Public Health
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Greene County

COMMUNITY HEALTH IMPROVEMENT PLAN

2017

ABSTRACT

This is a companion document to the Community Health Assessment, which resulted in the selection of strategic issues/priorities. This plan outlines the work that will be done to improve health outcomes by addressing the priorities. It will be used by community partners as a guide for the collaborative process of improving health in Greene County.

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1.0	Initial Version	10/22/17	A. Steveley
2.0	Revised all workplans to remove and add strategies as needed. Updated the Mental Health & Substance Abuse objective and data graph. Added the sustainability chart. Updated quarterly reporting survey.	10/26/17	A. Steveley

Acknowledgements

The dedication, expertise, and leadership of the following agencies made the 2017 Greene County Community Health Improvement Plan a collaborative, and engaging plan that will guide our community in improving health and wellness for all who live, work, and play in Greene County.

Special Thanks to the following:

Greene County Public Health for the leadership, coordination and facilitation of the process.

Steering Committee and Workgroup Members

Beavercreek Chamber of Commerce

Central State University

City of Xenia

Clark State Community College

Council on Rural Services

Dayton Children's Hospital

Department of Job and Family Services

Fairborn Municipal Court

Greene CATS Public Transit

Greene County Board of Developmental Disabilities

Greene County Council on Aging

Greene County Educational Service Center

Greene County Family and Children First

Greene County Parks and Trails

Greene Memorial Hospital/Soin Medical Center

Layh & Associates, Inc.

Mental Health and Recovery Board of Clark, Greene & Madison Counties

Ohio State University Extension, Greene County

TCN Behavioral Health Services

The Feminist Health Fund

United Way of the Greater Dayton Area

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Executive Summary

There are many factors that influence health and well-being in our community, addressing them all would be a monumental task. In an effort to most effectively direct resources toward improving health in our county, a dedicated group of representatives from various agencies and organizations have been working together since November of 2016 on assessing the health of the community and identifying priority areas where collaborative efforts could result in change. This effort resulted in a very comprehensive Community Health Assessment (CHA) report. The CHA provided the data needed to identify the top priority health issues allowing for an informed process in the development of targeted strategies and objectives toward community health improvement. The priority areas identified were:

Chronic Disease

Mental Health & Substance Abuse

Maternal & Child Health

Injury Prevention

Many entities and individuals in the community have a role to play in responding to and addressing health needs. This plan provides a framework within which we can take a comprehensive approach to addressing the priority areas and improving health outcomes. This plan describes the process and methods used to develop a plan of action. It also details how the goals, objectives, strategies and actions will be implemented, monitored and evaluated over the next three years.

In developing this health improvement plan, workgroups were established around the four priorities. These workgroups considered the data, the social determinants of health, resources, capacities, policy, and competing needs. Additionally, state and national health improvement plans and strategies were taken under consideration for alignment.

The health improvement process is both continuous and evolving. It is designed to facilitate a continual flow of monitoring data and information to guide ongoing analysis and planning.[1] We believe community collaboration is the most effective way to address the health priority issues and a systematic approach to health improvement that makes use of performance monitoring tools will aid in achieving our goals. To maintain a sustainable plan, workgroups will report on implementation efforts quarterly beginning in 2018. This plan will be updated annually to reflect the progress, barriers and changes in our communities and our nation that impact the priority issues being addressed in this plan.

[1] Institute of Medicine (US) Committee on Using Performance Monitoring to Improve Community Health; Durch JS, Bailey LA, Stoto MA, editors. Improving Health in the Community: A Role for Performance Monitoring. Washington (DC): National Academies Press (US); 1997. Retrieved from: www.ncbi.nlm.nih.gov/books/NBK233012.

Introduction

Purpose

This Community Health Improvement Plan (CHIP) was developed as an extension of the work done in the Community Health Assessment (CHA). The CHA allows the local public health system to periodically evaluate the needs of the community and subsequently via a CHIP, set goals to address identified opportunities to improve community health outcomes. The CHIP outlines the actions to address the strategic issues identified in the CHA. These actions are defined by the goals and objectives for each issue and the associated strategies selected. This document is a reflection of community wide planning for the purpose of working collaboratively to improve health outcomes. The main goal is to work toward achieving the shared vision and values set by the steering committee at the beginning of the process. The following are the vision and values.

Vision: A vibrant health conscious community concerned with preserving the environment, where all people are informed, have equitable opportunity and are empowered to access what they need to be healthy.

Values: Collaboration, Inclusivity, Environment and Resiliency

Process

Greene County Public Health began implementing the Mobilizing through Planning and Partnership (MAPP) process in November of 2016 by organizing a steering committee that represents the various sectors that make up the local public health system in Greene County. The MAPP process is a community wide strategic planning process in which two companion documents are created, the first is the Community Health Assessment (CHA) which outlines the use of data to prioritize public health issues and the second is the Community Health Improvement Plan (CHIP) which is the plan to address the issues identified. The CHA report discusses the results of the first four steps in the MAPP process:

- Organize for Success
- Visioning
- Four MAPP Assessments
- Identify Strategic Issues/Priorities

This CHIP report will outline the last two steps in the MAPP process which are:

- Formulate Goals & Strategies
- Action Cycle (Plan, Implement & Evaluate)

In order to assist our steering committee in completing the formulation of goals and strategies and begin the planning process for the action cycle, a tool developed by the Health Collaborative of Bexar County, TX, titled, “A Community Engagement Approach for Developing the

Community Health Improvement Plan" was used.[2] This tool uses Results Based Accountability (RBA) in a step by step guide for CHIP planning. We adapted the tool to fit our community needs. The goal of this tool is to help communities begin working with the end in mind, developing a goal and the measurable indicators to guide the selection of strategies to address the strategic issues/priorities, and the tracking of the strategies impact over time. The following is a summary of the steps in the process:

1. Results Statement (Goal)
2. Select Indicators/Objectives
3. Data Development Agenda –If Applicable
4. Root Cause Analysis
5. Identify Additional Partners
6. Select Strategies
7. Develop Action Steps

To complete this process the original CHA steering committee was asked to break up and work in one of four workgroups (one for each of the four priority areas identified in the CHA; Chronic Disease, Mental Health & Substance Abuse, Maternal & Child Health, and Injury Prevention). At the first CHIP meeting on August 9th, the groups began working on the first 4 steps listed above. The results statement/goal was developed using a "victory circle", which is a brainstorming tool for what the workgroup members would like to see occurring in the community in regard to the priority area. This is a desired future state for the community. After a goal was developed, indicators were brainstormed then selected using a ranking process based on the criteria of: data power, proxy power, communication power, impact on life expectancy and significant impact on population health. This criterion allowed all the potential indicators to be narrowed down to one headline indicator (the main indicator being tracked) and associated indicators that support the headline indicators. In some cases, data was not being collected for indicators or the workgroup did not know how to access the data, these indicators were added to the data development agenda. Next, root causes of the selected headline indicator were listed on a fishbone diagram to get down to the social determinants impacting these headline indicators, encompassing access issues including cost and navigation, that may be addressed through resources or by educating the community on available resources. A root cause is listed and "why" is asked five times to get down to the structural root cause. After this process the root causes were ranked based on the criteria of leverage, influence, feasibility/reach and values. The resulting root causes became the prioritized root causes. As a next step, the workgroups identified any additional partners that may be missing from the process and could play a role in improving the headline indicator.

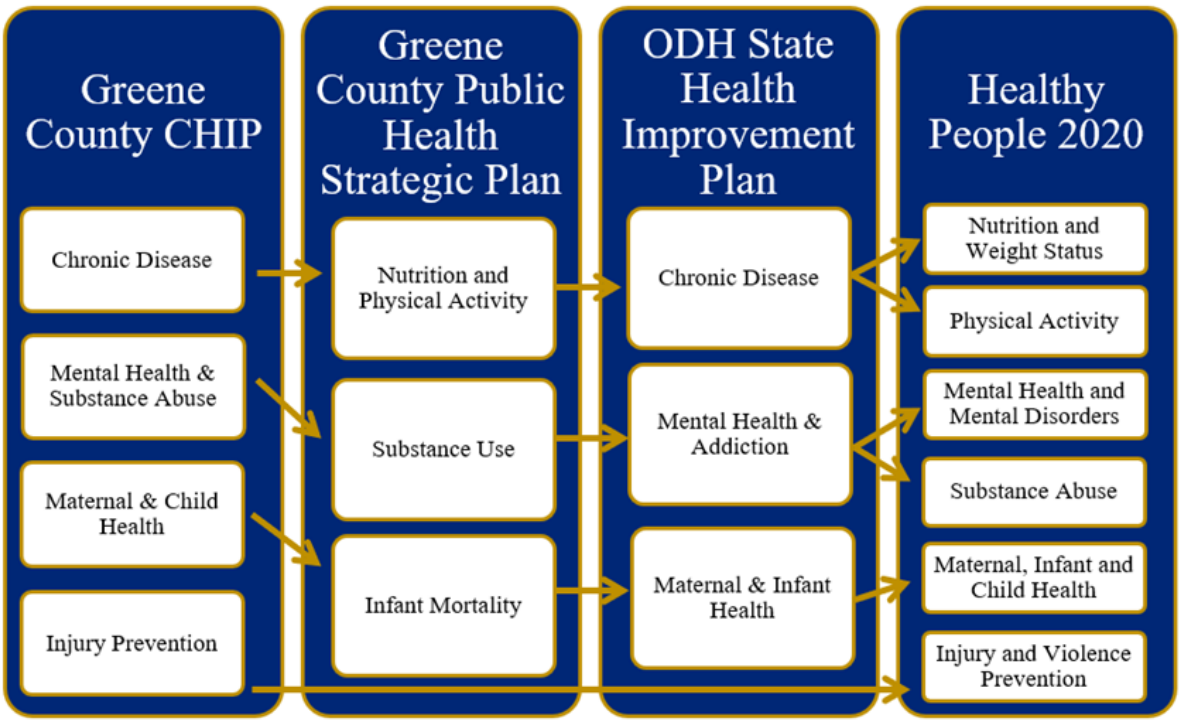
On September 5th and September 13th, the workgroups reconvened (two workgroups per meeting) to continue working through the RBA process. Prior to these meetings, information sheets including headline and associated indicators data, completed fishbones with root causes,

[2] A Community Engagement Approach for Developing the Community Health Improvement Plan, PHIT 2017, Albuquerque, New Mexico; Cara Hausler, Community Health Senior Management Analyst at the San Antonio Metropolitan Health District at cara.hausler@sanantonio.gov and Dr. Caroline D. Bergeron, Program Manager at the Health Collaborative at caroline.bergeron@healthcollaborative.net.

the list of additional partners and evidence-based strategies were provided (see Appendix A for listing of evidence based strategies) to each workgroup via email. These meetings allowed groups to finalize and prioritize the root causes and begin to review evidence-based strategies as well as come up with innovative strategies to help in turning the curve toward improving the headline indicators. The final two steps of strategy selection and developing action steps also included selecting time-framed targets and the responsible party. A complete listing of evidence-based strategies considered can be found in Appendix A, this listing of strategies was compiled with consideration of what is already going on in the community. The full committee received a draft of this CHIP prior to the steering committee meeting on September 28th, at the meeting the workgroups reviewed the information and provided edits. Two workgroups scheduled follow up meetings to review strategies further for inclusion in this plan. Plan review and revision will continue throughout the next phase of the MAPP action cycle which is implementation. Implementation will occur over three years and will include continual work in the action cycle to plan, implement and evaluate the work being done.

Alignment

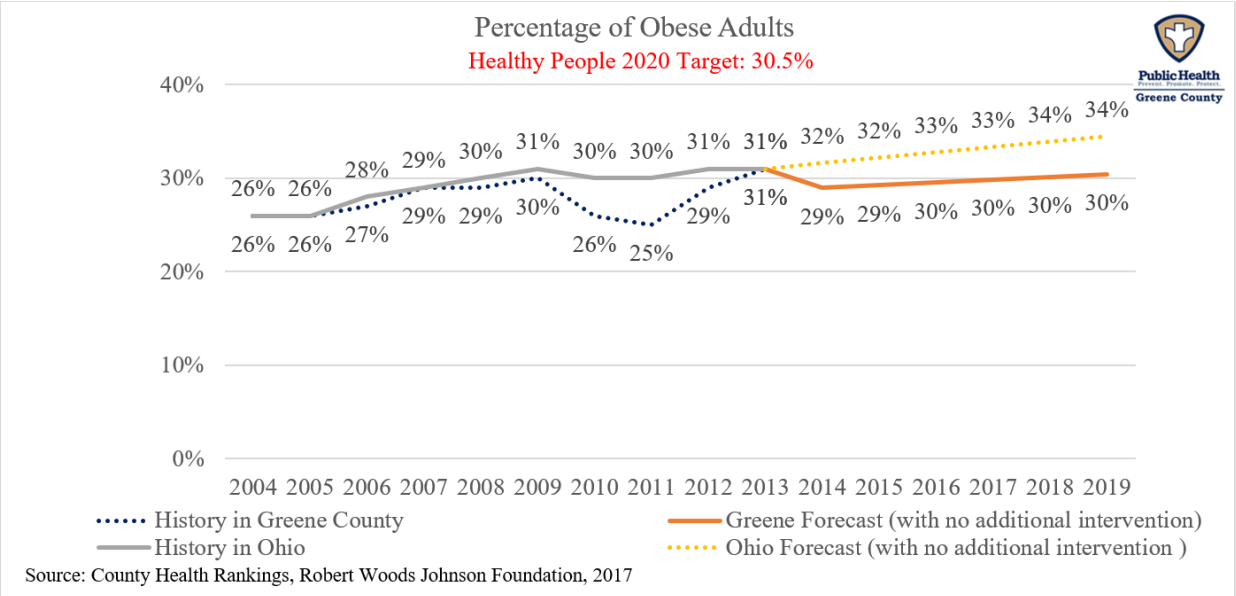
The CHIP was designed to complement and build upon other guiding documents, plans, initiatives, and coalitions already in place to improve the health of the public in Greene County. It was also designed to align with both the State Health Improvement Plan (SHIP) and National Healthy People 2020 goals and strategies. The Ohio Department of Health (ODH) provided guidance to local health districts for alignment with the SHIP priorities and evidence-based strategies. Greene County is already implementing numerous strategies identified by ODH, these are outlined in Appendix B. The information in Appendix B is organized by three cross-cutting factors identified by the SHIP (social determinants of health, public health & prevention, and healthcare system & access) and includes the ODH indicators and the lead entity facilitating the work here in Greene County.



Priorities

Priority 1: Chronic Disease

Goal: People of Greene County are preventing and managing chronic disease.
Headline Indicator: number of adults who are obese
Associated Indicators: active lifestyle, rates of hypertension/diabetes mellitus (Type 2 diabetes), consumption of good nutrition
Objective: Reduce the percentage of obese adults from 31% (2013) to 29% by December 2019.



As of 2013, the percentage of obese adults in Greene County at 31% is the same as the state but is higher than the national Healthy People 2020 target of 30.5%. Over the past ten years, there has been fluctuation between 25% and 31% locally and for the state. However, Greene County has consistently remained at the same percentage or lower than the state. The forecasted future based on past trends for local and state data project that in 2019 the Greene County percentage will remain stable at 30% and the state percentage will increase to 34%.

Although this trend may not appear significant, there is still cause for concern and a need for additional resources to address obesity. In the 2017 Community Health Assessment phone survey, 38.5 % of people reported being overweight. In addition, obesity is a major contributor to a number of chronic diseases including diabetes, hypertension, cardiovascular disease and cancer.[3] Specifically, diseases like diabetes which 13.3% of household telephone survey respondents indicated they have.[4] The Ohio Department of Health has a current baseline that 11% of people in Ohio are living with diabetes and their target for 2022 is to reduce this to 10.4%.[5] In addition, five percent (5.2%) of Greene County adults have been told they have kidney disease, and this is higher than the Ohio rate (3.2%).[6]

[3] World Health Organization http://www.who.int/dietphysicalactivity/publications/trs916/summary/en/
[4] Greene County Public Health, Greene County Community Health Assessment, 2017
[5] Ohio Department of Health, State Health Improvement Plan, 2017
[6] Ohio 2015 BRFSS Annual Report

Prioritized Root Causes: lack of knowledge, lack of physical activity, poor food choices

Work Plan

Strategy	**Actions**	**Time Frame Target**	**Responsible Party**
Establish a Coalition or Collaborative around eating well and moving more	Research coalition building or how collective Impact could be used	January 2018	Greene County Public Health
	Implementation	September 2018	Community Roots
Point-of-decision prompts for physical activity: including resources and incentives to make healthy food choices*	Research messaging and methods to develop and promote	January 2018	Greene County Public Health
	Beta test with select county organizations	June 2018	Community Roots
	Develop Presentation packet to promote the idea to businesses and organizations throughout the county	September 2018	Community Roots
	Evaluate the response via survey with a random selection of participating businesses/ organizations	June 2019	Community Roots
Partner with current initiatives to enhance the promotion of physical activity and healthy eating	Conduct an assessment of all current initiatives addressing nutrition and physical activities to inform decisions on needs for collaboration or new initiatives	October 2018-December 2018	Greene County Public Health
NEW STRATEGY 2019: Community Gardens**	To be determined by Community Roots coalition	January 2019 – September 2019	Community Roots

Resource Needs (Potential Partners)

- Athletes in Action
- Central State - Extension
- Chamber of Commerce
- Council on Aging
- Fairfield Commons
- Greene County Food Council
- Greene County Libraries
- Greene County Public Health WIC
- Key Ads
- Local Colleges & Universities
- Mayors/County Commissioners
- Ohio River Road Runners Club
- Ohio State University Extension, Greene County
- One Bistro
- Parks and Recreational Facilities
- RTA
- Schools
- Spectrum Cable
- YMCA

Strategy Evidence:

*Practice-Based/ Policy: Point-of-decision prompts for physical activity, retrieved from: http://www.countyhealthrankings.org/policies/point-decision-prompts-physical-activity.

** Some Evidence: Community Gardens, retrieved from: http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/community-gardens

Assets/Resources:

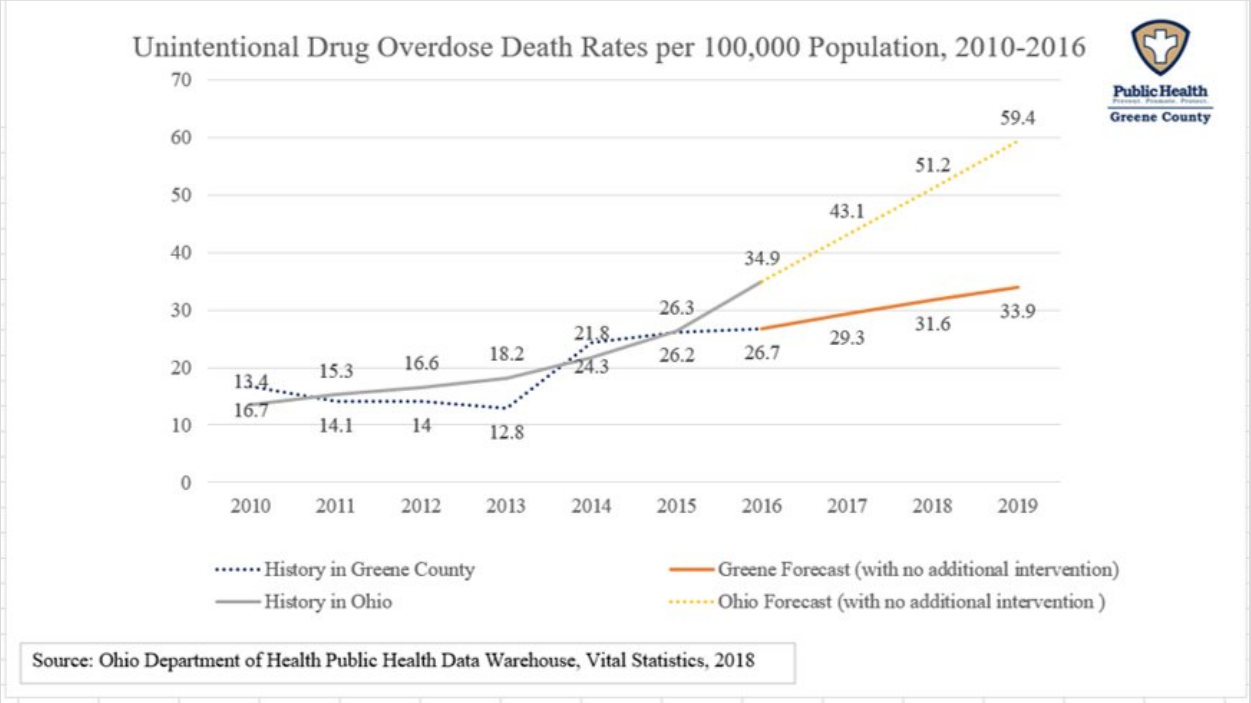
- City of Xenia
- Dr. Ahmad A. Abdul-Karim, MD, Interventional Cardiology
- Dr. Santosh Khurma, Internal Medicine
- Five Rivers Health Center
- Greene County Council on Aging
- Greene County Parks and Trails
- Greene County Public Health
- Greene/Soin Medical Centers
- Heartfulness Center Fairfield Mall
- Department of Job & Family Services
- Kidney Care Specialists
- One Bistro
- Ohio State University Extension, Greene County
- Star Pediatrics
- The Foodbank, Inc.
- X-Out Hunger Backpack Cuisine
- YMCA

Summary

The main theme in preventing and managing chronic disease is in the choices people make. At all levels, nationally, in our state and locally, there is a growing number of people who are overweight and obese. Obesity is one chronic disease which has a major impact on developing other chronic diseases and contributes to difficulty in managing chronic diseases. There is an extensive amount of resources available in Greene County already to address the root causes of lack of knowledge and physical activity. However, there is still more work to be done to expand upon all the root causes including poor food choices. The key being in choice and individual decision making. The two strategies selected here with the point of decision prompts and health communications will aim to unify messaging to make information about the resources that exist more readily available and create new resources and messages to aid in decision making that improves health. Overall, it is a big task to address chronic disease because there are so many components, however we are uniquely positioned to work better at communicating what is already available.

Priority 2: Mental Health & Substance Abuse

Goal: Greene County residents can access prevention, treatment and support services they need to reduce and manage substance abuse and mental health issues.
Headline Indicator: unintentional drug overdose deaths per 100,000 population
Associated Indicators: suicide, child abuse/neglect, homelessness
Objective: Reduce the rate of unintentional drug overdose deaths per 100,000 from 26.7(2016) to 24.7by December 2019. (Updated Objective)



The Ohio Department of Health (ODH) maintains unintentional drug overdose death data. Both in the state and locally, the death trend is on the rise. The projection also outlines a continuous increase. Dips in the historical data for Greene County from a rate of 15.9 per 100,000 in 2011 to 14.7 in 2012 are not clearly defined by any particular events. There have been changes in prescribing practices by physicians, legislative action to help close pill mills and the introduction of naloxone (medication that rapidly reverses the effects of opioid overdose) administered in non-healthcare settings.[1] Even with all of these actions being taken, there is still a growing epidemic among illicit opioids such as heroin, fentanyl and carfentanil. From 2013 to 2014 there was an alarming increase from 14.1 per 100,000 to 24.4 that is not explained by any particular events. Neighboring Montgomery County has seen some of the highest rates in the state which led them to form an opiate task force in 2012. In the recently completed State Health Improvement Plan, ODH has set an unintentional drug overdose death rate target of 26.9 per 100,000. The current rate in Ohio as of 2015, is 27.2 and in Greene County the rate is 29.6. The forecasted projection for 2019 is 38.2 (Ohio) and 40.6 (Greene County).

[1]U.S. Department of Health and human Services "About the Epidemic", retrieved from: https://www.hhs.gov/opioids/about-the-epidemic/index.html.

Prioritized Root Causes: harm reduction literacy, navigating the healthcare system, untreated mental health issues and early adverse childhood experience exposure.

Work Plan

Strategy	Actions	Time Frame Target	Responsible Party
Collective Impact*: collaborative commitment of agencies from various sectors to address a targeted social issue.	Conduct Collective Impact training	December 2017	United Way
	Establish Collective Impact group	April 2018	Greene County Public Health, Mental Health and Recovery Board of Clark, Greene & Madison Counties, Greene County Drug-Free Coalition
	Develop the five components of the Collective Impact Framework	January 2019	Greene County Collective Impact Group
	Develop strategies to implement based on evidence and need in the community.	May 2019	Greene County Drug-Free Coalition
Integrate public health data and healthcare system clinical data (e.g. link Vital Statistics data with other data systems)	Develop data reports for collective impact group - ODH Unintentional Drug Overdose Deaths and EpiCenter Alerts	Bi-annually in 2019	Greene County Public Health

Resource Needs (Potential Partners)

- Community Action Partnership Homeless Crisis Response Program
- Greene County Housing Program
- Medical healthcare provider(s)

Strategy Evidence (practice-based): Hanleybrown, F., Kania, J., & Kramer, M. *Channeling Change: Making Collective Impact Work*. Stanford Social Innovation Review, retrieved from: https://ssir.org/articles/entry/channeling_change_making_collective_impact_work.

Assets/Resources:

- Greene County Drug-Free Coalition
- Fairborn Municipal Drug Court
- Family and Children First Council
- Family Violence Prevention Center
- Greene County Educational Service Center
- Layh & Associates, Inc.

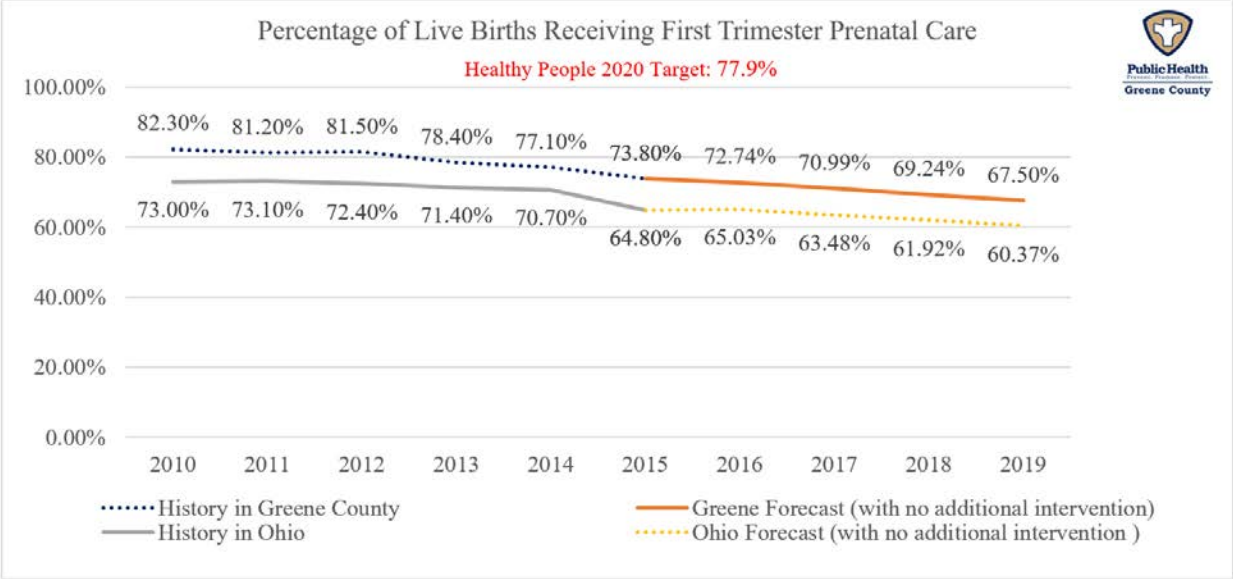
- Mental Health and Recovery Board of Clark, Greene & Madison Counties
- Michael's House
- National Alliance on Mental Illness for Clark, Greene & Madison Counties
- Greene County Suicide Prevention Coalition
- TCN Behavioral Health Services
- The Hope Spot
- Women's Recovery Center

Summary

There is a need for mental health providers to develop a coordinated response to getting people into treatment. Community partners are essential in facilitating collaborative efforts as unbiased sources of data and non-mental health-based initiatives to link people to care. Prevention and recovery communities must be able to plug into a coordinated treatment community. Collective Impact allows for the coordination of prevention, treatment and recovery communities to close the gap and address the root causes of the headline indicator; unintentional drug overdose deaths. The root causes will be addressed through creation of common messages for community development of skills in harm reduction literacy and navigating the healthcare system so untreated mental health issues and early adverse childhood experience exposure are no longer reducing the quality of life for our residents. The associated indicators of homelessness, child abuse/neglect and suicide are all areas that can be impacted through the Collective Impact work. There is a need for data to be developed and provider counts to be researched to understand the extent of the impact of the opioid epidemic. Additional information was collected from the community regarding the four priority issues identified in the Community Health Assessment and this information highlighted the breadth of opinions and the overwhelming identification of mental health and substance abuse as a leading health issue in our community (see Appendix C for survey results).

Priority 3: Maternal & Child Health

Goal: Women of childbearing age, teens and families in Greene County have equal access to high quality preventative and mental health education and care.
Headline Indicator: percent of live births receiving first trimester prenatal care
Associated Indicators: distribution/density of providers/Medicaid, childhood obesity, domestic abuse adult/children, child abuse/neglected removals
Objective: Increase the percentage of women seeking first trimester prenatal care from 73.80% (2015) to 82.30% (the 2010 percentage) by December 2019.



The percentage of live births receiving first trimester prenatal care is on the decline in Ohio and in Greene County. In 2014, Greene County dropped below the healthy people 2020 target of 77.9% by reporting 77.1%. Historical data for the previous 4 years (2010-2013) was above the healthy people 2020 target but the trend shows a decline. This declining trend is also seen in the state of Ohio, however, the 6 years of historical data (2010-2015) show that Ohio was not achieving the healthy people 2020 target of 77.9%. The average percentage from 2010-2015 for Ohio was 70.9%. Based on this historical data the 2019 forecasted percentage is 67.5% for Greene County and 60.37% for Ohio. With the implementation of the Patient Protection and Affordable Care Act after it was signed in 2010, there has been an increase demand for services and a decrease in access based on a limited number of physicians and some physicians electing to only accept certain insurance types. In many cases, physicians are limiting the number of Medicaid clients or not accepting Medicaid clients at all.

Prioritized Root Cause: education (address cultural stigma and generational barriers)

Work Plan

Strategy	Actions	Time Frame Target	Responsible Party
Public Message Campaign	Develop Subcommittee (possibly **EC3)	January 2018	Greene County Public Health – Early Intervention
	Develop public message campaign	September 2018	Subcommittee
	Share public message campaign (marketing plan)	January 2019	Greene County Public Health – Early Intervention & Subcommittee
NEW STRATEGY 2019: IMPLICIT (Interventions to Minimize Preterm and Low Birthweight Infants using Continuous Improvement Techniques) Interconception Care Toolkit	To be determined by the workgroup	January 2019-December 2019	Greene County Public Health

Resource Needs (Potential Partners)

- Business Community
- Chambers of Commerce
- Department of Developmental Disabilities
- **Early Childhood Coordinating Committee
- Family & Youth Initiatives
- Family Violence Prevention Center
- GRADS
- Greene CATS
- Greene County Educational Service Center
- Hospitals
- Housing Coalition
- Media
- Mental Health and Recovery Board of Clark, Greene & Madison Counties
- TCN Behavioral Health Services
- Ohio State University Extension, Greene County
- School Nurses
- United Way
- Women's Center
- Women's Recovery Center

***Strategy Evidence (promising practice):** Preconception education interventions, retrieved from: http://www.countyhealthrankings.org/policies/preconception-education-interventions.

Assets/Resources:

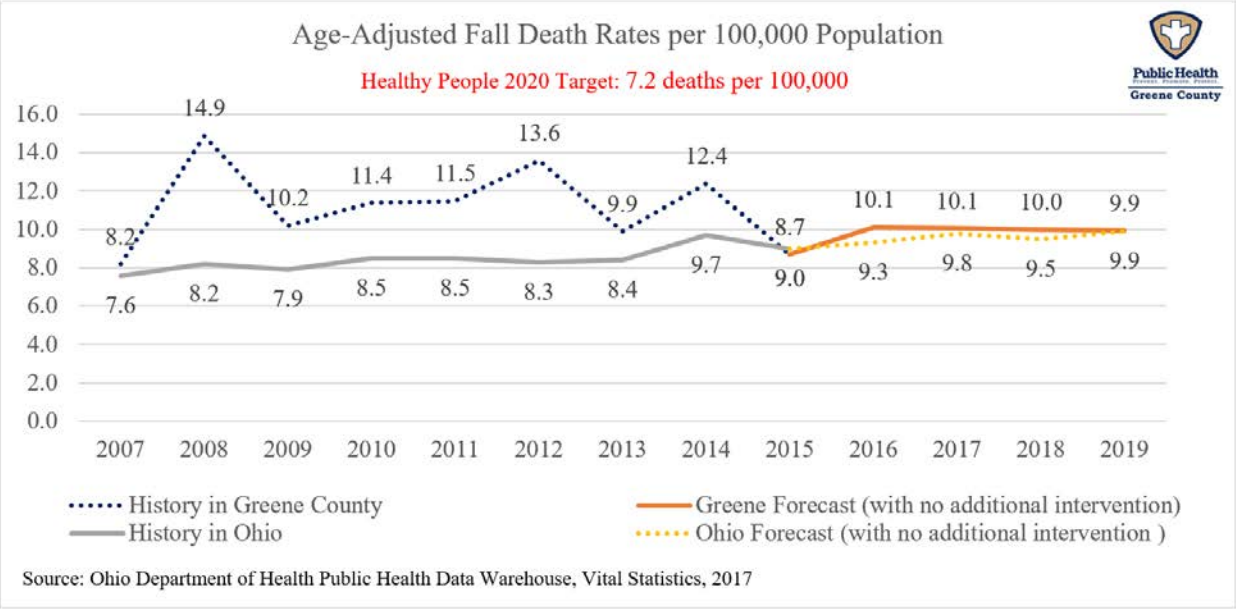
- Child Fatality Review Board
- Department of Job and Family Services
- Dr. Keith Watson, OBGYN
- Early Head Start
- Family & Children First
- Family Violence Prevention Center
- Five Rivers Greene County Health Center
- Greene County Public Health
- Parenting Network
- Raising Ready Kids Greene Program
- Yellow Springs Community Children's Center

Summary

To turn the curve and keep prenatal care utilization from declining as projected by the data, the workgroup identified education as an essential root cause to guide the intervention strategy. Many community organizations and agencies can have an impact on whether or not mothers seek early prenatal care. To aid in the linkage and improve access to prenatal health care services, this workgroup will be taken over by a community organization that already convenes many of the partners mentioned in the resource needs, the group is named the Early Childhood Coordinating Committee. They intend to work toward approval by their leaders in implementing the strategies of being the subcommittee, developing a single message and sharing the message and developing a toolkit for members of the subcommittee to use with clients. Many future negative health outcomes can be addressed through our residents starting in the womb with adequate and regular care. Knowledge of resources and how to access and navigate the health care system is a barrier that can be addressed through education and can help in reversing generational barriers to health and the stigma associated with seeking care.

Priority 4: Injury Prevention

Goal: A community of active people, free of chronic injuries from falls, out and about on bike paths, smooth sidewalks, and pot hole-free streets in well-lit areas.
Headline Indicator: fall related deaths
Associated Indicators: emergency department visits, hospitalizations, injury related surgeries
Objective: Reduce the rate of fall deaths per 100,000 from 8.7 (2015) to 7.8 by December 2019.



Fall related death rates have been high in Greene County for the past 9 years. Fluctuating from 8.2 in 2007 to 14.9 per 100,000 in 2008. This fluctuation has continued over time but the rate is still higher than the Healthy People 2020 target of 7.2. In Ohio, the rates fluctuated between 7.6 in 2007 and 9.7 in 2014. The data for both the state and county between 2007 and 2015 were all higher that the Healthy People 2020 target of 7.2, however it is noteworthy that the State of Ohio has consistently had lower rates than Greene County during this time. The forecasted data continues to show Greene County as having higher rates than Ohio, but the fluctuation in Greene County over time is unexplained and is in need of further study to understand what may have impacted the data spikes.

Prioritized Root Causes: chronic disease, inactivity, living alone

Work Plan

Strategy	Actions	Time Frame Target	Responsible Party
Research Agenda/Data Development: seek out additional or develop collection of data.	Emergency Department Visits (area hospitals), Hospitalizations	March 2019	Greene County Public Health
	Causes of injury related falls	Ongoing in 2019	Greene County Board of Department of Developmental Disabilities
NEW STRATEGY 2019: Falls Survey	Revise survey to make it easier to use and read	January – March 2019	Greene County Public Health
	Identify possible events to distribute the survey and plan for distribution	March – August 2019	Greene County Council on Aging
	Analyze results	September 2019	Greene County Public Health

Resource Needs (Potential Partners)

- Adult Protective Services
- Area Physicians
- Miami Valley Hospital emergency department data tracking
- WBZI (local radio station)
- YMCA
- Greene County Board of Developmental Disabilities
- Greene County Department of Job and Family Services
- Greene County Disability Coalition
- First Responders

Assets/Resources:

- Greene County Council on Aging
- Greene County Public Health
- Legal Aid of Western Ohio, Inc.
- Xenia Adult Recreation and Services Center

Summary

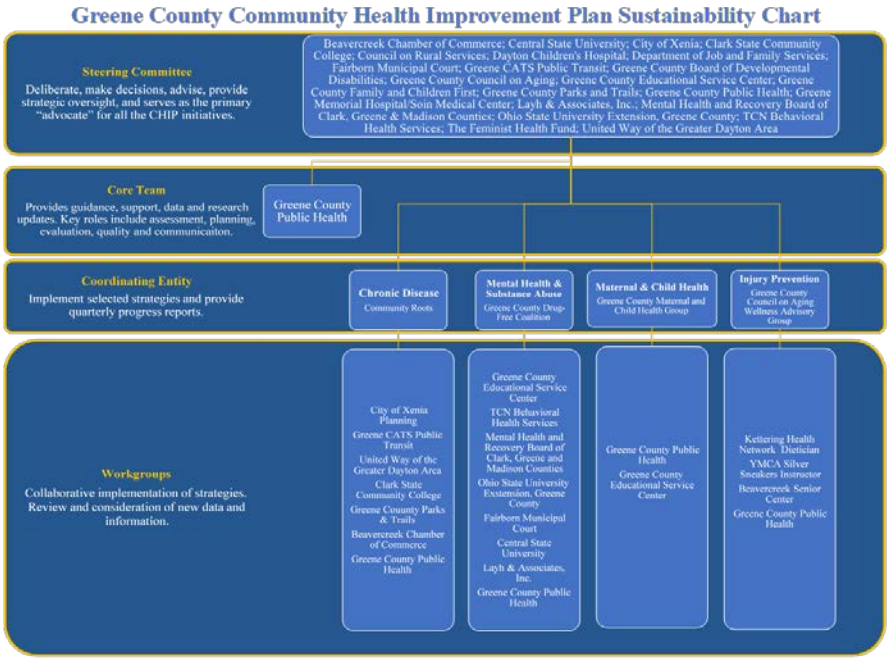
Data from the Community Health Assessment highlighted the high rate of falls in the Greene County population, specifically, among the senior population. There is a need for additional data to better understand what is causing the high rates of falls and what the resulting injuries are that people are typically experiencing a need for surgery to address. Root causes of chronic disease, inactivity and living alone were all focused around addressing falls among the senior population. Various community programs already exist to address prevention and management of chronic disease as well as programs to address inactivity. So, the main focus is on developing the data to better understand the problem.

Conclusion

There were several common themes discussed among the four workgroups: seeking additional partners, developing common messaging, sharing current assets and resources and access to care. Several of the groups included some component of convening additional partners around the issue in their work plan. This would help in the development of common messages and allow for additional assessment of the current assets and resources that exist in the community. Additionally, access to care was something that was identified in the Community Health Assessment as a cross cutting factor and was specifically discussed in more detail by the Mental Health & Substance Abuse and the Maternal & Child Health workgroups. Both groups focused on the ability of community organizations to connect people to community resources. For mental health, strategies need to be further developed to link people to treatment and for maternal and child health, there is a need to inform people on when and how to seek treatment. Overall, these two workgroups came up with various strategies to address the fact that messaging in our communities is about connecting the current resources to the people who need them. The Injury Prevention workgroup identified a need to better understand the cause of the problem by furthering data collection and the Chronic Disease workgroup identified ways to use messaging to encourage behavior change.

Sustainability Plan

This plan represents the strategic framework for a data-driven, community enhanced health improvement planning and implementation. It is vital for this to be considered a living document. The Community Health Improvement Planning Steering Committee will continue to serve and provide executive oversight for the improvement plan, progress and process. We will look to expand the membership of the workgroups by reaching out to the identified potential partners, and /or working through exisiting community coalitions. Greene County Public Health will act as convenor and provide support and oversight. The current sustainability structure is outlined in the diagram below.



A quarterly status report will be completed and shared on each of the four priority areas, using the template in Appendix D. To maintain a sustainable plan, coordianting entities will report on implementation efforts quarterly beginning in 2018. This plan will be updated annually to reflect the progress, barriers and changes in our communities and our nation that impact the priority issues being addressed in this plan.

The Core Team will seek to engage the residents of Greene County by providing opportunities for dialogue, input and feedback regarding the CHIP. There will be regular communication via various media platforms to community members and stakeholders throughout the implementation phases.

Definitions[7]

Priority: A category of focus.

Goal: A projected state of affairs that a person or a system plans or intends to achieve. Identifies in broad terms how your initiative is going to change things in order to solve the problem you have identified. A result that one is attempting to achieve.

Objective: Objectives articulate goal-related outcomes in specific and measurable terms. Objectives are narrow, precise, tangible, and concrete. Objectives are SMART (specific, measurable, achievable, relevant, time-phased).

Strategies: A strategy describes your approach to getting things done. It is less specific than action steps but tries broadly to answer the question, "How can we get from where we are now to where we want to be?" The best strategies are those which have impact in multiple areas, also known as leverage or "bang for the buck."

Actions: the specific, concrete steps you will take to achieve each strategy.

Indicator: a single measure that is reported on regularly and that provides relevant and actionable information about population health and/or health system performance and characteristics. An indicator can provide comparable information, as well as track progress and performance over time.

Healthy People 2020: Healthy People provides science-based, 10-year national objectives for improving the health of all Americans.[8]

[7] Health Resources in Action: Advancing Public Health and Medical Research. Action Plan. 2016. and Canadian Institute for Health information. Retrieved from: https://www.cihi.ca/en/cihi-health-indicators

[8] https://www.healthypeople.gov/2020/About-Healthy-People

Appendix A: Evidence-Based Strategies

Chronic Disease: Diabetes/Obesity/Kidney Disease

National Diabetes Prevention Program: Lifestyle Change Program (Research-Based Prevention Program) * (*CHR & CG)

CDC-approved curriculum with lessons, handouts, and other resources to help you make healthy changes.

A lifestyle coach, specially trained to lead the program, to help you learn new skills, encourage you to set and meet goals, and keep you motivated. The coach will also facilitate discussions and help make the program fun and engaging.

A support group of people with similar goals and challenges. Together, you can share ideas, celebrate successes, and work to overcome obstacles. In some programs, the participants stay in touch with each other during the week. It may be easier to make changes when you're working as a group than doing it on your own.

Text message-based health interventions (Some Evidence)

Text messaging interventions can provide reminders, education, or self-management for health conditions. These interventions are most frequently used in health promotion efforts or to help individuals manage chronic diseases. Technology-based interventions, such as text messaging, can be combined with other approaches or delivered as part of a stepped care/progressive intervention, beginning with the least intensive treatment and moving to more intensive, and often expensive, treatments based on the needs of the individual patient.

Obesity: Worksite Programs (Recommended) ° (CG& CDC)

Worksite nutrition and physical activity programs are designed to improve health behaviors and results. They may be used alone or as part of a comprehensive worksite wellness program. Interventions include one or more of the following:

- Information and education (e.g., lectures, written materials, educational software)
- Activities that target thoughts (e.g. awareness, self-efficacy) and social factors that affect behavior change. Examples include behavioral counseling, skill-building activities, rewards or reinforcement, and inclusion of co-workers or family members to build support systems.
- Changes to physical or organizational structures that make healthy choices easier and target the entire workforce. Examples include making healthy foods more available, providing more opportunities to be physically active, changing health insurance benefits, or providing health club memberships.

Worksite: Assessment of Health Risks with Feedback (AHRF) to Change Employees' Health – AHRF Plus Health Education With or Without Other Interventions (Recommended) ° (CG)

This intervention includes:

- An assessment of personal health habits and risk factors (that may be used in combination with biomedical measurements of physiologic health)
- A quantitative estimation or qualitative assessment of future risk of death and other adverse health outcomes
- Provision of feedback in the form of educational messages and counseling that describes how changing one or more behavioral risk factors might change the risk of disease or death
- Worksite interventions may use an assessment of health risks with feedback (AHRF) alone or as part of a broader worksite health promotion program that includes health education and other health promotion components offered as follow-up to the assessment.

Chronic Disease: Physical Activity

Point-of-decision prompts for physical activity (Scientifically Supported) ° (CHR & CG)

Point-of-decision prompts are motivational signs placed on or near stairwells, elevators, and escalators to encourage individuals to use stairs. Point-of-decision prompts can be implemented in workplaces or in public venues such as train, subway, and bus stations, airports, shopping malls, banks, and libraries. Point-of-decision prompts can be implemented alone or in combination with stairwell enhancements such as music, art, signs, carpet, paint, or lighting upgrades (CG-Physical activity).

Community-based social support for physical activity (Scientifically Supported) * (CHR & CG)

Community-based social support interventions for physical activity focus on changing physical activity behavior through building, strengthening, and maintaining social networks that provide supportive relationships for behavior change (e.g., setting up a buddy system or a walking group to provide friendship and support).

Shared use agreements (Some Evidence) *° (CHR)

Shared use, joint use, open use, or community use agreements allow public access to existing facilities by defining terms and conditions for sharing the costs and risks associated with expanding a property's use. School districts, government entities, faith-based organizations, and private or nonprofit organizations may create shared use agreements to allow community access to their property before or after hours. Shared use agreements can be formal (i.e., based on a written, legal document) or informal (i.e., based on historical practice), and can be tailored to meet community needs (ChangeLab-Joint use).

Community-wide physical activity campaigns (Some Evidence) * (CHR & CG)

Community-wide physical activity campaigns involve many community sectors, include highly visible, broad-based, multi-component strategies (e.g., social support, risk factor screening or health education) and may address cardiovascular disease risk factors (CG-Physical activity).

Physical Activity: Family-Based Interventions (Recommended) (CG)

Family-based interventions combine activities to build family support with health education to increase physical activity among children. Interventions include one or more of the following:

- Goal-setting tools and skills to monitor progress, such as a website to enter information
- Reinforcement of positive health behaviors, such as reward charts or role modeling of physical activity by parents or instructors
- Organized physical activity sessions, such as instructor-led opportunities for active games
- Interventions also may provide information about other lifestyle behaviors, such as choosing healthier foods or reducing screen time.

Health Communication and Social Marketing: Campaigns That Include Mass Media and Health-Related Product Distribution (Recommended) (CG)

Based on strong evidence of effectiveness for producing intended behavior changes, the Community Preventive Services Task Force recommends health communication campaigns that use multiple channels, one of which must be mass media, combined with the distribution of free or reduced-price health-related products (defined above).

The specific behaviors promoted in the included studies were the use of products that:

Facilitate adoption and/or maintenance of health-promoting behaviors (i.e., increased physical activity through pedometer distribution combined with walking campaigns).

Facilitate and/or help to sustain cessation of harmful behaviors (i.e., smoking cessation through free or reduced cost over-the-counter nicotine replacement therapy [OTC NRT]).

Protect against behavior-related disease or injury (i.e., condoms, child safety seats, recreational safety helmets, sun-protection products).

Because results were positive across all of the six behaviors evaluated, these findings are likely to apply to a broader range of health-related products that meet the review's product eligibility criteria in the intervention definition. The effectiveness of interventions promoting the use of health-related products other than those distributed in the reviewed studies should be assessed to ensure applicability.

The systematic review focused only on interventions that included a mass media component; therefore, this recommendation is specific to such interventions. The results may or may not apply to campaigns that do not include a mass media component, which were outside of the scope of the review.

Chronic Disease: Nutrition

*Community Gardens (Some Evidence) *° (CHR)*

A community garden is any piece of land that is gardened or cultivated by a group of people, usually for home consumption. Community gardens are typically owned by local governments, not-for-profit groups, or faith-based organizations; gardens are also often initiated by groups of individuals who clean and cultivate vacant lots. Local governments, non-profits, and communities may support gardens through community land trusts, gardening education, distribution of seedlings and other materials, zoning regulation changes, or service provision such as water supply or waste disposal.

*Healthy food in food banks (Some Evidence) * (CHR)*

Food bank and food pantry healthy food initiatives combine hunger relief efforts with nutrition information and healthy eating opportunities for low income individuals and families. Such initiatives offer clients healthy foods such as fruits, vegetables, whole grains, low-fat dairy products, and lean proteins. Initiatives can include fruit and vegetable gleaning programs, farm Plant-a-Row efforts, and garden donations. Healthy food initiatives can also modify the food environment via efforts such as on-site cooking demonstrations and recipe tastings, produce display stands, or point-of-decision prompts. Some food banks and food pantries establish partnerships with health and nutrition professionals to offer screening for food insecurity and medical conditions (e.g., diabetes), provide nutrition and health education, and health care support services as part of their healthy food initiatives (HFBH-Foods to encourage).

*Healthy food in convenience stores (Some Evidence) *° (CHR)*

Convenience stores, corner stores, or gas station markets often provide the only retail food options in food deserts and low income neighborhoods. Corner stores sell a limited selection of food items and other products; these items are frequently non-perishable and unhealthy. Corner stores can also carry fresh produce and healthier food options.

*Competitive pricing for healthy foods (Scientifically Supported) *° (CHR)*

Competitive pricing assigns higher costs to non-nutritious foods relative to nutritious foods. Competitive pricing can be implemented in various settings, including schools, worksites, grocery stores or other food retail outlets, cafeterias, and vending machines. Competitive pricing can take the form of incentives, subsidies, or price discounts for healthy foods and beverages and/or disincentives or price increases for unhealthy foods and beverages.

Mental Health & Substance Abuse

*SBIRT: Screening, Brief Intervention, and Referral to Treatment *° (SAMHSA)*

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.

The American Public Health Association manual, Alcohol Screening and Brief Intervention: A guide for public health practitioners, provides public health professionals such as health educators and community health workers with the information, skills, and tools needed to conduct screening and brief intervention to help at-risk drinkers limit or stop drinking.

Peer Support (consumer-operated programs) (Ohio MHA)

Ohio Peer Recovery Supporter Certification

Maternal & Child Health

*Preconception education interventions (Some Evidence) * (CHR)*

Preconception education interventions provide information about the risks and benefits of behaviors that affect a woman's health before, during, and after pregnancy; improving certain health behaviors prior to pregnancy reduces risks to mothers' and infants' health. Preconception education interventions cover a variety of topics related to those behaviors, such as nutrition, exercise and weight management, birth control methods, STI prevention, controlling chronic disease, reducing alcohol consumption, quitting smoking and other tobacco use, or improving mental health. Interventions can be delivered in clinical or community settings, and may be presented by medical providers, public health professionals, lay people, or others with relevant education and training (e.g., community health workers). Ongoing well-woman care, as well as education for men partnered with women of child bearing age, often compliment these interventions.

Mobile reproductive health clinics (Some Evidence) (CHR)

Mobile reproductive health clinics are medically equipped vans with clinicians that offer reproductive health services, usually to women in low income areas. Services can include pregnancy tests, prenatal and postpartum care, gynecological exams, sexually transmitted infection (STI) screenings, health education, and referrals to social services. Vans may include a waiting room, private exam areas, an education area, and a laboratory, as well as monitors, diagnostic equipment, and educational materials (O'Connell 2010). Vans sometimes offer screening and referral services for health concerns outside reproductive health (AHRQ HCIE-Bennett).

Patient financial incentives for preventive care (Scientifically Supported) (CHR)

Financial incentives such as payments, vouchers, and tickets for prize drawings can be used to encourage patients to undergo preventive care such as screenings, vaccinations, and other brief interventions. Personal incentive programs are usually offered through the public sector and typically offer incentives to low income individuals (Sutherland 2008).

Group-based parenting programs (Scientifically Supported) (CHR)

Group-based parenting programs use standardized curriculums to teach parenting skills in a group setting. Such programs are usually based on behavioral or cognitive-behavioral approaches and targeted at parents whose children display aggressive and disruptive behaviors, possess low self-esteem or poor social skills. Participants' children are often at risk of, or diagnosed with, Conduct Disorder or Oppositional Defiant Disorder (Cochrane-Furlong 2012)

Injury Prevention

CAPABLE (Community Aging in Place – Advancing Better Living for Elders) is a five-month structured program delivered at home to community dwelling older adults to decrease fall risk, improve safe mobility, and improve ability to safely accomplish daily functional tasks. CAPABLE is delivered by an occupational therapist, who makes six visits to each participant; a nurse, who makes four visits; and a handyman, who contributes up to a full day's work—providing home repairs, installing assistive devices, and making home modifications. Participants work with the therapist and nurse to identify three achievable goals per discipline, examine the barriers to achieving those goals, and make action plans, supported by changes to the home and medication environment, to achieve those goals.

FallsTalk is an individual program for anyone who has experienced a fall or regular loss of balance; regardless of walking ability, medical condition, mobility or fitness level. The program begins with a personal FallsTalk Interview in-home or community space to discuss their unique situation. The intervention consists of initial and follow-up interviews with a trained facilitator, daily personal reflection (2-3 min.), 3 brief weekly and then monthly check-in calls. Clinical trials and community results provide evidence that FallsTalk significantly reduces falls compared to untreated fallers.

FallScape is a customized program for anyone who has experienced a fall or regular loss of balance; regardless of walking ability, medical condition, mobility, cognitive or fitness level. FallScape consists of one or two training sessions with a set of brief (less than 1 min.) multimedia vignettes that are selected specifically to help an individual prevent falls in their own unique situation. FallScape is offered in-home or community space in conjunction with FallsTalk. Research shows that Participants achieve maximum benefit with the addition of this multimedia training.

Healthy Steps for Older Adults (HSOA) is an evidence-based falls prevention program for adults ages 50 and over. The program is designed to raise participants' fall prevention knowledge and awareness, introduce steps they can take to reduce falls and improve their health and well-being, and provide referrals and resources. Two 2-hour workshops are offered to interested individuals in the community at facilities such as senior community centers and health care organizations. HSOA was developed by the Fall Prevention Initiative of the Pennsylvania Department of Aging.

STEADI Materials for Health Care Providers (CDC)

STEADI materials can be used to assess, treat, and refer older adult patients based on their fall risk. Educational materials specifically designed for older adults and their friends and family are also included. See the complete list of materials included in the STEADI Tool kit.

Appendix B: State Health Improvement Plan Evidence Based Strategies Alignment

The following is more detail about the alignment between the Greene County Community Health Improvement Plan (CHIP) and the Ohio Department of Health (ODH) State Health Improvement Plan (SHIP). More information on alignment requirements for Local Health Departments (see, "Local Planning Guidance") and the SHIP document (see, "Ohio 2017-19 State Health Improvement Plan") can be found here: https://www.odh.ohio.gov/en/odhprograms/chss/HealthPolicy/ship/State-Health-Improvement-Plan.

	Greene County CHIP	**ODH SHIP**
Priority Topic:	Maternal & Child Health	Maternal and Infant Health
Priority Outcome:	Increase first trimester prenatal care	Total preterm births
Priority Outcome Indicator:	Percent of live births receiving first trimester prenatal care	Percent of live births that are preterm: <37 weeks gestation (Vital Stats, ODH)
Priority Topic:	Mental Health & Substance Abuse	Mental Health and Addiction
Priority Outcome:	Reduce unintentional drug overdose deaths	Reduce unintentional drug overdose deaths
Priority Outcome Indicator:	Unintentional drug overdose deaths per 100,000 population (age-adjusted)	Number of unintentional deaths due to drug overdoses per 100,000 population (age adjusted)

Cross – Cutting Factors	Evidence-Based Strategy	Related Indicator	Lead Entity
Healthcare System & Access	Preconception Education Intervention	Preconception Planning - health improvement	Greene County Public Health
Public Health & Prevention	Integrate public health data and healthcare system clinical data	ODH Unintentional Drug Overdose Deaths and EpiCenter Alerts	Greene County Public Health

The following are the evidence based strategies presented in the State Health Improvement Plan Community Strategy and Indicator Toolkits that are currently being implemented in Greene County. The lead entities represent local organizations. This information is based on the knowledge of Greene County Public Health and after consultation with community stakeholders. The associated indicators from the Ohio Department of Health are listed for comparative purposes for future consideration of potential community level data that could be collected or obtained.

Cross Cutting Factor: Social Determinants of Health		
Evidence-Based Strategy	**ODH Identified Related Indicator**	**Lead Entity**
Early Childhood Education	Kindergarten Readiness Preschool Enrollment	Council on Rural Services
Early Childhood Home Visiting	Child abuse and neglect Kindergarten Readiness Home Visiting During Infancy	Greene County Public Health – Help Me Grow
Home Improvement Loans and Grants	Adult depression	People Working Cooperatively
Service Enriched Housing	Severe Housing Problems High Cost housing Access to housing assistance	Greene Metropolitan Housing, Community Action Partnership: Homeless Crisis Response Program
Vocational Training for Adults	Household income Unemployment Labor force participation	Greene County Career Center, Ohio Means Jobs
Transitional Jobs	Household income Unemployment Labor force participation	Community Action Partnership, Harding Place Transitional Housing Program
Community- scale urban design land use policies and Streetscape design (Complete Streets)	Physical inactivity (adult) Insufficient physical activity (adult) Physical inactivity (youth)	Miami Valley Regional Planning Commission

Cross Cutting Factor: Social Determinants of Health		
Evidence-Based Strategy	**ODH Identified Related Indicator**	**Lead Entity**
Bike and Pedestrian Master Plans	Physical inactivity (adult) Insufficient physical activity (adult) Physical inactivity (youth) Alternative commute modes Driving alone to work	Miami Valley Regional Planning Commission
Greene Spaces and Parks	Physical inactivity (adult) Insufficient physical activity (adult) Physical inactivity (youth) Access to exercise opportunities	Greene County Parks & Rec, City Parks Departments and City Planners
Smoke-free environments (Smoke-free policies for indoor areas, smoke-free policies for outdoor areas and smoke-free policies for multi-unit housing)	Children exposed to secondhand smoke at home Adolescents exposed to secondhand smoke Adults exposed to secondhand smoke — all environments Adults exposed to secondhand smoke at home Tobacco-free policies enacted Adult smoking Youth all-tobacco use	Greene County Public Health
Breastfeeding Promotion Programs	Breastfeeding information Ever breastfed Breastfed at 6 months Breastfed at discharge from hospital Exclusively breastfed at discharge from hospital	WIC Peer Supporters – Greene County Public Health

Cross Cutting Factor: Public Health & Prevention		
Evidence-Based Strategy	**ODH Identified Related Indicator**	**Lead Entity**
Preconception Education Intervention	Preconception planning—birth control Preconception planning—health improvement Preconception planning—healthy weight Preconception planning—medical conditions	Greene County Public Health (2017 CHIP Strategy)
Increase Awareness of the full-range of efficacy-based contraceptive options including LARC	Inter-pregnancy intervals	Five Rivers Health Center Greene County
Positive Behavioral Interventions and Support programs	School behavior problems Third grade reading School engagement	PAX Good Behavior Game – Greene County Educational Service Center
School-based social and emotional instruction	School behavior problems Social-emotional skills	Kernels for Life – Wright State University
School-based violence prevention programs	Physical fighting (youth) Unsafe at school Electronic bullying Bullying at school Sexual dating violence Physical dating violence	School Dating and Domestic Violence Prevention Education Program - Family Violence Prevention Center Anger Management, Stress Management, & Anti-bullying – Family Solutions Center

Cross Cutting Factor: Public Health & Prevention		
Evidence-Based Strategy	**ODH Identified Related Indicator**	**Lead Entity**
School-based alcohol/other drug prevention programs including youth-led prevention	Youth alcohol use (past 30 days) Youth marijuana use (past 30 days) Youth non-prescribed prescription drug use (past 30 days) Illicit drug use (past 30 days), ages 12+ Youth perceived risk marijuana Youth perceived risk of alcohol Youth perceived risk of cigarette smoking Youth perceived parental disapproval of smoking, alcohol and marijuana Youth perceived peer disapproval of smoking, alcohol and marijuana	Youth-Led Prevention, Alcohol Literacy Challenge, Strengthening Families 10-14, and Risky Business - Greene County Educational Service Center
Universal school-based suicide awareness and education	Suicide deaths Suicide ideation (youth)	Mental Health: Suicide Prevention and Education (teachers and students) – Family Solutions Center
Suicide crisis hotlines and cell phone-based support programs (including text “4hope”)	Suicide deaths (priority outcome)	TCN Behavioral Health
Additional strategies from Ohio’s 2016-2017 Suicide prevention Plan (OMHAS)	Suicide deaths Suicide ideation (adult) Suicide ideation (youth) Suicide help seeking	QPR (Question, Persuade, and Refer) Trainings – Greene County Educational Service Center, TCN Behavioral Health, Mental Health and Recovery Board of Clark, Greene and Madison Counties, NAMI Clark, Greene and Madison Counties

Cross Cutting Factor: Public Health & Prevention		
Evidence-Based Strategy	**ODH Identified Related Indicator**	**Lead Entity**
Community Gardens	Vegetable consumption (adult)	Maintained by various government and community organizations based on community – data kept by Greene County Public Health MCHP Nutrition & Physical Activity Partnership
Healthy food initiatives in food banks	Food insecurity Fruit consumption (adult) Vegetable consumption (adult) Fruit consumption (youth) Vegetable consumption (youth)	Various structures based on community and vendor providing food – Food Council Ohio State University Extension, Greene County
Farmers' Markets/Stands	Fruit consumption (adult) Vegetable consumption (adult) Fruit consumption (youth) Vegetable consumption (youth)	Farmers Markets are randomly in all counties - – Food Council Ohio State University Extension, Greene County (most informed)
WIC and senior farmers' market nutrition programs	Fruit consumption (adult) Vegetable consumption (adult) Fruit and vegetable consumption among young children	WIC – Greene County Public Health Seniors - GCCOA
SNAP infrastructure at farmers' markets/EBT payment at farmers' markets	Fruit consumption (adult) Vegetable consumption (adult) Fruit consumption (youth) Vegetable consumption (youth)	Food Council Ohio State University Extension, Greene County

Cross Cutting Factor: Public Health & Prevention		
Evidence-Based Strategy	**ODH Identified Related Indicator**	**Lead Entity**
Shared use (joint use agreements)	Access to exercise opportunities Physical inactivity (no leisure time physical activity) (adult) Insufficient physical activity (adult) Physical inactivity (youth)	Greene County Public Health MCHP Nutrition & Physical Activity Partnership
Activity Programs for Older Adults	Physical inactivity (no leisure time physical activity, adult) Insufficient physical activity (adult)	Parkinson's Disease Movement Classes, Yoga, Tai Chi – Greene County Council on Aging Senior Fitness Programs – Fairborn/Xenia YMCA Various Senior Center Programs
Community Fitness Programs	Access to exercise opportunities Physical inactivity (no leisure time Physical activity) (adult) Insufficient physical activity (adult)	Various Zumba, Tai Chi, and Yoga Classes Offered
Mass-reach communications	Adult smoking Youth all-tobacco use Quit attempts (adults)	Quit Line Promotion, ODH advertising, CDC Tips campaign - Greene County Public Health
Links to Cessation Support	Quit attempts (adults)	Community Cessation Classes Partner – Greene County Public Health

Cross Cutting Factor: Healthcare System & Access		
Evidence-Based Strategy	**ODH Identified Related Indicator**	**Lead Entity**
Health Insurance Enrollment & Outreach	Uninsured adults Uninsured children Out-of-pocket spending	Greene County Department of Job & Family Services
Monitor Implementation of Behavioral Health Parity Legislation	Unmet need- mental health (adult) Unmet need- mental health (youth) Unmet need- illicit drug use treatment (12+)	Mental Health and Recovery Board of Clark, Greene and Madison Counties
Improve Access to Comprehensive Primary Care	Medical home, children Unable to see doctor due to cost Without usual source of care Potentially avoidable emergency department visits for Medicare	Five Rivers Health Center Greene County
Trauma – informed health care	Depression screening Adult depression (major depressive episode) Adolescent depression (major depressive episode) Suicide ideation (adult) Suicide ideation (youth) Suicide deaths	Mental Health and Recovery Board of Clark, Greene and Madison Counties

Cross Cutting Factor: Healthcare System & Access		
Evidence-Based Strategy	**ODH Identified Related Indicator**	**Lead Entity**
Increased use of Medication-Assisted Treatment (MAT) and continuing education for primary care and substance use disorder providers regarding drug use/ dependence screening tools, MAT and other evidence-based treatments for drug dependence	Drug dependence or abuse Unintentional drug overdose deaths	TCN Behavioral Health
Naloxone access, including training on identification of overdose and use of Naloxone to all appropriately licensed first responders and community providers, including libraries, transit, emergency shelter and food providers, etc.	Naloxone community distribution sites Naloxone pharmacy distribution sites	Greene County Public Health
Cultural competence training for healthcare professionals, with a focus on behavioral health professions	Cultural understanding and skills	Greene County Educational Services Center & Wright State University
Integrate public health data and healthcare system clinical data (e.g. link Vital Statistics data with other data systems)	N/A	Greene County Public Health (2017 CHIP Strategy)
Intensive tobacco cessation services for people with behavioral health conditions	Tobacco use among adults with behavioral health condition	TCN Behavioral Health
Cessation Services for pregnant women and people of childbearing age	Smoking during pregnancy Tobacco before pregnancy Tobacco use in last 3 months of pregnancy	Baby & Me Tobacco Free – Greene County Public Health

The following are strategies indicated by ODH that are not occurring in Greene County. Strategies specific to asthma, suicide and depression were not included due to their lack of inclusion in the priority discussion based on the Community Health Assessment data. Following the table, there is a section specific to the strategies that would be implemented by physicians or medical professionals. Limitation of the Community Health Improvement Plan include the lack of involvement of physicians and educators in the process. It is identified as an area that will be improved through work with the Greene County Medical Society and the regional exploration into expanding school based surveys such as the Youth Risk Behavior Survey.

Evidence-Based Strategies

School-based health centers https://www.thecommunityguide.org/findings/promoting-health-equity-through-education-programs-and-policies-school-based-health-centers and centers that include: Multi- tiered Systems of Support http://www.sst13.org/home/multi-tiered-system-of-supports/

Earned income tax credits (local option: outreach to increase uptake) http://www.cdc.gov/policy/hst/hi5/taxcredits/index.html

Public building sitting considerations https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448000 /

School-based physical activity programs and policies:
Safe routes to school, active recess, physically active classrooms, school-based physical education, extracurricular activities for physical activity (see toolkit for links, https://www.odh.ohio.gov/-/media/ODH/ASSETS/Files/chss/ship/CommunityToolkitMIH02082017.pdf?la=en_)

School- based nutrition programs and policies: School breakfast programs, competitive pricing for healthy food, school-based nutrition education programs (see toolkit for links, https://www.odh.ohio.gov/-/media/ODH/ASSETS/Files/chss/ship/CommunityToolkitMIH02082017.pdf?la=en_)

Nutrition and physical activity interventions in preschool/child care http://www.countyhealthrankings.org/policies/nutrition-and-physical-activity-interventions-preschool-child-care

Healthy food in convenience store http://www.countyhealthrankings.org/policies/healthy-food-convenience-stores

Competitive pricing – fruit and vegetable incentive programs http://www.countyhealthrankings.org/policies/competitive-pricing-healthy-foods

Social support interventions for physical activity in community settings https://www.thecommunityguide.org/findings/physical-activity-social-support-interventions-community-settings

Individually – adapted health behavior changes programs https://www.thecommunityguide.org/findings/physical-activity-individually-adapted-health-behavior-change-programs

Community-wide physical activity campaigns https://www.thecommunityguide.org/findings/physical-activity-community-wide-campaigns

Increasing the price of tobacco products https://www.cdc.gov/policy/hst/hi5/tobaccointerventions/index.html

Evidence-Based Strategies (Continued)

Policies to decrease availability of tobacco products
http://tobaccocontrolnetwork.org/wp-content/uploads/2016/07/TCN-2016-Policy-Recommendations-Guide.pdf

Community Health Workers
http://www.countyhealthrankings.org/policies/community-health-workers

Pathways Community HUB
https://innovations.ahrq.gov/qualitytools/connecting-those-risk-care-quick-start-guide-developing-community-care-coordination

Progesterone Treatment
http://www.countyhealthrankings.org/policies/synthetic-progesterone-17p-access

Screening, brief intervention and referral to treatment
http://www.integration.samhsa.gov/clinical-practice/sbirt

Physician and Medical Professional Specific Strategies

Maternal & Infant Health

- Provider counseling with patients about preconception health and reproductive life plans http://www.countyhealthrankings.org/policies/preconception-education-interventions & http://www.countyhealthrankings.org/policies/reproductive-life-plans
- Comprehensive contraceptive options (includes provider reimbursement, removing administrative and
- logistical barriers, unbundling payments to allow for immediate post-partum insertion of LARC) http://www.cdc.gov/sixeighteen/pregnancy/index.htm
- Cultural competence training for healthcare professionals http://www.countyhealthrankings.org/policies/cultural-competence-training-health-care-professionals

Mental Health & Addiction

- Integrate information about drug use and dependence screening and treatment in primary care
- Curriculum
- Provider training on opioid prescribing guidelines and use of OARRS (Prescription Drug Monitoring Program) http://www.countyhealthrankings.org/policies/prescription-drug-monitoring-programs-pdmps
- Behavioral Health Workforce Pipeline Program

Chronic Disease

Prediabetes screening

- Prediabetes Screening and Referral http://www.cdc.gov/sixeighteen/docs/6-18-evidence-summary-diabetes.pdf, Prediabetes Risk Assessment http://www.diabetes.org/are-you-at-risk/diabetes-risk-test/ , Prevent Diabetes STAT Toolkit https://preventdiabetesstat.org/index.html

Hypertension management

- Hypertension Screening and Follow Up, Management, Improved access and adherence of antihypertensive meditations and Team-based approach to controlling hypertension http://www.cdc.gov/sixeighteen/bloodpressure/index.htm

Physician and Medical Professional Specific Strategies (Continued)

Referral and follow up to increase patient use of community-based nutrition and physical activity resources:

- Nutrition prescriptions - http://www.countyhealthrankings.org/policies/nutrition-prescriptions
- Prescription for physical activity - http://www.countyhealthrankings.org/policies/prescriptions-physical-activity
- Food insecurity screening and referral - http://www.aappublications.org/content/early/2015/10/23/aapnews.20151023-1

All Areas

Higher education financial incentives for health professionals serving underserved areas (such as tuition reimbursement and loan repayment programs)
http://www.countyhealthrankings.org/policies/higher-education-financial-incentives-health-professionals-serving-underserved-areas

Health career recruitment for minority students (can also include rural/Appalachian regions of the state and other underrepresented population groups):
http://www.countyhealthrankings.org/policies/health-career-recruitment-minority-students

Appendix C: Community Survey (Greene County Fair)

58 Total Respondents

1. Are you a Greene County Residents
   - ***57 Greene Co.***
   - 1 Not Greene County (responses removed from analysis)

2. What is the biggest health issue in Greene County? (Chronic Disease, Mental Health & Substance Abuse, Maternal & Child Health, Injury Prevention, Other)

   39 Mental Health and Substance Abuse
   6 Chronic Disease
   5 Chronic Disease & Mental Health and Substance Abuse
   2 Mental Health & Substance Abuse and Maternal & Child Health
   1 Chronic Disease and Maternal & Child Health
   2 Selected All
   2 Other:
   - Heroin
   - Alzheimer's Awareness

3. What could be done to improve it? (43 Total Comments)

   Education -16
   Enforcement/Punishment - 6
   Rehab -3
   Religion -2
   Access - 6

   No Narcan – 2
   I Don't Know – 1
   No Drugs - 1
   Chronic Disease (mixed comments) – 6

Detailed Responses to #3, "What could be done to improve it?"

Education - 16

- Continue education programs
- Education, small group approach to educating public
- Way too many people smoke and overweight. Need some education in Greene county's cities more often and incentives to get healthier. I'm sure chronic disease is the biggest issue for these reasons.
- More education
- Education
- Education
- "that's the big question! Education opportunities
  Stricter law enforcement"
- Education in schools at early age and ongoing
- Education and stricter law enforcement
- More community outreach by org with mental health programs & education
- Education at the middle school level, 2. Hotline-local-to get help info fear of prosecution, 3. Repeat offenders required sober program while incarcerated

- Early intervention?
- Most people w/ substance abuse problems end up with kids so if we talk to the kids more we might be able to stop substance abuse
- More people to care more dr to get on board. Also what goes on in school on bullying. This has to stop
- Making more awareness working closely with families that have children who are bullied and adults both texting and Facebook and personal. Also stalkers who stalk and start trouble with good people on phones, computers, etc.

Enforcement/Punishment – 6

- More drug enforcement
- Harder punishment by law enforcement
  Stricter punishment
- "that's the big question! Education opportunities
  Stricter law enforcement"
- Education and stricter law enforcement
- More police
- No 2nd or 3rd chances with drugs

Rehab – 3

- Don't know what to do w/drugs and people on them, but maybe more rehab.
- More rehab places and more help for those who have no way to pay
- Increasing support groups and addressing the poverty situation in the u.s.

Religion – 2

- Have doctors not give out so many pills for pain. My husband had surgery and they gave him Percocet 60 pills and he only took 1 so he had to destroy 59 pills - if people think they need to take all of them they get addicted. Also teach creation in schools and not evolution.
- Preach the word of god

Access – 6

- Easier access to counseling and doctors
- Easy access to mental health programs and not expensive or free
- More programs for mentally ill individuals
- Need more help and stuff like that
- More immediate help for addicts then they are ready to make a change & not have to wait months for referral
- Help those reach out have safe spots especially for dv victims they go through so much and just want loved

No Narcan – 2

- No narcan!! Waste and money and resources
- Stop giving narcan out like candy

I Don't Know – 1

No Drugs – 1

Chronic Disease – 6

- scholarships to ymca or programs for low income families to exercise together
- get rid of fast food!
- education, small group approach to educating public
- healthy environments, healthy food choices, but most importantly, more jobs and better paying jobs

- more green space for exercise
- way too many people smoke and overweight. Need some education in greene county's cities more often and incentives to get healthier. I'm sure chronic disease is the biggest issue for these reasons.

Appendix D: Quarterly Reporting Survey

Each coordinating entity that represents the workgroups completes the following online survey to report on progress for each CHIP priority and the associated activities.

1. Select the reporting quarter (select the option that ends with the current month, for example January - March is reported in March)

- January - March
- April - June
- July - September
- October – December

2. Select the CHIP priority that you * are reporting on.

- Chronic Disease (Obesity)
- Mental Health and Substance Abuse (Overdose)
- Maternal & Child Health (Prenatal Care)
- Injury Prevention (Falls)

Note: Based on the answer question #3, the respondent is presented with a strategy and asked to select not started, in progress or completed for each activity associated with the strategy.

3. Please provide a brief summary of activities initiated/completed toward strategy implementation during this reporting period. If no progress has been made on the strategy implementation, please describe the reason.

4. Please describe any major successes that have been recorded while implementing activities associated with this objective during this reporting period. Successes could be acquisition of funding or other resources, recognition for efforts, documented successes, or other important achievements associated with the work being done toward this CHIP objective.

5. Please describe any barriers or challenges that have affected the successful implementation of activities associated with this objective. If there are barriers or challenges reported, please also describe efforts taken to address these barriers/challenges.

6. Please outline any collaborative efforts or partnerships that have been developed in an effort to implement activities associated with this objective. List partner agencies, organizations, etc. and briefly describe the role they play in the strategy's implementation.

7. What is the overall status of progress on addressing the CHIP priority?

- No Progress
- In Progress
- Completed