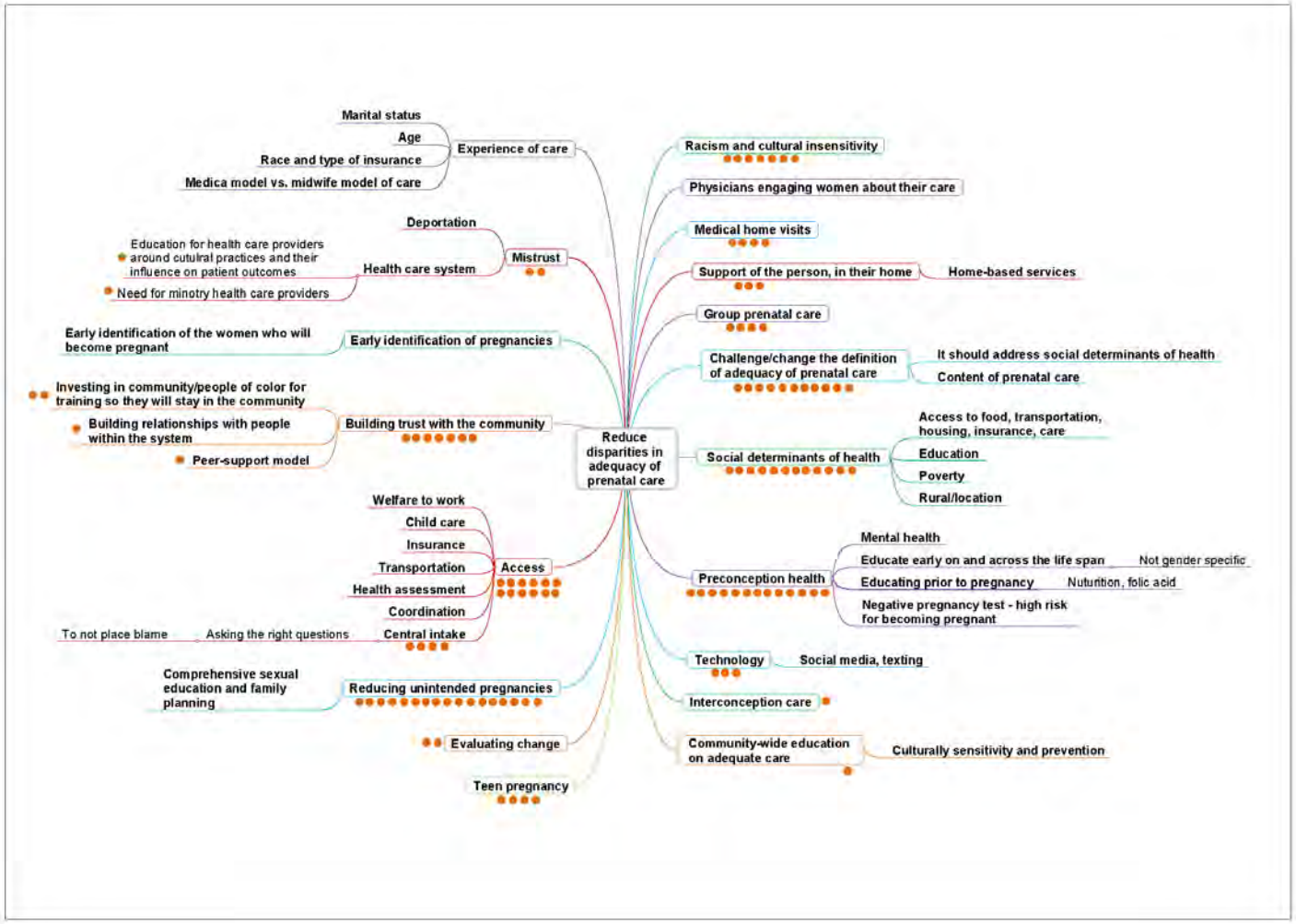
Amanda Bliss

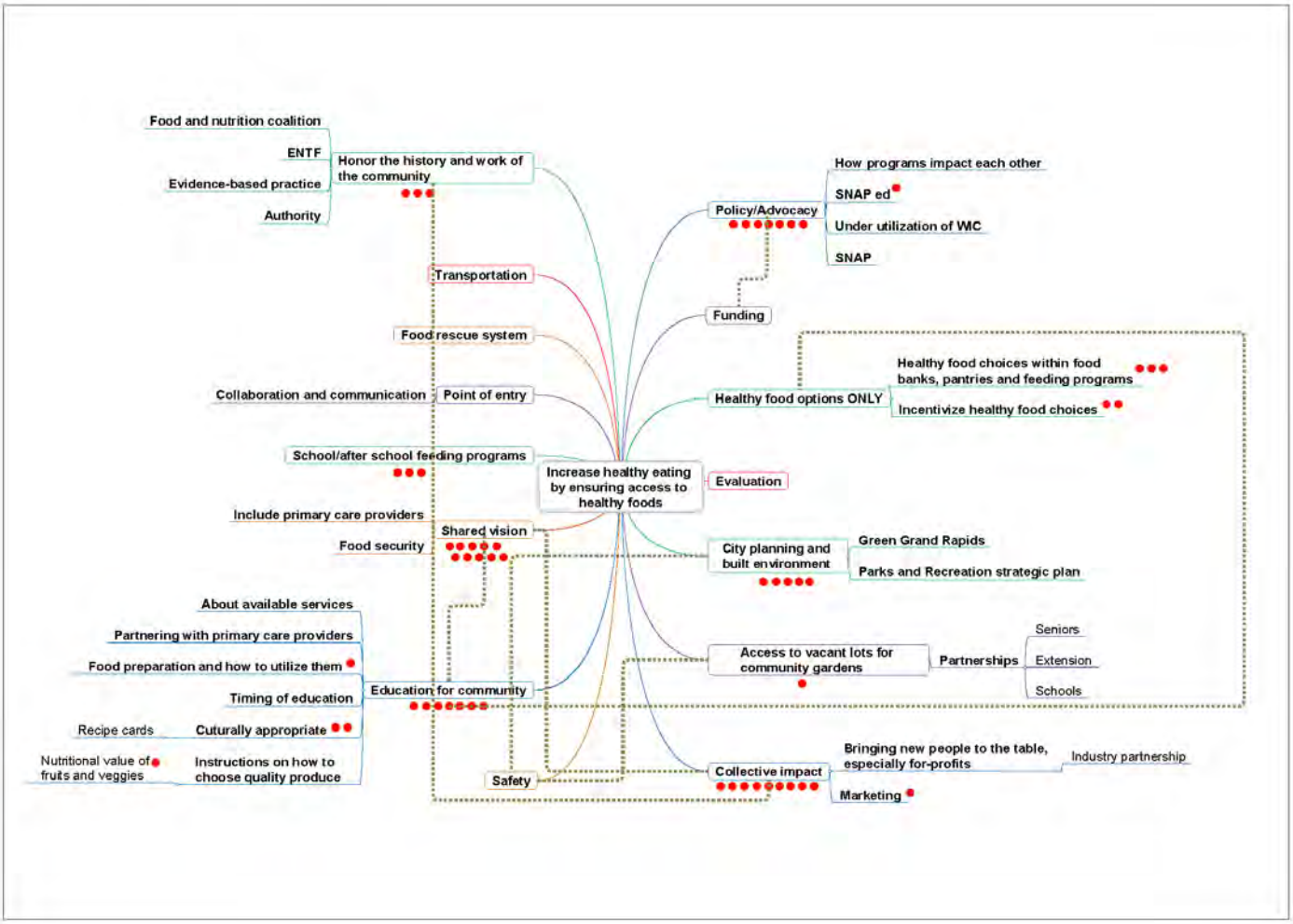
Appendix B: Mind Maps

Priorities 1 and 2

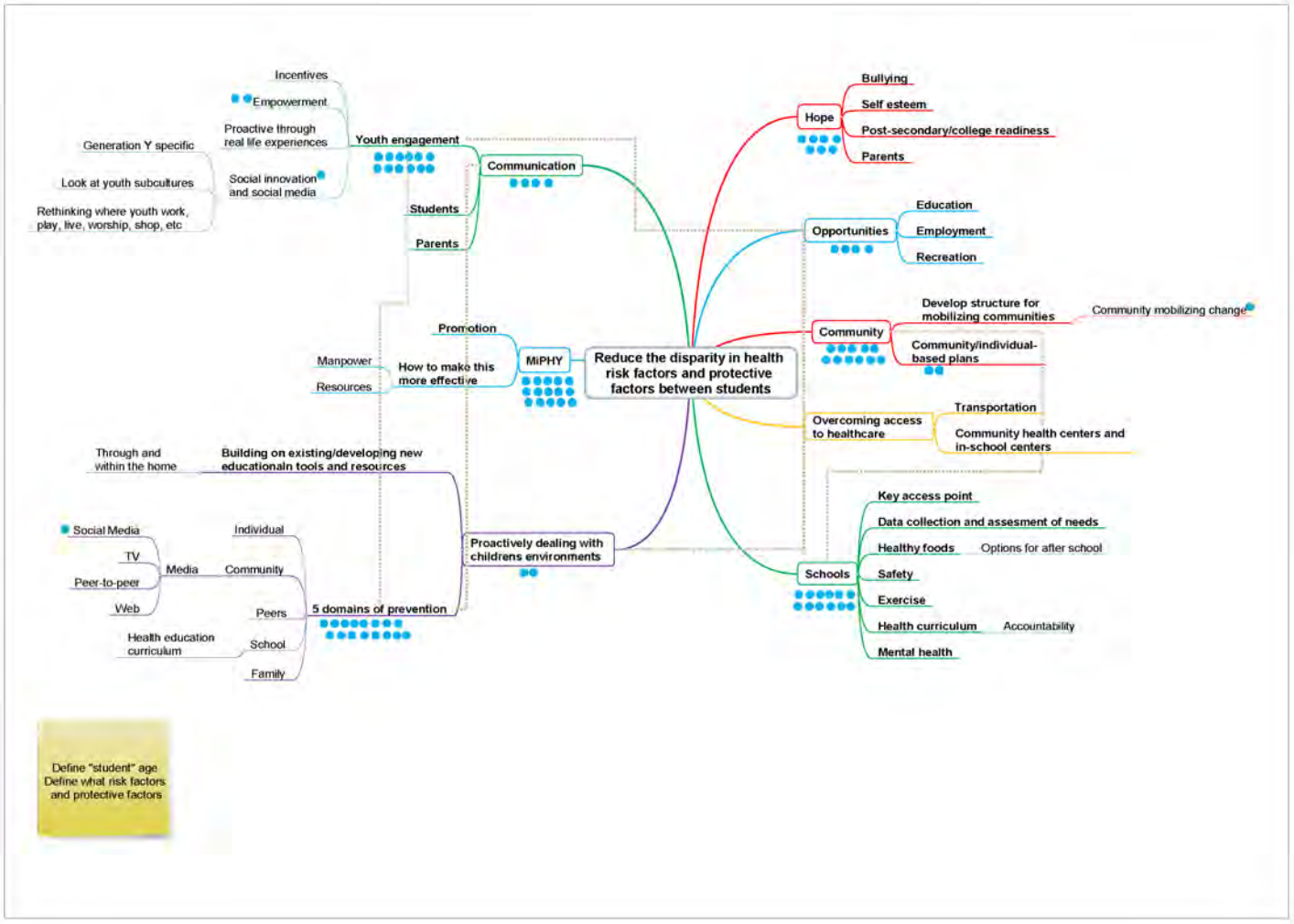


Priority 3


Reduce disparities in adequacy of prenatal care
Experience of care
Marital status
Age
Race and type of insurance
Medica model vs. midwife model of care
Mistrust
Deportation
Health care system
Education for health care providers around cutulral practices and their influence on patient outcomes
Need for minotry health care providers
Early identification of pregnancies
Early identification of the women who will become pregnant
Building trust with the community
Investing in community/people of color for training so they will stay in the community
Building relationships with people within the system
Peer-support model
Access
Welfare to work
Child care
Insurance
Transportation
Health assessment
Coordination
Central intake
To not place blame
Asking the right questions
Reducing unintended pregnancies
Comprehensive sexual education and family planning
Evaluating change
Teen pregnancy
Racism and cultural insensitivity
Physicians engaging women about their care
Medical home visits
Support of the person, in their home
Home-based services
Group prenatal care
Challenge/change the definition of adequacy of prenatal care
It should address social determinants of health
Content of prenatal care
Social determinants of health
Access to food, transportation, housing, insurance, care
Education
Poverty
Rural/location
Preconception health
Mental health
Educate early on and across the life span
Not gender specific
Educating prior to pregnancy
Nuturition, folic acid
Negative pregnancy test - high risk for becoming pregnant
Technology
Social media, texting
Interconception care
Community-wide education on adequate care
Culturally sensitivity and prevention


Increase healthy eating by ensuring access to healthy foods
Honor the history and work of the community
Food and nutrition coalition
ENTF
Evidence-based practice
Authority
Transportation
Food rescue system
Point of entry
Collaboration and communication
School/after school feeding programs
Shared vision
Include primary care providers
Food security
Education for community
About available services
Partnering with primary care providers
Food preparation and how to utilize them
Timing of education
Cuturally appropriate
Recipe cards
Instructions on how to choose quality produce
Nutritional value of fruits and veggies
Safety
Policy/Advocacy
How programs impact each other
SNAP ed
Under utilization of WIC
SNAP
Funding
Healthy food options ONLY
Healthy food choices within food banks, pantries and feeding programs
Incentivize healthy food choices
Evaluation
City planning and built environment
Green Grand Rapids
Parks and Recreation strategic plan
Access to vacant lots for community gardens
Partnerships
Seniors
Extension
Schools
Collective impact
Bringing new people to the table, especially for-profits
Industry partnership
Marketing

Priority 5


Reduce the disparity in health risk factors and protective factors between students
Youth engagement
Incentives
Empowerment
Proactive through real life experiences
Social innovation and social media
Generation Y specific
Look at youth subcultures
Rethinking where youth work, play, live, worship, shop, etc
Communication
Students
Parents
MiPHY
Promotion
How to make this more effective
Manpower
Resources
Proactively dealing with childrens environments
Building on existing/developing new educationaln tools and resources
Through and within the home
5 domains of prevention
Individual
Community
Peers
School
Family
Media
Social Media
TV
Peer-to-peer
Web
Health education curriculum
Hope
Bullying
Self esteem
Post-secondary/college readiness
Parents
Opportunities
Education
Employment
Recreation
Community
Develop structure for mobilizing communities
Community mobilizing change
Community/individual-based plans
Overcoming access to healthcare
Transportation
Community health centers and in-school centers
Schools
Key access point
Data collection and assesment of needs
Healthy foods
Options for after school
Safety
Exercise
Health curriculum
Accountability
Mental health
Define "student" age
Define what risk factors and protective factors

Appendix C: Priorities 1 and 2 Action Plans

Action Plan: Priorities 1 and 2, Strategy S2

Priorities:

1. Increase the proportion of community members, including the uninsured and working poor, who have access to affordable physical, mental, and dental healthcare.
2. Increase the number of providers available that accept Medicaid or offer low-cost/free services.

Goal: Ensure community members have access to primary and specialty healthcare.

Objective: By October 1, 2015, reduce the disparity in healthcare access among adults in Kent County:

- Decrease from 16.9% to 15.2% the percentage of African American adults withouth health care access
- Decrease from 23.6% to 21.2% the percentage of adults with less than a high school education without health care access and by education.

Strategy: Increase the capacity of providers to accept patients with Medicaid.

Milestones	Outputs	Responsible	Deadline
1. Workgroup formed and current landscape assessed	Workgroup formed; list of current Medicaid providers in County generated; barriers to expanding capacity identified	KCHD & hospital partners	March 2013 (6 months)
2. Impact of Affordable Care Act (ACA) on reimbursement rates assessed	ACA reviewed; projections generated	KCHD & hospital partners	March 2013 (6 months)
3. Strategies to expand provider capacity to accept patients with Medicaid planned	Plan for expansion	KCHD & hospital partners	March 2014 (18 months)
4. Strategies to expand capacity implemented	Additional providers recruited	KCHD & hospital partners	March 2014 (24 months)
5. Medicaid providers oriented to Healthcare Hub	Healthcare Hub materials; provider orientation meetings	KCHD & hospital partners	September 2014 (24 months)
6. Disparity in healthcare access reduced	Final report	KCHD & hospital partners	September 2015 (36 months)

Action Steps: Months 1-9	10/12	11/12	12/12	1/13	2/13	3/13	4/13	5/13	6/13
1. Identify key stakeholders and form workgroup.	X								
2. Hold monthly/biweekly workgroup meetings.		X	X	X	X	X	X	X	X
3. Compile a comprehensive list of current Medicaid providers in the county.		X	X						
4. Review content in the ACA pertaining to Medicaid reimbursement rates.		X	X						
5. Develop a brief survey instrument to assess reasons why providers in the county do not take Medicaid and possible effects of ACA.			X	X					
6. Field survey and analyze results.					X	X	X	X	
7. Begin to plan strategies to expand provider capacity to accept patients with Medicaid.									X

Action Plan: Priorities 1 and 2, Strategy S4			
Priorities: 1. Increase the proportion of community members, including the uninsured and working poor, who have access to affordable physical, mental, and dental healthcare. 2. Increase the number of providers available that accept Medicaid or offer low-cost/free services.			
Goal: Ensure community members have access to primary and specialty healthcare.			
Objective: By October 1, 2015, reduce the disparity between students who received a check up in the past 12 months by increasing from 52.4% to 57.6% the percentage of students with Ds/Fs who received a checkup.			
Strategy: Strengthen and expand comprehensive school-based health services, including primary care services where appropriate (i.e. school nurses, school-based health centers, health education, etc.).			
Milestones	Outputs	Responsible	Deadline
1. Gaps in school-based health services assessed and needs documented	Key stakeholders identified and workgroup formed; list of schools in Kent County and current offerings; assessment methodology, instrument, and findings	Spectrum	June 2013 (6 months)
2. Awareness of school-based health services increased and partners engaged	Community partners and target population identified; strategy to raise awareness developed; presentation; awareness activities	Spectrum	June 2013 (6 months)
3. Business plan to support expansion of school-based health services finalized	Business plan	Spectrum	March 2014 (18 months)
4. School-based health services expanded	Comprehensive list of expanded services	Spectrum	September 2015 (36 months)
5. Kent County school boards approve health policies	Policies; school boards approvals	Spectrum	September 2015 (36 months)

Action Steps: Months 1-9	10/12	11/12	12/12	1/13	2/13	3/13	4/13	5/13	6/13
1. Identify key stakeholders and form workgroup.	X								
2. Determine community partners and target population for awareness activities.	X								
3. Hold monthly/biweekly workgroup meetings.		X	X	X	X	X	X	X	X
4. Identify and determine what the workgroup would like to learn from the assessment.		X							
5. Develop a strategy and presentation for community partners re: school-based health services.		X							
6. Implement awareness activities.			X	X	X				
7. Compile list of all schools in Kent County.			X						
8. Obtain list of schools currently offering school-based health services, including what services the schools offer (on School Health Advocacy Program (SHAP)).			X						
9. Determine which services are utilized and which are not.			X						
10. Develop assessment methodology and the instrument.			X	X					
11. Field assessment instrument and analyze the results.					X	X	X		
12. Share assessment results with key community stakeholders.								X	
13. Begin developing a business plan to support expansion of school-based health services.								X	X

Action Plan: Priorities 1 and 2, Strategy S13

Priorities:

1. Increase the proportion of community members, including the uninsured and working poor, who have access to affordable physical, mental, and dental healthcare.
2. Increase the number of providers available that accept Medicaid or offer low-cost/free services.

Goal: Ensure appropriate, timely, well-coordinated access to a continuum of health and social services.

Objective: By October 1, 2015, reduce ER visits for conditions that can be prevented through access to quality primary care by 10%.

Strategy: Explore the implementation of a Kent County Community Healthcare Hub.

Milestones	Outputs	Responsible	Deadline
1. Key stakeholders identified and steering committee established	Key stakeholders list; steering committee meeting	United Way; First Steps; Kent Health Plan	November 2012 (2 months)
2. Feasibility study plan finalized	Document that details study; meetings with decision makers; budget for study; funding sources	United Way; First Steps; Kent Health Plan	April 2013 (7 months)
3. Access to care landscape assessed	Meetings with partners and stakeholders; focus groups results; proposal for agency consolidation/mergers; budget for implementation; technology/data collection options; possible 'homes' for hub	United Way; First Steps; Kent Health Plan	September 2013 (12 months)
4. Need and Feasibility of Community Hub report finalized	Hub Need and feasibility Report	United Way; First Steps; Kent Health Plan	December 2013 (15 months)

Action Steps: Months 1-9	10/12	11/12	12/12	1/13	2/13	3/13	4/13	5/13	6/13
1. Identify key stakeholders.	X								
2. Form steering committee with key stakeholders to oversee study.	X								
3. Hold monthly/biweekly steering committee meetings.		X	X	X	X	X	X	X	X
4. Develop document that establishes a common language for healthcare hub to obtain buy-in from decision makers.		X							
5. Convene meetings with key decision makers (hospital boards, manage care plans, etc.) to obtain buy-in for study.			X	X					
6. Review existing data reports from various community stakeholders to develop preliminary needs statement/summary.				X	X				
7. Identify key components of study and develop preliminary budget for study.					X	X			
8. Identify funding, including in-kind services, to support feasibility study.						X	X		
9. Meet with community partners to determine potential interest/willingness to invest in hub.								X	X
10. Meet with key stakeholder agencies and institutions to determine willingness to partner and participate, and what their desired outcomes would be.								X	X
11. Develop community conversation/focus group protocol to learn how community members currently access care and identify target populations for conversations/focus groups.								X	X
12. Conduct community conversations/focus groups with clients/patients to learn how people currently access care in the community.									X

Kent County Oral Health Coalition Workplan[29]				
Mission: Improve the oral health of the citizens of Kent County. **Vision:** Improve awareness of the need for oral health in the community and improve access to educational and clinical resources.				
Goals	**SMART Objectives (what, when)**	**Evidence-Based Strategies (how)**	**Coalition members working in this area**	**Action Plan**
Ensure Kent County community members have access to high-quality, affordable oral health care.	By October 1, 2015, increase by 5% the proportion of adults who report having visited a dentist in the past 12 months.[30] By October 1, 2015, reduce by 10% the disparity between adults with less than a high school education and all adults who report having visited a dentist in the past 12 months.[31] By October 1, 2015, increase by 10% the number of children under 10 years of age that have a dental provider. By October 1, 2015, increase by X% the numbers of dental providers who take Medicaid OR ....increase proportionate to the population on Medicaid, OR...increase by X% the percentage of adults with some form of dental insurance.	Increase access and access points for all patients in Kent County needing and seeking dental care.	First Steps, KCHD, Cherry Street, WMDDS, Mel Trotter, MCDC	1) By 11/2012, compile a comprehensive report to document local need for access to dental services, identify barriers to accessing dental care including and beyond financial, and quantify current resources. 2) By 1/2013, develop a comprehensive community plan to increase the availability of clinical dental services, with specific focus on access for underserved. 3) By 10/2015, expand clinical services to address the dental needs of all populations in Kent County.
		Promote and advance dental education programs/ residencies in West Michigan.	WMDDS, HDVCH, GRCC, Ferris	1) By 7/2014, establish a pediatric dentistry residency program in Kent County. 2) By 10/2015, establish a hospital-based general practice dentistry program in Kent County. 3) By 9/2013, explore workforce alternatives with local, CODA accredited dental programs.
		Strengthen and maintain the Kent County Oral Health Coalition as a clearinghouse/ collaborative "communication facilitator" for dental initiatives and a venue for networking, sharing resources, and avoiding duplication in Kent County.	First Steps, all Coalition members	1) By 1/2013, hire a coordinator to staff the Coalition. 2) By 3/2013, establish the Coalition as the central resource for oral health collaboration in Kent County.
		Advocate with state and local governmental entities and philanthropy for increased funding for oral health.	All Coalition members	1) By 3/2013, implement a legislative advocacy plan for the Coalition. 2) By 6/2013, implement a broad community advocacy plan for the Coalition.

[29] The Kent County Oral Health Coalition Workplan was adopted to address Priority 1 and 2's Objective 6.
[30] Behavioral Risk Factor Survey
[31] Behavioral Risk Factor Survey

Goals	SMART Objectives (what, when)	Evidence-Based Strategies (how)	Coalition members working in this area	Action Plan
Ensure Kent County community members possess oral health literacy and knowledge of basic oral health information and services.	By October 1, 2015, increase by 20% the percentage of parents of children 0-5 who demonstrate an understanding of basic oral health care for their children. By October 1, 2015, increase by 15% the percentage of parents of children 0-5 who indicate they will take their child to the dentist by age 1. By October 1, 2015, increase by 15% the percentage of parents who indicate awareness that dental disease is preventable.	Provide education on the importance of oral health to all populations in Kent County.	MOMS, KCHD MIHP, Family Futures, WMDDS, Cherry Street	1) By 12/2012, begin implementation of consistent oral health education messaging by early childhood providers. 2) By 4/2013, launch a county-wide community education campaign.
		Promote the use of best practices in oral health among dentists, primary care providers, and nurses.	WMDDS, First Steps, HDVCH, GRCC, Ferris	1) By 9/2013, implement an educational strategy for primary healthcare providers in Kent County. 2) By 1/2014, implement an educational strategy for other healthcare providers in Kent County.
		Promote the use of best practices in oral health among dentists, primary care providers, and nurses.	WMDDS, HDVCH, GRCC, Ferris	1) Beginning in 10/2013, pilot a CHAP project at CSHS to decrease no shows and provide resources to families. 2) By 9/2013, implement a fluoride varnish education program in Kent County. 3) By 2015, establish a one-year-old dental visit as the standard of care in Kent County. 4) By 2014, establish partnerships with area nursing schools to provide education regarding best practices in oral health prevention and education.

Appendix D: Priority 3 Action Plans

Action Plan: Priority 3, Strategy S2			
Priority: Reduce disparities in adequacy of prenatal care.			
Goal: Ensure all women receive prenatal care in the first trimester.			
Objective: By September 2015, increase from 75.7% to 79.5% the percent of women with a live birth in Kent County who received their first prenatal visit in their first trimester.			
Strategy: Implement a system for ensuring pregnant women presenting in the ED are scheduled an appointment with a prenatal care provider at discharge and referred to a home visiting or support program if eligible.			
Milestones	Outputs	Responsible	Deadline
1. Identify Key People	Key stakeholders identified		November 2012 (2 months)
2. Develop Rationale for Needed System	Literature review; list of support services available in county; business case		December 2012 (3 months)
3. Convene Committee of Key Stakeholders	Workgroup meetings held		January 2013 (4 months)
4. Create a Referral Plan	Referral plan		September 2013 (12 months)
5. Provide Tools and Training to ED Staff	Tools; training provided to ED staff		November 2013 (14 months)
6. Implement Plan	Data collected on plan implementation		December 2013 (15 months)
7. Monitor and Evaluate Plan	Evaluation plan; monitoring system; final report		September 2015 (36 months)

Action Steps: Months 1-9	10/12	11/12	12/12	1/13	2/13	3/13	4/13	5/13	6/13
1. Identify key stakeholders.	X								
2. Determine point person at each hospital in Kent County.	X								
3. Perform a literature review to determine best practices.		X							
4. Obtain and review data (e.g. FIMR, PRAMS, etc.)		X							
5. Complete a resource scan of support services in the county.		X							
6. Develop a business case that defines why it is important for all EDs to complete referrals with pregnant women.		X							
7. Share business case with key stakeholders.			X						
8. Define roles and responsibilities of partners.			X						
9. Secure commitment from health systems.			X						
10. Hold monthly/biweekly workgroup meetings.				X	X	X	X	X	X
11. Investigate referral process through Health Connects & determine how KCHD can join Health Connects.					X				
12. Work with home visiting providers to agree on a referral system.					X				
13. Develop materials for ED tools.					X				
14. Begin to create a referral plan.						X	X	X	X
15. Begin to set up a monitoring/evaluation system.						X	X	X	X

Action Plan: Priority 3, Strategy S4			
Priority: Reduce disparities in adequacy of prenatal care.			
Goal: Ensure all women receive prenatal care in the first trimester.			
Objective: By September 2015, increase from 75.7% to 79.5% the percent of women with a live birth in Kent County who received their first prenatal visit in their first trimester.			
Strategy: Promote OB provider adherence to ACOG guidelines pertaining to first trimester entry to prenatal care and Medicaid "guarantee letter."			
Milestones	Outputs	Responsible	Deadline
1. Enhance Existing Partnerships	Partner gaps assessed; additional partners engaged in I-Team; I-Team meetings held	Healthy Kent 2020 I-Team Core Concepts Group	December 2012 (3 months)
2. Analyze Current Provider Practices	List of providers; provider assessment method; provider assessment tool & protocol; database; assessment results	Healthy Kent 2020 I-Team Core Concepts Group	June 2013 (9 months)
3. Develop Coordinated Messages	Messaging literature review; messages developed	Healthy Kent 2020 I-Team Core Concepts Group	September 2013 (12 months)
4. Develop Strategy for Implementation	Implementation plan	Healthy Kent 2020 I-Team Core Concepts Group	December 2013 (15 months)
5. Implement Strategies	Strategies implemented	Healthy Kent 2020 I-Team Core Concepts Group	September 2014 (24 months)
6. Evaluate Implementation of Strategies	Provider post assessment; implementation report	Healthy Kent 2020 I-Team Core Concepts Group	September 2015 (36 months)

Action Steps: Months 1-9	10/12	11/12	12/12	1/13	2/13	3/13	4/13	5/13	6/13
1. Identify additional partners to engage in I-Team.	X								
2. Recruit and engage additional partners in I-Team.		X							
3. Orient new partners to the I-Team.			X						
4. Hold monthly I-Team Meetings with new partners.			X	X	X	X	X	X	X
5. Determine and develop provider assessment method, including a list of providers to assess.				X	X				
6. Develop provider assessment tool and protocol.					X				
7. Develop database for data entry.						X			
8. Complete provider assessment.						X	X		
9. Enter provider assessment data.						X	X		
10. Analyze and interpret provider assessment results.								X	
11. Compare assessment results to ACOG Guidelines.									X
12. Share assessment results with applicable partners.									X

Appendix E: Priority 4 Action Plans

Action Plan: Priority 4, Strategy S4			
Priority: Increase healthy eating by ensuring access to healthy foods.			
Goal: Increase healthy eating within Kent County.			
Objective: By September 30, 2015, increase the number of adults eating five or more servings of fruits and vegetables per day by 5%.			
Strategy: Implement a county-wide campaign to use a consistent message across agencies and at food outlets to promote healthier food choices.			
Milestones	Outputs	Responsible	Deadline
1. Establish Commitment from Partners	Letters of commitment from partner agencies	Fit Kids 360	December 2013 (3 months)
2. Decide and Select Consistent Messaging	List of current messages & tools being used in Kent County; sample campaigns obtained; strategy defined for selecting message; messaged selected and approval obtained	Fit Kids 360	March 2013 (6 months)
3. Establish Community Support	Letters of commitment from community leadership; community meetings held	Fit Kids 360	June 2013 (9 months)
4. Locate Resources for Implementation	Budget established; Funding proposals submitted	Fit Kids 360	June 2013 (9 months)
5. Complete Marketing Strategies	Marketing strategies	Fit Kids 360	September 2013 (12 months)
6. Complete Marking Plan	Marketing plan	Fit Kids 360	December 2014 (15 months)
7. Campaign Implemented	Campaign implemented	Fit Kids 360	March 2014 (18 months)
8. Complete Market Research	Pre-post tests and analysis complete; final report	Fit Kids 360	September 2015 (36 Months)

Action Steps: Months 1-9	10/12	11/12	12/12	1/13	2/13	3/13	4/13	5/13	6/13
1. Engage partners and form workgroup.	X								
2. Determine workgroup meeting schedule, define roles and responsibilities of partners, and establish letters of commitment.		X							
3. Hold monthly/biweekly workgroups meetings.			X	X	X	X	X	X	X
4. Review current messages and tools being used in Kent County and create a list.				X					
5. Perform an environmental scan to find sample campaigns.				X					
6. Develop and define a strategy for selecting one message.				X					
7. Research campaign strategies to determine which work best.					X				
8. Brainstorm marketing strategy and determine the best mode(s) of message delivery.					X				
9. Select message and obtain needed approval for message use.						X			
10. Identify resources that currently exist in the community that could possibly aid in campaign implementation.							X		
11. Research funding opportunities for implementing the campaign and write grant applications.							X		
12. Identify who to approach in the community for support.								X	
13. Share and educate community and leaders on selected message to gather support.									X

Appendix F: Priority 5 Action Plans

Action Plan: Priority 5, Strategy S1			
Priority: Reduce the disparity in health risk factors and protective factors between students.			
Goal: Coordinate and improve the collection of demographically representative data related to health risk and protective factors to identify current disparities.			
Objective: By spring 2014, a demographically representative 20% of school districts in Kent County will complete the 2013-2014 cycle of the MiPHY.			
Strategy: Identify and address barriers to MiPHY participation.			
Milestones	Outputs	Responsible	Deadline
1. Barriers to MiPHY participation are understood and documented.	Barriers report; action plan to address barriers	KCHD, Network 180/KCPC, North View, Kent ISD	March 2013 (6 months)
2. School needs are understood and documented.	Needs assessment report; action plan to address needs	KCHD, Network 180/KCPC, North View, Kent ISD	June 2013 (9 months)
3. The MiPHY marketed to schools.	Marketing and education materials; school meetings	KCHD, Network 180/KCPC, North View, Kent ISD	September 2013 (12 months)
4. Technical assistance is provided to schools.	Volunteers recruited; Ongoing TA provided to schools	KCHD, Network 180/KCPC, North View, Kent ISD	September 2014 (24 months)
5. Participation in the MiPHY increases.	Number of participating schools	KCHD, Network 180/KCPC, North View, Kent ISD	September 2014 (24 months)

Action Steps: Months 1-9	10/12	11/12	12/12	1/13	2/13	3/13	4/13	5/13	6/13
1. Identify leadership willing to support the effort.	X								
2. Identify partners and establish workgroup.	X								
3. Hold monthly/biweekly workgroup meetings.		X	X	X	X	X	X	X	X
4. Identify point person for each school district, designated by the district.		X							
5. Develop and program survey instruments to survey schools who are participating as well as not participating in the MiPHY.		X	X						
6. Field surveys with schools.				X					
7. Develop short interview and contact school superintendents to assess how they use MiPHY data in their district.				X	X				
8. Analyze survey and interview data.					X				
9. Develop action plan to address implementation of the MiPHY based on survey results.					X	X			
10. Develop brief survey to assess school technology needs.							X		
11. Field survey with technology departments and analyze results.								X	
12. Develop short interview instrument and talk to point person for each district about types of assistance they could use for the MiPHY.							X	X	
13. Develop brief report that addresses school needs for implementing the MiPHY.									X

Action Plan: Priority 5, Strategy S5			
Priority: Reduce the disparity in health risk factors and protective factors between students.			
Goal: Engage and empower youth to reduce disparities in risk and protective factors.			
Objective: By spring 2015, increase the number of adult mentors available to youth in the community by 10%.			
Strategy: Expand mentoring programs for youth.			
Milestones	Outputs	Responsible	Deadline
1. Mentoring program partners are aligned.	Establish advisory committee; secure CHNA representation on Kent County Mentoring Collaborative; common goals and objectives for advisory committee	Girl Scouts, GRAAN, North View, Kent ISD	March 2013 (6 months)
2. Opportunities to expand mentoring are defined based on the current landscape.	Assessment of where mentoring gaps exist; document describing expansion of mentoring	Girl Scouts, GRAAN, North View, Kent ISD	June 2013 (9 months)
3. What youth want in a mentor is understood and barriers mentors face are identified.	Survey instruments; survey results	Girl Scouts, GRAAN, North View, Kent ISD	June 2013 (9 months)
4. Funding sources to expand mentoring are identified and secured.	List of possible funding sources; proposal; contract	Girl Scouts, GRAAN, North View, Kent ISD	September 2014 (24 months)
5. Online mentoring technology is identified.	List of technology sources for online mentoring; technology sources identified and purchased (if needed) for online mentoring	Girl Scouts, GRAAN, North View, Kent ISD	September 2015 (36 months)
6. Mentoring in the schools and community is promoted.	Informational and promotional materials; school and community meetings	Girl Scouts, GRAAN, North View, Kent ISD	September 2015 (36 months)
7. Mentoring opportunities in the school and community are expanded.	Number of mentors available	Girl Scouts, GRAAN, North View, Kent ISD	September 2015 (36 months)

Action Steps: Months 1-9	10/12	11/12	12/12	1/13	2/13	3/13	4/13	5/13	6/13
1. Identify partners (current mentoring programs) to serve on advisory committee.	X	X							
2. Identify CHNA representative to sit in on monthly Kent County Mentoring Collaborative meetings.	X								
2. Hold monthly/biweekly advisory committee meetings.		X	X	X	X	X	X	X	X
3. CHNA representative attends monthly Kent County Mentoring Collaborative meetings.		X	X	X	X	X	X	X	X
4. Develop common goals and objectives for advisory committee in order to align partners for this effort.			X	X					
5. Develop a comprehensive document of current mentoring programs in the county including each program's goals, who the program targets, expansiveness of services, number of slots available, etc.					X	X			
6. Assess where mentoring gaps exist based on comprehensive document of current mentoring programs.							X		
7. Based on assessment of current programs, develop a document that defines how mentoring should be expanded in the county through these efforts.								X	
8. Develop survey instruments to determine what youth want from mentors and barriers mentors face.								X	
9. Identify youth and current mentors to survey.								X	
10. Field survey instruments with youth and current mentors and analyze results.									X

Action Plan: Priority 5, Strategy S9

Priority: Reduce the disparity in health risk factors and protective factors between students.

Goal: Ensure all youth have access to the services they need based on the risk factors they face in order to reduce disparities between youth.

Objective: By spring 2015, reduce the risk and protective factor disparities between youth in Kent County, including:

- 5% reduction in the percent of male (14.7% to 14.0%), African American (14.4% to 12.7%), Hispanic/Latino (13.4% to 12.7%), and American Indian (16.0% to 15.2%) students who are obese.
- 5% increase in seatbelt use among African American (13.7% to 13.0%), Hispanic/Latino (13.3% to 12.6%), and Asian (12.3% to 11.7%) students.
- 5% increase in condom use among Hispanic/Latino (47.4% to 49.8%) students who are sexually active.
- An average 5% reduction in the disparities in risk factors between students who get Ds/Fs and students who get As/Bs.

Strategy: Advocate for expansion of comprehensive health education programs in all Kent County schools.

Milestones	Outputs	Responsible	Deadline
1. Evidence based curricula and current practices are identified.	Evidence based curriculum list; current practices list	Kent ISD	March 2013 (6 months)
2. Parents, students, and community partners are educated, engaged, and heard.	Informational and promotional materials; school and community meetings	Kent ISD	March 2014 (18 months)
3. School leadership is educated, engaged, and heard.	Informational and promotional materials; school and community meetings	Kent ISD	March 2014 (18 months)
4. Schools are committed to implementing comprehensive health education programs.	Signed Memorandum of Understanding (MOU) from schools	Kent ISD	September 2014 (24 months)
5. Advocacy for policy change at state level is conducted.	Materials used for advocacy; attendance at state/legislative meetings	Kent ISD	September 2015 (36 months)

Action Steps: Months 1-9	10/12	11/12	12/12	1/13	2/13	3/13	4/13	5/13	6/13
1. Create a document that speaks to the purpose, vision, and mission of the milestone for potential workgroup members.	X								
2. Identify necessary partners to serve on workgroup and establish workgroup.	X	X							
3. Secure an intern to work on the project.	X	X							
4. Hold monthly/biweekly workgroup meetings.		X	X	X	X	X	X	X	X
5. Collect data on existing local, state, and national health curricula.		X	X	X					
6. Gather measured outcomes from Kent County Public Schools (KCPS) health curricula.		X	X	X					
7. Identify programs with the most positive outcomes.					X				
8. Identify and select a health curriculum for Kent County based on the data collected in steps 5, 6, and 7.						X			
9. Develop informational and promotional materials on selected curricula for parents, students, school leadership, and community.							X	X	X

Action Plan: Priority 5, Strategy S10

Priority: Reduce the disparity in health risk factors and protective factors between students.

Goal: Ensure all youth have access to the services they need based on the risk factors they face in order to reduce disparities between youth.

Objective: By spring 2015, reduce the risk and protective factor disparities between youth in Kent County, including:

- 5% reduction in the percent of male (14.7% to 14.0%), African American (14.4% to 12.7%), Hispanic/Latino (13.4% to 12.7%), and American Indian (16.0% to 15.2%) students who are obese.
- 5% increase in seatbelt use among African American (13.7% to 13.0%), Hispanic/Latino (13.3% to 12.6%), and Asian (12.3% to 11.7%) students.
- 5% increase in condom use among Hispanic/Latino (47.4% to 49.8%) students who are sexually active.
- An average 5% reduction in the disparities in risk factors between students who get Ds/Fs and students who get As/Bs.

Strategy: Strengthen and expand the provision of comprehensive health services with the school system.

Milestones	Outputs	Responsible	Deadline
1. Current Program resources and existing program gaps are assessed.	Resource/Gap Report	KCHD (lead), Kent ISD, Community Research Institute, KSSN (Stephanie P), DHS, Spectrum Health Healthier Communities	January 2013
2. Promotion of KSSN/School Nurse model promoted as a community best practice.	Evaluation report of existing KSSN programs	KSSN, Spectrum Health Healthier Communities	April 2013
3. Sustainability plan adapted by partner organizations.	Collaborative Financial Sustainability Model	KSSN, Kent County Collective Impact, Kent County Family and Children's Coordinating Council, Spectrum Health Healthier Communities	July 2013
4. Schools are committed to implementing school-based health services.	Signed Memoranda of Understanding from Schools	Kent County Collective Impact	July 2014
5. Expansion of KSSN/School Nurse model into additional schools.	Number of participating schools	KSSN Leadership, Spectrum Health Healthier Communities	Spring 2015

Action Steps: Months 1-9	10/12	11/12	12/12	1/13	2/13	3/13	4/13	5/13	6/13
1. Collect data on current number of schools with programs, number of students by school, % of students in poverty by school, % of students receiving free/reduced lunch by school	X	X	X	X					
2. Create a report that summarizes current program numbers and identifies gaps in service.				X					
3. Analyze program data, focusing on improvement of student health and achievement.				X	X	X			
4. Create an evaluation report that summarizes the successes of existing programs in Kent County.							X		
5. Develop branding for the KSSN/School Nurse Model and a communication/marketing plan for the release of the two reports.						X	X	X	
6. Release data to the community via mainstream media and school and community presentations.									X