MARION COUNTY
PUBLIC
HEALTH
DEPARTMENT

Prevent. Promote. Protect.

COMMUNITY HEALTH IMPROVEMENT PLAN

2019—2024
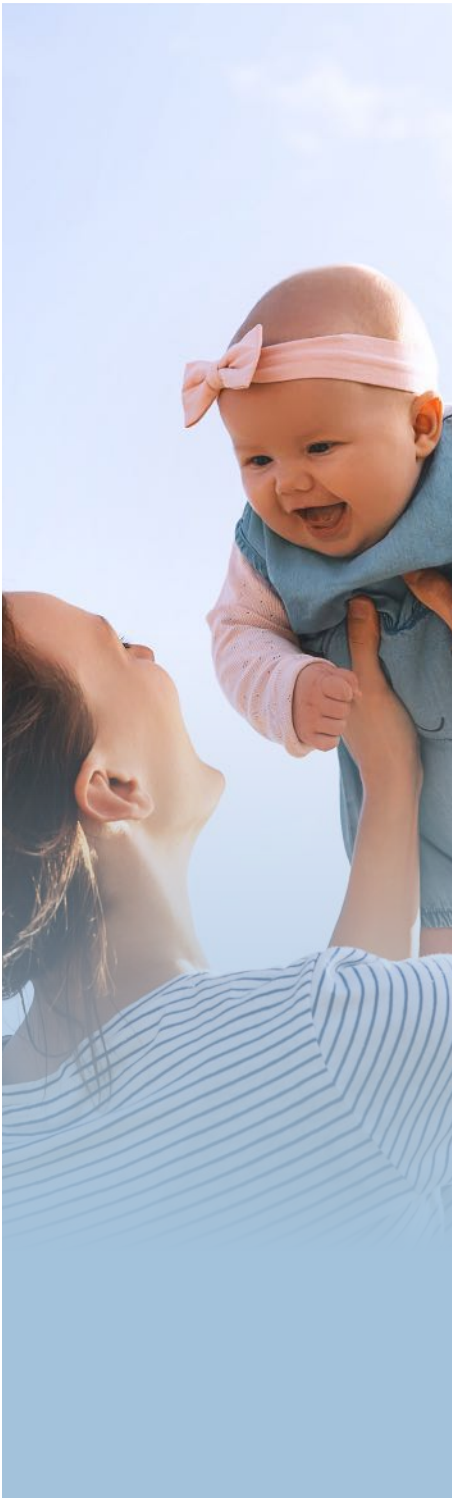
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LETTER FROM THE DIRECTOR

Dear Partner in Health:

It is a pleasure for me to present this 2019 Marion County Community Health Improvement Plan. We discovered and learned a great deal in developing this plan, mainly by accessing the expertise and participation of traditional and non-traditional public health partners. You are encouraged to review this plan and think about how you could participate in this effort aimed at improving the health of Indianapolis.

The 2019 Marion County Community Health Assessment, through community deliberations, identified three health priorities: obesity/diabetes, mental health, and poverty. These health objectives, and health equity, also are reflected in many plans across our county that have been developed by neighborhood organizations and coalitions.

Addressing these issues over the five year CHIP period will be hard work for the members of the 2019 Marion County Community Health Improvement Plan Strategy Committee who have developed goals, objectives, and strategies that will make an impact on these health priorities. I encourage all residents to read this report and work in your own neighborhoods to help us realize these goals and objectives. On behalf of the 2019 Marion County Community Health Improvement Plan Strategy Committee and partnering agencies, we look forward to each of you becoming involved in making Indianapolis a healthy, thriving community.

Sincerely,

Virginia A. Caine, MD

Virginia A. Caine, MD

PUBLIC HEALTH IN INDIANAPOLIS

VISION

Healthy People and Families Living in Healthy Neighborhoods

MISSION

To Promote Physical, Mental and Environmental Health; Prevent and Protect Against Disease, Injury and Disability

C.L.E.A.R. VALUES

COMMUNITY — Promote and protect the health of everyone in the community and provide healthcare to those who are underserved.

LEADERSHIP — Lead the community in health care services, behavior and attitude. We will lead through example.

EXCELLENCE — Embrace the community to excellence in our service delivery, employee performance, facility cleanliness and overall safety.

ACCOUNTABILITY — Accept and embrace the expectations of accountability for our actions. Every employee shall strive to "exceed their expectations" of their job to protect and promote the health of everyone in the community.

RESPECT — Commitment to treat every employee, patient, customer and visitor with dignity and respect at all times.

CORE FUNCTIONS OF PUBLIC HEALTH

Assessment
Policy Development
Assurance

ACKNOWLEDGMENTS

ADVISORY BOARD

Kendale Adams Indianapolis Metropolitan Police Department

Brad Beaubien Department of Metropolitan Development

Dennis B. Buckley City of Beech Grove

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Gregory K. Steele IU Fairbanks School of Public Health

Jim Whitehead American College of Sports Medicine

Sarah Wiehe CHEP: Community Health Partnerships

Amy Wojtyna University of Indianapolis

OVERVIEW OF THE COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

The Community Health Improvement Plan is a long-term, systematic plan to address issues identified in the most recent Community Health Assessment process in November 2018. The purpose of the Community Health Improvement Plan is to describe how the MCPHD and the communities it serves will work together to improve the health of the population of Marion County. Community stakeholders and partners will use the Community Health Improvement Plan to direct the use of available resources concerning health priorities and to develop and implement policies, programs, and strategies to address health status priorities.

The priorities identified in the Community Health Assessment process in November 2018 are:

• Obesity/Diabetes

• Mental Health

• Poverty

• Health Equity*

The Plan reflects the results of a collaborative planning process that includes significant involvement by a variety of community sectors. The Plan will be communicated to Marion County public health partners and constituents through the IndyIndicators website upon completion.

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* Please note, after the last meeting of the CHIP Strategy Committee, health equity has become a recognized area of great public health importance and was added as a fourth priority area in the 2019 – 2024 CHIP. This change is not reflected in the appendices.

WHAT IS THE CHIP?

The Community Health Improvement Plan (CHIP) is a guide for future health services and policies in Marion County for the next five years. It is a community health planning effort to measurably improve the health of Marion County residents.

The CHIP is a strategic framework for community health, while also being specific enough to guide action. The CHIP is highly collaborative and incorporates and builds upon a broad set of community efforts that have similar purpose and intent. The CHIP brings together a volunteer group of stakeholders from across sectors—private and non-profit organizations, government agencies, academic institutions, community and faith-based organizations, and citizens—to improve health, quality of life, and equity for all residents and visitors of Marion County. The strategy committee reflects a broad group of these stakeholders and additional collaboration is expected during implementation.

The CHIP is flexible and will be modified as conditions, resources, and environmental factors change. In addition to guiding future services and policies for Marion County, the Community Health Assessment and Community Health Improvement Plan are required for the MCPHD to acquire and maintain national public health accreditation. National public health accreditation indicates that the Marion County Public Health Department meets hundreds of standards and measures in delivering the Ten Essential Public Health Services. (See Appendix F.)

2019 MARION COUNTY COMMUNITY HEALTH ASSESSMENT (CHA) PROCESS AND PRIORITIES

The Community Health Assessment Process was as Follows:

January 1 - August 9, 2018:
Planned and prepared the draft topics list.

August 9 - August 23, 2018:
Form Advisory Board and invited it to edit the draft topics list.

August 23 - September 6, 2018:
Created 66 topic comparison table.

September 7 - September 19, 2018:
Advisory Board voted for its top 15 final topics.

September 20 - October 22, 2018:
Epidemiology Dept. prepared the top 15 topics packets.

October 23 - November 7, 2018:
Advisory Board reviewed the topics packets.

November 8, 2018:
Final prioritization meeting with Advisory Board and community members.

Prioritization Criteria were as Follows:

1. How many people are affected by the condition?
2. How severe is the condition for each individual who has it?
3. Does this condition impact multiple outcomes? If so, what other outcomes?
4. Does our community have resources to address these issues?
5. What type of prevention, if any, can be used?
6. Is this an area that has increased, decreased, or stayed the same?
7. Is there disparity in incidence of occurrence among subpopulations?

OBESITY AND DIABETES

Diabetes and obesity lead to many problems among individuals and populations. Each contributes to negative health impacts, and therefore increased medical costs, and decreased years of life.

Diabetes is a chronic disease characterized by high blood sugar (blood glucose), due to problems with the body's insulin. The high levels of blood sugar cause damage to organs and tissue throughout the body, resulting in an increased risk of developing many chronic health conditions. In addition, 9 out of 10 people with diabetes are obese, which brings its own health problems. Obesity, or having too much body fat, increases the risk of developing nearly every chronic disease, including hypertension, coronary heart disease, stroke,[i] cancer,[ii] Alzheimer's disease, and any other type of dementia.[iii] In the U.S. in 2017, the cost of diagnosed diabetes was $327 billion,[iv] and the estimated national cost of obesity is $147 billion - $210 billion per year.[v] With Marion County having about 0.3% of the U.S. population, that translates to a local, annual cost of $950 million for diabetes and $430 million to $610 million for obesity.

Among Marion County adults in 2018, about four out of ten (38%) are obese, and more than one in ten (14%) have chronic diabetes. Roughly half (46-53%) of those with obesity indicated that they had been diagnosed with asthma, depression, high cholesterol, heart conditions, or high blood pressure. Similarly, those with diabetes were nearly twice as likely to have asthma, and three times more likely to have heart conditions than the Marion County population.[vi] Nationally, diabetes was the 7th leading cause of death in 2017, accounting for over 80,000 deaths.[vii] In Marion County diabetes was the 6th leading cause of death in 2017, with a mortality rate of 27 per 100,000.

Life style changes and system-level interventions are two of the valuable strategies for decreasing obesity and diabetes rates. Increasing physical activity and eating more healthy foods, such as fruits and vegetables, are the safest and most cost-effective solutions to reduce fat and weight. However, to see significant county-wide decreases, system-level changes are needed. Research suggests that education, without environmental or economic changes, has little influence on behavior.[viii] Increasing safe and convenient access to grocery stores with fresh fruits and vegetables and green space for exercise will remove some of the barriers to making these lifestyle changes.

[i] Reilly and Kelly, "Long-Term Impact of Overweight and Obesity in Childhood and Adolescence on Morbidity and Premature Mortality in Adulthood."

[ii] Polednak, "Estimating the Number of U.S. Incident Cancers Attributable to Obesity and the Impact on Temporal Trends in Incidence Rates for Obesity-Related Cancers."

[iii] Anstey et al., "Body Mass Index in Midlife and Late-Life as a Risk Factor for Dementia."

[iv] Drive, Arlington, and Va 22202 1-800-Diabetes, "Statistics About Diabetes."

[v] Cawley and Meyerhoefer, "The Medical Care Costs of Obesity."

[vi] 2018 Marion County Community Health Assessment Survey (DR3708)

[vii] National Center for Health Statistics, "Diabetes."

[viii] Mozaffarian, "Dietary and Policy Priorities for Cardiovascular Disease, Diabetes, and Obesity – A Comprehensive Review."

OBESITY AND DIABETES

Appendix C contains data summary sheets on each of the possible priority areas voted on in the CHA Advisory Board Meeting, including the four CHIP priorities — Obesity/Diabetes, Mental Health, Poverty, and Health Equity. Each summary sheet has the following sections:

Health Impacts:
What health outcomes are most affected by the topic?

Treatment:
How can the topic be mitigated or treated?

Comparison:
How is Marion County doing, compared to other locations, in terms of some key measure regarding the topic?

Trend:
How is some key measure of the topic changing in the past few years?

Risk Factors:
What increases the likelihood of the topic's occurrence?

Equity:
What are important differences, if any, in how the topic impacts different groups within the county?

Mental illness can reduce productive activities, the capacity for fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Some of the more common mental illnesses include depression, anxiety, addictions, and eating disorders. Without treatment or effective management, any of these can be very debilitating, resulting in estrangement from friends and family, loss of income, job, or home, and even death. There are notable impacts on family and the community, as well.

Mental distress (having frequent poor mental health days) was similarly common in Marion County (13%)[ix], Indiana (13%) and the U.S. overall (12%).[x] In 2018, 23.7% of Marion County adults reported ever having been diagnosed with depression[xi], which is somewhat higher than the 18% reported in the U.S. overall.[xii] Each year in the last decade, Marion County has had close to 14 suicides per 100,000 residents. Over that period, the national rate rose from 12 to the Marion County rate of 14 per 100,000. As in the rest of the U.S., overdose deaths have risen rapidly; overdose deaths in Marion County doubled from 2010 to 2017, reaching 39 per 100,000 residents. The rise is almost entirely due to opioid overdose.

Two important strategies to improve mental health are to increase access to treatment and to decrease the stigma attached to mental illness. With increased access to care and decreased stigma, people will be more likely to seek treatment and other support needed to manage their illness. Increasing access to treatment includes increasing the number of treatment providers and improving insurance or other financial coverage of the costs of treatment. Technologies such as online therapy may also expand the reach and convenience of counseling and other treatment. Anti-stigma work will involve education and awareness programs and campaigns in workplaces, schools, faith communities, and other settings.

MENTAL HEALTH

[ix] University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2019. Indiana "Frequent mental distress" 2016 data https://www.countyhealthrankings.org/app/indiana/2019/measure/outcomes/145/data

[x] 2016 BRFSS, CDC BRFSS Web Enabled Analysis Tool, https://nccd.cdc.gov/weat/?#/crossTabulation "frequent (14+ days) poor mental health (MENTHLTH)", "All" locations and "Indiana".

[xi] 2018 Marion County Community Health Assessment Survey (DR3708)

[xii] 2018 BRFSS, CDC BRFSS Web Enabled Analysis Tool, https://nccd.cdc.gov/weat/?#/crossTabulation "Ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression (ADDEPEV2)", "All" locations.

POVERTY

Poverty has pervasive impacts on health. Having little income makes it difficult to maintain safe and stable housing, timely and good quality health care, and good nutrition, among other things. Poverty has been linked to chronic stress, particularly among children, which has been linked to a decreased executive function.[xiii] Poverty is also associated with a shorter life expectancy, hypertension, asthma, and many other chronic diseases that decrease well-being and quality of life.

In Marion County, we found on the 2018 Marion County Community Health Assessment Survey that higher poverty was strongly related to higher rates of asthma, hypertension, high blood cholesterol, and heart disease diagnoses, among other health outcomes. For all four conditions, a higher percentage of people below the poverty guideline had been diagnosed with the condition than those who earned an income three times or more of the Federal Poverty Guideline (FPG). Adults who made less than 100% FPG were 43.3% more likely

to have been diagnosed with asthma, 44.0% more likely to have been diagnosed with hypertension, 27.5% more likely to have been diagnosed with high blood cholesterol, and just over twice as likely to have been diagnosed with heart disease than adults who made more than 300% FPG.

To decrease poverty is difficult, but possible, and important. In fact, the CHA advisory group identified poverty as the top priority to address in improving health within the county. A primary way to address poverty is through policy changes. Policies that improve employment, increase wages, and support social programs that soften the impact of unexpected health or financial needs can lessen the health consequences of poverty, and even decrease poverty itself. For example, providing Medicaid coverage has increased the use of health care services, reduced financial strain, increased diagnosis and management rates of diabetes, and decreased the rate of depression among Medicaid recipients.[xiv]

[xiii] Blair and Raver, "Poverty, Stress, and Brain Development."

[xiv] Baicker et al., "The Oregon Experiment — Effects of Medicaid on Clinical Outcomes."
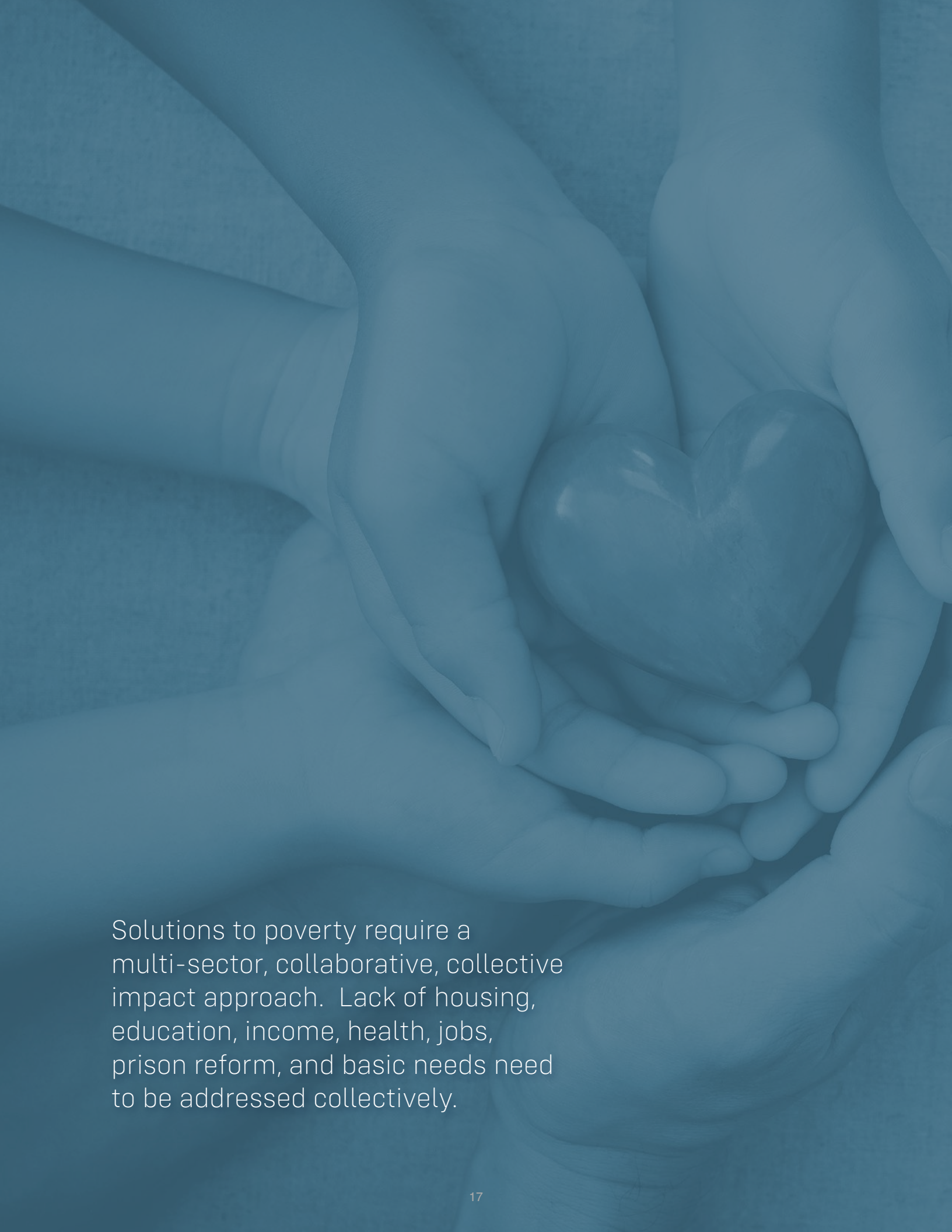
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FEEDBACK ON POVERTY

The MCPHD Community Health Improvement Plan covers a five year time period — 2019-2024. The CHIP Strategy Committee was limited to the issue of health as it is impacted by poverty for that limited five-year time frame in this planning effort. However, this does not mean that the Committee does not understand that reducing poverty as a whole will take a comprehensive, multi-sectoral approach. To that end, the following feedback comments seem in order:

- There are no silver bullets or quick fixes to addressing the issue of poverty, as poverty is a systemic issue.

- Structural/institutional racism is a significant contributor to generational poverty.

- Solutions to poverty require a multi-sector, collaborative, collective impact approach. Lack of housing, education, income, health, jobs, prison reform, and basic needs need to be addressed collectively.

- Elevating the conversation about poverty in Central Indiana is long overdue and must continue to stay on the radar of policymakers and elected officials.

- Investment in relational work must be a key ingredient in every aspect of reducing poverty.

- There are interventions in Marion County that are working—they just need to be scaled up, elevated, and supported.

Solutions to poverty require a multi-sector, collaborative, collective impact approach. Lack of housing, education, income, health, jobs, prison reform, and basic needs need to be addressed collectively.

2019 COMMUNITY HEALTH IMPROVEMENT PLAN PROCESS

The 2019 Community Health Improvement Plan process involved three phases of activity including, generally, the steps outlined in the Association for Community Health Improvement (ACHI) Assessment Toolkit and are as follows:

1. Complete Community Health Assessment

2. Engage external stakeholders.

3. Align strategies with community stakeholder organizations.

4. Determine community assets.

5. Develop goals, objectives, and actions/strategies to address the priority needs.

6. Assign lead organization and partnering organizations for each action/strategy.

7. Implement the actions/strategies.

8. Evaluate progress annually
    A) Measure progress on each priority regularly.
    B) Use the results to modify or improve the actions/strategies.
    C) Communicate results to public health partners and to the community at large.

PHASE ONE

The first phase was the development of the Community Health Assessment using the data development of the MCPHD Department of Epidemiology, which is described in the previous section. One hundred thirty community members and representatives of community organizations selected three priorities: Obesity/Diabetes, Mental Health and Poverty. Health Equity was added later as a fourth priority.

In the final meeting of the Community Health Assessment Planning Committee on November 8, 2018, MCPHD made a call for volunteers to join the subsequent Community Health Improvement Plan Strategy Committee. Thirty one community members volunteered. A list of volunteers is shown in the Acknowledgments section at the beginning of this report.

2019 COMMUNITY HEALTH IMPROVEMENT PLAN PROCESS

PHASE*TWO*

The second phase was the development of the CHIP. The CHIP Strategy Committee met nine times between December 2018 and November 2019. The process was facilitated by Jamie Palmer of the Indiana University Public Policy Institute, a consulting partner to provide strategic guidance and facilitation of the CHIP process and develop the resulting reports and plan. The process was staffed by MCPHD staff.

The Committee identified an initial set of community assets for the three priority areas, including stakeholder organizations and current efforts. This list was updated with additional assets as the planning process progressed. A final list appears in Appendix B. The Committee, with the assistance of the facilitator and staff, identified local, state, and federal health efforts related to the three priorities as background and to ensure the alignment of the CHIP with these plans (Appendix D). After the final CHIP Strategy Committee meeting, Health Equity was added as a fourth priority area.

The Committee developed goals, objectives, and actions steps for each of the priorities. The CHIP Strategy Committee also identified lead and partnering organizations for each action step, as well as, indicators for tracking progress on the goals, objectives, and action steps during implementation. Full detail for the selected goals, objectives, action steps, lead and participating organizations, and indicators for each priority area are provided in Appendix A.

MCPHD will place the CHIP on an existing community engagement platform to assure residents have access to review the document and provide comments. The idea is to ensure that all members of the community have an opportunity to participate in plan development. This will also help to engage underrepresented residents. The diversity of our community is a source of pride for Indianapolis. As we continue to strive for participation from everyone, it is important to acknowledge the inequities, disparities, and environmental injustices that some of our community members face from historical and systemic discrimination and exclusion.

2019 COMMUNITY HEALTH IMPROVEMENT PLAN PROCESS

PHASE THREE

The third step is implementation and tracking. After adoption, MCPHD and its partners will work to implement the plan. The CHIP Strategy Committee will continue to provide executive oversight for the Plan's progress. The Strategy Committee will expand membership to match the scope of the four priority areas and meet at regular intervals determined by the committee. Periodic community listening sessions will be held to share progress and engage residents in implementation and solicit feedback to strengthen the CHIP. The Committee and MCPHD staff will explore new and creative ways engage all interested parties.

After the CHIP has been vetted by community residents it will be placed on the MCPHD website and the Indy Indicators website. Indy Indicators is a free data resource which helps communities perform community health needs assessments, guides the development of community improvement plans, and much more.

IndyIndicators is a website about measuring, assessing and engaging people in the quality of life of Indianapolis and Marion County in the context of Central Indiana, the state and the nation. Users can also delve into school districts and townships and neighborhoods. It is managed by the Indiana Business Research Center and sponsored by the Marion County Public Health Department. Indicators to track the progress on the Marion County Community Health Improvement Plan — 2019-2024 will be posted on IndyIndicators at **http://indyindicators.iupui.edu**.

COMMUNITY HEALTH IMPROVEMENT PLAN STRATEGY COMMITTEE

Community health improvement is a shared responsibility. The CHIP Strategy Committee is composed of the broad set of community organizations shown below. Many were previously working on efforts around the four priority areas and plan to participate actively in the implementation of the CHIP. The Committee will be expanded as implementation progresses.

Jonathan Barclay	Jump IN for Healthy Kids; Indiana Public Heath Association
Brad Beaubien	City of Indianapolis Department of Metropolitan Development
David Berman	Mental Health of America—Indiana
Andrea Bochenek	MCPHD Department of Epidemiology
Elizabeth Bowman	MCPHD Department of Epidemiology
Amy Carter	Eskenazi Health Services
Abby Church	IU Health
Sandy Cummings	MCPHD Chronic Disease Program
Mary de Groot	Indiana University School of Medicine
Vickie Driver	Oxford Neighborhood Association
Kim Ewers	Indianapolis Public Library
Indra Frank	Hoosier Environmental Council
Joe Gibson	MCPHD Department of Epidemiology
Marion Greene	Indiana University Richard M. Fairbanks School of Public Health
James Groh	MCPHD Department of Epidemiology
Ellie Hansotte	MCPHD Department of Epidemiology
Taylor Hughes	Indianapolis Chamber of Commerce
Kim Irwin	Health By Design; Indiana Public Health Association
Nitika Jain	MCPHD Department of Epidemiology
Frankye Johnson	MCPHD Social Work Department
Karla Johnson	MCPHD Healthy Homes, Environmental Consumer Management and Senior Care
Darren Klingler	MCPHD Bureau Chief, Population Health
Denise Luster	United Way of Central Indiana
Lindsey Rabinowitch	Faith and Action Project, Christian Theological Seminary
Alison Redenz	MCPHD Chronic Disease Program
Rachel Redington-Noble	MCPHD Tuberculosis Control Program
Kelli Smith	Covering Kids and Families
Cindy Stone	Indiana University Richard M. Fairbanks School of Public Health
Thomas Thaman	Eskenazi Health Services
Sarah Wiehe	CTSI, IU School of Medicine
Chelsy Winters	YMCA/Top 10 Coalition

2019 CHIP GOALS, OBJECTIVES AND ACTIONS

As the basis for developing the plan goals, objectives, and action steps, the Committee agreed on the following selection criteria for goals and objectives:

1. Realistic

2. No duplication of effort

3. Resources available

4. MCPHD partner involvement

5. Addresses equity

6. Strategic investment
   (i.e., If it's missing, would other efforts not hold together.)

7. Needs to be SMART
   (specific, measurable, achievable, realistic, and timely)

GOAL AND OBJECTIVE SETTING

Since community health improvement is a shared responsibility, the Plan's development must include participation of a broad set of community partners. Over a period of ten months, the Community Health Improvement Plan Strategy Committee, made up of community partners supported by MCPHD staff and the Indiana University Public Policy Institute, developed and drafted goals, objectives, strategies, and action steps to address each priority area.

The committee members decided to concentrate on policy strategies as these produce the most impact on health matters. Participating partners also identified potential community assets and resources who may assist in the community health improvement effort. As these tasks were completed, committee members volunteered to accept responsibility to be a lead organization or a partner organization for implementing the outlined strategies.

OBESITY AND DIABETES

GOAL 1

Reduce the disease burden of obesity and diabetes, and improve the quality of life for all persons (adults and children) who are obese or have diabetes.

GOAL 1A

Increase access to affordable, healthy food wherever food is sold or served.

OBJECTIVE #1: Increase availability and access to fruits, vegetables, and other nourishing foods in a variety of venues.

1. Expand the double-up produce incentive program, Fresh Bucks, offered for families on the Supplemental Nutrition Assistance Program.

2. Develop and expand a Produce Prescription (Rx) Program.

3. Increase the number of farmers markets authorized to use SNAP and redeeming SNAP.

4. Develop action plan for addressing census tracts with low income/low food access.

5. Expand community gardening and provide technical assistance and education about soil health.

6. Identify strategies to food initiatives to increase healthy food access.

7. Contribute needs assessment information and analysis for community level planning.

8. Explore funds for a dedicated staff person for the Indy Food Council.

OBJECTIVE #2: Increase the availability and access to fruits, vegetables, and other nourishing foods through nutrition standards and institutional policy strategies.

1. Incorporate extensive and creative nutrition "nudges" into food pantry environments to help guide pantry clients toward making healthier choices.

2. Expand the number of small stores and other retail outlets that have healthy food options that meet USDA Dietary Guidelines.

3. Advocate for healthy vending options in Marion County parks.

4. Work with food service management entities to increase nutritious foods offerings in public venues, worksites, congregate meals sites, and other sites where food is sold or served.

5. Expand the system of cooking education.

OBJECTIVE #3: Increase the percentage of women who initiate and sustain breast-feeding along with increasing supportive work environments for lactating mothers.

1. Facilitate access to existing breastfeeding resources.

2. Promote classes at 15 drop-in centers available at WIC clinics and healthcare settings.

OBJECTIVE #4: Strengthen the implementation of the IDOH school wellness provisions related to healthy eating best practices.

1. Provide education in schools re: healthy foods.

2. Assist community partners in developing resources and toolkits that equip the school community to respond to opportunities and threats to a healthy food environment.

3. Provide support for policy advocacy promoting healthy eating in school environments.

4. Promote comprehensive school wellness objectives that include but are not limited to employee wellness, modeling healthy behaviors, and the Whole School Whole Community Whole Child framework (see CDC/ASTD).

OBJECTIVE #5: Build awareness of the detrimental effects of sugar sweetened beverages have on health, particularly among children and vulnerable populations.

1. Create a brief white paper describing sugar sweetened beverage consumption data and an annotated bibliography of the health impact literature.

2. Create or sustain counter marketing efforts to reduce the consumption of sugar sweetened beverages.

OBJECTIVE #6: Build awareness about healthy food in all sectors (business, schools, faith communities, etc.) using a variety of current communications methods.

1. Develop a communications plan for the promotion of healthy food in the community.

2. Implement the communications plan.

GOAL 1B

Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.

OBJECTIVE #1: Expand walking, biking, and transit infrastructure in Marion County.

1. Work in priority areas (determined by high numbers of pedestrian crashes and other factors) to achieve improved walking conditions).

2. Update pedestrian crash analyses annually.

3. Promote walking, biking and transit use through programming, campaigns, shared-use agreements and/or other partner activities.

4. Provide thought leadership to elected officials, agency leaders, stakeholders and partners.

5. Offer technical assistance to neighborhoods and partner organizations.

6. Contribute to the development, adoption and implementation of active transportation plans and plan elements.

7. Advocate at the federal, state, regional and local levels for policies and funding that support active transportation.

8. Ensure plan, policy and project implementation at federal, state, regional and local levels.

OBJECTIVE #2: Encourage responsible land use by promoting affordable, inviting compact and mixed land uses that improve connectivity between destinations, neighborhoods, and communities.

1. Advocate for appropriate policies at the state, regional and local levels.

2. Contribute to the development, adoption and implementation of land use plans and plan elements.

3. Provide technical input on rezoning and variance petitions to City of Indianapolis Department of Metropolitan Development Current Planning Division and before the Metropolitan Development Commission.

4. Partner on place-based land use and active transportation initiatives.

OBJECTIVE #3: Increase physical activity opportunities and access.

1. Create a list of public assets available for physical activity and promote the use of those assets

2. Promote the utilization of the Indiana Department of Health's Small Business Toolkit and the MCPHD Heart Alive! Program among employers.

3. Assist local schools and community partners, such as parks, with the implementation of the shared use law

4. Promote MPCHD's Indy in Motion and Indy Silver Striders programs.

5. Continue the work of Health by Design's Walkways Program.

OBJECTIVE #4: Strengthen the implementation of the IDOH school wellness provisions related to physical activity best practices.

1. Encourage schools to offer more opportunities for physical activity including more physical activity in the classroom ("brain breaks").

2. Support school and community partners to increase safe and fun opportunities to walk and bike to school.

3. Strengthen standards-based physical education curriculum and professional development for physical education teachers.

4. Support the implementation of best practices for recess and active recess.

OBJECTIVE #5: Build awareness about the health benefits of walking, biking, and transit in all sectors (business, schools, faith communities, etc.) using a variety of current communications methods.

1. Develop a communications plan to promote the health benefits of physical activity in the community, to include the CDC's Active People, Healthy Nation physical activity campaign.

2. Implement the communications plan.

GOAL 1C

Foster a system of clinic- community linkages that supports obesity and diabetes prevention and control.

OBJECTIVE #1: Improve diagnosis and health care access and continuity of care for people with and at risk for diabetes.

1. Support the expansion of screening, testing, and referral for those at high risk for diabetes to evidence based programs for prevention and control of diabetes through participation in the State Diabetes Plan.

2. Provide extensive outreach to African Americans and Latinos to facilitate linkages to diabetes prevention and management programs, cooking classes, and other existing resources.

3. Provide diabetes self-management education and training programs.

OBJECTIVE #2: Increase accessibility to affordable health care, preventative services, insurance, medications, and tobacco cessation assistance as related to obesity and diabetes.

1. Increase access for all individuals through referrals from the clinical setting to community organizations.

2. Educate and connect individuals to evidence-based intervention programs using new information pathways between physicians and community organizations.

3. Advocate for an electronic health records (EHRs) program to incentivize and motivate clinicians and healthcare systems to identify patients who use tobacco and to provide them with evidence-based treatment.

4. MCPHD Covering Kids and Families navigators connect patients with or at risk for obesity and diabetes with health insurance and/or low-cost health services.

OBJECTIVE #3: Increase the number of environments that are smoke free.

1. Increase the number of comprehensive smoke free ordinances in Marion County's excluded cities (Speedway, Beech Grove, and Southport).

2. Encourage smoke free policies in multi-unit housing properties.

OBJECTIVE #4: Compile research on obesogens and identify potential public health responses.

1. Compile research on obesogens and identify potential public health responses.

GOAL 2

Improve mental health outcomes and access to mental health care in Marion County.

OBJECTIVE #1: Form a Marion County coordinating council for mental health care.

1. Form a Marion County coordinating council for mental health care.

OBJECTIVE #2: Develop a mental health data profile for Marion County.

1. Explore available data sources.

2. Prepare profile.

OBJECTIVE #3: Expand mental health screenings and referrals for treatment for the general population and for children.

1. Increase mental health screening in primary care settings.

2. Promote the use of an evidence-based suicide assessment in EMRs in all health care systems.

3. Continue work in IPS and encourage all school systems, schools, and universities to provide screening for mental health and referrals for care.

4. Advocate for additional funding for school mental health services.

5. Strengthen appropriate mental health responses by public safety and emergency preparedness institutions.

6. Advocate for training on suicide prevention, psychological first aid, and ACES.

7. Encourage mental health screening and services for persons coming out of incarceration.

8. Advocate for the provision of mental health and substance use disorder screening and services for pre-and-post-natal mothers by maternal health providers and pediatricians.

OBJECTIVE #4: Address shame-based stigma as an impediment to accessing mental health and substance abuse treatment.

1. Participate in upcoming stigma campaigns.

2. Incorporate anti-stigma materials into relevant services.

OBJECTIVE #5: Expand the number of mental health providers, the number of culturally and linguistically competent mental health providers and health translators, and providers and resources for integrated case management.

1. Inventory current available mental health provider, culturally and linguistically competent provider, and health translator resources in Marion County and identify current barriers to provider licensure.

2. Convene a conversation among relevant stakeholders about expanding the number of mental health providers, the number of culturally and linguistically competent mental health providers and health translators.

3. Support mental health policy initiatives to remove licensure, reimbursement, and other impediments to deploying community health workers and peer recovery coaches.

OBJECTIVE #6: Strengthen access to recovery supports such employment, housing, etc.

1. Convene a conversation among relevant stakeholders about collaborative ways to ensure and improve access to recovery supports.

PRIORITY AREA
POVERTY

GOAL 3

Raise awareness about poverty and other social determinants of health and their influence on quality of life and morbidity with the intent of decreasing the poverty burden in Marion County.

OBJECTIVE #1: Enhance MCPHD partnerships and the inclusion of public health elements in community efforts to address poverty.

1. Participate in partner efforts.

2. Create an inventory of MCPHD partnerships and participating staff and develop internal protocols for maintaining participation and for sharing information about partners efforts within MCPHD.

OBJECTIVE #2: Build awareness with local audiences about the role of poverty and other social determinants of health in community health status; policy, systems, and environmental (PSE) change; and Health in All Policies.

1. Build awareness with local audiences about the role of poverty and other social determinants of health in community health status; policy, systems, and environmental (PSE) change; and Health in All Policies.
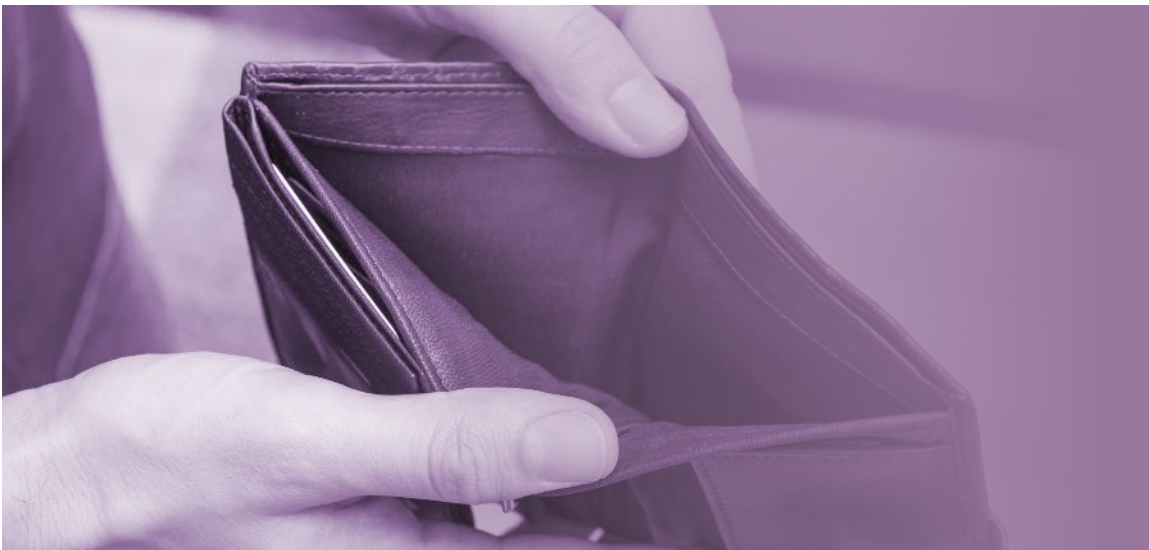
— *GOAL 4* —

Achieve health equity by eliminating disparities and providing opportunities for every person to achieve their highest level of health

OBJECTIVE #1: Provide regular health equity data.

1. Provide regular health equity data.

2. Disseminate the MCPHD Epidemiology Health Equity data report.

3. Update the MCPHD Epidemiology Health Equity data report by 2023.

OBJECTIVE #2: Create and implement a health equity strategy for Marion County.

1. Create a health equity strategy for Marion County.

2. Convene community conversations and educational opportunities around health equity.

3. Encourage the adoption of Health in All Policies across agencies and governments in Marion County to ensure that services have a health equity lens.

4. Make basic health equity training a requirement for all MCPHD staff.

OBJECTIVE #3: Enhance MCPHD partnerships and the inclusion of public health elements in community efforts to address health equity.

1. Participate in partner efforts.

2. Create an inventory of MCPHD partnerships and participating staff and develop internal protocols for maintaining participation and for sharing information about partners efforts within MCPHD.
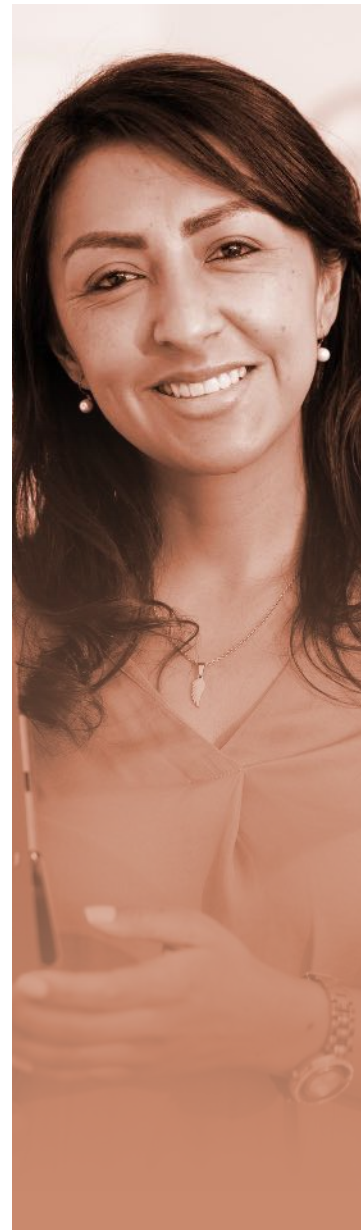
RELATIONSHIP BETWEEN THE CHIP AND OTHER INITIATIVES

The table in Appendix D is a non-exhaustive list of other plans in Marion County that contain objectives that relate to or will inform further planning and implementation strategies in the 2019 Marion County Community Health Improvement Plan. Those plans with an asterisk (*) have representation from the Marion County Public Health Department staff in their planning and implementation activities.

The table in Appendix E is a list of community plans that contain objectives and/or activities that relate to one or more of the 2018 Marion County Community Health Assessment priorities — obesity/diabetes, mental health, poverty, and health equity. A link to each plan is also provided.

SUSTAINABILITY AND REPORTING

The continuing CHIP process will ensure successful implementation and coordination of activities and resources among key partners. The CHIP Strategy Committee will continue to provide executive oversight for the Plan's progress. The Strategy Committee will expand membership to match the scope of the four priority areas and meet at regular intervals determined by the committee. Periodic community listening sessions will be held to share progress and engage residents in implementation and solicit feedback to strengthen the CHIP. New and creative ways to feasibly engage all interested parties will be explored at the aforementioned engagement opportunities.

MOVING FORWARD

MCPHD will take the lead on providing a tracking report of actions taken in implementing the Community Health Improvement Plan. The report will include an evaluation of the strategies outlined and any revisions that were needed to the Plan.

FOR ADDITIONAL INFORMATION

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APPENDIX A

Marion County Community Health Improvement Plan
Version: December 27, 2019

Master Goal: Improve the health and well-being of Marion County residents by addressing three focus areas—obesity/diabetes, mental health, and poverty—and by:
1. Aligning institutional priorities and resources
2. Engaging in strategic partnerships
3. Promoting a culture of health
4. Addressing health inequities and social determinants of health
5. Educating and communicating on priorities
6. Recommending and advocating for policy, systems, and environmental (PSE) changes
7. Empowering community members and organizations and ensuring that community members have meaningful decision-making roles in community health improvement efforts

PRIORITY AREA: **Obesity and Diabetes**
GOAL 1: Reduce the disease burden of obesity and diabetes, and improve the quality of life for all persons (adults and children) who are obese or have diabetes.
Outcome Indicators:
Indicator 1: Decreased rate of obesity among adults measured (2023 CHA)
Indicator 2: Decreased rate of diabetes among adults measured (2028 CHA)
Indicator 3: Decreased rate of obesity among children measured (2023 CHA)
Indicator 4: Decreased rate of diabetes among children measured (2028 CHA)

PRIORITY AREA: **Obesity and Diabetes**

GOAL 1A: Increase access to affordable, healthy food wherever food is sold or served.

Outcome Indicators:
Indicator 1: Reduced adult food insecurity rate (Feeding America; may require calculation locally 2023 CHA)
Indicator 2: Reduced child food insecurity rate (Feeding America; may require calculation locally 2023 CHA)
Indicator 3: Increased percentage of people who eat the recommended number of dark green vegetables measured (2023 CHA)
Indicator 3: Increased percentage of people who eat the recommended number of orange vegetables measured (2023 CHA)
Indicator 3: Increased percentage of people who eat the recommended number of fruits measured (2023 CHA)

OBJECTIVE #1: Increase availability and access to fruits, vegetables, and other nourishing foods in a variety of venues

ACTION PLAN

Action Steps	Indicators	Lead Organization	Partner Organizations	Notes
1. Expand the double-up produce incentive program, Fresh Bucks, offered for families on the Supplemental Nutrition Assistance Program.	Indicator: Increased participation in Fresh Bucks program.	MCPHD Chronic Disease	Community Health Network Eskenazi Health Growing Places Indy	
2. Develop and expand a Produce Prescription (Rx) Program.	Indicator: Increased use of Produce Prescription (Rx) program.	MCPHD Chronic Disease	Community Health Network Eskenazi Health	
3. Increase the number of farmers markets authorized to use SNAP and redeeming SNAP.	Indicator 1: Increased number of farmers markets authorized to use SNAP. Indicator 2: increased number of farmers markets redeeming SNAP. Indicator 3: Increased utilization of farmers markets by SNAP consumers.	MCPHD Chronic Disease	Jump IN for Healthy Kids	
4. Develop action plan for addressing census tracts with low income/low food access.	Indicator: Action plan developed.	MCPHD Epidemiology MCPHD Chronic Disease	Top 10 Coalition Ad Hoc Data Group	

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Action Steps	Indicators	Lead Organization	Partner Organizations	Notes
5. Expand community gardening and provide technical assistance and education about soil health.	Indicator 1: Increased number of community gardens. Indicator 2: Document soil health technical assistance activities.	MCPHD Lab Purdue Extension	MCPHD Chronic Disease City of Indianapolis Office of Sustainability	
6. Identify strategies to food initiatives to increase healthy food access.	Indicator: Increased number of delivery recipients receiving healthy foods.	City of Indianapolis Department of Public Health and Safety	MCPHD Chronic Disease City of Indianapolis Office of Sustainability Indy Hunger Network Jump IN for Healthy Kids	
7. Contribute needs assessment information and analysis for community level planning.	Indicator: Document distribution of needs assessment data.	MCPHD Epidemiology		
8. Explore funds for a dedicated staff person for the Indy Food Council.	Indicator: Document amount of funding and creation of position.	City of Indianapolis Department of Public Health and Safety	MCPHD Indianapolis Food Council	

PRIORITY AREA: **Obesity and Diabetes**
GOAL 1A: Increase access to affordable, healthy food wherever food is sold or served.
Outcome Indicators:
Indicator 1: Reduced adult food insecurity rate (Feeding America; may require calculation locally 2023 CHA)
Indicator 2: Reduced child food insecurity rate (Feeding America; may require calculation locally 2023 CHA)
Indicator 3: Increased percentage of people who eat the recommended number of dark green vegetables measured (2023 CHA)
Indicator 3: Increased percentage of people who eat the recommended number of orange vegetables measured (2023 CHA)
Indicator 3: Increased percentage of people who eat the recommended number of fruits measured (2023 CHA)
OBJECTIVE #2: Increase the availability and access to fruits, vegetables, and other nourishing foods through nutrition standards and institutional policy strategies
ACTION PLAN

Action Steps	Indicators	Lead Organization	Partner Organizations	Notes
1. Incorporate extensive and creative nutrition "nudges" into food pantry environments to help guide pantry clients toward making healthier choices.	Indicator: Document nutrition nudges used.	MCPHD Chronic Disease	Community Health Network Eskenazi Health Gleaners Food Bank Indy Hunger Network	
2. Expand the number of small stores and other retail outlets that have healthy food options that meet USDA Dietary Guidelines.	Indicator: Increased number of stores and retail outlets that have healthy food options that meet USDA Dietary Guidelines.	MCPHD Chronic Disease	LISC Jump IN City of Indianapolis Office of Public Health and Safety	
3. Advocate for healthy vending options in Marion County parks.	Indicator: Increased number of locations with healthy vending options.	MCPHD Chronic Disease	Jump IN for Healthy Kids	
4. Work with food service management entities to increase nutritious foods offerings in public venues, worksites, congregate meals sites, and other sites where food is sold or served.	Indicator: Increased number of nutritious foods in public venues, worksites, congregate meals sites, and other sites where food is sold or served.	MCPHD Chronic Disease	Community Health Network U.S. Department of Defense Finance Center Purdue Extension	This action step includes the MCPHD Sodium Reduction in Communities and REACH programs.
5. Expand the system of cooking education.	Indicator: Increased number of cooking classes.	Indy Hunger Network	MCPHD Chronic Disease	

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PRIORITY AREA: **Obesity and Diabetes**

GOAL 1A: Increase access to affordable, healthy food wherever food is sold or served.

OBJECTIVE #3: Increase the percentage of women who initiate and sustain breastfeeding along with increasing supportive work environments for lactating mothers.

Outcome Indicators:
Indicator 1: Increased percentage of women initiating breastfeeding (Marion County Birth Records)
Indicator 2: WIC participants who initiate breastfeeding (Marion County WIC)
Indicator 3. WIC participants who sustain breastfeeding (Marion County WIC)
Indicator 4: Increased number of employers with supportive work environments for lactating mothers (developmental; REACH data available)

ACTION PLAN

Activity	Indicators	Lead Organization	Partner Organizations	Notes
1. Facilitate access to existing breastfeeding resources.	Indicator: Increased implementation of workplace lactation programs.	MCPHD Maternal and Child Health	MCPHD Chronic Disease Breastfeeding coalitions	
2. Promote classes at 15 drop-in centers available at WIC clinics and healthcare settings.	Indicator: Document class attendance.	MCPHD Maternal and Child Health	MCPHD Chronic Disease Breastfeeding coalitions	

PRIORITY AREA: **Obesity and Diabetes**

GOAL 1A: Increase access to affordable, healthy food wherever food is sold or served.

OBJECTIVE #4: Strengthen the implementation of the ISDH school wellness provisions related to healthy eating best practices.

Outcome Indicators:

Indicator 1: Annual number of unique school buildings completing a healthy eating improvement project (developmental; Jump IN for Healthy Kids and partner organizations)

Indicator 2: Annual number of first-time school buildings completing a healthy eating improvement project (developmental; Jump IN for Healthy Kids and partner organizations)

Indicator 3: Cumulative number of unique school buildings that have completed at least one healthy eating improvement project since 2019 (developmental; Jump IN for Healthy Kids and partner organizations)

ACTION PLAN

Activity	Indicators	Lead Organization	Partner Organizations	Notes
1. Provide education in schools re: healthy foods.	Indicator: Document healthy food meetings in schools.	Jump IN for Healthy Kids	Schools MCPHD Chronic Disease	
2. Assist community partners in developing resources and toolkits that equip the school community to respond to opportunities and threats to a healthy food environment.	Indicator: Document resources and toolkits developed.	Jump IN for Healthy Kids	MCPHD Health Education, Promotion, and Training	
3. Provide support for policy advocacy promoting healthy eating in school environments.	Indicator: Document policy support meetings in schools.	Jump IN for Healthy Kids	MCPHD Health Education, Promotion, and Training	
4. Promote comprehensive school wellness objectives that include but are not limited to employee wellness, modeling healthy behaviors, and the Whole School Whole Community Whole Child framework (see CDC/ASTD).	Indicator: Document meetings about school wellness objectives.	Jump IN for Healthy Kids	MCPHD Health Education, Promotion, and Training	

PRIORITY AREA: **Obesity and Diabetes**				
GOAL 1A: Increase access to affordable, healthy food wherever food is sold or served.				
OBJECTIVE #5: Build awareness of the detrimental effects of sugar sweetened beverages have on health, particularly among children and vulnerable populations.				
Outcome Indicators: Indicator 1: Decreased proportion of Marion County residents who consume sugar sweetened beverages, for all residents and vulnerable populations (2023 CHA) Indicator 2: Decreased number of sugar sweetened beverages per day among Marion County residents, for all residents and vulnerable populations (2023 CHA)				
ACTION PLAN				
Activity	**Indicators**	**Lead Organization**	**Partner Organizations**	**Notes**
1. Create a brief white paper describing sugar sweetened beverage consumption data and an annotated bibliography of the health impact literature.	Indicator: White paper created by 2020.	MCPHD Chronic Disease MCPHD Epidemiology		
2. Create or sustain counter marketing efforts to reduce the consumption of sugar sweetened beverages.	Indicator: Marketing strategies created by end of 2020.	MCPHD Chronic Disease	Top 10 Coalition Jump IN for Healthy Kids Appropriate professional associations Child health stakeholders	

PRIORITY AREA: **Obesity and Diabetes**

GOAL 1A: Increase access to affordable, healthy food wherever food is sold or served.

OBJECTIVE #6: Build awareness about healthy food in all sectors (business, schools, faith communities, etc.) using a variety of current communications methods.

Outcome Indicators:
Indicator 1: Increased number of places with healthy nutrition standards (REACH)
Indicator 2: Increased number of people impacted by healthy nutrition standards (REACH)

ACTION PLAN

Activity	Indicators	Lead Organization	Partner Organizations	Notes
1. Develop a communications plan for the promotion of healthy food in the community.	Indicator: Communications plan developed by 2021.	MCPHD Chronic Disease	Top 10 Coalition MCPHD Public Relations	Herron School of Art may be a good partner.
2. Implement the communications plan.	Indicator: Communications plan implemented 2021.	MCPHD Chronic Disease Top 10 Coalition	MCPHD Public Relations	

PRIORITY AREA: **Obesity and Diabetes**
GOAL 1: Reduce the disease burden of obesity and diabetes for adults and children, and improve the quality of life for all persons who are obese or have diabetes.
GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.
Outcome Indicators:
Indicator 1: Increase the proportion of Marion County residents who reported having access to sidewalks (2023 CHA) Indicator 2: Increased miles of sidewalks (DPW 2023) Indicator 3: Proportion of intersections with pedestrian signals (DPW 2023) Indicator 4: Decreased number of pedestrian crashes and fatalities (ARIES, Indianapolis Emergency Medical Services (I-EMS), Marion County Vital Records) Indicator 5: Increased miles of bike facilities (DPW 2023) Indicator 6: Increase average Neighborhood Walk Score (Walk Score) Indicator 7: Increased proportion of Marion County residents who have safe and convenient access to a park, greenway, or playground (2023 CHA) Indicator 8: Increase the proportion of Marion County residents who reported feeling safe in their neighborhood (2023 CHA)
OBJECTIVE #1: Expand walking, biking, and transit infrastructure in Marion County.
Outcome Indicators:
Indicator 1: Increased miles of sidewalks (DPW 2023) Indicator 2: Proportion of intersections with pedestrian signals (DPW 2023) Indicator 3: Decreased number of pedestrian crashes and fatalities (ARIES, I-EMS, Marion County Vital Records) Indicator 4: Increased miles of bike facilities (DPW 2023) Indicator 5: Increase transit ridership (IndyGo 2023)
ACTION PLAN

Action Steps	Indicators	Lead Organization	Partner Organizations	Notes
1. Work in priority areas (determined by high numbers of pedestrian crashes and other factors) to achieve improved walking conditions.	Indicator 1: Decreased number of pedestrian crashes and fatalities in targeted neighborhoods. Indicator 2: Increased miles of sidewalks in target neighborhoods (DPW 2023). Indicator 3: Proportion of intersections in target neighborhoods with pedestrian signals (DPW 2023).	Health by Design	MCPHD Chronic Disease	

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Action Steps	Indicators	Lead Organization	Partner Organizations	Notes
2. Update pedestrian crash analyses annually.	Indicator: Pedestrian crash analyses updated each year.	Health by Design	MCPHD Chronic Disease MCPHD Healthy Communities	
3. Promote walking, biking and transit use through programming, campaigns, shared-use agreements and/or other partner activities.	Indicator 1: Document campaigns, and other partner activities. Indicator 2: Document thought leadership activities.	MCPHD Chronic Disease	Top 10 Coalition Hoosier Environmental Council Health by Design	
4. Provide thought leadership to elected officials, agency leaders, stakeholders and partners.				
5. Offer technical assistance to neighborhoods and partner organizations.	Indicator: Document activities with neighborhood and partner organizations.	MCPHD Healthy Communities	Health by Design	
6. Contribute to the development, adoption and implementation of active transportation plans and plan elements.	Indicator 1: Document the number of plans and plan elements developed. Indicator 2: Document the number of active transportation plans and plan elements adopted. Indicator 3: Document the number of implementation activities.	MCPHD Healthy Communities	Health by Design	
7. Advocate at the federal, state, regional and local levels for policies and funding that support active transportation.	Indicator 1: Document the number of policies adopted. Indicator 2: Document funding secured.	Health by Design	Health and Hospital Corporation of Marion County Hoosier Environmental Council MCPHD Healthy Communities	
8. Ensure plan, policy and project implementation at federal, state, regional and local levels.	Indicator 1: Document participation in implementation at these levels. Indicator 2: Document active transportation improvements secured.	Health by Design	Health and Hospital Corporation of Marion County MCPHD Healthy Communities Top 10 Coalition	

PRIORITY AREA: **Obesity and Diabetes**				
GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.				
OBJECTIVE #2: Encourage responsible land use by promoting affordable, inviting compact and mixed land uses that improve connectivity between destinations, neighborhoods, and communities.				
Outcome Indicators: Indicator 1: Number of new mixed use developments (DMD) Indicator 2: Number of new mixed use developments within half mile of a current or proposed BRT stations (DMD)				
ACTION PLAN				
Activity	**Indicators**	**Lead Organization**	**Partner Organizations**	**Notes**
1. Advocate for appropriate policies at the state, regional and local levels.	Indicator 1: Document policy activities. Indicator 2: Document policies adopted.	Health by Design	Health and Hospital Corporation of Marion County Hoosier Environmental Council MCPHD Healthy Communities	
2. Contribute to the development, adoption and implementation of land use plans and plan elements.	Indicator: Document participation and outcomes.	MCPHD Healthy Communities	Health by Design	
3. Provide technical input on rezoning and variance petitions to City of Indianapolis Department of Metropolitan Development Current Planning Division and before the Metropolitan Development Commission.	Indicator 1: Document participation with Metropolitan Development Commission. Indicator 2: Document adoption of recommendations.	MCPHD Healthy Communities	Health by Design	
4. Partner on place-based land use and active transportation initiatives.	Indicator 1: Document participation and outcomes related to place-based land use. Indicator 2: Document participation and outcomes for active transportation initiatives.	MCPHD Healthy Communities	Health by Design	

PRIORITY AREA: **Obesity and Diabetes**

GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.

OBJECTIVE #3: Increase physical activity opportunities and access.

Outcome Indicators:

Indicator1 : Increased proportion of adults who achieve adequate amounts of physical activity, per WHO standards (2023 CHA)

Indicator 2: Increased in mode split for walking, biking, and transit (2023 CHA, split based on predominant mode indicated by respondents; ACS)

ACTION PLAN

Activity	Indicators	Lead Organization	Partner Organizations	Notes
1. Create a list of public assets available for physical activity and promote the use of those assets.	Indicator 1: Create list of places for physical activity. Indicator 2: Track promotion activities.	MCPHD Chronic Disease	MCPHD Chronic Disease MCPHD Health Education, Promotion, and Training Indy Parks Top 10 Coalition	
2. Promote the utilization of the Indiana State Department of Health's Small Business Toolkit and the MCPHD Heart Alive! Program among employers.	Indicator 1: Document meetings with employers. Indicator 2: Document businesses that adopt the program.	MCPHD Chronic Disease	Top 10 Coalition LISC Indy Chamber	
3. Assist local schools and community partners, such as parks, with the implementation of the shared use law.	Indicator: Increased number of shared use agreements.	Top 10 Coalition	MCPHD Health Education, Promotion, and Training	
4. Promote MPCHD's Indy in Motion and Indy Silver Striders programs.	Indicator: Document program participation.	MCPHD Health Education, Promotion, and Training		
5. Continue the work of Health by Design's Walkways Program.		Health by Design	MCPHD Chronic Disease	

PRIORITY AREA: **Obesity and Diabetes**

GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.

OBJECTIVE #4: Strengthen the implementation of the ISDH school wellness provisions related to physical activity best practices.

Outcome Indicators:
Indicator: Increased proportion of children who achieve adequate amounts of physical activity, per WHO standards (2023 CHA)

ACTION PLAN

Activity	Indicators	Lead Organization	Partner Organizations	Notes
1. Encourage schools to offer more opportunities for physical activity including more physical activity in the classroom ("brain breaks").	Indicator: Document meetings with Marion County schools.	Jump IN for Healthy Kids	MCPHD Chronic Disease YMCA Youth Development	
2. Support school and community partners to increase safe and fun opportunities to walk and bike to school.	Indicator 1: Increase the number of schools adopting walking and biking to school. Indicator 2: Increase the number of students walking and biking to school.	Health by Design	MCPHD Healthy Communities Jump IN for Healthy kids	
3. Strengthen standards-based physical education curriculum and professional development for physical education teachers.	Indicator 1: Document school districts/schools that update curriculum. Indicator 2: Document school districts/schools that provide specialized professional development.	Indiana Society for Health and Physical Educators (INSHAPE)	MCPHD Health Education, Promotion, and Training Jump IN for Healthy Kids	
4. Support the implementation of best practices for recess and active recess.	Indicator: Document schools that adopt best practices.	Jump IN for Healthy Kids	MCPHD Health Education, Promotion, and Training	

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PRIORITY AREA: **Obesity and Diabetes**

GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.

OBJECTIVE #5: Build awareness about the health benefits of walking, biking, and transit in all sectors (business, schools, faith communities, etc.) using a variety of current communications methods.

Outcome Indicators:
Indicator: Increased use of transportation methods other than driving (2023 CHA; ACS)

ACTION PLAN

Activity	Indicators	Lead Organization	Partner Organizations	Notes
1. Develop a communications plan to promote the health benefits of physical activity in the community, to include the CDC's Active People, Healthy Nation physical activity campaign.	Indicator: Communications plan developed by 2021.	MCPHD Chronic Disease	Top 10 Coalition MCPHD Public Relations	
2. Implement the communications plan.	Indicator: Communications plan implemented by 2021.	MCPHD Chronic Disease	Top 10 Coalition	

PRIORITY AREA: **Obesity and Diabetes**
GOAL 1: Reduce the disease burden of obesity and diabetes for adults and children, and improve the quality of life for all persons who are obese or have diabetes.
GOAL 1C: Foster a system of clinic- community linkages that supports obesity and diabetes prevention and control.
Outcome Indicators: Indicator 1: Increased number of people receiving care for diabetes (Indiana Network for Patient Care (INPC) Indicator 2: Increased number of screenings for diabetes (INPC)
OBJECTIVE #1: Improve diagnosis and health care access and continuity of care for people with and at risk for diabetes.
Outcome Indicators: Indicator 1: Increased proportion of persons diagnosed with diabetes (Diabetes Impact Project (DIP IN) Indicator 2: Increased proportion of persons diagnosed with pre-diabetes (DIP IN) Indicator 3: Increased number of people enrolled in diabetes prevention programs (2023 CHA) Indicator 4: Increased number of African Americans enrolled in diabetes prevention programs (2023 CHA) Indicator 5: Increased number of Latinos enrolled in diabetes prevention programs (2023 CHA) Indicator 6: Increased number of patients in diabetes and self-management education and training programs (American Association of Diabetes Educators; developmental)
ACTION PLAN

Action Steps	Indicators	Lead Organization	Partner Organizations	Notes
1. Support the expansion of screening, testing, and referral for those at high risk for diabetes to evidence based programs for prevention and control of diabetes through participation in the State Diabetes Plan.	Indicator: Document meetings with partners.	MCPHD Epidemiology (tracking) MCPHD Office of the Public Health Director (Docs4Docs system communications)	Service Providers: Community Health Network Eskenazi Health YMCA Diabetes Prevention Program MCPHD Chronic Disease Top 10 Coalition Fairbanks School of Public Health National Kidney Foundation Lions Project	The State Diabetes Plan is expected to be released after this plan. Once available this plan should be incorporated in the activities under this goal.

Action Steps	Indicators	Lead Organization	Partner Organizations	Notes
2. Provide extensive outreach to African Americans and Latinos to facilitate linkages to diabetes prevention and management programs, cooking classes, and other existing resources.	Indicator 1: Increased diabetes prevention and management program referrals for African Americans. Indicator 2: Increased diabetes prevention and management program referrals for Latinos.	MCPHD Chronic Disease	Top 10 Coalition Fairbanks School of Public Health Diabetes Prevention Programs, including the YMCA and Indiana Minority Health Coalition Indiana Latino Institute Latino Health Organization Minority Health Coalition of Marion County	
3. Provide diabetes self-management education and training programs.	Indicator: Increased number of patients in diabetes and self-management education and training programs (American Association of Diabetes Educators; developmental).	MCPHD Chronic Disease MCPHD ABC's of Diabetes Top 10 Coalition Diabetes Self-Management Education Program	Service Providers: Health systems Eskenazi Health Board of the American Association of Diabetes Educators (AADE) Fairbanks School of Public Health	
4. Support diabetes prevention programs.	Indicator: Document activities with diabetes prevention program partners.	YMCA	MCPHD Chronic Disease Fairbanks School of Public Health Eskenazi Health IU Health Community Health Network Indiana Minority Health Coalition	

PRIORITY AREA: **Obesity and Diabetes**				
GOAL 1C: Foster a system of clinic- community linkages that supports obesity and diabetes prevention and control.				
OBJECTIVE #2: Increase accessibility to affordable health care, preventative services, insurance, medications, and tobacco cessation assistance as related to obesity and diabetes.				
Outcome Indicators:				
Indicator: Increased proportion of people who reported seeing a doctor in the past 12 months by income level (2023 CHA)				
ACTION PLAN				
Action Steps	**Indicators**	**Lead Organization**	**Partner Organizations**	**Notes**
1. Increase access for all individuals through referrals from the clinical setting to community organizations.	Indicator: Increased number of clinical referrals to community resources.	Top 10 Clinic-Community Linkages Work Team	MCPHD Chronic Disease	
2. Educate and connect individuals to evidence-based intervention programs using new information pathways between physicians and community organizations.	Indicator: Develop at least one new information pathways between physicians and community organizations.	Top 10 Clinic-Community Linkages Work Team	MCPHD Chronic Disease	
3. Advocate for an electronic health records *(EHRs)* program to incentivize and motivate clinicians and healthcare systems to identify patients who use tobacco and to provide them with evidence-based treatment.	Indicator: Increased number of referrals to evidence based treatment (DIP IN).	Smoke Free Indy	MCPHD Chronic Disease Top 10 Clinic-Community Linkages Work Team Fairbanks School of Public Health	
4. MCPHD Covering Kids and Families navigators connect patients with or at risk for obesity and diabetes with health insurance and/or low-cost health services.	Indicator: Increased number of referrals for patients with or at risk for obesity and diabetes with health insurance and/or low-cost health services from Covering Kids and Families.	Health and Hospital Corporation of Marion County Covering Kids and Families		

PRIORITY AREA: **Obesity and Diabetes**				
GOAL 1C: Foster a system of clinic- community linkages that supports obesity and diabetes prevention and control.				
OBJECTIVE #3: Increase the number of environments that are smoke free.				
Outcome Indicators: Indicator: Increased number of environments that are smoke-free (Chronic Disease's MUFH Survey)				
ACTION PLAN				
Action Steps	**Indicators**	**Lead Organization**	**Partner Organizations**	**Notes**
1. Increase the number of comprehensive smoke free ordinances in Marion County's excluded cities (Speedway, Beech Grove, and Southport).	Indicator: Increased number of comprehensive smoke free ordinances in Marion County (Chronic Disease's MUFH Survey).	Smoke Free Indy	MCPHD Chronic Disease Top 10 Coalition Tobacco Prevention and Cessation Work Team	
2. Encourage smoke free policies in multi-unit housing properties.	Indicator: Increased implementation of smoke free policies in multi-unit housing properties by at least one.	Smoke Free Indy	MCPHD Chronic Disease Top 10 Coalition Tobacco Prevention and Cessation Work Team	

PRIORITY AREA: **Obesity and Diabetes**				
GOAL 1C: Foster a system of clinic- community linkages that supports obesity and diabetes prevention and control.				
OBJECTIVE #4: Compile research on obesogens and identify potential public health responses.				
ACTION PLAN				
Action Steps	**Indicators**	**Lead Organization**	**Partner Organizations**	**Notes**
1. Compile research on obesogens and identify potential public health responses.	Indicator 1: Create list of research by 2020. Indicator 2: Create list of potential public health responses by 2020.	Hoosier Environmental Council	Improving Kids Environment MCPHD Epidemiology	Research compilation complete.

PRIORITY AREA: **Mental Health**				
GOAL 2: Improve mental health outcomes and access to mental health care in Marion County.				
Outcome Indicators:				
Indicator: Decreased proportion of Marion County population with ten or more mentally unhealthy days in the past 30 days (2023 CHA)				
OBJECTIVE #1: Form a Marion County coordinating council for mental health care.				
ACTION PLAN				
Action Steps	**Indicators**	**Lead Organization**	**Partner Organizations**	**Notes**
1. Form a Marion County coordinating council for mental health care.	Indicator: Form the Marion County coordinating council for mental health care.	Mental Health America of Indiana Mental Health America of Indianapolis	MCPHD Social Work	

PRIORITY AREA: **Mental Health**				
GOAL 2: Improve mental health outcomes and access to mental health care in Marion County.				
OBJECTIVE #2: Develop a mental health data profile for Marion County.				
ACTION PLAN				
Action Steps	**Indicators**	**Lead Organization**	**Partner Organizations**	**Notes**
1. Explore available data sources.	Indicator: Build a mental health data inventory.	Mental Health America of Indiana Mental Health America of Indianapolis MCPHD Epidemiology	Indiana FSSA Division of Mental Health and Addiction MCPHD Vital Records Indiana State Department of Health Epidemiology, Violent Death Registry, Child Fatalities	
2. Prepare profile.	Indicator: Prepare a Marion County mental health profile by August 2022.	Mental Health America of Indiana Mental Health America of Indianapolis MCPHD Epidemiology	Indy Recovery Council Indiana FSSA Division of Mental Health and Addiction	

PRIORITY AREA: **Mental Health**				
GOAL 2: Improve mental health outcomes and access to mental health care in Marion County.				
OBJECTIVE #3: Expand mental health screenings and referrals for treatment for the general population and for children.				
ACTION PLAN				
Action Steps	**Indicators**	**Lead Organization**	**Partner Organizations**	**Notes**
1. Increase mental health screening in primary care settings.	Indicator: Increase the reporting of PHQ9 questionnaire and the total score of all at risk patients in the primary care settings.	Mental Health America of Indiana Mental Health America of Indianapolis	Indiana Primary Health Care Association (IPHCA) Community Mental Health Centers (CMHCs)	
2. Promote the use of an evidence-based suicide assessment in EMRs in all health care systems.	Indicator: Track adoption and use of suicide assessment tools.	Mental Health America of Indiana Mental Health America of Indianapolis		
3. Continue work in IPS and encourage all school systems, schools, and universities to provide screening for mental health and referrals for care.	Indicator: Increase the number of schools and universities in Marion County which provide screening for mental health and referrals to care.	Mental Health America of Indiana Mental Health America of Indianapolis		
4. Advocate for additional funding for school mental health services.	Indicator: Document funding secured.	Mental Health America of Indiana Mental Health America of Indianapolis		
5. Strengthen appropriate mental health responses by public safety and emergency preparedness institutions.	Indicator: Increase the number of mental health related visits in Marion County where the residents/ patients are being referred by EMS, police or other public safety institutions.	Mental Health America of Indiana Mental Health America of Indianapolis		
6. Advocate for training on suicide prevention, psychological first aid, and ACES.	Indicator: Document training activities.	Mental Health America of Indiana Mental Health America of Indianapolis	CMHC Reentry Coalition	

Action Steps	Indicators	Lead Organization	Partner Organizations	Notes
7. Encourage mental health screening and services for persons coming out of incarceration.	Indicator: Increase the number of mental health related visits for patients who were just released from prison.	Mental Health America of Indiana Mental Health America of Indianapolis	Recovery Works Indiana FSSA Division of Mental Health and Addiction	
8. Advocate for the provision of mental health and substance use disorder screening and services for pre-and-post-natal mothers by maternal health providers and pediatricians.	Indicator: Document number of providers who adopt screening.	Mental Health America of Indiana Mental Health America of Indianapolis Indiana Organization on Fetal Alcohol Syndrome (INOFAS)		

PRIORITY AREA: Mental Health
GOAL 2: Improve mental health outcomes and access to mental health care in Marion County.
OBJECTIVE #4: Address shame-based stigma as an impediment to accessing mental health and substance abuse treatment.
Outcome Indicators: Indicator: Measure campaign outcomes
ACTION PLAN

Action Steps	Indicators	Lead Organization	Partner Organizations	Notes
1. Participate in upcoming stigma campaigns.	Indicator: Document activities.	Indiana Recovery Council	MCPHD Social Work	
2. Incorporate anti-stigma materials into relevant services.	Indicator: Materials incorporated into relevant services by 2023.	MCPHD Social Work		

PRIORITY AREA: **Mental Health**

GOAL 2: Improve mental health outcomes and access to mental health care in Marion County.

OBJECTIVE #5: Expand the number of mental health providers, the number of culturally and linguistically competent mental health providers and health translators, and providers and resources for integrated case management.

Outcome Indicators:
Indicator 1: Increases number of mental health providers
Indicator 2: Increased number of culturally and linguistically competent mental health providers
Indicator 3: Increased number of health translators
Indicator 4: Increased number of community health workers and peer recovery coaches

ACTION PLAN

Action Steps	Indicators	Lead Organization	Partner Organizations	Notes
1. Inventory current available mental health provider, culturally and linguistically competent provider, and health translator resources in Marion County and identify current barriers to provider licensure.	Indicator: Document completion of the inventory of current available resources and research on current barriers to licensure.	Mental Health America of Indiana	Indiana FSSA Division of Mental Health and Addiction US Department of Health and Human Services Substance Abuse and Mental Health Services Administration MCPHD Social Work	
2. Convene a conversation among relevant stakeholders about expanding the number of mental health providers, the number of culturally and linguistically competent mental health providers and health translators.	Indicator: Document discussions and resulting activities.	Mental Health America of Indiana	MCPHD Public Health Practice Indiana FSSA Division of Mental Health and Addiction Universities with relevant programs within Marion County	
3. Support mental health policy initiatives to remove licensure, reimbursement, and other impediments to deploying community health workers and peer recovery coaches.	Indicator: Document policies proposed and adopted.	Mental Health America of Indiana	Health and Hospital Corporation of Marion County	

| PRIORITY AREA: **Mental Health**				
GOAL 2: Improve mental health outcomes and access to mental health care in Marion County.				
OBJECTIVE #6: Strengthen access to recovery supports such employment, housing, etc.				
ACTION PLAN				
Action Steps	**Indicators**	**Lead Organization**	**Partner Organizations**	**Notes**
1. Convene a conversation among relevant stakeholders about collaborative ways to ensure and improve access to recovery supports.	Indicator: Document discussions and resulting activities.	Mental Health America of Indiana Mental Health America of Indianapolis	MCPHD Social Work Indiana FSSA Division of Mental Health and Addiction – Office of Family and Consumer Affairs Indiana Recovery Council Goodwill Industries Coalition for Homelessness Intervention & Prevention (CHIP) Marion County Re-entry Coalition Marion County Minority Faith Based Coalition Indiana Minority Health Coalition Recovery Café Indy Wellness Council IMPD Crisis Intervention Team (CIT) program National Alliance on Mental Illness (NAMI) of Indiana	

PRIORITY AREA: **Poverty**

GOAL 3: Raise awareness about poverty and other social determinants of health and their influence on quality of life and morbidity with the intent of decreasing the poverty burden in Marion County.

Outcome Indicators:

Indicator 1: Decrease the poverty rate among children in Marion County by 2024 (American Community Survey (ACS))

Indicator 1: Decrease the poverty rate among all Marion County residents by 2024 (ACS)

OBJECTIVE #1: Provide regular health equity data.

ACTION PLAN

Action Steps	Indicators	Lead Organization	Partner Organizations	Notes
1. Provide regular health equity data.	Indicator: Add new health equity data at least annually to Indy Indicators.	MCPHD Epidemiology	Indiana Business Research Center Indy Indicators	
2. Disseminate the MCPHD Epidemiology Health Equity data report.	Indicator: Document release of 2018 Health Equity Report.	MCPHD Epidemiology	Indiana Business Research Center Indy Indicators	
3. Update the MCPHD Epidemiology Health Equity data report every three years.	Indicator: Document completion of Health Equity Report Update in 2022.	MCPHD Epidemiology	Indiana Business Research Center Indy Indicators	

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PRIORITY AREA: **Poverty**				
GOAL 3: Raise awareness about poverty and other social determinants of health and their influence on quality of life and morbidity. with the intent of decreasing the poverty burden in Marion County.				
OBJECTIVE #2: Create and implement a health equity strategy for Marion County.				
ACTION PLAN				
Action Steps	**Indicators**	**Lead Organization**	**Partner Organizations**	**Notes**
1. Create a health equity strategy for Marion County.	Indicator: Health equity strategy completed by 2024.	Health and Hospital Corporation of Marion County	MCPHD Chronic Disease Health by Design	
2. Convene community conversations and educational opportunities around health equity	Indicator: Document activities.	Health by Design	MCPHD Chronic Disease	
3. Encourage the adoption of Health in All Policies across agencies and governments in Marion County to ensure that services have a health equity lens.	Indicator: Increased number of agencies adopting Health in All Policies.	MCPHD Healthy Communities		
4. Make basic health equity training a requirement for all MCPHD staff and encourage cities and towns in Marion County to adopt a similar requirement.	Indicator 1: Document training selected by health department and required for staff viewing by 2021. Indicator 2: Document as part of electronic learning management system.	MCPHD Public Health Practices	City of Indianapolis Departments Health by Design Indy Chamber	

PRIORITY AREA: **Poverty**				
GOAL 3: Raise awareness about poverty and other social determinants of health and their influence on quality of life and morbidity with the intent of decreasing the poverty burden in Marion County.				
OBJECTIVE #3: Enhance MCPHD partnerships and the inclusion of public health elements in community efforts to address poverty and equity.				
ACTION PLAN				
Action Steps	**Indicators**	**Lead Organization**	**Partner Organizations**	**Notes**
1. Participate in partner efforts.	Indicator: Document MCPHD involvement and partner efforts.	Current Relevant Partnerships: • Indy Chamber (Inclusive Growth and Health Council) • Health by Design (REACH; other walking, biking, and transit initiatives; health equity initiative) • Top 10 (Improving the built environment, increasing access to safe physical activity, increasing access to better nutrition, promoting smoke free air and tobacco cessation) • Indiana Minority Health Coalition • LISC (DIP-IN, Quality of Life Plans, and Great Places) • Clinical and Translational Science Institute (CTSI) (All IN for Healthy Communities, Monon Project) • Fairbanks SPH (DIP IN, Public Health Training Center)	MCPHD Various Units	Resources: Polis Center Poverty Report and Indiana United Way 2018 Indiana Alice Report

Action Steps	Indicators	Lead Organization	Partner Organizations	Notes
1. Participate in partner efforts. (continued)	Indicator: Document MCPHD involvement and partner efforts.	Partnerships (continued): • United Way of Central Indiana (UWCI) (Great Families and Family Opportunity Impact Fund) • Central Indiana Community Foundation (CICF)(Strategic Plan for Equity) • Marion County hospital community health assessments (CHAs) • Marion County Re-entry Coalition Fair Housing Center of Central Indiana • Indianapolis Neighborhood Housing Partnership • Hoosier Environmental Council (environmental justice) • Faith & Action Project • Faith in Action • Indiana Suicide Prevention Network		
2. Create an inventory of MCPHD partnerships and participating staff and develop internal protocols for maintaining participation and for sharing information about partners efforts within MCPHD.	Indicator: Inventory and internal protocols created by September 2020.	MCPHD Public Health Practice		

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PRIORITY AREA: **Poverty**				
GOAL 3: Raise awareness about poverty and other social determinants of health and their influence on quality of life and morbidity with the intent of decreasing the poverty burden in Marion County.				
OBJECTIVE #4: Build awareness with local audiences about the role of poverty and other social determinants of health in community health status; policy, systems, and environmental (PSE) change; and Health in All Policies.				
ACTION PLAN				
Action Steps	**Indicators**	**Lead Organization**	**Partner Organizations**	**Notes**
1. Build awareness with local audiences about the role of poverty and other social determinants of health in community health status; policy, systems, and environmental (PSE) change; and Health in All Policies.	Indicator 1: Document participation in meetings and/or trainings. Indicator 2: Follow up with meeting attendees to see how training has been used to impact their practices 1 year after training. Indicator 3: Document education campaigns, presentations, and news stories.	Greater Indianapolis Progress Committee Race and Cultural Relations Leadership Network United Way of Central Indiana Local Initiative Support Corporation (LISC) Indianapolis	Top 10 Coalition City of Indianapolis Office of Sustainability MCPHD Healthy Communities Diversity Roundtable of Central Indiana Central Indiana Community Foundation	

APPENDIX B
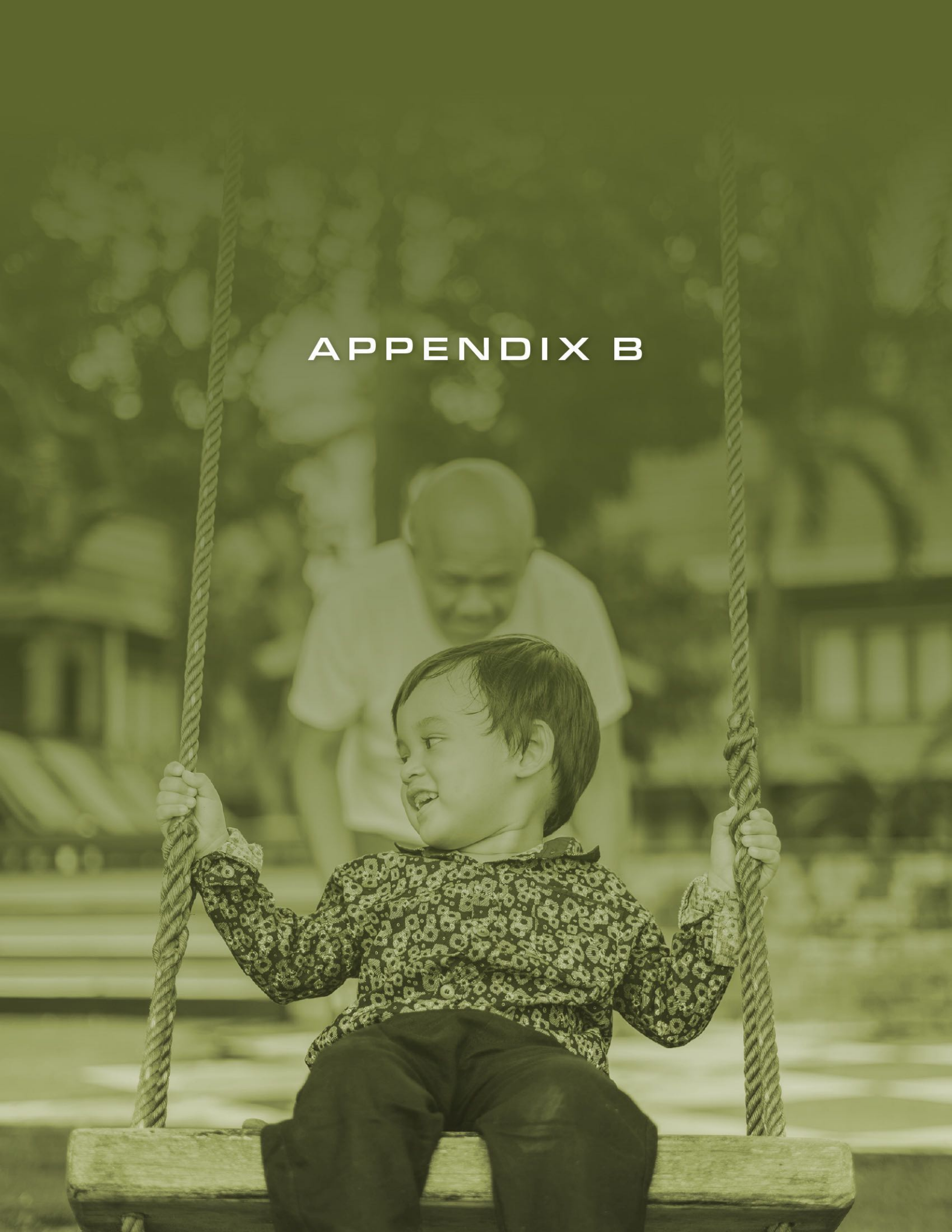
**Marion County Community Health Improvement Planning
Existing Assets for Poverty, Mental Health, and Obesity/Diabetes**

November 29, 2018 List and Member Additions

Obesity/Diabetes

General/Overlapping
- Purdue Extension Community Health workers—work in SNAP census tracts around nutrition and physical activity
- Indianapolis Urban League—nutrition programs, farmers markets, diabetes programs, mental health classes www.indplsul.org/
- Top 10 coalition—collective impact network http://top10in.org/
- Jump IN—healthy communities, healthy neighborhoods, and healthy places to prevent and reduce childhood obesity www.jumpinforhealthykids.org/
- Black and Minority Health Fair www.in.gov/isdh/25116.htm
- American Heart Association (government relations)
- EnergyKrazed—Nonprofit organization empowering families to take charge of their health http://energykrazed.org
- Girls on the Run of Central Indiana, https://www.facebook.com/GOTRCentralIndiana
- Nine13 Sports—Nonprofit organization offering bike-based programming for kids, https://www.nine13sports.org
- Indiana Pacers BikeShare—a bike is there when you need it, and safely docked away when you don't! https://www.pacersbikeshare.org
- Cardiovascular and Diabetes Coalition of Indiana http://indianacadi.org/

Nutrition
- Indy Hunger Network—association of food organizations (Meals on Wheels, Gleaners, Second Helpings) www.indyhunger.org/
- Food Compass—food access tool—project of City of Indianapolis, Indy Chamber, Level Up Developing https://tinyurl.com/qlygf6y
- Big Green—putting gardens in schools (outdoor classroom)—funded by two restauranteurs with restaurants in town biggreen.org/
- Meals on Wheels http://mealsonwheelsindy.org/
- MCPHD REACH grant—healthy food, especially for minority groups
- Healthy Food Financing Initiative—state level policy initiative https://www.facebook.com/Indyhealthyfoodaccess/
- Urban Farms—Flanner House, Finish Line, Brandywine Creek Farms, Lawrence Community Gardens flannerhouse.org/flanner-farm/ www.brandywinecreekfarms.org/ http://lawrencecommunitygardens.org/
- Healthy corner store project on the Far Eastside (contact Jump IN for Healthy Kids, www.jumpinforhealthykids.org)

- Chef for Hire—lunches for Indy Parks and CICOA Aging and In-home Solutions that meet nutritional standards www.chefforhire.com/
- Ryan's Meals for Life https://tinyurl.com/tof6cgg
- IndyGo Food for Transit https://tinyurl.com/us9vc35
- School lunch program www.doe.in.gov/nutrition/national-school-lunch-program
- Schools Nutrition and Food Service Programs (primarily IPS) www.doe.in.gov/nutrition/school-nutrition-programs
- Purdue Extension Marion County https://extension.purdue.edu/Marion
- Marion County Health Department Nutrition Services http://marionhealth.org/programs/population-health/nutrition-services/
- Indiana Women, Infants, and Children Program (WIC) https://www.in.gov/isdh/19691.htm

Diabetes Programming
- Indiana State Department of Health funding for Medicaid coverage of diabetes prevention
- American Diabetes Association http://www.diabetes.org/
- MCPHD Chronic Disease Department—diabetes training http://marionhealth.org/programs/population-health/chronic-disease/diabetes/
- Diabetes Impact Project (DIP IN)—Lilly grant to Fairbanks School of Public Health and Polis Center—community health workers to promote diabetes prevention, screening, and treatment http://polis.iupui.edu/index.php/diabetes-impact-project/
- YMCA Diabetes Prevention Program (DPP)
- Indiana Minority Health Coalition (IMHC), Marion County Minority Health Coalition—IMHC has diabetes training, covered by Medicaid www.imhc.org/ http://www.minorityhcmc.org/
- ABCs of Diabetes—MCPHD https://tinyurl.com/vfuawxw
- State Diabetes Plan development—workgroups in progress
- Diabetes Prevention Program—Medicare coverage and potential Medicaid (1 year state funding) www.in.gov/isdh/26609.htm#Map

Physical Activity and Built Environment/Infrastructure
- Health by Design http://healthbydesignonline.org/index.html
- Central Indiana Community Foundation (CICF)—Connected Indy Initiative—equity focus, pedestrian bike focus in residential neighborhoods
- Complete Streets—City of Indianapolis, Indianapolis Metropolitan Planning Organization, Indiana Department of Transportation—already in place, opportunity to expand https://tinyurl.com/ufuvx84
- Pedestrian zones—already in place, opportunity to expand

- Shared use policies—already in place, opportunity to expand
- Transit and safe routes to school, work, and parks—already in place, opportunity to expand
- YMCA
- Parks
- Indy in Motion https://tinyurl.com/vy6vh6q
- Indy Greenways—promoting Indy trails https://www.indygreenways.org/
- MCPHD Healthy Communities Program (built environment)
- MCPHD Cardiovascular Disease Program (physical activity programming)

Other
- American College of Obstetrics and Gynecology—released statement about prenatal exposures—endocrine disrupters, obesogenic exposures of fetus www.acog.org/?IsMobileSet=false

Mental Health
Planning/Professional/Advocacy/Resource Groups
- Mental Health of America of Indiana–public education, advocacy, and legislative health policy reform as related to mental health and addiction issues, as well as the provision of treatment and support services www.mhai.net/
- Indiana FSSA Division of Mental Health and Addiction (DMHA) www.in.gov/fssa/dmha/index.htm
- Indiana Council of Community Mental Health Centers committees http://www.iccmhc.org/
- Community Mental Health planning taskforce—local mental health centers meet to discuss gaps in services
- American Foundation for Suicide Prevention Indiana afsp.org/our-work/chapters/
- National Alliance for Mental Illness (NAMI)—national, state, and local chapters www.nami.org/
- Mental Health and Addiction Planning and Advisory Council
- Interdenominational Ministry Alliance—works with Interfaith Coalition
- Zero Suicide zerosuicide.sprc.org/
- Indiana Coalition Against Domestic Violence has a CDC grant to address trauma-informed care www.icadvinc.org/
- Indiana Suicide Prevention Network and Indiana Suicide Prevention Network Advisory Council www.indianasuicideprevention.org
- Indiana Association of Peer Recovery Support Services peerrecoveryindiana.org/iaprss-home/
- Indiana Association of Community Mental Health Centers, Inc. www.iccmhc.org/

- Indiana Workforce Recovery Initiative www.wellnessindiana.org/indiana-workforce-recovery-initiative-recovery/
- Open Beds database—real time data on mental health treatment slot availability
- Stigma Free Indiana (Women's Fund, Suzanne Clifford)
- Campaign to Change Direction (Women's Fund, Suzanne Clifford and Tavonna Harris Askew)
- Indiana Recovery Council www.facebook.com/ircdhma
- Depression and Bipolar Support Alliance of Indiana (MHAI subsidiary)
- Indiana Addiction Issues Coalition (MHAI subsidiary)
- Marion County Faith Based Coalition
- Recovery Café Indy www.recoverycafeindy.org
- Eskenazi Midtown Mental Health www.eskenazihealth.edu/our-services/midtown-community-mental-health
- Families First www.familiesfirstindiana.org
- Key Consumer Organization www.keyconsumer.org
- Ascend Indiana, part of the Central Indiana Corporate Partnership portfolio or organizations, was announced 2/13/19 and may be a useful partner/resource. AI has a grant from the Richard M Fairbanks Foundation, Inc. "to develop a plan in partnership with a health system and post-secondary institutions to build a model that will grow the supply of licensed clinical social workers trained to treat substance use disorder that will meet the needs of health systems across Indianapolis." Contact: Jason Kloss. ascendindiana.com/talent

Youth
- Project Advancing Wellness and Resilience Education (AWARE) is an Indiana Department of Education program funded with a $9 million SAMHSA grant. "The goal of Project AWARE is to increase awareness of mental and emotional health concerns, and to improve connections to services for students by developing and expanding school-based mental health teams" https://tinyurl.com/r643e8o
- Governor's report on school safety includes recommendations on mental health www.in.gov/dhs/files/2018-Indiana-School-Safety-Recommendations.pdf
- Playworks—work with kids, education and prevention, expressing disagreement without fighting www.playworks.org/indiana/
- LifeSmart Youth—Work with kids, education and prevention, expressing disagreement without fighting lifesmartyouth.org/
- Teaching social and emotional health skills in schools legislation
- Indianapolis Public Schools mental health stakeholders
- Boys and Girls Clubs of Indianapolis https://bgcindy.org/programs
- Indiana Youth Institute https://www.iyi.org/

Services

- Indiana Center for Children and Families—mental health counseling and crisis intervention—indcenter.org/
- Emberwood Center—addiction counseling services www.emberwoodcenter.org/
- Ezkenazi Health https://eskenazihealth.edu/
- Eskenazi Health—point services, opioid and depression screenings
- Peace Learning Center—work with kids and adults, education and prevention, expressing disagreement without fighting peacelearningcenter.org/
- Goodwill—services and job training for handicapped
- Horizon House—Street Outreach Rapid Response Team (SORRT) www.horizonhouse.cc/programs-and-services/sorrt/
- Families First provides mental health counseling, education, crisis intervention, Indiana's suicide prevention hotline (317/251-7575 or Text CSIS to 839863) www.familiesfirstindiana.org/
- Community Mental Health Centers (CMHCs) www.iccmhc.org/
- New psychiatric Hospital on Community East campus/Neuro Diagnostic Institute
- Community Justice Campus—Assessment and Intervention Center—diverts from incarceration to mental health treatment indycjc.com/
- Fairbanks Foundation—grants to school counselors and mental health systems www.rmff.org/
- Mobile Crisis Assistance Team—IMPD, paramedic, social worker team to divert mental health/substance abuse cases from jail to services. www.indy.gov/eGov/City/DPS/IMPD/Services/Pages/cit.aspx
- Horizon House—find homeless needing services, including mental health care www.horizonhouse.cc/
- ARC of Indiana—advocate for folks with developmental and intellectual disabilities. Big coalition around intellectual disabilities. www.arcind.org/
- Campaign to Change the Direction (CICF Women's Fund)—5 signs of emotional suffering, and what to do www.changedirection.org/
- Midtown Mental Health www.eskenazihealth.edu/mental-health
- Inpatient hospital units
- Indianapolis Urban League www.indplsul.org/
- Indiana FSSA Division of Mental Health and Addiction (DMHA) www.in.gov/fssa/dmha/index.htm
- Recovery Works www.in.gov/fssa/dmha/2929.htm
- Goodwill—Nurse Family Partnership and employment-related programming
- IU Health has a new initiative to connect emergency room patients with outpatient services including virtual peer counseling. Also addressing pain management to avoid opioid addiction.
- MCPHD Social Work Department goes into MCPHD clinics, WIC clinics, homes, schools—provides "bridge" counseling for patients.

- Engaging Employers for Workforce Recovery (Indy Chamber)
- Indiana Workforce Recovery (Indiana Chamber, Mike Thibideau)

Other
- Interfaith Coalition of Mental Health (ICMH) at Center for Interfaith Cooperation (CIC) —Educate clergy about MH issues in Indianapolis http://www.centerforinterfaithcooperation.org/icmh
- Lilly www.lilly.com/
- Opioid funding

Poverty

General
- Faith in Indiana (was ICAN) — group of religious leaders working on policy (ban-the-box, livable wage, transit issues) faithinaction.org/federation/faith-in-indiana/
- Faith and Action—Christian Theological Seminary program gives anti-poverty grants to agencies www.cts.edu/faith-action-project/
  - Interfaith Hospitality Network https://tinyurl.com/qrdwmo6
- Grameen Bank—micro-loans http://www.grameen.com/introduction/#
- Community Action of Greater Indianapolis—nonprofit organization dedicated to the reduction/elimination of poverty among clients in Boone, Hamilton, Hendricks, Marion and Tipton Counties. www.cagi-in.org/
- United Way of Central Indiana (UWCI) https://uwci.org
- UWCI Impact Fund Strategy—revising how they distribute funds, greater focus on poverty, somewhat on youth
- Inclusive Growth Advisory Group (Indy Chamber, Central Indiana Corporate Partnership, UWCI, Local Initiative Support Corporation, City of Indianapolis, EmployIndy, IU Public Policy Institute)
- Anchor institution strategy—partnership of Indy Chamber and anchor institutions (hospitals, universities, cultural institutions to maximize benefit of local neighborhoods through a live, buy, hire local strategy.
- Community development corporations (CDCs)
- Marion County Township Trustees offices, linked from https://www.indy.gov/agency/township-trustees
- Indy Chamber engagement (support from many sectors)
- Fairbanks School of Public Health Center for Public Health Practice—Poverty simulation fsph.iupui.edu/research-centers/centers/public-health-practice/index.html
- Connect to Help 211 http://www.connect2help211.org/
- Indiana Legal Services www.indianalegalservices.org/
- Center for Research on Inclusion and Social Policy (part of the IU Public Policy Institute). Research on urban poverty reduction, education, homelessness,

housing, neighborhood and community development, public health and safety, and youth and families. policyinstitute.iu.edu/about/crisp.html
- Medical legal partnerships assist with housing and health legal issues Indiana Legal Services, Inc. https://www.indianalegalservices.org/
- Student Outreach Clinic on the eastside provides free care joint effort (medical school, nursing school, social work, rehab science, pharmacy, dental and public health students). McKinney School of Law students and faculty do probono work at the clinic. https://tinyurl.com/rt3q47m

Mobility
- Personal Mobility Network Project—developing tech tools/align systems to create a one-step planning and payment platform for personal mobility across all transportation modes (Blue Indy, IndyGo, Lyft/Uber, Bird/Lime, and Pacers Bikeshare). A project of Central Indiana Corporate Partnership (CICP) and other groups.
- IndyGo/Shared Mobility—Transit upgrades, improved access, transportation savings accounts, equitable transit oriented development fund https://tinyurl.com/romxz6l
- Transit Oriented Development Strategic Plan - Metropolitan Planning Organization. Make sure folks who benefit most from public transit can live near it https://tinyurl.com/vqpca4a
- Indiana Family and Social Services Administration (FSSA) doing a pilot with Lyft to help get people to appointments
- Indiana Statewide Independent Living Council (INSILC) https://www.insilc.org/
- AccessABILITY http://www.abilityindiana.org/

Food Insecurity/Nutrition
- Second Helpings—provides meals for many organizations and job training uwci.org/agencies/second-helpings-inc/
- Indianapolis Mayor's task force on food banks and community food resources
- Indy Hunger Network—association of food organizations (Meals on Wheels, Gleaners, Second Helpings) www.indyhunger.org/
- Gleaners Food Bank https://www.gleaners.org
- Neighborhood community food resources
- Food Compass—Indy Civic Hack product—application that indicates who accepts SNAP and provides other 211 data. https://tinyurl.com/qlygf6y
- Marion County Public Health Department—nutrition incentive programs (Fresh Bucks and Produce Rx); nutrition education in pantries, libraries, many venues upon request; breastfeeding support; technical assistance for organizations, neighborhoods, conference meals, etc. for increasing nutritious foods wherever food is sold/served.
- Summer Servings—no cost meal program for children over the summer www.doe.in.gov/nutrition/summer-food-service-program

- At Risk After School Meals Program – Indy Parks and other local organizations provide meals for children out of school hours https://www.doe.in.gov/nutrition/cacfp-risk-afterschool-programs
- Indiana Women, Infants, and Children Program (WIC; Marion County Public Health Department is local administrator) www.in.gov/isdh/19691.htm
- Supplemental Nutrition Assistance Program (SNAP) www.in.gov/fssa/dfr/2691.htm
- Eskenazi sends new diabetics home with 30 days of meals on wheels to help with the diet modifications needed

Income/Employment
- Back on your feet—running group for homeless/formerly homeless, leading to job training backonmyfeet.org/about-us/
- Goodwill
- Goodwill's New Beginnings program—job training for persons recently out of prison (work 4 days per week, attend finance training on the remaining day)
- Indianapolis Urban League (IUL) with Goodwill New Beginnings www.indplsul.org/
- Indiana self-sufficiency standard–effort of the Indiana Institute for Working Families http://www.indianaselfsufficiencystandard.org/
- Prosperity Now—national organization promoting living wage prosperitynow.org/
- Chamber audit of our economy, Central Indiana Corporate Partnership research with Brookings Institute—how do we create jobs that naturally pay a living wage
- Center for Working Families http://liscindianapolis.org/what-we-do/centers-for-working-families/
- Re-entry coalition and Recycleforce http://recycleforce.org/workforce-training/
- Income security and training programs—Workforce
- Income security and training programs—Goodwill Excel Center
- Income security and training programs—Purdue Extension
- Brookings Research—inclusive growth and opportunity jobs
- Summer Youth Employment—program run by ProjectIndy to provide Indianapolis and Marion County residents ages 16–24 with summer job opportunities. http://projectindy.net/
- FSSA—Welfare assistance (Temporary Assistance for Needy Families; TANF) www.in.gov/fssa/
- Indiana Wellness Council www.wellnessindiana.org
- Employ Indy https://employindy.org/

Families
- Fathers and Families Center—Strong Fathers, Strengthening Families. Education for young fathers or expectant fathers, connection to support services http://www.fatherresource.org/
- The Child Care and Development Fund (CCDF)—Federal program designed to help low-income families obtain child care so they may work, attend training or continue education www.in.gov/fssa/carefinder/3900.htm
- United Way Great Families/Social Innovation Fund (SIF)—Four-year initiative to improve family stability for vulnerable children and their parents living in five neighborhoods in Indianapolis uwci.org/great-families-2020/
- Center for Working Families http://liscindianapolis.org/what-we-do/centers-for-working-families/
- Indiana Institute for Working Families http://www.incap.org/iiwf.html
- Nurse family partnerships through Goodwill for at risk moms before and up to 3 years after delivery

Health
- Medicaid
- Neighborhood Health Profiles—Clinical Translational Science Institute and Fairbanks School of Public Health—health profiles of 99 neighborhoods comprising Marion County, analyzing health outcomes alongside assets and challenges.
- Children's Health Insurance Plan (CHIP)/Healthy Indiana Plan (HIP) www.in.gov/fssa/hip/

Housing
- Coalition for Homelessness Intervention and Prevention (CHIP) www.chipindy.org/
- Habitat for Humanity http://indyhabitat.org/
- Indianapolis Housing Agency—Housing Choice Voucher/Section 8 http://www.indyhousing.org/housing-choice-voucher/
- Indianapolis Neighborhood Housing Partnership (INHP) www.inhp.org/unlock/
- Fair Housing Law Project (FHLP) http://www.lawfoundation.org/fair-housing-law-project-fhlp/
- Wheeler Mission https://wheelermission.org/
- Indianapolis Homeless initiative
- Ggennesaret Health Care goes to homeless shelters and has 3 small residences where homeless can recover after surgery and chemo treatments.

Education
- Pre-K Programs—United Way Pathways to Quality, Public Funding https://tinyurl.com/u36j25l

Racial Equity/Racism

- Undoing Racism—child advocates who sponsor workshops, using approach from Peoples' Workshop. www.childadvocates.net/undoingracism/
- Racial Equity Institute www.racialequityinstitute.com/
- Indianapolis Urban League www.indplsul.org/
- Indiana Black Expo, Inc. www.indianablackexpo.com/
- The Greater Indianapolis NAACP Branch #3053 www.indynaacp.org/
- Greater Indianapolis Progress Committee (GIPC), Race and Cultural Relations Leadership Network indygipc.org/initiatives/rcrln/
- Indiana Minority Health Coalition https://www.imhc.org/

APPENDIX C

Marion County Community Health Assessment Topic Summaries

Preparing for the November 8 meeting!

Thank you for being part of the Advisory Board for the 2018 Marion County Community Health Assessment. The effort's culmination will be our meeting on November 8 to set priorities from among our narrowed list of topics. Please review these sheets before the meeting – you may want to bring them to the meeting, shuffled into the order in which you would prioritize them, or otherwise marked to indicate your thoughts.

In the meeting, we will briefly review each topic, discuss prioritization criteria, and select the top priorities to be included in the Community Health Assessment.

Topic summary sheets

We have created a summary sheet for each of the 15 topics. Each summary sheet has the following sections:

Health Impacts: What health outcomes are most affected by the topic?
Treatment: How can the topic be mitigated or treated?
Comparison: How is Marion County doing, compared to other locations, in terms of some key measure regarding the topic?
Trend: How is some key measure of the topic changing in the past few years?
Risk Factors: What increases the likelihood of the topic's occurrence?
Equity: What are important differences, if any, in how the topic impacts different groups within the county?

Page 2 has information about the Impact Score and about interpreting graphs on the summary sheets. At the end of this document are more details about the Impact Score. In a separate document are appendices contain more information about the statistics in the summary sheets, their sources, and other details about the topic.

Contents

Impact Score – use it cautiously

The Impact Score should be viewed as a very rough guideline, and <u>not</u> an exact measure. It is our attempt to summarize the county-wide health impact of the topic with one number. We intend it to stimulate discussion; it should <u>not</u> be viewed as a deciding factor. For some topics, we had no direct data for some components of the score; for instance, we know that our data about the prevalence of domestic violence is very incomplete. And some criterion were difficult to apply to some topics, such as, "by how much do the impacts of poverty increase medical costs?". So, for some issues, we had to extrapolate or make very rough estimates based on uncertain assumptions, to create parts of the impact scores. See the topic-specific appendix for details about the sources and calculation of each topic's impact score.

Bar graph "whiskers" and line graph "bands"

Some bar graphs on the summary sheets have "whiskers"—lines extending above and below the bar, to indicate the potential error in the estimate. The ends of the whiskers indicate the upper and lower ends of the 95% confidence limits; it is very likely (95% likely) that the actual value is somewhere within this range. The top of the bar (in the middle of the whiskers) is just our best estimate of the actual value. When the top of one bar is within the range of the whiskers of another bar, there is a notable chance that any difference could be due to random fluctuations, rather than meaningful, underlying differences.

Example: A bar graph with "whiskers"
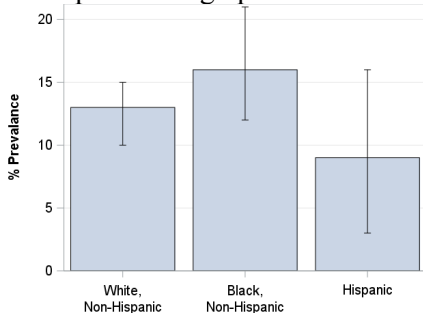
The 95% confidence interval whiskers of "White, non-Hispanic" and "Hispanic" overlap with the top of each other group's bar, so obesity rate of Whites and Hispanics could be considered to be similar to each other. They do not overlap with the whiskers on the "Black, non-Hispanic" bar, so it is likely that there is a significant difference between the Black obesity rate and that of Whites or Hispanics.

Likewise, some of the line graphs have lines with lighter colored bands. These bands also indicate the 95% confidence range. If two points on a line fall within the confidence range of each other, there is a notable chance that the actual values are not significantly different.

Example: A line graph with a band:
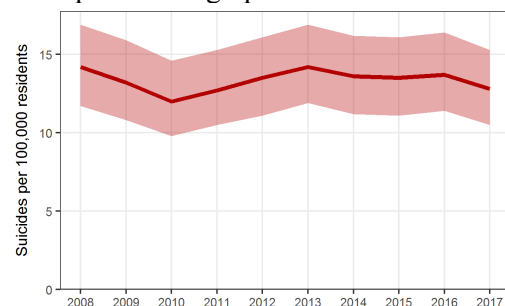
The 95% confidence interval band for each year in this graph overlaps the point values of every other year. So the changes in the suicide rate are within a range that could be caused by random chance, rather than by notable changes in important risk factors.

Graphs without whiskers or bands indicating 95% confidence limits still have measurement error. For those graphs, the confidence limits were not available.

Crime

Violent crimes consist of murder, rape, robbery, assault, property crime, burglary, larceny, and motor theft. Crimes often influence the safety and wellbeing of a community.

Health Impacts

Increased risk of:

- Injury
- Depression
- Post traumatic stress disorder (PTSD)
- Death
- Negative perceptions of neighborhood safety

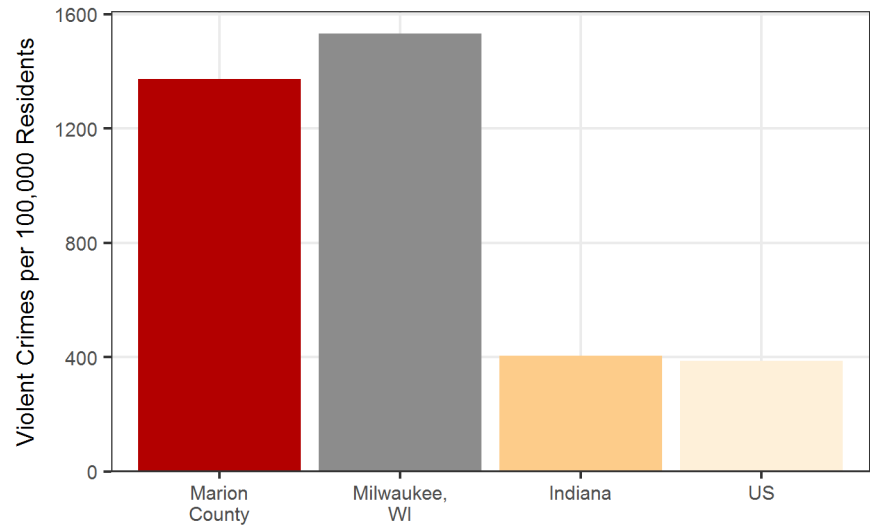Source: WHO World Report on Violence and Health 2002

Treatment

- Community building
- Enhancing community resources
- Improve community infrastructure
- Reduce social stressors (e.g. poverty)

Source: WHO World Report on Violence and Health 2002

Comparison

Violent Crime, Marion Co. vs. other locations, 2016

Source: FBI NIBRS

Trend

Marion Co. Violent Crimes, 2012-2016
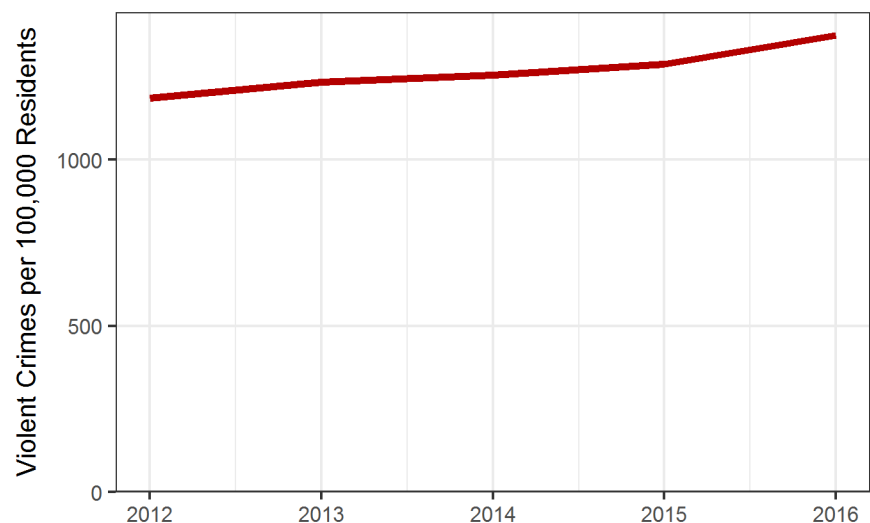
Source: FBI NIBRS

DR3774

Risk Factors

Personal Risk factors

- Past violent behaviors
- Use and abuse of alcohol or drugs
- Bullying

Source: New York State Office of Mental Health

Environmental and Community Risk Factors

- Economic disadvantage
- Community disorganization
- Access to guns or other weapons

Source: New York State Office of Mental Health

Equity

Perceptions of Safety by Race

Blacks may be slightly more likely than Whites and Latinos to consider their neighborhood to be unsafe.

Uncertain Neighborhood Safety by Race, Marion Co. 2018
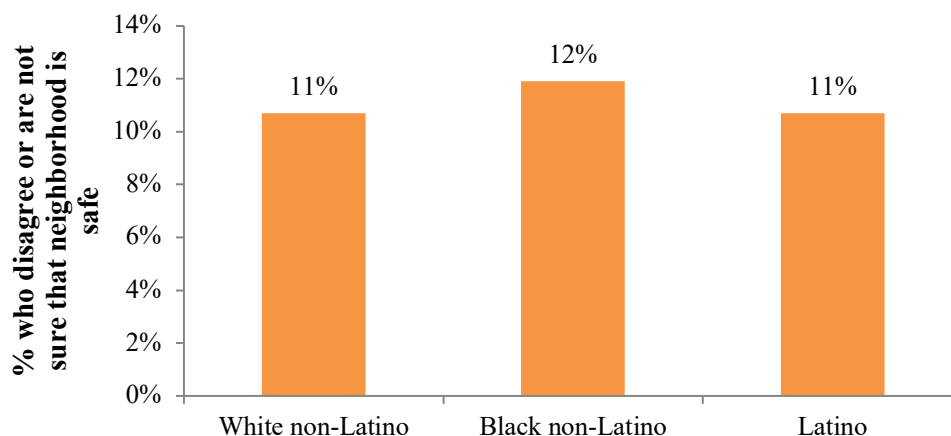
Source: 2018 Marion County Community Health Assessment Survey

Uncertain Neighborhood Safety by Gender, Marion Co. 2018

Perceptions of Safety by Gender

Women may be slightly more likely than men to consider their neighborhood to be unsafe.
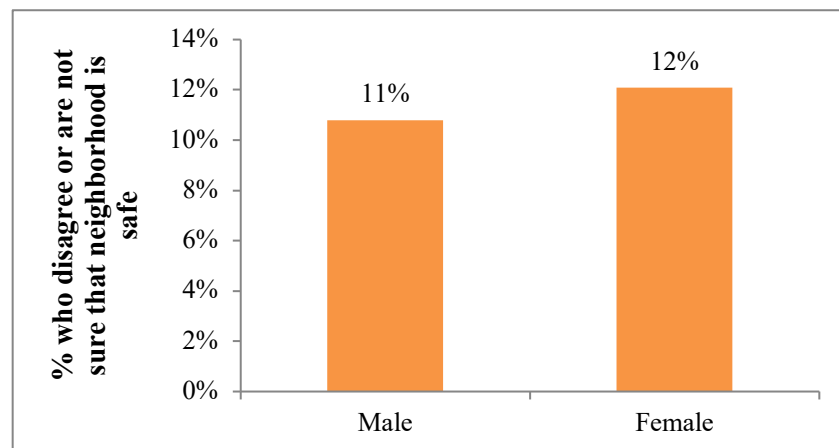
Source: 2018 Marion County Community Health Assessment Survey

Diabetes

A disease that occurs when blood glucose is too high and not enough insulin is produced

Health Impacts

Increased risk of:

- Stroke
- Heart disease
- Kidney disease
- Hypertension
- Neuropathy
- Gastroparesis

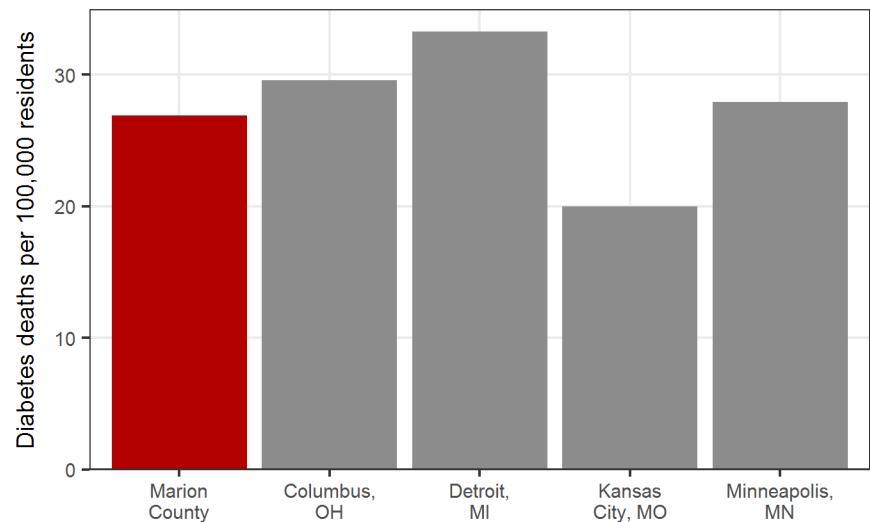26.9 death per 100,000 persons, annually

Source: American Diabetes Association

DALY: 1.57

Source: Institute for Health Metrics and Evaluation

Comparison
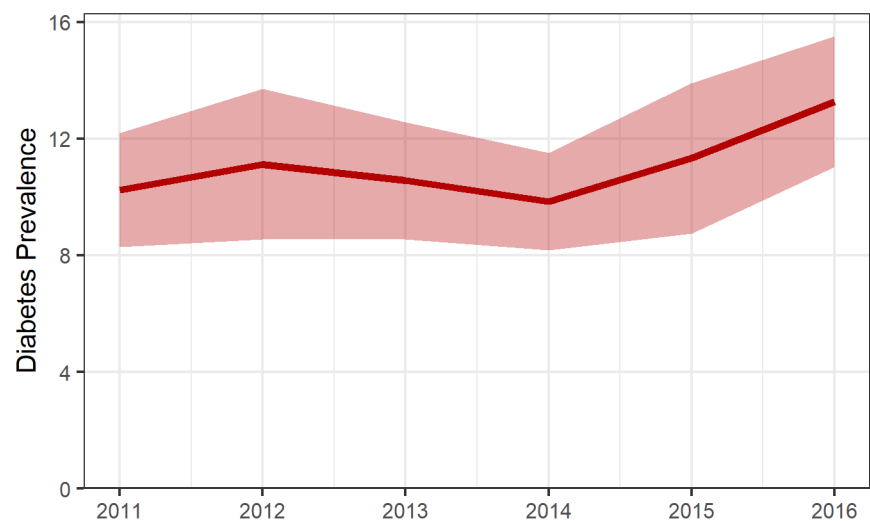
Diabetes Mortality, Marion Co. vs. other locations, 2015-2016

Source: Big Cities Health Coalition

Treatment

- Exercise
- Increase access and consumption of nutritious foods
- Oral medication
- Insulin

Trend

Marion Co. Diabetes Prevalence, 2011-2016

Source: BRFSS

DR3787

Risk Factors

- Overweight or obese
- Inactive
- Over the age of 45
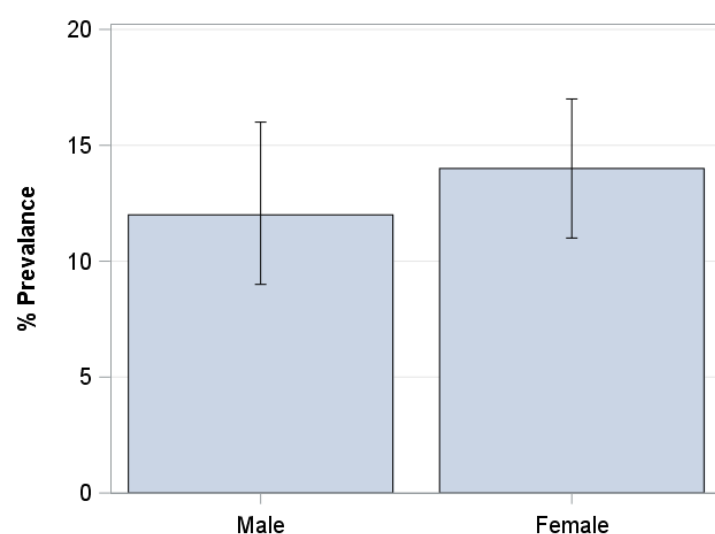- African American, Hispanic/ Latino, American Indian, or Alaska Native

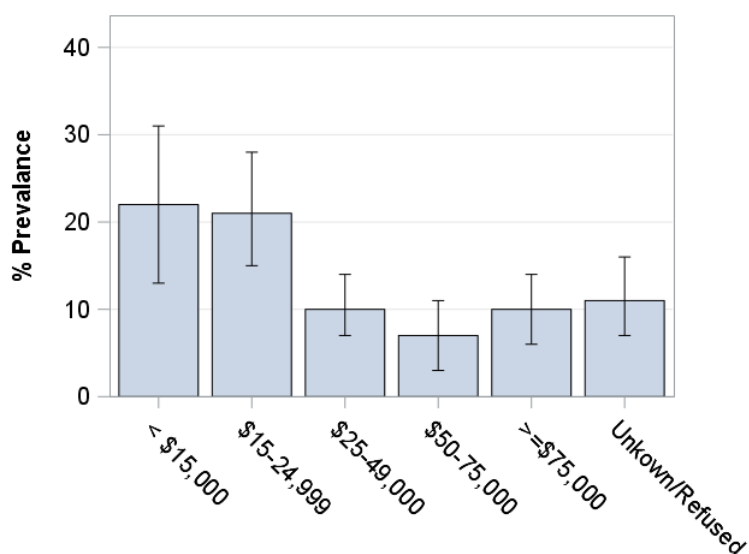# Equity

Adults with Diabetes by Race/Ethnicity, Marion Co. 2016
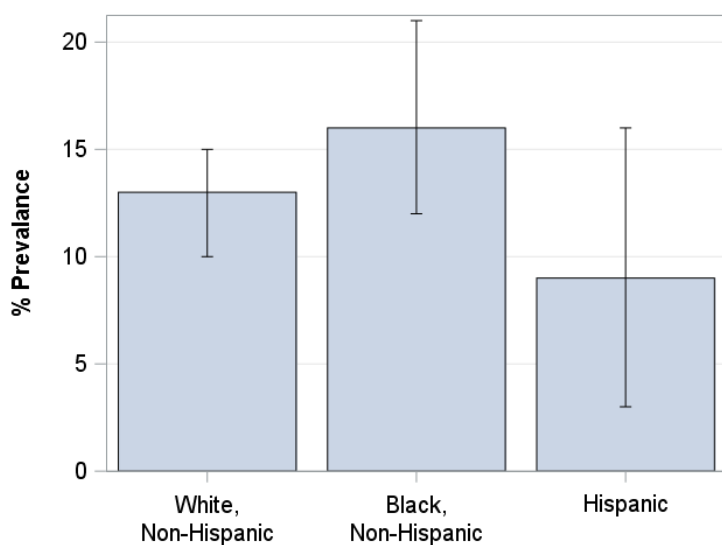
Source: BRFSS

Adults with Diabetes by Gender, Marion Co. 2016

Source: BRFSS

Adults with Diabetes by Income, Marion Co. 2016

Source: BRFSS

Domestic Violence

Domestic violence (DV) takes the form of physical, psychological, or sexual violence, stalking, or control of reproductive health by a current or former intimate partner. Women are disproportionately impacted, but men are also victimized.
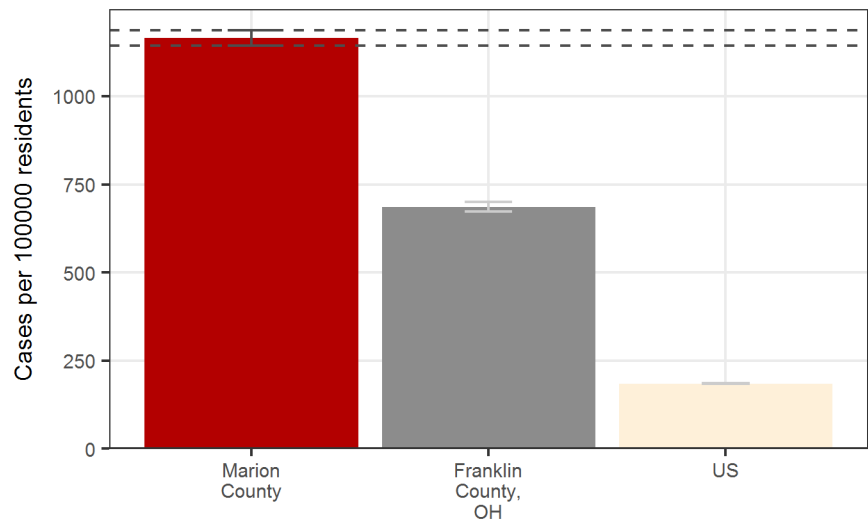
Health Impacts

Increased risk of:

• Physical injury/death
• Poor mental health
• Risky health behaviors
• Increased medical cost lasting up to 15 years
• Years of life lost

1165 new domestic violence cases per 100,000 persons, annually

Source: Marion County Health Department Vital Statistics

Comparison

**Domestic Violence, Marion Co. vs. other locations, 2016**

Source: 2007-2011 US ACS; Ohio Bureau of Criminal Identification and Investigation

Treatment

• Law enforcement intervention
• Access to housing and financial assistance
• Access to physical & mental health care and substance use disorder treatment
• Improved attitudes toward DV (i.e., increased reporting and prosecution, revised gender norms

Trend

Marion Co. Domestic Violence Incidents, 2009-2012

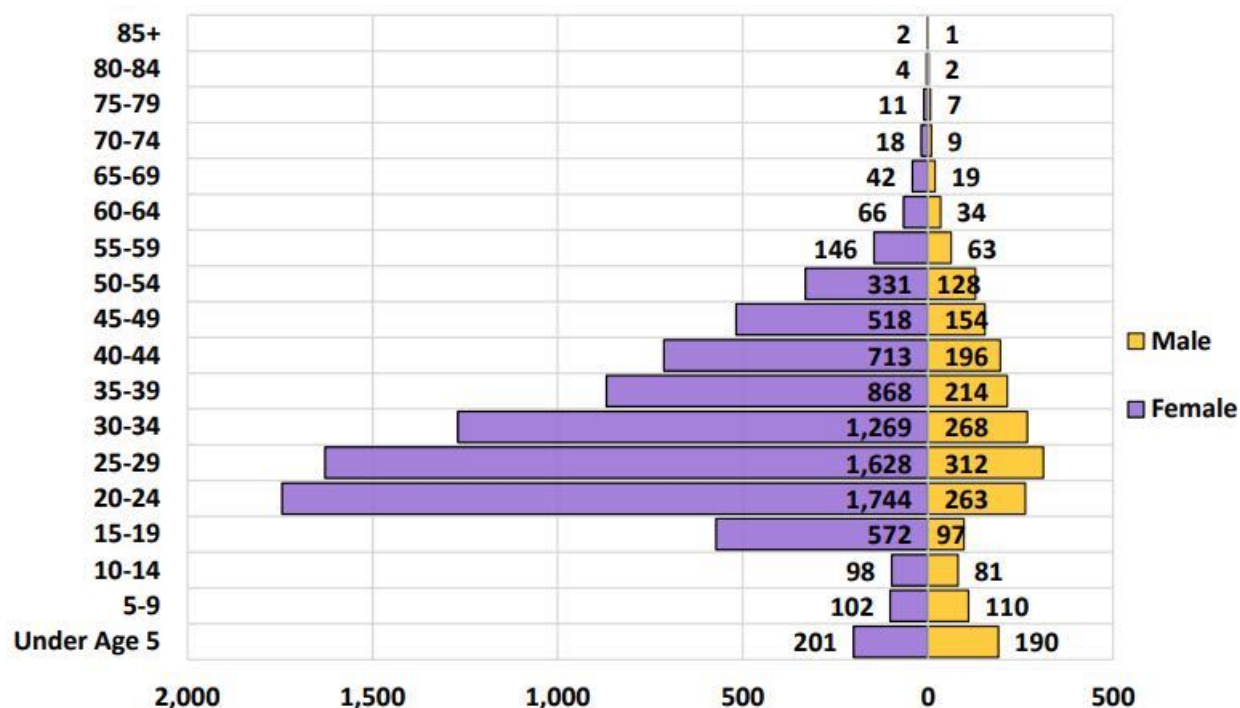Source: Domestic Violence Network

DR3773
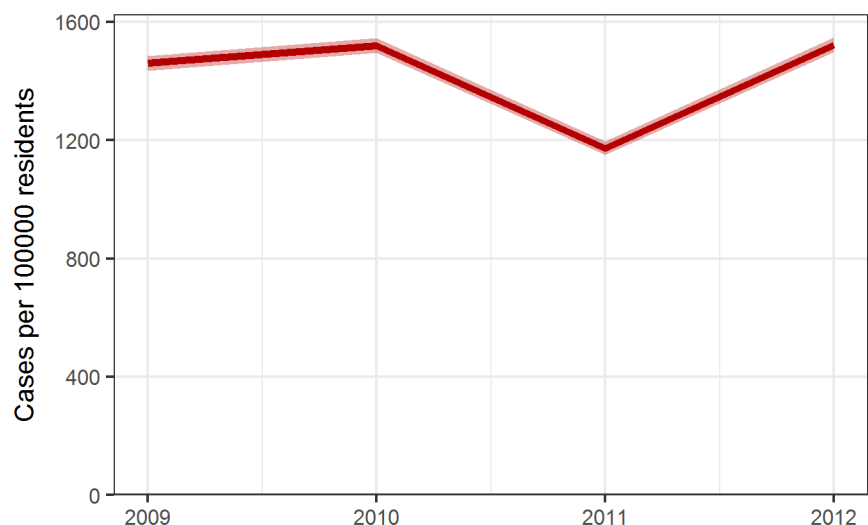
Risk Factors

- **Individual:** Low self esteem, income or education; young age; aggressive/ delinquent behavior as a youth; heavy alcohol/substance use; depression; and more
- **Relational:** Marital conflict or instability; dominance by one partner over the other; economic stress; unhealthy family interactions
- **Community Factors:** Poverty and associated factors
- **Societal Factors:** Traditional gender norms

Equity

- Women were victims at a ratio of 4:1 when compared to their male peers, and women 20-24 years of age were at greatest risk
- Nearly half of female deaths from assault/homicide are thought to be caused by intimate partners
- African Americans were impacted at more than twice the rate of their white peers (2,037.5 vs. 939.1 per 100,000)
- Low-income neighborhoods have a higher reported incidence of domestic violence than middle- and upper-income areas

Domestic Violence Victims by Age and Gender, Marion County, 2011

Age	Female	Male
85+	2	1
80-84	4	2
75-79	11	7
70-74	18	9
65-69	42	19
60-64	66	34
55-59	146	63
50-54	331	128
45-49	518	154
40-44	713	196
35-39	868	214
30-34	1,269	268
25-29	1,628	312
20-24	1,744	263
15-19	572	97
10-14	98	81
5-9	102	110
Under Age 5	201	190

*206 victims have unknown age

Source: Domestic Violence Network

Food Access

Food security is "the condition in which all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life."

Source: International Food Policy Research Institute

Health Impacts

Increased risk of:

- Overweight and obesity
- Cancer
- Diabetes
- Cardiovascular Diseases
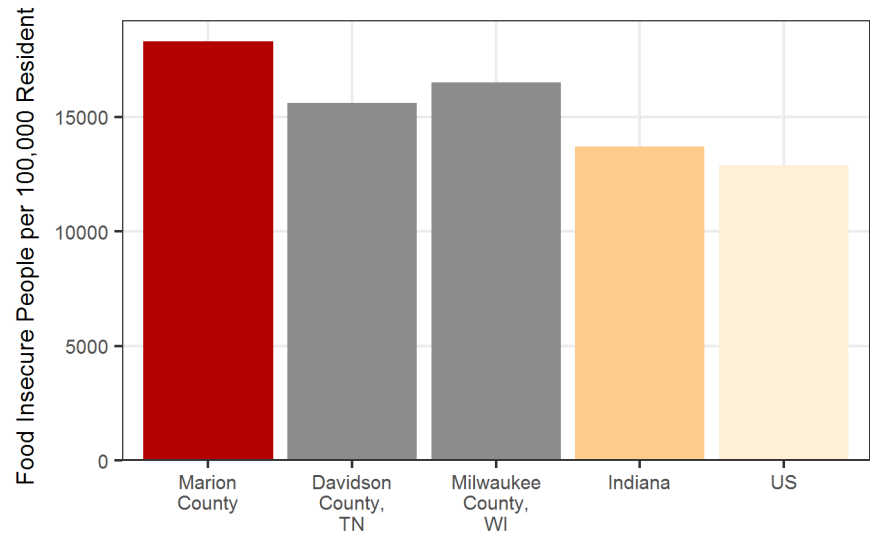- Malnutrition

Source: WHO

Treatment

- Establish community gardens
- Organize local farmers markets
- Improve local transportation
- Change zoning codes
- Offer incentives to attract retailers with healthier food options to food desert areas

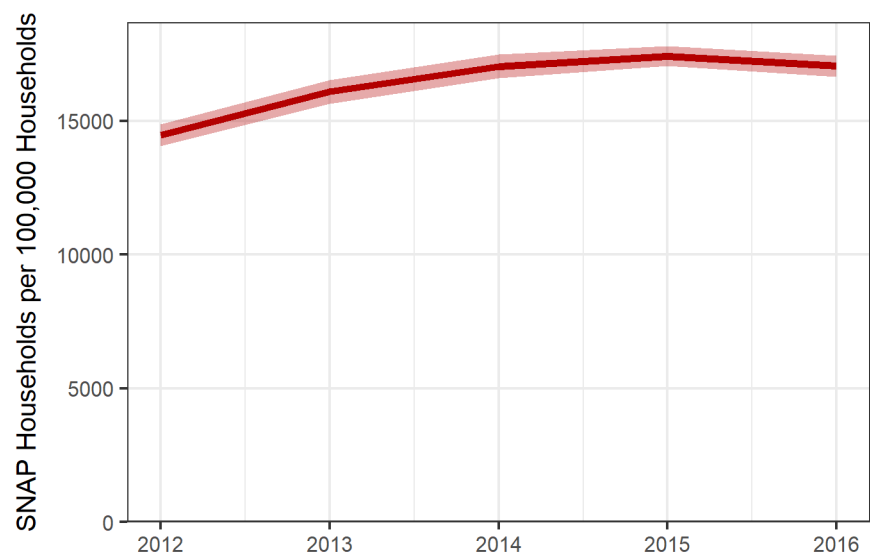Source: Centers for Disease Control and Prevention

Comparison

Food Insecurity, Marion Co. vs. other locations, 2016

Source: Feeding America

Trend

Marion Co. SNAP Households, 2012-2016

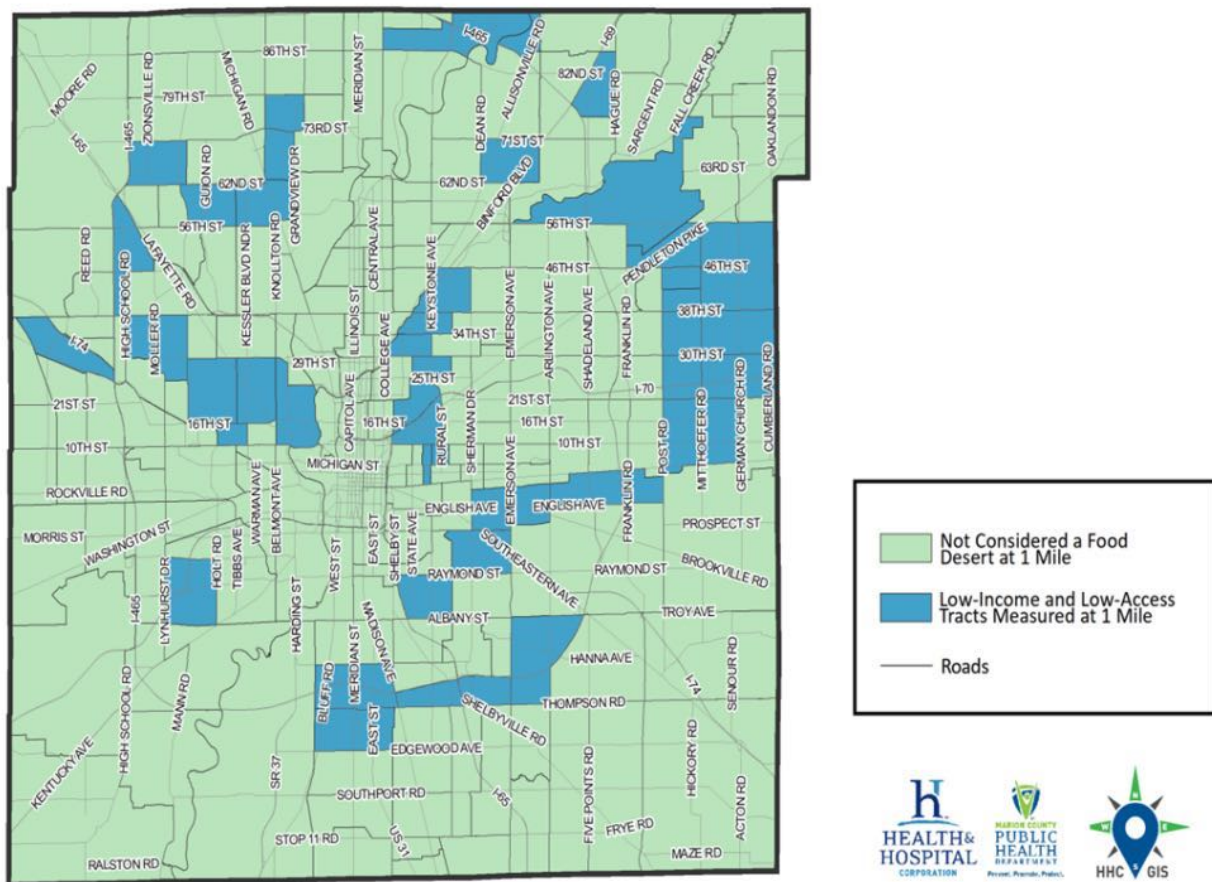
Source: ACS 5 Year Summaries

DR3792

Risk Factors

- Low-income households
- Households with children
- Single-parent households
- Households headed by Black, non-Hispanics or Hispanics (as compared to White, non-Hispanics)
- Adults with a mental health disability

Source: United State Department of Agriculture

Equity

Food Deserts, Marion Co. 2018

Source: Epidemiology Department, DR3512

About 21% of Marion County residents live in a food desert. A food desert is a low-income census tract in which at least 500 people or at least 33% of the population living more than 1 mile from the nearest supermarket, supercenter, or large grocery store.

Health Care Access

The ease with which an individual can obtain health services. The elements of health care access are health insurance coverage, the services provided, and the timeliness of deliveries.

Health Impacts

Increased risk of:

- Delay in receiving care
- Dying prematurely
- Untreated health complications
- Later diagnosis of a health condition
- Financial burdens
- Preventable hospitalizations.

Treatment

- Health insurance for unemployed and low-income individuals
- High quality health services
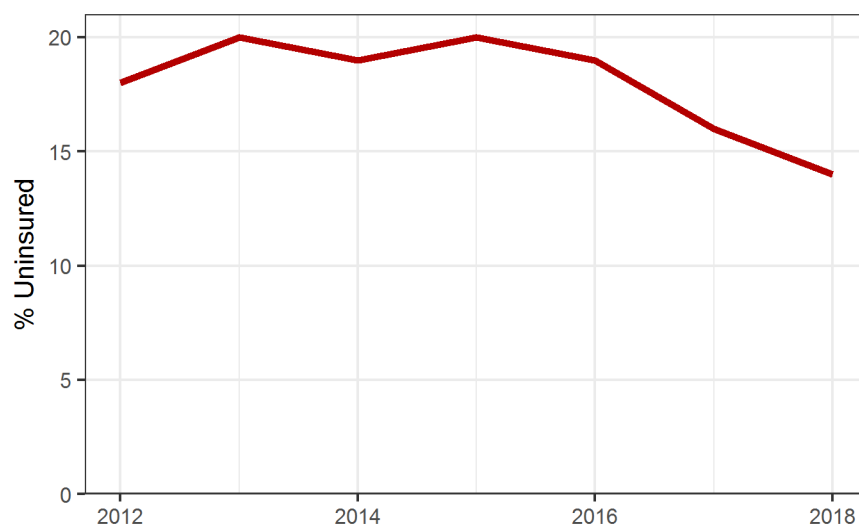- Transportation to services

Comparison

Uninsured, Marion Co. vs. other locations, 2016
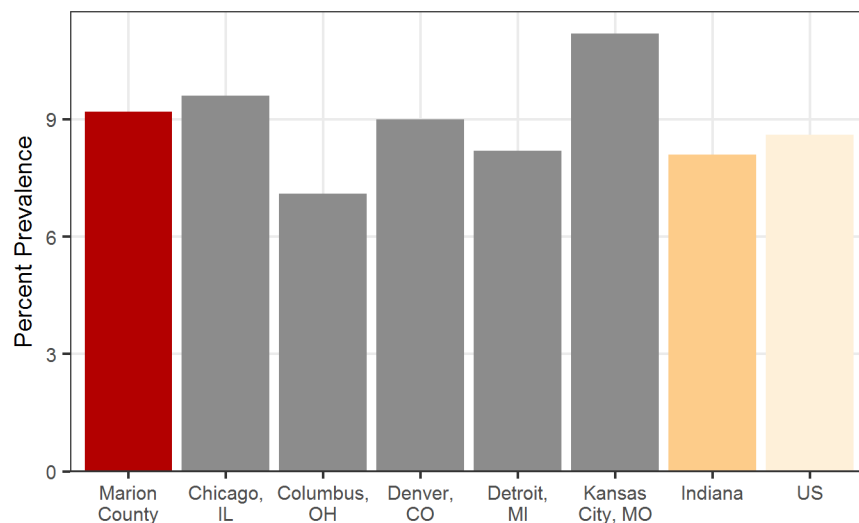
Source: Big Cities Health Coalition

Trend

Marion Co. Uninsured, 2012-2018

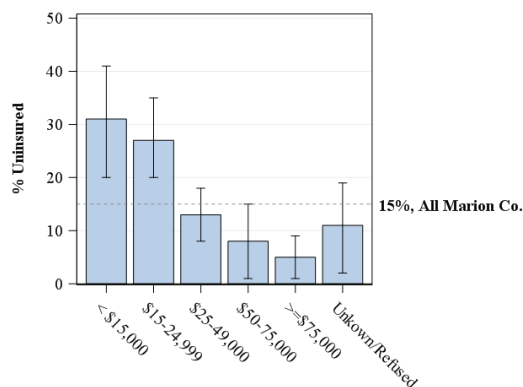Source: County Health Rankings and Roadmaps

DR3794

Risk Factors

- High cost of care
- Unemployment
- Inadequate or no insurance coverage

- Far proximity to or lack of health services
- Lack of culturally competent care, including linguistic barriers

Source: Centers for Disease Control and Prevention, Healthy People 2020

Equity

Uninsured by Income, Marion Co. 2016

Source: BRFSS

Uninsured by Income
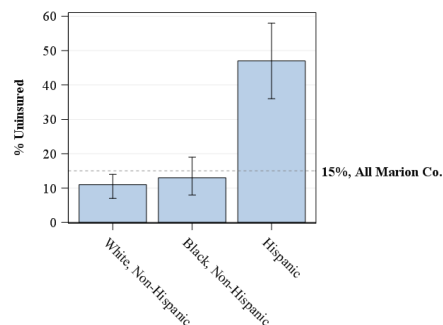
Marion County residents with lower incomes are less likely to have health coverage.

Uninsured by Race/Ethnicity, Marion Co. 2016

Source: BRFSS
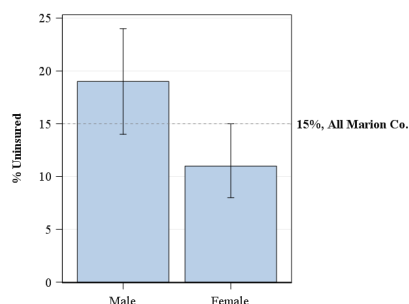
Uninsured by Race/Ethnicity

Marion County Hispanics are less likely to have health coverage.

Uninsured by Gender, Marion Co. 2016

Source: BRFSS

Uninsured by Gender

Marion County men are less likely to have health coverage.

Health Equity

"Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." Source: Robert Wood Johnson Foundation (RWJF)

Health Impacts

Increased risk of:

- Lower life expectancy
- Poor health outcomes
- Lack of access to care

Comparison

Life Expectancy, Marion Co. vs. other locations, 2016
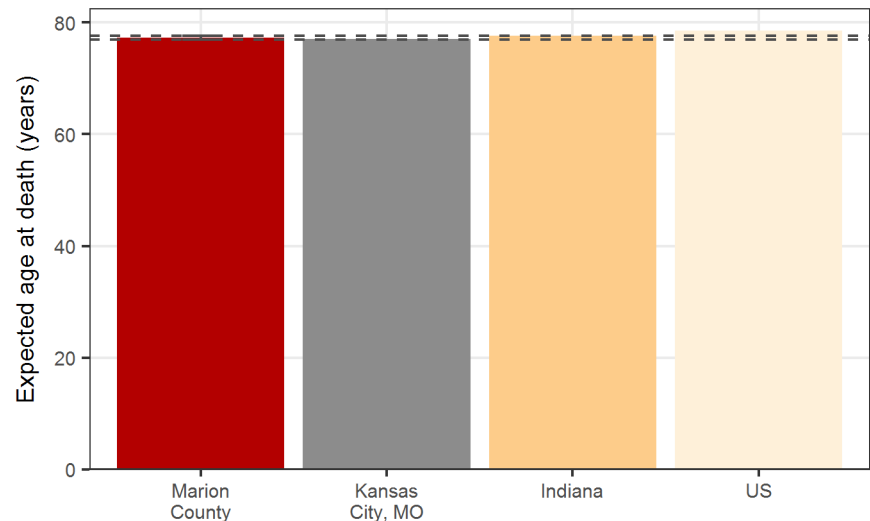
Source: Marion County Death Certificates, US Census Estimates, & Big Cities Health Coalition, www.savi.org, & www.cdc.gov

Treatment

- Reduce Poverty and other obstacles to health.
- Provide quality education and housing.
- Provide a safe environment for all.

Trend

Marion Co. Life Expectancy, 2007-2016
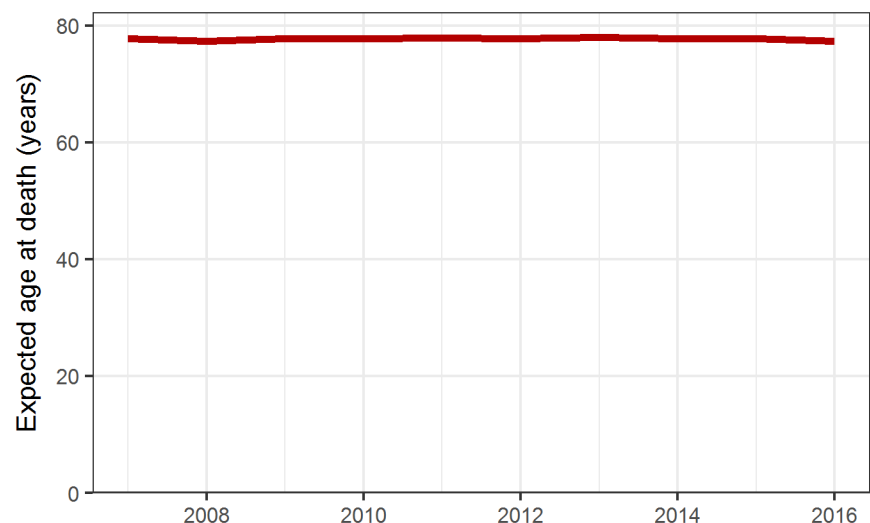
Source: Source: Marion County Death Certificates & US Census Estimates, DR3568

DR3780

Marion County Public Health Dept. Epidemiology, DR3749, 21OCT2018 Epidemiology@MarionHealth.org

Risk Factors

- Poverty.
- Discrimination.
- Lack of Fair Pay and Jobs.

- Lack of Access to Health Care.
- Lack of Policies to ensure safe and quality housing

Source: RWJF

Equity

Life Expectancy by ZIP Code, Marion Co. 2016

Marion County Life Expectancy, 2016

Life Expectancy varies by race and by location

- All Residents: 77.3
- Black non-Hispanic: 73.7
- White non-Hispanic: 78.3

Source: Marion County Death and Birth Certificates

LIFE EXPECTANCY BY ZIP CODE, 2016

Life Expectancy Not Calculated
70 - 73.9
74.0 - 77.9
78.0 - 81.9
82 - 86
Roads

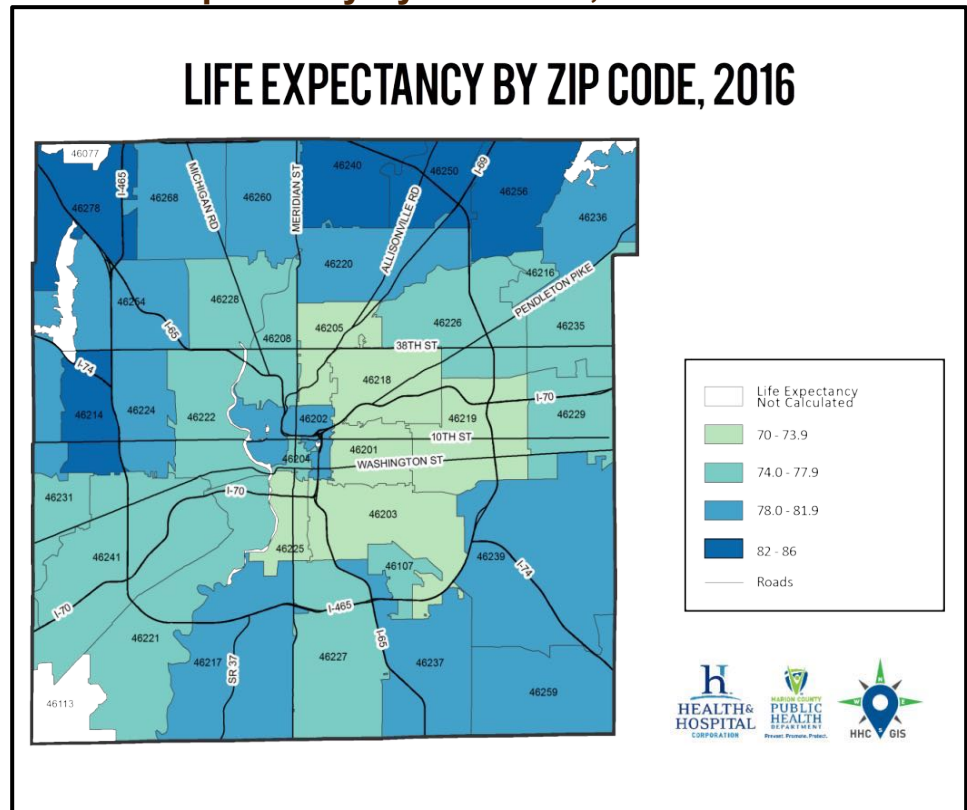Source: Marion County Death and Birth Certificates

Other Details

There is not one single metric for health equity. Instead, health inequities affect most indicators in public health. To try and succinctly show how health inequities can impact Marion County residents' lives, life expectancy has been chosen as the main metric for this fact sheet. Other examples of health indicators impacted by health equity are highlighted in the area below.

Diabetes Mortality Rate, 2016:

- Black, non-Latino: 39 per 100,000
- White, non-Latino: 25 per 100,000

Source: MCPHD Epidemiology Department, DR3563

Breastfeeding Initiation (early Postpartum), 2016:

- White, non-Hispanic: 78.2%
- Black, non-Hispanic: 67.3%
- Hispanic: 85.7%

Source: MCPHD Epidemiology Department, DR3484

Homelessness

Individuals who do not have a permanent residence, including those who are sheltered and unsheltered. This condition can touch individuals and families, all genders, and all age groups. Though there are many who suffer chronic homelessness, others will be at risk and suffer homelessness for shorter periods.

Health Impacts

Increased risk of:

- Mental health disorders
- Substance abuse
- Tuberculosis
- Hypertension
- Asthma
- Diabetes
- Sexually Transmitted Infections
- HIV/AIDS.

179 homeless people per 100,000 persons, annually

Source: Point-in-time estimates CHIP

Comparison

Homelessness, Marion Co. vs. other locations, 2017
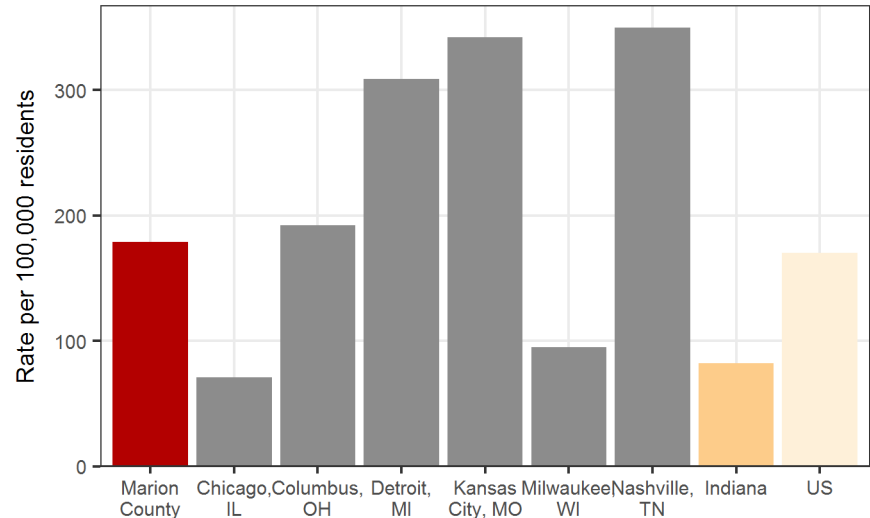
Source: US Department of Housing and Urban Development

Treatment

- Permanent supportive housing
- Increase employment and income
- Make support services more accessible

Trend

Marion Co. Homelessness, 2014-2018

Source: Coalition for Homelessness Intervention & Prevention (CHIP)

DR3794

Risk Factors

- Low income
- Loss of income or unemployment
- Prior imprisonment
- Prior history of homelessness
- Mental health issues
- Substance abuse
- Lack of family/community support
- Fleeing or attempting to flee domestic violence

Source: National Alliance to End Homeless

Equity

Homeless Adults by Race/Ethnicity, Marion Co. January 2018
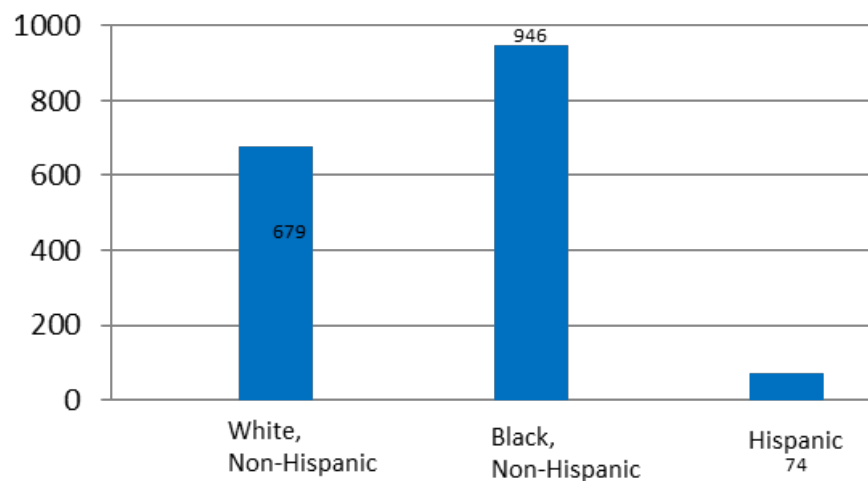
Source: Point-in-time estimates CHIP

Where People Live

- On the streets
- Camping outdoors
- In cars or abandoned buildings
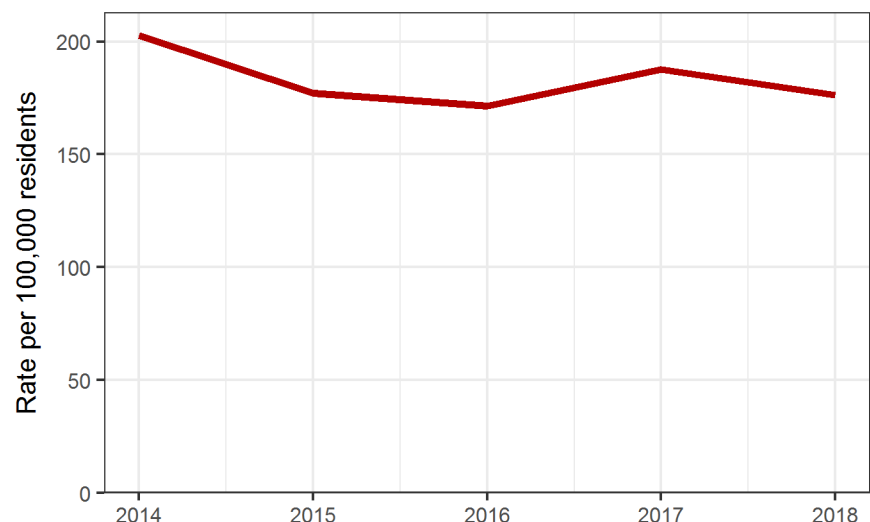- Staying in emergency shelters or transitional housing
- Staying with friends or family temporarily

Source: Substance Abuse and Mental Health Services Administration

Indianapolis Point-In-Time Count

On January 24, 2018:

- Approximately 12% of homeless adults were chronically homeless
- There were 128 families who experienced homelessness including 383 individuals in which 251 of them were under the age of 18
- Majority of school-aged children experiencing housing instability were in Indianapolis Public Schools (IPS)
- A total of 261 veterans were homeless

Source: Coalition for Homelessness Intervention & Prevention

Infant Mortality and Low Birth Weight

Infant mortality is the death of an infant that occurs during the first 365 days of life. An Infant Mortality Rate (IMR) is the number of babies who died in their first year of life per 1,000 live births. Note: Low birth weight (LBW) is defined as a birth weight less than 2,500 grams, or 5.5 lbs. Source: CDC

Health Impacts

Increased risk of:

- Cardiovascular diseases
- Respiratory problems
- Infections
- Delayed motor and social development
- Learning disabilities

Source: CDC, County Health Rankings

Treatment

- Quit smoking
- See a doctor for a medical checkup before pregnancy
- Control diseases such as high blood pressure or diabetes
- Get preconception health care and early prenatal care
- Discuss concerns during pregnancy with a doctor
- Seek medical attention for any warning signs or symptoms of preterm labor
- Daily multivitamin containing 400 micrograms of folic acid before and throughout pregnancy

Source: CDC

Comparison

Infant Mortality, Marion Co. vs. other locations, 2012
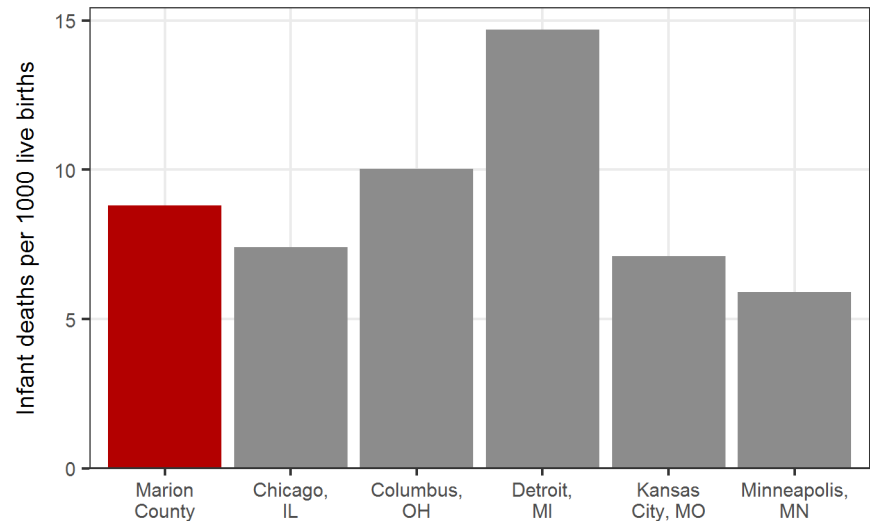
Source: Big Cities Health Coalition

Trend

Marion Co. Infant Mortality, 2012-2017
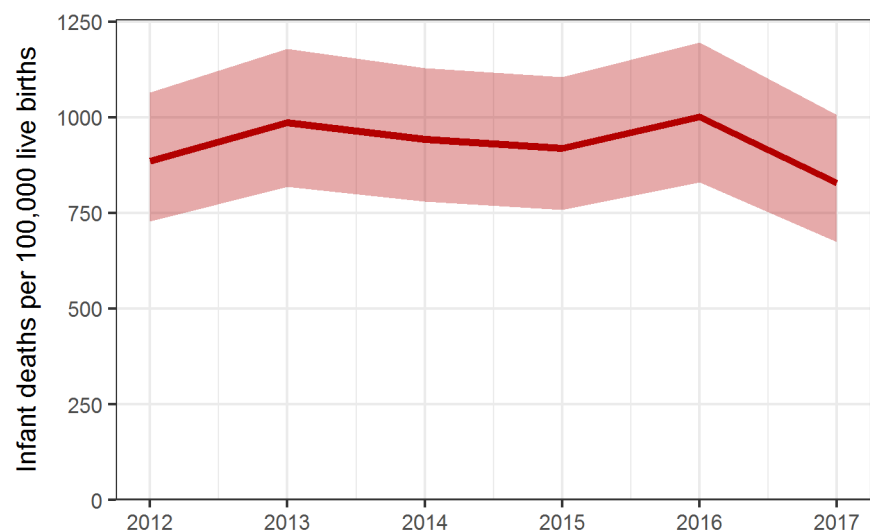
Source: Marion County Death and Birth Certificates, DR3728

DR3789

Risk Factors

Infant Mortality Risk factors

- Preterm birth
- Birth defects
- Low birth weight
- Maternal complications during pregnancy
- Unsafe sleeping practices

Source: HHS, CDC

Low Birth Weight Risk Factors

- Smoking and alcohol consumption
- Lack of weight gain
- Being under 15 years or over 35 years old
- Previous preterm birth
- Exposure to air pollution
- Drinking water contaminated with lead
- Low educational level or income
- Stress
- Domestic violence or abuse
- Being unmarried

Source: HHS, CDC

Equity

Infant Mortality by Race/Ethnicity, 2017

Number of infant deaths per 1,000 persons, annually:

- All Marion County   8.3
- White, non-Hispanic   5.5
- Black, non-Hispanic   12.6
- Hispanic   6.8

Source: Marion County Death and Birth Certificates, DR3484

Infant Mortality by Race/Ethnicity, Marion Co. 2007-2017
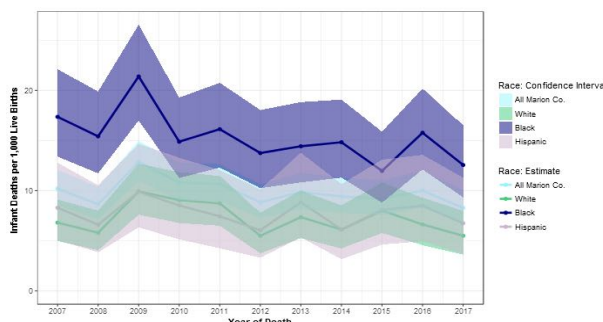
Source: Marion County Death and Birth Certificates, DR3484

Low Birth Weight by Race/Ethnicity, Marion Co. 2007-2017
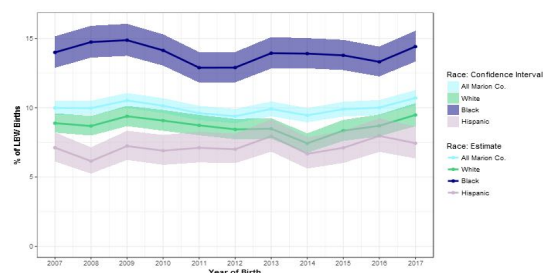
Source: Marion County Death and Birth Certificates, DR3484

Low Birth Weight by Race/Ethnicity, 2017

Percent of low birth weights:

- All Marion County   10.70%
- White, non-Hispanic   9.50%
- Black, non-Hispanic   14.40%
- Hispanic   7.40%

Source: Marion County Death and Birth Certificates, DR3484

Mental Health

Mental health encompasses a multitude of diagnoses. Depression is one of the most common mental health diagnoses made and it is characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life. Depression can lead to suicide, or the act of intentionally causing one's own death.

Health Impacts

Increased risk of:

- Suicide – 50% of all suicides are due to depression
- Substance abuse – 2x more likely to be diagnosed with a substance use disorder
- Sleep disorders
- Poor social skills
- Relationship issues

Treatment

- Medication (Antidepressants)
- Psychotherapy
- Electroconvulsive therapy

Comparison

Suicide Mortality, Marion Co. vs. other locations, 2016
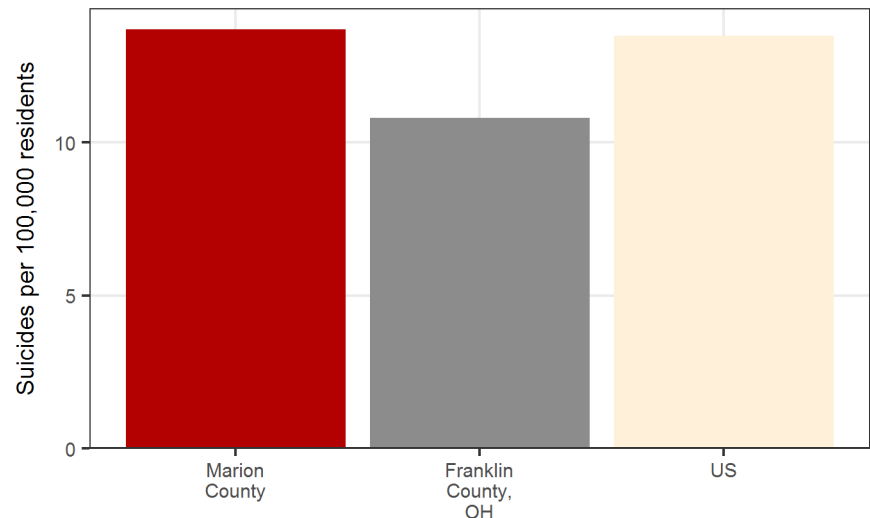
Source: Big Cities Health Coalition

Trend

Marion Co. Suicide Mortality, 2008-2017

Source: Marion County Coroner Data

DR3783
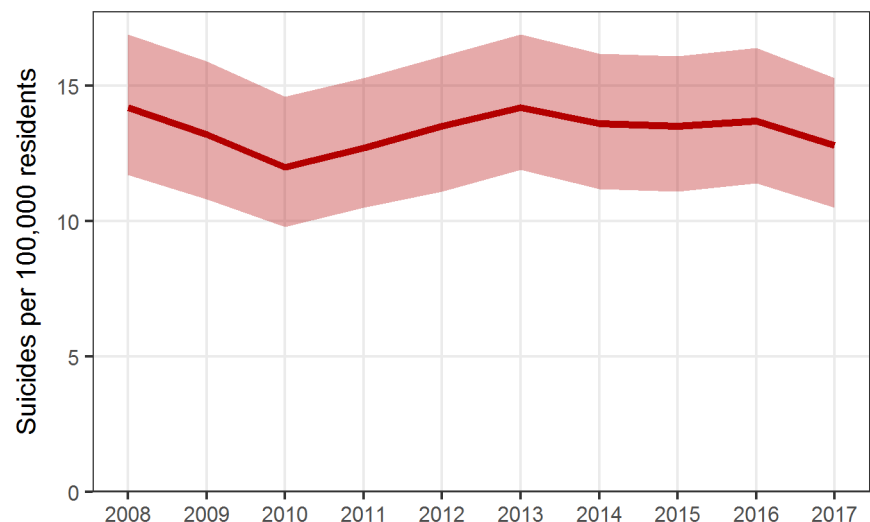
Risk Factors

- Personal or family history of mental illness
- Major life changes
- Trauma
- Stress
- Certain medications
- Genetics

Equity

Depression by Gender, Marion Co. 2016

Depression by Gender

Marion County women were nearly twice as likely as men to report feeling depressed.
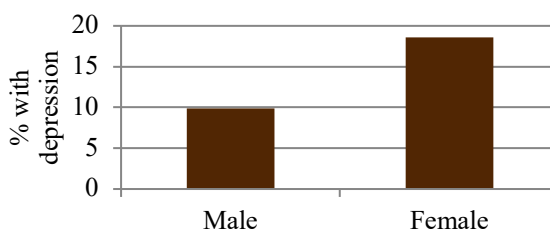
Source: BRFSS

Depression by Income, Marion Co. 2016
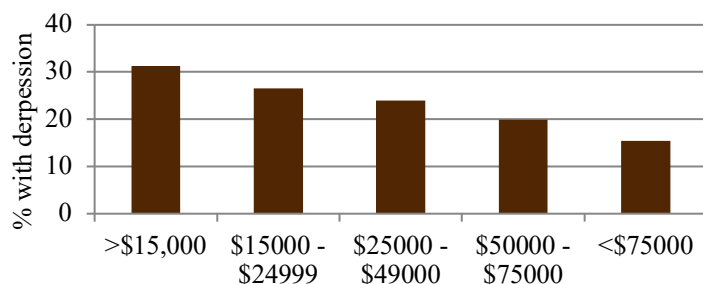
Source: BRFSS

Depression by Income

Among Marion County residents there was a direct correlation between income and self-reported depression.

Indiana Mental Health Ranking, 2017

Prevalence (Indiana's rank = 43)	Indiana	U.S.
Adult prevalence of any mental illness	20.25%	18.29%
Adults with dependence or abuse of Illicit Drug or Alcohol	8.9%	8.47%
Adults with serious thoughts of Suicide	4.13%	3.94%
Youth with at least one past year Major Depressive Episode	12.19%	11.01%
Youth with severe Major Depressive Episode	9%	7.4%
Youth with Dependence or Abuse of Illicit Drugs or Alcohol	5.09%	5.13%
Adults with a mental illness who did not receive treatment	57.2%	56.50%
Access to care (Indiana's rank = 37)	Indiana	U.S.
Adults with a mental illness Reporting unmet Need	24%	20.30%
Adults with a mental illness who are uninsured	19.1%	17%
Adults with disability who Could Not See a Doctor Due to Costs	25.4%	22.9%
Youth with Major depression who did not receive mental health services	71.1%	64.1%
Youth with Major depressive disorder who received Some consistent treatment	21%	21.7%
Children with private insurance that did not cover mental or emotional problems	6.7%	7.9%
Students identified with emotional disturbance for an Individualized Education Program	13.31 per 1000	7.71 per 1000
Mental Health Workforce Availability	710:1	529:1

Source: State of Mental Health in America

Obesity

A weight that is higher than what is considered to be healthy, determined by a Body Mass Index (BMI) of ≥ 30 (calculated using height and weight)

Health Impacts

Increased risk of:

- Stroke
- Heart disease
- Diabetes
- Certain types of cancer
- Poor mental health
- Arthritis

139 deaths per 100,000 persons, annually

Source: CDC

Comparison

Obesity, Marion Co. vs. other locations, 2015-2016
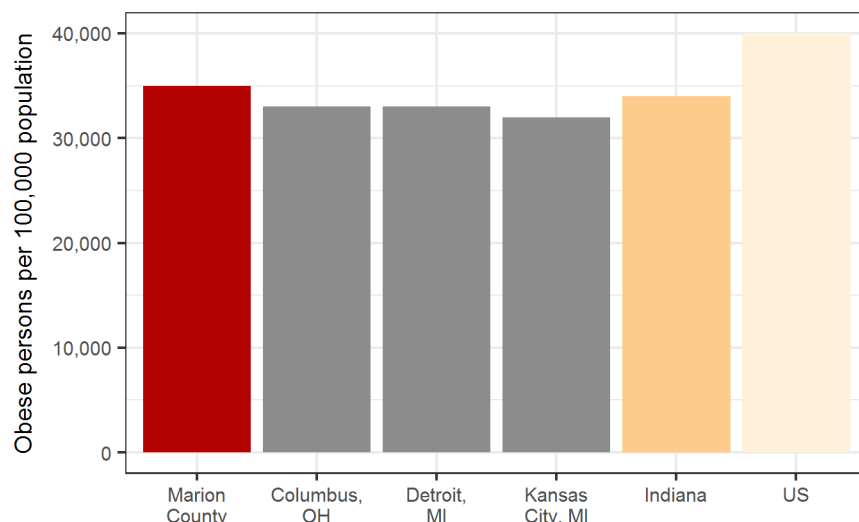
Source: Big Cities Health Coalition

Treatment

- Exercise
- Increase access and consumption of nutritious foods

Trend

Marion Co. Obesity, 2011-2016
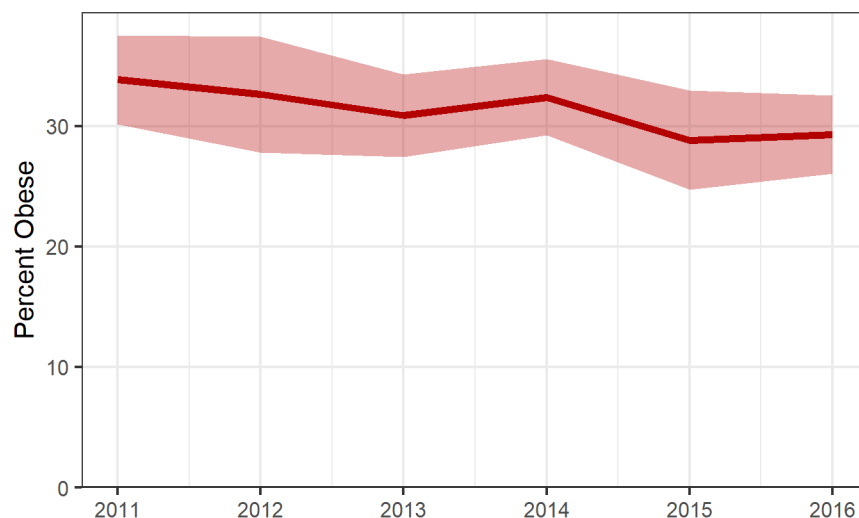
Source: BRFSS

DR3769

Risk Factors

Behavior

- inadequate exercise: < 150 minutes of moderate exercise and 2 days of strength training
- unhealthy diet: lacking fruits, vegetables, whole grains, and lean protein, and drinking water

Source: RWJF

Environment

- Lacking a safe environment for walking/biking
- Friends and family members who are not active and do not eat healthy foods

Source: RWJF

Equity

Obesity by Gender, Marion Co. 2016

Source: BRFSS

Obesity by Gender

Males reported a higher rate of obesity compared to females in Marion County.

Obesity by Race/Ethnicity, Marion Co. 2016
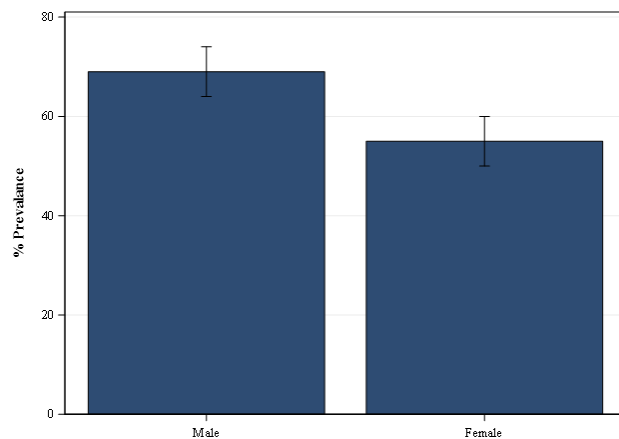
Source: BRFSS

Obesity by Race/Ethnicity

Non-Hispanic African Americans reported a higher rate of obesity compared to their non-Hispanic White and Hispanic counterparts in Marion County.

Opioids

High dose use of opioids may result in serious, harmful symptoms or death.

Health Impacts

Increased risk of:

- Respiratory depression
- Death

Comparison

Opioid Overdose Deaths, Marion Co. vs. other locations, 2016
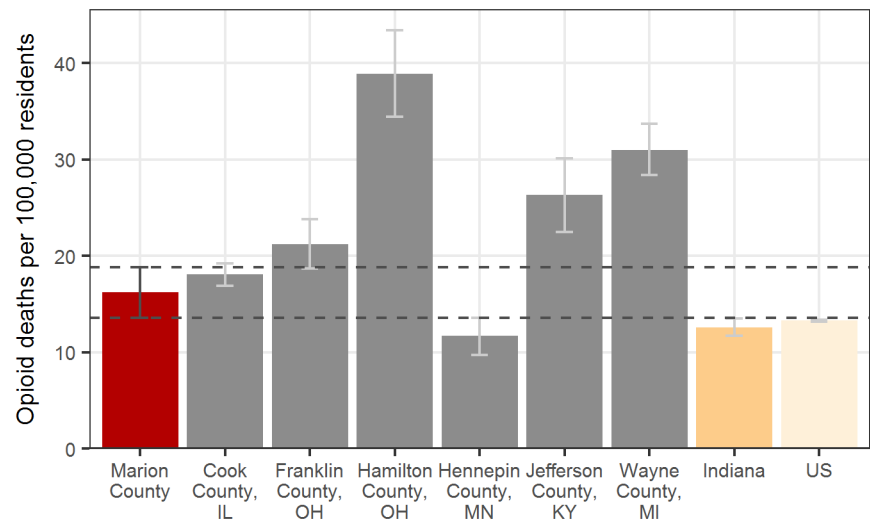
Source: CDC WONDER Fatal Drug Overdose

Treatment

- Medication Assisted Therapy (MAT) via Methadone, Naltrexone or Buprenorphine
- Cognitive-behavioral therapy
- Motivational enhancement therapy
- Inpatient and Residential treatment or intensive outpatient treatment

Source: WHO, Information sheet on opioid overdose & CDC Risk Factors for Prescription Opioid Abuse and Overdose

Trend

Marion Co. Opioid Overdose Deaths, 2010-2016
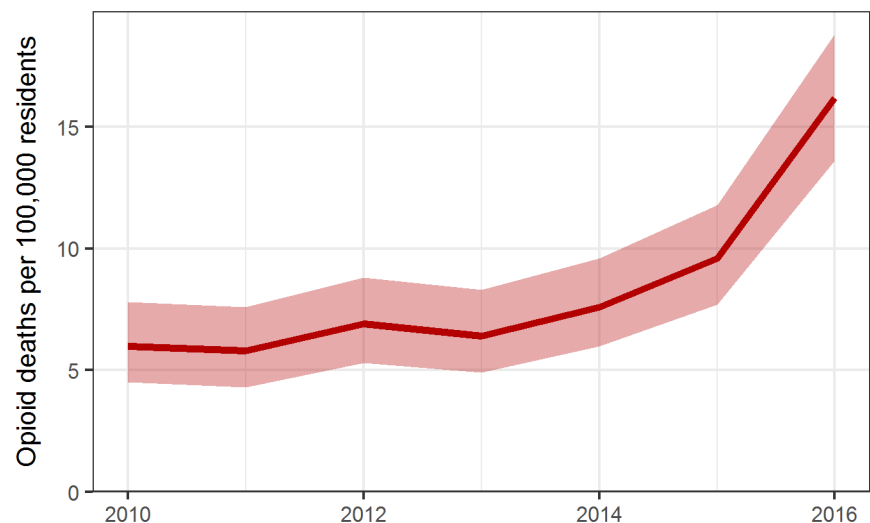
Source: CDC WONDER Fatal Drug Overdose

DR3788

Risk Factors

- History of substance use disorder
- High prescribed dosage or multiple prescriptions
- Male gender or older age
- Mental health conditions

Source: WHO, Information sheet on opioid overdose & CDC, Risk Factors for Prescription Opioid Abuse and Overdose

Equity

Overdose Deaths by Drug Type, Marion Co. 2017

79%   21%

■ Opioid involved

■ Opioid not involved

0%   50%   100%

Source: Marion County Coroner's Office Toxicology Data (of 406 overdose deaths with toxicology)

Naloxone EMS Runs by Age, Marion Co. 2013-2016
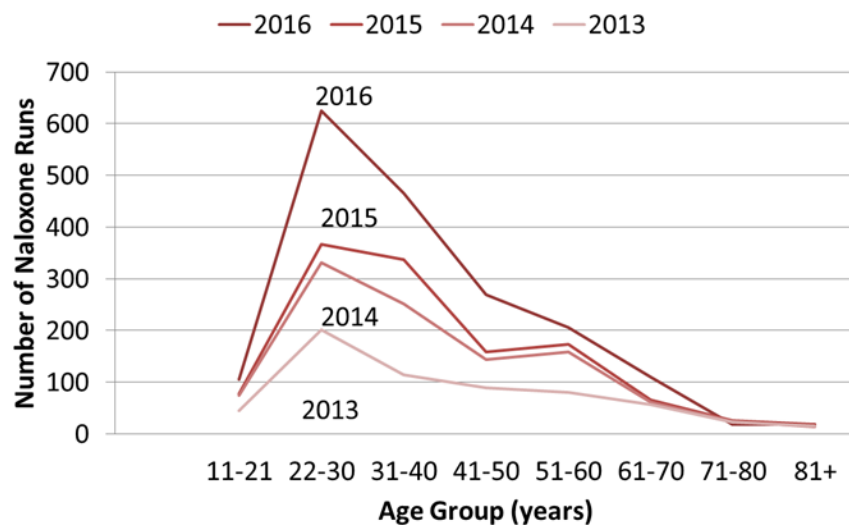
Source: I-EMS Naloxone Administration Data

Overdose

Taking more than the normal or recommended amount of a substance which may result in serious, harmful symptoms or death.

Health Impacts

Increased risk of:

- Respiratory depression
- Death

Comparison

Overdose Deaths, Marion Co. vs. other locations, 2016
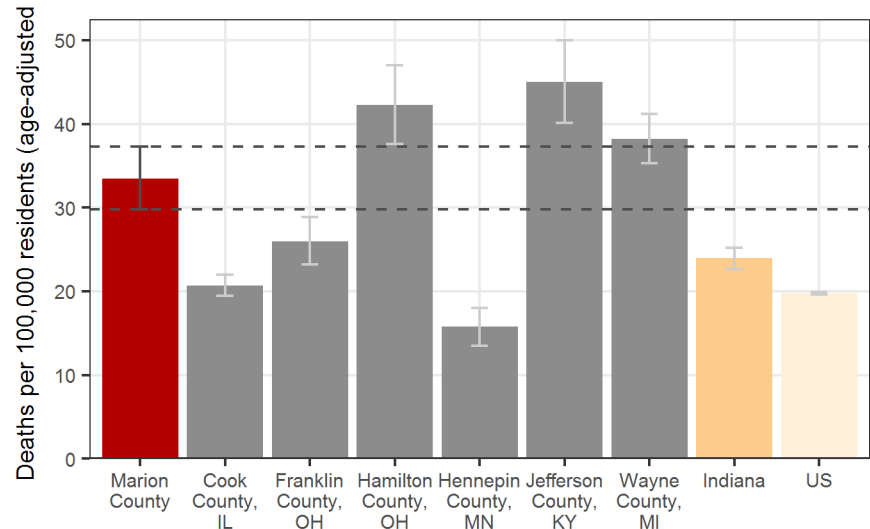
Source: CDC WONDER Fatal Drug Overdose

Treatment

- Cognitive behavioral therapy
- Motivational enhancement therapy
- Inpatient and Residential treatment or intensive outpatient treatment
- Medication Assisted Therapy

Source: WHO, Information sheet on opioid overdose

Trend

Marion Co. Overdose Deaths, 2010-2016
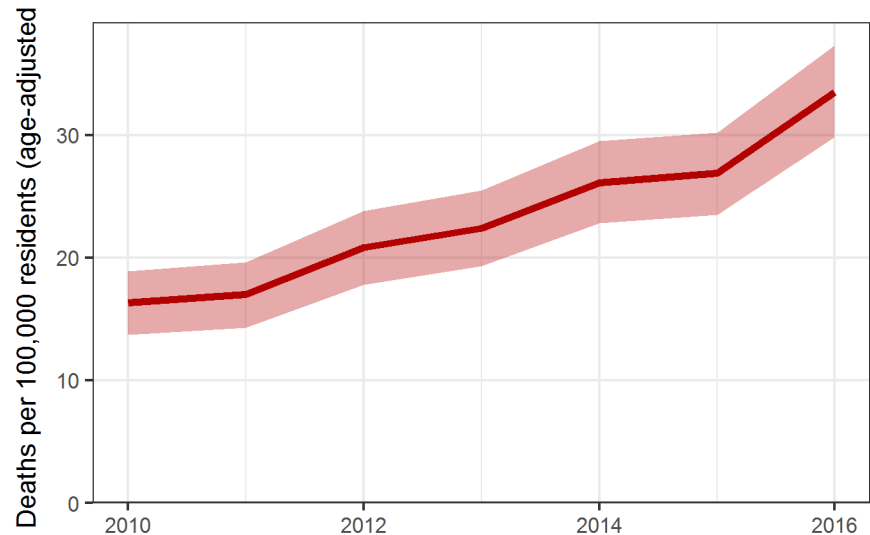
Source: CDC WONDER Fatal Drug Overdose

DR3788

Risk Factors

- History of substance use disorder
- High prescribed dosage or multiple prescriptions
- Male gender or older age
- Mental health conditions

Source: WHO, Information sheet on opioid overdose & CDC, Risk Factors for Prescription Opioid Abuse and Overdose

Equity

Overdose Deaths by Drug Type, Marion Co. 2017

79%   21%

■ Opioid involved

■ Opioid not involved

0%   50%   100%

Source: Marion County Coroner's Office Toxicology Data (of 406 overdose deaths with toxicology)

Overdose Deaths by Race/Ethnicity, Marion Co. 2000-2017

White, 230
AA, 83
Hispanic, 14
Other, 6
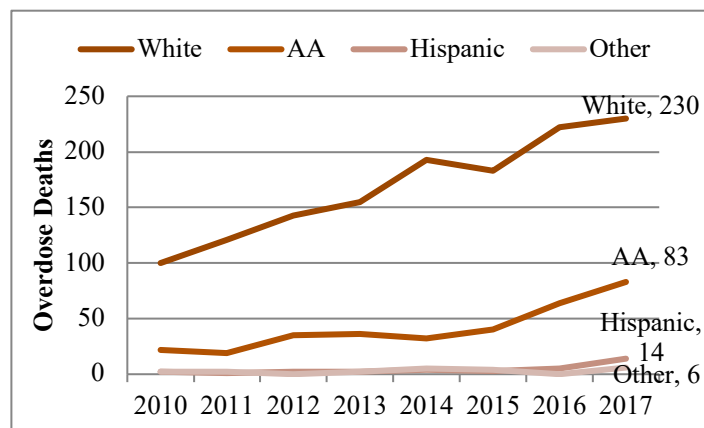
Source: Marion County Death Certificates

Overdose Deaths by Gender, Marion Co. 2000-2017
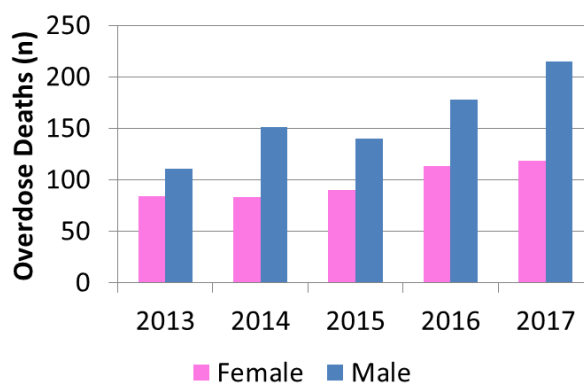
Source: Marion County Death Certificates

Poverty

In the U.S., poverty refers to individuals and families whose income is below the Federal Poverty Guideline. The Federal Poverty Guideline in 2016 was $11,880 for an individual and $24,300 for a four-person household.

Health Impacts

Increased risk of:

- Poor academic achievement
- Crime
- Greater health expenditures
- Inadequate nutrition
- Food insecurity
- Some studies have shown a 2 times increased risk of Coronary Heart Disease

Comparison

Percent of Population Below Federal Poverty Guideline, Marion Co. vs. other locations, 2016
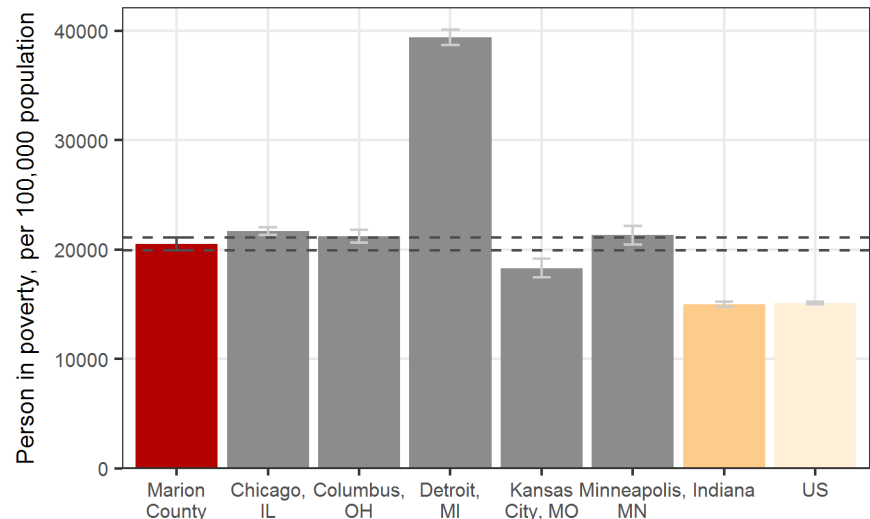
Source: ACS 5 Year Summaries, 2010-2016

Treatment

- Policy Changes
- Social Reform

Trend

Poverty, Marion Co. 2012-2016

Source: ACS 5 Year Summaries

DR3780
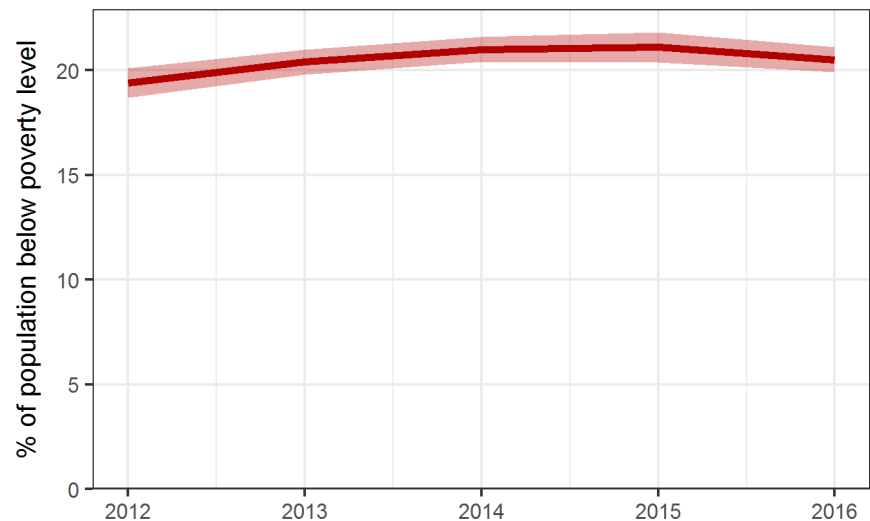
Risk Factors

Risk factors for poverty in childhood include low parental education (where parents both lack a high school degree), non-employed parents, teen mothers, single-parents, large families with four or more children, children in families who have changed residences one or more times in the last 12 months, and households without English speakers.

Source: NCCP, National Center for Children in Poverty

Equity

Percent of Population Below Federal Poverty Guideline in Marion County, by Race
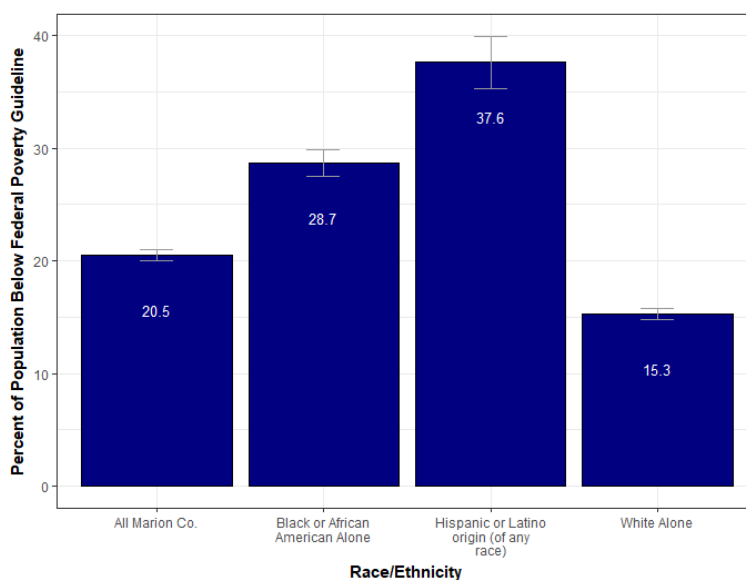
Data Source: ACS 5-Year Estimates, DR3780

Percent of Population Below Federal Poverty Guideline in Marion County, by Educational Attainment for those 25 years and over
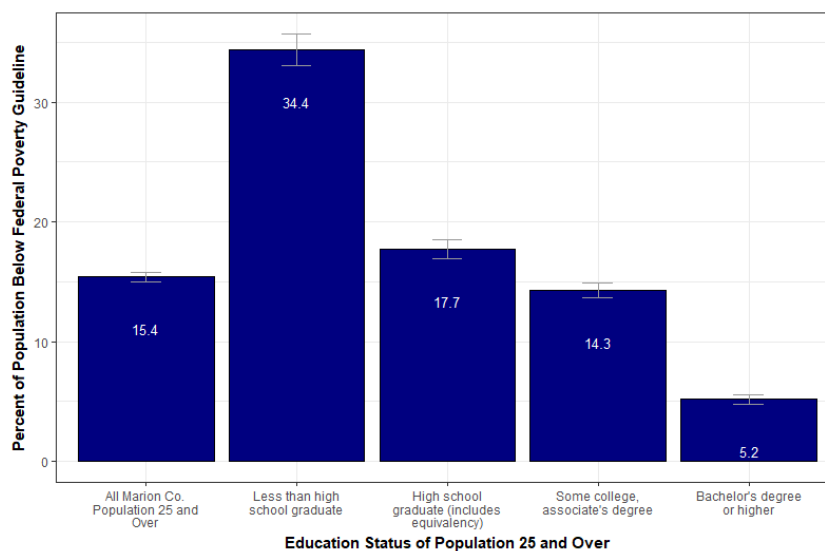
Data Source: ACS 5-Year Estimates, DR3780

Tobacco Use, E-cigarettes

A product made from the tobacco plant, used to smoke or chew

Health Impacts

Increased risk of:

- lung cancer
- Stroke
- Heart disease
- Diabetes
- Certain types of cancer
- Lung diseases
- Chronic obstructive pulmonary disease

146 deaths per 100,000 persons, annually

Source: CDC

Comparison

Cigarette Use, Marion Co. vs. other locations, 2015-2016
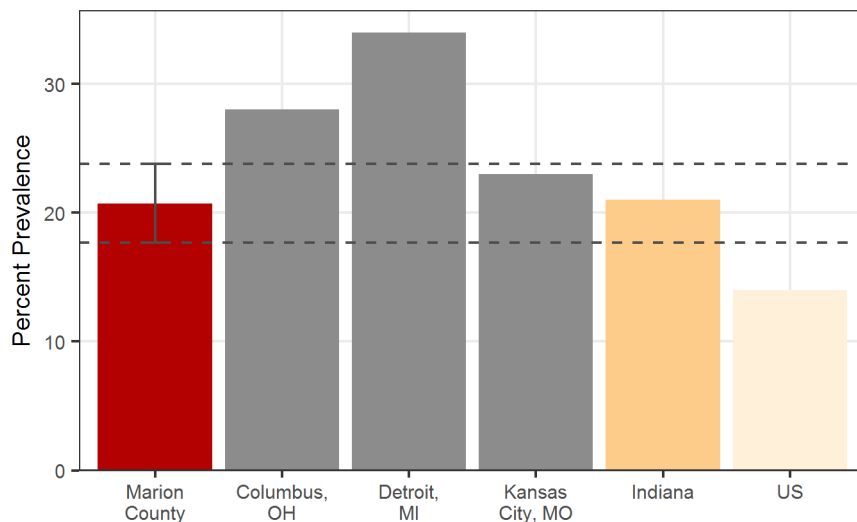
Source: Big Cities Health Coalition

Treatment

- Cessation of tobacco use
- Products with nicotine intended to assist with cessation (e.g. Nicotine gum, Nicotine patches, Medication Assisted Therapy)

Trend

Marion Co. Cigarette Use, 2011-2016
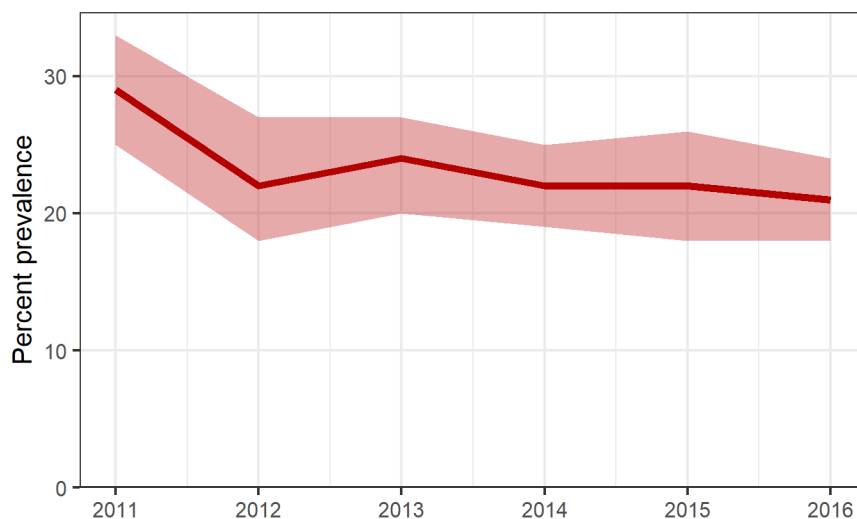
Source: BRFSS

DR3786

Risk Factors

Characteristics

- Male
- White
- Did not attend college

Environment

- Family members or friends who smoke
- Exposure to tobacco advertisements

Equity

Cigarette Use by Gender, Marion Co. 2016
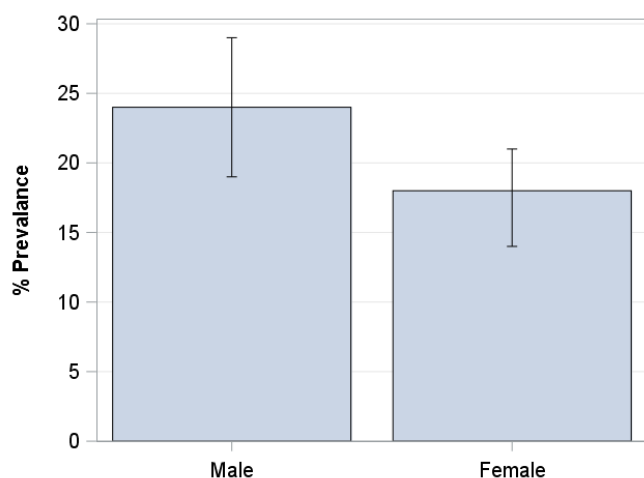
Source: BRFSS

Cigarette Use by Race/Ethnicity, Marion Co. 2016
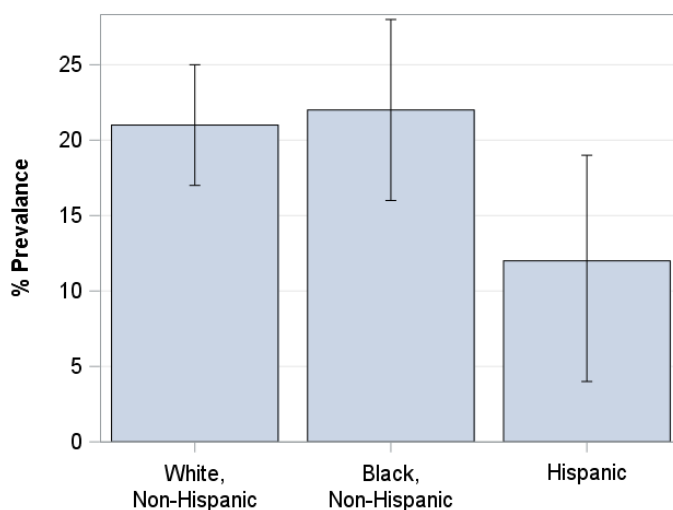
Source: BRFSS

Cigarette Use by Income, Marion Co. 2016
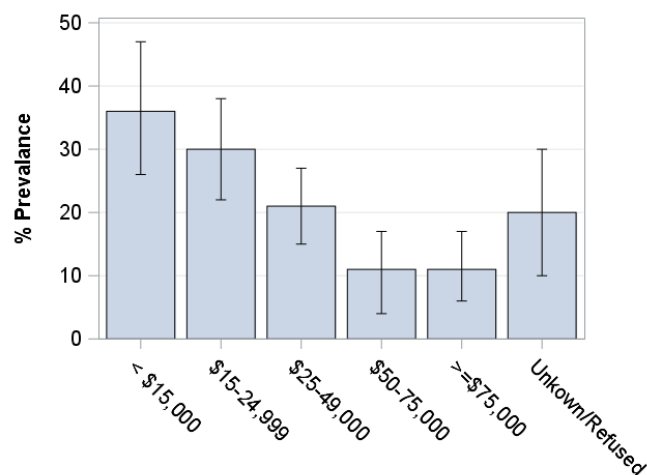
Source: BRFSS

E-Cigarettes Use among Adolescents

According to the 2015 Indiana Youth Risk Behavior Survey (YRBS), nearly 44% of Indiana high school students reported trying e-cigarettes.

Source: Indiana YRBS

Violence

Violence is the physical use of force to hurt, injure, abuse, harm, or kill someone.

Health Impacts

Increased risk of:

- Injury
- Chronic pain
- Post traumatic stress disorder (PTSD)
- Psychological distress
- Death
- Poor community safety and wellbeing

Source: WHO World Report on Violence and Health 2002

Comparison

Homicide Rates, Marion Co. vs. other locations, 2016
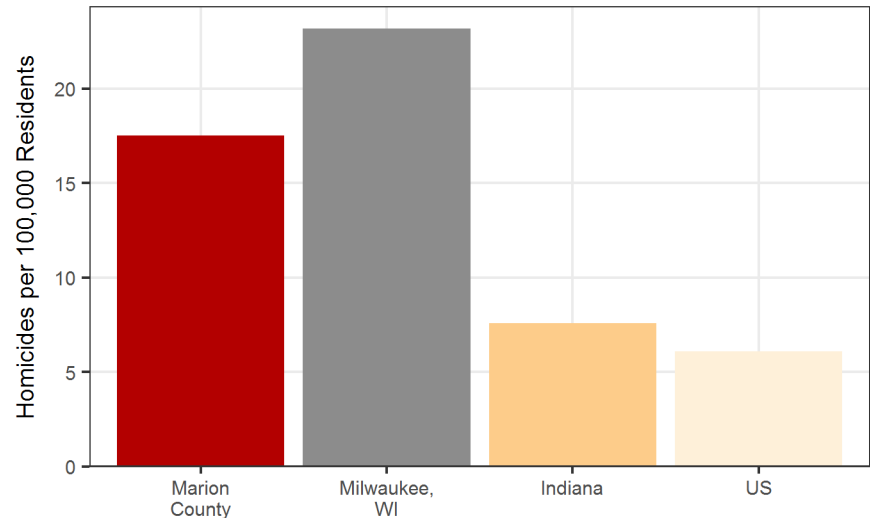
Source: Marion County Coroner Data 2016; Milwaukee Homicide Commission Report 2016; CDC 2016

Treatment

- Short- and long-term medical care
- Mental health services
- Improve community environment
- Reduce social stressors (e.g. poverty)

Source: WHO World Report on Violence and Health 2002

Trend

Marion Co. Homicide Rate 2012-2017
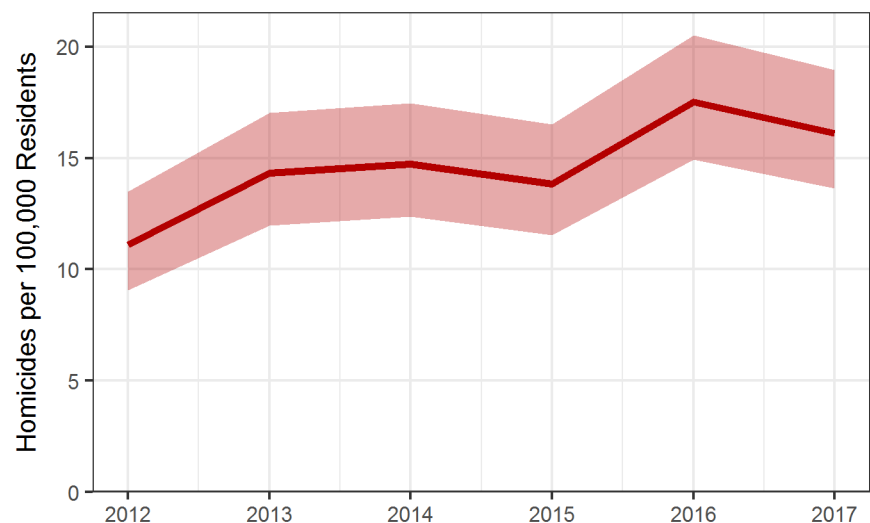
Source: Marion County Coroner Data

DR3774

Risk Factors

Personal

- Past violent behaviors
- Use and abuse of alcohol or drugs
- Bullying

Source: New York State Office of Mental Health

Environmental and Community

- Economic disadvantage
- Community disorganization
- Access to guns or other weapons

Source: New York State Office of Mental Health

Equity

Homicide Rate by Race, Marion Co. 2012-2017

Racial Disparities in Homicide Rates

Higher homicide rate among **NH-Black** residents compared to NH-White residents.
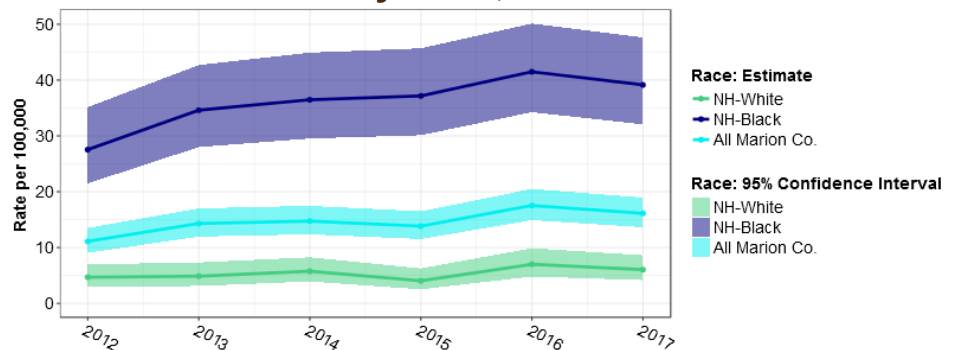
Source: Marion County Coroner Data (2012-2017)

Homicide Rate by Gender, Marion Co. 2012-2017
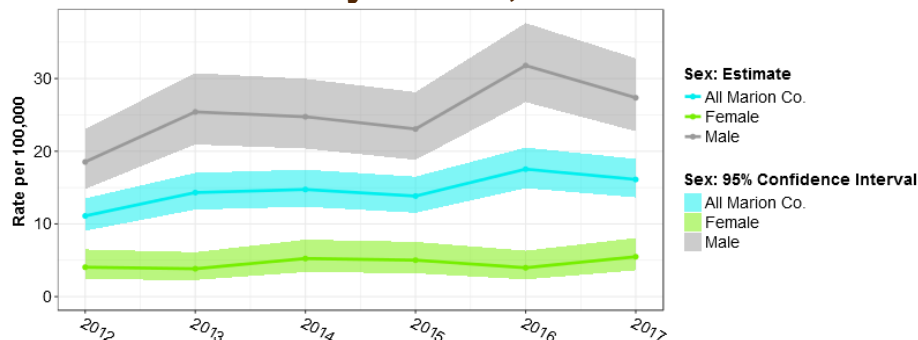
Source: Marion County Coroner Data

Gender Disparities in Homicide Rates

Higher homicide rate among **male** residents compared to female residents.

Gender Disparities in Violence-Related ED Visits

Greater proportion of violence-related emergency department (ED) are **males** compared to females.

Stabbing- or Firearm-related ED Visits by Gender, Marion Co. 2012-2018
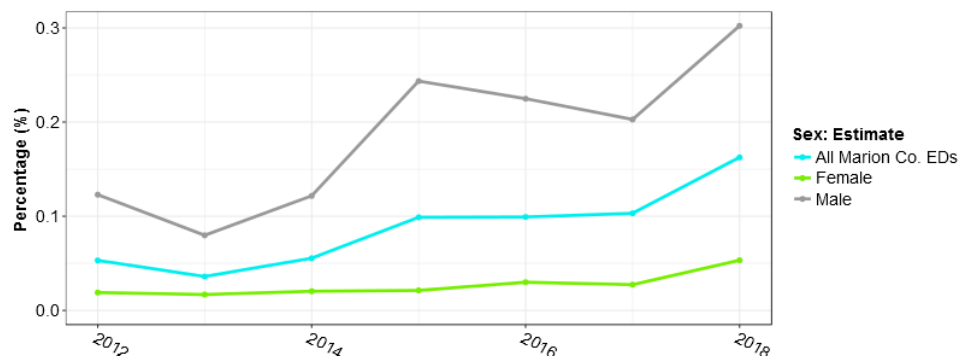
Source: Marion County hospital emergency dept. data

Impact Score Summary (all topics)

		Criteria	Crime	Diabetes	Domestic Violence	Food Access	Health Care Access	Health Equity	Homelessness	Infant Mortality & Low Birth Weight	Mental Health	Obesity	Opioids	Overdoses	Poverty	Tobacco Use	Violence
	Size	Prevalence*	7	7	6	8	7	9	3	7	8	10	6	7	8	8	5
Severity	Morbidity	Impacts Quality of Life?	1	1	1	1	1	1	1	1	1	1	1	1	0-1	1	1
		>$300 annual medical cost	1	1	1	1	1	0-1	1	1	1	1	1	1	0-1	1	1
		>$1000 annual related costs	1	1	0	1	1	0-1	1	1	0	1	1	1	1	1	1
	Mortality	Early death	1	1	1	0-1	1	1	1	1	1	1	1	1	1	1	1
		In top 5 causes of death	0	0	0	0	0	1	0	0	0	1	0	0	1	1	0
		In top 15 causes of death	0	1	1	0-1	0	1	0	0	1	1	1	1	1	1	1
	Equity	Prevalence diff.	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1
		Morbidity or Mortality diff.	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Trend	Getting worse	0	1	0	0	0	0	1	0-1	1	1	1	1	0	0	1
	Comparability	Equivalent*	0.5	0.5	0	0	0.5	0.5	0.5	0.5	0	0	0.5	0.5	-	0	0
		Worse	0	0	1	1	0	-	0	0	1	1	-	0	1	0	0
		Overall Score	18	24	20	20-24	20	22-26	18	20-22	24	30	23	24	22-26	24	21

* Topics get one point per criterion met, except: 1) If "Equivalent", give 0.5 points. 2) Prevalence is scored 0-10: 9 or 10 for a prevalence of 25% or more; 7 or 8 for 10% - 24.9%; 5 or 6 for 1% - 9.9%; 3 or 4 for .1% - .9%; 1 or 2 for .01% - .09%; 0 for < .01%.

Impact Score Concept and Calculation

Calculation of the Impact Score

The impact score combines the size and severity of the topic. It assigns points to 1) the number of cases (the number of persons affected) and 2) how much each of those cases (each person) is affected. We used a modified Hanlon Score method[1], similar to that used in Cook County, Illinois, for their community health assessment of few year ago. For each topic, we assigned 1) between 0 and 10 points based on the number of cases (the prevalence), and 2) 0 to 10 points based on the impact per case (the severity). We multiplied the severity points by two, then added the prevalence points, to get the overall impact score.

Example of the Impact Score calculation: Diabetes

Diabetes got a severity score of 8 and a prevalence score of 7, for a total impact score of 23, because $(2 * 8) + 7 = 16 + 7 = 23$.

Why did diabetes get 7 points for its prevalence? The prevalence of diabetes in Marion County is about 16%, which is in the 7 to 8 point range (between 10% and 25%) and closer to 10% than to 25%, so diabetes got 7 prevalence points. See below for a table of points per prevalence range, and other scoring details.

Why did diabetes get 8 severity points? Each topic got up to one severity point for each of ten criteria. Three criteria were related to morbidity (quality of life impact, medical costs, and other costs), three to mortality (early death, in top 5 causes of death, in top 15 causes of death), two to equity (are some subpopulations in our county have notably greater prevalence, or greater morbidity or mortality), and one each for worsening trend and for whether Marion County had poorer related health statistics that other cities. Diabetes in Marion County met all those criteria except being in the top 5 causes of death, and being worse than other cities, and so got a severity score of 8. See below for a table of points per severity criterion, and other scoring details.

Impact Scoring Instructions

Documentation

As you create a Hanlon score, be sure to document your sources of information. If you have reliable but conflicting data, or no reliable data, or if you had to make a questionable methodology choice, include notes about that issue **if it had a notable impact on the score**. Do not include extensive notes about things that would not impart the score.

Calculation

The Hanlon Score is calculated as:

  Hanlon Score = Size + (2*Seriousness)

Size and Seriousness are calculated as indicated below.

Size score (up to 10 points)

Rating	Size of Health Problem (% of population with health problem [incidence or prevalence])
9 or 10	>25% (STDs)
7 or 8	10% - 24.9%
5 or 6	1% - 9.9%
3 or 4	.1% - .9%
1 or 2	.01% - .09%
0	< .01%
Guiding considerations when ranking health problems against the 3	Size of health problem should be based on baseline data collected from the individual Community

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[1] https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf

criteria	

Seriousness score (up to 10 points)

Broken into 4 components, with sub-components:

Component	Score range	Criteria
Morbidity	0-3	Quality of Life. Costs
Mortality	0-3	Early Death, Top Cause
Equity	0-3	Disadvantaged Populations
Comparability	0-1	Comparison Counties, state, US

Component or sub-component	Points	Criteria
Morbidity	(0-3)	
- QoL	1	Reduces quality of life
- Medical costs	1	> $300 annual
- Related costs	1	> $1000 annual
Mortality	(0-3)	
- Early death	1	Top rankable cause for age <75 (we may replace this with something based on YPLL, like "top cause by YPLL")
- Top 5 cause	2	Rankable causes
- Top 6-15 cause	1	Rankable causes
Equity	(0-2)	Disadvantaged Populations
- prevalence diff.	1	greater in a disadvantaged pop.
- morbidity or mortality diff.	1	greater in a disadvantaged pop (per case)
Trend	(0-1)	Significant trend for the worse
Comparability	(0-1)	Comparison Counties, state, US
- equivalent	0.5	
- worse	1	

Morbidity
- Does the condition reduce an individual's Quality of Life?
- Does the condition cost more than $300 annually in medical expenses?
- Does the condition cost more than $1000 annually in all related costs?

Mortality
- Does the condition contribute to early death? (top rankable causes of death for individuals < 75 years)
- Is it one of the identified top 15 rankable causes of death? (1-5 rank = 2pts, 6-15 = 1pt)

Equity
- Is the condition more prevalent in disadvantaged populations?
- Is the per-case morbidity burden greater in disadvantaged populations, or are disadvantaged populations more likely to die of this condition?

Trend
- Is the prevalence or severity getting significantly worse?

Comparability
- Relative to data available for other geographies (state or national), is our jurisdiction better (0pts), equivalent (0.5 pts), or worse (1pt)?

Example: Cardiovascular Disease/Hypertension (from Cook County, without the Trend criterion)

		Criteria	Results	Score	Source
Size		Prevalence	35%	10	Local survey
Severity	Morbidity	Impacts QoL?	Yes	1	Illinois Vital Statistics, 2009-2013
		>$300 annual medical cost	Yes	1	Davis, K. Expenditures for Hypertension among Adults Age 18 and Older, 2010. Estimates for the U.S. Civilian Noninstitutionalized Population. Statistical Brief #404. April 2013. Agency for Healthcare Research and Quality, Rockville, MD.
		>$1000 annual related costs	No	0	CDC High Blood Pressure Frequenty Asked Questions, 2015
	Mortality	Early death	Yes	1	Detailed Mortality Data. CDC WONDER (2010-2014). http://wonder.cdc.gov/
		Top 5 cause	Yes	2	Detailed Mortality Data. CDC WONDER (2010-2014). http://wonder.cdc.gov/
		Top 6-15 cause	No	0	Detailed Mortality Data. CDC WONDER (2010-2014). http://wonder.cdc.gov/
	Equity	Prevalence diff.	Yes	1	Illinois Department of Public Health, The Burden of Cardiovascular Disease in Illinois, 2009-2013
		Morbidity diff.	Yes	1	Quatromoni & Jones. Int J Clin Pract. 2008 Dec;62(12):1910-9. doi: 10.1111/j.1742-1241.200801943
		Mortality diff.	Yes	1	Detailed Mortality Data. CDC WONDER (2010-2014). http://wonder.cdc.gov/
	Compar-ability	Equivalent	Yes	0.5	Illinois Behavioral Risk Factor Surveillance System, 2007-2009
		Worse	No	0	Illinois Behavioral Risk Factor Surveillance System, 2007-2009

Total = Size + (2 * Severity) = 10 + (2 * 8.5) = 27

APPENDIX D

Marion County Community Plans that inform CHIP
Activities: (NOTE: An * indicates MCPHD participation.)

- Top 10 *
- LISC Quality of Life Plans *
- Indy Food Council *
- Indiana Healthy Weight Initiative *
- Hospitals CHA/CHIP *
- Hospitals' Community Benefit Reports
- Indiana Sports Corporation
- Jump IN for Healthy Kids *
- Health by Design Strategic Plan *
- National Prevention Strategy (U.S. Surgeon General)
- National Quality Strategy (Agency for Healthcare Research and Quality)
- OpportunIndy *
- Indiana Minority Health Coalition *
- Marion County Minority Health Coalition *
- Indiana Latino Institute *
- Latino Health Organization *
- Latino Health Expo *
- Indiana State Health Improvement Plan 2018-2021 *
- Hoosier Environmental Council *
- Indy Hunger Network *
- Coalition Conversations *
- Indy Chamber of Commerce (including Indy Workforce Recovery) *
- Smoke Free Indy *
- Faith and Action Project (Fall 2019 Focus Groups)*
- 2018 City of Indpls – Thrive Indy Plan * (Bloomberg grant Resilience Hub prototyping *)
- Indianapolis City County Council and Government Alliance for Race and Equity Racial Equity Initiative (GARE) *
- Hoosier Resilience Index-Grand Challenge
- Great Places 2020 *
- DIP IN (Lilly Diabetes Project) *
- EmployIndy/LISC Neighborhood-Based Workforce Development Strategic Plan
- Public Good Index—Sagamore Institute
- Plan 2020 Land Use Plan Pattern Book
- IndyMoves Action Plan
- Earth Justice Diversity, Equity, Inclusion Plan (2017)
- HHS Strategic Plan
- Thriving Communities, Thriving State Report (IUPPI)
- CICF Undoing Racism Strategic Plan (2018)
- United Nations Sustainable Development Goals
- Alliance for a Healthier Indiana *
- ISDH Chronic Disease Plan *
- 2018-2021 Syringe Service Strategic Plan *
- Fourth National Climate Assessment Report (U.S)

Resources:

- Public Health Accreditation Board website: www.phaboard.org
- NALBOH: www.nalboh.org
- PHAB Standards and Measures Version 1.5: http://www.phaboard.org/wp-content/uploads/PHABSM_WEB_LR1.pdf
- Core Competencies of Public Health: www.phf.org
- Council on Linkages: www.councilonlinkages@phf.org
- Healthy People 2020-2030 Objectives: www.healthypeople.gov
- Ten Essential Services of Public Health: https://www.cdc.gov/stltpublichealth/publichealthservices/pdf/Ten_Essential_Services_and_SDOH.pdf
- Health Equity Guide: https://healthequityguide.org/about/ (Health Impact Partners)Facing Addiction in America: The Surgeon General's Spotlight on Opioids.:ISDH Survey on Access to Care
- Indiana Recovery Council—2019 *Stigma Never Helps* Campaign

APPENDIX E

Community Plan & Link/CHA Priorities	Obesity/ Diabetes	Poor Mental Health/Substance Abuse	Poverty
MCPHD Community Health Improvement Plan www.marionhealth.org	X	X	
Top 10 www.top10in.org	X		
Plan 2020 www.plan2020.com	X		X
Indy Food Council www.indyfoodcouncil.org	X		
Health By Design www.healthbydesignonline.org	X		
Jump IN for Healthy Kids www.jumpinforhealthykids.org	X		
Community Health Network-(All Hospitals Report) https://www.ecommunity.com/sites/default/files/uploads/2017-08/Community_Health_Needs_Assessment_Final_Report-_all_counties.pdf	X		
OpportunIndy www.opportunindy.com	X	X	X
Reconnecting to Our Waterways www.ourwaterways.org	X	X	
Binford Redevelopment and Growth http://www.instituteccd.org/uploads/iccd/documents/indy_qofl_plan_brag.pdf	X		
Crooked Creek http://www.instituteccd.org/uploads/iccd/documents/indy_qofl_plan_crookedcreek.pdf	X		
Near Eastside http://www.instituteccd.org/uploads/iccd/documents/indy_qofl_plan_neareast.pdf	X	X	X
Englewood Village http://greatplaces2020.org/wp-content/uploads/2016/05/2016_0505-GP-Englewood-Village-FINAL-Web-min.pdf	X		
Near West http://liscindianapolis.org/media/Near-West-Quality-of-Life-Plan-Updated.pdf	X	X	
River West http://greatplaces2020.org/wp-content/uploads/2016/05/16-0510-River-West_LR.pdf	X		

Southeast Neighborhood QOL http://southeastneighborhood.org/plan/index.html	X		
West Indianapolis Neighborhood QOL http://www.westindianapolis.org/wp-content/uploads/2011/06/QOL_Plan_WestIndy_web.pdf			X
Far Eastside QOL Plan (CAFÉ) Link doesn't work.	X	X	
Mid North QOL https://www.midnorthplan.org/	X	X	X
Maple Crossing Strategic Plan http://greatplaces2020.org/wp-content/uploads/2016/05/2016_0510-GP-Maple-Crossing-FINAL-Web-min.pdf	X	X	X
Northeast Corridor QOL http://necorridor.com/			
Northwest Area QOL https://flannerhouse.org/north-west-quality-of-life-plan/	X	X	X
International Marketplace (Market Analysis and Strategy 2016) https://flannerhouse.org/north-west-quality-of-life-plan/	X		
South Indy Quality of Life Plan http://soindy.org/	X		X
Indy Chamber of Commerce—Indiana Vision 2025: A Plan for Hoosier Prosperity https://www.indianachamber.com/wp-content/uploads/2017/09/IN-Vision2025-Report-WithForums.pdf	X		
Smoke Free Indy			
Indiana Minority Health Coalition			
Marion County Minority Health Coalition			
Ryan White Planning Council		X	
Indiana Latino Institute http://indianalatinoinstitute.org/wp-content/uploads/2016/07/ILI_Latino-Community-Survey_FINAL_v1.pdf	X	X	X
Latino Health Organization			
Latino Health Expo			
Coalition Conversations (formerly Coalition of Coalitions) (In process.)			
Hoosier Environmental Council (In process)			

Domestic Violence Network https://dvnconnect.org/learn/community-wide-plan/substance-abuse-domestic-violence/			
Forest Manor Citywide Crime Prevention and Reduction Plan http://www.fmmsc.org/wp-content/uploads/2012/08/CPRPFINAL3.24.14.pdf		X	
Mayor Hogsett's Public Safety Plan			
CICF Indianapolis Foundation Violence Prevention Grant Program (2016-2017) http://www.fmmsc.org/wp-content/uploads/2012/08/CPRPFINAL3.24.14.pdf			
Indy Hunger Network Community Impact Goal https://www.indyhunger.org/who-we-are/community-impact	X		
National Prevention Strategy https://www.surgeongeneral.gov/priorities/index.html	X	X	X
CDC – Hi 5	X	X	X
CDC 6-18	X		
INCHWA			
Indianapolis Congregation Action Network http://www.fmmsc.org/wp-content/uploads/2012/08/CPRPFINAL3.24.14.pdf			X
Faith and Action (CTS)			X
Criminal Justice Reform Summary Report			
Alliance for a Healthier IN https://www.healthierindiana.org/	X		
Indiana Healthy Weight Initiative http://www.indianaobesity.org/wp-content/uploads/2017/05/state_plan_final-with_cover-low.pdf	X		

APPENDIX F

The Ten Essential Public Health Services
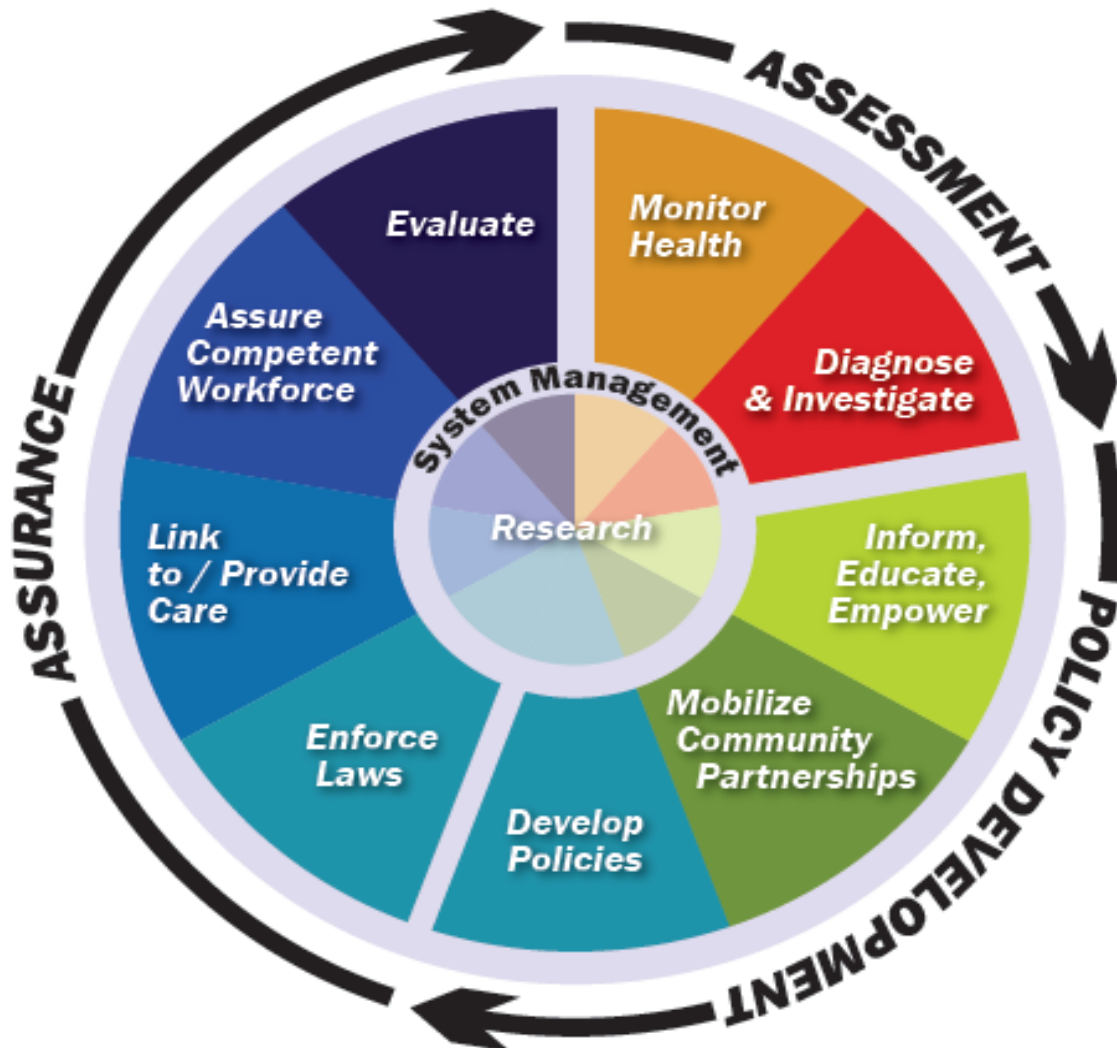
APPENDIX G

Alignment with City, County, State, and National Priorities

Local, state, and national goals related to *GOAL 1: Reduce the disease burden of obesity and diabetes, and improve the quality of life for all persons (adults and children) who are obese or have diabetes*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
Healthy People 2020	Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.	**Weight Status** **NWS-8** Increase the proportion of adults who are at a healthy weight **NWS-9** Reduce the proportion of adults who are obese **NWS-10** Reduce the proportion of children and adolescents who are considered obese **NWS-11** (Developmental) Prevent inappropriate weight gain in youth and adults	
	Reduce the disease burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM.	**Diabetes** **D-1** Reduce the annual number of new cases of diagnosed diabetes in the population **D-3** Reduce the diabetes death rate **D-4** Reduce the rate of lower extremity amputations in persons with diagnosed diabetes	
ISDH State Health Assessment and Improvement Plan	Flagship Priority 3—Reduce Chronic Disease Goal 1: Reduce the burden of obesity.	Increase the percentage of adults at a healthy weight from 31.0% in 2016 to 32.5% in 2021.	1. Increase the number of employers who utilize multi-component worksite wellness programs in Indiana.
		Increase the percentage of children and adolescents at a healthy weight from 60.3% in 2016 to 63.0% in 2021.	2. Increase the number of schools that utilize the whole school, whole community, whole child model for school wellness.
		Decrease obesity among the adult black, non-Hispanic, population from 42.1% in 2016 (Indiana average is 32.5%) to 40.0% in 2021.	3. Increase the number of out-of-school-time programs that follow healthy eating and active living guidelines (HEAL).
		Decrease obesity among the black, non-Hispanic, population from 42.1% in 2016 (Indiana average is 32.5%) to 40.0% in 2021.	4. Increase the number of trainings, including webinars, provided to early care and education centers (ECEs) that provide guidance on increasing healthy foods and beverages and increasing opportunities for physical activity.
ISDH State Health	Flagship Priority 3—	Reduce diabetes mortality from 26 per 100,000 in 2016 to 25 per 100,000 in 2021.	1. Increase awareness amongst rural and primary care

Local, state, and national goals related to *GOAL 1: Reduce the disease burden of obesity and diabetes, and improve the quality of life for all persons (adults and children) who are obese or have diabetes*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
Assessment and Improvement Plan	Reduce Chronic Disease Goal 5: Decrease the burden of cardiovascular disease and diabetes in Indiana and encourage chronic disease self-management.	Reduce diseases of the heart from 180.6 per 100,000 in 2016 to 178 per 100,000 by 2021.	programs of community resources. 2. Create a referral network for chronic disease between health care providers and community resources which may include hospitals, fire departments, primary care physicians, rural hospitals, EMS providers, and QI advisors. 3. Increase the use of reimbursable care coordination claims among health care providers.
		Increase the number of Hoosier adults with pre-diabetes who have completed the National Prediabetes Prevention Program from 661 persons in 2017 to 1000 persons by 2021.	1. Increase the number of CDC recognized diabetes prevention programs in Indiana. 2. Increase the number of diabetes prevention programs that are reimbursed.
		Increase the number of people with diabetes who report that they have taken a formal diabetes self-management course annually: 24,424 in 2017 to 27,000 in 2021.	1. Increase the number of locations where accredited diabetes self-management training, DSMT sites offer DSMT services. 2. Increase the number of AADE-accredited, ADA-recognized diabetes self-management education programs that are reimbursed.
Indiana Healthy Weight Initiative/ Indiana's Comprehensive Nutrition and Physical Activity Plan 2010-2020	Increase efforts aimed at enabling people to achieve and maintain a healthy weight across the lifespan. Reduce environmental and policy-related disparities for breastfeeding, nutrition, physical activity, overweight, obesity, and chronic disease	**Overarching Objectives for Healthy Weight and Obesity** • Increase the percentage of adults who are at a healthy weight from 35% to 38% by 2020.* • Increase the percentage of high school students who are at a healthy weight from 71% to 76% by 2020.† • Decrease the percentage of adults who are obese from 30% to 25% by 2020.* • Decrease the percentage of high school students who are obese from 13% to 10% by 2020.† * Data Source: 2009 Behavior Risk Factor Surveillance System (BRFSS) † Data Source: 2009 Youth Risk Behavior Survey (YRBS)	For specific work group objectives and selected strategies, consult the plan.
Indiana Healthy Weight Initiative/ Indiana's	Increase the capacity of communities and the	**Overarching Objectives for Healthy Weight and Obesity**	For specific work group objectives and selected strategies, consult the plan.

Local, state, and national goals related to *GOAL 1: Reduce the disease burden of obesity and diabetes, and improve the quality of life for all persons (adults and children) who are obese or have diabetes*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
Comprehensive Nutrition and Physical Activity Plan 2010-2020 (continued)	settings within those communities (e.g., schools, worksites, faith-based organizations, etc.) to develop and sustain environmental and policy support systems that encourage healthy eating and active living. Increase state and local strategic partnerships to more effectively coordinate efforts, share resources, and identify and reach priority populations.	• Increase the percentage of adults who are at a healthy weight from 35% to 38% by 2020.* • Increase the percentage of high school students who are at a healthy weight from 71% to 76% by 2020.† • Decrease the percentage of adults who are obese from 30% to 25% by 2020.* • Decrease the percentage of high school students who are obese from 13% to 10% by 2020.† * Data Source: 2009 Behavior Risk Factor Surveillance System (BRFSS) † Data Source: 2009 Youth Risk Behavior Survey (YRBS)	
The Better Together Plan http://indianacadi.org/	All Hoosiers are living free of risk factors for heart disease, stroke, and diabetes	• Prevent the development of risk factors in youth and adults: smoking, poor nutrition, and low physical activity. • Increase knowledge and awareness of risk factors, signs, and symptoms • Improve built environment • Increase access to primary care • Increase wellness supports and policies	For strategies and indicators, consult the plan.
	Individuals with increased risk levels for disease do not develop heart disease, stroke, or diabetes	• Reduce the prevalence of high cholesterol, hypertension, pre-diabetes, and obesity. • Reduce the prevalence of diagnosed heart disease, stroke, and diabetes • Increase screening • Increase knowledge and awareness of specific signs and symptoms and what to do about them. • Decrease risk factors: cholesterol, blood pressure, glucose/pre-diabetes, smoking, obesity, poor nutrition, and low physical activity •	For strategies and indicators, consult the plan
The Better Together Plan http://indianacadi.org/	Individuals with increased risk levels for disease do	• Increase early diagnosis and access to the appropriate level of care and treatment	For strategies and indicators, consult the plan

Local, state, and national goals related to *GOAL 1: Reduce the disease burden of obesity and diabetes, and improve the quality of life for all persons (adults and children) who are obese or have diabetes*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
(continued)	not develop heart disease, stroke, or diabetes		
	Individuals with heart disease, stroke, or diabetes experience improved quality of life and extended years of life	• Reduce hospitalizations/[emergency department] admissions due to heart disease, stroke, and diabetes • Reduce (early) mortality due to: heart disease, stroke, and diabetes • Increase quality of care: coordinated systems, transitions, EMR data, interdisciplinary team-based care, usage of standards of care, and effective emergency response. • Increase access to care • Increase adherence to disease management: medications, lifestyle • Increase quality of life: palliative care, complications, activities of daily living	For strategies and indicators, consult the plan

Local, state, and national goals related to *GOAL 1A: Increase access to affordable, healthy food wherever food is sold or served.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
Healthy People 2020	Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.	**Healthier Food Access** **NWS-1** Increase the number of States with nutrition standards for foods and beverages provided to preschool-aged children in child care **NWS-2** Increase the proportion of schools that offer nutritious foods and beverages outside of school meals **NWS-3** Increase the number of States that have State-level policies that incentivize food retail outlets to provide foods that are encouraged by the Dietary Guidelines for Americans **NWS-4** (Developmental) Increase the proportion of Americans who have access to a food retail outlet that sells a variety of foods that are encouraged by the Dietary Guidelines for Americans **Food Insecurity** **NWS-12** Eliminate very low food security among children **NWS-13** Reduce household food insecurity and in doing so reduce hunger **Food and Nutrient Consumption** **NWS-14** Increase the contribution of fruits to the diets of the population aged 2 years and older **NWS-15** Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older **NWS-16** Increase the contribution of whole grains to the diets of the population aged 2 years and older **NWS-17** Reduce consumption of calories from solid fats and added sugars in the population aged 2 years and older **NWS-18** Reduce consumption of saturated fat in the population aged 2 years and older **NWS-19** Reduce consumption of sodium in the population aged 2 years and older **NWS-20** Increase consumption of calcium in the population aged 2 years and older **Iron Deficiency** **NWS-21** Reduce iron deficiency among young children and females of childbearing age **NWS-22** Reduce iron deficiency among pregnant females	

Local, state, and national goals related to *GOAL 1A: Increase access to affordable, healthy food wherever food is sold or served.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
ISDH State Health Assessment and Improvement Plan	Flagship Priority 3—Reduce Chronic Disease Goal 3 Increase opportunities for healthy eating in Indiana.	Increase average mPINC (Maternity Practices in Infant Nutrition and Care) survey scores from 80 in 2015 to 95 in 2021.	1. Provide professional development and support to hospital staff on how to incorporate breastfeeding friendly practices in labor and delivery. 2. Provide consultation and peer learning opportunities or collaborative networking opportunities for hospital staff to share experiences with providing breastfeeding friendly practices.
		Decrease the percentage of adults who report consuming vegetables less than 1 time a day from 26.7% in 2015 to 25.9% in 2021.	3. Increase the number of SNAP participants utilizing vouchers at Farmers Markets. 4. Increase the number of WIC participants who redeem fruit and vegetable vouchers. 5. Increase the number of fresh food options in Indiana.
		Decrease the number of adolescents who don't eat fruits from 6.5% in 2015 to 6.0% in 2021.	6. Increase the number of sites that send healthy meals home for children 18 and under during school breaks, i.e., summer meals, back pack meals, fall/winter/spring breaks. 7. Increase the number of schools participating in Farm to School activities.
		Decrease the number of adolescents who don't eat vegetables from 7.3% in 2015 to 6.1% in 2021.	7. Increase the number of schools participating in Farm to School activities. 8. Increase the number of out-of-school organizations that follow nutrition standards for the foods and beverages that are provided to the children in their care.

Local, state, and national goals related to *GOAL 1A: Increase access to affordable, healthy food wherever food is sold or served.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
Indiana Healthy Weight Initiative/ Indiana's Comprehensive Nutrition and Physical Activity Plan 2010-2020	Increase access to and consumption of healthy foods and beverages.	**Overarching Objectives—Fruit and Vegetable Consumption** • Increase the percentage of adults who eat the recommended amounts of fruits and vegetables per day from 21% to 24% by 2020.* • Increase the percentage of high school students who eat the recommended amounts of fruits and vegetables per day from 16% to 21% by 2020.† * Data Source: 2009 Behavior Risk Factor Surveillance System (BRFSS) † Data Source: 2009 Youth Risk Behavior Survey (YRBS) **Overarching Objectives—Sugar-Sweetened Beverages** • Decrease the percentage of adults who drink 1 or more sugar-sweetened beverages per day from 69% to 59% by 2020. • Decrease the percentage of high school students who drank a can, bottle, or glass of soda or pop 1 or more times per day during the past 7 days from 30% to 22% by 2020. † * Data Source: 2009 Behavior Risk Factor Surveillance System, Indiana (BRFSS). Sugar-sweetened beverages include regular soda, sweet tea, energy drinks, specialty coffee drinks, sports drinks, and fruit drinks containing less than 50% juice. Diet beverages are not included. † Data Source: 2009 Youth Risk Behavior Survey (YRBS) **Overarching Objectives— Breastfeeding** • Increase the percentage of mothers who breastfeed their babies from 71% to 75% by 2020 • Increase the percentage of mothers who breastfeed their babies exclusively at 3 months from 29% to 40% by 2020.† • Increase the percentage of mothers who breastfeed their babies at 6 months from 38% to 50% by 2020.† • Increase the percentage of mothers who breastfeed their babies at 12 months from 17% to 25% by 2020.† * Indiana State Department of Health, PHPC, ERC, Data Analysis Team † Data Source: Centers for Disease Control and Prevention 2007 National Immunization Survey	For specific work group objectives and selected strategies, consult the plan.
STAR Communities	Food Access and	Outcome 1: Food Security and Assistance	**Action 1: Inventory, Assessment, or Survey**

Local, state, and national goals related to *GOAL 1A: Increase access to affordable, healthy food wherever food is sold or served.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
The STAR communities standards that Indianapolis utilized are sometimes different than the standards in the guidebook.	Nutrition: Purpose Ensure that adults and children of all income levels have physical and economic access to fresh and healthful food and have opportunities to learn about nutritious eating and food safety	Demonstrate an increase over the past 3 years in the percentage of people who are food secure Outcome 2: Access to Healthful Food Option A: Demonstrate an increase over the past 3 years in the percentage of residents within a walkable 1/4-mile of a healthful retail food outlet --OR-- Option B: Demonstrate a decrease over the past 3 years in the percentage of residents living in an urban or rural food desert Outcome 3: School Nutrition Demonstrate an increase over the past 3 years in the food service sales of fresh fruits and vegetables in the largest public school district	Conduct an assessment of the local food system, including existing policies and programs that address the 6 steps of the food cycle: grow or produce, sell, process, distribute, consume, and Compost **Action 2: Policy and Code Adjustment** Adopt zoning and development regulations that allow farmer's markets, community gardens, and other forms of urban agriculture that promote increased food access **Action 3: Policy and Code Adjustment** Adopt menu-labeling requirements, zoning restrictions, or development regulations that discourage, tax, or prohibit the sale of unhealthful foods or beverages **Action 4: Policy and Code Adjustment** Demonstrate that the local government has adopted the most recent U.S. Food Code **Action 5: Policy and Code Adjustment** Demonstrate that the local public school district has adopted a model school wellness policy **Action 6: Partnerships and Collaboration** Establish a local or regional food policy council that includes health professionals, community organizations, schools, farmers, and/or related businesses **Action 7: Education and Outreach** Support the development of healthy eating campaigns for residents to learn about nutrition, food safety, and food assistance programs
STAR Communities	Food Access and	Outcome 1: Food Security and Assistance	**Action 8: Practice Improvements**

Local, state, and national goals related to *GOAL 1A: Increase access to affordable, healthy food wherever food is sold or served.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
(continued) *The STAR communities standards that Indianapolis utilized are sometimes different than the standards in the guidebook.*	Nutrition: Purpose Ensure that adults and children of all income levels have physical and economic access to fresh and healthful food and have opportunities to learn about nutritious eating and food safety	Demonstrate an increase over the past 3 years in the percentage of people who are food secure Outcome 2: Access to Healthful Food Option A: Demonstrate an increase over the past 3 years in the percentage of residents within a walkable 1/4-mile of a healthful retail food outlet --OR-- Option B: Demonstrate a decrease over the past 3 years in the percentage of residents living in an urban or rural food desert Outcome 3: School Nutrition Demonstrate an increase over the past 3 years in the food service sales of fresh fruits and vegetables in the largest public school district	Demonstrate that local schools or the public school district has received certification from the USDA Healthier US Schools Challenge or an award from the Alliance for a Healthier Generation in the past 3 years **Action 9: Practice Improvements** Purchase and sell healthful food at facilities owned, leased, and operated by the local **Action 10: Programs and Services** Implement an "Increase Your Food Bucks" program and accept federal food assistance through SNAP or WIC programs at farmer's markets **Action 11: Programs and Services** Support programs that enable healthful retail food outlets to locate in underserved areas, promote mobile vendors that only sell fresh food, or increase the mix of healthful food sold in existing establishments

Resource	Goals	Objectives	Actions Steps/Interventions
		Local, state, and national goals related to *GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.*	
Healthy People 2020	**Physical Activity** Improve health, fitness, and quality of life through daily physical activity.	**PA-1** Reduce the proportion of adults who engage in no leisure-time physical activity **PA-2** Increase the proportion of adults who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity **PA-3** Increase the proportion of adolescents who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity **PA-4** Increase the proportion of the Nation's public and private schools that require daily physical education for all students **PA-5** Increase the proportion of adolescents who participate in daily school physical education **PA-6** Increase regularly scheduled elementary school recess in the United States **PA-7** Increase the proportion of school districts that require or recommend elementary school recess for an appropriate period of time **PA-8** Increase the proportion of children and adolescents who do not exceed recommended limits for screen time **PA-9** Increase the number of States with licensing regulations for physical activity provided in child care **PA-10** Increase the proportion of the Nation's public and private schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours (that is, before and after the school day, on weekends, and during summer and other vacations) **PA-11** Increase the proportion of physician office visits that include counseling or education related to physical activity **PA-12** (Developmental) Increase the proportion of employed adults who have access to and participate in employer-based exercise facilities and exercise programs **PA-13** Increase the proportion of trips made by walking **PA-14** Increase the proportion of trips made by bicycling **PA-15** (Developmental) Increase legislative policies for the built environment that enhance access to and availability of physical activity opportunities	

Local, state, and national goals related to *GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
Local, state, and national goals related to *GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
ISDH State Health Assessment and Improvement Plan	Flagship Priority 3—Reduce Chronic Disease Goal 2 Increase opportunities for active living in Indiana.	Decrease the percentage of adults who report not meeting the aerobic recommendations of 150 minutes per week of moderate activity from 44.1% in 2015 to 43.3% in 2021.	1. Increase the number of built environment plans and policies adopted to encourage physical activity, such as bicycle and pedestrian plans. 2. Provide technical assistance and support for communities designing neighborhoods that support active living.
		Increase the number of adolescents who meet the recommendations for physical activity of 60 minutes per day from 25.3% in 2015 to 27.3% in 2021.	3. Increase the number of school based prevention programs and policies such as Safe Routes to School, active recess, enhanced school based physical education, classroom physical activity breaks, and extracurricular activities. 4. Provide professional development to school staff on how to incorporate enhanced physical activity programs and policies before, during and after the school day.
Indiana Healthy Weight Initiative/ Indiana's Comprehensive Nutrition and Physical Activity Plan 2010-2020	Increase opportunities for and engagement in regular physical activity	**Overarching Objective—Physical Activity •** Increase the percentage of adults who meet the recommended amounts of physical activity per day from 64% to 68% by 2020.* • Increase the percentage of high school students who meet the recommended amounts of physical activity per day from 41% to 55% by 2020.† * Data Source: 2009 Behavior Risk Factor Surveillance System (BRFSS) † Data Source: 2009 Youth Risk Behavior Survey (YRBS)	For specific work group objectives and selected strategies, consult the plan.
STAR Communities *The STAR communities standards that Indianapolis utilized are sometimes different than the standards in the guidebook*	**Active Living: Purpose** Enable adults and kids to maintain healthy, active lifestyles by integrating physical activity into their daily routines	**Outcome 1: Active Adults** Demonstrate 20% or less of adults aged 20+ report no leisure time physical activity within the past month **Outcome 2: Active Kids** Option A: Increase the percentage of high school students that are physically active for 60 minutes per day on 5 or more days --OR-- Option B: Increase the percentage of public schools that require some form of physical activity daily, such as physical education classes or recess	**Action 1: Plan Development** Include a chapter, section, or plan element focused on active living or active transportation in the comprehensive plan or transportation plan **Action 2: Policy and Code Adjustment** Require or incentivize bicycle and pedestrian amenities in new major development projects in high-density, mixed-use areas or near transit stations **Action 3: Policy and Code Adjustment** Create guidelines to encourage the incorporation of active building design features in new public, commercial, office, or multi-family

Local, state, and national goals related to *GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
			residential buildings

Local, state, and national goals related to *GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
STAR Communities (continued) *The STAR communities standards that Indianapolis utilized are sometimes different than the standards in the guidebook*	**Active Living: Purpose** Enable adults and kids to maintain healthy, active lifestyles by integrating physical activity into their daily routines	**Outcome 1: Active Adults** Demonstrate 20% or less of adults aged 20+ report no leisure time physical activity within the past month **Outcome 2: Active Kids** Option A: Increase the percentage of high school students that are physically active for 60 minutes per day on 5 or more days --OR-- Option B: Increase the percentage of public schools that require some form of physical activity daily, such as physical education classes or recess	**Action 4: Policy and Code Adjustment** Establish school siting guidelines that give preferential considerations to locations that maximize the number of students who can walk or bicycle safely to school **Action 5: Partnerships and Collaboration** Create or designate a committee or board to advise the local government on issues related to active living in the community **Action 6: Practice Improvements** Achieve recognition as a Bicycle-Friendly Community or Walk-Friendly Community OR achieve an average community Walk Score or Bike Score of 70 or above **Action 7: Practice Improvements** Appoint a physical activity specialist within the local government to serve as a liaison between relevant local government departments or agencies, including the health department **Action 8: Programs and Services** Host or partner with community groups to support at least 3 annual programs that encourage active living for adults and kids **Action 9: Facility and Infrastructure Improvements** Implement a local enhancement program that systematically improves at least 3 bicycle and pedestrian amenities communitywide (**Action 10: Facility and Infrastructure Improvements** Provide at least 3 types of active recreation facilities that are available for community use, by population size

Local, state, and national goals related to *GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
			Action 11: Facility and Infrastructure Improvements Enable joint use of school-based recreation facilities during non-school hours

Local, state, and national goals related to *GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
STAR Communities (continued) *The STAR communities standards that Indianapolis utilized are sometimes different than the standards in the guidebook*	**Public Park Land: Purpose** Create a system of well-used and enjoyable public parkland that features equitable and convenient walkable access for residents throughout the community	**Outcome 1: Acreage** Provide ample parkland based on population density as follows: • High: 6.8 acres per 1,000 residents • Intermediate-High: 7.3 acres per 1,000 residents • Intermediate-Low: 13.5 acres per 1,000 residents • Low: 20.3 acres per 1,000 residents **Outcome 2: Proximity** Demonstrate that housing units are located within a 1⁄2-mile walk distance of public parkland based on population density as follows: • High or Intermediate-High: 85% or greater • Intermediate-Low or Low: 70% or greater **Outcome 3: Connectivity** Demonstrate that 90% of households are located within 3 miles of off-road trail access **Outcome 4: Use and Satisfaction** Option A: Demonstrate that 66% or more of surveyed residents visit a park at least once a year --OR-- Option B: Demonstrate that 66% or more of surveyed residents respond favorably regarding the quality of the community's public park system	**Action 1: Plan Development** Adopt a parks and/or open space plan that promotes a communitywide network of public spaces that provide recreational and transportation benefits while protecting natural, historic, and cultural resources **Action 3: Policy and Code Adjustment** Adopt regulatory strategies or development incentives to create, maintain, and connect public parkland **Action 4: Policy and Code Adjustment** Adopt site design guidelines for new public parklands and improvements to existing facilities to strengthen environmental benefits and provide visitor amenities **Action 5: Partnerships and Collaboration** Participate in a local or regional alliance working to improve and expand the communitywide or regional park system **Action 6: Partnerships and Collaboration** Create an advisory board to regularly receive feedback from residents and organizations regarding planning, decision-making, and other issues affecting the quality and availability of public **Action 8: Programs and Services** Provide assistance for low-income users to access and use public parklands and programming through subsidy, scholarships, and discounts **Action 9: Programs and Services**

Local, state, and national goals related to *GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
			Host programs and events in public parkland that bring the community together and encourage physical activity

Action 10: Facility and Infrastructure Improvements
Consistently invest sufficient capital and operational funding to create and maintain parklands |

Local, state, and national goals related to *GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
STAR Communities (continued)

The STAR communities standards that Indianapolis utilized are sometimes different than the standards in the guidebook | **Transportation Choices: Purpose**
Promote diverse transportation modes, including walking, biking, and public transit, that are safe, low-cost, and reduce vehicle miles traveled | **Outcome 1: Mode Split**
Achieve the following thresholds for journey-to-work trips:
• Drive alone maximum: 60%
• Bike + Walk + Transit minimum: 25%
• Bike + Walk minimum: 5%

Outcome 2: Transportation Affordability
Show that the average total driving cost is 15% or less of the regional typical household income

Outcome 3: Transportation Safety
Part 1: Demonstrate that pedestrian and bicyclist fatalities are making incremental progress towards zero fatalities by 2040
--AND--
Part 2: Demonstrate that vehicular fatalities are making incremental progress towards zero
fatalities by 2040

Outcome 4: Vehicle Miles Traveled
Demonstrate an annual decrease in vehicle miles traveled measured from a baseline year | **Action 1: Plan Development**
Adopt a bicycle and/or pedestrian master plan that prioritizes future projects to improve safety and access to non-motorized transportation and connections to public transit

Action 2: Policy and Code Adjustment
Adopt a complete streets policy that addresses all users, applies to all projects with limited exceptions, and includes specific next steps for implementation

Action 3 :Policy and Code Adjustment
Subdivision and other development regulations require walkability standards that encourage walking and enhance safety

Action 4: Practice Improvement

Conduct early development reviews of subdivisions and other developments that includes an analysis of destinations within ½ mile of project borders and multi-modal access routes

Action 5: Practice Improvements
Offer local government employees incentives to commute by modes other than single-occupancy vehicles
Action 6: Enforcement and Incentives
Implement at least 2 types of focused enforcement programs to ensure pedestrian, bicycle, and motorist safety |

Local, state, and national goals related to *GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
			Action 7: Facility and Infrastructure Improvements Increase the percentage of households with access to public transit **Action 8: Facility and Infrastructure Improvements** Increase the mileage of sidewalks, particularly on arterial or collector roads, that connect people with destinations

Local, state, and national goals related to *GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
STAR Communities (continued) *The STAR communities standards that Indianapolis utilized are sometimes different than the standards in the guidebook*	**Transportation Choices: Purpose** Promote diverse transportation modes, including walking, biking, and public transit, that are safe, low-cost, and reduce vehicle miles traveled	**Outcome 1: Mode Split** Achieve the following thresholds for journey-to-work trips: • Drive alone maximum: 60% • Bike + Walk + Transit minimum: 25% • Bike + Walk minimum: 5% **Outcome 2: Transportation Affordability** Show that the average total driving cost is 15% or less of the regional typical household income **Outcome 3: Transportation Safety** Part 1: Demonstrate that pedestrian and bicyclist fatalities are making incremental progress towards zero fatalities by 2040 --AND-- Part 2: Demonstrate that vehicular fatalities are making incremental progress towards zero fatalities by 2040 **Outcome 4: Vehicle Miles Traveled** Demonstrate an annual decrease in vehicle miles traveled measured from a baseline year	**Action 9: Facility and Infrastructure Improvements** Increase the mileage of striped or buffered bicycle lanes, cycle-tracks, parallel off-street paths and/or other dedicated facilities **Action 10: Facility and Infrastructure Improvements** Establish or support a communitywide public bike share program **Action 11: Facility and Infrastructure Improvements** Construct or retrofit transportation infrastructure to meet standards in the Americans with Disabilities Act (ADA)

Resource	Goals	Objectives	Actions Steps/Interventions
Local, state, and national goals related to *GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.*			
STAR Communities (continued)\n\n*The STAR communities standards that Indianapolis utilized are sometimes different than the standards in the guidebook*	**Compact & Complete Communities: Purpose** Concentrate development in compact, human-scaled, walkable centers and neighborhoods that connect to public transit, offer diverse uses and services, and provide housing options for families of all income levels	**Outcome 1: Density, Destinations, and Transit** Option A: Demonstrate that each CCC achieves thresholds related to residential density, nonresidential density, diverse uses, and public transit availability [Partial credit available] --OR-- Option B: Demonstrate that each CCC achieves a minimum score of 70 using the EPA's Smart Location Calculator\n\n**Outcome 2: Walkability** Demonstrate that each CCC achieves the following thresholds: • 90% of roadway length contains sidewalks on both sides or connection pathways • 100% of crosswalks are ADA accessible • 60% of block faces contain street trees at no more than 40 feet intervals • 70% of roadway length are designed for a travel speed of no more than 25 mph • Minimum intersection density of 300 intersections per square mile\n\n**Outcome 3: Design** Demonstrate that each CCC achieves the following thresholds: • 80% of buildings along primarily single-family residential blocks have front setbacks that are not more than 25 feet from the property line • 80% of buildings along primarily commercial blocks have front setbacks that are not more than 10 feet from the property line • 40% of primarily commercial blocks have ground floor street frontages free from blank walls and loading docks, and do not have structured or surface parking as the principal land use along the street	**Action 1: Plan Development** Demonstrate that the comprehensive plan supports compact, mixed-use development\n\n**Action 2: Plan Development** Adopt a specific mobility or circulation plan for compact, mixed development\n\n**Action 3: Inventory, Assessment, or Survey** Identify areas appropriate for compact, mixed-use development on the community's official future land use map\n\n**Action 4: Policy and Code Adjustment** Adopt regulatory strategies that permit or incentivize increased residential and employment densities and diverse uses in transit-served areas and areas identified for compact, mixed-use development\n\n**Action 5: Policy and Code Adjustment** Require build-to lines for commercial and residential structures in transit-served areas and areas identified for compact, mixed-use development\n\n**Action 6: Policy and Code Adjustment** Adopt advanced parking strategies in transit-served areas and areas identified for compact, mixed-use development\n\n**Action 7: Partnerships and Collaboration** Establish a design review board or similar appointed body that provides comments on the sustainability implications of proposed development projects

Local, state, and national goals related to *GOAL 1B: Increase equitable, safe, accessible, convenient, and connected options for physical activity throughout the county.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
STAR Communities (continued) *The STAR communities standards that Indianapolis utilized are sometimes different than the standards in the guidebook*	**Infill & Redevelopment: Purpose** Focus growth and redevelopment in infill areas to reduce sprawl and ensure existing infrastructure that supports the community is in satisfactory working condition	**Outcome 1: Infill Development** Option A: Demonstrate at least 51% of new residential and non-residential development occurred in locally designated infill and redevelopment areas or on infill sites that were previously developed, brownfield, and/or greyfield sites --OR-- Option B: Demonstrate an increased percentage of all new residential and non-residential development occurred in locally designated infill and redevelopment areas or on infill sites that were previously developed, brownfield, and/or greyfield sites **Outcome 2: Existing Infrastructure** Option A: Demonstrate at least 90% of existing public infrastructure is in good or better condition --OR-- Option B: Demonstrate an increased percentage of existing public infrastructure is in good or better condition over time [Partial credit applies]	**Action 2: Inventory, Assessment, or Survey** Develop an inventory of existing public infrastructure assets, current infrastructure conditions, and priorities for maintenance or rehabilitation **Action 4: Policy and Code Adjustment** Use regulatory and design strategies to encourage compatible infill and redevelopment with a mix of housing types in neighborhoods close to employment centers, commercial areas, and where public transit or transportation alternatives exist **Action 11: Facility and Infrastructure Improvements** Target local infrastructure improvements to underserved and blighted areas to revitalize redevelopment and catalyze private investment (
	Aging in Community: Purpose Encourage active aging by optimizing opportunities for health, participation, and security in order to enhance quality of life as people age	**Outcome 1: Successful Aging** Option A: Demonstrate that the community places in the top 25 percentile of the Best Cities for Successful Aging --OR-- Option B: Achieve a Total Index Score of 60 or greater from the Livability Index	**Action 4: Policy and Code Adjustment** Adopt design standards, zoning or transportation policy overlays that account for a senior's perspective **Action 7: Practice Improvements** Be an active member of the WHO Global Network of Age-friendly Cities and Communities **Action 8: Programs and Services** Provide mobility options that address the needs of seniors

Local, state, and national goals related to *GOAL 1C: Foster a system of clinic- community linkages that supports obesity and diabetes prevention and control.*			
Resource	**Goals**	**Objectives**	**Actions Steps/Interventions**
Healthy People 2020	Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.	**Health Care and Worksite Settings** **NWS- 5** Increase the proportion of primary care physicians who regularly measure the body mass index of their patients **NWS-6** Increase the proportion of physician office visits that include counseling or education related to nutrition or weight **NWS-7** (Developmental) Increase the proportion of worksites that offer nutrition or weight management classes or counseling	
	Reduce the disease burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM.	**Diabetes:** **D-1** Reduce the annual number of new cases of diagnosed diabetes in the population **D-2** (Developmental) Reduce the death rate among persons with diabetes **D-3** Reduce the diabetes death rate **D-4** Reduce the rate of lower extremity amputations in persons with diagnosed diabetes **D-5** Improve glycemic control among persons with diabetes **D-6** Improve lipid control among persons with diagnosed diabetes **D-7** Increase the proportion of persons with diagnosed diabetes whose blood pressure is under control **D-8** Increase the proportion of persons with diagnosed diabetes who have at least an annual dental examination **D-9** Increase the proportion of adults with diabetes who have at least an annual foot examination **D-10** Increase the proportion of adults with diabetes who have an annual dilated eye examination **D-11** Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement at least twice a year **D-12** Increase the proportion of persons with diagnosed diabetes who obtain an annual urinary microalbumin measurement **D-13** Increase the proportion of adults with diabetes who perform self-blood glucose-monitoring at least once daily **D-14** Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education **D-15** Increase the proportion of persons with diabetes whose condition has been diagnosed **D-16** Increase prevention behaviors in persons at high risk for diabetes with prediabetes	

Local, state, and national goals related to *GOAL 2: Improve mental health outcomes and access to mental health care in Marion County.*			
Resource	**Goals**	**Objectives**	**Interventions**
Healthy People 2020	Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.	**Mental Health Status Improvement** MHMD-1 Reduce the suicide rate MHMD-2 Reduce suicide attempts by adolescents MHMD-3 Reduce the proportion of adolescents who engage in disordered eating behaviors in an attempt to control their weight MHMD-4 Reduce the proportion of persons who experience major depressive episodes (MDEs) **Treatment Expansion** MHMD-5 Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral MHMD-6 Increase the proportion of children with mental health problems who receive treatment MHMD-7 Increase the proportion of juvenile residential facilities that screen admissions for mental health problems MHMD-8 Increase the proportion of persons with serious mental illness (SMI) who are employed MHMD-9 Increase the proportion of adults with mental health disorders who receive treatment MHMD-10 Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders MHMD-11 Increase depression screening by primary care providers MHMD-12 Increase the proportion of homeless adults with mental health problems who receive mental health services	• Music Therapy for Depression • Screening in Children Age 11 and Younger • Screening for Adolescents, Adults, and Older Adults • Primary Prevention of Suicide in University and Post-Secondary Settings • Improve Return to Work in Depressed People • Third Wave Cognitive and Behavioral Therapies • Mental Health Benefits (Legislation) • Collaborative Care for Management of Depressive Disorders • Clinic based Depression Care Management for Older Adults • Home Based Depression Care Management for Older Adults • Cognitive Behavior Therapy (Individual and Group) – Psychological Harm from Traumatic Events Among Children and Adolescents

Local, state, and national goals related to *GOAL 2: Improve mental health outcomes and access to mental health care in Marion County*.			
Resource	**Goals**	**Objectives**	**Interventions**
STAR Communities

The STAR communities standards that Indianapolis utilized are sometimes different than the standards in the guidebook | **Human Services**

Purpose: Ensure that essential human services are readily available for the most vulnerable community members | **Outcome 2: Mental Health & Substance Abuse Services**
Option A: Demonstrate the timely provision of mental health and substance abuse treatment programs and services
--OR--
Option B: Demonstrate improvements in the timely provision of mental health and substance abuse treatment programs and services [Partial credit applies] | *These are general and could be applied to specific services*

Action 1: Inventory, Assessment, or Survey
Conduct a community needs assessment to identify priority service needs and resources, including the needs of vulnerable populations

Action 2: Plan Development
Adopt a human services plan designed to guarantee that basic human needs are met in the community

Action 3: Partnerships and Collaboration
Establish an advisory committee that provides ongoing consultation to local government departments and agencies responsible for providing human services

Action 4: Education and Outreach
Establish and support programming and events that inform residents of available human services and connect vulnerable community members to available programs or services

Action 5: Practice Improvements
Implement information technology solutions to improve client support services and management

Action 6: Practice Improvements
Monitor and evaluate the quality, comprehensiveness, and effectiveness of provided human services

Action 7: Practice Improvements
Equip human services personnel with the skills and training needed to effectively improve the well-being of vulnerable populations |

Local, state, and national goals related to *GOAL 2: Improve mental health outcomes and access to mental health care in Marion County*.			
Resource	**Goals**	**Objectives**	**Interventions**
STAR Communities (continued) *The STAR communities standards that Indianapolis utilized are sometimes different than the standards in the guidebook*	**Human Services** Purpose: Ensure that essential human services are readily available for the most vulnerable community members	**Outcome 2: Mental Health & Substance Abuse Services** Option A: Demonstrate the timely provision of mental health and substance abuse treatment programs and services --OR-- Option B: Demonstrate improvements in the timely provision of mental health and substance abuse treatment programs and services [Partial credit applies]	**Action 8: Programs and Services** Support the provision of high quality human services in coordination with non-governmental service providers **Action 9: Facility and Infrastructure Improvements** Upgrade existing facilities or build new facilities to better provide needed human services
Fishers Mental Health Task Force/Initiative https://tinyurl.com/r6pzlol Detail taken from the *2017 Mental Health Report*	Goal 1. Improve education and training *Education and training goals encourage thorough and consistent training among professionals most likely to encounter residents who may require care as well as community education to eliminate the stigma surrounding mental illness and mental health.*	1. Develop and implement mental health training and operations programs for Fishers' first responders and HSE Schools	
		2. Develop collaborative relationships to share information and conduct quarterly audit/review of mental health runs	
		3. Develop and implement a community-wide outreach and communications campaign	
		4. Create and implement an awareness training program for SPORTS coaches	
		5. Facilitate a partnership and action plan for the interfaith community to address and support mental health within their mission	
	Goal 2. Enhance local resources and access to services *Resources and access goals are aimed at enhancing the delivery of services across the spectrum including those services needed when a mental health crisis occurs and those that work to prevent a crisis.*	1. Remodel the community para-medicine program to include protocols for mental health runs	
		2. Develop intensive care coordination program for youth.	

Local, state, and national goals related to *GOAL 2: Improve mental health outcomes and access to mental health care in Marion County.*			
Resource	**Goals**	**Objectives**	**Interventions**
Westfield Wellbeing Coalition Partnership with the Westfield Washington School System and the Hamilton County Community Foundation "The group is focused on creating a community where care comes first and is working to improve wellbeing across the spectrum of health--mental, physical, social, emotional and spiritual-- by bettering community-wide processes, resources and training opportunities." "The Wellbeing Coalition convened a cross-community group to drive action with input from public safety agencies, as well as school, religious, non-profit, business, healthcare and sports organizations. The group will launch its webpage and release its strategic action plan to the community in May during National Mental Health Month." http://wellbeingcoalitionwestfield.com/	Focus 1: Awareness	Coalition is just getting started. More detail expected in the coming months	
	Focus 2: Access	Coalition is just getting started. More detail expected in the coming months	
	Focus 3: Advocacy	Coalition is just getting started. More detail expected in the coming months	

Local, state, and national goals related to *GOAL 2: Improve mental health outcomes and access to mental health care in Marion County.*			
Resource	Goals	Objectives	Interventions
Zero Suicide Framework https://zerosuicide.sprc.org/about		Essential Elements: 1. Lead system-wide culture change committed to reducing suicides 2. Train a competent, confident, and caring workforce 3. Identify patients with suicide risk via comprehensive screenings 4. Engage all individuals at-risk of suicide using a suicide care management plan 5. Treat suicidal thoughts and behaviors using evidence-based treatments 6. Transition individuals through care with warm hand-offs and supportive contacts 7. Improve policies and procedures through continuous quality improvement	

Local, state, and national goals related to *GOAL 3: Raise awareness about poverty and other social determinants of health and their influence on quality of life and morbidity. with the intent of decreasing the poverty burden in Marion County*			
Resource	**Goals**	**Objectives**	**Interventions**
Healthy People 2020	Create social and physical environments that promote good health for all (Social Determinants of Health).	**Economic Stability** **SDOH-1** Proportion of children aged 0-17 years living with at least one parent employed year round, full time<u>d</u> **SDOH-3** Proportion of persons living in poverty **SDOH-4** Proportion of households that experience housing cost burden **NWS-12** Eliminate very low food security among children **NWS-13** Reduce household food insecurity and in doing so reduce hunger **Education** **SDOH-2** Proportion of high school completers who were enrolled in college the October immediately after completing high school **AH-5.1** Increase the proportion of students who graduate with a regular diploma 4 years after starting 9th grade<u>d</u> **AH-5.3.1** Increase the proportion of 4th grade students whose reading skills are at or above the proficient achievement level for their grade **DH-20** Increase the proportion of children with disabilities, birth through age 2 years, who receive early intervention services in home or community-based settings **EMC-2.3** Increase the proportion of parents who read to their young child There are objectives regarding health and health care, neighborhood and built environment, and social and community context	**Literature Summaries – Economic Stability** - Access to Health Services - Employment - Enrollment in Higher Education - Food Insecurity - Housing Instability - Poverty - Social Cohesion

Local, state, and national goals related to *GOAL 3: Raise awareness about poverty and other social determinants of health and their influence on quality of life and morbidity. with the intent of decreasing the poverty burden in Marion County*			
Resource	Goals	Objectives	Interventions
Local, state, and national goals related to *GOAL 3: Raise awareness about poverty and other social determinants of health and their influence on quality of life and morbidity. with the intent of decreasing the poverty burden in Marion County*			
Resource	Goals	Objectives	Interventions

Local, state, and national goals related to *GOAL 3: Raise awareness about poverty and other social determinants of health and their influence on quality of life and morbidity. with the intent of decreasing the poverty burden in Marion County*

Resource	Goals	Objectives	Interventions
STAR Communities *The STAR communities standards that Indianapolis utilized are sometimes different than the standards in the guidebook*	**Poverty Prevention & Alleviation** Purpose: Alleviate the impacts of poverty, prevent people from falling into poverty, and proactively enable those who are living in poverty to obtain greater, lasting economic stability and security	**Outcome 1: Poverty Reduction** Demonstrate progress towards reducing the percentage of residents living below the poverty line by 50% by 2030 [Partial credit available] **Outcome 2: Equitable Poverty Reduction** Demonstrate a decrease over time in the percentage of women, men, children, and additional subgroups of residents living below the poverty line [Partial credit available]	**Action 1: Plan Development** Adopt a communitywide plan to reduce poverty (full credit) **Action 2: Partnerships and Collaboration** Create a team of local government staff to work collaboratively and coordinate with nongovernmental organizations to provide high-quality services and reduce poverty (full credit) **Action 3: Education and Outreach** Develop public education campaigns to inform residents about how to enroll in available service programs to help meet basic needs **Action 4: Programs and Services** Establish or support programs that reduce the costs of basic needs for low-income households (full credit) **Action 5: Programs and Services** Implement supportive workplace programs for people living at or near the poverty line (full credit) **Action 6: Programs and Services** Connect low-income community members with workforce development programs to strengthen hard and soft work skills (full credit) **Action 7: Programs and Services** Provide child development (full credit) t programs for children living at or near the local poverty line **Action 8: Programs and Services** Provide financial literacy, money management, and banking programs or services for low-income residents

Local, state, and national goals related to *GOAL 3: Raise awareness about poverty and other social determinants of health and their influence on quality of life and morbidity. with the intent of decreasing the poverty burden in Marion County*				
Resource	Goals	Objectives	Interventions
Local, state, and national goals related to GOAL 3: Raise awareness about poverty and other social determinants of health and their influence on quality of life and morbidity. with the intent of decreasing the poverty burden in Marion County				
Resource	Goals	Objectives	Interventions
STAR Communities (continued) *The STAR communities standards that Indianapolis utilized are sometimes different than the standards in the guidebook*	**Quality Jobs and Living Wages** Purpose: Expand job opportunities that support upward economic mobility, offer supportive workplace policies, and pay living wages so that all working people and their families can afford basic necessities without governmental assistance	**Outcome 1: Median Household Income** Increase real median household income over time **Outcome 2: Living Wages** Option A: Demonstrate that 80% of household incomes in the jurisdiction meet or exceed the living wage standard --OR-- Option B: Demonstrate an increase in the percentage of household incomes in the jurisdiction that meet or exceed the living wage standard over time [Partial credit applies] **Outcome 3: Income Inequality** Demonstrate that income inequality in the region and locally is decreasing over time	**Action 1: Policy and Code Adjustment** Enact a living wage policy that covers local government employees, contractors, and entities receiving financial incentives or assistance from the local government **Action 2: Policy and Code Adjustment** Enact family-friendly workplace policies for all local government employees that include at least 3 of the following benefits: paid sick days, paid family leave, flexible scheduling, teleworking, job sharing, and easily available childcare (full credit) **Action 3: Policy and Code Adjustment** Require that local government contractors provide at least 2 of the following benefits to their employees: paid sick days, paid family leave, flexible scheduling, job sharing, and easily accessible childcare **Action 4: Education and Outreach** Support living wage campaigns in the community **Action 8: Programs and Services** Provide training programs and assistance to local businesses to encourage them to provide family-friendly workplace policies and extended benefits

Local, state, and national goals related to GOAL 3: Raise awareness about poverty and other social determinants of health and their influence on quality of life and morbidity. with the intent of decreasing the poverty burden in Marion County			
Resource	**Goals**	**Objectives**	**Interventions**
Indy Plan 2020	Economic Mobility: Access to better jobs and income	Increase the number of and raise the visibility of "earn while you learn" training opportunities for adults who want to increase their skills but are unable to go to school full-time because of other obligations.	Community Partner: Employ Indy Expand the number of opportunities provided by flexible, locally created on the job training programs (work-based learning training opportunities, etc.) Increase visibility and community based connections to training opportunities in neighborhoods. Increase the opportunities for youth to improve their skills and their earning potential.
		Leverage the economic strength and place-based nature of Indianapolis' anchor institutions to expand neighborhood-based pilots for hiring and training unemployed and underemployed residents in the neighborhood where the business is located/locating.	Community Partner: Indy Chamber Partner with EmployIndy to convene anchor institution human resource leaders to identify the challenges and opportunities to training, hiring and retaining workers from the surrounding neighborhoods. Create employer education and outreach effort among Indy Chamber members to enlist more private sector employers voluntarily adopting "ban the box."
		Expand the number of youth participating in career preparation opportunities to increase the likelihood they will be knowledgeable about and prepared to pursue high quality post-secondary opportunities leading to career pathways.	Community Partner: MCCOY Create, implement and monitor an ongoing program that links youth that have completed job-readiness training with (public and private) employers during school breaks. Actively partner with Indiana Black Expo to recruit and support at risk youth to get them engaged in the "job readiness" certificate program and the "school break" youth employment program.

Local, state, and national goals related to GOAL 3: Raise awareness about poverty and other social determinants of health and their influence on quality of life and morbidity. with the intent of decreasing the poverty burden in Marion County			
Resource	**Goals**	**Objectives**	**Interventions**
Indy Plan 2020 (continued)	Economic Mobility: Access to better jobs and income	Increase our community's capacity to provide supportive services and employment (including transitional jobs) leading to long-term economic and social stability for residents who face employment barriers due to involvement with the criminal justice system.	Community Partner: Marion County Re-Entry Coalition. Identify effective best practices in wrap-around services and their core components which support ex-offenders in securing employment and/or engaging in transitional jobs. Quantify target increase of employment and transitional job placements with service providers implementing best practices. Identify and work with public and philanthropic funding sources to secure funding needed to increase number of evidence based employment and transitional job placements. Identify and ensure delivery of high quality technical assistance needed to support organizations adding employment and/or transitional job placements. Monitor outcomes in order to improve ongoing availability of increased employment and/or transitional job placements. Develop jobs pipeline with employers who have agreed to give priority in interviewing clients of the employment training and/or transitional jobs programs. Convene decision makers in the judiciary and state and county agencies administrating probation, parole, and community corrections to identify and implement changes in procedures and staffing to reduce barriers for ex-offenders to meet court appearances and probation and parole obligations outside of their working hours. Create an accountability framework for ensuring that all City and County agencies consistently implement the "ban the box" ordinance internally and with their contractors and support implementation in the private sector.

Local, state, and national goals related to GOAL 3: Raise awareness about poverty and other social determinants of health and their influence on quality of life and morbidity. with the intent of decreasing the poverty burden in Marion County

Resource	Goals	Objectives	Interventions
Indy Plan 2020 (continued)	Economic Mobility: Access to better jobs and income	Create industry-led, sector-specific workforce development infrastructure which provides clear information about career pathways and identify quality training opportunities enabling job seekers to pursue opportunities for higher skilled, higher wage employment.	Community Partner: Ascend Indiana Create and support collaborative of community-based organizations providing training and support to underprepared workers. Create and implement initiatives or support and incentivize initiatives to close training resource gaps across platforms, including work readiness training programs, and around data collection and data sharing to enable ongoing improvement in job training and placement efforts. Create clear, easily accessible and understandable information about where to access "career pathways" sector specific training. Identify training resources gaps (no partner identified).
		Expand the number of youth participating in career preparation opportunities to increase the likelihood they will be knowledgeable about and prepared to pursue high quality post-secondary opportunities leading to career pathways.	Work in partnership with Marion County schools to introduce the Junior Achievement Career Readiness Curriculum to ask as many students in Marion County schools as possible.
		Grow supportive services for adult workers seeking to overcome barriers to gaining employment at wages that will get them out of poverty.	Create a network of Bridge workforce training programs that link Centers for Working Families with technical certification programs. Community Partner: LISC Expand the number of Centers for Working Families to 13 in Marion County, and increase the number of families served by each center. Community Partner: United Way of Central Indiana
		Increase the opportunities for adult learners of all ages to successfully complete a diploma recovery program; one that focuses on attainment of post-secondary credentials or job placement.	Community Partner: Goodwill Quantify the total capacity at and costs for all existing adult high schools in Marion County. Increase the number of adult high school graduates from post-secondary or a dual credit programs.

Local, state, and national goals related to GOAL 3: Raise awareness about poverty and other social determinants of health and their influence on quality of life and morbidity. with the intent of decreasing the poverty burden in Marion County

Resource	Goals	Objectives	Interventions
Indy Plan 2020 (continued)	Economic Mobility: Access to better jobs and income	Increase the opportunities for adult learners of all ages to successfully complete a diploma recovery program; one that focuses on attainment of post-secondary credentials or job placement.	Community Partner: Goodwill

Track state budget and legislative action around charter funding and the impact that the expansion of the number of adult high schools could have on the local community.

Advocate at city and state levels for increased funding to support adult high schools. |
| Thrive Indianapolis Plan | | Upward trend in the percentage of the population that reports being active, healthy, and happy. | PH-1A: Collaboratively engage the Marion County Public Health Department and relevant local government departments or agencies to integrate health considerations (typically referred to as "Health in All Policies") into local plans and policies related to the built environment, physical activity and access to fresh food with equitable benefits for everyone in the community before 2024. |

APPENDIX H

Glossary:

Built Environment – includes all of the physical parts of where we live and work (e.g., homes, buildings, streets, open spaces, and infrastructure). The built
environment influences a person's level of physical activity. For example, inaccessible or nonexistent sidewalks and bicycle or walking paths contribute to sedentary habits.
These habits lead to poor health outcomes such as obesity, cardiovascular disease, diabetes, and some types of cancer.
(https://www.cdc.gov/nceh/publications/factsheets/impactofthebuiltenvironmentonhealth.
pdf CDC [Cited 2018 April 5])

Chronic Disease – defined by the U.S. National Center for Health Statistics, a disease lasting three months or longer.
(Learn more at: http://www.nationalhealthcouncil.org/
newsroom/about-chronic-conditions#1 Cited 2018 April 5)

Community - Community is a group of people who have common characteristics; communities can be defined by location, race, ethnicity, age, occupation, interest in particular
problems or outcomes, or other similar common bonds. Ideally, there would be available assets and resources, as well as collective discussion, decision-making and action. (Turnock, BJ.
Public Health: What It Is and How It Works. Jones and Bartlett, 2009)

Community Health - Community health is a field within public health concerned with the study and improvement of the health of biological communities. Community
health tends to focus on geographic areas rather than people with shared characteristics.
(http://dictionary.reference.com/browse/community+health) The term "community health"
refers to the health status of a defined group of people, or community, and the actions and conditions that protect and improve the health of the community. Those individuals who
make up a community live in a somewhat localized area under the same general regulations, norms, values, and organizations. For example, the health status of the people living in a
particular town, and the actions taken to protect and improve the health of these residents would constitute community health. (http://www.encyclopedia.com/topic/Community_
Health.aspx)

Culture of Health - A culture of health is achieved when the collective set of individual and institutional priorities promotes comprehensive health, generates a perception of
the need for well-being, and empowers all to lead healthier lives now and in generations to come. A culture of health is best accomplished by weaving health into all policies, decisions
and activities.

Demographics - Demographics are characteristic-related data, such as size, growth, density, distribution, and vital statistics, which are used to study human populations.
(Turnock, BJ. *Public Health: What It Is and How It Works.* Jones and Bartlett. 2009)

Evidence-based (public health) - defined as the development, implementation, and evaluation of effective programs and policies in public health through application
of principles of scientific reasoning, including systematic uses of data and information systems, and appropriate use of behavioral science theory and program planning models.
(https://phpartners.org/tutorial/04-ebph/2-keyConcepts/4.2.2.html *Partners in Information Access for Public Health Workforce*

[Cited 2018 April 5) **Goals** – Goals are general statements expressing a program's aspirations or intended effect on one or more health problems, often stated without time limits. (Turnock, B.J. *Public Health: What It
Is and How It Works.* 4th ed. Sudbury, MA: Jones and Bartlett; 2009.)

Health Disparities - Health disparities are differences in population health status (incidence, prevalence, mortality, and burden of adverse health conditions) that can result from environmental,
social and/or economic conditions, as well as public policy. These differences exist among specific population groups in the United States and are often preventable. (Adapted from: National
Association of County and City Health Officials (US). Operational Definition of a Functional Local Health Department [online]. 2005 [cited 2012 Nov 8]. Available from URL http://www.naccho.org/
topics/infrastructure/accreditation/OpDef.cfm. National Cancer Institute (US). Health Disparities Defined [online]. 2010 [cited 2012 Nov 8] http://crchd.cancer.gov/disparities/defined.html)

Healthy People 2020 – Healthy People 2020 is a document that provides science-based, 10-year national objectives for improving the health of all Americans. For three decades,

Healthy People has established benchmarks and monitored progress over time in order encourage collaborations across sectors; guide individuals toward making informed health decisions and

measure the impact of prevention activities. (www.healthypeople.gov/2020)

Objectives – Objectives are targets for achievement through interventions. Objectives are time limited and measurable in all cases. Various levels of objectives for an intervention include

outcome, impact, and process objectives. (Turnock, B.J. *Public Health: What It Is and How It Works.* 4th ed. Sudbury, MA: Jones and Bartlett; 2009.)

Partnership – A partnership is a relationship among individuals and groups that is characterized by mutual cooperation and responsibilities. (Scutchfield, FD, and CW Keck. *Principles of Public*

Health Practice. Delmare CENGAGE Learning. 2009)

Population Health - Population health is a cohesive, integrated and comprehensive approach to health considering the distribution of health outcomes within a population, the health

determinants that influence the distribution of care, and the policies and interventions that impact and are impacted by the determinants. (Nash, Reifsnyder, Fabius, and Pracilio. *Population Health:*

Creating a Culture of Wellness. Jones and Bartlett. MA, 2011)

Public Health System – Public health systems are commonly defined as "all public, private, and voluntary entities that contribute to the delivery of essential public health services

within a jurisdiction." This concept ensures that all entities' contributions to the health and well-being of the community or state are recognized in assessing the provision of public health services.

The public health system includes:

· Public health agencies at state and local levels

· Healthcare providers

· Public safety agencies

· Human service and charity organizations

· Education and youth development organizations

· Recreation and arts-related organizations

· Economic and philanthropic organizations

· Environmental agencies and organizations

Social Determinants of Health – Healthy People 2020 defines social determinants of health as conditions in the environments in which people live, learn, work, play, worship,

and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g.,

school, church, workplace, and neighborhood) have been referred to as "place." In addition to the more material attributes of "place," the patterns of social engagement and sense of security and

well-being are also affected by where people live. (https://www.cdc.gov/socialdeterminants/faqs/index.htm CDC [Cited 2018 April 5])

State Health Assessment (SHA) – State health assessment is a systematic examination of the health status indicators for a given population that is used to identify key problems

and assets in a State. The ultimate goal of a State health assessment is to develop strategies to address the state's health needs and identified issues. A variety of tools and processes may be used to

conduct a state health assessment; the essential ingredients are community engagement and collaborative participation. (Turnock, B. *Public Health: What It Is and How It Works.* Jones and Bartlett,

2009).

State Health Improvement Plan (SHIP) – A state health improvement plan is a long-term, systematic effort to address public health problems on the basis of the results

of state health assessment activities and the state health improvement process. A plan is typically updated every three to five years. (http://www.cdc.gov/stltpublichealth/cha/plan.html) This plan

is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A state health

improvement plan is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the state through a collaborative process

and should address the gamut of strengths, weaknesses, challenges, and opportunities that exist in the state to improve the health status of that state (Adapted from: United States Department of

Health and Human Services, Healthy People 2010. Washington, DC)

Strategic Plan – A strategic plan results from a deliberate decision-making process and defines where an organization is going. The plan sets the direction for the organization and,
through a common understanding of the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward.
(Swayne, Duncan, and Ginter. *Strategic Management of Health Care Organizations.* Jossey Bass. New Jersey. 2008).

SWOT Analysis – A strategic planning method used to evaluate the strengths, weaknesses, opportunities, and threats to determine strategic objectives. Strengths are characteristics of
organization that give it an advantage over others; Weaknesses are characteristics that place the organization at a disadvantage relative to others; Opportunities are elements that the organization
could exploit to its advantage; Threats are elements in the environment that could cause trouble for the organization. The analysis associates the internal and external data to develop strategies.

Values – Values describe how work is done and what beliefs are held in common as a basis for that work. They are fundamental principles that organizations stand for. (Swayne, Duncan, and
Ginter. *Strategic Management of Health Care Organizations.* Jossey Bass. New Jersey. 2008)

Wellness – Wellness is the quality or state of being in good health especially as an actively sought goal.

(www.merriamwebster.com/dictionary/wellness)

APPENDIX I

Appendix I – Acronym List

<u>A</u>

AADE	American Association of Diabetes Educators
ACEs	Adverse Childhood Experiences
ACHI	Association for Community Health Improvement
ACS	American Community Survey
ASTD	American Society for Training & Development
ADA	American Diabetes Association
ADA	Americans with Disabilities Act
AH	Adolescent Health
AWARE	Advancing Wellness and Resilience Education

<u>B</u>

BRFSS	Behavioral Risk Factor Surveillance Systems

<u>C</u>

CCC	Compact and Complete Communities
CCDF	Child Care and Development Fund
CDC	Centers for Disease Prevention and Control
CHA	Community Health Assessment
CHIP	Children's Health Insurance Program
CHIP	Coalition for Homelessness Intervention and Prevention
CHIP	Community Health Improvement Plan
CIC	Center for Interfaith Cooperation
CICF	Central Indiana Community Foundation
CICP	Central Indiana Corporate Partnership

<u>H</u>

HIP	Healthy Indiana Plan

I

ICMH	Interfaith Coalition of Mental Health
IMHC	Indiana Minority Health Coalition
IMPD	Indianapolis Metropolitan Police Department
INPC	Indiana Network for Patient Care
INSILC	Indiana Statewide Independent Living Council
INCHWA	Indiana Community Health Worker Association
INOFAS	Indiana Organization on Fetal Alcohol Syndrome
INSHAPE	Indiana Society for Health and Physical Educators
IPHCA	Indiana Primary Health Care Association
IPS	Indianapolis Public Schools
IUL	Indianapolis Urban League

L

LISC	Local Initiative Support Corporation

M

MCCOY	Marion County Commission on Youth
MCPHD	Marion County Public Health Department
MHAI	Mental Health America of Indiana
MHMD	Mental Health and Mental Disorders
MUFH	
MPINC	Maternity Practices in Infant Nutrition and Care

N

NAAPC	National Association for the Advancement of Colored People
NALBOH	National Association of Local Boards of Health
NAMI	National Alliance on Mental Illness of Indiana
NWS	Nutrition and Weight Status

P

PA	Physical Activity
PH	Public Health

PHQ-9	Patient Health Questionnaire-9
PSAW	Policy, Systems, and Environmental Change

Q

QI	Quality Improvement
QOL	Quality of Life

R

REACH	Racial and Ethnic Approaches to Community Health

S

SAMHSA	Substance Abuse and Mental Health Service Administration
SDOH	Social Determinants of Health
SIF	Social Innovation Fund
SMART	Specific, Measurable, Achievable, Realistic, Timebound (referring to characteristics of objectives)
SORRT	Street Outreach Rapid Response Team
SNAP	Supplemental Nutrition Assistance Program
STAR	STAR Communities Rating System

U

USDA	United States Department of Agriculture
UWCI	United Way of Central Indiana

W

WHO	World Health Organization
WIC	Women, Infants and Children

Y

YRBS	Youth Risk Behavior Survey