Pickaway County

Community Health Improvement Plan

Our Community. Our Health.

2020

to

2022

Released 12/1/2020

PICKAWAY COUNTY PUBLIC HEALTH
We Care.

OhioHealth

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Note: Throughout the report, hyperlinks will be highlighted in bold, gold text. If using a hard copy of this report, please see Appendix II for links to websites.

Executive Summary

Introduction

A community health improvement plan (CHIP) is a community-driven, long-term, systematic plan to address issues identified in a community health assessment (CHA). The purpose of the CHIP is to describe how hospitals, health departments, and other community stakeholders will work to improve the health of the county. A CHIP is designed to set priorities, direct the use of resources, and develop and implement projects, programs, and policies. The CHIP is more comprehensive than the roles and responsibilities of health organizations alone, and the plan's development must include participation of a broad set of community stakeholders and partners. This CHIP reflects the results of a collaborative planning process that includes significant involvement by a variety of community sectors.

The Pickaway County Health Partners have been conducting CHAs since 2019 to measure community health status. The most recent Pickaway County CHA was cross-sectional in nature and included a written survey of adults within Pickaway County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention (CDC) for their national and state Behavioral Risk Factor Surveillance System (BRFSS). This has allowed Pickaway County to compare their CHA data to national, state and local health trends. Community stakeholders were actively engaged in the early phases of CHA planning and helped define the content, scope, and sequence of the project.

The Pickaway County Health Department contracted with the Hospital Council of Northwest Ohio (HCNO), a neutral, regional, nonprofit hospital association, to facilitate the CHIP. The health district invited various community stakeholders to participate in the community health improvement process. Data from the most recent CHA was carefully considered and categorized into community priorities with accompanying strategies. This was done using the National Association of County and City Health Officials' (NACCHO) national framework, Mobilizing for Action through Planning and Partnerships (MAPP). Over the next three years, these priorities and strategies will be implemented at the county-level with the hope to improve population health and create lasting, sustainable change. It is the hope of the Pickaway County Health Alliance that each agency in the county will tie their internal strategic plan to at least one strategy in the CHIP.

Amid the planning process, Pickaway County was struck by COVID-19 along with the rest of the country. As the State of Ohio works to mitigate the impact of COVID-19, there is uncertainty around funding for Medicaid and education, both critical to the health of Pickaway County residents. Community leaders expressed great concern over the impact of COVID-19 on Pickaway County and therefore this Implementation Plan considers the changing and unknown environment brought about by COVID-19.

Public Health Accreditation Board (PHAB) Requirements

National Public Health Accreditation status through the Public Health Accreditation Board (PHAB) is the measurement of health department performance against a set of nationally recognized, practice-focused and evidenced-based standards. The goal of the national accreditation program is to improve and protect the health of the public by advancing the quality and performance of Tribal, state, local, and territorial public health departments. PHAB requires that CHIPs be completed at least every five years, however, Ohio state law (ORC 3701.981) requires that health departments and hospitals collaborate to create a CHIP every three years. Additionally, PHAB is a voluntary national accreditation program, however the State of Ohio requires that all local health departments become accredited by 2020, making it imperative that all PHAB requirements are met.

PHAB standards also require that a community health improvement model is utilized when planning CHIPs. This CHIP was completed using NACCHO's MAPP process. MAPP is a national, community-driven planning process for improving community health. This process was facilitated by HCNO in collaboration with various local agencies representing a variety of sectors.

Inclusion of Vulnerable Populations (Health Disparities)

Approximately 12% of Pickaway County residents were below the poverty line, according to the 2013-2017 American Community Survey 5 year estimates. For this reason, data is broken down by income (less than $25,000 and greater than $25,000) throughout the report to show disparities.

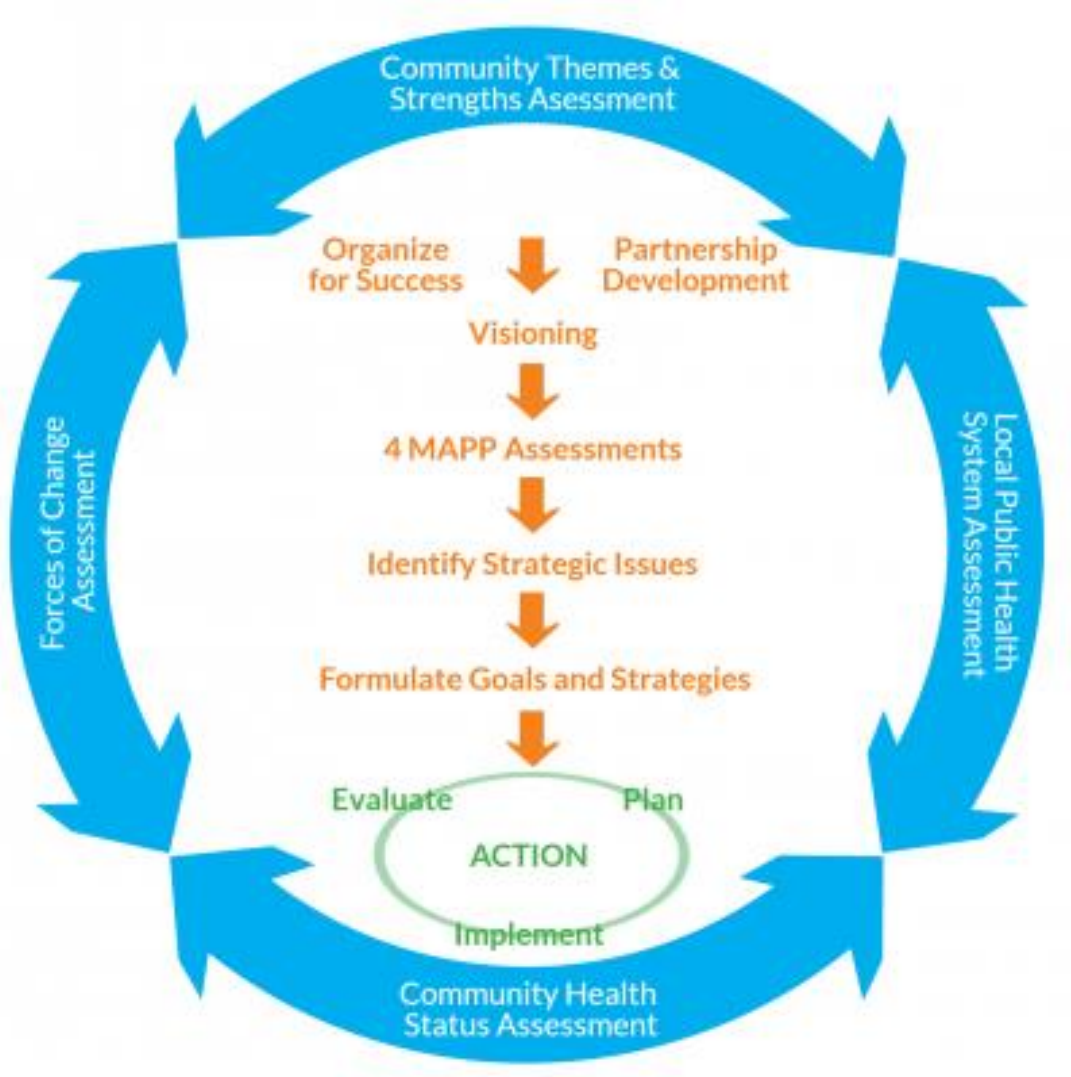
Mobilizing for Action through Planning and Partnerships (MAPP)

NACCHO's strategic planning tool, MAPP, guided this community health improvement process. The MAPP framework includes six phases which are listed below:

1. Organizing for success and partnership development
2. Visioning
3. The four assessments
4. Identifying strategic issues
5. Formulate goals and strategies
6. Action cycle

The MAPP process includes four assessments: community themes and strengths, forces of change, local public health system assessment, and the community health status assessment. These four assessments were used by the Pickaway Partners for Health to prioritize specific health issues and population groups which are the foundation of this plan. Figure 1.1 illustrates how each of the four assessments contributes to the MAPP process.

Figure 1.1 The MAPP model



Alignment with National and State Standards

The 2020-2022 Pickaway County CHIP priorities align with state and national priorities. Pickaway County will be addressing the following priorities: Community Conditions, Mental Health and Addiction, Chronic Disease, and Maternal and Infant Health.

Ohio State Health Improvement Plan (SHIP)

Note: This symbol will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2020-2022 SHIP.

SHIP Overview

The 2020-2022 SHIP serves as a strategic menu of priorities, objectives, and evidence-based strategies to be implemented by state agencies, local health departments, hospitals and other community partners and sectors beyond health including education, housing, employers, and regional planning.

The SHIP includes a strategic set of measurable outcomes that the state will monitor on an annual basis. Given that the overall goal of the SHIP is to ensure all Ohioan's achieve their full health potential, the state will track the following health indicators: self-reported health status (reduce the percent of Ohio adults who report fair or poor health) and premature death (reduce the rate of deaths before age 75).

SHIP Priorities

The SHIP also takes a comprehensive approach to improving Ohio's greatest health priorities by identifying 3 priority factors that impact the 3 priority health outcomes.

The three priority factors include the following:

1. **Community Conditions** (includes housing affordability and quality, poverty, K-12 student success, and adverse childhood experiences)
2. **Health Behaviors** (includes tobacco/nicotine use, nutrition, and physical activity)
3. **Access to Care** (includes health insurance coverage, local access to healthcare providers, and unmet needs for mental health care)

The three priority health outcomes include the following:

1. **Mental Health and Addiction** (includes depression, suicide, youth drug use, and drug overdose deaths)
2. **Chronic Disease** (includes conditions such as heart disease, diabetes and childhood conditions [asthma and lead])
3. **Maternal and Infant Health** (includes infant and maternal mortality and preterm births)

CHIP Alignment with the 2020-2022 SHIP

The Pickaway CHIP was required to select at least 1 priority factor, 1 priority health outcome, 1 indicator for each identified priority, and 1 strategy for each selected priority to align with the 2020-2022 SHIP.

Note: This symbol will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2020-2022 SHIP. Whenever possible, the Pickaway County CHIP identifies strategies likely to reduce disparities and inequities. Throughout the report, hyperlinks will be highlighted in bold, gold text.

The following Pickaway County CHIP priority factors, priority indicators, and strategies very closely align with the 2020-2022 SHIP:

Figure 1.2: 2020-2022 Pickaway County CHIP Alignment with the 2020-2022 SHIP

Priority Factors	Priority Indicators	Strategies to Impact Priority Indicators	Additional Aligned Strategies
Community Conditions	• Adult poverty • Chronic absenteeism • Homeless population • Affordable housing units • Youth fruit/vegetable consumption	• Affordable housing and development preservation • Implement school-based social and emotional instruction • Community gardens	• N/A
Priority Outcomes	**Priority Indicators**	**Strategies to Impact Priority Indicators**	**Additional Aligned Strategies**
Chronic Disease	• Heart disease • High blood pressure • High blood cholesterol • Obesity • Pre-diabetes • Diabetes	• Hypertension screening and follow-up	• Healthy eating practices through fostering self-efficacy • Online community wellness calendar
Mental Health and Addiction	• Depression • Deaths by suicide • Unintentional drug overdose deaths	• Mental health first aid	• Overdose fatality review board (OFRB) • Integrated information about depression and suicide screening and treatment in primary care curriculum
Maternal and Infant Health	• Child fatality review	• Safe sleep practices	• N/A

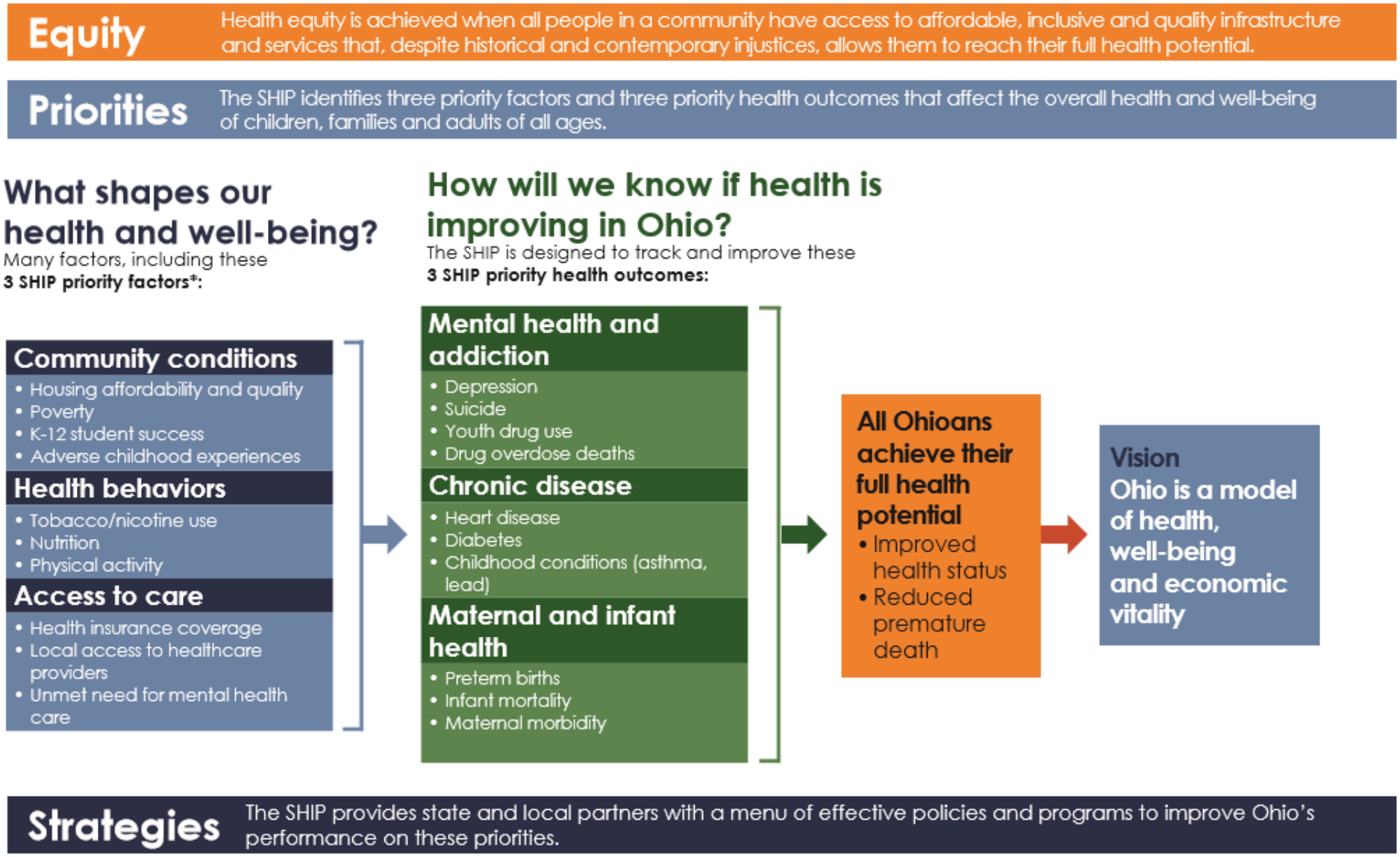
N/A – Not Available

U.S. Department of Health and Human Services National Prevention Strategies

The Pickaway County CHIP also aligns with three of the National Prevention Priorities for the U.S. population: preventing drug abuse and excessive alcohol use, healthy eating, and mental and emotional well-being. For more information on the national prevention priorities, please go to **surgeongeneral.gov**.

Alignment with National and State Standards, continued

Figure 1.3 2020-2022 State Health Improvement Plan (SHIP) Overview



Vision and Mission

Vision statements define a mental picture of what a community wants to achieve over time while the mission statement identifies why an organization/coalition exists and outlines what it does, who it does it for, and how it does what it does.

The Vision of the Pickaway Partners for Health

Collaboration between community members, professionals, and key stakeholders working together to create a safe, healthy, and desirable Pickaway County.

The Mission of the Pickaway Partners for Health

Empowering Pickaway County's residents to improve their health and safety by implementing strategies to help every person reach their fullest potential within a caring environment.

Community Partners

The CHIP was planned by various agencies and service-providers within Pickaway County. From July 2020 to September 2020, the Pickaway Partners for Health reviewed many data sources concerning the health and social challenges that Pickaway County residents are facing. They determined priority issues which, if addressed, could improve future outcomes; determined gaps in current programming and policies; examined best practices and solutions; and determined specific strategies to address identified priority issues. We would like to recognize these individuals and thank them for their dedication to this process:

Pickaway Partners for Health

Pickaway County Public Health
Pickaway County Community Action
Pickaway County OSU Extension Office
Pickaway County Board of Developmental Disabilities
Pickaway County Job and Family Services
Pickaway County Educational Services Center
Ohio Health/Berger

Hospital Council of Northwest Ohio (HCNO)

The community health improvement process was facilitated by and Gabrielle Mackinnon, MPH, Community Health Improvement Coordinator, from HCNO.

Community Health Improvement Process

Beginning in July 2020, the Pickaway County Health Alliance met four (4) times and completed the following planning steps:

1. Initial Meeting
    - Review the process and timeline
    - Finalize committee members
    - Create or review vision
2. Choose Priorities
    - Use of quantitative and qualitative data to prioritize target impact areas
3. Rank Priorities
    - Rank health problems based on magnitude, seriousness of consequences, and feasibility of correcting
4. Community Themes and Strengths Assessment
    - Open-ended questions for committee on community themes and strengths
5. Forces of Change Assessment
    - Open-ended questions for committee on forces of change
6. Local Public Health Assessment
    - Review the Local Public Health System Assessment with committee
7. Gap Analysis
    - Determine discrepancies between community needs and viable community resources to address local priorities
    - Identify strengths, weaknesses, and evaluation strategies
8. Quality of Life Survey
    - Review results of the Quality of Life Survey with committee
9. Strategic Action Identification
    - Identification of evidence-based strategies to address health priorities
10. Best Practices
    - Review of best practices, proven strategies, evidence continuum, and feasibility continuum
11. Resource Assessment
    - Determine existing programs, services, and activities in the community that address specific strategies
12. Draft Plan
    - Review of all steps taken
    - Action step recommendations based on one or more of the following: enhancing existing efforts, implementing new programs or services, building infrastructure, implementing evidence-based practices, and feasibility of implementation

Community Health Status Assessment

Phase 3 of the MAPP process, the Community Health Status Assessment, or CHA, is a 100+ page report that includes primary data with over 100 indicators and hundreds of data points related health and well-being, including social determinants of health. Over 50 sources of secondary data are also included throughout the report. The CHA serves as the baseline data in determining key issues that lead to priority selection. The full report can be found at pickawaycountypublichealth.org/community-health/. Below is a summary of county primary data and the respective state and national benchmarks.

Adult Trend Summary

Comparisons	Pickaway County 2020	Ohio 2018	U.S. 2018
Healthcare Coverage			
Uninsured	10%	7%	11%
Access and Utilization			
Had at least one person they thought of as their personal doctor or health care provider	88%	80%	77%
Visited a doctor for a routine checkup in the past year	66%	79%	77%
Needed to see a doctor in the past 12 months but could not because of cost	14%	10%	12%
Preventive Medicine			
Had a pneumonia vaccination (age 65 and over)	80%	74%	74%
Had a flu vaccine in the past year (age 65 and over)	80%	56%	55%
Ever had a shingles or zoster vaccine	23%	29%*	29%*
Women's Health			
Had a mammogram within the past two years (age 40 and older)	74%	74%	72%
Had a Pap smear within the past three years (age 21-65)	73%	79%	80%
Men's Health			
Had a prostate-specific antigen (PSA) test in the past two years (age 40 and older)	56%	34%	33%
Oral Health			
Visited a dentist or dental clinic in the past year	72%	67%	68%
Health Status Perceptions			
Rated health as excellent or very good	50%	49%	51%
Rated health as fair or poor	11%	19%	18%
Rated physical health as not good on four or more days (in the past 30 days)	20%	24%	23%
Average days that physical health not good in past month	3.4	4.0¥	3.7¥
Rated mental health as not good on four or more days (in the past 30 days)	28%	26%	24%
Average days that mental health not good in past Month	4.1	4.3¥	3.8¥
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past 30 days)	27%	24%	24%

Indicates alignment with Ohio State Health Assessment (SHA)
**2017 BRFSS*
¥2016 BRFSS data as compiled by 2019 County Health Rankings

Comparisons	Pickaway County 2020	Ohio 2018	U.S. 2018
Obese	35%	34%	31%
Overweight	37%	34%	35%
Tobacco Use			
Current smoker (currently smoke some or all days)	11%	21%	16%
Former smoker (smoked 100 cigarettes in lifetime & now do not smoke)	25%	25%	25%
Current e-cigarette user (vaped on some or all days)	2%	5%*	5%*
Former e-cigarette user	15%	19%*	16%*
Alcohol Consumption			
Current Drinker (drank alcohol at least once in the past month)	49%	52%	54%
Binge drinker (defined as consuming more than four [women] or five [men] alcoholic beverages on a single occasion in the past 30 days)	20%	16%	16%
Cardiovascular Disease			
Had angina or coronary heart disease	2%	5%	4%
Had a heart attack or myocardial infarction	5%	6%	5%
Had a stroke	2%	4%	3%
Had high blood pressure	33%	35%*	32%*
Had high blood cholesterol	40%	33%*	33%*
Had blood cholesterol checked within past 5 years	90%	85%*	86%*
Asthma			
Ever been told they have asthma	9%	13%	15%
Arthritis			
Ever diagnosed with arthritis	33%	31%	26%
Diabetes			
Ever been told by a doctor they have diabetes (not pregnancy-related)	11%	12%	11%
Had been diagnosed with pre-diabetes or borderline diabetes	6%	2%	2%

Indicates alignment with the Ohio State Health Assessment (SHA)
**2017 BRFSS Data*

Key Issues

The Pickaway Partners for Health reviewed the 2020 Pickaway County Health Assessment. The detailed primary data for each individual priority area can be found in the section it corresponds to. Each organization completed an "Identifying Key Issues and Concerns" worksheet. The following tables were the group results.

What are the most significant health issues or concerns identified in the 2020 health assessment report? Examples of how to interpret the information include: 39% of adults were obese, increasing to 45% of those ages 30-64.

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Mental health (6 votes)			
Adults feeling so sad or hopeless almost every day for two weeks or more in a row that stopped them from doing usual activities (in the past year)	14%	Age: Under 30 (22%) Income: <$25K (27%)	Female (15%)
Adults considering attempting suicide (in the past year)	4%	N/A	N/A
Number of deaths by suicide – 2018 Pickaway County *(Source: Ohio Department of Health)*	7 deaths	N/A	N/A
Drug Use (5 votes)			
Adults who had used medication not prescribed for them or took more than prescribed to feel good or high/or more active or alert (in the past 6 months)	4%	Age: Under 30 (13%) Income: <$25K (10%)	Female (6%)
Unintentional drug overdose deaths – 2018 Pickaway County *(Source: Ohio Department of Health)*	20 deaths	N/A	N/A
Opiate and pain reliever doses per capita – 2018 Pickaway County *(Source: Ohio Automated Prescription Reporting System)*	60.4 doses	N/A	N/A
Opiate and pain reliever doses per patient – 2018 Pickaway County *(Source: Ohio Automated Prescription Reporting System)*	309.2 doses	N/A	N/A
Adult obesity (4 votes)			
Adult obesity (includes severely and morbidly obese, BMI of 30.0 and above)	35%	Age: 65+ (38%) Income: <$25K (49%)	Female (37%)
Health Care Coverage/Access (4 votes)			
Adults who were without health coverage	10%	Age: Under 30 (11%) Income: $25K Plus (8%)	Female (13%)

N/A- Not Available

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Chronic disease (4 votes)			
Adults who had high blood pressure	33%	Age: 65+ (60%) Income: <$25K (37%)	Male (38%)
Adults who had high blood cholesterol	40%	Age: 65+ (60%) Income: <$25K (52%)	Male (45%)
Adults who had angina or coronary heart disease	2%	Age: 65+ (9%)	N/A
Adults who had been diagnosed with diabetes	11%	Age: 65+ (30%) Income: <$25K (16%)	Male (13%)
Adults who had been diagnosed with pre-diabetes	6%	N/A	N/A
Adults reported they were limited in some way because of physical, mental, or emotional problems	22%	N/A	N/A
Social Determinants of Health (SDOH) (3 votes)			
Adult who had four or more Adverse Childhood Experiences (ACEs) (in their lifetime)	7%	Age: Under 30 (10%) Income: <$25K (16%)	Female (8%)
Adults living in poverty – Pickaway 2018 *(Source: U.S. Census Bureau, Small Area Income and Poverty Estimates)*	12%	N/A	N/A
Preventative Health Screenings and Exams (2 votes)			
Women who had a mammogram (in the past year)	36%	Age: 40 & Older (57%) Income: <$25K (33%)	Female (36%)
Men who had a digital rectal exam (in the past year)	17%	Age: 50 & Older (33%) Income: $25K (14%)	Male (17%)
Sexual Behavior (1 vote)			
Adults who reported being forced to have sexual activity when they did not want to	6%	N/A	Female (9%)
Tobacco Use (1 vote)			
Adults who were current smokers (at least 100 cigarettes in their lifetime)	11%	Age: 30-64 & 65+ (12%) Income: $25K Plus (10%)	Male & Female (11%)
Alcohol Consumption (1 vote)			
Adults who had at least one alcoholic drink (in the past month)	49%	Income: $25K Plus (59%)	Male (54%)
Health Status (1 vote)			
Adults who rated their health as fair or poor	11%	Age: 65+ (20%) Income: <$25K (21%)	Male (8%)

N/A- Not Available

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Cancer (1 vote)			
Adults who were current smokers (at least 100 cigarettes in their lifetime)	11%	Age: 30-64 & 65+ (12%) Income: $25K Plus (10%)	Male & Female (11%)
Age-adjusted mortality rates for lung & bronchus cancer (per 100,000 people) – Pickaway 2016-2018 *(Source: Ohio Public Health Data Warehouse)*	N/A	Age: 70 years old	N/A
Maternal and Infant Health (1 vote)			
Total live births (per year) – Pickaway 2018 *(Source: ODH, Ohio Public Health Data Warehouse Updated 1-26-2020)*	637 births	N/A	N/A
Preterm births (<37 weeks gestation) (per year) – Pickaway 2018 *(Source: ODH, Ohio Public Health Data Warehouse Updated 1-26-2020)*	10%	N/A	N/A
Neonatal, post-neonatal and infant mortality – Pickaway 2017 *(Source: Ohio Department of Health, Bureau of Vital Statistics, 2017 Ohio Infant Mortality Data: General Findings)*	3 deaths	N/A	N/A

N/A- Not Available

Priorities Chosen

Based on the 2020 Pickaway County Health Assessment, key issues were identified for adults. Overall, there were 13 key issues identified by the Pickaway Partners for Health. The Pickaway Partners for Health then voted and came to a consensus on the priority areas Pickaway County will focus on over the next three years. The key issues and their corresponding votes are described in the table below.

Key Issues	Votes
1. Mental Health	6
2. Drug Use	5
3. Adult Obesity	4
4. Health Care Coverage/Access	4
5. Chronic Disease	4
6. Social Determinants of Health	3
7. Preventative Health Screenings and Exams	2
8. Sexual Behavior	1
9. Tobacco Use	1
10. Alcohol Consumption	1
11. Health Status	1
12. Cancer	1
13. Maternal & Infant Health	1

Pickaway County will focus on the following four priority areas over the next three years:

Priority Factor(s):

1) Community Conditions

Priority Health Outcome(s):

1) Chronic Disease
2) Mental Health and Addiction
3) Maternal and Infant Health

Community Themes and Strengths Assessment (CTSA)

The Community Themes and Strengths Assessment (CTSA) provides a deep understanding of the issues that residents felt were important by answering the questions: "What is important to our community?" "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?" The CTSA consisted of two parts: open-ended questions to the committee and the Quality of Life Survey. Below are the results:

Open-ended Questions to the Committee

1. **What do you believe are the 2-3 most important characteristics of a healthy community?**
    - Access to healthy foods
    - Access to health care
    - Access to fitness opportunities
    - Community collaboration/involvement
    - Community contribution
    - Significant stakeholders

2. **What makes you most proud of our community?**
    - Community collaboration
    - Agency/organization collaboration

3. **What are some specific examples of people or groups working together to improve the health and quality of life in our community?**
    - Re-launching 211 system
    - Health department involving community and stakeholders

4. **What do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life in our community?**
    - Mental health and addiction (2)
    - Better health care coverage (2)
    - Access to care (2)
    - Chronic disease – access to healthier foods and fitness (2)
    - Addressing social determinants of health in the community
    - Maternal and infant health

5. **What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?**
    - Limited funding
    - Limited resources
    - Motivation/enthusiasm

6. **What actions, policy, or funding priorities would you support to build a healthier community?**

    - Mental health and addiction
    - Chronic disease
    - Maternal and infant health
    - Access to care

7. **What would excite you enough to become involved (or more involved) in improving our community?**

    - Being able to offer expertise/advice
    - Collaboration led by Pickaway County Public Health and various community leaders
    - Partnering with community stakeholders

Quality of Life

The Pickaway Partners for Health urged community members to fill out a short Quality of Life Survey via SurveyMonkey. There were 181 Pickaway County community members who completed the survey. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1. For all responses of "Don't Know," or when a respondent left a response blank, the choice was a non-response and was assigned a value of 0 (zero). The non-response was not used in averaging response or calculating descriptive statistics.

Quality of Life Questions	Likert Scale Average Response 2020 (n=181)
1. Are you satisfied with the quality of life in our community? (Consider your sense of safety, well-being, participation in community life and associations, etc.) [IOM, 1997]	3.60
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.24
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.66
4. Is this community a good place to grow old? (Consider elder-friendly housing, transportation to medical services, churches, shopping; elder day care, social support for the elderly living alone, meals on wheels, etc.)	3.56
5. Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)	2.95
6. Is the community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?)	3.74
7. Are there networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, or organizations) during times of stress and need?	3.62
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.39
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.07
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	2.77
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.09
12. Is there an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments? (Are citizens working towards the betterment of their community to improve life for all citizens?)	3.08

Forces of Change Assessment

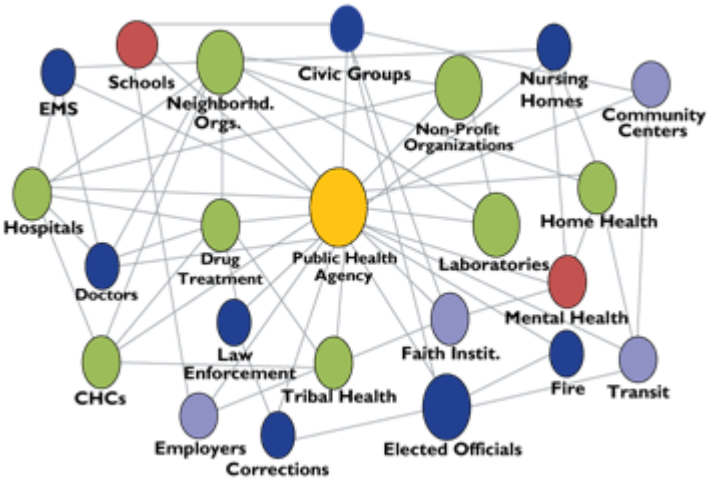
The Forces of Change Assessment focuses on identifying forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. This assessment answers the questions: "What is occurring or might occur that affects the health of our community or the local public health system?" and "What specific threats or opportunities are generated by these occurrences?" The Pickaway Partners for Health were asked to identify positive and negative forces which could impact community health improvement and overall health of this community over the next three years. This group discussion covered many local, state, and national issues and change agents which could be factors in Pickaway County in the future. The table below summarizes the forces of change agent and its potential impacts:

Force of Change	Threats Posed	Opportunities Created
1. COVID-19	• Lack of community participation (3) • Job loss (2) • Social distancing • Food insecurity • Increase in sickness	• Using more online platforms • Vaccination promotion • Increased health education
2. Increase in drug usage	• Overdose • Poverty • Poor health	• Wellness programs • Overdose/drug use prevention
3. Increase in obesity	• Poor health	• Wellness programs • Increased health education

Local Public Health System Assessment

The Local Public Health System

Public health systems are commonly defined as "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction." This concept ensures that all entities' contributions to the health and well-being of the community or state are recognized in assessing the provision of public health services.



The public health system includes:

- Public health agencies at state and local levels
- Healthcare providers
- Public safety agencies
- Human service and charity organizations
- Education and youth development organizations
- Recreation and arts-related organizations
- Economic and philanthropic organizations
- Environmental agencies and organizations

The 10 Essential Public Health Services

The 10 Essential Public Health Services describe the public health activities that all communities should undertake and serve as the framework for the NPHPS instruments.

Public health systems should:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

(Source: **Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services**)

The Local Public Health System Assessment (LPHSA)

The LPHSA answers the questions, "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services being provided to our community?"

This assessment involves the use of a nationally recognized tool called the **National Public Health Performance Standards Local Instrument.**

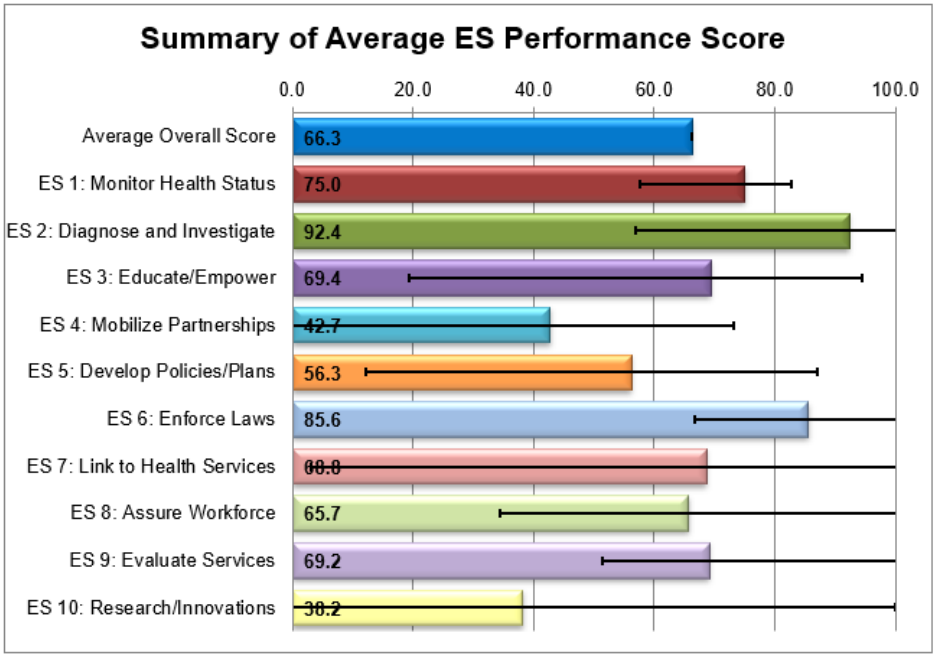
Members of the Pickaway County Health Department completed the performance measures instrument. The LPHSA results were then presented to the Pickaway Partners for Health for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard was discussed, and the group came to a consensus on responses for all questions. The challenges and opportunities that were discussed were used in the action planning process.

The Pickaway Partners for Health identified 10 indicators that had a status of "minimal" and 5 indicators that had a status of "no activity." The remaining indicators were all moderate, significant or optimal.

As part of minimum standards, local health departments are required to complete this assessment at least once every five years.

To view the full results of the LPHSA, please contact Sasha Payadnya at 740-477-9667.

Pickaway County Local Public Health System Assessment 2020 Summary



Note: The black bars identify the range of reported performance score responses within each Essential Service

Gap Analysis, Strategy Selection, Evidence-Based Practices, and Resources

Gaps Analysis

A gap is an area where the community needs to expand its efforts to reduce a risk, enhance an effort, or address another target for change. A strategy is an action the community will take to fill the gap. Evidence is information that supports the linkages between a strategy, outcome, and targeted impact area. The Pickaway Partners for Health were asked to determine gaps in relation to each priority area, consider potential or existing resources, and brainstorm potential evidence-based strategies that could address those gaps.

Strategy Selection

Based on the chosen priorities, Pickaway Partners for Health were asked to identify strategies for each priority area. Considering all previous assessments, including but not limited to the CHA, CTSA, quality of life survey and gap analysis, committee members determined strategies that best suited the needs of their community. Members referenced a list of evidence-based strategies recommended by the Ohio SHIP, as well as brainstormed for other impactful strategies. Each resource inventory can be found with its corresponding priority area.

Evidence-Based Practices

As part of the gap analysis and strategy selection, the Pickaway Partners for Health considered a wide range of evidence-based practices, including best practices. An evidence-based practice has compelling evidence of effectiveness. Participant success can be attributed to the program itself and have evidence that the approach will work for others in a different environment. A best practice is a program that has been implemented and evaluation has been conducted. While the data supporting the program is promising, its scientific rigor is insufficient. Each evidence-based practice can be found with its corresponding strategy.

Resource Inventory

Based on the chosen priorities, the Pickaway Partners for Health were asked to identify resources for each strategy. The resource inventory allowed the committee to identify existing community resources, such as programs, policies, services, and more. The Pickaway Partners for Health was then asked to determine whether a policy, program or service was evidence-based, a best practice, or had no evidence indicated. Each resource inventory can be found with its corresponding strategy.

Priority #1: Community Conditions

Strategic Plan of Action

To work toward improving community conditions outcomes, the following strategies are recommended:

Community Conditions Strategies:

<table>
<tr><td colspan="5">Priority #1: Community Conditions</td></tr>
<tr><td colspan="5">Strategy 1: Affordable housing development and preservation</td></tr>
<tr><td>Action Step</td><td>Timeline</td><td>Priority Population</td><td>Indicator(s) to measure impact of strategy:</td><td>Lead Contact/Agency</td></tr>
<tr><td>Year 1: Identify housing issues within the county that are impacting personal health.
Identify what policy or legislative changes that Pickaway Partners for Health can assist in (ex: advocate to landlords/management companies regarding accepting those on housing assistance programs/complying with HUD safe housing regulations).</td><td>December 31, 2020</td><td rowspan="3">Low Income Adults/Families</td><td rowspan="3">SDOH: Percent of adults who are living in poverty (via U.S. Census)

Decreased homeless population

Affordable and available housing units</td><td rowspan="3">Health Department</td></tr>
<tr><td>Year 2: Continue efforts from year 1.
Research low income housing tax credits, home improvement grant opportunities, and service-enriched housing to support efforts.
Create a coordinated campaign of planned strategies and define interventions and resources.</td><td>December 31, 2021</td></tr>
<tr><td>Year 3: Begin addressing strategies identified and implementing policy changes.</td><td>December 31, 2022</td></tr>
<tr><td colspan="5">Strategy identified as likely to decrease disparities?
⊗ Yes ○ No ○ Not SHIP Identified</td></tr>
<tr><td colspan="5">Resources to address strategy:
Pickaway County Affordable Housing Coalition</td></tr>
<tr><td colspan="5">Outcome:
Improve housing affordability and quality</td></tr>
</table>

Priority #1: Community Conditions				
Strategy 2: Implement school-based social and emotional instruction				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Gather baseline data on which bullying prevention programs are currently being implemented in the County.	December 31, 2020	Economically Disadvantaged Youth	Chronic absenteeism (K-12 students): Percent of students, grades K-12, who are chronically absent (ODE)	Educational Service Center
Year 2: Continue efforts from year 1. Introduce at least one of the following programs to the educational service board: • **The PAX Good Behavior Game** • **The Second Step Social-Emotional Learning (SEL) Program** • **The Incredible Years** • **ROX (Ruling Our Experience)** • **Strengthening Families** Pilot the program(s) in at least one County school district.	December 31, 2021			
Year 3: Continue efforts of years 1 and 2. Implement the program(s) in two additional County school districts.	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Family and Children First Council				
Outcome: Improve K-12 student success				

Priority #1: Community Conditions

Strategy 3: Community Gardens

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Obtain baseline data regarding how many districts, churches, and organizations currently have community gardens and where they are located. Research grants and funding opportunities to increase the number of community gardens.	December 31, 2020	School Age Youth	Youth fruit consumption Youth vegetable consumption	OhioHealth OSU Extension
Year 2: Help school districts and other organizations apply for grants to obtain funding to start a garden.	December 31, 2021			
Year 3: Implement community gardens in all school districts and double the number of organizations with community gardens from baseline.	December 31, 2022			

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy:

N/A

Outcome:

Improve nutrition

Increase access and education on fruits and vegetables

**Note: Identified as health behavior strategy (impacts multiple priorities)*

Priority #2: Chronic Disease

Strategic Plan of Action

To work toward improving chronic disease, the following strategies are recommended:

Priority #2: Chronic Disease				
Strategy 1: Hypertension screening and follow-up				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Determine the baseline number of healthcare providers that currently screen for hypertension and regularly follow up with patients diagnosed with hypertension.	December 31, 2020	Adult	Heart disease: Percent of adults who had been diagnosed with angina or coronary heart disease High blood pressure: Percent of adults who had been diagnosed with high blood pressure High blood cholesterol: Percent of adults who had been diagnosed high blood cholesterol	???
Year 2: Increase provider education on hypertension screening, treatment, and the importance of routine follow up with patients diagnosed with hypertension. Partner with local organizations to administer the screening and/or raise awareness of hypertension. Promote and market free/reduced cost screening events within the county (ex: health fairs, hospital screening events, etc.). Continue to distribute educational materials. Work with primary care physician (PCP) offices to assess what information and/or materials they may be lacking to provide better resources for pre-hypertensive or hypertensive patients. Develop a campaign encouraging residents to "know their numbers" (i.e., blood pressure and cholesterol) and the signs and symptoms of heart disease.	December 31, 2021			
Year 3: Continue to raise awareness of existing free/reduced cost blood pressure screenings throughout the county. Increase the number of healthcare providers that currently screen for hypertension and follow up by 5% from baseline. Implement campaign.	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: N/A				
Outcome: Reduce hypertension				

Priority #2: Chronic Disease				
Strategy 2: Healthy eating practices through fostering self-efficacy				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to implement the Share Our Strength's **Cooking Matters** program to SNAP-eligible adults through the Ohio State University Extension. Work with at least one new organization, such as a school, senior center, or community center, to pilot an additional 6-week course of the Cooking Matters program. Offer the program to all adults and families. Measure knowledge gained through evaluations.	December 31, 2020	Adult	Obesity: Percent of adults who were obese (includes severely and morbidly obese, BMI of 30.0 and above) Pre-diabetes: Percent of adults who had been diagnosed with pre-diabetes Diabetes: Percent of adults who had been diagnosed with diabetes	OSU Extension
Year 2: Continue efforts to implement at least one Cooking Matters class per quarter. Utilizing the **Cooking Matters at the Store framework**, conduct quarterly grocery store tours by a Registered Dietitian or Health Educator in grocery stores throughout the County. Measure knowledge gained through evaluations.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Measure knowledge gained through evaluations.	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: N/A				
Outcome: Reduce diabetes				

**Note: Identified as health behavior strategy (impacts multiple priorities)*

Priority #3: Mental Health and Addiction

Strategic Plan of Action

To work toward improving mental health and addiction, the following strategies are recommended:

<table>
<tr><td colspan="5">Priority #3: Mental Health and Addiction</td></tr>
<tr><td colspan="5">Strategy 1: Mental Health First Aid</td></tr>
<tr><td>Action Step</td><td>Timeline</td><td>Priority Population</td><td>Indicator(s) to measure impact of strategy:</td><td>Lead Contact/Agency</td></tr>
<tr><td>Year 1: Obtain baseline data on the number of mental health first aid (MHFA) trainings that have taken place in the County.</td><td>December 31, 2020</td><td rowspan="3">Adult</td><td rowspan="3">Depression: Percent of adult who had been sad or hopeless almost every day for two week or more in a row

Deaths by suicide: Number of deaths by suicide (via ODH)</td><td rowspan="3">Health Department

OhioHealth</td></tr>
<tr><td>Year 2: Continue efforts from year 1.
Market the training to local churches, schools, rotary clubs, law enforcement, chambers of commerce, city councils, college students, etc.
Provide at least two MHFA trainings.</td><td>December 31, 2021</td></tr>
<tr><td>Year 3: Continue efforts of years 1 and 2.
Provide at least three additional trainings and continue marketing the training.</td><td>December 31, 2022</td></tr>
<tr><td colspan="5">Strategy identified as likely to decrease disparities?
○ Yes ⊗ No ○ Not SHIP Identified</td></tr>
<tr><td colspan="5">Resources to address strategy:
N/A</td></tr>
<tr><td colspan="5">Outcome:
Reduce depression
Reduce suicide deaths</td></tr>
</table>

Priority #3: Mental Health and Addiction				
Strategy 2: Overdose Fatality Review Board (OFRB)				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Create an Overdose Fatality Review Board (OFRB) to standardize practices.	December 31, 2020	Adult	Unintentional drug overdose deaths (via ODH)	Health Department
Year 2: Recruit members from law enforcement, hospitals, health departments, and other community agencies to participate in the OFRB. Collaborate with other counties with an Overdose Fatality Review Board to share experiences and lessons learned. Consider a train-the-trainer approach.	December 31, 2021			
Year 3: Create a standardized model to implement. Enter OFRB data into ODH database (if appropriate), or another database. Host regular calls or meetings to discuss trends.	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: N/A				
Outcome: Reduce drug overdose deaths				

Priority #4: Maternal and Infant Health

Strategic Plan of Action

To work toward maternal and infant health, the following strategies are recommended:

Priority #4: Maternal and Infant Health				
Strategy 1: Safe sleep practices				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Work with local hospitals, FQHC's and other organizations to integrate safe sleep practices (i.e. The ABC's of Safe Sleep, Cribs for Kids) into the community. Disseminate materials targeted at education and awareness.	December 31, 2020	Child	Child fatality review	Health Department
Year 2: Continue to raise awareness and promote safe sleep practices through coordinated messages. Work with hospital and health department to start talking about safe sleep practices from the initial prenatal visit.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2.	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: N/A				
Outcome: Reduce infant mortality				

Progress and Measuring Outcomes

Progress will be monitored with measurable indicators identified for each strategy. Most indicators align directly with the SHIP. The individuals or agencies that are working on strategies will meet on an as- needed basis. The Pickaway Partners for Health will meet every other month to report out progress. The Pickaway Partners for Health will create a plan to disseminate the CHIP to the community. Strategies, responsible agencies, and timelines will be reviewed at the end of each year by the committee. As this CHIP is a living document, edits and revisions will be made accordingly.

Pickaway County will continue facilitating CHAs every three years to collect data and determine trends. Primary data will be collected for adults and secondary data will be analyzed for youth using national sets of questions to not only compare trends in Pickaway County, but also be able to compare to the state and nation. This data will serve as measurable outcomes for each priority area. Indicators have already been defined throughout this report and are identified with the icon.

In addition to outcome evaluation, process evaluation will also be used on a continuous basis to focus on the success of the strategies. Areas of process evaluation that the CHIP committee will monitor include the following: number of participants, location(s) where services are provided, number of policies implemented, economic status and racial/ethnic background of those receiving services (when applicable), and intervention delivery (quantity and fidelity).

Furthermore, all strategies have been incorporated into a "Progress Report" template that can be completed at all future meetings, keeping the committee on task and accountable. This progress report may also serve as meeting minutes.

Contact Us

For more information about any of the agencies, programs, and services described in this report, please contact:

Adam J. Negley, MPH
Health Commissioner
Pickaway County Public Health
110 Island Rd. Suite C.
P.O. Box 613
Circleville, OH 43113
740-477-9667

Appendix I: Gaps and Strategies

The following tables indicate community conditions, chronic disease, mental health and addiction, and maternal and infant health gaps and potential strategies that were compiled by the Pickaway Partners for Health

Priority #1: Community Conditions

Gaps	Potential Strategies
1. Lack of community-based health events for families	• Community health fairs • Healthy cooking classes • Exercise programs • Free outdoor activities
2. Healthcare coverage (Access)	• Promote health department programs (access)
3. Lack of healthy pro-social activities and events for youth and entering young adulthood	• Youth and young adults engaging in with community adult members to encourage youth participation and development
4. Poverty rates	• Childcare eligibility and availability
5. Domestic violence – child abuse/neglect (ACEs)	• Anti-bullying prevention programs

Priority #2: Chronic Disease

Gaps	Potential Strategies
1. Obesity rates	• Access to healthy foods • Health promotion events
2. Lack of healthy living information & promotion	• Health fairs • Free screenings • PSAs
3. Adults who reported being limited in some way	• Increased activities
4. Lack of free screenings	• Free screenings at public places frequently visited by community members
5. Heart disease	• Hypertension prevention programs

Priority #3: Mental Health and Addiction

Gaps	Potential Strategies
1. Drug use/overdose (2)	• Outreach school programs • Overdose programs
2. Adults feel sad or hopeless	• Mental health outreach programs • Increased mental health coverage
3. Suicide rates	• Mental health promotion events
4. Community based mental health and addiction supports such as mentors, inclusive activities, community training on supports for members struggling	• Free community trainings on mental health and addiction • Specialty court dockets for victims/perpetrators involved in legal system due to mental health and addiction issues.
5. Youth drug use	• Resiliency programs/mentoring programs

Priority #4: Maternal and Infant Health

Gaps	Potential Strategies
1. Single mothers	• Pregnancy outreach resources to build relationships
2. Lack of funding for Early Intervention and Maternal Health	• Increase capabilities of local maternal and infant health programming
3. Infant mortality rates	• Increased education on SIDS and safety for infants
4. Lack of community awareness	• Increased maternal and infant health fairs
5. High preterm birth rates	• Group prenatal care • Care coordination and access to well-woman care

Appendix II: Links to Websites

Title of Link	Website URL
Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services	http://www.cdc.gov/nphpsp/essentialservices.html
Cooking Matters	https://cookingmatters.org/courses
Cooking Matters at the Store Framework	https://cookingmatters.org/node/2274
Home Improvement grant opportunities	https://www.cdc.gov/policy/hst/hi5/homeimprovement/index.html
PAX Good Behavior Game	https://www.hazelden.org/HAZ_MEDIA/gbg_insert.pdf
ROX (Ruling Our Experience)	https://rulingourexperiences.com/#!about_us/csgz
The Second Step Social-Emotional Learning (SEL) Program	https://www.secondstep.org/second-step-social-emotional-learning
Service-enriched housing	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/service-enriched-housing
Strengthening Families	https://strengtheningfamiliesprogram.org/