Georgia Department of Public Health
District 4 Public Health

Community Health Improvement Plan Annual Report for July 23, 2018-August 30, 2019

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DISTRICT 4 PUBLIC HEALTH

Contents

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Introduction

Background Information

District 4's CHIP was developed alongside our community partners between April 2018 and July 2018. Several public meetings were held and were attended by community members from all 12 counties (see CHIP for detailed description). During those meetings, the top 3 priorities for the district were determined, a plan was developed to address those issues, and it was agreed that all involved would work together as one community to get the work done[1]. In addition to the CHIP (which covers all 12 counties as 1 district), District 4 is also in the process of creating individual county-level assessments for each of the 12 counties, based on their unique data, needs, and capacities. As of this publication, the first 6 assessments are being finalized.

Process for Monitoring and Revision

The CHIP will be reviewed and revised annually, during this time the CHIP Steering Committee will identify areas that are no longer feasible (due to changing partnerships, funding, or circumstances), at that time they will either be altered to fit the current situation or will be replaced with a more feasible goal. The goals and strategies that are working will be reviewed to ensure that they are on schedule to be completed in the time allotted.

The CHIP will be monitored by the Accreditation Coordinator through the VMSG Dashboard. This cloud-based dashboard is used to track various plans and projects and can be used by outside partners as well. Anyone responsible for implementation of a goal or strategy will get an email reminder on a monthly basis, in which they will be instructed to go to the website and update their progress.

Community Context

In the first year of the CHIP, District 4 experienced a shift in our relationship with Mercer University, necessitating the removal of several strategies that were originally planned to be carried out by Mercer MPH students. District 4 and Mercer University have agreed to monitor the implementation of the CHIP until August 2020 and resume using Mercer MPH students at that time.

Progress on CHIP Priority Areas

Priority 1: Poverty

About this Priority

District 4's vision for addressing poverty in our community is that we will foster a collaborative approach to poverty reduction through the utilization of existing assets as well as community outreach and education.

Goal 1A: Address poverty throughout District 4.

Objective 1.1: Measure and increase capacity in all 12 counties, to create a district-wide network of community partners by 2021.

Our intervention strategies include:

- Analyze poverty-centered resources identified in county-level asset lists.
- Identify gaps in poverty-centered services.
- Conduct poverty simulations and trainings.

Objective 1.2: By 2013, develop, implement, and evaluate a poverty reduction plan

Our intervention strategies include:

- Using best practices models, develop a plan that addresses poverty.
- Implement the plan on a local level through local Family Connection Collaboratives.
- Evaluate the plan (Process Evaluation).
- Reduce the number of people living below the poverty line in District 4.

Progress

District 4 is nearing the completion of the first 6 county-level assessments, which include the asset lists that will be used to identify gaps in poverty resources in each county. The next step, to be completed in the next year, is to partner with Circles of LaGrange to analyze the asset lists. District 4's goal is to work with Circles to train members of all 12 Family Connection Collaboratives in poverty simulations, so that they can disseminate that information into their communities.

Next Steps

Moving forward, District 4 has decided to avoid the redundancy of establishing new, priority-based subcommittees, the plan will instead use the existing structure of the Family Connection Collaboratives, with whom the district already has an established relationship. To that end, *the Poverty Priority section of the CHIP was edited to reflect those changes (under Responsible for*

Implementation). It was also clarified that District 4 will be using the asset lists to analyze the poverty-centered resources. Although it is not stated directly in the plan, the District does plan to replace Columbus State University's Center for Health Disparities with another Academic Partner (Information will be updated upon the identification of a new academic partner).

Priority 2: Obesity

About this Priority

The vision for this priority is that District 4 will support obesity prevention and offer broad opportunities for all populations, regardless of socioeconomic status, to lead healthy, productive lives.

Goal 2A: Create an environment that is conducive to healthy behaviors, thus reducing the prevalence of obesity and its related maladies in District 4.

Objective 2.1: By 2021, increase the number of schools in District 4 that participate in the Georgia SHAPE program by 50%.

Our intervention strategies Include:

- Gain buy-in from local school boards and principals.
- Gain buy-in from County Boards of Health.
- Reach out to State DPH for trainings and funding.

Objective 2.2: By 2022, increase the accessibility of existing WIC farmers markets to residents of all 12 counties.

Our intervention strategies include:

- Locate and begin communication with farmers who accept WIC vouchers.
- Identify locations for potential markets.
- Educate WIC participants about this service.
- Promote the program to Boards of Health
- Include Cooking Matters demonstrations in the farmers markets.

Goal 2B: Health is considered in all local policies.

Objective 2.3: By 2021, increase the number of local officials and leaders that receive education and information on the benefits of taking a health approach to traditionally non-health policies that include components to promote health from zero to 24.

Our intervention strategies include:

- Educate decision makers regarding the benefits of taking a health approach to all policies.

Goal 2C: Address obesity-related chronic diseases identified in the Community Health Assessment.

Objective 2.4: By 2023, reduce the rates of obesity-related chronic disease, in the five counties with the highest obesity rates, by 3%.

Our intervention strategies include:

- Include identified chronic disease outcomes from the CHA in the county-level workplans.
- Develop action steps in the county workplans to address obesity-related chronic diseases.

Progress

In the first year of the CHIP, WIC was able to locate and begin communication with farmers who accept WIC vouchers, identify locations for potential markets, educate WIC participants about the service, promote the program to the Boards of Health, and were able to include food demonstrations in the farmers markets.

Next Steps

Over the next year, the District Health Director will be educating local governmental agencies and organizations about health in all policies to encourage physical activity, as well as begin promoting the GA SHAPE program to our Boards of Health (specifically the School Superintendent). *Changes that were made to Objective 2.2 include changing the wording of the objective to more accurately describe WIC farmers market activities. In Objective 2.4 one of the intervention strategies was changed to "develop" action steps, rather than "put into practice". Language about "subcommittees" was removed.*

Priority 3: Access to Care and Preventative Services

About this Priority

District 4's vision is that all residents will have equitable access to healthcare and preventative services, including mental healthcare, substance abuse prevention and treatment, as well as standard medical care.

Goal 3A: Increase access to quality healthcare services for vulnerable populations and the underserved.

Objective 3.1: Measure and increase capacity in all 12 counties, to create a district-wide network of community partners that address access by 2021.

Our intervention strategies include:

- Conduct county-level assessments to identify gaps in services and assess information flow.

- Publish assessment results on District website and social media

- Conduct necessary trainings for community partners, based on assessment results; trainings may include cultural competency, leadership, grant writing, six sigma, telemedicine, best practices, and conflict resolution.

Goal 3B: Build capacity for health services using telehealth.

Objective 3.2: By 2022, increase capacity for health services using telemedicine by 20%.

Our intervention strategies include:

- Educate providers on the benefits of telehealth.
- Create peer-to-peer support system for those who use telehealth.
- Partner with State DPH for trainings and funding.
- Conduct a conference or summit for providers to share best practices and learn more about telehealth.
- Partner with State DPH for trainings and funding.

Goal 3C: Build capacity for school-based health programs.

Objective 3.3: By 2022, increase the number of school systems that offer school-based health services by 20%.

Our intervention strategies include:

- Use assessment results to approach school systems regarding the implementation of school-based health services.
- Find existing (or create new) Youth Advisor Advocacy groups to build support.
- Garner support from PTA/PTO groups in individual schools.
- Present at School Nurse Summit.
- Reach out to Hospital Authority.

Goal 3D: Build capacity for evidence-based mental health and substance abuse services.

Objective 3.4: By 2022, implement a plan to increase mental health and substance abuse linkages and fill gaps in public health and allied services, which were identified in goal 3A.

Our intervention strategies include:

- Continue to partner with ACT coalition.
- Create, Implement, and Evaluate a Communication Plan for CHIP Coalition.
- Develop a workplan to bridge linkage gaps identified in goal 3A.

Progress

This year, District 4 joined the Troup County Family Connection School Based Health Center advisory team and steering team. The district currently assessing how our organization can be an asset to this project, particularly in the areas of billing, immunizations, and health education. ACT Coalition has met quarterly over the past year to help increase mental health and substance abuse linkages and fill gaps in public health and allied services. ACT will have the tools to be more specific with their efforts when the county-level assessments are complete (so far, 6 are near completion).

Next Steps

Over the next year, District 4 will complete the county-level assessments, so that gaps in information flow can be addressed. The District will continue to partner with Troup Family Connection to establish a school-based health center in Troup county, and will use this experience to reach out to other counties to encourage them do the same. Tracking exactly where telehealth is already being used in the district and reaching out the State office to begin planning our Telehealth Conference is also a top priority over the next year. *Changes that were made to this priority area include removing the "subcommittee" language from the "Responsible for Implementation" section of Objective 3.1 and replacing it with Family Connection, rearranging the order of the Intervention strategies in Objective 3.2, adding Troup Family Connection to the "Responsible for Implementation" section of Objective 3.3, clarifying that the public health and allied services being targeted in Objective 3.4 were specifically mental health and substance abuse, and correcting the name of the possible collaborator from Amanda Pierce to Sheila Pierce.*