NMDOH
NEW MEXICO DEPARTMENT OF HEALTH

Investing for tomorrow, delivering today.

Improving the Health of Your Community

An orientation to the
Community Health Improvement Process (CHIP)

1190 S. St. Francis Drive • Santa Fe, NM 87505 • Phone: 505-827-2613 • Fax: 505-827-2530 • nmhealth.org

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The Concept of Health

Let's assume…

- health means both well-being and the absence of illness or other health problems.
- health is influenced by many different factors (social, personal, economic, environmental).
- health is inter-related with a wide range of human service issues and needs.
- many different individuals and entities can and should play a role in maintaining and improving health in the community.

Centering Ourselves

- Identify the #1 thing in your life that improves or maintains your personal health.
- Think about the #1 health issue your family and/or close friends deal with daily.
- Keep in mind the community or communities you represent as you move through this content and…
- Consider how you will work with your community to identify the #1 health issue that your community is facing.

Course Objectives

Upon completion you will be able to :

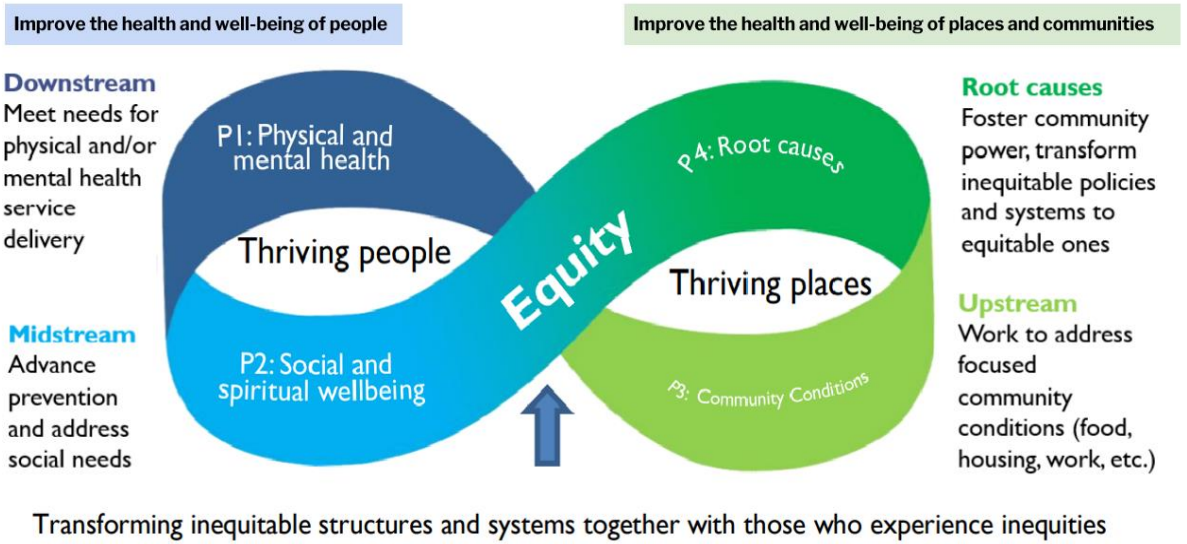
- describe the concept of health and context of community health improvement and health equity work in New Mexico
- define at least 4 Key Elements of Population Health
- give examples of Social Determinants/Drivers of Health (SDoH)
- explain how SDoH impact outcomes at a population level
- list some reasons for using a population health approach
- explain the key components of Community Health Improvement Process (CHIP)
- fill out and submit a training record.

The Statewide Context:

New Mexico Dept. of Health is a centralized state system and develops a State Health Improvement Plan every 3 years which is informed by local Community Health Improvement Assessments and Plans.

Mission: To ensure health equity, we work with our partners to promote health and well-being and improve health outcomes for all people in New Mexico.

Pathways to Population Health Equity

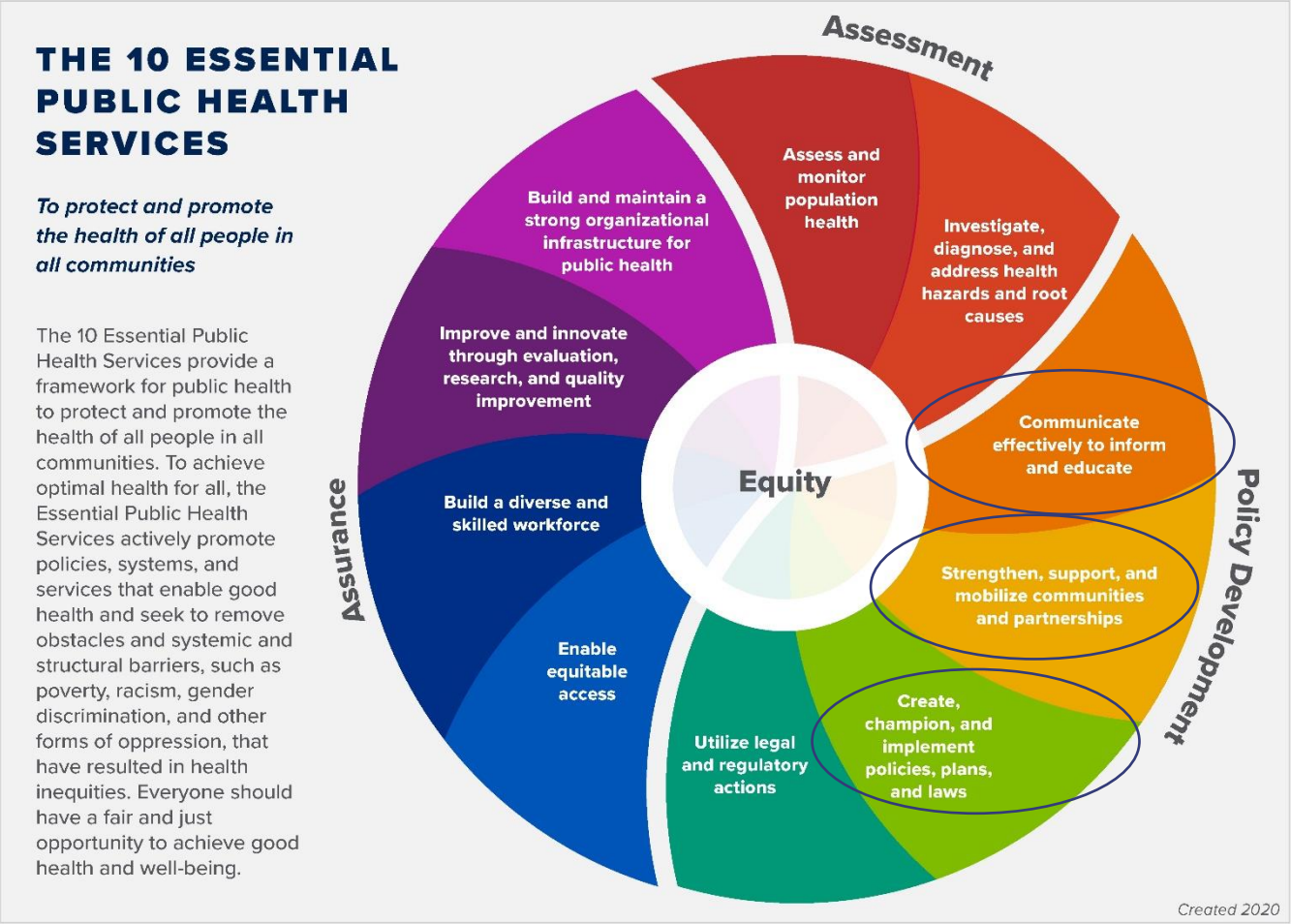


Adapted from PathwaystoPopulationHealth_Framework.pdf (ihi.org)

The Local Context:

- The NM Public Health System includes Health Promotion in partnership with community. NMDOH uses this CHIP Framework as a process for comprehensive health planning with communities.
- Five regional Health Promotion Teams (HPT's) with:
  - Program Manager; Health Promotion Coordinators; Health Promotion Specialists; Community Epidemiologist; and in some cases, a Health Equity Specialist
- HPTs support local collaborative effort and provide health councils and community partners with data, technical assistance and other resources.
- What HPTs Do:
  - Focus on population health and health equity
  - Influence systems and policy for long term impact
  - Identify and support leaders in communities
  - Connect people to resources and each other
  - Share and interpret data
  - Help move community forward

Health Promotion functions in NM Public Health



Health Promotion tends to focus on these three aspects of public health.

- 3. Communicate effectively to inform and educate.
- 4. Strengthen, support and mobilize communities and partnerships.
- 5. Create, champion and implement policies, plans and laws.

[10-essential-public-health-services.jpg (5010×3502) (cdc.gov)]

Some Background on Community Health Councils

- New Mexico's 41 Community Health Councils (county and tribal) are part of a statewide network acting as official advisory bodies to local governments.
- Health councils, set up in 1992 by the NM Maternal and Child Health Plan Act with NMDOH core funding, expanded their planning and coordinating roles over time.
- Health councils later became more comprehensive, providing key leadership in local public health systems.
- They convene community members, health providers, schools, businesses, and other stakeholders to improve the health of communities, linking DOH and other state agencies to their work.

Please note: Health councils often partner with other groups, including Maternal Child Health Councils, DWI Councils, Substance Use Prevention Coalitions, and more to collaboratively work together across interest areas or silos to improve overall community health and well-being.

Current Health Council Context

HB 137 (2019) encourages Health Councils to have more clout, mandating certain functions as their responsibility in addressing and advocating for improved health and policies.

Each council is part of New Mexico's network of community-based health planning councils that plays a key role in the state and/or tribal public health system. Local members of diverse community groups have an active say in health decision-making by being health council members. These councils strive to make their work reflect "the voice" of all community members, including groups made disadvantaged or underserved because data show that people of color across health and health systems are most impacted. A health council:

(1) *listens to*, *communicates with*, *and involves* different community members in order to…

(2) *review* how healthy ALL people are in the community, and *pinpoint root causes* for health gaps or biases, so its members can…

(3) *plan and carry out,* with partners, community-driven *solutions* in a CHIP (Community Health Improvement Plan) to fairly improve the health of all, and…

(4) *advise* leaders *about policies* that can improve community health for all.

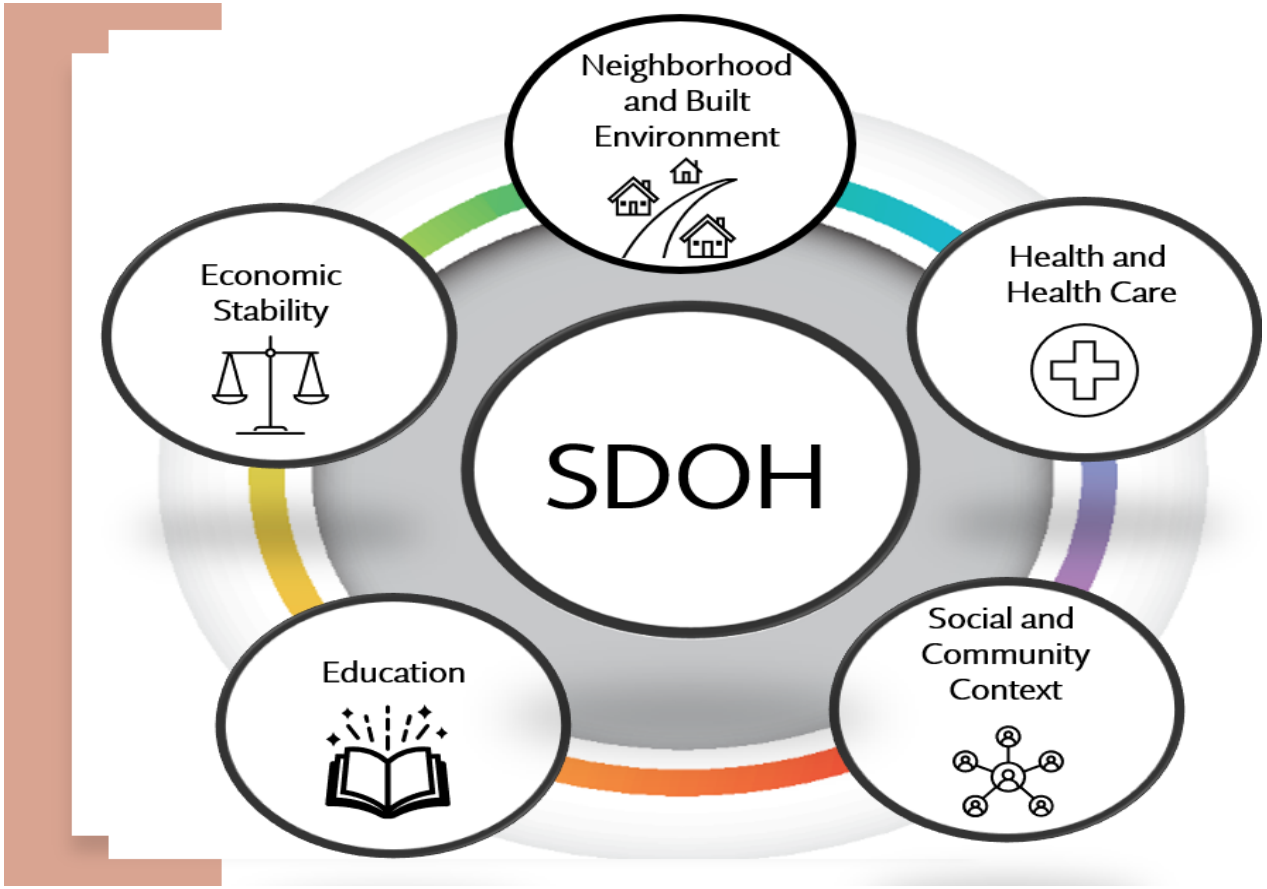
Now that you understand how Health Councils can operate with the New Mexico Public Health System, let's learn about concepts like:

- Population Health
- Social Determinants/Drivers of Health
- Community Health Improvement Process
- Collective Impact

Population Health: Key Elements

- Focus on the health of populations, not individuals
- Address determinants of health and their interactions
- Base decisions on evidence/research
- Intervene *upstream* with investments and prevention strategies
- Apply multiple strategies
- Collaborate across sectors, professions and levels
- Find ways to leverage public involvement
- Demonstrate accountability for reaching health outcomes

What are “Social Determinants/Drivers of Health?”



Can you name others?

Examples of the "Social Determinants/ Drivers of Health"

- Access to safe, affordable housing, transportation, and neighborhoods
- Racism, classism, discrimination, and violence
- Education, job opportunities, and wealth
- Access to nutritious foods and safe physical activity opportunities
- Polluted air and water
- Language and literacy skills
- Others? List 2 more different ones on your own.

Reflection Questions

How might the presence or lack of youth activities in a community affect the:

- mental health of youth?
- rates of youth substance use?
- mental health of parents/grandparents?
- obesity rates?
- graduation rates?
- crime rates?

What other social determinants/ drivers could also impact these indicators of health?

Checklist to Use a Population Health Approach:

- Is the situation a population level issue?
- What is the burden on community?
- What population needs can be addressed?
- What assets does the community have to offer?
- Is there a relevant evidence-based or innovative practice available?
- What short & long-term indicators are at play?
- Are there other partners available to assist?
- Might a CHIP process be warranted? (see next slide)

Community Health Improvement Process

~Is ongoing and deliberate

~Is evidence-based

~Includes a Community Health Assessment (CHA) which can inform the State Health Assessment (SHA)

~Informs a plan called a CHIP – *Community Health Improvement Plan* which informs the State Health Improvement Plan (SHIP)

~Leads to community change and health improvement via active partnerships and measurement of outcomes

#1 Build a Health Council

Center diversity, health equity and inclusion

Work together collaboratively

Support leadership development

Commit to conflict resolution

Decide on structure and process

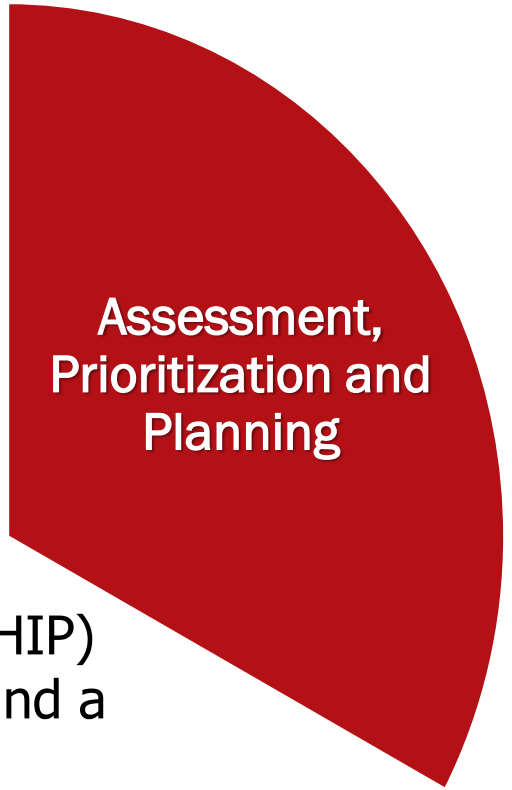
Engage community meaningfully

Select a suitable fiscal agent

Find ways to share power / expand ownership

Ensure quality meeting facilitation and documentation

#2 Research and Plan



Compile community health & SDoH data

Engage stakeholders to complete a Community Health Assessment (CHA)

Establish Priorities (about 3 but at least one)

Develop a Community Health Improvement Plan (CHIP) with action steps assigned to perhaps committees and a plan for execution as well as evaluation in order to amend as necessary.

Submit full CHA and CHIP to NMDOH to inform the State Health Improvement Plan (SHIP)

#3: Make it Happen

Community Action and Evaluation

Follow the plan developed in prior step.

Use Evidence-Based or Best, Promising, and Innovative Practices.

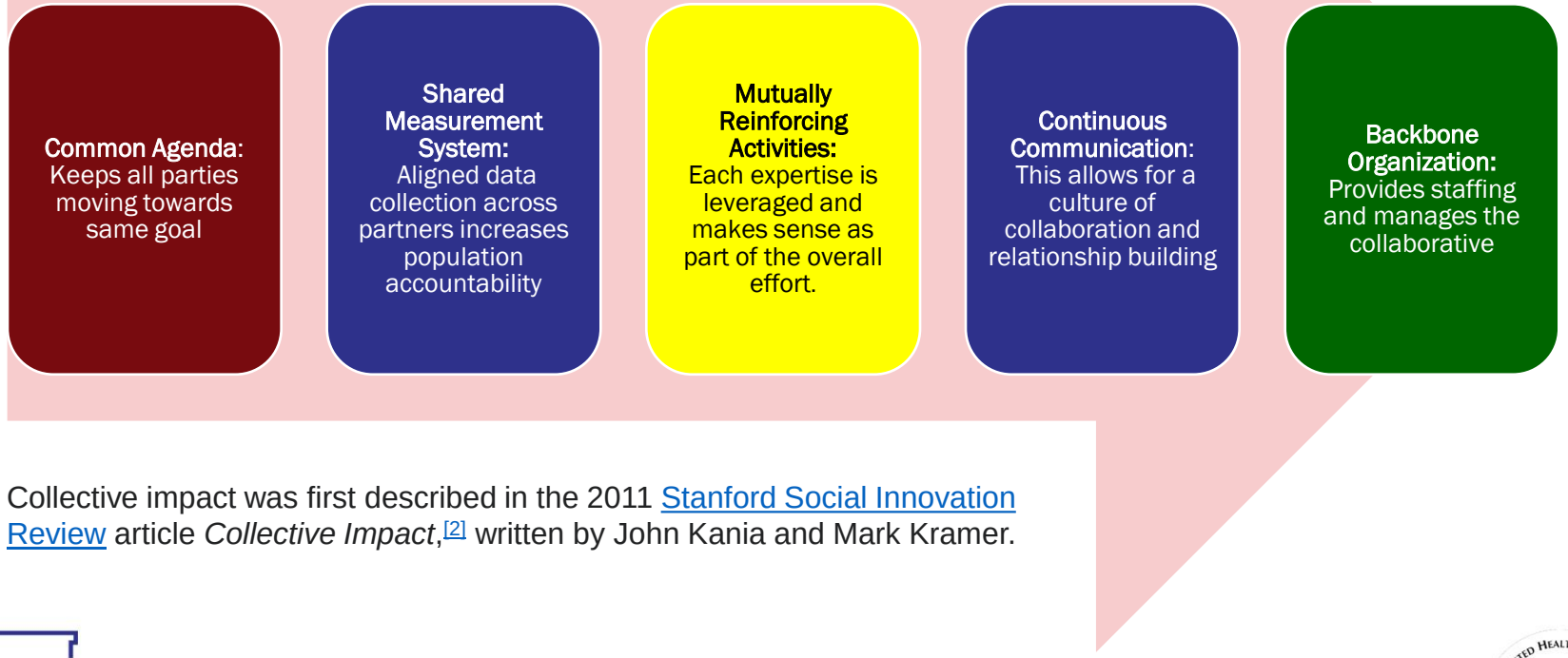
Implement the selected collaborative intervention(s) and evaluate process and outcomes.

Engage others to assist as necessary.

Secure funding or support for sustainability.

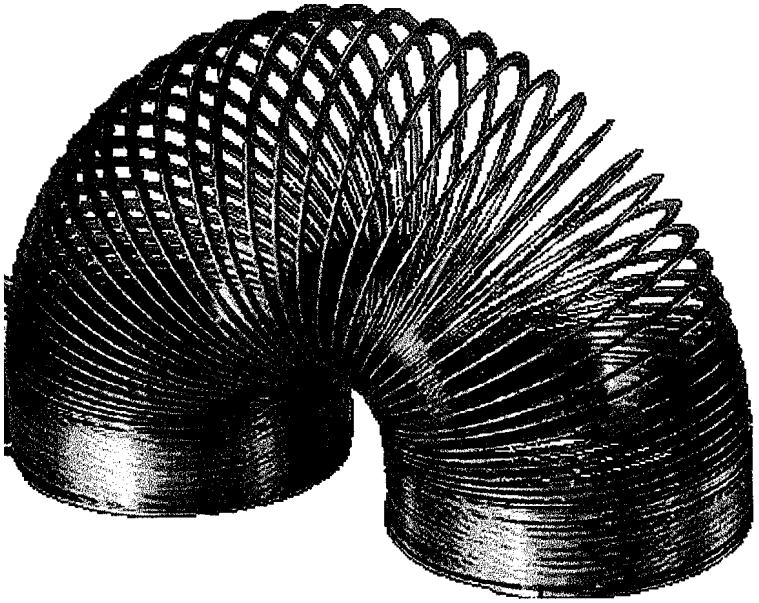
Ways to accomplish a CHIP

The CHIP framework can incorporate other models of community work. Health Councils are urged to use a Collective Impact approach (below), and Results Based Accountability/Turn the Curve which is a Collective Impact model. (See next trainings.)



Collective impact was first described in the 2011 Stanford Social Innovation Review article *Collective Impact*,[2] written by John Kania and Mark Kramer.

A Slinky Approach…



Progress can be slow and feel like two steps forward one step back, but communities can get better at health. It takes many partners working together to make sustained gains over time. Have reasonable expectations of yourselves and partners. Take Slinky Steps!

"The arc of the moral universe is long, but it bends towards justice."

— **Theodore Parker**

What's next?

- Please fill out the training record provided to you and submit to your Health Promotion team.
- The next modules in this series will take a deeper dive into each step of the CHIP process and define in greater detail what is meant by each item. Please view these.
- Consider what parts of this process your health council needs to grow in. What support(s) do you need? Feel free to reach out and ask any Health Promotion team member!