NACCHO
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2017 Model Practices

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Model Practice Title

Please provide the name or title of your practice: *

WeTHRIVE!: Community Wellness in Action

Practice Categories

Model and Promising Practices are stored in an online searchable database. Applications may align with more than one practice category. Please select all the practice areas that apply.: *

- ☐ Access to Care
- ☑ Advocacy and Policy Making
- ☐ Animal Control
- ☑ Coalitions and Partnerships
- ☐ Communications/Public Relations
- ☑ Community Involvement
- ☐ Cultural Competence
- ☑ Emergency Preparedness
- ☑ Environmental Health
- ☐ Food Safety
- ☐ Global Climate Change
- ☑ Health Equity
- ☐ HIV/STI
- ☐ Immunization
- ☐ Infectious Disease
- ☐ Informatics
- ☐ Information Technology
- ☑ Injury and Violence Prevention
- ☐ Marketing and Promotion
- ☐ Maternal-Child and Adolescent Health
- ☐ Organizational Practices
- ☐ Other Infrastructure and Systems
- ☐ Organizational Practices
- ☐ Primary Care
- ☐ Quality Improvement
- ☐ Research and Evaluation
- ☑ Tobacco
- ☐ Vector Control
- ☐ Water Quality
- ☐ Workforce
- ☐ Conference Theme: Bridging Clinical Medicine and Population Health

Other::

Healthy eating, active living, substance use and abuse prevention, social health

Is this practice evidence based, if so please explain. :

This practice is evidence-based. WeTHRIVE! includes community engagement; assessment, planning, implementation, evaluation process; and population-based policy, systems, and environmental change strategies.

Winnable Battles

To keep pace with emerging public health challenges and to address the leading causes of death and disability, CDC initiated an effort called Winnable Battles to achieve measurable impact quickly.Winnable Battles are public health priorities with large-scale impact on health and known effective strategies to address them. Does this practice address any CDC's seven Winnable Battles? If so, please choose from the following:: *

- ☐ Food Safety
- ☐ HIV in the U.S.
- ☑ Nutrition, Physical Activity, and Obesity
- ☑ Tobacco
- ☐ Healthcare-associated Infections
- ☑ Motor Vehicle Injuries
- ☐ Teen Pregnancy
- ☐ None

Overview: Provide a brief summary of the practice in this section (750 Word Maximum)

Your summary must address all the questions below:

- Brief description of LHD- location, demographics of population served in your community
- Describe public health issue
- Goals and objectives of the proposed practice
- How was the practice implemented/activities
- Results/Outcomes (list process milestones and intended/actual outcomes and impacts.
  - Were all of the objectives met?
  - What specific factors led to the success of this practice?
- Public Health impact of practice
- Website for your program, or LHD.

750 Word Maximum

Please use this portion to respond to the questions in the overview section. : *

Hamilton County is located in the southwest corner of Ohio and is home to 802,374 residents (Census 2010). Hamilton County Public Health (HCPH) serves more than 475,000 Hamilton County residents living outside the cities of Cincinnati, Norwood, and Springdale. As part of the Affordable Care Act, all non-profit hospitals were required to file a community health needs assessment (CHNA) with the IRS every three years to determine how best to allocate community benefit dollars and meet the needs of the communities they serve. Rather than producing separate, disjointed reports, local hospitals in the Greater Cincinnati area joined HCPH, other local health departments, and community serving organizations to identify the region's most pressing health needs. Medically underserved people from each community, as well as the community organizations that serve them, participated in forums to help identify barriers to good health. State and county-level data were combined with these on-the-ground perspectives to develop a single, cohesive report across the entire region. This coordinated approach to the CHNA provided efficient collection of county-level health data and common ground as hospitals and health departments consider the needs of their respective communities. Results of the 2012 CHNA for Hamilton County cited a "sickness mindset" that does not place enough emphasis on wellness and prevention as a critical need. Service providers also indicated that improvement in prevention services in all areas (medical, dental, and mental health, as well as healthy lifestyle support) is critical for improving the health of residents; however, a change in mindset from a "culture of sick care" to a "culture of wellness" is also necessary to make significant changes in health behaviors and health outcomes. Prior to the regional CHNA, WeTHRIVE! began as a county-wide initiative to make healthy living easier with support of grant funding provided by the Centers for Disease Control and Prevention. HCPH engaged schools, businesses, churches, elected officials, and residents to address chronic disease by increasing access to healthy foods and physical activity opportunities, while decreasing exposure to secondhand smoke. This collaboration resulted in numerous policy and environmental changes that will have lasting impact in our communities. Following careful review of successes and lessons learned, HCPH expanded the focus of the WeTHRIVE! initiative in 2014 to include additional pathways in an effort to create a culture of health, safety, and vitality throughout Hamilton County that further aligned with CHNA findings. There are five distinct activities included as part of the WeTHRIVE! initiative, including community outreach and engagement, resolution adoption, assessment and evaluation, action plan development, and implementation. To become a WeTHRIVE! community, local governments must adopt a resolution in support of the WeTHRIVE! initiative, establish a WeTHRIVE! team, select at least one pathway, and designate at least one representative to serve on the WeTHRIVE! Community Learning Collaborative. Teams must be made up of diverse and multi-sectoral representation. The six pathways are chronic disease, emergency preparedness, environmental health, injury prevention, social health, and substance use and abuse prevention. All pathways aim to make the healthy choice the easiest choice through implementation of population-based policy, systems, and environmental change (PSEC) and PSEC-supportive strategies. A logic model was developed to guide evaluation of the overall WeTHRIVE! initiative; each pathway has a detailed logic model and comprehensive list of indicators to monitor progress over time. Long-term indicators for the WeTHRIVE! initiative include: • Increase average life expectancy • Improve quality of life • Improve health outcomes Facilitating factors of success include: • Meet people where they are. The WeTHRIVE! initiative is community-driven process with guidance and expertise provided by public health staff and partner organizations. • Communities who connect existing programs and infrastructure to WeTHRIVE! initiative efforts are better positioned to maximize effectiveness and efficiency. • Having a council member and a member of administration on the WeTHRIVE! team makes decision-making more quickly. • When community members are able to lead WeTHRIVE! initiative efforts as part of their job responsibilities, these individuals are able to build momentum and keep the momentum moving forward. What started with 50 people in three priority communities in 2009 has expanded to impact more than 200,000 people throughout 21 communities. This still-growing movement, which provides a framework to communities for healthy living, is a result of sustainable thinking from the start. The WeTHRIVE! initiative was recognized as a community spotlight on Active Living By Design's website for the Community Action Model Relaunch in May 2016. Additional information regarding WeTHRIVE! can be found on the initiative website at www.watchusthrive.org.

Responsiveness and Innovation

A Model Practice must be responsive to a particular local public health problem or concern. An innovative practice must be (1) **new to the field of public health (and not just new to your health department)** OR **(2) a creative use of an existing tool or practice**, including but not limited to use of an Advanced Practice Centers (APC) development tool, The Guide to Community Preventive Services, Healthy People 2020 (HP 2020), Mobilizing for Action through Planning and Partnerships (MAPP), Protocol for Assessing Community Excellence in Environmental Health (PACE EH). Examples of an inventive use of an existing tool or practice are: tailoring to meet the needs of a specific population, adapting from a different discipline, or improving the content.

- Statement of the problem/public health issue
- What target population is affected by problem (please include relevant demographics)
    - What is the target population size?
    - What percentage did you reach?
- What has been done in the past to address the problem?
- Why is the current/proposed practice better?
- Is current practice innovative? How so/explain?
    - Is it new to the field of public health
      OR
    - Is it a creative use of existing tool or practice:
      What tool or practice did you use in an original way to create your practice? (e.g., APC development tool, The Guide to Community Preventive Services, HP 2020, MAPP, PACE EH, a tool from NACCHO's Toolbox etc.)

- Is the current practice evidence-based? If yes, provide references (Examples of evidence-based guidelines include the Guide to Community Preventive Services, MMWR Recommendations and Reports, National Guideline Clearinghouses, and the USPSTF Recommendations.)

2000 Word Maximum

Please state the Responsiveness and Innovation of your practice (2000 Word Maximum) : *

The goal of Hamilton County Public Health's (HCPH) WeTHRIVE! initiative is to create a culture of health, safety, and vitality throughout Hamilton County. Everyone deserves the opportunity to achieve a healthy fulfilling life. We can achieve and sustain a healthier community for everyone by working with others to enact systemic changes that have lasting impact for future generations. The WeTHRIVE! initiative is about real people making a difference where they live, work, learn, worship, or play. Since the WeTHRIVE! initiative began in 2009, HCPH has worked with many people in the community to make healthy living possible. It is imperative that "health" be embedded into the vernacular of the community to achieve safe, healthy, and vibrant communities where everyone can thrive. WeTHRIVE! serves as a catalyst to this process through the engagement of local jurisdictions. Health Equity Focus In an effort to root "health" as a community priority, local governing entities are engaged to catalyze the shift towards a culture of healthy living. A resolution is adopted by the local governing entity (e.g. council or township trustees) to indoctrinate health, safety, and vitality as a unifying vision for the community. While the community-at-large (via the local governing entity) assumes primary leadership of the effort, members from all sectors of the community are engaged, including residents, fire/EMS, law enforcement, youth, school, faith-based organizations, businesses, community-based organizations, and public health. Health equity and the health status of an individual are influenced by many factors. One way to look at how multiple factors influence the health of an individual and community is to look at the level of concentrated disadvantage. Concentrated disadvantage is calculated using five indicators: (1) percent of individuals living below the poverty line; (2) percent of individuals on public assistance; (3) percent of female-headed households; (4) percent of the population who are unemployed; (5) and percent of the population who are less than 18 years of age. It is often associated with worse overall health. Of the 48 political jurisdictions in Hamilton County, 16 communities are considered to be of high concentrated disadvantage (2014). Communities with high concentrated disadvantage include: Lincoln Heights, Elmwood Place, Lockland, Addyston, Cincinnati (non-HCPH jurisdiction), Cleves, Arlington Heights, Whitewater Township, Golf Manor, Springdale (non-HCPH jurisdiction), Springfield Township, Woodlawn, St. Bernard, Forest Park, Mt. Healthy and North College Hill. Of these communities, 10 are current WeTHRIVE! communities. Life expectancy is another important indicator of the overall health of a community. In 2014, the average life expectancy for Hamilton County was 78.13 years with a range of 68.45 years to 88.12 years. As of November 2016, there are 21 WeTHRIVE! communities in Hamilton County impacting nearly 200,000 residents. Among these 21 are communities experiencing the lowest life expectancy in the county, those who are disproportionately affected by the burden of disease and disability, and are considered to be of high concentrated disadvantage. WeTHRIVE! INITIATIVE Community engagement is critical to the success of the WeTHRIVE! initiative. A community outreach coordinator works collaboratively with communities to recruit individuals and organizations to participate in WeTHRIVE! at the grassroots level. Every attempt is made to recruit individuals that are representative of each community's unique makeup, including race/ethnicity, gender, age, and socioeconomic status. WeTHRIVE! Community To become a WeTHRIVE! Community, five key actions occur: review community data, establish a WeTHRIVE! team, adopt a resolution, select at least one pathway, and designate a representative to serve on the WeTHRIVE! Community Learning Collaborative. Resolution WeTHRIVE! Overall Resolution solidifies the commitment to partnering with HCPH and collaborating organizations to create a safe, healthy, thriving community for all members of the community. Community Health Assessments Community-specific Community Health Assessments (CHA) are developed and presented to communities. The CHA is made of various data points that address social and community context, educational attainment, economic stability, neighborhood and built environment, healthcare and health outcomes. A community environmental asset and opportunity audit is conducted to highlight existing strengths, as well as areas for potential intervention. Community input is crucial to the assessment process. A one-question survey is administered through multiple mediums to gather an understanding of what the community sees as the biggest obstacles to creating a healthy community. The survey asks: "In your opinion, what are the most important issues that affect the health, safety, and well-being of the community?" All quantitative and qualitative data is compiled and analyzed. Recommendations are made based on findings and linked back to the corresponding pathway(s) that can be selected to address the areas for improvement. WeTHRIVE! Teams Establishing a WeTHRIVE! team that is part of the community's infrastructure (e.g. council committee, commission) ensures that there is a sustainable group of people who are dedicated to improving the health, safety and vitality of the community. However, as a community-led initiative, voice of the community is essential. As such, one council member or trustee, one member of the administration (e.g. City Manager, Fire Chief), and two residents are required on the core team at a minimum. The team should consist of multi-sectoral representation (e.g. business, residents, government, law enforcement, fire/EMS, media, religious/faith-based organizations, healthcare/public health, schools, youth, and social service) and be representative of the community's unique racial, ethnic, age, gender, and economic makeup to the extent possible. WeTHRIVE! Community Learning Collaborative The WeTHRIVE! Community Learning Collaborative (Learning Collaborative) is designed to offer communities and partners an opportunity to network, share ideas, and receive training on a variety of topics. Each WeTHRIVE! community selects at least one team member to attend the quarterly meetings. The Learning Collaborative is also open to other Hamilton County communities—even those not officially participating in the WeTHRIVE! initiative. Participants include WeTHRIVE! team leaders, elected officials, community volunteers, and partner organizations. In addition to the quarterly meetings, monthly communication is sent to Learning Collaborative members with information regarding grant opportunities, training, and resources that can help strengthen community health efforts and improve sustainability. Furthermore, a capacity-building training schedule is developed annually and includes a wide-range of topics and target audiences. Training is offered in-person and via webinar. Archived webinars are placed on the WeTHRIVE! initiative website and YouTube! channel for viewing at a later date. WeTHRIVE! communities are also connected to training opportunities provided by partner organizations. Pathway Selection WeTHRIVE! Communities can select one or more of the following pathways: Chronic Disease Pathway—The goal of the chronic disease pathway is to make the healthy choice the easy choice through implementation of policy, systems and environmental change (PSEC) and PSEC-supportive strategies to support healthy eating, active living, and tobacco-free environments. Nine communities are actively working on strategies to increase physical activity and access to healthy foods, and decrease tobacco exposure. Primary efforts include: increasing access to healthy food through farmers markets and

mobile pantries; electronic benefits transfer acceptance at farmers markets, stores, and pantries; breastfeeding-friendly policies and designated lactation spaces; healthy menu options; shared use agreements; walking/bicycling trails; and tobacco-free policies. These strategies are best-practices recommended by the Centers for Disease Control and Prevention (CDC). Emergency Preparedness Pathway—The goal of the emergency preparedness pathway is to solidify a community's capacity to prepare for and respond to a public health emergency. While HCPH works with all 45 of our jurisdictions to plan for public health emergencies, currently three communities are working to enhance community and personal preparedness through the WeTHRIVE! initiative. Primary preparedness efforts include: designating a Points of Dispensing (POD) site in the event that medical supplies need to be distributed in an area of risk during a large-scale public health emergency; developing a POD plan; exercising the POD plan; recruitment of volunteers to the Tri-State Medical Reserve Corp and/or Community Emergency Response Team; and strategies to enhance personal preparedness (e.g. assemble emergency supply kit, family communication plans, pet preparedness plans, etc.). These strategies are best-practices recommended by the CDC, Federal Emergency Management Agency, and Department of Homeland Security. Environmental Health Pathway—The goal of the environmental health pathway is to make the healthy choice the easy choice through implementation of PSEC and PSEC-supportive strategies to support improved access to safe outdoor activities and recreation, decreased exposure to secondhand tobacco smoke, and increased safe housing. Two communities are actively working on strategies to improve environmental health through the WeTHRIVE! initiative. Primary efforts include: residential recycling; electronic recycling; composting; solar energy solutions; accessibility; Safe Routes to School; walking/bicycling infrastructure; storm water pollution prevention; watershed improvements; proper waste management of prescription drugs; anti-idling policies; and tobacco-free policies. These strategies are best-practices recommended by the CDC and Environmental Protection Agency. Injury Prevention Pathway—The goal of the injury prevention pathway are to build safe communities through implementation of PSEC and PSEC-supportive strategies that decrease preventable injuries, increase child safety, decrease bicycle, pedestrian, and motor vehicle-related injuries, and decrease community violence. Three communities are currently working on strategies to prevent intentional and unintentional injury. Primary efforts include: in-home environmental assessments and modifications (e.g. child locks, gates, hand rails); child passenger safety; Safe Routes to School; older adult mechanical falls; drug overdose; and infant safe sleep. These strategies are best-practices recommended by the CDC. Social Health Pathway—The goals of the social health pathway are to: (1) eliminate preventable disease, disability, injury and premature death; (2) achieve health equity, eliminate disparities, and improve health of all groups; (3) create social and physical environment that promotes good health for all; and (4) promote healthy development and healthy behaviors across every stage of life. Launched in March 2016, social health is the newest pathway created to help communities address social and environmental factors that impact health outcomes. Two communities are actively working on social health pathway strategies through the WeTHRIVE! initiative. Primary efforts include: job training; housing and property code enforcement; securing or razing abandoned property; establishment of an education commission to facilitate expanded access to GED, ESL, literacy, tutoring, and other educational services. These strategies are best-practices recommended by CDC and World Health Organization. Substance Use and Abuse Pathway—The goal of the substance use and abuse pathway is to change social norms around substance use and abuse through the implementation of PSEC and PSEC-supportive strategies that support decreased tobacco use and exposure, decrease illegal substance use and abuse, and decreased alcohol consumption. Eight communities are working on strategies to prevent substance use and abuse through the WeTHRIVE! initiative. Primary efforts include: tobacco-free policies; prescription lock boxes; blood-borne pathogen reduction (syringe exchange); drug take back events; and referral to treatment and social services for individuals with drug addiction and their families. These are best-practices recommended by the CDC and Drug Enforcement Agency. PATHWAY PROCESS Each of the six pathways has similar key action steps. Following pathway selection, a pathway-specific resolution is adopted by the governing entity further signifying a commitment to work on a specific focus area. Some PSEC strategies are cross-cutting and can be found within multiple pathways. As a community-driven process, communities self-select the pathway(s) they would like to work through. An assessment is completed for each pathway. The Community Health Assessment aNd Group Evaluation (CHANGE) tool is the primary assessment tool used for the chronic disease pathway. Evidence-informed assessments were developed for the emergency preparedness, environmental health, injury prevention, social health, and substance use and abuse prevention pathways that were modeled after the CHANGE Tool. These assessment tools are utilized to identify community strengths and areas for improvement; assist with prioritization of population-based PSEC and PSEC-supportive strategies that create a culture of health; and identification and allocation of resources. Pathway assessments are completed by WeTHRIVE! communities every two years. Following assessments, recommendations are generated by the WeTHRIVE! teams, in conjunction with public health expert staff and partners. Action plans are created to outline goals, objectives, activities, timelines, and measures of success. This process is repeated every two years.

LHD and Community Collaboration

The LHD should have a role in the practice's development and/or implementation. Additionally, the practice should demonstrate broad-based involvement and participation of community partners (e.g., government, local residents, business, healthcare, and academia). If the practice is internal to the LHD, it should demonstrate cooperation and participation within the agency (i.e., other LHD staff) and other outside entities, if relevant. An effective implementation strategy includes outlined, actionable steps that are taken to complete the goals and objectives and put the practice into action within the community.

- Goal(s) and objectives of practice
- What did you do to achieve the goals and objectives?
    - Steps taken to implement the program
- Any criteria for who was selected to receive the practice (if applicable)?
- What was the timeframe for the practice
- Were other stakeholders involved? What was their role in the planning and implementation process?
    - What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers

the practice goal(s)

- Any start up or in-kind costs and funding services associated with this practice? Please provide actual data, if possible. Otherwise, provide an estimate of start-up costs/ budget breakdown.

5000 words maximum

Enter the LHD and Community Collaboration related to your practice (5000 words maximum): *

WeTHRIVE! AS A CATALYST FOR CHANGE WeTHRIVE! is community-driven initiative designed to make lasting changes and create healthy environments where people live, work, learn, worship, and play. Vision Healthy Choices. Healthy Lives. Healthy Communities. Mission The mission of Hamilton County Public Health's (HCPH) WeTHRIVE! initiative is to create a culture of health, safety, and vitality throughout Hamilton County. Everyone deserves the opportunity to achieve a healthy fulfilling life. We can achieve and sustain a healthier community for everyone by working with others to enact systemic changes that have lasting impact for future generations. FOCUS AREAS AND GOALS OF PRACTICE Focus Area 1: Community Engagement The goal of community engagement is to establish sustainable infrastructure within Hamilton County Public Health (HCPH) jurisdictions for addressing public health issues to create a culture of health, safety, and vitality throughout the County. Focus Area 2: Partner Engagement The goal of partner engagement is to engage a multi-disciplinary group of organizations and agencies to support WeTHRIVE! communities with implementation of policy, systems, and environmental change (PSEC) strategies aimed at creating a culture of health, safety, and vitality. Focus Area 3: Chronic Disease The goal of the chronic disease pathway is to make the healthy choice the easy choice through implementation of PSEC strategies to support improved nutrition, increased physical activity, decreased exposure to secondhand tobacco smoke, and decreased burden of disease. Focus Area 4: Emergency Preparedness The goal of the emergency preparedness pathway is to improve a community's capacity to respond in event of a public health emergency. Focus Area 5: Environmental Health The goal of the environmental health pathway is to create environments that promote healthy living and reduce the risk of disease, injury, and disability. Focus Area 6: Injury Prevention The goal of the injury prevention pathway is to build safe communities through implementation of PSEC strategies that decrease preventable injuries, increase child safety, decrease bicycle, pedestrian, and motor vehicle-related injury, and decrease community violence. Focus Area 7: Social Health The goal of the social health pathway is to eliminate preventable disease, disability, injury, and premature death; achieve health equity, eliminate disparities, and improve health of all groups; create social and physical environment that promotes good health for all; and promote healthy development and healthy behaviors across every stage of life. Focus Area 8: Substance Use and Abuse Prevention The goal of the substance use and abuse prevention pathway is to change social norms around substance use and abuse through the implementation of PSEC strategies that support decreased tobacco use and exposure, decrease illegal substance use and abuse, and decreased alcohol consumption. Desired outcomes include: increase in knowledge, increase in skills, change in actions, change in behaviors, improved health outcomes, improve quality of life, and increase in life expectancy. Need As part of the Affordable Care Act, all non-profit hospitals were required to file a community health needs assessment (CHNA) with the IRS every three years to determine how best to allocate community benefit dollars and meet the needs of the communities they serve. Rather than producing separate, disjointed reports, local hospitals in the Greater Cincinnati area joined HCPH, other local health departments, and community serving organizations to identify the region's most pressing health needs. Medically underserved people from each community, as well as the community organizations that serve them, participated in forums to help identify barriers to good health. State and county-level data were combined with these on-the-ground perspectives to develop a single, cohesive report across the entire region. This coordinated approach to the CHNA provided efficient collection of county-level health data and common ground as hospitals and health departments consider the needs of their respective communities. Results of the 2012 CHNA for Hamilton County cited a "sickness mindset" that does not place enough emphasis on wellness and prevention. Service providers indicted that improvement in prevention services in all areas (medical, dental, and mental health as well as healthy lifestyle support) is critical for improving the health of residents; however, a change in mindset from "culture of sick care" to "culture of wellness" is also necessary to make significant changes in health. The CHNA was repeated in 2015. Among the priorities identified for Hamilton County were: substance abuse, obesity, mental health, infant mortality, diabetes, social determinants of health, systemic health-related factors, healthy behaviors, cardiovascular disease, health inequity, and smoking. Furthermore, the top 10 most common causes of death among Hamilton County residents (2015) were: chronic heart disease, lung cancer, organic dementia, chronic obstructive pulmonary disorder, accidental poisonings, Alzheimer's Disease, congestive heart failure, acute heart disease, diabetes mellitus, and stroke. Prior to the regional CHNA, WeTHRIVE! began as a county-wide initiative to make healthy living easier with support of grant funding provided by the Centers for Disease Control and Prevention. HCPH engaged schools, businesses, churches, elected officials, and residents to address chronic disease by increasing access to healthy foods and physical activity opportunities, while decreasing exposure to secondhand smoke. This collaboration resulted in numerous policy and environmental changes that will have lasting impact in our communities. Following careful review of successes and lessons learned, HCPH expanded the focus of the WeTHRIVE! initiative in 2014 to include additional pathways in an effort to create a culture of health, safety, and vitality throughout Hamilton County that further aligned with CHNA findings. Ongoing review of the CHNA data will continue to ensure that the WeTHRIVE! initiative is responsive to the needs of the community. CRITERIA FOR POPULATION SERVED BY MODEL PRACTICE Health equity and the health status of an individual are influenced by many factors. One way to look at how multiple factors influence the health of an individual and community is to look at the level of concentrated disadvantage. Concentrated disadvantage is calculated using five indicators: (1) percent of individuals living below the poverty line; (2) percent of individuals on public assistance; (3) percent of female-headed households; (4) percent of the population who are unemployed; (5) and percent of the population who are less than 18 years of age. It is often associated with worse overall health. Prioritization of communities for engagement is based on highest concentrated disadvantage. However, any community within HCPH's public health jurisdiction is eligible to join the WeTHRIVE! initiative. As of November 2016, the 21 WeTHRIVE! communities by level of concentrated disadvantage are: High Concentrated Disadvantage (10) Lincoln Heights—The average life expectancy is 72.96 years. There were 3,345 people residing in Lincoln Heights. African Americans make up 95 percent of the population. Twenty-six percent of adults have less than a high school education. Nearly 41 percent are living in poverty; 58 percent of children are living in poverty. More than 25 percent of residents are unemployed, and 55 percent are on public assistance (2014). Lockland—The average life expectancy is 71.87 years. There were 3,453 people residing in Lockland. African

Americans make up just over 37 percent of the population, Hispanic 17 percent, and White 45 percent. Six percent of adults have less than a high school education. Nearly 32 percent are living in poverty; 55 percent of children are living in poverty. Approximately 14 percent of residents are unemployed, and 50 percent are on public assistance (2014). Addyston—The average life expectancy is 69.0 years. There were 943 people residing in Addyston. African Americans make up just over six percent of the population, Hispanic one percent, and White 90 percent. Twenty-one percent of adults have less than a high school education. Nearly 25 percent are living in poverty; 32 percent of children are living in poverty. Approximately 14 percent of residents are unemployed, and 45 percent are on public assistance (2014). Arlington Heights—The average life expectancy is 70.16 years. There were 788 people residing in Arlington Heights. African Americans make up 16 percent of the population, Hispanic 0.4 percent, and White 80 percent. Nearly 14 percent have less than a high school education. Over 14 percent are living in poverty; four percent of children are living in poverty. Approximately 14 percent of residents are unemployed, and 25 percent are on public assistance (2014). Whitewater Township—The average life expectancy is 76.36 years. There were 5,479 people residing in Whitewater Township. The population is 94 percent White, two percent African American, and three percent Hispanic. Eighteen percent of adults have less than a high school education. Nearly 22 percent are living in poverty; 43 percent of children are living in poverty. Ten percent of residents are unemployed, and 52 percent are on public assistance (2014). Woodlawn—The average life expectancy is 77.53 years. There were 3,274 people residing in Woodlawn. African Americans make up 62 percent of the population, 31 percent White, and one percent Hispanic. Almost 13 percent of adults have less than a high school education. Seventeen percent are living in poverty; 33 percent of children are living in poverty. Eleven percent of residents are unemployed, and 37 percent are on public assistance (2014). Saint Bernard— The average life expectancy is 77.62 years. There were 4,362 people residing in Saint Bernard. The population is 75 percent White, 20 percent African American, and one percent Hispanic. Six percent of adults have less than a high school education. Fifteen percent are living in poverty; 30 percent of children are living in poverty. Nine percent of residents are unemployed, and over 45 percent are on public assistance (2014). Forest Park—The average life expectancy is 75.86 years. There were 18,687 people residing in Forest Park. African Americans make up 68 percent of the population, Hispanics seven percent, and White 21 percent. Eleven percent of adults have less than a high school education. Nearly 17 percent are living in poverty; 25 percent of children are living in poverty. Ten percent of residents are unemployed, and 35 percent are on public assistance (2014). Mount Healthy—The average life expectancy is 74.7 years. There were 6,060 people residing in Mount Healthy. African Americans make up 35 percent of the population, Hispanic two percent, and White 56 percent. Eleven percent of adults have less than a high school education. Twenty-five percent are living in poverty; 38 percent of children are living in poverty. More than nine percent of residents are unemployed, and 33 percent are on public assistance (2014). North College Hill—The average life expectancy is 73.76 years. There were 9,379 people residing in North College Hill. African Americans make up 47 percent of the population, Hispanic two percent, and White 49 percent. Over 19 percent of adults have less than a high school education. Nearly 17 percent are living in poverty; 27 percent of children are living in poverty. Over 13 percent of residents are unemployed, and 17 percent are on public assistance (2014). Medium Concentrated Disadvantage (8) North Bend— The average life expectancy is 78.16 years. There were 4,603 people residing in North Bend. The population is 99 percent White. About 11 percent of adults have less than a high school education. Nearly 17 percent are living in poverty; 58 percent of children are living in poverty. Eleven percent of residents are unemployed, and 56 percent are on public assistance (2014). Colerain Township—The average life expectancy is 77.52 years. There were 58,559 people residing in Colerain Township. African Americans make up 18 percent of the population, Hispanic eight percent, and White 75 percent. Nearly 12 percent of adults have less than a high school education. Eleven percent is living in poverty; 20 percent of children are living in poverty. Over eight percent are unemployed, and 28 percent are on public assistance (2014). Reading—The average life expectancy is 77.01 years. There were 10,370 people residing in Reading. African Americans make up just over nine percent of the population, Hispanic one percent, and White 87 percent. Eleven percent of adults have less than a high school education. Nearly 16 percent are living in poverty; 24 percent of children are living in poverty. Over 10 percent of residents are unemployed, and 36 percent are on public assistance (2014). Silverton— The average life expectancy is 76.04 years. There were 4,777 people residing in Silverton. The population is 50 percent African American, 43 percent White, and two percent Hispanic. Over 15 percent of adults have less than a high school education. Nearly 14 percent are living in poverty; nine percent of children are living in poverty. About eight percent of residents are unemployed, and 27 percent are on public assistance (2014). Fairfax—The average life expectancy is 79.06 years. There were 1,766 people residing in Fairfax. Almost five percent of the population is African American, one percent Hispanic, and 92 percent White. Ten percent of adults have less than a high school education. Eight percent are living in poverty; nine percent of children are living in poverty. Over five percent of residents are unemployed, and 22 percent are on public assistance (2014). Newtown— The average life expectancy is 78.66 years. There were 2,670 residents in Newtown. Ninety-three percent of the population is White, three percent Hispanic, and just under a percent of the population is African American. Approximately six percent of adults have less than a high school education. Four percent are living in poverty; five percent of children are living in poverty. Seven percent of residents are unemployed, and nearly seven percent are on public assistance (2014). Anderson Township— The average life expectancy is 81.08 years. There were 43,464 people residing in Anderson Township. African Americans make up one percent of the population, Hispanic nearly two percent, and White 93 percent. Approximately four percent of adults have less than a high school education. Six percent are living in poverty; eight percent of children are living in poverty. More than five percent of residents are unemployed, and 10 percent are on public assistance (2014). Crosby Township—The average life expectancy is 77.26 years. There were 2,759 people residing in Crosby Township. The community is 99 percent White. Just over six percent of adults have less than a high school education. Six percent are living in poverty; three percent of children are living in poverty. Six percent of residents are unemployed, and nearly six percent are on public assistance (2014). Low Concentrated Disadvantage (3) Amberley Village—The average life expectancy is 84.83 years. There were 3,588 people residing in Amberley Village. African Americans make up eight percent of the population, Hispanic two percent, and White 88 percent. Only one percent of adults have less than a high school education. Nearly six percent are living in poverty; 13 percent of children are living in poverty. Approximately five percent of residents are unemployed, and 10 percent are on public assistance (2014). Montgomery—The average life expectancy is 81.53 years. There were 10,283 people residing in Montgomery. The population is 89 percent White, two percent African American, and two percent Hispanic. Ten percent of adults have less than a high school education. Nearly three percent are living in poverty; one percent of children are living in poverty. Five percent of residents are unemployed, and three percent are on public assistance (2014). Evendale—The average life expectancy is 82.55 years. There were 2,768 people residing in Evendale. The population is 86 percent White and seven percent African American. Approximately six percent of adults have less than a high school

education. Almost four percent are living in poverty; three percent of children are living in poverty. Nearly three percent of residents are unemployed, and one percent is on public assistance (2014). COMMUNITY HEALTH IMPROVEMENT PLAN INTEGRATION HCPH has been working to increase healthy behaviors in communities since 2009 through the WeTHRIVE! initiative. However, in 2014 two key actions occurred. First, the WeTHRIVE! initiative was in a transition period due to staffing and budget changes. HCPH began an in-depth review of the CHNA in order to begin Community Health Improvement Plan (CHIP) development. Secondly, HCPH recognized that the common themes identified in the CHNA were connected to our mission and vision and could be addressed through the WeTHRIVE! initiative framework. WeTHRIVE! initiative priorities and strategies were integrated into the agency's 2015—2018 CHIP. TIMEFRAME The WeTHRIVE! initiative has now become institutionalized across HCPH in a way that addresses a broader culture of health across the County. HCPH is fully invested into the WeTHRIVE! initiative. The 2015—2018 CHIP is operationalized through the WeTHRIVE! initiative; it is also a key element of the 2017—2020 HCPH Strategic Plan. STAKEHOLDERS The WeTHRIVE! initiative engages individuals and organizations from all levels to create a culture of health, safety, and vitality. Every stakeholder—whether grassroots, grass stalks, or grass tops—has an integral role in the success of the WeTHRIVE! initiative. WeTHRIVE! Leadership Team—The Leadership Team consists of HCPH staff from senior and middle management, including the Health Commissioner, Assistant Health Commissioner of Community Health Services, Assistant Health Commissioner of Environmental Health Services, Health Promotion and Education Director, Epidemiology Director, Public Information Officer, and Emergency Response Supervisor. As the primary decision-making entity, the Leadership Team is responsible for monitoring progress, navigating road blocks or areas of concern, and allocating resources to support the overall WeTHRIVE! initiative. Public Health Advisory Council (PHAC)—The PHAC is a multi-disciplinary team charged with overseeing CHIP progress, as well as to participate in its implementation. The latter is accomplished through staff assignment to the WeTHRIVE! Implementation Team, in-kind contributions, financial commitments, connections to other key organizations, data sharing, or access to volunteers. PHAC members include: Cincinnati Children's Hospital Medical Center, Cincinnati USA Regional Chamber, Hamilton County Administration, Hamilton County Developmental Disabilities Services, Hamilton County Educational Services Center, Hamilton County Department of Environmental Services, Hamilton County Emergency Management & Homeland Security Administration, Hamilton County Job & Family Services, Hamilton County Mental Health & Recovery Services, Hamilton County Regional Planning & Development, Interact for Health, Lincoln Heights Missionary Baptist Church, Mercy Health, PreventionFIRST!, The Christ Hospital Health Network, The HealthCare Connection, TriHealth, U.C. Health, and United Way of Greater Cincinnati. Implementation Team—The WeTHRIVE! Implementation Team was established to align local health and safety initiatives, leverage expertise, and maximize our collective impact. In addition to the PHAC member organizations, other committed partners on the Implementation Team include: Creating Healthy Communities Program, Street Rescue, Local Initiative Support Corporation, YMCA of Greater Cincinnati, Our Harvest, Freestore Foodbank Healthy Harvest Mobile Market, Hamilton County Special Olympics, Restoring Hope Counseling and Coaching, Hamilton County Soil & Water Conservation District, and UC Breast & Cervical Cancer Project. This consortium of partners continues to expand. Examples of successful collaboration include the following: • Creating Healthy Communities Program (CHCP) led by the Cincinnati Health Department was an integral partner with tobacco-free multi-unit housing efforts impacting properties managed by the Cincinnati Metropolitan Housing Authority in Lincoln Heights and Mt. Healthy. The CHCP provided Crime Prevention through Environmental Design (CPTED) training to WeTHRIVE! teams. In exchange, the Business Case for Breastfeeding training was provided to CHCP members, and resources were provided to interested worksites. • The Hamilton County Educational Services Center (ESC) has been an instrumental partner with building relationships between public health and schools. The ESC is a champion for institutionalizing the WeTHRIVE! initiative within schools and communities. As a result, three school districts signed a statement of commitment to actively engage as a WeTHRIVE! School District; connections also opened doors to other school districts to begin the dialogue for engagement. • Interact for Health, a local grant-making agency, recognizes the significance of the "WeTHRIVE! Community" designation. As a result, Mt. Healthy and Forest Park received a Thriving Communities grant to increase community capacity and sustainability of healthy eating and active living efforts. Interact for Health also provides a discounted rate for WeTHRIVE! community members to participate in capacity-building trainings sponsored by the organization. • PreventionFIRST! is a community leader in substance use prevention. PreventionFIRST! partnered with Lockland, Mt. Healthy, Colerain Township, Anderson Township, and others to hold community forums on opiate addiction. Grant funding was provided to Lockland to purchase medication lock boxes and participate in National Drug Take Back Day. • Hamilton County Department of Environmental Services (DOES) provided composting classes, recycling demonstrations, and supported the annual One Stop Drop electronic recycling event in Amberley Village. Hamilton County DOES, along with Hamilton County Soil & Water Conservation District, HCPH, Cincinnati Parks, and the Mill Creek Watershed Council held a Creek Walk to promote environmental stewardship, where residents learned about the geology of the area, storm water pollution prevention, sanitary sewer and combined system overflows, proper waste management of prescription drugs, and water sampling. • Hamilton County Planning & Development provides many of our WeTHRIVE! communities with technical support for Safe Routes to School, trails, and community development projects. They were a key partner with Evendale's Safe Routes to School Infrastructure Grant proposal. Planning & Development also awarded Mini Planning Grants to Lockland, Woodlawn, Reading, North Bend, and Mt. Healthy for various projects and feasibility studies to improve the built and natural environment and support comprehensive strategic planning. Public health has, for the first time, been offered a seat at the table to ensure "health" is included in projects that are funded by Hamilton County Planning & Development. • Our Harvest and Freestore Foodbank are expanding their harvest days and mobile market efforts to extend into communities of high concentrated disadvantage and low food access outside of the City of Cincinnati. The Harvest Days (Our Harvest) and Healthy Harvest Mobile Market (Freestore Foodbank) also accept EBT and Produce, thereby reducing barriers to accessing fresh produce. Local Jurisdictions—One of the most integral partnerships is with the local jurisdictions. Without their partnership, much of the community transformation successes would not have occurred. With Ohio being a "home rule" state, broad sweeping policy and systems change at a county-level is complex, and at times nearly impossible. Therefore, it is imperative to engage policymakers at the local jurisdiction level to enact long-term, sustainable change. To date, 21 of 45 local governmental entities (councils or trustees) in HCPH's health jurisdiction adopted resolutions to solidify their commitment to the WeTHRIVE! initiative. These governmental entities set the expectation that health and safety need to be included in all policies. WeTHRIVE! Ambassadors—The WeTHRIVE! Ambassador Program is a volunteer leadership program for community members (Ambassadors) who work locally to build healthy communities. Ambassadors participate in a four hour overview training, attend a minimum of one pathway- or topic-specific training per year, connect with a community WeTHRIVE! team or help to form a team if one

does not exist, and recruit like-minded people or organizations to engage in the WeTHRIVE! initiative. Ambassadors are able to make a difference in their own communities, while being part of a larger movement to make healthy living easier for everyone in Hamilton County. The WeTHRIVE! Ambassador Program connects Ambassadors to the people, resources and training needed to make communities a healthier place to live now and for all future generations. The HCPH staff primarily responsible for leading WeTHRIVE! initiative efforts are active on numerous multi-sectoral partnerships at the state, regional, and local level, including: Gen-H, Creating Healthy Communities Coalition, Connecting Active Communities Coalition, Green Umbrella Local Food Action Team and Leadership Team, Green Umbrella Regional Food Policy Council, Safe Routes to School State Network, Ohio Injury Prevention Partnership, Ohio Early Childhood Health Network, Tobacco Free Ohio Alliance, Hamilton County Tobacco-Free Partnership, Hamilton County Lead Collaborative, Cincinnati Children's Hospital Community Advisory Council, PreventionFIRST! Center for Community Engagement, and the newly formed Equity Coalition. RESOURCES LEVERAGED The Board of Health for HCPH has committed a long-term investment into the WeTHRIVE! initiative. The HCPH budget supports a full-time Health Promotion and Education Director, three public health educators, one epidemiologist, and a community outreach coordinator dedicated to the WeTHRIVE! initiative. Furthermore, 34 staff from across the agency completed the WeTHRIVE! Ambassador training. These Ambassadors are frontline staff that is integral in recruiting communities, organizations, and individuals to join the movement towards creating a culture of health, safety, and vitality. In addition to agency funds, HCPH leverages numerous grants to support implementation of WeTHRIVE! initiative strategies, including: • Child & Family Health Services Grant from the Ohio Department of Health (ODH) • Maternal & Child Health Grant from ODH • Tobacco Use Prevention & Cessation Grant from ODH • Lead Prevention & Education from ODH • Public Health Emergency Preparedness from ODH Since 2015, WeTHRIVE! communities secured over $1.6 million is funding to support health and safety initiatives, such as: • Safe Routes to School Infrastructure, Non-Infrastructure, and School Travel Plan grants from the Ohio Department of Transportation • Clean Ohio Fund | Green Space Conservation from the Ohio Public Works Commission • Trails Planning Grants from Interact for Health • Put a Lid On It! Bike Helmet Safety Grant from the Ohio Chapter of the American Academy of Pediatrics • Injury Prevention Grant from the Ohio Injury Prevention Partnership • Buckle Up for Life Child Safety Grant from Toyota/Cincinnati Children's Hospital Medical Center • Community Development Block Grant Mini Planning Grants from Hamilton County Planning & Development • Call to Action: Community Forum on Opiates funding from PreventionFIRST! • Thriving Communities Grants from Interact for Health • Private donations for Student Drug Use Survey administration, gift cards, garden supplies and plants, printing, and more. There is considerable effort to secure and leverage resources and funding to support WeTHRIVE! initiative strategies. Capacity- and skill-building—including grant writing and resource development—are paramount to the implementation and evaluation of the WeTHRIVE! initiative.

Evaluation

Evaluation assesses the value of the practice and the potential worth it has to other LHDs and the populations they serve. It is also an effective means to assess the credibility of the practice. Evaluation helps public health practice maintain standards and improve practice. Two types of evaluation are **process** and **outcome**. Process evaluation assesses the effectiveness of the steps taken to achieve the desired practice outcomes. Outcome evaluation summarizes the results of the practice efforts. Results may be long-term, such as an improvement in health status, or short-term, such as an improvement in knowledge/awareness, a policy change, an increase in numbers reached, etc. Results may be quantitative (empirical data such as percentages or numerical counts) and/or qualitative (e.g., focus group results, in-depth interviews, or anecdotal evidence).

- What did you find out? To what extent were your objectives achieved? Please re-state your objectives.
- Did you evaluate your practice?
    - List any primary data sources, who collected the data, and how (if applicable)
    - List any secondary data sources used (if applicable)
    - List performance measures used. Include process and outcome measures as appropriate.
    - Describe how results were analyzed
    - Were any modifications made to the practice as a result of the data findings?

2000 Words Maximum

Please enter the evaluation results of your practice (2000 Words Maximum): *

Evaluation is essential for monitoring progress and provides direction for how to allocate available resources. Benefits of logic models include: (1) integration of planning, implementation, performance management, and evaluation; (2) helps prioritize most effective activities for allocating resources; (3) uses evidence-based models and practice to design and refine a program; and (4) reveals data needs and framework for analyzing data. Logic Model A logic model was developed to guide evaluation of the overall WeTHRIVE! initiative; each pathway also has a detailed logic model and comprehensive list of indicators to monitor progress. Long-term indicators for the WeTHRIVE! initiative include: • Increase average life expectancy. Average life expectancy is the estimated number of years an individual would expect to live, if they were born today, based on mortality statistics. At baseline, the average life expectancy for Hamilton County was 76.9 years (Ohio Department of Health, Public Health Information Data Warehouse Death Data Set, 2010-2014) • Improve quality of life. Many of the health outcomes and socioeconomic indicators monitored as part of the WeTHRIVE! initiative can have lasting effects on an individual's quality of life and can lead to having difficulty doing everyday tasks. One way to measure the quality of life of an individual is to look at independent living difficulties. Individuals with independent living difficulties are the percent of individuals in a community, 18 years of age and older who, due to a physical, mental, or emotional problem, have difficulty doing errands alone such as visiting a doctor's office or shopping for necessities. At baseline, the percent of Hamilton County residents with an independent living difficulty was 6.0 percent (U.S. Census Bureau/FactFinder, 2012-2014 American Community Survey 5-Year Estimates). • Improved health outcomes. Mortality rates are a powerful measure for assessing the overall health of a community. They are important because they provide a snapshot of health problems, identify potential patterns of risk within a community, and show trends in death over time. At

baseline, Hamilton County had a mortality rate from all causes of death of 94.8 per 100,000 residents (Ohio Department of Health, Public Health Information Data Warehouse Death Data Set, 2010-2012). Process Evaluation Pre-Implementation Survey: The purpose of the WeTHRIVE! Pre-Implementation Survey was to collect feedback from WeTHRIVE! Teams regarding the initiative process, materials/tools, and staff technical support. Specifically, survey questions focused on the areas of community outreach and engagement, WeTHRIVE! team formation, resolution adoption, the WeTHRIVE! Community Learning Collaborative, action planning, and HCPH staff/agency performance and customer service. Results of the most recent Pre-Implementation Survey administered in December 2015 led to the following actions: • A Community Outreach Contractor was hired in January 2016 to provide support with community engagement and recruitment of multi-sectoral teams that are diverse and representative of the community's population, including members of the community who experience the highest burden of health disparities and social inequities. The Community Outreach Contractor also assists with recruitment of community members to participate in the community health assessment (CHA) presentation, events, and pathway assessments (e.g. CHANGE tool, ENHANCE tool, etc.). • A copy of the CHA is provided to the community WeTHRIVE! team and governmental entity at least two weeks prior to the community presentation. This allows community members to review the report, invite key stakeholders, and come prepared with questions. • A WeTHRIVE! Community Champions award was created to provide further recognition of individuals and organizations that make extraordinary contributions to achieve community health, safety, and vitality. Eighteen WeTHRIVE! Community Champions will be recognized in December 2016 at the annual WeTHRIVE! Recognition Event, the first year for such an award. • Modifications were made to the community action plan template to provide space to track ongoing progress. Community-level evaluation plans are being developed to monitor progress and evaluate efforts. WeTHRIVE! Team Evaluations: After WeTHRIVE! teams are established and begin working through the process, a team evaluation is completed to determine existing assets and identify capacity-building and infrastructure development opportunities. A triad approach is used consisting of key informant interviews, meeting observations, and member surveys. Key informant interviews and member surveys focus on membership, team leadership, member roles and expectations, teamwork and member satisfaction, team goals and purpose, decision-making, communication, meetings, training needs, adaptability, and sustainability. Meeting observations focus on meeting goals, team composition, organizational skills, decision-making, conflict resolution, and member engagement. Analysis is completed, and assets and opportunities are identified and shared with each WeTHRIVE! team. Team evaluation results are used to isolate infrastructure development training and technical assistance needs that are commonly identified across WeTHRIVE! communities. Predominant themes of the 2016 WeTHRIVE! Team Evaluation included: diversity in recruitment, external communication, and team facilitation. To address the training and skill-building needs identified, a three-part sustainability series that addresses meeting facilitation, fundraising and grant writing, and communication strategies will be provided in 2017 as part of the annual Capacity-Building Training Schedule. Furthermore, each WeTHRIVE! team is provided with recommendations to improve the team's efficiency, effectiveness, and sustainability. Action Plan Audits: Action plans are essential documents for outlining the steps needed in order to achieve a specific goal. The purpose of the action plan audit is to review thoroughness, level of detail, impact of strategies, and progress. Audit results indicated that greater emphasis needs to be placed on educating team regarding the importance of implementing policy, systems, and environmental change (PSEC) strategies due to its sustainable, cost-effective, and widespread impact on large segments of the population. PSEC-supportive strategies have a role in the change process; however, they should be implemented alongside a PSEC strategy. Several tactics are being employed as a result of these findings to increase PSEC strategy implementation: • Training on the differences between PSEC and PSEC-supportive strategies and their impacts. • Modifications to guidance documents utilized with WeTHRIVE! teams during the assessment and planning process to challenge creativity and the status quo. • Increase in one-on-one technical assistance to WeTHRIVE! teams during the action planning process to increase inclusion of PSEC strategies. WeTHRIVE! Community Master Communication Database (CMCD): The purpose of the WeTHRIVE! CMCD is to collect information on the amount and type of communication between HCPH staff and WeTHRIVE! Communities related to the WeTHRIVE! Initiative. The database collects the date of communication, type of communication (e.g. meeting, site visit, phone call, email, mail, fax, training), brief summary (includes with whom, purpose, outcome, and next steps), and related pathway. Data entries are in the process of being analyzed by the HCPH epidemiology division to determine if trends can be observed, such as number of contacts needed prior to a jurisdiction becoming a WeTHRIVE! community or the key community stakeholders (e.g. council person, resident, city manager, etc.) that are most effective in advancing the WeTHRIVE! initiative. Outcome Evaluation Community Health Assessment: Community-specific Community Health Assessments (CHA) are developed and presented to communities. The CHA is modeled after the health equity report "Does Place Matter?: Health Equity in Hamilton County" prepared by HCPH's epidemiology division (2015) and is made of various data points that address social and community context, educational attainment, economic stability, neighborhood and built environment, healthcare and health outcomes. A community environmental asset and opportunity audit is conducted to highlight existing strengths, as well as areas for potential intervention. Community input is crucial to the assessment process. A one-question survey is administered through multiple mediums to gather an understanding of what the community sees as the biggest obstacles to creating a healthy community. The survey asks: "In your opinion, what are the most important issues that affect the health, safety, and well-being of the community?" All quantitative and qualitative data is compiled and analyzed. Recommendations are made based on findings and linked back to the corresponding pathway(s) that can be selected to address the areas for improvement. Pathway Assessments: Evidence-informed assessments were developed for emergency preparedness, environmental health, injury prevention, social health, and substance use and abuse prevention that were modeled after the CDC's CHANGE Tool. These assessment tools are utilized to identify community strengths and areas for improvement; assist with prioritization of population-based PSEC and PSEC-supportive strategies to create a culture of health; and identification and allocation of resources. Pathway assessments are completed by WeTHRIVE! communities every two years. • The Chronic Disease Pathway uses the CHANGE Tool to assess PSECs related to physical activity, nutrition, tobacco, chronic disease management, and leadership. • The assessment for the Emergency Preparedness Pathway focuses on community points-of-dispensing plans, community preparedness, and volunteer engagement. A community survey is also provided to determine level of personal preparedness in the event of an emergency. • The Environmental Health Pathway uses the Environmental Health Assessment aNd Community Evaluation (ENHANCE) Tool to assess PSECs related to air quality, housing and nuisance, built and natural environment, waste management, and water quality. • The Injury Prevention Pathway assessment focuses on PSECs related to falls, violence, pedestrian and bicycle safety, motor vehicle safety, and child safety. • The Social Health Pathway assessment focuses on social and environmental determinants of health, including economic stability, education, health and healthcare,

neighborhood and built environment, and social and community context. • The Substance Use and Abuse Prevention Pathway assessment focuses on alcohol, tobacco and electronic cigarettes, marijuana, prescription drugs, and other illicit drugs. Monitoring Health Outcomes Changes in long-term health outcomes can take a decade or more to be observed. Epidemiologic surveillance is a key strategy for monitoring health status of Hamilton County communities. Community Access to Hamilton County Epidemiology & Assessment Data (AHEAD) is an online tool prepared by HCPH in an effort to share public health data with the community. The goal of Community AHEAD is to improve our understanding of the health issues that affect our local communities. The first step in advancing the health status our county is to understand local trends associated with disease and injury. WeTHRIVE! communities can access this tool on the HCPH website to monitor health status over time. HCPH's epidemiology division will continue to monitor health trends to determine if PSEC and PSEC-supportive strategies are making measurable impact in health outcomes.

Sustainability

Sustainability is determined by the availability of adequate resources. In addition, the practice should be designed so that the stakeholders are invested in its maintenance and to ensure it is sustained after initial development (*NACCHO acknowledges that fiscal challenges may limit the feasibility of a practice's continuation*.)

- Lessons learned in relation to practice
- Lessons learned in relation to partner collaboration (if applicable)
- Did you do a cost/benefit analysis? If so, describe.
- Is there sufficient stakeholder commitment to sustain the practice?
    - Describe sustainability plans

1500 Words Maximum

Please enter the sustainability of your practice (2000 Words Maximum): *

The WeTHRIVE! initiative is sustained through HCPH general funds and leveraging partnerships and resources. LESSONS LEARNED Facilitating factors of success related to practice and partner collaboration includes: — Meet people where they are. The WeTHRIVE! initiative is community-driven process with guidance and expertise provided by public health staff and partner organizations. While policy, systems, and environmental change (PSEC) strategies are most impactful, PSEC-supportive strategies may be needed to build awareness, support, and momentum due to the visibility and immediacy. — Communities who are able to connect existing programs and infrastructure to the WeTHRIVE! initiative efforts are better positioned to maximize effectiveness and efficiency. — Having a council member and a member of administration on the WeTHRIVE! team makes decision-making more quickly, especially if municipal resources (e.g. funding, staff time) are needed. — When community members are able to lead WeTHRIVE! initiative efforts as part of their job, these individuals are able to build momentum and keep the momentum moving forward. — The WeTHRIVE! initiative is widely recognized by local organizations due to the framework it provides and its emphasis on PSEC. As such, WeTHRIVE! communities are looked upon favorably for funding and other collaborative opportunities. Barriers and plans to overcome related to practice and partner collaboration includes: — Social and environmental factors that impact health must be a primary strategy, especially for communities with high concentrated disadvantage. For example: While active living is an important step to preventing chronic disease, community members who are fearful to go outside due to violence, drugs, or crime are not likely to engage in physical activity—even if well intentioned. The social health pathway was launched in March 2016 to provide a framework for WeTHRIVE! communities to work on issues that impact daily living. — Small, homogenous teams limit the creativity and understanding needed to address factors that impact the health, safety, and vitality of all residents. An outreach coordinator was hired to focus on grassroots recruitment within WeTHRIVE! communities to ensure multi-sectoral and diverse participation that is representative of the community. — Lack of a strong team leader can hinder progress. Partners whose efforts align with the WeTHRIVE! initiative are engaged to provide technical support and resources. WeTHRIVE! Ambassadors are connected to WeTHRIVE! communities who could use assistance to jumpstart movement. — Lack of sub-county data limits real-time prioritization and intervention of strategies that may be able to shift the trajectory of one's disease state. Publicly available data sets indicate what conditions individuals are being diagnosed with, as well as causes of death. However, it is challenging to know what conditions individuals are living with day-to-day that are preventable. Partnerships are established with the local hospital systems and foundations to determine what options may exist for obtaining quality behavioral and health data while adhering to HIPAA standards. SUSTAINABILTY PLAN There is sufficient stakeholder commitment to sustain the WeTHRIVE! initiative. The core components of the WeTHRIVE! sustainability plan are: shared vision; building community capacity and support; resource development; communication and marketing; infrastructure development; focus on PSEC; and evaluation. Shared vision: Shared vision creates a sense of commitment where individuals and organizations align their own interests with the vision of the community-at-large. Having an identity that the community recognizes is essential to advocate for policy and environmental change. A visual identity, or brand, was developed to encompass the vision and mission of WeTHRIVE!, as well as build awareness and unite Hamilton County communities. Community members joined in the development of the initiative brand and selected the final version of the logo. "WeTHRIVE!" was selected as the brand name; the tagline, "Community Wellness in Action," was created to encompass a broad range of strategies that impact health, safety, and vitality. WeTHRIVE! communities receive a customized WeTHRIVE! logo (e.g. WeTHRIVE! in Mt. Healthy) to use when conveying the vision and mission of the initiative. A Style Guide was created to help ensure brand consistency across communities. Maintaining a consistent appearance of the WeTHRIVE! brand builds trust in the community, as well as provides strength behind the WeTHRIVE! message. The WeTHRIVE! initiative is aligned with several sister initiatives in the Greater Cincinnati region to leverage collective impact, including Gen-H (regional collective impact for health), Creating Healthy Communities led by the Cincinnati Health Department (2016 NACCHO Model Practice award winner), and LiveWell NKY. A WeTHRIVE! Implementation Team is convened quarterly and consists of partners whose organizational mission and vision aligns to the overall initiative and/or to one or more pathways. Building community capacity and support: Capacity- and skill-building are fundamental to

building long-term sustainability and support for the WeTHRIVE! initiative. Primary efforts include: • Capacity-building training: A capacity-building training schedule is developed annually and includes a wide-range of topics and audiences. Training is offered in-person and webinar. Archived webinars are placed on the WeTHRIVE! initiative website and YouTube! channel for viewing at a later date. WeTHRIVE! communities are also connected to training opportunities provided by partner organizations. • WeTHRIVE! Ambassador Program: The WeTHRIVE! Ambassador Program is a volunteer leadership program for community members (Ambassadors) who work locally to build healthy communities. Ambassadors participate in a four hour overview training, attend a minimum of one pathway- or topic-specific training per year, connect with a community WeTHRIVE! team or help to form a team if one does not exist, and recruit like-minded people or organizations to engage in the WeTHRIVE! initiative. Ambassadors are able to make a difference in their own communities, while being part of a larger movement to make healthy living easier for everyone in Hamilton County. The WeTHRIVE! Ambassador Program connects Ambassadors to the people, resources and training needed to make communities a healthier place to live now and for all future generations. WeTHRIVE! Ambassador Training is offered 4-6 times per year. Resource Development: WeTHRIVE! is a voluntary, community-driven initiative. Technical assistance is provided to obtain funding and resources to support PSEC and PSEC-supportive strategy implementation. Grant opportunities are shared with WeTHRIVE! communities on a monthly basis at a minimum. Since 2015, nearly $1.6 million in grant funding and resources were secured by WeTHRIVE! communities to support implementation of PSEC and PSEC-supportive strategies. This number continues to grow as communities become increasingly proficient in writing funding proposals. Communication and Marketing: Spreading the word about WeTHRIVE! and its successes helps people to see changes being implemented in the community that make it a healthier, safer place to live. The WeTHRIVE! initiative has a strong social media presence and maintains a website (watchusthrive.org) where progress, successes, and resources are shared. Infrastructure Development: The WeTHRIVE! initiative operates with sustainability in mind from the start. One of the first actions of a community is to adopt a resolution, thereby solidifying a commitment to work towards creating a culture of health, safety, and vitality. After WeTHRIVE! teams are established and begin working through the process, a team evaluation is completed to determine existing assets and identify capacity-building and infrastructure development opportunities. A triad approach is used consisting of key informant interviews, meeting observations, and member surveys. Key informant interviews and member surveys focus on membership, team leadership, member roles and expectations, teamwork and member satisfaction, team goals and purpose, decision-making, communication, meetings, training needs, adaptability, and sustainability. Meeting observations focus on meeting goals, team composition, organizational skills, decision-making, conflict resolution, and member engagement. Analysis is completed. Assets and opportunities are identified and shared with each WeTHRIVE! team. Team evaluation results are used to isolate consistent infrastructure development training and technical assistance needs that are commonly identified across WeTHRIVE! communities. Results are used to craft training and technical assistance opportunities to increase capacity and sustainability. Focus on PSEC: Greater emphasis is placed on implementation of PSEC strategies due to its sustainable, cost-effective, and widespread impact on large segments of the population. PSEC-supportive strategies have a role in the change process; however, they should be implemented alongside a PSEC strategy. Several tactics are being employed to increase PSEC strategy implementation, including: training on the difference between PSEC and PSEC-supportive strategies and their impact; modifying to guidance documents utilized with WeTHRIVE! teams during the assessment and planning process that challenge creativity and the status quo; and increasing one-on-one technical assistance to WeTHRIVE! teams during the action planning process to increase inclusion of PSEC strategies. Evaluation: Evaluation is essential for monitoring progress and provides direction for how to allocate available resources. A logic model guides evaluation of the overall WeTHRIVE! initiative; each pathway also has a detailed logic model. Evaluation strategies include: surveys, observation, key informant interviews, photo documentation, and epidemiologic surveillance of health outcomes. At the community level, assessments are completed by WeTHRIVE! communities every two years to define and prioritize areas for improvement and build an action plan. Community-specific CHAs are completed every five years as a way to monitor health outcomes and other measures related to the social and environmental determinants of health which take longer periods of time to determine impact. Community action plans include metrics to determine ways to measure success.

Additional Information

How did you hear about the Model Practices Program:: *

- [ ] I am a previous Model Practices applicant
- [ ] At a Conference
- [ ] NACCHO Website
- [ ] Public Health Dispatch
- [x] Colleague in my LHD
- [ ] Model Practices brochure
- [ ] NACCHO Exhibit Booth
- [ ] NACCHO Connect
- [ ] Colleague from another public health agency
- [ ] E-Mail from NACCHO
- [ ] NACCHO Exchange