FAYETTE COUNTY

COMMUNITY HEALTH IMPROVEMENT PLAN

2022

FAYETTE COUNTY
COMMUNITY HEALTH ALLIANCE

The creation of a Community Health Improvement Plan, or CHIP, is a collaborative and interactive process that represents the engagement of a wide range of community partners. Although there are a number of ways for a community group to facilitate a community-wide strategic planning process, the Fayette County Community Health Alliance utilized an evidence-based planning framework to create its plan. This framework, M.A.P.P., or Mobilizing Action through Planning and Partnership, was developed as a collaboration by the Centers for Disease Control and the National Association of City and County Health Officials. It resulted in a comprehensive planning process that included assessment of the local public health environment, as well as strategic analysis of the data collected.

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EXECUTIVE SUMMARY

The 2022 Community Health Improvement Plan (CHIP) is Fayette County's roadmap to address the health challenges identified in the 2021 Community Health Assessment (CHA). Given the scope and complexity of health challenges within Fayette County, the CHIP framework is constructed of cross-sector partnerships and alignment to meet a manageable set of goals to improve health outcomes for those that live in Fayette County.

By working together in partnership, the community can improve health outcomes by building programs, collaborations, and services through a focused effort on addressing the major health factors identified in the CHA. The CHIP is a tool to strengthen local efforts to improve health and well-being for those in Fayette County. The CHIP's main components are:

- Focus on health priorities areas to improve overall health
- Utilizing evidence-informed strategies to improve health outcomes and services
- An evaluation plan to track, report, and analyze progress

With the long-term goal of ensuring all citizens in Fayette County achieve their full health potential, the CHIP takes a comprehensive approach to achieving equity and addressing the many factors that shape health, including housing and environment, poverty, and education.

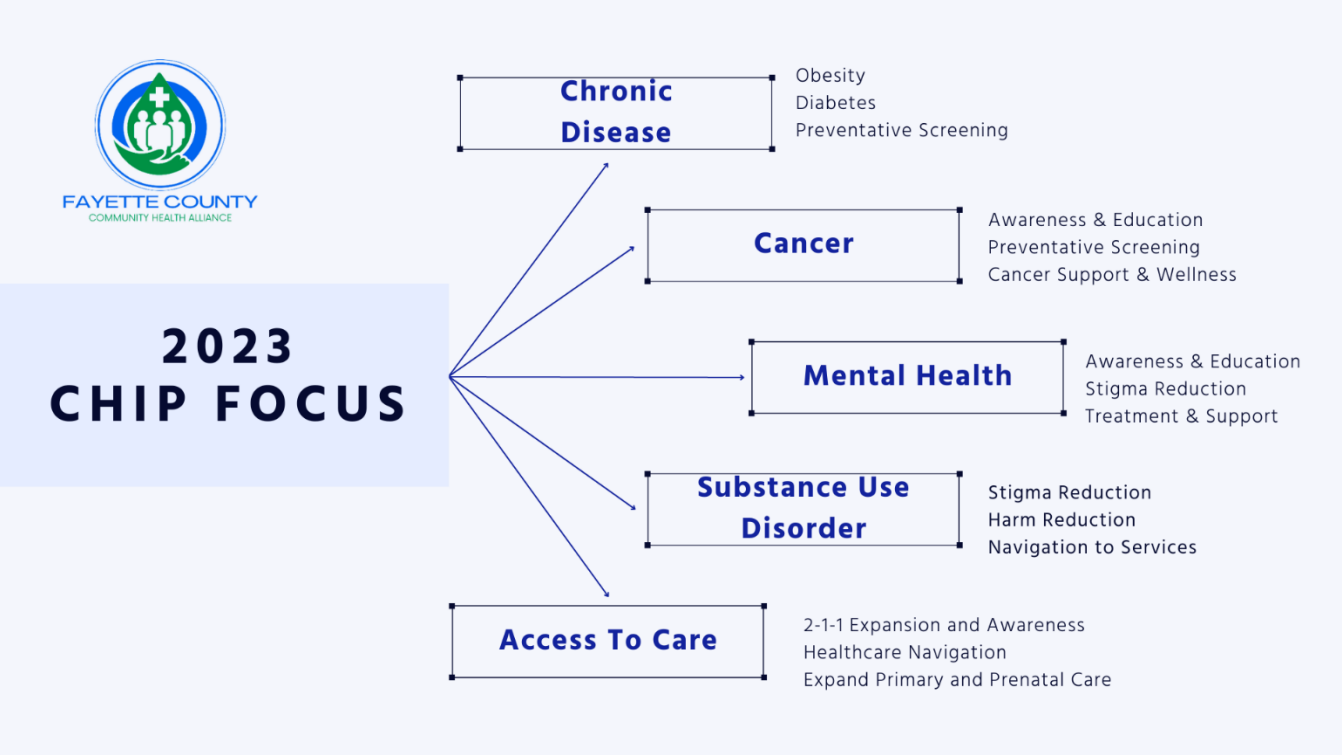

Figure 1: 2023 Fayette County CHIP Focus

FAYETTE COUNTY COMMUNITY HEALTH ALLIANCE

The Fayette County Community Health Alliance is a collaborative, community-based group whose efforts are aimed at improving the quality of life for residents of Fayette County. The coalition is structured with a steering committee focused on specific health priorities. There is representation from the following agencies:

ADAMH BOARD
Fayette County Community Action
Community Action-Transportation
Dialysis Center
Emergency Management Agency
Fayette County Department of DD
Fayette County EMS
Fayette County Coroner
Fayette County Farmer's Market
Fayette County YMCA
Ohio Hospice of Fayette County
Miami Trace Local Schools
Pathways to Recovery
St. Catherine's and Court House Manor LTC
Washington Court House City Schools
Adena Fayette Medical Center
American Red Cross
Fayette County Commissioners
Domestic Violence Shelter
Fayette County Job and Family Services
Fayette County Public Health
Jefferson Township EMS
Fayette County Sherriff's Department
Fayette County Parks and Recreation District
Fayette County Homeless Shelter
Medical Reserve Corp
Fayette County Commission on Aging
Rose Avenue Community Center
Washington Court House City Government
Scioto Paint Valley Mental Health

"A vision of educating and empowering individuals and families in order to achieve a thriving, engaged and resilient community."

Coalition efforts are driven by a vision of educating and empowering individuals and families in order to achieve a thriving, engaged and resilient community. Keeping in mind the values of collaboration, integrity, equity and equality, the FCCHA is focused on raising awareness and ultimately improve the health and wellness of the residents of Fayette County through the ongoing cooperation and focus of its community leaders, local health care providers, and citizens. By working through socioeconomic issues of Fayette County residents, this will be achieved.

The Fayette County Community Health Alliance utilized the data-driven Mobilizing Action for Planning and Partnership (M.A.P.P.) process developed by the National Association of City and County Health Officials (NACCHO) and the Centers for Disease Control (CDC). To prioritize key public health issues, a six-phase process is utilized that includes a four-part community health needs assessment; an in-depth analysis of current community trends, gaps, and resources with which to comprehensively evaluate the current state of health in Fayette County.

A LETTER FROM THE HEALTH COMMISSIONER

Dear Fayette County,

It is my pleasure to introduce to you the 2022 Community Health Improvement Plan (CHIP) for Fayette County, Ohio. The CHIP identifies key areas and health challenges Fayette County Faces daily. It allow us to face those health challenges by setting manageable goals, building partnerships and implementing changes to improve the health and wellbeing of our community. Knowing the extent to which the health of our community is being negatively impacted is a vital component for us to take informed actions.

We have identified 5 key areas of focus: chronic disease, cancer, mental health, substance use disorder and access to care. These areas of focus were derived from primary causes of death data, as well as from public opinion from residents who recognize the health issues among their peer. Feedback was solicited from individuals and focus groups through a Community Health Assessment (CHA). When we compared these identified health challenge with health indicators from state and national averages, it became clear they were definite areas needing our attention. Throughout this plan you will see each area addressed more specifically, as well as the plan for improvement.

Fayette County Public Health and Adena Fayette Medical Center partnered with over 30 area agencies to prioritize our strategies for completing this plan. It is our responsibility to find ways to improve the quality of life for our community of Fayette County. Each partnering agency, as well as YOU yourself holds this responsibility for CHANGE. As your local public health department, we will continue to work together with our agency partners to strategically plan and implement changes that will make our county safer, healthier and happier.

Respectfully,

Leigh N. Cannon
Health Commissioner
Fayette County Public Health

INTRODUCTION

The term "health" is a complex concept, particularly from a community perspective. An individual's health is measured by the presence and/or severity of illness; whether or not they engage in behaviors that are a risk to their health, and if so, the length of time the behavior has occurred. It can also be measured by asking individuals to report their personal perception of their overall health. The health of an entire community is measured by collecting and compiling individual data. Commonly used measurements of population health status are morbidity (incidence and prevalence of disease) and mortality (death rates). Socioeconomic data is usually included as it relates to the environment in which individuals live. A particular population's level of health is usually determined by comparing it to other populations, or by looking at health related trends over time. Everyone in a community has a stake in health. Poor health is costly to people trying to maintain employment, and employers pay for it via high rates of absenteeism and higher health insurance costs. Whole communities can suffer economic loss when groups of citizens are ill. As a result, everyone benefits from addressing social, environmental, economic, and behavioral determinants of health.

COMMUNITY HEALTH ASSESSMENT & PLANNING

Comprehensive community health assessments (CHA) and improvement plans (CHIP) can provide better understanding of a population's health needs, as well as direction toward positive change. Provisions of the Patient Protection and Affordable Care Act (ACA) requires all 501(c) (3) health systems operating one or more hospitals, as well as federally qualified health centers (FQHC's) to complete one every three years. All public health departments are also required to complete health needs assessments. The purpose is to provide the health continuum in a community with a foundation for their community health planning and to provide information to policymakers, provider groups, and community advocates for improvement efforts, including the best ways to direct health-related grants and appropriations.

While conducting a community health assessment can help provide clearer focus on a population's health needs, a community health improvement plan (CHIP) constructs "a long-term, systematic effort to address public health problems based on the results of the community health assessment and the community health improvement process (Centers for Disease Control, 2015)." The plan can be utilized by all entities on the public health continuum – hospitals, healthcare providers, health departments, social service agencies, etc. – to help focus efforts around specific goals aimed at improving the health of the community. These plans should identify, strengths, weaknesses, opportunities and threats, as well as include a shared vision and metrics for success. The plan should also align with broader efforts at the state and federal level.

Figure 2: M.A.P.P Community Health Assessment Process

The U.S. Department of Health and Human Services established five overarching health objectives and measures for 2030:

Figure 3: Healthy People 2030 Objectives and Measures

To achieve these goals a comprehensive action model (Figure 3) was established (Healthy People 2030), with leading health indicators arranged into topics used to set priorities and measure health over a 10-year period. These indicators, selected on the basis of their ability to motivate action, the availability of data to measure progress, and their importance as health issues for the public, influence the development of state and local health improvement plans.

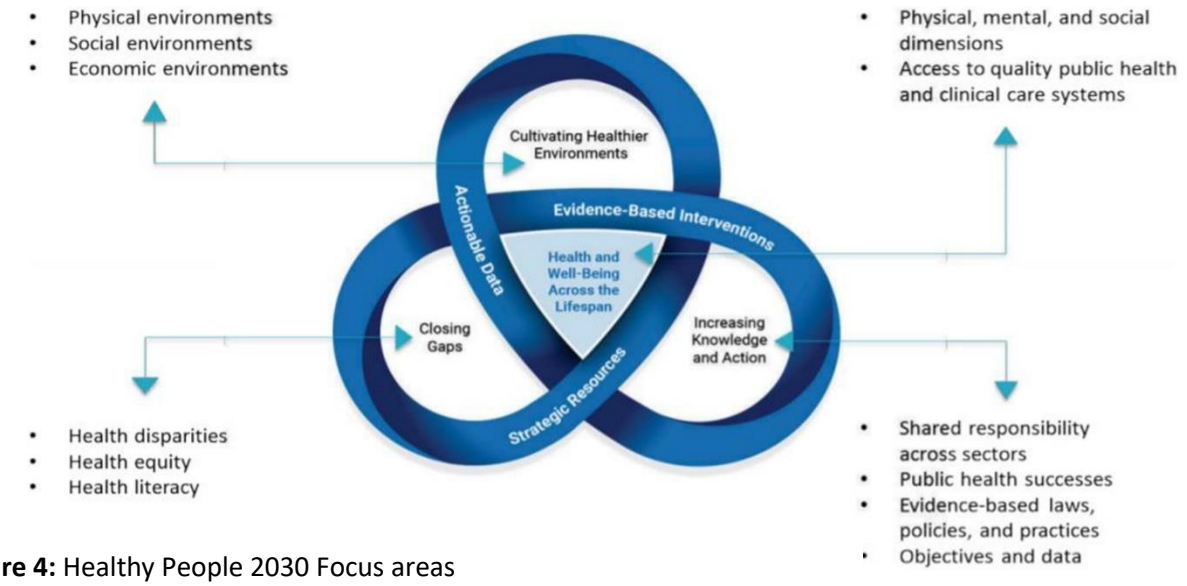

Figure 4: Healthy People 2030 Focus areas

The Ohio Department of Health has aligned statewide community health planning with the Healthy People 2030 approach. With the long-term goal of ensuring all Ohioans achieve their full health potential, the Ohio state health improvement plan (SHIP) takes a comprehensive approach to achieving equity and addressing the many factors that shape our health, including housing, poverty, education and trauma (Figure 2). The SHIP is a tool to strengthen state and local efforts to improve health, well-being and economic vitality in Ohio. The Fayette County Community Health Alliance have aligned several of the local CHIP priorities with the SHIP. The SHIP's main components are:

- Six priorities including three factors and three health outcomes
- Thirty-seven measurable objectives
- A menu of evidence-informed strategies
- An evaluation plan to track and report progress

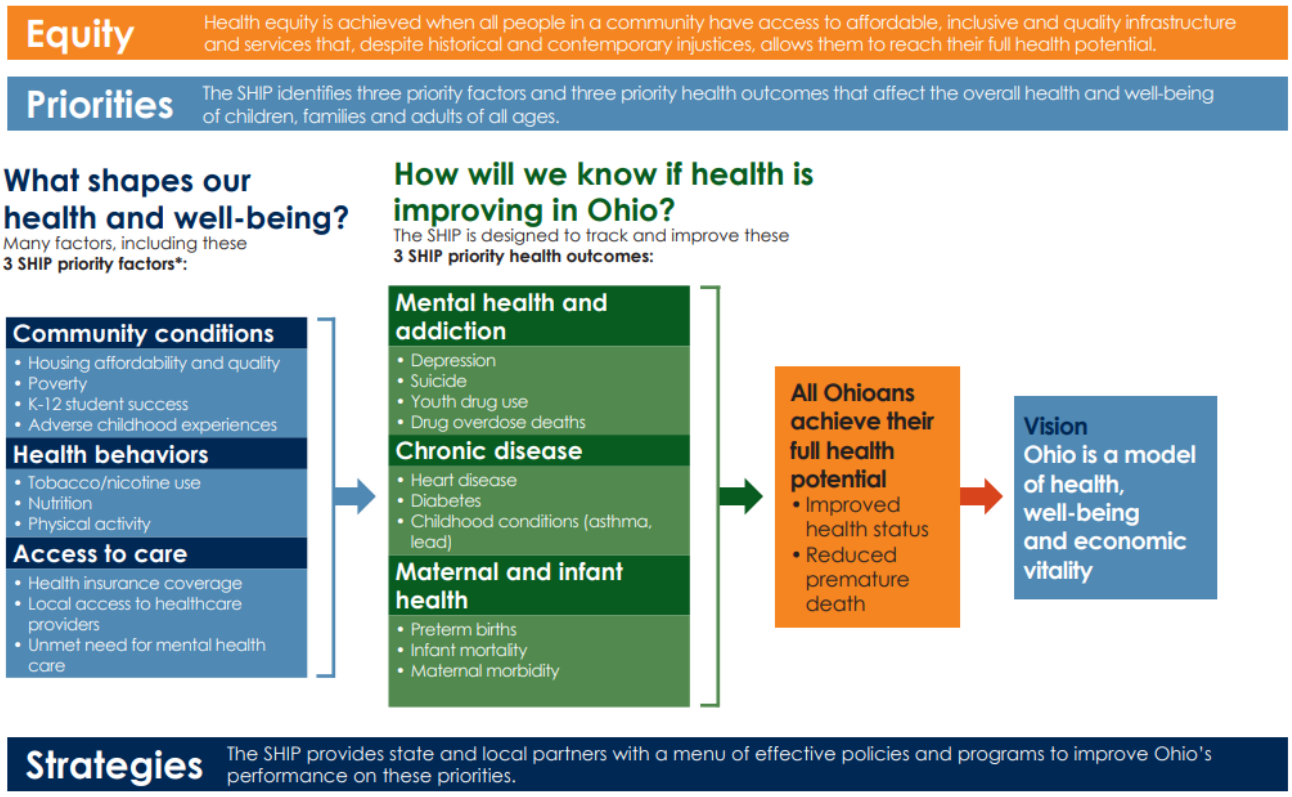

Figure 5: Ohio State Health Improvement Plan Framework

ased group whose efforts are aimed at improving the health and quality of life for residents of Fayette County, Ohio, have utilized the Healthy People 2030 and Ohio SHIP as guides for developing a community health strategic plan. Alignment with these plans not only ensures more efficient use of resources at the local and state level, but also opportunity to leverage funding and other opportunities to coordinate projects. The coalition has continued its collaboration to complete an updated community health assessment in 2021 and a community health improvement plan in 2022.

PROCESS

Creating a comprehensive community health assessment and effective strategic plan requires an interactive process not facilitated by one agency or group, but by a collective, engaged group of participants that are representative of the broader community. There are many strategic planning frameworks available to create such a process. However, a health focused framework, facilitated by public health leaders is an evidence-based recommendation.

The Fayette County Community Health Alliance looked to their local public health leaders for recommendations on models that could be utilized for the 2017 and 2021 community health assessment and health improvement planning processes. The M.A.P.P. model was successfully utilized to create the 2017 CHIP and it was the consensus of the group to utilize it again for the 2021 CHIP

MOBILIZING ACTION THROUGH PLANNING & PARTNERSHIP

M.A.P.P., developed by the Center for Disease Control (CDC) and National Association of City and County Health Officials' (NACCHO), is a six-phase process that guides the assessment of the community's health needs and development of a community health improvement plan (CHIP). The assessment portion of this process includes a four-part strategy focused on collecting qualitative and quantitative data from both primary and secondary sources to identify community themes and strengths, community health status and forces of change in the community, as well as assess the local public health system. More than 600 public surveys, five local stakeholder interviews, were conducted and demographic, socio-economic, health outcomes and factors data were also obtained to create the assessment (Figure 6).

Figure 6: MAPP Framework

Both the published assessment and plan are intended to inform decision makers and funders about the challenges Fayette County faces in improving community health, and the priority areas where support is most needed. The community health improvement plan is also intended to be used as a planning tool for community organizations, including the local public health department, and to align their agency efforts and programming with the broader goals set to improve health in Fayette County.

While M.A.P.P. involves a six-step process, Fayette County Community Health Alliance had the benefit of focusing its efforts on phases three, four and five. Having been well established for more than three years, completing phase one and two during the 2017 process, the Alliance did not feel phases one and two were necessary to complete, but agreed review of the vision and values during this cycle would be appropriate.

The four assessments yielded data for the primary causes of death, as well as data and public opinion on the primary health issues in the Fayette County community. The prevalence of death and disease and the corresponding behaviors and environmental factors were then aligned to help prioritize the issues the Fayette County Community Health Alliance would focus on and use to develop a community health improvement plan. Figure x provides a summary.

The top causes of death in Fayette County are heart disease, cancer (all forms), unintentional injury (all kinds of injury), pulmonary and respiratory disease, and stroke. The health issues contributing to these leading causes of death include addiction (unintentional injury); obesity and diabetes (heart disease and stroke); depression and anxiety (obesity and unintentional injury); lung cancer and respiratory issues (cancer and pulmonary/respiratory disease), and infant mortality (unintentional injury). Figure 7 provides a summary.

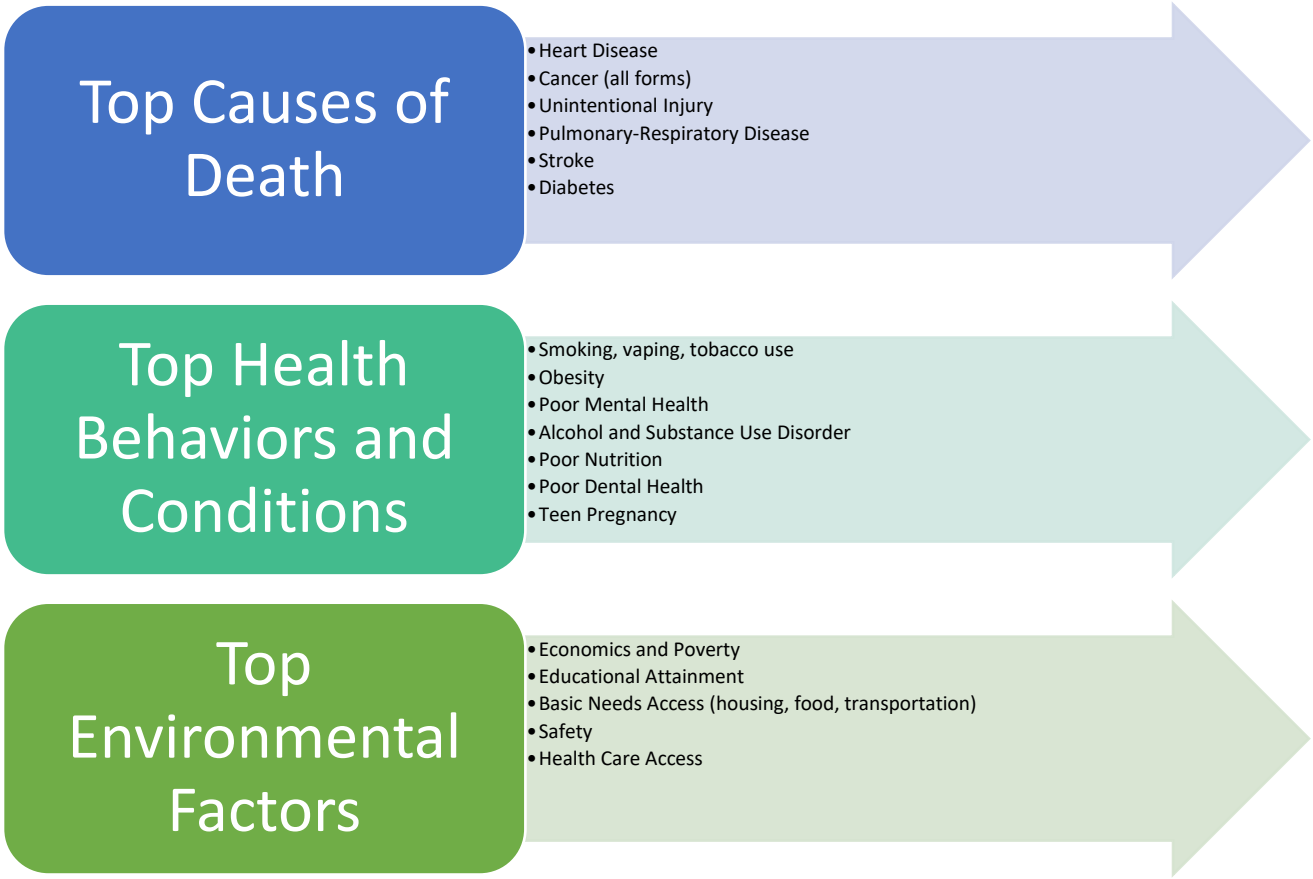

Figure 7: Leading Fayette County Factors

Health behaviors that directly correlate to these top health issues include drug and alcohol use (addiction, depression and anxiety), mental health management (depression and anxiety), tobacco use and vaping (lung cancer and respiratory), poor nutrition and limited physical activity (obesity and diabetes), and limited primary care use (all health issues).

In addition, the top environmental factors contributing to the primary health issues were identified through the data collection and a public survey. Those factors identified were: economics and poverty;

access to basic needs such as housing, food, and transportation; safety from crime and violence; access to healthcare, including preventative services and education.

This information was summarized and presented to the Fayette County Community Health Alliance members for review and consideration in October of 2021. This information was utilized as the building blocks for a strategic planning workshop held shortly after to outline the strategy and priorities of the 2021 community health improvement plan.

STRATEGIC PLANNING WORKSHOP

A strategic planning workshop was held on July 7, 2022 at the Center for Economic Opportunity. A total of 13 members of the Fayette County Community Health Alliance, and other community agency representatives attended the event. A certified Lean Six Sigma Green Belt helped facilitate the meeting where participants reviewed the previous CHIP, including work from the previous plan that had been completed. The facilitator then assisted the group in completing a matrix of health outcomes, behaviors and factors reported in the assessment to outline a cross-walk that demonstrated priority health issues.

The team utilized the 2021 health assessment and 2017 community health improvement plan to compare the updated data and matrix. This included review of the strategic questions and final priorities developed in the last improvement plan. Time was also spent discussing current community and agency capacity to address health priorities, as well as what progress had been made from the previous community health improvement plan. Opportunity was also taken to obtain feedback from participants.

PLANS TO ADDRESS PRIORITIES

After analysis of the updated data from the 2021 assessment, review of the 2017 community health improvement plan and discussion regarding current community need and capacity, the Fayette County Community Health Alliance reached consensus on the approach to the 2022 Community Health Improvement Plan. This includes:

1. Continuing to focus on the major health issues identified in the 2017 assessment – chronic illness prevention, education and management; cancer prevention, education and management (including tobacco and vaping cessation and prevention); mental health; and substance use disorder.
2. Add Access to Care as a priority area to better address the indicators identified by the community in the public survey data, including access to much needed primary care services and prenatal services
3. Monitor health outcomes and indicators over the course of the project timeline along with tracking progress on subcommittee goals, objectives and metrics by the development and use of a community health improvement plan dashboard.

The project timeline is set to start in January 2023 and end on December 31, 2025.

STRATEGIC GOALS

The community health improvement plan developed by the Fayette County Community Health Alliance is aligned with the group's overarching vision of "***educating and empowering individuals and families in order to achieve a thriving, engaged and resilient community."*** Specific metrics around each goal and objective have been established to measure the success of the plan.

The group will utilize County Health Rankings to measure the broader improvement of health factors and outcomes, as well as quality of life and environmental indicators. The Coalition aims for more than a 5% improvement in rankings over the next 3 years and more than 10% over the next six years (Figure 8). This is based on current improving socio-economic data and plans to improve health communication, accesses and navigation along the continuum.

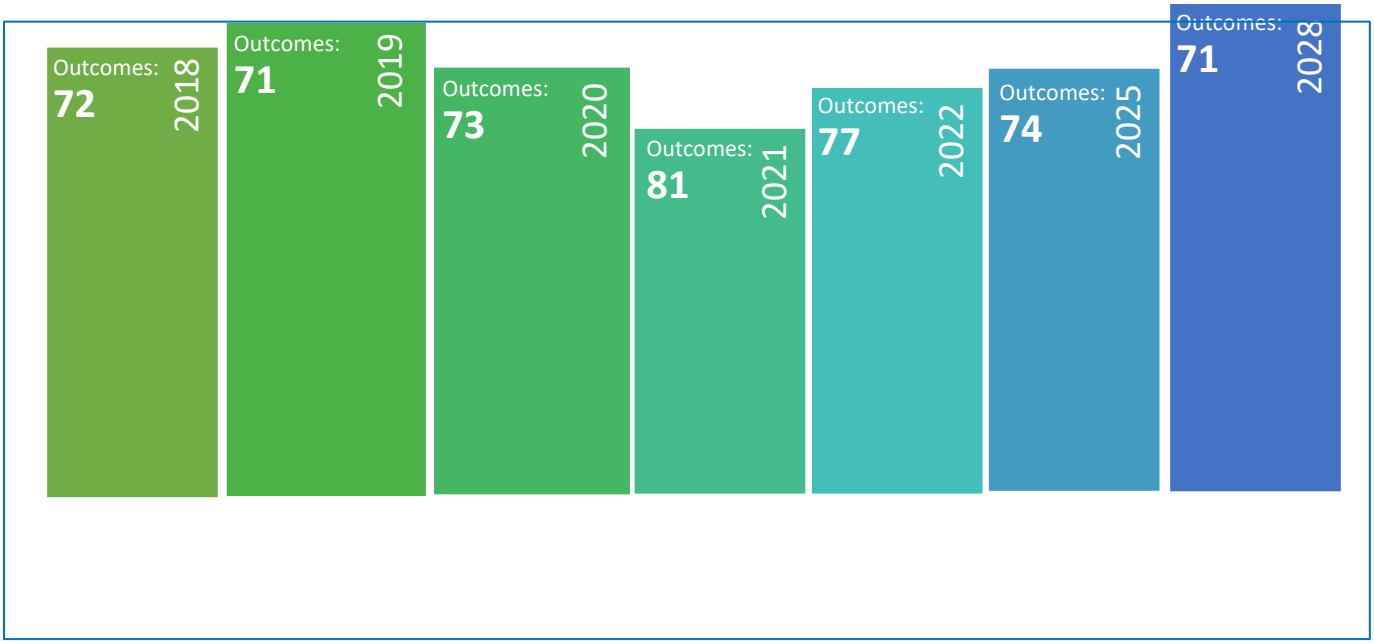

Figure 8: County Health Rankings Metrics

UPDATED GOALS AND OBJECTIVES

The following charts provide an outline of the updated 2022 Fayette County Community Health Improvement Plan. This document will be updated on a yearly basis. Goals and Objectives with an asterisk (*) are in alignment with Ohio Department of Health's State Health Improvement Plan (SHIP) strategies and initiatives.

Table 1: Health Priority 1 for Fayette County-Chronic Disease

Priority Area 1: Chronic Illness Prevention, Education and Management *		
GOAL: Establish a baseline and increase utilization of chronic illness risk management.		
Performance Measures: How will we know we are making a difference?		
Short Term Indicators	**Source**	**Frequency**
An increase in referrals and engagement in classes and an increase in classes offered.	Program Tracking	Quarterly
Long Term Indicators	**Source**	**Frequency**
Show a decrease in the number of pre-diabetics who become diabetic.	County Health Data	Annually
Show a decrease in individuals who have complications from poor diabetes management	County Health Data	Annually

Objective #1
Fayette County will increase the number of diabetic and pre-diabetic individuals participating in educational programs designed to improve diabetes management and minimize complications from the disease.

BACKGROUND ON STRATEGY

"More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death.1 Healthy People 2030 focuses on reducing diabetes cases, complications, and deaths.

Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases."

Source: https://health.gov/healthypeople/objectives-and-data/browse-objectives/diabetes
Evidence Base: Centers for Disease Control and Prevention. (2017). National Diabetes Statistics Report, 2017: Estimates of Diabetes and its Burden in the United States. Retrieved from https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf

Table 2: Chronic Disease Related Activities

Activity	Deliverable/Metric	Responsible	Resources	Timeline
Develop public education and service announcements about preventative screening.	Social Media Engagement #s Preventative Screening Rates from Payers	Fayette County Public Health Adena Fayette Medical Center	Fayette County Community Health Alliance FCPH	6/1/23 - 12/31/25
Promote diabetes education resources at Adena Fayette Medical Center	Enrollment and completion rates of program	Adena Fayette Medical Center	Adena Health System Communications	6/1/23 - 12/31/25
Promote Healthy U Program at Fayette County Community Action	Enrollment and completion rates of program	Fayette County Community Action	FCCAC Communications	6/1/23 - 12/31/25
Promote YMCA Diabetic Education Program	Enrollment and completion rates of program	Fayette County YMCA	YMCA Communications	6/1/23 - 12/31/25
Promote the Commission on aging diabetic education classes	Enrollment and completion rates of program	Commission on Aging	COA Communications	6/1/23 - 12/31/25

Objective #2
Fayette County will work to decrease the number of children and adults engaged in physical activity and nutrition programming.

BACKGROUND ON STRATEGY
"Obesity is a complex disease, and treatment approaches will have to be equally complex. Because of its multifactorial causes, discerning the impact of any one intervention is difficult. However, the magnitude of the problem warrants an active exploration of new approaches, despite methodologic challenges.

Source: http://www.aafp.org/afp/2009/0315/p446.html
Evidence Base: American Academy of Family Physicians Policy

Table 3: Chronic Disease Related Activities

Activity	Deliverable/Metric	Responsible	Resources	Timeline
Develop public education and service announcements about exercise benefits and opportunities in the community (facilities, parks and trails)	Social Media Reach Engagement #s	Fayette County Public Health	Fayette County Community Health Alliance	6/1/23 - 12/31/25

Increase participation in Fayette Fat Fighters and Rolling Rimples Programs in the community by 10%	Enrollment and completion rates of program	Fayette County Public Health	FCPH Communications	6/1/23 - 12/31/25
Train members of the community to lead Rolling Rimples or Fayette Fat Fighters Program	Enrollment and completion rates of program	Fayette County Public Health	FCDH Communications	6/1/23 - 12/31/25
Increase participation in Just Walk! Program (Silver Sneakers, YMCA and Adena Health partnership) by 25% over three years	Enrollment and completion rates of program	Fayette County YMCA, Commission on Aging and Adena Health	FCDH Communications	1/1/23 - 12/31/25
Establish a baseline and increase participation in the Cooking Matters program to increase nutrition education and eating healthy on a budget	Enrollment and completion rates of program	OSU Extension-Fayette County Adena Health	OSU Extension-Fayette Communications	6/1/23 - 12/31/25

Table 4: Health Priority 2 for Fayette County-Cancer

Priority Area 2: Cancer Prevention, Education and Management		
GOAL: Decrease cancer mortality through increased education opportunities and preventative screening opportunities.		
Performance Measures: How will we know we are making a difference?		
Short Term Indicators	**Source**	**Frequency**
More providers will educate patients on preventative screening	Program Tracking	Quarterly
Long Term Indicators	**Source**	**Frequency**
Lower breast, prostate, lung and colon cancer mortality rates	ODH Data	Annually
Increased rates of mammograms, colonoscopies, lung CT scans and prostate exams.	ODH Data	Annually

Objective #1

Fayette County will work to increase literacy and understanding of symptoms and screenings needed, especially for the top five cancers resulting in death in Fayette County by increasing the number of individuals receiving preventative screenings.

BACKGROUND ON STRATEGY

"Early detection of cancer greatly increases the chances for successful treatment. There are two major components of early detection of cancer: education to promote early diagnosis and screening. Recognizing possible warning signs of cancer and taking prompt action leads to early diagnosis. Increased awareness of possible warning signs of cancer, among physicians, nurses and other health care providers as well as among the general public, can have a great impact on the disease."

Source: http://www.who.int/cancer/detection/en/
Evidence Base: World Health Organization (WHO)

Table 5: Cancer Related Activities

Activity	Deliverable/Metric	Responsible	Resources	Timeline
Develop public education and service announcements about cancer screening, access and prevention strategies	Social Media Reach Engagement #s	Fayette County Health Department Adena Health	Adena Health Communications	6/1/23 - 12/31/25
Provide a cancer screening education for businesses throughout the county	Engagement #s	Fayette County Health Department Adena Health	Adena Cancer Center	6/1/23 - 12/31/25

Objective #2
Fayette County will work to increase the number of medical offices, providers, and urgent care clinics that encourage preventative screenings as recommended by CDC.

BACKGROUND ON STRATEGY
Cancer is the second leading cause of death globally, accounting for an estimated 9.6 million deaths, or one in six deaths, in 2018. Lung, prostate, colorectal, stomach and liver cancer are the most common types of cancer in men, while breast, colorectal, lung, cervical and thyroid cancer are the most common among women.

The cancer burden continues to grow globally, exerting tremendous physical, emotional and financial strain on individuals, families, communities and health systems. Many health systems in low- and middle-income countries are least prepared to manage this burden, and large numbers of cancer patients globally do not have access to timely quality diagnosis and treatment. In countries where health systems are strong, survival rates of many types of cancers are improving thanks to accessible early detection, quality treatment and survivorship care.

Source: https://www.cancer.gov/about-cancer/screening/hp-screening-overview-pdq
Evidence Base: National Cancer Institute, National Institutes of Health

Table 6: Cancer Related Activities

Activity	Deliverable/Metric	Responsible	Resources	Timeline
Baseline and track primary care and dental referrals and screenings	Number of screenings	Adena Health Local Dental providers	Adena Health Communications	6/1/23 - 12/31/25
Collect and report data on cancer screenings completed each year	Publicized Report	Fayette County Health Department	Fayette County Health Department Communications	6/1/23 - 12/31/25

Objective #3
Fayette County will work to support cancer patients through their treatment and beyond to extend life expectancy and quality of life.

BACKGROUND ON STRATEGY

Palliative care, which focuses on improving the quality of life of patients and their families, is an essential component of cancer care. Survivorship care includes a detailed plan for monitoring cancer recurrence and detection of new cancers, assessing and managing long-term effects associated with cancer and/or its treatment, and services to ensure that cancer survivor needs are met.

Source: https://www.who.int/health-topics/cancer#tab=tab_3
Evidence Base: World Health Organization

Table 7: Cancer Related Activities

Activity	Deliverable/Metric	Responsible	Resources	Timeline
Develop local cancer support group	Engagement #s	Fayette YMCA	Adena Cancer Center American Cancer Society	6/1/23 - 12/31/25
Promote the YMCA Livestrong Wellness program for cancer patients	Referrals Participation rate	Adena Health Fayette YMCA	Adena Cancer Center	6/1/23 - 12/31/25

Objective #4
Fayette County will decrease the rate of smoking in the county.

BACKGROUND ON STRATEGY
More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.1 Healthy People 2030 focuses on preventing people from using tobacco products and helping them quit.

Most deaths and diseases from tobacco use in the United States are caused by cigarettes.1 Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer.

Source: https://health.gov/healthypeople/objectives-and-data/browse-objectives/tobacco-use
Evidence Base: U.S. Department of Health and Human Services. (2014). The Health Consequences of Smoking — 50 Years of Progress: A Report of the Surgeon General. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK179276/This link is external to health.gov.

Table 8: Cancer Related Activities

Activity	Deliverable/Metric	Responsible	Resources	Timeline
Develop public education and service announcements about tobacco cessation and resources	Social Media Reach Engagement #s	Fayette County Health Department	CDC Community Resources American Lung Association	6/1/23 -12/31/25
Develop a tobacco cessation resource list to distribute across the county	Distribution reach	Fayette County Health Department Adena Health	CDC Community Resources American Lung Association	6/1/23 -12/31/25
Assemble and distribute smoke-free workplace kits	Number of Smoke Free Workplaces	Fayette County Health Department Adena Health	Fayette County Chamber of Commerce	6/1/23 -12/31/25

Table 9: Health Priority 3 for Fayette County-Mental Health

Priority Area 3: Mental Health		
GOAL: Reduce stigma surrounding mental health and seeking support		
Performance Measures: How will we know we are making a difference?		
Short Term Indicators	**Source**	**Frequency**
Increase the number of individuals seeking counseling/treatment	Compile data	Annual
Long Term Indicators	**Source**	**Frequency**
Decrease the number of poor mental health days reported	County Health Rankings	Annually
Decrease the suicide rate in Fayette County	ODH Data	Annually

Objective #1
Fayette County will increase promotion of mental and behavioral health resources in the community.

BACKGROUND ON STRATEGY
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime.[1] Healthy People 2030 focuses on the prevention, screening, assessment, and treatment of mental disorders and behavioral conditions. The Mental Health and Mental Disorders objectives also aim to improve health and quality of life for people affected by these conditions.

Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.[2]

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health

problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

Source: https://health.gov/healthypeople/objectives-and-data/browse-objectives/mental-health-and-mental-disorders

Evidence Base:

1. Centers for Disease Control and Prevention. (2018). Mental Health: Data and Publications. Retrieved from https://www.cdc.gov/mentalhealth/data_publications/index.htmThis link is external to health.gov.
2. National Institutes of Mental Health. (2018). Statistics. Retrieved from https://www.nimh.nih.gov/health/statistics/index.shtmlThis link is external to health.gov

Table 10: Mental Health Related Activities

Activity	Deliverable/Metric	Responsible	Resources	Timeline
Develop public education and service announcements about mental health resources and seeking help	Media reach	Fayette County Health Department Paint Valley ADAMH	SAMHSA CDC	6/1/23 - 12/31/25
Promote the use of Crisis Text Line	Media reach Fayette County engagement #s	Fayette County Health Department Paint Valley ADAMH	SAMHSA CDC	6/1/23 - 12/31/25
Promote local mental health support groups	Media reach	Fayette County Health Department Paint Valley ADAMH	SAMHSA CDC	6/1/23 - 12/31/25
Increase utilization of suicide prevention programs at local schools	Participation and engagement data	Adena Health Nationwide Children's Hospital Paint Valley ADAMH	SAMHSA CDC	9/1/23 - 12/31/25

Objective #2

Fayette County will work to decrease the stigma associated with seeking support for mental illness needs by providing education and working with medical providers to have open dialogue with their patients.

BACKGROUND ON STRATEGY

"Reducing the stigma associated with mental illness may be a critical step in prevention and early intervention for mental disorders and may improve the quality of life of individuals with mental illness."

Source: http://calmhsa.org/wp-content/uploads/2011/12/Literature-Review_SDR_Final01-02-13.pdf

Evidence Base: California Mental Health Services Authority, National Alliance on Mental Illness

Table 11: Mental Health Related Activities

Activity	Deliverable/Metric	Responsible	Resources	Timeline
Establish baseline and increase Mental Health First Aid courses for community organizations and groups	Number of courses delivered Engagement #s	Paint Valley ADAMH Board	OMHAS Adena Fayette Medical Center Fayette YMCA	1/1/23 - 12/31/25
Establish baseline and increase Trauma Informed Care trainings	Number of courses delivered Engagement #s	Paint Valley ADAMH Board	OMHAS Adena Fayette Medical Center Fayette YMCA	1/1/23 - 12/31/25
Establish baseline and increase mental health screenings by providers at wellness checks	Number of courses delivered Engagement #s	Adena Health	OMHAS Adena Fayette Medical Center Fayette YMCA	1/1/23 - 12/31/25
Establish baseline and increase QPR trainings in Fayette County	Number of courses delivered Engagement #s	Paint Valley ADAMH Board	OMHAS Adena Fayette Medical Center Fayette YMCA	1/1/23 - 12/31/25

Table 12: Health Priority 4 for Fayette County-Substance Use Disorder

Priority Area 4: Substance Use Disorder*		
GOAL: Increase the number of individuals in long-term recovery		
Performance Measures: How will we know we are making a difference?		
Short Term Indicators	**Source**	**Frequency**
Increase the number of individuals seeking treatment	Compile data	Annual
Decrease the number of overdoses in the county	Health Department	Quarterly
Long Term Indicators	**Source**	**Frequency**
Decreased rate of substance use disorder	County Health Rankings	Annually

Objective #1

Fayette County will work towards the development of a peer recovery support network for people who have completed treatment and are moving to the next stage of recovery.

BACKGROUND ON STRATEGY

"Those who participated in treatments, including peer support groups, showed higher rates of abstinence than common in substance-abusing populations while also being more satisfied with the treatment. Furthermore, significant reductions in relapse rates were shown in addition to significant reductions in return to homelessness in a challenging population to treat. Reported benefits extended beyond those being the recipient of the peer support groups to those also delivering the services, where significant reductions in alcohol and drug use were shown not only for mentees but also for

sustained abstinence in the majority of mentors." The Centers for Disease Control and Prevention identifies the health disparities among youth in its "Action Steps to Address Health and Educational Disparities" among adolescents. Having a CHIP strategy focused on youth is recognition of these health disparities.

Social Determinants of Health for Youth

- Community norms; community culture
- Having a history of alcohol use either among parents or youth
- Parents that allow underage drinking or abuse of substances and parents using and present with the youth at parties
- Culture of independence which may result in people not seeking help
- Early use of substances
- Advertising and media/digital media influence on substance abuse
- Families affected by incarceration
- Not living with a mother or father
- Grandparents as caregivers
- Having been a victim of child abuse and/or neglect
- Having anxiety and/or depression
- Isolation and lack of socialization
- Having a complex treatment process with limited treatment options in this rural County

Source: Tracy, K., & Wallace, S. P. (2016). Benefits of peer support groups in the treatment of addiction. Substance Abuse and Rehabilitation, 7, 143–154. http://doi.org/10.2147/SAR.S81535
Evidence Base: National Institutes of Health

Table 13: Substance Use Disorder Related Activities

Activity	Deliverable/Metric	Responsible	Resources	Timeline
Expand peer recovery supporters, treatment options, care coordination, or mentorship programs in conjunction with existing substance abuse community organizations	# of trained PRSs # of treatment providers # of those engaged in treatment	Fayette County Recovery and Prevention Coalition	HRSA RCORP Grant HRSA RCORP MAT Grant	1/1/23 - 12/31/25

Objective #2

Fayette County will work to increase harm reduction education and resources.

BACKGROUND ON STRATEGY

Despite substantial increases in naloxone dispensing, the rate of naloxone prescriptions dispensed per high-dose opioid prescription remains low, and overall naloxone dispensing varies substantially across the country. Naloxone distribution is an important component of the public health response to the opioid overdose epidemic. Health care providers can prescribe or dispense naloxone when overdose risk factors are present and counsel patients on how to use it. Efforts to improve naloxone access and distribution work most effectively with efforts to improve opioid prescribing, implement other harm-reduction strategies, promote linkage to medications for opioid use disorder treatment, and enhance public health and public safety partnerships

Source: https://www.cdc.gov/mmwr/volumes/68/wr/mm6831e1.htm?s_cid=mm6831e1_w
Evidence Base: Vital Signs: Pharmacy-Based Naloxone Dispensing — United States, 2012–2018

Table 14: Substance Use Disorder Related Activities

Activity	Deliverable/Metric	Responsible	Resources	Timeline
Expand Narcan access across the community	Units of Narcan distributed	Fayette County Recovery and Prevention Coalition Fayette County Community Action	HRSA RCORP Grants Project Dawn	1/1/23 - 12/31/25
Offer Narcan training to community members and organizations	Numbers of community members trained	Fayette County Recovery and Prevention Coalition Fayette County Community Action	HRSA RCORP Grants Project Dawn	1/1/23 - 12/31/25

Objective #3

Fayette County will work to expand drug education programs to kids in local school systems.

BACKGROUND ON STRATEGY

“A considerable proportion of students have begun using substances by the time they reach middle school, the grade level at which most prevention curricula are implemented. As the review of elementary curricula conducted by Hopfer and colleagues in the current issue indicates, implementing curricula prior to middle school grades may hold promise in reducing or delaying the onset of substance use among preadolescents. As they point out, intervening at this developmental stage may be particularly effective because the risk factors associated with substance use may be more malleable as compared to those of older students. Given the well-documented adverse effects of early substance use, it is critical that school districts implement prevention curricula during elementary school that are evidence-based. Relying on curricula not shown to be effective threatens the ability of our elementary schools to assist in reducing the onset of substance use among our nation’s children.

Source: Hanley, S., Ringwalt, C., Ennett, S. T., Vincus, A. A., Bowling, J. M., Haws, S. W., & Rohrbach, L. A. (2010). The prevalence of evidence-based substance use prevention curricula in the nation's elementary schools. Journal of Drug Education, 40(1), 51–60.
Evidence Base: National Institutes of Health

Table 15: Substance Use Disorder Related Activities

Activity	**Deliverable/Metric**	**Responsible**	**Resources**	**Timeline**
Engage elementary school students in Dare program	Number of students engaged	Fayette County Sherriff	Paint Valley ADAMH board	1/1/23 - 12/31/25
Engage middle school students in the Too Good For Drugs program	Number of students engaged	County prevention education organization	Paint Valley ADAMH board	1/1/23 - 12/31/25
Identify and implement a vaping prevention program	Number of students engaged	Adena Health Fayette County Health Department	Nationwide Children's Hospital	9/1/23 - 12/31/25

Table 16: Health Priority 5 for Fayette County-Access to Care

Priority Area 5: Access to Care *		
GOAL: Improve the health factors for Fayette County		
Performance Measures: How will we know we are making a difference?		
Short Term Indicators	**Source**	**Frequency**
Increase the number of preventative care visits	Compile data	Annually
Increase utilization of social supports in the community	Agency service data	Quarterly
Long Term Indicators	**Source**	**Frequency**
Increase rates of early intervention	Insurance providers	Annually

Objective #1
Fayette County will expand access to information on community resources.

BACKGROUND ON STRATEGY

Early adopters of social referral platforms described significant relational, strategic, legal, and technical challenges to implementation but also reported that even early in implementation, platforms can facilitate both increased awareness of local resources and referrals between health care and social services organizations. Meaningful and early community partner engagement, clarity around funding models to support ongoing direct and indirect costs, and stronger evidence of effectiveness could help advance this rapidly evolving field.

Source: https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01588

Evidence Base: Implementing Community Resource Referral Technology: Facilitators And Barriers Described By Early Adopters authors Yuri Cartier, Caroline Fichtenberg, and Laura M. Gottlieb

Activity	**Deliverable/Metric**	**Responsible**	**Resources**	**Timeline**
Identify 2-1-1 provider for the county	Executed contract	Fayette County Community Health Alliance	Ross County United Way	6/1/23 - 12/31/25
Secure community funding sources to support operation of the 2-1-1 line	Yearly operation expense	To be determined	Fayette County United Way	6/1/23 - 12/31/25
Broadly promote 2-1-1 resource and referral line	Call volume	Fayette County Community Health Alliance		6/1/23 - 12/31/25

Objective #2
Fayette County will increase utilization of preventative care and community resources.

BACKGROUND ON STRATEGY
Access to healthcare services is critical to good health, yet rural residents face a variety of access barriers. By promoting access to healthcare services, CHWs can help improve health outcomes and quality of life in rural communities. Integrating CHWs as a member of the care delivery team, so they are working alongside physicians, nurses, and other healthcare staff, is an effective strategy for achieving improvements in health outcomes. Incorporating CHWs as a member of the care delivery team also frees up resources and enables rural healthcare professionals to focus on more complex patients and issues.

Source: https://www.ruralhealthinfo.org/toolkits/community-health-workers/1/advantages
Evidence Base: 2002–2023 Rural Health Information Hub

Activity	**Deliverable/Metric**	**Responsible**	**Resources**	**Timeline**
Develop public education and service announcements about healthcare resources and utilization (primary care, urgent care and emergency)	Media reach	Fayette County Health Department	Fayette County Community Health Alliance	6/1/23 - 12/31/25
Increase primary care and health screening utilization	Primary care visits Cancer screenings	Adena Health	Fayette County Community Health Alliance	6/1/23 - 12/31/25
Develop community health worker network to increase	Number of certified CHWs	Fayette County Health Department	Fayette County Community Health Alliance	6/1/23 - 12/31/25

navigation to community resources.	Utilization of Pathways programs			

COMMUNICATION PLAN

The Fayette County Community Health Alliance will utilize multiple means to make the completed plan visible and accessible to participating partners, as well as the broader community. A communication plan (see Appendix) will be developed to outline venues such as community events, social media, local media and civic groups to share the information from the community health assessment and the community health improvement plan. Executive summaries for each document will be distributed along with the full version of each plan made available on multiple coalition partner agency websites, including the Fayette County Public Health and the Adena Fayette Medical Center.

A project charter will also be utilized to summarize and simplify the components of the plan. The community health needs assessment and community health improvement plan process incorporated several Lean Sigma tools that assisted in data collection and analysis. Rolling action item lists or RAILS will be utilized to help each of the major sub-committees break-out the goals and objectives out into more detailed activities with aligned timelines to ensure each of the objectives continue to move forward.

NEXT STEPS

The Fayette County Community Health Alliance will begin integrating the community health improvement plan into established community efforts and use it to bridge the gap of infrastructure needed to ensure that activities to improve the health of the Fayette County community are focused, communicated, documented and measured to benchmark long-term success. Communication of the finalized plan, as well as integration of it into established work groups, will begin in January 2023, with new work group convening in February 2023.

The Alliance believes community-based projects have the best opportunity to make a real difference in the health of individuals and their families, and those providing care. Visions for future community support in all of the priority areas will require identifying suitable leadership, raising awareness among stakeholders, determining how to involve them, and agreeing on the areas of, and how each group will collaborate. In addition, different strategies will be used depending on the capability of participating agencies to address the issues.

The Alliance will utilize the Ten Essential Public Health Services as guide and framework for the activities coordinated around its health priorities and goals. The key principles involved with this framework involve:

- A primary focus on the population
- A public service ethic, while considering concerns for the individual
- An emphasis on prevention and health promotion for the whole community
- Employment of a spectrum of interventions aimed at the environment, human behavior and lifestyle and medical care
- Promoting Health Equity.