Community Health
IMPROVEMENT PLAN

Partners for a Healthier Ross County

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 Partners for a Healthier Ross County looked to their local public health leaders for recommendations on models that could be utilized for the 2016 community health assessment and health improvement planning processes. This model was successful in creating the 2016 CHIP and it was the consensus of the group to utilize it again for the 2020 CHIP.

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EXECUTIVE SUMMARY

Strategic Highlights

The 2020 Community Health Improvement Plan (CHIP) is Ross County's roadmap to address the many health challenges in our community identified in the 2019 Community Health Assessment (CHA). Given the scope and complexity of health challenges within Ross County identified in the CHA, the CHIP calls for cross-sector partnerships and alignment to meet a manageable set of goals to improve health outcomes for those that live in Ross County. By working together in partnership, our 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 Ross 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 Ross Countians achieve their full health potential, the CHIP takes a comprehensive approach to achieving equity and addressing the many factors that shape our health, including housing and environment, poverty, and education.

PARTNERS FOR A HEALTHIER ROSS COUNTY

In November of 2016, the Partners for a Healthier Ross County, now a collaboration of 17 community agencies, published its first Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP). The health, social service and education organizations of Partners include Adena Health System and the Ross County Health District (coordinators of the coalition and associated committees), the City of Chillicothe, Ross County Community Action, Chillicothe and Ross County Public Library, Hopewell Health Center, Elizabeth's Hope, The Ohio State University Extension Office – Ross County, United Way of Ross County, Hope Clinic of Ross County, Paint Valley ADAMH Board, Ross County YMCA, The Pioneer Center, Scioto Paint Valley Mental Health Center, the Ross County Park District, and the Child Protection Center of Ross County.

[VISION STATEMENT]

"All people within the region are empowered and inspired to reach their fullest physical and mental potential in a clean and safe environment through positive community collaborations."

Utilizing the values of commitment, engagement, communication, and respect, it is the vision of Partners for a Healthier Ross County that ***all people within the region are empowered and inspired to reach their fullest physical and mental potential in a clean and safe environment through positive community collaborations.*** By working through strategic initiatives that improve the physical, mental, emotional, and socioeconomic well-being of Ross County residents, this will be achieved.

For both the 2016 and 2019 assessments and strategic plans, Partners used 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). This six-phase process includes a four part CHNA, as well as an in-depth analysis of current community trends, gaps, and resources with which to comprehensively evaluate the current state of health in Ross County and to prioritize key public health issues. The CHNA identified the top causes of death, health issues, health behaviors and environmental factors for the Ross County community based upon public health data related to top causes of death, county health rankings, health outcomes and health factors.

WELCOME FROM THE HEALTH COMMISSIONER

To all Residents of Ross County:

I would like to thank our committed community partners in the implementation of the 2016 Community Health Improvement Plan (CHIP). By working together on the 2016 CHIP over the past 4 years, we as a community built the framework needed for successful collaborations as we strive to improve health outcomes and behaviors for all Ross Countians. As we continue moving forward with our 2020 CHIP initiatives, we will continue to engage our community residents, strengthen our community partnerships, and focus on achieving health equity for all in Ross County.

Evidence-based strategies show us that communities that work in collaboration on a systematic approach to addressing health needs and gaps can improve health outcomes of those who reside in the community. We value the commitment of our community partners in working together to address the health needs and gaps identified in our Community Health Assessments as we know this hard work can lead to better health outcomes for our community.

It is our ultimate goal to make Ross County one of the best communities to live, raise a family, and grow old. Our Community Health Improvement Plan is a tool that can help our community address health issues in our community to make it a better place to live and be healthy.

We thank all those who assisted in development of the plan. We look forward to implementing the strategies in this plan with hopes of improving the health of all those we serve.

Respectfully

Garrett Guillozet, MPA, RS/REHS, AEMT
Health Commissioner
Ross County Health District

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 and 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 districts are also required to complete health needs assessments and . 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.

U.S. Department of Health and Human Services established five overarching health goals for 2020:

- Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining full potential for health and well-being for all.
- Promote healthy development, healthy behaviors and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

INTRODUCTION (continued)

To achieve these goals a comprehensive action model (Figure 1) 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 1: Action Model for Healthy People 2030

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 Partners for a Healthier Ross County have aligned several of our 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

The Partners for a Healthier Ross County, a collaborative, community-based group whose efforts are aimed at improving the health and quality of life for residents of Ross County, Ohio, have utilized the Healthy People 2030 and Ohio SHIP as tools for assessing the health of its community, and developing a community health strategic plan. The coalition has continued its collaboration to complete an updated community health assessment in 2019 and a community health improvement plan in 2020.

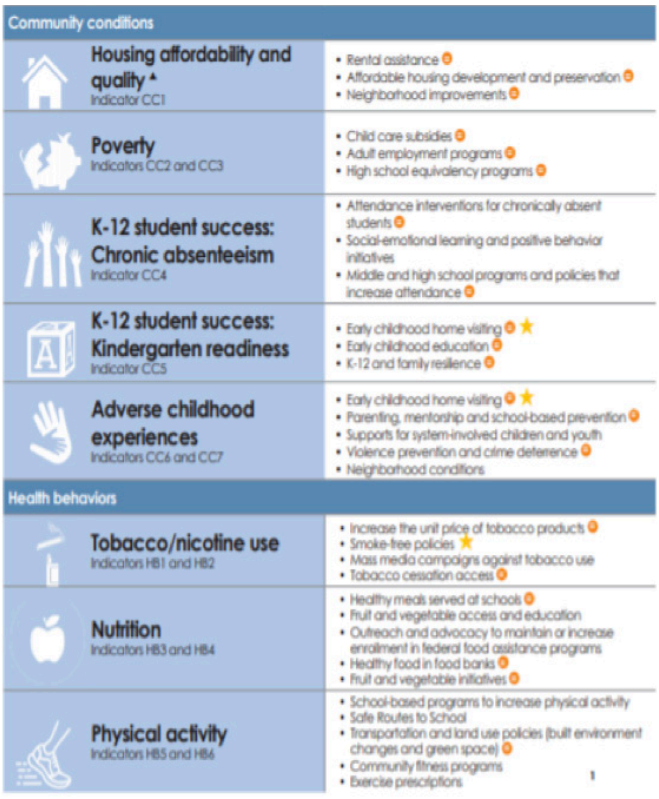


Figure 2: Ohio SHIP Areas of Focus

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 Partners for a Healthier Ross County looked to their local public health leaders for recommendations on models that could be utilized for the 2016 community health assessment and health improvement planning processes. This model was successful in creating the 2016 CHIP and it was the consensus of the group to utilize it again for the 2020 CHIP.

Mobilizing Action Through Planning and 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 5).

Figure 5: M.A.P.P Six Phase Process and Four Assessments

Both the published assessment and plan are intended to inform decision makers and funders about the challenges Ross 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 Ross County.

While M.A.PP involves a six step process, Partners for a Healthier Ross County 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 2016 process, the Partners did not feel phases one and two were not necessary to complete, but agreed regular review of the vision and values regularly during this cycle would be appropriate.

ASSESSMENT DATA SUMMARY

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 Ross County community. The prevalence of death and disease and the corresponding behaviors and environmental factors were then aligned to help prioritize the issues the Ross County Health Coalition would focus on and use to develop a community health improvement plan. Figure 6 provides a summary.

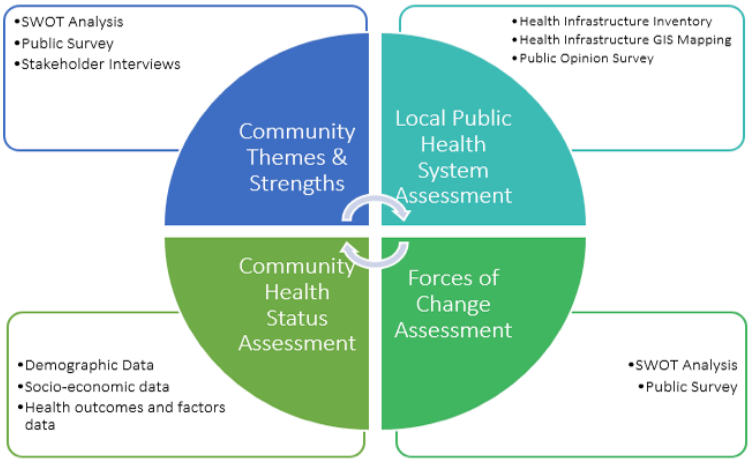


Figure 6: 2020 CHIP Data & Collection Process

The top causes of death in Ross 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.

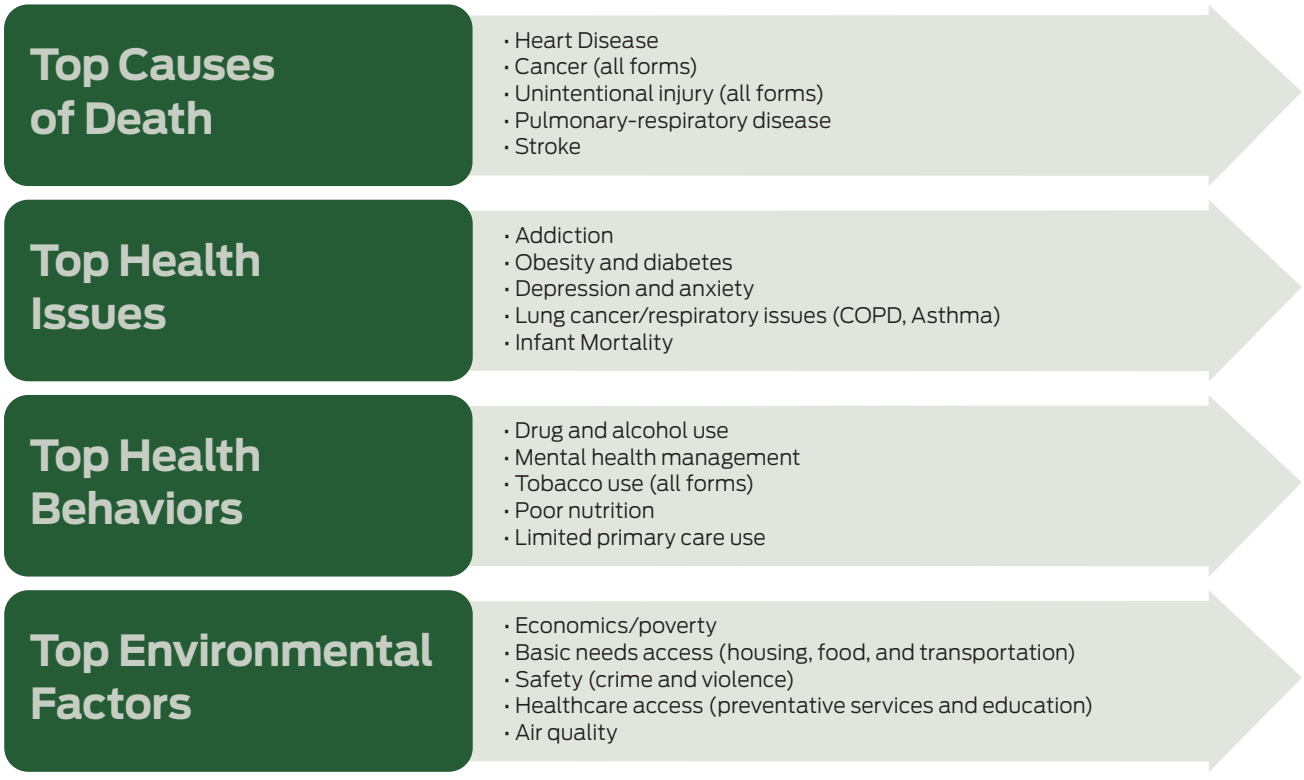


Figure 7: 2019 Ross County, OH Community Health Assessment Top Health Issues and Factors

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).

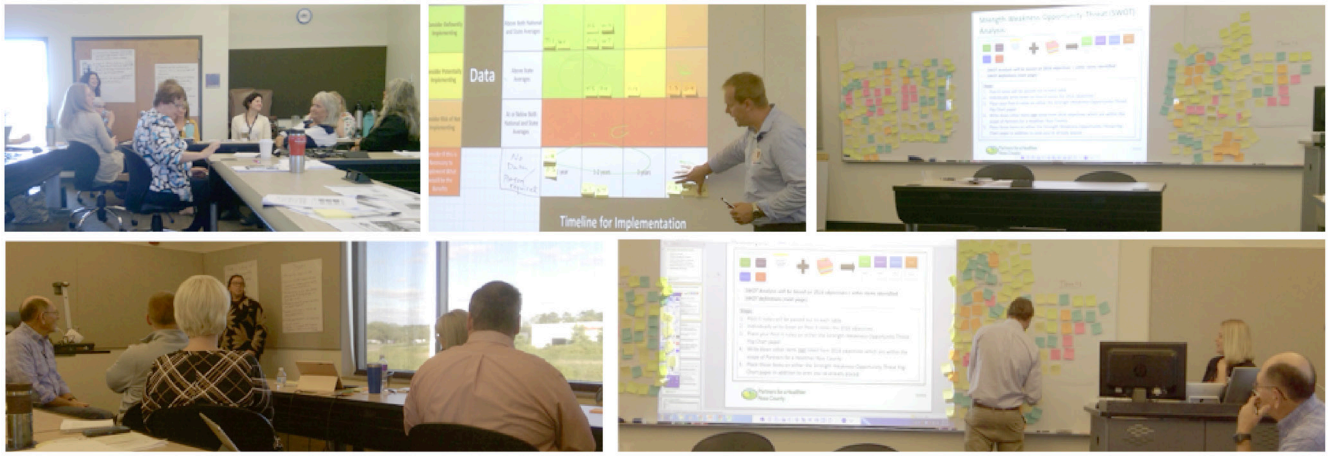
In addition, the top environmental factors contributing to the primary health issues were identified through the data collection and a public survey. Those factors identified were: economics and poverty; access to basic needs such as housing, food, and transportation; safety from crime and violence; access to healthcare, including preventative services and education.

This information was summarized and presented to the Partners for a Healthier Ross County members for review and consideration in August of 2019. This information was utilized as the building blocks for a strategic planning workshop scheduled in December of 2019 to outline the strategy and priorities of the 2020 community health improvement plan.

STRATEGIC PLANNING WORKSHOP

A strategic planning workshop was held on October 4, 2019 at the PACCAR Medical Education Center. A total of 21 members of the Partners for a Healthier Ross, and other community agency representatives attended the event. A certified Lean Six Sigma Black 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 2016 health assessment and 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.



OUR PLANS TO ADDRESS PRIORITIES

After analysis of the updated data from the 2019 assessment, review of the 2016 community health improvement plan and discussion regarding current community need and capacity, the Partners For a Healthier Ross County reached consensus on the approach to the 2020 Community Health Improvement Plan. This includes:

1. Continuing to focus on the major health issues identified in the 2016 assessment – substance use disorder, mental health, lung and respiratory disease (including tobacco use and vaping prevention / cessation and environments), obesity and diabetes prevention and child safety and wellness.

2. 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.

3. Add Access to Care as a priority area to better address the indicators identified by the community in the public survey data, as well as coordinate more efforts around health literacy, an objective not addressed in the last assessment.

4. Align the Child Safety and Wellness objective with the Appalachian Whole Child initiative coordinated by the Ross Pike Educational Service and Nationwide Children's Hospital.

The project timeline is set to start in January 2021 and end on December 31, 2023.

Future State

The community health improvement plan developed by the Partners for a Healthier Ross County is aligned with the group's overarching vision of *"all people within the region being empowered and inspired to reach their fullest physical and mental potential in a clean and safe environment through positive community collaborations."* 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 10% improvement in rankings over the next 3 years and more than 30% over the next six years (Figure 6). This is based on current improving socio-economic data and plans to improve health communication, accesses and navigation along the continuum.

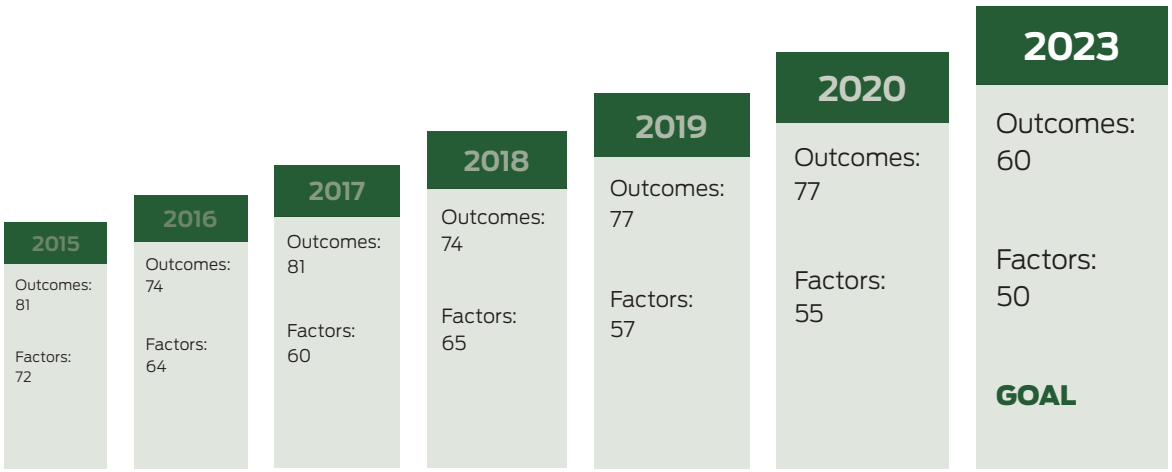


Figure 6: County Health Rankings: Current and Goal Metrics for Ross County, OH

UPDATED GOALS AND OBJECTIVES

The following Gantt chart provides an outline of the updated 2020 Ross County Community Health improvement plan. Details on activities, deliverable and responsibilities can be found in Appendix B. This document be updated on a yearly basis. Goals and Objectives with a asterisk (*) are in alignment with Ohio Department of Health's State Health Improvement Plan (SHIP) strategies and initiatives.

Strategic Question 1:
How do we as a public health community ensure continued access and improve navigation to all points of the public health continuum?

Work Plan

Goal 1:

Demonstrate engagement and cross-system collaboration across the community health continuum in Ross County.

Task	Deliverable	Who	Timeline
Ongoing assessment of community needs and gaps in resources	Ongoing 211 utilization reports CMS Utilization Data	Steering Committee (Jones, RCHD Rep) 211 Advisory Committee (Henning) Access to Care Committee (Long, Jones)	Ongoing
Establish venues and calendar of engagement for agencies on the continuum to interact and highlight services.	4 executed quarterly events each year	Steering Committee	First quarter 2021
Establish inter-agency referral protocol for organizations on the healthcare continuum.	Finalized policy and procedure Addendum to MOU	Steering Committee	Second quarter 2021
Design and implement a community health assessment education initiative.	Community education plan 100% executed	Steering Committee (Jones, RCHD Rep)	First quarter 2021 Ongoing
Improve transportation access and navigation in Ross County. * AC3, AC4	Coordinated Transportation Plan Mobility Management Program Utilization and Referral Data	Ross County Coordinated Transportation committee (Harris)	Ongoing
Develop and implement a comprehensive communication plan to highlight community health services.	Yearly communication plan 100% executed	Access to Care Committee (Long, Jones)	First quarter 2021
Develop and implement an agency leadership campaign to encourage inter-agency participation, education and engagement in the continuum and in the community.	Finalized communication plan Communication plan 100% executed	Steering Committee (Jones, RCHD Rep)	First quarter and Second quarter 2021

Goal 2:

Develop a long-term sustainability and operations plan for Partners for a Healthier Ross County.

Task	Deliverable	Who	Timeline
Develop operational infrastructure for coordination of activities and success measurement.	Dashboard of Community Health Metrics Business Plan	Steering Committee Advisory Council (Jones, RCDH Rep)	First quarter and Second quarter 2021
Align CHIP with community development priorities.	Inclusion of community health plan in regional development plans.	County Government City Government Economic Development	First quarter and Second quarter 2021

Strategic Question 2:
How do we as a public health community impact the culture of acceptance around unhealthy choices and environments?

Goal 1:

Establish a baseline and improvement plan for community health literacy.

Task	Deliverable	Who	Timeline
Design and implement health literacy measurement initiative across community health continuum.	Healthy Literacy Survey ED/Primary Care Utilization Campaign	Access to Care Committee (Long, Jones)	First quarter 2021
Create coordinated, accessible and culturally appropriate health messages around the five health priorities.	# Completed Surveys Agency Participation	Access to Care Committee (Long, Jones)	Second and third quarter 2021
Evaluate agency population outcomes.	Data reports	Access to Care Committee (Long, Jones)	First quarter 2022

Goal 2:

Develop improvement strategies and metrics for success for top health priorities.

Hope Partnership Project

Task	Deliverable	Who	Timeline
Integrate PHRC CHIP with the Heroin Partnership Advisory council strategic plan.	Integration plan 100% complete	Steering Committee (Jones, RCHD Rep)	First quarter 2021
Support youth drug prevention strategy. * HB2, MHA5, MHA6	Youth drug prevention work plan	Pike-Ross ESD (Kitchen)	Fourth quarter 2021
Support affordable housing. * CC1			Second quarter 2021
Support employment initiatives that support people in recovery. * CC3, MHA7			Fourth quarter 2021
Increase visibility of the Hope Partnership Project.			First and Second quarter 2021

Ross Mental Health Forum

Task	Deliverable	Who	Timeline
Align the Mental Health Forum with the Paint Valley ADAMH board strategic plan.	MOU	ADAMH (Swisher)	First quarter 2021
Develop a comprehensive campaign to reduce mental health stigma. * AC5, AC6, MHA1, MHA2, MAH3, MHA4	Communication plan	ADAMH (Swisher) NAMI (Cramner)	Second quarter 2021
Develop operational partnership with courts to reduce recidivism	Special court docket	Municipal Court (Schmidt)	First quarter 2021
Develop operational partnership with jails to reduce recidivism	Medication Access Transitional care	Ross County Jail (Dick)	First, Second and Third quarter 2021

Goal 2: (continued)

Develop improvement strategies and metrics for success for top health priorities.

Breathe Well Ross

Task	Deliverable	Who	Timeline
Decrease the number of people exposed to secondhand smoke in public spaces or multi-unit housing. * CD5, CD2, MIH2, MIH3	Policy Development Education Initiative	Breathe Well Ross (Hardesty)	Ongoing
Decrease the number of people exposed to secondhand smoke in public spaces or multi-unit housing. * CD5, CD2, MIH2, MIH3	Policy Development Education Initiative	Breathe Well Ross (Hardesty)	Second quarter 2021
Increase community readiness of community orgs and service providers to address tobacco dependence and increase individuals readiness to quit tobacco.* HB1, HB2	Community training Increased Cessation Services Peer support initiative	Breathe Well Ross (Hardesty)	Fourth quarter 2021
Create evidence of program sustainability.	CHIP Integration Increased partnerships	Breathe Well Ross (Hardesty)	Fourth quarter 2021
Raise community awareness of youth and vaping.*HB2	Community training Vaping task force Community action plan	Breathe Well Ross (Hardesty)	Ongoing

Live Well Ross

Task	Deliverable	Who	Timeline
Align Live Well Ross with the Creating Healthy Communities grant at RCHD.	CHIP integration	LiveWell Ross (Martin)	First and Second quarter 2021
Improve healthy eating across Ross County * HB3, HB4	Yearly activity plan	LiveWell Ross (Martin)	Fourth quarter 2022
Engage schools with healthy eating education, activities and initiatives * HB3, HB4	Education plan Healthy celebrations guide Updated menus	LiveWell Ross (Martin)	Third quarter 2021
Engage community with healthy eating education, activities and initiatives *HB3, HB4		LiveWell Ross (Martin)	First and Second quarter 2021
Increase active living across Ross County * HB5, HB6	Active transportation plan	LiveWell Ross (Martin)	Fourth quarter 2022
Improve bike and pedestrian infrastructure *HB5, HB6	Active transportation plan	LiveWell Ross (Martin)	Ongoing

The Children's Alliance

Task	Deliverable	Who	Timeline
Align PHRC with the Pike Ross ESD whole child initiative.*CC6, CC7, CC4, CC5	MOU Yearly goals and plan	Pike Ross ESD (Kitchen) Steering Committee (Jones, RCHD Rep)	Second quarter 2021
Align PHRC with the Appalachian Whole Child Initiative *CC6, CC7, CC4, CC5	MOU Yearly goals and plan	Adena Health System (Jones) Nationwide Children's Hospital (Irwin)	First quarter and second quarter 2021
Review collaboration data and priorities to identify key projects and partnership opportunities	Monthly report	Steering Committee	Third quarter 2021

PROJECT COMMUNICATION

The Partners For a Healthier Ross County 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 Ross County Health District and the Adena Health System.

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 subcommittees break-out the goals and objectives out into more detailed activities with aligned timelines to ensure each of the objectives continue to move forward.

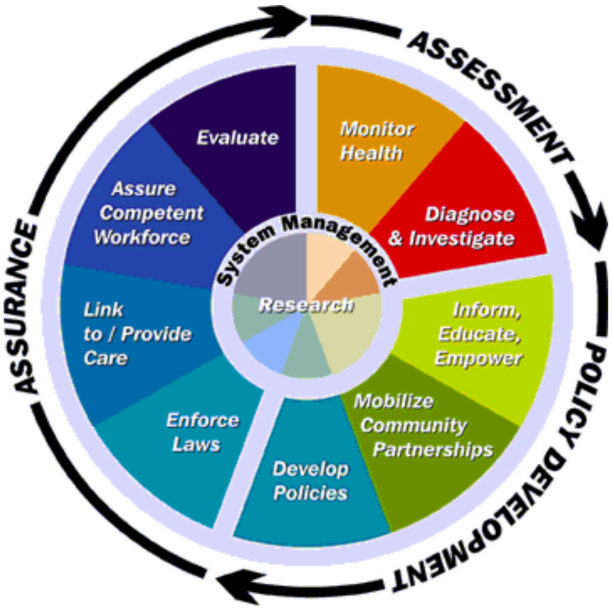
NEXT STEPS AND CALL TO ACTION

The Partners for a Healthier Ross County 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 Ross 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 September 2020, with new work group convening in October 2020.

The Partners for a Healthier Ross County believe 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 Partners for a Healthier Ross County 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.



APPENDICES

Partners for a Healthier Ross County

Appendix A: Community Partners

Partners for a Healthier Ross County Agency Members

Agency	Member	Role
Adena Health System	S. Kim Jones, MAS, GPC	Co-chair, Steering Committee, Member BreathWell Ross, LiveWell Ross, Access to Care and Mental Health Forum Member
	Donna Collier-Stepp, LISW, MSW	Steering Committee, Mental Health Forum Member
	Heather Welshimer	Steering Committee Member
Child Protection Center of Ross County	Julie Oates, PhD	Steering Committee, Mental Health Forum Member
Chillicothe and Ross County Public Library	James Hill, MLIS	Steering Committee Member
City of Chillicothe	Bill Bonner, Asti Powell, MPA	Steering Committee and BreathWell Ross Member, Access to Care
Hope Clinic of Ross County	Jamie Easterday, CNP	Steering Committee Member
Hopewell Health Center	Mark Bridenbaugh	Steering Committee Member
Paint Valley ADAMH Board	Melanie Swisher, LISW	Steering Committee and Mental Health Forum Member
The Pioneer Center	Amy Beeler	Steering Committee Member
Ross County Community Action	Julie Bolen-Kellough	Steering Committee Member
Ross County Health District	Michelle Long, RN, BSN	Co-chair, Steering Committee, Access to Care Member Steering Committee, Access to Care
	Kelly Dennis, RS	BreathWell Ross, LiveWell Ross and Mental Health Forum Member
	Kim Hardesty	Steering Committee, Access to Care, and BreathWell Member
Ross County Park District	Myranda Vance	Steering Committee Member
Ross County YMCA	Steve Clever, LISW	Steering Committee and LiveWell Ross Member
Scioto Paint Valley Mental Health Center	James Hagen, PhD Tonnie Guagenti, LSW	Steering Committee and Mental Health Forum Member
The Ohio State University Extension Office – Ross County	Lisa Barlage	Steering Committee Member
United Way of Ross County	Kasha Henning	Steering Committee Member and 2-1-1 Advisory Board Coordinator
VA Medical Center	Sherri Goudy	Steering Committee Member

Appendix B: Communication Plan

2020 CHIP Communication Plan

Goal 1:

Community awareness around Partners for a Healthier Ross County, Community Health Needs Assessment and County Health Rankings.

Task	Deliverable	Who	J-20	F-20	M-20	A-20	M-20	J-20	J-20	A-20	S-20	O-20	N-20	D-20	J-21	F-21	M-21	A-21	M-21	J-21	J-21	A-21	S-21	O-21	N-21	D-21
Community visibility of CHNA and CHRs	Infographic Press release Social Media Engagement	Smith DeBoard Jones Dennis																								
Facebook Live Event w/Mayor	Views and Engagement	Feeney Jones Dennis																								
Radio segment w/local media	Views and Engagement	Feeney Jones Dennis																								
Community feedback survey	Survey responses Social Media Engagement	Jones Dennis Smith																								
Civic and community group presentations	PP Presentation # of engagements	Jones Dennis PHRC Reps																								

Goal 2:

Community awareness and education around priority health issues.

Task	Deliverable	Who	J-20	F-20	M-20	A-20	M-20	J-20	J-20	A-20	S-20	O-20	N-20	D-20	J-21	F-21	M-21	A-21	M-21	J-21	J-21	A-21	S-21	O-21	N-21	D-21
Community health priority visibility	Infographics for each health priority Social Media Engagement	Smith DeBoard Jones Dennis																								
Facebook Live Series w/Adena	Views and Engagement	Adena Physicians Jones, Smith																								
Radio segment series on each health priority w/Mike Smith	Engagement	Feeney Jones Dennis																								
Community survey series	Survey responses Social Media Engagement	Jones Dennis Smith																								
Ongoing report on progress	Survey responses Social Media Engagement	Jones Dennis Smith																								

Appendix C: Partners for a Healthier Ross County List of CHIP Indicators

The CHIP Indicators will be utilized to monitor progress of the community health improvement plan over time by measuring health outcomes, health behaviors, and social determinants of health as they relate to key health improvement strategies led through the collaborative efforts of the Partners. Through program development, policy development, and health improvement initiatives, the ultimate goal of the partnership is to improve health of all Ross Countians over time. Tracking the key indicators will help the Partners evaluate successes and aim for continuous improvements of community programs, policies, and services for better health outcomes in our communities.

PHRC Health Outcomes

Desired Outcome	Indicator	Data Source	Lead Agency	Data Availability
Improve Overall Health	**Adult Health Status:** Percent of Adults, 18 and older that self-report having fair or poor health.	CHA, County Health Rankings	RCHD	Yes
	Years of Potential Life Lost before age 75: Years of potential life lost before age 75, per 100,000 population (age adjusted)	ODH	RCHD	Yes
	County Health Outcomes Rankings: Health Outcome Ranking for Ross County	County Health Rankings, RWJ Foundation	AHS	Yes
	County Health Factors Ranking: Health Factors Ranking for Ross County	County Health Rankings, RWJ Foundation	AHS	Yes

PHRC Identified Social Determinants that can affect Health Outcomes

Desired Outcome	Indicator	Data Source	Lead Agency	Data Availability
Achieve Health Equity for all Ross Countians	**Adult Poverty:** Percentage of Adults 18 years and older that live in households at or below the poverty threshold	UK	JFS	Yes
	Childhood Poverty: Percentage of children, ages 17 and below who live in households at or below the poverty threshold	UK	JFS	Yes
	Housing affordability: Number of affordable and available units per 100 renters with income below 50% of area median income.	UK	RCHD	Yes

PHRC Subcommittee: Live Well Ross (Diabetes and Obesity Prevention)

Desired Outcome	Indicator	Data Source	Lead Agency	Data Availability
Reduce Obesity, Diabetes, and Heart Disease	**Adult Diabetes:** Percentage of Adults 18 years and older that experience Diabetes	CHA, County Health Rankings	RCHD	Yes
	High risk populations identified in 2019 CHA: Age 65+, Less than $25K income, Males			
	Adult Obesity: Percentage of Adults 18 years and older that experience obesity	CHA, County Health Rankings	RCHD	Yes
	High risk populations identified in 2019 CHA: Age 30-64, Females			
	Adult Heart Disease: Percent of Adults, ages 18 and older that experience heart disease	CHA	RCHD	Yes
	High risk populations identified in 2019 CHA: Age 65+, Male, less than $25k income			
	Adult Physical Inactivity: Percent of Adults, ages 18 and older that report less than 30 minutes of physical activity each week	CHA	RCHD	Yes
	Youth Physical Activity: Percent of children, ages 6 – 11 who are physically active at least 60 minutes per day	UK	RCHD	No
	Priority Populations for activity indicators identified by the CHA: Income less than $25k per year, females, age 65+ (youth not included in 2019 CHA)			
	Adult fruit consumption: Percent of Adults ages 18 and older that did not report having more than one servings of fresh fruit and / vegetables per day.	CHA	RCHD	Yes
	Youth fruit and vegetable consumption: Percent of children, ages 6 – 11 who did not consume fruit in past 7 days	Creating Healthy Communities program	RCHD	Yes
	Priority Populations for fruit and vegetable consumption identified by the CHA: Income less than $25k per year, Males, those that are Less than 30 years of age (youth not included in 2019 CHA)			

Appendix C: (continued)

PHRC Subcommittee: Hope Partnership Project (Substance use prevention)

Desired Outcome	Indicator	Data Source	Lead Agency	Data Availability
Reduce Addiction and Substance Use Disorder	**Unintentional Overdoses:** Number of unintentional Overdoses per year for Ross County Residents	Ross County Coroner	PORT, RCHD DR Program	Yes
	High risk populations identified in 2019 CHA: Age 65+, Less than $25K income			
	Adult Alcohol Use: Percent of Adults, 18 and older that report consuming alcohol	CHA, County Health Rankings	RCHD, HPP	Yes
	High risk populations identified in 2019 CHA: income greater than $25K, Males, those that are less than 30 years of age			
	Adult Marijuana Use: Percent of Adults, 18 and older that report using marijuana	CHA	RCHD, HPP	Yes
	High risk populations identified in 2019 CHA: Age 65+, Less than $25K income			
	Youth Drug Use: Percent of high school students that have used alcohol in last 30 days.	UK	RCHD DR Program, HPP	Yes

PHRC Subcommittee: Mental Health Forum

Desired Outcome	Indicator	Data Source	Lead Agency	Data Availability
Improve Mental Health of all Ross Countians	**Adult Depression or anxiety:** Percentage of Adults ages 18 and older that experience depression or anxiety	CHA	Mental Health Forum	Yes
	High risk populations identified in 2019 CHA: Females, Less than 30 years of age, Age 30-64, Less than $25K income			
	Adult suicide deaths: Percent of Adults, 18 who died of suicide, per 100,000 population	ODH Vital Statistics, OHMAS	Mental Health Forum	Yes
	Youth suicide deaths: Number of deaths due to suicide for youth, ages 8-17 per 100,000 population	ODH Vital Statistics, OHMAS	Mental Health Forum	Yes
	Youth depression: Percent of youth, ages 12-17 who experienced a major depressive episode within the past year	UK	Mental Health Forum	No

Appendix C: (continued)

PHRC Subcommittee: Access to Care

Desired Outcome	Indicator	Data Source	Lead Agency	Data Availability
Improve access to healthcare for all Ross Countians	**Uninsured Adults:** Percent of adults ages 19-64 who are uninsured	ACS	Access to Care	Yes
	High risk populations identified in 2019 CHA			
	Uninsured children: Percent of children, ages 0- 18 who are uninsured.	ACS	Access to Care	Yes
	Primary Care health professional shortage areas: Percentage of Ross Countians living in a mental care health professional shortage area.	HRSA	Access to Care	Yes, County Health Rankings
	Adult mental health care: Percent of adults, ages 18 and older, who reported need within last year for treatment / counseling that was not received	UK	Access to Care	No

PHRC Subcommittee: Breathe Well Ross

Desired Outcome	Indicator	Data Source	Lead Agency	Data Availability
Reduce Lung and Respiratory Disease	**Adult cancer Rates:** Percent of Adults, 18 and older that experience cancer.	CHA, County Health Rankings	RCHD	Yes
	Adult Lung Cancer Rates: Percent of Adults, 18 and older that experience lung cancer	ODH cancer registry, CHA	RCHD	Yes
	High risk populations identified in 2019 CHA: Age 65+, Less than $25K income			
	Adult Asthma: Percent of Adults, 18 and older that experience asthma	CHA	RCHD	Yes
	High risk populations identified in 2019 CHA: Less than $25K income			
	Adult Smoking: Percent of Adults, ages 18 and older that are current smokers	CHA	RCHD	Yes
	Youth all-Tobacco and Nicotine use: Percent of high school students who have used cigarettes, smokeless tobacco, cigars, e-cigarettes, and vaping products			
	Priority Populations identified by the CHA: Income less than $25k per year, Males, those that are Less than 30 years of age and Youth.			

Appendix C: (continued)

PHRC: Infant Mortality and Child Behavioral Health

Desired Outcome	Indicator	Data Source	Lead Agency	Data Availability
Reduce Infant Mortality	**Infant Mortality:** Number of deaths for infants under age of 1 per 1,000 live births.	ODH Vital Statistics	RCHD WIC	Yes
Improve Childhood Health	**Preterm births:** Percent of live births that are preterm, before 37 weeks	ODH Vital Statistics	RCHD WIC	Yes
	Adverse Childhood Experiences (ACES): Percent of children, ages 0-17 who have experienced two or more adverse experiences.	UK	JFS	Yes
	Child abuse and neglect: Rate of screened-in child abuse and neglect reports per 1,000 children in population	UK	JFS	Yes