COMMUNITY HEALTH IMPROVEMENT PLAN

Shelby County, Ohio

2016-2019

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Executive Summary

In 2015, The Sidney-Shelby County Health Department (SSCHD) joined forces with Wilson Health, Shelby County Family and Children First Council, the Shelby County United Way, City and County officials, Big Brothers Big Sisters, Catholic Social Services, Head Start, the Senior Center, and the YMCA to provide data for the Community Health Needs Assessment (CHNA). This research effort included 16 consumer and 12 agency surveys. Wilson Health collaborated with the Greater Dayton Area Hospital Association to study the secondary data such as top causes of death, health outcomes, substance abuse and health behaviors.

The Sidney-Shelby County Health Department is pleased to present the 2016-2019 Community Health Improvement Plan (CHIP). The CHIP is a community-driven, strategic and measurable work plan. It defines how community partners will come together to address priority health issues identified by the Community Health Assessment. The Health Department along with input from community organizations identified three priority areas for the CHIP. The priority areas identified for Shelby County are:

- Substance abuse
- Access to care
- Chronic disease

Community Health Assessment

A community health assessment (CHA) is a process by which community members gain an understanding of the health concerns and needs of the community. Participation in the survey was voluntary, and care was taken to ensure that respondents' answers were confidential. The steps for conducting the CHA can be found within the Community Health Assessment (available at shelbycountyhealthdept.org). The community health assessment provided information for problem and asset identification, along with policy formulation, implementation, and evaluation. The data regarding demographic information and health outcomes for the residents of Shelby County gathered through the CHA, along with data from other community organizations needs assessments, guided the validation of the three focal health issues that are addressed in the CHIP.

Purpose of Plan

The purpose of this Community Health Improvement Plan is to inform Shelby county residents of goals and strategies for addressing the priority health issues identified in the

Community Health Assessment. Initiated in 2015 this process is part of a broad community initiative to ultimately improve health and quality of life in Shelby County, Ohio. This plan will provide the strategic framework to guide the community to better health and wellness for all residents. It is a broad strategic framework for community health and should be modified and adjusted as conditions, resources and external environmental factors change.

It is important to recognize that multiple factors affect health and there is a dynamic relationship between people and their environments. Where and how we live, work, play and learn are interconnected factors that are critical to consider. That is, not only do people's genes and lifestyle behaviors affect their health, but health is also influenced by more upstream factors such as employment status and quality of housing stock. The social determinants of health framework addresses the distribution of wellness and illness among a population; its patterns, origins, and implications.

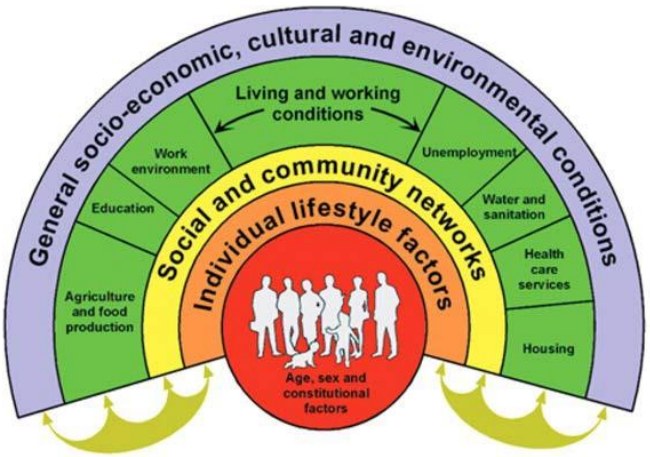

Figure 1: Social Determinants of Health
Source: *National Association of County & City Officials*

Relationship between CHIP and other Guiding Documents

The CHIP does not replace or supersede any concurrent action planning document produced by SSCHD or any of their community partners. It was designed to complement and build upon guiding documents, plans, and coalitions developed to shape the public health of the Shelby County community. Sidney-Shelby County Health Department does not own the process and is not the sole organization responsible for CHIP implementation.

Vision and Values

The Sidney-Shelby County Health Improvement Plan officially adopted a vision statement that

provides a shared picture of an ideal future. Complementing the vision, the SSCHD identified five core values, which serve as guiding principles.

Vision

SSCHD is a leader and partner in public health, providing education and solutions to help residents reach their full potential. We strive to make our community a healthy place to live, learn, work and play.

Values

The SSCHD commits to:

1. Deliver excellent customer service
2. Respect and care about people
3. Create positive change
4. Be fiscally responsible
5. Do the right thing

Cross-Cutting Factors

There are many factors that shape health outcomes. These factors are cross cutting because they permeate all aspects of Public Health. The priorities chosen include objectives and strategies that address the following factors:

Health Equity: By assuring the equal distribution of opportunity and resources, all people are able to attain the highest level of health. This includes addressing avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities; thus providing all residents the opportunity to make choices that allow them to live a long, healthy life, regardless of income, educational achievement, ethnic background, race gender, age, and place of residence.

Access: All people have timely use of comprehensive integrated and appropriate health services to achieve the best possible health outcome. All residents have access to affordable care, insurance coverage, quality healthcare providers and appropriate transportation.

Prevention: Addresses health problems before they occur rather than after people have shown signs of disease, injury or disability. 7 out of 10 deaths among Americans each

year are from chronic illnesses which are preventable; therefore focusing on prevention in our community will help improve health, quality of life and prosperity (CDC, 2014).

The SSCDH implemented SMART objectives. SMART is a mnemonic acronym giving the criteria to guide project management and objectives. It stands for specific, measurable, attainable, realistic, and time-bound

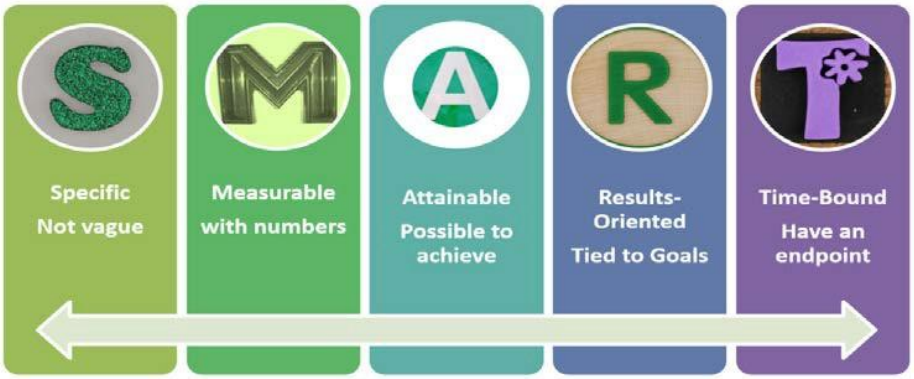

Figure 2: SMART
Source: zoeticamedia.com

Substance Abuse

BACKGROUND:

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, costly, physical, mental and a public health problem.

Problems include:

- Teenage pregnancy
- Communicable Disease
- Aids
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Crime
- Homicide
- Suicide

In Shelby County, substance abuse was mentioned by the focus group, surveyed consumers, surveyed agencies and the health department. Community Health Rankings reported 43 deaths

in 2014 and 49 deaths in 2015 related to drug poisoning. Alcohol-impaired driving deaths increased to 45% in 2015, compared to 37% in 2014.

Priority 1: Increase community outreach regarding substance abuse
Objective 1: Prevent substance abuse through education and awareness
Strategy 1- Provide presentations or events to educate the community on substance abuse
Strategy 2- Develop an education committee with community partners
Objective 2: Distribution of alcohol and drug materials to law enforcement, first responders, healthcare providers and other social service agencies
Strategy 1- Provide Naloxone to police department, sheriff's office and first responders
Strategy 2- Provide education on naloxone administration and other related materials
Objective 3: Collect data regarding substance abuse to distribute to the community
Strategy 1- Create a monthly data dashboard
Strategy 2- Share data with community partners

Access to Care

BACKGROUND

Access to care is essential in preventing illness, promoting wellness and fostering vibrant communities. According to County Health Rankings & Roadmaps, Shelby County patient to Primary Care Physician ratio is 2,732:1, patient to dentist ratio is 4,099:1 and patient to mental health providers is 1,968:1.

As of 2015, 87 percent of Shelby County residents were insured. However, some residents may lack a usual source of care because they do not have insurance or providers will not accept their coverage. In 2015, there were 15% of children living in poverty and 29% of children living in single-parent households, which can impact access to care. Other factors include non-native English-speaking residents and those with poor English language skills.

An increase to access to care and services may bridge gaps and allow all residents access to healthcare services needed to support health and wellbeing.

Priority 2: Increase Access to Care
Objective 1: Expand health care services and availability

Strategy 1- Provide outreach immunization clinics
Strategy 2- Offer extended hours for services offered
Strategy 3-Provide information to clients on how to obtain Medicaid coverage
Strategy 4- Provide information on Managed Care and assist BCHM clients with Medicaid enrollment
Strategy 5- Provide vaccines for underinsured children.
Objective 2: Create educational and informational materials to increase awareness of local health care services
Strategy 1- Develop and distribute materials listing local health care services
Strategy 2- Share information with other agencies on health care services provided in Shelby County
Objective 3: Promote screening, early diagnosis and self-management
Strategy 1- Collaborate with other community agencies to promote detection, diagnosis and management
Strategy 2- Provide information on screenings, early diagnosis and self-management to the public
Objective 4: Collaborate with partners in implementing system of referral to link individuals with needed health care services
Strategy 1- Develop referral form and provide to public when services are offered
Strategy 2- Coordinate and monitor referrals with partner agencies
Strategy 3- Provide referral hotline to link clients with services

Chronic Disease

BACKGROUND

A decrease in chronic diseases is essential to a healthy community. According to the Centers for Disease Control and Prevention, chronic conditions are among the most common, costly and preventable of all health problems. Multiple factors contribute to the development of chronic conditions, including health behaviors, clinical care, socioeconomic determinants, and the physical environment.

Priority 3: Chronic Disease Prevention
Objective 1: Create, promote and distribute preventative healthcare specific educational materials and tools throughout the Shelby County community
Strategy 1- Educate agencies, medical providers and the community on the Human papillomavirus (HPV) and cancers associated with the virus
Strategy 2 – Attend multiple health fairs annually promoting disease prevention

and providing educational materials
Objective 2: Collaborate with community partners to promote healthy lifestyles
Strategy 1- Collaborate with faith and community-based groups to provide chronic disease education, resources and information
Strategy 2- Partner with schools to initiate healthy behavior in younger children
Objective 3: Provide health screenings throughout the community
Strategy 1- Participate in health screening events annually, providing blood pressure, BMI and derma scans
Strategy 2- Collaborate with agencies to promote information on community health screenings

Priority 1: Substance Abuse / Increase Community Outreach Regarding Substance Abuse				
Objective 1: Prevent Substance Abuse Through Education and Awareness				
Strategy 1:1				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Provide presentations to educate the community on substance abuse	Drug Task Force	1/1/2020	Less overdose deaths, less criminal activity	A reduction in deaths and overdoses
Strategy 1:2				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Develop an education committee with community partners	Drug Task Force	1/1/2020	An Education committee will educate community on substance abuse	A reduction of deaths and overdoses
Objective 2: Distribution of alcohol and drug materials to law enforcement, first responders, healthcare providers and other social service agencies.				
Strategy 2:1				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Provide Naloxone to police department, Sheriff's office and first responders	SSCHD	1/1/2020	Overdose reversals, less deaths	Increase use of Naloxone, increase of overdose reversals

Strategy 2:2				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Provide education on naloxone administration and other related materials	SSCHD	1/1/2020	More people trained in naloxone use	Increase of Naloxone being distributed
Objective 3: Collect data regarding substance abuse to distribute to the community				
Strategy 3:1				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Create a monthly dashboard	Drug Task Force	5/1/2019	To track and monitor overdoses and deaths	Data collected from community partners
Strategy 3:2				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Share data with community partners	Drug Task Force	5/1/2019	To educate the community	Data shared with partners

Priority 2: Increase Access to Care				
Objective 1:Expand health care services and availability				
Strategy 1:1				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Provide 5 outreach immunization clinics per year	SSCHD	12/1/2019	Decrease the number of vaccine preventable diseases by making immunizations available in different locations	Reduction of flu cases by 10%
Strategy 1:2				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Offer extended hours for services offered	SSCHD	1/1/2019	Will serve more people in the community	Data collected on clients seen during extended hours
Strategy 1:3				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Provide information to clients on how to obtain Medicaid coverage	SSCHD	7/1/2017	Will increase the number of people with health insurance	Data collected on the number of referrals made.
Strategy 1:4				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Provide information on Managed Care and assist BCHM clients with Medicaid enrollment	SSCHD	1/1/2017	Will increase the number of people with Managed Care programs	Data collected on the number of referrals made.

Strategy 1:5				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Provide Vaccines for underinsured children through the VFC program	SSCHD	2/1/2017	Underinsured children can obtain needed vaccines	Data collected on the number of vaccines given by the VFC program
Objective 2: Create Educational and informational materials to increase awareness of local health care services				
Strategy 2:1				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Develop and distribute materials listing local health care services	SSCHD	5/1/2019	Increase awareness of resources in community	Awareness of community resources
Strategy 2:2				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Share information with other agencies on health care services offered in Shelby County	SSCHD	5/1/2019	SSCHD will be able to refer those in need to the appropriate agency or service	Data collected will be shared by two different ways

Objective 3: Promote screening, early diagnosis and self-management				
Strategy 3:1				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Collaborate with 2 agencies to promote detection, diagnosis and management	SSCHD	5/1/2019	Community members will be able to seek assistance with medical needs	Data on collaboration with 2 different agencies
Strategy 3:2				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Provide information on screenings, early diagnosis and self-management to the public	SSCHD	5/1/2019	To increase the number of screenings, early diagnosis and educate on self-management	5% increase on those receiving screening services
Objective 4: Collaborate with partners in implementing system of referral to link individuals with needed health care services				
Strategy 4:1				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Develop referral form and provide to public when services are offered	SSCHD	8/1/2016	Members of the community will be referred to partner agencies and programs	Form created

Strategy 4:2				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Provide referral hotline to link clients with services	Shelby County United Way	1/1/2017	Community members will have a resource to locate needed services	Data collected on the number of people using the system
Strategy 4:3				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Coordinate and monitor referrals with partner agencies	SSCHD	1/1/2017	Members of the community will be obtaining needed healthcare services	Data collected on the number of people referred.
Priority 3: Chronic Disease Prevention				
Objective 1: Create, promote and distribute preventative healthcare specific educational materials and tools throughout the Shelby County community				
Strategy 1:1				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Educate agencies, medical providers and the community on the Human papillomavirus (HPV) and cancers associated with the virus	SSCHD	7/1/2018	Increased awareness of HPV and associated cancers	25% of providers in Shelby County will be educated

Strategy 1:2				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Attend 3 health fairs annually promoting disease prevention and providing educational materials	SSCHD	1/1/2018	Increase health awareness in the community	Data collected on 3 health fairs
Objective 2: Collaborate with community partners to promote healthy lifestyles				
Strategy 2:1				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Collaborate with faith and community-based groups to provide chronic disease education, resources and information.	SSCHD	7/1/2019	Increase education on diseases and prevention	Information will be distributed to 50% of faith based groups in Shelby County
Strategy 2:2				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Partner with schools to initiate healthy behavior in younger children	SSCHD	1/1/2019	To decrease the risk of unhealthy behavior as they become adults	3 schools will participate in a program that encourages health behavior

Objective 3: Provide health screenings throughout the community				
Strategy 3:1				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Participate in 3 health screening events annually, providing blood pressure, BMI and derma scans	SSCHD	1/1/2018	To educate the community and provide resources	Data in 3 health events
Strategy 3:2				
Activities	**Lead Organization**	**Target Date**	**Anticipated Results/ Outcomes**	**Performance Measures/Outputs**
Collaborate with agencies to promote information on health screenings	SSCHD	1/1/2019	To increase community health screening awareness	Collaboration with 5 agencies

References

Figure 1: Social Determinants of Health Source: *National Association of County & City Officials*

Figure 2: SMART
Source: zoeticamedia.com