Public Health
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Greene County

COMMUNITY HEALTH IMPROVEMENT PLAN

2020-2022

ABSTRACT

This is a companion document to the Community Health Assessment, which resulted in the selection of strategic 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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Acknowledgements

The dedication, expertise, and leadership of the following agencies made the 2020 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
Beavercreek Township Board of Trustees
City of Xenia
Clark State Community College
Dayton Children's Hospital
Family and Children First Council
Greene CATS Public Transit
Greene County Board of County Commissioners
Greene County Board of Developmental Disabilities
Greene County Council on Aging
Greene County Job and Family Services
Greene County Educational Service Center
Greene County Emergency Management Agency
Greene County Housing
Greene County Parks & Trails
Greene County Public Health
Greene Memorial Hospital & Soin Medical Center
Layh & Associates, Inc.
Mental Health & Recovery Board of Clark, Greene & Madison Counties
Ohio State University Extension
TCN Behavioral Health Services
United Way of the Greater Dayton Area
Village of Yellow Springs

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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 August of 2019 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:

Obesity

Substance Use Disorders

Preventative Health Services

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 objectives, strategies and actions will be implemented, monitored and evaluated over the next three years.

In developing this health improvement plan, lead agencies were established for the three priorities. These leaders 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, strategy leads will report on implementation efforts quarterly beginning in 2021. 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 restarted the Mobilizing through Planning and Partnership (MAPP) process in August of 2019 by bringing together the existing Growing Healthy Together Greene County (GHTGC) committee that represent 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 focuses on two parts of the MAPP process:

- Organize for Success
- Community Health Status Assessment

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

- Review of Vision and Values
- Stakeholder Assessments: Forces of Change & Local Public Health System
- Community Assessment: Community Themes & Strengths
- Identify Priorities
- Formulate Goals & Strategies
- Action Cycle (Plan, Implement & Evaluate)

To accomplish the steps of the MAPP process for the CHIP this year, we utilized various forms of virtual communication. These included online surveys, virtual meetings and emails to gain information and make decisions. This action is based on the coronavirus (COVID 19) pandemic

but it has allowed for various levels of involvement and a display of continued dedication to this work during a difficult time. The following actions contributed to the process:

- April 21,2020: The final data collection and information for the CHA was presented virtually to the GHTGC committee. This presentation was conducted by the Hospital Council of Northwest Ohio who assisted with the CHA process and writing the report. At the conclusion of the presentation, all stakeholders in the committee were invited to complete a survey by weeks end to select priorities based on the data provided including a draft of the report. Survey results were included in the report.

- May 8, 2020 – May 22,2020: GHTGC committee members were sent a Stakeholder Survey which included a review of the 2017-2019 CHA/ CHIP vision and values (which was approved without revision and is listed on page 3 above), answer questions regarding the forces of change which include factors such as legislation, technology, and other impending changes that affect how the public health system operates and finally questions regarding the local public health system which includes an analysis of how entities contribute to the essential services provided by the local public health system.

  During this same timeframe (May 8th – May 22nd) a Community Survey which focused on community themes and strengths was conducted. This was shared with partners via email and shared on social media. The goal of this survey is to ask questions to determine what the community feels is important regarding health.

- June 9, 2020 – June 19, 2020: All stakeholders of the GHTGC committee were emailed a document that listed circles of involvement which outlines descriptions of how they would like to engage in the CHIP process. The majority of members responded and a gap existed in the core circle which would participate in strategy selection. To fill this gap the Community Roots Coalition which led some great work in the 2017-2019 CHA/CHIP cycle was asked to fill the core circle role with additional participants from GHTGC.

- July 20, 2020: The Community Roots Coalition met and reviewed all assessments of the MAPP process (community health status assessment (this data makes up the CHA), forces of change, local public health system assessment and community themes and strengths). Based on this information and the priorities selected by the GHTHC steering committee the group worked through the end of July and into part of August via email to determine strategy selection based on priorities based on the data.

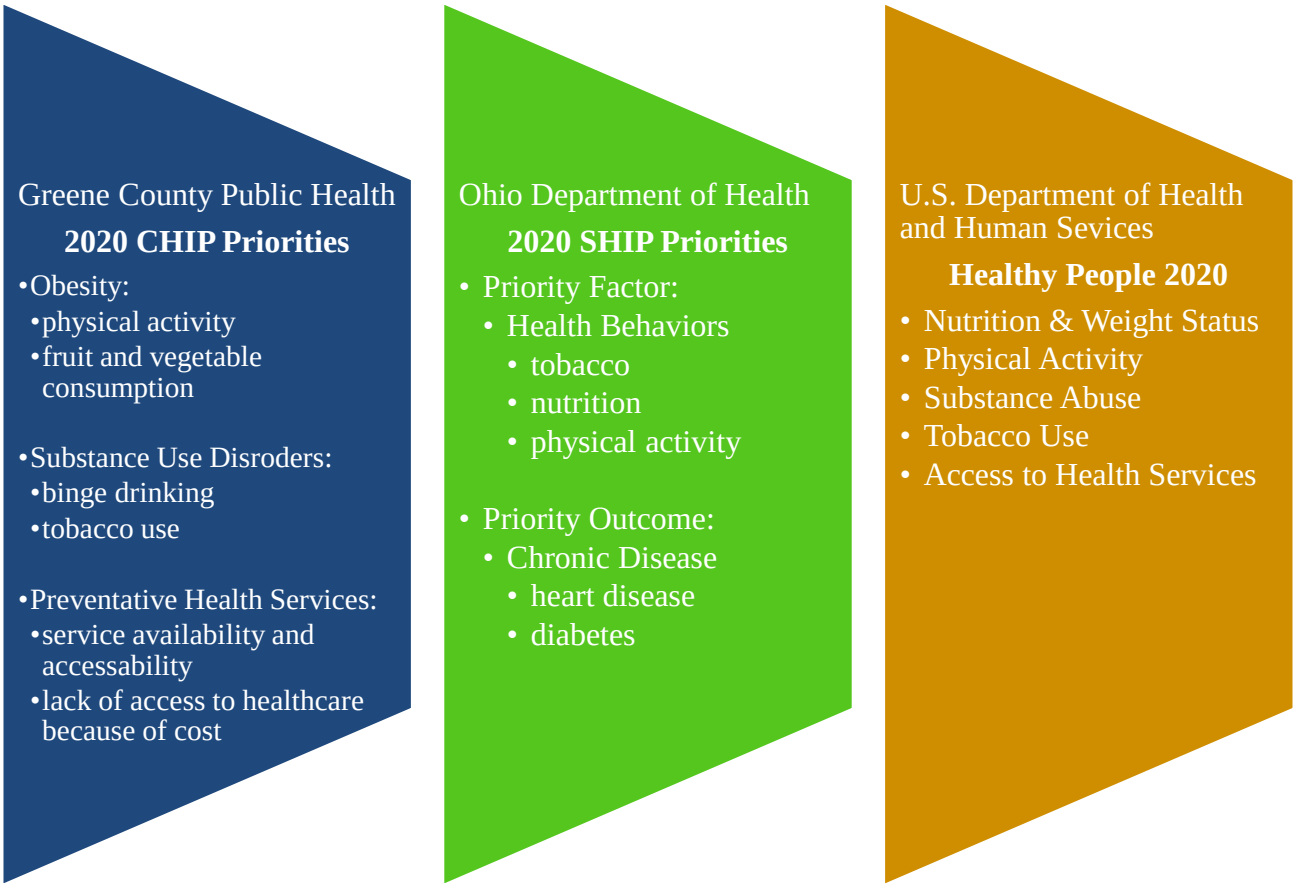
- August 2020: A draft of the CHIP was sent to the Community Roots Coalition for Feedback.

- September 2020: A second draft was sent to GHTGC for feedback.

- October 2020: Final CHIP submitted to Greene County Board of Health for approval.

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 Ohio Department of Health State Health Improvement Plan (SHIP) and U.S. Department of Health and Human Services Healthy People 2020 focus areas. The Ohio Department of Health (ODH) provided guidance to local health districts for alignment with the SHIP priorities and evidence-based strategies. The following graphic outlines the specific areas of alignment.



Priority Selection

Data highlights from the 2020 CHA for consideration:

Obesity:

- 63% of Greene County adults were overweight or obese based on body mass index (BMI)
- 17% of adults did not participate in any physical activity in the past week
    - Including 1% who were unable to exercise

Nutrition:

- In 2019, 32% of adults ate 1 to 2 servings of fruits and/or vegetables per day, 49% ate 3 to 4 servings per day, and 17% ate 5 or more servings per day. Two percent (2%) of adults ate no servings of fruits and vegetables per day.

Alcohol Consumption:

- 66% of Greene County adults had at least one alcoholic drink in the past month, increasing to 75% of those with incomes more than $25,000
- 22% of adults were binge drinkers
- 32% of current drinkers were binge drinkers

Cholesterol, blood pressure:

- 30% were diagnosed with high blood pressure
- 37% were diagnosed with high blood cholesterol

Adverse childhood experiences (ACEs,) are potentially traumatic events that occur in childhood (0-17 years):

- 12% of Greene County adults had four or more adverse childhood experiences (ACEs) in their lifetime. Thirteen percent

Poverty:

- 12.7% individuals, 8.2% families
- 13% of adults had experienced at least one issue related to hunger/food insecurity in the past year.

Access CHA Here: http://www.gcph.info/files/resources/Community_Health_Assessment.pdf

In the 2020 CHA, focus groups occurred in four communities and the following priorities were selected by community members:

Xenia and Yellow Springs	Jamestown, Bowersville, Cedarville and New Jasper	Fairborn and Beavercreek	Bellbrook and Spring Valley
• Drug Issues • Recreation Opportunities • Food Deserts and Food Insecurity • Chronic Disease	• Drug and Addiction • Mental Health	• Drug Use • Mental Health • Cost of Health Care • Prevention • Nutrition • Opportunities for Exercise • Safety • Built Environment • Homeless	• Drug Issues • Immunizations • Mental Health • Accessibility

After the April 21st release of the 2020 CHA, stakeholders were asked in a survey, "**Based on the Community Health Needs Assessment, what health topics do you see as the most important? Please list 2 or more choices.":**

- Obesity/physical activity/nutrition (7)
- Mental health/suicide (4)
- Alcohol/substance use (3)
- Preventive health/screenings (3)
- Binge drinking (2)

From May 8th – May 22nd the Community Themes and Strengths survey was conducted virtually. There were 43 respondents who identified five themes for the health of the community to address and consider:

- Healthcare
- Access to services
- Income Disparity
- Community Connectedness
- Organizations

During the same time, May 8th – May 22nd, stakeholders were asked to complete another survey which addressed Visioning, Forces of Change and the Local Public Health System. Twenty-three stakeholders complete the survey and the following results emerged:

- **Visioning** (approval to keep the vision and values the same):
    - Vision: A vibrant health-conscious community concerned with preserving the environment, where all people are informed, have an equitable opportunity and are empowered to access what they need to be healthy.
    - Values: Collaboration, Inclusivity, Environment and Resiliency
- **Forces of Change:**
    - COVID 19 (Socioeconomic Impact & Pandemic Resurgence)
    - Opportunity for Collaboration
    - Funding changes impact community
    - Policies can benefit community and business
    - Policies can harm community and vulnerable populations
    - Changing policies is up to the Government and agencies
- **Local Public Health System Assessment:**
    - Main area in need of development is Essential Service 5 which addresses the development of policies and plans that support individual and community health efforts.

The following themes emerged from the surveys:

4 CHA Community Focus Groups (10/16/19 & 10/17/19)	CHA Stakeholder Priorities (4/21/20)	CHIP Community Themes and Strengths (5/8/20 – 5/22/20)	CHIP Stakeholder Forces of Change (5/8/20 – 5/22/20)
Priority health topics Greene County should work to address or prevent • Drug Issues, use, addiction (4/4) • Mental Health (3/4) • Recreational opportunities, opportunities for exercise, built environment (2/4) • Food deserts and insecurity, nutrition (2/4)	**Based on the Community Health Needs Assessment, what health topics do you see as the most important? Please list 2 or more choices.** • Obesity/physical activity/nutrition (7) • Mental health/suicide (4) • Alcohol/substance use (3) • Preventive health/screenings (3) • Binge drinking (2)	**Themes:** • Healthcare • Access to services • Income disparity **Strengths:** • Community Connectedness • Organizations	• COVID 19 (Socioeconomic Impact & Pandemic Resurgence) • Opportunity for Collaboration • Funding changes impact community • Policies can benefit community and business • Policies can harm community and vulnerable populations • Changing policies is up to the Government and agencies

After review of data collected from the community and stakeholders, the following format for priorities was proposed to the Community Roots coalition, who has been tasked with leading the CHIP work. Feedback at the July 20th meeting led to selection of leads and strategies to address the priorities identified: obesity, substance use disorders and preventative health services.

Priorities	Obesity	Substance Use Disorders	Preventative Health Services
Personal Health	Physical Activity* Fruit & Vegetable Consumption	Binge Drinking Tobacco Use*	Lack access to healthcare because of cost (inequity) Service availability and accessibility
Contributing Factors	Lack motivation for physical activity Food insecurity (inequity) Diabetes* Adverse Childhood Experiences (inequity)*	Adverse Childhood Experiences (inequity)* Stress Poor mental health	Health Insurance Coverage* Health Literacy (inequity)

*State Health Improvement Plan Alignment

Addressing inequity is very important to this work. Items noted with inequity above have been identified based on CHA data. The following table notes three priority populations based on data collected. It is important to also note that racial inequity will also be addressed in strategy implementation, although our data was not representative of all racial groups.

Age 65+	Age < 30	Income < $25,000
14% had been diagnosed with COPD, emphysema, or chronic bronchitis 17% had been diagnosed with diabetes 37% were most likely to rate their physical health as not good	9% had used recreational marijuana or hashish in the past six months 33% needed help meeting their general daily needs 54% were most likely to rate their mental health as not good	13% had used recreational marijuana or hashish in the past six months 14% had been diagnosed with COPD, emphysema, or chronic bronchitis 17% had been diagnosed with diabetes 21% of the adult smokers 23% experienced 4 or more ACEs 44% needed help meeting their general daily needs 49% were most likely to rate their mental health as not good 54% were most likely to rate their physical health as not good

In selecting priority leads and strategies, it was important to review existing work for alignment and the willingness and ability of agencies to partner in this work. Strategies selected come from a variety of sources of evidence base, promising practice and innovation. Appendix A outlines workplans with performance measures and objectives specific to each priority that will be updated quarterly.

Priority	Lead	Strategy
Obesity	Public Health J. Drew OSU Extension L. Halladay OSU Extension T. Corboy	Physical Activity: Community-Wide Campaign* Dining with Diabetes: Beyond the Kitchen On-line self-paced course information: https://fcs.osu.edu/BTK Healthy food initiatives in food banks Ohio Ag Program: http://ohiofoodbanks.org/programs/program-detail.php?id=3&page=10*
Substance Use Disorders	Students Against Destructive Decisions (SADD) T. Carper Public Health K. Williams OSU Extension R. Supinger	Alcohol Brief Interventions Smoke-Free Policies Indoor Places* Mental Health First Aid*
Preventative Health Services	Layh & Associates A. Poortinga TBD	Greene County Mental Health Collaborative Telemedicine

*State Health Improvement Plan Alignment

Conclusion and Plan Sustainability

So far, 2020 has been a very challenging year in our community, nation and world. It is important that we keep in mind that there is a need to be flexible in how we address the CHIP work going forward. As lives are impacted by the global pandemic from all facets of socioeconomics, public health has a major role to play. The entire local public health system has an opportunity to serve now more than ever. Engaging new partners will be essential to the work outlined and acknowledging that there may be a time of adjustment to the heavily virtual world which will present new challenges and opportunities. Partnerships in Greene County have always been critical to the positive health outcomes and health improvement.

As we enter 2021, the Community Roots Coalition will be the lead in this work and will convene at least quarterly to update progress on the work outlined. Bi-annual meetings of the full Growing Healthy Together Greene County Steering Committee will be established to allow for full feedback for improvement. Annual updates to this plan will also be provided in the fall of each year beginning in 2021.

Definitions[2]

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.[3]

[2] 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

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

Appendix A: Workplans 2020-2021

Priority 1: Obesity

CHA Data Point(s)/ Indicators:	Objective(s):	Measurable Outcome(s)	Strategy	Lead
• 63% of Greene County adults were overweight or obese based on body mass index (BMI) • 17% of adults did not participate in any physical activity in the past week o Including 1% who were unable to exercise	• HP2020 Increase the proportion of adults who are at a healthy weight	• Number of campaign activities • Number of campaign participants	Physical Activity: Community-Wide Campaign*	Public Health J. Drew
• 32% of adults ate 1 to 2 servings of fruits and/or vegetables per day, 49% ate 3 to 4 servings per day, and 17% ate 5 or more servings per day. Two percent (2%) of adults ate no servings of fruits and vegetables per day.	• HP2020 Increase the contribution of fruits to the diets of the population aged 2 years and older • HP2020 Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older	• Number of participants	Dining with Diabetes: Beyond the Kitchen On-line self-paced course information: https://fcs.osu.edu/BTK	OSU Extension L. Halladay
		• Lbs. of food donated	Healthy food initiatives in food banks Ohio Ag Program: http://ohiofoodbanks.org/programs/program-detail.php?id=3&page=10*	OSU Extension T. Corboy

Priority 2: Substance Use Disorders

CHA Data Point(s)/ Indicators:	Objective(s):	Measurable Outcome(s)	Strategy	Lead
• 66% of Greene County adults had at least one alcoholic drink in the past month, increasing to 75% of those with incomes more than $25,000 • 22% of adults were binge drinkers • 32% of current drinkers were binge drinkers	• HP2020 Reduce the proportion of persons engaging in binge drinking during the past 30 days—adults aged 18 years and older	• Number of activities • Number of participants	Alcohol Brief Interventions	Students Against Destructive Decisions (SADD) TBD
• Adverse childhood experiences (ACEs,) are potentially traumatic events that occur in childhood (0-17 years): 12% of Greene County adults had four or more adverse childhood experiences (ACEs) in their lifetime.	• HP2020 Increase the proportion of adults with mental health disorders who receive treatment	• Number of trainings • Number of participants	Mental Health First Aid*	OSU Extension R. Supinger
• 10% of Greene County adults were current smokers • 24% of adults were considered former smokers	• HP2020 Reduce tobacco use by adults and adolescence • HP2020 Increase tobacco-free environments in schools, including all school facilities, property, vehicles, and school events	• Quitline utilization • Number of newly implemented tobacco control policies	Smoke-Free Policies Indoor Places*	Public Health K. Williams

Priority 3: Preventative Health Services

CHA Data Point(s)/ Indicators:	Objective(s):	Measurable Outcome(s)	Strategy	Lead
• 30% Rated mental health as not good on four or more days (in the past 30 days) • 17% of adults used a program or service for help with depression, anxiety, or other emotional problem for themselves or a loved one. • Focus Groups: All groups suggested marketing existing programs and services more effectively in order to increase community awareness	• HP2020 Increase the proportion of adults with mental health disorders who receive treatment	• Number of participants	Greene County Mental Health Collaborative	Layh & Associates A. Poortinga
• 38% of adults identified cost as an issue regarding their healthcare coverage • 13% of adults reported there was a time in the past year they needed to see a doctor but could not because of cost o Increasing to 17% of females	• HP2020 Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care	• Client access numbers by client type (consider demographics)	Telemedicine	TBD