Community Health Improvement Plan 2011

Developed by MAPP of the Southern Kenai Peninsula Communities

Mobilizing for Action through Planning and Partnership

MAPP

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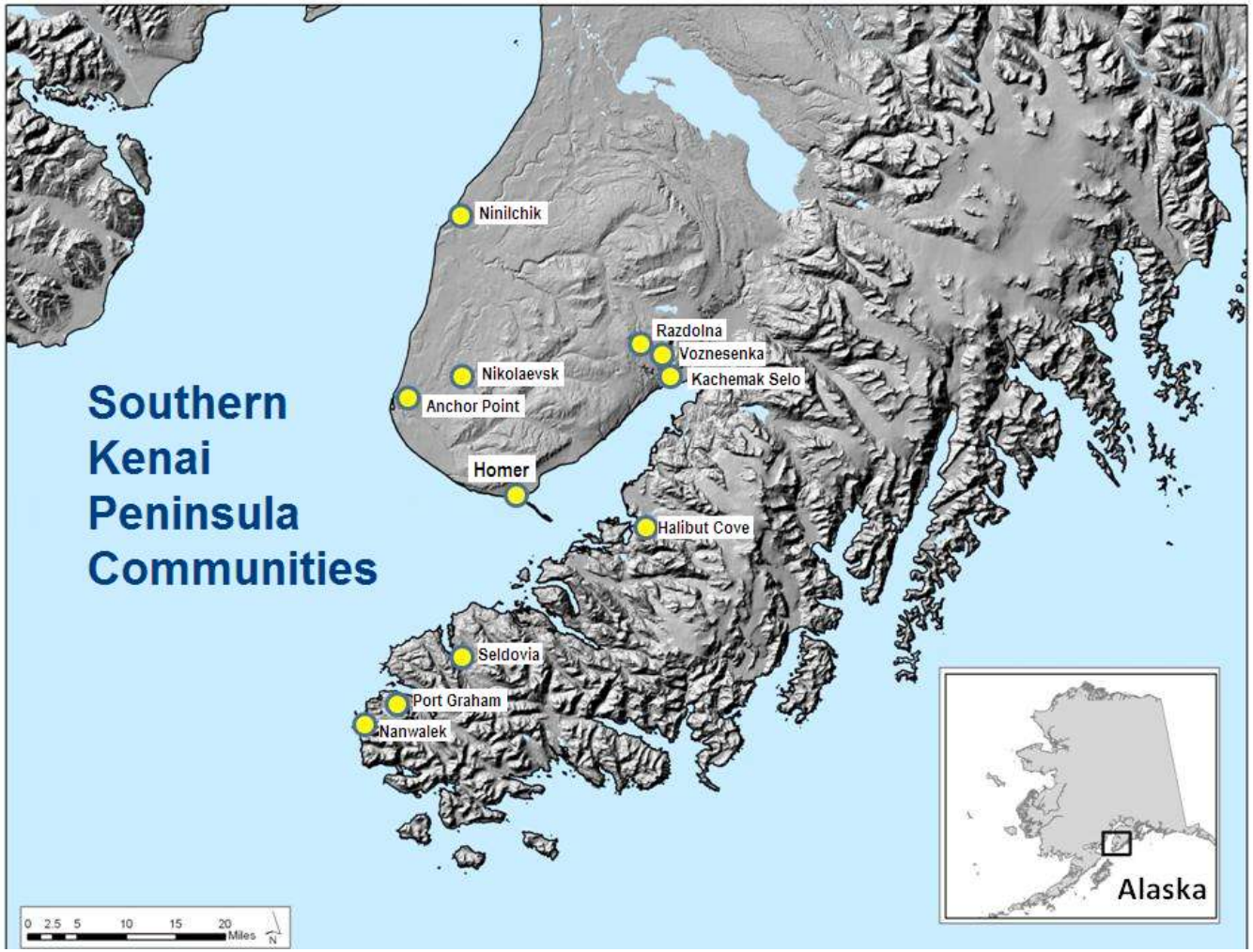
With many thanks to the individual and organizational partners who have contributed staff time and other resources to the project.

Partner organizations include:

AK Family Violence Prevention Project	Homer Downtown Rotary Club	Kenai Public Health Center
AK Small Business Development Center	Homer Foundation	Kenai Peninsula Youth Court
	Homer - Kachemak Bay Rotary Club	Kenai Peninsula Borough School District
Alzheimers Resource Agency of Alaska	Homer Medical Clinic	Lifeline
Birth 2Three (Homer Children's Services)	Homer News	Midtown Café and Refuge Chapel
	Homer Police Department	Nature Rocks Homer
Bunnell Street Arts Center	Homer Public Health Center	Ninilchik Clinic
The Center	Homer Senior Citizens, Inc.	Ninilchik Health and Wellness Club
Center for Alaskan Coastal Studies	Independent Living Center	Ninilchik Indian Housing
City of Homer	Inner Nature Chiropractic	Ninilchik Senior Center
Cook Inlet Council on Alcohol and Drug Abuse (CICADA)	Kachemak Bay Campus - Kenai Peninsula College	Ninilchik Tribal Council
		NoFAS (Fetal Alcohol Syndrome) Alaska
Cook Inletkeeper	Kachemak Bay Conservation Society	Pratt Museum
Families First-Best Beginnings	Kachemak Bay Family Planning Clinic	South Peninsula Haven House
Food Pantry	Kachemak Bay National Estuarine Research Reserve	South Peninsula Hospital
Homer Chamber of Commerce		Sustainable Homer
Homer Council on the Arts	Kachemak Heritage Land Trust	SVT Health Center

SERVICE AREA OVERVIEW



MAPP of the SKP Communities

Geography and Brief Demographics

The Southern Kenai Peninsula is a rural area in Southcentral Alaska with a population of about 15,000, which includes several small, culturally diverse communities. As with most of Alaska, large geographic and service area challenges complicate access to care. The service hub is Homer, population 5600, which is about 95% Caucasian and known for its halibut fishing, arts, and environmentalism. It is often referred to as "the end of the road," since it is the official northern end of Coastal Hwy 1.

The southern boundary of the service area includes three villages across Kachemak Bay (7 x 19 mi. long). Two of the villages, Port Graham and Nanwalek, are Alaska Native villages with the Suqpiaq culture and the other one, Seldovia, is a blend of Aleut, Yupik, Alutiiq, Athabascan and Caucasian. These three are accessible only by boat or plane. There is ferry service to Seldovia.

The northern boundary of the service area is on the road system 45 miles north, marked by the village of Ninilchik. Ninilchik's population is a blend of Aleut, Alutiiq, Athabascan and Caucasian. Four Russian Old Believer communities also inhabit the area, at each end of the highway. Ancestors of these villagers left Russia in the revolution near the turn of the 20th century, and have lived in other countries since then. They first came to Alaska in 1968.

See our Community Health Status Assessment Report for more demographic information. (http://MAPPofSKP.net)

Current Medical Providers

There are two private medical clinics and one Community Health Center (CHC - federally funded, sliding scale clinic) in Homer. There is one hospital in the area, South Peninsula Hospital in Homer; the nearest Alaska Native services are accessed at Alaska Native Medical Center (in Anchorage, 230 road miles away), except in emergencies.

Alaska Native villagers access healthcare in varied ways. Most care is provided by community health aides. These are village residents who receive centralized training and access daily phone supervision with physicians at the Alaska Native Medical Center in Anchorage. Specialists visit some villages quarterly or at other longer intervals. Seldovia has a federally funded Community Health Clinic (CHC). Russian Old Believer villages have no local healthcare providers, except for quarterly public health nurse clinics and, in one case, their own volunteer EMS services. They utilize some herbal/alternative and folk remedies, as do Native villagers and other area-wide residents.

PROJECT BACKGROUND

Developing and sustaining a healthy community requires participation from many diverse organizations and individuals who live, work and play in a community. The Southern Kenai Peninsula (SKP) Communities Project came together in November of 2008, spearheaded by South Peninsula Hospital, to create just such a partnership. It gathered to conduct the first collaborative, area-wide health needs assessment, with the goal of identifying opportunities for health improvement and to serve as a catalyst for community action. The group defined health very broadly, to include not only physical, but mental/emotional, cultural, educational and environmental health. To be effective, the local public health system needs all of us. This plan is an outgrowth of four assessments conducted using the "Mobilizing for Action through Planning and Partnership" (MAPP) framework.[1]

This model shows the four assessments as the key content that drive the process leading to development of a Community Health Improvement Plan.

MAPP of the Southern Kenai Peninsula Communities

Between November 2008 and December 2009, the project formed, members created a vision statement, and conducted a health needs assessment. That first vision was "Vision to Action for a Better Life." The Project compiled data from the Census, state and local data sources, and conducted citizen surveys and interviews. Final reports on the four assessments and a project summary are now available on our website, http://MAPPofSKP.net. The group then held two days of facilitated community meetings to present themes from the assessments. Here, about 80 community members also generated a vision for the Southern Kenai Peninsula over the next 5-10 years, which they conceived in the shape of a circle, with 9 "bubbles" surrounding and defining it.

[1] MAPP is "a tool that helps communities improve health and quality of life through community-wide and community driven strategic planning," Achieving Healthier Communities through MAPP: A User's Handbook, CDC (Centers for Disease Control and Prevention) and NACCHO (National Association of City and County Health Organizations), 2008.

Our Vision for Healthy SKP Communities

MAPP of the SKP Communities

Next, the group identified 12 prominent themes and some core values.

Priority Themes for the Southern Kenai Peninsula Community Health Improvement Plan (CHIP)

Recreation
Preventing violence and substance abuse in families
Public transportation
Community resources
Healthy lifestyle choices
Encourage sustainable businesses
Local Public Health System Coalition
Organizational collaboration and communication
Expand vocational education
Identify youth needs and wants
Arts & Culture
Affordable housing

Integrated Methods or Core Values

Data collection – monitor what we are doing
Use media
Find new partnerships/collaboration
Outreach to engage outlying communities
Identify roles for volunteers
Consider needs of youth and include them in planning
Local preference
Compassion: give value to everyone
Involve schools
Diversity
Value the natural environment

Recognizing that 12 themes could not be effectively addressed all at once, on "Day 3," about 35 people from 25 organizations gathered, in spring of 2010, to select top project goals for the first year (7/10-7/11) and asked the question, "What do we envision for our community?" *It is important to note that these do not represent a rank ordering of the 12 priorities.* This group identified available resources and interest among participants, and formed workgroups to develop one-year action plans for three, noting that the rest of the themes might be selected to be addressed in subsequent years. In fact, other entities may already be addressing some of the other priorities, so the current groups selected according to criteria of available resources, those projects that might generate immediate success, as well as those that reflect identified issues that would have consequences too grave to ignore the first year. Some projects will undoubtedly require multi-sector, multi-factorial approaches. Some workgroups plan to connect groups that already exist, to avoid duplication and make resources more widely available. By seeking new levels of collaboration community-wide and non-traditional partners, this project seeks community benefit through more effective, creative solutions that build on the many strengths residents identified throughout the needs assessment. (See "Community Strengths and Themes Assessment Report," http://MAPPofSKP.net).

THREE PRIORITIES FOR THE FIRST YEAR

- Healthy Lifestyle Choices
  Current Contact Person: Jeff Szarzi, 299-7475, 235-9713
  Jszarzi@kpbsd.k12.ak.us

- Addressing Substance Abuse and Violence in Families
  Current Contact Person: Bonnie Betley, 235-8857
  bonnie.betley@alaska.gov

- Connecting Community Resources
  Current Contact Person: Patti Boily, 235-7911
  homeril2@peninsulailc.org

Or contact M.A.P.P. Coordinator, Sharon Whytal at 399-4027, or swhytal@gmail.com

Ongoing updates available at project website: http://MAPPofSKP.net

WORK PLANS

The initial work plans for the local work groups are provided below in logic model format as recommended by the State of Alaska. They are currently Homer-centered. All individual communities within the Southern Kenai Peninsula are invited to develop work plans to their own specific needs, while connecting to the bigger workgroups, who offer support and to coordinate resources and avoid duplication.

STEERING COMMITTEE

Purpose: The primary purpose of the Steering Committee is to support an ongoing health needs assessment and facilitate, monitor and report on the progress of the community health improvement plan. The committee serves as a network and provides leadership, decision making, and support to the work groups. It connects resources and people in support of the plan, and will consider support of projects that meet the vision from the plan and are supported by the assessment. It provides leadership and direction for the project coordinator.

Members: Membership on the committee will include representatives from community organizations which represent broad community health interests as defined in the health needs assessment. The total number of individuals on the committee (not organizations) will not exceed 15. The committee may appoint new members based on need by unanimous vote of all active organization members. An *active member* is one who attends or whose representative attends most regularly scheduled meetings and participates as a member of at least one priority workgroup. It can also include attending additional sub- committee meetings and contributing to the project outside of committee meetings. An *inactive member* is one which has provided advance notification of extended non-participation in the project but is not removed from the committee.

Committee Members: Nina Allen and Carol Barrett (The Center), Bonnie Betley (Homer Public Health Center), Jeanette Desimone (CICADA-Kenai), Beckie Noble and Emiley Faris (SVT Health Center), Bob Letson and Derotha Ferraro (South Peninsula Hospital), Megan Murphy (Kachemak Bay Research Reserve), Carol Swartz (Kachemak Bay Campus, Kenai Peninsula College), Kyra Wagner (Sustainable Homer), Anne Walker (Community member (on leave)), Michelle Waneka (Kachemak Bay Family Planning Clinic), Sharon Whytal (Project Coordinator)

Goal: Solutions-based, locally driven partnership for collective community action to improve health

Resources	Activities	Outputs	Outcomes -- Impact		
			Short (Learning)	*Medium (Action)*	*Long (Behavioral change)*
• Project Partners • Steering Committee • Jayne Andreen-tech support • Media: ○ Homer News ○ Homer Tribune ○ KBBI ○ KGTL • <Funding> • Collaborative partnerships for funding • Coordinator • Current data • Project workgroups • Operation Guidelines	1. Conduct ongoing health needs assessment utilizing MAPP 2. Write, implement and update CHIP 3. Regularly Hold Community Visioning/Forums/Updates 4. Provide framework for project workgroups 5. Participate in project groups 6. Inform community membership of project 7. Make current local data accessible 8. Foster new collaborative partnerships	1. Group/agencies participate in data collection 2. Yearly updated CHIP - identifying needs - defining project workgroups 3. Increased: - Number of partners. - Validity of project workgroups - New innovations/connections 4. Groups all have logic model, mtg. times, communicate on website and clearly defined values to follow. 5. All steering group members on a workgroup and all project groups have representative steering group members 6. Regular communication through: - Website - Media - Community presentations 7. SKP is identified as a data source. 8. - Host quarterly meetings - Host workshop(s) on collaboration - Seek integrated service funding	-Community has increased awareness of local assessment data and health improvement plans (CHIP); able to access it. -Steering Group rep on each of the workgroups to ensure integration of core values in projects. -Provide opportunities to network -Engage and expand collaboration community-wide, including between non-traditional partners	-Data informs decisions on community-wide health planning -Identify gaps in local data -Advocate for improved data collection -Wide range of partners from various fields of interest and expertise participate in health planning and action steps -Public officials support project goals -Network created to share info and resources. -Decreased misperceptions and improved services. a. Agencies throughout community understand services and limitation of individual organizations. b. Community perception improves	-Community-wide commitment to health; national recognition of our area. -Data demonstrates area-wide health improvement -Borough and State data is made specific to SKP region. -Community perception reflects health improvement - CHIP- based partnership and collaboration drives community action -Projects well-funded (money flows freely) -Funders seek to fund on community self-determination process/community-identified priorities -Community defines health/ public health system broadly.

Steering Committee

Resources	Activities	Output	Outcomes -- Impact		
			Short	Medium	Long
	9. Promote and foster broad definition of health and the local public health system. (It takes all of us). 10. Weave/incorporate/ integrate health values in community actions/activities 11. Create and maintain "virtual office" website 12. Advocate for policy change in operations 13. Actively seek funding to support coordinator position 14. Promote community self-determination in funding 15. Marketing - Ongoing community engagement - Support smaller Communities Develop business plan Develop message (elevator speech) Outreach to community leaders	9. Steering Committee member org. and project partners reflect the broad range of health in activities 10. SKP sponsored activities model SKP values 11. Website is used. Social marketing tools engaged. 12. Testimonies given at public meetings and with elected officials 13. Coordinator position adequately funded 14. Project budget is sustainably funded 15. - Articles/media coverage -Community meetings -Regular communication/visits -Website developed - Statewide awareness Business plan developed New leaders in the community are informed about the project	-Educate or engage public officials on community data and ongoing health improvement projects -Increased info sharing between organizations Market website to project partners Identify opportunities and prioritize ID grant and funding opportunities Learn about sustainability models Understand marketing opportunities	-Integrated awareness of opportunities outside of own organization - Multidisciplinary approaches used to achieve CHIP mission Project partners access, use, contribute to website Advocate for policy change Apply for, advocate and receive funding Identify and implement marketing strategies	- Agency cultural change: a. Org. decisions are made considering broad community perspective; b. free and generous sharing of info; c. total community collaboration and sharing of resources. Virtual office is interactive and a primary means of communication Policy change Coordinator position secures long term viability of project Local and Statewide awareness and support of project

Steering Committee

Outcomes	Indicators	Data Collection Strategies
Short Term (Learning/Awareness Happening)		
Community has increased awareness of local assessment data and health improvement plans (CHIP); able to access it.	1. # of website hits 2. # of inquiries for data 3. Contribution of data 4. # of presentations of CHIP 5. Increased participation in groups 6. # of people/organizations participating in process	Collect and compile indicators, surveys, manual count, technology, #of people participating
Steering Group rep on each of the workgroups to ensure integration of core values in projects.	1. Workgroups demonstrate project core values	Meeting reports and minutes
Provide opportunities to network	1. Communication (emails) increases 2. Increased information sharing	Website hits, e-mail volume, informal survey
Engage and expand collaboration community-wide, including between non-traditional partners	1. Increased collaboration and coordination between organizations 2. Increase in collaborative funding opportunities	Self-report, observation
Educate or engage public officials on community data and ongoing health improvement projects	1. # of Elected officials participating in workgroups and quarterly meetings 2. Public policy is influenced by CHIP 3. # of presentations seen by public officials on CHIP topics.	Head counts, news sources, meeting attendance
Increased info sharing between organizations	Ongoing steering committee meetings with all members participating	Self report, individual organizational surveys
Market website to project partners	Increased communication with partners	Hit counter and analytics built into website
Identify opportunities and prioritize	ID policy change opportunities	Meeting minutes
ID grant and funding opportunities	# of funding options identified	Meeting minutes
Learn about sustainable funding models	Examples shared	Meeting minutes
Understand marketing opportunities	List of identified marketing options/tools	Have a list

Outcomes	Indicators	Data Collection Strategies
Medium Term (Action/Change Happening)		
Data informs decisions on community-wide health planning	1. Increase in programmatic decisions based on local data	Self report, news reports, annual reports
Identify gaps in local data	1. # of non-responders to data collection requests 2. # of gaps identified/discovered during projects	Count, track
Advocate for improved data collection at state and borough level	The number of communications regarding changes in data reporting	Number of communications requesting changes in data
Wide range of partners from various fields of interest and expertise participate in health planning and action steps	1. # of participating agencies and individuals increases	Track and count number of participants
Public officials support project goals	1. # of Elected officials participating in workgroups and quarterly meetings 2. Public policy is influenced by CHIP	Attendance, observation. Track relevant policy changes
Network created to share info and resources	1. Website up-to-date (pop411 and SKP)	User feedback
Decrease misperceptions and improve services. a. Agencies throughout community understand services and limitation of individual organizations. b. Community perception improves	1. Utilization of services increase 2. Collaborations increase	Agency reporting anecdotal observations Interagency referrals
Increased awareness of opportunities outside of own organization	Collaborations increase	-Self report -Success stories
Multidisciplinary approach to achieving CHIP mission	Multiple partners working together in workgroups to implement CHIP	Number of participating agencies represented Type/scope of agencies represented

Outcomes	Indicators	Data Collection Strategies
Medium Term (continued)		
Project partners access, use, contribute to website	Website up-to-date and informative	Hit counter/ analytics on website
Advocate for policy change	Assign tasks for advocacy and compile results	Success stories
Apply for, advocate and receive funding	Amount of $$	Budget accounting
Identify and implement marketing strategies	Number of audiences being reached	Number of venues marketed to, amount of time and money spent

Outcomes	Indicators	Data Collection Strategies
Long Term Goal (Behavioral/Policy/Attitudinal Change)		
Community-wide commitment to health; national recognition of our area.	1. Project groups have high participation and find successful completion 2. Community members see their own role in health 3. Homer recognized as model community	Assessment findings reflect health improvement Awards, funding, recognition
Data demonstrates area-wide health improvement	Shift in data	Assessment updates
Borough and State data is made specific to SKP region.	1. Regional data is more relevant, a better reflection of regional realities.	Data in reports is broken down into smaller groups
Community perception reflects health improvement	Survey findings Bumper stickers change	Survey
CHIP- based partnership and collaboration drives community action	Increased collaborative action	Success stories

Outcomes	Indicators	Data Collection Strategies
Long Term Goal (Behavioral/Policy/Attitudinal Change)		
Projects well-funded (money flows freely)	1. Budget is sustainable	Lack of funding scramble/search
Funders seek to fund community self-determination process/community-identified priorities	Increased funding opportunities	Meeting minutes
Community defines health/ public health system broadly	1. Quality of life is understood to include health of ecosystems, health, education, etc. 2. Community has a greater awareness of how multiple fields of health interrelate	Success stories
Agency cultural change: a. Org. decisions are made considering broad community perspective; b. free and generous sharing of info; c. total community collaboration and sharing of resources.	1. Organizations collaborating to solve community issues beyond individual organizations missions 2. The work of agencies with regional administrations become more responsive to local data/needs 3. Ongoing participation of locals on regional boards	Success stories
Virtual office is interactive and a primary means of communication	No gaps in communication	Hit counter and analytics
Policy change supports community health	Track policy change as result of advocacy	Success stories
Coordinator position secures long term viability of project	Position funded and filled for 10 years	$ and person
Local and Statewide awareness and support of project	1. Measure media coverage, surveys, website, and project involvement funding 2. Favorable policy change 3. Elected officials legislate broad health values	1. Number of request to present on project 2. $ Success stories

STRATEGIC ISSUE: How Do We Encourage Healthy Lifestyle Choices?

Rationale: One of the three priority themes identified to work on by the community in this first year (7/10-7/11), from our '09 health needs assessment was "healthy lifestyle choices". This priority also happens to be a national public health priority (often named chronic disease prevention or obesity prevention) which is based on sharp increases in national obesity rates over the past 2 decades*. This priority is supported locally as a result of findings in all areas of our needs assessment. Key informant interviews revealed that diverse leaders voiced a common view; improving our health depends on a shift to prevention and personal responsibility. Of 1441 residents surveyed, physical health was a top priority for families and substance abuse was identified as the top community problem. Health status data showed that behavior risk factors play a large role in the leading 7 causes of death in our area. Although we have no local data at present, state survey data (from BRFSS**) showed that prevalence rates for behavior risk factors in AK are higher than national rates. Clearly there is room for improving our overall health status, as well as life expectancy of the population, by addressing lifestyle choices. Our community members and organizations in attendance voted this a top area to begin to build a positive initiative and immediate success in our action stage. Some of this change can happen through personal responsibility and some could be greatly enhanced by systems changes.

For our one year focus, the community selected food and food systems as its priority issue, while noting that physical activity, a built environment and outdoor recreation are related issues that could be addressed later. In order to achieve immediate successes and connect multiple projects toward a shared vision, the group chose this narrower focus, with a vision that "Homer eats Healthy." The varied organizations involved can participate in this community-wide campaign through each organization's own version of work to encourage healthy eating with programs that encourage local food purchasing and growing, nutrition and dietary education for youth and adults, and/or any other form of healthy lifestyle choices promotion.

*Last decade increases: adolescents reporting overweight in ’99-25.1%, in ’07- 28.8%. Adults showed a similar trend and a higher rate of 56.6% in’99 to 63.0% in ’07. Data source: YRBS and BRFSS respectively - CDC bi-annual national surveys.
**BRFSS=Behavioral Risk Factor Survey, YRBS=Youth Behavioral Risk Factor Survey

Committee Chair: Jeff Szarzi (Flex Alternative High School)
Committee Members: Leslie Callaway and Judy Dean (Public Health), Mary Fries and Peggy Ellen Kleinleder (South Peninsula Hospital), Beckie Noble (SVT Health Center), Megan Murphy (Kachemak Bay Research Reserve), Emily Garrity (Twitter Creek Farms), Claudia Haines (Paul Banks Elementary Wellness committee), Kyra Wagner (Sustainable Homer), Mike Allen (Center for Alaskan Coastal Studies), Sharon Whytal (M.A.P.P. coordinator).

Goal: Homer Eats Healthy

			Outcomes -- Impact		
Resources	**Activities**	**Outputs**	**Short**	**Medium**	**Long**
· -Natural Resource Conservation Service · USDA · High Tunnel Greenhouses · Sustainable Homer Website · Healthy Lifestyle Choices Work group · Kenai Peninsula Borough: School District, Health Services, Food Services, Teachers, Volunteers, -Parents · Center for Alaska Food Program · Farm to School Bill · Community Gardens · Land Trust · Coal Point · Homer High School · Farmers Market · Future Farmers of America · Homer Garden Club · UAF Cooperative Extension · Nature Rocks Homer ·	Paul Banks Wellness Committee. Data Collection: Vista Volunteer: Local Obesity data: Advocate collaboration with Alaska Food Policy Council. Healthy Lifestyle Choices group members exchange information on nationwide obesity movement. Propose Food Changes USDA School lunch menu. SKP Communities Project actively supports Paul Banks Wellness Committee. Encourage quality food in school lunches. Develop healthy meal recipes for under $4. Advocate engaging school nurses.	Number of students receiving weekly snack. Data base of types and quantities of local food available. Obesity rate in SKP. Number of Alaska Food Policy meetings attended by SKP Coordinator. A webpage space created to post articles. Number of articles posted on web page. Identify USDA commodities. Number of schools that implemented healthy food choice changes. Number of contacts with Paul Banks Wellness Committee. Number of changes adopted in school lunches. Number of recipes distributed in community. Flex school students' research healthy meals under $4. Number of school nurses participating in activities.	Decrease access to sugar, fat & process foods in Homer organizations & schools by 5/11. Youth involved in local food movement/healthy options. Increase availability of local foods throughout the year, due to local processing in Homer (Coal Point).	Residents in the Homer area have increased awareness of nutritious food choices. Organizations motivated to participate. Kenai Peninsula Borough School District open exchange with parents regarding input on school menus. Residents expect healthy, local food options in schools, restaurants and events. Increased number of local producers. Increased number of restaurants purchasing local food.	Increase access to local foods. Funding at federal level to support change in food systems. The population is aware and has increased access to healthy food choices. Stronger, local food economy.

Healthy Lifestyle Choices

Continued…

			Outcomes -- Impact		
Resources	Activities	Outputs	Short	Medium	Long
· Grocery Stores · Restaurants · Schools · Facilities: Homer High School, Flex School, Non-profit agencies, government agencies, Community Schools, City of Homer, Hospital.	Outreach parents regarding healthy benefits & role in determining school menu. Increase parent participation in menu planning. Schools increase use of gardens & greenhouses for student curriculum. Local faith based organizations offering to assist with feeding students in need. Encourage Senior Center to decrease availability of process foods.	Number of articles in School newsletter, Homer News, SKP e-news, Farmers Market e-news. Number of parents participating in menu planning. Number of schools involved. Number of students served. Monitor changes in purchasing processed food currently vs. last year			

Outcomes	Indicators	Data Collection Strategy
Short Term:		
Decrease access to sugar, fat & process foods in Homer organizations & schools by 5/11.	Changes in menus	Collaborate with senior center, schools and others to get meaningful info on food purchases
Youth involved in local food movement/healthy options.	formation of school garden committees, young adults under 30 benefiting economically from local food	-Number of students participating -Coordinate with HFM, VISTA volunteer, HGC, local farms
Increase availability of local foods throughout the year, due to local processing in Homer (Coal Point).	amount of food (pounds or dollars)	Nancy's receipts
Media engaged to report good news of healthy food choices.	Increased number of reports	Local newspapers
Medium Term:		
Residents in the Homer area have increased access to affordable nutritious food choices.	-Increase of healthy food purchases by stores -Increase of healthy food options at restaurants and functions	Observe, and interview restaurants
Organizations motivated to participate.	Number of organizations serving healthy food	Direct observation, SKP newsletter updates
Kenai Peninsula Borough School District takes input from parents regarding school menus.	Parent comment effects successful changes	PTA reports positive results
Residents expect healthy, local food options in schools, restaurants and events.	-Increased demand -Increase supply	Observable change in menus
Increased number of local producers.	Increased number of local producers.	VISTA, HFM, Farm Service, NRCS
Increased number of restaurants purchasing local food.	Increased number of restaurants purchasing local food.	VISTA, HFM, restaurants
On site cooking facilities established/used	-Number of kitchens installed or reinstated at schools and organizations	Observe additional infrastructure

Continued…

Outcomes	Indicators	Data Collection Strategy
Medium Term: (Continued)		
Alaska state policies support strong local food economy	Increase in political actions supporting food security	Food Policy Council updates
City of Homer supports food system business development from production to distribution and marketing	Increase in political actions supporting food security	Newspapers' reports
Long Term:		
Increase awareness and access to affordable, healthy local foods.	-Increased CSA shares -High tunnel data -Increased number food production related businesses -Increased number of local meat sales	-Observation of food options availability -NRCS/USDA -Chamber of Commerce -VISTA collection
Funding at federal level to support change in food systems.	-An agenda of Alaska needs for the food system -To increase level of participation in political process, make information available on hearings and related legislation	-Food Policy Council -Number of alerts in e-newsletter
Stronger, local food economy.	-More agricultural exemptions on tax rolls -Less imported food	-Borough data -stores purchases compared

STRATEGIC ISSUE: How Do We Address Domestic Violence and Substance Abuse?

Rationale: Based on the 2009 MAPP Assessments, the community identified substance abuse and domestic violence (together) as a priority issue for the coming year (7/10-7/11). Key findings from the Community Themes assessment included substance abuse as the number one community problem overall, with interpersonal violence in the top four problems affecting the community amongst respondents aged 45-65 and 66+. Additionally, key informant interviews suggested that adverse childhood experiences (ACE) are pervasive in our culture and substance abuse prevention/intervention services are severely lacking. Community health status data indicated that the southern peninsula has one report of interpersonal violence per day, and that substance abuse-involved arrests in both minors and adults is a concern. The association of alcohol and crimes of sexual assault was also evident in local and statewide data. The service data from local organizations showed an increase in both violence and substance abuse during this present economic downturn, causing pressure on all local services at a time when funding is less. Please note that the literature supports what shelters see clearly, that substance abuse is NOT a cause of domestic violence, only a correlation. The Forces of Change assessment identified a challenge regarding more and different drugs available to teens in recent years, while at the same time there is an opportunity for increased SAMSHA (federal prevention and treatment) money available for substance abuse. A greater community awareness of the lifelong impact of trauma upon individuals and families, and also new care modalities available for people with fetal alcohol spectrum disorder (FASD), were discussed as contributing to the community's choosing this co-occurrence as a priority issue to address in the first year of our action phase.

Goals:

1. Development of a coordinated community response to the issues of domestic violence, substance abuse, sexual assault, mental health issues, and fetal alcohol spectrum disorder.

2. Local access to trauma-informed prevention, intervention and treatment of substance abuse; as well as prevention and intervention for domestic violence. This would also include local access to trauma-informed interventions for co-occurring substance abuse and domestic violence.

Committee Members: Bonnie Betley (Homer Public Health) - point person, Jennifer Baker (Homer Public Health), Nina Allen (The Center), Carol Barrett (The Center), Peg Coleman (Haven House), Linda Chamberlain (Family Violence Prevention Project), Susan Cushing (Council on DVSA), Deb Evensen (NoFAS), Jeanette Desimone (Cook Inlet Council on Alcohol and Drug Abuse), Barbara Howard (Homer City Council), Paige Smith (South Peninsula Hospital), Sharon Whytal (M.A.P.P. coordinator).

Goal #1: Develop Coordinated Community Response to Domestic Violence (DV) and Substance Abuse (SA) and the Related Issues

Goal #2: Increase Local Access to Trauma-Informed Prevention, Intervention and Treatment of SA as well as for DV.

			Outcomes -- Impact		
Resources	Activities	Outputs	Short	Medium	Long
-Donated space for meetings. -Subcommittee that pursues grant funding for sustainability of programs is already in place. <u>-Current Partners:</u> Public Health City of Homer ILP SPH CICADA Haven House The Center SVTHC Linda Chamberlain Sharon Whytal -TIME -Funding for project activities -Media and art communities	#1. ↑ collaboration in program development and referral among agencies working with SA/DV clients, including the local "drug-free" community group, CICADA , the Center, Haven House, Prescription Abuse Task Force,etc. #2. Sponsor Bach Harrison Youth Survey. #3. Integrated Screening tool/WEB	- Monthly planning meeting will be established by leaders of CICADA and HH. -Monthly meeting for entire SA/DV workgroup to discuss local concerns in current prevention and treatment services, as noted in community-needs assessment (both hard data and community perceptions -Collaboration between Kenai agencies, Homer school representatives, and SADV Work -Group to complete the BH Youth Survey for school year 2011-2012. -Add cultural component to tool and adapt to enhance consumer comfort level -Subcommittee and meeting plan established specifically for the research, development and pilot of integrated screening tool that identifies SA, DV, BH, and FAS. -Pilot of tool will include training/guidance related to how to follow-up on any positive screening result -Cultural relevancy will be examined thru qualitative methods in several communities (interviews and community dialog) to make adaptations as needed prior to agency implementation. -Agencies will implement tool and give provider feedback thru provider focus groups	SA/DV agencies will participate in monthly planning meetings to discuss community trends, needs, youth behaviors and available services. Complete preparation for BH survey by 9/30/11. ↑ Knowledge and skill of providers related to conducting universal screening and making appropriate referrals for positive screening results. result.	-Agencies formalize collaborative agreements. -Barriers to local service delivery are reduced. Bach Harrison Survey is conducted in SKP high schools during the FY11-12 school year. ↑Number of screenings.	↑ Availability and quality of substance abuse and co-occurring SA/DV services. Data is available from local schools re: youth behaviors by spring 2012. ↑ Identification of SA, DV, BH, and FAS ↑Referrals to appropriate agencies ↑Community Awareness of SA, DV, BH, and FAS -Consumer satisfaction surveys

Outcomes	Indicators	Data Collection Strategy
Short Term: SA/DV agencies will participate in monthly planning meetings to discuss community trends, needs, youth behaviors and available services.	Each planning meeting will have at least 4 participants from different agencies at each meeting. Interagency MOU drafted and sent to Steering Group by 10/31/10 Letter to CICADA board is written and submitted to Steering Group by 10/31/10. Home visiting program is researched and fundraising committee formed to look for funds	Meeting minutes.
Complete preparation for Bach Harrison Survey in collaboration with Soldotna CAC and KPBSD prior to administration 11/11	KPBSD school staff engaged/committed to administering survey by 3/11. Subcommittee for funds/incentives established 10/31/10. PSAs/media plan completed by fall 11.	Central Admin/ # of school staff committed to survey administration is confirmed. Funding/incentives are in place and documented. Qualitative date from community members aware of survey.
↑ Knowledge and skill of providers related to conducting integrated screening with cultural component and making appropriate referrals for positive screening results.	Providers will have ↑ comfort level with asking screening questions. Providers will have ↑ ability to recognize connections between domestic violence, substance abuse, sexual assault, and mental health diagnoses. Providers will have ↑ knowledge of referral sources and harm reduction techniques.	Pre-training and post-training test, as well as a test 6 months post-training. Focus group of providers 6 months after training and implementation of screening tool.
Continued….		

Continued…

Outcomes	Indicators	Data Collection Strategy
Medium Term:		
Agencies formalize collaborative agreements.	Greater local (SKP) involvement in CICADA by 1/1/11. Services established for clients with co-occurring SA/DV by 7/11/11.	Documentation of at least one active CICADA member from the Southern Kenai Peninsula (SKP) is present. # of clients served with co-occurring SA/DV is collected by HH/CICADA.
Barriers to local service delivery are reduced.	Confidential, accessible (ADA) services are consistently available for substance abuse client by 7/11/11.	An ↑ number of clients served by the Homer CICADA office, in Homer, will be documented.
Bach Harrison Survey is conducted in SKP high schools during the FY11-12 school year.		
↑Number of screenings.	Self-reported by providers Documented screenings.	Provider survey. Chart audit.
Long Term:		
↑ Availability and quality of substance abuse and co-occurring SA/DV services. Data is available from Homer schools, regarding youth behaviors by Spring 2012.		
↑ Identification of SA, DV, BH, and FAS will be made. ↑Referrals to appropriate agencies will be made. ↑Community Awareness of SA, DV, BH, and FAS will result.	↑ Number of clients report being screened by their provider.	Consumer survey before tool is implemented and one year after.

STRATEGIC ISSUE: How Do We Connect Community Resources?

Rationale: Connecting community resources was identified as one of three priorities to address in the upcoming year (7/10-7/11), among 12 top community themes from the MAPP assessments. The issue represented two general arenas, one the desire for all residents to have easy access to the many resources that exist in our community. Secondly, this priority represents widespread interest in "breaking down silos" and fostering the "no wrong door" concept. In the community strengths and themes portion of our assessment, residents spoke passionately about how many exceptional nonprofits, services and businesses exist on the Southern Peninsula, yet also that it can be overwhelming to find a needed service. In addition, providers and consumers alike spoke of a need for seamless services, where one person with several issues could find help in a single organization or location or records transfer could occur successfully. Insurance billing and a lack of collaboration between providers were identified as creating difficulties. Technology, media and education were all named as potential solutions to this issue. Our community health status data confirms that much care is accessed without payment each year, yet there is a widespread perception that many community needs go unmet. Data confirms that a lack of transportation is a factor, and lack of insurance or other factors prevent many from accessing care before it becomes an emergency. Unemployment rates and lack of insurance are a larger factor in our area than in some neighboring ones. Forces of change include the current economic downturn, which suggested to many residents that working together is more important than ever. The Local Public Health System Assessment found that our community stands to benefit from greater innovation in providing essential services, and that we could do better in evaluating our services and empowering consumers. These complex issues will require new levels of collaboration, to address an issue that has collaboration at its core. Still, many community strengths were identified with which to launch a campaign, perhaps suggesting this is a root cause and an issue worth addressing in our first year.

Committee Chair: Patti Boily (Independent Living Center) - point person
Committee Members: Nina Allen (The Center), Adam Bauer (Homer News), Greg Browngoetz (SVT Health Center), Judy Dean (Homer Public Health), Gail Edgerly (Homer Council on the Arts), Emiley Faris (SVT Health Center), Lolita Brache (Best Beginnings), Sandy Stark (community resident), Doug Stark (community resident), Sharon Whytal (M.A.P.P. coordinator).

Goal: All residents have easy access to the many resources that exist within our community

			Outcomes -- Impact		
Resources	**Activities**	**Outputs**	**Short**	**Medium**	**Long**

· Committee Members
· Volunteers
· Media:
  ○ Homer News
  ○ Homer Tribune
  ○ KBBI
  ○ KGTL
· South Peninsula Hospital
· Best Beginnings
· SVTC
· Public Health Nursing
· The Center
· Independent Living Center
· Community Organizations
· Free Computer access
  ○ Library
  ○ KBC (for students/ registrants)
	Establishing Community Resource workgroup
	
	Creating Website
	
	Marketing project
	
	Maintain Website
		1) Service provider survey
		2) # of people attending workgroup meetings
		3) # of agencies actively represented in workgroup
		4) # of meetings per year
		5) # of subscribers to the listserve
		
		1) # of organizations in database
		2) # of users in database
		3) # of visits to site
		4) Web survey(%of users who complete)
		5) Return traffic
		6) Track searches
		7) Click-throughs
		
		1) # ads on radio
		2) # ads in local papers
		3) #press releases/PSA's/ Outreach activities
		
		1) Current
		2) Updated
		3) Accurate
			Increased ability for agencies to connect with agencies.
			
			Increased ability for people to connect with agencies.
			
			Increase ability for people to connect with people.
			
			Increase ability for families to connect with activities and resources.
				Improve agency collaboration
				
				Increase access to care.
				
				Connecting community resources.
					"One Stop Shop"

Outcomes	Indicators	Data Collection Strategy
Short Term:		
. 1. Increase ability for agencies to connect with agencies.	1. 100% functioning website 2. # links that are functioning and website is up-to-date 3. free computer access	1. Direct Observation 2. Partners track and report referral sources 3. Committee updates site regularly
2. Increase ability for people to connect with people and people to connect with agencies	1. 100% functioning website 2. # links that are functioning and website is up-to-date 3. All the indictors are the same for each of the activities	1.Direct Observation 2.Partners track and report referral sources
Medium Term:		
. 1. Improve agency collaboration	1. # of interagency referrals increase by __% in ____ time frame	1. Partners track and report … 2. provider surveys
2. Increase access to care & services	1. are consumers getting access to care or services they need?	1. website will pose question "was it useful? Did you find what you were looking for?" 2. satisfaction surveys 3. track site use and movement within
3. Connecting community resources	1. multiple listing for given topic in one website	1. Key word searches
Long Term:	1. "ombudsman" for website	1. Someone to contact & answer question did you find what you were looking for?
. One Stop Shop (website)		

We encourage participation from all interested community members, groups, and agencies who would like to be part of the action planning, implementation or evaluation process. It takes all of us to improve our community's health and to manifest the vision! There's a place for all interest/skills, and there are many ways to be involved. See our website for ongoing updates, events, links, meeting minutes, and contact people:

http://MAPPofSKP.net

or call MAPP Coordinator, Sharon Whytal at 399-4027.