HEALTH IMPROVEMENT PARTNERSHIP OF MARICOPA COUNTY

COMMUNITY HEALTH IMPROVEMENT PLAN

MARICOPA COUNTY

2012-2017

Maricopa County Department of Public Health

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PREFACE

This report describes the Community Health Improvement Plan (CHIP) of Maricopa County, a community-initiated plan to address the five public health priorities determined by the recent community health assessment (CHA) in 2012. These public health priorities are: reducing obesity, diabetes, cardiovascular disease, lung cancer, and improving access to care. The purpose of the CHIP is to set priorities, coordinate and target resources, and define actions taken by members of the public health system to promote health. The CHIP identifies strategies that can have the largest impact on improving the quality of life for all Maricopa County residents, particularly the most vulnerable in our community, by reducing preventable illness and death.

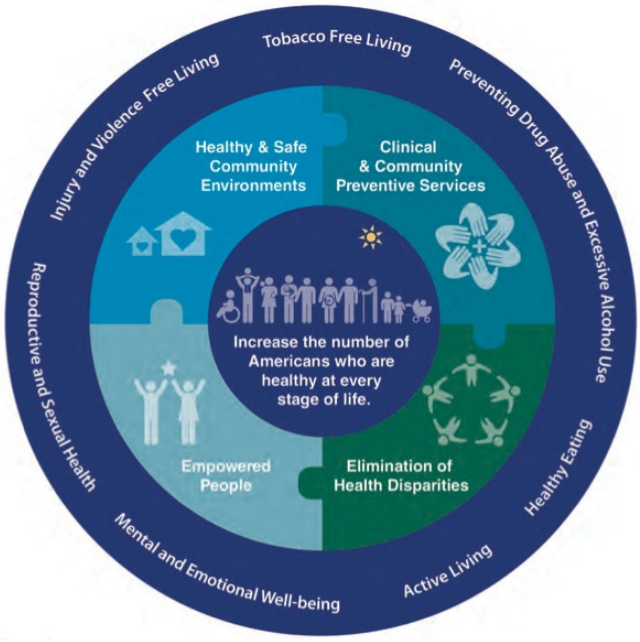

FIGURE 1. THE NATIONAL PREVENTION STRATEGY

The CHIP addresses chronic disease and access to care in the places where people spend significant amounts of time. It creates a framework along four community sectors: *Where We Live* (Community), *Where We Work* (Worksites), *Where We Learn* (Education), and *Where We Seek Care* (Healthcare). This approach It emphasizes the importance of wellness and prevention in all aspects of our lives and follows the approach embraced by *The National Prevention Strategy*[1] (see Figure 1).

The *Health Improvement Partnership of Maricopa County (HIPMC)* is a collaborative effort between Maricopa County Department of Public Health and more than 60 public and private organizations addressing the five priority health issues through the 2012-2017 Community Health Improvement Plan. Many participants are from organizations that have been involved since the CHA process, while others continue to join as the CHIP takes shape.

The information provided in this report is intended for the use of members of Maricopa County's public health system and to inform the community health improvement process among the broader Maricopa County community. The CHIP Workplan is updated bi-annually and revised every five years based on the most recent community health needs assessment.

[1] http://www.cdc.gov/features/preventionstrategy/

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EXECUTIVE SUMMARY

A community health assessment (CHA) was initiated in 2011 to determine five public health priorities for Maricopa County. This 18-month process included more than 1,000 residents, health professionals, and community partners working through the Mobilizing for Action through Planning and Partnership (MAPP) framework.[2] Through this systematic research and data collection process, five health priorities emerged. They are:

- Obesity
- Diabetes
- Lung Cancer
- Cardiovascular Disease
- Access to Health Care

In June 2012, a Community Action Planning (CAP) day set the key directions and strategies to impact these conditions within the next five years. Over 80 participants met to form this initial phase of a community health improvement plan. The planning meeting produced an interrelated set of evidence-based strategies emphasizing policy, systems, and environmental approaches (PSE). This CHIP report details the processes and partnerships that have created this five year action plan.

The *Health Improvement Partnership of Maricopa County* (HIPMC) has created a health improvement framework, as well as a workplan of specific goals and strategies, to impact these health priorities. Currently, task forces composed of health professionals, governmental, and community partners, have formed to coordinate implementation of the CHIP. Many task force members have been drawn from organizations engaged in the process to date, while others continue to step forward to implement the five-year plan. The overarching goal of this collaborative effort is to foster successful partnerships among diverse segments of our community in order to improve the health of Maricopa County residents.

In order to coordinate with the simultaneous development of the *Arizona Chronic Disease Strategic Plan 2012-2015*,[3] HIPMC built the framework to align strategies along four community sectors: *Where We Live, Where We Work, Where We Learn,* and *Where We Seek Care*. Because the five health priorities are impacted by similar risk factors and social determinants of health, strategies were categorized by the following topics: *tobacco use, physical activity, nutrition,* and *linkage to care*.

[2] National Association of County and City Health Officials (NACCHO). (2013). *MAPP Framework*. Retrieved from http://www.naccho.org/topics/infrastructure/mapp/framework/index.cfm

[3] Arizona Department of Health Services (2012). Bureau of Tobacco and Chronic Disease. *Arizona Chronic Disease Strategic Plan 2012-2015*. Retrieved from: http://www.azdhs.gov/phs/chronicdisease/

This Community Health Improvement Plan identifies the following targets for "moving the needle" with Maricopa County's five health priorities: reduction in high blood pressure prevalence of less than 24.5% (down from 25.8% at 2011 baseline); decreased prevelance of adults with diabetes rate of less than 8.6% (down from 9.2% at 2011 baseline); increased rate of adults with health insurance rate of at least 89.5% (up from 76.6% at 2012 baseline); less adults who are current smokers rate of less than 15% (down from 18.5% at 2011 baseline); and the reduction of the rate of obese adults of less than 24% (down from 25.2% at 2011 baseline).

INTRODUCTION

The Maricopa County Department of Public Health (MCDPH) serves the third largest local public health jurisdiction in the U.S., with more than 3.8 million residents according to the 2010 census.[4] Maricopa County encompasses over 9,200 square miles, roughly the size of the state of Massachusetts, composed of a mix of urban, suburban, and rural areas including the whole or parts of five sovereign American Indian Reservations. Home to the major metropolitan cities of Phoenix, Scottsdale, Mesa, Glendale, and Tempe, Maricopa County serves as the state's major geopolitical and economic center.

In 2011, the Maricopa County Department of Public Health (MCDPH) and the Arizona Department of Health Services (ADHS) collaborated on facilitating Maricopa County's first comprehensive community health assessment (CHA). The purpose of a CHA is to determine public health needs and priorities. This joint effort produced a CHA aligned with community values that reflect the needs of Maricopa County's diverse population. The desire for a community-driven approach led MCDPH to adopt the Mobilizing through Planning and Partnerships (MAPP) framework. This 18-month process included the engagement of a wide variety of community members and partners within the local public health system. The effort included a broad representation of public health partners; both traditional and non-traditional (see Appendix A for a list of partners). The results and recommendations from this process are detailed in the full *Maricopa County Community Health Assessment 2012 Report.*[5]

[4] U. S. Census Bureau. (2012). *American FactFinder fact sheet: Maricopa County, AZ.* Retrieved from http://www2.census.gov/census_2010/03-Demographic_Profile/Arizona/az2010.dp.zip

[5] Maricopa County Department of Public Health. (2014). *Maricopa County Community Health Assessment 2012 report*. Retrieved from http://www.maricopa.gov/publichealth/Programs/OPI/resources.aspx.

The overarching goal of this collaborative effort was to foster successful partnerships among diverse segments of our community in order to improve the health of Maricopa County residents. The foundational work that was laid through the health assessment created an integral network for community health planning.

The 2012-2017 Community Health Improvement Plan (CHIP) is a community-wide action plan for addressing the priority health issues identified in the CHA in Maricopa County over the next five years. It identifies areas where we can have the largest impact to improve the quality of life for all Maricopa County residents, particularly the most vulnerable in our community, by reducing preventable illness and death.

COMMUNITY HEALTH ASSESSMENT APPROACH

As shown in Figure 2, The *Mobilizing for Action through Planning and Partnerships* (MAPP) framework guided the Maricopa County community health assessment. MAPP is a community-wide strategic planning tool for improving community health. It has been implemented nationally by many public health jurisdictions to aid communities in prioritizing public health issues and identify resources to address them. The MAPP process was developed in collaboration between National Association of County and City Health Officials (NACCHO) and Centers for Disease Control and Prevention (CDC). Public health professionals in Maricopa County initiated this planning framework through an interactive process using community advisory teams.

The key phases of the MAPP process included:

- Organizing for success and developing partnerships
- Visioning
- Conducting the four MAPP assessments
- Identifying strategic issues
- Formulating goals and strategies
- Taking action (planning, implementation, and evaluation)

The four assessments conducted as part of the process include:

1. Community Strengths and Themes Assessment
2. Forces of Change Assessment
3. Local Public Health Systems Assessment
4. Community Health Status Assessment

FIGURE 1 MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) FRAMEWORK

The findings from each of these assessments are highlighted in the full CHA report, and found on two related websites. The MaricopaHealthMatters.org website is a community health portal built for sharing the community health assessment, local community health needs assessments of collaborating non-profit hospitals, and population health data. Materials related to the Health Improvement Partnership of Maricopa County (HIPMC) for the planning, implementation, and monitoring of the community health improvement plan can also be found there. The PublicHealthPerformance.org website also includes these materials for the Maricopa County Department of Public Health, Office of Performance Improvement.

PUBLIC HEALTH PRIORITIES FOR MARICOPA COUNTY

The public health priorities, for the next five years were identified by exploring the convergence of the results of the four MAPP assessments and determining how those issues affect the achievement of the shared vision. Advisory group members and staff used quality improvement tools, including a control/influence diagram and the nominal group technique[6] to organize and prioritize the health conditions determined in the assessment.

The recommendations were prioritized based on the following criteria:

- The top three most important issues identified by the community health survey;
- Conditions that were responsible for the highest number of years of potential life lost (YPLL);
- Inpatient hospital days; and emergency room visits; prevalence and trends over a ten-year period from 2001 through 2010;
- Existence of health disparities by racial/ethnic subgroups.
- Potential for prevention impact

Listed below are the five public health strategic priorities selected, along with a detailed description of selection rationale incorporating both the scientific data and community input.

[6] R. Bialek, G. Duffy, & J. Moran. (2009). *The Public Health Quality Improvement Handbook*. ASQ Quality Press.

PRIORITY #1: OBESITY

Maricopa County has a high prevalence of obesity among both children and adults; 1 in 4 adults are obese and 1 in 7 children are obese.[7] Among children 5 years old and under, 15.5% are obese.[8] Obese individuals are at increased risk for co-morbidities such as breast cancer, heart disease, and diabetes. The potential life years lost from heart disease and diabetes total 30,914 in 2010. Obesity disproportionately affects Hispanics (32.8%) in Maricopa County as compared to Whites (22.8%).[9]

> *"A family services center to include a gym and exercising as a groups, this would improve our community health. We could go on diets together. We need a nutritionist to be fed into from all angles: Schools, Gardens, Foodbanks, etc."*

Combating obesity among the county population is also in the best interest of cost. If obesity continues to rise at the present rate, by 2020 Maricopa County adults will spend $910 million more on healthcare. However, if obesity declines to 1987 levels, Maricopa County adults will spend $945 million less on healthcare by the year 2020. This is a $1.85 billion difference in the cost of these alternative futures. Health costs for sedentary patients cost $1,500 per year than physically active patients.[10,11]

> *"…lack of grocery stores. We don't have a grocery store close to us. We don't have health food stores either. Our stores are mom & pop and they sell beer, candy, and tobacco products."*

Obesity was ranked as the second most important health problem among community members (African American, American Indian, Asian American, and Hispanic) and MCDPH health professionals in the Maricopa County Community Health Survey.[12]

These data support the urgency to combat obesity among the Maricopa County community and its status as a public health priority. Community members that participated in focus groups expressed their perception of why obesity was a problem in their community.

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[7] Centers for Disease Control and Prevention (CDC). (2012). *Behavioral Risk Factor Surveillance System (BRFSS) 2010*. Atlanta, GA: Author.

[8] Maricopa County-PedNSS, 2009. *Pediatric Nutrition Surveillance System (PedNSS)* http://www.cdc.gov/PEDNSS

[9] Maricopa County Department of Public Health (MCDPH). (2012). *Maricopa County Health Status Report 2010*. Retrieved from http://www.maricopa.gov/publichealth/Services/EPI/Reports/status.aspx

[10] Levi, J., Vinter, S., Richardson, L., Laurent, R., & Segal, L.M. (2009). *F as in fat: How obesity policies are failing in America 2009*. Washington, D.C.: Trust for America's Health, Robert Wood Johnson Foundation. Retrieved from http://healthyamericans.org/reports/obesity2009/Obesity2009Report.pdf

[11] Ogden, C.L., Carroll, M.D., Curtin, L.R., Lamb, M.M., & Flegal, K.M. (2010). Prevalence of high body mass index in US children and adolescents, 2007-2008. *Journal of the American Medical Association, 303*(3).

[12] Maricopa County Department of Public Health. (2014). *Maricopa County Community Health Assessment 2012 report*. Retrieved from http://www.maricopa.gov/publichealth/Programs/OPI/resources.aspx.

PRIORITY #2: DIABETES

Diabetes is the seventh leading cause of death in Maricopa County.[13] In 2010, the prevalence of diabetes in Maricopa County resulted in 5,407 emergency room visits, 6,378 hospital visits, and 7,083 years of potential life lost.[14] Diabetes rates are higher in Blacks, Hispanics, and American Indians in Maricopa County.[15]

> *"…kids are not as active. It's all about the computer, internet, cell phone. There is an increase of kids with diabetes."*

The cost impact of diabetes in healthcare is substantial. In 2006, costs totaled 3.4 billion dollars, including $2.3 billion in medical bills for diabetes care and $1.1 billion in indirect costs. The cost burden is nation-wide; in 2007 the cost of diagnosed diabetes in the United States totaled $174 billion, including $116 billion for direct medical costs and $58 billion for indirect costs (disability, work, premature mortality). The average expenditures in the U.S. among people with diagnosed diabetes were 2.3 times higher than what expenditure would be in the absence of diabetes.[16,17]

Diabetes was ranked the most important health problem by community members (African American, American Indian, Asian American, and Hispanic) in the Maricopa County Community Health Survey.[18] Focus group participants described the impact of diabetes in children, contributing factors, and barriers in their community.

> *"We have young children with diabetes and who are overweight. PE classes are limited to two to three times per week… My daughter wanted to play T-ball but it was $250 per season. Options for local sports are not affordable. The Boys & Girls Clubs are expensive, and there are additional fees for different activities."*

[13] Maricopa County Department of Public Health (MCDPH). (2012). *Maricopa County Health Status Report 2001-2010*. Retrieved from http://www.maricopa.gov/publichealth/Services/EPI/Reports/status.aspx
[14] Maricopa County Department of Public Health (MCDPH). (2012). *Maricopa County Health Status Report 2010*. Retrieved from http://www.maricopa.gov/publichealth/Services/EPI/Reports/status.aspx
[15] Maricopa County Department of Public Health (MCDPH). (2012). *Maricopa County Health Status Report 2010*. Retrieved from http://www.maricopa.gov/publichealth/Services/EPI/Reports/status.aspx
[16] Arizona Department of Health Services. (2011). *Arizona Diabetes Burden Report: 2011*. Retrieved from http://azdhs.gov/azdiabetes/documents/pdf/AZ-Diabetes-Burden-Report_2011.pdf
[17] American Diabetes Association. (n.d.). The Cost of Diabetes. Retrieved from http://www.diabetes.org/advocate/resources/cost-of-diabetes.html
[18] Maricopa County Department of Public Health. (2014). *Maricopa County Community Health Assessment 2012 report*. Retrieved from http://www.maricopa.gov/publichealth/Programs/OPI/resources.aspx.

PRIORITY #3: CARDIOVASCULAR DISEASE

> *"We are busy working… we don't pay attention to our health. Plus, we worry too much and we get stress… that will affect our health… high blood pressure and stroke…"*

Cardiovascular disease is the second leading cause of death in Maricopa County.[19] In 2010, cardiovascular disease resulted in 21,413 emergency room visits, 58,176 hospital stays, and 5,143 deaths resulting in over 30,000 years of potential life lost.[20]

High blood pressure is a major risk factor for cardiovascular disease, and one in four Maricopa County residents have been told by their doctor that they have high blood pressure.[21] Obesity is also a risk factor for cardiovascular disease, and one in four Maricopa County adults is obese.[22] Binge drinking doubles your risk to suffer a stroke or heart attack among those with normal blood pressure; for those with high blood pressure binge drinking increases the risk fivefold. One in eight Maricopa County adults report that they binge drink.[23]

> *"Nutrition in the school is not very good, especially for the 'gorditos.' They serve them hamburgers, hot dogs, and pizza; it's better to send them with a lunch from home."*

In Arizona, hospital charges from heart disease totaled nearly $3.8 billion in 2005 according hospital discharge data. Charges associated with stroke contributed an additional $400 million that year.[24] (This does not include in-patient physician charges, non-hospital direct costs such as outpatient charges, or direct costs associated with missed work, early deaths, etc.).

High blood pressure was the fourth most important health problem chosen by community members and heart disease was the seventh (African American, American Indian, Asian American, and Hispanic participants) in the Maricopa County Community Health Survey.[25]

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[19] Murhpy, S. L., Jiaquan, X., & Kochanek, K. D. (2012). Deaths: Preliminary data for 2010. *National Vital Statistics Reports, 60* (4). Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_04.pdf

[20] Maricopa County Department of Public Health (MCDPH). (2012). *Maricopa County Health Status Report 2001-2010*. Retrieved from http://www.maricopa.gov/publichealth/Services/EPI/Reports/status.aspx

[21] Centers for Disease Control and Prevention (CDC). (2012). *Behavioral Risk Factor Surveillance System (BRFSS) 2010*. Atlanta, GA: Author.

[22] Centers for Disease Control and Prevention (CDC). (2012). *Behavioral Risk Factor Surveillance System (BRFSS) 2010*. Atlanta, GA: Author.

[23] Centers for Disease Control and Prevention (CDC). (2012). *Behavioral Risk Factor Surveillance System (BRFSS) 2010*. Atlanta, GA: Author.

[24] Arizona Department of Health Services. (n.d.). *Burden of Cardiovascular Disease Report: Arizona Hospital Discharge Data*. Retrieved from http://www.azdhs.gov/azcvd/documents/pdf/az-burden-of-cardiovascular-disease.pdf

[25] Maricopa County Department of Public Health. (2014). *Maricopa County Community Health Assessment 2012 report*. Retrieved from http://www.maricopa.gov/publichealth/Programs/OPI/resources.aspx.

PRIORITY #4: LUNG CANCER

> *"…another obnoxious thing is smoking… The U.S. Government treats people who sell cigarettes really well and are afraid of offending them. If they cannot sell it to Americans, they will sell it to Chinese."*

Cancer is the leading cause of death in Maricopa County.[26] In 2010, cancer resulted in 1,164 emergency room visits, 16,318 hospital stays, and 5,508 deaths.[27] Cancer was the third most important health problem chosen by community members in the Maricopa County Community Health Survey.[28] Of all types of cancers, lung cancer causes the most deaths in the county and is the easiest to prevent.[29] Smoking is the leading cause of lung cancer, and one in seven Maricopa County adults smoke.[30] Lung cancer death rates in the county are highest among Whites (57.1%).[31]

The cost impacts that result from cancer in Arizona are substantial. In 2004, approximately $3.72 billion was spent on cancer-related treatment. The total direct medical cost totaled $1.36 billion in the same year.[32]

Among focus group conversation, community member participants expressed their views about the influences of the tobacco industry and the perception of fear and lack of open communication among doctor-patient interactions.

> *"…how are we going to help people in our community to express their feeling in front of doctors? I've seen many people don't feel comfortable to discuss with their doctors when they're having cancer. It will be too late for them when they realize that."*

[26] Murhpy, S. L., Jiaquan, X., & Kochanek, K. D. (2012). Deaths: Preliminary data for 2010. National Vital Statistics Reports, 60 (4). Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_04.pdf

[27] Maricopa County Department of Public Health (MCDPH). (2012). *Maricopa County Health Status Report 2001-2010*. Retrieved from http://www.maricopa.gov/publichealth/Services/EPI/Reports/status.aspx

[28] Maricopa County Department of Public Health. (2014). *Maricopa County Community Health Assessment 2012 report*. Retrieved from http://www.maricopa.gov/publichealth/Programs/OPI/resources.aspx

[29] Centers for Disease Control and Prevention (CDC). (2012). *Behavioral Risk Factor Surveillance System (BRFSS) 2010*. Atlanta, GA: Author.

[30] Centers for Disease Control and Prevention (CDC). (2012). *Behavioral Risk Factor Surveillance System (BRFSS) 2010*. Atlanta, GA: Author.

[31] Murhpy, S. L., Jiaquan, X., & Kochanek, K. D. (2012). Deaths: Preliminary data for 2010. *National Vital Statistics Reports, 60* (4). Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_04.pdf

[32] Arizona Department of Health Services. (n.d.). *The Arizona Comprehensive Cancer Control Plan*. Retrieved from http://www.azdhs.gov/azcancercontrol/documents/pdf/az-comp-cancer-control-plan.pdf

PRIORITY #5: ACCESS TO CARE

Access to health care and related services has the ability to influence all other components of health. One in four Maricopa County residents have not seen a provider in the past year, while one in six delayed or did not get medical care because of cost, and one in seven does not have health insurance.[33] Lower income residents are less likely to visit a doctor.

Access to care was the most important health problem chosen by MCDPH health professionals and the sixth most important factor affects the quality of life chosen by community members (African American, American Indian, Asian American, and Hispanic participants) in the Maricopa County Community Health Survey.[34]

> *"…need a program that supports those who have worked. I worked for 25 years, I paid into systems, I am unemployed now, I need a program that will provide me health care."*

Focus group participants shared their personal experiences regarding access to care, including how it has affected their lives and the lives of their neighbors.

> *"I'm a professional, an entrepreneur; I do not qualify for health care. My neighbors are immigrants. They don't know where to go. For them as well, health care is secondary. Health care is a crisis based on need. No insurance for preventive care. Where do I go? Nowhere. I wait until it's an emergency and go to the emergency room."*

[33] St. Luke's Health Initiatives. (2011). Arizona *Health Survey 2010*, St. Luke's Health Initiatives. http://www.arizonahealthsurvey.org/

[34] Maricopa County Department of Public Health. (2014). *Maricopa County Community Health Assessment 2012 report*. Retrieved from http://www.maricopa.gov/publichealth/Programs/OPI/resources.aspx

ALIGNMENT OF HEALTH PRIORITIES

Maricopa County's health priorities align with and complement other health improvement efforts at the state and national levels, as shown in Figure 3. Two national level plans for population health improvement, *Healthy People 2020*[35] and the *National Prevention Strategy,*[36] include both current chronic disease conditions and the risk factors and social determinants of health that impact them. At the state level, Maricopa County's priorities reflect those of the *Arizona Chronic Disease Strategic Plan 2012-2015*.[37] The graphic below displays the interaction of local, state, and federal priorities.

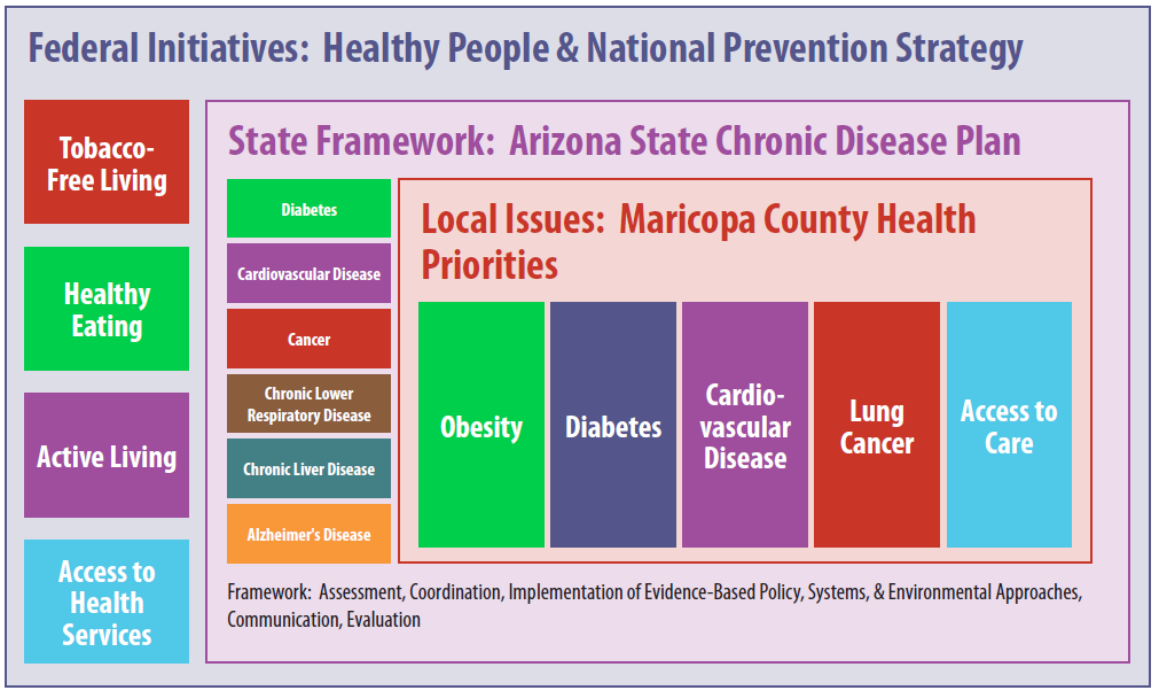

FIGURE 3. ALIGNMENT OF PRIORITIES WITH STATE AND NATIONAL INITIATIVES

LAYING THE GROUNDWORK FOR SUCCESS

EVIDENCE-BASED APPROACHES

At the conclusion of the community health assessment process, a Community Action Planning (CAP) session was held to identify key directions and evidence based strategies for impacting the health priorities. More than 80 participants gathered to review evidence based strategies related to the five health priorities and identified risk factors and social determinants of health.

[35] Arizona Department of Health Services (ADHS). (2013). Arizona Chronic Disease Strategic Plan 2012-2015. Retrieved from http://www.azdhs.gov/phs/chronicdisease/documents/az-chronic-disease-strategic-plan-2012-2015.pdf

[36] U.S. Department of Health and Human Services. (2013). *Healthy People 2020.* Retrieved from http://www.healthypeople.gov/2020/default.aspx

[37] National Prevention, Health Promotion and Public Health Council. (2011). *National Prevention Strategy*. Rockville, MD: Office of the Surgeon General. Retrieved from http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf

(See Appendix B for the initial list of strategies). These strategies set the stage for the CHIP Framework. The strategies were gleaned from national recommendations from the Centers for Disease Control and Prevention's (CDC) *Public Health Approach*,[38] U.S. Health and Human Services' *Healthy People 2020*,[39] the Community Preventive Services Task Force's *The Community Guide*,[40] and from foundations such as the Trust of America's Health and the Robert Wood Johnson Foundation.[41]

"Evidence-based" is a term in popular use in public health today and with good reason. Evidence-based interventions should provide the best outcomes for patients and populations.

The following definition for evidence-based public health practice is currently being used by some public health departments:

> *Evidence-based practice in public health is the careful, intentional, and sensible use of current best scientific evidence in making decisions about the choice and application of public health interventions.* [42]

Maricopa County Department of Public Health, in consultation with representatives from national public health organizations, including the CDC and others, created the following categories to understand the levels of evidence-based practice:

- Recommended: A practice with positive effects that has been rigorously examined, reviewed using strong scientific methods, and replicated across multiple settings.
- Promising practice: A practice that demonstrates generally positive effects, but may lack rigorous scientific design methods or multiple scientific reviews that strongly demonstrate replicable positive effects across settings.
- Insufficient evidence: A practice with inconclusive effects, or those which lack scientific data or examination.
- Not Recommended: A practice that has been demonstrated as having no effect, being potentially harmful or having negative effects.
- ADHS: Strategies recommended by the Arizona Department of Health Services.
- [Left blank]: No information is available on the evidence for this practice.

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[38] Centers for Disease Control and Prevention, Chronic Disease Prevention and Health Promotion. (n.d.). *Public Health Approach*. Retrieved from http://www.cdc.gov/chronicdisease/about/public-health-approach.htm

[39] U.S. Department of Health and Human Services. (2013). *Healthy People 2020.* Retrieved from http://www.healthypeople.gov/2020/default.aspx

[40] Centers for Disease Control and Prevention. (2014). *Guide to Community Preventive Services.* Retrieved from http://www.thecommunityguide.org/index.html

[41] Trust for America's Health (TFAH) and the Robert Wood Johnson Foundation (RWJF). (2013). *F as in Fat: How Obesity Threatens America's Future 2013.* Retrieved from http://healthyamericans.org/report/108/

[42] New Mexico Department of Health. (2013). *Evidence-Based Public Health Practice*. Retrieved from https://ibis.health.state.nm.us/resources/EvidenceBased.html

COMPREHENSIVE STRATEGIES: INCLUDING POLICY, SYSTEMS, AND ENVIRONMENTAL APPROACHES

In order to "move the needle" to affect the five health priority areas, participants were introduced to the *Spectrum of Prevention* framework (see Figure 4) from the Prevention Institute in California.[43] This framework presents a multifaceted approach to injury prevention. The value of the tool is that it can help practitioners develop and structure comprehensive initiatives in any content area. The tool is comprised of six levels of increasing scope (see below) beginning with a focus on the individual and family, moving to community norms, institutional practices, and finally laws.

Level of Spectrum	Definition of Level
1. Strengthening Individual Knowledge and Skills	Enhancing an individual's capability of preventing injury or illness and promoting safety
2. Promoting Community Education	Reaching groups of people with information and resources to promote health and safety
3. Educating Providers	Informing providers who will transmit skills and knowledge to others
4. Fostering Coalitions and Networks	Bringing together groups and individuals for broader goals and greater impact
5. Changing Organizational Practices	Adopting regulations and shaping norms to improve health and safety
6. Influencing Policy Legislation	Developing strategies to change laws and policies to influence outcomes

Figure 2. The Prevention Institute's Spectrum of Prevention

In a facilitated activity, participants created matrices of prioritized strategies by selecting those recommended evidence-based approaches relevant to our community and matching them to the appropriate level of prevention (or early intervention). This process ensured that while strategies could focus on the initial levels of intervention, emphasis was placed on identifying activities at the "higher" levels to influence policy, systems, and environmental approaches (PSE). The philosophy of targeting the higher-level strategies aligns with the *Arizona Chronic Disease Strategic Plan 2012-2015*,[44] the MCDPH Strategic Plan,[45] the CDC Public Health

[43] Cohen, L. (1999). *Spectrum of Prevention*. Retrieved from http://www.preventioninstitute.org/index.php?option=com_jlibrary&view=article&id=105&Itemid=127

[44] Arizona Department of Health Services. (2012). Bureau of Tobacco and Chronic Disease. *Arizona Chronic Disease Strategic Plan 2012-2015*. Retrieved from: http://www.azdhs.gov/phs/chronicdisease/

[45] Maricopa County Department of Public Health. (2014). MCDPH Strategic Plan 2014-2017. Retrieved from www.WeArePublicHealth.org

Approach,46 and the Arizona Department of Health Services' Arizona Nutrition Network Public Health Approaches.47 The result of this planning became the basis for the CHIP Framework (See Appendix C).

The Maricopa County CHIP uses a framework similar to the *Arizona Chronic Disease Strategic Plan 2012-2015,*[48] which aligns prevention and intervention strategies along four community sectors: *Where We Live* (Community), *Where We Work* (Worksites), *Where We Learn* (Education), and *Where We Seek Care* (Healthcare). This approach addresses chronic disease in places where people spend significant amounts of time. It emphasizes the importance of wellness and prevention in all aspects of our lives. See Figure 5 for the Maricopa County CHIP infographic.

The CHIP is anchored on the premise that all sectors must work collaboratively to address the health priorities defined within these sectors. This collaboration enables us to build and strengthen the capacity of the public health system to prevent chronic disease and promote wellness. The following infographic visually describes the importance of the work of the sectors by focusing on interventions that can help manage chronic diseases and access to care by addressing tobacco use, physical activity, nutrition, and linkages to care in a more coordinated and focused way.

[46] Centers for Disease Control and Prevention, Chronic Disease Prevention and Health Promotion. (n.d.). *Public Health Approach*. Retrieved from http://www.cdc.gov/chronicdisease/about/public-health-approach.htm

[47] Arizona Department of Health Services. (2014). Arizona Nutrition Network Public Health Approaches. Retrieved from http://www.azdhs.gov/phs/bnp/nupao/index.htm

[48] Arizona Department of Health Services (2012). Bureau of Tobacco and Chronic Disease. *Arizona Chronic Disease Strategic Plan 2012-2015*. Retrieved from: http://www.azdhs.gov/phs/chronicdisease/

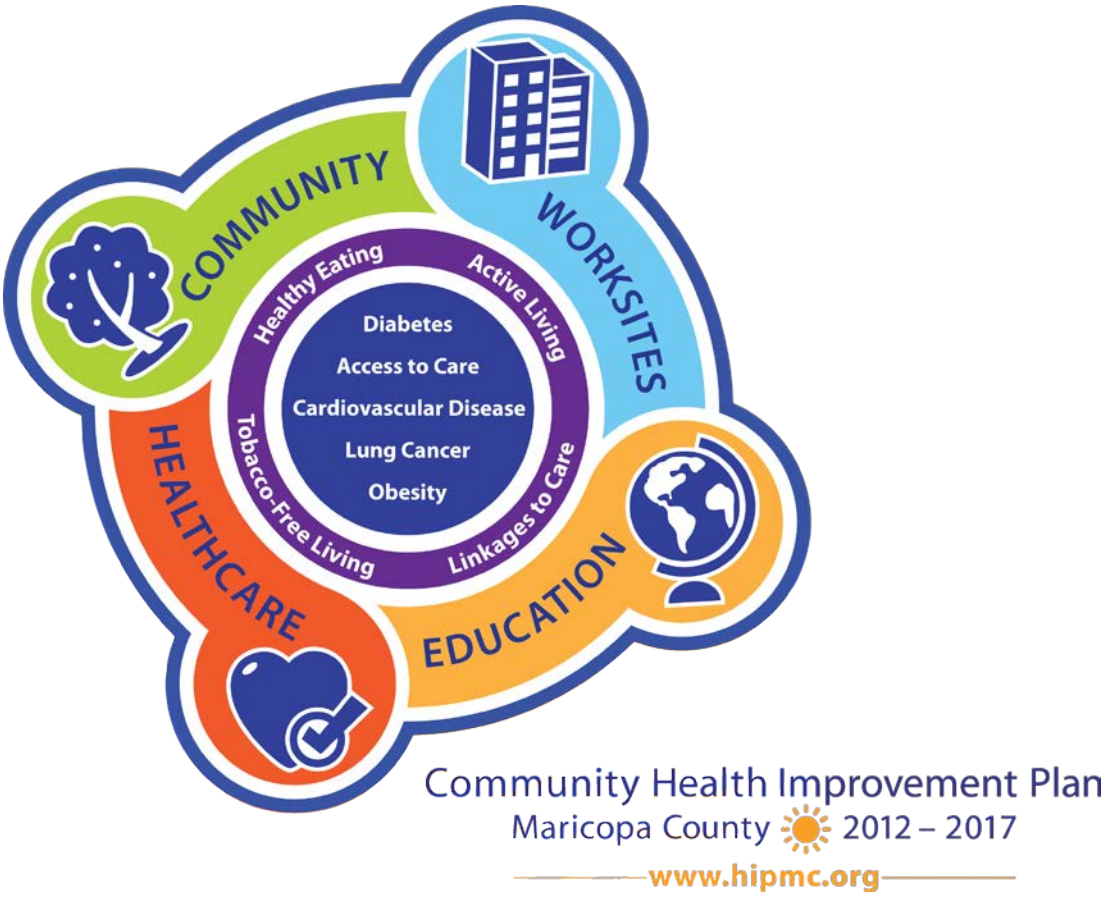

FIGURE 5. HEALTH IMPROVEMENT PARTNERSHIP OF MARICOPA COUNTY

Focusing on risk and protective factors, as well as the social determinants of health, the CHIP aligns its strategies to *Healthy People 2020*[49] and the *National Prevention Strategy's*[50] targeted priorities. Community partners and MCDPH contribute initiatives to the CHIP through the sector approach; also called "clouds," which are more fully described in the following section.

Partners in the CHIP planning process generated action plans using the affinity diagram technique from the Technology of Participation.[51] The affinity diagram is a quality improvement tool for gathering, grouping, organizing, and understanding large amounts of information.[52] This method was professionally facilitated to identify and draw out common themes from a large amount of information, reveal hidden linkages, and gain consensus among community participants and public health department staff.

[49] Department of Health and Human Services. (2013). *Healthy People 2020.* Retrieved from http://www.healthypeople.gov/2020/default.aspx

[50] National Prevention, Health Promotion and Public Health Council. (2011). *National Prevention Strategy*. Rockville, MD: Office of the Surgeon General. Retrieved from http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf

[51] Institute of Cultural Affairs. (2014). Technology of Participation. Retrieved from http://www.ica-usa.org/?page=whatistop

[52] R. Bialek, G. Duffy, & J. Moran. (2009). *The Public Health Quality Improvement Handbook*. ASQ Quality Press.

BUILDING A CROSS-SECTORED PARTNERSHIP

The Health Improvement Partnership of Maricopa County (HIPMC) became the mechanism for a broad, inclusive, and collaborative effort between MCDPH and community partners to address the priority health areas through the creation of the 2012-2017 Community Health Improvement Plan (CHIP). Because of the size and diverse population of the county, MCDPH became the convener of public and private organizations to collaboratively develop the CHIP.

MCDPH uses the term "clouds" to describe the collaborative effort happening among different community sectors (Worksites, Education, Community, and Healthcare). This is much like the computing concept of storing a large, diverse amount of data in a "cloud" in order to increase capacity or add capabilities to an existing system. For our purposes, that "system" is public health. The cloud approach allows participants to address environmental conditions and social determinants of chronic diseases and access to health care within their purview. At the same time, participants leverage exisiting resources and capabilities by linking to, coordinating with, and building on the contributions of others. Participation in each cloud may vary depending on the nature of an organization, its desired involvement, and available resources. Community partners may choose to work within one cloud or more.

The Community Cloud focuses on improving health outcomes by addressing issues and activities that touch people through the course of everyday life in Maricopa County. The Community Cloud is also where health issues relating to physical, environmental, social, or cultural characteristics may be addressed.

The Worksite Cloud focuses on improving health status within places of employment in Maricopa County. Workplaces may be public or private, and includes both the perspectives and needs of employees and employers. The Worksite Cloud is also interested in engaging organizations, associations, insurers, and other groups that support worksite health and employee wellness initiatives.

The Education Cloud focuses on positively affecting health within learning environments or settings, both public and private in Maricopa County. This includes pre-K, elementary schools, middle schools, high schools, charter schools, colleges, and universities as well as before- and after-school programs for children that are offered in school or a community-based facility. The Education Cloud is also interested in engaging with organizations, associations, and advocacy groups within the education spectrum.

The Healthcare Cloud focuses on improving the health status of the community via settings in Maricopa County in which clinical decisions are made or where medical services are provided. This includes hospitals, urgent care centers, primary care facilities, mobile medical facilities, physician's offices, community health centers, and other clinically-oriented settings. The Healthcare Cloud is also interested in engaging advocacy groups, associations, and organizations concerned with the provision of health care services and health-related products.

Identifying Assets, Resources, and Challenges

Participants in the HIPMC began meeting by sector, in December 2012, to begin developing the CHIP. A professional facilitator led participants through several quality improvement techniques for action planning. The initial step was to identify strengths and challenges to implementing strategies in that sector. The results of those documented sessions follow:

Community Cloud

Strengths	Challenges
• There is trust in our partners; a long history of working together • Implementing programs already without a lot of funding • We have connections with partners that are missing right now, but could be included • We have a population that is ready for change • Many people here are already doing work that is embedded deeply in the community • MAG just printed 100,000 bike maps – also available online • Working with all cities • Already beginning to work interdisciplinary – instead of siloed • Good leaders who want to collaborate and listen to everyone • A lot of momentum being built with other projects such as Reinvent Phoenix • The timing is right! We must share resources • National climate supports the work we are doing.	• Getting the political leaders to understand bike and pedestrian transit is just as important as building freeways and highways • Ensure that our work is culturally and linguistically appropriate • Asking people to think differently – about health and its integration into a variety of issues • People can be resistant to change – and are loaded • Multiple efforts make it hard to collaborate – going to multiple meetings that are focused on the same thing • Schools are overloaded • Resistance with executive leadership – health literacy • Culture against mandates • Marketing based message that reaches more people vs. clinically based. • Can't do it all – must partner – which is new to some • Affordable Care Act – loaded with prevention services – causing cuts already to certain programs – "ACA will be magical" • Economic challenges – as we make changes to Sugar-Sweetened Beverage Tax (SSB), for example, we are also putting people out of business and causing job losses.

WORKSITE CLOUD

Strengths	Challenges
• Strong technical knowledge of public health • A passion for public health • Having MCDPH coordinating the CHIP effort; to analyze data and frame problems • We have a foundational product • Resources • Coordination between ADHS and MCDPH and AZ. Small Business Association (ASBA) • Learn from others that have programs implemented; have some mechanics and experience • Starting to get top-level buy in; opportunistic time with Affordable Care Act imminent • Financial linkage	• Behavior change is hard work • Return on investment (ROI) for prevention is delayed; difficult to communicate that; employers may not see the benefit • There's a dilemma between enterprise/corporate implementation and pilot sites; corporate infrastructure can be a barrier • Employees don't want to be told what to do • Finding proof that is not reliant just on numbers; evaluative data • Customizing program to meet needs of employee base; how to engage when people feel like they don't need it • Management support and participation

EDUCATION CLOUD

Strengths	Challenges
• Statewide reach • Funding with ADHS to reach these goals • Private companies are interested; the timing is right • Corporations like Home Depot willing to donate items such as plants for community/school gardens • Reach all age groups • Education for medical personnel • Innovative practices and existing programs that could be replicated • Parent involvement groups that are interested in helping • Trusted health org./ providers like Phx Fire and others to deliver services/message to kids & families	• Health is not a priority in most schools • Time; so much competition for what to prioritize • Limited funding • Lack of follow-through • Embedding the programs • Lack of follow through after the school day • Need more policies around health and wellness in schools • Lack of health class requirement in college-level coursework to prepare them as they transition into adulthood/parenthood • Lack of innovation in bringing nutrition and physical activity throughout the schools • Nobody wants to be under the same umbrella • Public/private/charter schools have no coordinated efforts • Coordinating efforts while maintaining organizational individuality

HEALTHCARE CLOUD

Strengths	Challenges
• Trust in relationships; used to working together • Awareness of the problems we are surrounded with • Timing; the environment is ripe for this issue • Dedicated public health services support • Great resources in our state • Access to data • Commitment of public health to provide training and support to health centers; creating linkages to health care; moving Federally Qualified Health Centers to electronic medical records; creating medical home models • Anticipatory; wanting to create change; recognize a need • Better tools to reach underserved populations • Growing consensus to combine efforts; move away from a silo'd approach	• Need more strategies/communication related to how AZ is going to be impacted by the Affordable Care Act (ACA). • Need more work on health information exchange • Need to integrate data; better organization to share this data • Need to share/integrate best practices • Need more data to fill in gaps we can't answer • We need to use data to better tell the story of what the problem is • Need to address issues of trust in the medical community; addressing health myths (i.e., vaccines) • Need to determine the best audience; timing for trainings • Need more language access; culturally sensitive treatment and approaches • Understanding ACA and how public health dept. is going to play a role • Continuum of health care is not as strong as it could be—we need a connection between public health, healthcare and back to community • A lot of agencies doing community health assessments; some don't want to share information • People don't understand the opportunities with community-based organizations. • Thinking ACA is the magic bullet; going to solve problems. Won't necessarily apply to all organizations, like small businesses. • Culture change is very hard; shifting culture in AZ is tough; we have an aversion to policy change in AZ. • Physicians need to be more focused on prevention messaging in their offices • Make an investment in younger people/physicians; start changing that medical culture • Different "language" within each organization/different disciplines. • Need to get more services for over 21age group

DEVELOPING THE CHIP FRAMEWORK AND WORKPLAN

The framework for the CHIP evolved out of the community partner data collection process as described above as well as internal cloud discussions. In order to increase transparency and better reflect the coordinated effort of the CHIP, the framework incorporates both community-based and MCDPH program strategies, with an emphasis placed on using evidence-based measurable objectives. The CHIP Framework (See Appendix C) outlines the foundational components of the plan including the priority health conditions, risk factors and determinants, and cloud sector(s) impacted by each strategy. To coordinate efforts with the *Arizona Chronic Disease Strategic Plan 2012-2015,*[53] the CHIP organizes strategies along the same public health framework:

- Assess Needs
- Coordinate Public Health Partnerships
- Implement Strategies Emphasizing Evidence-based, Policy, Systems, and Environmental Approaches
- Coordinate Communication, and
- Evaluate Efforts

Strategies for the CHIP initiated from recommended approaches from *The Community Guide*[54] and were developed by studying the goals and objectives derived by both internal program staff as well as those identified by community partners. MCDPH and community-based initiatives are reflected as measurable objectives under these defined strategies in the CHIP Workplan (see Appendix D).

Together, the Maricopa County 2012-2017 CHIP Framework and Workplan set forth the strategic blueprint for how public health and community partners will work collectively through the HIPMC in making Maricopa County a healthier place to live and work. The Workplan is viewed as a dynamic document and is reviewed quarterly to include new initiatives and to conduct a process evaluation of the objectives, The most updated version of the Maricopa County CHIP can be found on MaricopaHealthMatters.org.

[53] Arizona Department of Health Services (2012). Bureau of Tobacco and Chronic Disease. *Arizona Chronic Disease Strategic Plan 2012-2015*. Retrieved from: http://www.azdhs.gov/phs/chronicdisease/

[54] Centers for Disease Control and Prevention. (2014). *Guide to Community Preventive Services.* Retrieved from http://www.thecommunityguide.org/index.html

WORKING TOGETHER FOR A HEALTHIER COMMUNITY

The HIPMC brings together partner agencies and collaborative groups and provides a stable infrastructure to share ideas and resources, identify gaps and barriers to existing services, and engage in thoughtful planning to achieve a shared vision. Professionals from public and private organizations, as well as community residents, hear about the CHIP and the HIPMC through quarterly meetings, MCDPH collaborative projects, community networking, and communication outreach activities, including the website, a HIPMC Facebook page, and a monthly HIPMC e-newsletter which is sent to more than 400 partners.

Some of the benefits of becoming a HIPMC Partner include access to MCDPH technical assistance including: data support, guidance on using evidence-based approaches, strategic planning, marketing and communications, evaluation, and meeting coordination. Professional development, educational events and quarterly partner meetings provide connection to other HIPMC members. Partners also receive organizational visibility through established print and online marketing platforms and co-branding across the HIPMC and MCDPH networks.

There is a space for all levels of engagement in the HIPMC. Some partners have reported using the identified health priorities as a way to align their own organizational goals. Others find value in the networking opportunities afforded by the partnership by working on a shared vision. Feedback through meeting evaluations and a partner satisfaction survey (developed by a community-based HIPMC workgroup) indicated a large percentage of respondents wanted a deeper level of partner accountability and commitment to the health improvement action planning process. In response, MCDPH worked with the previously mentioned HIPMC workgroup to develop a partner agreement. The HIPMC Partner Acknowledgement (See Appendix E) was officially presented to the partnership at the January 2014 meeting.

The HIPMC Partner Acknowledgement outlines the time and commitment needed to plan and mobilize resources to create a collaborative, sustainable community health improvement planning process. It welcomes the contributions and expectations of other HIPMC partners. Partners are invited to keep the HIPMC staff informed of their organization's CHIP- related activities, as applicable. This may include sharing data and other evaluation information with

MCDPH for the purposes of tracking evaluation outcomes for the CHIP. Partners are informed about the Partner Acknowledgement at each quarterly meeting, but there is no requirement to participate.

A special designation of "HIPMC Partner Champion" has been created to acknowledge those partners that have signed the Partner Acknowledgement and have contributed SMART objectives to the CHIP that are aligned with any of the five identified health priorities. MCDPH evaluators follow-up with partners on an agreed upon time interval to assess progress and offer support. These partners are recognized prominently at partner meetings as well as other communication channels as described in the following section. Since offering this enhanced level of engagement in Jan. 2014, more than a dozen partners have come aboard and are reflected in the CHIP Workplan (See Appendix D)

PUBLIC HEALTH INFRASTRUCTURE AND SUPPORT

MCDPH is committed to the ongoing coordination, implementation, and evaluation of the CHIP and the HIPMC. Maintaining momentum of a large and long-term community initiative requires more than the initial excitement of a collaborative project. Such an effort requires an infrastructure of staff and resources. The leadership of MCDPH has designated two full-time staff members to oversee the coordination and communication tasks required to ensure success as well as allowing additional program staff dedicated time to contribute to implementation, evaluation, policy, and data support. Securing full-time, paid staff to this project ensures sustainability and success.

Infrastructure developed for the HIPMC includes a public porta l for communication and dissemination of all related materials and activities. MCDPH funded the build out of the State's Arizona Health Matters website with a Maricopa County specific branch for all HIPMC materials (see MaricopaHealthMatters.org). The MaricopaHealthMatters website houses a virtual "toolbox" for each of the clouds as a resource for evidence-based practices, grant opportunities, communication tools, and related reports, data, and health indicators. The site houses all the documents of the CHA and CHIP and provides a venue for inclusion of new community partners. The website also highlights the broad array of community partners involved with the CHIP and the community health needs assessments (CHNAs) of partnering non-profit hospitals.

As mentioned above, MCDPH has committed staff and resources to the coordination, implementation, and evaluation of the HIPMC and the CHIP. In addition to the lead full-time staff, county health employees work among the four cloud groups as active participants in the CHIP. These same employees also facilitate MCDPH *internal* cross-departmental cloud groups that contribute to CHIP initiatives and improve relationships with the broader community. Both the community and internal clouds include staff with policy expertise (from the MCDPH Office of Public Health Policy), data and statistical support (from the MCDPH Office of Epidemiology), communication support (from the MCDPH Office of Community Engagement) and evaluators (from the MCDPH Office of Performance Improvement). These staffs contribute their time in-kind.

COMMUNITY HEALTH IMPROVEMENT PLAN IMPLEMENTATION AND EVALUATION

The CHIP Workplan is a dynamic document dependent on contributions from both MCDPH and community partners. MCDPH staff members maintain the CHIP Workplan to ensure that all contributing initiatives include clear, specific, realistic, and action-oriented goals that are measurable and time-bound. Work is formulated into objectives under the appropriate categories and strategies in the framework. Each objective has performance measures and indicators of progress that are collected and updated bi-annually.

The MCDPH evaluation team monitors the workplan initiatives through a performance dashboard and provides reports to HIPMC partners (and are available on the two websites). Tracking the accomplishments of cloud workgroups alongside objectives being accomplished by MCDPH programs and HIPMC partners, provides a good snapshot of the public health work happening in our community that relates to the identified CHA priorities which make up the Community Health Improvement Plan (CHIP).

The evaluation team also works closely with the MCDPH Office of Epidemiology to report on population health surveillance measures annually. In order to review CHIP progress in the context of population health surveillance data, a series of indicators relevant to health priorities are collected and reported. Population health objectives from *Healthy People 2020*[55] have been identified and are being tracked at the county level and in smaller sample areas when data is available. The MCDPH Office of Epidemiology provides this epidemiological support for the data analysis, interpretation, and reporting of health indicators related to obesity, diabetes, cardiovascular disease, lung cancer and access to care in addition to tobacco use, physical activity, and nutrition.

Surveillance of health indicators for the five priority indicators are reviewed and presented annually to HIPMC partners to aid in program planning strategies for ongoing program years.

[55] Department of Health and Human Services. (2013). *Healthy People 2020.* Retrieved from http://www.healthypeople.gov/2020/default.aspx

For ease of access to these data, MCDPH has created a local CHIP Tracker on MaricopaHealthMatters.org (See Appendix G). The Healthy People 2020[56] targets and community indicators for the five health priority areas will be updated annually with data from the US Census[57], the Behavioral Risk Factor Surveillance System[58], state and local health department data reports, and other sources. These measures track rates of obesity, diabetes, smoking, heart disease and related indicators, as well as children and adults with health insurance. These target indicators should be observable by the end of this current CHIP cycle.

The following targets for indicators related to Maricopa County's five health priorities that should be observable by the end of this three-year grant cycle have been set for this CHIP period. These are: reduce high blood pressure prevalence to less than 24.5% (down from 25.8% at 2011 baseline); decrease the reate of adults with diabetes to a rate of less than 8.6% (down from 9.2% at 2011 baseline); increase adults with health insurance to the rate of at least 89.5% (up from 76.6% at 2012 baseline); decrease in adults who are current smokers less than 15% (down from 18.5% at 2011 baseline); and reduce the rate of obese adults to less than 24% (down from 25.2% at 2011 baseline). See Appendix F for the full range surveillance indicators tracked annually as part of the CHIP evaluation and the related *Healthy People 2020*[59] targets.

CREATING A SUSTAINABLE HEALTH IMPROVEMENT SYSTEM

Maricopa County Department of Public Health is committed to sustaining the work of the HIPMC. A full time staff position is dedicated to the coordination of the collaborative and many other staff members contribute their time as part of their job responsibilities. The Department has paid for the buildout of the MaricopaHealthMatters.org site to foster ongoing collaboration.

Members of HIPMC and MCDPH staff are identifying opportunities for additional funding and coordination of efforts through infrastructure improvements. For instance, MCDPH staff was awarded a technical assistance grant from a local foundation, St. Luke's Health Initiatives, to receive training on how to develop a community advisory board or governance structure. Creation of this board will help ensure a diverse representation of community voices in creating a shared vision and strategy for sustainable health improvement.. Another core group of staff from non-profit hospitals and federally qualified community health centers, are in the final review process to formalize a joint effort for coordinated community health assessment and

[56] U.S. Department of Health and Human Services. (2013). *Healthy People 2020.* Retrieved from http://www.healthypeople.gov/2020/default.aspx
[57] U. S. Census Bureau. (2012). *American FactFinder fact sheet: Maricopa County, AZ.* Retrieved from http://www2.census.gov/census_2010/03-Demographic_Profile/Arizona/az2010.dp.zip
[58] Centers for Disease Control and Prevention (CDC). (2014). *Behavioral Risk Factor Surveillance System (BRFSS) 2010*. Atlanta, GA: Author.
[59] Department of Health and Human Services. (2013). *Healthy People 2020.* Retrieved from http://www.healthypeople.gov/2020/default.aspx

health improvement planning. HIPMC partners have joined department staff in applying for two federal grant opportunities to provide funding for ongoing related activities.

To learn more about the health assessment and community health improvement planning process for Maricopa County, visit MaricopaHealthMatters.org.

APPENDIX A. CHIP COMMUNITY PARTNERS AND PARTICIPANTS LIST

Community Health Assessment and Community Health Improvement Plan Participant Partner Organizations and Sectors participating since June 2012 (a more updated HIPMC Partner list may be found on MaricopaHealthMatters.org.).

Organizations	Sector
Adelante Healthcare	Health care
Advisory Council on Indian Health Care	Tribal- health
Aetna	Private-health
Alliance for a Healthier Generation	Non-profit – health
Alzheimer's Association - Desert Southwest Chapter	Private- health
American Academy of Pediatrics - Arizona Chapter	Private- health
American Cancer Society Cancer Action Network	Non-profit - health
American Heart Association	Non-profit – health
American Red Cross	Non-profit – health
Anthony Bates Foundation	Non-profit – health
Area Agency on Aging	Non-profit- government funded
Arizona Association for Home Care	Private- health
Arizona Association of Community Health Centers	Non-profit- government funded
Arizona Alliance for Community Health Centers	Advocacy – health/education
Arizona Department of Education	Education- public
Arizona Department of Emergency & Military Affairs	Government-emergency management
Arizona Department of Health Services	Government- health
Arizona Health Disparities Center	Government- health
Arizona Spinal Cord Injury Association	Non-profit – health
Administrative Counsel & Rules	Government- health
Bureau of Nutrition and Physical Activity	Government- health
Bureau of Public Health Emergency Preparedness	Government- health
Bureau of Public Health Statistics	Government- health
Bureau of State Laboratory Services	Government- health
Bureau of Tobacco and Chronic Disease	Government- health
Bureau of Women's and Children's Health	Government- health
Division of Behavioral Health Services	Government- health
Epidemiology & Disease Control	Government- health
HIV prevention Program	Government- health
Arizona Department of Transportation	Government- built environment
Arizona Diabetes Coalition	Non-profit- health
Arizona Family Health Partnership	Private- non-profit – health
Arizona Hemophilia Association	Non-profit – health

Arizona In ACTION	Advocacy
Arizona Living Well Institute	Public/Private – health Care
Arizona Partnership for Immunization	Non-profit- health
Arizona Public Health Association	Professional association- health
Arizona Public Health Training Center	Education- post-secondary
Arizona Public Interest Research Group (PIRG)	Advocacy
Arizona Small Business Association	Professional association –advocacy
Arizona Smokers Helpline	Health – social services
Arizona State University	Education- post-secondary
College of Nursing & Healthcare Innovation	Education- post-secondary
Southwest Interdisciplinary Research Center	Education- post-secondary
Artisan Food Guild	Advocacy
Asian Pacific Community in Action	Non-profit- minority focused
Banner Health Systems	Health care
Be A Leader Foundation	Non-profit- Education
Black Nurse Association of Greater Phoenix	Professional association- health
Blue Cross Blue Shield	Private Healthcare
Boys & Girls Clubs of Metro Phoenix	Non-Profit- social services
Bridgeway Health Solutions	Public – Healthcare
Build Arizona	Advocacy
Cardon Children's Medical Center	Health Care
Carl Hayden High School	Education- public
Catalina Ventura/Alhambra School District	Education- public
Catholic Health Partners	Health care
Cave Creek Unified School District	Education – public
Center for Health Information Research	Non-profit- health
Central Village Planning	Government- planning
Chandler Fire Department	Government –safety
Chicanos Por La Causa	Non-profit - minority focused
Children's Action Alliance	Advocacy
Cigna	Private healthcare
City of Glendale	Government
City of Goodyear	Government
City of Phoenix - FitPHX	Government –health
City of Phoenix Housing Department Hope VI	Government- social services
City of Phoenix Parks & Recreation	Government –social service
City of Phoenix Prosecutors Office	Government –social services
City of Scottsdale	Government
City of Tempe	Government
Community Housing Partnership	Non-profit- social services

Concilio Latino de Salud	Non-profit- health
Crisis Preparation and Recovery	Non-profit- health
Desert Thunder/Avondale Elementary School District	Education- public
Emergency Management	Government- health
EMPACT	Non-profit –health
Esperanca	Non-profit – social services
First Baptist Children's Center	Education -public
First Things First	Non-profit – social services
FIT Clinic	Private- health
Foundation for Senior Living	Non-profit- social services
Garfield Elementary School	Education- public
GateWay Community College	Education- post-secondary
Gilbert Public Schools	Education - public
Girl Scouts Arizona Cactus-Pine	Non-profit – Social Services
Glendale Care Center	Private- health
Glendale Fire Department Public Information Officer	Government- safety
Golden Gate Community Center	Education- post-secondary
Greater Phoenix Chamber of Commerce	Government
Greater Valley Area Health Education Center	Education/healthcare
Greenway High School	Education- public
Griffith Elementary School	Education- public
Health-e Options	Private- health
Healthways, Inc.	Private - health
IASIS Healthcare	Private- healthcare
J.B. Sutton Elementary School	Education- public
Jewish Family and Children's Services	Non-profit – social services
Kivel Care Center- Phoenix	Private- health, seniors
Kyrene School District	Education - public
Leukemia & Lymphoma Society	Non-profit- health
Lifewell Behavioral Wellness	Non-profit – social services
Livable Communities Coalition	Non-profit – advocacy
Magellan Health Services	Private social services
Maricopa Association of Governments	Government- built environment
Maricopa Community Colleges	Education – post secondary
Maricopa County Board of Health	Government- health
Maricopa County Department of Air Quality	Government- safety
Maricopa County Education Service Agency	Education – public
Maricopa County Depart of Emergency Management	Government- safety
Maricopa County Depart of Environmental Services	Government- safety
Maricopa County Department of Public Health	Government - health

Clinic, STD Programs	Government- health
Clinic, TB Control	Government- health
Community Health Nursing	Government- health
Community Health Services	Government- health
Healthcare for the Homeless	Government- health
Office of Health Promotion and Education	Government- health
Office of Performance Improvement	Government- health
Office of Preparedness and Response	Government- health
Office of Public Health Policy	Government- health
Office of the Director	Government- health
Office of Tobacco and Chronic Disease	Government- health
Ryan White Planning Council	Government- health
Maricopa County Sheriff's Office	Government- safety
Maricopa County Wellness Works	Non-profit- Government funded
Maricopa Integrated Health Services	Non-profit- government funded
Refugee Women's Health Clinic	Non-profit- government funded
Mayo Clinic Hospital	Private- health
Mercy Care Plan	Non-profit –health
Midwestern University - Glendale	Education- post-secondary
Mission of Mercy	Non-profit-faith-based/health
Mountain Park Health Center	Non-profit- government funded
National Kidney Foundation of Arizona	Non-profit - health
Native Health	Non-profit- social services/tribal
Neighborhood Outreach Access to Health	Non-profit – social services/health
Phoenix Fire Department	Government- safety
Phoenix Indian Center	Tribal- social services
Phoenix Police Department	Government- safety
Phoenix Revitalization Corporation	Non-profit- housing
Phoenix Union High School District	Education- public
People of Color Network, Inc.	Non-profit – social services
Pinnacle Prevention	Non-profit-health
Preventative Health Consulting, LLC	Private- health
Project for Livable Communities	Advocacy
Quality Care Network	Non-profit – social services
Rancho Solano Preparatory School	Education – public
RPG Medical Holdings	Private- health
Rose Howe and Associates	Private- health
Saguaro High School	Education- public
Sanford Brown College - Phoenix	Education- post-secondary
SCAN Health Plan Arizona	Private-Health

Scottsdale Healthcare	Private- health
Scottsdale Training and Rehabilitation Services	Non-profit - health
Scottsdale Unified School District	Education – public
Southwest Center for HIV/AIDS	Non-profit- health
Spectrum Medical Group	Private- health
St. Joseph's Hospital/Dignity Health	Non-profit- health
St. Luke's Health Initiatives	Non-profit- health
Tanner Community Development	Non-profit- social services
Tempe High School	Education – public
Tempe Unified High School District	Education – public
Terros	Non-profit- health
The Area Agency on Aging, Region One	Non-profit – health
The Arizona Partnership for Immunization (TAPI)	Non-profit - health
The Faithful City	Faith Based
The Keogh Health Foundation	Non-profit- health
The Wellness Community - Arizona	Non-Profit – social service
Town of Gila Bend	Government
United Healthcare	Private –health
University of Arizona College of Medicine Phoenix	Education- post-secondary
University of Arizona Cooperative Extension	Education – post-secondary
Valle Del Sol	Non-profit social services
Valley Metro	Government- transportation
Valley of the Sun United Way	Non-profit- social services
Valley Permaculture Alliance	Non-profit-health/education
Virginia G. Piper Charitable Trust	Private/Non-profit – social services
Viridian Health Management	Healthcare
Volunteers with the American Heart Association	Non-profit- health
Wesley Community and Health Center	Non-profit
Western Governors University	Education – post-secondary

APPENDIX B. EVIDENCE-BASED STRATEGIES LISTS BY SECTOR

The following pages detail the strategies developed at the Community Action Planning prior to beginning the Community Health Improvement Plan. These have not been prioritized; some have landed on the CHIP. As previously noted, the framework for the strategies falls along four sectors: *Where We Live, Where We Work, Where We Learn,* and *Where We Seek Care*. They also are categorized by risk factors, the CDC Chronic Disease Prevention and Health Promotion Domains, and substantiation of evidence-based practices.

Key to Identifiers in the Strategy Matrix

Risk Factors and Social Determinant Topics

Nutrition	N
Physical Activity	P
Tobacco Use	T
Linkage to Care	LC

CDC Chronic Disease Prevention and Health Promotion Domains

Epidemiology and Surveillance	Domain 1
Environmental Approaches	Domain 2
Health Systems Interventions	Domain 3
Strategies to Improving Community-Clinical Linkages	Domain 4

Evidence-Based Practices

"Evidence-based" is a term in popular use in public health today and with good reason. Evidence-based interventions should provide the best outcomes for patients and populations. The following definition for evidence-based public health practice that is currently being used by some public health departments:

Evidence-based practice in public health is the careful, intentional, and sensible use of current best scientific evidence in making decisions about the choice and application of public health interventions.

Recommended: A practice with positive effects that has been rigorously examined, reviewed using strong scientific methods, and replicated across multiple settings.

Promising practice: A practice that demonstrates generally positive effects, but may lack rigorous scientific design methods or multiple scientific reviews that strongly demonstrate replicable positive effects across settings.

Insufficient evidence: A practice with inconclusive effects, or those which lack scientific data or examination.

Not Recommended: A practice that has been demonstrated as having no effect, being potentially harmful or having negative effects.

ADHS: Strategies recommended by the Arizona Department of Health Services.

[Left blank]: No information is available on the evidence for this practice.

Where We Live	Topic	CDC Domain	Evidence-Based
Provide incentives to food retailers to locate and/or offer healthy food and beverage choices in underserved areas to improve availability of healthy food options.	N	2	Recommended
Create public/private partnerships to open and sustain full-service grocery stores in communities without access to healthy food.	N	2	Recommended
Community partnerships and collaboration that helps incentivize and encourage convenience stores and bodegas to offer healthy food options.	N	2	Recommended
Education programs and campaigns to increase and enhance application of nutrition information on menus (chain restaurants, publicly funded property) and informed use of info by customers to encourage healthy eating.	N	2	Promising practice
Increase accessibility, availability, affordability, and identification of healthful foods in communities, including provision of full service grocery stores, farmers markets, small store initiatives, mobile vending cars, and/or restaurant initiatives.	N	2	ADHS
Improve geographic availability of fresh food vendors.	N	2	Recommended
Impose portion limits in restaurants.	N	2	
Provide incentives to produce and procure healthy foods from local farms.	N	2	Recommended
Promoting affordable healthy food and beverage: improve geographic availability of supermarkets in underserved areas in order to increase access to healthy food.	N	2	Recommended
Industry develops and adheres to marketing and advertising guidelines that minimize the risk of obesity for youth.	N	2	Promising practice
Food and beverage companies use creativity, resources, and marketing to advertise and promote healthful diets for children and youth.	N	2	Promising practice
List main ingredients.	N	2	
Food served or sold in government facilities (including schools, prisons, and administrative buildings) meets the USDA guidelines for Americans.	N	2	Promising practice
Soda excise taxes to reduce consumption of soda while raising revenue (with proceeds going to Medicaid, higher education, or public health prevention programs).	N	2	Promising practice
Fund SNAP programs.	N	4	
Interim land use policies that promote nutrition and physical activity; permit use of vacant lots for gardens, recreational space, or public art displays.	P N	2	Promising practice
Community-wide campaigns and multi-component strategies to increase physical activity and physical fitness.	P	2	Recommended

Where We Live	Topic	CDC Domain	Evidence-Based
Strategies to create safe communities that support physical activity: improve access to public transportation.	P	2	Recommended
Strategies to create safe communities that support physical activity: enhance personal safety in mixed use areas.	P	2	Recommended
Require a min% of highway funds to be allocated for walkways & bike paths.	P	2	Promising practice
Enhance infrastructure to support biking.	P	2	Recommended
Enhance infrastructure to support walking.	P	2	Recommended
Promote active lifestyles; facilitate joint-use agreements between communities and schools.	P	2	Recommended
Creation of or enhanced access to places for physical activity combined with information outreach to increase physical activity and fitness levels.	P	2	Recommended
Establish community design standards to make streets safe for all users, including pedestrians, bicyclists, and user of public transit.	P	2	ADHS
Establish community design protocols through Health Impact Assessment's (HIA's) to assess the impact of community design changes on community health and wellbeing.	P	2	ADHS
Increase tobacco use cessation: mass media campaign combines with other interventions.	T		Recommended
Reducing tobacco use initiation: mass media campaign combined with other intervention to raise tobacco prices, provide school-based education, or other community-based education program.	T	2	Recommended
Use of online networks and resources (viral marketing, social networks, and blogs) for targeted, tailored tobacco control messaging.	T	2	Recommended
Increase tobacco use cessation: increasing unit price of tobacco products.	T		Recommended
Increase tobacco tax.	T	2	
Reducing tobacco use initiation: increasing unit price of tobacco products to reduce use among adolescents and adults, reduce population level consumption, and increase cessation.	T	2	Recommended
Tobacco free living: policies that prohibit smoking or all tobacco products on residential, commercial, or health care facility properties.	T		Recommended
Reducing secondhand smoke exposure: smoking bans and restrictions, used alone or as part of a multi-component community or workplace intervention.	T	2	Recommended
Restricting minors' access to tobacco products: community mobilization combined with additional interventions (laws, enforcement, and retailer education).	T	2	Recommended

Where We Live	Topic	CDC Domain	Evidence-Based
Restricting minors' access to tobacco products: sales laws directed at retailers, implemented alone.	T	2	
Support and/or facilitate tobacco prevention and/or control coalition developments, and links to related coalitions with shared goals	T	2	Recommended
Promote insurance coverage to include tobacco use treatment.	T	3	Recommended
Improve tobacco cessation incentives.	T	3	
Multiple risk factor interventions using counseling and educational methods aimed at behavior change to reducing coronary heart disease mortality in high-risk hypertensive and diabetic populations.	T	4	Promising practice
Tobacco cessation: expand and tailor culturally competent quit line services for diverse populations and languages.	T	4	Promising practice
Social media to increase health services utilization per ACA.	LC	2	
Outreach strategies that expand health insurance coverage among eligible children.	LC	2	Promising practice
Specialist outreach programs and outreach clinics to improve access to care, quality of care, health outcomes and patient satisfaction.	LC	3	Promising practice
Multi-component interventions targeting health professionals and health organizations at primary care, outpatient, or community settings that increase continuity of care and diabetes management.	LC	3	Recommended
Self-management education programs led by lay leaders for people with chronic conditions.	LC	3	Promising practice
Obesity prevention and control: technology supported multi-component coaching or counseling interventions to reduce weight.	LC	4	Recommended
Implement chronic disease-based treatment protocols and/or self-management programs.	LC	4	ADHS

Where We Work	Topic	CDC Domain	Evidence-Based
Employers offer and promote access to healthy foods and beverages and opportunities for physical activity.	P N	2	Recommended
Increase opportunities for physical activity in the workplace.	P	2	ADHS
Incentives in worksites for employees to be more physically active.	P	2	
Enhance infrastructure to support biking.	P	2	Recommended
Enhance infrastructure to support walking.	P	2	Recommended
Require a minimum percentage of highway funds (1%) be allocated for walkways and bike paths.	P	2	Promising practice
Community level urban design, land use policies, and practices that support an increase physical activity in urban areas.	P	2	Recommended
Increase policies and practices to support breastfeeding in the workplace.	N	2	ADHS
Improve procurement policies around the nutrition quality of foods served in institutional cafeterias and/or vending machines.	N	2	ADHS
Healthy eating: food served or sold in government facilities (including schools, prisons, and administrative buildings) meets the USDA guidelines for Americans.	N	2	Promising practice
Workplaces and employers offer and promote access to healthy foods and beverages and opportunities for physical activity.	N	2	Recommended
Decreasing tobacco use among workers: smoke free policies.	T	2	Recommended
Improve tobacco cessation incentives.	T	2	Insufficient Evidence
Incentivize insurance costs for living tobacco free.	T	3	
Worksite incentive to encourage employees to get preventive care.	LC	2	
Social media to increase health services utilization per ACA.	LC	2	
Continuing education meetings and workshops for professional practice, either alone or combined with other intervention components, that improve health care practices and health care outcomes for patients.	LC	3	Recommended
Worksite programs intended to improve diet and/or physical activity behaviors and outcomes- multiple strategies.	LC	4	Recommended
Obesity prevention and control: technology supported multi-component coaching or counseling interventions to maintain weight loss or reduce weight.	LC	4	Recommended
Assessment of health risks with feedback and combined with health education programs to improve employee health behavior; implemented with or without additional components.	LC	4	Recommended

Where We Learn	Topic	CDC Domain	Evidence-Based
Require a minimum percentage of highway funds to be allocated for walkways and bike paths.	P	2	Promising practice
School-based physical education programs that increase physical activity lengths or activity levels to improve physical activity and fitness levels.	P		Recommended
Schools districts policies that include 150 minutes of physical activity/week.	P	2	Promising practice
Require standards-based physical education classes taught by certified physical education teachers.	P	2	Recommended
Require all schools (K- 12) to include time for all children to be physically active every day.	P	2	Recommended
Healthy eating: food served or sold in government facilities (including schools, prisons, and administrative buildings) meets the USDA guidelines for Americans.	N	2	Promising practice
Creating healthy eating and active living environments: offer and promote only healthy foods and beverages to students.	N	2	Recommended
Improve the nutrition quality of foods and beverages served in schools.	N	2	ADHS
Reducing secondhand smoke exposure: smoking bans and restrictions, used alone or as part of a multi-component community or workplace intervention.	T	2	Recommended
Social media to increase health services utilization per ACA.	LC	2	
Obesity prevention: implement BMI screenings in schools with confidential reporting results to parents.	LC	2	Promising practice
Sharing cost savings and increasing efficiencies.	LC	2	
Obesity prevention: integration of school based health centers (SBHCs) into school settings and allow for reimbursement through managed care organizations, as well as CHIP.	LC	3	Promising practice
Obesity prevention and control: technology supported multi-component coaching or counseling interventions to reduce weight.	LC	4	Recommended

Where We Seek Care	Topic	CDC Domain	Evidence-Based
Conduct physical activity assessments by a health professional, provide counseling, and refer patients out to allied health care or fitness professionals to promote more active lifestyle.	P	4	Promising practice
Food served or sold in government facilities (including schools, prisons, and administrative buildings) meets the USDA guidelines for Americans.	N	2	Promising practice
Encourage breastfeeding: implement community interventions that increase support for breastfeeding (for the first 4-6 months of life) in health care settings to reduce pediatric obesity.	N	2	Recommended
Increase tobacco use cessation: provider reminders with provider education.	T	3	Recommended
Tobacco cessation: expand and tailor culturally competent quit line services for diverse populations and languages.	T	3	Promising practice
Social media to increase health services utilization per ACA.	LC	2	
Integration of behavioral health physical health.	LC	3	
Diabetes prevention and control: disease management programs to improve glycemic control, provider monitoring of glycated hemoglobin, screening for diabetic retinopathy among those with type 1 or 2 diabetes.	LC	3	Recommended
Encouraging use of Culturally and Linguistically Appropriate Services (CLAS) standards.	LC	3	
Equalizing the pay for primary care providers.	LC	3	
Obesity prevention: integration of school based health centers (SBHCs) into school settings and allow for reimbursement through managed care organizations, as well as CHIP.	LC	3	Promising practice
Integrated behavioral and medical (traditional and non-traditional).	LC	3	
Sharing cost savings and increasing efficiencies.	LC	3	
Organizational effectiveness, coaching, process improvement, assessment.	LC	3	
Obesity prevention and control: technology supported multi-component coaching or counseling interventions to reduce weight.	LC	4	Recommended
Standardized training for community health workers.	LC	4	
Mental health and mental illness: collaborative care for management of depressive disorders.	LC	4	Recommended

Maricopa County 2012-2017 CHIP Framework

Goal: *To strategically impact the current top five health priorities of Maricopa County: Obesity, Diabetes, Cardiovascular Disease, Lung Cancer, and Access to Care, through collaboration of public and private partnerships.*

Objectives: By July, 2017 Maricopa County will report:
- High blood pressure prevalence of less than 24.5% (from 25.8% at 2011 baseline)
- Adults with diabetes rate of less than 8.6% (from 9.2% at 2011 baseline)
- Adults with health insurance rate of at least 89.5% (from 76.6% at 2012 baseline)
- Adults who are current smokers rate of less than 15% (from 18.5% at 2011 baseline)
- Adults rated obese less than 24% (from 25.2% at 2011 baseline)

Public Health Priority Issues		Risk Factor /Determinants	
X	Obesity	X	Nutrition
X	Diabetes	X	Physical Activity
X	Lung Cancer	X	Tobacco Use
X	Cardiovascular Disease	X	Linkage to Care
X	Access to Care		

Sector or "cloud" indicators		EBA codes
Community	Healthcare	**EB** = Evidence Based
Education	Worksite	**PP**= Promising Practice

Status Indicators	
★	CHIP objectives that have already been completed are marked in the status column with a gold star.
New!	Newly added CHIP objectives or aligning goals are labeled in the status column as new.

Category 1: Assess Needs

Strategy 1.1 Conduct community health needs assessments
Strategy 1.2 Involve chronic disease epidemiology in surveillance and planning activities
Strategy 1.3 Develop and implement community health improvement plans
Strategy 1.4 Develop infrastructure to support county-wide health data needs and sharing

Category 2: Coordinate Public Health Partnerships

Strategy 2.1 Coordinate opportunities for community-engaged and health department coalitions
Strategy 2.2 Impact public policy and system approaches by engaging decision-makers
Strategy 2.3 Increase awareness and usability of community assets and resources, especially to underserved populations
Strategy 2.4 Create a toolbox for best practices, resources, learning modules, & data sharing

Category 3: Implement strategies; evidence-based, policy, systems, and environmental approaches

Strategy 3.1 Establish sites for community gardens in institutional settings and/or underserved areas
Strategy 3.2 Increase accessibility, availability, affordability, and identification of healthful foods in communities
Strategy 3.3 Make the healthy choice the easy choice at AZ worksites
Strategy 3.4 Designing healthy communities: Built Environment
Strategy 3.5 Integrate health in all policies in community design
Strategy 3.6 Create healthy school environments with School Health Advisory Councils, School Health Improvement Plans, and parental involvement, and training
Strategy 3.7 Identify and promote model school-based wellness practices locally
Strategy 3.8 Improve clinical-community linkages ensuring that communities support and clinics refer patients to programs that improve management of chronic conditions
Strategy 3.9 Implement chronic disease-based prevention and treatment protocols and/or self-management programs
Strategy 3.10 Implement smoke-free environments

Category 4: Coordinate Communication

Strategy 4.1 Coordinate, create, and distribute messaging to impact healthy communities

Category 5: Evaluate Efforts

Strategy 5.1 Evaluate both process and outcomes of change effort

CHIP objectives are collected by the Maricopa County Department of Public Health from agencies participating in the Health Improvement Partnership of Maricopa County (HIPMC). Initiatives reflected in this plan are referenced by organization or as agencies participating in collaborative workgroups and are categorically placed into the above framework to create the **Maricopa County CHIP Workplan.** This workplan is a dynamic document updated on a quarterly basis through progress updates collected via phone or email by the Maricopa County Department of Public Health.

Maricopa County 2012-2017 CHIP Workplan

January 2014 (Please go to maricopahealthmatters.org for CURRENT CHIP Workplan that is updated quarterly)

Category 1: Assess Needs

Strategy 1.1
Conduct community health needs assessments

Public Health Priority Issues		Risk Factor / Determinants	
X	Obesity	X	Nutrition
X	Diabetes	X	Physical Activity
X	Lung Cancer	X	Tobacco Use
X	Cardiovascular Disease	X	Linkage to Care
X	Access to Care		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
★	The MCDPH Office of Performance Improvement conducted a community health needs assessment (CHNA) on a five-year cycle in cooperation with non-profit hospitals, federally qualified community health centers, universities, foundations, and community partnering organizations. Completed: 2013		MCDPH	
★	The MCDPH Office of Community Empowerment conducted an assessment of services and needs of children with special health care needs. Completed: 2013		MCDPH	
New!	By May 31, 2014, the MCDPH Office of Community Empowerment will follow up on the initial assessment addressing children and youth with special healthcare needs by completing at least one population subgroup specific needs assessment.		MCDPH	
New!	By September 30, 2014, the MCDPH Office of Nutrition and Physical Activity will create a needs assessment to identify nutrition/physical activity educational preferences for SNAP eligible audiences		MCDPH	

Strategy 1.2
Involve chronic disease epidemiology in surveillance and planning activities

Public Health Priority Issues		Risk Factor / Determinants	
X	Obesity	X	Nutrition
X	Diabetes	X	Physical Activity
X	Lung Cancer	X	Tobacco Use
X	Cardiovascular Disease	X	Linkage to Care
	Access to Care		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
★	The MCDPH Office of Epidemiology provided natality, morbidity, mortality, and behavioral data for the 2012 community health needs assessment (CHNA).		MCDPH	
★	The MCDPH Office of Epidemiology provided stakeholders annual surveillance data on the agreed upon common health indicators for the priority issues by demographic groupings. Completed: 2013		MCDPH	
★	The MCDPH Office of Epidemiology provides epidemiological data and reports to the public annually and responds to stakeholder requests for epidemiological data within 14 days.		MCDPH	

Strategy 1.3 Develop and implement community health improvement plans	Public Health Priority Issues		Risk Factor / Determinants	
	X	Obesity	X	Nutrition
	X	Diabetes	X	Physical Activity
	X	Lung Cancer	X	Tobacco Use
	X	Cardiovascular Disease	X	Linkage to Care
	X	Access to Care		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
	The MCDPH Office of Performance Improvement coordinated a collaborative, community-based community health improvement plan which will be updated annually and revised every 5-years based on the CHNA. Completed: March 2013		MCDPH	

Strategy 1.4 Develop infrastructure to support county-wide health data needs and sharing	Public Health Priority Issues		Risk Factor / Determinants	
	X	Obesity	X	Nutrition
	X	Diabetes	X	Physical Activity
	X	Lung Cancer	X	Tobacco Use
	X	Cardiovascular Disease	X	Linkage to Care
	X	Access to Care		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
	The MCDPH Office of Epidemiology trained two program staff in GIS to provide map requests of priority diseases with available data to assist in the communication of community health status. Completed: June 2013		MCDPH	
	As of June 2013, The Office of Epidemiology had provided more than 15 data requests, including GIS analyses, to MCDPH and community stakeholders for planning, grant writing, surveillance, and evaluation.		MCDPH	
	As of October 2013, data users in Maricopa County can now access specific (i.e. zip code, ethnicity, age-adjusted) health-related data at MaricopaHealthMatters.org. Indicators will be updated annually.		MCDPH, ADHS, St. Luke's Health Initiative	
	By June 30, 2014, the "Data" Education Cloud group will create an online tracking system for wellness programs and policies in schools (connected to the clouds) will be available to all.		MCDPH, ADHS	
New!	By June 30, 2014, the MCDPH Office of Epidemiology will develop at least one new data sharing partner relationship.		MCDPH	

Category 2: Coordinate Public Health Partnerships							
Strategy 2.1 **Coordinate opportunities for community-engaged and health department coalitions**	Public Health Priority Issues			Risk Factor / Determinants			
	X	*Obesity*		X	*Nutrition*		
	X	*Diabetes*		X	*Physical Activity*		
	X	*Lung Cancer*		X	*Tobacco Use*		
	X	*Cardiovascular Disease*		X	*Linkage to Care*		
	X	*Access to Care*					

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
	The MCDPH Office of Community Empowerment created cross-jurisdictional workgroups to improve department performance while coordinating implementation of departmental CHIP activities.		MCDPH	
	The MCDPH Office of Community Empowerment coordinates ongoing workgroups engaging community members into public health efforts and processes to identify community needs, barriers, issues, and to leverage resources and capacity between partners.		MCDPH	
	By June 30, 2014, the MCDPH Office of Community Empowerment will develop a mechanism to effectively track MCDPH community partners.		MCDPH	
	By June 30, 2014, The "Together We Can" community cloud workgroup will increase HIPMC partner meeting attendance through strategic outreach & engagement of 20 new committed partners within the 5 priority areas.		City of Phoenix, AzPHA, Native Health, First Things First, MCDPH	
New!	By December 31, 2014, the City of Phoenix Housing HOPE VI Community and Supportive Services (CSS) Program will increase the current health partnerships to include three additional agencies.		City of Phoenix Housing Dept HOPE VI CSS Program	
New!	By December 31, 2014, all Maricopa County Government departments will have identified an employee to participate as a Wellness Champion.		Maricopa County Wellness Works	
New!	By June 30, 2014, the MCDPH Office of Community Empowerment will increase its number of partners within the Early Childhood Preventative Health system by 10%.		MCDPH	
New!	By June 30, 2014, the MCDPH Office of Tobacco and Chronic Disease Prevention will get 15 worksites and/or community organizations to pledge to become a partner in the Million Hearts Campaign		MCDPH	
New!	By March 31, 2014, TAPI will re-engage 4 or more healthcare professional associations in TAPI coalition activities.		TAPI	
New!	By December 31, 2014, six HIPMC partner agencies will be invited by TAPI to present their agencies' services at a regularly scheduled TAPI committee meeting to reduce siloing of immunization services and increase partner collaboration		TAPI	

Strategy 2.2 **Impact public policy and system approaches by engaging decision makers**	Public Health Priority Issues		Risk Factor / Determinants	
	X	*Obesity*	X	*Nutrition*
	X	*Diabetes*	X	*Physical Activity*
	X	*Lung Cancer*	X	*Tobacco Use*
	X	*Cardiovascular Disease*	X	*Linkage to Care*
	X	*Access to Care*		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
	By June 30, 2014, the "Healthy Arizona Leadership" worksite cloud workgroup will document 10 Maricopa County leaders who have committed to be a comprehensive worksite wellness "champion."		MCDPH, AZ Small Business Assoc., Viridian, AZ Dept. Of Education	
	By June 30, 2014, the MCDPH Office of Oral Health will educate a minimum of 4 community advocacy groups in Maricopa County identified by the Community Cloud members about the importance of oral health to overall health.		MCDPH	
New!	By May 31, 2014, FitPHX will become designated as a Let's Move! city by the National League of Cities Let's Move! Initiative.		Fit Phx Program	
New!	By December 31, 2013, MCDPH will coordinate at least 2 OCYSHCN Council meetings to support policy promotion for children and youth with special healthcare needs		MCDPH	
New!	By June 30, 2014, the MCDPH Office of Public Health Policy will attend a minimum of 10 stakeholder meetings to provide guidance related to public health's inclusion within the General Plan processes for cities in Maricopa County.	PP	MCDPH	
New!	By June 30, 2014, STAND coalition members under the guidance of the MCDPH Office of Tobacco and Chronic Disease Prevention will collect, analyze and present information on tobacco policy initiatives including a smoke-free parks initiative to at least one local decision-maker.	EB	MCDPH	

Strategy 2.3 **Increase awareness and usability of community assets and resources, especially to underserved populations**	Public Health Priority Issues		Risk Factor / Determinants	
	X	*Obesity*	X	*Nutrition*
	X	*Diabetes*	X	*Physical Activity*
	X	*Lung Cancer*	X	*Tobacco Use*
	X	*Cardiovascular Disease*	X	*Linkage to Care*
	X	*Access to Care*		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
	As of June 30, 2013, the MCDPH has increased the number of website hits on FindHelpPhoenix.org by users in Maricopa County by 300% over the 2012 baseline.		MCDPH	
	By June 30, 2014, the MCDPH Office of Community Empowerment will mobilize a council of providers, parents and caregivers of children and youth/young adults with special health care needs that will coordinate policy promotion efforts that affect this population.		MCDPH	
	By June 30th, 2014,the "Health in All Policies" community cloud workgroup will identify a minimum of 5 parks and recreation programs with income-sensitive scholarships or fees to be entered into findhelpphx.org.		City of Phoenix, ADHS, St. Luke's Health Initiative, MCDPH	

New!	By June 30, 2014, the MCDPH Office of Health Promotion and Education will offer the Ryan White Dental Insurance program to 1,500 people in Maricopa County living with HIV/AIDS to mitigate the detrimental impacts of poor oral health upon HIV/AIDS treatment		MCDPH	
New!	By June 30, 2014, the MCDPH Office of Oral Health will conduct at least 15 outreach activities and participate in at least 6 community events in Maricopa County to educate the community on oral health and promote First Teeth First program services.		MCDPH	
New!	By June 30, 2014, the MCDPH Office of Oral Health will partner with at least 10 dentists willing to provide free dental work for children.		MCDPH	
New!	By June 30, 2014, the MCDPH Office of Oral Health will have established permanent services for the First Teeth First Program at a site in the northeast region of Maricopa County		MCDPH	
New!	By June 30, 2014, Healthcare for the Homeless will provide services to at least 2,822 homeless clients.		MCDPH	
New!	By June 30, 2014, Healthcare for the Homeless will conduct street outreach at least 16 days per month to assess barriers and identify needs of at least 200 homeless individuals monthly.		MCDPH	
New!	95% of all HIV positive cases diagnosed through the MCDPH clinic will be referred to an HIV medical provider within 30 days.		MCDPH	

Strategy 2.4 **Create a toolbox for best practices, resources, learning modules and data sharing**	Public Health Priority Issues		Risk Factor / Determinants	
	X	*Obesity*	X	*Nutrition*
	X	*Diabetes*	X	*Physical Activity*
	X	*Lung Cancer*	X	*Tobacco Use*
	X	*Cardiovascular Disease*	X	*Linkage to Care*
	X	*Access to Care*		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
	In August 2013, the MCDPH Office of Performance Improvement launched an online database describing and sourcing evidence-based public health approaches that are classified by a number of different criteria. Data requests can be submitted to OPI@mail.maricopa.gov.		MCDPH	
	By June 30th, 2014, the "Go To Guys" community cloud workgroup will promote a web based central data source of community resources for Maricopa County residents.		Phx Fire Dept., AZLWI, ADHS, MCDPH	
	By June 30th, 2014, the MCDPH Worksite Cloud will create one comprehensive worksite wellness resource guide (based on the CDC Health Scorecard and current ONPA Guide to Worksite Wellness).		MCDPH	
	By June 30, 2014, the MCDPH Health Care Cloud will produce a searchable database that contains the primary contact information of at least 50% of the Maricopa County licensed health care facilities.		MCDPH	

Category 3: Implement Strategies, especially evidence based PSE (Policy, Systems and Environmental) approaches

Strategy 3.1
Establish sites for community gardens in institutional settings and/or underserved areas

Public Health Priority Issues		Risk Factor / Determinants	
X	Obesity	X	Nutrition
X	Diabetes		Physical Activity
	Lung Cancer		Tobacco Use
X	Cardiovascular Disease		Linkage to Care
	Access to Care		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
★	The MCDPH Office of Nutrition and Physical Activity, in collaboration with the University of Arizona Cooperative Extension, utilized the Phoenix Urban Research Farm (PURF) as a nutrition and gardening educational venue for two events in 2013.		MCDPH	
★	The MCDPH Office of Nutrition and Physical Activity currently maintains a school garden resource webpage that is updated quarterly as new information and resources become available.	EB	MCDPH	
★	The MCDPH Office of Nutrition and Physical Activity lead two Food Day Activities with the parallel office at the Arizona Department of Health Services and other stakeholders. Completed November 2013	EB	MCDPH	
	By June 30, 2014, the "Leveragers" education cloud workgroup will Identify and develop a case study of two model school gardens in Maricopa County.	PP	MCDPH, UofA Coop. Extension, AZLWI, ADE, Native Health, Artisan Food Guild	
	By June 30, 2014, The Office of Nutrition and Physical Activity will collaborate with 21 SNAP-Ed school districts to assess readiness to create and/or sustain school gardens.	EB	MCDPH	
New!	By June 30, 2014, the Office of Nutrition and Physical Activity will provide technical assistance to interested SNAP-Ed school districts to implement and/or maintain five school gardens.	EB	MCDPH	
New!	By June 30, 2014, at least one staff member from the Office of Nutrition and Physical Activity will complete the Master Gardener program.		MCDPH	

Strategy 3.2
Increase accessibility, availability, affordability, and identification of healthful foods in communities

Public Health Priority Issues		Risk Factor / Determinants	
X	Obesity	X	Nutrition
X	Diabetes		Physical Activity
	Lung Cancer		Tobacco Use
X	Cardiovascular Disease		Linkage to Care
	Access to Care		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
	By June 30, 2014, The Office of Nutrition and Physical Activity will increase the availability of fruits and vegetables by establishing a linkage between St. Mary's Food Bank and a local school to deliver fresh produce through a mobile food pantry.	PP	MCDPH	
New!	By June 30, 2014, at least 300 childcare providers in the NW and SW regions of Maricopa County will have been trained to administer the Color me Healthy Program		MCDPH	
New!	By March 31, 2014, Native Health will increase the number of people residing in environments with access to healthy food or beverage	EB	Native Health	

	options, by eliminating or diminishing adverse conditions by facilitating Market on the Move events within 10 of approximately 20 Maricopa County "food deserts."			
New!	By June 30, 2014, the MCDPH Office of Public Health Policy will assist the Phoenix Parks and Rec Department to adopt a policy to improve the nutritional content of foods provided within Phoenix Parks and Rec facilities.	PP	MCDPH	
Status	**Aligning Goals**	**EBA**	**Agency/Workgroup**	**Cloud**
New!	Healthy eating education in the Phoenix Afterschool Center (PAC) program.		Fit Phx, MCDPH, UofA Cooperative Extension, Phoenix Children's Hospital Kohl's FIT program	

Strategy 3.3 **Make the healthy choice the easy choice at Arizona worksites**	Public Health Priority Issues		Risk Factor / Determinants	
	X	*Obesity*	X	*Nutrition*
	X	*Diabetes*	X	*Physical Activity*
	X	*Lung Cancer*	X	*Tobacco Use*
	X	*Cardiovascular Disease*	X	*Linkage to Care*
	X	*Access to Care*		

Status	**CHIP Objectives**	**EBA**	**Agency/Workgroup**	**Cloud**
	The MCDPH Office of Nutrition and Physical Activity promotes worksite wellness by providing access for MCDPH employees to at least ten healthier snack options through the Healthy Snack Shack Program.	EB	MCDPH	
	In April 2013, the Maricopa County Department of Public Health established voluntary nutrition guidelines for foods at meetings, events, and vending machines in Maricopa County worksites.	EB	MCDPH	
	The MCDPH PHitness Committee and Office of Public Health Policy created a document containing recommendations for healthy worksite policies applicable to MCDPH. Completed June 2013	EB	MCDPH	
	The Healthy AZ Worksites Program, which provides training and technical assistance to Maricopa County businesses, was launched in 2012.		MCDPH, Viridian, AZ Small Business Assoc	
	By June 30, 2014, the "Empowerment Through Policy" worksite cloud workgroup will increase the number of existing worksites with comprehensive wellness policies by 5.		ADHS, MCDPH, MCCCD, City of Tempe, Maricopa Wellness Works	
	By June 30, 2014, the MCDPH Office of Nutrition and Physical Activity will expand healthy vending program to two additional campuses in Maricopa County.	EB	MCDPH	
	By June 30, 2014, the MCDPH Office of Nutrition and Physical Activity will provide five or more nutrition hand-outs and resources that support the healthy foods resolution to Maricopa County employees.	EB	MCDPH	
New!	By December 31, 2014, Maricopa County Wellness Works will provide Maricopa County Government employees in at least three locations different or improved opportunities for physical activity tailored to the specific County location.	EB	Maricopa County Wellness Works	
New!	By February 1, 2014, ten Maricopa County Department walking clubs will walk at least 2 times a week for a minimum of ten minutes at a time.	EB	Maricopa County Wellness Works	

New!	By December 31, 2014, every Maricopa County Government facility with vending machines will participate in the Maricopa County Wellness Works Better Bites, Better Gulps initiative with 50% of vending items being healthier choices as defined by Maricopa County standards.	EB	Maricopa County Wellness Works	
New!	By December 31, 2014, Maricopa County Wellness Works will implement Avanti vending markets at five Maricopa County locations as a way to increase access to fresh and healthy food and beverages.	EB	Maricopa County Wellness Works	
New!	By March 31, 2014, Native Health REACH program will increase the number of Native Health worksites with access to physical activity opportunities from 0 to 1.	EB	Native Health	
New!	By February 5, 2014, FitPHX will partner with Healthy Arizona Worksite Program (HAWP) to train at least 10 Phoenix businesses in the HAWP and brand them as "FitPHX" businesses.		Fit Phx Program	
New!	By June 30, 2014, the MCDPH Phitness committee will have coordinated at least 48 fitness related activities (12 per month) at the MCDPH administration worksite.	EB	MCDPH	
New!	By March 31, 2014, the MCDPH Office of Public Health Policy in conjunction with the Arizona Small Business Association will deliver training, resources and/or technical assistance to 10 employers to make policy, systems or environmental changes related to physical activity.		MCDPH	
New!	By March 31, 2014, the MCDPH Office of Public Health Policy in conjunction with the Arizona Small Business Association will deliver training, resources and/or technical assistance to 5 employers to make policy, systems or environmental changes related to linkages to care.		MCDPH	
Status	**Aligning Goals**	**EBA**	**Agency/Workgroup**	**Cloud**
New!	Maricopa Community Colleges is interested in implementing a Healthy Vending policy (similar to the Maricopa County Healthy Vending policy) throughout its campuses and administrative buildings.	EB	Maricopa Community Colleges	

Strategy 3.4 **Designing healthy communities:** **Built Environment**	Public Health Priority Issues		Risk Factor / Determinants	
	X	Obesity	X	Nutrition
	X	Diabetes	X	Physical Activity
	X	Lung Cancer	X	Tobacco Use
	X	Cardiovascular Disease	X	Linkage to Care
	X	Access to Care		

Status	**CHIP Objectives**	**EBA**	**Agency/Workgroup**	**Cloud**
	By June 30, 2014, the community design toolkit will be disseminated to a minimum of 4 "champions" and 40 partners.		Livable Communities Coalition, Scottsdale Healthcare, ASU, MCDPH, AZ Dept of Transportation	
New!	By May 31, 2014, FitPHX will establish Walk PHX program at 8 sites at various City of Phoenix locations.	EB	Fit Phx Program	

Strategy 3.5 Integrate health in all policies in community design	Public Health Priority Issues		Risk Factor / Determinants	
	X	Obesity	X	Nutrition
	X	Diabetes	X	Physical Activity
	X	Lung Cancer	X	Tobacco Use
	X	Cardiovascular Disease	X	Linkage to Care
	X	Access to Care		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
	In 2013, The MCDPH Office of Public Health Policy organized two Health Impact Assessment (HIA) trainings to develop HIA practitioners.		MCDPH	
	By June 30, 2014, the Office of Public Health Policy will work with partners to incorporate at least one evidence-based Healthy Community Design principle into the general plan of at least one major city in Maricopa County (Phoenix, Tempe, Mesa, or Scottsdale).		MCDPH	
	By June 30, 2014, the MCDPH Office of Public Health Policy in conjunction with the City of Phoenix will establish community design standards to make streets safe for all users, including pedestrians, bicyclists, and users of public transit through the adoption of a complete streets policy.	EB	MCDPH, City of Phoenix	
New!	By June 30, 2014, the MCDPH Office of Public Health Policy will have at least two staff each attend 6 trainings and/or meetings to learn, promote, and contribute to Health Impact Assessments (HIAs).		MCDPH	

Strategy 3.6 Create healthy school environments with School Health Advisory Councils, School Health Improvement Plans, parental involvement and training	Public Health Priority Issues		Risk Factor / Determinants	
	X	Obesity	X	Nutrition
	X	Diabetes	X	Physical Activity
	X	Lung Cancer	X	Tobacco Use
	X	Cardiovascular Disease	X	Linkage to Care
	X	Access to Care		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
	As of June 2013, the MCDPH Office of Public Health Policy has trained over 100 parents to become Parent Ambassadors.	PP	MCDPH	
	In the 2012-2013 school year, the MCDPH Office of Tobacco and Chronic Disease Prevention funded 90 mini-grants to schools who included plans in their School Health Improvement Plan (SHIP) to improve in areas related to the Arizona Chronic Disease State Plan for 2012-2015 and/or the coordinated school health model.	PP	MCDPH	
	In the 2012-2013 school year, the MCDPH Office of Tobacco and Chronic Disease Prevention contracted with 110 schools to complete the School Health Index.	PP	MCDPH	
	The MCDPH Office of Nutrition and Physical Activity, in collaboration with the University of Arizona Cooperative Extension and Arizona State University, held a 1 day training at ASU with credit hours to SNAP-Ed School district staff on the Local Wellness Policy in June 2013.		MCDPH	
	The MCDPH Office of Nutrition and Physical Activity has developed nutrition and physical activity curricula and collateral resources for use by teachers that are available on the MCDPH website for three age groups: grades K-2, grades 3-4, grades 5+.	PP	MCDPH	
	By June 30, 2014 the Education Cloud will develop a tracking tool to		MCDPH	

	record Maricopa County schools' wellness policies, infrastructure (i.e. SHACs and/or wellness council(s)) and other current wellness activities.			
	By June 30, 2014, the Office of Community Empowerment will enlist 10 schools enrolled in the Safe Routes to School program to implement a helmet required policy for 100% of students who roll to school (bike, roller-skate/blade, scooter, skateboard, etc.).	PP	MCDPH	
New!	By June 30, 2014, the MCDPH Office of Public Health policy will begin a draft of a modified curriculum which will expand the parent ambassador program to a broader audience.		MCDPH	

Strategy 3.7 **Identify and promote model school-based wellness practices locally**	Public Health Priority Issues		Risk Factor / Determinants	
	X	*Obesity*	X	*Nutrition*
	X	*Diabetes*	X	*Physical Activity*
	X	*Lung Cancer*	X	*Tobacco Use*
	X	*Cardiovascular Disease*	X	*Linkage to Care*
	X	*Access to Care*		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
	The MCDPH Office of Public Health Policy hosted an "Understanding and Working with Schools" school-related policy learning opportunity for the Internal Education Cloud in November 2013 to improve their understanding on school policy at all levels.		MCDPH	
	By December 31, 2013, The Safe Routes to School program will see a 10% increase in the number of children walking and biking safely to school over the previous baseline.	PP	MCDPH	
	By June 30, 2014, the Office of Community Health Nursing, Child Care Health Consultant program will update the Arizona Child Care Health and Safety Policy Manual with input from First Things First, the Arizona Department of Health Services Bureau of Child Care Licensing, Child and Adult Care Food Program, and the Arizona Child Care Association.		MCDPH	
	By June 30, 2014, the Office of Community Health Nursing, Child Care Health Consultant program, in collaboration with the Arizona Child Care Association and Rio Salado Community College, will offer online child care health and safety curricula that can be accessed by child care providers in order to gain continuing education credits for the Arizona Department of Health Services Bureau of Child Care Licensing and potentially college credit.		MCDPH	
New!	By September 30, 2014, 75% of SNAP eligible school districts will receive 5 toolkits (one each on the following topics: Fruits and Vegetables, Calcium, Whole Grains, Physical Activity, My Plate) to promote nutrition education during the 2013-2014 school year.	PP	MCDPH	
Status	**Aligning Goals**	**EBA**	**Agency/Workgroup**	**Cloud**
New!	Native Health will increase the number of people with access to physical activity opportunities by working with local school districts		Native Health	

Strategy 3.8 Improve clinical-community linkages ensuring that communities support and clinics refer patients to programs that improve management of chronic conditions	Public Health Priority Issues		Risk Factor / Determinants	
	X	Obesity	X	Nutrition
	X	Diabetes	X	Physical Activity
	X	Lung Cancer	X	Tobacco Use
	X	Cardiovascular Disease	X	Linkage to Care
	X	Access to Care		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
	As of June 2013, the MCDPH Office of Tobacco and Chronic Disease Prevention had trained 50+ healthcare professionals on Basic Tobacco Interventions Skills.	PP	MCDPH	
	As of June 2013, the MCDPH Office of Tobacco and Chronic Disease Prevention had trained 50+ community members on Basic Tobacco Interventions Skills.	PP	MCDPH	
New!	By June 30, 2014, at least 85% of clients served by MCDPH through the Lead Hazard Control Program, Healthy Start, the Newborn Intensive Care Program, and the Nurse Family Partnership Program who report at least one smoker in the home will receive tobacco cessation referral information.	EB	MCDPH	
New!	By June 30, 2014, the Oral Health Tobacco Prevention and Education Program at MCDPH will complete outreach to at least 64 dental offices and conduct at least 5 group presentations to oral health-related professionals on tobacco related oral health and ASHLine referrals.	EB	MCDPH	
New!	By June 30, 2014, at least 50% of patients seen at Healthcare for the Homeless will receive a BMI screening and be offered nutrition counseling.	PP	MCDPH	
New!	By June 30, 2014, the MCDPH Office of Tobacco and Chronic Disease Prevention will increase ASHLine referrals in Maricopa County to 3,600 through referral development and organizational policy.	EB	MCDPH	
New!	By June 30, 2014, the MCDPH Office of Tobacco and Chronic Disease Prevention will increase community capacity to promote cessation services by offering skills trainings and establishing a volunteer pool for community events.		MCDPH	
New!	By June 30, 2014, the MCDPH Office of Tobacco and Chronic Disease Prevention will train at least 60 individuals (student and/or faculty and staff) at schools participating in the IGNITE program to increase capacity for self-monitoring of tobacco-free policy and referring tobacco users to the ASHLine.	EB	MCDPH	
New!	By June 30, 2014, the MCDPH Office of Tobacco and Chronic Disease Prevention will train 10 public health nurses on Ask-Advise-Refer tobacco intervention method and the million hearts campaign.	EB	MCDPH	

Strategy 3.9 **Implement chronic disease-based prevention and treatment protocols and/or self-management programs**	Public Health Priority Issues		Risk Factor / Determinants	
	X	*Obesity*	X	*Nutrition*
	X	*Diabetes*	X	*Physical Activity*
	X	*Lung Cancer*	X	*Tobacco Use*
	X	*Cardiovascular Disease*	X	*Linkage to Care*
	X	*Access to Care*		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
★	As of June 2013, the MCDPH Office of Tobacco and Chronic Disease Prevention has provided training materials and follow-up to 111 health care providers assisting them with developing referral mechanisms for AshLine and chronic disease self-management programs.	EB	MCDPH	
★	In March 2013, the MCDPH Office of Tobacco and Chronic Disease Prevention completed a pilot project with Wesley Health Center to implement a promotora-led hypertension self-management curriculum and support program.	PP	MCDPH	
★	The MCDPH Office of Tobacco and Chronic Disease Prevention conducted a pilot project to incorporate ASHLine referrals into a healthcare practitioner's electronic health records. Completed: June 2013	EB	MCDPH	
	By June 30, 2014, the MCDPH Office of Nutrition and Physical Activity will work with Empower Pack plus workgroup to strengthen child care center standards around chronic disease prevention.		MCDPH	
New!	By December 31, 2014 the City of Phoenix Housing HOPE VI Community and Supportive Services (CSS) Program will train and increase the number of Community Health Workers (CHW) who provide the "With Every Heartbeat Is Life"(WEHL) program by two.	PP	City of Phoenix Housing Department HOPE VI CSS Program	
New!	By December 31, 2014, the City of Phoenix Housing Department HOPE VI Community and Supportive Services (CSS) Program will Increase the current number of With Every Heartbeat is Life (WEHL) workshops from a minimum of four per year to a minimum of six per year and expand current audience to include non-public housing sites.	PP	City of Phoenix Housing Department HOPE VI CSS Program	
New!	By June 30, 2014, at least 90% of clients served by MCDPH through the Healthy Start Program will receive a chronic disease and healthy weight screening.		MCDPH	
New!	By June 30, 2014, the First Teeth First program administered by MCDPH will complete at least 16,000 oral health screenings of children ages 0-5 living within Maricopa County and provide fluoride varnish applications to at least 20,000 children.	EB	MCDPH	
New!	By June 30, 2014, the First Teeth First program administered by MCDPH will complete at least 660 oral health screenings of pregnant women living within Maricopa County.		MCDPH	
New!	By June 30, 2014, 100% of patients seen at Healthcare for the Homeless will be screened for tobacco use and offered cessation counseling.	EB	MCDPH	
New!	By June 30, 2014, the MCDPH Office of Tobacco and Chronic Disease Prevention will implement a Tobacco Retailer Training program that will be delivered on a quarterly basis to educate retailers on tobacco laws.		MCDPH	

New!	By June 30, 2014, the MCDPH Office of Tobacco and Chronic Disease Prevention will recruit at least 10 youth volunteers to participate in the Counter Strike program which conducts compliance checks with local retailers to ensure tobacco is not being sold to minors.	PP	MCDPH	
New!	By June 30, 2014, the MCDPH Office of Tobacco and Chronic Disease Prevention will sponsor training of 8 individuals to become lay leaders in the Chronic Disease Self-Management Program (CDSMP).	PP	MCDPH	
New!	By June 30, 2014, the Smoke-Free Arizona team in the MCDPH Office of Tobacco and Chronic Disease Prevention will inspect 1000 worksites for compliance with the Smoke-Free Arizona Act (A.R.S. 36-603.01) and complete 2500 education advisory sessions with Maricopa County worksites pertaining to this law.	PP	MCDPH	

Strategy 3.10 **Implement smoke-free environments**	Public Health Priority Issues		Risk Factor / Determinants	
	X	*Obesity*	X	*Nutrition*
	X	*Diabetes*	X	*Physical Activity*
	X	*Lung Cancer*	X	*Tobacco Use*
	X	*Cardiovascular Disease*	X	*Linkage to Care*
	X	*Access to Care*		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
	As of June 2013, the MCDPH Office of Tobacco and Chronic Disease Prevention has invited 380 apartment complexes in Maricopa County that have expressed an interest in becoming smoke free to participate in trainings and/or educational workshop(s).	EB	MCDPH	
New!	By June 30, 2015 the City of Phoenix Housing HOPE VI Community and Supportive Services (CSS) Program will work with the Housing Development staff to increase the number of housing smoke free sites by one additional site.	EB	City of Phoenix Housing Department HOPE VI CSS Program	
New!	By June 30, 2014, the MCDPH Office of Tobacco and Chronic Disease Prevention will assist college campuses participating in the IGNITE program in completing 60 projects (5 per campus at 12 campuses) designed to increase awareness of and compliance with recently implemented tobacco-free campus policies, promote tobacco cessation and increase referrals to ASHLine.	EB	MCDPH	
New!	By June 30, 2014, the MCDPH Office of Tobacco and Chronic Disease Prevention will develop a Smoke-Free Campus Advocacy Plan and Timeline with student leaders at Midwestern University	EB	MCDPH	
New!	By June 30, 2014, the MCDPH Office of Tobacco and Chronic Disease Prevention, in collaboration with the Arizona Smoke-Free Living (ASFL) coalition will provide technical assistance to five properties to announce their intention to go smoke-free	EB	MCDPH	

Category 4: Coordinate Communication

Strategy 4.1
Coordinate, create, and distribute messaging to impact healthy communities

Public Health Priority Issues		Risk Factor / Determinants	
X	Obesity	X	Nutrition
X	Diabetes	X	Physical Activity
X	Lung Cancer	X	Tobacco Use
X	Cardiovascular Disease	X	Linkage to Care
X	Access to Care		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
	By June 30, 2014 the Office of Epidemiology will draft guidelines pertaining to the prevention of animal and insect-borne disease threats in Maricopa County for the school wellness guidebook.		MCDPH	
New!	By May 31, 2014, Maricopa County Wellness Works program will offer all Maricopa County Government employees participating in the biometric screening resources at the time of their screening that will enable them to make positive changes in their behaviors.	EB	Maricopa County Wellness Works	
New!	By December 31, 2014, Maricopa County Wellness Works will provide all cohort-one Maricopa County Wellness Champions with resources, tools, and guidance necessary to create healthier worksites.		Maricopa County Wellness Works	
New!	By June 30, 2014, MCDPH will distribute 2 newsletters at least quarterly to community stakeholders on relevant topics		MCDPH	
New!	By June 30, 2014, MCDPH will develop at least two cloud communication channels for HIPMC partners		MCDPH	
New!	By June 30, 2014, at least 60% of clients enrolled in the Healthy Start, Nurse Family Partnership and Newborn Intensive Care programs delivered by MCDPH will receive education and resources to promote breastfeeding.	PP	MCDPH	
New!	By June 30, 2014 at least 90% of clients enrolled in the Healthy Start, Nurse Family Partnership and Newborn Intensive Care programs delivered by MCDPH will receive education and information on tummy time activity.		MCDPH	
New!	By June 30, 2014, at least 80% of clients served by MCDPH through the Lead Hazard Control Program, Healthy Start, the Newborn Intensive Care Program, and the Nurse Family Partnership Program will receive education regarding the importance of a medical home		MCDPH	
New!	By September 30, 2014, the MCDPH Office of Nutrition and Physical Activity will distribute Arizona Nutrition Network literature regarding dietary recommendations for calcium by consuming low fat and fat free dairy to at least 5,000 SNAP-ed eligible participants.		MCDPH	
New!	By September 30, 2014, the MCDPH Office of Nutrition and Physical Activity will distribute Arizona Nutrition Network Fruit and Vegetable promotional campaign material to qualified students in the 26 schools that participate in the Fresh Fruit and Vegetable Grant through the Arizona Department of Education.		MCDPH	
New!	By September 30, 2014, the MCDPH Office of Nutrition and Physical Activity will distribute at least 22,000 pieces of Arizona Nutrition Network literature to SNAP-ed eligible participants at community events and DES offices.		MCDPH	
New!	By June 30, 2014, the MCDPH Office of Public Health Policy will develop a communications strategy to provide timely highlighting federal, state and local legislation which impacts the public health system.		MCDPH	

New!	By June 30, 2014, a minimum of 8 outreach events providing education on tobacco free living will be completed by STAND youth coalition members under the direction of the MCDPH Office of Tobacco and Chronic Disease Prevention.	EB	MCDPH	
New!	By June 30, 2014, the MCDPH Office of Tobacco and Chronic Disease Prevention will collaborate with one early childhood agency to deliver one training per quarter to a minimum of 10 childcare professionals on preventing secondhand smoke exposure to children and families.	PP	MCDPH	
New!	By June 30, 2014, the MCDPH Office of Tobacco and Chronic Disease Prevention will promote healthy heart messages through social media on a quarterly basis		MCDPH	
New!	By June 30, 2014, the MCDPH Office of Tobacco and Chronic Disease Prevention will post ABCS (Asprin for people at risk, Blood pressure control, Cholesterol management, and Smoking cessation) in 12 Maricopa County WIC Clinics.		MCDPH	
New!	By December 31, 2015, TAPI will develop a "grassroots", evidence-based immunization campaign that will be disseminated to lay persons (including parents) in locations where families live, work and play		TAPI	

Category 5: Evaluate Efforts

Strategy 5.1
Evaluate both process and outcomes of change efforts

Public Health Priority Issues		Risk Factor / Determinants	
X	Obesity	X	Nutrition
X	Diabetes	X	Physical Activity
X	Lung Cancer	X	Tobacco Use
X	Cardiovascular Disease	X	Linkage to Care
X	Access to Care		

Status	CHIP Objectives	EBA	Agency/Workgroup	Cloud
	The MCDPH Office of Performance Improvement continually provides quarterly monitoring for evaluation of CHIP objectives.		MCDPH	All
	As of June 30, 2013, the MCDPH Office of Performance Improvement has conducted three evaluation trainings for MCDPH staff and community partners.		MCDPH	All
New!	By June 30, 2014, the MCDPH Office of Health Promotion and Education will have conducted an assessment to measure the number of users accessing FindHelpPhx.org and the number of agencies using the site to assist their clients in Maricopa County.		MCDPH	
New!	By June 30, 2014, the MCDPH Office of Tobacco and Chronic Disease Prevention will work with ASU Southwest Interdisciplinary Research Center to complete a post implementation return on investment evaluation of ASU's tobacco free campus policy.		ASU-SIRC, MCDPH	
New!	By December 31, 2014, TAPI will review MCDPH billing data to assess if the Affordable Care Act has had an impact on MCDPH immunization and billing programs.		TAPI	
New!	By June 30, 2014, the MCDPH Office of Tobacco and Chronic Disease Prevention will complete a policy impact assessment with ten multi-unit housing properties that have implemented smoke-free policies in the past 5 years.		MCDPH	

APPENDIX E. HIPMC PARTNERSHIP ACKNOWLEDGEMENT

HIPMC Partner Organization Acknowledgement

Our organization is committed to be an active member of the Health Improvement Partnership of Maricopa County (HIPMC). We support the overarching vision, values, and strategies that have been identified in the 2012-2017 Maricopa County Community Health Improvement Plan (CHIP). We understand that the planning and collaboration that such activities require takes time and commitment to participate in this effort for the foreseeable future. We recognize that much coordination and effort is needed to produce lasting health impacts in our community and welcome the contributions and expectations of other HIPMC partners.

We agree to the following HIPMC Partner Organization Expectations:

1) Appoint a representative(s) to attend and fully participate in quarterly HIPMC meetings with representation on at least one of the following Cloud Sectors: *Community, Worksite, Education, or Healthcare*.
2) Participate in Cloud initiative work groups, when applicable, including attending scheduled work group meetings and completing assigned tasks; calling on HIPMC support staff and team members as needed.
3) Keep the HIPMC informed of our organization's CHIP- related activities, if applicable. This may include sharing data and other evaluation information with Maricopa County Department of Public Health (MCDPH) for the purposes of tracking evaluation outcomes for the CHIP.
4) Read minutes, reports, and newsletters to keep abreast of HIPMC decisions and activities.
5) Respond to HIPMC requests outside of meetings such as completing surveys, disseminating relevant information to organizational members or employees, connecting partners, and supporting CHIP activities.
6) Share our organizational contact information with other participating partners of the HIPMC and the community through a Partner Directory published on maricopahealthmatters.org.

Benefits of becoming an active HIPMC Partner Organization include:

- Access to MCDPH technical assistance including: data support, information on evidence-based strategies, strategic planning, marketing and communications, evaluation, and meeting coordination.
- Professional development and educational events.
- Networking opportunities and connection to other HIPMC members.
- Organizational visibility through established print and online marketing platforms and co-branding across the HIPMC and MCDPH networks.

Name of Organization _____ Date _____
Signature of Representative to HIPMC _____
Representative's Printed Name _____
Representative Email _____ Phone _____
Alternative Organization Representative(s): Name and email address: _____
Name and email address: _____
Identified Cloud Sector(s): Community, Worksite, Education, Healthcare _____

Please send completed form and any questions to hipmc@mail.maricopa.gov

APPENDIX F. POPULATION HEALTH SURVEILLANCE MEASURES

OBESITY

Goal: Promote health & reduce chronic disease risk through the consumption of healthful diets & achievement & maintenance of healthy body weights.								
HP2020	Objective							Target
NWS-10.3	Reduce the proportion of adolescents aged 12 to 19 years who are considered obese							16.1%
NWS-8	Increase the proportion of adults who are at a healthy weight							33.9%
NWS-9	Reduce the proportion of adults who are obese							30.5%
		Baseline	2011	2012	2013	2014	2015	2020 Goal
	Overweight Highschoolers (YRBS) #	14%	14%					12.4%
NWS-10.3	Obese Highschoolers (YRBS) #	11%	11%					9.7%
NWS-8	Proportion of adults healthy weight	37.8%	37.8%					33.9%
	Overweight Adults (BRFSS)	37.0%	37.0%					33.3%
NWS-9	Obese Adults (BRFSS)	25.2%	25.2%					22.7%

DIABETES

Goal: Reduce the disease & economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM.								
HP2020	Objective							Target
D-1	Reduce the annual number of new cases of diagnosed diabetes in the population							7.2 per 1,000 (10% improvement)
(based on 2008 NIHS which has too small of a data set to even get State level data)								
D-3	Reduce the diabetes death rate							65.8 per 100,000 (10% improvement)
		Baseline	2011	2012	2013	2014	2015	Goal
D-1	Adults who have been told they have Diabetes (BRFSS)	9.2%	*9.2%*					8.3% *National Avg.**
D-3	Death rate due to Diabetes (HSR)	25.8	25.8					23.22 *2020 Goal*

* http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf

LUNG CANCER

Goal: Reduce the number of new cancer cases, as well as the illness, disability, and death caused by cancer.									
HP2020	Objective								Target
C-2	Reduce the lung cancer death rate								45.5 per 100,000 *(10% improvement)*
Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.									
TU-1.1	Reduce cigarette smoking by adults								12.0%
TU-2.2	Reduce use of cigarettes by adolescents (past month)								16.0%
TU-3.2	Reduce the initiation of the use of cigarettes among children and adolescents aged 12 to 17 years								4.2%
		Baseline	2010*	2011	2012*	2013	2014	2015	2020 Goal
TU-1.1	Adults who are current smokers (BRFSS)	18.5%		18.5%					12.0%
TU-2.2	Highschoolers who smoked 20 of the last 30 days (YRBS)#	5.8%		5.8%					5.2%
TU-3.2	Highschoolers who tried smoking (YRBS)#	30.9%	30.9%	30.9%	26.0%				4.2%
TU-3.2	Highschoolers who smoked one of the last 30 days (YRBS)#	13.2%	13.2%	13.2%	11.6%				4.2%
C-2	Lung Cancer death rate (HSR)	36.3		36.3					32.67

* *AZ Youth Survey*

CARDIOVASCULAR DISEASE

Goal: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke								
HP2020	Objective					Target		
HDS-2	Reduce coronary heart disease deaths					100.8 deaths per 100,000 population		
HDS-3	Reduce stroke deaths					33.8 deaths per 100,000 population		
HDS-5.1	Reduce the proportion of adults with hypertension					26.90% *(10% improvement)*		
HDS-7	Reduce the proportion of adults with high total blood cholesterol levels					13.50% *(10% improvement)*		
		Baseline	2011	2012	2013	2014	2015	*2020 Goal*
HDS-2	Deaths due (attributable) to coronary heart disease (Vitals)	117.0	117.0					105.3
HDS-3	Deaths due (attributable) to stroke *(cerebrovascular disease)* (Vitals)	28.0	28.0					25.2
HDS-5.1	Adults who have been told they have High Blood Pressure (BRFSS)	25.8%	25.8%					23.2%
HDS-7	Adults who have been told they have High Cholesterol (BRFSS)	39.3%	39.3%					13.5%

ACCESS TO HEALTHCARE

Goal: Improve access to comprehensive, quality health care services.								
HP2020	Objective					Target		
AHS-1.1	Increase the proportion of persons with health insurance					100.0%		
AHS-3	Increase the proportion of persons with a usual primary care provider					83.9%		
		Baseline	2011	2012	2013	2014	2015	2020 Goal
AHS-1.1	Adults age 18-64 who have health care coverage (BRFSS)	77.1%	77.1%					100.0%
HS-3	Adults who have a usual source of health care (BRFSS)	73.1%	73.1%					83.9%

APPENDIX G. MARICOPAHEALTHMATTERS.ORG CHIP TRACKER SCREEN SHOT