

CHA/CHIP REPORT

SHELBY COUNTY, TN

COMMUNITY HEALTH IMPROVEMENT PLAN

2012-2018



Facilitated by:
Shelby County Health Department

Published on September 2015



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A WORD FROM OUR LEADERS



Mayor Mark Luttrell, Jr.
Shelby County Government

The MAPP process reflects the health needs of our citizens. We have collected data from across the county and developed goals and strategies to address the most pressing health issues. MAPP will continue to be an important tool to meet the overall health needs of our community.



Yvonne Madlock
**Former Director, Shelby
County Health Department**

MAPP is the key to making a meaningful difference to improve the health needs of our community. Through the dedication and efforts of our community partners, we have completed both the Community Health Assessment and the Community Health Improvement Plan.

These will ensure we know the most pressing health concerns of our citizens so Shelby County will be one of the healthiest places to live in the nation.



REFLECTIONS FROM COMMUNITY PARTNERS

The YMCA of Memphis & the Mid-South is committed to helping create a healthier community. We work with our partners to increase access to proper nutrition, increase physical activity, to reduce obesity and to prevent and manage chronic disease. The MAPP process was instrumental in providing the data and community opinions which helped us assess and understand the challenges to improving health outcomes. MAPP leads the way to creating effective partnerships to solve problems together.

Cynthia Magallon Puljic
YMCA

What is most important about MAPP is the fact that it is not a new program, intervention, or collaborative arising on the scene. Rather, it is a process or vehicle that provides the opportunity for existing coalitions, programs, organizations, interventions, and engaged community members to gather together to identify and tackle the challenging public health issues facing our community. This is where the strength in the MAPP process is found. At the very start, MAPP acknowledges that no one entity can impact these community health issues on its own; success requires honest, meaningful partnerships that the MAPP process can facilitate.

Jason Hodges
St. Jude Children's Research Hospital
(Former SCHD Community Health Planner)

Through the Mobilizing for Action through Planning and Partnership (MAPP) initiative, the Shelby County Health Department is demonstrating its commitment assuring and improving the health of Shelby County residents. The MAPP process has been thorough, engaging, and collaborative and is already producing actionable objectives, goals, and strategies on a number of key community-driven priorities that will benefit the community for years to come.

Erik L. Carlton, DrPH, MS
University of Memphis

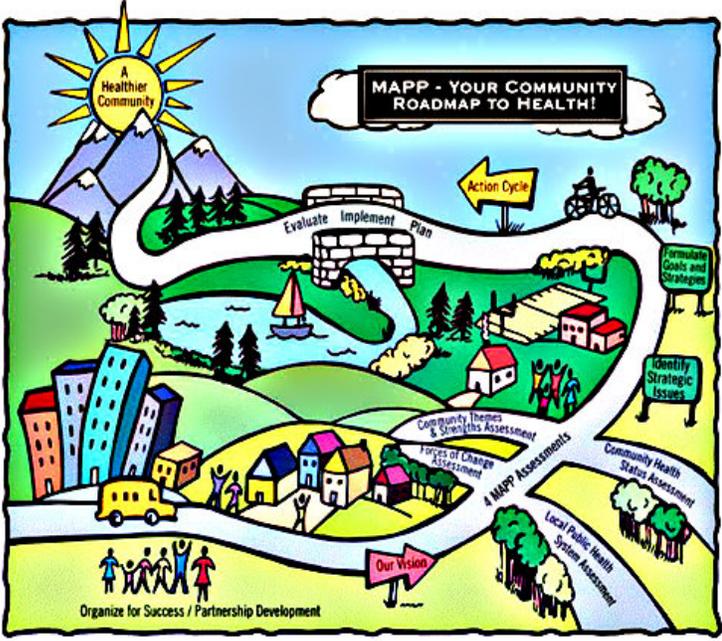
MAPP is an exhilarating process where the community has discussed and researched the health conditions in Shelby County and is now working together to identify our concerns and build a healthier, happier Shelby County for all of its people.

Kay Price
Brunswick Community Association

United Way of the Mid-South has been proud to be a partner with the Shelby County Health Department in the MAPP process. The comprehensive community health assessment, conducted in coordination with a diversity of partners as well as the voice of the community, is a vital tool to be used by all organizations to inform our work in improving community health.

Diana Bedwell
United Way of the Mid-South

Introduction





SHELBY COUNTY STRIVES FOR A HEALTHIER PLACE TO LIVE

Place matters. Health outcomes and quality of life are *not* solely contingent on genetics; how *and* where we live, work, play, learn, and worship also influence our quality of life and health outcomes. Therefore, understanding the social and environmental factors in addition to the health status of Shelby County is critical to the efforts of improving community health. Painting a clearer picture of our community illustrates current, existing health issues and, as a result, informs the development of plans to align partnerships to address those issues. Assessment and planning are essential tools that we use to ensure that Shelby County continues to become one of the *healthiest places to live in the nation*.

In 2011, the Shelby County Health Department (SCHD) spear-headed an effort to create a community health profile for Shelby County, TN, to mobilize community partnerships, and to identify, prioritize, and plan to address key health issues within the community. With the help of its community partners, SCHD conducted a Community Health Assessment in 2012-2013 using a community-driven tool called Mobilizing Action through Planning and Partnerships (MAPP). The intent of the assessment was to share its contents to the community and organizations. As a result of the assessment, SCHD also facilitated community efforts in 2014-2015 to develop a Community Health Improvement Plan which is a compilation of goals, strategies, and action items that community partners adopted to advance health in Shelby County.

This document compiles the *summary* of Shelby County's Community Health Assessment with the *full* Community Health Improvement Plan.

The following document provides *only a glimpse* of the health status in Shelby County as well as key strategies to enhance residents' health, well-being, and quality of life. The document highlights the following:

- status of health outcomes and health behaviors
- status of social and physical environments
- resident views on community health and needs
- state of the Local Public Health System
- barriers and opportunities to community health
- selection of key health issues for the county
- strategies and community partner commitment to address key health issues

What is the MAPP Process?

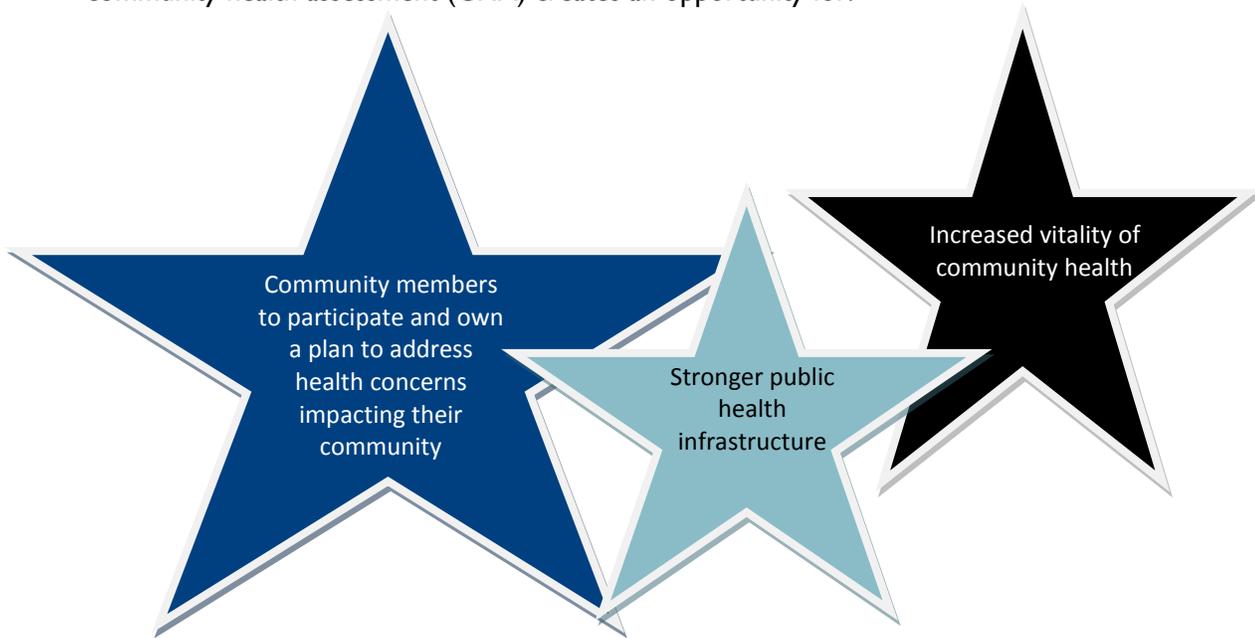
The MAPP Process helps Shelby County strive to become one of the healthiest places to live in the nation. Developed by the National Association of County and City Health Officials and the Centers for Disease Control and Prevention, the acronym MAPP stands for *Mobilizing Action through Planning and Partnerships*. This strategic framework is designed to help communities *improve health and quality of life* through a community-wide and community-driven strategic planning process. Through MAPP, Shelby County seeks to achieve optimal health by 1) *identifying and using their resources wisely*, 2) taking into account the residents' *unique circumstances and needs*, and 3) forming *effective partnerships for strategic action*. MAPP focuses on strengthening the entire local public health system by bringing together *diverse interests* to *collaboratively* determine the most *effective* way to conduct community health activities. This cultivation and development of a strong community consensus around the needs of the local public health system serves as a springboard towards future collective action and collective impact.



MAPP is divided into *six phases*: I) Organizing; II) Visioning; III) Conducting assessments; IV) Identifying priorities; V) Developing goals and strategies; and VI) Taking Action. *Two deliverables* are produced from this 6 phase process: the Community Health Assessment and the Community Health Improvement Plan.

What is a Community Health Assessment?

Community Health Assessments are conducted during Phase III of the MAPP process. One of the essential Public Health Services is to monitor the health status of the residents and environment of a community. Conducting a community health assessment is a collective activity of this function. A community health assessment (CHA) creates an opportunity for:



A CHA answers the following questions:

- What are the health problems in a community?
- Why do health issues exist in a community?
- What factors create or determine the health problems?
- What resources are available to address the health problems?
- What are the health needs of the community from a population-based perspective?

What is a Community Health Improvement Plan?

Developed in Phase V and VI of the MAPP process, a Community Health Improvement Plan (CHIP) is a **living document** that provides a long-term strategic plan addressing key public health issues.

The purpose of CHIP is to:

- Define a shared vision and priorities
- Coordinate action of various partners across local public health systems for community health improvement in the identified priority areas
- Monitor progress and collaborative efforts toward the five strategic health priorities identified by the community
- Identify assets
- Inform other strategic planning processes



What is the relationship between the CHA and CHIP?

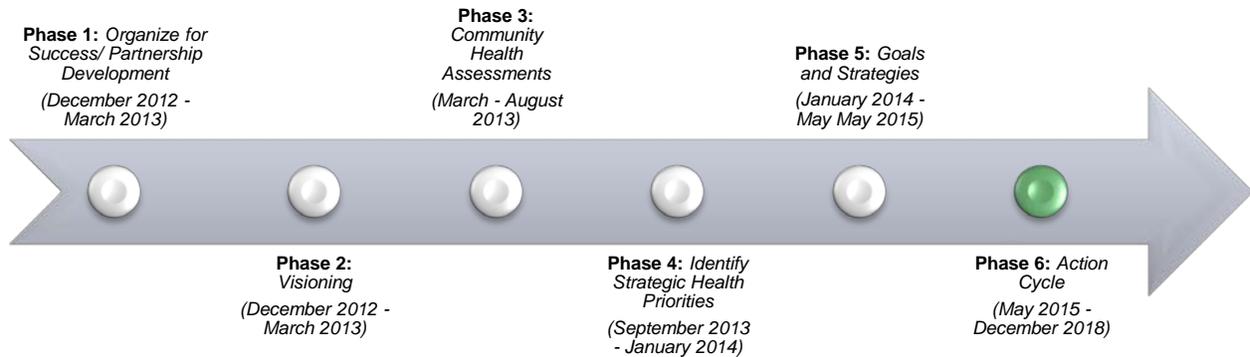
As the two deliverables of the MAPP process, the CHA and the CHIP are integral documents for institutions and individuals working to improve community health across Shelby County. The Community Health Assessment *informs* the Community Health Improvement Plan. While the results from the CHA drive the selection of key health priorities, the CHIP, in turn, compiles strategies to address those key health priorities. In short, the CHIP illustrates *how* Shelby County is becoming one of the healthiest places to live in the nation. **The following diagram illustrates the relationship of MAPP, its six phases, and its two key deliverables: CHA and CHIP.**





The MAPP Process in Shelby County

To move towards being a healthy place to live, Shelby County began its six phase process in 2012.



Phase I and Phase II: December 2012-March 2013

The MAPP Steering Committee and MAPP Community Partnership were established during phase I and II to plan and implement the MAPP process. The committee included academic institutions, government, social and health agencies, social and health agencies, community associations, hospital systems, and public school systems. Information was shared with the general public via email and a Community Commons portal. The first significant piece of work completed by the MAPP Steering Committee and Community Partnership was the creation of a vision and value statements for the MAPP Process.

Shelby County MAPP Vision

A Shelby County that provides and assures opportunities for every resident to develop and participate in activities and services that enhance their health, well-being, and quality of life.

Shelby County MAPP Value Statements

- ❖ **Assurance:** Through policy and environmental level support, every resident is assured the proper support to engage in healthy lifestyle and behaviors.
- ❖ **Collaboration:** Every resident, business, organization or association throughout Shelby County is important and will work together to achieve our vision of a healthy community.
- ❖ **Inclusivity:** Every resident, every organization, and every institution is involved and respected for its voice and perspective toward achieving our vision of a healthy community.
- ❖ **Ownership:** Every resident has a stake in achieving our vision of a healthy community.
- ❖ **Health Equity:** Every resident has access to quality, culturally appropriate health care and opportunities to engage in activities that contribute to healthy living and lifestyle.
- ❖ **Efficient & Effective Healthcare:** Every resident has access to both efficient and effective healthcare that considers the effects of care services as well as the costs.
- ❖ **Healthy Environment:** Every resident has the opportunity to live, work, and play in environments with a positive infrastructure and free from harmful pollutants.
- ❖ **Knowledge:** Every resident has an opportunity to equip themselves with knowledge that will positively impact their healthy lifestyle choices and overall health.
- ❖ **Wellness:** Every resident embraces all components of a healthy community -prevention, early detection/intervention, healthy lifestyle, and culturally appropriate care services for the mind, body, emotion, and spirit.
- ❖ **Safety:** Every resident has the opportunity to live, work, and play in a safe community.



Phase III: March-August 2013

During Phase III (May - September 2013), the Community Health Assessment comprised of four MAPP assessments was conducted:

Community Health Status

- overall landscape of health within Shelby County
- results compiled from existing National, State, and Local data sources
- includes metrics on Demographics and Social Environment, Health Care (Assess & Quality), Health Outcomes, Health Behaviors, and Physical Environment.

Community Themes & Strengths

- wants, needs, and desires of residents around their community's health
- self-reported data collected by survey
- includes metrics on Quality of Life Statements, Health Outcomes, Child Health Information, Personal Behaviors, Community Related Behaviors, Physical Environment, Health Care, Emergency Preparedness, and Demographics

Local Public Health System

- components, activities, competencies, and capacities of our local public health system and description of how the 10 Essential Public Health Services are provided in the community
- data collected by group discussion and utilizing a tool developed by NPHPS
- provides score cards based on the 10 Essential Public Health Services

Forces of Change

- trends, factors, and/or events that influence health and quality of life in Shelby County
- data collected by group discussion and qualitative worksheet

Over 2,500 concerned citizens and organizations (such as academia, faith-based organizations, government, social and health agencies, public school systems, etc.) provided input into these four assessments by:

- Participating in a focus group,
- Completing on-line and written surveys, and
- Participating in group sessions.

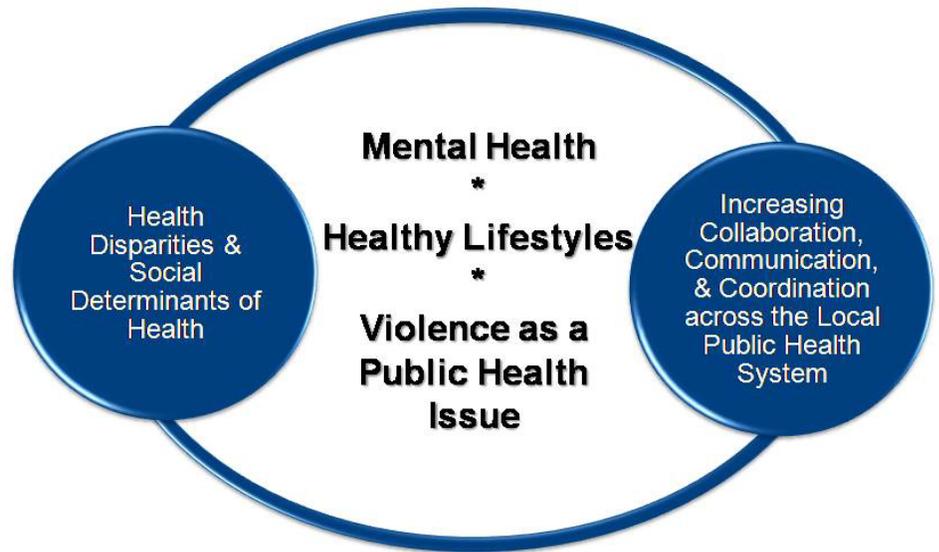
Phase IV – VI: September 2013-Ongoing

The data from MAPP assessments was used to identify the strategic health priorities in Phase IV. In January 2015, community partners began convening within each strategic health priority to develop the *Community Health Improvement Plan* in Phase V. The work ahead for Shelby County lies with putting the Community Health Improvement Plan into action. With commitment from local government and the community-at-large to address these health priorities, Shelby County *will* become one of the healthiest places in the nation.

Strategic Health Priorities

As result of the MAPP process, the Community Health Assessment, and community input, community partners identified five strategic health priorities for Shelby County's Community Health Improvement Plan:

1) Health Disparities & Social Determinants of Health, 2) Increasing Collaboration, Communication, & Coordination across the Local Public Health System, 3) Mental Health, 4) Healthy Lifestyles, and 5) Violence as a Public Health Issue.



All five of these strategic health priorities represent some of the most pressing issues and barriers in Shelby County's mission to be the healthiest place to live. However, two of the five priorities were system-related and cross-cutting issues. Because of the significance and magnitude of the two cross-cutting priorities, addressing health disparities & social determinants of health and increasing collaboration, communication, and coordination were integrated within the main three priorities.

The Value of Community Input and Working Together: Community of Practice

After the selection of MAPP's strategic health priorities, SCHD, alongside community partners, provided input on how to narrow the focus of each strategic health priority. Community input maximizes the value of the Community Health Improvement Plan and strengthens our ability to establish healthy communities throughout Shelby County. For this reason, Shelby County MAPP uses a *community of practice (CoP)* model to collectively develop and adopt goals and strategies. The CoPs serve as a form of think tank to allow for free flow of ideas and sharing of knowledge and dialogue. Participation in a CoP is open to all; every perspective is welcome and respected.

Following the reveal of the strategic health priorities, a CoP formed for each issue. The CoPs reconvened from January to April 2015. The three main CoPs met monthly while the cross-cutting priorities met in March 2015 to assure that these priority areas were being addressed throughout the other SHPs. Each CoP is comprised of community members and various organizations across sectors including: public health, education, non-profit, health care, and government.

Communities of Practice & Developing the *Shelby County CHIP*

STRATEGIC HEALTH PRIORITIES

»»» GOALS «««

CROSS-CUTTING PRIORITIES



Health Disparities & Social Determinants of Health



Collaboration, Communication, & Coordination across the Local Public Health System



MENTAL HEALTH

To enhance mental health, wellbeing, and quality of life by addressing depression in Shelby County

HEALTHY LIFESTYLES



To establish healthy lifestyles and community wellness as a norm in Shelby County



VIOLENCE AS A PUBLIC HEALTH ISSUE

To prevent youth violence, limit exposure to violence, and enhance youth safety in Shelby County

With a shared vision of building a healthier Shelby County, community partners within each CoP agreed upon focus area(s) and goals and compiled strategies and tactics related to those goals as part of what their individual organization has planned or as a part of an existing or budding collaboration. Focus area(s) and goals of each community of practice were selected through facilitated discussion, brainstorming activities, and, if the focus area required more definition after discussion and brainstorming, a survey. As a result, community partners selected focus areas by considering the following criteria:

- Seriousness: There will be serious consequences if we do not address this issue
- Impact: We are in a position to effectively make a difference
- Feasibility: We have the knowledge, control, and/or resources necessary to affect change
- Trends: The problem is getting worse

The following became the focus areas for each main Strategic Health Priority:

1. Mental Health: **Depression**
2. Healthy Lifestyles: **Healthy Eating, Active Living, and Diabetes Management**
3. Violence as a Public Health Issue: **Youth Violence**

Goals and strategy statements were drafted and edited based on the facilitated discussions and existing plans and recommendations nationally, statewide, and locally. Existing plans and recommendations that were used to inform strategy statements are as follows:

- Mental Health
 - Tennessee Department of Mental Health Substance Abuse Services: Three Year Plan
 - CDC Public Health Action Plan to Integrate Mental Health Promotion and Mental Illness Prevention with Chronic Disease Prevention, 2011- 2015
- Healthy Lifestyles
 - Healthy People 2020
 - Shelby County's Office of Sustainability: Greenprint
- Violence as a Public Health Issue
 - Operation: Safe Community
 - Department of Justice: Defending Childhood Recommendations
 - Shelby County's Defending Childhood Initiative: Network for Overcoming Violence and Abuse (DCI NOVA)
 - Healthy People 2020

After goals and strategies were finalized, community partners completed a survey to compile tactics relevant to the agreed upon strategies for each strategic health priority. These tactics demonstrate the



commitment to make Shelby County a healthier place by providing activities that organizations are currently implementing or are planning to implement in the next three years. Those tactics are compiled later in this document.

Relationship between the Shelby County CHIP and Other Planning Efforts

The Shelby County CHIP does not replace or supersede any concurrent action planning produced by any of our community partners. Although the Shelby County Health Department took the lead in facilitating the MAPP process, it does not own the process nor is it the sole responsibility of the health department to implement the plan. In fact, the CHIP is a collaborative effort that complements the various efforts and initiatives taking place in our great county. The CHIP can be used as a compilation of those great efforts as well as a tool to inform further strategic planning and action.

Transitioning the Plan to Action: Phase VI

The Community Health Improvement Plan serves as a transition for the MAPP process in Shelby County. For the next three years, we will be in the sixth and final phase of MAPP: the **action cycle**. During this time, our communities of practice will meet quarterly to update on progress and discuss unforeseen barriers within each of our strategies. This phase —implementation of tactics, collaboration between partners, and constant evaluation of our strategies— will ultimately build Shelby County into one of the healthiest places to live in the nation.

The Shelby County Community Health Improvement Plan is a living document and will be updated and altered as we continue the action phase of our planning process. As with every phase of MAPP, **new community partners are always welcome**.

Contact the Shelby County Health Department's community health planners for more information on how you and your organization can help to implement this CHIP:

Amy Collier | 901-222-9618 | amy.collier@shelbycountyttn.gov

Angela Moore | 901-222-9620 | angela.p.moore@shelbycountyttn.gov

Community Health Assessment Summary





COMMUNITY HEALTH ASSESSMENT STRUCTURE

Becoming one of the healthiest places to live in the nation begins by assessing the current state of health in our community. The following sections provide detail of Shelby County’s health as described through the four MAPP assessments. Together, these assessments inform the selection of strategic health priorities and the Community Health Improvement Plan. Below is a snapshot of what to expect in each of the four assessments.

Community Health Status

- overall landscape of health within Shelby County
- results compiled from existing National, State, and Local data sources
- includes metrics on Demographics and Social Environment, Health Care (Assess & Quality), Health Outcomes, Health Behaviors, and Physical Environment.

Community Themes & Strengths

- wants, needs, and desires of residents around their community's health
- self-reported data collected by survey
- includes metrics on Quality of Life Statements, Health Outcomes, Child Health Information, Personal Behaviors, Community Related Behaviors, Physical Environment, Health Care, Emergency Preparedness, and Demographics

Local Public Health System

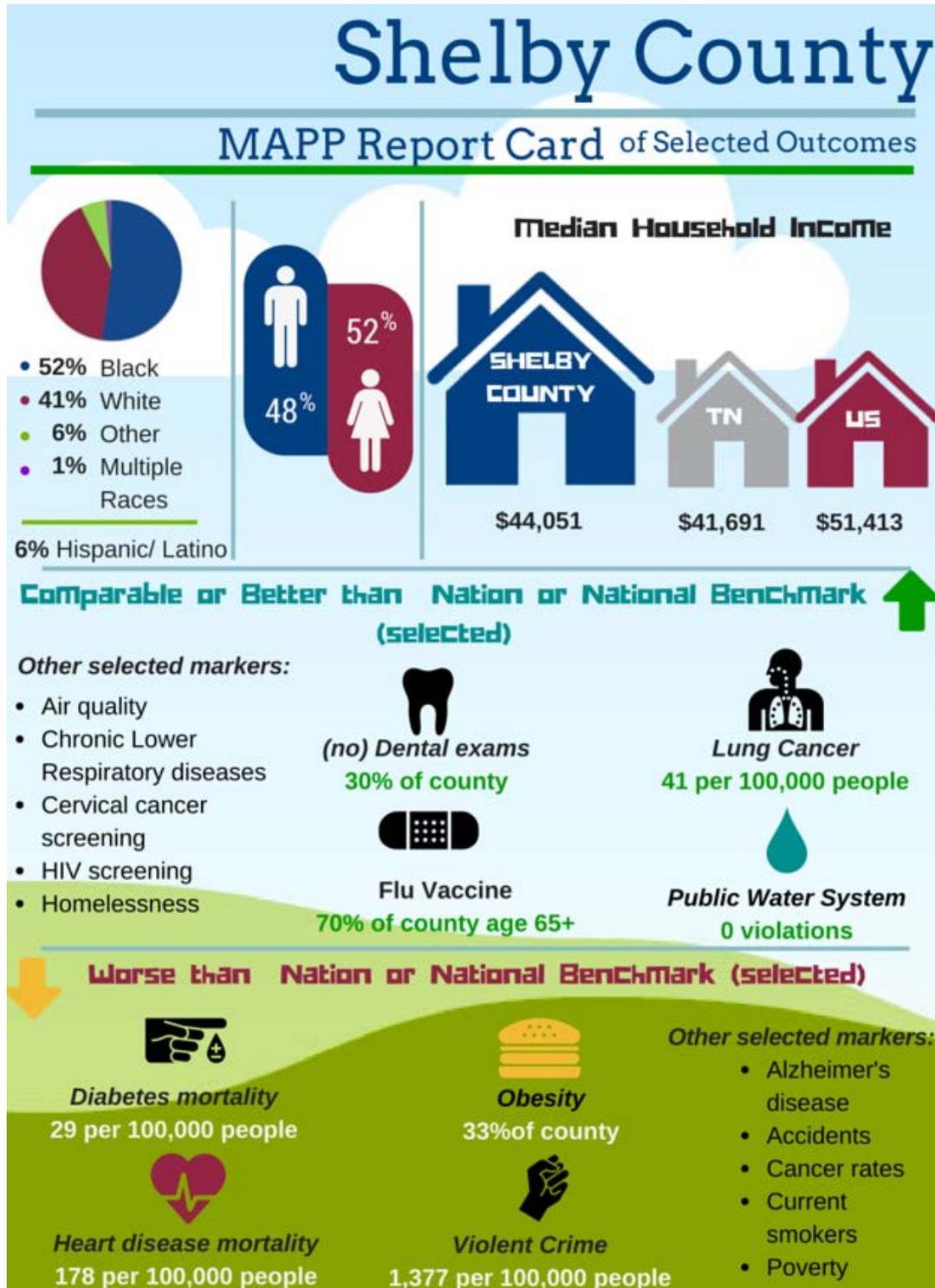
- components, activities, competencies, and capacities of our local public health system and description of how the 10 Essential Public Health Services are provided in the community
- data collected by group discussion and utilizing a tool developed by NPHPS
- provides score cards based on the 10 Essential Public Health Services

Forces of Change

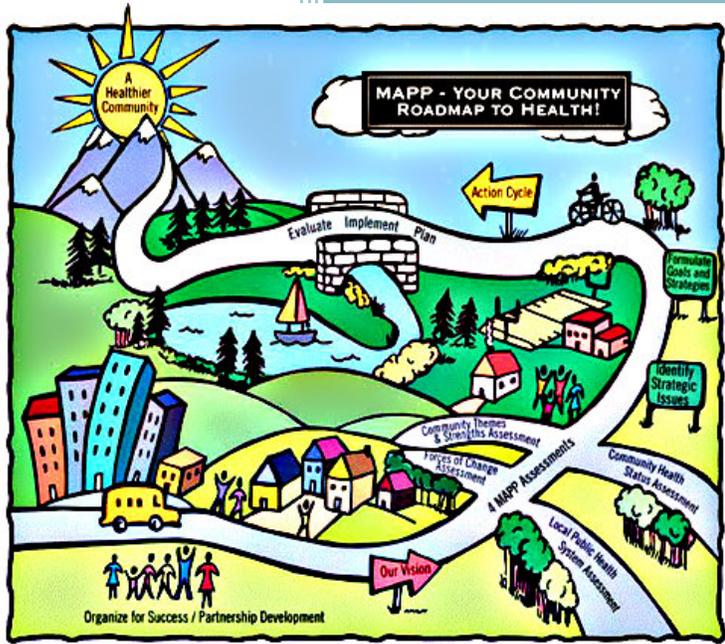
- trends, factors, and/or events that influence health and quality of life in Shelby County
- data collected by group discussion and qualitative worksheet

SUMMARY HIGHLIGHTS

The info graphic below highlights some of the findings of the Community Health Assessment, including some strengths and weakness in health outcomes found in Shelby County. More information on these health outcomes and other factors can be found throughout the CHA summary as well as the full versions of the assessments.



Community Health Status Assessment Report Summary





METHODS

Using the Centers for Disease Control and Prevention's (CDC) Community Health Assessment for Population Health Improvement¹ as a guide, members of the CHSA Working Group selected data that aligned with the Core Indicators. The CDC's guide provides a framework of metrics that have been determined to be key indicators in community health, see **Table I** for more information.

Table I Health Metrics for Community Health Assessments

| Community Health Assessment for Population Health Improvement Most Frequently Recommended Health Metrics ² | | | | | |
|---|-----------------------|--|-----------------------------|-----------------------------------|----------------------|
| Health Outcome Metrics | | Health Determinant and Correlate Metrics | | | |
| Mortality | Morbidity | Health Care (Access & Quality) | Health Behaviors | Demographics & Social Environment | Physical Environment |
| Leading causes of death | Obesity | Health insurance coverage | Tobacco use/ smoking | Age | Air quality |
| Infant mortality | Low birth- weight | Provide rates | Physical activity | Sex | Water quality |
| Injury-related mortality | Hospital utilization | Asthma-related hospitalization | Nutrition | Race/ Ethnicity | Housing |
| Motor vehicle mortality | Cancer rates | | Unsafe sex | Income | |
| Suicide | Motor vehicle injury | | Alcohol use | Poverty level | |
| Homicide | Overall health status | | Seatbelt use | Educational attainment | |
| | STDs | | Immunization and screenings | Employment status | |
| | HIV/AIDS | | | Foreign born | |
| | Tuberculosis | | | Homelessness | |
| | | | | Language spoken at home | |
| | | | | Marital status | |
| | | | | Domestic violence and child abuse | |
| | | | | Violence and crime | |
| | | | | Social capital/ social support | |

¹ Centers for Disease Control and Prevention. (2013). Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants. Retrieved from: <http://chna22.org/wp-content/uploads/2013/06/Community-Health-Assessment-for-Population-Health-Improvement.pdf>

² Centers for Disease Control and Prevention. (2013). Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants. Retrieved from: <http://chna22.org/wp-content/uploads/2013/06/Community-Health-Assessment-for-Population-Health-Improvement.pdf>



This report will follow the guidelines of the health metrics suggestions put forth by the CDC. In some instances additional data points are included. In future drafts of this report, sub-county data will be provided to allow for examination of zip code level data and distribution of certain indicators. Maps will be provided as appendices. Data sources are provided in their respective tables.

DEMOGRAPHICS & SOCIAL ENVIRONMENT

The CHSA reports several indicators on demographics and the social environment of Shelby County. Demographic and social environment indicators include the following:

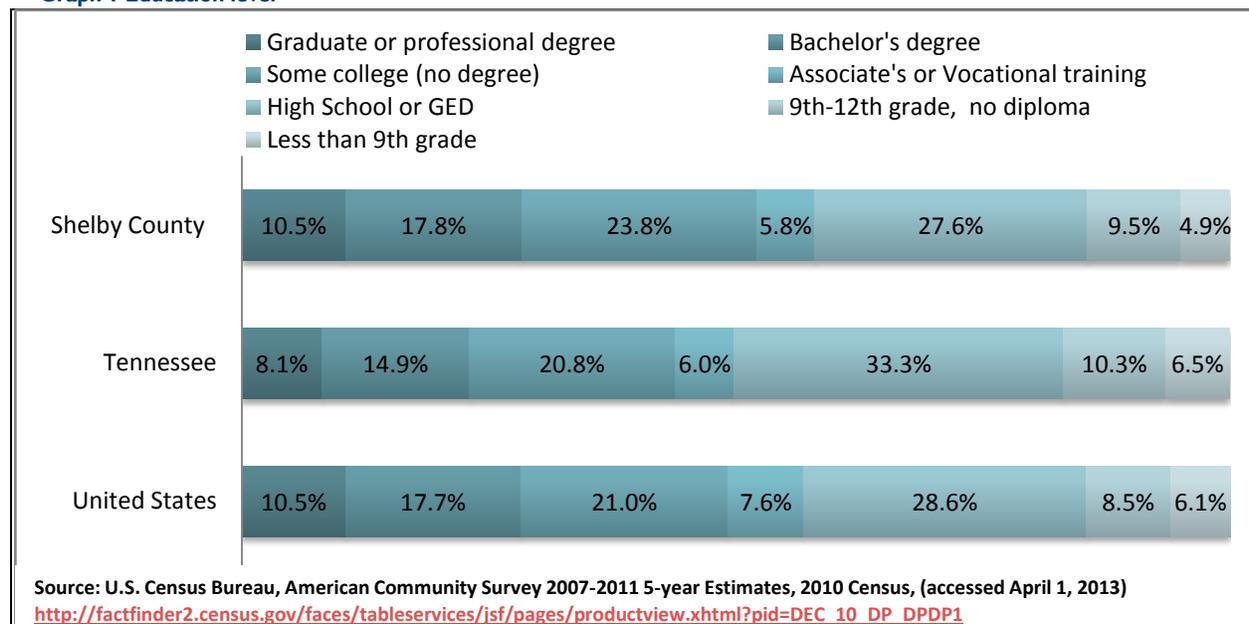
As of the 2009 Population Data from the Tennessee Department of Health, 930,689 residents live in Shelby County. In Shelby County, 47.7% of the residents are male and 52.3% are female.³ In the context of race and

- age,
- race/ethnicity,
- socioeconomic measures,
- educational attainment,
- employment status,
- foreign born status,
- homelessness,
- language,
- marital status,
- domestic violence and child abuse,
- violence and crime, and
- social capital/social support.

ethnicity, a higher proportion of Black or African American residents live in Shelby County (52.1% Black, 40.6% White, 0.2% American Indian and Alaskan Native, 2.3% Asian, 5.6% Hispanic or Latino, and 3.3% Other Race).⁴

A few tables and graphs **highlighting** other demographic and social environment indicators are provided below. The full CHA will provide the demographic and social environment section in its entirety.

Graph I Education level



³ Tennessee Department of Health, 2009 Population Data, (accessed April 1, 2013) Retrieved from: <http://hit.state.tn.us/pop.aspx>

⁴ U.S. Census Bureau, 2010 Census, (accessed April 1, 2013) Retrieved from: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_DP_DPDP1



Table 2 Socioeconomic measures

| Socioeconomic Measure | Shelby County ¹ | Tennessee ¹ | United States |
|--|----------------------------|------------------------|---------------|
| Core Indicators | | | |
| Percent below Poverty Level (100% FPL[*]) | | | |
| Children | 30.3% | 24.0% | 19.9% |
| Families | 16.7% | 13.7% | - |
| Total | 20.1% | 16.8% | 14.3% |
| Median Household Income | | | |
| | \$44,051 | \$41,691 | \$51,413 |
| Percent receiving SNAP^{**} benefits in last 12 months² | | | |
| | 27.7% | 20.5% | 14.5% |
| Employment- Percent Unemployed⁴ | | | |
| | 9.8% | 8.4% | 7.7% |
| Special Populations | | | |
| Population with less than HS diploma | 14.4% | 16.8% | 14.6% |
| Population receiving Medicaid | 24.4% | 18.5% | 19.9% |
| Veteran population | 9.1% | 10.5% | - |
| Population speaking English less than “very well” | 4.1% | 2.9% | 8.7% |
| Population without health insurance | 16.3% | 14.1% | 15.2% |
| Homelessness rate (per 10,000) | 15 | 14.7 | 20.3 |
| Population ages 65 and older | 10.2% | 13.3% | 12.9% |
| Foreign born | 6% | 4.5% | 12.8% |
| Source: | | | |
| ² US Census Bureau, Small Area Income & Poverty Estimates: 2010 . Source geography: County. | | | |
| ³ The State of Homelessness in America, 2012 http://b.3cdn.net/naeh/a18b62e5f015e9a9b8_pdm6iy33d.pdf http://b.3cdn.net/naeh/025f630bc6a9728920_y6m6ii6hp.pdf | | | |
| ⁴ US Department of Labor, Bureau of Labor Statistics: 2013-July . Source geography: County. | | | |
| Definitions: | | | |
| [*] Federal Poverty Level | | | |
| ^{**} Supplemental Nutrition Assistance Program | | | |

Other indicators to note within this section are child abuse, domestic violence, violent crime, and social support. Shelby County’s substantiated child abuse neglect rate (5.3 per 1,000 children) is lower than TN (6 per 1,000 children) and US (9 per 1,000 children).⁵ However, Shelby County’s domestic violence rate (2,949 per 100,000) is

⁵ Kid Count Data Center, (2010) Retrieved from:
<http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=TN&ind=2986&dtm=13282>



higher than the state (1,323 per 100,000).⁶ Shelby County's violent crime rate (1,377 per 100,000) is also higher than TN (667 per 100,000) and higher than the national benchmark (66 per 100,000).⁷ In regards to social support, 19.7% of respondents reported inadequate social support which slightly higher than TN (18.9%) but slightly lower than US (20.9%).⁸

Table 3 Domestic Violence and Child Abuse

| | Shelby County | Tennessee | United States |
|--|---------------|--------------|---------------|
| Substantiated child abuse neglect rate (per 1,000 children)¹ | 5.3 | 6 | 9 |
| Domestic violence rate (per 100,000)² | 2,949 | 1,323 | - |

Source:

¹Kid Count Data Center, 2010

<http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=TN&ind=2986&dtm=13282>

²Urban Child Institute, <http://www.urbanchildinstitute.org/articles/research-to-policy/overviews/domestic-violence-hurts-children-even-when-they-are-not-direct>

Table 4 2004-2010 Violence and crime rates

| | Shelby County | Tennessee | National Benchmark |
|---|---------------|------------|--------------------|
| Violent crime rate (per 100,000) | 1,377 | 667 | 66 |
| Homicide rate (per 100,000) | 17 | 8 | - |

Source:

2013 County Health Rankings,

<http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank>

⁶ Urban Child Institute (2010) Retrieved from: <http://www.urbanchildinstitute.org/articles/research-to-policy/overviews/domestic-violence-hurts-children-even-when-they-are-not-direct>

⁷ 2013 County Health Rankings, <http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank>

⁸ Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2005-11. Accessed using the [Health Indicators Warehouse](#).. Source geography: County.



HEALTH OUTCOME METRICS

In regards to health outcome metrics, the CHSA includes both mortality and morbidity data within Shelby County. *Mortality* metrics report the state of *death*, whereas *morbidity* metrics report the state of *illness*.

Mortality

The CHSA features several types of mortality data:

- leading causes of death,
- infant mortality,
- injury-related mortality,
- motor vehicle mortality,
- suicide, and
- homicide.

Leading Causes of Death

According to CDC’s National Vital Statistics System (2006-2010), the leading causes of death in Shelby County, Tennessee were the following: 1) cancer (all), 2) heart disease, 3) stroke, 4) unintentional injury, 5) chronic lower respiratory diseases, 6) Alzheimer’s disease, 7) diabetes mellitus, 8) influenza and pneumonia, 9) homicide, 10) nephritis, nephritic syndrome, and nephrosis (kidney).⁹

The table below provides more information on the leading causes of death in Shelby County, Tennessee from 2006-2010. The age- adjusted rates are compared against the rates for the State of Tennessee as well as the Healthy People 2020 (HP) target rate if available. The rates below are per 100,000 persons.

Table 5 2006-2010 Leading Causes of Death per 100,000

| Cause of Death | Shelby County ¹ | Tennessee ¹ | US ¹ | HP 2020 Target ² |
|--|----------------------------|------------------------|-----------------|-----------------------------|
| Cancer (all) | 210.2 | 199.1 | 176.6 | <=160.6 |
| Heart disease | 177.6 | 175.5 | 134.6 | <=100.8 |
| Cerebrovascular diseases (stroke) | 59.4 | 52.4 | 41.7 | <=33.8 |
| Accidents (unintentional injury) | 45.1 | 52.7 | 39.1 | <=36.0 |
| Chronic lower respiratory diseases | 41.2 | 51.7 | 42.4 | - |
| Alzheimer’s Disease | 38.8 | 36.2 | 25.9 | - |
| Diabetes Mellitus | 28.9 | 26.4 | 23.1 | - |
| Influenza and Pneumonia | 19.5 | 21.9 | 17.8 | - |
| Assault (homicide) | 16.8 | 7.6 | 5.8 | <=5.5 |
| Nephritis, Nephrotic Syndrome and Nephrosis | 16.4 | 13.8 | - | - |

Source:

¹ [Centers for Disease Control and Prevention, National Vital Statistics System: 2006-10](#). Accessed using [CDC WONDER](#)

² <http://www.healthypeople.gov/2020/default.aspx>

⁹ [Centers for Disease Control and Prevention, National Vital Statistics System: 2006-10](#). Accessed using [CDC WONDER](#)



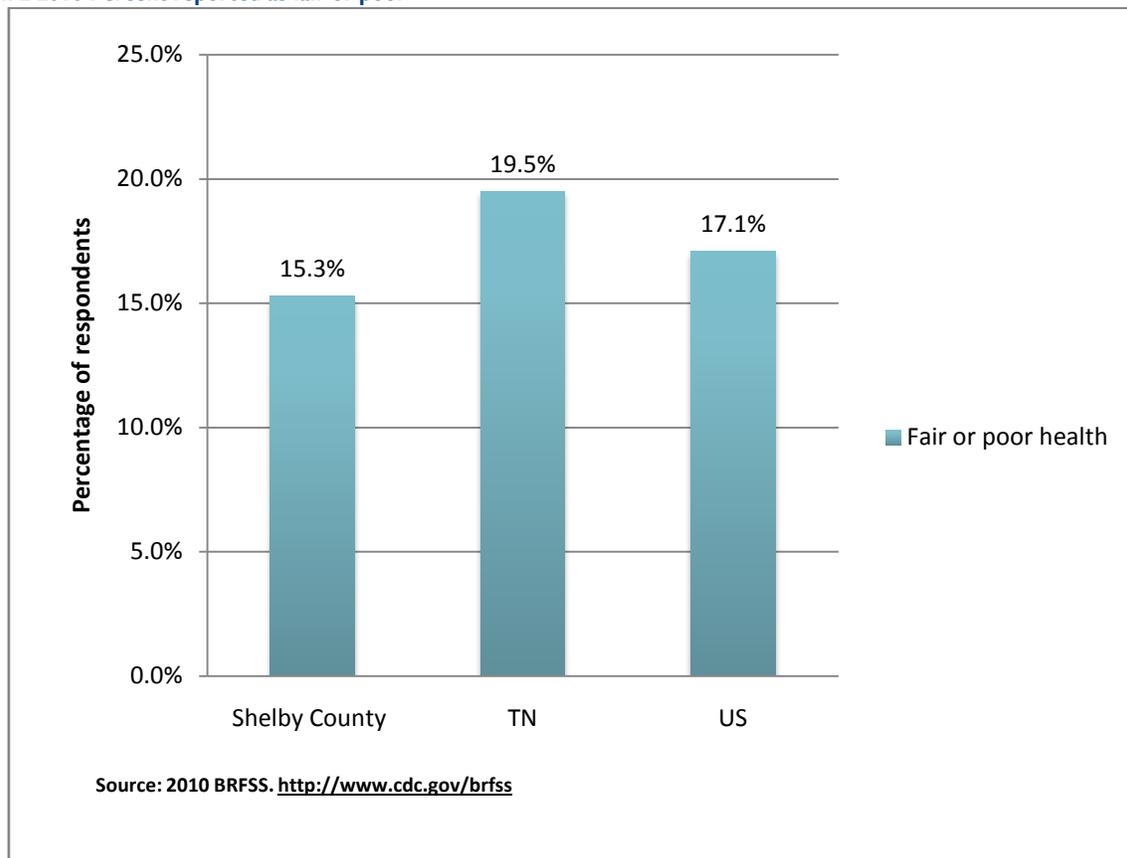
Additional Mortality Metrics

The CHSA also provides mortality data on infants, injury-related, motor vehicle, suicide, and homicide. Both infant mortality and injury-related mortality are higher in Shelby County (12.6 per 1,000 live births and 45.1 per 100,000, respectively) than TN, US and the Healthy People 2020 Target. According to the National Vital Statistics System of 2006-2010, Shelby County has lower motor vehicle mortality and suicide rates than the state. Although Shelby County's motor vehicle mortality (15.3 per 100,000) is lower the state's rate (19.1 per 100,000), motor vehicle deaths in Shelby County are slightly higher than the national rate (13.0 per 100,000). However, Shelby County's suicide rate (10.6 per 100,000) is slightly lower than the national rate (11.6 per 100,000).^{10, 11}

Morbidity

Morbidity indicators are as follows: overall health status, obesity, low birth-weight, diabetes, hospital utilization, cancer rates, sexually transmitted infections (STIs), HIV/ AIDS, and tuberculosis. According to the 2010 BRFSS, 15.3% of Shelby County respondents reported fair or poor health.¹²

Graph 2 2010 Percent reported as fair or poor



¹⁰ Death Certificate Data (Tennessee Resident Data) Tennessee Department of Health

¹¹ <http://www.healthypeople.gov/2020/default.aspx>

¹² 2010 BRFSS. <http://www.cdc.gov/brfss>



Although residents reported lower percentages of fair or poor health than the state and nation, the morbidity statistics provide a different picture of the health status in Shelby County. The following conditions have a **higher** percentage, rate, or prevalence in **Shelby County** than Tennessee and US:

- **Obesity** (33.4% Obese in Shelby County; 31.1% in TN; 27.6% in US) ¹³
- **Percent of total births that are low-weight** (11.1% in Shelby County; 9.3% in TN; 8.1% in US) ¹⁴
- **Diagnosed with diabetes** (13.0% in Shelby County; 11.3% in TN; 8.7% in US) ¹⁵
- **Diabetes with pre-diabetes or borderline diabetes** (6.6% in Shelby County; 5.2% in TN; 1.2% in US) ¹⁶
- **Cancer** ¹⁷
 - **Breast** (126 per 100,000 in Shelby County; 118.7 per 100,000 in TN; 119.7 per 100,000 in US)
 - **Cervical** (10.5 per 100,000 in Shelby County; 8.7 per 100,000 in TN; 7.7 per 100,000 in US)
 - **Colon and rectum** (50.6 per 100,000 in Shelby County; 46 per 100,000 in TN; 43.9 per 100,000 in US)
 - **Prostate** (180.8 per 100,000 in Shelby County; 144.3 per 100,000 in TN; 143.7 per 100,000 in US)

Shelby County also has higher rates in Sexually Transmitted Infections, HIV/AIDS, and Tuberculosis than Tennessee and US.

- Sexually Transmitted Infections ^{18, 19}
 - **Chlamydia** (1,048.2 per 100,000 in Shelby County; 490.1 per 100,000 in TN; 452.1 per 100,000 in US)
 - **Gonorrhea** (361.7 per 100,000 in Shelby County; 120.8 per 100,000 in TN; 102.8 per 100,000 in US)
 - **Syphilis** (11.8 per 100,000 in Shelby County; 4.4 per 100,000 in TN; 4.5 per 100,000 in US)
- **HIV/AIDS** (848.5 per 100,000 in Shelby County; 300.5 per 100,000 in TN; 340.4 per 100,000 in US) ²⁰
- **Tuberculosis** (6.1 per 100,000 in Shelby County; 2.5 per 100,000 in TN; 3.2 per 100,000 in US) ²¹

However, in regards to lung cancer, the State Cancer Profiles of 2006-2010 reveals that Shelby County (64.8 per 100,000) fares better than Tennessee (79.1 per 100,000) and US (64.9 per 100,000).

¹³ 2012 BRFSS. <http://www.cdc.gov/brfss>

¹⁴ Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Atlas: 2010.

¹⁵ 2012 BRFSS. <http://www.cdc.gov/brfss>

¹⁶ 2012 BRFSS. <http://www.cdc.gov/brfss>

¹⁷ State Cancer Profiles: 2006-10. Source geography: County.2 <http://www.healthypeople.gov/2020/default.aspx>

¹⁸ Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2011.

¹⁹ Shelby County Health Department, HIV Disease and STD Annual Surveillance Summary 2011

²⁰ Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2010.

²¹ State of Tennessee, Department of Health, Communicable and Environmental Disease Services: Tuberculosis Elimination Program. http://health.state.tn.us/ceds/tb/PDFs/2012_Regional_TB_Cases_and_Rates_by_County.pdf



OTHER HEALTH DETERMINANT AND CORRELATE METRICS

In addition to demographics and the social environment, other health determinants that affect health outcomes are access to and quality of health care, health behaviors, and the physical environment. This section of the CHSA focuses on those particular health determinant metrics.

Healthcare (Access & Quality)

In regards to access and quality metrics, the CHSA provides data on health insurance coverage, medical provider ratios, and asthma-related hospitalizations. The percentage of uninsured is higher in Shelby County (16.3%) than Tennessee (14.1%) and US (15.2%). Asthma-related hospitalizations are higher in Shelby County (301 per 100,000) than TN (168 per 100,000).²² The ratio of the Shelby County population to medical providers is lower than Tennessee but higher than the national benchmark.

Table 6 2011-2012 Ratio of population to provider

| | Shelby County | Tennessee | National Benchmark |
|---|---------------|------------|--------------------|
| Primary care physicians (PCP) | 1,274 to 1 | 1,409 to 1 | 1,067 to 1 |
| Dentists | 1,707 to 1 | 2,186 to 1 | 1,516 to 1 |
| Mental health providers | 2,299 to 1 | 3,470 to 1 | - |
| Source: 2013 County Health Rankings, http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank | | | |

Health Behaviors

Tobacco use, physical inactivity, inadequate nutrition, unsafe sex, heavy consumption of alcohol use, and low rates of immunizations and screenings are all behaviors that can lead to poor health outcomes. In Shelby County, 37.7% of respondents were former or current smokers compared to 45.7% in Tennessee and 42.9% in US.²³ Although tobacco use is lower in Shelby County than US, physical inactivity is higher in Shelby County (29.3%) and Tennessee (30.7%) than US (23.4%). Inadequate fruit/vegetable consumption is relatively high nationally at 75.8%, in Tennessee at 74.6%, and locally in Shelby County at 73.3%.²⁴ In regards to alcohol consumption, heavy consumption of alcohol is also higher in Shelby County (11.7%) than Tennessee (8.5%) but lower than US (15%).²⁵ In addition, Shelby County has high rates of teen pregnancies (62 per 1,000 females ages 15-19) and sexually transmitted infections (1,076 per 100,000) compared to the state and national benchmarks.²⁶

Shelby County does not meet or exceed state or national rates for the following screenings and immunizations:

- **Breast cancer screening** (62.1% in Shelby County; 63.3% in TN; 65.3% in US)

²² 2013 County Health Rankings,
<http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank>

²³ Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2005-11. Accessed using the [Health Indicators Warehouse](#)..

²⁴ Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Atlas: 2010. Source geography: County.

²⁵ Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2005-11. Accessed using the [Health Indicators Warehouse](#)..

²⁶ 2013 County Health Rankings,
<http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank>



- **Colorectal screening** (55.1% in Shelby County; 54% in TN; 57.4% in US)
- **Diabetic screening** (84% in Shelby County; 86% in TN; 60.1% in US)
- **Annual Pneumonia vaccine (Age 65+)** (58.1% in Shelby County; 66.2% in TN; 66.3% in US)²⁷
- **On time immunizations for 24 month year olds** (67.9% in Shelby County; 74.9% in TN)²⁸

In addition, Shelby County has a higher percentage of respondents with no or late prenatal care (38.6%) than TN (29.6%) and US (17.2%).

However, according to BRFSS 2006-2010, Shelby County has either better rates than or close rates to TN and/or US for the following screenings, immunizations, and services:

- **Cervical cancer screening (Pap Test)** (83% in Shelby County; 81.4% in TN; 80.4% in US)
- **Adults never screened for HIV** (46.7% in Shelby County; 58.5% in TN; 60.1% in US)
- **Adults with no dental exam** (30.1% in Shelby County; 33.9% in TN; 30.1% in US)
- **No primary care doctor** (15.7% in Shelby County; 16.5% in TN; 19.3% in US)
- **Flu vaccine (Age 65+)** (69.5% in Shelby County; 69.9% in TN; 60.1% in US)²⁹

Physical Environment

Air and water quality, the food environment, as well as access to food and physical activity also influence health outcomes. Most of Shelby County fares better than US in air and water quality. In 2008, there were 0% of days above ozone standards and 0.28% of days above particular matter standards. Shelby County has an average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) of 13.0; however, it is higher than the national benchmark of 8.8 PM2.5. In 2013, 0% of the population received water from a public water system with at least one health-based violation.^{30, 31}

Although Shelby County has good air and water quality, food access is an issue. Approximately 31% of the population has low food access which is higher than TN (27.4%) and US (23.6%).³²

In regards to access to physical activity, 44% of residents live with ½ mile of a park which is higher than TN (17%) and US (39%). However, the recreation and fitness facility rate is only 7.2 per 100,000—lower than the national rate of 9.5 per 100,000. Another element to physical activity access is use of public transportation. According to the American Community Survey, very few residents use public transportation in Shelby County (1.7%) which is lower than US (4.9%) but higher than TN (<1%).³³

²⁷ Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2006-10. Additional data analysis by CARES.. Source geography: County.

²⁸ State of Tennessee, 2011 Immunization Survey, <http://health.state.tn.us/ceds/PDFs/ImmunizationSurvey2011.pdf>

²⁹ Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2006-10. Additional data analysis by CARES.. Source geography: County.

³⁰ Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network: 2008. Additional data analysis by CARES.. Source geography: Tract.

³¹ 2013 County Health Rankings, <http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank>

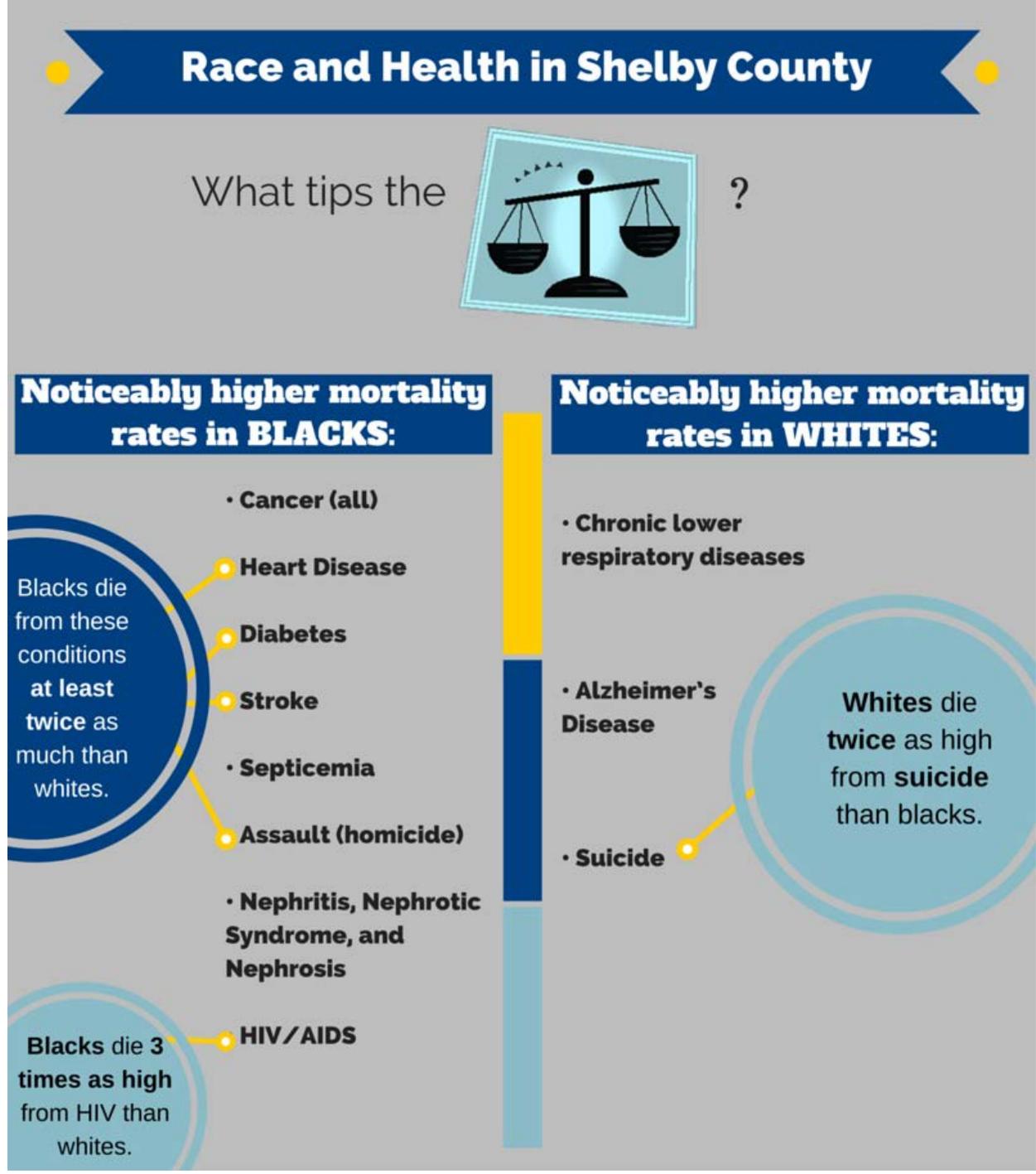
³² US Department of Agriculture, Economic Research Service, Food Access Research Atlas: 2010. Source geography: Tract.

³³ US Census Bureau, American Community Survey: 2007-11. Source geography: County.

ADDENDUM I: RACE AND HEALTH OUTCOMES

Addendum I examines health outcomes by race. The quantitative data shows there are noticeable racial differences in regards to health outcomes. The figure summarizes disproportionate deaths by race.

Addendum I Figure 1. Summary of 2007-2009 Age adjusted mortality rated by race (per 100,000)³⁴



³⁴ Death Certificate Data (Tennessee Resident Data) Tennessee Department of Health



ADDENDUM 2: COMPARISON SUMMARY

Addendum 2 summarizes the CHSA report into comparison tables. The tables below provide “at a glance” summaries of how Shelby County compares to Tennessee, United States, and existing benchmarks or Healthy People 2020 goals on community health indicators within the CHSA.

Addendum 2 Table 1. Summary of Shelby County Metrics Compared to State

| | Comparable or Better than TN | Worse than TN |
|--|---|--|
| Demographics and Social Environment | <ul style="list-style-type: none"> ● Population with less than HS diploma ● Substantiated child abuse neglect rate (per 1,000 children) | <ul style="list-style-type: none"> ■ Poverty Level: Children ■ Poverty Level: Families ■ Total Poverty Level ■ Employment- Percent Unemployed⁴ ■ Population without health insurance ■ Homelessness rate ■ Domestic violence rate ■ Violent crime rate ■ Homicide rate ■ Inadequate social support |
| Mortality | <ul style="list-style-type: none"> ● Accidents (unintentional injury) ● Chronic lower respiratory diseases ● Influenza and Pneumonia ● Injury-related mortality ● Motor vehicle mortality ● Suicide | <ul style="list-style-type: none"> ■ Cancer (all) ■ Heart disease ■ Cerebrovascular diseases (stroke) ■ Alzheimer’s Disease ■ Diabetes Mellitus ■ Assault (homicide) ■ Nephritis, Nephrotic Syndrome and Nephrosis ■ Infant mortality (All causes) ■ Homicide |
| Morbidity | <ul style="list-style-type: none"> ● Preventable hospital stays ● Lung cancer rate ● Overall health status (Fair or poor health) | <ul style="list-style-type: none"> ■ Obese (BMI 30.0 and above) ■ Overweight (BMI 25.0-29.9) ■ Low birth-weight ■ Diagnosed with diabetes ■ Diagnosed w/ pre-diabetes or borderline diabetes ■ Breast cancer rate ■ Cervical cancer rate ■ Colon and rectum cancer rate ■ Prostate cancer rate ■ Chlamydia ■ Gonorrhea ■ Syphilis (primary and secondary) ■ HIV |



| | Comparable or Better than TN ● | Worse than TN ■ |
|---|---|--|
| | | <ul style="list-style-type: none"> ▪ Tuberculosis |
| Health Care Access and Quality | <ul style="list-style-type: none"> ● Primary care physicians (PCP) ● Dentists ● Mental health providers | <ul style="list-style-type: none"> ▪ Uninsured population ▪ Asthma- related Inpatient hospitalization rate (1 to 17 year olds) |
| Health Behaviors, Immunizations, and Screenings | <ul style="list-style-type: none"> ● Tobacco use (current smokers) ● Tobacco use (former and current smokers) ● Tobacco use (quit attempt in past 12 months) ● No leisure time physical activity ● Inadequate fruit/vegetable consumption ● Cervical cancer screening (Pap Test) ● Colorectal screening (colonoscopy) ● HIV screening (adults never screened) ● Dental care (no dental exam) ● Primary care (no regular doctor) | <ul style="list-style-type: none"> ▪ Teen birth rate ▪ Sexually transmitted infections ▪ Heavily consuming alcohol ▪ Breast cancer screening (mammogram) ▪ Diabetic screening (Medicare enrollees) ▪ No or late prenatal care ▪ Annual Pneumonia vaccine (Age 65+) ▪ Flu vaccine (Age 65+) ▪ 24 month year olds w/on time immunizations |
| Physical Environment | <ul style="list-style-type: none"> ● Ozone- Percent of days exceeding standards ● Daily fine particulate matter ● Population receiving water from public water system with at least one health-based violation ● SNAP Food store rate ● Within ½ mile of a park ● Recreation and fitness facility rate ● Use of public transportation | <ul style="list-style-type: none"> ▪ Particulate matter – Percent of days exceeding standards ▪ Fast food restaurant rate ▪ Grocery store rate ▪ Liquor store rate ▪ WIC Food store rate ▪ Population with low food access ▪ Low income population with low food access |



Addendum 2 Table 2. Summary Shelby County Metrics Compared to Nation

| | Comparable or Better than US ● | Worse than US ■ |
|--|---|--|
| Demographics and Social Environment | <ul style="list-style-type: none"> ● Population with less than HS diploma ● Homelessness rate ● Substantiated child abuse neglect rate (per 1,000 children) ● Inadequate social support | <ul style="list-style-type: none"> ■ Poverty Level: Children ■ Total Poverty Level ■ Employment- Percent Unemployed⁴ ■ Population without health insurance |
| Mortality | <ul style="list-style-type: none"> ● Chronic lower respiratory diseases ● Suicide | <ul style="list-style-type: none"> ■ Cancer (all) ■ Heart disease ■ Cerebrovascular diseases (stroke) ■ Accidents (unintentional injury) ■ Alzheimer’s Disease ■ Diabetes Mellitus ■ Influenza and Pneumonia ■ Assault (homicide) ■ Infant mortality (All causes) ■ Injury-related mortality ■ Motor vehicle mortality ■ Homicide |
| Morbidity | <ul style="list-style-type: none"> ● Overweight (BMI 25.0-29.9) ● Lung cancer rate ● Overall health status (Fair or poor health) | <ul style="list-style-type: none"> ■ Obese (BMI 30.0 and above) ■ Low birth-weight ■ Diagnosed with diabetes ■ Diagnosed w/ pre-diabetes or borderline diabetes ■ Breast cancer rate ■ Cervical cancer rate ■ Colon and rectum cancer rate ■ Prostate cancer rate ■ Chlamydia ■ Gonorrhea ■ Syphilis (primary and secondary) ■ HIV ■ Tuberculosis |
| Health Care Access and Quality | | <ul style="list-style-type: none"> ■ Uninsured population |
| Health Behaviors, Immunizations, and Screenings | <ul style="list-style-type: none"> ● Tobacco use (former and current smokers) ● Tobacco use (quit attempt in past 12 months) ● Inadequate fruit/vegetable consumption ● Heavily consuming alcohol ● Cervical cancer screening (Pap Test) | <ul style="list-style-type: none"> ■ Tobacco use (current smokers) ■ No leisure time physical activity ■ Breast cancer screening (mammogram) ■ Colorectal screening (colonoscopy) ■ No or late prenatal care ■ Annual Pneumonia vaccine (Age 65+) |



| | Comparable or Better than US  | Worse than US  |
|-----------------------------|---|--|
| | <ul style="list-style-type: none"> • HIV screening (adults never screened) • Dental care (no dental exam) • Primary care (no regular doctor) • Flu vaccine (Age 65+) | |
| Physical Environment | <ul style="list-style-type: none"> • Ozone- Percent of days exceeding standards • Particulate matter – Percent of days exceeding standards • Grocery store rate • SNAP Food store rate • Within ½ mile of a park | <ul style="list-style-type: none"> ▪ Fast food restaurant rate ▪ Liquor store rate ▪ WIC Food store rate ▪ Population with low food access ▪ Low income population with low food access ▪ Recreation and fitness facility rate ▪ Use of public transportation |



Addendum 2 Table 3. Summary of Shelby County Metrics Compared to Existing National Benchmarks or Healthy People 2020 Goals

| | Comparable or Better than National Benchmarks or Healthy People 2020 Goals  | Worse than National Benchmarks or Healthy People 2020 Goals  |
|--|---|--|
| Demographics and Social Environment | | <ul style="list-style-type: none"> ▪ Violent crime rate |
| Mortality | | <ul style="list-style-type: none"> ▪ Cancer (all) ▪ Heart disease ▪ Cerebrovascular diseases (stroke) ▪ Accidents (unintentional injury) ▪ Assault (homicide) ▪ Infant mortality (All causes) ▪ Injury-related mortality ▪ Suicide ▪ Homicide |
| Morbidity | | <ul style="list-style-type: none"> ▪ Preventable hospital stays ▪ Cervical cancer rate ▪ Colon and rectum cancer rate |
| Health Care Access and Quality | | <ul style="list-style-type: none"> ▪ Primary care physicians (PCP) ▪ Dentists |
| Health Behaviors, Immunizations, and Screenings | | <ul style="list-style-type: none"> ▪ Teen birth rate ▪ Sexually transmitted infections ▪ Diabetic screening (Medicare enrollees) |
| Physical Environment | <ul style="list-style-type: none"> • Population receiving water from public water system with at least one health-based violation | <ul style="list-style-type: none"> ▪ Daily fine particulate matter |

Community Themes & Strengths Assessment Report Summary





METHODS

The CTSA Working Group decided that a survey combined with focus groups would be the best approach to gather data for this assessment. The working group was able to use a Community Health Opinion Survey developed by the Centers for Disease Control and Prevention (CDC) and helped determine how the instrument worked at the local level. Due to the length of the original survey, the CTSA Working Group decided to use a two-pronged approach in administering the survey: 1) full length online version and 2) a shorter in-person version.

The survey was developed by the CDC using the Community Health Assessment for Population Health Improvement¹ as a guide and is sectioned into nine content areas:

1. Quality of Life Statements
2. Health Outcomes
3. Child Health Information
4. Personal Behaviors
5. Community Related Behaviors
6. Physical Environment
7. Health Care
8. Emergency Preparedness
9. Demographics

The shorter, in-person survey contained the following sections only:

1. Quality of Life Statements
2. Health Outcomes
3. Community Related Behaviors
4. Demographics

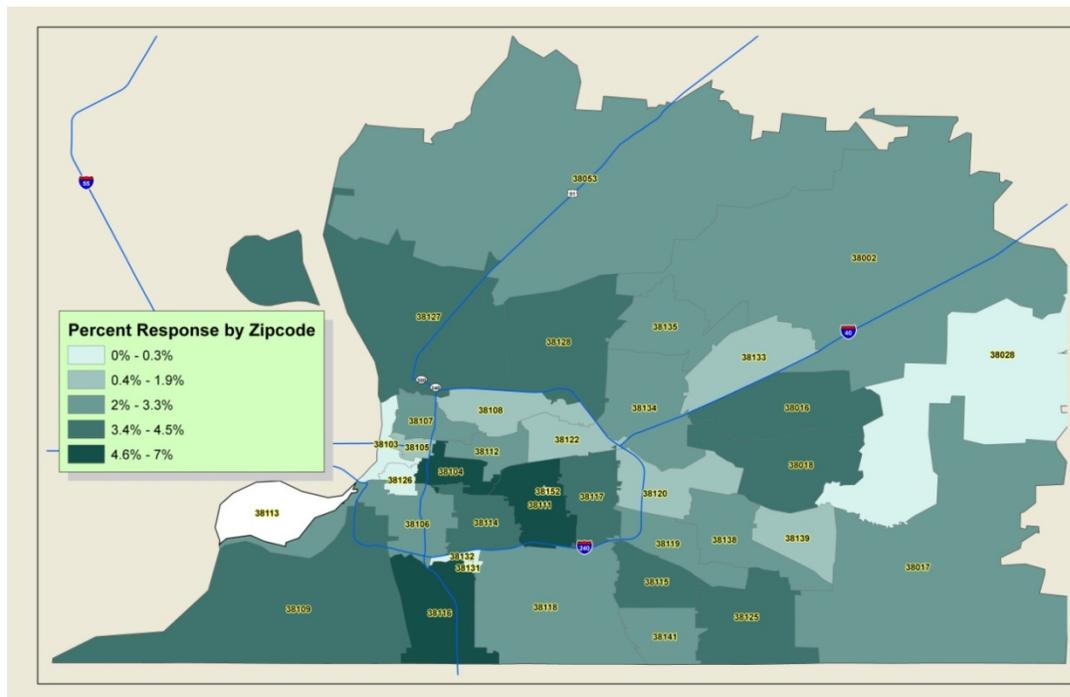
¹ Centers for Disease Control and Prevention. (2013). Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants. Retrieved from: <http://chna22.org/wp-content/uploads/2013/06/Community-Health-Assessment-for-Population-Health-Improvement.pdf>

SURVEY SAMPLE

The sample for this survey was a *convenience sample*. It was determined by the CTSA Working Group that, given available resources (staff, time, money), the best approach would be to rely on partner networks to disseminate the online and in-person survey. The survey was open from June through September 2013, resulting in 1,536 responses (911 online; 625 in-person).

Respondents' Zip code

All respondents were asked to provide their zip code. Overall, responder location distribution covered most parts of the county. Notable exceptions included 38126, 38103, and 38028. Zip codes with highest percentages of responders included 38104, 38116, and 38111.



Demographics

Basic demographic questions were asked of all survey respondents. According to The American Community Survey 2010, survey respondent makeup closely matched the demographic profile of Shelby County in age, income, race, and marital status. Some discrepancies existed in the following:

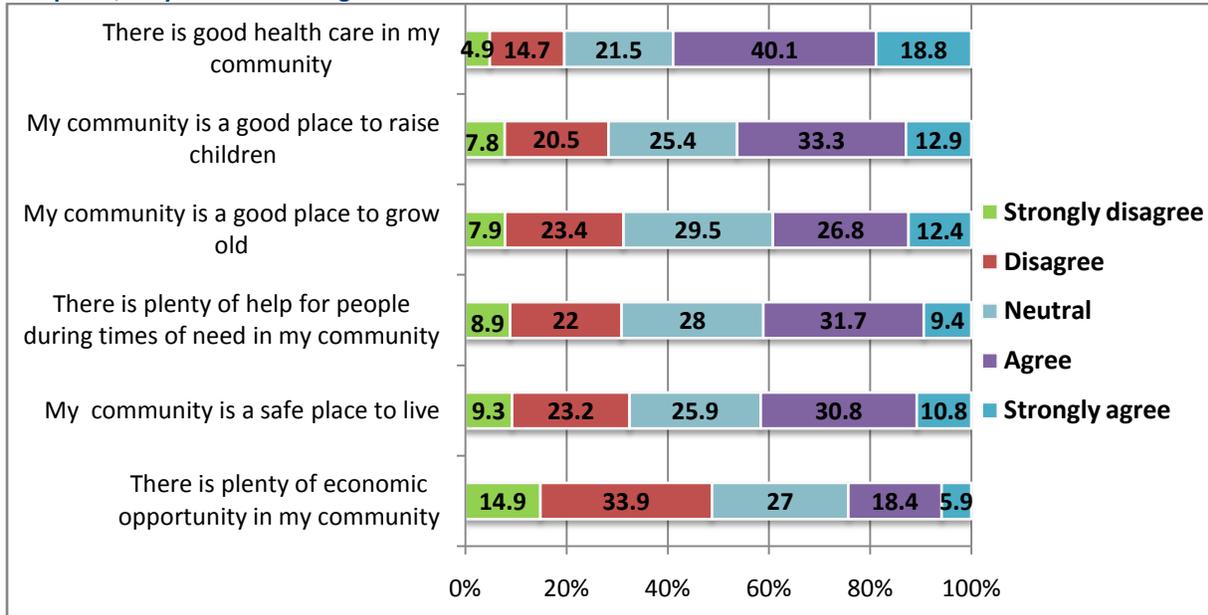
- **Race/Ethnicity-** Both the Asian and Pacific Islander community and individuals with Hispanic or Latino origin were slightly underrepresented in the CTSA survey.
 - Asian/Pacific Islander respondents: 0.7%; compared to 2.4% of Shelby County
 - Respondents with Hispanic/Latino(a) origin: 2.9%; in Shelby County: 5.6%
- **Education-** The CTSA survey overrepresented the population that was college educated and above in Shelby County. In particular, those with a high school diploma only or lower were underrepresented in the CTSA survey.
 - 21.6% of respondents had a bachelor's degree and 29.1% had a graduate or professional degree (compared to 17.8% and 10.5% of Shelby County)
 - 8% of respondents did not graduate from high school (compared to 14.4% of Shelby County)
- **Sex-**The number of female vs. male respondents was relatively high in comparison to sex statistics for Shelby County.
 - Male respondents: 23.3%; compared to 47.7% of Shelby County
 - Female respondents: 74.2%, compared to 52.3% of Shelby County



QUALITY OF LIFE STATEMENTS

This section gathered information regarding perception of the general well-being of the community. This data provides background to both strengths and challenges for Shelby County.

Graph 3 Quality of Life Percentage Breakdown



PERSONAL BEHAVIORS

The following section queried respondents about their own personal habits and health activities. This section was presented in the online survey only.

- **Physical Activity:** 74.5% of respondents reported that they engaged in physical activity for at least 30 minutes.
 - Most common places for activity: neighborhood, home, gym/rec center, public parks/trails
 - Common reasons for not engaging in physical activity: being too tired, not having enough time, not liking to exercise
- **Access to Fresh Foods:** 83.3% reported easy access to fresh foods; 16.7% reported not easy access
 - 60.9% of respondents bought fresh food from full service grocery stores
- **Secondhand smoke exposure:** 55% of respondents reported second hand smoke exposure
- **Access to Mental Health Care:** 13% reported a need for mental health care without receiving services
 - Most common reasons for not receiving care: couldn't afford cost, other reasons (thought I could handle the problem without treatment, don't have time, no transportation, etc), concern for effect on employment



COMMUNITY RELATED BEHAVIORS AND ISSUES

The following section asked respondents to rank their concern level (major concern, concern, minor concern, not a concern) for each of a list of community related behaviors and issues.

Behaviors Results

Highest concern: Unsafe sex, Poor nutrition, Illegal drug use

Lowest concern: Binge drinking, Lack of seatbelt use, Low immunization rates

Issues Results

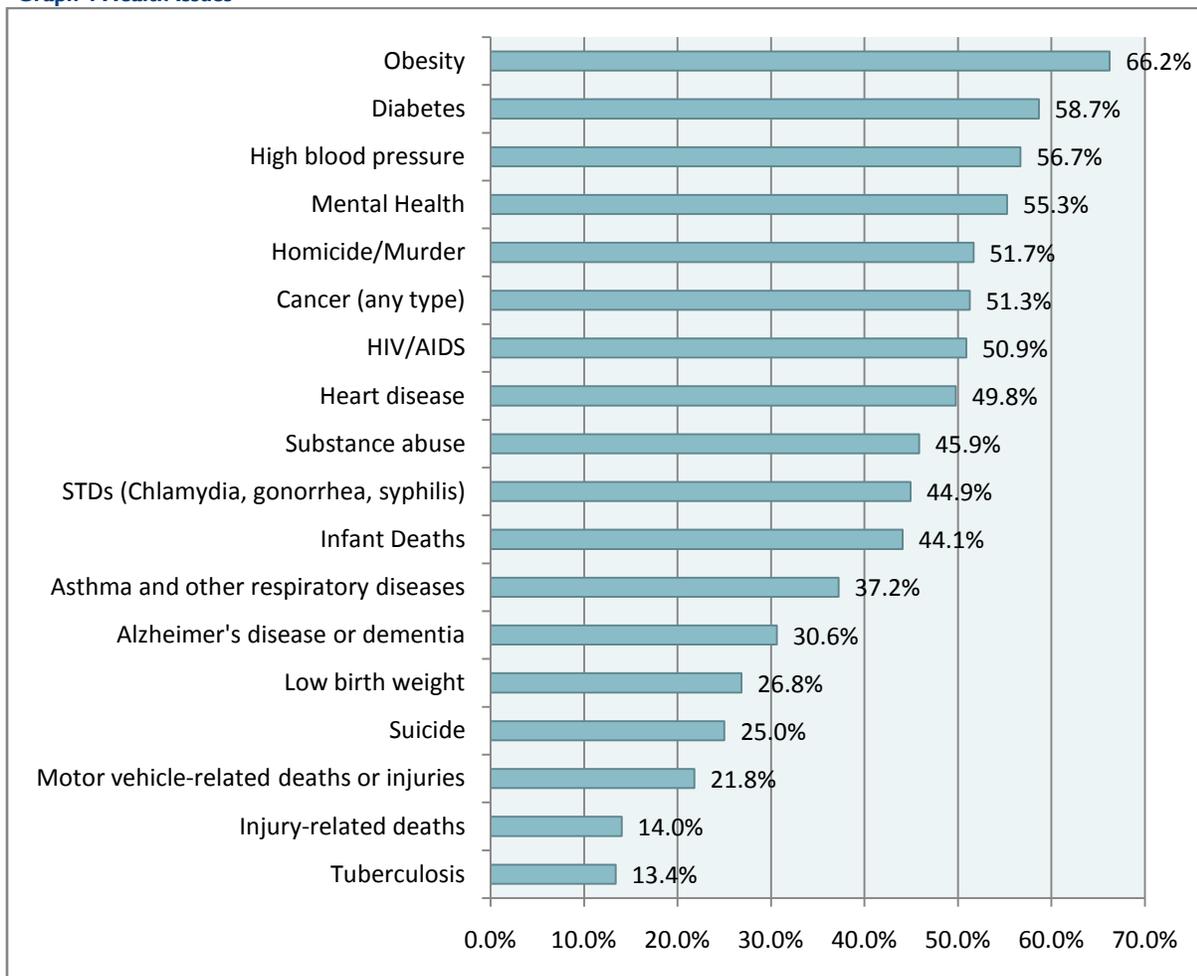
Highest Concern: Crime, Violence, Poverty, Domestic Violence

Lowest Concern: Community Support and Neighborliness

HEALTH OUTCOMES

The following section asked respondents to select issues that required the most attention from a list of 18 health issues. Respondents were able to select as many of those health issues as needed.

Graph 4 Health Issues





EMERGENCY PREPAREDNESS

Questions in this section queried respondents about emergency preparedness related behaviors.

- Smoke Detectors: 55.7% had smoke detectors only; 33.8% also had a carbon monoxide detector
- Emergency supply kit: 55.9% did not have a kit
 - About 46% of respondents with a kit believed it would last more than a week
- Most frequent communication methods during emergency: television (31.7%), radio (20.3%), and text messaging (18.9%)

PHYSICAL ENVIRONMENT

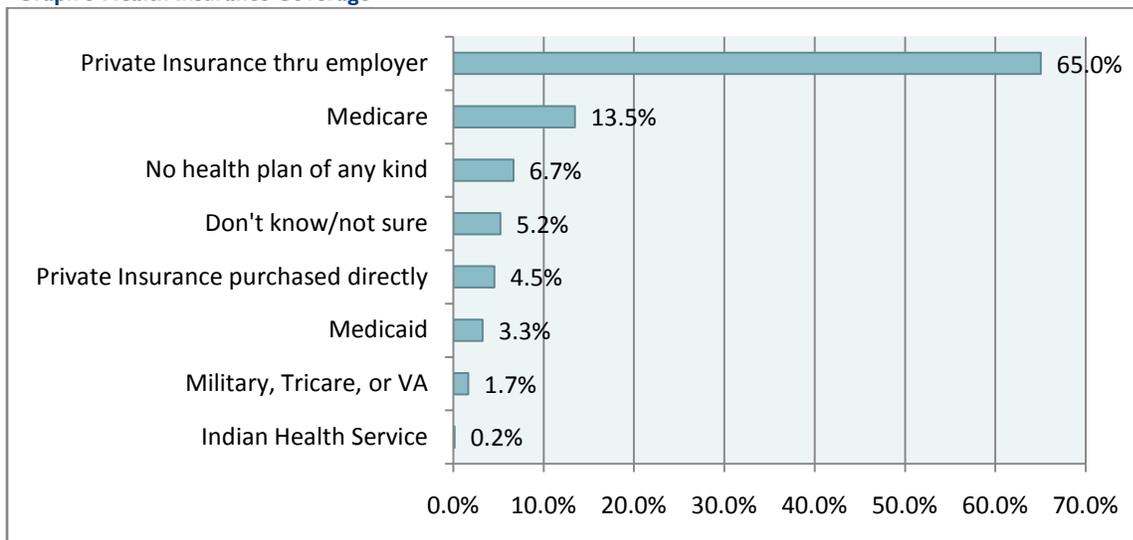
This section asked respondents about the physical environment and health of their neighborhood.

- Public Transportation: 17.2% use public transportation
 - Bus was the most frequently identified type of public transit used at 49%.
- Walking and Biking: Close to 50% of responders stated that they either walked or biked either inside or outside of their neighborhood during a typical week.
 - Of the responders, a majority indicated they walked only; around 5% biked only
 - Reasons for not biking/walking: Safety concerns, no bicycle, too much traffic
 - Adequate sidewalks: 27% said no; Adequately lighted sidewalks: about 41% said no
 - Bike lanes in neighborhood: just over 56% said no
- Food Availability: 94.8% stated there was both a grocery and a drug store within a 15 minute drive
 - 69.1% had access to a full service grocery only; 1.7% had access to convenience store only
 - 61.5% indicated their convenience store did not have quality fruits and vegetables

HEALTH CARE

The following section asked respondents about topics related to health care, including insurance coverage and access to care.

Graph 5 Health Insurance Coverage



Problems Accessing Health Care: Almost 17% said yes

- Most common service access issues: General practitioner (20.9%), Dentist (19.5%), Eye care (11.3%)
- Reasons for not receiving care: Insurance did not cover, Have no insurance, Share of the cost was too high

Local Public Health System Assessment Report Summary



METHODS

To conduct this assessment, the LPHSA working group used the Local Public Health Assessment Instrument developed by NPHPS. This tool assesses the performance and capacity of the collective and interactive system as a whole by using the 10 Essential Public Health Services as the framework for assessing the local system¹. The assessment was divided by Essential Service area to ensure participation and appropriate expertise at the table. Over the course of 5 separate meetings, approximately 65 individuals from various organizations took part in this assessment. On August 29, 2013, these participants were invited for follow-up discussion concerning preliminary results of the assessment, identification of priorities, and proposing next steps.

The LPHSA’s goal is to assess the entire local public health system not one entity, organization, or agency. Figure 1 below provides a commonly used graphic to demonstrate the interconnectedness and diversity of the local public health system. To assess the local public health system as a whole, the Centers for Disease Control and Prevention (CDC) worked to develop the National Public Health Performance Standards (NPHPS)², which provides a framework to identify areas for system improvement, strengthening partnerships, and ensuring a strong system is in place for addressing public health issues.

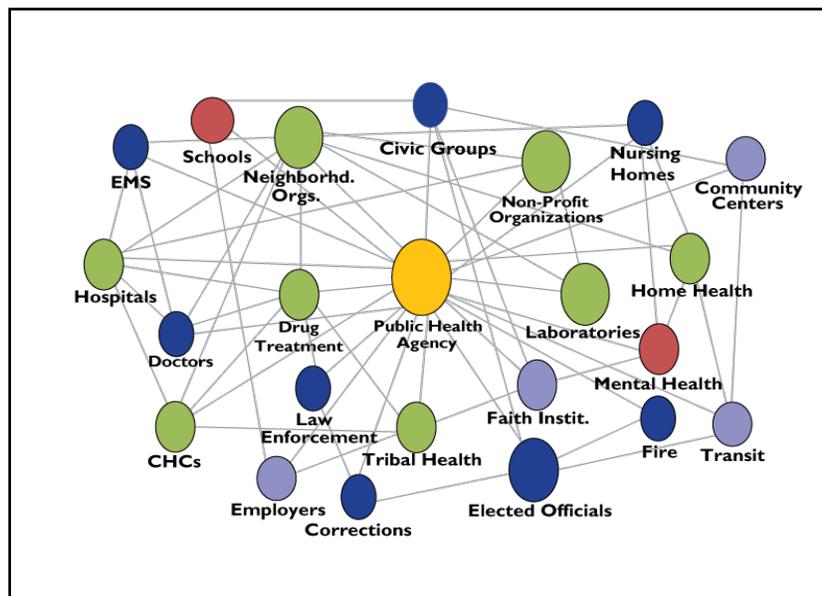


Figure 1: Local Public Health System

¹ Centers for Disease Control and Prevention. (2014) The public health system and the 10 essential public health services. Retrieved from: <http://www.cdc.gov/nphsp/essentialservices.html>

²Centers for Disease Control and Prevention. (2015) National public health performance standards. Retrieved from: <http://www.cdc.gov/nphsp/>

SUMMARY OF RESULTS

The summary below provides a brief synopsis of the Local Public Health System Assessment (LPHSA) results and discussion. The scores represent the average level of perceived activity occurring for each of the Essential Services.

| Scoring Card | Activity Level |
|--------------|----------------|
| Optimal | 76-100% |
| Significant | 51-75% |
| Moderate | 26-50% |
| Minimal | 1-25% |
| No Activity | 0% |

Table 1: Scoring key

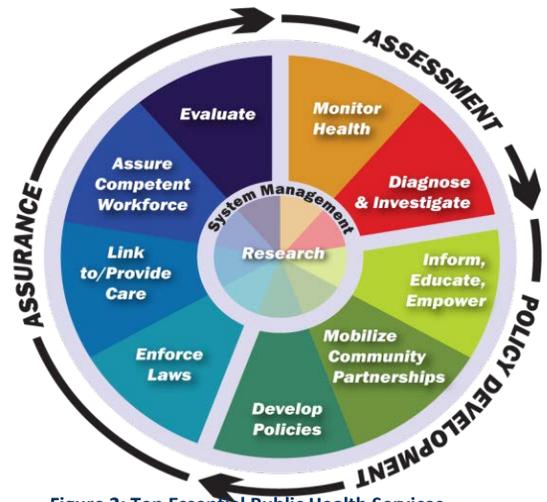
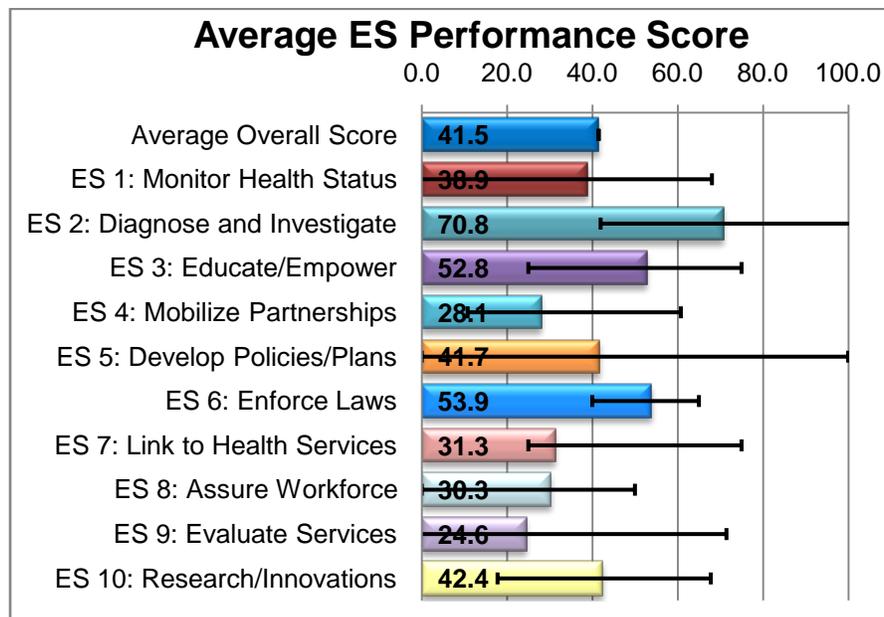


Figure 2: Ten Essential Public Health Services



Graph 1: Summary of Average ES Performance Scores (black bars indicate range)



Table 2: Overall Scores for LPHSA

| Essential Public Health Services | Score |
|--|--------------|
| 1. Monitor health status to identify community health problems. | 38.9 |
| 2. Diagnose and investigate health problems and health hazards in the community. | 70.8 |
| 3. Inform, educate, and empower people about health issues. | 52.8 |
| 4. Mobilize community partnerships to identify and solve health problems. | 28.1 |
| 5. Develop policies and plans that support individual and community health efforts. | 41.7 |
| 6. Enforce laws and regulations that protect health and ensure safety. | 53.9 |
| 7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable. | 31.3 |
| 8. Assure a competent public health and personal health care workforce. | 38.3 |
| 9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services. | 24.6 |
| 10. Research for new insights and innovative solutions to health problems | 42.4 |
| Overall score | 41.5 |



DISCUSSION SUMMARY

Participants of this assessment convened to discuss the resulting scores in August 2013. As a result of this discussion, strengths and areas of challenge were identified and several priorities were selected as foci for improving the delivery of the Essential Services in Shelby County.

Strongest areas:

- ES#2: Diagnose and investigate health problems and health hazards in the community
- ES#6: Enforce laws and regulations that protect health and ensure safety
- ES# 3: Inform, educate, and empower people about health issues

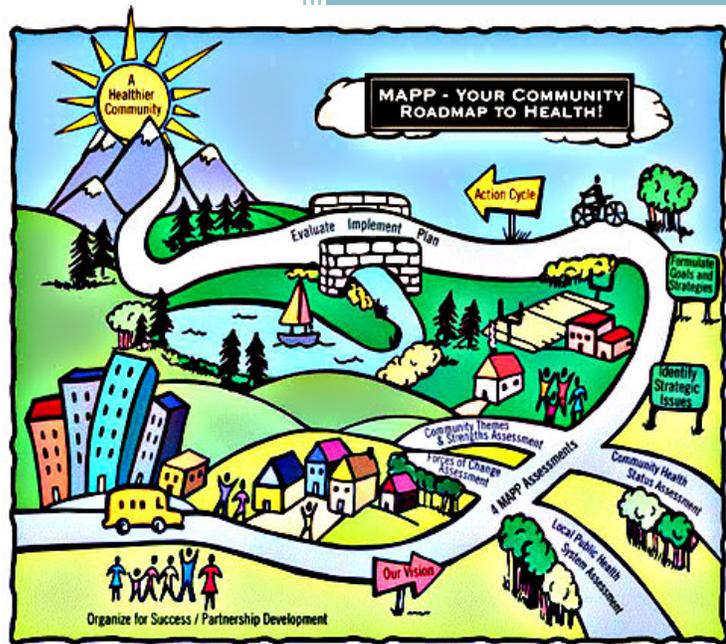
Areas of challenge:

- ES# 9: Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- ES# 4: Mobilize community partnerships to identify and solve health problems
- ES# 7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable

DISCUSSED PRIORITIES:

1. Acknowledge impact of social determinants throughout delivery of all essential services.
2. Establish collective accountability across the local public health system via a Board of Health, Regional Health Council, or similar entity.
 - Helps to guide, oversee, and facilitate communication among stakeholders engaged in community health related activities
 - Establishes a recognized entity that emphasizes accountability among public health system partners
3. Increase willingness and ability to share data among partners in the local public health system.
 - Helps to increase activity around system-wide evaluation of delivery of personal and population-based health services
 - Helps to understand the gaps in personal health care delivery and how to leverage existing resources to address found gaps
 - Helps to increase activity around system-wide evaluation of delivery of personal and population-based health services
4. Continue engagement and community outreach
 - Increases community knowledge and builds on desire for transparency and civic involvement

Forces of Change Assessment Report Summary





METHODS

The Forces of Change Assessment Work Group met throughout April and June 2013 to formulate the logistics of conducting the FOCA. The finalized approach involved a three hour brainstorming session held in lieu of the MAPP partnership meeting in July 2013. Prior to the session, participants were provided with a Forces of Change worksheet to stimulate thoughts about forces that are impacting community health in Shelby County.

Brainstorm session participants were divided into small groups to discuss forces and identify the threats and opportunities posed by these forces. At the conclusion of the session, the notes gathered from each small group were compiled into a single “Forces of Change Worksheet” and shared among all MAPP partners for edits, comments, and general feedback. At the end of this comment period, the FOCA identified twenty forces that could impact community health in Shelby County.

IDENTIFIED FORCES OF CHANGE

In the Forces of Change Assessment, MAPP partners were asked “*What is occurring or might occur that affects health of Shelby County?*” and, “*What specific threats or opportunities are generated by these forces?*” The following table provides some of the major forces identified by the MAPP partnership.

These forces are categorized as trends, events, and factors, defined as:

- Trends are patterns over time
- Events are one-time occurrences
- Factors are discreet elements

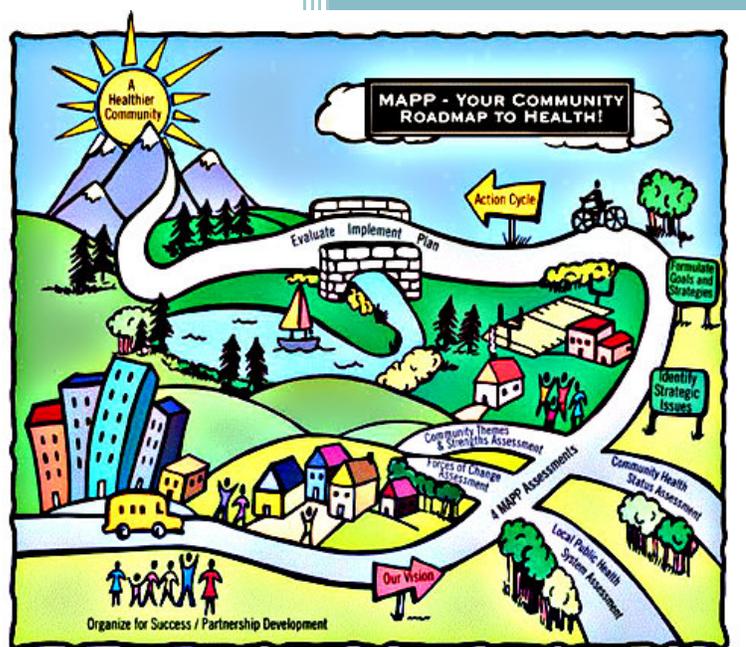
In compiling this list, we understand that forces will dissipate and rise, as will the threats and opportunities which each present. Therefore, this assessment should be viewed as a snapshot of forces of change versus a definitive list.



Table 1: Identified Forces of Change

| Trends | Events | Factors |
|---|-----------------------------------|---|
| Changing demographics | School district merger | Racial & economic divisions in Shelby County |
| Decreases in local, state, and federal funding | Affordable Care Act | Elected officials and politics |
| Growing inequalities (health and wealth) | Local flooding | Public health language: Individual-minded vs. Community-minded |
| Urban planning initiatives | Extreme heat | High poverty rates |
| Culture and lifestyle | Obesity declared a disease | Geographic location (Tri-State area) |
| Crime and violence | | Technology |
| Health disparities | | Tax policy |
| Lack of mental health care | | |
| Changes in local food system | | |

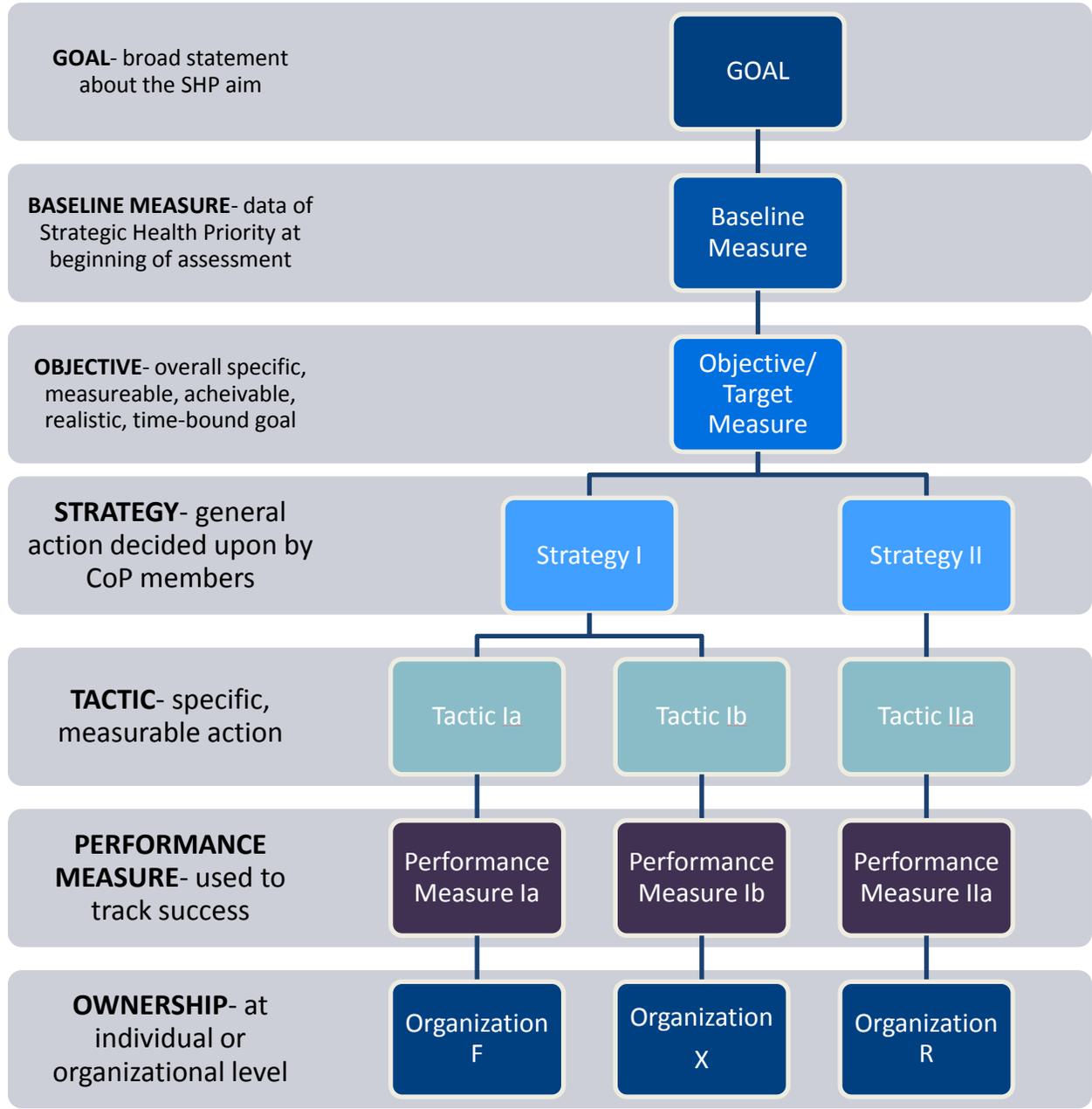
Community Health Improvement Plan





COMMUNITY HEALTH IMPROVEMENT PLAN: STRUCTURE

In order to transform Shelby County into the healthiest place to live in the nation, we, as a community, need a roadmap for success. The Community Health Improvement Plan is a **living document** that provides a long-term strategic plan addressing key public health issues. The following sections highlight goals, strategies, tactics and performance measures for each Strategic Health Priority. Each Community of Practice used these particular definitions when developing the strategic plan to improve health in Shelby County.



Shelby County 2012-2018 Community Health Improvement Plan (CHIP) Framework

Goal: *A Shelby County that provides and assures opportunities for every resident to develop and participate in activities and services that enhance their health, wellbeing, and quality of life.*

The Shelby County *Community Health Improvement Plan* is a three-year plan addressing five strategic health priorities, or key public health issues. This plan was developed using data identified via a community health assessment process conducted in 2013. The Shelby County CHIP framework compiles goals, strategies, and tactics which aim to strategically impact the identified priority areas in our community. Because two of the strategic health priorities are considered system-related and therefore cross-cutting priorities, tactics which address these priorities are identified via the symbology shown below. The statuses of individual tactics are classified as completed, in progress, or new additions; those symbols can also be viewed below.

Shelby County Strategic Health Priorities

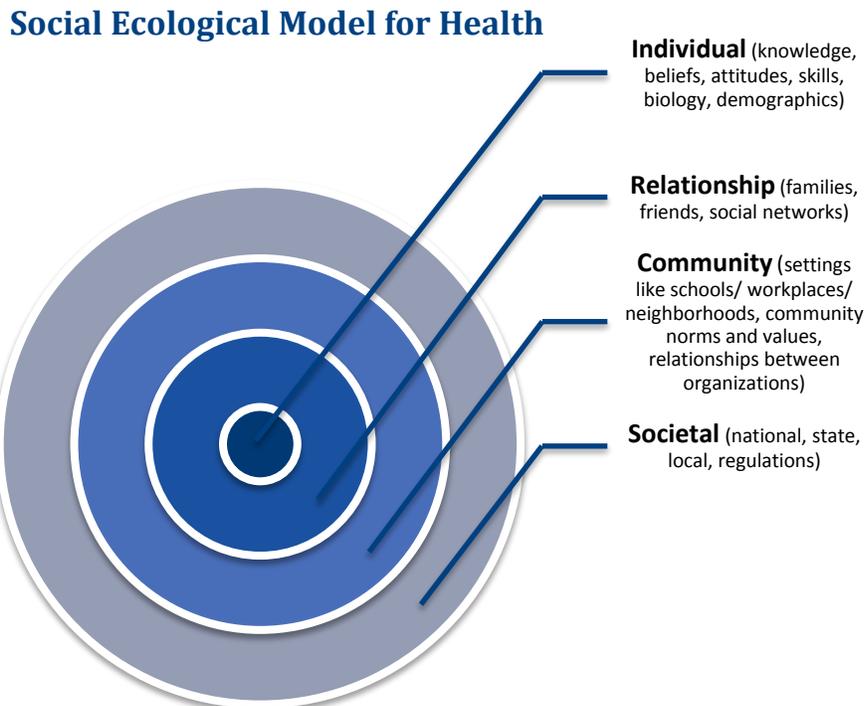
| | |
|--|--|
| | |
| <p>Health Disparities & Social Determinants of Health</p> <div style="text-align: center;"></div> | <p>Communication, Collaboration, & Coordination across the Local Public Health System</p> <div style="text-align: center;"></div> |
| | |
| <div style="text-align: center;"></div> <p>Mental Health: Depression</p> | <div style="text-align: center;"></div> <p>Healthy Lifestyles</p> |
| <div style="text-align: center;"></div> <p>Violence as a Public Health Issue: Youth Safety</p> | |

Status Indicators

| | |
|---|--|
|  | Completion: This tactic has reached completion status. |
|  | In Progress: This tactic is currently being implemented. |
|  | New Additions: This tactic has been recently added or revised. |

IMPACTING HEALTH & ADDRESSING CROSS-CUTTING PRIORITIES

Enhancing the health and well-being of Shelby County compels us to act on multiple levels. The diagram below illustrates the different levels of health intervention.¹



Community health methods range from education and awareness to systemic approaches. Improving community health via a systems approach is to consider “connections among different components, plans for the implications of their interaction, and requires transdisciplinary thinking as well as active engagement of those who have a stake in the outcome to govern the course of change.”² A systems approach calls for the understanding of relationships between levels of the social ecological model for health, the incorporation of a wide array of factors (from race and ethnicity to access to care), and a willingness to work and plan across sectors to advance community health.

Two systemic issues that Shelby County will focus on during the implementation phase are 1) addressing health disparities and social determinants of health and 2) increasing collaboration, communication, and coordination. Because of their significance and magnitude, these systemic issues were integrated within the main three priorities: Healthy Lifestyles, Mental Health, and Violence as a Public Health Issue. By focusing on these issues as cross-cutting priorities, Shelby County is better positioned to become one of the healthiest places to live in the nation.

Health Disparities & Social Determinants of Health

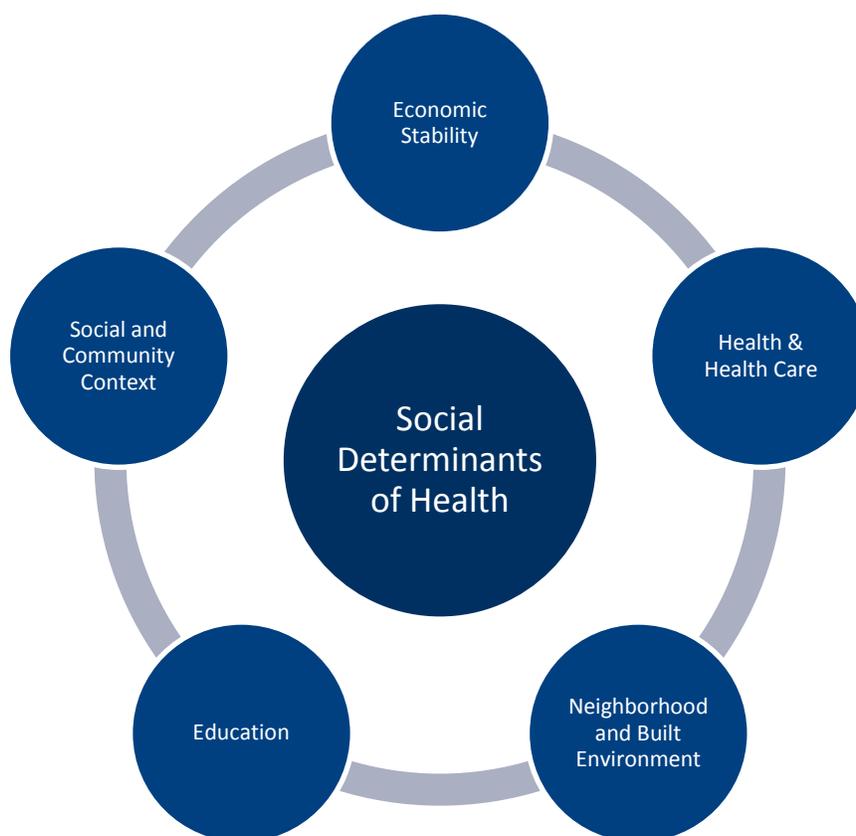
Health disparities are *differences in health outcomes* of distinct groups of people. Health disparities negatively affect groups of people who have systematically experienced greater social or economic

¹ Adapted from: CDC. *The Social Ecological Model: A Framework for Prevention*. Retrieved 2015, from <http://www.cdc.gov/violenceprevention/overview/social-ecological-model.htm>

² Leischow, S.J. et al. (2006). *Systems Thinking and Modeling for Public Health Practice*. *American Journal of Public Health*, 96(3): 403-405.

obstacles to health.³ According to the World Health Organization, social determinants of health are largely the cause of health disparities, and if these gaps are to be reduced, socioeconomic factors must be addressed.⁴

Healthy People 2020 defines social determinants of health (SDOH) as “conditions in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.” Some examples of SDOH include access to health care, culture, literacy, poverty, public safety, quality of education, race, and transportation. Five key domains make up the social determinants of health spectrum: economic stability, health and health care, neighborhood and built environment, education, and social and community context. These domains are depicted in the diagram below.⁵



As we become one of healthiest places to live in the nation, communities must tackle social determinants of health since addressing these factors yields the *highest community impact and benefit*. The pyramid below depicts the impact level on population health for various public health interventions. In the pyramid, Dr. Thomas Frieden (Director of the Centers for Disease Control and Prevention) illustrates that the level of impact decreases as we climb the pyramid, with counseling and education having the lowest impact on population health. The bottom tier represents socioeconomic factors, or as

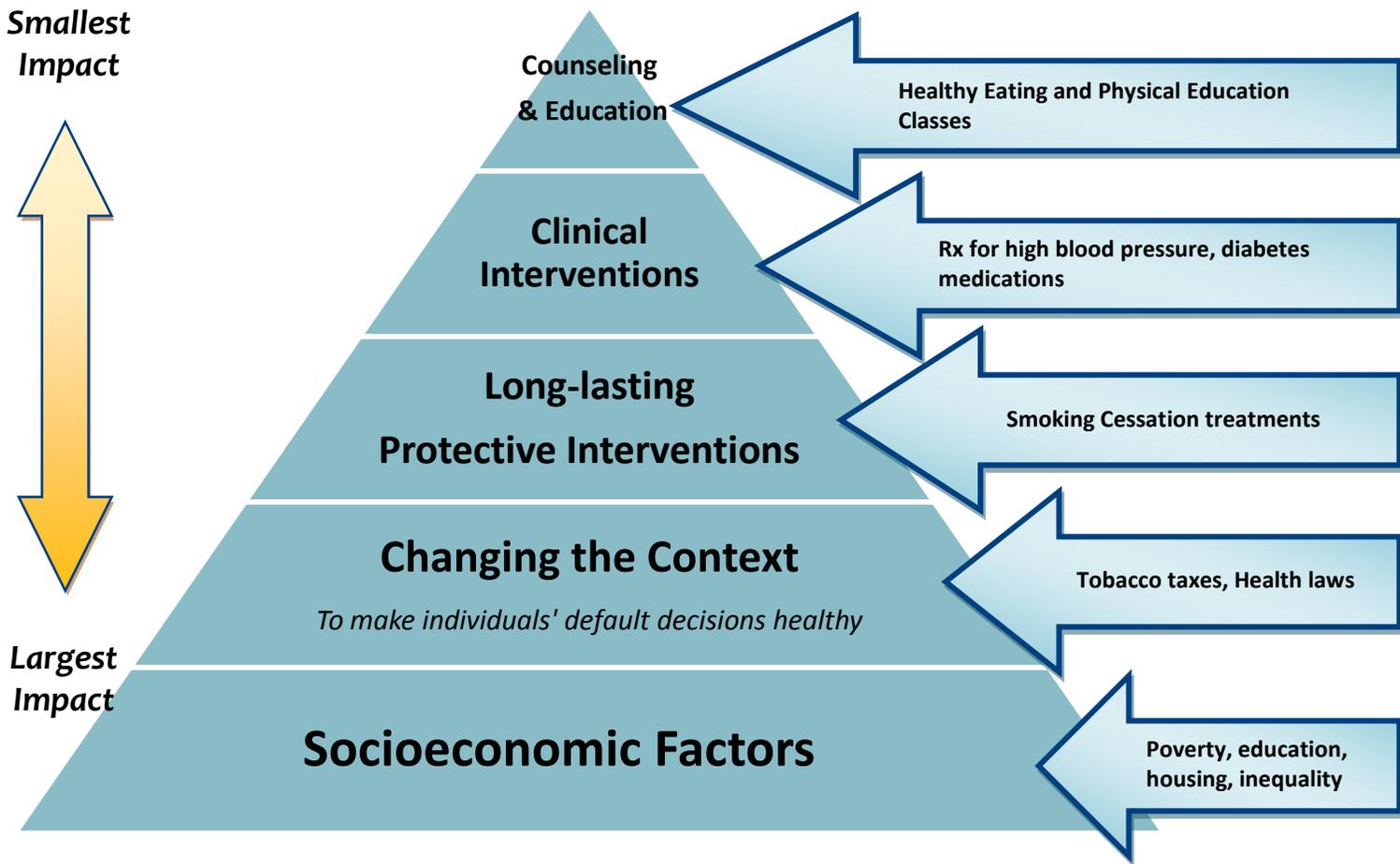
³ Centers for Disease Control and Prevention. (2014). *Social Determinants*. Retrieved from: <http://www.cdc.gov/socialdeterminants/Definitions.html>

⁴ World Health Organization. (2012). *Social determinants of health*. Retrieved from: http://www.who.int/social_determinants/sdh_definition/en/

⁵ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2015). *Social determinants of health*. Retrieved from: <http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/addressing-determinants>

commonly referred to, the social determinants of health. According to Frieden and the CDC, “Interventions that address social determinants of health have the greatest potential public health benefit.”⁶ In order to truly create a healthier place to live in Shelby County, our local public health system must shift its philosophy and begin to prioritize interventions that are proven to have the greatest impact on community health and well-being.

CDC Health Impact Pyramid: Factors that Affect Health



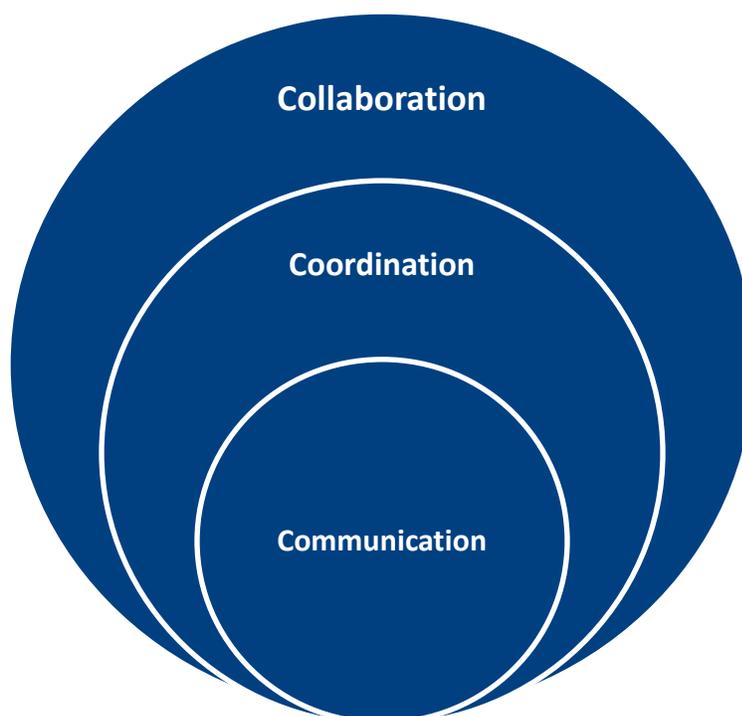
⁶ Frieden, T. R. (2010). A framework for public health action: the health impact pyramid. *American journal of public health*. Retrieved from: https://www.idph.state.ia.us/adper/common/pdf/healthy_iowans/health_pyramid.pdf

Collaboration, Communication, & Coordination Across The Local Public Health System

Increasing collaboration, communication and coordination across the Local Public Health System is another system-related strategic health priority for Shelby County. Impacting the community on a large scale requires enhancing the often great work being accomplished in silos across Shelby County. Connecting these silos both within the traditional healthcare setting and across diverse sectors ultimately will lead to a healthier place to live. Some benefits of effective collaboration include: better use of scarce resources, reduction in duplication of efforts, integration of diverse perspectives, and opportunity for institutional learning.

The relationship between communication, coordination, and collaboration is depicted in the figure below. NACCHO defines these terms as follows⁷:

- **Collaboration**- working jointly to accomplish a shared vision and mission using joint resources
- **Coordination**-exchanging information and linking existing activities for mutual benefit
- **Communication**- exchanging information



⁷National Association of County & City Health Officials. (2015). *Section Two: Building Collaboration*. Retrieved from: <http://www.naccho.org/topics/environmental/pullingtogether/sectiontwo.cfm>

CROSS- CUTTING PRIORITIES WITHIN THE CHIP

In order to emphasize the importance of implementing interventions with **the greatest potential community health benefit** in Shelby County, those tactics within each strategic health priority which address social determinants of health and incorporate collaboration, communication, and coordination are identified in the community health improvement plan framework in the following sections. The chart below highlights the criteria for tactics identified as addressing the cross-cutting priorities.

| Cross-cutting Strategic Health Priorities | |
|--|---|
| Criteria | |
| Social Determinants of Health & Health Disparities | Collaboration, Communication, & Coordination |
|  |  |
| <ul style="list-style-type: none"> • Action at the population level or scalability to population level impact • Addresses one of the five Healthy People 2020 sectors for social determinants of health⁵ • Classified in one of Healthy People 2020's "critical components"⁵ <p><i>(Must meet all of the three criteria.)</i></p> | <ul style="list-style-type: none"> • Exchanging information • Linking activities for mutual benefit • Working jointly • Have a shared vision • Using joint resources <p><i>(Must meet three of the following five criteria.)</i></p> |

MENTAL HEALTH :DEPRESSION

Mental health includes our emotional, psychological, and social well-being. Often, Mental Health gets left out of the equation in regards to improving community health. However, mental health is a growing public health concern and critical to the well-being of residents. *It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices.* ¹

SHELBY COUNTY QUICK FACTS FROM COMMUNITY HEALTH ASSESSMENT



people with inadequate social support

one in five

Mental Health ranked 4th most important of 18 health topics.

25%

felt suicide was a health topic that needed attention in their community

13%

felt they needed mental health care in the last 12 months but did not receive it

2,229

the ratio for population to providers of mental health care is 2,229:1

38%

of caregivers stated that mental health was a topic their children should know more about

Local Public Health System Factors

- Informing, educating, and empowering the community about health issues
- Need for increased partnership with mental health care and substance abuse treatment partners

Forces of Change

- Lack of mental health care
- Affordable Care Act
- Growing inequalities in health and income
- Decreases in funding
- Economic downturn

¹ U.S. Department of Health & Human Services. What is Mental Health? <http://www.mentalhealth.gov>

Mental Health: Depression

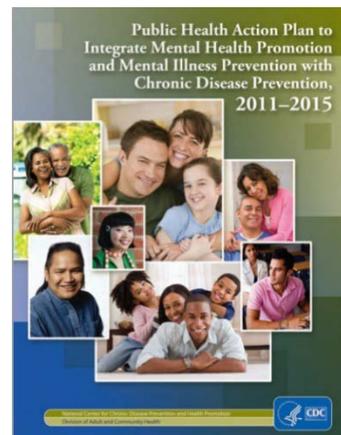
Goal: *To enhance mental health, wellbeing, and quality of life by addressing depression in Shelby County*

| CHIP Outcome Objectives | Baseline | Target |
|--|----------|--------|
| Reduce the proportion of persons who experience major depressive episodes (MDEs) (Healthy People 2020: MHMD-4) | TBD | TBD |
| Increase the proportion of adults aged 18 years and older with major depressive episodes who receive treatment (Healthy People 2020: MHMD-9.2) | TBD | TBD |
| Increase depression screening by primary care providers (Healthy People 2020: MHMD-11). | TBD | TBD |

The scope of Mental Health need in Shelby County encompasses a myriad of mental health issues. However, in order to focus the energy of community partners in this field, the Mental Health Community of Practice decided to highlight **Depression** as the major theme of this strategic health priority. Some reasons for this selection include the pervasive nature of depression in our society, recent media attention on this mental health issue, and the feasibility and possibility of making an impact in Shelby County.

Depression is considered by the CDC to be an affective disorder and if not properly treated, can grow into a chronic illness. This condition is largely overlooked and misunderstood, and often considered a weakness instead of a condition requiring appropriate treatment. Also, depression is correlated with some adverse health behaviors, including tobacco use, alcohol consumption, physical inactivity, and sleep disturbance. ¹

Goal and strategy statements for this strategic health priority were drafted and edited based on facilitated discussions and references to existing plans and recommendations both nationally and statewide. These existing plans and recommendations for mental health set the stage for community health improvement work on depression in Shelby County.



¹ Centers for Disease Control and Prevention. (2013). *Depression*. Retrieved from: <http://www.cdc.gov/mentalhealth/basics/mental-illness/depression.htm>

Strategy I: Identify opportunities to expand access to services and address systematic change

| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|--------|---|---|------------------|--|-----------------------|
| ◆ | Implement behavioral health screenings | Implement within 3 centers Implement throughout Methodist system | 2016 2018 | Methodist Le Bonheur | |
| ◆ | Include mental health assessment on candidates for bariatric program | Assess 1500 individuals | 2016 | St Francis Hospital | |
| ◆ | Conduct clinical assessments for mental health and depression | Conduct 147 assessments per month | 2016 | St Francis Hospital | |
| ◆ | Advocate for universal access to healthcare | Increase membership of mental health care providers and students | Ongoing | Physicians for a National Health Program | ⚖️ |
| ◆ | Mental Health clinicians and school social workers provide providing direct services | Provide services 1 day per week in every school | TBD | Shelby County Schools | ⚖️ |
| ◆ | Develop partnerships to expand treatment opportunities for Center patients/clients/members | Noticeable increase in utilization of services | TBD | Church Health Center | ⚖️ 🧩 |
| ◆ | Explore multiple partnerships and opportunities to expand services in both scope and location | Implement 2-3 more partnerships | 2015-2016 | Compass Intervention Center | ⚖️ 🧩 |
| ◆ | Help Christ Community Health Services identify new sites | Establishment of new service sites | TBD | Consultant | 🧩 |
| ◆ | Design and implement place-based assessments | Complete assessments for 8 zip code areas | October 2016 | Shelby County Health Department/UTHSC | 🧩 |
| ◆ | Utilize Living Well Network as a referral source for community partners | TBD | Ongoing | Methodist Le Bonheur | |

KEY:  Social Determinants of Health & Health Disparities  Collaboration, Communication, & Coordination

| Strategy 1: Identify opportunities to expand access to services and address systematic change | | | | | |
|---|---|-----------------------|-------------|---------------------------|-----------------------|
| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|  | Expand outreach efforts and services to homeless veterans, veterans living in transitional housing, and incarcerated veterans | TBD | TBD | Memphis VA Medical Center | |

| Strategy 2.1: Increase education and awareness | | | | | |
|---|--|--|-------------|--------------------------------------|---|
| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|  | Offer trainings in Youth and Adult Mental Health First Aid USA | Certify 240 people as Mental Health First Aiders | | Church Health Center | |
|  | Increase community outreach and education, especially education and awareness of children's mental health issues | Provide or participate in 4 events annually | Ongoing | Compass Intervention Center | |
|  | Increase education with clients in regards to medications, treatment plans and discharge transition plans | Increase education offerings to 5 times per week | 2015 | | |
|  | Increase media coverage of programs and prevention initiatives | Increase media events by 10% | TBD | Shelby County Schools | |
|  | Expand outreach efforts for suicide prevention, to include media outreach, health fairs, presentations, and events | Reach 6000 people | 2018 | Tennessee Suicide Prevention Network |  |
|  | Train individuals for suicide prevention | Train 2500 people | 2018 | | |
|  | Host annual Mental Health Breakfast | Increase attendance to 750 individuals | 2016 | Methodist Le Bonheur | |
|  | Offer mental health classes at churches through Congregational Health Network | 40 individuals completing classes | 2015 | | |

| Strategy 2.2: Increase education and awareness: Target underserved and vulnerable populations | | | | | |
|---|---|--|------------------------------|---------------------------------|---|
| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|  | Inclusion of clients in Region VII mental health policy and planning council | Increase participation to at least two youth in attendance at each quarterly meeting | 2015-16 | Compass Intervention Center |   |
|  | Offer trainings in Youth and Adult Mental Health First Aid USA, expanding to Spanish-speaking community | Conduct at least one training in Spanish within the first year | 2016 | Church Health Center |  |
|  | Implement mental health awareness outreach for Memphis veterans through events, speakers, and creative arts | TBD | TBD | Memphis VA Medical Center | |
|  | Increase screening and assessment capacity for underserved/vulnerable youth | Increase trainings to quarterly for the year. And increase screening assessments to <ul style="list-style-type: none"> o 725 o 850 o 1000 | 2015 2015 2016 2018 | Compass Intervention Center | |
|  | Cultivate a Youth Health Council | TBD | TBD | Shelby County Health Department |   |

HEALTHY LIFESTYLES

Ensuring that environments are conducive to healthy eating and active living can help reduce the risk of obesity and in turn reduce the risk of obesity-related diseases such as diabetes and hypertension. For those with chronic diseases, a healthy lifestyle means management - staying in control and adherent - to reduce the risk of complications.

SHELBY COUNTY QUICK FACTS FROM COMMUNITY HEALTH ASSESSMENT



Nearly 7 out of 10 residents are overweight or obese.



The death rate among persons with **diabetes** is **29 per 100,000** for Shelby County- **higher** than TN and US.

2:7



There are **20 Grocery Stores** per 100,000 people vs **73 Fast Food** restaurants per 100,000 people.

Top 2

OBESITY and **DIABETES** ranked as the two **most important** community health issues

83%

felt that *physical inactivity* was a community concern

85%

felt that *poor nutrition* was a community concern

73%

of residents have *inadquate fruit and vegetable* consumption

Local Public Health System Factors

- Strengths in informing, educating, and empowering the community about health issues
- Strengths in diagnosing, investigating, and evaluating
- Lack of coordinated action

Forces of Change

- Obesity declared a disease by AMA
- Emphasis on local food and food access
- Aging population--> increase in diabetes rates
- Having "sugar" is seen as a norm in South
- Ads and marketing of unhealthy foods

Healthy Lifestyles: Healthy Eating, Active Living, and Chronic Disease Management

Goal: *To establish healthy lifestyles and community wellness as a cultural norm in Shelby County.*

| CHIP Outcome Objectives | Baseline | Target |
|---|------------------------------|------------------|
| Reduce the proportion of adults who are obese (Healthy People 2020: NWS-9) | 35% ¹ | 32% |
| Reduce the death rate among persons with diabetes (Healthy People 2020: D-2) | 29 per 100,000 ^{2*} | 26.5 per 100,000 |
| 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 (Healthy People 2020: NWS-4) | 83.3% ² | 85% |
| Reduce the proportion of adults who engage in no leisure-time physical activity (Healthy People 2020: PA-1) | 24% ² | 20% |

Establishing healthy lifestyles and community wellness as a cultural norm in Shelby County is certainly a daunting task and a lofty goal. What does this mean to Shelby County residents? Creating this cultural norm requires that healthy choices be easily incorporated into our lifestyles and that barriers to making healthier choices be significantly decreased no matter where we are. This cultural norm means that every resident is educated, equipped, and encouraged to make the choices that can improve and positively maintain his or her health outcomes. A cultural norm of healthy lifestyles in Shelby County alludes to safe, affordable access to opportunities for improved nutrition, physical activity, and chronic disease management- all of which are focus areas for this strategic health priority.

Strategies adopted for this strategic health priority were created through the Healthy Lifestyles community of practice, as well as references to the regional sustainability plan, Mid-South Regional Greenprint, and national objectives via Healthy People 2020.



¹County Health Rankings & Roadmaps. (2015). *Shelby*. Retrieved from:

<http://www.countyhealthrankings.org/app/tennessee/2015/rankings/shelby/county/factors/overall/snapshot>

² Shelby County Health Department. (2015). *Community Themes and Strengths Assessment*. (Community Health Assessment.).

*Age-adjusted diabetes death rate

| Strategy 1: Implement health in all policies. | | | | | |
|---|---|--|-------------|---|---|
| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|  | Advocate for transportation system investments and improvements that promote healthy neighborhoods. | TBD | Ongoing | Livable Memphis |   |
|  | With community members, identify land use and food system policies that foster a healthy, sustainable, and just local food culture in Memphis and Shelby County | Identify 1-2 land use or food system policies <i>annually</i> and create an action plan to address | Ongoing | Food Advisory Council for Memphis and Shelby County |   |
|  | Educate MAPP Community Partners and other community organizations on operationalizing HEPA Standards | TBD | TBD | YMCA of Memphis & the Mid-South | |
|  | Advocate for YMCA's Diabetes Prevention Program as a covered health insurance benefit | TBD | TBD | YMCA of Memphis & the Mid-South |  |
|  | Create stronger connections between health and academics within Shelby County Schools | TBD | TBD | Shelby County Schools | |

| Strategy 2: Advocate for and develop a spectrum of healthcare metrics that are reliable and can be used for the community to track progress. | | | | | |
|---|---|---|-----------------------|---------------------------------------|---|
| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|  | Track performance on County Health Rankings, BRFSS, and YRBFSS | Improve trends and higher rankings annually over time | Ongoing | Shelby County Health Department | |
|  | Design and implement place-based assessments | Complete assessments for 8 zip code areas | October 2016 | Shelby County Health Department/UTHSC |  |
|  | Increase school-based screening program for mandated grades | 7% increase in completed mandated screenings | 2015-2016 school year | Shelby County Schools | |
|  | Partner completed EPSDTs | 5% increase in EPSDTs | 2015-2016 school year | | |
|  | Support community partners in the development of shared goals and metrics | TBD | TBD | United Way of the Mid-South |  |
|  | Track weight changes over the course of treatment | TBD | TBD | Compass Intervention Center | |

| Strategy 3: Increase healthy eating, active living, and chronic disease management through awareness, access to resources, education, and outreach. | | | | | |
|---|---|---|---------------|---------------------------------|---|
| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
| Community-Wide Focus | | | | | |
|  | Healthy in a Hurry: Healthy Convenience Store Initiative | Implement at least one Healthy In A Hurry Convenience Store Project in each of the REACH Zip Codes | 2018 | YMCA of Memphis & the Mid-South |   |
|  | Increase food access and awareness of local food system | Completion of Local Healthy Food Guide in print and online formats | December 2015 | GrowMemphis |   |
| | | Completion of Shelby County Famers Market Directory | 2015 | | |
|  | Provision of primary care services for working uninsured | Increase number of working uninsured who receive primary care services at CHC (specifics TBD) | TBD | Church Health Center |  |
|  | County-wide campaign to encourage physical activity at a designated weekly day and time | 3000 Shelby County residents will walk or do some type of exercise for 30 minutes every Saturday at 9 am. | TBD | Shelby County Health Department | |
|  | Strategic Funding of Health Promotion Activities | TBD | TBD | United Way of the Mid-South |  |

KEY:  Social Determinants of Health & Health Disparities  Collaboration, Communication, & Coordination

| Strategy 3: Increase healthy eating, active living, and chronic disease management through awareness, access to resources, education, and outreach. | | | | | |
|--|---|--|--------------------|---|---|
| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|  | B5210 Workgroup of the Let's CHANGE Collaborative | Build awareness of the B5210 "recipe for healthy living" among the WIC target population | TBD | Le Bonheur Community Health and Well-Being (LCHWB) |  |
|  | Offer sliding scale (discount) fitness memberships | Increase fitness memberships by 5% | 2016 | Church Health Center | |
|  | Increase community diabetes education | Increase participation by 5% | 2016 | Church Health Center | |
|  | YMCA's Diabetes Prevention Program | Increase access to the YMCA's Diabetes Prevention Program to eligible adults in the YMCA Service Area | TBD | YMCA of Memphis & the Mid-South | |
|  | CDC's Blood Pressure Management Program | Increase access to the CDC's Blood Pressure Management Program to eligible adults in the YMCA's Service Area | TBD | YMCA of Memphis & the Mid-South | |
|  | Provision of Wellness Education focused on chronic disease | Offer 2 classes a week and a 5 hour all-in-one session monthly in 2015; goal: an average of 20 participants | 2015 | Church Health Center | |
|  | Increase educational outreach | Increase by 5% | 2016 | Church Health Center | |
|  | Promote awareness of the food system as a whole, and the critical relationships between the system's social and economic components | Host four public educational sessions annually | Ongoing | Food Advisory Council for Memphis and Shelby County |  |

KEY:  Social Determinants of Health & Health Disparities  Collaboration, Communication, & Coordination

| Strategy 3: Increase healthy eating, active living, and chronic disease management through awareness, access to resources, education, and outreach. | | | | | |
|--|--|---|--------------------|--|---|
| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|  | Organize a Health and Wellness Committee in the community to promote walking and healthy eating | TBD | TBD | Healthy Lifestyle Alliance | |
|  | Interpret educational sessions and videotape sessions for website | 20%(specifics TBD) | TBD | DeafConnect of the Mid-South |  |
|  | Act as a referral source | TBD | TBD | DeafConnect of the Mid-South | |
|  | Operate the statewide Breastfeeding Hotline to promote/support breastfeeding | TBD | TBD | Le Bonheur Community Health and Well-Being (LCHWB) | |
| Employee-Focused | | | | | |
|  | Promoting Healthy Workplaces | TBD | TBD | United Way of the Mid-South |  |
|  | Implement a worksite wellness program | 75 (unduplicated) employees participate in activities hosted by P3 Wellness Committee | 2016 | Shelby County Health Department | |
|  | Offer Weight Watcher incentive program and free group exercise programs for employees; provide healthy eating choices at meetings and events | TBD | TBD | Le Bonheur Community Health and Well-Being (LCHWB) | |
|  | Increase training for RNs related to the prevention and management of childhood diabetes | All RNs complete diabetes training module and competency | December 2015 | Compass Intervention Center | |

Strategy 3: Increase healthy eating, active living, and chronic disease management through awareness, access to resources, education, and outreach.

| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|---|---|--|-----------------------|--|---|
| Youth-Focused | | | | | |
|  | Install learning gardens for Memphis schools | Install 100 new gardens | 2016-2017 school year | The Kitchen Community |  |
|  | Encourage healthy eating through various health initiatives during the school year | See a 1% decrease in BMI rates | 2015-2016 school year | Shelby County Schools | |
|  | Educate on the need for exercise and provide resources such as OrganWise Guys and GoNoodle | See a 1% decrease in BMI rates | 2015-2016 school year | | |
|  | Expand Healthy School Teams | Healthy School Teams in place in 100% of Shelby County Schools | 2015-2016 school year | | |
|  | Host health awareness promotion events, fairs, and expos district-wide | Increase events by 10% | 2015-2016 school year | |  |
|  | Partner with the four target schools in the Whitehaven area to offer ongoing nutrition and physical activity programs | Participation of four target schools | August 2018 | Shelby County Health Department/ Shelby County Schools/Le Bonheur |  |
|  | Cultivate a Youth Health Council | TBD | TBD | Shelby County Health Department |   |
|  | At the church, teach children about health and how to eat healthy food | Offer healthy choices (fruits and vegetables) to the children at church 1-2 times a week | 2015-2018 | Healthy Lifestyle Alliance | |
|  | Focus education efforts on obesity, nutrition and healthy lifestyles | Include a range of topics that support healthy lifestyles in children in | August 2015 | Compass Intervention Center | |

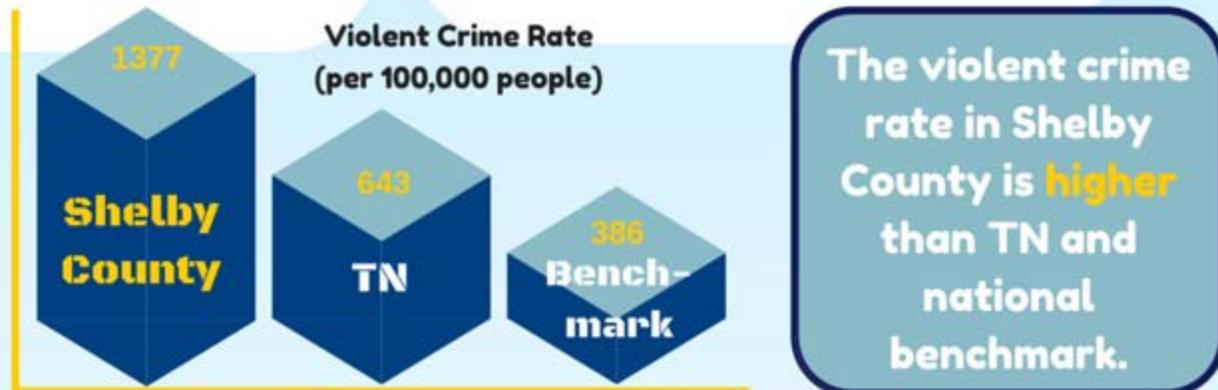
Strategy 3: Increase healthy eating, active living, and chronic disease management through awareness, access to resources, education, and outreach.

| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|--------|----------------------------------|--|-------------|-------------------|-----------------------|
| | | group schedule | | | |
| ♦ | Evaluate and implement new menus | Deploy new menus that are child-focused and build healthy habits | August 2015 | | |

VIOLENCE AS A PUBLIC HEALTH ISSUE

Just 30 years ago the words “violence” and “health” were rarely used in the same sentence. Now, we know that violence has a tremendous impact on health and well-being. Using the public health approach in regards to violence involves a systematic, scientific approach for understanding and preventing violence. ¹

SHELBY COUNTY QUICK FACTS FROM COMMUNITY HEALTH ASSESSMENT



Local Public Health System Factors

- Informing, educating, and empowering the community about health issues
- Lack of coordinated action

Forces of Change

- Poverty
- Decreases in funding
- Economic downturn
- Social and cultural environment
- Seasonal increases in crime

¹ Dahlberg LL, Mercy JA. History of violence as a public health issue. AMA Virtual Mentor. Feb 2009. Vol 11, No. 2: 167-172.

Violence as a Public Health Issue: Youth Safety

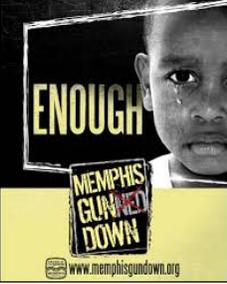
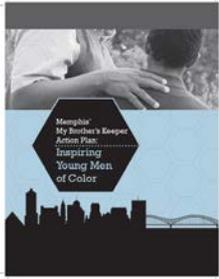
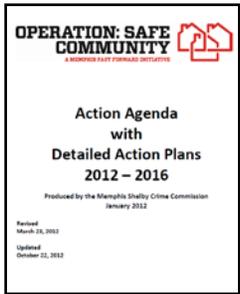
Goal: *To prevent youth violence, limit exposure to violence, and enhance youth safety in Shelby County*

| CHIP Outcome Objectives | Baseline | Target |
|--|------------------|--------|
| Reduce adolescent and young adult perpetration of, and victimization by, crimes (Healthy People 2020: AH-11) | TBD | TBD |
| Increase perception of safety in community | 58% ¹ | 65% |
| Increase number of youth with positive role models | TBD | TBD |

Violence as a Public Health Issue comprises a plethora of themes such as Child Maltreatment, Domestic Violence, Sexual Violence, Suicide, and Youth Violence. Due to growing momentum, feasibility of making an impact, and consensus among community partners, the Community of Practice selected Youth Violence Prevention as the focus area. The Community of Practice is particularly interested in the alignment of existing work and planning efforts on youth violence prevention, emphasizing youth safety, and decreasing exposures to violence throughout the lifespan.

The social and physical environment affects youth safety. Not only does the youth’s current environment play a role, the effect of adverse child events throughout a child’s development greatly impacts the behavior, health and well-being of youth. Therefore, the target population is young people from birth to 24 years old with key outcome objectives for youth ages 10 to 24.

This work plan is **not** intended to be comprehensive **nor** a replacement of the great work and momentum already surrounding youth violence prevention in Memphis/Shelby County. However, it highlights key strategies from the Department of Justice that community partners can commit to and continue to collaborate on to help further the agenda on youth violence prevention. Below are a few examples of existing planning efforts and violence prevention interventions occurring in Memphis/ Shelby County:



¹ Shelby County Health Department. (2015). *Community Themes and Strengths Assessment*. (Community Health Assessment).

Strategy I: Maximize and engage partnerships and community involvement in youth safety

Strategy I.1: Engage youth as leaders and peer experts in all initiatives (DOJ 1.2)

| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|---|--|---|------------------|--|---|
|  | Inclusion of clients in Region VII mental health policy and planning council | Increase participation to at least two youth in attendance at each quarterly meeting | 2015-16 | Compass Intervention Center |   |
|  | Increase identification and training for youth leaders in Mid-South | Identify and train 10 youth leaders | 2016 (tentative) | |  |
|  | Continue working with organizations focused on youth involvement. | Maintaining quarterly communication with such organizations | 2015-2018 | Memphis Shelby Crime Commission |  |
|  | Continue seeking youth focused opportunities for training and engagement. | Providing training opportunities to at least 3 youth annually and 2 organizations engaged directly with youth | 2015-2018 | |   |
|  | Incorporate higher grade tutoring and mentoring within our PreK Program. | Increase engaging youth as leaders by 10% school | 2015-16 | Church Health Center - Perea Preschool |  |
|  | Cultivate a Youth Health Council | TBD | TBD | Shelby County Health Department |   |

KEY:  Social Determinants of Health & Health Disparities  Collaboration, Communication, & Coordination

Strategy I: Maximize and engage partnerships and community involvement in youth safety

Strategy I.2: Enhance multidisciplinary councils or coalitions to assure system-wide collaboration and coordinated community response (Edited from DOJ 4.5)

| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|---|--|---|-------------|---|---|
|  | Continue to maintain quarterly updates on what all aspects of affiliated organizations are doing in connection with youth violence reduction and/or exposure to violence | Quarterly updates | 2015-2018 | Memphis Shelby Crime Commission |  |
|  | Support the development of multidisciplinary councils or coalitions | Provide \$50,000 for a partnership between the Shelby County Crime Commission and the Family Safety Center to support partners in accessing, understanding and using data | 2015 | United Way of the Mid-South |  |
|  | Develop effective tools for merging existing and new data across silos and identify strategies for data sharing in regard to youth violence and youth safety | Include at least 5 coalitions and/or community partners across sectors to share data | 2015-2018 | Shelby County Health Department / AIR YVP TTA |  |
|  | Align Youth Safety Community of Practice strategies with Operation: Safe Community and DCI/NOVA | TBD | Ongoing | Shelby County Health Department/ AIR YVP TTA |   |
|  | Identify strategies to develop an effective communication plan around Youth Violence Prevention | TBD | Ongoing | Shelby County Health Department/ AIR YVP TTA |   |

KEY:  Social Determinants of Health & Health Disparities  Collaboration, Communication, & Coordination

Strategy I: Maximize and engage partnerships and community involvement in youth safety

Strategy I.2: Enhance multidisciplinary councils or coalitions to assure system-wide collaboration and coordinated community response (Edited from DOJ 4.5)

| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|---|--|--|-------------|---------------------------------|---|
|  | Identify the unmet needs (i.e. education, mental health, family support, housing, etc) of individuals who are in contact with the justice system | TBD | TBD | My Brother's Keeper |   |
|  | Continue to participate in other coalitions designed to reduce youth violence | Maintain participation in monthly JJB, OYS, and other collaborative bodies | 2015-2018 | Memphis Shelby Crime Commission |   |
|  | Enhance localized provider networks (systems of care) serving Southeast Memphis and Frayser/Raleigh areas to strengthen the ability of community and faith-based organizations to serve children exposed to violence | TBD | TBD | Family Safety Center |  |
|  | Meeting with local youth to discuss these issues | TBD | TBD | Sanofi | |
|  | Blogging and speaking on these issues | TBD | Ongoing | backinrivercity.com | |

KEY:  Social Determinants of Health & Health Disparities  Collaboration, Communication, & Coordination

Strategy 2: Create safe and nurturing homes, schools, and neighborhoods

Strategy 2.1: Share information on community resources related to youth safety and on coordinated and adaptive trauma specific treatments and activities (DOJ 3.4 and 5.10)

| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|--------|--|--|-------------|------------------------------------|---|
| ♦ | Promoting preschool readiness | Reach 10 homes to promote preschool readiness | 2016 | Binghamton Development Corporation |  |
| | | Have 80% of 3 to 4 year olds in Binghamton to receive some type of preschool service: by 2016 | | | |
| | | 90% of the children in that age group receiving services | 2018 | | |
| ♦ | Providing parenting services through Parents As Teachers Program(PAT) in Binghamton | At least a 20% increase in the number of parents in Binghamton being served by the PAT Program | 2018 | |  |
| ♦ | Provide access to services for children impacted by violence in the home | TBD | TBD | Family Safety Center |  |
| ♦ | Connect families with children exposed to violence in the home to the various services | TBD | TBD | | |

KEY:  Social Determinants of Health & Health Disparities  Collaboration, Communication, & Coordination

Strategy 2: Create safe and nurturing homes, schools, and neighborhoods

Strategy 2.1: Share information on community resources related to youth safety and on coordinated and adaptive trauma specific treatments and activities (DOJ 3.4 and 5.10)

| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|---|---|--|--------------|---|---|
|  | OSC Goal 1 is reduce violence in the home. Goal 5 is reduce youth violence. | Maintain information on coordinated responses across the community, serving as a source for information sharing and best practices | 2015-2018 | Memphis Shelby Crime Commission |  |
|  | Utilize the www.immemphis.com website to share information | Increase unique visitors of website. (Target TBD) | 2018 | UTHSC/ Research Center on Health Disparities, Equity and the Exposome |  |
|  | Blogging and Speaking on these issues | TBD | Ongoing | backinrivercity.com | |
|  | Design and implement place-based assessments | Complete assessments for 8 zip code areas | October 2016 | Shelby County Health Department/UTHSC |  |

KEY:  Social Determinants of Health & Health Disparities  Collaboration, Communication, & Coordination

Strategy 2: Create safe and nurturing homes, schools, and neighborhoods

Strategy 2.2: Foster, promote, and model healthy relationships, positive alternatives, and safe environments for children and youth

| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|---|--|---|-------------|---|---|
|  | Develop strategies to revitalize distressed neighborhoods | Housing constructed or rehabilitated; elimination of blight | TBD | City of Memphis Housing and Community Development/Memphis Housing Authority |  |
|  | Coordinate OSC plan sections on safe neighborhoods including Safeways program | quarterly progress of Safeways and place-based programming | 2018 | Memphis Shelby Crime Commission |  |
|  | Maintain relationships with SCS as well as other organizations in order to coordinate and review best practices | Quarterly reporting on specific plan components | 2018 | Memphis Shelby Crime Commission |  |
|  | Facilitate training opportunities through site visits and other methods | Send SCS and/or JC personnel to site based training | | | |
|  | Build educational outcomes and opportunities for African-American men and boys in Memphis/ Expand the number of male-centered mentoring opportunities in and out of school | High school graduation rates/ number of male-centered mentoring opportunities | Ongoing | My Brother's Keeper (Education Domain) |  |
|  | Develop and promote interventions that prepare young people for "second-chance" opportunities that reduce recidivism | Detention rates | Ongoing | My Brother's Keeper (Justice Domain) |  |
|  | Speaker programs | TBD | Ongoing | Sanofi | |

KEY:  Social Determinants of Health & Health Disparities  Collaboration, Communication, & Coordination

Strategy 2: Create safe and nurturing homes, schools, and neighborhoods

Strategy 2.2: Foster, promote, and model healthy relationships, positive alternatives, and safe environments for children and youth

| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|---|---------------------------------------|-----------------------|-------------|-----------------------------|---|
|  | Funding of youth programs | TBD | TBD | United Way of the Mid-South |  |
|  | Blogging and speaking on these issues | TBD | Ongoing | backinrivercity.com | |

KEY:  Social Determinants of Health & Health Disparities

 Collaboration, Communication, & Coordination

Strategy 3: Promote and provide comprehensive awareness, education, and training on exposure and reduction of violence.

Strategy 3.1: Promote professional education and training on the issue of children exposed to violence

| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|---|---|--|-------------|--|---|
|  | Encourage nonprofit agency staff participation in training | Support the Child Advocacy Center in reaching their goal of 30,000 Shelby County residents trained | 2015-2016 | United Way of the Mid-South | |
|  | Support DCI as part of OSC plan, (Goal 5) | Quarterly reporting updated by DCI | 2018 | Memphis Shelby Crime Commission |  |
|  | Offer Stewards of Children training module to Shelby County employees | Offer ~2 training per week | TBD | Shelby County Health Department | |
|  | Ensuring a culturally competent workforce in health service providers | TBD | Ongoing | My Brother's Keeper (Health and Wellness Domain) |  |
|  | Continue to promote education related to TF-CBT and trauma | Conduct or participate in at least 2 formal and 2 informal trainings annually | Ongoing | Compass Intervention Center | |
|  | Building sustainable trauma-informed system: Trauma workshop | Conduct free of charge trauma workshop July 2015 | 2015 | Compass Intervention Center |  |
|  | Program in 2015 to address childhood exposure to violence | TBD | 2015 | Sanofi | |

KEY:  Social Determinants of Health & Health Disparities  Collaboration, Communication, & Coordination

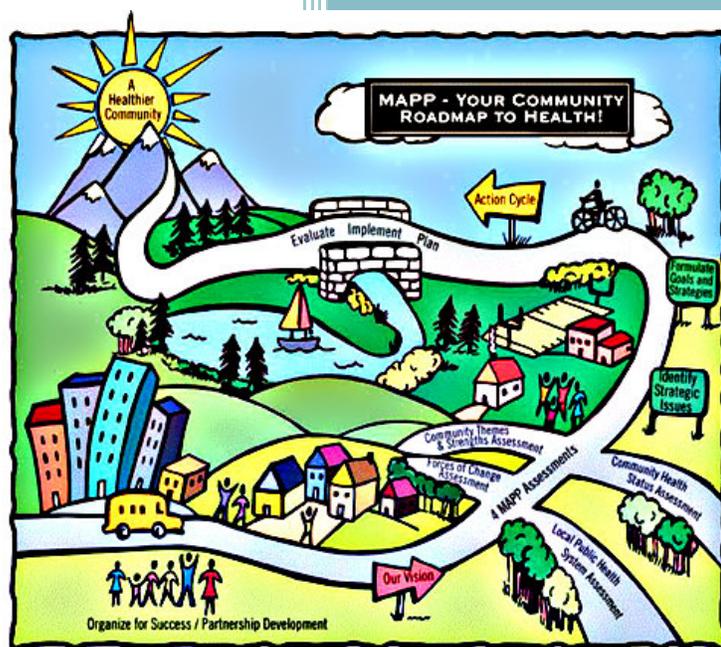
Strategy 3: Promote and provide comprehensive awareness, education, and training on exposure and reduction of violence.

Strategy 3.2: *Provide comprehensive awareness, education, and training to neighborhood stakeholders, including youth and families, on exposure and reduction of violence*

| STATUS | TACTIC | PERFORMANCE INDICATOR | TARGET DATE | COMMUNITY PARTNER | Crosscutting Priority |
|---|---|--|----------------------|---------------------------------|---|
|  | Train community members and stakeholders on child sexual abuse prevention and response through the Stewards of Children training module | 3,000 trained 3,250 trained 3,500 trained | 2016 2017 2018 | Memphis Child Advocacy Center |  |
|  | Coordinated OSC plan on neighborhood stakeholders, youth and families, etc. | Quarterly reporting on progress of evidence-based programs | TBD | Memphis Shelby Crime Commission |  |
|  | Funding of programs | TBD | TBD | United Way of the Mid-South |  |

KEY:  Social Determinants of Health & Health Disparities  Collaboration, Communication, & Coordination

Making Shelby County a Healthier Place to Live



ACTION CYCLE

The Community Health Improvement Plan serves as a transition for the MAPP process in Shelby County. For the next three years, we will be in the sixth and final phase of MAPP: the **action cycle**. During this time, each community of practice will meet quarterly to update on progress and discuss unforeseen barriers within each of the strategies. This phase —implementation of tactics, collaboration between partners, and constant evaluation of our strategies— will ultimately build Shelby County into one of the healthiest places to live in the nation.

As we move towards improving the health of Shelby County residents, we must emphasize the need for collaboration, communication, and coordination across our public health system. We must not only implement the Community Health Improvement Plan but also take into account the wide array of efforts that are taking place in Shelby County to make this community a healthy place to live.

HEALTHY SHELBY

One great example of a collaborative effort to make Shelby County a healthy place to live is Healthy Shelby. The first program of its kind in Tennessee, Healthy Shelby was created to focus on better health, better care, and lower costs as strategies for economic vitality. Healthy Shelby's guiding principles include:



- increased appeal for business growth
- decreased health care burden on employers, state and local budgets, and individuals
- improved quality of life for citizens
- a healthier and more productive community
- enhanced ability for health systems and providers to address calls for improved quality and cost containment/cost reduction

Working within the Memphis Fast Forward framework, Healthy Shelby has committed to meeting these monumental challenges through collective action. Healthy Shelby strives to concentrate efforts on three main goals during a three year time frame. The current goals of Healthy Shelby include: Childhood Obesity Prevention, Chronic Disease Prevention and Reduction, and Control and End of Life Care.

Healthy Shelby recognizes the need and value of addressing health issues across the life span. The primary goals, which Healthy Shelby calls its “Triple Aim,” have been narrowed to focus on specific health outcomes:

Reduction of childhood obesity, ages 0 – 5 years old

Control of hypertension in adults, ages 18 -65 years old

Reduction of end of life cost for adults, ages 65+



With funding from Shelby County and City of Memphis governments, Methodist LeBonheur Healthcare, Baptist Memorial Healthcare, St. Francis Hospital, and the Regional One Healthcare System, Healthy Shelby views successful initiatives as ones that possess a potential for scalability, an ability to improve significant health disparities, and an opportunity both for to capitalizing on community energy and resources already invested in the region, and for residents to take ownership of their own health.

How Healthy Shelby Aligns with the CHIP

The goals of Healthy Shelby align and overlap with Shelby County's Community Health Improvement Plan at several points to varying degrees: direct correlation with the strategic health priorities identified in the MAPP process, use of existing community data and information, values and guiding principles, and most importantly, emphasis on collaboration, partnership and collective action. While the Healthy Shelby domains may differ from the priorities chosen through the MAPP process, there is room for broader community activation, system change, and advocacy for all of these major public health issues. Both Healthy Shelby's triple aim and the continuous engagement of diverse partnerships through the MAPP process are essential to Shelby County's rise as one of the healthiest places to live in the nation.

WHAT CAN YOU DO TO MAKE SHELBY COUNTY THE HEALTHIEST PLACE TO LIVE?

Making Shelby County a healthy place to live is not a static process. Health improvement is constantly evolving, and it involves a wide array of partners across disciplines. The Shelby County Community Health Improvement Plan is a **living document** and will be updated and altered as we continue the action phase of our planning process. As with every phase of MAPP, **new community partners are always welcome**. We are always looking for diverse partners to take on the charge of making Shelby County the healthiest place to live.

Contact the Shelby County Health Department's community health planners for more information on how you and your organization can help to implement this CHIP:

Amy Collier | 901-222-9618 | amy.collier@shelbycountyttn.gov

Angela Moore | 901-222-9620 | angela.p.moore@shelbycountyttn.gov

Thank you to all the community partners and assessment working group members who participated and contributed to the Community Health Assessment and the Community Health Improvement Plan!



COMMUNITY PARTNER BRIEFS

The following are some of the community partners and individuals who have contributed their time, knowledge, and expertise throughout the MAPP Process thus far. We sincerely appreciate your commitment to community-driven community health improvement.

American Institutes for Research

Conducting and applying the best behavioral and social science research and evaluation towards improving peoples' lives



Backinrivercity.com

A Memphis & Shelby County public policy blog, in addition to speaking engagements

Baptist Memorial Health Care

A Health care provider also featuring community outreach through Baptist Healthy Communities



Binghamton Development Corporation

Creating a healthier Binghamton community



Brunswick Community Association

Promoting harmony with neighbors, preserving the integrity of our community, and promoting pride, beautification, and progress in the Brunswick community



Church Health Center

Reclaiming the Church's Biblical commitment to care for our bodies and spirits



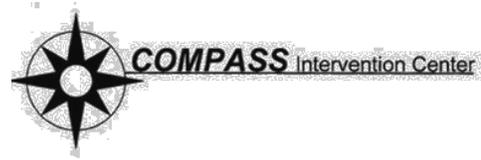
**City of Memphis Housing and
Community Development**

To drive community revitalization through a
seamless system



Compass Intervention Center

Providing residential and outpatient service to
children and adolescents with serious mental
health needs; creating a safe, therapeutic, and
caring environment for healing to take place



The Corners of Highland Heights

A Community of Shalom focused on
community development



DeafConnect of the Mid-South

Uniting the Deaf/Hard of Hearing and Hearing
communities through interpreting, advocacy,
education, and support



Family Safety Center

Providing one location to coordinate civil,
legal, health, and social services for victims of
family violence



**Food Advisory Council for Memphis and
Shelby County**

Advance policy and practice in Memphis and
Shelby County that strengthen food security
and the local food economy



Grow Memphis

Partnering with communities in Memphis and
Shelby County to promote a sustainable local
food system



Healthy Lifestyle Alliance

Promoting natural, holistic, and healthy
practices

Healthy Shelby

Focusing on better health, better care, and lower costs for economic vitality



Le Bonheur Community Health & Well-Being

LCHWB is the community-based health promotion and prevention arm of Le Bonheur Children’s Hospital.



Livable Memphis

Supporting Memphis neighborhoods through public policy development and advocacy, organizational capacity building, and community education



Memphis Child Advocacy Center

Serving children who are victims of sexual and severe physical abuse through prevention, education, and intervention



Memphis Gun Down

Making Memphis streets safer using a five prong, evidence based approach



Memphis Shelby Crime Commission

Coordinates Operation: Safe Community, a comprehensive, coordinated plan to reduce violence and make Memphis-Shelby County one of safest cities of its size in the country.



Memphis VA Medical Center

Providing veterans with quality care, outstanding customer service, education of tomorrow’s health care providers, and improvement in health care outcomes



Methodist Le Bonheur Healthcare

An integrated health care delivery system, dedicated to the art of healing through our faith-based commitment to minister to the whole person.



My Brother's Keeper: Inspiring Young Men of Color

In Memphis, the goal is to build upon existing work to improve outcomes in education, healthcare, justice, and employment for young men of color

Physicians for a National Health Program

A non-profit research and education organization supporting single-payer national health insurance



Sanofi

A global healthcare leader focused on patient needs



Shelby County Health Department

Promote, protect, and improve the health and environment of all Shelby County residents



Shelby County Schools Coordinated School Health

Providing a better coordinated system of health services



St. Francis Hospital

To heal, support, and comfort all whom we serve in the tradition of Catholic healthcare



Tennessee Suicide Prevention Network

Eliminating the stigma of and educating about signs of suicide, ultimately reducing suicide rates in the state of Tennessee



The Kitchen Community

Creating community through food.



United Way of the Mid-South

Improving the quality of life for Mid-Southerners by mobilizing and aligning community resources to address priority issues



**University of Memphis
School of Public Health**

Producing the next generation of public health leaders



**University of Tennessee
Health Science Centers**

Promoting health equity across all populations through research, education, and service



YMCA of Memphis & the Mid-South

To put Christian principles into practice through programs that build healthy spirit, mind, and body for all



**FOR YOUTH DEVELOPMENT[®]
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY**

Appendix





DEFINITIONS

CHA - Community Health Assessment- describes the health status of the population, identifies areas for health improvement, determines factors that contribute to health issues, and identifies assets and resources that can be mobilized to address population health improvement. (National Association of County and City Health Officials)

CHIP – Community Health Improvement Plan which is based on the CHA, a plan that describes the health status of a community and how it plans to work to improve the health of the population

Chronic Disease - A chronic disease is one lasting 3 months or more, by the definition of the U.S. National Center for Health Statistics. Chronic diseases generally cannot be prevented by vaccines or cured by medication, nor do they just disappear. (MedicineNet)

Community Health Status Assessment - analysis of data to identify trends, health problems, environmental health hazards, and social and economic conditions that adversely affect the public's health.(National Association of County and City Health Officials)

CoP – Communities of Practice - a group of people with a shared interest or concern who regularly interact to improve their knowledge and skills and to achieve individual and group goals

CTSA - Community Themes and Strengths Assessment - provides a deep understanding of the issues that residents feel are important. (National Association of County and City Officials)

FOC - Forces of Change Assessment - focuses on identifying forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. (National Association of County and City Health Officials)

Health Disparities - a type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health. (Centers for Disease Control and Prevention)

Health Equity - When all people have "the opportunity to 'attain their full health potential' and no one is "disadvantaged from achieving this potential because of their social position or other socially determined circumstance." (Center for Disease Control and Prevention)



DEFINITIONS

Healthy Lifestyles – a lifestyle that helps to keep and improve one's health and well-being, including adequate sleep, sufficient hydration, daily physical activity, good nutrition, etc.

LPHSA - Local Public Health System Assessment – focuses on all of the organizations and entities that contribute to the public's health system... (National Association of County and City Health Officials)

MAPP - Mobilizing for Action through Planning and Partnerships - a six-phase, community-driven strategic planning process for improving community health. (Centers for Disease Control and Prevention)

Mental Health—a person's condition regarding his/her psychological and emotional well-being.

Mobilizing – bringing together and connecting the community to identify and solve health problems

Cross-cutting Priorities – priorities that influence every part of improving the public's health such as health equity, infrastructure, capacity, etc.

Public Health – seeks to benefit the health of the largest number of people; population health

Public Health System— both public-sector agencies and private-sector organizations whose actions have significant consequences for the public's health. (U.S. Department of Health and Human Services)

Social Determinants of Health - factors that contribute to a person's current state of health - biological, socioeconomic, psychosocial, behavioral, or social

Strategic Health Priorities - identified by exploring the convergence of the results of the four MAPP Assessments and determining how those issues affect the achievement of the shared vision. (National Association for County and City Health Officials)

Violence as a Public Health Issue – addressing violence with the public health approach of: 1) Defining and Monitoring the Problem; 2) Identifying Risk and Protective Factors; 3) Developing and Testing Prevention Strategies; and, 4) Assuring Widespread Adoption.

SHELBY COUNTY HEALTH DEPARTMENT

814 Jefferson Ave.
Memphis, TN 38105



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