



# **Public Health**

Prevent. Promote. Protect.

**MORGAN COUNTY HEALTH DEPT.**

## **Community Health Improvement Plan 2022-2024**

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**Date:** 02/11/22

**Approved:** 02/17/22

**Revised:** 10/18/23 & 7/14/24

# 2022-2024



# Morgan County Community Health Improvement Plan

*Released February 2022*



**Public Health**  
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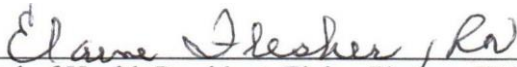
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## Signature Page

This Community Health Improvement Plan (CHIP) has been developed for use by the Morgan County Health Department. By affixing the signature indicated below, this CHIP is hereby approved for implementation and intended to provide specific decision-making guidelines, as well as protocols for the execution of the plan. This document is a "living document" and will be updated on an as needed basis. This CHIP will be reviewed annually. Review dates will be recorded in the table below.

This CHIP was approved and adopted by the Morgan County General Health District Board of Health:

  
 Board of Health President, Elaine Flesher, RN

2/17/2022  
 Date

  
 Health Commissioner, Richard D. Clark, MD

2/17/2022  
 Date

## Review History

Date	Description of Action	Name and Title
02/08/23	Pg 26 - Added two policy goals	Accreditation Team
05/17/23	Pg 23 - Updated action steps in years 2 & 3	Accreditation Team
05/17/23	Pg 24 - Updated action steps in year 2	Accreditation Team
10/11/23	Pg 14 – Clarified that participants were of varying background	Accreditation Team
10/11/23	Pg 15 – Included additional assessments that were used	Accreditation Team
10/11/23	Pg 15 – Clarified that the vote was based on health data provided	Accreditation Team
10/11/23	Pg 27 – Changed timeline for meeting to report on progress	Accreditation Team
10/18/23	Pg 24 – Add new action step in year 3	Accreditation Team
07/14/24	Pg 25 - Added policy goals	Accreditation Team

## Executive Summary

### Introduction

Public health is influenced by many factors including individual health behaviors, access to health care, community characteristics, the environment, and services offered and delivered by local agencies. All of these factors are identified and considered when developing a Community Health Improvement Plan (CHIP). A CHIP is a community driven, long-term plan to address issues identified in a Community Health Assessment (CHA). The purpose of the CHIP is to improve the health of the county. A CHIP is designed to set priorities, direct the use of resources, and develop and implement projects, programs, and policies. The CHIP involves more than the roles and responsibilities of the health department alone and must include participation from a broad spectrum of community partners. This CHIP reflects the results of a collaborative planning process that includes involvement by a variety of community agencies. Over the next three years, these priorities and strategies will be implemented at the county level with the goal of improving community health and creating lasting, sustainable change.

### Public Health Accreditation Board (PHAB) Requirements

National Public Health Accreditation status through the Public Health Accreditation Board (PHAB) is the measurement of health department performance against a set of nationally recognized, practice-focused and evidenced-based standards. The goal of the national accreditation program is to improve and protect the health of the public by advancing the quality and performance of Tribal, state, local, and territorial public health departments. PHAB requires that CHIPs be completed at least every five years, however, Ohio state law (ORC 3701.981) requires that health departments and hospitals collaborate to create a CHIP every three years. Additionally, PHAB is a voluntary national accreditation program, however the State of Ohio requires that all local health departments become accredited by 2020, making it imperative that all PHAB requirements are met.

PHAB standards also require that a community health improvement model is utilized when planning CHIPs. This CHIP was completed using NACCHO's MAPP process. MAPP is a national, community-driven planning process for improving community health. This process was facilitated by HCNO in collaboration with various local agencies representing a variety of sectors.

### Inclusion of Vulnerable Populations (Health Disparities)

Approximately 19% of Morgan County residents were below the poverty line, according to the 2014-2018 American Community Survey 5-year estimates. For this reason, data is broken down by income (less than \$25,000 and greater than \$25,000) throughout the report to show disparities.

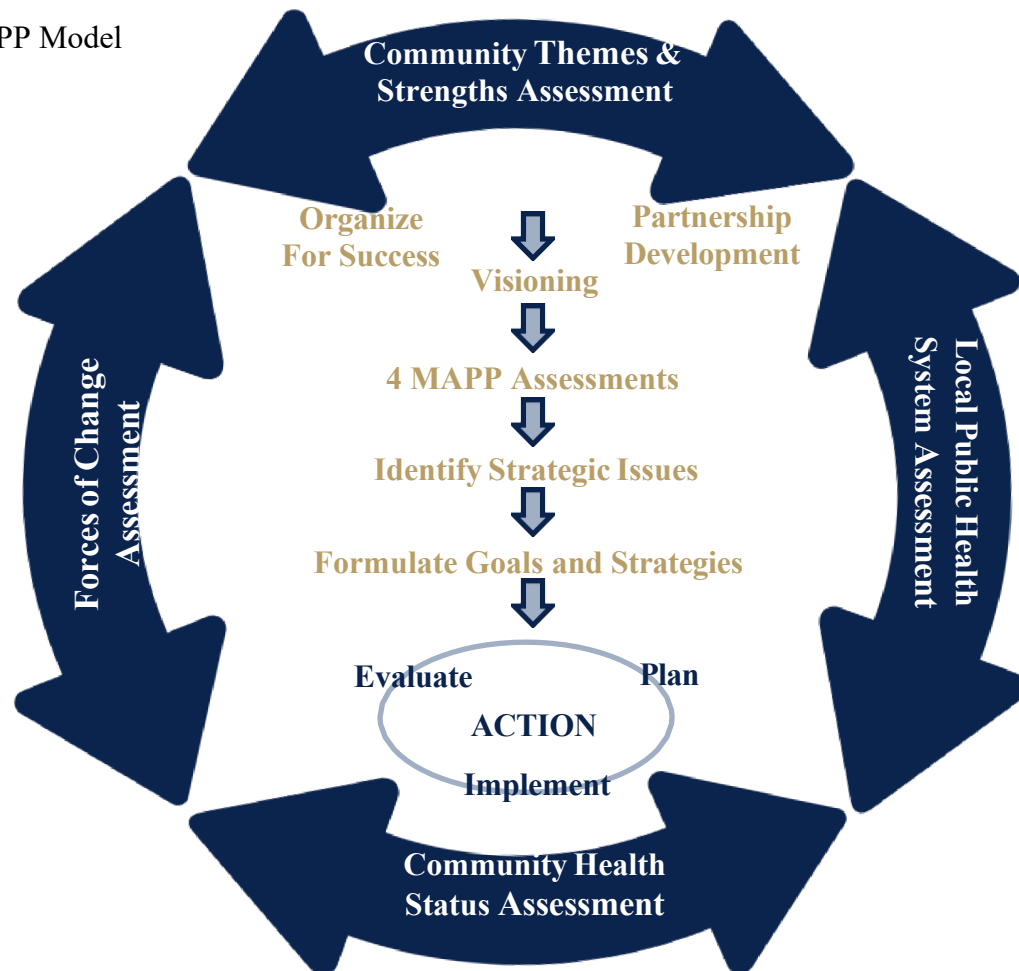
## Mobilizing for Action through Planning and Partnerships (MAPP)

NACCHO's strategic planning tool, MAPP, guided this community health improvement process. The MAPP framework includes six phases which are listed below:

1. Organizing for success and partnership development
2. Visioning
3. The four assessments
4. Identifying strategic issues
5. Formulate goals and strategies
6. Action cycle

The MAPP process includes four assessments: community themes and strengths, forces of change, local public health system assessment, and the community health status assessment. These four assessments were used by the Morgan County Health Department to prioritize specific health issues and population groups which are the foundation of this plan. Figure 1.1 illustrate how each of the four assessments contributes to the MAPP process.

Figure 1.1. The MAPP Model



## MCHD Community Health Improvement Plan

### Alignment with National and State Standards

The 2022 Morgan County Community Health Improvement Plan priorities align perfectly with regional, state, and national priorities. Morgan County will be addressing the following priority health factors: Access to care, health behaviors, and community conditions. Additionally, Morgan County will be addressing the following priority health outcomes: Communication of available resources for access to care, mental health and addiction, and chronic disease prevention and management.

#### Healthy People 2030

Morgan County's priorities also fit specific Healthy People 2030 goals. For example:

- Health Care Access and Quality (AHS) – 01: Increase the proportion of people with health insurance
- Chronic Disease (NWS) – 03: Reduce the proportion of adults with obesity

Please visit [Healthy People 2030](#) for a complete list of goals and objectives.

### Ohio State Health Improvement Plan (SHIP)

The **2020-2022 SHIP** serves as a strategic menu of priorities, objectives, and evidence-based strategies to be implemented by state agencies, local health departments, hospitals and other community partners and sectors beyond health including education, housing, employers, and regional planning.

The SHIP includes a strategic set of measurable outcomes that the state will monitor on an annual basis. Given that the overall goal of the SHIP is to ensure all Ohioan's achieve their full health potential, the state will track the following health indicators: self-reported health status (reduce the percent of Ohio adults who report fair or poor health) and premature death (reduce the rate of deaths before age 75).

The SHIP also takes a comprehensive approach to improving Ohio's greatest health priorities by identifying 3 priority factors (community conditions, health behaviors, and access to care) that impact the 3 priority health outcomes (mental health and addiction, chronic disease, and maternal and infant health).

The three priority factors include the following:


1. **Community Conditions** (includes housing affordability and quality, poverty, K-12 student success, and adverse childhood experiences)
2. **Health Behaviors** (includes tobacco/nicotine use, nutrition, and physical activity)
3. **Access to Care** (includes health insurance coverage, local access to healthcare providers, and unmet needs for mental health care)

MCHD Community Health Improvement Plan

The three priority health outcomes include the following:

1. **Mental Health and Addiction** (includes depression, suicide, youth drug use, and drug overdose deaths)
2. **Chronic Disease** (includes conditions such as heart disease, diabetes and childhood conditions [asthma and lead])
3. **Maternal and Infant Health** (includes infant and maternal mortality and preterm births)

The Morgan County CHIP was required to select at least 1 priority factor, 1 priority health outcome, 1 indicator for each identified priority, and 1 strategy for each selected priority to align with the 2020-2022 SHIP.

Note: This symbol  will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2020-2022 SHIP. Whenever possible, the Morgan County CHIP identifies strategies likely to reduce disparities and inequities. Throughout the report, hyperlinks will be highlighted in **bold, gold text**.

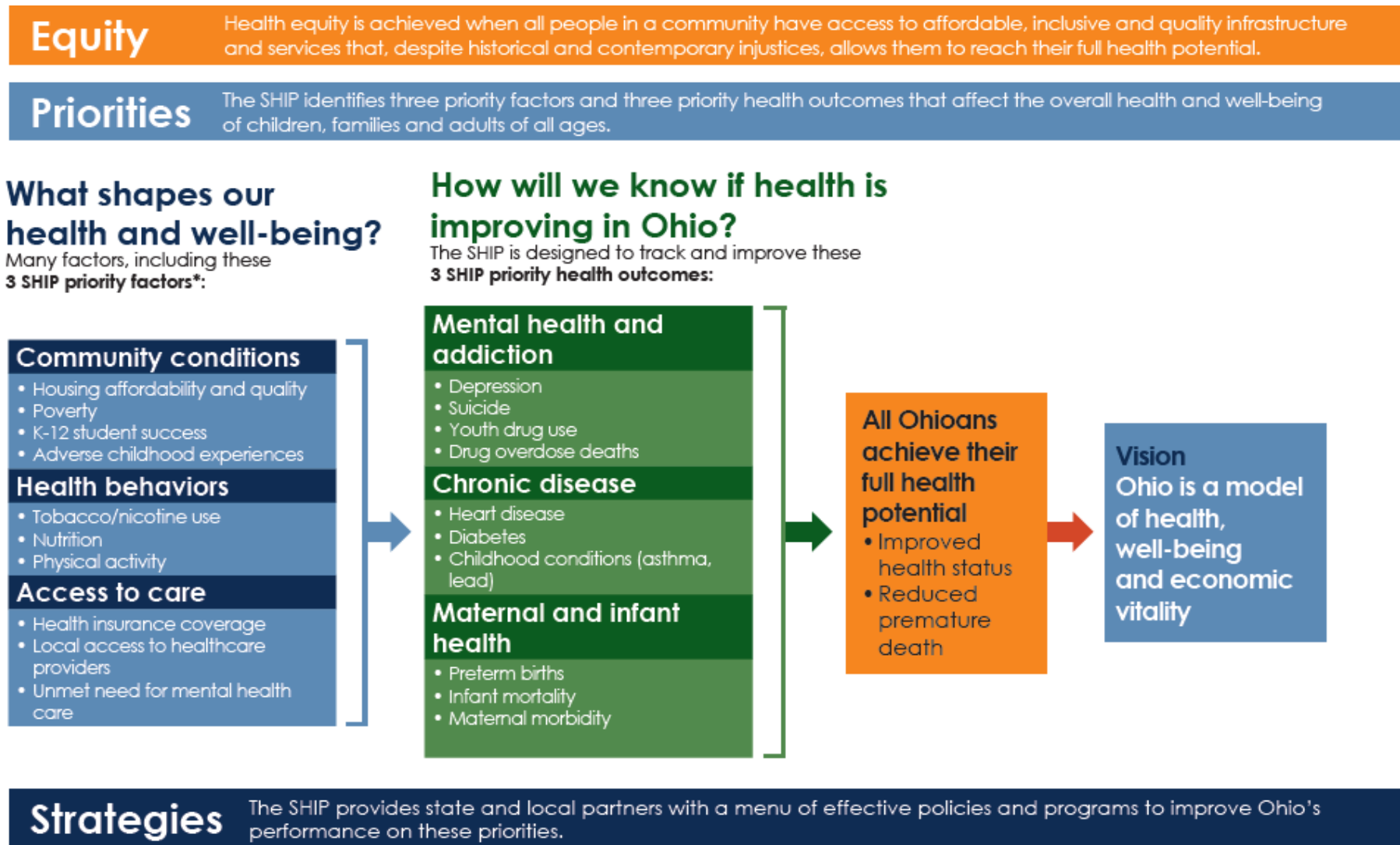
The following Morgan County priority factors, priority indicators, and strategies very closely align with the 2020-2022 SHIP:

**Figure 1.2 2022 Morgan County CHIP Alignment with the 2020-2022 SHIP**

Priority Factors	Priority Indicators	Strategies to Impact Priority Indicators
Access to Care	Lack of knowledge of available resources	Communication of community resources
Priority Health Outcomes	Priority Indicators	Strategies to Impact Priority Indicators
Chronic Disease	High rate of obesity and tobacco use impacting health	Health and wellness education



**Figure 1.3 2020-2022 State Health Improvement Plan (SHIP) Overview**



## Vision and Mission

Vision statements define a mental picture of what a community wants to achieve over time while the mission statement identifies why an organization/coalition exists and outlines what it does, who it does it for, and how it does what it does.

### The Vision of the Morgan County Health Department

The greatest wealth of a community is the health of the people.

### The Mission of the Morgan County Health Department

To provide quality client-centered public health services to enhance the well-being of the entire population of Morgan County.

## Community Partners

The CHIP was planned by various agencies and service-providers within Morgan County. From September 2021 to December 2021, the Morgan County Health Department and community leaders from various agencies reviewed many data sources concerning the health and social challenges that Morgan County residents are facing. They determined priority issues which, if addressed, could improve future outcomes; determined gaps in current programming and policies; examined best practices and solutions; and determined specific strategies to address identified priority issues. We would like to recognize these individuals and thank them for their dedication to this process:

### Morgan County Health Department Community Partners Participation List

Grace United Methodist Charge	Morgan County Engineers
Kate Love Simpson Morgan County Library	Morgan County Jobs & Family Services
Maxwell's Hunting & Fishing Supplies	Morgan County Mobility Services
MedMoCo	Morgan County United Ministries
MoCo Family Practice	Morgan Metropolitan Housing
Morgan County Board of Health	North Valley Bank
Morgan County Commissioners	Riverside Landing
Morgan County Developmental Disabilities	Washington-Morgan Community Action
Morgan County Emergency Management Agency	Windsor Township Trustees
Morgan County Emergency Medical Services	Workman Wood

## Community Health Improvement Process






Beginning in September 2021, the Morgan County Health Department and community leaders met multiple times and completed the following planning steps:

1. Initial Meeting
  - Review the process and timeline
  - Identify CHIP committee members as any and all interested community partners
  - Create or review vision
2. Identify five regional health issues based on the CHA
3. Community Themes and Strengths Assessment
  - Open-ended questions for committee on community themes and strengths reviewed and discussed
4. Forces of Change Assessment
  - Open-ended questions for community partners on forces of change reviewed and discussed
5. Local Public Health Assessment
  - Review the Local Public Health System Assessment with community partners
6. Gap Analysis
  - Determine discrepancies between community needs and viable community resources to address local priorities
  - Identify strengths, weaknesses, and evaluation strategies
7. Quality of Life Survey
  - Review results of the Quality-of-Life Survey with community partners
8. Choose Priorities
  - Use of quantitative and qualitative data to prioritize target impact areas
9. Rank Priorities
  - Rank health problems based on magnitude, seriousness of consequences, and feasibility of correcting
10. Strategic Plan Identification
  - Identification of evidence-based strategies to address health priorities
11. Best Practices
  - Review of best practices, proven strategies, evidence continuum, and feasibility continuum
12. Resource Assessment
  - Determine existing programs, services, and activities in the community that address specific strategies
13. Draft Plan
  - Review of all steps taken
  - Action step recommendations based on one or more of the following: enhancing existing efforts, implementing new programs or services, building infrastructure, implementing evidence-based practices, and feasibility of implementation

# Community Health Status Assessment

Phase 3 of the MAPP process, the Community Health Status Assessment, or CHA, is a 100+ page report that includes primary data with over 100 indicators and hundreds of data points related to health and well-being, including social determinants of health. Over 50 sources of secondary data are also included throughout the report. The CHA serves as the baseline data in determining key issues that lead to priority selection. The full report can be found at <https://morganpublichealth.org/>. Below is a summary of county primary data and the respective state and national benchmarks.

## Adult Trend Summary

Comparisons	Morgan County 2021	Ohio 2019	U.S. 2019
<b>Health Care Coverage</b>			
Uninsured 	6%	9%	11%
<b>Access and Utilization</b>			
Had at least one person they thought of as their personal doctor or healthcare provider	84%	80%	77%
Visited a doctor for a routine checkup in the past year 	64%	78%	78%
Needed to see a doctor in the past 12 months but could not because of cost 	8%	12%	12%
<b>Preventive Medicine</b>			
Had a pneumonia vaccination (age 65 and over)	74%	75%	73%
Had a flu vaccine in the past year (age 65 and over)	71%	63%	64%
Ever had a shingles or zoster vaccine	25%	29%*	29%*
<b>Women’s Health</b>			
Had a mammogram within the past two years (age 40 and older)	80%	74%**	72%**
Had a Pap smear within the past three years (age 21-65)	67%	79%**	80%**
<b>Men’s Health</b>			
Had a prostate-specific antigen (PSA) test in the past two years (age 40 and older)	55%	34%**	33%**
<b>Oral Health</b>			
Visited a dentist or dental clinic in the past year	59%	67%**	68%**
<b>Health Status Perceptions</b>			
Rated health as excellent or very good	49%	48%	51%
Rated health as fair or poor 	21%	19%	18%
Rated physical health as not good on four or more days (in the past 30 days)	22%	24%**	23%**
Average days that physical health not good in past month † 	4.6	4.1**	3.7**
Rated mental health as not good on four or more days (in the past 30 days)	39%	26%**	24%**

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Comparisons	Morgan County 2021	Ohio 2019	U.S. 2019
<b>Health Status Perceptions Continued</b>			
<b>Average days that mental health not good in past month</b> ‡	5.4	4.8**	4.1**
<b>Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation</b> (on at least one day during the past 30 days)	43%	24%**	24%**
<b>Weight Status</b>			
<b>Obese</b>	45%	35%	32%
<b>Overweight</b>	29%	35%	35%
<b>Tobacco Use</b>			
<b>Current smoker</b> (currently smoke some or all days)	21%	21%	16%
<b>Former smoker</b> (smoked 100 cigarettes in lifetime & now do not smoke)	22%	24%	25%
<b>Current e-cigarette user</b> (vaped on some or all days)	4%	5%*	4%*
<b>Alcohol Consumption</b>			
<b>Current drinker</b> (drank alcohol at least once in the past month)	56%	51%	54%
<b>Binge drinker</b> (defined as consuming more than four [women] or five [men] alcoholic beverages on a single occasion in the past 30 days)	21%	18%	17%
<b>Drove after having perhaps too much alcohol to drink</b> (in the past month)	6%	4%**	3%* *
<b>Cardiovascular Disease</b>			
<b>Had angina or coronary heart disease</b>	6%	5%	4%
<b>Had a heart attack or myocardial infarction</b>	7%	5%	4%
<b>Had a stroke</b>	2%	4%	3%
<b>Had high blood pressure</b>	38%	35%	32%
<b>Had high blood cholesterol</b>	52%	33%	33%
<b>Had blood cholesterol checked within past 5 years</b>	87%	85%	87%
<b>Asthma</b>			
<b>Ever been told they have asthma</b>	16%	16%	15%
<b>Arthritis</b>			
<b>Ever diagnosed with arthritis</b>	35%	31%	26%
<b>Diabetes</b>			
<b>Ever been told by a doctor they have diabetes</b> (not pregnancy-related)	15%	12%	11%
<b>Had been diagnosed with pre-diabetes or borderline diabetes</b>	5%	2%	2%

‡ Indicates alignment with the Ohio State Health Assessment (SHA)

\*2017 BRFSS

\*\*2018 BRFSS

‡ 2018 BRFSS as compiled by 2021 County Health Rankings

## Key Issues

The Morgan County Health Department and members of the community reviewed and discussed the 2021 Regional Community Health Assessment, which included Morgan County results, in September. At another community meeting in October 2021, participants--who were of varying age and background--continued reviewing and discussing primary data. Through these discussions, the participants identified key issues and concerns. The following tables reflect the group discussions.

Key Issue or Concern	Percent of Population at Risk	Age Group Most at Risk	Gender Most at Risk
<b>Access to Healthcare</b>			
Morgan County adults went outside of Morgan County for healthcare services in the past year	73%	Adults	N/A
<b>Mental Health</b>			
Felt sad or hopeless every day for two or more weeks	23%	Adults	Female
<b>Unsafe/Unhealthy Housing</b>			
Impacted by mold, insects, and/or rodents	29%	All ages	N/A
<b>Substance and Alcohol Use</b>			
Binge drinking, marijuana use, misuse of prescription drugs	21% binge drink 4% use marijuana 3% misuse prescription drugs	Adults	50% Male 34% Female
<b>Chronic Disease</b>			
High rate of obesity contributing to chronic disease such as diabetes, heart attack, stroke, high cholesterol, and high blood pressure	45% obese 52% high cholesterol 38% high blood pressure 15% diabetes 7% heart attack 2% stroke	All ages	46% Male 43% Female

*N/A- Not Available*


## Priorities Chosen

Based on the 2021 Morgan County Health Assessment, Community Themes and Strengths Assessment, Forces of Change Assessment, Quality of Life Survey, and Local Public Health Assessment, key issues were identified for adults. Overall, there were five key issues identified by the Morgan County Health Department and community leaders. The Morgan County Health Department and community leaders then voted, based on health data provided, and came to a consensus on the priority areas Morgan County will focus on over the next three years. The key issues ranked from most votes to least number of votes are listed in the table below.

Key Issues	Rank
Access to Care – Communication of Resources and Services	1
Chronic Disease	2
Mental Health	3
Substance and Alcohol Use	4
Social Conditions/Unsafe, unhealthy housing	5

Morgan County will focus on the following two priority areas over the next three years:

**Priority Factor:**

1. Access to Care 

**Priority Health:**

1. Chronic Disease 

## Community Themes and Strengths Assessment (CTSA)

The Community Themes and Strengths Assessment (CTSA) provides a deep understanding of the issues that residents felt were important by answering the questions: "What is important to our community?" "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?" The CTSA consisted of two parts: open-ended questions to the community partners and the Quality-of-Life Survey. Below are the results:

### Open-ended Questions to the Community Partners

1. What do you believe are the 2-3 most important characteristics of a healthy community?
  - Physical environment is clean and safe
  - Health services are accessible
2. What makes you most proud of our community?
  - Supportive of people in need
  - Friendly
  - Small local businesses
  - Great place to raise kids
  - Small enough to see the impact of your actions
  - Safe community
  - Elected officials are approachable and easy to get in touch with
  - Financial assistance is available
3. What are some specific examples of people or groups working together to improve the health and quality of life in our community?
  - Health Department giving vaccines
  - Local food program/free meals
  - Library programs for people of all ages
  - Free health screenings
4. What do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life in our community?
  - Housing (inadequate and not enough)
  - Support services for those wanting to maintain independence
  - Communication of available resources
  - Lack of after school leisure and recreational activities for kids
  - Mental health services (People have feelings of hopelessness, sadness and depression)



## MCHD Community Health Improvement Plan

5. What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?
  - Lack of financial resources to improve the housing situation – tried attracting private investors but have not been successful. Have also explored public money options for housing. It seems like an insurmountable problem.
  - Lack of employment
  - Lack of mental health resources
  
6. What actions, policy, or funding priorities would you support to build a healthier community?
  - Services for middle income people. They make too much to qualify for some services but can't afford things on their own.
  
7. What would excite you enough to become involved (or more involved) in improving our community?
  - Strong participation and collaboration in action—finding out what other agencies are doing.
  - Programming and services for seniors

## Quality of Life Survey

The Morgan County Health Department invited community members to fill out a short Quality of Life Survey via Qualtrics. There were 125 Morgan County community members who completed the survey. The table below shows the average response to each item. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of “Definitely” = 5, “Probably” = 4, “Possibly” = 3, “Probably Not” = 2, and “Definitely Not” = 1. For all responses when a respondent left a response blank, the choice was a non-response and was assigned a value of 0 (zero). The non-response was not used in averaging responses.

Quality of Life Questions	Likert Scale Average Response
	2021 (n=#)
Are you satisfied with the quality of life in our community? (Consider your sense of safety, well-being, participation in community life and associations, etc.) [IOM, 1997]	3.6
Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.0
Is this community a good place to raise children? (Consider school quality, daycare, afterschool programs, recreation, etc.)	3.6
Is this community a good place to grow old? (Consider elder-friendly housing, transportation to medical services, churches, shopping; elder daycare, social support for the elderly living alone, meals on wheels, etc.)	3.4
Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)	2.5
Is the community a safe place to live? (Consider residents’ perception of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?)	3.9
Are there networks of support for individual and families (neighbors, support groups, faith community, outreach agencies or organizations) during times of stress and need?	3.6
Do you believe that as an individual you can make the community a better place to live?	3.8
Do you believe that working with others you can make the community a better place to live?	4.1
Is there a sense of community responsibility?	3.2
Do the people who provide services in the community work well together?	3.2
Is there an active sense of community pride in shared accomplishments?	3.6

## Forces of Change Assessment

The Forces of Change Assessment focuses on identifying forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. This assessment answers the questions: "What is occurring or might occur that affects the health of our community or the local public health system?" and "What specific threats or opportunities are generated by these occurrences?" The community leaders were asked to identify positive and negative forces which could impact community health improvement and overall health of this community over the next three years. This group discussion covered many local, state, and national issues and change agents which could be factors in Morgan County in the future. The table below summarizes the forces of change agent and its potential impacts:

Force of Change	Threats Posed	Opportunities Created
Pandemic	Misinformation about COVID and vaccines creating a highly charged landscape. Workforce shortage in lower paying positions and in healthcare overall. Increased need for mental healthcare and limited access. Demands for healthcare are outpacing capacity.	Those who want to work can find a job if they are qualified or willing to seek training. There is room for new businesses to come to the county. The high number of health issues are an opportunity for public health to make an impact and be seen for their contributions.
Aging Population	Need for more resources and services for the elderly	Opportunity for growth in local services
Access to Mental Health Resources	Inability to maintain job status, depression leading to self-harm	Opportunity to seek out additional resources for our community to improve quality of life
Businesses moving in and out of community	Workforce development suffers	Seek out funding for entrepreneurship training to create and support local small business owners

## Local Public Health System Assessment

### The Local Public Health System

Public health systems are commonly defined as “all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction.” This concept ensures that all entities’ contributions to the health and well-being of the community or state are recognized in assessing the provision of public health services.

The public health system includes:

- Public health agencies at state and local levels
- Healthcare providers
- Public safety agencies
- Human service and charity organizations
- Education and youth development organizations
- Recreation and arts-related organizations
- Economic and philanthropic organizations
- Environmental agencies and organizations



### The 10 Essential Public Health Services

The 10 Essential Public Health Services describe the public health activities that all communities should undertake and serve as the framework for the NPHPS instruments.

Public health systems should:

1. Assess and monitor population health status, factors that influence health, and community needs and assets.
2. Investigate, diagnose, and address health problems and hazards affecting the population.
3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.
4. Strengthen, support, and mobilize communities and partnerships to improve health.
5. Create, champion, and implement policies, plans, and laws that impact health-
6. Utilize legal and regulatory actions designed to improve and protect the public’s health.
7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy.
8. Build and support a diverse and skilled public health workforce.
9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.
10. Build and maintain a strong organizational infrastructure for public health.

(Source: **Centers for Disease Control; National Public Health Performance Standards; The PublicHealth System and the 10 Essential Public Health Services**)

## The Local Public Health System Assessment (LPHSA)

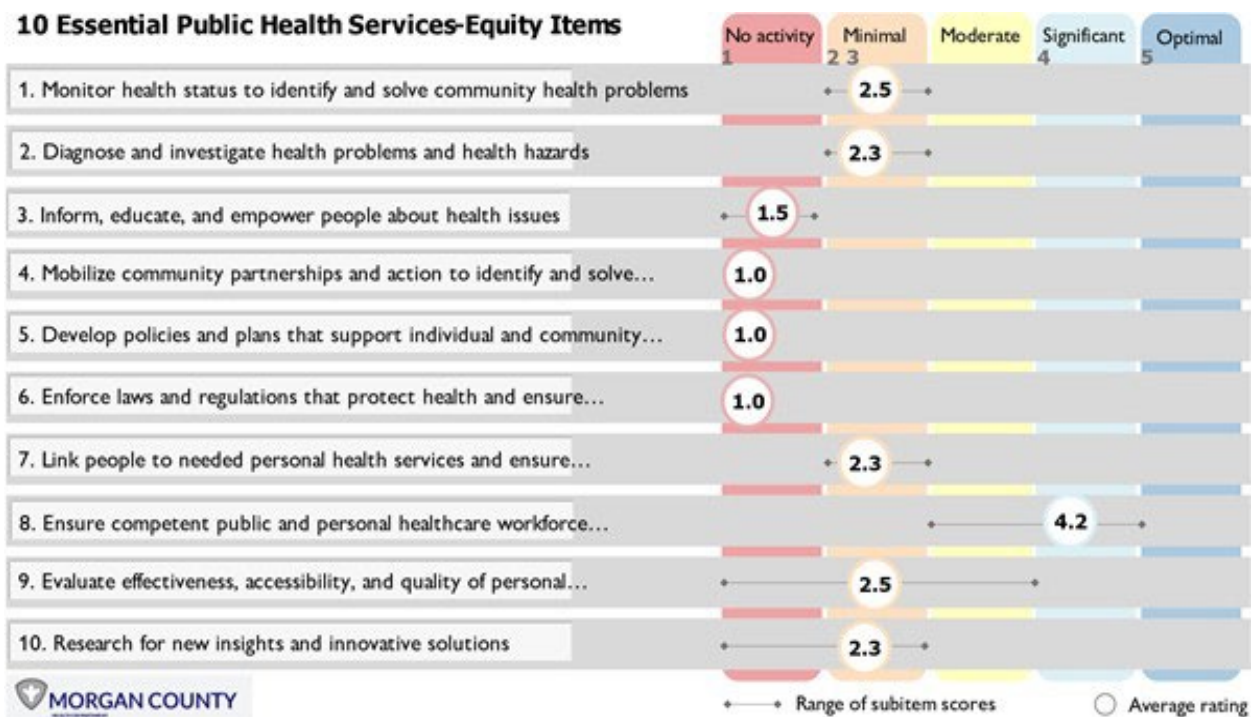
The LPHSA answers the questions, "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services being provided to our community?"

This assessment involves the use of a nationally recognized tool called the **National Public Health Performance Standards Local Instrument**.

Members of the Morgan County Health Department and community partners completed the local public system assessment instrument version 3.0 by looking at the 10 essential services through an equity lens. The results were then presented to the community partners for discussion at the community meeting held in October 2021. The 10 essential services in the instrument 3.0 lag behind the updated 2020 services but by completing this assessment through an equity lens the group was able to identify how well the public health system acknowledges and addresses health inequities. The challenges and opportunities that were discussed were used in the action planning process. Once an updated version of the LPHSA using updated 2020 Essential Services are released, the Morgan County Health Department will convene a community group to complete that assessment.

To view the full results of the LPHSA, please contact Jeff Michaels, Morgan County Health Department Administrator at [jeff.michaels@morgancounty-oh.gov](mailto:jeff.michaels@morgancounty-oh.gov) or 740-962-4572 Ext. 201.

## Morgan County Local Public Health System Assessment 2021 Summary



## **Gap Analysis, Strategy Selection, Evidence-Based Practices, and Resources**

### **Gaps Analysis**

A gap is an area where the community needs to expand its efforts to reduce a risk, enhance an effort, or address another target for change. A strategy is an action the community will take to fill the gap.

Evidence is information that supports the linkages between a strategy, outcome, and targeted impact area. The Morgan County Health Department and community partners were asked to determine gaps in relation to each priority area, consider potential or existing resources, and brainstorm potential evidence-based strategies that could address those gaps. To view the completed gap analysis exercise, please view Appendix I.

### **Strategy Selection**

Based on the chosen priorities, the Morgan County Health Department and community partners were asked to identify strategies for each priority area. Considering all previous assessments, including but not limited to the CHA, LPHSA, quality of life survey and gap analysis, committee members determined strategies that best suited the needs of their community. Members referenced a list of evidence-based strategies recommended by the Ohio SHIP, as well as brainstormed for other impactful strategies. Each resource inventory can be found with its corresponding priority area.

### **Evidence-Based Practices**

As part of the gap analysis and strategy selection, the Morgan County Health Department and community partners considered a wide range of evidence-based practices, including best practices. An evidence-based practice has compelling evidence of effectiveness. Participant success can be attributed to the program itself and have evidence that the approach will work for others in a different environment. A best practice is a program that has been implemented and evaluation has been conducted. While the data supporting the program is promising, its scientific rigor is insufficient. Each evidence-based practice can be found with its corresponding strategy.

### **Resource Inventory**

Based on the chosen priorities, the Morgan County Health Department and community partners were asked to identify resources for each strategy. The resource inventory allowed the committee to identify existing community resources, such as programs, policies, services, and more. The Morgan County Health Department and community partners were then asked to determine whether a policy, program or service was evidence-based, a best practice, or had no evidence indicated. Each resource inventory can be found with its corresponding strategy.

## Priority #1: Access to Care

### Strategic Plan of Action


To work toward improving access to care, the following strategies are recommended:

<b>Priority #1: Access to Care through education</b>				
<b>Strategy #1: Develop a comprehensive resource guide to increase awareness of community resources</b>				
<b>Action Step</b>	<b>Timeline</b>	<b>Priority Population</b>	<b>Indicator(s) to measure impact of strategy:</b>	<b>Lead Contact/Agency</b>
<b>Year 1:</b> <ul style="list-style-type: none"> <li>Form a community resource group to develop a resource guide</li> </ul>	Meet quarterly	Adults	Participation by various agencies	Morgan County Health Department & Morgan County Development Office
<b>Year 2:</b> <ul style="list-style-type: none"> <li>Increase awareness of 211 service</li> </ul>	By 12/31/23		Usage of the 211 service will increase in Morgan County	Morgan County Health Department & United Way of MPM
<b>Year 3:</b> <ul style="list-style-type: none"> <li>Participate in a community resource event</li> <li>Increase awareness of mental health resources</li> </ul>	By 6/30/24		Morgan County citizens will have information on available community resources	Morgan County Health Department
<b>Strategies identified as likely to decrease disparities?</b> <input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> Not SHIP Identified				
<b>Resources to address strategy:</b> Morgan County Health Department, Morgan County Development Office, and Morgan County IT Department				
<b>Expected Outcome:</b> Increased awareness of community resources				

## Priority #2: Chronic Disease

### Strategic Plan of Action

To work toward reducing obesity, which impacts chronic diseases such as diabetes, heart health, and hypertension, the following strategies are recommended:

Priority #2: Chronic Disease 				
Strategy # 1: Promote healthy eating				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
<b>Year 1:</b> <ul style="list-style-type: none"> <li>Offer cooking classes in the community</li> <li>Promote local Farmer’s Market</li> </ul>	07/31/22	Adults	Attendance at cooking classes  Increased attendance at Farmer’s Market	OSU Extension Office
<b>Year 2:</b> <ul style="list-style-type: none"> <li>Promote donation of produce to local food pantry</li> </ul>	05/31/23	Youth & Adults	Availability of fresh produce at food pantry will increase	Morgan County United Ministries
<b>Year 3:</b> <ul style="list-style-type: none"> <li>Explore a drop off site for excess produce from farmers</li> <li>Research local access to healthy meals – what is available, what can we promote?</li> </ul>	05/31/24	Youth & Adults	Community members have access to free produce  MCHD promotes healthy meal options within the community	OSU Extension Office  Morgan County Health Department
<b>Strategies identified as likely to decrease disparities?</b> <input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not SHIP Identified				
<b>Resources to address strategy:</b> OSU Extension Office, County Commissioners, Morgan County United Ministries				
<b>Expected Outcome:</b> Improved nutrition awareness in the community				



Strategic Plan of Action


To work toward reducing obesity and tobacco use, which impact chronic diseases such as diabetes, heart health, hypertension and lung disease, the following strategies are recommended:

<b>Priority #2: Chronic Disease</b>				
<b>Strategy # 2: Promote healthy living</b>				
<b>Action Step</b>	<b>Timeline</b>	<b>Priority Population</b>	<b>Indicator(s) to measure impact of strategy:</b>	<b>Lead Contact/Agency</b>
<b>Year 1:</b> <ul style="list-style-type: none"> <li>Reach out to existing partners that are focusing on this issue and determine how MCHD can provide support</li> <li>Provide a community wellness program or activity</li> </ul>	06/30/22	Youth & Adults	MCHD is able to connect with local partners to promote wellness initiatives  At least one community program or activity takes place	Buckeye Hills Regional Council, Washington-Morgan Community Action, Rotary, Family & Children First  Wellness Coalition, Morgan County Library
<b>Year 2:</b> <ul style="list-style-type: none"> <li>Sponsor a community campaign/challenge such as walking – Get out and move!</li> <li>Research evidence-based programs related to tobacco cessation</li> <li>Develop a policy to address health inequity in planning &amp; promotion of wellness activities</li> </ul>	06/30/23	Youth & Adults	A community wellness challenge takes place to promote physical activity  Programs on tobacco cessation are developed  Policy is complete and implemented	Wellness Coalition, Family & Children First  Morgan County Health Department  Morgan County Health Department
<b>Year 3:</b> <ul style="list-style-type: none"> <li>Promote community activities that promote exercise – may include pets as a form of exercise</li> <li>Develop a Mobile Services policy</li> <li>Become a Smoke Free Campus</li> </ul>	10/31/24	Youth & Adults	The community participates in physical activities MCHD Services are taken into the community to provide equal access  Tobacco cessation is encouraged	Morgan County Health Department  Morgan County Health Department  MCHD, Genesis Primary Care, KLS Morgan Co library
<input checked="" type="checkbox"/> <b>Strategies identified as likely to decrease disparities?</b>				
Yes <input type="checkbox"/> No <input type="checkbox"/> Not SHIP Identified				
<b>Resources to address strategy:</b> Buckeye Hills Regional Council, Washington-Morgan Community Action, Wellness Coalition, Kate Love Simpson Morgan County Library, Family & Children First, Rotary, Morgan County Health Department				
<b>Expected Outcome:</b> Improved healthy living awareness in the community				

## Progress and Measuring Outcomes

Progress will be monitored with measurable indicators identified for each strategy. Most indicators align directly with the SHIP. The individuals or agencies that are working on strategies will meet on an as-needed basis. The Morgan County Health Department will meet annually to report on progress. The Morgan County Health Department will create a plan to disseminate the CHIP to the community.

Strategies, responsible agencies, and timelines will be reviewed at the end of each year by the committee. As this CHIP is a living document, edits and revisions will be made accordingly.

Morgan County will continue facilitating CHAs every three years to collect data and determine trends. Primary data will be collected for adults and secondary data will be analyzed for youth using national sets of questions to not only compare trends in Morgan County, but also be able to compare to the state and nation. This data will serve as measurable outcomes for each priority area. Indicators have already been defined throughout this report and are identified with the  icon.

In addition to outcome evaluation, process evaluation will also be used on a continuous basis to focus on the success of the strategies. Areas of process evaluation that the CHIP committee will monitor include the following: number of participants, location(s) where services are provided, number of policies implemented, economic status and racial/ethnic background of those receiving services (when applicable), and intervention delivery (quantity and fidelity).

Progress reports will be completed at all future meetings, keeping the committee on task and accountable. This progress report may also serve as meeting minutes.

## Contact Us

For more information about any of the agencies, programs, and services described in this report, please contact:

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## Appendix I: Gaps and Strategies

The following tables indicate community conditions, access to care, and mental health and addiction gaps and potential strategies that were compiled by the Morgan County Health Department.

### Priority Factors: Community Conditions

Gaps	Potential Strategies
1. Lack of safe affordable housing	<ul style="list-style-type: none"> <li>Education on insect, rodent, and mold prevention</li> </ul>
2. Unsafe private water sources	<ul style="list-style-type: none"> <li>Monitoring and education</li> </ul>

### Priority Factors: Health Behaviors

Gaps	Potential Strategies
1. Poor nutrition	<ul style="list-style-type: none"> <li>Nutrition education, promotion of local farmer’s market</li> </ul>
2. Low physical activity	<ul style="list-style-type: none"> <li>Community wellness challenges such as walking</li> </ul>

### Priority Factors: Access to Care

Gaps	Potential Strategies
1. Lack of knowledge of services available	<ul style="list-style-type: none"> <li>Develop a resource directory</li> </ul>
2. Limited access to WIC program	<ul style="list-style-type: none"> <li>Seek grant opportunities</li> </ul>

### Priority Health Outcomes: Mental Health and Addiction

Gaps	Potential Strategies
1. Depression	<ul style="list-style-type: none"> <li>Promotion of quality-of-life initiatives</li> </ul>
2. Drug and alcohol use	<ul style="list-style-type: none"> <li>Education and referral services</li> </ul>

### Priority Health Outcomes: Chronic Disease

Gaps	Potential Strategies
1. High rate of obesity	<ul style="list-style-type: none"> <li>Healthy food and physical activity initiatives</li> </ul>
2. High blood pressure, heart health, diabetes, high cholesterol	<ul style="list-style-type: none"> <li>Community wellness activities</li> <li>Community education</li> </ul>

## Appendix II: Links to Websites

Title of Link	Website URL
Centers for Disease Control	<a href="http://www.cdc.gov/nphsp/essentialservices.html">http://www.cdc.gov/nphsp/essentialservices.html</a>
State Health Improvement Plan	<a href="https://odh.ohio.gov/about-us/sha-ship">https://odh.ohio.gov/about-us/sha-ship</a>
Healthy People 2030	<a href="https://health.gov/healthypeople/objectives-and-data">https://health.gov/healthypeople/objectives-and-data</a>
Morgan County Health Department	<a href="https://morganpublichealth.org/">https://morganpublichealth.org/</a>
National Public Health Performance Standards	<a href="http://www.cdc.gov/nphsp/essentialservices.html">http://www.cdc.gov/nphsp/essentialservices.html</a>
The Public Health System and the 10 Essential Public Health Services	<a href="http://www.cdc.gov/nphsp/essentialservices.html">http://www.cdc.gov/nphsp/essentialservices.html</a>