ABSTRACT
This plan began with an assessment process that brought together community representatives to identify priority community health issues. It is to be used as a guide by the community, and used as a reference and foundation for the many health improvement efforts within the county.
# Greene County Community Health Improvement Plan

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THANK YOU PLANNING PARTICIPANTS

The Greene County Combined Health District would like to thank the residents and organizations who donated their time to make the community health planning initiative a success, and one which will benefit the health and well-being of all Greene County residents.

The following individuals participated in the planning:

- **William Beeman**, Greene County Board of Health
- **Terry Bennington**, Fairborn Police Department
- **Jill Bissinger**, City of Beavercreek
- **Donald E. Brannen**, Greene County Combined Health District
- **Mike Brown**, Greene County Sheriff’s Office
- **Chief Dennis Evers**, Beavercreek Police Department
- **Mark Floro**, Greene Memorial Hospital
- **Robyn Fosnaugh**, Greene County Combined Health District
- **Sue Giga**, Greene County Family and Children First Council
- **Meg Gillis**, United Way
- **Gary Greenberg**, Public Media Connect - ThinkTV/CET
- **Pam Hamer**, Greene County Help Me Grow
- **Melanie Hart**, Greene County Ohio State University Extension
- **Melissa Howell**, Greene County Combined Health District
- **Belinda Huffman**, Dayton Children’s Hospital
- **John Larch**, Greene Memorial Hospital
- **Debbie Leopold**, Greene County Combined Health District
- **John Martin**, Bath Township Trustee
- **Shari Martin**, Greene County Combined Health District
- **Greta Mayer**, Mental Health & Recovery Board
- **Mark McDonnell**, Greene County Combined Health District
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- **Rebecca Olinsky**, Greene County Ohio State University Extension
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- **Roselin Runnells**, Mental Health & Recovery Board
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- **Mark Schlagheck**, City of Bellbrook
- **Kelli Steward**, Regional Air Pollution Control Agency
- **Dana Storts**, Greene County Environmental Services
- **Nancy Terwoord**, Greene County Board of Health
- **Bill Voskul**, Greene County Juvenile Court
Executive Summary

In 2012, the Greene County Combined Health District conducted a community health needs assessment in conjunction with Wright State University’s (WSU) Center for Urban Affairs. This assessment is conducted once every four years in order to assess the distribution of disease and behavioral risk factors, assess broad community health issues, shape a broader definition of community health, monitor the impact of community health action plans and trends in behavioral risk modifications and provide a vehicle to discuss ways to improve community health. The results of this assessment, in conjunction with longitudinal data from previous assessments, were used to identify critical health issues for the Community Health Improvement Plan (CHIP). These health issues will be the focus of strategic action for the next four years.

In November 2012, a core group of community leaders convened to (1) review the results of the community health needs assessment, (2) analyze longitudinal data from previous health needs assessments, and (3) establish critical health priorities yet to be resolved and (4) identify policy changes that need to be in place to improve health. These leaders represented educational institutions, government, community based organizations, and the health care system.

The community leaders reviewed the data, and identified eight critical health priorities within three areas of concern: lifestyle and behavioral health; access to health care for the uninsured/underinsured; and environmental health. These health priorities are displayed in the box below.

<table>
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<tr>
<th>Lifestyle and Behavioral Health</th>
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<td>Infant Mortality</td>
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<tr>
<td>Substance Abuse</td>
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<tr>
<td>Lack of Good Nutrition and Physical Activity</td>
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<th>Access to Health Care</th>
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<tr>
<td>Uninsured and Underinsured</td>
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<td>Declining Use of Screenings</td>
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<td>Lack of Primary Care Physicians</td>
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<th>Environmental Health</th>
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<tr>
<td>Asthma and Air Quality</td>
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<tr>
<td>Waste Disposal</td>
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Prior to the kickoff of the planning meetings, a survey was distributed to all community leaders and health stakeholders participating in the planning process. The purpose of the survey was to 1) understand the community’s vision and values, 2) vet the eight priority health issues with a broader audience and, 3) to identify the community’s assets and competencies to address the priority health issues as well as the forces of change, opportunities and challenges surrounding them. The results of this process are displayed in the following tables.
## Greene County Community Health Improvement Plan

### Lifestyle and Behavioral Health

<table>
<thead>
<tr>
<th>Assets</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Local BH system, community partnerships, Boards focus on community involvement</td>
<td>• Local BH system, coordination with other systems</td>
</tr>
<tr>
<td>• Health Department; Help me Grow; Home visiting;</td>
<td>• Resources for schools</td>
</tr>
<tr>
<td>• Health District Prenatal Clinic</td>
<td></td>
</tr>
<tr>
<td>• Health professionals working together</td>
<td></td>
</tr>
<tr>
<td>• schools</td>
<td></td>
</tr>
<tr>
<td>• Maternal risk factors affecting premature births</td>
<td></td>
</tr>
<tr>
<td>• Sleep safe project</td>
<td></td>
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</tbody>
</table>

### Infant Mortality

<table>
<thead>
<tr>
<th>Assets</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health Department; Help me Grow; Home visiting;</td>
<td>• FCFC; good collaboration among systems; many educational institutions with capacity for community involvement</td>
</tr>
<tr>
<td>• Health District Prenatal Clinic</td>
<td>• Screening, nutrition, social and post-partum transition</td>
</tr>
<tr>
<td>• Health professionals working together</td>
<td>• 2 hospitals, health dept.</td>
</tr>
<tr>
<td>• schools</td>
<td>• GRADS program</td>
</tr>
<tr>
<td>• Maternal risk factors affecting premature births</td>
<td>• Project will identify effects of Appalachian status on preterm births</td>
</tr>
<tr>
<td>• Sleep safe project</td>
<td>• Social counseling and evaluation of message effectiveness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Forces of Change</th>
<th>Threats/Opportunities from Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Funding, billing issues, thru put</td>
<td>• Maximize clinic census, ensure billing, seek alternate funding streams</td>
</tr>
<tr>
<td>• Policy--healthcare for all</td>
<td>• Physicians that do not accept Medicaid</td>
</tr>
<tr>
<td>• Academic requirements</td>
<td>• Lower graduation rates</td>
</tr>
<tr>
<td>• Increasing poverty due to poor economy</td>
<td>• Once effect is identified, population segment can be targeted with public health marketing message</td>
</tr>
<tr>
<td>• Migration of foreign born nationals to county making culturally sensitive messaging even more important</td>
<td>• Long term strategy to identify best message and contribute to basic science</td>
</tr>
</tbody>
</table>

### Forces of Change

<table>
<thead>
<tr>
<th>Assets</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Local BH system, community partnerships, Boards focus on community involvement</td>
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<td>• schools</td>
<td></td>
</tr>
<tr>
<td>• Maternal risk factors affecting premature births</td>
<td></td>
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<tr>
<td>• Sleep safe project</td>
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</tbody>
</table>

### Threats / Opportunities from Change

<table>
<thead>
<tr>
<th>Forces of Change</th>
<th>Threats/Opportunities from Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Changing health care system, reduction in funding, Mental Health homes</td>
<td>• Reductions in funding have reduced ability to respond, Mental Health homes</td>
</tr>
<tr>
<td>• Policy issues – resources within the school</td>
<td></td>
</tr>
</tbody>
</table>
## Greene County Community Health Improvement Plan

### Nutrition and Physical Activity

<table>
<thead>
<tr>
<th>Assets</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Nutrition educators, federal funded</td>
<td>• Trained nutrition educators specifically for low-income audience, general public education, and access to OSU state nutrition specialists</td>
</tr>
<tr>
<td>• Healthy lifestyle personnel and county capacities</td>
<td>• Local recreation facilities</td>
</tr>
<tr>
<td>• Medical Reserve Corps</td>
<td>• Prevention activities can be supported by MRC unit</td>
</tr>
<tr>
<td>• Schools; medical providers; parents</td>
<td></td>
</tr>
<tr>
<td>• Trained nutrition educators specifically for low-income audience</td>
<td></td>
</tr>
<tr>
<td>• General public education</td>
<td></td>
</tr>
<tr>
<td>• Access to OSU state nutrition specialists</td>
<td></td>
</tr>
<tr>
<td>• Local recreation facilities</td>
<td></td>
</tr>
<tr>
<td>• Prevention activities can be supported by MRC unit</td>
<td></td>
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</tbody>
</table>

**Forces of Change**

<table>
<thead>
<tr>
<th>Forces of Change</th>
<th>Threats / Opportunities from Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Federal, state, and county funding can be reduced or eliminated</td>
<td>• Access to OSU Nutrition specialist, research dollars, and workplace wellness programs</td>
</tr>
<tr>
<td>• Affordable participation</td>
<td>• Lifestyle becomes contagious</td>
</tr>
<tr>
<td>• Policy to support disaster reduction by building resilience through prevention</td>
<td>• Threat is lack of funding for MRC/opportunity to keep volunteers engaged between disasters</td>
</tr>
<tr>
<td>• Policy, worksites</td>
<td>• Higher than average educational levels</td>
</tr>
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</table>

**Drug Use**

<table>
<thead>
<tr>
<th>Assets</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• TCN; AA, NA, Al-Anon, AlaTeen, NarAnon; parents</td>
<td>• Courts</td>
</tr>
<tr>
<td>• Laws</td>
<td>• Again, feel like we have several groups on this</td>
</tr>
<tr>
<td>• Many groups already working on this</td>
<td></td>
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</tbody>
</table>

**Forces of Change**

<table>
<thead>
<tr>
<th>Forces of Change</th>
<th>Threats / Opportunities from Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Specialized dockets (Drug Court)</td>
<td>• Cost</td>
</tr>
<tr>
<td>• policy</td>
<td>• Must find out WHY people are choosing drugs</td>
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</table>

**Diabetes**

<table>
<thead>
<tr>
<th>Assets</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Dining with Diabetes Curriculum</td>
<td>• Nationally recognized program, pre and post evaluations</td>
</tr>
</tbody>
</table>

**Forces of Change**

<table>
<thead>
<tr>
<th>Forces of Change</th>
<th>Threats / Opportunities from Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Federal, state, and county funding can be reduced or eliminated</td>
<td>• Local diabetes programming is available</td>
</tr>
</tbody>
</table>
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Access to Care

<table>
<thead>
<tr>
<th>Assets</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Existing resources such as Dr. willing to treat</td>
<td>• ARA and its new services</td>
</tr>
<tr>
<td>• Medicaid outreach and possible expansion</td>
<td>• Partnerships between JFS, GCCHD, MHRB, and other systems</td>
</tr>
<tr>
<td>• Free clinic 1x/week</td>
<td>• Free clinic 1 day a week</td>
</tr>
<tr>
<td>• Reproductive health clinic at GCCHD free</td>
<td>• Reproductive health clinic free at the Health District</td>
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</table>

Forces of Change

<table>
<thead>
<tr>
<th>Assets</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ARA is a plus</td>
<td>• Limited resources</td>
</tr>
<tr>
<td>• Participation with 2014 implementation of Affordable Care Act</td>
<td>• Participation with 2014 implementation of Affordable Care Act</td>
</tr>
<tr>
<td>• Obama care and uncertainty of how this will affect needs/services</td>
<td>• Lack of finances</td>
</tr>
</tbody>
</table>

Primary Care Physicians

<table>
<thead>
<tr>
<th>Assets</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medicaid outreach</td>
<td>• GCCHD, JFS - how can we educate providers?</td>
</tr>
</tbody>
</table>

Forces of Change

<table>
<thead>
<tr>
<th>Assets</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 2014 Affordable Care implementation</td>
<td>• “Same as above”</td>
</tr>
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Screenings

<table>
<thead>
<tr>
<th>Assets</th>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• GCCHD public education</td>
<td>• GCCHD, JFS, Health-check and Pregnancy Related Services</td>
</tr>
<tr>
<td>• Health education professionals who could improve awareness and encourage screenings</td>
<td></td>
</tr>
</tbody>
</table>

Forces of Change

<table>
<thead>
<tr>
<th>Assets</th>
<th>Competencies</th>
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<tbody>
<tr>
<td>• Unknown</td>
<td>• Unknown</td>
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</table>

Survey participants confirmed the need to address the eight priority health issues. As a result, the planning participants were charged with the mission of developing and overseeing the implementation of a community health improvement plan to: 1) address priority lifestyle and behavioral health concerns; 2) promote the health and well-being of residents by advocating and actively pursuing affordable and accessible health care; and 3) value the natural environment.
Planning participants organized into task force groups based on these three core areas of concern. Each task force met via webinar in February-March 2013, to analyze local data on the issues; identify priorities and gaps in services and resources; and discuss potential strategies to address each priority.

A team of researchers and staff of the health district reviewed current literature to identify evidence based practices that could be used to remedy the priority issues. The Task Force Groups reconvened via webinar to review and determine the viability of the evidence based practices (EBP). Once consensus was reached, each task force outlined actionable, community-specific ways to implement the EBPs. This information was organized into a shared agency action plan and distributed to each task force for review.

The eight priorities addressed in this plan represent the most pressing public health issues for Greene County in 2013, and will be the focus of multiple strategic interventions over the next four years. This plan is designed as a roadmap to improved community health, and is a dynamic document that will change as conditions, resources, and the environment changes. The plan is presented to the Greene County community as a call to action; an opportunity for private/nonprofit/government agencies, academic/community/faith-based organizations, and residents to become involved in a unified effort to improve the health and quality of life for Greene County residents.
Lifestyle and Behavioral Health

Strategic Issue 1: Infant Mortality

**Goal:** Reduce the rate of infant mortality, particularly in high-risk populations.

**Key Result Areas:** Implementation of the “Sleep Safe” campaign. Increase in the number of mother’s breastfeeding beyond 6 months. Improving the local infrastructure for educating women of child bearing age.

**Strategy 1: Inform and Educate Infant Safe Sleep**

Conduct a County-wide multimedia and education and awareness campaign regarding infant safe sleep messages by implementing ODH and Ohio Injury Prevention Partnership (OIPP) Child injury Action Group (CIAG) campaign.

**Rationale:** Sleep related infant deaths are the leading cause of death between one month and one year of age. They include sudden infant death syndrome (SIDS), accidental suffocation, and undetermined causes.

**Action Step 1:** Target families of child bearing age using culturally appropriate infant safe sleep messages.

**Action Step 2:** Collaboration with community partners who also assist the same target population to disseminate the “safe sleep” message.

**Action Step 3:** Targeted education and messaging for Health District clients across all programs: Help Me Grow (HMG), Bureau of Children with Medical Handicaps (BCMH), Women Infant and Children (WIC), Immunization, Reproductive Health, Prenatal Care and Child and Adolescent Health.

**Lead Agents:** Greene County Combined Health District

**Current Situation:**

According to the Centers for Disease Control and Prevention (CDC), five causes account for the majority of infant deaths: Pre-term births; Sudden Infant Death Syndrome (SIDS); maternal complications of pregnancy; and injuries. Several risk factors contribute to these causes such as smoking, poor nutrition, under-education and poverty.

Preliminary data for 2011 show that in the United States, approximately 6 infants die per 1,000 live births (CDC). This rate is even higher for Ohio (7.9 deaths per 1,000 live births). Furthermore, statistics show that there are significant racial disparities. In 2010, the infant mortality rate of Ohio’s African-American infants was 14 per 1,000 compared to 6.4 per 1,000 for Caucasian infants.

The Infant mortality rate in Greene County is 7.56 which is higher than the national rate of 6.05.
Greene County Community Health Improvement Plan

**Partnering Agents:** Soin Medical Center, Greene Memorial Hospital, Greene Medical Society, Health Care Providers, Wright Patterson Air Force Base, Greene County Combined Health District Consortium, Local Government Entities.

**12 Month Outcome:** Resources data base developed along with a tracking system and evaluation plan for the education and awareness campaign actives implemented.

**24 Month Outcome:** Campaign will be fully implemented county wide.

**Strategy 2: Mobilize Partnerships Infant Safe Sleep**
Facilitate local infrastructure changes by educating professionals and organizations working with families to implement infant safe sleep strategies. Target audience includes: hospitals, health care professionals, WIC, JFS, HMG, child protective services, child care, child birth educators, home visiting programs, and Graduate Realities and Dual-role Skills (GRADS).

**Rationale:** Health professionals and organizations working with families should share the same messages about infant safe sleep strategies. Consistent messaging will strengthen the probability of the message being heard and put into practice by more Greene County families.

**Action Step 1:** Develop a resource list of agencies working with children.

**Action Step 2:** Collaborate for system-level changes at hospitals and other health care providers and retailers.

**Action Step 3:** Train and educate professionals and organizations working with families. This will include the Kinship Program via the Greene County Council on Aging.

**Action Step 4:** Identify and coordinate with at least one church in each high risk community to educate on SAFE SLEEP.
- Enlist support of African American Churches, local Historical Black Colleges and Universities (HBCUs) and Graduate Alumnae Chapters of the three major African American Sororities in creative strategies to reach those in the population with the disproportionate rate of infant mortality.

**Action Step 5:** Implement the “Cribs for Kids” program.

**Lead Agents:** Greene County Combined Health District (Maternal Child Consortium)

**Partnering Agents:** GCJFS, Greene Medical Society, Soin Medical Center, Greene Memorial Hospital, Council on Aging, Area Churches and/or the Ministerial Association.
Greene County Community Health Improvement Plan

12 Month Outcome: All professionals and organizations in the target audience will receive an educational information packet. At least 40 professionals and organizations will be trained regarding infant safe sleep strategies.

24 Month Outcome: 90% of the professionals and organizations trained will be implementing infant safe sleep strategies. The specific infrastructure changes made will be documented.

Strategy 3: Policies and Plans for Breastfeeding
Facilitate the establishment of breastfeeding friendly workplaces in the county by educating employers in the community about implementing The Business Case for Breastfeeding using the ODH training.

Rationale: According to the U.S. Department of Health and Human Services, companies successful at retaining valued employees after childbirth find that two components can make the difference: providing dedicated space for breastfeeding employees to express milk in privacy, and providing worksite lactation support.

The payoff is significant: more satisfied, loyal employees and cost savings to the business seen in such areas as:

- Retention of experienced employees;
- Reduction in sick time taken by both moms and dads for children’s illnesses; and
- Lower health care and insurance costs.

The Business Case for Breastfeeding can help employers create a breastfeeding-friendly worksite and achieve an enviable return on the investment.

Action Step 1: Develop a target list of businesses and organizations in the county that employ women of child bearing age and provide each with the information on the program.

Action Step 2: Follow-up with business and organizations regarding their interest in implementing the program and provide additional education support.

Action Step 3: Develop a list of agencies and organizations that work with families who could benefit from the breastfeeding initiative and provide guidance on the promotion and education for successful breastfeeding.

Action Step 4: Keep a log of activities regarding breastfeeding initiatives and evaluate progress to target and improve additional efforts to promote and implement the program.
Greene County Community Health Improvement Plan

**Action Step 5:** Work with local hospitals to implement “The Ten Steps to Successful Breastfeeding.”

**Action Step 6:** Recruit a representative from the hospital, African American churches, and local businesses to be on the Maternal Child Consortium.

**Lead Agents:** Greene County Combined Health District

**Partnering Agents:** Soin Medical Center, Greene County Breastfeeding Coalition, ODH

**12 Month Outcome:** 30 local employers trained about the Business Case for Breastfeeding. Increased community awareness around the breast feeding initiatives.

**24 Month Outcome:** All organizations trained implementing breastfeeding friendly workplaces.

**Strategy 4: Policies and Plans Women’s Health**

Promote comprehensive pre-conception and inter-conception health with women of child bearing age.

**Rationale:** Women in a healthy and safe environment will have a high probability of a healthy pregnancy and birth outcome. In Greene County 14.7% of pregnant women smoke. In 2012, Integrated Perinatal Health Information System (IPHIS) data showed that 55% of patients in the health district prenatal clinic had been exposed to second hand smoke, and 33% were currently smoking. Smoking during pregnancy can lead to adverse health effects for mother and infant. It also contributes to low birth weight and preterm births. The IPHIS data revealed that 21% of infant deaths were to mothers who smoked during pregnancy; 12% of Sudden Infant Death Syndrome (SIDS) were related to preterm birth; and 50% of infants born before 32 weeks die.

**Action Step 1:** Implement use of a comprehensive social services evaluation and screening for basic needs and overall health and safety in the Reproductive Health clinics of the Health District. The physical, mental, emotional and spiritual health will be assessed and the appropriate referrals made.

**Action Step 2:** Provide outreach packets to distribute educational materials that align with Ohio’s infant mortality initiatives.

- Integrate educational resources provided by Ohio Department of Health (ODH) into outreach packets, including:
  - Preventative health care
Greene County Community Health Improvement Plan

- Folic acid education materials
- Ohio Tobacco Quit-line and smoking cessation opportunities
- Nutrition and calcium intake guideline
- Physical activity
- Avoiding harmful substances
- Healthy relationships

**Lead Agents:** Greene County Combined Health District

**Partnering Agents:** Miami Valley Women’s Center, Kettering Physicians Network, University and college student health services, March of Dimes, YMCA, OSU Extension

**12 Month Outcome:** 5% of clients presenting to the health district’s Reproductive Health and Wellness clinic will decrease their frequency of smoking or stop smoking.

**24 Month Outcome:** Results of Reproductive Life Plans show a change in behaviors that support improved interconception and preconception health status.

**Strategy 5: Access to Care**
Align with state practices to improve access to perinatal care.

**Rational:** The need for early and comprehensive prenatal care in Greene County is depicted by the following maternal and child health indicators: the teen birth rate per 1,000 females ages 15-17 is 12.7%; of the babies born, 8.2% were low birth weight; 1.7% were very low birth weight; 11.1% were preterm and 2.5% very preterm. In deliveries among African American women, there 15.2% preterm births, and 3.3% very preterm births. In the prenatal clinic at the Health District, 693 perinatal visits were provided for 108 clients, 75 were new patients. 15% of these were uninsured. For this group, 36% were African American, 53% were on Medicaid and 47% qualified as “no-pay” on the sliding fee scale. Despite the fact that 97% of women we saw were high risk for poor pregnancy there were only 2 preterm births. **There is no other provider in Greene County that will see uninsured or underinsured perinatal clients.**

**Action Step 1:** Improve access to perinatal care by:
- Providing early access to prenatal care to the uninsured and underinsured before they are able to receive services in the healthcare system.
- Provide perinatal direct health care services at the Health District.
- Increase awareness of Health District services with high risk population.
- Provide assistance for clients to gain access to Medicaid.

**Action Step 2:** Reduce the rate of preterm births.
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- Identify women who are at risk for a preterm birth and refer to appropriate services (WIC, smoking cessation, education, counseling, etc.).

**Action Step 3:** Ensure that social/emotional health needs of pregnant women are met.
- Enhance coordination and collaboration of evidence-based strategies among diverse stakeholders in women’s health to address mental health needs before, during, and after pregnancy.

**Action Step 5:** Improve birth outcomes in at-risk subpopulations through outreach and care coordination:
- Conduct planning efforts.
- Ensure ongoing training.
- Provide adequate supervision.
- Ensure that standardized care processes are followed.
- Ensure ongoing data collection and evaluation.

**Lead Agents:** Greene County Combined Health District, Greene County Job and Family Services (GCJFS), Soin Medical Center

**Partnering Agents:** Wright State University

**12 Month Outcome:** Increase in the number of clients and referrals into the Health District Reproductive Health program for pre-natal visits.

**24 Month Outcome:** A reduction in the number of second and third trimester entries into the prenatal care.
Strategic Issue 2: Substance Abuse

Goal: Promote the mental health and well-being in elementary school children through increasing children’s self-regulation, building internal protective factors and resilience. These in turn will reduce risk factors and increase healthy decision making for them in adulthood. To reduce the availability of unused prescription drugs in Greene County.

Current Situation:

Abuse of prescription drugs has been on the rise for the last few decades. It has significantly affected highly educated and more affluent households, a segment of the population traditionally considered to be at a lower risk for addiction problems. These households are more likely to have access to prescription medications, including drugs that are frequently abused such as opioids and stimulants. Painkillers such as oxycodone or morphine, stimulants such as Ritalin, and central nervous system depressants such as barbiturates are the most frequently abused prescription medications.

Research is now showing that prescription opioids are a key gateway drug for teenagers who begin to use heroin. The Centers for Disease Control and Prevention has reported that one in eight high school seniors will use painkillers without a prescription. However, the expense of acquiring opioids as well as an effort to crack down on prescription drug abuse has led many teens to try heroin, which provides a faster, more intense high and is less costly.

Key Result Areas: Early intervention with school aged children through implementation of the PAX Good Behavior Game which is an evidence-based program currently utilized in classrooms. Decrease the availability of prescription drugs in Greene County homes.

Strategy 1: Deter youth
Increase use and fidelity of the PAX Good Behavior Game (GBG) in Greene County Schools as a way to increase childhood functioning and a deterrent to future drug abuse.

Rationale: The PAX Good Behavior Game (PAX GBG) is a series of positive behavioral support interventions used in the classroom with school-aged children to create a safe learning environment that builds voluntary control over attention and engagement. The interventions are designed to increase on-task behavior, increase social competency and internal regulation. In turn these decrease aggressive and disruptive behavior, as well as shy and withdrawn behavior, which often interfere with academic success. Long term research on PAX GBG has shown significant impact on mental health and substance use outcomes later in life. This evidence-based program
Greene County Community Health Improvement Plan

was introduced into the Greene County school districts in 2006. The highest concentration of current use is in Xenia and Beavercreek schools.

The long-term effects of GBG have shown that the program significantly improves health and behavior outcomes for children later in life. For example, “follow-up at ages 19–21 found significantly lower rates of drug and alcohol use disorders, regular smoking, antisocial personality disorder, delinquency and incarceration for violent crimes, suicide ideation, and use of school-based services among students who had played the GBG.”[1]

**Action Step 1:** Ongoing training and coaching of teachers currently working with the program.

**Action Step 2:** Maintain data tracking activity to document program success and opportunities.

**Action Step 3:** Seek additional funding to maintain the program in current participating schools and expand to additional schools.

**Action Step 4:** Provide information and PAX GBG overview sessions for interested school officials and teachers.

**Action Step 5:** Build upon the unique capacity in Greene County by the Greene ESC, PAXIS Institute and Wright State University partnering to design and implement PAX GBG strategies into teacher pre-service education curriculum.

**Lead Agent:** Greene County Education Service Center (ESC), & Mental Health and Recovery Board

**Partnering Agents:** Greene County Schools, Wright State University

**Funding Source:** Local MHRB levy dollars, Federal grants from SAMHSA, contracts from local school districts and educational agencies, Greene ESC.

**12 Month Outcome:**

In the 2013-14 school year:

- 60 teachers in 3 school districts, across 7 school buildings attended PAX GBG trainings
- 4 Wright State University staff attended PAX GBG trainings
- 39 student candidates in the teacher education major for K-4th grade certification at Wright State University attended a semester long course on implementing PAX GBG strategies. Pre and Post Efficacy Scales, completed by Wright State University students, indicate significant impact on teacher perceptions of preparedness compared to control groups not exposed to the PAX GBG strategies in their pre-service course work.
- Data collected across classrooms implementing PAX GBG indicated significant reduction (50% to 85%) in disruptive behaviors in the classroom. Antidotal
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Information provided by school district’s implementing teachers and building principals indicate significant positive impact in classroom and building environment, decreases in discipline issues requiring intervention by building principals, and reduction in teacher stress levels.

24 Month Outcome:
For the 2014-15 school year:
- Increase the number of teachers trained in PAX GBG by 50
- Increase the number of districts implementing PAX GBG by 1 district
- Increase the number of WSU students attending the PAX GBG pre-service course by 40.
- Continue to collect and report data related to student behaviors.

Strategy 2: Prescription drugs
Reduce the availability of unused and expired prescription drugs from homes in Greene County.

Rationale: The Ohio Prescription Drug Drop Box Program aims to provide a safe, convenient, and responsible means of disposing of unused and expired prescription drugs, while also educating the general public about the potential for abuse of medications. Research is showing that prescription opioids are a key gateway drug for heroin and other drug use among teens. The drugs not being readily available in the home with easy access may aid in the prevention of the initiation of prescription drug use which could lead to additional drug abuse problems.

These same drugs unfortunately have become the target of theft and misuse, oftentimes by people who have access to the residence. America’s 12 to 17 year olds have made prescription drugs the number one substance of abuse for their age group, and much of that supply is unwittingly coming from the medicine cabinets of their parents, grandparents, and friends. More and more adults recognize the need to remove these substances from the home and legally and safely turn them over to law enforcement for proper chain of custody and court ordered destruction. Law enforcement is the only entity legally able to accept these medications and process them properly so that they do not fall into the wrong hands. Law enforcement takes control of and destroys drugs as part of their regular operations.

Currently Greene County has four permanent drop box locations: Greene County Sheriff’s Office, Central State University Police Department, Beavercreek Police Department, and Fairborn Police Department.

Action Step 1: Promote awareness in the community about the Prescription Drop Box locations to Greene County residents via social media and through various community agencies and organizations.
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**Lead Agent:** Greene County Sheriff’s Office. Local Law Enforcement Agencies,

**Partnering Agents:** Greene County Combined Health District

**12 Month Outcome:** Increase in the amount of drugs taken in via the Ohio Prescription Drug Dropbox program.

**24 Month Outcome:** Decrease in the number of prescription drug overdose related deaths.
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Strategic Issue 3: Lack of Good Nutrition and Physical activity

**Goal:** Provide Greene County residents with actionable and accessible health information to empower them to make healthful and lasting changes to their diet and exercise routines.

**Key Result Areas:** Nutrition education and obesity prevention services delivered through multiple venues and involving activities at the individual and community level.

**Strategy 1: Inform and Educate Nutrition**
Implement a nutrition education program and obesity prevention program for adults in the community, senior adults, school age children, and the Graduation Reality and Dual-Role Skills (GRADS) program for pregnant and parenting teens.

**Rationale:** There is an opportunity with the Supplemental Nutrition Assistance Program nutrition education (SNAP-Ed) provisions of the Healthy, Hunger-Free Kids Act of 2010 to enhance nutrition education with the low income population. This will add a renewed focus on the critical problem of obesity by expanding the scope of existing nutrition education efforts. These changes are designed to increase the likelihood that low-income people will make healthy food choices within a limited budget and choose physically active lifestyles.

**Action Step 1:** Conduct outreach to schools, after-school programs, senior living facilities, and GRADS to bring the curriculum program in for the students, residents, and program participants.

**Action Step 2:** Coordinate with teachers, school lunch personnel and program directors to implement curriculum and programs at the facilities that agree to participate.

**Action Step 3:** Collaborate with community partners to promote and conduct the Dining with Diabetes curriculum in the community.

**Current Situation:**
Research has shown that chronic diseases make up approximately 70% of deaths (Partnership to Fight Chronic Disease). Major risk factors for chronic disease are behavioral, such as smoking, unhealthy diet and physical inactivity. According to the World Health Organization, the elimination of these risk factors would achieve at least an 80% decrease in the prevalence of heart disease, stroke and Type 2 diabetes as well as a 40% decrease in cancer.

The increasing incidents of diabetes and obesity have heightened the concern regarding risky health behaviors. From 2009 to 2010, the number of states with obesity rates greater than or equal to 30% increased from nine to twelve. According to the 2012 Greene County Health Status Assessment, 70.3 percent of Greene County adults are overweight (35.7 percent) or obese (34.6 percent), a significant increase from 2004, when 54.1 percent were overweight or obese.
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Lead Agents: Ohio State University Extension Office (OSUEO)

Partnering Agents: Greene County Schools, Senior Apartments, YMCA Afterschool Program, Health District, Kettering Health Network

12 Month Outcome: Confirm schools and other programs that will participate.

24 Month Outcome: Program implemented and evaluated. Potential expansion into additional schools that have 50% or more free and reduced lunch recipients. Program participants are expected to exhibit the following outcomes:

- Consumption of more fruits, vegetables, whole grains, low fat dairy, and lean protein.
- Increase in daily physical activity
- A balanced caloric intake

Strategy 2: Policies and plans
Work with childcare facilities to increase nutrition education, access to healthy food choices and physical activity.

Rationale: According to the BMI calculations, 26% of boys and 18% of girls in our region are considered obese, which is a total of 22% of all children. 84% of those who are overweight are not doing anything to lose weight. 71% of obese children are not doing anything to lose weight (Dayton Children’s Community Assessment, 2011). The ODH 3rd grade BMI report shows Greene County’s overweight/obesity rate for 2009-2010 at 28.5%.

Action Step 1: Outreach to child care facilities in the county which are not currently participating in the Ohio Child Care Resource and Referral Association (OCCRA) Ohio Healthy Projects (OHP) Program in child care facilities.

Action Step 2: Implement the intervention programs with the targeted child care facilities.

Lead Agents: Greene County Combined Health District

Partnering Agents: Local Child Care Facilities and Preschools, OSU Extension

12 Month Outcome: Commitment from child care facilities regarding participation, and the program planning and design completed.

24 Month Outcome: The program has been implemented and an evaluation process initiated. Childcare facility personnel and children are making healthy food choices and the level of physical activity is increased.
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**Strategy 3: Evidenced based practice**
Target men and women of childbearing age to reduce the risk of obesity.

**Rationale:** If healthy lifestyle habits are established in this target population there is a high probability that the practice will continue creating a healthy lifestyle for children to be brought up in this environment thereby reducing obesity rates in the next generation.

**Action Step 1:** Implement the ODH pilot program called Wellness Warriors which is a weight loss challenge.

**Action Step 2:** Evaluate the program results.

**Lead Agents:** Greene County Combined Health District

**Partnering Agents:** OSU Extension, ODH, Premier Community Healthy, KHN Weight Loss Solutions, YMCA

**12 Month Outcome:** Program participants identified and informed. Program organized and launched.

**24 Month Outcome:** The program has been implemented and evaluated. Participants are making good nutritional decisions and have made physical activity apart of their routine living. Participants are aware and committed to weight management long term.

**Strategy 4: Policies and Plans Recreation**
Implement an initiative to promote more recreation and physical activity in the city of Xenia.

**Rationale:** The rates of people considered overweight or obese is a major public health concern. The numbers have increased steadily over the last three decades nationwide. Xenia is one of the areas in Greene County with highest percentage of overweight and obese people. Physical activity is a key component in decreasing those numbers.

**Action Step 1:** Direct a community recreation initiative called “Play Xenia,” which will start with a community-wide recreational needs assessment in cooperation with residents, recreation facility owners and program managers.

**Action Step 2:** Evaluate the assessment results to determine viable community projects and establish an action plan. Projects may include park improvements, a funding drive for a recreation center, and improved program coordination and offerings.

**Action Step 3:** Develop partnerships and funding sources to implement the “Play Xenia” action plan.
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Lead Agents: City of Xenia

Partnering Agents: YMCA, Xenia Church of the Nazarene, Greene County Parks and Trails, Xenia Adult Recreation and Service Center, Athletes in Action, Xenia Community School District, Xenia Rotary, and Greene County Combined Health District

12-Month Outcome: Incorporate relevant park improvement projects into City of Xenia 5-year Capital Improvement Plan. Begin funding drive and partnership formation for development of a community recreation center. Incorporate relevant action items into work plans of partnering organizations.

24-Month Outcome: Complete high-priority park improvements. Secure funding and develop plans for new recreation center. Implement high-priority action recommendations to improve recreational programming.

Strategy 5: Policies and plans Bike and Pedestrian Paths
Study options to improve the bike and pedestrian level of service along Detroit Street between Church Street and Home Avenue in the City of Xenia.

Rationale: Bikeable and walkable communities are thriving, livable, sustainable places that give residents and visitors safe transportation choices, improved quality of life, and accessibility to businesses and shops using foot power. Creating and improving opportunities to be active can also result in a 25% increase in the percentage of people who exercise at least three times a week.

Action Step 1: Work in collaboration with an engineer, residents, and stakeholders on options and opportunities to improve bike and pedestrian safety and attract cyclists to downtown Xenia.

Lead Agent: City of Xenia

Partnering Agents: Miami Valley Regional Planning Commission (MVRPC)

12-month outcome: Submission of grant applications to fund the recommended improvements

24-month outcome: Completion of improvements (depending on funding and grant timeframe)
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Access to Care

Strategic Issue 1: Uninsured & Underinsurance

**Goal:** Increase access, quality, and efficiencies in providing health and social services to the underserved population in Greene County.

**Key Area Results:** Improved linkages, communication, information sharing and relationships between health care agencies. Agencies will obtain a better understanding of the current system’s strengths and weaknesses. Dialogue between agencies will help identify barriers to coordinated care.

**Current Situation:**

Data from the Greene County Health Status Assessment show that 11.9% of residents said they had no health care coverage in 2012, and this percentage has been increasing since 1999. Some residents with health insurance might be underinsured, because a higher percentage of respondents (13.9%) said that during the past year they were prevented from seeing a doctor or dentist because of the cost.

![No Health Care Coverage](chart.png)

**Strategy 1: Enrollment for Healthcare Coverage**
Greene County Community Health Improvement Plan

Encourage those who are eligible, but not insured to enroll in appropriate options as they are available. Provide application assistance to those eligible or interested in the Affordable Health Care Program and the Medicaid expansion program.

**Rationale:** The Affordable Care Act and the expansion of Medicaid in Ohio will provide additional opportunities for the uninsured and the underinsured to gain coverage. Coverage is available for virtually anyone, either through the federal marketplace with income-based tax incentives, or through Medicaid.

**Action Step 1:** Community agencies and advocates will promote the enrollment opportunities as they are available and offer assistance with registration where feasible.

**Action Step 2:** County representation to work with Voices of Ohio’s Children on statewide strategies focused on increasing the percentage of children with medical coverage.

**Lead Agents:** Greene County Job and Family Services (GCJFS), Greene County Family and Children First (GCFCFC)

**Partnering Agents:** Greene County Combined Health District

**12 Month Outcome:** A percentage of the population formerly without coverage will apply for coverage through the available programs.

**24 Month Outcome:** Implement plausible strategies identified from the statewide efforts regarding increasing the percentage of children with coverage.

**Strategy 2: Community Engagement Poverty**

To inspire and equip families and communities to resolve poverty and thrive by engaging the entire community in owning the solution to poverty via the Circles initiative.

**Rationale:** Circles is a community initiative that brings together the best efforts and resources of individuals, organizations, communities, and government in a program proven to raise people out of poverty. It works by mobilizing families to achieve economic stability through the long-term and consistent support of peers and volunteers from the community. This approach can improve the odds of individuals and families successfully transitioning out of poverty. The approach combines best practices in several disciplines including community organizing, grassroots leadership, SMART goal setting, financial literacy, developing healthy relationships and community, addressing racial and class barriers, and child/youth development.

**Action Step 1:** Research and establish the Circles program in the county as a 501C3.
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Action Step 2: Host a community meeting to introduce the concept and garner community support for the initiative.

Action Step 3: Identify systemic barriers to prosperity and strategies to remove them.

Action Step 4: Focus on three stages to achieve economic stability:
   - Crisis management and stabilization
   - Education and job placement
   - Advancement and economic stability

Action Step 5: Identify Circle Leaders and volunteers to participate.

Lead Agents: Greene County Circles Guiding Coalition

Partnering Agents: Greene County Combined Health District, Jeremiah Tree, local churches,

12 Month Outcome: Program officially established and a community meeting hosted to include a wide variety of community agencies, businesses and organizations.

24 Month Outcome: Circle Leaders and volunteers identified and the program officially launched.

Strategy 3: Access to Care Free Clinics
Promote the Living Well Clinic, and the Open Arms Clinic which are established and currently offer clinics one day per week.

Rationale: Although the county has a fair number of primary care physicians when compared to other counties in the region per 100,000 population however the number is deceptive regarding the poor and the uninsured. Not everyone has access to the physicians. The county has no Community Health Center nor Federally Qualified Health Centers. There are limited options for those individuals to receive primary and preventive care without presenting at the local ED.

Free primary and acute care services are an asset to the medical community as it not only reduces the burden of the emergency departments caring for non-emergent health care needs, but it most importantly provides an avenue for the uninsured and underinsured populations to receive treatment before preventable or easily treatable conditions worsen.

Action Step 1: Refer uninsured/underinsured clients who seek medical services for primary care to one of the Greene County free clinics.
Action Step 2: Partner with the Emergency Department at KMC/GMH to refer clients for follow-up care to one of the Greene County free clinics.
  o Provide a resource referral list
  o Include health district clinics in resource list

Action Step 3: Support the clinics with providing health promotion messaging and by providing flu shots with our ODH influenza vaccine set aside for at-risk individuals.

Lead Agents: Health District, Kettering Healthcare Network, Premiere Health Partners

Partnering Agents: Greene Medical Society, Greater Dayton Area Hospital Association, Center for Healthy Communities

12 Month Outcome: A referral process will be established

24 Month Outcome: Outcome will be measured by number of people referred

Strategy 3: Access to Care
Safety Net Dental Clinic
Offer dental services 3 days per week at Greene County Combined Health District

Rationale: Oral health is an integral component of health throughout life and is the number 1 unmet health need in every state including Ohio. Dental caries and periodontal disease may result in needless pain and suffering along with lost days of work and school. Approximately 19,000 to 21,000 people in Greene County do not have access to dental services. An increase in access to dental care in needed especially for children and adults who are un/underinsured or have Medicaid. There are limited options for those individuals to receive primary and preventive care without presenting at the local ED.

Action Step 1: Partner with the Emergency Department at KMC/GMH to refer clients for follow-up care to one of the clinics.

Action Step 2: Expand the dental clinic so that it can meet state eligibility requirements for grant funding.

Action Step 3: Partner with hygiene programs and grantors who are committed to supporting community-based initiatives for families who cannot afford dental care.

Lead Agents: Health District

Partnering Agents: Greene County Dental Society, Kettering Healthcare Network, ODH
**Greene County Community Health Improvement Plan**

**12 Month Outcome:** Apply and be awarded at least one new grant that supports serving those who are underserved or have limited access.

**24 Month Outcome:** Outcome will be measured by an increased number of people treated.
Strategic Issue 2: County Residents obtaining Health Screenings

Current Situation:

Data from the Greene County Health Status Assessment show that the percent of women who have had a clinical breast exam has been declining since 2004.

Sixty-four percent (63.7%) of all women have had a mammogram, a decrease from 73.9% in 2008 and 94.4% of all women ages 40 and older have had a mammogram, an increase from 90.5% in 2004.

The percentage of respondents over age of 50 reporting having had an occult blood stool test decreased significantly since 2004, but is similar to 2008 data. According to the American College of Gastroenterology, colonoscopy remains the screening test of choice and should be offered to all average-risk adults aged 50 years or older or 45 years of age for African Americans. This may explain the decrease in the number of Greene County residents getting the FOBT.
**Greene County Community Health Improvement Plan**

**Goal:** Improve knowledge and opportunities for breast and cervical cancer screening.

**Key Area Results:** Improve awareness and opportunities for screening mammograms.

**Strategy 1: Access to Care Screening**

Local hospital network, and public health will work collaboratively to educate the community on the importance of breast and cervical cancer screenings.

**Rationale:** Breast cancer diagnosis in Greene County decreased from 264.3 adult female cases in 2000 to 195.6 cases in 2005, but in 2006 the rates began increasing again – peaking in 2007 at 270.3 cases per 100,000 adult females and tapering off again to 212.2 in 2011. The mortality rate and inpatient hospitalizations (based on primary and secondary discharge diagnoses) due to breast cancer have remained relatively stable over this same period. Breast cancer incidence, and inpatient hospitalization and mortality due to breast cancer is lower in the County than in the State. If detected early, nearly all breast and cervical cancers can be treated successfully (*Ohio Cancer Facts and Figures 2010*). Not all Ohio women, however, can afford the screening and diagnostic services that help find breast and cervical cancers in time to assure the best outcome. Ohio’s Breast and Cervical Cancer Early Detection Project (BCCP) is a program that provides high quality breast and cervical cancer screening, diagnostic testing and case management services at no cost to eligible women in Ohio.

**Action Step 1:** Educate women at a younger age about the importance of breast and cervical cancer screenings.

1. Partner with the college/university institutions in the County to provide targeted breast cancer awareness and education to females on campuses.
2. Cross market breast and cervical health education to departments within the hospital and health district that have younger patients.
3. Provide Human Papilloma Virus (HPV) vaccine to eligible men and women, accessing the Manufacturer’s Patient Assistance Program for the un/underinsured.

**Action Step 2:** Promote and increase breast and cervical screenings among the at risk population.

1. Educate women about Affordable Care Act (ACA) coverage of screening mammograms. If age requirements are met, a physician referral is not necessary.
3. Provide opportunity for greater community access to screening through an annual event utilizing expanded clinic hours and/or mobile unit.
Greene County Community Health Improvement Plan

4. As medically appropriate, cross market mammography screenings with osteoporosis and other women’s health initiatives.
5. Expand breast cancer awareness month to encompass the first six months of the year.
6. Use current campaigns to promote cancer care awareness throughout the year.
7. Expand the number of breast cancer resource expositions & fairs and engage physicians as presenters.

Lead Agent: Kettering Health Network; Region 2. Breast & Cervical Cancer Early Detection Project, Premier Community Health

Partner Agents: Greene County Combined Health District, ODH

12 Month Outcome: Increase HPV vaccine administration of young men and women at the health district by 2%. Increase the referral of eligible women to BCCP by 2%.

24 Month Outcome: From 2014-2016, increase the number of women ages 40-69 years obtaining a screening mammogram by 2% annually as a result of education and outreach to the community (paying special attention to the low income areas around the cities of Xenia, Fairborn, and in the rural eastern portion of the County).
Strategic Issue 3: Lack of Physicians

Current Situation:
Most residents (76.1 percent) say they have one person who is a primary care physician or health care provider and 19.0 percent said they did not have someone they think of as their personal doctor (The others said they had more than one.) Not having a primary care physician can be an issue in terms of continuity of care. However, most residents (89.5 percent) also said they use a doctor’s office or HMO as their source of primary care, a seven percent increase from the 2008 assessment (82.5 percent).

Goal: Increase the number of primary care and specialty physicians in Greene County.

Key Area Results: To have a better distribution of physicians throughout the county. A primary health care option for our residents where the fees for services are on a sliding fee scale and the reimbursement rates are sufficient to entice physicians to provide services in addition to the clinic being eligible to get physicians through the rural health initiatives.

Strategy 1: Rural Health Initiative
Initiate the process to establish rural health centers in underserved areas of the county.
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**Rationale:** The County has a fair number of primary care physicians when compared to other counties in the region per 100,000 population however the number is deceptive regarding certain areas of the county. There is a high concentration of physicians in the west as compared to the east end of the county. The county currently has no Community Health Center nor Federally Qualified Health Centers. There are limited options for the poor and uninsured individuals to receive primary and preventive care which is conveniently located for all communities within the county.

**Action Step 1:** Cedarville and Yellow Springs will be converting to Rural Health Centers with 50% of the medical care coverage performed by Nurse Practitioners.

**Action Step 2:** Utilize mid-level providers to increase access for low income and uninsured residents.

**Action Step 3:** Develop a primary care physician strategy to increase the number of physicians in Greene County.

**Lead Agents:** Kettering Healthcare Network

**Partnering Agents:** Greene Medical Society, Greene County Combined Health District

**Funding Source:** Rural Health Initiative Funds

**12 Month Outcome:** Application to establish a rural health clinics in Greene County.

**24 Month Outcome:** Two rural health centers established and operational in the County.
Environmental Health

Strategic Issue 1: Waste Disposal

**Current Situation:**

Recycling and proper waste disposal are important community activities which can help improve water and air quality according to the Environmental Protection Agency (EPA). The disposal of electronics in landfills results in the release of toxins such as mercury, lead, cadmium and beryllium into the soil, water and air (CDC). In order to preserve the integrity of our natural resources, electronics recycling programs and prescription drug take-back programs have become more prevalent.

**Goal:** Increase awareness of how to properly dispose of waste products such as batteries and electronics.

**Key Area Results:** Residents will be more knowledgeable about proper waste disposal methods. More waste will be processed using the correct methods and through the appropriate authorities.

**Strategy 1: Inform and Educate Waste Disposal**

Use of local government media resources to provide additional education and increase community awareness regarding appropriate disposal of batteries and electronics.

**Rationale:** Providing educational materials via various media outlets throughout the community will enable a broad spectrum of residents to be reached with the information. With increased awareness of disposal options and knowledge the benefit to the environment, residents will be empowered to make informed waste disposal decisions.

**Action Step 1:** Collect information regarding local recycling events, disposal locations and options to include in the educational materials.

**Action Step 2:** Annually distribute the information via government agencies, local libraries and other community partner agencies via brochures, websites, and other media outlets as they are available.

**Lead Agents:** Greene County Solid Waste Management District,

**Partnering Agents:** Health District
12 Month Outcome: Program materials developed and shared broadly throughout the community.

24 Month Outcome: Program materials are updated and shared broadly. The number of batteries and electronics being disposed of properly will increase.

Strategic Issue 2: Asthma

Current Situation:

According to the National Heart, Lung and Blood Institute, over 25 million people in the United States have been diagnosed with asthma; approximately one-quarter (7 million) of these individuals are children. Data from the Greene County Community Health Assessment show that the percent of adults who have been told by a doctor that they have asthma (20.3 percent) is higher than the state (13.8 percent) and national (13.8 percent) rates. Moreover, 24.5 percent of residents reported one or more children diagnosed with asthma; this is higher than the percentage reported in the 2008 Community Health Assessment (22.8 percent).

Goal: Leverage partnerships and technology to increase awareness and utilization of community resources which provide asthma education.
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**Key Result Areas:** Increased coordination between organizations to connect residents with resources in the community.

**Strategy 1: Investigation of Health Hazards**
Develop a referral system which enables the Health District, school nurses and physicians to refer moderate to severe cases of asthma to Regional Air Pollution Control Agency (RAPCA) for home assessments.

**Rational:** Home assessments help asthma sufferers identify common environmental asthma triggers and help achieve solutions. This is also an opportunity to share educational materials, recommendations and tools for controlling in-home asthma triggers.

**Action Step 1:** Establish referral standards and protocols. Partners should determine who qualifies as a moderate to severe case of asthma and identify the proper contact persons within each agency.

**Action Step 2:** Create a list of physicians in the community. Provide each physician’s office with information about RAPCA’s services and how they can refer asthma patients.
   - Use data to target physicians in high need areas.

**Action Step 3:** Meet with school nurses, community physicians and public health nurses to provide information about RAPCA’s services and how they can refer asthma patients.

**Action Step 5:** Maintain an ongoing dialogue between the Health District, RAPCA and other referral system partners to track the success of the system.
   - The Health District could receive training to conduct in-home assessments to help RAPCA if it receives an overflow of referrals.

**Sub-Strategy 1.1:** Explore the possibility of partnerships with other organizations to increase awareness of asthma-related concerns. For example, consider a partnership with Think TV to increase awareness of asthma-related concerns among childcare providers in underserved areas of Greene County.
   - Assess the feasibility of a Think TV partnership and identify funding sources. Pursue the local United Way as a potential funding source.

**Lead Agent:** Health District and RAPCA

**Partnering Agents:** Greene County Medical Society, Kettering Health Network, and Premiere Systems, GDAHA, Think TV
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12 Month Outcome: Referral standards and protocols have been established. List of physicians in the community has been created.

24 Month Outcome: Referral system is in operation.

Strategy 2: Inform and educate Asthma
Integrate asthma related social media tools into the Health District’s website.

Rational: Social media is changing the way medicine is practiced and healthcare is delivered. Web tools, expert-based community sites, medical blogs and services can facilitate the work of physicians, scientists, medical students or medical librarians and can help patients find reliable medical information online.

Action Step 1: Provide online access to adult and child asthma control tests.

Action Step 2: Identify and post online recommendations for asthma mobile applications.

Action Step 3: Post relevant asthma related articles and publications provided by Dayton Children’s Hospital.

Lead Agent: Health District

Partnering Agents: Dayton Children’s Hospital

12 Month Outcome: Research has been conducted to identify top-tier asthma mobile applications. Mobile application recommendations and asthma control tests have been posted to the website.

24 Month Outcome: Website traffic has been tracked to measure the use of asthma resources posted online.

Summary
Community leaders identified eight critical health priorities within three areas of concern: lifestyle and behavioral health; access to health care for the uninsured/underinsured; and environmental health. These health priorities will guide efforts in the community to address health in Greene County.