BERGER HEALTH SYSTEM

Pickaway County General Health District
Quality Public Health Care
Planning • Developing
Educating • Implementing

Pickaway County

Community Health Improvement Plan

2016-2020

Prepared by the
Pickaway Partners for Community Health Improvement

Publication date: August 25, 2017.

**NOTE:
This CHIP document provides the following information from the CHIP Workplan (*Appendix A*) for three of the 2016 Pickaway County MAPP produced health areas to include the Strategic Health Priority, Goals, Supporting Data, Outcome Objectives, and Strategies. In addition, the workplan has linkages with and State and National Priorities (*Appendix B*).

Pickaway Partners for Community Health Improvement (PPCHI) have met quarterly since the CHIP planning kickoff in June 2016. They will continue to do so as the plan moves into implementation and evaluation phases in the fall of 2017 and the workplan documents assessment and reports on target achievement.

The workplans for the three MAPP priority health issues are also provided under separate cover in the document titled CHIP Supplement: 2016 - 2018 Pickaway County Community Health Improvement Plan Workplan. This document will be re- issued annually as the Action Plans are revised and updated.

Future updates and versions will be posted at: www.pchd.org and www.bergerhealth.org along with the most recent CHIP.

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Executive Summary

Pickaway Partners for Community Health Improvement (Pickaway Partners) are pleased to present the Pickaway County Community Health Improvement Plan (CHIP) 2016 – 2021. A community's CHIP is developed collaboratively by a partnership of community members (individuals, organizations, agencies) and the local health department. The collaborative partnership for this CHIP was made possible through the commitment and work of the Partners, which included over 40 individuals serving as representatives of local organizations or as local residents.

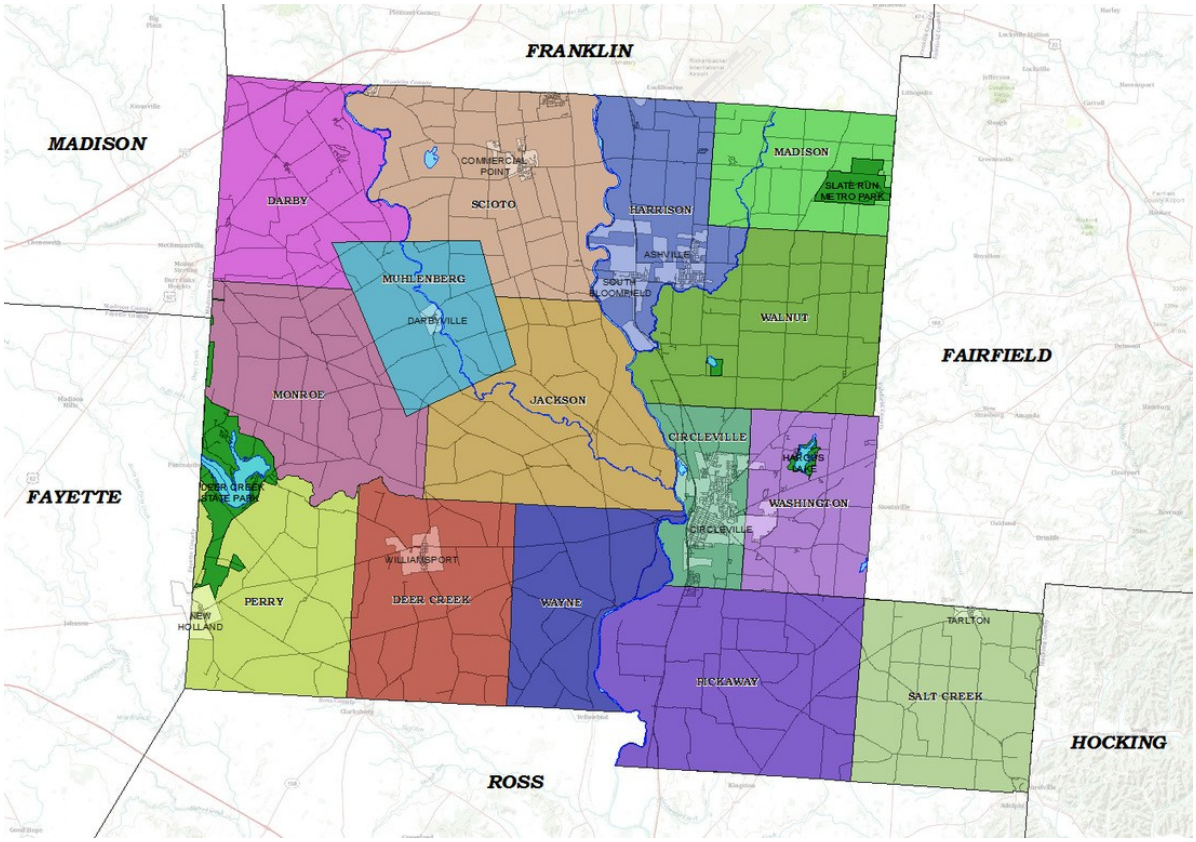
This CHIP is the product of the 2015 Pickaway County community health strategic planning process that used the nationally-recognized Mobilizing for Action through Planning and Partnerships (MAPP) framework. MAPP is a process that begins with careful planning and organizing followed by establishing a collective vision, and then proceeds with gathering information about the community's health and well-being through four broad community assessments. After the results of the assessments are reviewed and prioritized, final MAPP strategic issues are determined. These MAPP strategic issues are the strategic health issues that are addressed in the final two MAPP phases (developing goals, outcome objectives, and strategies; and developing the workplan actions to implement the identified strategies).

The first four phases of the Pickaway County MAPP (Organizing phase through Prioritization of assessment findings phase) in 2014 to December 2015, then the Partnership reviewed priorities from each of the four assessments and identified three MAPP strategic issues for CHIP action. Between June 2016 and August 2017, work on the last two phases of MAPP by the Partners and other community members resulted in the workplan for the strategic health action areas that are addressed in this CHIP:

- Mental Health and Addiction
- Community Health Outcomes
- Social Determinants of Health

As it proceeded with the community health strategic planning process, the Partners were guided by their vision for Pickaway County: *A Health Community* and mission: *Partnering for needed action to create a healthy community based on continuing community assessments.* The values that the Partners incorporate in work for the community are: *Excellence, Respect, Stewardship, Diversity, Accountability, Holistic, Social Justice (Common Good), Collaboration, Accessibility, and Empowerment.*

The CHIP belongs to the Pickaway County community. The commitment of the entire community will be essential to ensure that the strategies in the CHIP are implemented and monitored. Residents, organizations, and community leaders are encouraged to be part of the community- wide effort to carry out the CHIP and make Pickaway County a healthy community that continuously creates and improves its physical and social environments, where its members work together to support and empower each other toward their fullest potential in physical, mental, and social well- being.



How to Use the CHIP

The Community Health Improvement Plan – or CHIP – was created from the work of many community members who came together to address what they prioritized as the top four health issues facing our community. The CHIP contains a workplan for each health priority and lists specific activities that the community can take to make steady and continuous improvements in its health.

How can the community use the CHIP to address the strategic health issues to be part of the efforts to improve individual and community health?

- Individuals and families can:
  - Review the plan to learn more about health issues in the community.
  - Focus on an issue that fits best for their health goals.
  - Get involved by joining a CHIP community group, volunteering resources and support.
  - Talk with community leaders about why these strategic health issues are important and track what's being done to address them.
  - Be part of the community's efforts to make Pickaway County a healthier place to live.
- Organizations in the community can:
  - Discuss the plan with its stakeholders on how the strategic health issues affect the community.
  - Partner with other organizations to work across sectors and with community leaders to implement the plan.
- Workplaces can:
  - Adopt policy and environmental changes to address the identified strategic health issues.
  - Support wellness programs that address health issues among employees and their families.
  - Partner with other agencies to address the health issues in the community.
- Schools can:
  - Review the plan and identify strategies to integrate healthy habits and prevention into children's lives to support their learning and academic performance and their health.
  - Work with parents, administrators, and staff to implement programming, policies, and changes in the school environment- the place where children learn, where people work, and where the community comes together to maximize each child's education, health, and well-being.

- Healthcare providers can:
  - Implement some of the identified strategies in an area of practice.
  - Discuss the strategic health issues with patients and help them select an activity that addresses their health needs.
  - Address barriers and maximize assets in the practice that affect these health issues.
  - Partner with other providers and organizations to implement the CHIP and improve the health of the community.
- Government officials can:
  - As employers, sponsor work place activities to address the strategic health issues.
  - As policy-makers, provide community-wide support and investment through policy, system, and environmental changes to address the health issues.
  - Work with the Partners to attain its Vision, Mission, and Values, and definitions of health and a healthy community across all jurisdictions and populations in the community.
  - Actively promote the CHIP and mobilize the community about the importance of shared ownership of its health and well-being.

Other ways to get involved are:

- Share your questions and comments about the CHIP. You can post your comments or questions about the CHIP on the Berger Health System or Pickaway County General Health District websites. Another way to share your questions and comments is to contact the Pickaway County General Health District 740-477-9667 and ask to speak to someone about the CHIP.
- Follow the community's progress on putting the CHIP Workplan into action. Updates will be posted on two websites: http://www.pchd.org/ or https://www.bergerhealth.com.

Introduction to CHIP

The Partners participating in this CHIP process help improve our public's health. Understanding the prevalence of chronic health conditions, barriers to access to care, and other issues which get in the way of overall health can help direct resources where they will have the biggest impact. Also critical to the process for community strengths to stay in place and provide a foundation to build from.

The Pickaway County Community Health Improvement Plan (CHIP) is a "plan of plans," centralizing efforts to improve health to be shared and built upon by our entire community. The CHIP displays the efforts and passion of committed community organizations and residents to address the priority health issues that they want to improve as actions in a workplan (*Appendix A*). Programs, initiatives, and coalitions that address key health issues are outlined along with their goals and objectives on the following pages. In addition, our Community partners want to make sure that *how* we do our work is very important for outcomes that last and care was taken to align our workplans with evidence-based interventions and strategies (*Appendix B*). Using national and state standards such as Healthy People 2020 and Ohio's State Health Improvement Plan (SHIP), the improvement areas of a local community priority are included in this plan.

Dedicated community partners will continue to work to implement this plan to impact important health issues and their related indicators (*Appendix C*). There are various leaders for these community engagement efforts as well as our private business partners along with well- known partners in the governmental and non-governmental organizational area.

The CHIP initiatives were created during our initial planning meetings in June 2016, but we understand that others will be added and some adjusted at different points in our health improvement due to various planning cycles. This is a living and flexible document. It should be to assist us in improving the health of those who live in our county. Health promotion was defined in a World Health Organization Charter (2005) as a "process of enabling people to increase control over, and to improve their health" and that is exactly what this plan is designed to enable.

2014 - 2017 Pickaway County Community Health Assessment & Improvement Planning Process

Organizing

The Pickaway County General Health District (PCGHD) convened an initial meeting of community partners to conduct a community health strategic planning process for Pickaway County in December 2014. The meeting was attended by PCGHD Staff and 10 partner members. During this initial meeting, PCGHD staff reviewed two community health planning processes from 2014 conducted by Berger Health System and PICCA (Pickaway County Community Action Coalition). Partner members expressed support for undertaking a new community health strategic planning process and discussed who else should be included in the group, best times to meet, and next steps for planning the process.

In January 2015, this group met again and set parameters for organizing the community health strategic planning process. The group organized itself as the Steering Committee and initiated the Mobilizing for Action through Planning and Partners (National Association of County and City Health Officials [NACCHO], 2013) framework for the 2015 Pickaway County Community Health Strategic Planning Process. Subgroups were formed for the Visioning and the Assessment phases of MAPP, and two members were selected as Co-Chairs, including a health department representative and a family physician external to the department.

Visioning

Based on recommendations by the Visioning and Values groups, “A healthy community” was adopted as the vision of where the Pickaway County community should be by 2021 and ten Values to guide the community health strategic planning process: *Excellence, Respect, Stewardship, Diversity, Accountability, Holistic, Social Justice (Common Good), Collaboration, Accessibility, and Empowerment.*

Consistent with the Vision and Values, the partners verified its definition of health as complete physical, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organization, 1948).

The Four MAPP Assessments

Four assessments are prescribed by the MAPP process (NACCHO, 2013). The combined results of the four assessments provide a comprehensive picture of the community's health as well as the foundation for identifying key health and social issues and the MAPP strategic priorities. The four MAPP assessments for the Pickaway County community health strategic planning process were completed in 2015.

The four MAPP assessments were:

1) The Community Health Status Assessment
2) The Community Themes and Strengths Assessment
3) The Forces of Change Assessment
4) The Local Public Health System Assessment

Each of these MAPP assessments are a part of the December 1, 2015 CHA publication and appear in various forms within the CHIP process, as well.

The Five MAPP Strategic Priorities

After reviewing and prioritizing the priority issues from the Community Health Status Assessment, the Community Themes and Strengths Assessment, and the Forces of Change Assessment, and the Local Public Health System Assessment, the Steering Committee identified five MAPP strategic areas and seven health issues.

- Strategic Priority 1. Mental health issues coincident with drug use and crime.
- Strategic Priority 2. Community health outcomes, which include the promotion of independent living in older adults and access to dental care.
- Strategic Priority 3. Social determinants of health impacting community health, focusing on upgrading the current 211 system and implementing volunteer community health workers.
- Strategic Priority 4. Adequate funding for Pickaway County public health services and system.
- Strategic Priority 5.** Implications of the Affordable Care Act (ACA) and state legislative issues such as legalization of marijuana.
  **NOTE: *This priority was not addressed by any strategies in the 2016-2018 version of the CHIP Workplan. It will be addressed in forth coming versions and when better direction at the national level is made known after the 2016 election.*

These five priorities (also found in the 2016 CHA Addendum published by PCGHD in June of 2016) redeveloped into three strategic health areas and issues that would

become the focus of developing plans to achieve a healthy Pickaway County community in the next two phases of MAPP, including the development of goals, outcome objectives, and strategies; and planning, implementation, and evaluation (the Action Cycle).

The MAPP Planning Cycle

Members of the Partners, content experts, and community residents worked with Pickaway General Health District and Berger Health System staff serving as facilitators. Loose-knit workgroups gradually stood up for each of the strategic priorities, staying flexible to allow for overlapping development of action workplans for each strategic priority over a fourteen month period. The workgroups were meeting by January of 2017 and followed a systematic action planning process that was broken into two phases.

Phase 1, which was to be completed by the January 26, 2016 meeting of the Partners, included defining these elements of the MAPP Action Plan (*Appendix D*):

- Strategic Health Issue,
- Goal(s),
- Outcome Objective(s), and
- Justification statement describing the supporting data for the identified goals and objectives.

Phase 2, which was to be completed by the July 26, 2014 meeting of the Partners, included these activities:

- Conducting a root cause analysis with fishbone diagramming,
- Identifying strategies to address the issue,
- Identifying the evidence base for each strategy,
- Identifying whether the strategy was a policy, system, or environmental change,
- Describing how the strategy included a focus on health equity,
- Identifying areas of alignment between the strategy and state and/or national priorities,
- Identifying barriers, and assets and resources to implementing each strategy,
- Identifying priorities from the MAPP Local Public Health System Assessment that related to the strategy,
- Developing strategy objectives, identifying baseline data, and performance measure for the strategy objective, and
- Completing the Action Plan for the strategy (action steps, responsible agency/agencies, resources required, time frame, performance indicator).

Addressing health equity was a key component of the Action Cycle process. Achieving health equity, eliminating disparities, and improving health for all groups is one of the overarching goals of Healthy People 2020 (U.S. Department of Health and Human Services [USDHHS], 2010a). Healthy People 2020 defines health equity as attaining the highest level of health for all people and notes that achieving health equity requires continuous and focused efforts to address current and past avoidable inequalities and injustices and to eliminate health differences (disparities) among groups of people whose health is adversely affected by those social, economic, and/or environmental inequalities, injustices, and disadvantages (USDHHS, 2010b).

The CHIP Workplan is presented in *Appendix A* and *Appendix B* presents a table displaying the alignment between specific workplan strategies and state and national priorities. The CHIP Workplan is also provided under separate cover in the document titled *2016 – 2018 CHIP Supplement: Pickaway County CHIP Workplan*. This document will be re- issued annually in the late summer as the Action Plans are revised and updated. Future versions will be posted at: www.pchd.org and www.bergerhealth.org along with the most recent Community Health Improvement Plan (CHIP).

The MAPP Action Cycle – The Next Steps

Appendix D displays the MAPP Process to include the Action Cycle. Implementation of the CHIP Workplan will formally begin in September 2017. Coincident with the beginning of the CHIP implementation, the Partners' Communication Committee will begin the rollout of its plan for disseminating the CHIP to community residents and other organizations including schools, public and private sector agencies and business, the faith community, and service organizations.

The next section presents the following elements for each of the five MAPP strategic issues: Strategic Health Issue, Goal(s), Supporting Data, Outcome Objectives, and Strategies and Strategy Objectives.

The Three Health Priorities: One CHIP Workplan

***More details on any of the following priorities are found in Appendix A.**

Health Priority Area: Mental Health Issues Co-Incident with Drug Use/Crime

The Strategic Health Issue

Much work is occurring in prevention but agencies/organizations are currently working separately or in small clusters. The county must pull together internally for coordination and identify/collaborate with other partners outside the immediate locale to address this expanding problem. In addition, many of the current interventions are in the tertiary prevention realm: only addressing the issue after it has already occurred (Naloxone, treatment access). We must ensure that programming is targeted for primary prevention as well, ensuring that individuals are equipped to prevent addiction before it starts.

The Goals

- Group unification of organizations and services working in this area
- Targeted primary prevention programs in younger populations

Outcome Objectives

1) Actively collaborate with the Pickaway Addiction Action Coalition through support and promotion of PAAC activities and programs.
2) Provide PAAC baseline and measurement data from the Community Health Assessment.
3) Identify at least one program opportunity for primary prevention of substance abuse in youth.

Health Priority Area: Community Health Outcomes

The Strategic Health Issue

Pickaway County should be a place where getting healthy, staying healthy, and making sure our children grow up healthy are top priorities. We have a vision where we all strive together to build a Culture of Health that enables all in our county to lead healthy lives, now and for generations to come.

The Goals

- Build awareness of the multiple factors that influence health
- Provide a reliable, sustainable source of local data to communities to help them identify opportunities to improve their health
- Engage and activate local leaders from many sectors in creating sustainable community change
- Connect & empower community leaders working to improve health

Outcome Objectives

1) Provide increased access to preventative dental services (i.e. fluoride varnishes, oral care supplies, dental sealants, etc.).
2) Promote good oral health practices in the community to increase the proportion of children, adolescents, and adults who use the oral health care system.
3) Actively collaborate with the agencies and organizations in Pickaway County to support and promote activities and programs that promote healthy living to all community members; with a special focus on residents ages 65 and older.
4) Identify and implement two opportunities for increased hypertension screening and follow up.
5) Increase the number of participants in the local evidenced based Diabetes Prevention Programs.
6) Identify and implement two opportunities for nutrition and physical education aimed at youth.

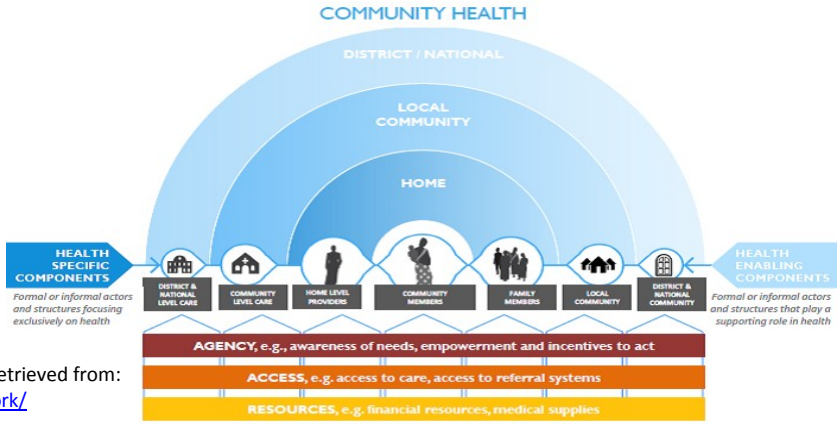


Figure 1: The Community Health Framework, USAID (2015). Retrieved from: http://mpoweringhealth.org/the-community-health-framework/

Health Priority Area: Social Determinants of Health

The Strategic Health Issue

There's a saying in the real estate business: "Location, location, location…" The same holds true for accessing delivered health services. We can have the best in programming and wrap around care, but unless it reaches the consumer in awareness or for provision, it is as if it does not exist. Pickaway County spans an area of 507 square miles with a population of 58,876 (2013). There are multiple communities (e.g., Derby, Ashville, Darbyville, Tarlton, Williamsport) that operate independently of the county seat of Circleville. There needs to be a concerted effort of outreach to enable service provision and assure environments that enhance health (and not just health care).

The Goals

- Identify and communicate with/through "health champions/community health advocates" in outlying communities
- Achieve better access and use of community health services through "health champions/community health advocates."

Outcome Objectives

1) Assess the existing 2-1-1 system for Pickaway County to determine if it meets our current needs.
2) Identify model 2-1-1 system that can serve Pickaway County and determine feasibility of implementation.
3) Recruit "health champions/community health advocates" in the following areas: Derby, Williamsport, Darbyville, Ashville, Tarlton, and Laurelville. The "health champions/community health advocates" will receive information and training about 2-1-1 system and how to promote in the community and refer people to the system.

Conclusion

In June 2016, the Partners for Pickaway County Health Improvement (Partners) came together to continue the community health strategic planning process that identified five health priorities: 1) Mental health and substance abuse, 2) Community health outcomes, 3) Social determinants of health impacting community health, 4) Adequate funding for Pickaway County public health services and system and 5) Implications of the Affordable Care Act (ACA) and state legislative issues such as legalization of marijuana. The CHIP presents the Action Plans for three of those five priority health issues.

Implementation for some of the Action Plans began in 2016 with full implementation of all Action Plans to begin in September 2017. The Partners will continue their leadership role by monitoring the progress of implementing the CHIP Workplan and by the efforts of its Communication Committee, which is developing a plan for promote information about the CHIP and how to get involved to all sectors of the community, including residents, healthcare professionals, schools, organizations, work sites, and government.

Through its leadership, the Partners is a key resource for implementing the plan. However, the CHIP is a community plan, and therefore its success in improving the health status of the Pickaway County community depends largely on that community. The collective efforts of our county to implement the CHIP will ultimately improve the Pickaway County's health status.

As a living plan, CHIP will evolve over time as additional data are gathered about the health issues and about the outcomes from the implementation of the Workplan. What will not change is the need for the community's commitment to collaborate across sectors to make Pickaway County a healthy community to live, work and play in. The Partners stand ready to support efforts to address the health issues and to make Pickaway County *a healthy community*.

Appendices

A. Pickaway County Community Health Improvement Workplan

B. Linkages: Workplan Strategies Compared to Other Priorities

C. Pickaway Partners Participants

D. MAPP Action Cycle Process

E. Glossary of Terms

F. References

Appendix A

CHIP Workplan

Pickaway County Community Health Improvement Plan (PC - CHIP) WORKPLAN

Based on Mobilizing for Action through Planning and Partnerships (MAPP) Process

PPCHI Vision:
A healthy community.

PPCHI Mission:
Partnering for needed action to create a healthy community based on continuing community assessments.

PPCHI Values:

Excellence: We believe in setting a high standard for all services provided to everyone within our community.
Respect: We value and acknowledge everyone in our community.
Stewardship: We will carefully and responsibly make decisions about the health and well-being of our community.
Diversity: We recognize, embrace, and appreciate our differences.
Accountability: We take responsibility for participating in the PC-CHIP, for prioritizing identified health problems in our community, for clearly communicating our findings to the community, and for stimulating action to create a healthier Pickaway County.
Holistic: We recognize that health and well-being reflect the wholeness of a person or a community. **Social Justice (Common Good):** Attained when we achieve health equity, eliminate health disparities, and create social and physical environments that promote good health for all.
Collaboration: We will work jointly with other partners to attain our vision.
Accessibility: We recognize our obligation to make the PC - CHA and CHIP accessible to the community, and we believe that information and services must be easily available to provide everyone in our community the opportunity to achieve complete health and well-being.
Empowerment: We will work to mobilize individuals and our community to act to improve its health and well-being.

Date Created: 15 Jan 17
Date Reviewed / Updated: *August 24, 2017*

Workgroup Facilitator(s): Dr. Vern Bolender / Ty Ankrom

PRIORITY AREA: Mental Health Issues Coincident with Drug Use / Crime

STRATEGIC ISSUE (Define what we are trying to solve. Base this on the data from all assessments and any secondary data): Much work is occurring in prevention but agencies/organizations are currently working separately or in small clusters. The county must pull together internally for coordination and identify/collaborate with other partners outside the immediate locale to address this expanding problem. In addition, many of the current interventions are in the tertiary prevention realm: only addressing the issue after it has already occurred (Naloxone, treatment access). We must ensure that programming is targeted for primary prevention as well, ensuring that individuals are equipped to prevent addiction before it starts.

GOAL(S):

- Group unification of organizations and services working in this area.
- Targeted primary prevention programs in younger populations.

OUTCOME OBJECTIVE(S) *All objectives are S.M.A.R.T. (Specific, Measurable, Achievable, Realistic, Time Specific)*	**Measurement (or type of measurement)**	**Measure Frequency**	**Short, mid, or long-term objective**
1. Actively collaborate with the Pickaway Addiction Action Coalition through support and promotion of PAAC activities and programs.	• Process Measure	Quarterly	Short term and ongoing
2. Provide PAAC baseline and measurement data from the Community Health Assessment.	• Process Measure	Quarterly	Short term and ongoing
3. Identify at least one program opportunity for primary prevention of substance abuse in youth.	• # of youth Participants • Evaluations	Quarterly	Mid term

JUSTIFICATION/RATIONALE:

Why Is Substance Abuse Important? *(Healthy People 2020 Overview: Substance Abuse)*
Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

Summary of Table Discussion during World Café (CHIP Kick-Off, June 2016):
Current tools and programs present include drug tests and treatment but it costs agencies $110 per hour to provide services with reimbursement at $60 dollars per hour. SPVMHC, for example, has to deny accepting certain types of insurance due to even more unrealistic reimbursement rates (e.g., $7 dollars/hour).
One recent success has been expanded Medicaid programs insuring adult single men; prior eligibility demanded parent status. Jobs and Family Services offer online registration to receive insurance benefits with a turnaround time on these requests are only 24-48 hours compared to bordering counties with a 4 week wait for the same service. Other programs that are present include Prism, PARS residential, placement for children in Youngstown, Facetime, and at least some current services that have no wait time and same day service. Individuals in the 50-60 age category have more of a tendency to state that they need services, both mental health veterans and substance abusers. SPVMHC provides outpatient Mental Health and Drug services and have had interns in the field 8 years and the strength of five practitioners in county. Tyler's Light at the HS level appears to work. A new program at the Pickaway County Jail proposes to decrease post-release drug use by driving them to Chillicothe for an every 28 day Vivitrol injection (per person cost of $15,600 annually covered by Medicare). There are currently 26-28 enrolled into the program. Integrated services are found to be better/cheaper in the experience of those at the table. Project Dawn is, at the anecdotal level, a success with harm statistics reduced.
GAPS: Transportation and communication remain a need, with government phone ceilings at 250 minutes. Some specific recommendations needed for Year 1 are 1) Narcan metrics and unification of all groups working on similar projects. In Year 2 of CHIP, this group recommends introduction of new programs and education (e.g., a needle exchange program). For example, each needle costs the agency 97 cents, but can save lives and help avoid later health care expenses. Finally, in Year 3 should bring local drug courts (e.g., a recommendation by Judge Long to start a new initiative in Juvenile Court). In the end, we must find a way to START YOUNGER and be proactive versus reactive, moving prevention into earlier grades.

Date Created: 15 Jan 17
Date Reviewed/Updated: *August 24, 2017*

Workgroup Facilitator: Susan Strawser/Jimmie Davis

PRIORITY AREA: Community Health Outcomes

STRATEGIC ISSUE (Define what we are trying to solve. Base this on the data from all assessments and any secondary data): Pickaway County should be a place where getting healthy, staying healthy, and making sure our children grow up healthy are top priorities. We have a vision where we all strive together to build a Culture of Health that enables all in our county to lead healthy lives, now and for generations to come.

GOAL(S):

- Build awareness of the multiple factors that influence health
- Provide a reliable, sustainable source of local data to communities to help them identify opportunities to improve their health
- Engage and activate local leaders from many sectors in creating sustainable community change
- Connect & empower community leaders working to improve health

OUTCOME OBJECTIVE(S) ***All objectives are S.M.A.R.T. (Specific, Measurable, Achievable, Realistic, Time Specific)***	**Measurement (or type of measurement)**	**Measure Frequency**	**Short, mid, or long-term objective** **1yr., 1-3 yrs., or 3 -5 yrs.**
1. Provide increased access to preventative dental services (i.e. fluoride varnishes, oral care supplies, dental sealants, etc.).	• # of Agencies providing services • # of clients served	Quarterly	Mid term
2. Promote good oral health practices in the community to increase the proportion of children, adolescents, and adults who use the oral health care system.	• # of Promotions • # of target population reached	Quarterly	Mid term
3. Actively collaborate with the agencies and organizations in Pickaway County to support and promote activities and programs that promote healthy living to all community members; with a special focus on residents ages 65 and older.	• # of promotional Activities	Semi-annual (6 months)	Short term
4. Identify and implement two opportunities for increased hypertension screening and follow up.	• # of Screenings • # of Participants	Semi-annual (6 months)	Mid term
5. Increase the number of participants in the local evidenced based Diabetes Prevention Programs.	• # of Participants	Semi-annual (6 months)	Mid term
6. Identify and implement two opportunities for nutrition and physical education aimed at youth.	• # of Participants • Assessments • Evaluations	Quarterly	Long term

JUSTIFICATION/RATIONALE

Independent living as an older adult: As Americans live longer, growth in the number of older adults is unprecedented. In 2014, 14.5% (46.3 million) of the US population was aged 65 or older and is projected to reach 23.5% (98 million) by 2060.[1]
Aging adults experience higher risk of chronic disease. In 2012, 60% of older adults managed 2 or more chronic conditions.[2]
Common chronic conditions include:[3]

- Heart Disease
- Cancer
- Chronic bronchitis or emphysema
- Stroke
- Diabetes mellitus
- Alzheimer's disease

Chronic conditions can lower quality of life for older adults and contribute to the leading causes of death among this population. – Healthy People 2020, Older Adults

Oral health:
The health of the teeth, the mouth, and the surrounding craniofacial (skull and face) structures is central to a person's overall health and well-being.[1, 2] Oral and craniofacial diseases and conditions include:

- Dental caries (tooth decay)
- Periodontal (gum) diseases
- Cleft lip and palate
- Oral and facial pain
- Oral and pharyngeal (mouth and throat) cancers[1, 2, 3, 4, 5]
- Xerostomia (dry mouth)

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems.[5, 6] However, some Americans do not have access to preventive programs.[1, 2, 3] People who have the least access to preventive services and dental treatment have greater rates of oral diseases.[1, 2, 3, 4, 5, 6] A person's ability to access oral health care is associated with factors such as education level, income, race, and ethnicity.[1] - Healthy People 2020, Oral Health

DENTAL CARE RESOURCES PICKAWAY*	
Number of Licensed Dentists	18
Number of Licensed Pediatric Dentists	0
Number of Dentists Who Treat Medicaid Patients	8
1-50 patients	2
51-249 patients	4
250+ patients	2
Number of OPTIONS Dentists	2
Ratio of Low-Income Patients per OPTIONS Dentist	9,429: 1
Number of Safety Net Dental Clinics	0

Dental Care Resources data is from County CHA, December 2015

Date Created: 15 Jan 17
Date Reviewed/Updated: *August 24, 2017*

Workgroup Facilitator: Susan Strawser/Jimmie Davis

PRIORITY AREA: Social Determinants of Health

STRATEGIC ISSUE (Define what we are trying to solve. Base this on the data from all assessments and any secondary data): There's a saying in the real estate business: "Location, location, location…" The same holds true for accessing delivered health services. We can have the best in programming and wrap around care, but unless it reaches the consumer in awareness or for provision, it is as if it does not exist. Pickaway County spans an area of 507 square miles with a population of 58,876 (2013).

There are multiple communities (e.g., Derby, Ashville, Darbyville, Tarlton, Williamsport) that operate independently of the county seat of Circleville. There needs to be a concerted effort of outreach to enable service provision and assure environments that enhance health (and not just health *care*).

GOAL:

- Identify and communicate with/through "health champions/community health advocates" in outlying communities
- Achieve better access and use of community health services through "health champions/community health advocates."

OUTCOME OBJECTIVE(S) ***All objectives are S.M.A.R.T. (Specific, Measurable, Achievable, Realistic, Time Specific)***			**Short, mid, or long-term objective**
	Measurement (or type of measurement)	**Measure Frequency**	**1yr., 1-3 yrs., or 3 -5 yrs.**
1. Assess the existing 2-1-1 system for Pickaway County to determine if it meets our current needs.	• Process Measure	Monthly	Short term
2. Identify model 2-1-1 system that can serve Pickaway County and determine feasibility of implementation.	• Process Measure	Monthly	Short term
3. Recruit "health champions/community health advocates" in the following areas: Derby, Williamsport, Darbyville, Ashville, Tarlton, and Laurelville. The "health champions/community health advocates" will receive information and training about 2-1-1 system and how to promote in the community and refer people to the system.	• # of health champions identified & trained • # of referrals	Quarterly	Mid term

JUSTIFICATION/RATIONALE:

The National Prevention Strategy recommends that State, Tribal, Local and Territorial Governments try the following interventions in order make an impact on Clinical and Community Preventive Services:

- Increase delivery of clinical preventive services, including ABCS, by Medicaid and Children's Health Insurance Program (CHIP) providers.
- Foster collaboration among community-based organizations, the education and faith-based sectors, businesses, and clinicians to identify underserved groups and implement programs to improve access to preventive services.
- Create interoperable systems to exchange clinical, public health and community data, streamline eligibility requirements, and expedite enrollment processes to facilitate access to clinical preventive services and other social services.
- Expand the use of community health workers and home visiting programs.

Health Champions/Community Health Advocates are members of a community who identify, link, and refer residents to services in their community that will help meet important needs and make a positive impact on health outcomes. These volunteers know their community well and are also well-known in their communities.

Using volunteers to serve as health champions/community health advocates can help bring improvements in many areas and partner for community health:

- underserved individuals will receive increased access to services, including those that can improve factors related to social determinants of health like food, environment, recreation;
- whole communities will have better resources to improve health looking at the big picture;
- health care delivery systems can benefit from the skills, community knowledge and cultural competency that CHWs possess to connect with those at risk for poor health; and
- public and private payers could reduce total health care spending.

Appendix B

Linkages: CHIP Workplan Strategies and Others' Priorities

State and National Priorities

CHIP HEALTH PRIORITY AREA	OHIO 2017 – 2019 STATE HEALTH IMPROVEMENT PLAN	HEALTHY PEOPLE 2020	OTHER ALIGNMENT
Mental Health Issues Co-Incident with Drug Use/Crime			
• **group unification** • **targeted primary prevention**	Number of deaths due to unintentional drug overdoses per 100,000 population (p.11)	SA-8.1 Increase the proportion of persons who need illicit drug treatment who received specialty treatment specialty treatment for abuse or dependence in the past year SA-2.4 Increase the proportion of high school seniors never using substances – illicit drugs	
Community Health Outcomes			
• **multiple factor identification** • **local data source** • **engagement of local leadership for needed changes** • **connect/empower community leaders**	Percent of adults ever with hypertension (p. 12) Percent of adults who have been told by a health professional that they have diabetes (p. 12) Percent of adults who have been told by a health professional that they have pre-diabetes (p. 12)	OH-7 Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year OA-2 Increase the proportion of older adults who are up to date on a core set of clinical preventive services	

CHIP HEALTH PRIORITY AREA	OHIO 2017 – 2019 STATE HEALTH IMPROVEMENT PLAN	HEALTHY PEOPLE 2020	OTHER ALIGNMENT
Social Determinants of Health			
• **"health champions/community health advocates" in outlying areas** • **better access and use of community health services**	Social Determinants of Health: Healthcare system and access strategies to include CHWs, health care workforce (p. 6, 20)	HC/HIT-8 Increase the proportion of quality, health-related websites HC/HIT-9 Increase the proportion of online health information seekers who report easily accessing health information	The National Prevention Strategy recommends that State, Tribal, Local and Territorial Governments try the following interventions in order make an impact on Clinical and Community Preventive Services:

Appendix C

Partners for Pickaway County Community Health Improvement (PPCHI) Members

Adena Health System	Jones, S. Kim
Berger Hospice	Gantner, Melissa
Berger Health System & CHIP Co-Chair	Strawser, Susan
Board of Commissioners	Dengler, April
Circleville City Schools	Borland, Karen
Circleville City Schools	Thornsley, Chris
Emergency Management Agency	Conrad, David
Faith Based - Heritage Nazarene Church	Hampton, Shawn
Faith Based - One Community Ministries	Griffith, Rodney
Family and Children First Council	Martin, Kim
HavenHouse	Johnson, Lisa
Head Start/Early Head Start	Solovey, Donna
Head Start/Early Head Start	Jonna Mathews
Help Me Grow	Roberts, Aimee
Job and Family Services	Ewing, Joy
Ohio Christian University	Hicks, Thad
OSU Extension	Treber, Michelle
PICCA Community Action	Robinson, Amy
Pickaway County Chamber of Commerce	Elsea, Amy
Pickaway County District Public Library	Callahan, Michelle
Pickaway County Education Service Center	Ankrom, Ty
Pickaway County Family YMCA	Crespo, Dolly
Pickaway County Juvenile Court	Paisley, Rachelle
PCGHD & PAAC Board	Bolender, Vernon
PCGHD	Miller, Elaine
PCGHD & CHIP Co-Chair	Davis, Jimmie
Pickaway Area Recovery	Bennett, Barry
Pickaway County Metro Housing Authority	Pontius, David
Pickaway County Park District	Davis, Tom
Pickaway County Schools	Downing, Nancy
Pickaway County Sheriff	Radcliff, Robert
Pickaway County Dev Disabilities	Pelcic, Michael
Pickaway Senior Center	Love, Cynthia
PrimaryOne Health	Vandermark, Lori
Public Member	Hill, Charlotte
Public Member	Stanley, Katarina
Public Member	Wastier, Olivia
Scioto Paint Valley Mental Health	Green, June

Veterans' Service Commission	Huffman, Todd
Veterans' Service Commission	Simison, John
WIC Women Infants Children	Wilson, Mary

CHIP Workgroup Members

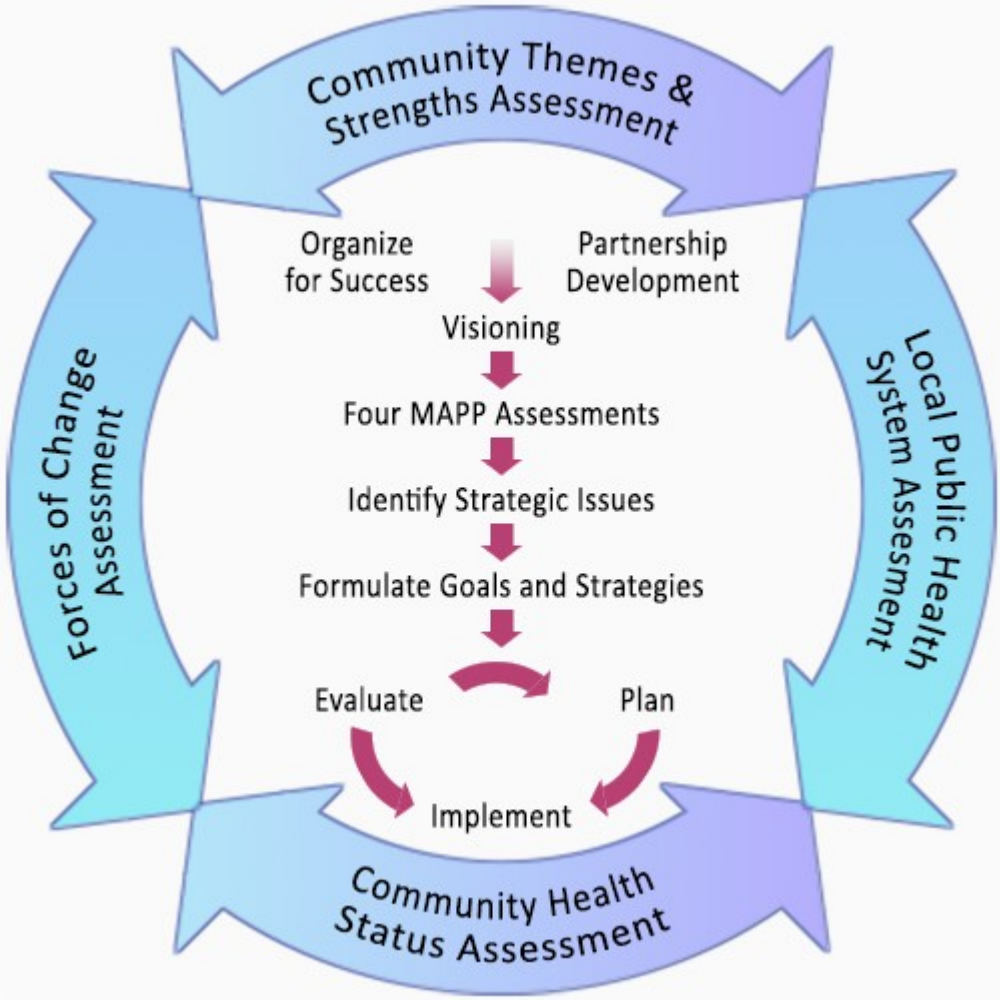
Mental Health and Addiction: PAAC Board – CHIP Co-Chairs: Ty Ankrom and Dr. Vernon Bolender; Barry Bennett, June Green, Chris Thornton,

Community Health Outcomes: CHIP Co-Chairs: Susan Strawser and Jimmie Davis; Jonna Mathews; Donna Solovey;

Social Determinants of Health: CHIP Co-Chairs: Sharon Stanley and Susan Strawser;

Appendix D

MAPP Process ~ including CHIP's Action Cycle



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Appendix E

Glossary of Acronyms/Terms

ACA	Affordable Care Act
BHS	Berger Health System
BRFSS	Behavioral Risk Factor Surveillance Survey
CHIP	Community Health Improvement Plan
CHA	Community Health Assessment
CHW	Community Health Worker
FCFC	Family and Children First Council
HC/HIT	Health Communication and Health Information Technology
JFS	Job and Family Services
MAPP	Mobilizing for Action through Planning and Partners
NACCHO	National Association of County and City Health Officials
ODH	Ohio Department of Health
OH-#	Oral Health Objective, Healthy People 2020
PAAC	Pickaway Addiction Action Coalition
PCDD	Pickaway County Developmental Disabilities
PCGHD	Pickaway County General Health District
PHI-#	Public Health Infrastructure Objective, Healthy People 2020
PICCA	Pickaway County Community Action
PPCHI	Pickaway Partners for Community Health Improvement (Pickaway Partners)
SA-#	Substance Abuse Objective, Healthy People 2020
SHIP	State Health Improvement Plan
USDHHS	United States Department of Health and Human Services

Appendix F

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