Hampton and Peninsula
HEALTH DISTRICTS

Healthy People in Healthy Communities

Hampton and Peninsula Health Districts

Community Health Improvement Plan 2023 -2028

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Healthy People in Healthy Communities

"Hampton and Peninsula Health Districts (HPHD)"

"Community Health Improvement Plan (CHIP)" 2023

PREPARED BY: MEG DEWITT

HPHD CHIP STEERING COMMITTEE

Dr. Natasha Dwamena
Hampton and Peninsula Health Districts

Deborah Hudson
Hampton University

Nicole Taylor-Baptiste
Hampton and Peninsula Health Districts

Mary Wainwright
Hampton and Peninsula Health Districts

Antone Green
Hampton – Newport News Community Services Board

Charvalla West
United Way

Deanna Van Hersh
Williamsburg Health Foundation

Vanessa Hill
Sentara Health

Toiya Sosa
Riverside Health System

Rebecca Vinroot
Barbara Watson
James City County Department of Social Services

ACKNOWLEDGEMENTS

HPHD would like to express its sincere appreciation to all who assisted with the creation, development, and implementation of the CHIP.

EXECUTIVE SUMMARY

Overview of CHIP Purpose and Process

A Community Health Improvement Plan, or CHIP, is an action-oriented plan that outlines strategies for improving identified priority health issues in a defined community. This report is the vision for the overall health and well-being of the Hampton and Peninsula Health Districts (HPHD) community, through 2028, and serves as a framework for leveraging resources and engaging community partners for community health improvement.

Community health improvement is a shared responsibility that presents both challenges and opportunities. The challenges lie in addressing community health issues that are too numerous and complex for any one sector to address all by itself. The opportunities can be found in collaborating to achieve more through collective impact than we could achieve by working in silos. Everyone has a role to play, including business, civic organizations, community service organizations, faith communities, education, government agencies, neighborhood groups, and philanthropy in addition to health care and public health.

It is important to recognize that there are six jurisdictions within HPHD. Our local jurisdictions are diverse in terms of their size, demography, geography, economy, government structures, civic organizations, and culture. They also have varied interests and priorities for community health improvement. As the local public health agency, HPHD is committed to helping our local jurisdictions act collectively for health improvement where interests align. We are also committed to assisting local initiatives that do not cross jurisdictional lines.

HPHD is committed to working with community partners from all sectors to address community health issues identified in the recent 2022 Community Health Assessment (CHA). Our work is guided by the input of community stakeholders who engage as partners in community health improvement. Together we can make a tremendous difference in the health and well-being of our shared community.

It is in this spirit of collaboration that HPHD presents the following framework for planning community health improvement initiatives.

Connection to the 2022 Community Health Assessment (CHA)

The Community Health Assessment (CHA) is the foundation for improving the health of a community and is the key step in the community health improvement process. The 2022 HPHD CHA process, which included insight from community health leaders and providers, along with residents, provided a rich set of data for our districts that work to identify major health concerns and issues. The information collected through this process, and the health concerns identified, were considered in establishing the priorities for our districts, which are included in this report.

*HPHD in collaboration with local hospitals, conducted surveys with 945 community professionals and 11,020 community residents - a much greater population than our previous Community Health Assessment conducted in 2019.

To access the full 2022 HPHD CHA report, please click the following link:
https://www.vdh.virginia.gov/content/uploads/sites/206/2022/08/CHA-FINAL-HPHD-2022.docx.pdf

Identified Health Concerns

Community members and professionals commonly identified several priority health concerns. Many of the health priorities identified align with Virginia's Plan for Well-Being, state and local health data, and current ongoing community work.

As is evident in the CHA report findings, there is an extensive list of health issues that could be addressed within our local communities. This is not unusual for a region of our size and diversity. No community can address all identified health needs at once; therefore, we have listed the identified priority health concerns from the 2022 CHA below, which were used to guide our work.

Priority Health Concerns (Adults), 2022

Behavioral / Mental Health	COVID-19	Alcohol / Substance Abuse	Alzheimer's Disease / Dementia

Priority Health Concerns (Children and Teens), 2022

Behavioral / Mental Health	COVID-19	Violence in the Community	Violence in the Home

PART I: BACKGROUND INFORMATION

1. CHIP Process

In defining the health priority focus areas, our first and most important step was to assure that the aims and action goals are grounded in the findings from the local 2022 CHA. Additionally, HPHD committed to grounding its efforts in Public Health 3.0 throughout the CHIP process.

Public Health 3.0 builds on the accomplishments of our past to create a healthier community for everyone. It goes beyond the traditional idea of primary prevention through clinical care and embraces the expansion of comprehensive public health services in the community.

As the region's local public health agency, Hampton and Peninsula Health Districts are committed to embracing the role of Chief Health Strategist to assist community health improvement efforts.

a. CHIP Charter

To better align HPHD's vision among community-based partners and staff, define goals and expectations, and set realistic timelines for CHIP completion, the HPHD Community Health Improvement Charter was developed and implemented. The Charter defined roles and responsibilities for the Core Team, Steering Committee, and CHIP Workgroups. The details of which can be found in the following sections.

b. HPHD Core Group

The community health improvement Core Group, led by the District Director, is a multi-tiered, team-driven framework which supports and leads the overall CHA/CHIP process. This group consists of the Health District Director, Population Health Manager, CHA-CHIP Lead, and Population Health Coordinator.

The HPHD Core Group convenes, as needed, to provide strategic direction for the CHA/CHIP process to include collection, analysis, and dissemination of data, mobilization of partners, and establishment of the timeline. The Core Group is also responsible for supporting the Steering Committee and CHIP Workgroup activities, as well as overall community health improvement and strategic planning efforts.

c. Steering Committee

Community health improvement efforts require a collective impact from public health, community-based partners, health systems, and the community to establish the processes, develop and plan interventions, and evaluate efforts to support maximum impact. With this key concept in mind, The HPHD CHIP Steering Committee was formed and comprised of representatives from community-based organizations that reach and engage a broader cross section of the Peninsula community. HPHD was intentional in its approach to ensure members of the Steering Committee were more reflective of the Peninsula community, as well as bring new partnerships to the district's community health improvement process.

The HPHD Steering Committee members are essential to providing guidance and strategic direction for the community health improvement initiative. Inclusive of higher-level representatives, who were also champions within their organization for community health improvement, allowed for greater decision making and forward movement with the identification and selection of priority health concerns and the corresponding indicator for measurement.

Steering Committee members ultimately selected four priority areas of focus, and indicators for measurement, which were further defined and delegated through the CHIP process. The selected focus areas are broad and inclusive of many of the themes described throughout the CHA, and there is certainly no shortage of work within each issue. These include:

- Firearm Violence (indicator for measurement = firearm violence death rate)
- Heart Disease (indicator for measurement = heart disease death rate)
- Infant Mortality (indicator for measurement = infant mortality death rate)
- Substance Use (indicator for measurement = drug overdose death rate)

The Steering Committee was led by a non-voting facilitator, appointed by the District Director, which helped streamline the planning process, maintain focused discussions, and deliver effective outcomes. This initial planning process is outlined below.

December 2022 – March 2023

HPHD CHIP Steering Committee Meeting and Activity Schedule

December	January	February	March
• Intro to the CHIP purpose and process • Geographic area	• CHA review and discussion • Secondary data review	• Secondary data review • Priority indicator and selection process • Priority health concerns identified	• Deep dive data review • Indicator selection for identified priorities

For a more detailed timeline, please see *Moving the CHA towards a CHIP: HPHD CHIP Timeline* located in Appendix 1.

d. Data Collection and Analysis

The CHA integrates a combination of data that reflects the opinions and the health of the community. Although data was collected from a variety of sources to include community and professional stakeholder surveys, focus groups, and key stakeholder interviews, it is not comprehensive.

To provide a more inclusive and complete picture of the health issues that are present in the Peninsula community, secondary data was also considered. HPHD pulled from multiple internal and external sources of data to form a more accurate understanding of the broader community.

All primary and secondary data sources can be found in the 2022 HPHD CHA Report https://www.vdh.virginia.gov/content/uploads/sites/206/2022/08/CHA-FINAL-HPHD-2022.docx.pdf

e. Health Priorities

Determining community health priorities helps direct time, energy, and resources to the areas, programs, and initiatives that matter most, have the most potential for a positive impact, and are the most practical to address. The prioritized HPHD focus areas, and the indicators for measurement, for the next 3 – 5 years include:

- Firearm Violence (indicator for measurement = firearm violence death rate)
- Heart Disease (indicator for measurement = heart disease death rate)
- Infant Mortality (indicator for measurement = infant mortality death rate)
- Substance Use (indicator for measurement = drug overdose death rate)

f. CHIP Action Planning Workgroups

Creating a shared community vision, that reaches across all six HPHD localities, takes sustainable collaboration to make an impact. Community health improvement efforts require a collective impact from public health, community-based partners, health systems, and the community to establish the processes, develop and plan interventions, and evaluate efforts to support maximum impact.

To achieve the above, HPHD hired Community Health Solutions (CHS) to work with invested staff and partners, across the various sectors, to create an innovative plan for a healthier Peninsula community. CHS served as a neutral convener, provided

objectivity and expertise, and was able to effectively engage community partners to develop broad action plans for community health improvement.

The action planning process, which kicked off in June 2023, consisted of three, full-group in-person meetings (June, September, and November) and two virtual Action Planning meetings. The meeting and activity schedule for the Action Planning groups can be found below.

Each Action Planning group was assigned to one of the four priority focus areas listed above (Section e) and were asked to support the overall process by participating in the in-person and virtual meetings, reviewing data and meeting materials, sharing experiences, expertise, ideas, and reviewing and refining drafts of the priority action plans. Action planning work is described in more detail in the following sections. For the full *CHIP Workgroup: Action Planning Summary Report*, please refer to Appendix 3.

CHIP Workgroup Meeting and Activity Schedule				
June	**Jun-Jul-Aug**	**September**	**Sep-Oct-Nov**	**November**
Meetings (In-Person)	Activities (Virtual)	Meetings (In-Person)	Activities (Virtual)	Meetings (In-Person)

i. CHIP Workgroup Action Plan Development

a. Driver Diagrams

According to Community Heath Solutions (CHS), a "driver diagram is a visual display of a theory of what "drives," or contributes to, the achievement of a project aim. It shows the relationship between the overall aim of the project, the primary drivers that contribute directly to achieving the aim, the secondary drivers that are components of the primary drivers, and a set of ideas for activating the drivers. It is important to note that a driver diagram is a high-level summary of a strategic approach, and just a starting point for more detailed action planning."

Driver Diagrams, created for each of the four Priority Areas, are based on the insight, ideas, and suggestions from each Action Planning Group. These guided the overall process for forming the final Action Plans.

b. Action Plans

The Year 1 CHIP Action Plan framework for the development and implementation of action is the proposed strategy for community health improvement. The Action Plan is a necessary tool to keep the scope of work on task and support health improvement efforts in the community. It's important to note that this plan is supported by key stakeholders and is feasible to complete within the identified 3–5-year cycle.

These plans serve as a starting point only, which HPHD can utilize to accomplish community health improvement efforts. However, there is still more work to be done to flush out the strategic details of the Action Plans.

The full Action Planning Summary Report can be found in Appendix 3.

c. Community Partners

The CHIP process engages participants as active partners and works to build commitment and buy-in. Therefore, HPHD aspired to include participation from a broad set of community stakeholders to accurately reflect the Peninsula community and public health system.

For both the Steering Committee and CHIP Workgroups, HPHD aimed to include representation from across sectors. As this plan looks at the district's population, efforts were made to guide collaboration around the identification of commonality across jurisdictions for the development of strategic action. This process, and the partnerships made, will serve as the basis for taking collective action and facilitating future collaborations.

ii. Process Evaluation Survey

A survey was conducted to better understand and assess the effectiveness of the CHIP Workgroup process. The ten-question survey was sent to all CHIP Workgroup members and was comprised of Likert Scale and open-ended questions.

13 responses were received and the average time to complete the survey was 20:48.

A few of the key findings include:

- Respondents were very involved in the process
- Respondents felt their contribution to the process was meaningful
- Respondents are committed to participating in the implementation of the action plan process

Some key takeaways include:

- More frequent meetings would be beneficial
- Increase community and stakeholder involvement
- Establish more concrete plans for implementation

A full summary report can be found in Appendix 2. The information provided will help improve future HPHD community health improvement efforts.

Guide and Template for Comprehensive Health Improvement Planning Version 2.1 (2009), NACCHO, Retrieved from https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/CHIP-Guide.pdf

g. CHIP Implementation Task Groups

HPHD recognized the challenge to move from broad action plans to effective and strategic implementation. Therefore, HPHD recruited partners and formed Task Groups for CHIP Implementation. These groups, comprised of former CHIP Workgroup members and subject matter experts, identified SMART objectives, established timelines, and worked to identify key partners to help lead the effort. CHIP Implementation Task Group work, facilitated by CHS, took place from February through April 2024, and all work was conducted through the online planning hub established during Phase I of the community health improvement process.

The work was grounded by the University of Wisconsin's implementation plan tool, which helped guide HPHD's efforts to be both focused and effective. The final product is a well-

thought-out implementation plan, with specific requirements and deliverables for community health improvement. The HPHD Implementation plan(s) is a dynamic tool that can be adapted, as needed, based on the community's needs. This plan will allow HPHD to track and report on progress, as well as engage and leverage support from partners.

The CHIP Implementation Plan can be found in Appendix 4.

PART II: PRIORITIZED COMMUNITY HEALTH ISSUES

Priority Area 1: Firearm Violence

Background and Rationale

The gun violence epidemic is a public health crisis and takes a toll on all our communities. According to Wikipedia, "Gun-related violence is violence committed with the use of a firearm. Gun-related violence may or may not be considered criminal. Criminal violence includes homicide, assault with a deadly weapon, and suicide, or attempted suicide, depending on jurisdiction". [1]

Source [1]: https://en.wikipedia.org/wiki/Gun_violence

In the HPHD 2022 CHA, community violence was noted as a top concern for both professional and community stakeholders, across all six of HPHD's localities (City of Hampton, Newport News, Poquoson, and Williamsburg and the Counties of James City and York), for adults (18+) and children and teens (0-17 y/o).

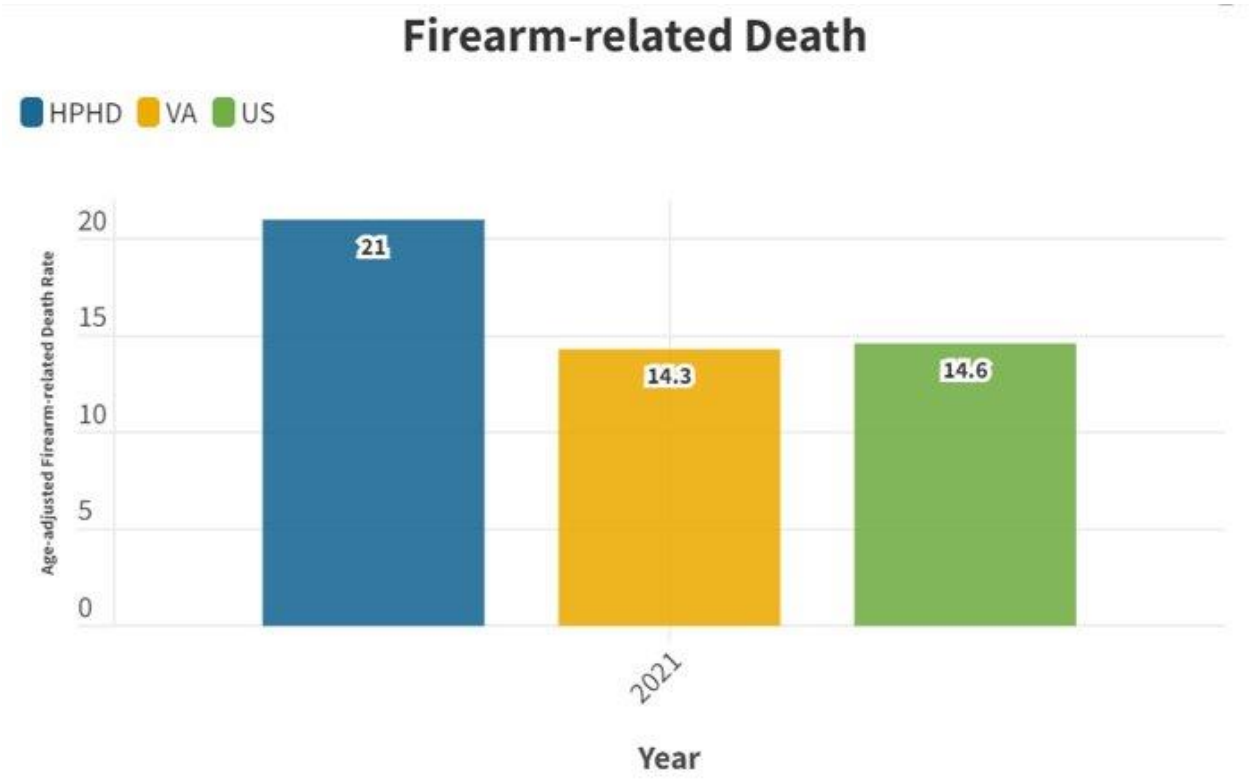
Additionally, the Cities of Hampton and Newport News specifically recognized community violence as one of the most important concerns (top 3) for their community's health and well-being. The data only serves to validate the concern, as these two localities share a higher burden of youth and community violence than the other localities in the district.

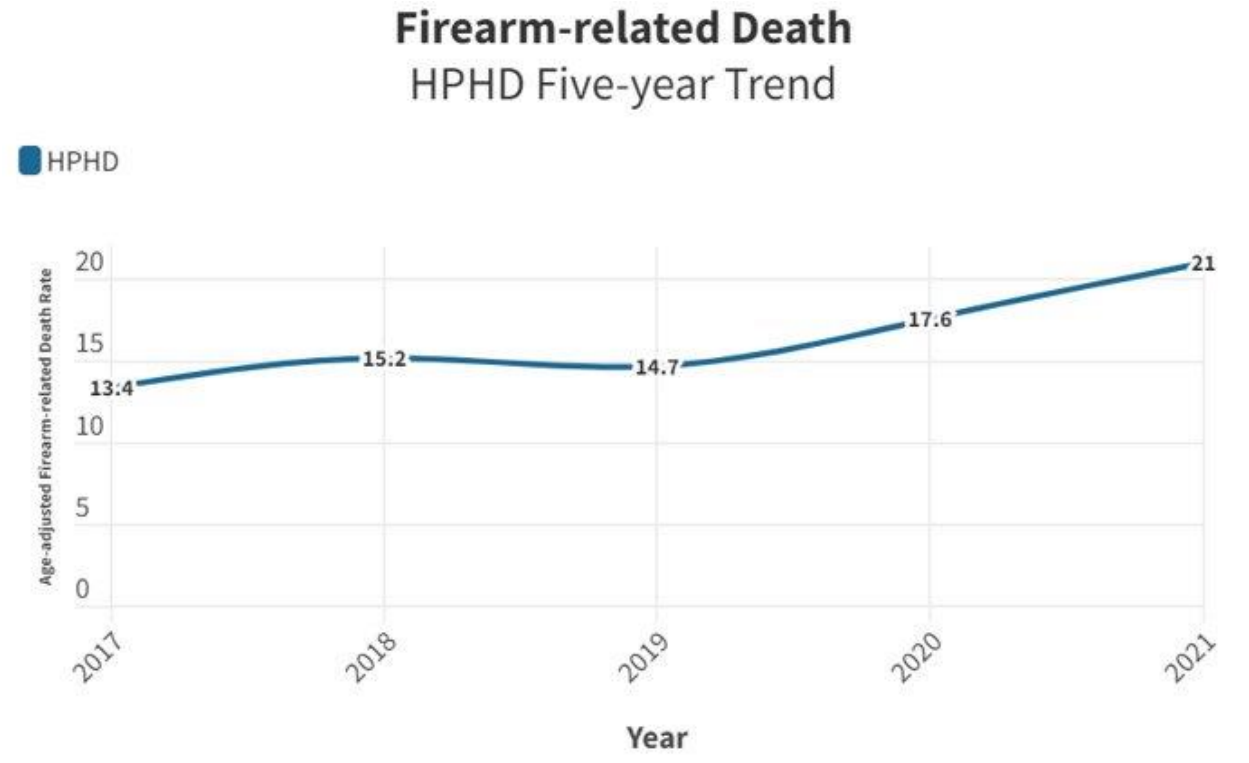
In 2022, the City of Newport News conducted a Comprehensive Gun Violence and Community Safety Assessment to better understand community concerns around safety, identify root causes, and gain insight into how violence effects the community. Out of approximately 2000 respondents, gun violence concerns rose to the top, with youth and respondents of color "more likely to face daily challenges in areas like mental health and financial strain, fear criminal justice system contact as well as gun violence victimization, feel like their neighborhood is unsafe, experience discrimination and/or prejudice, be unsatisfied with local policing, and experience barriers to community resources" [2]

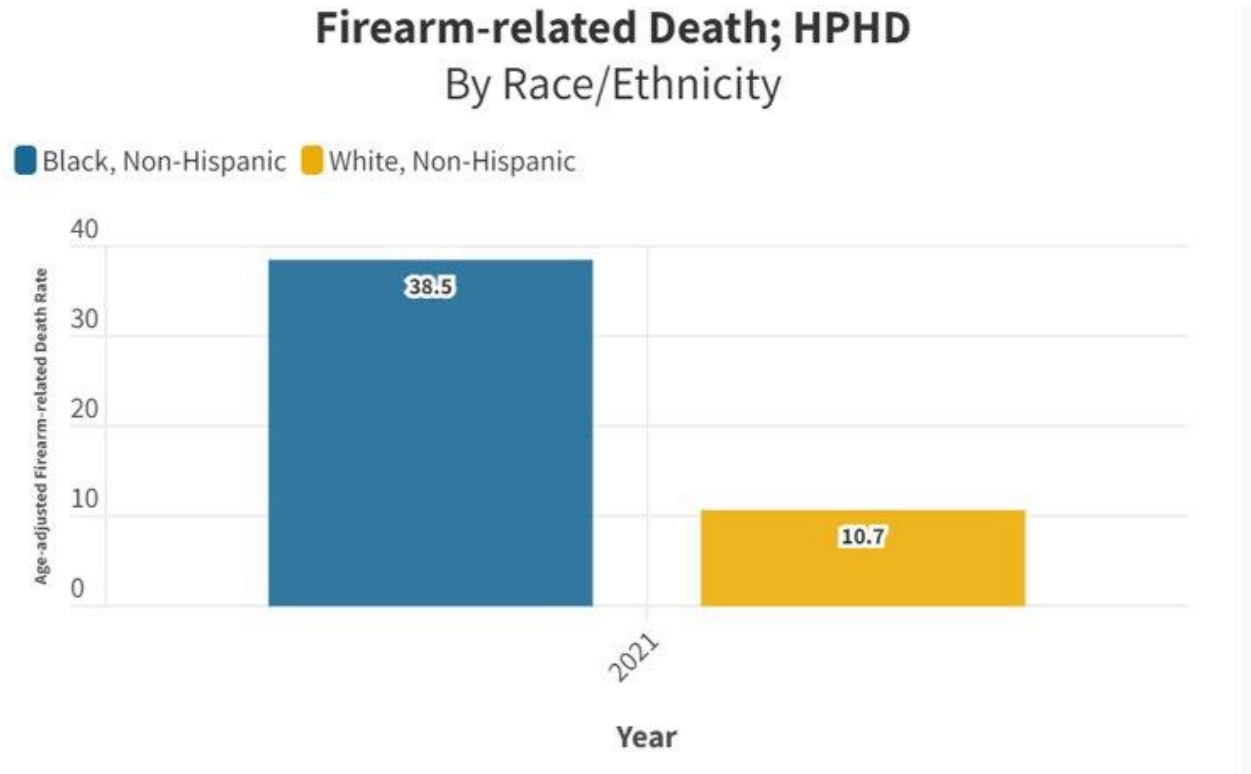
Source [2]: Newport News Community Assessment, 2022, https://www.nnva.gov/DocumentCenter/View/34409/Gun-Violence-and-Community-Safety-Assessment-CNU?bidId=

The City of Hampton also recognized the need for implementing strategies that would make their communities safter in the FY2022 Safe and Clean Report. The report, which can be viewed here, https://hampton.gov/DocumentCenter/View/42854/FY2023-Safe-and-Clean-Report-PDF?bidId= shows an increase in fatal and non-fatal shootings from 2021 to 2023. Based on this information, gun violence intervention is essential for offering alternative opportunities and providing support to the Hampton community.
[Describe CHA data that relates to this priority area. Include tables and figures if possible.]

The CHA data that relates to this priority and its indicator for community health improvement, firearm related death, is included in the charts below.


Firearm-related Death
HPHD
VA
US
Age-adjusted Firearm-related Death Rate
20
15
10
5
0
21
14.3
14.6
2021
Year


Firearm-related Death
HPHD Five-year Trend
HPHD
Age-adjusted Firearm-related Death Rate
20
15
10
5
0
13.4
15.2
14.7
17.6
21
2017
2018
2019
2020
2021
Year



Data Source: Population estimates came from http://www.census.gov/programs-surveys/popest/technical-documentation/methodology.html.
ED visits for firearm- related injury were collected from https://data.virginia.gov/stories/s/ixe4-998g.
Data Source: http://wonder.cdc.gov/ucd-icd10.html

PRIORITY AREA 1: FIREARM VIOLENCE ALIGNMENT WITH STATE AND NATIONAL PRIORITIES		
HPHD	**VDH Plan for Well-Being**	**Healthy People 2030 Goal**
Firearm Violence – Reduction in the firearm violence death rate	2024-2027 Priority #2 for the Virginia State Health Improvement Plan (SHIP): Firearm Related Deaths	Reduce firearm-related deaths – IVP-13 Reduce gun carrying among adolescents – IVP-12

Exhibit 3 Year 1 Action Plan for Firearm Violence

A. Aim and Community Reach

Guiding Aim	☐ Reduce Firearm Deaths
Community Reach	☐ Hampton | James City County | Newport News | Poquoson | Williamsburg | York County

B. Core Strategy

☐ The core strategy would be collaborative action for community health improvement.

☐ This strategy recognizes that collaborative action can be effective for assuring optimal use of existing community resources and creating additional strategies to fill gaps where needed.

☐ The strategy would adapt concepts from Project LEAD and Collective Impact with a practical focus on a 'first-up' initiative that is needed and feasible within a one-to-three-year time horizon.

C. Year 1 Action Objectives

Focus on a 'First-Up' Initiative from Driver Diagram	☐ Identify populations at risk for firearm violence ☐ Provide community outreach and education for at-risk community members ☐ Connect at-risk populations to health care and community supports
Create Community Linkages	☐ Create a virtual community collaboration hub for CBOs and public agencies interested in reducing firearm violence and deaths
Educate, Engage, and Equip Partners	☐ Educate, engage, and equip CBO and public agency partners with information, data, and tools for the first-up initiative
Raise Community Awareness	☐ Work together to raise community awareness and connect at-risk community members to available supports

D. Year 1 (2024) Action Steps

1. Convene Year 1 development team
2. Develop vision statement
3. Engage partner to host virtual community collaboration hub
4. Identify and engage prospective funders as needed
5. Develop and implement virtual community collaboration hub
6. Engage community stakeholders as hub partners and advisors
7. Develop data resources
8. Identify at-risk populations across the region
9. Equip hub partners with tools and strategies for providing community outreach and education
10. Encourage hub partners to connect at-risk populations to health care and community supports

E. Action Planning Group Ideas

Who would be among the key community populations to make sure we reach?

- Elder males
- High schoolers
- Hunting groups
- New gun owners
- New parents or parents (young kids, teens)
- Recent parolees/prisoners
- Veterans

Who would be among the key community partners to engage?

- DV shelters
- EMS
- Halfway homes
- Hampton Family Violence Council
- Homeless shelters
- Hospital/ER
- HPHD
- Perinatal Mental Health Coalition of Virginia
- Police
- Public schools and universities
- Sheriff's Department
- Transitions Family Violence Services
- VDH

What would be some creative ideas for collaborative outreach and education?

- Gun stores
- Military bases
- Pawn stores
- Safe storage education
- School groups

What would be some creative ideas for connecting community members to community supports?

- Attending events and/or festivals
- Unite Us
- Using social media

What would be some possibilities for regional collaboration?

Share Community Data	☐ Develop and disseminate community data sets to help identify at-risk populations and support community outreach		• Annual community events/weeks highlighting youth violence prevention • Collaborate locally to 'recognize' National Youth Violence Week (held annually in April) • Collaboration for trauma informed care wherever violence happens (i.e., Child Savers) • Education-based Gun Safety Day - police departments, local schools • Firearm safety training (all localities) • Suicide (attempt) follow-up counselors in hospitals (all localities)

Priority Area 2: Heart Disease

Background and Rationale

Heart disease, also known as cardiovascular disease, encompasses a variety of heart problems and is responsible for approximately 1 in every 5 deaths [3]. The Centers for Disease Control and Prevention reports that the most common type of heart disease in the United States is coronary artery disease (CAD), which can lead to heart attack.

There is a significant amount of interest at the local level to identify prevention strategies that work to improve heart health. As the data below shows, HPHD has a higher heart disease death rate than the State and our districts continue to trend in the wrong direction. With the age-adjusted death rate in Virginia at 149.6, the highest rates in the districts occur in the Cities of Hampton (182.0), Newport News (189.1), and Poquoson (158.1).

To further support this data, the recent CHA data reflects that heart disease remains a health concern for our community, with 22.2% of community stakeholders and 17.6% of professional stakeholders citing this among the top 10 health concerns for adults (age 18+).

Source [3]: https://www.cdc.gov/heartdisease/facts.htm

In alignment with VDH's Plan for Wellbeing, obesity – which was identified as a priority, is associated with an increased risk of heart disease. Obesity has been on the rise in Virginia and can impact a person's overall health and well-being. According to the American Heart Association, "Obesity also leads to the development of cardiovascular disease and cardiovascular disease mortality independently of other cardiovascular risk factors" [4].

Source [4]: https://www.ahajournals.org/doi/full/10.1161/CIR.0000000000000973

Adults Overweight or Obese by Year, 2011 through 2020

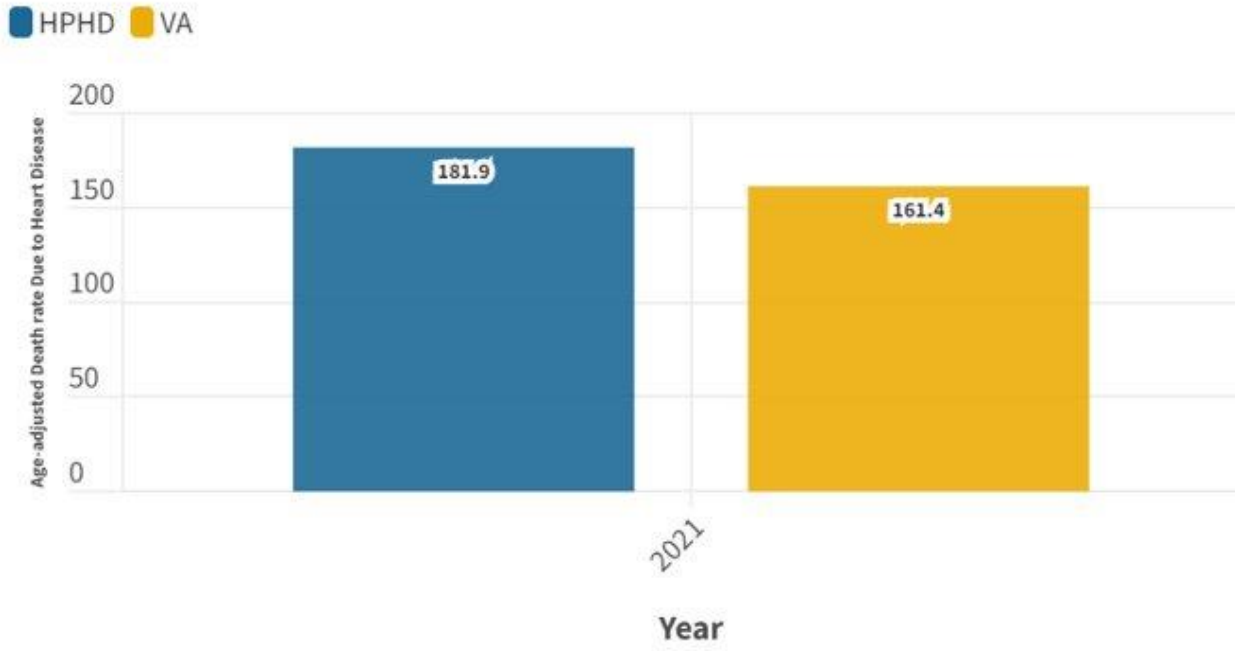
The table and chart below display trends in the percentage of adults who are overweight or obese (body mass index greater than 25.0) for years 2011 through 2020.
Note: An asterisk on rates denotes that rates were estimated based on a sample with sample size < 50. Use caution in interpreting such cases.

Report Area	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Virginia	63.3%	63.6%	64.0%	64.7%	64.1%	65.4%	66.3%	66.3%	66.4%	67.3%

Data Source: Virginia Department of Health, Behavioral Risk Factor Surveillance Survey. Data directly obtained via email from Virginia Department of Health. 2021

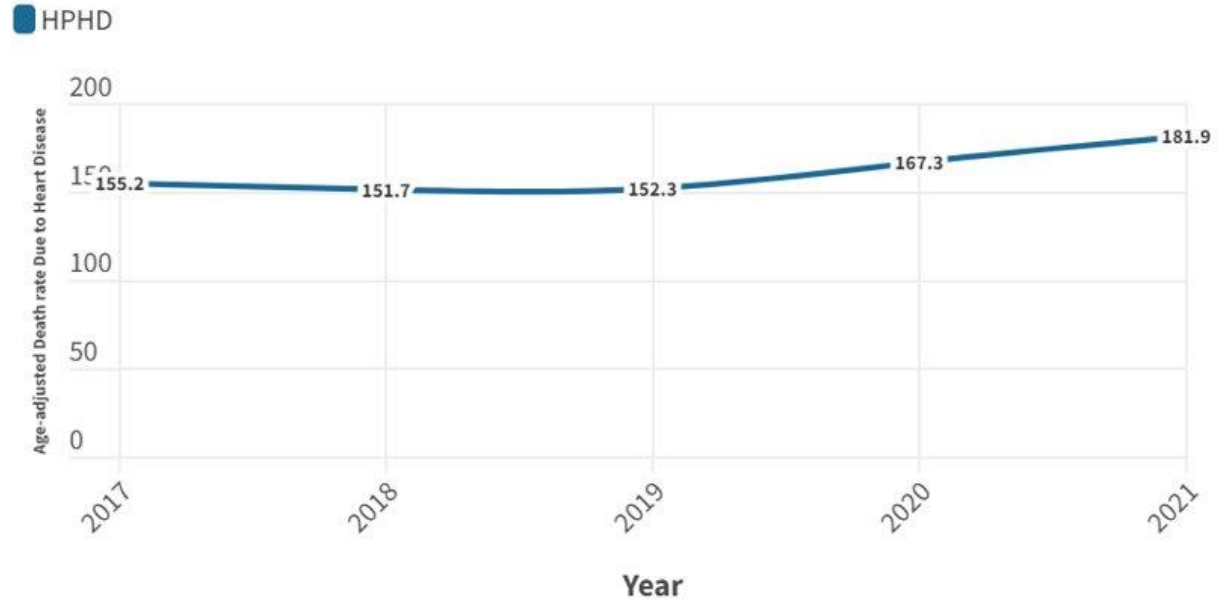
Death Due to Heart Disease

HPHD vs. VA



Death Due to Heart Disease

HPHD Five-year Trend



PRIORITY AREA 1: HEART DISEASE ALIGNMENT WITH STATE AND NATIONAL PRIORITIES		
HPHD	**VDH Plan for Well-Being**	**Healthy People 2030 Goal**
Heart Disease – Reduction in the heart disease death rate	2024-2027 Priority #3 for the Virginia State Health Improvement Plan (SHIP): Obesity Note: Although not directly aligned, obesity is a contributing factor to the heart disease death rate	Reduce coronary heart disease deaths — HDS-02

Heart Disease: YR 1 Action Plan

Exhibit 4
Year 1 Action Plan for Heart Disease

A. Aim and Community Reach	
Guiding Aim	☐ Reduce Heart Disease Deaths
Community Reach	☐ Hampton | James City County | Newport News | Poquoson | Williamsburg | York County

B. Core Strategy

☐ The core strategy would be collaborative action for community health improvement.

☐ This strategy recognizes that collaborative action can be effective for assuring optimal use of existing community resources and creating additional strategies to fill gaps where needed.

☐ The strategy would adapt concepts from Project LEAD and Collective Impact with a practical focus on a 'first-up' initiative that is needed and feasible within a one-to-three-year time horizon.

C. Year 1 Action Objectives	
Focus on a 'First-Up' Initiative from Driver Diagram	☐ Identify populations at risk for heart disease mortality ☐ Provide community outreach and education for at-risk community members ☐ Connect at-risk populations to health care and community supports
Create Community Linkages	☐ Create a virtual community collaboration hub for CBOs and public agencies interested in reducing heart disease mortality

D. Year 1 (2024) Action Steps

1. Convene Year 1 development team
2. Develop vision statement
3. Engage partner to host virtual community collaboration hub
4. Identify and engage prospective funders as needed
5. Develop and implement virtual community collaboration hub
6. Engage community stakeholders as hub partners and advisors
7. Develop data resources
8. Identify at-risk populations across the region
9. Equip hub partners with tools and strategies for providing community outreach and education
10. Encourage hub partners to connect at-risk populations to health care and community supports

E. Action Planning Group Ideas

Who would be among the key community populations to make sure we reach?

- Families at risk
- Individuals with multiple health conditions
- Underserved communities

Who would be among the key community partners to engage?

- Community Health Workers
- Hospitals, health clinics, and urgent care facilities
- Organizations that serve at-risk populations
- Primary Care Providers

What would be some creative ideas for collaborative outreach and education?

Educate, Engage, and Equip Partners	☐ Educate, engage, and equip CBO and public agency partners with information, data, and tools for the first-up initiative		• Employer wellness (especially for large employers), incentives? • Human services • Organizations and agencies • Pharmacy pharmacies • Schools - P.E. Health • SHIP in WJCC schools
Raise Community Awareness	☐ Work together to raise community awareness and connect at-risk community members to available supports		**What would be some creative ideas for connecting community members to community supports?** • Health fairs • Hotline and resource guides • Mobile education • Social Media as a preventative method
Share Community Data	☐ Develop and disseminate community data sets to help identify at-risk populations and support community outreach		**What would be some possibilities for regional collaboration?** • Cross jurisdictional survey distribution to continue the needs assessment • JCC, Williamsburg and York: Educational Outreach for Stroke Prevention (F.A.S.T.) • Social Services community health initiative
Share Community Data	☐ Develop and disseminate community data sets to help identify at-risk populations and support community outreach		

PRIORITY AREA 3: INFANT MORTALITY

Background and Rationale

The Centers for Disease Control and Prevention defines infant mortality as, “the death of an infant before his or her first birthday.” Additionally, “the infant mortality rate is the number of infant deaths for every 1,000 live births” [5]

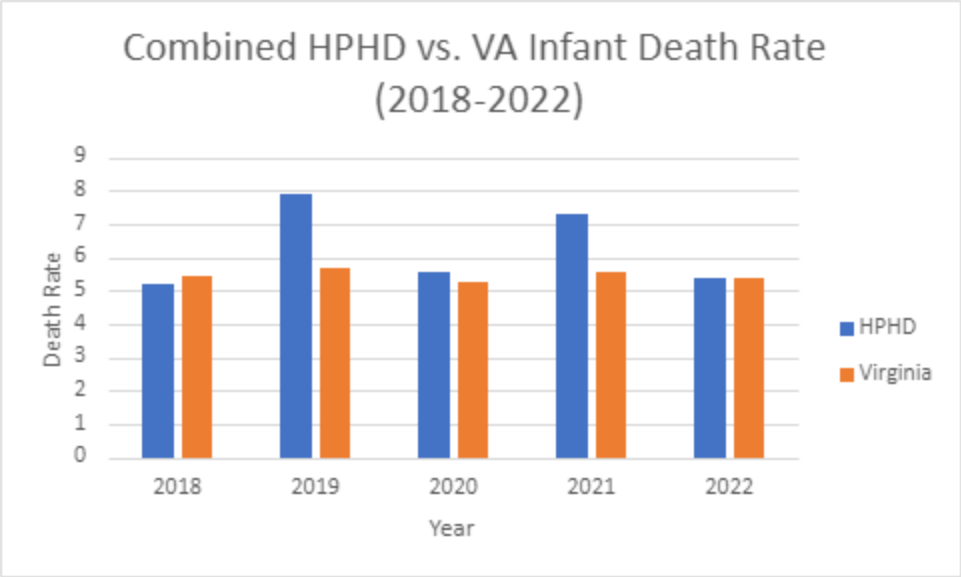
Infant mortality is one of the most important indicators of the health of a state, as it is associated with a variety of factors such as maternal health, quality and access to medical care, socioeconomic conditions, and public health practices. The Virginia Department of Health (VDH) recognizes this and assesses the health of women, infants, and children every five years, in alignment with Title V legislation. Based on the community health needs assessment findings and recommendations from the 2020 report, HPHD will be working to align efforts by hiring an MCH Educator to address health disparities such as racism, language, and cultural responsiveness.

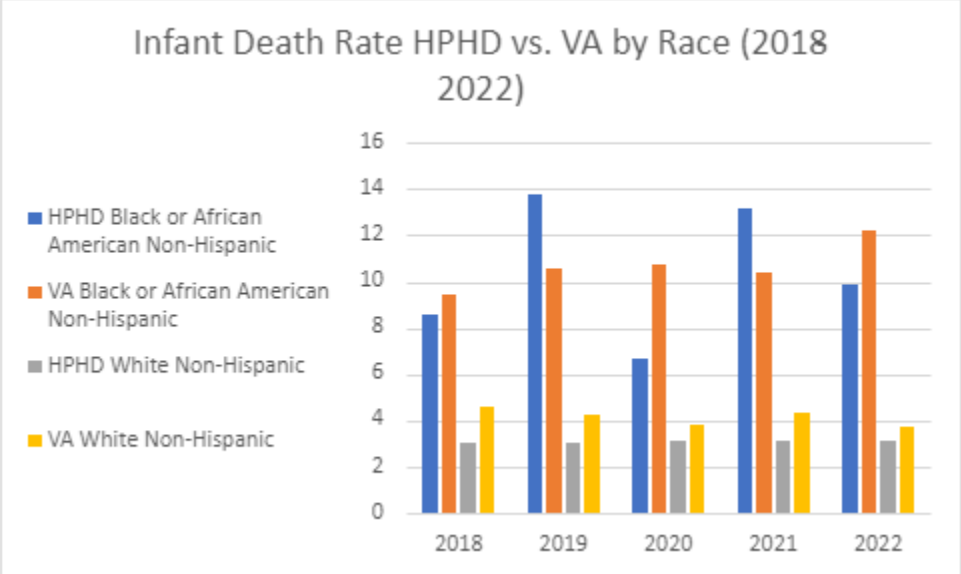
HPHD is committed to aligning strategic planning efforts with VDH findings and recommendations. In the HPHD localities, the infant mortality rate of black infants in recent years has been twice that of the rate for white infants. According to the 2023 March of Dimes Report Card for Virginia, “the infant mortality rate declined 10% in the last decade, but the rate among babies born to Black birthing people is still 1.9 x the national rate” [6].

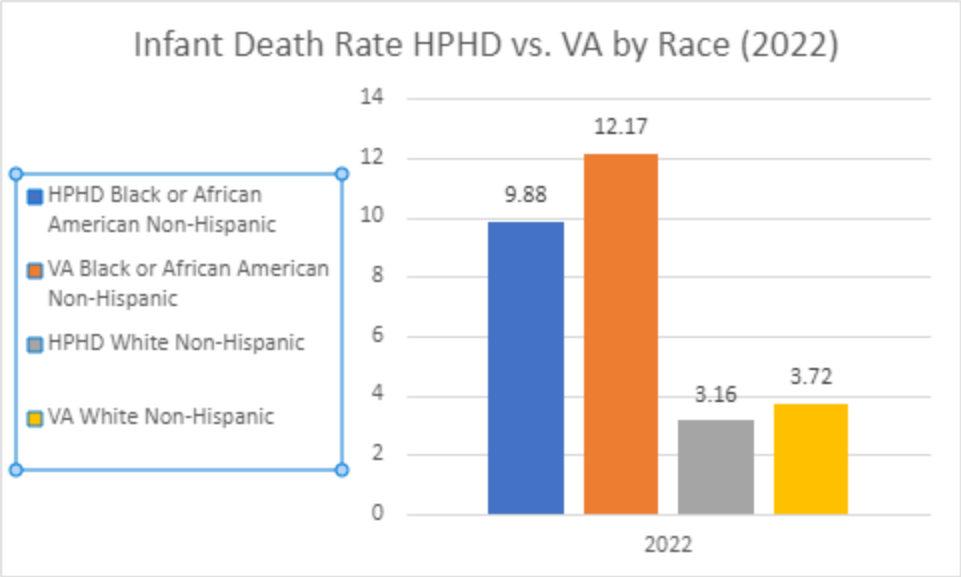
HPHD aims to reduce the racial disparity in infant mortality rates, as well as overall infant death rates for our districts. To achieve this, HPHD will continue to engage cross-sector partners and address social determinants of health that contribute to the overall death rate.

Source [5]: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm

Source [6]: The 2023 March of Dimes Report Card: The State of Maternal and Infant Health for American Families:file:///C:/Users/uxg41774/Downloads/March-of-Dimes-2023-Full-Report-Card.pdf


Combined HPHD vs. VA Infant Death Rate (2018-2022)
Death Rate
9
8
7
6
5
4
3
2
1
0
2018
2019
2020
2021
2022
Year
HPHD
Virginia


Infant Death Rate HPHD vs. VA by Race (2018 2022)
HPHD Black or African American Non-Hispanic
VA Black or African American Non-Hispanic
HPHD White Non-Hispanic
VA White Non-Hispanic
16
14
12
10
8
6
4
2
0
2018
2019
2020
2021
2022



PRIORITY AREA 1: INFANT MORTALITY ALIGNMENT WITH STATE AND NATIONAL PRIORITIES		
HPHD	**VDH Plan for Well-Being**	**Healthy People 2030 Goal**
Infant Mortality – Reduction in the infant mortality death rate	2024-2027 Priority #1 for the Virginia State Health Improvement Plan (SHIP): Infant Mortality	Reduce the rate of infant deaths — MICH-02

Infant Mortality: YR 1 Action Plan

Exhibit 5
Year 1 Action Plan for Infant Mortality

A. Aim and Community Reach		**D. Year 1 (2024) Action Steps**
Guiding Aim	☐ Reduce Infant Deaths	
Community Reach	☐ Hampton | James City County | Newport News | Poquoson | Williamsburg | York County	
B. Core Strategy		

- The core strategy would be collaborative action for community health improvement.
- This strategy recognizes that collaborative action can be effective for assuring optimal use of existing community resources and creating additional strategies to fill gaps where needed.
- The strategy would adapt concepts from Project LEAD and Collective Impact with a practical focus on a 'first-up' initiative that is needed and feasible within a one-to-three-year time horizon.

C. Year 1 Action Objectives

Focus on a 'First-Up' Initiative from Driver Diagram	☐ Identify populations at risk for infant mortality ☐ Provide community outreach and education for at-risk community members ☐ Connect at-risk populations to health care and community supports
Create Community Linkages	☐ Create a virtual community collaboration hub for CBOs and public agencies interested in reducing infant mortality
Educate, Engage, and Equip Partners	☐ Educate, engage, and equip CBO and public agency partners with information, data, and tools for the first-up initiative
Raise Community Awareness	☐ Work together to raise community awareness and connect at-risk community members to available supports
Share Community Data	☐ Develop and disseminate community data sets to help identify at-risk populations and support community outreach

1. Convene Year 1 development team
2. Develop vision statement
3. Engage partner to host virtual community collaboration hub
4. Identify and engage prospective funders as needed
5. Develop and implement virtual community collaboration hub
6. Engage community stakeholders as hub partners and advisors
7. Develop data resources
8. Identify at-risk populations across the region
9. Equip hub partners with tools and strategies for providing community outreach and education
10. Encourage hub partners to connect at-risk populations to health care and community supports

E. Action Planning Group Ideas

Who would be among the key community populations to make sure we reach?

- African American
- Low-income
- Non-English speakers
- Pregnant and new moms
  Refugees

Who would be among the key community partners to engage?

- CHW's
- Health Dept. - (at all advantage) 1. immunizations, 2. refugees, 3. MCH, 4. Hispanic population, 5. Low-income families
- Infant mortality - WIC, MCH programs, HCP

What would be some creative ideas for collaborative outreach and education?

- CHWs
- Health care systems teach patients about safe sleep practices, screening for services/needs

What would be some creative ideas for connecting community members to community supports?

- Collaborative grants
- Really make an effort to go out into the community to provide services

What would be some possibilities for regional collaboration?

- Fatherhood Program
- Motherhood Program

Background and Rationale

Substance Use Disorder (SUD) and resulting drug overdoses continue to impact our community. SUD is defined by the DSM-5 as "occurring when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home." Since SUD affects families and the greater community in addition to the individual, it is important to understand population level impacts of substance misuse outcomes. Notably, many cities across Hampton Roads experience higher drug overdose, emergency department visits, and drug overdose fatality rates compared to other cities in the Commonwealth of Virginia.

Of the six localities served by HPHD, the Cities of Hampton and Newport News have the highest burden of SUD. In fact, the age-adjusted rate for overdose deaths in Hampton (35.8) and Newport News (37.3) is much higher than that of the Commonwealth of Virginia's total rate (26.9). This is further supported by the CHA findings, where SUD was identified as a priority health concern in all HPHD localities – but was even more reflected in the results and data for Hampton and Newport News.

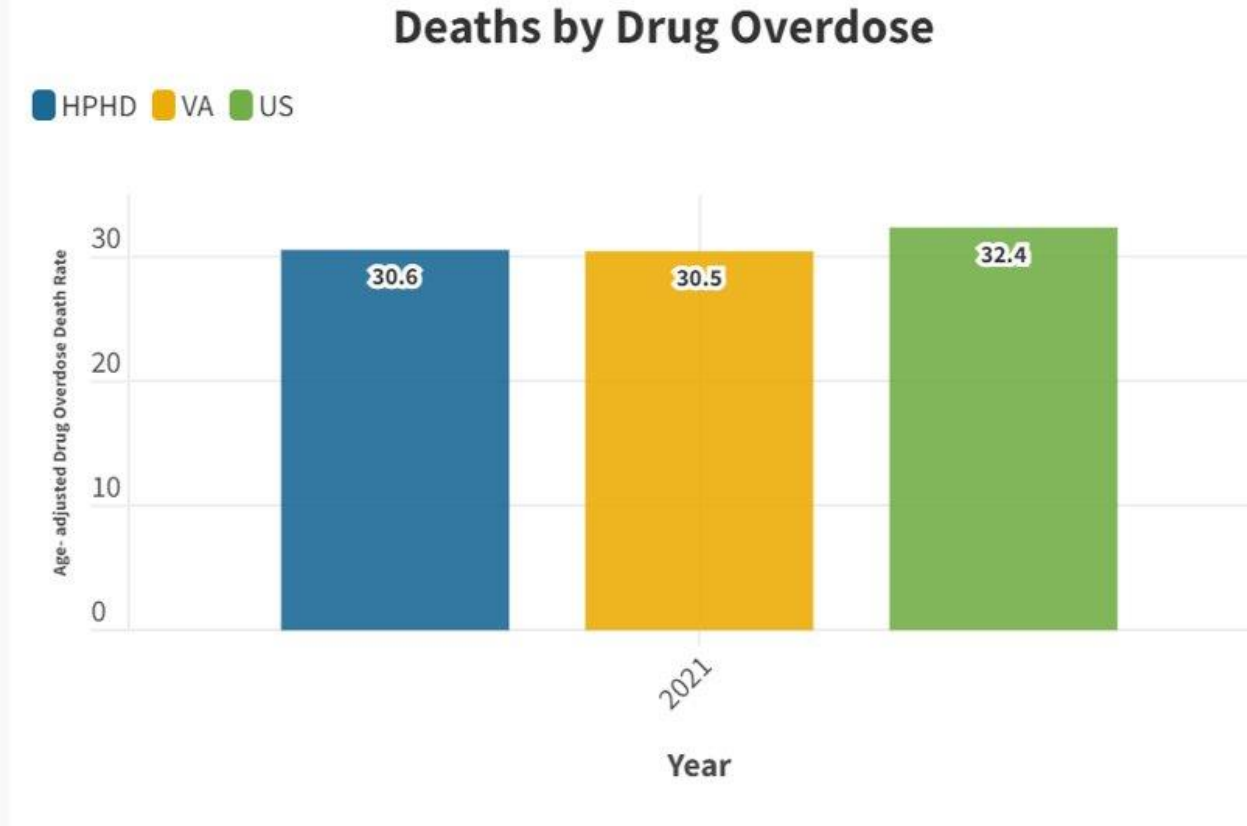
It's important to note that individuals from any background can struggle with SUD. In Hampton, most of the opioid-related Emergency Medical Services (EMS) incidents occur in White populations, whereas Black-African American populations are the majority of opioid-related EMS incidents in Newport News. Both cities share the commonality of those most affected in the 30 to 39 years of age group. Additionally, men are involved in more incidents than women (FAACT).

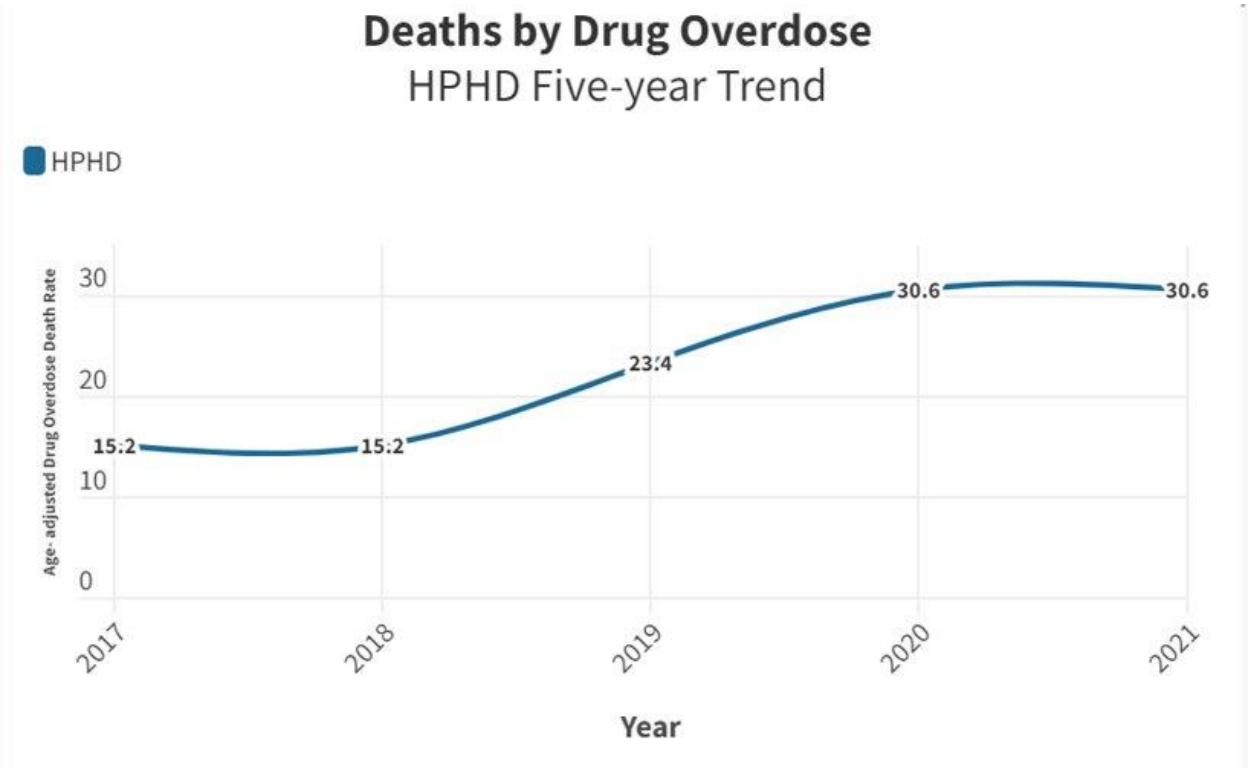
Although both cities have access to two non-specialized hospital systems and several SUD treatment facilities, opioid incident and fatality rates have increased throughout the COVID-19 pandemic. In part, this is due to an increase in overall risk behavior due to the socially isolating nature of COVID-19 prevention protocols. However, it can also be attributed to staff shortages in healthcare fields, including high staff turnover and a lack of adequate resources, as more resources were dedicated to COVID-19 efforts. This combination of pandemic-related problems led to long waitlists for SUD treatment, which contributed to overdose incidents.

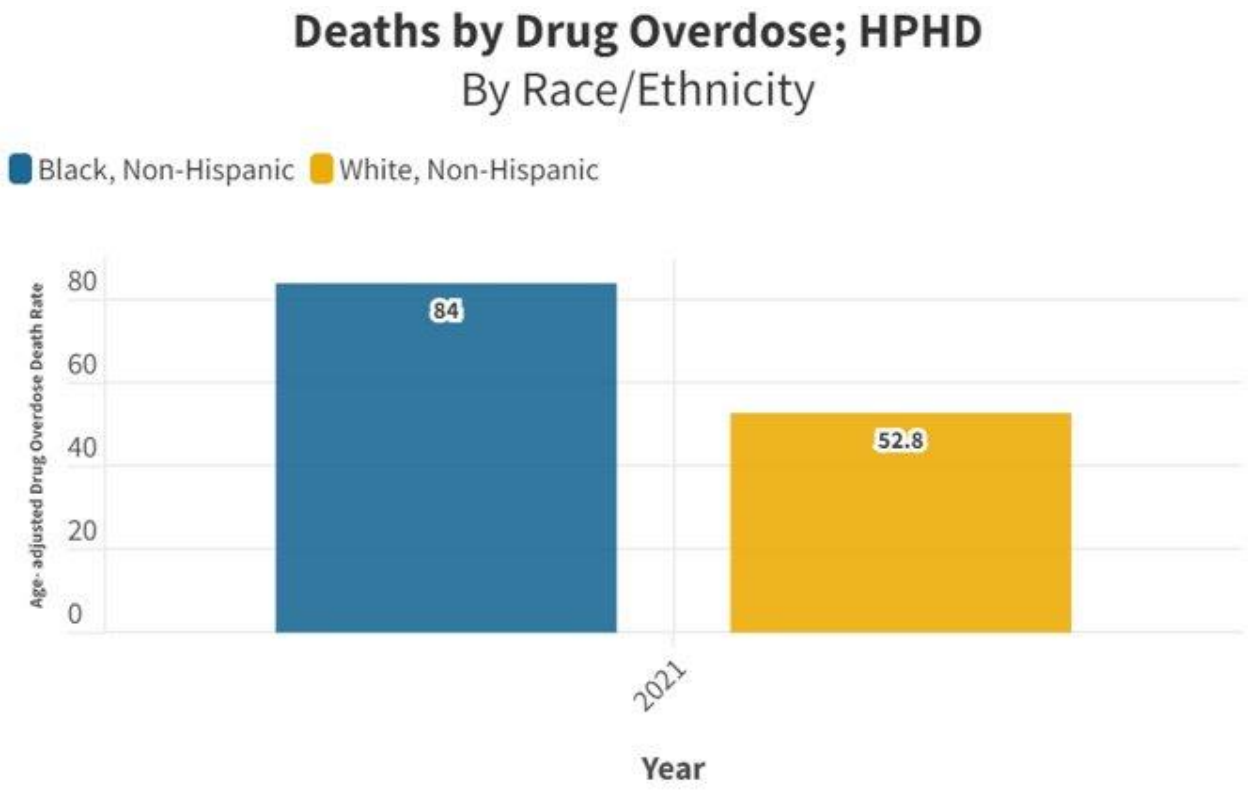
Other barriers to care for individuals struggling with SUD include lack of awareness of local support services. The data from the HPHD CHA found the support services most individuals were least aware of included addiction assistance services (54.3%), housing assistance (29.4%), and prescription assistance programs (27.8%). Additional barriers to care identified in the CHA were costs of care (33.6%), waitlists (28.3%), and lack of health insurance (20.9%). The barriers to access these social determinants of health further contribute to health disparities in our community.

However, most telling is what the community identified as their priority health concerns. Respondents were asked to review a list of common community health issues and identify what they view as the most important health concerns in the community where they live or work. Alcohol/Substance Use (Prescription, Illegal Drugs, Opioids) was identified as a top concern for professional stakeholders (44.6%). Alcohol/Substance Use was identified as a top priority for 29.9% of community members. Both professional and community stakeholders identified Behavioral/Mental Health as a top concern, 77.8% for professionals and 59.8% for community stakeholders.

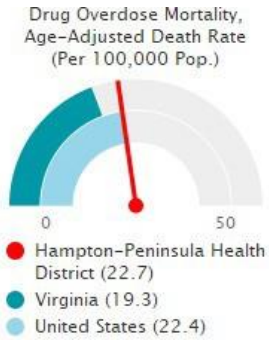
As a result of the data and identified need in our community, a substance use and opioid response program, Project LEAD, was initiated. Project LEAD is raising awareness and de-stigmatizing substance use in our community. The project aims to improve health resources and linkages to care, provide harm reduction resources, increase naloxone saturation in our community, and bridge gaps to improve health outcomes for all. Additional information on Project LEAD can be found on the HPHD website at https://www.vdh.virginia.gov/hampton-peninsula/lead/.


Deaths by Drug Overdose
HPHD
VA
US
Age- adjusted Drug Overdose Death Rate
30
20
10
0
30.6
30.5
32.4
2021
Year


Deaths by Drug Overdose
HPHD Five-year Trend
HPHD
Age- adjusted Drug Overdose Death Rate
30
20
10
0
15.2
15.2
23.4
30.6
30.6
2017
2018
2019
2020
2021
Year



PRIORITY AREA 1: SUBSTANCE USE ALIGNMENT WITH STATE AND NATIONAL PRIORITIES		
HPHD	**VDH Plan for Well-Being**	**Healthy People 2030 Goal**
Substance Use – Reduction in the drug overdose death rate	2024-2027 Priority #5 for the Virginia State Health Improvement Plan (SHIP): Substance Use and Drug Overdose	Reduce drug overdose deaths — SU-03



Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
Hampton-Peninsula Health District	486,027	519	21.4	**22.7**
James City County, VA	76,092	51	13.4	16.0
York County, VA	68,208	53	15.5	16.4
Hampton City, VA	134,873	174	25.8	27.3
Newport News City, VA	179,625	216	24.1	24.6
Poquoson City, VA	12,158	11	No data	No data
Williamsburg City, VA	15,071	14	No data	No data
Virginia	8,505,119	8,147	19.2	19.3
United States	326,747,554	363,665	22.3	22.4

Data source: https://virginiawellbeing.com/virginia-community-health-improvement-data-portal/vdh-assessment

Substance Use: YR 1 Action Plan

Exhibit 6
Year 1 Action Plan for Substance Use

Draft Action Plan

A. Aim and Reach

Guiding Aim	☐ Reduce Opioid Deaths
Community Reach	☐ Hampton | James City County | Newport News | Poquoson | Williamsburg | York County

B. Core Strategy

☐ The core strategy would be collaborative action for community health improvement.

☐ This strategy recognizes that collaborative action can be effective for assuring optimal use of existing community resources and creating additional strategies to fill gaps where needed.

☐ The strategy would continue the work of Project LEAD based on current strategic plans.

C. Year 1 Action Objectives

Focus on a 'First-Up' Initiative from Driver Diagram	☐ Continue Project LEAD strategies

D. Year 1 (2024) Action Steps

Continue with planned strategies for Project LEAD

E. Action Planning Group Ideas

Who would be among the key community populations to make sure we reach?

- EMS - other relations
- Family members
- PWUD
- Rehabs

Who would be among the key community partners to engage?

- EMS
- Hospitals
- Rehabs

Create Community Linkages	□ Continue Project LEAD strategies		**What would be some creative ideas for collaborative outreach and education?** • Community events health fairs • DARE - School education • Rotational staff for community partners
Educate, Engage, and Equip Partners	□ Continue Project LEAD strategies		**What would be some creative ideas for connecting community members to community supports?** • Funding opportunities for collaborative partners
Raise Community Awareness	□ Continue Project LEAD strategies		**What would be some possibilities for regional collaboration?** • Awareness Fairs • Data sharing • Mobile Units • Pop up events • Regional Coalition • Regional Summit
Share Community Data	□ Continue Project LEAD strategies		

PART III: Monitoring and Evaluation

Ensuring HPHD and its partners have a shared interest and investment of time, energy, and resources to improve community health is critical to the monitoring and evaluation of the CHIP. There may be situations that arise which require revisions to the plan and therefore, the act of consistently monitoring and revising the CHIP is essential to maintain a living, relevant document that accurately reflects the community's needs.

HPHD will observe and document progress - which results from the inclusion of community-based partners, and other partner's work, who have taken an active role in addressing the health priority. While HPHD may be the coordinator and convener for the identified health priority areas, HPHD may not always be the lead agency designated to move implementation strategies forward. Therefore, it's essential to monitor the work being done by external community partners to assure progress for improvement.

The CHIP priorities, objectives, and strategies will be reviewed, monitored, and/or revised on a quarterly basis, or as needed, to ensure effectiveness of the plan. This will be done in collaboration with the HPHD Steering Committee and other community-based partners, which will aid in the assessment of HPHD's efforts to improve the health of the community. To track and evaluate what is being done, the following questions will be asked at meetings, via surveys and other evaluation methods, to ensure HPHD is on track [6]:

- Are we doing what we said we'd do?
- Are we doing it well?
- Is what we are doing advancing the mission?

Source [6]: https://ctb.ku.edu/en/table-of-contents/structure/strategic-planning/develop-action-plans/main

Lastly, as HPHD and its partners begin CHIP implementation, progress will be monitored and reported to the community and key stakeholders. This will allow HPHD to adjust and revise the plan to meet the established goals and share lessons learned along the way.

PART IV: Summary and Next Steps

HPHD, together with the community, public health system stakeholders, and locality partners, will work to improve the health of the population on the Peninsula. To help guide this work, ensure community involvement, and maintain interest and support of health improvement efforts, HPHD will convene quarterly with Steering Committee members. Additionally, Steering Committee members will assist with monitoring the work of the Implementation Action Plans and recommend revisions on an as needed basis.

To achieve improved health outcomes, HPHD is committed to accountable community collaboration in the four priority areas of concern: Firearm Violence, Heart Disease, Infant Mortality, and Substance Use. HPHD recognizes that community health efforts take ongoing collaboration and is working to develop the Peninsula Community Hub, a virtual space where community organizations can connect, learn, focus, and collaborate on the identified initiatives.

Additional year one goals and objectives, which guide the work around the four priority areas of focus and support implementation of the virtual hub include:

- Connecting with community stakeholders across the region
- Learning about and identifying relevant community resources and sharing ideas for community health improvement
- Focusing our work in community data
- Collaborating with a diverse network of partners to conduct outreach, education, and connect at at-risk or in-need community members to critically necessary community supports

Details around these guiding aims can be found in the full HPHD CHIP Implementation Plan, located in Appendix 4.

HPHD will share both the CHIP report and Implementation Plan with locality partners to obtain buy-in and support for community health improvement efforts on the Peninsula. It is critical that HPHD meets the needs of the community, as well as community stakeholders, and align how the work will be done. While HPHD will be the coordinator and convener of this work, the CHIP is a community health improvement plan, not an agency plan. Therefore, HPHD is committed to accountable community collaboration to achieve improved health outcomes in the four priority areas of focus.

An Invitation

In this report, we have identified and prioritized focus areas for community health improvement. Within our defined role as your local public health agency, we are committed to working collaboratively with our community to identify and address specific health challenges. We invite you to act for health improvement in your sphere of influence, whether it be your home, neighborhood, school, workplace, or other community setting. We also invite you to view the Hampton and Peninsula Health Districts as your partners in health improvement. As a starting point, we will be pleased to talk with your local organization or group to discuss community health needs, ideas, and strategies for community health improvement. For more information, please contact us at 757-594-7300 or visit our website at https://www.vdh.virginia.gov/hampton-peninsula/.

Thank you for creating a healthier community!

Moving the CHA Towards a CHIP
HPHD CHIP Timeline

September – October 2022
BEGIN CHIP PLANNING PROCESS

- Outline preliminary planning process – completed
- Identify community partners / VDH leadership for Steering Committee – completed
- Develop CHIP outline – in progress

November 2022
CHIP STEERING COMMITTEE OUTREACH & DEVELOPEMENT

- Finalize PH 3.0 Workgroup Charter – completed 11/14/22
- Begin recruiting partners for Steering Committee – Email sent 11/14/22
- Meet with Dr. Landen to identify meeting outline and process – completed 11/2/22

December – January 2023
RECAP COMMUNITY CHIP PRIORITIZATION

- Complete Steering Committee and begin recapping data – completed
- Hold 1st Steering Committee meeting, at PHD, in early – mid Dec – completed 12/15
  (1st meeting = introductions, buy-in process, meeting outline and expectations)
- Develop presentation on identified CHA priority health concerns for **Jan**. meeting – Community Health EPI

January – February 2023

- Hold 2nd Steering Committee meeting in Jan. – completed 1/24

`

February 2023 – March 2023
CHIP WORKGROUP RECRUITMENT

- Hold 3rd Steering Committee meeting in Feb. – completed 2/16
  (3rd meeting = Identify ground rules; initial CHIP priority discussion; data review)
- Note: Mental Health & Community Violence = priority areas of focus
- Begin recruiting participants for priority CHIP workgroups

March 2023
CHA/CHIP PRESENTATION

- Hold 4th Steering Committee meeting in Mar. – completed 3/29
  (4th meeting = Identify and define top 3-4 priority focus areas; next steps; future meeting frequency & timeline)
- Conduct deep quantitative data dive for chosen priorities.
- Presented CHA/CHIP priorities to JCC CPMT – March 20
- Presented CHA/CHIP priorities to Hampton CPMT – March 23
- Created and purchased CHA/CHIP cards for community distribution

CHIP workgroups – *1st meeting to be held May / June (Conduct issues and solutions assessment on defined priorities; determine goals, objectives, and strategies)*

April - June 2023
CHIP WORKGROUP DEVELOPMENT
**Use April to develop materials, identify consultant, provide additional data, and share current projects/initiatives

- Present CHA/CHIP Priorities to ALL HPHD staff – April 26, 2023.
- Populate CHIP Workgroups – staff, CBO partners, and SC appointed representative – completed June 1, 2023
- Hire external facilitator for CHIP Workgroups – completed May 11, 2023 (Community Health Solutions)
- Identify expectations, deliverables, needs and resources for Workgroup activities – meeting held on June 8, 2023
- CHIP Workgroup Kickoff meeting #1 – **June 28, 2023 @ PHC**

July – September 2023

- Develop process and outcome metrics for CHIP Workgroups
- Update Steering Committee on CHIP Workgroup progress and next steps – completed 8/4
- Plan for next in-person CHIP Workgroup meeting #2 – meeting held on September 20, 2023 @ WHF

June 2023 – November 2023

CHIP Workgroup Meeting and Activity Schedule				
June	**Jun-Jul-Aug**	**September**	**Sep-Oct-Nov**	**November**
Meetings (In-Person or Virtual)	Activities (Virtual)	Meetings (In-Person or Virtual)	Activities (Virtual)	Meetings (Virtual or In-Person)

Inform Steering Committee, via email, of CHIP Workgroup progress

October - November 2023
CHIP ACTION PLANS

- CHIP Workgroups to complete strategic Action Plans for priory areas
- CHIP Workgroup in-person meeting #3 (to be held in Hampton) – **Nov. 30, 3-4:30pm**

December 2023
PROCESS EVALUATION

- CHIP Workgroup Member process survey
- Update CHIP Report

January 2024
CHIP IMPLEMENTATION

- Review CHIP Workgroup Action Plan Summary Report and workgroup member survey responses with Core Group
- Extension of CHS contract for CHIP Implementation Task Group consultant services
- Preparation for reconvening SC to provide insight, guidance, and additional support for implementation efforts

February 2024

CHIP STEERING COMMITTEE RECONVENED AND IMPLEMENTATION TASK GROUPS FORMED

- **5th Steering Committee meeting @ new PHC** (2/5/24) **–** 1-hour meeting – Dr. Landen to facilitate; SC to review Action Plans, provide additional implementation strategies, partner suggestions, brainstorm resources, encourage member to share with management on joint movement/how to proceed, etc.
- Outreach and identification of community partners for CHIP Implementation Task Groups
- Draft CHIP report due to EMT for review – 2/7/24; Final approval by 2/28/24

March - May 2024
CHIP IMPLEMENTAITON CONTINUED

- CHIP Implementation Task Group meetings: 3/7/2024; 3/28/2024; 4/18/2024
- HPHD CHIP Implementation Plan – Summary Version & Priority Area Plans – 4/25/2024
- CHIP Core Group Evaluation Plan
- CHIP Report – final approval

June - August 2024
SPRING INTO THE STRATEGIC PLAN

- Internal resource assessment, recruitment, etc.
- Continue search for funding and apply
- Bring the CHIP and our plans to the community, stakeholders, and locality partners
- Begin Strategic Plan process

HPHD WILL REPEAT CHA/CHIP PROCESS EVERY THREE YEARS IN ALIGNMENT WITH HEALTH PLANNING PROCESSES

*Appendix 2: **HPHD CHIP Workgroup Process Survey: Summary Report***

HPHD Community Health Improvement Workgroup Process Survey

13	20:48	Active
Responses	Average time to complete	Status

1. How would you rate your involvement in the CHI action planning process?

Very involved (attended almost ...	7
Somewhat involved (attended a...	3
A little involved (attended a cou...	3
Not very involved (attended less...	0

2. What were your primary reasons for being somewhat or very involved in the CHI action planning process?

10 Responses

Latest Responses

"*To hear the needs of the communities and also to provide feedback as t...*

"*I wanted to be able to help with the process of community involvement ...*

3. What prevented you from being more involved in the CHI action planning process?

13 Responses

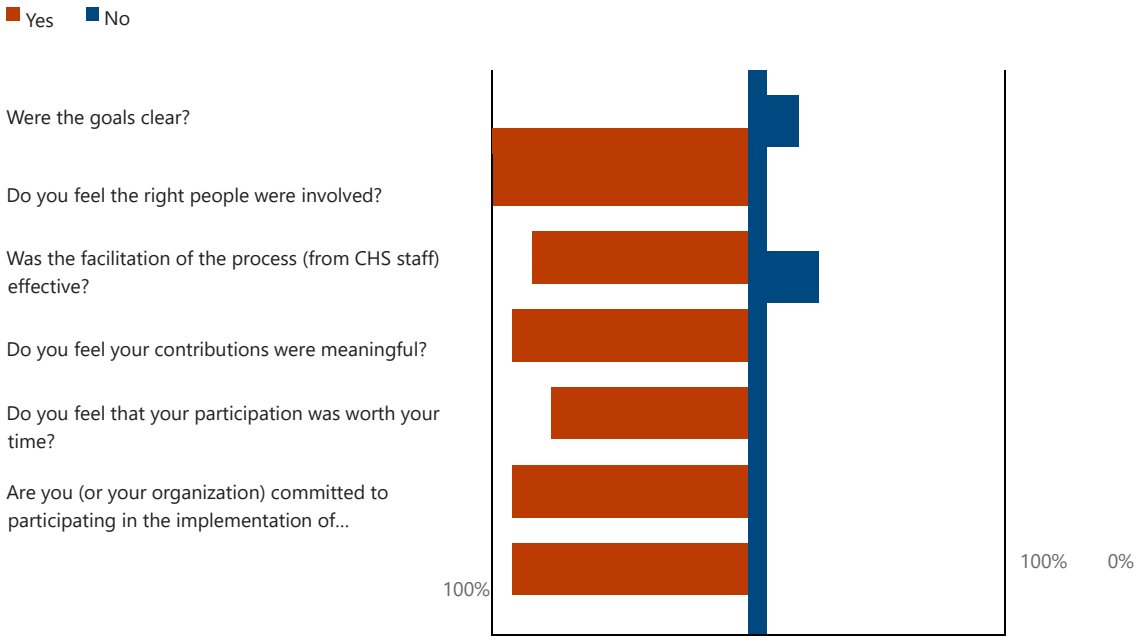
Latest Responses

"*Work schedule and workload*"

"*I missed one session because I was out sick with COVID. *"

"*Travel*"

1. Please give your opinion for the following questions as they relate to the Community Health Improvement Action Planning process.



5. Comments regarding your responses provided in question 4:

13

Responses

Latest Responses

"*None*"

"*I do not feel as if the health department staff (aside from those directly ...*

"*Still not sure of next steps and how I can contribute* "

6. What do you think went well during the CHI action planning process?

13

Responses

Latest Responses

"*Hearing what resources are available as well as seeing what folks are d...*

"*explaining how the health department would use the data to better out...*

"*Networking and learning about various stakeholders* "

1. What do you think should be done differently during the next CHI action planning process?

Latest Responses

13

Responses

"*Nothing*"

"*upfront clarity of the purpose of the meetings. I felt as though the meeti...*

"*More concrete plan and implementation* "

2. What factors, assets, or attributes of our community and/or of the local public health system do you believe will support implementation of the Community Health Improvement Plan?

Latest Responses

13

Responses

"*None*"

"*focusing our health department staff and resources on what the CHA h...*

"*Stakeholder involvement; build on existing programs* "

---

3. What challenges do you think we will have in implementing the Community Health Improvement Plan?

Latest Responses

13

Responses

"*Collaboration will always be a challenge and so we need to be cognosce...*

"*Health department staff involvement should be mandated to ensure tha...*

"*Lack of community involvement; building on what works currently* "

---

4. What ideas do you have for sustaining the efforts in implementing the Community Health Improvement Plan and repeating the process for the next cycle in 2025?

Latest Responses

13

Responses

"*None*"

"*Health department RN's to do community health screenings and aware...*

"*Focus on specific Evidence based interventions; apply for grants* "

CHIP Workgroup:
Action Planning Summary Report

December 8, 2023

Submitted to Hampton and Peninsula Health Districts by Community Health Solutions

1.0 Introduction

This report presents summary results of the action planning process undertaken by the CHIP Workgroup with staff support from Hampton and Peninsula Health Districts and Community Health Solutions.

- This Section (1.0) describes the action planning aims and process.
- Section 2.0 describes the rationale and components of the recommended core strategy, which is focused on supporting collaborative action through virtual community collaboration hubs.
- Section 3.0 presents draft action plans for each of the four focus areas, including: firearm violence, heart disease, infant mortality, and substance use.
- Appendix A lists CHIP Workgroup members by Action Planning Group.
- Appendix B provides an initial, provisional list of prospective community partners as identified by Action Planning Group members.
- Appendix C shows an initial set of ideas for regional collaboration as suggested by Action Planning Group members.
- Appendix D provides a set of driver diagrams for each of the four focus areas.

Report Outline

1.1 Action Planning Focus

The CHIP Workgroup is focused on developing a series of Community Health Improvement Plans for each of four community health concerns:

- **Firearm Violence** (indicator for measurement = firearm violence death rate)
- **Heart Disease** (indicator for measurement = heart disease death rate)
- **Infant Mortality** (indicator for measurement = infant mortality death rate)
- **Substance Use** (indicator for measurement = drug overdose death rate)

Members of the CHIP Workgroup are listed in **Appendix A**.

1.2 Action Planning Process

To facilitate action planning, each of the four focus areas outlined above was assigned to an **Action Planning Group**. The work of initial action planning was completed over a six-month period from June through November of 2023. This work was supported with:

- Coordination by Hampton and Peninsula Health Districts staff;
- Research and facilitation support by Community Health Solutions; and
- An online planning hub managed by Community Health Solutions.

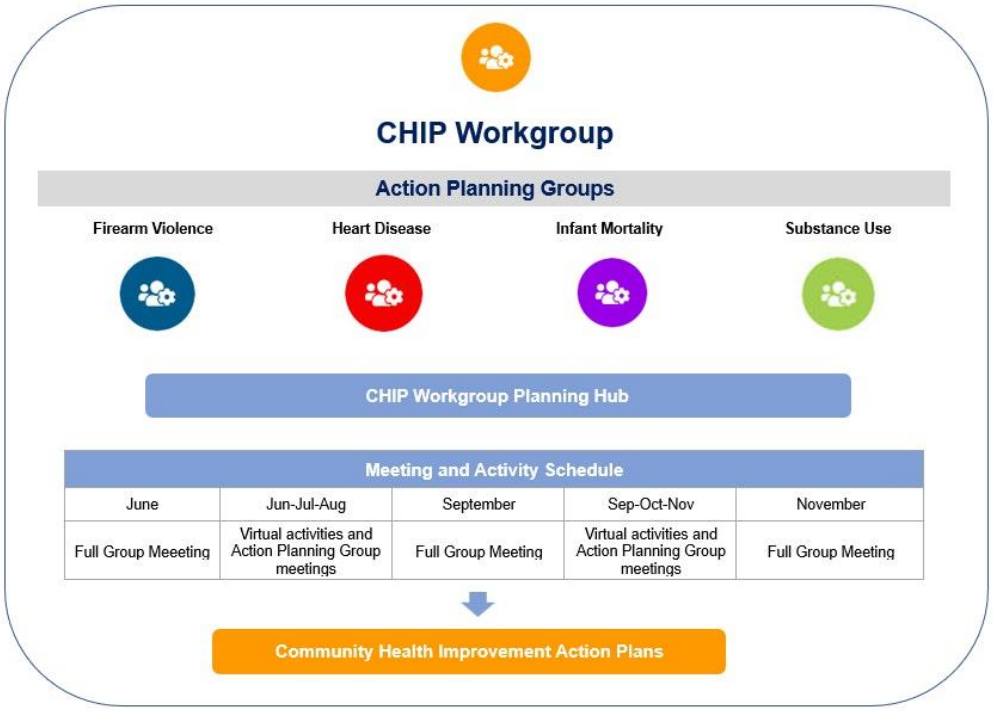
With these supports in place, each Action Planning Group was asked to:

- Participate in virtual group meetings and activities between full group meetings.
- Review evidence-based data, promising practices research, and other meeting materials to support the development of action planning process.
- Share insights and ideas to guide the action-planning process.
- Review and refine draft versions of community health improvement action plans for each of the four topic areas.

This work was accomplished through a series of action planning meetings as outlined in **Exhibit 1**. As shown:

- Three full-group meetings were held in June, September, and November.
- Each Action Planning Group held two virtual meetings between the full-group meetings.
- Staff provided research, materials, and facilitation in support of each meeting.

Exhibit 1
The Action Planning Process



2.0 Core Strategy Recommendation

This section describes a core strategy recommendation for community health improvement. As background, subsections 2.1 to 2.3 describe considerations for making choices, a set of driver diagrams, and a concept for a 'first-up initiative' approach. Subsection 2.4 presents the core strategy recommendation.

Section Outline	
2.1	Considerations for Making Choices
2.2	Driver Diagrams
2.3	A 'First Up Initiative' Approach
2.4	First-Up Initiative: Collaborative Action through Community Collaboration Hubs

2.1 Considerations for Making Choices

Community action planning typically requires choice-making to select which community initiatives to pursue from among multiple options. The CHIP Workgroup and the Action Planning Groups considered multiple factors in the process of selecting a focus for action. These considerations included the following

Four focus areas. The action plan would have to address each of four focus areas in some fashion. Firearm violence, heart disease, infant mortality, and substance are all important community issues. Each could be addressed through a comprehensive community approach with its own theory of change, intervention strategy, and set of objectives.

Six localities. The action plan would have to reach across six localities, including four cities (Hampton, Newport News, Poquoson, and Williamsburg), and two counties (James City and York). Each of these localities has a distinctive community culture and infrastructure. While some localities have a substantial history of collaboration, collaboration across all six would require significant efforts to build mutual understanding, relationships, and connections.

Community assets. The Action Planning Groups identified dozens of community organizations and programs that are working to address various aspects of firearm violence, heart disease, infant mortality, and substance use. All of these entities represent assets that could be mobilized to address community needs. It was also recognized that these organizations may not be fully aware of each other's scope of work and capabilities, and there is value in fostering mutual awareness of community partners working across the region.

Community data. The Action Planning Groups reviewed community data sets that indicate areas of need across the four topic areas. It was also acknowledged that readily available data sets are not adequate to support small-area analysis of risk at the zip code or census tract level. It may be possible to produce more granular community data through partnerships between public health and various community organizations, but this will require some capacity building over time.

Commitment to health equity. All of the planning partners share the commitment to advance health equity through community health improvement. The work of health equity requires deep understanding of people and populations at the neighborhood level, which in turn requires both data and dialog to develop deeper insights for designing community interventions.

Scope of intervention. In considering community needs and possibilities, it became apparent that the scope of intervention could include elements of early detection of risk, community-based prevention strategies, and strategies to facilitate access to treatment. These strategies would need to be differentiated across the four focus areas.

Evidence on 'what works.' As part of the planning process the four action planning groups reviewed the published evidence on 'what works' (promising practices, evidence-informed practices, evidence-based practices). The evidence review was conducted by staff with a focus on community-based interventions more so than primarily clinical or legal interventions. The results suggest that collaborating to identify at-risk populations and connect people to existing resources can be a logical starting point for community action. As these collaborative connections are built, there is potential to discover gaps in community supports that could be addressed through creation or expansion of community supports.

Project LEAD and Collective Impact. In the course of researching promising practices, Project LEAD was identified as a promising initiative already at work in the region. As background:

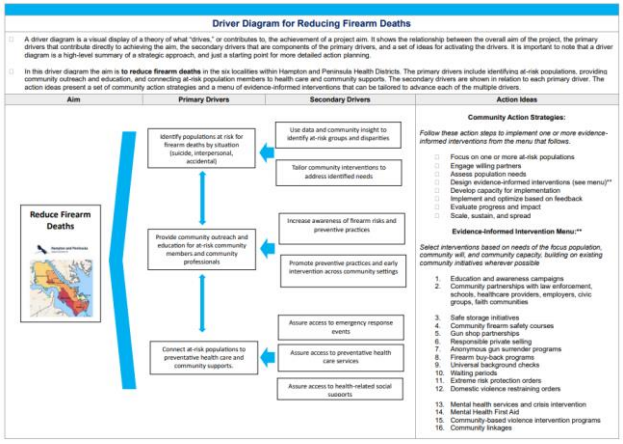
> **Project LEAD**, is substance use disorder and opioid response program by the Hampton & Peninsula Health Districts (HPHD). Project LEAD's mission is to reduce opioid overdose deaths, beginning in the Cities of Hampton and Newport News, where the age-adjusted opioid overdose death rates are much higher than that of the Commonwealth of Virginia. Project LEAD aims to accomplish this objective through several methods, all of which support HPHD's vision to have the healthiest cities and counties in the state. Project LEAD's strategies include Linkages, Education, Awareness, and Data.

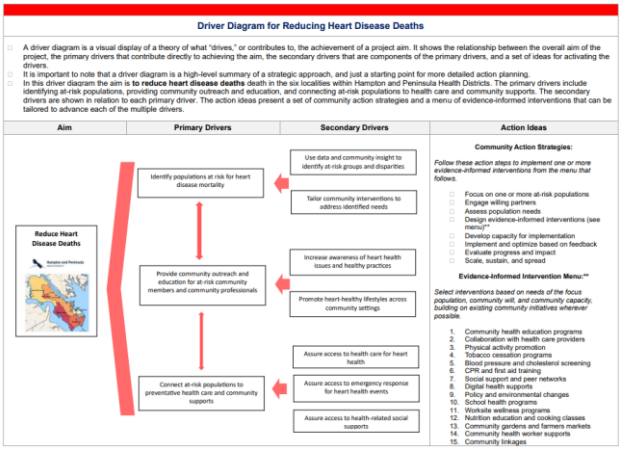
Among other reasons, Project LEAD is distinctive for its community-collaborative approach of bringing community partners together for learning and action. In concept, Project LEAD also reflects some elements of the **Collective Impact** model which is widely known and implemented in communities across the United States.

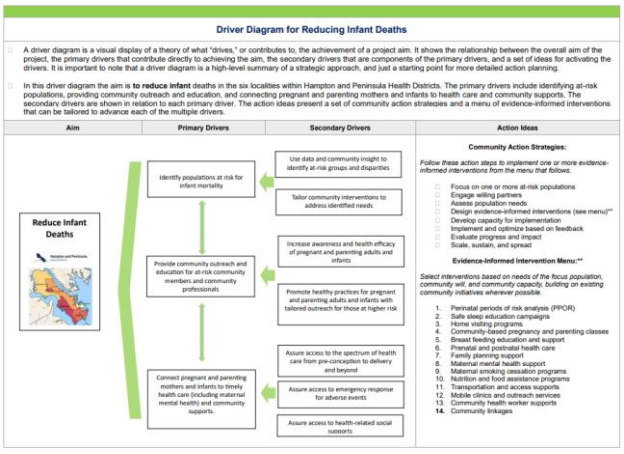
2.2 Driver Diagrams.

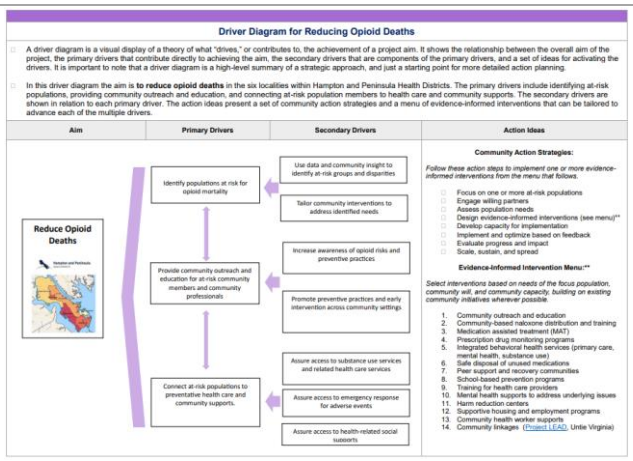
To bring additional focus to the planning process, the considerations outlined in Section 2.1 were incorporated into a set of four 'driver diagrams', one for each of the four topic areas. Thumbnails of the driver diagrams are shown in **Exhibit 2**, and the actual diagrams are provided in **Appendix C**.

Exhibit 2
Driver Diagrams
(see Appendix D for details)









A driver diagram is a visual display of a theory of what "drives," or contributes to, the achievement of a project aim. It shows the relationship between the overall aim of the project, the primary drivers that contribute directly to achieving the aim, the secondary drivers that are components of the primary drivers, and a set of ideas for activating the drivers.

As also noted earlier, the research behind the driver diagrams was focused on community-based interventions more so than purely clinical or legal approaches. Keeping this community focus in mind, note that in each of the driver diagrams, the primary drivers include identifying at-risk populations, optimizing community outreach and education, and connecting at-risk individuals to community supports.

2.3 A 'First Up Initiative' Approach

A common challenge in community action planning is choosing from among many deserving community intervention strategies while also recognizing constraints on resources and bandwidth of community partner organizations. This challenge was certainly present for the Action Planning Groups as they considered choices for what could work across four distinctive topic areas and six localities. In this scenario it is difficult to prioritize based on the health merits of different initiatives, because they all have merit to some degree. From a practical perspective, it is also important to consider what is feasible in the short-term, mid-term, and long-term horizon.

One way to break through this dilemma and get started on community action is to consider the possibilities for 'first up initiatives.' As a working definition:

- *A **'first-up initiative' is one that addresses a real community need and is probably feasible to implement within a one-to-three-year timeframe. In using the phrase 'first-up', we are not implying that other initiatives are not important or should not be implemented. We are acknowledging that not every possible initiative can be resourced and implemented all at once, and it can be helpful to start with a focused set of initiatives that are relevant and feasible. Additional initiatives such as new services or program expansions can be implemented over time*.**

2.4 First-Up Strategy: Collaborative Action through Community Collaboration Hubs

Given the considerations for making choices outlined in Section 2.1, and also considering the possibilities for a 'first up initiative' as outlined in section 2.2, the Action Planning Groups explored the possibilities for an approach that would focus on building community connections for collaborative action. This strategy is outlined in **Exhibit 2** on the following page, and further explained below.

Note that the strategies outlined in **Exhibit 2** would be new for firearm violence, heart disease, and infant mortality. The strategies for substance use would involve continuation of the **Project LEAD** strategies that are already underway.

The **core strategy** would be collaborative action through community collaboration hubs. The **focus areas** would include firearm violence, heart disease, infant mortality, and substance use.

The **Year 1 objectives** would include focusing on a 'first-up' initiative for collaborative community action, and supporting this initiative with linkages, education, awareness, and data.

- The **first-up initiatives** would focus on identifying at-risk populations, providing community outreach and education, and connecting at-risk populations to health care and community supports.

- **Linkages** would be created and facilitated through one or more **community collaboration hubs**. These would be virtual hubs that would use collaboration software to facilitate the work of bringing people together for collaborative learning and action. The community collaboration hub for substance use already exists with Project LEAD, Letting form follow function, the community collaboration hubs for firearm safety, heart disease, and infant mortality could be based separately or combined depending on community interest and capacity.

- **Education** would be focused on educating, engaging, and equipping community-based organizations (CBOs) and public agency partners with information, data, and tools for the first-up initiative.

- **Awareness** would be focused on working together to raise community awareness and connect at-risk community members to available supports.

- **Data** would be focused on developing and disseminating community data sets to community partners, to help them identify at-risk populations and support community outreach.

The **startup action steps for Year 1** would focus on engaging partners to host the virtual community collaboration hubs, and then supporting community organizations in the work of identifying at-risk populations, conducting community outreach and education, and connecting community members to health care and other community supports. An initial, provisional list of prospective partners identified by Action Planning Group members is provided in **Appendix B**.

The **Year 2 objectives** would involve continuation of the work begun in Year 1, with additional supports to help partner CBOs and public agencies connect and collaborate on program development. Supports would be open to all, and could possibly include:

- Virtual or physical spaces for people to meet
- Training and tools for program planning, evaluation, and resource development
- Data sharing to support program development and evaluation

Exhibit 2
CHIP Action Planning Strategic Outline:
Collaborative Action for Community Health Improvement

Strategic Approach				
Core Strategy	The core strategy would be collaborative action for community health improvement, facilitated through one or more community collaboration hubs. This strategy recognizes that collaborative action can be effective for assuring optimal use of existing community resources and creating additional strategies to fill gaps where needed. The strategy would adapt concepts from Project LEAD and Collective Impact with a practical focus on a 'first-up' initiative that is needed and feasible within a one-to-three-year time horizon.			
Focus Areas	**Firearm Violence**	**Heart Disease**	**Infant Mortality**	**Substance Use**
Guiding Aims	Reduce Firearm Deaths	Reduce Heart Disease Deaths	Reduce Infant Deaths	Reduce Opioid Deaths
Community Reach	Hampton James City County Newport News Poquoson Williamsburg York County	Hampton James City County Newport News Poquoson Williamsburg York County	Hampton James City County Newport News Poquoson Williamsburg York County	Hampton James City County Newport News Poquoson Williamsburg York County
Year 1 Action Objectives				
Focus on a "First-Up' Initiative from Driver Diagram	Primary Drivers: Identify populations at risk for firearm violence Provide community outreach and education Connect at-risk populations to health care and community supports	Primary Drivers: Identify populations at risk for heart disease mortality Provide community outreach and education Connect at-risk populations to health care and community supports	Primary Drivers: Identify populations at risk for infant mortality Provide community outreach and education Connect at-risk populations to health care and community supports	Continue Project LEAD strategies
	Note: The suggested approach is to focus on addressing the primary drivers within each driver diagram. These drivers would be tailored to each initiative, but they each would involve some form of data sharing, community outreach and education, and connecting community members to available resources. These drivers could be logical starting points for 'first up' initiatives because they would benefit from community collaboration and need not require substantial resource investment from partner CBOs and public agencies.			

Exhibit 2 CHIP Action Planning Strategic Outline: Collaborative Action for Community Health Improvement				
Create Community Linkages	Create a virtual community collaboration hub for all CBOs and public agencies interested in reducing firearm violence and deaths	Create a virtual community collaboration hub for all CBOs and public agencies interested in improving heart health and reducing heart disease deaths	Create a virtual community collaboration hub all CBOs and public agencies interested in improving maternal & infant health and reducing infant deaths	Continue Project LEAD strategies
	Note: Linkages would be created and facilitated through one or more **community collaboration hubs**. These would be virtual hubs that would use collaboration software to facilitate the work of bringing people together for collaborative learning and action. The community collaboration hub structure for substance use already exists with Project LEAD. Letting form follow function, the community collaboration hubs for firearm safety, heart disease, and infant mortality could be based separately or combined depending on community interest and capacity.			
Educate, Engage, and Equip Partners	Educate, engage, and equip CBO and public agency partners with information, data, and tools for the first-up initiative	Engage and equip CBO and public agency partners with information, data, and tools for the first-up initiative	Engage and equip CBO and public agency partners with information, data, and tools for the first-up initiative	Continue Project LEAD strategies
Raise Community Awareness	Work together to raise community awareness and connect at-risk community members to available supports	Work together to raise community awareness and connect at-risk community members to available supports	Work together to raise community awareness and connect at-risk community members to available supports	Continue Project LEAD strategies
Share Community Data	Develop and disseminate community data sets to help identify at-risk populations and support community outreach	Develop and disseminate community data sets to help identify at-risk populations and support community outreach	Develop and disseminate community data sets to help identify at-risk populations and support community outreach	Continue Project LEAD strategies
Startup Action Steps for Year 1				
To Accomplish Year 1 Objectives	1. Convene Year 1 development team 2. Develop vision statements 3. Engage partners to host virtual community collaboration hubs 4. Identify and engage prospective funders as needed 5. Develop and implement virtual community collaboration hubs 6. Engage community stakeholders as hub partners and advisors 7. Develop data resources 8. Identify at-risk populations across the region 9. Equip hub partners with tools and strategies for providing community outreach and education 10. Encourage hub partners to connect at-risk populations to health care and community supports			Continue program planning and development for Project LEAD
Year 2 Action Objectives				
Support Collaborative Community Innovation	Provide collaborative spaces, training, tools, and data to help partner CBOs and public agencies connect and collaborate to create, scale, or spread effective programs and supports across the region. Supports would be open to all, and could possibly include: - Virtual or physical spaces for people to meet - Training and tools for program planning, evaluation, and resource development - Data sharing to support program development and evaluation			

3.0 Year 1 Action Plans

The proposed approach for community health improvement is to apply the core strategy outlined in Section 2.0 to each of the four focus areas. The strategy would be applied in a tailored fashion to recognize the functional differences involved in addressing firearm violence, heart disease, infant mortality, and substance. But each would pursue the fundamental strategy of developing a 'first-up' initiative supported with community linkages, education, awareness, and data.

Action Plan Exhibits	
Exhibit 3	Firearm Violence
Exhibit 4	Heart Disease
Exhibit 5	Infant Mortality
Exhibit 6	Substance Use

Exhibits 3 through 6 show draft year 1 action plans for each focus area. Each action plan is divided into four main sections:

- Aim and Community Reach
- Core Strategy
- Year 1 Action Objectives
- Year 1 Action Steps
- Action Planning Group Ideas

Note that the key action step for each initiative is the creation of a **virtual community collaboration hub** within an appropriate organizational home. These organizational homes have not been identified as yet, and this would be a top priority for development in the year 1 action plan. As guidance for development, it may be helpful to consider:

- As described earlier, letting form follow function, the community collaboration hubs for firearm safety, heart disease, and infant mortality could be based separately or combined depending on community interest and capacity.

- The basic function of a hub would be to provide a central point of connection and communication for community partners interested in working together on identifying at-risk populations, conducting community outreach and education, and connecting community members to community resources.

- Software can be a key asset for engaging, connecting, and supporting community partners at an efficient cost. There are multiple software options for enabling this type of strategy in a cost-effective manner.

- Staffing of a community collaboration hub can also be managed cost-effectively if the hub is based within an organization that is already working in the realm of community collaboration. This creates possibilities for leveraging staff support from existing positions within the host organization as well as other community partners, thereby enabling a cost-efficient staffing model.

- Potential funding streams for a community collaboration hub can also be varied. A guiding principle is that organizations that have a mission-driven interest in supporting community collaboration may also have an interest in partnering to fund a hub, house a hub, or both. Without speaking for any particular organization, foundations, health systems, and managed care organizations all have compelling interests in supporting community collaboration to some degree.

- As a final note, each of the draft action plans shown in the exhibits includes a list of creative startup ideas shared by Action Planning Group members. These include ideas for:

    - Community populations to be included in outreach;
    - Community partners to be engaged in community collaboration;
    - Conducting community outreach and education;
    - Connecting community members to community supports; and
    - Possibilities for regional collaboration across city and county lines.

Exhibit 3
Year 1 Action Plan for Firearm Violence

A. Aim and Community Reach

Guiding Aim	☐ Reduce Firearm Deaths
Community Reach	☐ Hampton | James City County | Newport News | Poquoson | Williamsburg | York County

B. Core Strategy

☐ The core strategy would be collaborative action for community health improvement.

☐ This strategy recognizes that collaborative action can be effective for assuring optimal use of existing community resources and creating additional strategies to fill gaps where needed.

☐ The strategy would adapt concepts from Project LEAD and Collective Impact with a practical focus on a 'first-up' initiative that is needed and feasible within a one-to-three-year time horizon.

C. Year 1 Action Objectives

Focus on a 'First-Up' Initiative from Driver Diagram	☐ Identify populations at risk for firearm violence ☐ Provide community outreach and education for at-risk community members ☐ Connect at-risk populations to health care and community supports
Create Community Linkages	☐ Create a virtual community collaboration hub for CBOs and public agencies interested in reducing firearm violence and deaths
Educate, Engage, and Equip Partners	☐ Educate, engage, and equip CBO and public agency partners with information, data, and tools for the first-up initiative
Raise Community Awareness	☐ Work together to raise community awareness and connect at-risk community members to available supports
Share Community Data	☐ Develop and disseminate community data sets to help identify at-risk populations and support community outreach

D. Year 1 (2024) Action Steps

11. Convene Year 1 development team
12. Develop vision statement
13. Engage partner to host virtual community collaboration hub
14. Identify and engage prospective funders as needed
15. Develop and implement virtual community collaboration hub
16. Engage community stakeholders as hub partners and advisors
17. Develop data resources
18. Identify at-risk populations across the region
19. Equip hub partners with tools and strategies for providing community outreach and education
20. Encourage hub partners to connect at-risk populations to health care and community supports

E. Action Planning Group Ideas

Who would be among the key community populations to make sure we reach?

- Elder males
- High schoolers
- Hunting groups
- New gun owners
- New parents or parents (young kids, teens)
- Recent parolees/prisoners
- Veterans

Who would be among the key community partners to engage?

- DV shelters
- EMS
- Halfway homes
- Hampton Family Violence Council
- Homeless shelters
- Hospital/ER
- HPHD
- Perinatal Mental Health Coalition of Virginia
- Police
- Public schools and universities
- Sheriff's Department
- Transitions Family Violence Services
- VDH

What would be some creative ideas for collaborative outreach and education?

- Gun stores
- Military bases
- Pawn stores
- Safe storage education
- School groups

What would be some creative ideas for connecting community members to community supports?

- Attending events and/or festivals
- Unite Us
- Using social media

What would be some possibilities for regional collaboration?

- Annual community events/weeks highlighting youth violence prevention
- Collaborate locally to 'recognize' National Youth Violence Week (held annually in April)
- Collaboration for trauma informed care wherever violence happens (i.e., Child Savers)
- Education-based Gun Safety Day - police departments, local schools
- Firearm safety training (all localities)
- Suicide (attempt) follow-up counselors in hospitals (all localities)

Exhibit 4
Year 1 Action Plan for Heart Disease

A. Aim and Community Reach

Guiding Aim	☐ Reduce Heart Disease Deaths
Community Reach	☐ Hampton | James City County | Newport News | Poquoson | Williamsburg | York County

B. Core Strategy

☐ The core strategy would be collaborative action for community health improvement.

☐ This strategy recognizes that collaborative action can be effective for assuring optimal use of existing community resources and creating additional strategies to fill gaps where needed.

☐ The strategy would adapt concepts from Project LEAD and Collective Impact with a practical focus on a 'first-up' initiative that is needed and feasible within a one-to-three-year time horizon.

C. Year 1 Action Objectives

Focus on a 'First-Up' Initiative from Driver Diagram	☐ Identify populations at risk for heart disease mortality ☐ Provide community outreach and education for at-risk community members ☐ Connect at-risk populations to health care and community supports
Create Community Linkages	☐ Create a virtual community collaboration hub for CBOs and public agencies interested in reducing heart disease mortality
Educate, Engage, and Equip Partners	☐ Educate, engage, and equip CBO and public agency partners with information, data, and tools for the first-up initiative
Raise Community Awareness	☐ Work together to raise community awareness and connect at-risk community members to available supports
Share Community Data	☐ Develop and disseminate community data sets to help identify at-risk populations and support community outreach
Share Community Data	☐ Develop and disseminate community data sets to help identify at-risk populations and support community outreach

D. Year 1 (2024) Action Steps

11. Convene Year 1 development team
12. Develop vision statement
13. Engage partner to host virtual community collaboration hub
14. Identify and engage prospective funders as needed
15. Develop and implement virtual community collaboration hub
16. Engage community stakeholders as hub partners and advisors
17. Develop data resources
18. Identify at-risk populations across the region
19. Equip hub partners with tools and strategies for providing community outreach and education
20. Encourage hub partners to connect at-risk populations to health care and community supports

E. Action Planning Group Ideas

Who would be among the key community populations to make sure we reach?

- Families at risk
- Individuals with multiple health conditions
- Underserved communities

Who would be among the key community partners to engage?

- Community Health Workers
- Hospitals, health clinics, and urgent care facilities
- Organizations that serve at-risk populations
- Primary Care Providers

What would be some creative ideas for collaborative outreach and education?

- Employer wellness (especially for large employers), incentives?
- Human services
- Organizations and agencies
- Pharmacy pharmacies
- Schools - P.E. Health
- SHIP in WJCC schools

What would be some creative ideas for connecting community members to community supports?

- Health fairs
- Hotline and resource guides
- Mobile education
- Social Media as a preventative method

What would be some possibilities for regional collaboration?

- Cross jurisdictional survey distribution to continue the needs assessment
- JCC, Williamsburg and York: Educational Outreach for Stroke Prevention (F.A.S.T.)
- Social Services community health initiative

Exhibit 5
Year 1 Action Plan for Infant Mortality

A. Aim and Community Reach	
Guiding Aim	☐ Reduce Infant Deaths
Community Reach	☐ Hampton | James City County | Newport News | Poquoson | Williamsburg | York County

B. Core Strategy

☐ The core strategy would be collaborative action for community health improvement.

☐ This strategy recognizes that collaborative action can be effective for assuring optimal use of existing community resources and creating additional strategies to fill gaps where needed.

☐ The strategy would adapt concepts from Project LEAD and Collective Impact with a practical focus on a 'first-up' initiative that is needed and feasible within a one-to-three-year time horizon.

C. Year 1 Action Objectives	
Focus on a 'First-Up' Initiative from Driver Diagram	☐ Identify populations at risk for infant mortality ☐ Provide community outreach and education for at-risk community members ☐ Connect at-risk populations to health care and community supports
Create Community Linkages	☐ Create a virtual community collaboration hub for CBOs and public agencies interested in reducing infant mortality
Educate, Engage, and Equip Partners	☐ Educate, engage, and equip CBO and public agency partners with information, data, and tools for the first-up initiative
Raise Community Awareness	☐ Work together to raise community awareness and connect at-risk community members to available supports
Share Community Data	☐ Develop and disseminate community data sets to help identify at-risk populations and support community outreach

D. Year 1 (2024) Action Steps

11. Convene Year 1 development team
12. Develop vision statement
13. Engage partner to host virtual community collaboration hub
14. Identify and engage prospective funders as needed
15. Develop and implement virtual community collaboration hub
16. Engage community stakeholders as hub partners and advisors
17. Develop data resources
18. Identify at-risk populations across the region
19. Equip hub partners with tools and strategies for providing community outreach and education
20. Encourage hub partners to connect at-risk populations to health care and community supports

E. Action Planning Group Ideas

Who would be among the key community populations to make sure we reach?

- African American
- Low-income
- Non-English speakers
- Pregnant and new moms
  Refugees

Who would be among the key community partners to engage?

- CHW's
- Health Dept. - (at all advantage) 1. immunizations, 2. refugees, 3. MCH, 4. Hispanic population, 5. Low-income families
- Infant mortality - WIC, MCH programs, HCP

What would be some creative ideas for collaborative outreach and education?

- CHWs
- Health care systems teach patients about safe sleep practices, screening for services/needs

What would be some creative ideas for connecting community members to community supports?

- Collaborative grants
- Really make an effort to go out into the community to provide services

What would be some possibilities for regional collaboration?

- Fatherhood Program
- Motherhood Program

Exhibit 6
Year 1 Action Plan for Substance Use

Draft Action Plan

A. Aim and Reach

Guiding Aim	☐ Reduce Opioid Deaths
Community Reach	☐ Hampton | James City County | Newport News | Poquoson | Williamsburg | York County

B. Core Strategy

☐ The core strategy would be collaborative action for community health improvement.

☐ This strategy recognizes that collaborative action can be effective for assuring optimal use of existing community resources and creating additional strategies to fill gaps where needed.

☐ The strategy would continue the work of Project LEAD based on current strategic plans.

C. Year 1 Action Objectives

Focus on a 'First-Up' Initiative from Driver Diagram	☐ Continue Project LEAD strategies
Create Community Linkages	☐ Continue Project LEAD strategies
Educate, Engage, and Equip Partners	☐ Continue Project LEAD strategies
Raise Community Awareness	☐ Continue Project LEAD strategies
Share Community Data	☐ Continue Project LEAD strategies

D. Year 1 (2024) Action Steps

Continue with planned strategies for Project LEAD

E. Action Planning Group Ideas

Who would be among the key community populations to make sure we reach?

- EMS - other relations
- Family members
- PWUD
- Rehabs

Who would be among the key community partners to engage?

- EMS
- Hospitals
- Rehabs

What would be some creative ideas for collaborative outreach and education?

- Community events health fairs
- DARE - School education
- Rotational staff for community partners

What would be some creative ideas for connecting community members to community supports?

- Funding opportunities for collaborative partners

What would be some possibilities for regional collaboration?

- Awareness Fairs
- Data sharing
- Mobile Units
- Pop up events
- Regional Coalition
- Regional Summit

Appendix A
CHIP Workgroup Members

HPHD CHIP Workgroup Roster - FINAL

HPHD Community Health Improvement Workgroup Members			
Workgroup / Member Name	*Member Affiliation*	*Phone #*	*Member Email*
Substance Use | *Indicator for Measurement = Drug overdose death rate*			
Adam Hess	HPHD	757-617-0540	adam.hess@vdh.virginia.gov
Audra Kennedy	HPHD	757-594-7812	audra.kennedy@vdh.virginia.gov
Denise Kirshbaum	JCC DSS		denise.kirschbaum@jamescitycountyva.gov
Nikki Bacilio-High	HNNCSB	757-788-0002	nbacilio@hnncsb.org
Dr. Shanea Brown	Hampton University	757-371-9730	shanea.Brown@hamptonu.edu
Jan Brown	SpiritWorks Foundation	757-871-5279	jan@spiritworksfoundation.org
Firearm Violence | *Indicator for Measurement = Firearm related death rate*			
Mary Hudnall	HPHD	(757)594-7386	mary.hudnall@vdh.virginia.gov
Clarity Cotman	HPHD	757-817-4988	clarity.cotman@vdh.virginia.gov
Elaine Nelson	HPHD	757-728-2170	elaine.nelson@vdh.virginia.gov
Leigh Jacques	HPHD	757-727-3237	leigh.jacques@vdh.virginia.gov
Sandra McMasters	Sentara	530-355-6834	smmcmast@sentara.com
Tony Dallman	JCC Police		tony.dallman@jamescitycountyva.gov
LaKeisha Brooks-Tyson	Enduring Keys, Inc.	757-231-5852	information@enduringkeysinc.org
Dr. Michael Landen	VDH	804-461-0736	michael.landen@vdh.virginia.gov
Infant Mortality | *indicator for measurement = infant mortality death rate*			
Tes La Dieu	HPHD	757-594-7411	taylor.ladieu@vdh.virginia.gov
Keenya Crumpton	HPHD	(757) 594-7426	keenya.crumpton@vdh.virginia.gov
Leeanna Lanciault	HPHD	757-594-7259	leeanna.lanciault@vdh.virginia.gov
Michelene Minapace	Smart Beginnings	757-777-5720	mmenapace@smartbeginningsvp.org
Paul Scott	Child Development Resources	757-566-3300	pauls@cdr.org
Peighton Terrill	CHKD	757-751-7324	peighton.terrill@chkd.org
Jenny Landen	VCU	505-501-9883	annburksJL@gmail.com
Heart Disease | *indicator for measurement = heart disease death rate*			
Ashanti Perrish	HPHD	757-594-7437	ashanti.perrish@vdh.virginia.gov
Corey Bruce	HPHD	757-594-7271	corey.bruce@vdh.virginia.gov
Alyson Wilkinson	HPHD	804-840-4554	a.wilkinson@vdh.virginia.gov
Debbie Campbell	Riverside	757-534-7071	debbie.campbell@rivhs.com
Kelly Metcalf-Meese	Williamsburg Health Foundation	757-345-0912	kmetcalfmeese@williamsburghealthfoundation.org
Easha Juma	Peninsula Agency on Aging	757-933-2612	easha.juma@paainc.org
Aaron Thompson	Old Towne Med. Center	757-259-3275	aaron.thompson@jamescitycountyva.gov

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Appendix B
Prospective Community Partners

Note: The following list was identified by CHIP Workgroup members during the September 20 working session. This is an initial list and not presented as a comprehensive inventory of prospective community partners.

Organization	Firearm Violence	Heart Disease	Infant Mortality	Substance Use
(HII) Shipyard		x		
3E Restorations				x
4 Oaks				x
American Heart Association		x		
Avalon				x
Bacon Street				x
Ben's Friends				x
Boys and Girls Clubs	x			
CDR			x	
Churches			x	
Colonial Behavioral Health				x
Community Clinics		x		
Community Coordinated Response Team	x			
Community Corrections				x
Community Foundation				x
Community Health Workers		x		
Courts				x
Early Impact Virginia			x	
EMS				x
Faith-Based Organizations		x		x
First Spark (Smart Beginning)	x		x	
Food Banks			x	x
Hampton City Government	x			
Hampton Family Violence Council	x			
Hampton Healthy Families	x			
Hampton New News CSB	x			x
Hampton VA				x
Hand-in-Hand	x			
Healthy Families (Home Visitation)			x	
Heart Specialist		x		
HELP				x
Historic Triangle Drug Prevention Coalition				x
Home Visitation Programs			x	
Homeless Shelters	x			
Hopeful Hampton	x			
Hospital ER	x			
Hospitals			x	
Hospitals (Mother Baby Units)			x	
House of Mercy				x
HPHD			x	
Insurance Companies (Case Coordinator, Case Mgmt)		x		
James City County DSS				x
Lackey SEVHS			x	
LGBT Life Center	x			
Link				x
Local Chambers				x

Organization	Firearm Violence	Heart Disease	Infant Mortality	Substance Use
Local Departments of Social Services				x
Local Healthcare Systems / Hospitals		x		x
Local Law Enforcement				x
MASS - Minority AIDS Support Services	x			
MAT Providers (nonprofit & for-profit)				x
Medical Center			x	
NAMI	x			
Newport News Hispanic Advisory Council			x	
Non-English-Speaking Communities				x
NRA	x			
OB Offices			x	
Opioid Response Network				x
PCOR Coalitions				x
Places Offering CPR Classes		x		
Project Link				x
Public Schools			x	
Public Schools			x	
Recovery Center				x
Recovery Houses				x
Red Cross		x		
Riverside Mental Health				x
Salvation Army	x			x
School Systems	x			
Schools				x
Sleep Tight Hampton Roads			x	
Social Services			x	
Social Workers		x		
South Eastern Family Project				x
Spirit Works				x
Transitions Family Violence Services	x			
Universities / Higher Ed		x		x
Urgency of Now	x			
Veterans Affairs	x			
Virginia Department of Health		x		
WIC			x	
Women's Violence Shelters			x	
YMCA	x			
York Poquoson DSS				x
Youth Violence Prevention Week	x			
YWCA	x			

Appendix C
Ideas for Regional Collaboration

Note: The following list was identified by CHIP Workgroup members during the September 20 working session. This is an initial list and not presented as a comprehensive inventory of prospective ideas.

Firearm Violence
Annual community events/weeks highlighting youth violence prevention
Collaborate locally to 'recognize' *National Youth Violence Week* (held annually in April)
Collaboration for trauma informed care wherever violence happens (i.e., Child Savers)
Education-based *Gun Safety Day* - police departments, local schools
Firearm safety training (all localities)
Suicide (attempt) follow-up counselors in hospitals (all localities)
Heart Disease
Cross jurisdictional survey distribution to continue the needs assessment
JCC, Williamsburg and York: Educational Outreach for Stroke Prevention (F.A.S.T.)
Social Services community health initiative
Infant Mortality
Fatherhood Program
Motherhood Program
Substance Use
Awareness Fairs
Data sharing
Mobile Units
Pop up events
Regional Coalition
Regional Summit

Driver Diagram for Reducing Firearm Deaths

- A driver diagram is a visual display of a theory of what "drives," or contributes to, the achievement of a project aim. It shows the relationship between the overall aim of the project, the primary drivers that contribute directly to achieving the aim, the secondary drivers that are components of the primary drivers, and a set of ideas for activating the drivers. It is important to note that a driver diagram is a high-level summary of a strategic approach, and just a starting point for more detailed action planning.

- In this driver diagram the aim is **to reduce firearm deaths** in the six localities within Hampton and Peninsula Health Districts. The primary drivers include identifying at-risk populations, providing community outreach and education, and connecting at-risk population members to health care and community supports. The secondary drivers are shown in relation to each primary driver. The action ideas present a set of community action strategies and a menu of evidence-informed interventions that can be tailored to advance each of the multiple drivers.

Aim	Primary Drivers	Secondary Drivers	Action Ideas

Reduce Firearm Deaths

Identify populations at risk for firearm deaths by situation (suicide, interpersonal, accidental)

Use data and community insight to identify at-risk groups and disparities

Tailor community interventions to address identified needs

Provide community outreach and education for at-risk community members and community professionals

Increase awareness of firearm risks and preventive practices

Promote preventive practices and early intervention across community settings

Connect at-risk populations to preventative health care and community supports.

Assure access to emergency response events

Assure access to preventative health care services

Assure access to health-related social supports

Community Action Strategies:

Follow these action steps to implement one or more evidence-informed interventions from the menu that follows.

- Focus on one or more at-risk populations
- Engage willing partners
- Assess population needs
- Design evidence-informed interventions (see menu)**
- Develop capacity for implementation
- Implement and optimize based on feedback
- Evaluate progress and impact
- Scale, sustain, and spread

Evidence-Informed Intervention Menu:**

Select interventions based on needs of the focus population, community will, and community capacity, building on existing community initiatives wherever possible

1. Education and awareness campaigns
2. Community partnerships with law enforcement, schools, healthcare providers, employers, civic groups, faith communities

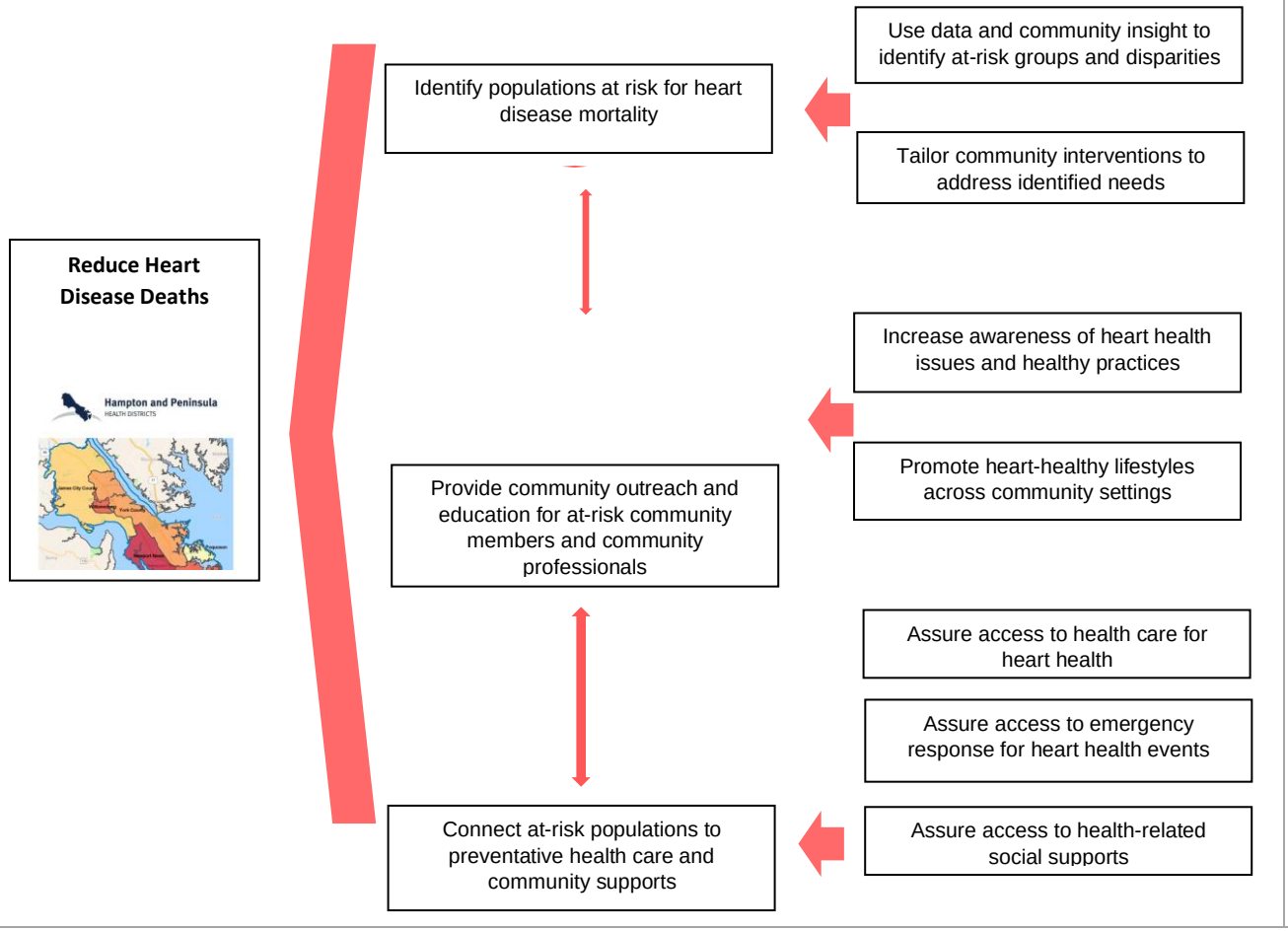
3. Safe storage initiatives
4. Community firearm safety courses
5. Gun shop partnerships
6. Responsible private selling
7. Anonymous gun surrender programs
8. Firearm buy-back programs
9. Universal background checks
10. Waiting periods
11. Extreme risk protection orders
12. Domestic violence restraining orders

13. Mental health services and crisis intervention
14. Mental Health First Aid
15. Community-based violence intervention programs
16. Community linkages

Driver Diagram for Reducing Heart Disease Deaths

- A driver diagram is a visual display of a theory of what "drives," or contributes to, the achievement of a project aim. It shows the relationship between the overall aim of the project, the primary drivers that contribute directly to achieving the aim, the secondary drivers that are components of the primary drivers, and a set of ideas for activating the drivers.
- It is important to note that a driver diagram is a high-level summary of a strategic approach, and just a starting point for more detailed action planning.
- In this driver diagram the aim is **to reduce heart disease deaths** death in the six localities within Hampton and Peninsula Health Districts. The primary drivers include identifying at-risk populations, providing community outreach and education, and connecting at-risk populations to health care and community supports. The secondary drivers are shown in relation to each primary driver. The action ideas present a set of community action strategies and a menu of evidence-informed interventions that can be tailored to advance each of the multiple drivers.

Aim	Primary Drivers	Secondary Drivers	Action Ideas



Community Action Strategies:

Follow these action steps to implement one or more evidence-informed interventions from the menu that follows.

- Focus on one or more at-risk populations
- Engage willing partners
- Assess population needs
- Design evidence-informed interventions (see menu)**
- Develop capacity for implementation
- Implement and optimize based on feedback
- Evaluate progress and impact
- Scale, sustain, and spread

Evidence-Informed Intervention Menu:**

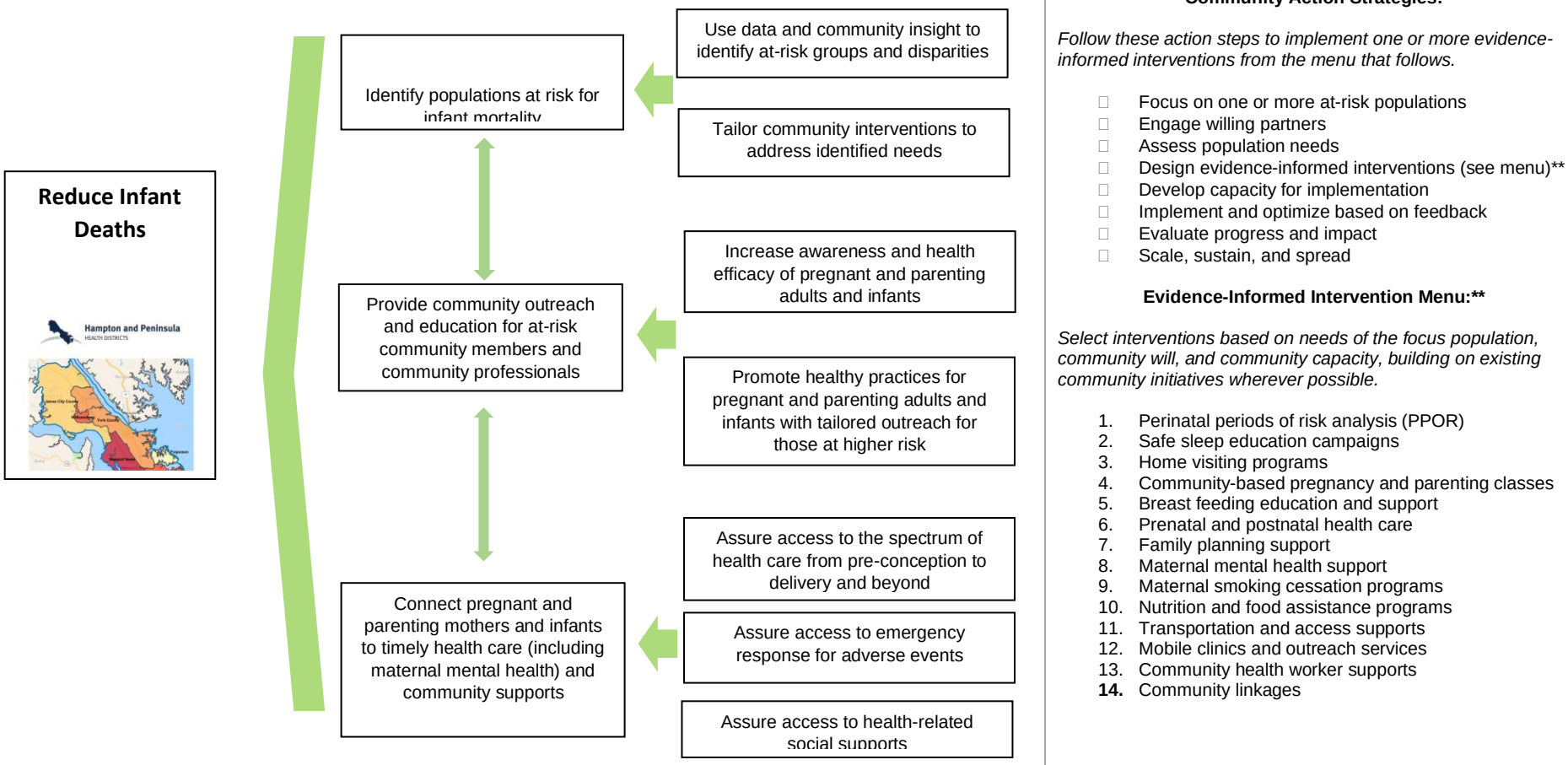
Select interventions based on needs of the focus population, community will, and community capacity, building on existing community initiatives wherever possible.

1. Community health education programs
2. Collaboration with health care providers
3. Physical activity promotion
4. Tobacco cessation programs
5. Blood pressure and cholesterol screening
6. CPR and first aid training
7. Social support and peer networks
8. Digital health supports
9. Policy and environmental changes
10. School health programs
11. Worksite wellness programs
12. Nutrition education and cooking classes
13. Community gardens and farmers markets
14. Community health worker supports
15. Community linkages

Driver Diagram for Reducing Infant Deaths

- A driver diagram is a visual display of a theory of what "drives," or contributes to, the achievement of a project aim. It shows the relationship between the overall aim of the project, the primary drivers that contribute directly to achieving the aim, the secondary drivers that are components of the primary drivers, and a set of ideas for activating the drivers. It is important to note that a driver diagram is a high-level summary of a strategic approach, and just a starting point for more detailed action planning.

- In this driver diagram the aim is **to reduce infant** deaths in the six localities within Hampton and Peninsula Health Districts. The primary drivers include identifying at-risk populations, providing community outreach and education, and connecting pregnant and parenting mothers and infants to health care and community supports. The secondary drivers are shown in relation to each primary driver. The action ideas present a set of community action strategies and a menu of evidence-informed interventions that can be tailored to advance each of the multiple drivers.



Community Action Strategies:

Follow these action steps to implement one or more evidence-informed interventions from the menu that follows.

- Focus on one or more at-risk populations
- Engage willing partners
- Assess population needs
- Design evidence-informed interventions (see menu)**
- Develop capacity for implementation
- Implement and optimize based on feedback
- Evaluate progress and impact
- Scale, sustain, and spread

Evidence-Informed Intervention Menu:**

Select interventions based on needs of the focus population, community will, and community capacity, building on existing community initiatives wherever possible.

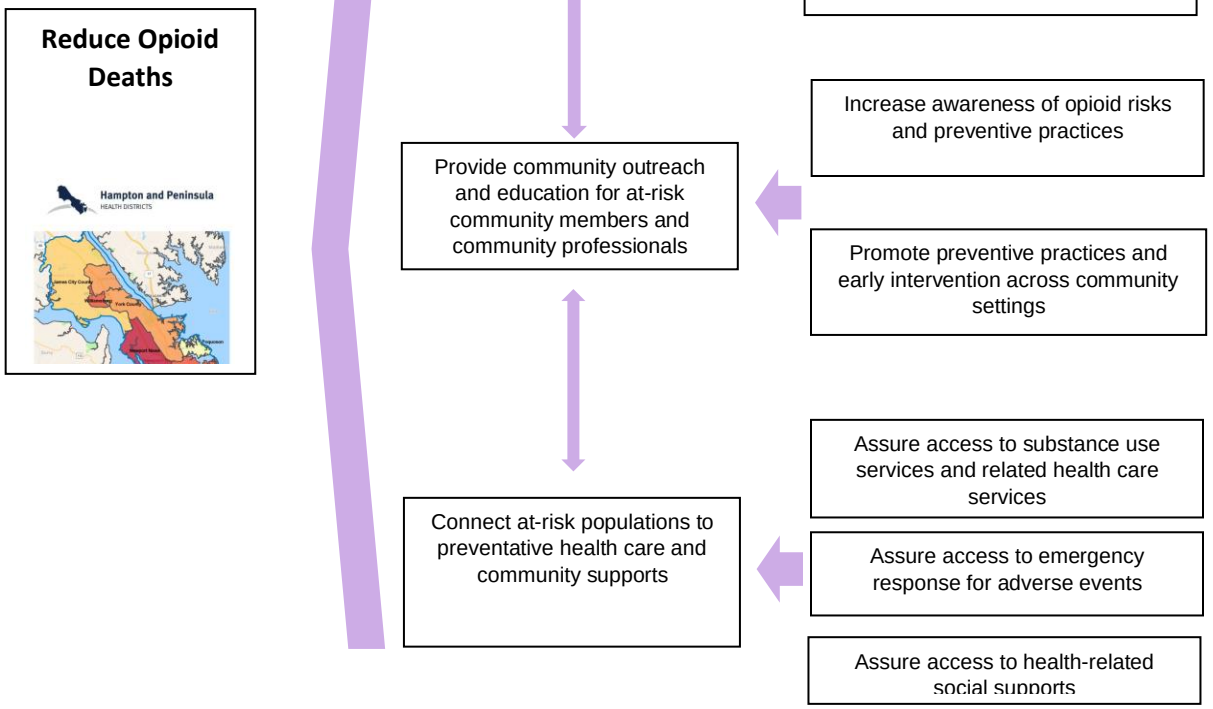
1. Perinatal periods of risk analysis (PPOR)
2. Safe sleep education campaigns
3. Home visiting programs
4. Community-based pregnancy and parenting classes
5. Breast feeding education and support
6. Prenatal and postnatal health care
7. Family planning support
8. Maternal mental health support
9. Maternal smoking cessation programs
10. Nutrition and food assistance programs
11. Transportation and access supports
12. Mobile clinics and outreach services
13. Community health worker supports
14. Community linkages

Driver Diagram for Reducing Opioid Deaths

- A driver diagram is a visual display of a theory of what "drives," or contributes to, the achievement of a project aim. It shows the relationship between the overall aim of the project, the primary drivers that contribute directly to achieving the aim, the secondary drivers that are components of the primary drivers, and a set of ideas for activating the drivers. It is important to note that a driver diagram is a high-level summary of a strategic approach, and just a starting point for more detailed action planning.

- In this driver diagram the aim is **to reduce opioid deaths** in the six localities within Hampton and Peninsula Health Districts. The primary drivers include identifying at-risk populations, providing community outreach and education, and connecting at-risk population members to health care and community supports. The secondary drivers are shown in relation to each primary driver. The action ideas present a set of community action strategies and a menu of evidence-informed interventions that can be tailored to advance each of the multiple drivers.

Aim	Primary Drivers	Secondary Drivers	Action Ideas



Community Action Strategies:

Follow these action steps to implement one or more evidence-informed interventions from the menu that follows.

- Focus on one or more at-risk populations
- Engage willing partners
- Assess population needs
- Design evidence-informed interventions (see menu)**
- Develop capacity for implementation
- Implement and optimize based on feedback
- Evaluate progress and impact
- Scale, sustain, and spread

Evidence-Informed Intervention Menu:**

Select interventions based on needs of the focus population, community will, and community capacity, building on existing community initiatives wherever possible.

1. Community outreach and education
2. Community-based naloxone distribution and training
3. Medication assisted treatment (MAT)
4. Prescription drug monitoring programs
5. Integrated behavioral health services (primary care, mental health, substance use)
6. Safe disposal of unused medications
7. Peer support and recovery communities
8. School-based prevention programs
9. Training for health care providers
10. Mental health supports to address underlying issues
11. Harm reduction centers
12. Supportive housing and employment programs
13. Community health worker supports
14. Community linkages (Project LEAD, Untie Virginia)

Appendix 4: HPHD CHIP Implementation Plan

Summary Version – 4.25.24

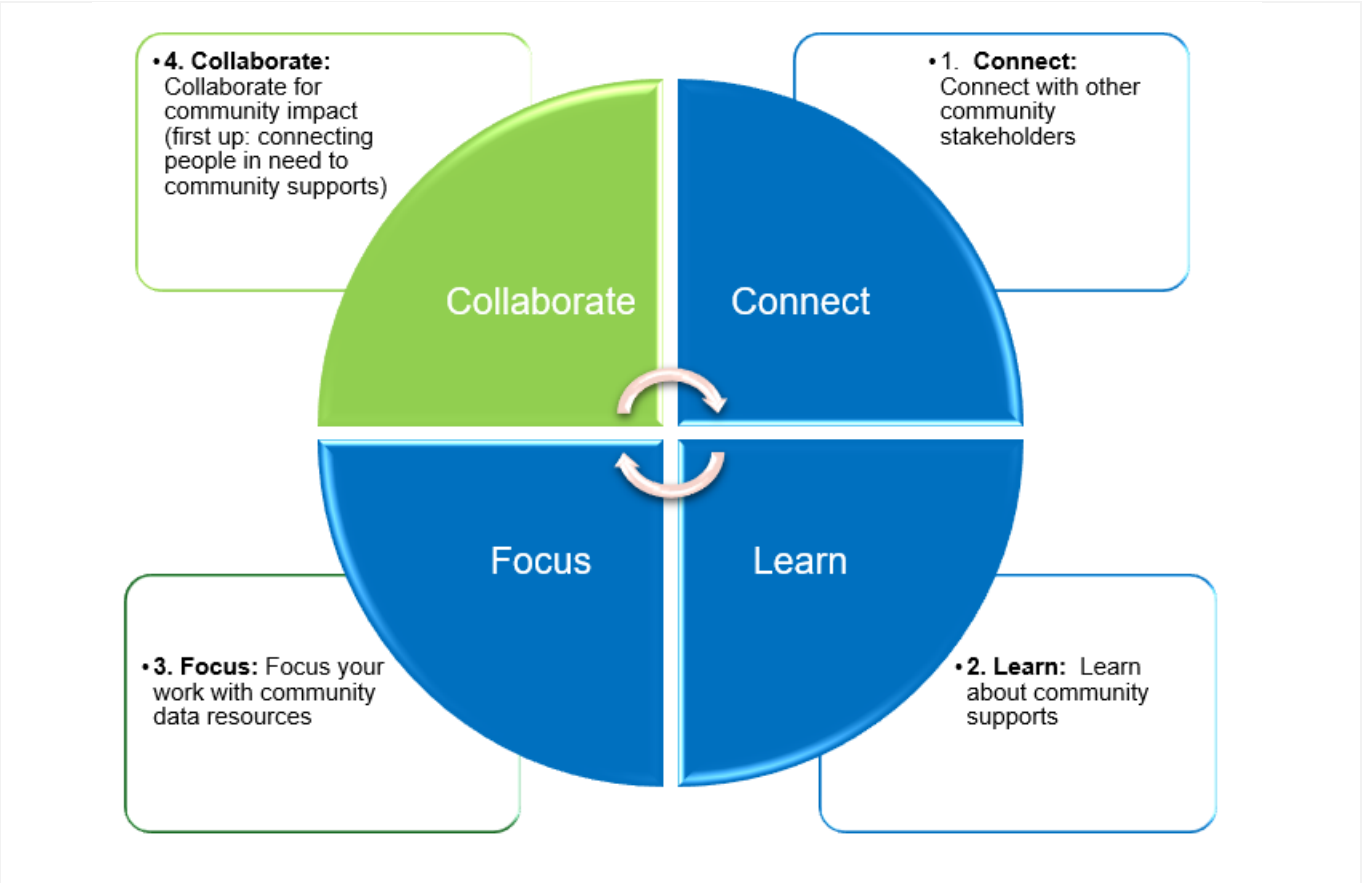
A. Priority Areas	Firearm Violence	Heart Disease	Infant Mortality	Substance Use
Guiding aims	Prevent firearm deaths	Prevent heart disease deaths	Prevent infant deaths	Prevent drug overdose deaths
B. Year 1 Goal				
Create a single **Community Collaboration Hub** as a virtual space where community organizations can connect, learn, focus, and collaborate:	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
Connect with other community stakeholders	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
Learn about community resources and ideas	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
Focus their work with community data	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
Collaborate for community outreach, education, and connecting at-risk or in-need community members to community supports	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
C. Year 1 Performance Measures				
1. Number of community stakeholder organizations engaged as members of the Community Collaboration Hub	20+ Y1	20+ Y1	20+ Y1	20+ Y1
2. Activation of a 'first-up' collaborative effort to help in-need or at-risk community members understand and utilize community supports	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
3. Inventory of supportive activities and resources shared with stakeholders as part of the first-up initiative	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
4. Description of in-need or at-risk populations targeted as part of the first-up initiative	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
5. Description of stakeholder activities conducted to reach, educate, and refer in-need or at-risk populations to available community resources	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
6. Quantification of reach, or estimates of how many in-need or at-risk population members were served through the first-up initiative, by locality	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
7. Begin planning at least one additional community initiative beyond the 'first-up' initiative	Y1 (planning)	Y1 (planning)	Y1 (planning)	Y1 (planning)
D. Year 1 SMART Objective				
Specific. Foster and support collaboration among community organizations, with an initial focus on collaboration to connect people in need of community supports.	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
Measurable. Engage at least 20 community organizations (public or private sector) in a virtual community collaboration hub, and foster measurable gains in mutual awareness, data capacity, and collaborative efforts for community outreach and referral.[1]	20+ Y1	20+ Y1	20+ Y1	20+ Y1
Achievable. Base the community collaboration hub at HPHD with startup accomplish in Q1 (July-Sept). No cost or resource requirements for participating community organizations.	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
Relevant. The community impact strategy is to address primary drivers by identifying populations in need or at risk, providing community outreach and education, and connecting in-need or at-risk individuals to health care and community supports.	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
Time-bound. This first-up objective will be accomplished during Year 1, with quarterly development objectives.	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
E. Implementation Objectives				
1. Implement the virtual Collaboration Hub at VDH (Years 1, continuing)	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
2. Engage target minimum of 20 community stakeholder organizations from across the six-locality region in Year 1; expand in Years 2-5.	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
3. As a 'first-up' initiative, launch a collaborative effort to help in-need or at-risk community members understand and utilize community supports (Years 1 and 2)	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
4. Facilitate stakeholder connection and learning through webinars and interaction through the virtual Collaboration Hub (Years 1-5)	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
5. Facilitate stakeholder focus by developing and sharing community data sets that identify in-need or at-risk populations. (Years 1-5)	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing
6. Develop additional community initiatives (by or before Years 2-5, contingent on stakeholder interest and resource feasibility)	Y1 ongoing	Y1 ongoing	Y1 ongoing	Y1 ongoing

CHIP Implementation Workplan

Firearm Violence

04.25.24

Contents	



CHIP Implementation Plan Draft: Firearm Violence

A. Priority Area

Firearm Violence was initially chosen as a priority area in consultation with community stakeholders during the HPHD CHA / CHIP process conducted in 2022 into 2023. The guiding aim is to prevent firearm deaths.

B. Goal

During **Phase I Implementation Planning in 2023**, HPHD facilitated further consultation with community stakeholders through a CHIP Planning Workgroup. As a result of this community-guided work, the chosen implementation strategy is to create a virtual **Community Collaboration Hub for Firearm Violence**. The Community Collaboration Hub will be a virtual space where community organizations can:

- **Connect** with other community stakeholders interested in reducing firearm violence
- **Learn** about community resources and ideas for preventing firearm violence
- **Focus** their work with community data about populations in need or at risk for firearm injury
- **Collaborate** to:
  - Help in-need or at-risk community members understand and utilize community supports during Years 1 and 2
  - Develop additional collaborative initiatives for preventing firearm violence by or before Years 3-5

C. Performance Measures

Demonstrate in this section how you will know you are making progress. State specifically what you will measure to determine whether changes have occurred. Select indicators of progress for both the short term (1-2 years) and long term (3-5 years). Specify the data source you will use for those indicators (or your plan to develop a measurement system if necessary).

Performance Measures	**Year 1**	**Years 2-5**
1. Number of community stakeholder organizations engaged as members of the Community Collaboration Hub.	Begin	continue
2. Activation of a 'first-up' collaborative effort to help in-need or at-risk community members understand and utilize community supports for firearm violence prevention (Years 1 and 2)	Begin	continue
3. Inventory of supportive activities and resources shared with stakeholders as part of the first-up initiative.	Begin	continue
4. Description of in-need or at-risk populations targeted as part of the first-up initiative.	Begin	continue
5. Description of stakeholder activities conducted to reach, educate, and refer in-need or at-risk populations to available community resources.	Begin	continue
6. Quantification of reach, or estimates of how many in-need or at-risk population members were served through the first-up initiative, by locality.	Begin	continue
7. Activation of at least one additional community initiative beyond the 'first-up' initiative	Year 1 planning Year 2 implementation	

D. First-Up (Year 1) SMART Objective

A Year 1 SMART objective for preventing firearm deaths is described below. This first-up objective will create a foundation for additional objectives to be added over time.

Specific	• Foster and support collaboration among community organizations interested in reducing firearm violence, with an initial focus on collaboration to connect people in need to community supports for preventing firearm deaths.
Measurable	• Engage at least 20 community organizations (public or private sector) in a virtual community collaboration hub, and foster measurable gains in mutual awareness, data capacity, and collaborative efforts for community outreach and referral. [1]
Achievable	• Base the community collaboration hub at HPHD with startup accomplish in Q1 (July-Sept). No cost or resource requirements for participating community organizations.
Relevant	• Referencing the driver diagram, the guiding aim is to reduce firearm deaths. • The community impact strategy is to address primary drivers by identifying populations in need or at risk, providing community outreach and education, and connecting in-need or at-risk individuals to health care and community supports. • The enabling implementation strategy is to create a community collaboration hub where community organizations can efficiently develop collaborative relationships while also receiving data supports and idea supports. • This initial work to foster community connections for collaboration will provide an essential foundation for developing additional initiatives over time.
Time-bound	• This first-up objective will be accomplished during Year 1, with quarterly development objectives.

E. Implementation Objectives

Describe the specific measurable end-products of your intervention. Objectives should be SMART: specific, measurable, achievable, realistic, and time-framed.

Implementation Objectives	Year 1	Years 2-5
1. Implement the virtual Collaboration Hub at VDH (Years 1-5)	Implement	Continue
2. Engage target minimum of 20 community stakeholder organizations from across the six-locality region in Year 1; expand in Years 2-5. (See **Appendix 2** for prospective partner list).	Implement	Continue
3. As a 'first-up' initiative, launch a collaborative effort to help in-need or at-risk community members understand and utilize community supports for firearm violence prevention (Years 1 and 2) (See ideas for populations, collaboration, and data in **Appendix 3**.)	Implement	Continue
4. Facilitate stakeholder connection and learning through webinars and interaction through the virtual Collaboration Hub (Years 1-5)	Implement	Continue
5. Facilitate stakeholder focus by developing and sharing community data sets that identify in-need or at-risk populations. (Years 1-5)	Implement	Continue
6. Begin planning to develop additional community initiatives for preventing firearm deaths (by or before Years 2-5, contingent on stakeholder interest and resource feasibility)	Year 1 planning Year 2 implementation	

F. Workplan

This section describe the workplan for achieving each of the implementation objectives listed in Section E.

Objective 1. Implement the virtual Collaboration Hub at VDH (Year 1, Q1, ongoing)

Background

The virtual Collaboration Hub is intended to facilitate community collaboration based on principles of the **collective impact framework**. (https://collectiveimpactforum.org/). The published literature on collective impact identifies five elements that are essential for supporting community collaboration: 1) A common agenda, 2) Shared measurement, 3) Mutually reinforcing activities, 4) Continuous communications, and 5) Strong background.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
1.1 Transfer Mighty Networks software to HPHD	May-July 2024	• Staff time • Software	• HPHD Lead • CHS support	HPHD owns software subscription	
1.2 Train HPHD staff to manage software	May-July 2024	• Staff time • Software	• HPHD Lead • CHS support	HPHD staff ready to manage software	
1.3 Build out workspace for Firearm Violence (Welcome, Connect, Learn, Focus, Collaborate)	May–July 2024	• Staff time • Software	• HPHD Lead • CHS support	Virtual workspace ready to go	
1.4 Post initial learning content, data sets, and collaboration guide for Firearm Violence	May-July 2024 ongoing	• Staff time • Software	• HPHD Lead • CHS support	Virtual workspace ready to go	

Objective 2. Engage target minimum of 20 community stakeholder organizations from across the six-locality region (Year 1, Q1, ongoing)

Background

See background on the collective impact framework under Objective 1. See Appendix 2 for an initial prospective partner list.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
2.1 Identify list of prospective members	May-July 2024	• Staff time • Software	• HPHD Lead • CHS support	List identified	
2.2 Develop communication strategy for prospective members (why, what, how, value of joining)	May-July 2024	• Staff time • Software	• HPHD Lead • CHS support	Communication strategy ready to go	
2.3 Conduct outreach to prospective members (email, telephone, personal, webinars)	Jul - Sep 2024	• Staff time • Software	• HPHD Lead • CHS support	Each target stakeholder is informed and invited	
2.4 Enroll members in virtual Hub	Jul - Sep 2024 ongoing	• Staff time • Software	• HPHD Lead • CHS support	Target of 20 organizations enrolled	

Objective 3. As a 'first-up' initiative, launch a collaborative effort to help in-need or at-risk community members understand and utilize community supports for reducing firearm deaths (Year 1, Q1, ongoing)

Background

This objective will be guided by the list of evidence-informed interventions for community-based outreach and education as listed in the Driver Diagram in Appendix 1.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
3.1 Promote member awareness of populations in-need or at-risk	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members aware	
3.2 Promote member awareness of existing supports for firearm deaths	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members aware	
3.3 Promote member awareness of evidence-informed ideas for reducing firearm deaths	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members aware	
3.4 Encourage members to promote community awareness of firearm death risks and supports	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members take action	

3.5 Encourage members to connect their at-risk / in-need clientele to community supports for reducing firearm violence and firearm deaths	Jul-Sep 2024 ongoing	• Staff time • Software	• Lead HPHD	Members take action	

Objective 4. In support of Objective 3, Facilitate stakeholder connection and learning through webinars and interaction through the virtual Collaboration Hub (Year 1, Q1, ongoing)

Background

This objective will be guided by best practices for developing virtual community networks as recommended Mighty Networks software and other sources of published literature.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
4.1 Welcome members individually and provide a guide for navigating the Hub and connecting with other members	Jul-Sep 2024 ongoing	• Staff time • Software	• Lead HPHD	Members join the Hub and connect with others	
4.2 Communicate with members every two weeks to share content and encourage engagement	Jul-Sep 2024 ongoing	• Staff time • Software	• Lead HPHD	Members are equipped with useful content to support their work	
4.3 Conduct member surveys on topics of interest at least quarterly	Jul-Sep 2024 ongoing	• Staff time • Software	• Lead HPHD	Members share their insights and ideas for optimizing the work	
4.4 Conduct member webinars on topics of interest at least quarterly	Jul-Sep 2024 ongoing	• Staff time • Software	• Lead HPHD	Members come together to share insights and ideas for working together on community outreach, education, and service connections	

Objective 5. In support of Objective 3, facilitate stakeholder focus by developing and sharing community data sets that identify in-need or at-risk populations. (Year 1, Q1, ongoing)

Background

This objective will focus on mining available data to produce concise data sets that can help members focus their work on community outreach, community education, and community connections.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
5.1 Identify community data sources on firearm deaths and related factors from the Virginia Community Health Improvement Data portal and other sources.	Jul-Sep 2024 ongoing	• Staff time • Software	• Lead HPHD	Inventory of relevant community data	

5.2 Query members about types of community data that could help them focus their work for community outreach, community education, and community connections.	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Member insights on types of data that would be helpful for focusing their work	
5.3 Develop community data sets and maps in response to member interests, as feasible.	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Concise, targeted products with data and maps.	
5.4 Deliver community data sets with supporting webinars and guides to help members use the data to focus their work.	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members utilize data products to focus their work.	

Objective 6. Develop additional community initiatives for reducing firearm deaths (Year 1 or Year 2)

Background

This objective will build upon the collective impact framework and the Year 1 work of the Community Collaboration Hub to engage members in exploring additional collaborative initiatives for Year 2 and beyond. See Appendix 3 for some possible ideas.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
6.1 Query members about ideas and level of interest in working on additional collaborative projects in 2025-26	Jan – Jun 2025 ongoing	• Staff time • Software	• HPHD Lead	Members share ideas for additional collaborative initiatives	
6.2 Offer to host and facilitate virtual meetings where members can begin to dialog about possibilities	Jan – Jun 2025 ongoing	• Staff time • Software	• HPHD Lead	Members meet to explore ideas with virtual supports from the Hub	
6.3 Offer to begin developing content and data that could be helpful for envisioning collaborative efforts, and provide those resources through the Hub	Jan – Jun 2025 ongoing	• Staff time • Software	• HPHD Lead	The Hub becomes a source of content and data to support collaborative efforts in Year 2	
6.4 Consider additional support strategies for Year 2 initiatives that the Hub could provide based on ideas emerging from member dialog	Jan – Jun 2025 ongoing	• Staff time • Software	• HPHD Lead	HPHD considers strategies for aligning Hub resources in support of member ideas for Year 2 collaborations	
Note: Also see Objectives 4 and 5 as enabling supports for this objective.					

G. Alignment with State and National Priorities

As of April 2024, the Virginia Department of Health most recent **State Health Assessment** identified a set of priorities including 1) infant mortality; 2) **firearm-related deaths**; 3) obesity; 4) mental health; 5) substance use and drug overdose; and 6) housing, transportation, and economic stability. The CHIP Implementation Plan for HPHD directly aligns with priorities 1, 2, and 5. It also relates to the obesity priority as one causal factor for heart disease.

From a national view, the four priorities areas identified in the HPHD CHIP Implementation Plan align with **Healthy People 2030 Leading Health Indicators** relating to **firearm deaths (homicide and suicide)**, heart disease risk factors (physical activity, blood pressure, smoking), infant deaths, and drug overdose deaths.

In addition, Healthy People 2030 has a **priority focus** on eliminating health disparities and creating equitable opportunities for people to live healthy lives. Core strategies include advancing health equity, increasing health literacy, and addressing social determinants of health in communities across the nation. A cross-cutting aim of the HPHD CHIP Implementation Plan is to engage community organizations in identifying community populations who need help with understanding and access community supports, including help with addressing social determinants that may influence disparities and affect their opportunities for health.

Appendix 2 – Workgroup Member Ideas for Prospective Partners

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Organization	Firearm Violence	Heart Disease	Infant Mortality	Substance Use
#757 Breastfeeds			*	
(HII) Shipyard		*		
3E Restorations				*
4 Oaks		*		*
American Heart Association		*		
Avalon				*
Bacon Street				*
Ben's Friends				*
Black Maternal Health Equity Action Alliance			*	
Boys and Girls Clubs	*			
CDR			*	
Center for Child & Family Services			*	
Churches / Faith Communities	*	*	*	*
Colonial Behavioral Health				*
Community Clinics		*		
Community Health Workers	*	*	*	*
Community Coordinated Response Team	*			
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Community Health Workers		*		
Community Services Boards	*			*
Courts				*
Drive Safe HR			*	
Early Impact Virginia			*	
Eastern Virginia Child Fatality Review Team			*	
EMS	*	*		*
Faith-Based Organizations		*		*
First Spark (Smart Beginning)	*		*	

Food Banks		*	*	*
Hampton City Government	*			
Hampton Family Violence Council	*			
Hampton Healthy Families	*			
Hampton VA				*
Hand-in-Hand	*			
Healthy Families (Home Visitation)			*	
Heart Specialist		*		
HELP				*
Historic Triangle Drug Prevention Coalition				*
Home Visitation Programs		*	*	
Homeless Shelters	*			
Hopeful Hampton	*			
Hospital ER	*			
Hospitals			*	
Hospitals (Mother Baby Units)			*	
House of Mercy		*	*	*
HPHD			*	
Insurance Companies (Case Coordinator, Case Mgmt)		*		
James City County DSS				*
Lackey/SEVHS/Local Clinics		*	*	
LGBT Life Center	*			
Link				*
Local Chambers				*
Local Departments of Social Services				*
Local Healthcare Systems / Hospitals		*		*
Local Law Enforcement				*
MASS - Minority AIDS Support Services	*			
MAT Providers (nonprofit & for-profit)				*
Medical Center			*	
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Recovery Center				*
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Riverside Mental Health				*
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School Systems	*			
Schools				*
Sleep Tight Hampton Roads			*	
Social Services			*	
Social Workers		*		
South Eastern Family Project				*
Spirit Works				*
Transit Hampton				*
Transitions Family Violence Services	*			
United Way		*		
Universities / Higher Ed		*	*	*
Urgency of Now	*			
Veterans Affairs	*	*		
Veterans Groups	*	*		
Virginia Department of Health	*	*	*	*
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Women's Violence Shelters			*	
YMCA	*	*		
York Poquoson DSS				*
Youth Violence Prevention Week	*			
YWCA	*			

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Firearm Violence	**Heart Disease**	**Infant Mortality**	**Substance Use**
Populations. Who are the key community populations that should be reached as part of the effort to connect people in need to available community services?			

• Young adults • Teens • Veterans • Elder males • High schoolers • Hunting groups • New gun owners • New parents or parents (young kids, teens) • Recent parolees/ prisoners • Veterans	• Schools • Community Centers and Recreation Centers • Senior Developments, assisted and independent • Support groups • Community Health Workers and Navigators • Anyone who utilizes the local senior centers, any local churches (especially if they have senior groups), any patients utilizing the free and charitable clinics, any patients with frequent/avoidable hospitalizations for heart-related issues, anyone utilizing the organizations listed in item #3 • Families at risk • Individuals with multiple health conditions • Underserved communities	• Women of child-bearing years. • Pregnant mothers, parents, legal guardians, families, school nurses, school guidance counselors, day care centers, and churches. • African American • Low-income • Non-English speakers • Pregnant and new moms • Refugees	• People returning from incarceration • People with history of SUD • People with unstable housing • People with mental health disorders • People of certain sexual orientations • EMS - other relations • Family members • PWUD • Rehabs
Collaboration. What are some creative ideas for collaborative community outreach?			
• Lock & Talk Va program on lethal means safety. • Gun shops education programs. • Gun stores • Military bases • Pawn stores • Safe storage education • School groups • Attending events and/or festivals • Unite Us • Using social media • Annual community events/weeks highlighting youth violence prevention • Collaborate locally to 'recognize' National Youth Violence Week (held annually in April) • Collaboration for trauma informed care wherever violence happens (i.e., Child Savers) • Education-based Gun Safety Day - police departments, local schools • Firearm safety training (all localities)	• Work with Hospitals, Clinics, Physician's offices, PE Teachers, United Way, Grove Outreach Center. • Work with the population who are English language learners such as CCC. • We are looking at utilizing the EDCC program offered by VDH. We think this could be a viable option for connecting people more quickly to post-hospital and follow-up services. This could possibly work for heart disease as well, especially for re-admits/inappropriate use of the EDs. • Community Health Workers • Hospitals, health clinics, and urgent care facilities • Organizations that serve at-risk populations • Primary Care Providers • Employer wellness (especially for large employers), incentives? • Human services • Organizations and agencies • Pharmacy pharmacies • Schools - P.E. Health • SHIP in WJCC schools • Health fairs	• Sending letters to each of Hampton's neighborhood associations and to each Hampton City public school nurses and guidance counselors with HPHD's Maternal Child Health programs flyer (Car Seat and Pack 'n Play portable crib distribution programs - which include child safety seat installation training and safe sleep education - to reduce the rates of child injury and hospitalizations, and to reduce the infant mortality rate. • Can be sent to all of HPHD cities and counties point of contacts as described above for Hampton. • CHW's • Health Dept. - (at all advantage) 1. immunizations, 2. refugees, 3. MCH, 4. Hispanic population, 5. Low-income families	• Unite Virginia and build the local network • EMS • Hospitals • Rehabs • Community events health fairs • DARE - School education • Rotational staff for community partners • Funding opportunities for collaborative partners • Awareness Fairs • Data sharing • Mobile Units • Pop up events • Regional Coalition • Regional Summit

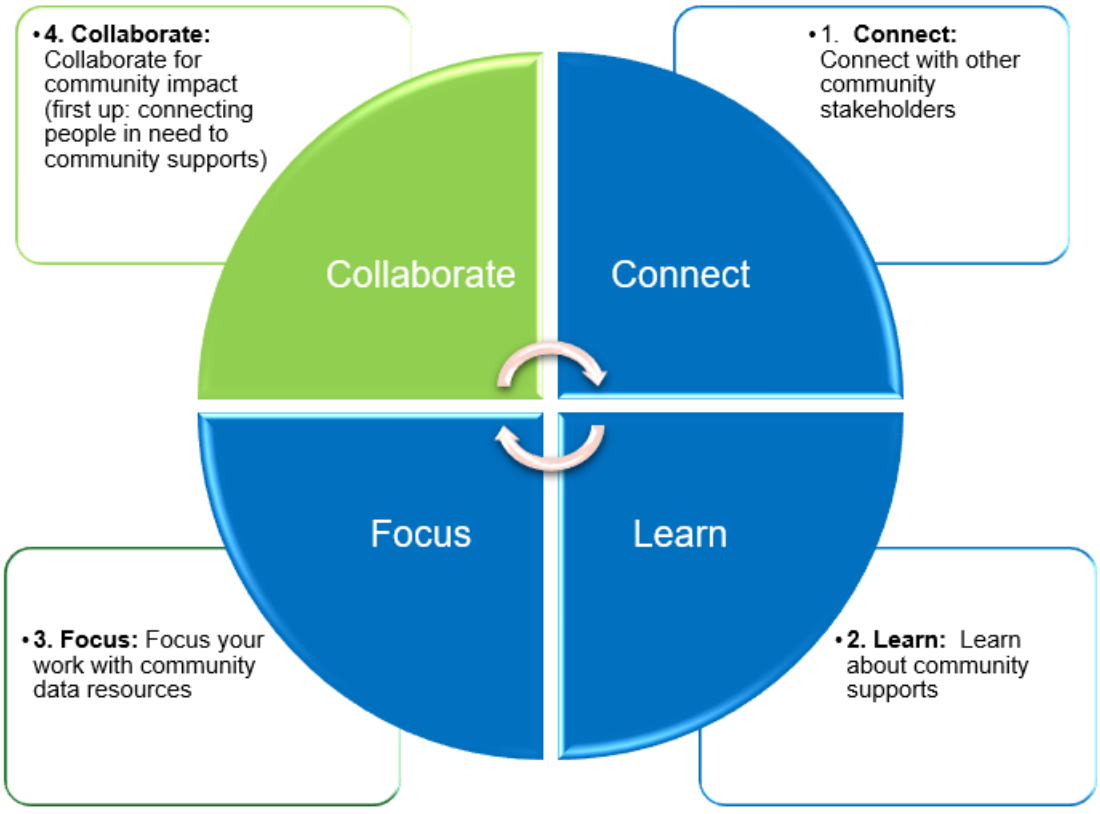
• Suicide (attempt) follow-up counselors in hospitals (all localities)	• Hotline and resource guides • Mobile education • Social Media as a preventative method • Cross jurisdictional survey distribution to continue the needs assessment • JCC, Williamsburg and York: Educational Outreach for Stroke Prevention (F.A.S.T.) • Social Services community health initiative	• Infant mortality - WIC, MCH programs, HCP • Health care systems teach patients about safe sleep practices, screening for services/needs • Collaborative grants • Really make an effort to go out into the community to provide services • What would be some possibilities for regional collaboration? • Fatherhood Program • Motherhood Program	
Data. What types of community data would be ideal for helping community organizations focus the work of connecting people in need to available community services?			
• Violent crime data including firearms. • School data about firearm violation • Suicide data •	• The data that would benefit and be ideal could be from PCPs, Hospitals, Rehab centers, Offices for Physical Therapy, Schools, and Universities. May be a good idea to compare data with close by cities as well. • Admission and re-admission rates at all local hospitals for heart-related issues/avoidable hospitalizations, rates of heart disease/heart failure for local cities/counties	• Data on birth outcomes will be crucial. • Infant Mortality Rates for US, Virginia, and Eastern region of VA, and each of HPHD localities. • SIDS and SUIDS rates. Data of deaths caused by Sudden Unexplained Infant Death associated with unsafe sleep. • Child Injury and Hospitalization rates for US, Virginia, and Eastern region of VA, and each of HPHD localities. • Percent of Infants ever breastfed and Percent of Infants breastfed exclusively through 6 months in the US, Virginia and in each of the HPHD localities.	• OD #s • Substance types used by locale and % • EMS responses for SUD by locale, type and % • ER visits for SUD by locale type and % • Arrests for substance reasons (top 3 zip codes by locale) • Court cases by substance type (top 3 zip codes by locale)

CHIP Implementation Workplan

Heart Disease

04.25.24

Contents	



CHIP Implementation Plan Draft: Heart Disease

A. Priority Area

Heart Disease was initially chosen as a priority area in consultation with community stakeholders during the HPHD CHA / CHIP process conducted in 2022 into 2023. The guiding aim is to prevent heart disease deaths.

B. Goal

During **Phase I Implementation Planning in 2023**, HPHD facilitated further consultation with community stakeholders through a CHIP Planning Workgroup. As a result of this community-guided work, the chosen implementation strategy is to create a virtual **Community Collaboration Hub for Preventing Heart Disease**. The Community Collaboration Hub will be a virtual space where community organizations can:

- **Connect** with other community stakeholders interested in preventing heart disease deaths
- **Learn** about community resources and ideas for preventing heart disease deaths
- **Focus** their work with community data about populations in need or at risk for heart disease death
- **Collaborate** to:
  - Help in-need or at-risk community members understand and utilize community supports during Years 1 and 2
  - Develop additional collaborative initiatives for preventing heart disease deaths by or before Years 3-5

C. Performance Measures

Demonstrate in this section how you will know you are making progress. State specifically what you will measure to determine whether changes have occurred. Select indicators of progress for both the short term (1-2 years) and long term (3-5 years). Specify the data source you will use for those indicators (or your plan to develop a measurement system if necessary).

Performance Measures	Year 1	Years 2-5
1. Number of community stakeholder organizations engaged as members of the Community Collaboration Hub	Begin	continue
2. Activation of a 'first-up' collaborative effort to help in-need or at-risk community members understand and utilize community supports for improving heart health and preventing heart disease deaths (Years 1 and 2)	Begin	continue
3. Inventory of supportive activities and resources shared with stakeholders as part of the first-up initiative	Begin	continue
4. Description of in-need or at-risk populations targeted as part of the first-up initiative	Begin	continue
5. Description of stakeholder activities conducted to reach, educate, and refer in-need or at-risk populations to available community resources	Begin	continue
6. Quantification of reach, or estimates of how many in-need or at-risk population members were served through the first-up initiative, by locality	Begin	continue
7. Begin planning at least one additional community initiative beyond the 'first-up' initiative	Year 1 planning Year 2 implementation	

D. First-Up (Year 1) SMART Objective

A 'first-up' SMART objective for preventing heart disease deaths is described below. This first-up objective will create a foundation for additional objectives to be added over time.

Specific	• Foster and support collaboration among community organizations interested in reducing heart disease deaths, with an initial focus on collaboration to connect people in need of community supports for preventing heart disease deaths.

Measurable	• Engage at least 20 community organizations (public or private sector) in a virtual community collaboration hub, and foster measurable gains in mutual awareness, data capacity, and collaborative efforts for community outreach and referral.[1]
Achievable	• Base the community collaboration hub at HPHD with startup accomplish in Q1 (July-Sept). No cost or resource requirements for participating community organizations.
Relevant	• Referencing the driver diagram, the guiding aim is to reduce heart disease deaths. • The community impact strategy is to address primary drivers by identifying populations in need or at risk, providing community outreach and education, and connecting in-need or at-risk individuals to health care and community supports. • The enabling implementation strategy is to create a community collaboration hub where community organizations can efficiently develop collaborative relationships while also receiving data supports and idea supports. • This initial work to foster community connections for collaboration will provide an essential foundation for developing additional initiatives over time.
Time-bound	• This first-up objective will be accomplished during Year 1, with quarterly development objectives.

E. Implementation Objectives

Describe the specific measurable end-products of your intervention. Objectives should be SMART: specific, measurable, achievable, realistic, and time-framed.

Implementation Objectives	Year 1	Years 2-5
1. Implement the virtual Collaboration Hub at VDH (Years 1-5)	Implement	Continue
2. Engage target minimum of 20 community stakeholder organizations from across the six-locality region in Year 1; expand in Years 2-5. (See **Appendix 2** for prospective partner list).	Implement	Continue
3. As a 'first-up' initiative, launch a collaborative effort to help in-need or at-risk community members understand and utilize community supports for improving heart health and preventing heart disease deaths (Years 1 and 2) (See ideas for populations, collaboration, and data in **Appendix 3**.)	Implement	Continue
4. Facilitate stakeholder connection and learning through webinars and interaction through the virtual Collaboration Hub (Years 1-5)	Implement	Continue
5. Facilitate stakeholder focus by developing and sharing community data sets that identify in-need or at-risk populations. (Years 1-5)	Implement	Continue
6. Begin planning to develop additional community initiatives for preventing heart disease deaths (by or before Years 2-5, contingent on stakeholder interest and resource feasibility)	Planning Year 1 Implementation Year 2	

F. Workplan

This section describe the workplan for achieving each of the implementation objectives listed in Section E.

Objective 1. Implement the virtual Collaboration Hub at VDH (Year 1, Q1, ongoing)

Background

The virtual Collaboration Hub is intended to facilitate community collaboration based on principles of the **collective impact framework**. (https://collectiveimpactforum.org/). The published literature on collective impact identifies five elements that are essential for supporting community collaboration: 1) A common agenda, 2) Shared measurement, 3) Mutually reinforcing activities, 4) Continuous communications, and 5) Strong background.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
1.1 Transfer Mighty Networks software to HPHD	May-July 2024	• Staff time • Software	• HPHD Lead • CHS support	HPHD owns software subscription	
1.2 Train HPHD staff to manage software	May-July 2024	• Staff time • Software	• HPHD Lead • CHS support	HPHD staff ready to manage software	
1.3 Build out workspace for Heart Disease (Welcome, Connect, Learn, Focus, Collaborate)	May–July 2024	• Staff time • Software	• HPHD Lead • CHS support	Virtual workspace ready to go	
1.4 Post initial learning content, data sets, and collaboration guide for Heart Disease	May-July 2024 ongoing	• Staff time • Software	• HPHD Lead • CHS support	Virtual workspace ready to go	

Objective 2. Engage target minimum of 20 community stakeholder organizations from across the six-locality region (Year 1, Q1, ongoing)

Background

See background on the collective impact framework under Objective 1. See Appendix 2 for an initial prospective partner list.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
2.1 Identify list of prospective members	May-July 2024	• Staff time • Software	• HPHD Lead • CHS support	List identified	
2.2 Develop communication strategy for prospective members (why, what, how, value of joining)	May-July 2024	• Staff time • Software	• HPHD Lead • CHS support	Communication strategy ready to go	
2.3 Conduct outreach to prospective members (email, telephone, personal, webinars)	Jul - Sep 2024	• Staff time • Software	• HPHD Lead • CHS support	Each target stakeholder is informed and invited	
2.4 Enroll members in virtual Hub	Jul - Sep 2024 ongoing	• Staff time • Software	• HPHD Lead • CHS support	Target of 20 organizations enrolled	

Objective 3. As a 'first-up' initiative, launch a collaborative effort to help in-need or at-risk community members understand and utilize community supports for improving heart health and preventing heart disease (Year 1, Q1, ongoing)

Background

This objective will be guided by the list of evidence-informed interventions for community-based outreach and education as listed in the Driver Diagram in Appendix 1.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*

3.1 Promote member awareness of populations in-need or at-risk	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members aware	
3.2 Promote member awareness of existing supports for promoting heart health and preventing heart disease death	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members aware	
3.3 Promote member awareness of evidence-informed ideas for promoting heart health and preventing heart disease death	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members aware	
3.4 Encourage members to promote community awareness of heart health risks and supports	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members take action	
3.5 Encourage members to connect their at-risk / in-need clientele to community supports for heart health	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members take action	
Note: Also see Objectives 4 and 5 as enabling supports for this objective.					

Objective 4. In support of Objective 3, Facilitate stakeholder connection and learning through webinars and interaction through the virtual Collaboration Hub (Year 1, Q1, ongoing)

Background

This objective will be guided by best practices for developing virtual community networks as recommended Mighty Networks software and other sources of published literature.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
4.1 Welcome members individually and provide a guide for navigating the Hub and connecting with other members	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members join the Hub and connect with others	
4.2 Communicate with members every two weeks to share content and encourage engagement	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members are equipped with useful content to support their work	
4.3 Conduct member surveys on topics of interest at least quarterly	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members share their insights and ideas for optimizing the work	
4.4 Conduct member webinars on topics of interest at least quarterly	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members come together to share insights and ideas for working together on community outreach, education, and service connections	

Objective 5. In support of Objective 3, facilitate stakeholder focus by developing and sharing community data sets that identify in-need or at-risk populations. (Year 1, Q1, ongoing)

Background

This objective will focus on mining available data to produce concise data sets that can help members focus their work on community outreach, community education, and community connections.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
5.1 Identify community data sources on heart disease and related factors from the Virginia Community Health Improvement Data portal and other sources.	Jul-Sep 2024 ongoing	● Staff time ● Software	● HPHD Lead	Inventory of relevant community data	
5.2 Query members about types of community data that could help them focus their work for community outreach, community education, and community connections.	Jul-Sep 2024 ongoing	● Staff time ● Software	● HPHD Lead	Member insights on types of data that would be helpful for focusing their work	
5.3 Develop community data sets and maps in response to member interests, as feasible.	Jul-Sep 2024 ongoing	● Staff time ● Software	● HPHD Lead	Concise, targeted products with data and maps.	
5.4 Deliver community data sets with supporting webinars and guides to help members use the data to focus their work.	Jul-Sep 2024 ongoing	● Staff time ● Software	● HPHD Lead	Members utilize data products to focus their work.	

Objective 6. Develop additional community initiatives for preventing heart disease deaths (Year 1 or Year 2)

Background

This objective will build upon the collective impact framework and the Year 1 work of the Community Collaboration Hub to engage members in exploring additional collaborative initiatives for Year 2 and beyond. See Appendix 3 for some possible ideas.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
6.1 Query members about ideas and level of interest in working on additional collaborative projects in 2025-26	Jan – Jun 2025 ongoing	● Staff time ● Software	● HPHD Lead	Members share ideas for additional collaborative initiatives	
6.2 Offer to host and facilitate virtual meetings where members can begin to dialog about possibilities	Jan – Jun 2025 ongoing	● Staff time ● Software	● HPHD Lead	Members meet to explore ideas with virtual supports from the Hub	

6.3 Offer to begin developing content and data that could be helpful for envisioning collaborative efforts, and provide those resources through the Hub	Jan – Jun 2025 ongoing	• Staff time • Software	• Lead HPHD	The Hub becomes a source of content and data to support collaborative efforts in Year 2	
6.4 Consider additional support strategies for Year 2 initiatives that the Hub could provide based on ideas emerging from member dialog	Jan – Jun 2025 ongoing	• Staff time • Software	• Lead HPHD	HPHD considers strategies for aligning Hub resources in support of member ideas for Year 2 collaborations	

G. Alignment with State and National Priorities

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House of Mercy		*	*	*
HPHD			*	
Insurance Companies (Case Coordinator, Case Mgmt)		*		
James City County DSS				*
Lackey/SEVHS/Local Clinics		*	*	
LGBT Life Center	*			
Link				*
Local Chambers				*
Local Departments of Social Services				*
Local Healthcare Systems / Hospitals		*		*
Local Law Enforcement				*
MASS - Minority AIDS Support Services	*			
MAT Providers (nonprofit & for-profit)				*
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Places Offering CPR Classes		*		
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Transitions Family Violence Services	*			
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Universities / Higher Ed		*	*	*
Urgency of Now	*			
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Collaboration. What are some creative ideas for collaborative community outreach?			
• Lock & Talk Va program on lethal means safety. • Gun shops education programs. • Gun stores • Military bases • Pawn stores • Safe storage education • School groups • Attending events and/or festivals • Unite Us • Using social media • Annual community events/weeks highlighting youth violence prevention • Collaborate locally to 'recognize' National Youth Violence Week (held annually in April) • Collaboration for trauma informed care wherever violence happens (i.e., Child Savers) • Education-based Gun Safety Day - police departments, local schools • Firearm safety training (all localities)	• Work with Hospitals, Clinics, Physician's offices, PE Teachers, United Way, Grove Outreach Center. • Work with the population who are English language learners such as CCC. • We are looking at utilizing the EDCC program offered by VDH. We think this could be a viable option for connecting people more quickly to post-hospital and follow-up services. This could possibly work for heart disease as well, especially for re-admits/inappropriate use of the EDs. • Community Health Workers • Hospitals, health clinics, and urgent care facilities • Organizations that serve at-risk populations • Primary Care Providers • Employer wellness (especially for large employers), incentives? • Human services • Organizations and agencies • Pharmacy pharmacies • Schools - P.E. Health • SHIP in WJCC schools • Health fairs	• Sending letters to each of Hampton's neighborhood associations and to each Hampton City public school nurses and guidance counselors with HPHD's Maternal Child Health programs flyer (Car Seat and Pack 'n Play portable crib distribution programs - which include child safety seat installation training and safe sleep education - to reduce the rates of child injury and hospitalizations, and to reduce the infant mortality rate. • Can be sent to all of HPHD cities and counties point of contacts as described above for Hampton. • CHW's • Health Dept. - (at all advantage) 1. immunizations, 2. refugees, 3. MCH, 4. Hispanic population, 5. Low-income families	• Unite Virginia and build the local network • EMS • Hospitals • Rehabs • Community events health fairs • DARE - School education • Rotational staff for community partners • Funding opportunities for collaborative partners • Awareness Fairs • Data sharing • Mobile Units • Pop up events • Regional Coalition • Regional Summit

• Suicide (attempt) follow-up counselors in hospitals (all localities)	• Hotline and resource guides • Mobile education • Social Media as a preventative method • Cross jurisdictional survey distribution to continue the needs assessment • JCC, Williamsburg and York: Educational Outreach for Stroke Prevention (F.A.S.T.) • Social Services community health initiative	• Infant mortality - WIC, MCH programs, HCP • Health care systems teach patients about safe sleep practices, screening for services/needs • Collaborative grants • Really make an effort to go out into the community to provide services • What would be some possibilities for regional collaboration? • Fatherhood Program • Motherhood Program	
Data. What types of community data would be ideal for helping community organizations focus the work of connecting people in need to available community services?			
• Violent crime data including firearms. • School data about firearm violation • Suicide data •	• The data that would benefit and be ideal could be from PCPs, Hospitals, Rehab centers, Offices for Physical Therapy, Schools, and Universities. May be a good idea to compare data with close by cities as well. • Admission and re-admission rates at all local hospitals for heart-related issues/avoidable hospitalizations, rates of heart disease/heart failure for local cities/counties	• Data on birth outcomes will be crucial. • Infant Mortality Rates for US, Virginia, and Eastern region of VA, and each of HPHD localities. • SIDS and SUIDS rates. Data of deaths caused by Sudden Unexplained Infant Death associated with unsafe sleep. • Child Injury and Hospitalization rates for US, Virginia, and Eastern region of VA, and each of HPHD localities. • Percent of Infants ever breastfed and Percent of Infants breastfed exclusively through 6 months in the US, Virginia and in each of the HPHD localities.	• OD #s • Substance types used by locale and % • EMS responses for SUD by locale, type and % • ER visits for SUD by locale type and % • Arrests for substance reasons (top 3 zip codes by locale) • Court cases by substance type (top 3 zip codes by locale)

CHIP Implementation Workplan

Infant Mortality

04.25.24

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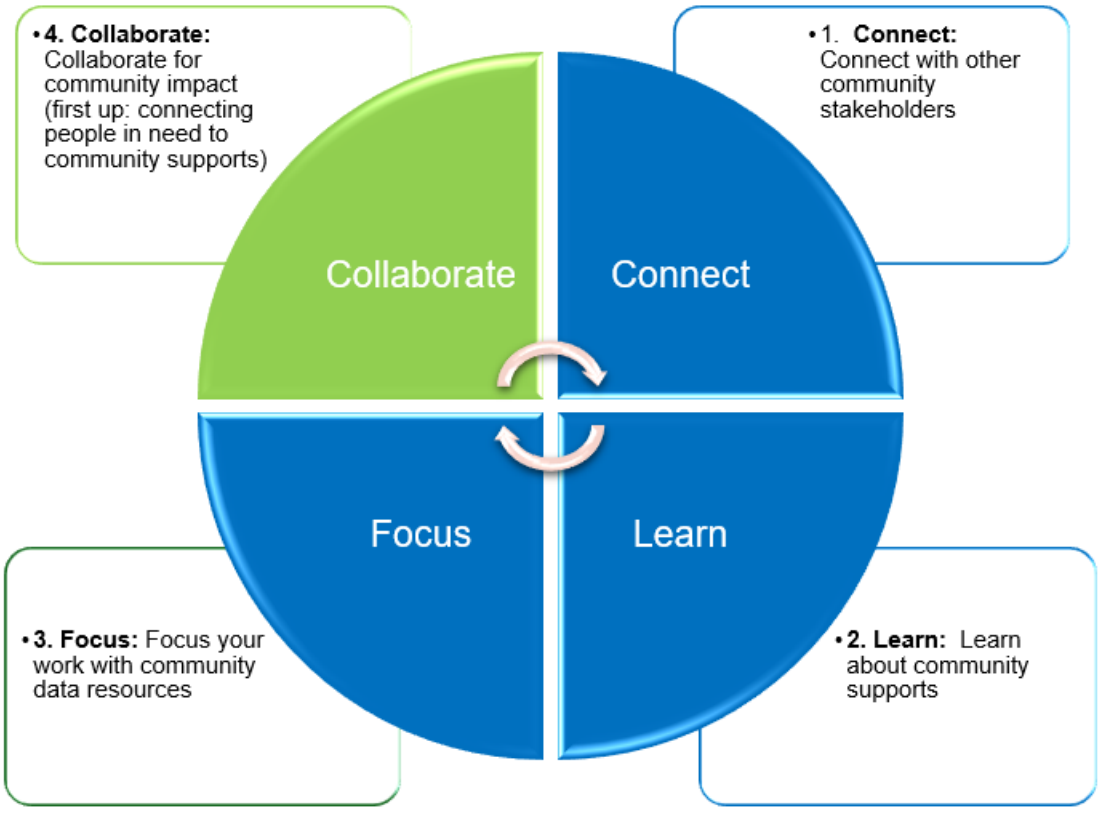

CHIP Implementation Workplan

Infant Mortality

04.25.24

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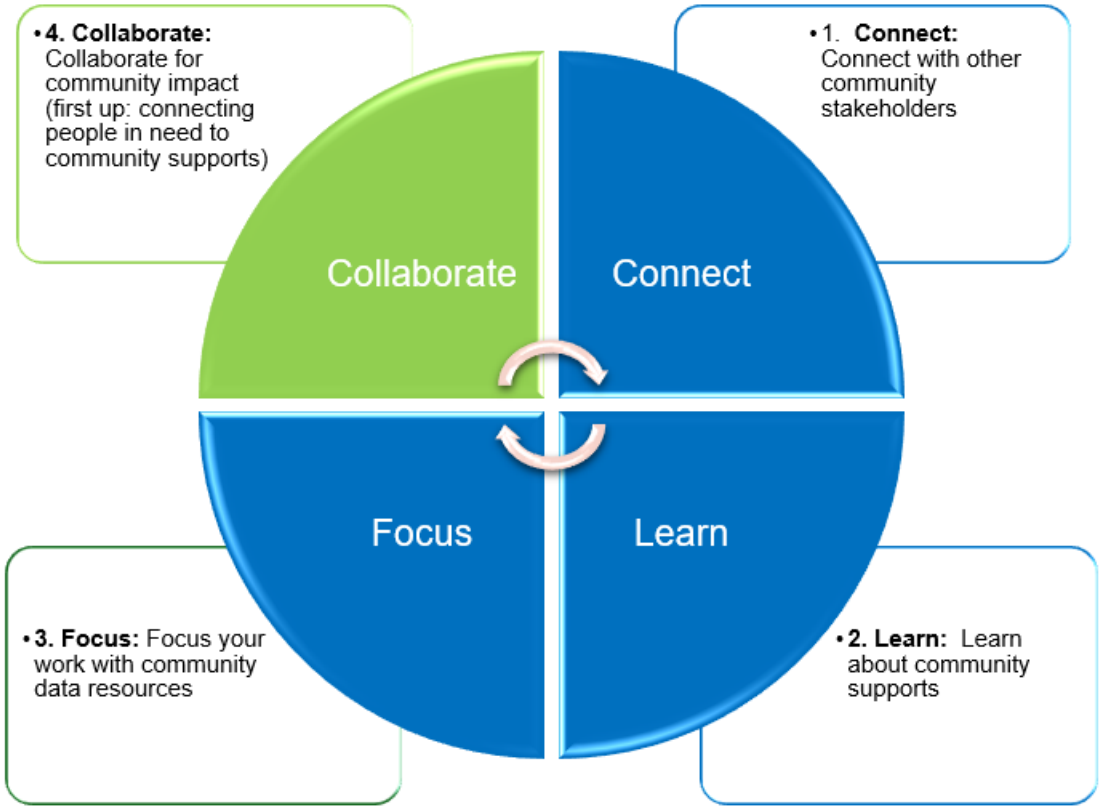

CHIP Implementation Plan Draft: Infant Mortality

A. Priority Area

Infant Mortality was initially chosen as a priority area in consultation with community stakeholders during the HPHD CHA / CHIP process conducted in 2022 into 2023. The guiding aim is to prevent infant deaths.

B. Goal

During **Phase I Implementation Planning in 2023**, HPHD facilitated further consultation with community stakeholders through a CHIP Planning Workgroup. As a result of this community-guided work, the chosen implementation strategy is to create a virtual **Community Collaboration Hub for Preventing infant Mortality**. The Community Collaboration Hub will be a virtual space where community organizations can:

- **Connect** with other community stakeholders interested in preventing infant deaths
- **Learn** about community resources and ideas for preventing infant deaths
- **Focus** their work with community data about populations in need or at risk for infant death
- **Collaborate** to:
  - Help in-need or at-risk community members understand and utilize community supports during Years 1 and 2.
  - Develop additional collaborative initiatives for preventing infant deaths by or before Years 3-5.

C. Performance Measures

Demonstrate in this section how you will know you are making progress. State specifically what you will measure to determine whether changes have occurred. Select indicators of progress for both the short term (1-2 years) and long term (3-5 years). Specify the data source you will use for those indicators (or your plan to develop a measurement system if necessary).

Performance Measures	Year 1	Years 2-5
1. Number of community stakeholder organizations engaged as members of the Community Collaboration Hub.	Begin	Continue
2. Activation of a 'first-up' collaborative effort to help in- need or at-risk community members understand and utilize community supports for preventing infant deaths (Years 1 and 2)	Begin	Continue
3. Inventory of supportive activities and resources shared with stakeholders as part of the first-up initiative.	Begin	Continue
4. Description of in-need or at-risk populations targeted as part of the first-up initiative.	Begin	Continue
5. Description of stakeholder activities conducted to reach, educate, and refer in-need or at-risk populations to available community resources.	Begin	Continue
6. Quantification of reach, or estimates of how many in-need or at-risk population members were served through the first-up initiative, by locality.	Begin	Continue
7. Activation of at least one additional community initiative beyond the 'first-up' initiative	Year 1 planning Year 2 implementation	

D. First-Up (Year 1) SMART Objective

A 'first-up' SMART objective for preventing infant deaths is described below. This first-up objective will create a foundation for additional objectives to be added over time.

Specific	• Foster and support collaboration among community organizations interested in reducing infant deaths, with an initial focus on collaboration to connect people in need to community supports for preventing infant mortality.
Measurable	• Engage at least 20 community organizations (public or private sector) in a virtual community collaboration hub, and foster measurable gains in mutual awareness, data capacity, and collaborative efforts for community outreach and referral. [1]
Achievable	• Base the community collaboration hub at HPHD with startup accomplish in Q1 (July-Sept). No cost or resource requirements for participating community organizations.
Relevant	• Referencing the driver diagram, the guiding aim is to reduce infant deaths. • The community impact strategy is to address primary drivers by identifying populations in need or at risk, providing community outreach and education, and connecting at-risk individuals to health care and community supports. • The enabling implementation strategy is to create a community collaboration hub where community organizations can efficiently develop collaborative relationships while also receiving data supports and idea supports. • This initial work to foster community connections for collaboration will provide an essential foundation for developing additional initiatives over time.
Time-bound	• This first-up objective will be accomplished during Year 1, with quarterly development objectives.

E. Implementation Objectives

Describe the specific measurable end-products of your intervention. Objectives should be SMART: specific, measurable, achievable, realistic, and time-framed.

Implementation Objectives	Year 1	Years 2-5
1. Implement the virtual Collaboration Hub at VDH (Years 1-5)	Begin	Continue
2. Engage target minimum of 20 community stakeholder organizations from across the six-locality region in Year 1; expand in Years 2-5. (See **Appendix 2** for working draft list).	Begin	Continue
3. As a 'first-up' initiative, launch a collaborative effort to help in-need or at-risk community members understand and utilize community supports for preventing infant deaths (Years 1 and 2) (See ideas for populations, collaboration, and data in **Appendix 3**.)		
4. Facilitate stakeholder connection and learning through webinars and interaction through the virtual Collaboration Hub (Years 1-5)	Begin	Continue
5. Facilitate stakeholder focus by developing and sharing community data sets that identify in-need or at-risk populations. (Years 1-5)	Begin	Continue
6. Begin planning to develop additional community initiatives for reducing infant deaths (by or before Years 2-5, contingent on stakeholder interest and resource feasibility)	Year 1 planning Year 2 implementation	

F. Workplan

This section describe the workplan for achieving each of the implementation objectives listed in Section E.

Objective 1. Implement the virtual Collaboration Hub at VDH (Year 1, Q1, ongoing)

Background

The virtual Collaboration Hub is intended to facilitate community collaboration based on principles of the **collective impact framework**. (https://collectiveimpactforum.org/). The published literature on collective impact identifies five elements that are essential for supporting community collaboration: 1) A common agenda, 2) Shared measurement, 3) Mutually reinforcing activities, 4) Continuous communications, and 5) Strong background.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
1.1 Transfer Mighty Networks software to HPHD	May-July 2024	• Staff time • Software	• HPHD Lead • CHS support	HPHD owns software subscription	
1.2 Train HPHD staff to manage software	May-July 2024	• Staff time • Software	• HPHD Lead • CHS support	HPHD staff ready to manage software	
1.3 Build out workspace for Infant Mortality (Welcome, Connect, Learn, Focus, Collaborate)	May–July 2024	• Staff time • Software	• HPHD Lead • CHS support	Virtual workspace ready to go	
1.4 Post initial learning content, data sets, and collaboration guide for Infant Mortality	May-July 2024 ongoing	• Staff time • Software	• HPHD Lead • CHS support	Virtual workspace ready to go	

Objective 2. Engage target minimum of 20 community stakeholder organizations from across the six-locality region (Year 1, Q1, ongoing)

Background

See background on the collective impact framework under Objective 1. See Appendix 2 for an initial prospective partner list.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
2.1 Identify list of prospective members	May-July 2024	• Staff time • Software	• HPHD Lead • CHS support	List identified	
2.2 Develop communication strategy for prospective members (why, what, how, value of joining)	May-July 2024	• Staff time • Software	• HPHD Lead • CHS support	Communication strategy ready to go	
2.3 Conduct outreach to prospective members (email, telephone, personal, webinars)	Jul - Sep 2024	• Staff time • Software	• HPHD Lead • CHS support	Each target stakeholder is informed and invited	
2.4 Enroll members in virtual Hub	Jul - Sep 2024 ongoing	• Staff time • Software	• HPHD Lead • CHS support	Target of 20 organizations enrolled	

Objective 3. As a 'first-up' initiative, launch a collaborative effort to help in-need or at-risk community members understand and utilize community supports for preventing infant deaths (Year 1, Q1, ongoing)

Background

This objective will be guided by the list of evidence-informed interventions for community-based outreach and education as listed in the Driver Diagram in Appendix 1.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
3.1 Promote member awareness of populations in-need or at-risk	Jul-Sep 2024 ongoing	● Staff time ● Software	● HPHD Lead	Members aware	
3.2 Promote member awareness of existing supports for promoting maternal and child health and preventing infant deaths	Jul-Sep 2024 ongoing	● Staff time ● Software	● HPHD Lead	Members aware	
3.3 Promote member awareness of evidence-informed ideas for promoting maternal and child health and preventing infant deaths	Jul-Sep 2024 ongoing	● Staff time ● Software	● HPHD Lead	Members aware	
3.4 Encourage members to promote community awareness of infant mortality risks and supports	Jul-Sep 2024 ongoing	● Staff time ● Software	● HPHD Lead	Members take action	
3.5 Encourage members to connect their at-risk / in-need clientele to community supports for maternal and child health	Jul-Sep 2024 ongoing	● Staff time ● Software	● HPHD Lead	Members take action	

Note: Also see Objectives 4 and 5 as enabling supports for this objective.

Objective 4. In support of Objective 3, Facilitate stakeholder connection and learning through webinars and interaction through the virtual Collaboration Hub (Year 1, Q1, ongoing)

Background

This objective will be guided by best practices for developing virtual community networks as recommended Mighty Networks software and other sources of published literature.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
4.1 Welcome members individually and provide a guide for navigating the Hub and connecting with other members	Jul-Sep 2024 ongoing	● Staff time ● Software	● HPHD Lead	Members join the Hub and connect with others	
4.2 Communicate with members every two weeks to share content and encourage engagement	Jul-Sep 2024 ongoing	● Staff time ● Software	● HPHD Lead	Members are equipped with useful content to support their work	

4.3 Conduct member surveys on topics of interest at least quarterly	Jul-Sep 2024 ongoing	• Staff time • Software	• Lead HPHD	Members share their insights and ideas for optimizing the work	
4.4 Conduct member webinars on topics of interest at least quarterly	Jul-Sep 2024 ongoing	• Staff time • Software	• Lead HPHD	Members come together to share insights and ideas for working together on community outreach, education, and service connections	

Objective 5. In support of Objective 3, facilitate stakeholder focus by developing and sharing community data sets that identify in-need or at-risk populations. (Year 1, Q1, ongoing)

Background

This objective will focus on mining available data to produce concise data sets that can help members focus their work on community outreach, community education, and community connections.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
5.1 Identify community data sources on infant mortality and related factors from the Virginia Community Health Improvement Data portal and other sources.	Jul-Sep 2024 ongoing	• Staff time • Software	• Lead HPHD	Inventory of relevant community data	
5.2 Query members about types of community data that could help them focus their work for community outreach, community education, and community connections.	Jul-Sep 2024 ongoing	• Staff time • Software	• Lead HPHD	Member insights on types of data that would be helpful for focusing their work	
5.3 Develop community data sets and maps in response to member interests, as feasible.	Jul-Sep 2024 ongoing	• Staff time • Software	• Lead HPHD	Concise, targeted products with data and maps.	
5.4 Deliver community data sets with supporting webinars and guides to help members use the data to focus their work.	Jul-Sep 2024 ongoing	• Staff time • Software	• Lead HPHD	Members utilize data products to focus their work.	

Objective 6. Develop additional community initiatives for reducing infant deaths (Year 1 or Year 2)

Background

This objective will build upon the collective impact framework and the Year 1 work of the Community Collaboration Hub to engage members in exploring additional collaborative initiatives for Year 2 and beyond. See Appendix 3 for some possible ideas.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*

6.1 Query members about ideas and level of interest in working on additional collaborative projects in 2025-26	Jan – Jun 2025 ongoing	• Staff time • Software	• HPHD Lead	Members share ideas for additional collaborative initiatives	
6.2 Offer to host and facilitate virtual meetings where members can begin to dialog about possibilities	Jan – Jun 2025 ongoing	• Staff time • Software	• HPHD Lead	Members meet to explore ideas with virtual supports from the Hub	
6.3 Offer to begin developing content and data that could be helpful for envisioning collaborative efforts, and provide those resources through the Hub	Jan – Jun 2025 ongoing	• Staff time • Software	• HPHD Lead	The Hub becomes a source of content and data to support collaborative efforts in Year 2	
6.4 Consider additional support strategies for Year 2 initiatives that the Hub could provide based on ideas emerging from member dialog	Jan – Jun 2025 ongoing	• Staff time • Software	• HPHD Lead	HPHD considers strategies for aligning Hub resources in support of member ideas for Year 2 collaborations	
Note: Also see Objectives 4 and 5 as enabling supports for this objective.					

G. Alignment with State and National Priorities

As of April 2024, the Virginia Department of Health most recent State Health Assessment identified a set of priorities including 1) **infant mortality**; 2) firearm-related deaths; 3) obesity; 4) mental health; 5) substance use and drug overdose; and 6) housing, transportation, and economic stability. The CHIP Implementation Plan for HPHD directly aligns with priorities 1, 2, and 5. It also relates to the obesity priority as one causal factor for heart disease.

From a national view, the four priorities areas identified in the HPHD CHIP Implementation Plan align with Healthy People 2030 Leading Health Indicators relating to firearm deaths (homicide and suicide), heart disease risk factors (physical activity, blood pressure, smoking), **infant deaths**, and drug overdose deaths.

In addition, Healthy People 2030 has a **priority focus** on eliminating health disparities and creating equitable opportunities for people to live healthy lives. Core strategies include advancing health equity, increasing health literacy, and addressing social determinants of health in communities across the nation. A cross-cutting aim of the HPHD CHIP Implementation Plan is to engage community organizations in identifying community populations who need help with understanding and access community supports, including help with addressing social determinants that may influence disparities and affect their opportunities for health.

Appendix 2 – Workgroup Member Ideas for Prospective Partners

Note: This list includes ideas shared by CHIP Workgroup Members in 2023, and Implementation Task Group Members in 2024. The list is provisional and does not imply approval by any of the listed organizations. Also, some organizations may be interested in working on topics beyond those indicated in the list.

Organization	Firearm Violence	Heart Disease	Infant Mortality	Substance Use
#757 Breastfeeds			*	
(HII) Shipyard		*		
3E Restorations		*		*
4 Oaks		*		*
American Heart Association		*		
Avalon				*
Bacon Street				*
Ben's Friends				*
Black Maternal Health Equity Action Alliance			*	

Boys and Girls Clubs	*			
CDR			*	
Center for Child & Family Services			*	
Churches / Faith Communities	*	*	*	*
Colonial Behavioral Health				*
Community Clinics		*		
Community Health Workers	*	*	*	*
Community Coordinated Response Team	*			
Community Corrections				*
Community Foundation				*
Community Health Workers		*		
Community Services Boards	*			*
Courts				*
Drive Safe HR			*	
Early Impact Virginia			*	
Eastern Virginia Child Fatality Review Team			*	
EMS	*	*		*
Faith-Based Organizations		*		*
First Spark (Smart Beginning)	*		*	
Food Banks		*	*	*
Hampton City Government	*			
Hampton Family Violence Council	*			
Hampton Healthy Families	*			
Hampton VA				*
Hand-in-Hand	*			
Healthy Families (Home Visitation)			*	
Heart Specialist		*		
HELP				*
Historic Triangle Drug Prevention Coalition				*
Home Visitation Programs		*	*	
Homeless Shelters	*			
Hopeful Hampton	*			
Hospital ER	*			
Hospitals			*	
Hospitals (Mother Baby Units)			*	
House of Mercy		*	*	*
HPHD			*	
Insurance Companies (Case Coordinator, Case Mgmt)		*		
James City County DSS				*
Lackey/SEVHS/Local Clinics		*	*	
LGBT Life Center	*			
Link				*
Local Chambers				*
Local Departments of Social Services				*
Local Healthcare Systems / Hospitals		*		*

Local Law Enforcement				*
MASS - Minority AIDS Support Services	*			
MAT Providers (nonprofit & for-profit)				*
Medical Center			*	
NAMI	*			
Newport News Hispanic Advisory Council			*	
Non-English-Speaking Communities				*
NRA	*			
OB Offices & Programs			*	
Opioid Response Network				*
PCOR Coalitions				*
Perinatal Mental Health Coalition			*	
Places Offering CPR Classes		*		
Postpartum Support VA			*	
Primary Care Clinicians		*		
Project Link				*
Public Schools	*	*	*	*
Recovery Center				*
Recovery Houses				*
Red Cross		*		
Riverside Mental Health				*
Salvation Army	*			*
School Systems	*			
Schools				*
Sleep Tight Hampton Roads			*	
Social Services			*	
Social Workers		*		
South Eastern Family Project				*
Spirit Works				*
Transit Hampton				*
Transitions Family Violence Services	*			
United Way		*		
Universities / Higher Ed		*	*	*
Urgency of Now	*			
Veterans Affairs	*	*		
Veterans Groups	*	*		
Virginia Department of Health	*	*	*	*
Virginia Neonatal Perinatal Collaborative			*	
WIC			*	
Women's Violence Shelters			*	
YMCA	*	*		
York Poquoson DSS				*
Youth Violence Prevention Week	*			
YWCA	*			

Appendix 3 – Workgroup Member Ideas for Populations, Collaboration, and Data

Note: This list includes ideas shared by CHIP Workgroup Members in 2023, and Implementation Task Group Members in 2024. The list is provisional and does not imply approval by any of the listed organizations. Also, some organizations may be interested in working on topics beyond those indicated in the list.

Firearm Violence	Heart Disease	Infant Mortality	Substance Use
Populations. Who are the key community populations that should be reached as part of the effort to connect people in need to available community services?			
• Young adults • Teens • Veterans • Elder males • High schoolers • Hunting groups • New gun owners • New parents or parents (young kids, teens) • Recent parolees/ prisoners • Veterans	• Schools • Community Centers and Recreation Centers • Senior Developments, assisted and independent • Support groups • Community Health Workers and Navigators • Anyone who utilizes the local senior centers, any local churches (especially if they have senior groups), any patients utilizing the free and charitable clinics, any patients with frequent/avoidable hospitalizations for heart-related issues, anyone utilizing the organizations listed in item #3 • Families at risk • Individuals with multiple health conditions • Underserved communities	• Women of child-bearing years. • Pregnant mothers, parents, legal guardians, families, school nurses, school guidance counselors, day care centers, and churches. • African American • Low-income • Non-English speakers • Pregnant and new moms • Refugees	• People returning from incarceration • People with history of SUD • People with unstable housing • People with mental health disorders • People of certain sexual orientations • EMS - other relations • Family members • PWUD • Rehabs
Collaboration. What are some creative ideas for collaborative community outreach?			
• Lock & Talk Va program on lethal means safety. • Gun shops education programs. • Gun stores • Military bases • Pawn stores • Safe storage education • School groups • Attending events and/or festivals • Unite Us • Using social media • Annual community events/weeks highlighting youth violence prevention • Collaborate locally to 'recognize' National Youth Violence Week (held annually in April) • Collaboration for trauma informed care wherever	• Work with Hospitals, Clinics, Physician's offices, PE Teachers, United Way, Grove Outreach Center. • Work with the population who are English language learners such as CCC. • We are looking at utilizing the EDCC program offered by VDH. We think this could be a viable option for connecting people more quickly to post-hospital and follow-up services. This could possibly work for heart disease as well, especially for re-admits/inappropriate use of the EDs. • Community Health Workers • Hospitals, health clinics, and urgent care facilities • Organizations that serve at-risk populations • Primary Care Providers • Employer wellness (especially for large employers), incentives?	• Sending letters to each of Hampton's neighborhood associations and to each Hampton City public school nurses and guidance counselors with HPHD's Maternal Child Health programs flyer (Car Seat and Pack 'n Play portable crib distribution programs - which include child safety seat installation training and safe sleep education - to reduce the rates of child injury and hospitalizations, and to reduce the infant mortality rate. • Can be sent to all of HPHD cities and counties point of contacts as described above for Hampton. • CHW's	• Unite Virginia and build the local network • EMS • Hospitals • Rehabs • Community events health fairs • DARE - School education • Rotational staff for community partners • Funding opportunities for collaborative partners • Awareness Fairs • Data sharing • Mobile Units • Pop up events • Regional Coalition

violence happens (i.e., Child Savers) • Education-based Gun Safety Day - police departments, local schools • Firearm safety training (all localities) • Suicide (attempt) follow-up counselors in hospitals (all localities)	• Human services • Organizations and agencies • Pharmacy pharmacies • Schools - P.E. Health • SHIP in WJCC schools • Health fairs • Hotline and resource guides • Mobile education • Social Media as a preventative method • Cross jurisdictional survey distribution to continue the needs assessment • JCC, Williamsburg and York: Educational Outreach for Stroke Prevention (F.A.S.T.) • Social Services community health initiative	• Health Dept. - (at all advantage) 1. immunizations, 2. refugees, 3. MCH, 4. Hispanic population, 5. Low-income families • Infant mortality - WIC, MCH programs, HCP • Health care systems teach patients about safe sleep practices, screening for services/needs • Collaborative grants • Really make an effort to go out into the community to provide services • What would be some possibilities for regional collaboration? • Fatherhood Program • Motherhood Program	• Regional Summit
Data. What types of community data would be ideal for helping community organizations focus the work of connecting people in need to available community services?			
• Violent crime data including firearms. • School data about firearm violation • Suicide data •	• The data that would benefit and be ideal could be from PCPs, Hospitals, Rehab centers, Offices for Physical Therapy, Schools, and Universities. May be a good idea to compare data with close by cities as well. • Admission and re-admission rates at all local hospitals for heart-related issues/avoidable hospitalizations, rates of heart disease/heart failure for local cities/counties	• Data on birth outcomes will be crucial. • Infant Mortality Rates for US, Virginia, and Eastern region of VA, and each of HPHD localities. • SIDS and SUIDS rates. Data of deaths caused by Sudden Unexplained Infant Death associated with unsafe sleep. • Child Injury and Hospitalization rates for US, Virginia, and Eastern region of VA, and each of HPHD localities. • Percent of Infants ever breastfed and Percent of Infants breastfed exclusively through 6 months in the US, Virginia and in each of the HPHD localities.	• OD #s • Substance types used by locale and % • EMS responses for SUD by locale, type and % • ER visits for SUD by locale type and % • Arrests for substance reasons (top 3 zip codes by locale) • Court cases by substance type (top 3 zip codes by locale)

CHIP Implementation Workplan

Substance Use

04.25.24

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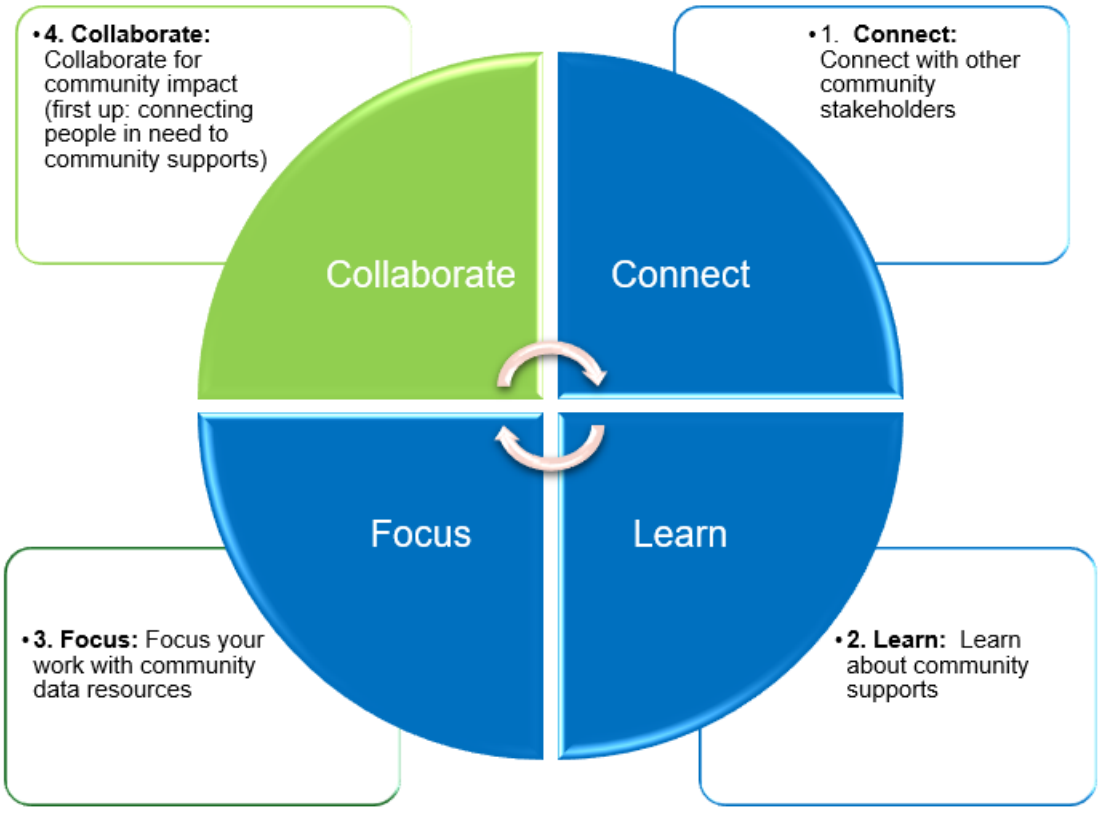

CHIP Implementation Plan Draft: Substance Use

A. Priority Area

Substance Use, and in particular preventing drug overdose deaths, was initially chosen as a priority area in consultation with community stakeholders during the HPHD CHA / CHIP process conducted in 2022 into 2023. The guiding aim is to prevent drug overdose deaths.

B. Goal

During **Phase I Implementation Planning in 2023**, HPHD facilitated further consultation with community stakeholders through a CHIP Planning Workgroup. As a result of this community-guided work, the chosen implementation strategy is to create a virtual **Community Collaboration Hub for Preventing Drug Overdose Deaths**. The Community Collaboration Hub will be a virtual space where community organizations can:

- **Connect** with other community stakeholders interested in reducing drug overdose deaths
- **Learn** about community resources and ideas for preventing drug overdose deaths
- **Focus** their work with community data about populations in need or at risk for drug overdose death
- **Collaborate** to:
  - Help in-need or at-risk community members understand and utilize community supports during Years 1 and 2
  - Develop additional collaborative initiatives for preventing drug overdose deaths by or before Years 3-5

C. Performance Measures

Demonstrate in this section how you will know you are making progress. State specifically what you will measure to determine whether changes have occurred. Select indicators of progress for both the short term (1-2 years) and long term (3-5 years). Specify the data source you will use for those indicators (or your plan to develop a measurement system if necessary).

Performance Measures	Year 1	Years 2-5
1. Number of community stakeholder organizations engaged as members of the Community Collaboration Hub.	Begin	Continue
2. Activation of a 'first-up' collaborative effort to help in-need or at-risk community members understand and utilize community supports for reducing substance use and preventing drug overdose deaths (Years 1 and 2)	Begin	Continue
3. Inventory of supportive activities and resources shared with stakeholders as part of the first-up initiative.	Begin	Continue
4. Description of in-need or at-risk populations targeted as part of the first-up initiative.	Begin	Continue
5. Description of stakeholder activities conducted to reach, educate, and refer in-need or at-risk populations to available community resources.	Begin	Continue
6. Quantification of reach, or estimates of how many in-need or at-risk population members were served through the first-up initiative, by locality.	Begin	Continue
7. Activation of at least one additional community initiative beyond the 'first-up' initiative	Year 1 planning Year 2 implementation	

D. A First-Up (Year 1) SMART Objective

A 'first-up' SMART objective for preventing drug overdose deaths is described below. This first-up objective will create a foundation for additional objectives to be added over time.

Specific	• Foster and support collaboration among community organizations interested in reducing drug overdose deaths, with an initial focus on collaboration to connect people in need to community supports for preventing drug overdose deaths.

Measurable	• Engage at least 20 community organizations (public or private sector) in a virtual community collaboration hub, and foster measurable gains in mutual awareness, data capacity, and collaborative efforts for community outreach and referral. [1]
Achievable	• Base the community collaboration hub at HPHD with startup accomplish in Q1 (July-Sept). No cost or resource requirements for participating community organizations.
Relevant	• Referencing the driver diagram, the guiding aim is to reduce drug overdose deaths. • The community impact strategy is to address primary drivers by identifying populations in need or at risk, providing community outreach and education, and connecting in-need or at-risk individuals to health care and community supports. • The enabling implementation strategy is to create a community collaboration hub where community organizations can efficiently develop collaborative relationships while also receiving data supports and idea supports. • This initial work to foster community connections for collaboration will provide an essential foundation for developing additional initiatives over time.
Time-bound	• This first-up objective will be accomplished during Year 1, with quarterly development objectives.

E. Implementation Objectives

Describe the specific measurable end-products of your intervention. Objectives should be SMART: specific, measurable, achievable, realistic, and time-framed.

Implementation Objectives	Year 1	Years 2-5
1. Implement the virtual Collaboration Hub at VDH (Years 1-5)	Implement	Continue
2. Engage target minimum of 20 community stakeholder organizations from across the six-locality region in Year 1; expand in Years 2-5. (See **Appendix 2** for prospective partner list).	Implement	Continue
3. As a 'first-up' initiative, launch a collaborative effort to help in-need or at-risk community members understand and utilize community supports for reducing substance use and preventing drug overdose deaths (Years 1 and 2) (See ideas for populations, collaboration, and data in **Appendix 3**.)	Implement	Continue
4. Facilitate stakeholder connection and learning through webinars and interaction through the virtual Collaboration Hub (Years 1-5)	Implement	Continue
5. Facilitate stakeholder focus by developing and sharing community data sets that identify in-need or at-risk populations. (Years 1-5)	Implement	Continue
6. Begin planning to develop additional community initiatives for preventing drug overdose deaths (by or before Years 2-5, contingent on stakeholder interest and resource feasibility)	Year 1 planning Year 2 implementation	

F. Workplan

This section describe the workplan for achieving each of the implementation objectives listed in Section E.

Objective 1. Implement the virtual Collaboration Hub at VDH (Year 1, Q1, ongoing)

Background

The virtual Collaboration Hub is intended to facilitate community collaboration based on principles of the **collective impact framework**. (https://collectiveimpactforum.org/). The published literature on collective impact identifies five elements that are essential for supporting community collaboration: 1) A common agenda, 2) Shared measurement, 3) Mutually reinforcing activities, 4) Continuous communications, and 5) Strong background.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
1.1 Transfer Mighty Networks software to HPHD	May-July 2024	• Staff time • Software	• HPHD Lead • CHS support	HPHD owns software subscription	
1.2 Train HPHD staff to manage software	May-July 2024	• Staff time • Software	• HPHD Lead • CHS support	HPHD staff ready to manage software	
1.3 Build out workspace for Substance Use (Welcome, Connect, Learn, Focus, Collaborate)	May–July 2024	• Staff time • Software	• HPHD Lead • CHS support	Virtual workspace ready to go	
1.4 Post initial learning content, data sets, and collaboration guide for Substance Use	May-July 2024 ongoing	• Staff time • Software	• HPHD Lead • CHS support	Virtual workspace ready to go	

Objective 2. Engage target minimum of 20 community stakeholder organizations from across the six-locality region (Year 1, Q1, ongoing)

Background

See background on the collective impact framework under Objective 1. See Appendix 2 for an initial prospective partner list.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
2.1 Identify list of prospective members	May-July 2024	• Staff time • Software	• HPHD Lead • CHS support	List identified	
2.2 Develop communication strategy for prospective members (why, what, how, value of joining)	May-July 2024	• Staff time • Software	• HPHD Lead • CHS support	Communication strategy ready to go	
2.3 Conduct outreach to prospective members (email, telephone, personal, webinars)	Jul - Sep 2024	• Staff time • Software	• HPHD Lead • CHS support	Each target stakeholder is informed and invited	
2.4 Enroll members in virtual Hub	Jul - Sep 2024 ongoing	• Staff time • Software	• HPHD Lead • CHS support	Target of 20 organizations enrolled	

Objective 3. As a 'first-up' initiative, launch a collaborative effort to help in-need or at-risk community members understand and utilize community supports for reducing drug overdose deaths (Year 1, Q1, ongoing)

Background

This objective will be guided by the list of evidence-informed interventions for community-based outreach and education as listed in the Driver Diagram in Appendix 1.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
3.1 Promote member awareness of populations in-need or at-risk	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members aware	
3.2 Promote member awareness of existing supports for reducing drug overdose deaths	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members aware	
3.3 Promote member awareness of evidence-informed ideas reducing drug overdose deaths	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members aware	
3.4 Encourage members to promote community awareness of substance use and drug overdose deaths and supports	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members take action	
3.5 Encourage members to connect their at-risk / in-need clientele to community supports for reducing drug overdose deaths	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members take action	
Note: Also see Objectives 4 and 5 as enabling supports for this objective.					

Objective 4. In support of Objective 3, Facilitate stakeholder connection and learning through webinars and interaction through the virtual Collaboration Hub (Year 1, Q1, ongoing)

Background

This objective will be guided by best practices for developing virtual community networks as recommended Mighty Networks software and other sources of published literature.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
4.1 Welcome members individually and provide a guide for navigating the Hub and connecting with other members	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members join the Hub and connect with others	
4.2 Communicate with members every two weeks to share content and encourage engagement	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members are equipped with useful content to support their work	
4.3 Conduct member surveys on topics of interest at least quarterly	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members share their insights and ideas for optimizing the work	

4.4 Conduct member webinars on topics of interest at least quarterly	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members come together to share insights and ideas for working together on community outreach, education, and service connections	

Objective 5. In support of Objective 3, facilitate stakeholder focus by developing and sharing community data sets that identify in-need or at-risk populations. (Year 1, Q1, ongoing)

Background

This objective will focus on mining available data to produce concise data sets that can help members focus their work on community outreach, community education, and community connections.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
5.1 Identify community data sources on drug overdose deaths and related factors from the Virginia Community Health Improvement Data portal and other sources.	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Inventory of relevant community data	
5.2 Query members about types of community data that could help them focus their work for community outreach, community education, and community connections.	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Member insights on types of data that would be helpful for focusing their work	
5.3 Develop community data sets and maps in response to member interests, as feasible.	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Concise, targeted products with data and maps.	
5.4 Deliver community data sets with supporting webinars and guides to help members use the data to focus their work.	Jul-Sep 2024 ongoing	• Staff time • Software	• HPHD Lead	Members utilize data products to focus their work.	

Objective 6. Develop additional community initiatives for reducing drug overdose deaths (Year 1 or Year 2)

Background

This objective will build upon the collective impact framework and the Year 1 work of the Community Collaboration Hub to engage members in exploring additional collaborative initiatives for Year 2 and beyond. See Appendix 3 for some possible ideas.

Workplan

Activity	*Timeline*	*Resources Required*	*Lead Person / Organization*	*Anticipated Product or Result*	*Progress Notes*
6.1 Query members about ideas and level of interest in working on additional collaborative projects in 2025-26	Jan – Jun 2025 ongoing	• Staff time • Software	• HPHD Lead	Members share ideas for additional collaborative initiatives	

6.2 Offer to host and facilitate virtual meetings where members can begin to dialog about possibilities	Jan – Jun 2025 ongoing	• Staff time • Software	• HPHD Lead	Members meet to explore ideas with virtual supports from the Hub	
6.3 Offer to begin developing content and data that could be helpful for envisioning collaborative efforts, and provide those resources through the Hub	Jan – Jun 2025 ongoing	• Staff time • Software	• HPHD Lead	The Hub becomes a source of content and data to support collaborative efforts in Year 2	
6.4 Consider additional support strategies for Year 2 initiatives that the Hub could provide based on ideas emerging from member dialog	Jan – Jun 2025 ongoing	• Staff time • Software	• HPHD Lead	HPHD considers strategies for aligning Hub resources in support of member ideas for Year 2 collaborations	
Note: Also see Objectives 4 and 5 as enabling supports for this objective.					

G. Alignment with State and National Priorities

As of April 2024, the Virginia Department of Health most recent State Health Assessment identified a set of priorities including 1) infant mortality; 2) firearm-related deaths; 3) obesity; 4) mental health; 5) **substance use and drug overdose**; and 6) housing, transportation, and economic stability. The CHIP Implementation Plan for HPHD directly aligns with priorities 1, 2, and 5. It also relates to the obesity priority as one causal factor for heart disease.

From a national view, the four priorities areas identified in the HPHD CHIP Implementation Plan align with Healthy People 2030 Leading Health Indicators relating to firearm deaths (homicide and suicide), heart disease risk factors (physical activity, blood pressure, smoking), infant deaths, and **drug overdose deaths**.

In addition, Healthy People 2030 has a **priority focus** on eliminating health disparities and creating equitable opportunities for people to live healthy lives. Core strategies include advancing health equity, increasing health literacy, and addressing social determinants of health in communities across the nation. A cross-cutting aim of the HPHD CHIP Implementation Plan is to engage community organizations in identifying community populations who need help with understanding and access community supports, including help with addressing social determinants that may influence disparities and affect their opportunities for health.

Appendix 2 – Workgroup Member Ideas for Prospective Partners

Note: This list includes ideas shared by CHIP Workgroup Members in 2023, and Implementation Task Group Members in 2024. The list is provisional and does not imply approval by any of the listed organizations. Also, some organizations may be interested in working on topics beyond those shown indicated in the list.

Organization	Firearm Violence	Heart Disease	Infant Mortality	Substance Use
#757 Breastfeeds			*	
(HII) Shipyard		*		
3E Restorations				*
4 Oaks		*		*
American Heart Association		*		
Avalon				*
Bacon Street				*
Ben's Friends				*
Black Maternal Health Equity Action Alliance			*	
Boys and Girls Clubs	*			
CDR			*	
Center for Child & Family Services			*	
Churches / Faith Communities	*	*	*	*
Colonial Behavioral Health				*

Community Clinics		*		
Community Health Workers	*	*	*	*
Community Coordinated Response Team	*			
Community Corrections				*
Community Foundation				*
Community Health Workers		*		
Community Services Boards	*			*
Courts				*
Drive Safe HR			*	
Early Impact Virginia			*	
Eastern Virginia Child Fatality Review Team			*	
EMS	*	*		*
Faith-Based Organizations		*		*
First Spark (Smart Beginning)	*		*	
Food Banks		*	*	*
Hampton City Government	*			
Hampton Family Violence Council	*			
Hampton Healthy Families	*			
Hampton VA				*
Hand-in-Hand	*			
Healthy Families (Home Visitation)			*	
Heart Specialist		*		
HELP				*
Historic Triangle Drug Prevention Coalition				*
Home Visitation Programs		*	*	
Homeless Shelters	*			
Hopeful Hampton	*			
Hospital ER	*			
Hospitals			*	
Hospitals (Mother Baby Units)			*	
House of Mercy		*	*	*
HPHD			*	
Insurance Companies (Case Coordinator, Case Mgmt)		*		
James City County DSS				*
Lackey/SEVHS/Local Clinics		*	*	
LGBT Life Center	*			
Link				*
Local Chambers				*
Local Departments of Social Services				*
Local Healthcare Systems / Hospitals		*		*
Local Law Enforcement				*
MASS - Minority AIDS Support Services	*			
MAT Providers (nonprofit & for-profit)				*
Medical Center			*	
NAMI	*			

Newport News Hispanic Advisory Council			*	
Non-English-Speaking Communities				*
NRA	*			
OB Offices & Programs			*	
Opioid Response Network				*
PCOR Coalitions				*
Perinatal Mental Health Coalition			*	
Places Offering CPR Classes		*		
Postpartum Support VA			*	
Primary Care Clinicians		*		
Project Link				*
Public Schools	*	*	*	*
Recovery Center				*
Recovery Houses				*
Red Cross		*		
Riverside Mental Health				*
Salvation Army	*			*
School Systems	*			
Schools				*
Sleep Tight Hampton Roads			*	
Social Services			*	
Social Workers		*		
South Eastern Family Project				*
Spirit Works				*
Transit Hampton				*
Transitions Family Violence Services	*			
United Way		*		
Universities / Higher Ed		*	*	*
Urgency of Now	*			
Veterans Affairs	*	*		
Veterans Groups	*	*		
Virginia Department of Health	*	*	*	*
Virginia Neonatal Perinatal Collaborative			*	
WIC			*	
Women's Violence Shelters			*	
YMCA	*	*		
York Poquoson DSS				*
Youth Violence Prevention Week	*			
YWCA	*			

Appendix 3 – Workgroup Member Ideas for Populations, Collaboration, and Data			
Firearm Violence	**Heart Disease**	**Infant Mortality**	**Substance Use**
Populations. Who are the key community populations that should be reached as part of the effort to connect people in need to available community services?			

• Young adults • Teens • Veterans • Elder males • High schoolers • Hunting groups • New gun owners • New parents or parents (young kids, teens) • Recent parolees/ prisoners • Veterans	• Schools • Community Centers and Recreation Centers • Senior Developments, assisted and independent • Support groups • Community Health Workers and Navigators • Anyone who utilizes the local senior centers, any local churches (especially if they have senior groups), any patients utilizing the free and charitable clinics, any patients with frequent/avoidable hospitalizations for heart-related issues, anyone utilizing the organizations listed in item #3 • Families at risk • Individuals with multiple health conditions • Underserved communities	• Women of child-bearing years. • Pregnant mothers, parents, legal guardians, families, school nurses, school guidance counselors, day care centers, and churches. • African American • Low-income • Non-English speakers • Pregnant and new moms • Refugees	• People returning from incarceration • People with history of SUD • People with unstable housing • People with mental health disorders • People of certain sexual orientations • EMS - other relations • Family members • PWUD • Rehabs
Collaboration. What are some creative ideas for collaborative community outreach?			
• Lock & Talk Va program on lethal means safety. • Gun shops education programs. • Gun stores • Military bases • Pawn stores • Safe storage education • School groups • Attending events and/or festivals • Unite Us • Using social media • Annual community events/weeks highlighting youth violence prevention • Collaborate locally to 'recognize' National Youth Violence Week (held annually in April) • Collaboration for trauma informed care wherever violence happens (i.e., Child Savers) • Education-based Gun Safety Day - police departments, local schools • Firearm safety training (all localities)	• Work with Hospitals, Clinics, Physician's offices, PE Teachers, United Way, Grove Outreach Center. • Work with the population who are English language learners such as CCC. • We are looking at utilizing the EDCC program offered by VDH. We think this could be a viable option for connecting people more quickly to post-hospital and follow-up services. This could possibly work for heart disease as well, especially for re-admits/inappropriate use of the EDs. • Community Health Workers • Hospitals, health clinics, and urgent care facilities • Organizations that serve at-risk populations • Primary Care Providers • Employer wellness (especially for large employers), incentives? • Human services • Organizations and agencies • Pharmacy pharmacies • Schools - P.E. Health • SHIP in WJCC schools • Health fairs	• Sending letters to each of Hampton's neighborhood associations and to each Hampton City public school nurses and guidance counselors with HPHD's Maternal Child Health programs flyer (Car Seat and Pack 'n Play portable crib distribution programs - which include child safety seat installation training and safe sleep education - to reduce the rates of child injury and hospitalizations, and to reduce the infant mortality rate. • Can be sent to all of HPHD cities and counties point of contacts as described above for Hampton. • CHW's • Health Dept. - (at all advantage) 1. immunizations, 2. refugees, 3. MCH, 4. Hispanic population, 5. Low-income families	• Unite Virginia and build the local network • EMS • Hospitals • Rehabs • Community events health fairs • DARE - School education • Rotational staff for community partners • Funding opportunities for collaborative partners • Awareness Fairs • Data sharing • Mobile Units • Pop up events • Regional Coalition • Regional Summit

• Suicide (attempt) follow-up counselors in hospitals (all localities)	• Hotline and resource guides • Mobile education • Social Media as a preventative method • Cross jurisdictional survey distribution to continue the needs assessment • JCC, Williamsburg and York: Educational Outreach for Stroke Prevention (F.A.S.T.) • Social Services community health initiative	• Infant mortality - WIC, MCH programs, HCP • Health care systems teach patients about safe sleep practices, screening for services/needs • Collaborative grants • Really make an effort to go out into the community to provide services • What would be some possibilities for regional collaboration? • Fatherhood Program • Motherhood Program	
Data. What types of community data would be ideal for helping community organizations focus the work of connecting people in need to available community services?			
• Violent crime data including firearms. • School data about firearm violation • Suicide data •	• The data that would benefit and be ideal could be from PCPs, Hospitals, Rehab centers, Offices for Physical Therapy, Schools, and Universities. May be a good idea to compare data with close by cities as well. • Admission and re-admission rates at all local hospitals for heart-related issues/avoidable hospitalizations, rates of heart disease/heart failure for local cities/counties	• Data on birth outcomes will be crucial. • Infant Mortality Rates for US, Virginia, and Eastern region of VA, and each of HPHD localities. • SIDS and SUIDS rates. Data of deaths caused by Sudden Unexplained Infant Death associated with unsafe sleep. • Child Injury and Hospitalization rates for US, Virginia, and Eastern region of VA, and each of HPHD localities. • Percent of Infants ever breastfed and Percent of Infants breastfed exclusively through 6 months in the US, Virginia and in each of the HPHD localities.	• OD #s • Substance types used by locale and % • EMS responses for SUD by locale, type and % • ER visits for SUD by locale type and % • Arrests for substance reasons (top 3 zip codes by locale) • Court cases by substance type (top 3 zip codes by locale)