

Toward a healthier glynn county









Glynn County Health Improvement Plan

And Community Health Needs Assessment

2014 - 2018



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## Community Health Needs Assessment Supporters

Conducted by College of Coastal Georgia and Glynn County Health Department

August 18 – October 31, 2013

*The Following Organizations, Community Members, and Students Were Instrumental:*

Glynn County Board of Commissioners Human Resources Department

City Manager Bill Weeks and the City of Brunswick

Brunswick Senior Center

College of Coastal Georgia Students: Stephanie Basey, Suncica Beba, Jannronn Bradford, April Davis, Maurey Moss, Maurice Mason, Corliss Wade, Jay Moreno, John Lander, Jennifer Dougherty, Chris Bray, and Karen Dawson

Coastal Georgia Area Community Action Authority

Gateway Community Service Board

Glynn County Family Connection and Executive Director Tony Kreimborg

Jones Hooks and Jekyll Island Authority

Woody Woodside and Brunswick Glynn Chamber of Commerce

College of Coastal Georgia

Glynn County Board of Health

Southeast Georgia Health System

Coastal Medical Access Project

Glynn County School System

St. Andrews CME Church

New Covenant Interdenominational Church

Members of St. Simons Community Church

Lowe’s

## Community Collaborative Participants in

## Community Health Improvement Planning Process

**Tony Kreimborg and Family Connection Glynn Collaborative Participants:**

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Lori Strande, American Red Cross

Ed Reilly, Glynn County Juvenile Court

Antoinette Gant, Glynn County Head Start

Ellen Murphy, STAR Foundation

Markisha Butler, Altamaha Technical College

Carla Mathis, Juvenile Court

Leslie Hartman, Safe Harbor Children’s Center

Craig Campbell, Pastor

Dana Haza, United Way

Cody Cocchi and Phillis George, College of Coastal Georgia, Service Learning Program

Lewis Persons and Kristal Jones, Department of Family and Children Services

Pascale Alcindor, Georgia Campaign for Adolescent Power and Potential

Elizabeth Runkle, Georgia Center for Nonprofits

Karen Mikell, Glynn County Health Department

Janice Applegate, FaithWorks

Shuntia Lewis, Goodwill Industries

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Greg Jaudan, Glynn County Schools

S. Forest Cowan, Safe Harbor Child Advocacy Center

Mary Aloia, College of Coastal Georgia

Celese Orr, Georgia Family Connection Partnership

Ellen Post, Coastal Community Foundation

Chandra Mahony, America’s Second Harvest

Shannon Farnsworth, Girl Scouts of Historic Georgia

Katherine Johnson, Glynn Community Crisis Center

Regina Hedgeman Johnson, Glynn Department of Family and Children Services and SEGA Auxiliary

Forest Cowan, Natalee Miles and Leslie Decker, Safe Harbor Children’s Advocacy Center

Nena Keller, Glynn Community Crisis Center, Inc.

Jonathan Watkins, Job Corp

Anthony Fulton, Wellcare of Georgia

Scott Runkle, Coastal Coalition 4 Children

Tres Hamilton and Delron Butler, Coastal Georgia Area Community Action Authority

Keandra Hill, Lillie Cares Health Services, LLC

Cyndie Casey and Patrick Eades, Care Net Pregnancy Center

Bruce N. Freitas, Fathers Against Drugs

## Elected/Public Officials Who Provided Support/Input

**Glynn County**

County Manager Allen Ours and Glynn County Board of Commissioners

Michael Browning, District 1

Dale Provenzano, District 2

Richard Strickland, District 3

Mary Hunt, District 4

Allen Booker, District 5

Clyde Taylor, At-Large Post 1

Bob Coleman, At-Large Post 2

**City of Brunswick**

Mayor Cornell Harvey

Mayor Protem Julie Martin

City Commissioner Johnny Cason

City Commissioner Felicia Harris

City Commissioner Vincent Williams

City Manager Bill Weeks

## Invited Plan Reviewers

Beth Cain, Physical Education Teacher, Satilla Marsh Elementary School

Janet Mitchell, Nutrition Director, Glynn County School System

Karen Mikell, Public Health Administrator, Glynn County Health Department

Tony Kreimborg, Family Connection Glynn

Janice Applegate, Faithworks

Elizabeth Gunn, Southeast Georgia Health System

Linda Mincey, Healthy Families of Glynn County

Barbara Meyers, Coastal Community Health Services, Federally Qualified Health Center

## Community Health Improvement Plan Steering Committee

*Board of Health Members*

Allen Booker, Glynn County Board of Commissioners

Dr. Joan Boorman, Glynn County Board of Education

Cornell Harvey, Mayor, City of Brunswick

Deborah Riner, C.Ht., Advocate, President of the Georgia Public Health Association

James Fedd, R.N., Consumer Advocate

Frances L. Owen, M.D., Physician

Valerie Hepburn, Ph.D., Consumer Advocate

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Dana Haza, United Way

Barbara Meyers, Coastal Community Health Services (FQHC)

Alexandria Manglaris, Southeast Georgia Health System

Cornell Harvey, Mayor of Brunswick, Georgia

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Diane Z. Weems, M.D., District Health Director, Coastal Health District

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Deborah Johnson, County Nurse Manager, Coastal Health District

Phyllis Phillips, CDC Fellow, Coastal Health District

Todd Driver, Environmental Health District Director, Coastal Health District

# Executive Summary

## A Roadmap for Action

Between August and December 2013, Glynn County Health Department, one of eight counties comprising the Coastal Health District, worked collaboratively with community agencies, individuals, and civic and elected leaders to understand more about the community and its health status through a comprehensive community health needs assessment. With the assessment in hand, a broad-based coalition of community groups, mediated by Family Connection Glynn, used the insights from the assessment and their knowledge of needs gained through experience with the clients and communities they serve, to begin the process of building a roadmap for a healthier Glynn County. The plan that follows represents findings from public and survey data (See Community Health Needs Assessment results), input from focus groups, broad outreach to civic and elected officials for input, and a focused effort with dozens of partners to identify resources, activities, and objectives to improve the health of the community. The result is a dynamic Community Health Improvement Plan (CHIP) that is intended to be a guide for action and a foundation for future efforts at health improvement.

## The Process: Planning for a Healthier Community

A team from Public Health shared the Community Health Needs Assessment (CHNA) with collaborative members in January 2014. The Community Health Improvement Planning steps were as follows:

* After learning more about the CHNA, in January 2014, collaborative members were asked to make suggestions about a vision for a healthier community and were invited to discuss and recommend goals to improve community health.
* Using the goals derived from the January session, in late January and February 2014, a “digital meeting” was held using Survey Monkey to provide opportunity for additional input and selection of the preferred vision and priority goals.
* These goals, as prioritized by collaborative participants with consideration of the CHNA findings, were grouped together to reflect seven broad-based problem statements that reflect priority order of public concerns. The problem statements reflect awareness that social determinants of health must be addressed in order for change to take place.
* In February 2014 at the collaborative meeting, collaborative members reviewed the vision, problem statements, and goals and set to work to build a plan through identification of activities and resources/inputs, establishment of benchmarks for outputs, and identification of potential outcomes and the long- term impact of implementation of the identified goals. During March 2014, this work was used to create logic models for each goal recommended.
* The draft Community Health Improvement Plan was built using logic models to demonstrate the relationships among partners/resources, outputs, outcomes, and impacts. This document was widely circulated to all participants and invited community stakeholders in late March and April for feedback and commentary. Feedback helped refine the goals, and new activities and partners were added.
* In April, the plan was reviewed and final input was obtained from the Steering Committee.
* Beginning in June 2014, a Community Health Coalition of stakeholders, led by Public Health, will begin the process of implementing the CHIP and will create more formal timelines and assigned responsibilities and set up a schedule for performance review.

The plan to address these problems and to meet identified goals is expansive and rich in content, both in the efforts to build on existing, proven activities and in ideas and activities yet to be implemented. The plan effectively captures current, evidence-based best practices, recommends resources for best practices for new activities, and builds on those practices by setting performance targets for the future. Some new ideas/plans/activities do not yet have funding or assigned responsibility, but collectively, the broader goals, outputs and outcomes reflect shared responsibility of those groups and individuals who are listed as resources, as well as commitment and belief by collaborative members that this plan can be carried out over the next five years. The success of the Community Health Improvement Plan; therefore, depends in great part on the community itself and on those who came together to help create the plan.

This plan is not a static document. It must be reviewed and revised at least annually to determine successes and new realities and areas where additional efforts are needed. It is also important to note that this plan is largely based on social determinants of health and, therefore, reflects the broader concerns of community members that relate to health. The plan is, in reality, a self-directed community plan for improved health – not just a public health plan, though public health will take a leadership role in implementation and further engagement of community partners.

## Looking Forward: Implementation and Evaluation of the Plan

The goal of the ongoing Community Health Improvement planning process is to create a document to be used by the community, in partnership with Public Health, as a roadmap and foundation for cultural, environmental, and social change that leads to health improvement. Glynn County Health Department is now establishing a Community Health Coalition to share the plan with the wider community, to fully engage participants, to review and revise activities and responsible parties as needed, and to monitor outputs and outcomes. The plan will be reviewed at least annually, though the Community Health Coalition will meet more often. Goals of the Community Health Coalition for the next five years include the following:

* Hold regular meetings of stakeholders;
* Work to ensure sustainability and viability of the mission of community health improvement;
* Continue the effort to research and make training available to community partners on evidence-based best practices to both improve health and to assure effectiveness of the plan;
* Work collaboratively across all sectors, including the business sector, to address the socio-economic barriers to good health;
* Work with the elected officials, schools, and the media to ensure that community health is considered an important factor in policymaking; and
* Educate and communicate the message of good health across all sectors.

## An Invitation to the Community

While a core group of volunteers has already stepped up, others are invited and encouraged to take an active role in the ongoing implementation process. The contact for plan implementation and evaluation is Karen Mikell, Public Health Administrator, Glynn County Health Department, ksmikell@dhr.state.ga.us.

# Glynn County Community Health Improvement Plan

## Introduction

Good health is essential to quality of life and to the well-being of the larger community. Healthier communities and economically vibrant communities are often one and the same. In Georgia in 2011, the top ten most economically successful counties also placed in the top fifth of Georgia’s health rankings (Hayslett 2012). While Public Health must take a leadership role in ensuring healthy communities, health improvement is not a solitary task. Key to improvement is engaging partners throughout the community in identifying and tackling challenges, including the social determinants of health, and finding resources to improve health outcomes for all citizens.

Since mid-2013, Coastal Health District has begun a broad-based effort to engage the community, its leaders and its citizens in identifying problems and setting goals as part of planning to improve the health of the community. A comprehensive Community Health Needs Assessment (CHNA) was conducted in Fall 2013 with the support of faculty and students at the College of Coastal Georgia. CHNA results were shared with the community beginning in November 2013 (See Community Health Needs Assessment results). Outreach to community groups, elected officials, and individual citizens continued through April 2014 to build awareness of community concerns – health issues, economic issues, and social issues – in order to educate and engage community partners in setting goals to create a plan of action for a healthier community.

## Planning Theory and Design

The Community Health Improvement Plan design employs a theory known as the Socio-Ecological Model, which helps explain that many factors influence the health of an individual. This model recognizes the relationship that exists between the individual and his or her environment. While the individual may be responsible for making lifestyle choices that lead to good health, the ability to make these choices and changes also depends on other factors like the culture, the physical environment, schools, the workplace and other organizations, health care institutions, and public policy. When the community works together to address the socio-ecological determinants of health, change is more likely to occur (See illustration below).



The Socio-Ecological framework is illustrated in the chart at left (McLeroy, Steckler, & Bibeau, 1988).

The collaborative effort employed for CHIP development embraced the Socio-Ecological Model for health promotion by identifying participants and resources, many of whom are already engaged in components of the plan, to identify additional resources and partners, and to establish both measurable outputs and longer-term outcomes that can improve community health.

Healthy People 2020 offers the following theoretical support (and the chart at left) for use of the social determinants model: “Healthy People 2020 highlights the importance of addressing the social determinants of health by including ‘Create social and physical environments that promote good health for all’ as one of the four overarching goals for the decade. This emphasis is shared by the World Health Organization, whose Commission on Social Determinants of Health in 2008 published the report, ‘Closing the gap in a generation: Health equity through action on the social determinants of health.’ The emphasis is also shared by other U.S. health initiatives such as the National Partnership for Action to End Health Disparities and the National Prevention and Health Promotion Strategy” (http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39).



The model at right, recommended by NACCHO for development of a Community Health Improvement Plan, is a good representation of the process employed by the Coastal Health District. Based on community input, the plan represents the strategy and overall accountability for goals, though some specific responsibilities are not yet adopted and specific tasks have not yet been assigned (except where indicated to specific parties)indicators have been established. In the next phase, beginning in June 2014, the Community Health Coalition for Glynn County will continue work with problem statements to ensure accountability and implementation of strategies and monitoring of performance indicators.

J.S. Durch, L.A. Bailey, and M.A. Stoto, eds. *Improving Health in the Community*, Washington, DC: National Academy Press, 1997.

The format for the plan itself is the use of a logic model, which has proven in other public efforts, according to Miller, Simeone, and Carnevale, to be

Invaluable in focusing disparate participants on a common performance target for which they were jointly accountable, an analytical tool with which to forge some degree of political and organization consensus . . . The tool eventually became a vehicle for developing a community of stakeholders focused on the desired end-result – a key link in tying budget, community, and evaluation . . . (2001, p. 2).

## MAPP Themes Guided Planning

Coastal Health District and Glynn County Health Department elected to use as guidance for the Community Health Improvement Process (CHIP) five themes from the Mobilizing for Action through Planning and Partnerships (MAPP). The Public Health Team focused on key advantages of the MAPP process:

1. *Create a healthy community and a better quality of life.* Public Health leadership recognizes that the presence of health services does not singlehandedly make a healthy community. Economic factors and social determinants need to be a part of the planning effort, and any plan must build on community strengths. Findings from the broad-based Community Health Needs Assessment (CHNA) were widely publicized, and individuals, elected officials, and organizations were engaged in developing community goals that recognize the links between good health and other factors, including risk factors in the community, including jobs, insurance-status, poverty, recreation, the environment, and social concerns including drug and alcohol abuse and child abuse.
2. *Increase the visibility of Public Health within the community.* The community survey and publicity surrounding the survey provided a good kick-off for efforts to increase the visibility of the role of Glynn County Public Health. Once the assessment was complete, data and analysis were shared with individuals, elected officials, and organizations who were asked to identify goals, prioritize goals, and engage in developing a Community Health Improvement Plan with goals that recognize the links between good health and other factors. Data was shared with local media, placed in the public library, made accessible on the Public Health website, and provided in digital form to community leaders. Other organizations including the Chamber of Commerce and Glynn Family Connection shared the data with hundreds of members of their organizations, including business, industry, agriculture, services, and health care. Local Public Health and District Public Health staff were in all instances engaged in the assessment and planning processes.
3. *Anticipate and manage change.* Not every approach in this health improvement process worked the first time. When online surveys were inadequate for collecting data for the needs assessment, paper surveys were provided and additional outreach conducted with community organizations. When groups did not express interest in helping, other groups were contacted. Participants in the process also changed over the course of the work, and new collaborators were included as needs changed. It is important to note that the collaborative approach used in this effort brought into view perspectives that had not previously been recognized or addressed, driving potential changes in Public Health focus and resource allocation. In addition to the CNHA, external forces, like reduced state budgets and changing trends, have also caused Coastal Health District to reevaluate its role in service delivery and population health. Change is our only constant, but having a plan of action allows Public Health to embrace and lead for change.
4. *Create a stronger Public Health infrastructure*. The Community Health Improvement Process provided tremendous opportunity, not only to educate the community about Public Health, but also to identify partners with similar goals. This collaborative approach and sharing of information and resources effectively reduces overlap in services and makes the department’s efforts more efficient and effective. The engagement of local elected officials has also reinforced the role of Public Health in meeting community needs that would otherwise not be met. In addition, the planning process has created a much stronger foundation for strategic planning.
5. *Engage the community and create community ownership for Public Health issues.* Participation in the needs assessment, followed by widespread data sharing has had a tremendous influence on community perspectives on health care. County and city governments were provided an overview of findings to help engage them in Public Health issues, which have not always been considered as matters of local government concern. While different sections of the data were of varying relevance to different audiences, the compilation of economic and social data with health data was eye-opening to interests ranging from teen pregnancy educators to the business community, hospital leadership, and elected officials. Discovering, for example, the rate of teen pregnancy or child abuse or those most often using the emergency room for primary care provided insights into issues that are community concerns, not just Public Health concerns. The collaborative approach helped achieve buy-in from community stakeholders desiring to partner with Public Health to address these issues.

## The Process

### The First Phase: Community Health Needs Assessment

The Community Health Needs Assessment, conducted between September 1 and October 31, 2013, was composed of four pillars:

* The use of public data including demographic, economic, community resources, and health data to provide a standard of comparison for local survey data. Resources included Centers for Disease Control, the Agency for Healthcare Research and Quality, Georgia’s On-Line Statistical Information System (OASIS), data from Coastal Health District, the U.S. Census, the Bureau of Labor, University of Wisconsin County Health Rankings, Georgia Bureau of Investigation, Georgia Department of Highway Safety, Georgia Department of Natural Resources, and numerous other public resources;
* A survey that included 498 residents of Glynn County (95% confidence level with a margin of error of plus/minus 4) that included demographic, economic, community resources, social and health concerns, and health data and both close-ended and open-ended questions about issues that faced respondents and their families and the larger community. Both online and paper surveys were used to ensure access to diverse populations;
* Information gleaned from a focus group (open to the public) of invited leaders and interested citizens who commented on the survey results, offering perspective on issues that might have been overlooked or misunderstood; and
* Data analysis to identify trends, special populations affected by health issues and health risks, and comparison of local data with state and national data.

The data gained through this process allowed the collaborative to begin to:

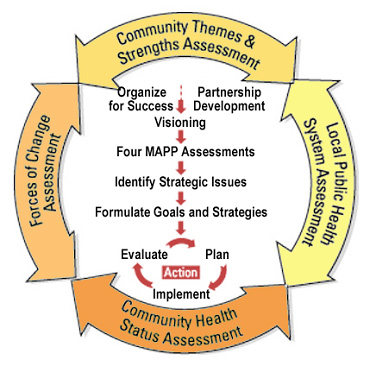
* Identify community strengths and needs;
* Understand more fully the health status of the community;
* Learn more about the perception of the public about public health system and where residents receive services and where they perceive barriers to care or good health;
* Identify public policy and technological changes that could improve the health status of the community.

The Community Health Needs Assessment reports were widely disseminated. Links were provided through media contacts and posted on the county and district Public Health websites, PDF versions were e-mailed to community leaders, and community group members were provided flash drives with a copy of the CHNA, as well as an executive summary and alternative visual comparison of the county with state and federal health outcomes based on the University of Wisconsin’s County Health Rankings. Bound copies were placed in local libraries. Elected officials were briefed on the results of the CHNA and invited to participate in discussion of goal-setting as part of the Community Health Improvement Plan. Other community groups were provided an overview of the CHNA and links or PDFs versions. Included with the information about the CHNA was an invitation to participate in building a Community Health Improvement Plan.

### The Second Phase: Community Health Improvement Planning

### and Priority Setting

Using a modified MAPP Framework, the six phases were followed to complete the CHIP: organizing, visioning, completing assessments, identifying strategic issues, setting goals/identifying strategies, and preparing for the action cycle by setting performance indicators.

Family Connection Glynn, already engaged in planning for major concerns like teen pregnancy, homelessness, early learning, asset building for social service organizations, and addressing the high-school dropout rate, volunteered to serve as the key community collaborative to work with Public Health in visioning, goal-setting, prioritizing goals, and formulating a plan to share with the larger community. A broad-based coalition that is well-established and influential, the collaborative includes educators, health professionals, social service organizations, Public Health, state agency representatives, business people, and interested citizen volunteers. A description of Family Connection from its website follows:

Controlled at the community level, Family Connection is present in every county in Georgia. It is the largest statewide network of communities in the nation that have made a commitment to improve results for children and families. Family Connection Glynn is a voluntary network of organizations serving Glynn County with a focus on improving the lives of children and their families. We are not a non-profit or a governmental agency and have no legal authority. Our strength and authority comes from our partners and what they bring to the table (http://glynn.gafcp.org/about-us/).



Local nonprofits engaged in the collaborative include: United Way of Coastal Georgia, Safe Harbor Children’s Center, STAR Foundation, Coastal Coalition for Children, CASA, America’s Second Harvest, Georgia Center for Non-Profit, Communities of Coastal Georgia Foundation, Girls Scouts of America, Children In Action, Southeast Georgia Regional Health Center, Morningstar, Community Crisis Center, Faithworks, Boys and Girls Club of Southeast Georgia, STAR Foundation, Hospice of the Golden Isles, Coastal Georgia Community Action, Manna House, American Red Cross, Coastal Care Net, Aging and Disabilities Resource Connection, Living Independence for Everyone, and Wellcare of Georgia. Among the organization’s participants are the following federal, state, and local government agencies: Department of Family and Children Services, Department of Public Health, Glynn County Board of Education, College of Coastal Georgia, Glynn County Juvenile Court, Gateway Behavioral Health, College of Coastal Georgia, National Parks Service, Altamaha Technical College, Coastal Regional Commission, Internal Revenue Service, and City of Brunswick.

A team from Public Health shared the CHNA results with collaborative members in January 2014. The Community Health Improvement Plan steps were as follows:

* In January 2014, collaborative members were asked to make suggestions about a vision for a healthier community, and, after learning more about the CHNA, were invited to select community goals to improve community health.
* In late January and early February 2014, a “digital meeting” was held using Survey Monkey. Collaborative participants were invited to select from nominations from the collaborative meeting a vision statement and goals from the list of goals suggested at the January meeting.
* Once goals were determined, the goals were grouped together under problem statements that reflected priority order of public concern, based on the participants’ ranking of goals. The problem statements reflect awareness that social determinants of health must be addressed in order for change to take place.
* In February 2014 at the collaborative meeting, collaborative members reviewed the vision, problem statements, and goals and set to work to build activities, identify resources/inputs for activities, establish benchmarks for outputs, and identify potential outcomes and the longer term impact of implementation of the identified goals. During March 2014, this work was used to create logic models for each goal recommended.
* The draft CHIP with partners/resources, outputs, outcomes, and impacts was widely circulated to all participants and invited community stakeholders in late March to hear feedback and commentary. Feedback helped refine the goals and some new activities and partners were added or altered.
* With input from the community, the CHIP was further revised and the draft document shared with Steering Committee members in early April for final review. The Steering Committee included community stakeholders, Glynn County Public Health leaders, and Coastal Health District staff. Final input was invited and the plan updated to reflect those changes.
* Public health staff further reviewed the plan with technical advisors in April. Final changes were made to the document, the CHIP was published on the Public Health website for community input, and plans made for final Board of Health adoption at the next quarterly meeting in Summer 2014.

The illustration below describes the process as one with increasing focus, based on needs, resources, and community partnerships.

|  |  |  |  |
| --- | --- | --- | --- |
| Broad-based community input from survey/focus groups/community meetings | Priorities/partner identification set by community partners that create vision and broad goals and identify outputs and outcomes  Clarity/Specificity | Goals/partnerships refined by a steering committee with knowledge of resources and insights from data collection | Using budget information and community priorities, Public Health uses community, collaborative, steering committee input to formalize strategic plan and set performance goals |
|  | C:\Users\mwickersham\Downloads\dreamstimefree_108970.jpg |  |  |

* (© Jenny Solomon | Dreamstime Stock Photos, http://www.dreamstime.com/abstract-background-stock-photo-imagefree108970)

The cycle illustrated below indicates the CHIP process is both iterative and cyclical.



### The Third Phase: Implementation and Evaluation

The goal of the ongoing Community Health Improvement planning process is to create a document to be used by the community, in partnership with Public Health, as a roadmap and foundation for cultural, environmental, and social change that leads to health improvement. Glynn County Health Department is now establishing a Community Health Coalition to share the plan with the wider community, to fully engage participants, to review and revise activities and responsible parties as needed, and to monitor outputs and outcomes. The plan will be reviewed at least annually, though the Coalition will meet more often. While a core group of volunteers has already stepped up, others are invited and encouraged to take an active role in this process. The contact for plan implementation and evaluation is Karen Mikell, Public Health Administrator, Glynn County Health Department, [ksmikell@dhr.state.ga.us](mailto:ksmikell@dhr.state.ga.us)

### The Fourth Phase: The Action Cycle - Logic Models and Leadership for Implementation of the Five-Year Plan

Recommendations for policy changes were also identified by the collaborative. The result was a “preliminary” logic model that was then vetted by community partners, volunteer reviewers of the draft plan, and local Public Health, before going to the CHIP Steering Committee for consideration, review and recommendations. The steering committee included local and district Public Health staff, county Board of Health members, and local leaders and elected officials. These recommendations were incorporated into the final plan and logic models created for each goal related to problem statements.

The resulting Community Health Improvement Plan is intended to serve as a roadmap for a healthier Glynn County. At the Steering Committee meeting held in April 2014, a group of citizens agreed to come together to form a Community Health Coalition to guide implementation of the plan and to seek commitment and follow-through from the partners identified through the collaborative process. With their guidance, improved health can be achieved through:

* alignment of local goals with state and federal goals;
* reducing overlap to improve the efficiency and effectiveness of limited resources;
* assigning responsibility to specific groups/organizations/individuals;
* assuring that evidence-based strategies are followed;
* periodic review of the plan to ensure that it meets current needs; and
* monitoring of performance standards that allow for measuring change.

## Next Steps for Public Health

In the phase that follows the Community Health Improvement Planning process, Public Health will engage in both “external” and “internal” strategic planning to further align goals with resources, to ensure that performance standards are appropriate for the population, to measure progress on performance indicators, and to build a more detailed five year timeline for implementation of the CHIP.

The Community Health Improvement Plan provides a framework that ensures that Public Health and its community partners are creating goals and setting performance standards for performing the Ten Essential Public Health Services (www.apha.org):

* Monitor health status to identify community health problems.
* Diagnose and investigate health problems and health hazards in the community.
* Inform, educate, and empower people about health issues.
* Mobilize community partnerships to identify and solve health problems.
* Develop policies and plans that support individual and community health efforts.
* Enforce laws and regulations that protect health and ensure safety.
* Link people to needed personal health services and assure the provision of health care when unavailable.
* Assure a competent public health and personal health care workforce.
* Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
* Research for new insights and innovative solutions to health problems.

On the following pages are logic models in which major social determinant issues are identified with their related goals, inputs, activities, outputs, outcomes, and long- term impact. Each of these problem statements and goals were derived from a collaborative approach, which was the basis for the Glynn County Community Health Improvement Plan.

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| --- |
| A **Vision for a Healthier Glynn County** |
| We envision an environmentally-friendly, economically vibrant, and compassionate community where citizens work together to ensure access to health care and services for all, safe places to work play and live, and access to education and supports needed to foster healthy families and healthy lifestyles. |
| **Glynn County Health Planning Values** |
| * A vibrant and healthy community * Full employment in an economically thriving community * A community where people feel safe and have safe places to live and play * A community where all families have access to affordable health care and services * A community that values education * A community that offers access to knowledge and supports that foster healthy lifestyles |
| **Problem Statements and Goals Identified****Through the Collaborative Process** |
| Problem Statement: Glynn residents face barriers in accessing medical and dental care. |
| * Goal #1: Increase the proportion of residents who have health insurance. * Goal #2: Increase the proportion of Glynn residents who have access to a primary care provider. * Goal #3: Improve access to care and services for special populations |
| Problem Statement: Glynn’s most vulnerable populations are at risk because of poverty and other social factors that affect their well-being. |
| * Goal #1: Reduce the rate of teen pregnancy. * Goal #2: Parents know about the need for prenatal care and effective care and nurturing of children. * Goal #3: All children live in safe homes. * Goal #4: Increase affordable and safe housing alternatives for low-income families and persons with special needs. |
| Problem Statement: Low high school graduation rates and illiteracy, including health illiteracy, limit access to good jobs, and good health. |
| * Goal #1: Increase the proportion of Glynn residents who have at least a high school diploma. * Goal #2: Implement a community health literacy campaign that is part of a larger campaign for literacy. * Goal #3: Work collaboratively across all types of organizations to recruit and retain good jobs that offer insurance benefits. |
| Problem Statement: According to County Health Rankings, in 2013, 27% of Glynn Residents were obese. |
| * Goal #1: Decrease the percentage of Glynn County adults who are obese. * Goal #2: Decrease the proportion of Glynn residents who are physically inactive. * Goal #3: Increase access to healthy foods and information about nutrition. * Goal #4: Decrease the prevalence of diabetes among Glynn residents. * Goal #5: Decrease the prevalence of hypertension among residents of Glynn County. |
| Problem Statement: Safety issues, environmental hazards, and risk-taking behaviors affect the health and well-being of Glynn County residents. |
| * Goal #1: Reduce violence in Glynn County, including family violence and criminal acts. * Goal #2: Increase the use of seatbelts. * Goal #3: Reduce drug abuse that causes poor judgment and links to violence and injury. * Goal #4: Reduce the incidence of sexually transmitted diseases. * Goal #5: Reduce environmental risks. |
| Problem Statement: According to County Health Rankings, in 2013, 15% of Glynn adults were binge drinkers. |
| * Goal #1: Prevent/delay initiation of drinking among people under 21. * Goal #2: Decrease the percentage of Glynn residents who binge drink. * Goal #3: Reduce the number of deaths/injuries of Glynn residents related to driving under the influence. |
| Problem Statement: According to County Health Rankings, in 2013, 17% of Glynn residents smoked. |
| * Goal #1: Prevent initiation of smoking/tobacco use among youth. * Goal #2: Decrease the total number of people who smoke/use tobacco. |
|  |

## Alignment with National Goals

It is important to note the alignment of the Glynn County Health Improvement Plan with the overarching goals of Healthy People 2020 (http://www.healthypeople.gov/2020/about/default.aspx).

**Crosswalk between Healthy People 2020 Goals and Glynn County CHIP Goals**

|  |  |
| --- | --- |
| **Healthy People 2020 Overarching Goals** | **Glynn County Health Improvement Plan** |
| Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death. | * Reduce the number of deaths/injuries of Glynn residents related to driving under the influence. * Increase the use of seatbelts. * Decrease the percentage of Glynn County adults who are obese. * Decrease the proportion of Glynn residents who are physically inactive. * Decrease the prevalence of diabetes among Glynn residents. * Decrease the prevalence of hypertension among residents of Glynn County. * Prevent initiation of smoking/tobacco use among youth. * Decrease the total number of people who smoke/use tobacco. * Prevent/delay initiation of drinking among people under 21. * Decrease the percentage of Glynn residents who binge drink. * Reduce drug abuse that causes poor judgment and links to violence and injury. |
| Achieve health equity, eliminate disparities, and improve the health of all groups. | * Increase access to healthy foods and information about nutrition. * Increase the proportion of Glynn residents who have at least a high school diploma. * Implement a community health literacy campaign that is part of a larger campaign for literacy. * Work collaboratively across all types of organizations to recruit and retain good jobs that offer insurance benefits. * Increase the proportion of residents who have health insurance. * Increase the proportion of Glynn residents who have access to a primary care provider. * Improve access to care and services for special populations. |
| Create social and physical environments that promote good health for all. | * Reduce violence in Glynn County, including family violence and criminal acts. * Reduce environmental risks. * All children live in safe homes. * Increase affordable and safe housing alternatives for low-income families and persons with special needs. |
| Promote quality of life, healthy development, and healthy behaviors across all life stages. | * Parents know about the need for prenatal care and effective care and nurturing of children. * Reduce the rate of teen pregnancy. * Reduce the incidence of sexually transmitted diseases. |

## Problem Statement: Glynn residents face barriers to accessing medical care and dental care.

According to County Health Rankings, in 2013, Glynn County had a population-physician ratio of 1,629:1, compared to 1,611:1 for Georgia. County Health Rankings 2013 reports that 11% of Glynn residents had not seen a doctor in the past two years due to cost. In 2013, County Health Rankings reported that the proportion of Glynn residents without insurance was 23%. Of 498 CHNA survey respondents, 20% were uninsured. Of CHNA survey respondents, 7% all respondents, 17% of the uninsured, and 18% of Medicaid recipients depend on the Emergency Room for primary care. One limitation identified by focus group members is that some doctors do not accept Medicaid or new Medicaid patients, effectively limiting access.

The ratio of residents to mental health providers is 2851:1, slightly better than the Georgia ratio of 3,504:1. Only 5% of survey respondents identified mental health as a gap in care, although focus group members believe lack of access to mental health care is a concern, and this gap and lack of continuity in mental and physical health were reiterated in community meetings.

According to County Health Rankings, Glynn County has a population-dentist ratio of 2,032:1, compared to the Georgia rate of 2249:1 and the U.S. benchmark rate of 1516:1. Of survey respondents, 29% had not seen a dentist in the past two years. Focus group respondents indicate that some dentists are not taking new patients or do not accept Medicaid; thereby, limiting access. Of survey respondents listing a gap in care, 20% identified dental care. Data from the CHNA survey indicate that access to dental care is correlated with income, that is, the higher the income, the more likely the respondent has seen a dentist in the last two years.

Georgia has a shortage of Public Health nurses. In 2012, 20% of public health nursing jobs were vacant. According to *Georgia Health News*, between 2003 and 2011, the state lost almost 400 nurses at the same time the population grew by 1.5 million. The American Public Health Association, according to the article, recommends one public health registered nurse per 5,000 people. Pay is significantly lower than in the private sector, which makes the positions difficult to fill, since need is high in other sectors <http://www.georgiahealthnews.com/2012/08/public-health-nurses-vital-georgia/>).

Glynn focus group members and the collaborative identified transportation as a barrier to access to health services. Other barriers to receiving health services were identified by survey respondents in priority order were the following: co-payments and deductibles too high; cost of prescription medications; finding free or reduced-cost health care services; inability to pay; finding an office or clinic open during non-work hours; and lack of a regular provider.

Special populations may require additional support to increase access. Glynn has 1,924 residents who receive SSI or SSI Disability. Of survey respondents, 8% of respondents say that they need assistance with activities of daily living. The proportion of Glynn residents who are 65 and older grew from 14.6% in 2004 to 15.7% in 2011, and the 85 and over population grew from 1.9% to 2% in the same time frame.

According to Healthy People 2020, “Access to health care impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; [and] life expectancy” (http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=1). Healthy People 2020 has established national goals to “increase the proportion of persons with a usual primary care provider to 83.9%,” to reduce the proportion of persons who have delays in accessing care to 9%, and to increase to 100% the proportion of persons who have medical insurance by 2020 (<http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=1>).

**Best Practice Resources/Recommendations:** According to The National Outreach Guidelines for Underserved Populations, outreach is key to improving quality of life. The following represent best practices in outreach and are included in activities/recommendations for this problem statement:

* facilitating access to quality health care and social services,
* bringing linguistically and culturally responsive health care directly to the community, and
* increasing the community’s awareness of the presence of underserved populations (<http://www.enrollamerica.org/best-practices-in-outreach-and-enrollment-for-health-centers/>.

**Rationale:** Improved access to health services can improve health outcomes for Glynn citizens.

**Assumptions:**

* Primary care delivered in hospital emergency rooms is expensive and does not foster improved outcomes.
* Having a medical home through which all care can be coordinated can improve quality of care for patients, including patients with special needs, and reduce costs.
* Lack of transportation for medical services can limit access to services.
* Primary care/dental care professional shortages limit access.
* Access to mental health services can improve outcomes.
* Lack of insurance coverage limits access.
* Persons whose care is covered by Medicaid may have a greater challenge in getting access to care.
* **Goal #1:** Increase the proportion of Glynn residents who have health insurance coverage.
  + According to County Health Rankings, 23% of Glynn residents are uninsured, more than the state average of 22%. Of all survey respondents, 20% were uninsured.
  + *Glynn Primary Performance Indicator:* Using County Health Rankings data for benchmarking, decrease the proportion residents who are uninsured from 23% to 18% by 2016 and to 10% by 2018.
  + *Glynn Primary Performance Indicator:* Using County Health Rankings for benchmarking, by 2018 decrease the number of years of potential life lost by 20%.
* **Goal #2:**  Increase the proportion of Glynn residents who have access to a primary care provider.
  + According to County Health Rankings, 11% of residents have not seen a doctor in the last two years due to cost.
  + *Glynn Primary Performance Indicator:* Using 2013 County Health Rankings Data for comparison, decrease by 2018 from 11% to 5% the percentage of residents who are unable to access a doctor due to cost.
* **Goal #3**: Improve access to care and services for special populations\*.

\*Special populations includes those in poverty, persons with mental illness, young mothers and their babies, elderly, personals with mental/physical disabilities, persons with chronic diseases, and those without insurance.

* + *Glynn Primary Performance Indicator:* Using 2013 County Health Rankings for benchmarking, the proportion of uninsured residents will decrease from 23% to 18% by 2016 and to 10% by 2018.
  + *Glynn Primary Performance Indicator:* By 2018, the number of persons accessing WIC, immunizations, and other preventive services at Public Health will increase by 5% over 2013 totals, from 32,869 to 34,512.
  + *Glynn Primary Performance Indicator:* Coastal Community Health Services, the FQHC funded in Brunswick in 2013, will by 2015 accept all-comers with special needs and without insurance coverage, providing greater access to care.
  + *Glynn Primary Performance Indicator:* Using 2013 County Health Rankings Data for comparison, by 2018 decrease to 5% the percentage of residents who are unable to access a doctor due to cost.
  + *Glynn Primary Performance Indicator:* By 2018, Glynn County will have additional doctors and dentists who accept Medicaid (Department of Community Health Data).

### Goal #1: Increase the proportion of Glynn residents who have health insurance coverage.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Planned Work | | | Intended Results | | |
| Increase the proportion of Glynn residents who have health insurance coverage. | **Resources/**  **Inputs**  Resources essential to conduct this effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often at individual level and within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Southeast Georgia Health System/Cooperative Health Services  Community non-profit organizations including Coastal Georgia Area Community Action Agency, FaithWorks, STAR, Gateway  Benefits managers at area businesses  Navigators  Department of Family and Children Services  Public Health  Coastal Community Health Services (FQHC)  Libraries  Medicaid managed care plans  Local media | Case managers/nurses at DFCS/nonprofits/Public Health will provide resources about insurance coverage to all uninsured clients  Cooperative Health Services (Southeast Georgia Health System physician group) will provide information for Medicare/Medicaid qualification and contact information for ACA navigators  Community groups/Public Health will engage with Navigators at their locations 2014 - 2016  Local media outlets will publish articles/run public service announcements about insurance options  Public Health and nonprofit websites will include link to navigators and agencies that can help link uninsured to insurance  Emergency room referrals to navigators/FQHC/case managers (Southeast Georgia Health System)  Those not eligible for exchange can access available services through CMAP, Coastal Community Health Services, Public Health  SGHS will trend data about inappropriate ER use | Develop and distribute 50 pamphlets to uninsured clients per month  Develop brochure on Medicare/Medicaid qualification and contact information for ACA navigators  Engage with at least 25 ACA navigators  Disseminate 4 press releases per month  At least 20 community partners will provide links to navigators or the ACA website on their websites  Make 4 referrals per week  Coastal Community Health Services (FQHC) will, accept all-comers that they can appropriately serve without insurance coverage, providing greater access for care  Create and distribute trend report monthly to ER | Increased knowledge of insurance options, access to free/affordable care  Higher number of persons whose primary source of care is a doctor’s office/clinic (CHNA data 2013 to be updated)  More people will have insurance coverage and access to health care (County Health Rankings and CHNA) | More appropriate use of ER, thereby providing cost savings to hospitals  More money for other purposes for agencies that help clients pay for meds/dental services  Consistent care that leads to improved care  Better patient education  Less stress on families without coverage  More preventive care for the newly insured  Better health outcomes for Glynn residents  Fewer hospitalizations  Fewer persons with mental illness in jail  More people can purchase necessary medications |

Policy changes needed:

* Make Medicaid sustainable/dependable for families, that is, create eligibility for longer or set period of time rather than month to month; and
* Expand Medicaid to 138% of FPL.

### Goal #2: Increase the proportion of Glynn residents who have access to a primary care provider.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Planned Work | | | Intended Results | | |
| Increase the proportion of Glynn residents who have  access to a primary care provider. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often at individual level and within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Southeast Georgia Health System/Discharge planners and ER  Gateway  Coastal Community Health Services (FHQC)  Community Case Management Programs, including Community Care, Area Agency on Aging, FaithWorks, SOURCE, chronic disease management  School system/school nurses  Public Health  Churches  AppleCare | Public Health will educate adults about the role of primary care  Community forums led by trained laypersons/navigators in churches to discuss primary care (pending grant funding for equipment/training)  School nurses will make referrals to available providers  Information provided through hospital, nonprofits/Public Health  “Frequent fliers” to Emergency Room identified by hospitals with referrals to physicians (SGHS)  Recruitment of primary care providers/mid-levels by health system  Coastal Community Health Services (FQHC) implementation and expansion of services  Case Management through Community Care, Source, other programs and through nonprofits (Faithworks) to link residents to primary care providers  Increase number of offices/clinics that are available after normal office hours (SGHS, AppleCare)  Work to reduce the shortage of Public Health Nurses by offering incentives and/or raising pay that make the jobs more competitive with the private sector (state policymakers) | Distribute educational materials at health fairs and community events  Train 25 Glynn County residents  Make 4 referrals per month  Distribute 100 pamphlets  Distribute 5 frequent fliers per month  Recruit 8-10 primary care providers/mid-levels per year  Develop a strategic plan to implement and expand services  Refer 25 individuals  Recruit 3 offices/clinics that are available after normal office hours  Develop a strategic plan for incentives | Fewer patients will use the ER inappropriately  More doctors will accept Medicaid and other insurance on the Exchange  More clinics open after hours for better access to primary care  More patients can identify their own primary care physicians | Less waste and redundancy in care provided as tests are not repeated  Improved access to primary care  Improved continuity of care for better outcomes  Increased patient awareness of cost of care and appropriate care |

Policy changes needed:

* State could revisit implementing assignment to primary care provider and authorization for specialty care/ER care;
* Medicaid implements higher co-payments for inappropriate ER use to encourage primary care;
* More clinics open after hours; and
* Retain short-term increases in pay in Medicaid to encourage providers to accept Medicaid patients.

### Goal #3: Improve access to care and services for special populations.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Planned Work | | | Intended Results | | |
| Improve access to care and services for special populations. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often at individual level and within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Coastal Regional Coaches  Local physicians  Mental health court system  Mental Health: Gateway, St. Simons by the Sea  Coastal Community Health Services  Grant funding for layperson outreach to churches  Churches  Medicaid  Southeast Georgia Health System  Health benefits managers  Southeast Georgia Health System  School nurses  Volunteers  Law enforcement agencies  Area Agency on Aging, SOURCE  Medicaid waiver programs  Public Health  NAMI | Law enforcement will collect and trend data of persons jailed with a diagnosis of mental illness  PeachCare and transportation providers coordinate with media on talking points about transportation, access to providers  Provide access to mental health consults in jail (law enforcement)  Make appropriate referrals for mental health at ER, provider offices, and jail (SGHS, law enforcement)  Make referrals for substance abuse at ER, doctors’ offices, jail (SGHS)  School nurses will make referrals for appropriate services including mental health  Increased training for school nurses on psychiatric issues (Gateway, NAMI)  Telepsychiatry available in schools (long term activity through Georgia Partnership for Telehealth)  Elderly/disabled/persons with chronic diseases will have access to appropriate case management/disease management through SOURCE, Community Care, Faithworks, other waiver programs and nonprofits  Implement system of volunteer lay people/navigators to visit churches to provide information about health resources, answer questions, take blood pressures, etc., role of primary care (grant-funded)  Increase number of providers, including mental health providers, who speak Spanish (Gateway, SGHS) | Create and distribute monthly report on trends  Disseminate 4 press releases per month  Conduct 5 consultations per month  Make 4 referrals per month following standard guidelines  Make 4 referrals per month  Make 4 referrals per month  Conduct monthly trainings in schools  Implement telepsychiatry in four schools per district  Increase case management staff  At least 25 lay people will be trained to serve as health navigators in churches in the community (pending grant funds)  Recruit 6 providers per year | Persons with mental illness will be able to access care  Persons with chronic disease will better understand how to care for themselves  Churches will serve in a health information role to expand outreach  Hospitals will make appropriate referrals  Coastal Community Health Services will allow for integration of care  Transportation will be available to those who need it | Mental health is no longer taboo for discussion  All citizens know how to access needed resources  Persons with disabilities fully access health care in the community  Volunteers support good health by expanding outreach |

Policy changes needed:

* Fully implement drug and mental health courts;
* Add GED/job training requirements to drug and mental health court mandates;
* Job programs for parents while incarcerated for training, family support;
* Identify employers willing to hire persons who have completed drug court and incarceration;
* Implement contractor programs for persons who are incarcerated for job experience;
* Provide vouchers for Coastal Regional Coaches for those who cannot afford even minimal fees;
* Encourage the development of a day health program that provides nursing services;
* Encourage lay people to work with elderly/disabled/mentally ill in navigator role as volunteers, outreach to churches and disenfranchised; and
* Create a Public Health career ladder for nursing or employ some other means to raise pay so that Public Health can offer competitive wages with the private sector.

## Problem Statement: Glynn’s most vulnerable populations\* are at risk because of poverty and other social factors that affect their well-being.

\*Vulnerable populations are, for purposes of this problem, defined as children at risk of abuse or neglect, people in poverty, aged with need for assistance, persons with mental health problems, teen mothers and children born to teen parents, persons with mental or physical disabilities, and persons who live in substandard housing.

Social determinants of healthy are increasingly recognized as key factors to health promotion and prevention. Healthy People 2020 highlights “the importance of addressing the social determinants of health by including ‘Create social and physical environments that promote good health for all’ as one of the four overarching goals for the decade. This emphasis is shared by the World Health Organization, whose Commission on Social Determinants of Health in 2008 published the report, ‘Closing the gap in a generation: Health equity through action on the social determinants of health.’ The emphasis is also shared by other U.S. health initiatives such as the National Partnership for Action to End Health Disparities and the National Prevention and Health Promotion Strategy” (<http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>).

According to data from Family Connection Partnership, the rate of child abuse in Glynn County was 7/1000 in 2012, which translates to 149 substantiated incidents of child abuse/neglect. The CDC reports that one of seven children will experience some sort of abuse in their lifetimes (<http://www.cdc.gov/violenceprevention/pdf/cm-data-sheet--2013.pdf>). Of the Glynn CHNA survey respondents who identified a social problem, 7% expressed concern about child abuse and neglect.

In Georgia in 2012, according to the “Child Maltreatment Report” published by the HHS Administration for Children and Families (http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf), the rate of abuse of girls was slightly higher than that of boys, 7.7 versus 7.4. Of all substantiated cases, almost 73% were for neglect. Nearly 21% of children who were abused had a drug abuser as caregiver. There were 71 child fatalities reported by child agencies in 2012 in Georgia. Children with disabilities are more likely to be abused. Glynn County’s child mortality rate, according to County Health Rankings, was 98.6/100,000 in 2013 with 75 deaths of children under 18.

Between 2007 and 2011, nearly 32.6% of Glynn families with children lived in homes with annual incomes less than 150% of the Federal Poverty Level (Kids Count Database, n.d.). County Health Rankings reports that in 2013, 51% of children were eligible for free lunch. In 2011, 193 young people had contact with the Department of Juvenile Justice (Georgia Department of Juvenile Justice). Over 31% of Glynn children lived in poverty in 2011 (USDA Economic Research, n.d.).

According to County Health Rankings, 41% of Glynn County children live in single parent homes. Children who live in single parent households are more likely to be in poverty and, according to researchers from the Office on Child Abuse and Neglect, these children are

• 77% greater risk of being physically abused

• 87% greater risk of being harmed by physical neglect

• 165% greater risk of experiencing notable physical neglect

• 74% greater risk of suffering from emotional neglect

• 80% greater risk of suffering serious injury as a result of abuse

* 120% greater risk of experiencing some type of maltreatment overall (<https://www.childwelfare.gov/pubs/usermanuals/foundation/foundatione.cfm>).

According to the National Campaign to Prevent Teen Pregnancy, teen mothers are more likely to have low birthweight babies and twice as likely to abuse or neglect their children. The children of teen mothers also fare poorly: sons are twice as likely to go to prison than children of older mothers; daughters three times more likely be teenage mothers; and children of teen mothers are more likely to repeat a grade or drop out of school before graduation (<http://www.thenationalcampaign.org/why-it-matters/pdf/child_well-being.pdf>).

“Poor housing conditions are associated with a wide range of health conditions, including respiratory infections, asthma, lead poisoning, injuries, and mental health” (Kreiger& Higgins 2002). From 2007 – 2011, Glynn had 398 households without adequate plumbing.

**Best Practice Resources and Recommendations:** According to FRIENDS National Resource Center for Community-Based Child Abuse Prevention, the following are evidence-based best-practices in child abuse prevention: home visits, parent education/support, and skills-based training for children. Details about successful programs/models are available at <http://friendsnrc.org/joomdocs/eb_prog_direct.pdf>. The federal Office of Justice Programs makes available best practices for juvenile justice prevention programs at <http://www.ojjdp.gov/mpg/>. According to the National Campaign to Prevent Teen and Unplanned Pregnancy reports that best-practice programs can: “delay teen sexual activity, improve contraceptive use among sexually active teens; and/or; prevent teen pregnancy. Evidence-based effective interventions are available at <http://thenationalcampaign.org/sites/default/files/resource-primary-download/Briefly_Effective_Interventions.pdf>. Successful programs that have attacked housing disparities can be found at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1257572/>.

**Rationale:** Healthy and stable homes produce healthier children.

**Assumptions:**

* Community awareness of child abuse/neglect will increase reporting and allow for intervention and support.
* Community partnerships are essential to address the multi-faceted needs of families who face the challenges of poverty and other social issues, including drug and alcohol abuse.
* Research indicates that parents who have knowledge of parenting and the stages of child development and who have access to support in times of emotional stress are less likely to abuse their children.
* Identification of and greater collaboration among service providers can improve functionality of existing resources.
* Drug and alcohol abuse place children at higher risk of abuse.
* **Goal #1:** Reduce the rate of teen pregnancy.
  + According to County Health Rankings, the teen birthrate (ages 15-19) for Glynn County was 69/1000, higher than that of Georgia at 50/1000. The Healthy People 2020 target for adolescent births (15 – 17) is 36.2/1000.
  + *Glynn Primary Performance Indicator:* Using 2013 County Health Rankings data for benchmarking, reduce by 2018 from 69/1000 to 50/1000 births to teenage mothers.
* **Goal #2:** Parents know about the need for prenatal care and for effective care and nurturing of children.
  + In 2013, according to County Health Rankings, 9.6% babies born to Glynn mothers were considered to have low birthweights, which is a risk factor for other problems. The national rate of low birthweight babies is 6.0%. The infant mortality rate was 1013.5 with 55 deaths compared to the state crude rate of 793. Healthy People 2020 has set a target to reduce low birthweight babies to 7.8% for live births.
  + *Glynn Primary Performance Indicator:* Using 2013 County Health Rankings data as the source of data, by 2018 Glynn will reduce from 9.6% to 7.8% the proportion of low birthweight babies.
  + *Glynn Primary Performance Indicator:* By 2018, all at-risk families will have at least one in-home visit after the birth of a child (dependent on grant funding).
  + *Glynn Primary Performance Indicator:* by 2015, parenting classes will be available at least four times a year in Glynn County.
* **Goal #3:** All children live in safe homes**.**
  + According to data from the Administration for Children and Families and the Administration on Children, Youth and Families from the 2012 *Child Maltreatment Report*, the rate of child victims in Georgia in 2012 was 7.2/thousand; Glynn’s rate was 7/1000. In 2013, according to County Health Rankings, 30% of Glynn children lived in single family households, compared to 36% for Georgia and 20% for the nation.
  + *Glynn Primary Performance Indicator:* Using the Child Maltreatment Report for benchmarking, by 2018 reduce the rate of substantiated child abuse in Glynn from 7/1000 to 5/1000.
* **Goal #4:** Increase affordable and safe housing alternatives for low-income families and persons with special needs.
  + The percent of households in Glynn with housing costs representing more than 30% of household income was 33% in 2013, compared to 36% for all of Georgia, according to County Health Rankings. According to The Urban Institute, in 2012, for every extremely low income renter households there were only 23 affordable and available units (<http://www.urban.org/housingaffordability/>).
  + *Glynn Primary Performance Indicator:* By 2018, reduce from 30% (2013 data) to 25% the proportion of households where more than 30% of household income is required for housing costs (County Health Rankings).
  + *Glynn Primary Performance Indicator:* By 2018, using Urban Institute data for benchmarking, increase the availability of available/affordable housing units for extremely low-income residents from 2012 levels of 23/100.
  + *Glynn Primary Performance Indicator:* Using Census data, by 2018, reduce by half the number of Glynn County homes without complete plumbing.

### Goal #1: Reduce the rate of teen pregnancy.

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| Planned Work | | | Intended Results | | |
| Reduce the rate of teen pregnancy. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often at individual level and within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Schools  School nurses  Churches  Public Health  Physicians, including pediatricians/OB-GYNs  Parents  Sex education curriculum  Law enforcement  Teen mothers  DFCS  CareNet | Using guidelines approved by the Georgia Board of Education, continue to offer age-appropriate sex education in schools  Churches speak out about the high teen pregnancy rate, work with CareNet and other nonprofits to lead discussions  Parental training on signs that a child is sexually active (schools)  Law enforcement makes referrals to family violence non-profits, Faithworks  Family violence counselors identify and work with teens in the home  School nurses offer classes  Teen mothers invited to talk to student groups about challenges of teen pregnancy (Care Net)  Public Health/community partners work with teens who have had a pregnancy to reduce chances of a second pregnancy  Public Health tracks age of teen births for trending  Public Health will expand outreach through social media to older teens about free/low cost birth control (need technology)  DFCS makes referrals to Public Health/community partners for education and counseling | All middle and high school have curriculum in place about sex education, teen pregnancy (schools)  Train 2 church leaders per church to speak with teens about teen pregnancy  Offer monthly classes to parents  Make 4 referrals per month  Family violence counselor identifies teens on a weekly basis  Offer 2 classes per semester  Offer monthly discussions after school  Develop a program and enroll 10-15 committed teens per year  Create and distribute quarterly report  Technology will be employed for outreach to older teens, including birth control reminders, appointment reminders (Public Health data)  Refer 10-15 clients per month | Teen birthrate decreased (County Health Rankings data)  Teen birth rate among minors decreased (OASIS)  Students stay in school longer  (graduation rate)  Fewer low birthweight babies  (OASIS)  Fewer children in poverty  (Kids Count) | More high school graduates get better jobs, change cycle  Fewer children born to single mothers  Lower cost to system if parents are mature and working  Healthier babies |

Policy changes needed:

* Offer affordable daycare programs that allow teens to continue schooling; and
* Offer substantive and collaborative andragogical parent involvement opportunities.

### Goal #2: Parents know about effective care and nurturing of children.

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| Planned Work | | | Intended Results | | |
| Parents know about effective care and nurturing of children. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often at individual level and within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| After-school programs like Boys and Girls Club, YMCA, school programs  Public Health  Care Net  School system/school nurses  Day care providers, including YMCA  Community partners that work with families/family violence  Ob/Gyn/hospital referrals to DFCS or provision of materials from Public Health when indicated  DFCS  Grant funding for in-home visits  SGHS  Mandated reporters  Parent-teacher organizations  Babies Can’t Wait  Grandparent Connection  Family Connection Glynn  Healthy Families of Glynn County  YMCA  Coastal Coalition for Children | DFCS makes recommendation to visit Public Health when aware of teen pregnancy or pregnancies in at-risk families  Care Net’s “Earn While You Learn” program continues  In-home visits for new mothers In at-risk families (dependent on grant funding)  Free parenting classes offered by partners (SGHS, Public Health, schools, daycare providers, DFCS)  Improve referral processes for at-risk families to parenting classes, nutrition classes offered by Public Health/community partners (DFCS, Public Health, schools, nonprofits, Community Health Coalition)  Public Health follows positive pregnancy tests to offer services, counseling  Continue offering mandated reporter online training through Georgia Office for Children and Families  All new mothers receive information on community resources for parenting classes while in the hospital (SGHS, Public Health upon contact, OB/Gyn offices)  Parent-teacher organizations host annual meeting on helping children succeed in school  Promotion for “Back to Sleep” programs for new mothers (SGHS, Public Health, doctors’ offices, media, Grandparent Connection)  Help with access to cribs to prevent co-sleeping risks of injury (needs funding, nonprofit)  Parenting classes for grandparents of young children (Grandparent Connection of Coastal Coalition for Children, YMCA)  Training opportunities on housekeeping/sanitation/ nutrition/food safety/food storage (DFCS, Public Health, Grandparent Connection)  New parent support group development (needs nonprofit home) | DFCS creates and distributes quarterly report to Public Health  Recruit 10 participants per month  Conducts 4 visits per month  At least one no-cost or low-cost parenting class available at least quarterly in Glynn County  At-risk families receive at least one home visit after birth of baby (dependent on grant funds)  After every positive test provide a consultation  Implement policy; Offer 2 trainings per month  Distribute materials to mothers  Each school parent-teacher organization will offer at least one annual event on helping children succeed in school  Develop partnerships  Develop partnerships  Offer twice a month  Offer 2 trainings per month  Develop support group and offer once a month | Fewer children in single parent families (County Health Rankings)  Mandatory reporters better trained  Parenting classes available for all teens and at-risk families throughout the year | More agencies collaborating for effective outcomes  Fewer cases of child abuse  Healthier children  Higher graduation rate  More students with on-time graduation rates  Lower rate of child abuse |

Policy changes needed:

* Mandatory parenting classes for persons suspected of child abuse/neglect (not just referrals);
* Resources for parenting provided to at-risk families while in the hospital; and
* Families with history of child abuse/neglect have mandatory in-home visits after birth of new baby.

### Goal #3: All children live in safe homes.

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| Planned Work | | | Intended Results | | |
| All children live in safe homes. | **Resources/Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often at individual level and within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Public Health  DFCS  Community organizations that work with family violence, i.e., Glynn Community Crisis Center – Amity House, Glynn County Task Force Against Family Violence  Georgia Commission on Family Violence, Coalition Against Domestic Violence  Georgia Bureau of Investigation/local law enforcement  CareNet  Coastal Coalition for Children  Mandatory reporters  SGHS  Churches  Social service organizations including Salvation Army, Good Will, Faith Works  Schools  Safe Harbor Children’s Center  CASA Glynn  Georgia Office for Children and Families  Child Care Resource and Early Referral Agency  Babies Can’t Wait  Georgia Department of Early Care and Learning  Grandparent Connection  Head Start | Promote WIC, expand offsite WIC information session at housing complexes, community health fairs to increase awareness  DFCS requires parenting classes for families with reported child abuse/neglect  Community resource list given to parents when abuse/neglect suspected but not substantiated (DFCS)  GBI/local law enforcement handles criminal cases, but also makes referrals to community resources  Include resource material on Family Connection partner web pages, when applicable  Churches/social service organizations provide family counseling as needed, appropriate  Churches/social service organizations (e.g., Faithworks, CareNet, Safe Harbor, Grandparent Connection, publicize counseling options  Online training for mandatory reporters (Georgia Office for Children and Families)  CareNet offers “learn to earn” classes for at-risk mothers | Attend 10 community health fairs per year and distribute 100 pamphlets at each event  Parenting classes available at least four times during the year (PH/DFCS, Grandparent Connection, Safe Harbor)  Resource list of community organizations readily available for law enforcement, hospital, DFCS, social service organizations, print and web-versions – updated annually (cooperative effort of nonprofits, Public Health, Coalition)  Make 10 referrals per month  Add link to website and update quarterly  Offer counseling once a week  Disseminate 4 press releases per month  Establish trainings for new hires and current employees  Offer monthly classes | Fewer children in single parent homes (County Health Rankings)  Fewer children in foster care (Administration on Children and Families)  Fewer substantiated cases of child abuse (Administration on Children and Families)  More people are made aware of how to report child abuse/neglect | Higher graduation rates  More intact families  Higher family incomes  Healthier families  Lower crime rate  More collaboration between medical providers and social service agencies |

Policy changes needed:

* Provide a continuum of care among social service providers; and
* Provide affordable and safer housing for families.

### Goal #4: Increase affordable and safe housing alternatives for low-income families and persons with special needs.

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| Planned Work | | | Intended Results | | |
| Increase safe and affordable housing alternatives for  low-income families and persons with special needs. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often at individual level and within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Developers  Chamber of Commerce  Department of Community Affairs  Habitat for Humanity  Department of Housing and Urban Development  City/county home inspectors, code enforcement  City Commission  County Commission  Coastal Regional Commission  Law enforcement  Glynn County Community Action Authority  Churches  FaithWorks and other social service organizations | More affordable housing starts (developers, local governments)  Revitalization of Brunswick to provide jobs and to encourage people to stay in the community, thereby reducing the number of abandoned homes that are substandard (local governments, Chamber)  Home inspections to identify substandard housing and refer to community agencies, when appropriate (local governments)  GCCAA provides financial counseling to home buyers, provides weatherization services  Link persons who live in homes without adequate insulation and moisture barriers to GCCAA, Habitat  Community nonprofits make referrals to Habitat for Humanity | Develop a partnership among housing developers and banks  Develop a strategic plan for community organizing and mobilizing  Conduct 5 home inspections per month  Financial counseling is provided before customers purchase homes  Refer 20 individuals to CGCAA per month  Maker 4 referrals per month | Fewer people live in substandard homes  Neighborhoods are more stable when housing is decent  Crime is decreased as there are fewer abandoned homes | Crime is reduced and more people venture out of their homes to use local parks, thus healthier community  Brunswick has fewer abandoned, neglected homes  More people visit and shop in downtown Brunswick, creating new job opportunities  More pride in community |

Policy changes needed:

* Redraft local ordinances to promote affordable infill development;
* Develop local planning ordinances to reduce setbacks and encourage affordable cottage development; and
* More aggressive inspections of abandoned homes.

## Problem Statement: Low high school graduation rates and illiteracy, including health illiteracy,

## limit access to good jobs and good health.

Under the new federally-mandated formula for setting the graduation rate, in 2012 Glynn’s graduation rate was 74%. Of respondents to the Community Health Needs Assessment survey, those with lower educational levels were much more likely to report poor or fair health status than those with higher educational levels. The unemployment rate for Glynn County was 9.7% in late 2013. Focus group respondents indicated that many jobs pay low wages and do not offer benefits.

**Best Practice Resources/Recommendations:** Communities in Schools, Glynn and United Way’s Blueprint campaign, and Boys and Girls Club programs are effective best practices currently in place in Glynn. Other evidence-based best practice ideas are available at the National Dropout Prevention Center/Network at <http://www.dropoutprevention.org/customized-seminars/effective-strategies-increasing-graduation-rates>. To improve health literacy, the CDC recommends that all materials be “accurate, accessible, and actionable” (<http://www.cdc.gov/healthliteracy/developmaterials/index.html>).

**Rationale:** Higher education levels are associated with higher incomes and better health.

**Assumptions:**

* More education is related to the ability to get better jobs that can lift people from poverty and help families with better understanding of practices that lead to good health.
* Persons who complete high school are more likely to get better jobs that include health insurance.
* Persons with higher educational levels are more to have a higher level of health literacy and more likely to report good or excellent health status.
* Health literacy can be a part of an overall literacy program.
* **Goal #1:** Increase the proportion of Glynn residents who have at least a high school diploma.
  + Glynn’s high school graduation rate was 71% in 2012.
  + *Glynn Primary Performance Indicator:* Increase by 2018 the high school graduation rate from 71% to 80%.
* **Goal #2:** Implement a community health literacy campaign that is part of a larger campaign for literacy.
  + In 2003, the most recent year for literacy statistics, 13.3% of the Glynn population lacked basic literacy skills (National Center for Education Statistics).
  + *Glynn Primary Performance Indicator:* Using updated information from the National Center for Education Statistics, increase by 2018 years the literacy rate to 97% of the population.
* **Goal #3:** Work collaboratively across all types of organizations to recruit and retain good jobs that offer insurance benefits.
  + In late 2013, the unemployment rate in Glynn County was 9.7%. In 2013, according to County Health Rankings, 23% of the population was uninsured. (Of CHNA survey respondents, 20% were uninsured.)
  + *Glynn Primary Performance Indicator:* By 2018, reduce to 10% from 23% the proportion of population that is uninsured.
  + *Glynn Primary Performance Indicator:* Between 2014 and 2018, Camden’s unemployment rate will trend downward from the 9.7% rate in late 2013

### Goal #1: Increase the proportion of Glynn residents who have at least a high school diploma*.*

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| Planned Work | | | Intended Results | | |
| Increase the proportion of Glynn residents who have at  least a high school diploma. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Communities in Schools (CIS)  Wellcare of Georgia GED Benefits Program  Teachers/school counselors/principals  Parent-teacher organizations  Job Corps  Boys and Girls Club of SE Georgia  Family Connection Glynn  Glynn Career Academy  College of Coastal Georgia  United Way  Altamaha Tech  YCMA | Communities in Schools: Focus Graduation Program continues to encourage/monitor graduation for at-risk students  Publicize Wellcare’s offer to pay for GED for members of the health plan  Job Corp continues GED offerings  Tutoring Available at Boys and Girls Club  Teachers/school counselors identify students are risk for referral to CIS, Job Corps, other resources  College will offer classes for students for early admission and at the high schools to encourage secondary education  High schools will track college/tech school admission rate  High School Graduation Blue Print campaign (United Way) continues  Literacy programs will include components of health literacy (Altamaha Tech, WellCare)  Altamaha Tech will continue to offer literacy training for learners 16 and over not in school | Create and distribute annual report  Disseminate 4 press releases per month  Disseminate to community three times a year  Offer tutoring 3 times a month  Make 4 referrals per month  Offer 20 classes per semester  Create and distribute annual report  Conduct campaign annually  Add 2 components; revise when necessary  Disseminate information to community members at least 3 times a year | More students graduating from high school (County Health Rankings)  More students furthering their education after high school (school data)  Greater numbers of Glynn residents successfully completing GED exams (GED Testing Program, Altamaha Tech, Wellcare) | More collaboration among communities, schools  More educated workforce, ready for work  More educated people, healthier community  Improved literacy increases health literacy |

Policy changes needed:

* State should consider raising drop-out age to 18 or a high school diploma; and
* State should implement home-visits to at-risk students.

### Goal #2: Implement a community health literacy campaign that is part of a larger campaign for literacy*.*

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| Planned Work | | | Intended Results | | |
| Implement a community health literacy campaign  that is part of a larger campaign for literacy. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Wellcare of Georgia  Public libraries  Altamaha Tech  Hospital  4-H Club  CMAP  Family Connection Glynn  Public Health  Ferst Foundation – Glynn: Childhood Literacy of Glynn  Girl Scouts/Boy Scouts  School system  Coastal Community Health Services (FQHC) | Increase number of residents who complete the GED through Wellcare or Altamaha Tech (Wellcare data, Altamaha Tech)  Altamaha Tech will track and trend students in literacy programs  Ferst Foundation will provide one book on good health as part of its childhood literacy campaign  Public Health/hospitals will continue to provide low literacy materials for health education  4-H will introduce health education into programming  Libraries will maintain low-literacy materials on health education  Girl Scout/Boy Scout programs will include health education/fitness activities  Health education included in all schools, according to Georgia guidelines  Translators are available when necessary to ensure provider-patient communications | At least 20 students will complete the GED through Wellcare or Altamaha Tech  Create and distribute report annually  Low literacy materials are available at public locations, including library, Public Health, hospital, and Coastal Community Health Services (FQHC)  Add 3 components of health education in educational activities; revise as necessary  Low literacy materials are available at public locations, including library, Public Health, hospital, and Coastal Community Health Services (FQHC)  Add 2 health education activities in programs  Implement Georgia guidelines  Recruit 3 translators | Adults who earn a GED credential improve health status  Children engaged in healthy living activities will transfer information to their parents | More residents go on to graduate from secondary educational programs  Healthier community  Culture fosters self-awareness, personal responsibility for health  Improved collaboration among agencies |

Policy changes needed:

* The Technical College should develop agreements for literacy programs;
* Prepare and implement a strategic plan that defines the financial, human and organizational resources needed to achieve established priorities; and
* Establish relationships and communicate with policy makers at the local, state, and federal level to educate them on literacy issues and discuss and advocate for key policy positions.

### Goal #3: Work collaboratively across all types of organizations to recruit and retain good jobs that offer insurance benefits.

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| Planned Work | | | Intended Results | | |
| Work collaboratively across all types of organizations to  recruit and retain good jobs that offer insurance benefits. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| FaithWorks  Altamaha Tech  Chamber of Commerce/Economic Development Authority  Case managers/job coaches  Altamaha Tech | Foster job placements through prisoner reentry programs (Faithworks, others)  Collect and trend data on enrollment at Altamaha Tech/Career Academy  Chamber/Economic Development Authority joins with Collaborative to collaborate on economic development/health improvement  Social service organizations provide skills training (Job Corps)  Enhance public transportation for rides to work, consider vouchers when needed (would require policy change)    Job coaching by social service organizations, Job Corps | Make 15 job placements per month  Distribute quarterly report  Develop partnership  Offer 2-3 skills training and monthly  Develop partnership; create transportation schedules  Offer job coaching twice a month | Better jobs mean income and benefits, access to health care | Healthier community  Lower crime rate as more people have jobs |

Policy changes needed:

* Reduce sentencing and increased limited probation for offenders and recently paroled offenders to be simultaneously enrolled in earning educational credentials during their incarceration. Provide access to both direct and online instruction but link service to achievement of the person who is incarcerated or paroled;
* Providing equitable salaries; and
* Ongoing professional learning.

## 

**Problem Statement: County Health Rankings reports that 27% of Glynn Residents are obese.**

Of Glynn CHNA survey respondents, 51% report that they are overweight, 52% say that they do not eat a healthy diet, and 33% say that they never exercise. Healthy People 2020 reports that nationally, almost 82% of adults do not get adequate exercise and that one in three adults and one in six children and adolescents are obese. Obesity related conditions include heart disease, stroke, and type 2 diabetes and are associated with some cancers and complications during pregnancy. According to the Center for Nutrition Policy and Promotion, diet‐linked diseases account for an estimated $250 billion each year in increased medical costs and lost productivity. Focus group participants expressed concern that residents cannot readily access healthy foods.

According to Georgia Department of Public Health, heart disease and cerebrovascular disease/stroke are the second and third greatest causes of non-accidental death in Glynn.

Focus group members point out that lack of sidewalks, high crime rate, and access to safe neighborhood parks may limit activity. Glynn County has 11 parks/100,000 people, compared to the national benchmark of 16/100,000, according to County Health Rankings.

**Best Practice Resources and Recommendations:**

From the Centers for Disease Control and Prevention: “CDC’s *MMWR* report ‘[Recommended Community Strategies and Measurements to Prevent Obesity in the United States](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5807a1.htm)’ contains 24 recommended obesity prevention strategies focusing on environmental- and policy-level changes that can be implemented by local governments and school districts to promote healthy eating and active living. A detailed [*Implementation and Measurement Guide* Adobe PDF file](http://www.cdc.gov/obesity/downloads/community_strategies_guide.pdf) was developed by the Division of Nutrition, Physical Activity, and Obesity to assist local governments, states, and policy makers with implementing these obesity prevention strategies and reporting on the associated measurements. The guide includes measurement data protocols, a listing of useful resources, and examples of communities that successfully implemented each obesity prevention strategy” <http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/index.htm#ag>.

Leadership Strategies for Healthy Communities reports the following in its best-practice recommendations on increasing activity: “An increasing body of evidence suggests that children who live in communities with open spaces—such as parks, ball fields, nature centers, picnic areas and campgrounds—are more physically active than those living in areas with fewer recreation facilities. One study . . . found that the people with the greatest access were 43 percent more likely to exercise for 30 minutes on most days compared with those with poorer access . . . A 2006 study of more than 1,500 teenage girls found that they achieved 35 additional minutes of physical activity weekly for each park that was within a half mile of their homes. . . [T]he results of a 2007 study of low-income areas found that people who live within one mile of a park exercised at a rate 38 percent higher than those who lived farther away, and were four times as likely to visit a park at least once a week (<http://www.leadershipforhealthycommunities.org/action-strategies-toolkitmenu-122/open-spaces-parks-a-rec-toolkitmenu-129?task=view&id=298>).

Best practice recommendations for diabetes and hypertension link directly to other wellness activities. According to the CDC, improving clinical care, self-management education, and increased use of lifestyle management programs are effective interventions to prevent or control diabetes. Details are available from the CDC’s compendium of best practices at <http://www.cdc.gov/diabetes/pubs/pdf/PublicHealthCompedium.pdf>.

Best practice recommendations for systemic change from the American Heart Association include the following: “identifying all patients eligible for management; monitoring at the practice/population level; increasing patient and provider awareness; providing an effective diagnosis and treatment guideline; systematic follow-up of patients for initiation and intensification of therapy; clarifying roles of healthcare providers to implement a team approach; reducing barriers for patients to receive and adhere to medications as well as to implementing lifestyle modifications; leveraging the electronic medical record systems being established throughout the us to support each of these steps” <http://hyper.ahajournals.org/content/early/2013/11/14/HYP.0000000000000003.full.pdf>.

**Rationale:** Obesity is associated with increased risk of premature mortality and chronic disease.

**Assumptions:**

* Regular exercise can help people lose weight.
* Nutrition education and support groups can encourage weight loss.
* Elementary school children whose weight is normal are less likely to be obese as adults.
* Ready access to affordable fresh foods and healthy foods can reduce caloric intake and reduce obesity.
* Access to safe neighborhood parks, walking and bike trails, and other recreation venues can increase exercise opportunities.
* Good nutrition and exercise can reduce negative outcomes associated with diabetes and hypertension.
* **Goal #1:** Reduce the percentage of Glynn County adults who are obese.
  + County Health Rankings reports that 27% of Glynn adults are obese.
  + Healthy People 2020 reports that in 2009 only 31% of adults were at a healthy weight. Their target for 2020 is 34%.
  + In 2006, only 3.2% of elementary schools across the country required daily physical exercise for all students.
  + Healthy People 2020 has set the national goal of 4.2% of all schools requiring exercise for all students.
  + *Glynn Primary Performance Indicator:* Using data from state-required Fitnessgram®, between 2014 and 2018, increasing number of children with normal-range BMI.
  + *Glynn Primary Performance Indicator:* Using benchmark data from County Health Rankings, Glynn seeks to reduce the proportion of obese adults from 27% to 22% by 2018.
* **Goal #2:** Decrease the proportion of Glynn residents who are physically inactive.
  + County Health Rankings reports that 26% of Glynn residents are physically inactive. CHNA survey data indicates that 33% never exercise. Healthy People 2020 reports that in 2008 over 36% of adults did not exercise.
  + *Glynn Primary Performance Indicator:* Using County Health Rankings for benchmarking, by 2018, Glynn County will increase recreational facilities per capita from 2013 data.
  + *Glynn Primary Performance Indicator:* Using County Health Rankings data for benchmarking, by 2018, Glynn will reduce the proportion of citizens who are physically inactive from 26% to 21%.
* **Goal #3:** Increase access to healthy foods and knowledge about nutrition.
  + 44% of Glynn restaurants are fast-food outlets. 9% of Glynn residents are low-income and do not live close to a grocery store.
  + *Glynn Primary Performance Indicator:* Nutrition education will be offered by Public Health and Coalition partners at least annually.
* **Goal #4:** Decrease the prevalence of diabetes among Glynn residents.
  + From 2007 to 2011, diabetes was the 10th leading cause of death in Glynn County. In 2009, according to the Centers for Disease control, 10.6% of Glynn residents had diagnosed diabetes. According to OASIS, diabetes is most prevalent in the African American community in Glynn. From 2007 – 2010, the hospital discharge rate for diabetes for males was approximately 380/100,000 and for females, 368/100,000. Rates for Caucasians were less than half that of African-Americans.
  + *Glynn Primary Performance Indicator:* Using CDC data for benchmarking, by 2018, reduce the prevalence of diabetes for all citizens from 10.6% to 9.6%.
* **Goal #5:** Decrease the prevalence of hypertension among residents of Glynn County.
  + Of Glynn residents participating in the CHNA survey, 19% said that they had hypertension. According to OASIS, the discharge rate for African-Americans for hypertension from 2007- 1010 was 147.3, about four times that of Caucasians. In 2009, according to the Institute for Health Metrics and Evaluation, 42.1% of women and 40.1% of men had high blood pressure. It is likely that many Glynn residents are not aware of their hypertension.
  + *Glynn Primary Performance Indicator:* Using OASIS data for benchmarking, by 2018, reduce by 5% the discharge rate for hypertension.

### Goal #1: Reduce the percentage of Glynn County residents who are obese*.*

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| Planned Work | | | Intended Results | | |
| Reduce the percentage of Glynn County residents who are obese. | Resources/Inputs  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Public Health  WIC  Parent-teacher organizations  Hospital  Community volunteers with interest in wellness/nutrition  4-H  Girl Scouts/Boy Scouts  Grant funding  Medical providers  Housing Authority  Schools  CMAP  Elected officials/local celebrities  Coastal Georgia Community Action Authority  Fire departments  Grocery stores | Create awareness of link between obesity and chronic disease through education at health fairs, nonprofits, Public Health, FQHC, case management entities  WIC consults with new mothers  Health fairs with BP, cholesterol checks, weight, blood sugar screens (SGHS, other)  Community food and fitness events like Bridge Walk  Help clarify what obesity is (people do not realize that they are obese) through media  Create competition with other counties (collaboration with Public Health in other counties)  Engage local “celebrities” in weight loss effort, “biggest loser” type contest (need sponsor)  Continue to formalize policy on outside snacks and healthy snacks per school system wellness policy; evaluate changes annually  Food distribution sites offer weigh-in and nurse consults  Classes that foster children educating parents (4-H, Girl Scouts)  Weight/scales available at fire departments  Health laypersons who visit churches to check blood pressure/nutrition classes (grant-funded)  Grocery stores will conduct healthy cooking demonstrations  Schools track, trend, and compare mean BMI for all students required to take FitnessGram® | Have monthly health fairs and distribute 100 pamphlets  Conduct 4 consultations with new mothers weekly  At least 2 community-wide wellness events are held annually  Develop partnerships among farmer’s markets and gyms  Disseminate 4 press releases per month  Conduct monthly meetings with surrounding counties; develop partnerships  Recruit 2 celebrities per week to participate; Media coverage for “biggest loser” county competition  Discuss policies in monthly meetings and distribute minutes to school officials  Offer weigh-in and nurse consults twice a week  Offer one class per week  Provide 2 weight/scales at each fire department  At least 25 churches are visited each year by a trained layperson to talk about nutrition and do blood pressure checks (pending grant)  Conduct 1 health cooking demonstrations at a different grocery store weekly  Schools will evaluate wellness program to determine compliance; address weaknesses | Individuals will distinguish between healthy and unhealthy foods  Persons who lose weight more likely to exercise, further improving health  Individuals will recognize and address weight problems  Children will influence parents  Churches will take leadership role in improving health status of members  Changes in eating habits | Healthier community  More active community  Community has culture of good health/fitness  Less chronic disease  More children are active |

Policy changes needed:

* School policies on high-fat, high sugar snack availability reinforced and enforced;
* Businesses will offer vending/options for healthy snacks; and
* Seek grant funding for layperson training, equipment.

### Goal #2: Decrease the proportion of Glynn residents who are physically inactive.

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| Planned Work | | | Intended Results | | |
| Decrease the proportion of Glynn residents who are physically inactive. | **Resources/ Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Public Health  Law enforcement  City/county government  Recreation departments  WIC  Parent-teacher organizations  Hospital/volunteers  4-H  Girl Scouts/Boy Scouts  Grant funding  Medical providers  Housing Authority  Schools  School nurses  College of Coastal Georgia  CMAP  Coastal Georgia Community Action Authority | Recreation department will identify opportunities for more active playgrounds  Recreation department will identify more opportunities for adult physical activity (not team based)  Medical providers recommend exercise as a prescription for good health  Local governments or volunteers will conduct a walkability/bikeability assessment of all schools to determine how accessible schools are to children who could walk/ride bikes to school  City/county governments will identify and plan for areas where sidewalks are needed for biking/walking (grant funded)  Schools will comply with state guidelines for physical education; as part of school wellness plan, seek opportunities to incorporate physical activity into learning; seek ways to move closer to CDC recommendation of 60 minutes/day by increasing activity, “brain breaks,” in the classroom and recess time  After-school programs will include some form of physical activity  Community fitness events like Bridge Walk  Churches offer exercise classes or group walk and talk time for adults/children  Schools will track and trend average BMI for comparison to national norms for age group | At least two additional active-play parks will be added to low-income neighborhoods to provide greater access for exercise  Identify 3 opportunities per year  Implement daily when consulting with clients  Conduct 3 assessments per month  Three grant applications will be made for walkability/bikeability of areas near schools annually  Discuss policies at monthly meetings and create a report  3 after-school programs per week will include physical activity  Glynn County will have at least 2 community-wide fitness/health events per year  Offer once a week  Distribute quarterly report to school board officials and parents | County has fewer overweight individuals who are engaging in exercise  Rates of hypertension, diabetes decrease | Community engagement  Culture of physical fitness  Healthier community  More productive workforce |

Policy changes needed:

* All new apartments, housing developments require consideration of sidewalks and active play spaces; and
* Make schools, grocery stores more accessible for walkers/bikers.

### Goal #3: Increase access to healthy foods and information about nutrition.

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| Planned Work | | | Intended Results | | |
| Increase access to healthy foods and information about nutrition. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Public Health  WIC  Parent-teacher organizations  Hospital  Community volunteers with interest in wellness/nutrition  4-H  Businesses/Chamber  Girl Scouts/Boy Scouts  Medical providers  Housing Authority  Schools  CMAP  Coastal Georgia Community Action Authority  Fire departments  Grocery stores  College of Coastal Georgia Culinary Program  College of Coastal Georgia Nursing Program | Offer nutrition classes at least annually  WIC consults with new mothers  Health fairs will offer nutrition information  Community food and fitness events like Bridge Walk  Have at least one Farmer’s Market (seasonal) that accepts EBT cards  Enforce/reinforce school policies that remove sugary, high-fat snacks from schools, including homemade snacks and fund-raising foods  Food distribution sites offer weigh-in and nurse consults (Coastal Georgia Community Action Authority)  4-H, Boys and Girls Clubs offer nutrition education  Weight/scales available at fire departments  Health laypersons who visit churches to check blood pressure/take weights, offer nutrition classes (Grant funded)  Grocery stores will conduct healthy cooking demonstrations  Schools will track and trend BMI from Fitnessgram®  More businesses will provide incentives for healthy eating habits (Chamber of Commerce)  Businesses will change out unhealthy snacks for healthy snacks (Chamber of Commerce) | Provide 4 consultations per week to new mothers  Conduct 4 times a year  At least 2 community-wide wellness events are held annually  Recruit 1 Farmer’s Market per month  Review policies monthly  Offer twice a week  Girl Scouts/Boy Scouts and Boys and Girls Club will offer at least annually learning opportunities on nutrition  Provide 2 weights/scales at each fire department  At least 25 churches are visited each year about layperson to talk about nutrition and do blood pressure checks, cooking demonstrations (pending grant)  Conduct one healthy cooking demonstration per month  Distribute quarterly reports to parents and school officials  Recruit 2 business per month who will provide incentives  Healthy snacks are available for employees | Individuals will distinguish between healthy and unhealthy foods  Persons who lose weight more likely to exercise, further improving health  Individuals will recognize and address weight problems  Children will influence parents  Churches will take leadership role in improving health status of members  Changes in eating habits  Businesses encourage healthy habits | Healthier community  More active community  Community has culture of good health/fitness  Less chronic disease  More children are active  More productive workforce |

Policy changes needed:

* Healthy snacks accessible at schools;
* Policies enforced at schools on limits on unhealthy snacks, outside foods in classrooms/lunchroom; and
* Businesses provide access to healthy snacks, meals in lieu of high fat, high sugar snacks.

#### Goal #4: Decrease the prevalence of diabetes among Glynn residents.

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| Planned Work | | | Intended Results | | |
| Decrease the prevalence of diabetes among Glynn residents. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Public Health  WIC  Hospital  Medical providers  CMAP  Churches  Glynn County Against Diabetes  Coastal Georgia Community Action Authority | Offer nutrition classes at least annually (Public Health)  WIC consults with new mothers  Diabetes support group available (SGHS)  Diabetes screening available at no or low cost at Health Department  Blood sugar screenings available at annual community health fair  Food distribution sites offer diabetes screenings (pending grant funding, consider using laypersons, CGCAA) | Conduct 4 consultations with new mothers per month  Offer support groups per month  Diabetes screenings available at least 2 times/year in community  One distribution site per month | Pre-diabetics increase awareness  Diabetics better manage disease through better nutrition and exercise  Churches will take leadership role in improving health status of members | Healthier community  More active community  Less chronic disease  More productive workforce  Lower health care costs |

Policy changes needed:

* Provide case managers for high risk, non-compliant patients; and
* Implement diabetes screenings at community based organizations.

### Goal #5: Decrease the prevalence of hypertension among residents of Glynn County.

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| Planned Work | | | Intended Results | | |
| Increase access to healthy foods and information about nutrition. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Public Health  WIC  Fire departments Hospital  Medical providers  CMAP  Churches  Grant for blood pressure cuffs, training of laypersons | Blood pressure screenings available at fire departments 24/7  Food distribution sites offer blood pressure screenings (CGCAA, grant funding, volunteer laypersons)  Team of laypersons trained to check blood pressures at churches (pending grant funding)  Most at-risk can be provided blood pressure cuffs at little or no cost in returning for reporting blood pressure (pending grant funding) | Conduct monthly screenings  One distribution site offer screening monthly  At least 25 churches are visited each year by layperson to check blood pressures (dependent on grant funding)  Hypertension education available at least quarterly in community | Hypertensives more aware of need to monitor blood pressure  Persons with hypertension better manage disease through better nutrition and exercise  Churches will take leadership role in improving health status of members | Healthier community  More active community  Less chronic disease  More productive workforce  Lower health care costs  Reduce prevalence of strokes |

Policy changes needed:

* Provide case managers for high risk, non-compliant patients; and
* Implement hypertension screenings at community based organizations.

## Problem Statement: Safety issues, environmental hazards, and risk-taking behaviors affect the health and well-being of Glynn County residents.

County Health Rankings indicates that the rate of violent crime in Glynn is 801/100,000, well above the Georgia rate of 437. In 2012, there were 6 murders, 13 rapes, 125 robberies, 312 assaults, 957 burglaries, 2813 cases of larceny, and 112 vehicle thefts. There were 343 men and 192 who were documented aggressors in family violence cases. According to the Department of Juvenile Justice, 193 children had interactions with the system in 2011.

Of 2011 fatalities from motor vehicle accidents, 80% were not restrained by seatbelts. According to the Georgia Governor’s Office of Highway Safety, the MVA crash death rate for Glynn in 2013 was 18/100,000 compared with 16/100,000 for the state. From 1999 – 2010, motor vehicle accidents were the leading cause of death from injury in Glynn County. According to the Centers for Disease Control, “Adults age 18-34 are less likely to wear seatbelts than adults 35 or older (CDC, 2010). Men are 10% less likely to wear seatbelts than women (CDC, 2010, unpublished data). Adults who live in rural areas are 10% less likely to wear seatbelts than adults who live in urban (78%) and suburban areas (87%) (CDC, 2010) (www.cdc.gov/motorvehiclesafety/seatbelts/facts/html).

According to the Georgia Drug and Narcotics Agency, during the first 8 months of 2013, there were 1.4 controlled substance prescriptions per capita for residents. The Georgia Department of Education Student Health Survey indicates that about 15.5% of 9 – 12th graders reported using marijuana in the last 30 days. In the same survey, 6.5% of 9-12th graders reported a drug other than marijuana in the last 30 days.

**Best Practice Resources and Recommendations**: Safe Start: Promising Approaches Communities lists the following best practices in assisting children exposed to violence: “For all children, participation in high-quality early care and education programs can enhance physical, cognitive, and social development and promote readiness and capacity to succeed in school. For at-risk families, early identification of high-risk children and intervention by early education programs and schools, pediatric care and mental health programs, child welfare systems, and court and law enforcement agencies can prevent threats to healthy development by detecting and addressing emerging problems. For children and families already exposed to violence, intensive intervention programs delivered in the home and in the community can improve outcomes for children well into the adult years” <http://www.safestartcenter.org/sites/default/files/documents/publications/PDF_SSCImprovingOutcomes.pdf>.

For substance abusers, SAMHSA has a National Registry of Evidence-based Programs and Practices available online at <http://www.nrepp.samhsa.gov/ViewAll.aspx>.

“Click it or Ticket,” in place in Georgia, is a nationally recognized evidence-based best practice in self-belt safety. Healthy People 2020 recommends the following resource for best practices: <http://www.safety.fhwa.dot.gov/provencountermeasures/> in highway safety.

The Department of Health and Human Services recommends the following approaches to raise awareness and reduce toxic wastes that affect minority populations, though these strategies are appropriate for all communities with toxic waste issues: Strengthen the application of health and environmental statutes and policies; Identify and address, as appropriate, human health or environmental effects of policies . . .; and Support and advance a “health in all policies” approach that protects and promotes the health and well-being of . . . populations and Indian tribes with disproportionately high and adverse environmental exposures” (<http://www.hhs.gov/environmentaljustice/strategy.html>).

The CDC recommends inclusion of the following best practices in STD prevention programs: “delivered by trained instructors, are age appropriate, and include components on skill-building, support of healthy behaviors in school environments, and involvement of parents, youth-serving organizations, and health organizations” (<http://www.cdc.gov/healthyyouth/sexualbehaviors/effective_programs.htm>).

**Rationale:** Education, reporting, and enforcement can reduce unnecessary injury and death due to violence and risky behaviors.

**Assumptions:**

* Providing a safe environment for reporting and community supports can reduce harm from family violence.
* Wearing seatbelts saves lives.
* Drug abuse is a risky behavior that is linked to violence, illness, injury, and death.
* Education and resources about risky sexual behavior can reduce risk.
* **Goal #1:** Reduce violence in Glynn County, including reducing family violence and the number of criminal acts.
  + According to County Health Rankings, in 2013, Glynn’s violent crime rate, at 801/100,000, was higher than that of the state violent crime rate of 477/100,000.
  + *Glynn Primary Performance Indicator:* Using County Health Rankings data as the benchmark, reduce crime to the level of the state rate by 2018.
* **Goal #2:** Increase the use of vehicle seatbelts and child safety seats.
  + According to the Georgia Governor’s Office of Highway Safety, 80% of those who died in 2011 motor vehicle accidents were unrestrained.
  + *Glynn Primary Performance Indicator:* Using data obtained from the Governor’s Office of Highway Safety to benchmark, no fatalities will be associated with lack of seatbelt restraint use by 2015.
* **Goal #3:** Prevent initiation of drug abuse that causes poor judgment and links to violence and injury.
  + *Glynn Primary Performance Indicator:* Using the Georgia Department of Education Student Health Survey as the benchmarking tool, by 2018, reduce from 15.5% to 12% students in grades 9 – 12 who indicate that they have used marijuana.
  + *Glynn Primary Performance Indicator:* Using the Georgia Department of Education Student Health Survey as the benchmarking tool, by 2018 reduce from 6.5% to 5% the use of other drugs by students in grades 9 – 12.
* **Goal #4:** Reduce the incidence of sexually transmitted diseases.
  + In 2010, according to the Georgia Department of Public Health, there were 477 cases of sexually transmitted diseases reported in Glynn County.
  + *Glynn Primary Performance Indicator:* Using data from the Georgia Department of Public Health as a benchmark, reduce by 20% to 380 cases/year (or lower) the cases of sexually transmitted diseases by 2018.
* **Goal #5:** Reduce environmental risks.
  + According to the data collected by the Georgia Statistics System, in 2011, 1,335,967 pounds of toxic chemicals were released in Glynn County.
  + Almost 400 homes lacked complete plumbing.
  + Glynn had 14 hazardous waste sites in 2012.
  + *Glynn Primary Performance Indicator:* By 2018, using Georgia Statistics System data as the benchmark, decrease toxic releases from 1,335,967 to below 1,000,000.
  + *Glynn Primary Performance Indicator:* by 2018, reduce the nearly 400 homes without complete plumbing by 75% to 100 homes.

### Goal #1: Reduce violence in Glynn County, including reducing family violence and the number of criminal acts*.*

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| Planned Work | | | Intended Results | | |
| Reduce violence in Glynn County, including family  Violence and criminal acts. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Juvenile court  Gateway  FaithWorks  Schools  Law enforcement  Family Violence Shelter  Georgia Family Violence Commission  Mandated reporters  Georgia Office for Children and Families  Department of Juvenile Justice  Domestic Violence Task Force  Emergency Room  DFCS  Churches  Fatherhood Initiative  Golden Isles Children’s Advocacy Center  Safe Harbor | Prisoner re-entry program in place to put more ex-cons to work and reduce recidivism (FaithWorks, others)  Schools/school counselors/school nurses identify and refer for treatment cases of family/school violence  Increase community reporting of crime to hotline; law enforcement track and trend  In-school telepsychiatry/  telepsychology in place (longer range planning)  Encourage participation in education available online for mandatory reporters through Georgia Office for Children and Families.  Change attitudes toward family violence victims through information campaign  Provide additional services to victims through victim’s program/shelters  DFCS tracks and trends family violence, substantiated cases of child abuse for Glynn  Enhanced law enforcement to provide feeling of safety and get people back on the streets  Use of testimonials from former abusers to community groups (Family Violence prevention advocates)  Increased community awareness of family violence (media, local family violence prevention groups)  Tracking and trending by local shelter | Conduct rehabilitation programs with 100 ex-cons  Refer 10-15 cases per month  Conduct campaign annually  Implement in 3 schools per month  Disseminate 4 press releases per month  Assess attitudes using surveys; conduct information campaign annually  Develop strategic plan for 4 additional services  Create and distribute report monthly  Develop partnerships with community members  Recruit 5-10 individuals who will provide testimonials  At least 2 Family Violence Prevention Programs presented in Glynn annually  Create and distribute monthly report | Fewer children in foster care/adoption system  Fewer single parent families  More people finding treatment and resources  Lower crime rate  Perception of community as safe | Neighborhoods safer, more people likely to be aside, further reducing crime  More people working  Fewer people in poverty  Fewer cases of family violence |

Policy changes needed:

* Mandatory counseling, drug/alcohol abuse counseling, if applicable, for abusers
* Integrate behavioral health checks with physical health checks in school sports and activities.

### Goal #2: Increase the use of vehicle seatbelts and child safety seats*.*

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| Planned Work | | | Intended Results | | |
| Increase the use of vehicle seatbelts and child safety seats. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Law enforcement  State Patrol  Education campaigns (Click It or Ticket and other)  WIC/Public Health  Fire departments  Governor’s Office of Highway Safety  Hospital | Fire departments provide seat safety checks  WIC provides training on child safety seats to mothers  WIC provides child safety seats to mothers who cannot afford them  Law enforcement enforces seatbelt laws  Continue seatbelt education (State Patrol, law enforcement, “Click It or Ticket” campaign)  All new parents are required to have a safety seat installed before leaving the hospital | Conduct monthly  Conduct training weekly to mothers  Seek grant funding 4 times a year  Check 50-75 people at monthly checkpoints  Examine the data on usage of seatbelts and distribute report to state officials  Law enforcement ensure safety seat is installed | Injuries and fatalities will not be related to failure to wear a seatbelt | Wearing a seatbelt will be the social norm.  Automobile travel will be safer if all people use seatbelts. |

Policy changes needed:

* Training at all license renewals;
* Make sure that seatbelt laws apply to everyone in the car, not just those in the front seat;
* Ensure that fines for not wearing a seatbelt are high enough to be effective; and
* Make sure that police and state troopers enforce all seatbelt laws.

### Goal #3: Prevent initiation of drug abuse that causes poor judgment and links to violence and injury.

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| Planned Work | | | Intended Results | | |
| Prevent initiation of drug abuse that causes poor  judgment and links to violence and injury | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Public Health  Churches  Schools  School nurses  Parent-teacher organization  Youth organizations  Boys and Girls Club  4-H  Youth leaders, pastors  Parents  Head Start  Law enforcement | Educate young people about the dangers of drugs (schools, 4-H, Boys and Girls Clubs, churches)  Create the social norm that drug abuse is not socially acceptable (seek funding for social norms campaign about drinking/drug use)  School counselors/nurses notify parents of suspected drug abuse  Improve process for referral to drug treatment services (Coalition)  Testimonial events in schools (Schools, Gateway)  Start young in teaching dangers of drugs  School tracks and trends marijuana, alcohol, and other drug use among students  Conduct simulations of drug use and driving (need community partner, funding)  Existing laws enforced | Conducting 2 classes per month and distribute education materials  Conduct social norms campaign annually  Notify parents weekly  Examine referral process at monthly meetings and revise as needed  Four testimonials per year in schools  Recruit 3 middle schools per month and offer class once a month  Create and distribute quarterly report  Conduct 4 simulations per year  Review existing laws and collect data | Students who do not use drugs are less likely to use as adults  Students who do not use drugs are more likely to finish school  Reduction in teen pregnancy rate  Reduction in motor vehicle accidents | Healthier students without long-term problems  Students who do not use drugs are less likely to engage in risky behaviors  Increase in graduation rates  Greater likelihood of attending post-secondary schools  More productive workforce  Healthier community |

Policy change needed:

* Integrate behavioral health checks with physical health checks in school sports and activities.

### Goal #4: Reduce the incidence of sexually transmitted diseases*.*

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| Planned Work | | | Intended Results | | |
| Reduce the incidence of sexually transmitted diseases. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Public Health  W.I.S.E.  Schools  Boys and Girls Club  YMCA  Hospital/Medical Providers  Parents  Parent-Teacher Organizations  Case managers at advocacy organizations  DFCS  Gateway | Remove embarrassment from asking for condoms from Public Health  Provide ready access to condoms at Public Health for those who cannot afford them  Provide STD information to DFCS, nonprofit, waiver program case managers for sharing with clients  Educate WIC clients  DFCS provides education/educational materials to its clients  Gateway provides education to clients  Provide sex education to middle and high school students per state requirements  Provide education to parents about STDs (schools) | Distribute 3 condoms to every client in a secluded office  Distribute 3 condoms to every client  Provide 5 trainings a year to case managers about STD information  Educate each WIC client daily  Provide monthly education; distribute materials  Provide monthly education to clients  Offer 3 sex education classes  Offer annual class to parents | Less disease, less worry  Ease of obtaining condoms  Increased knowledge of STDs and risks | Students make better choices  Adults have ready access to condoms  Reduced health care costs |

Policy changes needed:

* Foster LGBTQ advocacy group;
* Improve STD surveillance, electronic health record case reporting, and integrated data systems; and
* Foster collaboration between public health and primary care to identify new ways to expand STD prevention services and quality of existing services.

### Goal #5: Reduce environmental risks.

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| Planned Work | | | Intended Results | | |
| Reduce environmental risks. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Department of Natural Resources, Environmental Protection Division  Public Health  Industries  Environmental Protection Agency  Local governments  Environmental groups  School groups | Increase awareness of hazardous waste sites and dumping of toxic wastes through news releases, discussion at government meetings (local governments, DNR, EPA)  Make considerations of health a part of all public policy decisions, when applicable (local governments)  Encourage citizens and environmental groups to report illegal dumping (800 # would require funding)  Publish annual environmental scorecard for increased awareness (local governments, DNR)  Water testing results publicized (Riverkeeper groups)  Count and publicize the number of septic tanks in Glynn County (Public Health) | Disseminate 4 press releases per quarter  Conduct monthly meetings regarding health and public policy  Distribute educational materials to citizens and environmental groups about illegal dumping  Distribute scorecards  Distribute results to public and environmental officials quarterly  Conduct quarterly | Lower likelihood of impact from toxic chemicals  Pressure for additional clean-up of hazardous waste sizes | Fewer toxic chemicals, cleaner environment  Cleaner environment, healthier community |

Policy changes needed:

* Increases fines for illegal dumping; and
* Foster collaboration between environmental officials and policy makers.

## Problem Statement: According to County Health Rankings, in 2013, 15% of Glynn residents were binge drinkers.

Glynn’s 15% rate of binge drinking is slightly higher than that of Georgia at 14%. The Glynn Community Health Needs Assessment survey indicates that 13% of women and 10% of men binge drink several times a month. Binge drinking is defined by the Centers for Disease Control as follows: drinking four or more alcoholic beverages in a two-hour period for a woman and five or more alcoholic beverages in a two-hour period for a man.

According to National Institute on Alcohol Abuse and Alcoholism, in 2009, about 10.4 million young people between ages 12 and 20 drank alcohol. By 15, half of teens have had at least one drink and by 18, more than 70% of teens have had at least one drink. Youth drinking is associated with serious injury and death and the impaired judgment associated with teen drinking is associated with high risk behaviors. Alcohol may also affect brain development.

HealthyPeople.gov reports that in 2005, “an estimated 22 million Americans struggled with a drug or alcohol problem. Almost 95% of people with substance abuse problems are considered unaware. . . .” Substance abuse issues are related to psychiatric disorders, teenage pregnancy, HIV/AIDs, STDs, domestic violence, child abuse, motor vehicle crashes, physical fights, crime, homicides, and suicides.

According to the National Institute on Alcohol and Alcoholism, populations at special risk of problems from alcohol include:

* People under 21 - NIAA says that while young people may drink less often, they are more likely to binge drink, which puts them at greater risk of injury.
* College students – NIAA says that about 80% of college students drink alcohol and many of them binge drink.
* Older adults – NIAA reports that older adults maybe more sensitive to alcohol and that alcohol may interfere with medications and may exacerbate chronic health conditions.
* Women – NIAA reports that women may be more susceptible to alcohol due to weight and may require less alcohol to become addicted. Pregnant women are advised not to drink.

**Best Practice Resources and Recommendations:** SAMHSA has a National Registry of Evidence-based Programs and Practices for substance abuse available online at <http://www.nrepp.samhsa.gov/ViewAll.aspx>.

**Rationale:** Reducing binge drinking can improve decision making, which can result in fewer injuries, less risky behavior, and improved health outcomes.

**Assumptions:**

* Awareness of the risks of binge drinking can reduce consumption of alcohol.
* Reducing drinking among those under 21 can reduce binge drinking.
* Preventing initiation among young people will reduce adult alcohol use and dependence.
* Enforcement of laws can reduce underage drinking and drinking while driving.
* **Goal #1**: Prevent/delay initiation of drinking among people under 21.
  + According to the Georgia Department of Education 2013 Student Health Survey, 12.75% of 9th graders, 18.49% of 10th graders, 28.3% of 11th graders, and 32.79% of 12th graders reported drinking alcoholic beverages in the last 30 days.
  + *Glynn Primary Performance Indicator:* Using the Georgia DOE Student Health Survey as the benchmark, by 2018, reduce by 20 percent the number of students who reported drinking alcohol in the last 30 days in 2013.
* **Goal #2**: Decrease the percentage of Glynn residents who binge drink.
  + According to Healthy People 2020, in 2008, 28.2% of adults ages 18 and over drank excessively in the last 30 days. The goal for Healthy People 2020 is to reduce binge drinking by 10% by 2020.
  + *Glynn Primary Performance Indicator:* Using County Health Rankings at the benchmark, by 2018, reduce from 15% to 12% the proportion of adults who report that they binge drink.
* **Goal #3:** Reduce the number of deaths/injuries of Glynn residents related to driving under the influence.
  + Between 2007 and 2011, according to the Governor’s Office of Highway Safety, motor vehicle accidents were the fifth leading cause of death of Glynn residents. There were 5 motor vehicle fatalities due to alcohol in 2007, 11 in 2008, 4 in 2009, 2 in 2010, and 2 in 2011. Motor vehicle accidents were the 6th leading cause for admission to the ER between 2006 and 2010, according to the Georgia Department of Public Health.
  + According to the CDC, about a third of all traffic-related deaths were due to alcohol impaired drivers. Of traffic deaths involving children, 17% were related to DUI.
  + *Glynn Primary Performance Indicator:* Reduce between 2014 and 2018 the total number of injuries/fatalities than those that occurred from 2007 – 2011 that are related to driving under the influence, using the Governor’s Office of Highway Safety for benchmarking.

### Goal #1: Prevent/delay initiation of drinking among people under 21.

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| --- | --- | --- | --- | --- | --- |
| Planned Work | | | Intended Results | | |
| Prevent/delay initiation of drinking among people under 21. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Law enforcement  Public health  Schools  Parents  Boys and Girls Club  4-H  Social service organizations that work with children  Stores that sell alcoholic beverages  Courts  Radio/billboards | Schools, parents work with students use social norms efforts to demonstrate that most teens don’t drink (Use data from Georgia Department of Education Student Health Survey)  Law enforcement conducts compliance checks with stores by sending out young looking people to purchase alcohol; publicize stores that broke the law  Law enforcement makes arrests of minors in possession of alcohol, according to Georgia law  Teens caught DUI will be prosecuted and lose licenses, within Georgia law  Law enforcement sets up sobriety checkpoints at community events that are alcohol-free  Virtualization exercise for driving under the influence for students  Testimonials  Teen Maze (find community partner)  Focus education on high-risk opportunities for drinking like spring break, prom, etc. | 100% of middle school students will participate in health education programs that include discussion of high risk behaviors like alcohol use (state curriculum)  Conduct monthly compliance checks  Create a program that will reduce the number of arrests  Create a program that will reduce teens prosecuted  Implement at every community event  Conduct virtualizations for once students once a month  Recruit 5 individuals who would be willing to provide testimonials per year  Develop partnership  Offer 4 classes quarterly | Fewer teens starting drinking means fewer adults drinking  Fewer automobile accidents involving alcohol  Fewer deaths and injuries related to DUI  Fewer auto accidents | Risky behaviors reduced  Teens more likely to be active and engaged in community  The community social norm will be that teens do not drink alcoholic beverages  Fewer teen auto accidents |

Policy changes needed:

* Graduated license plates to identify teen drivers/new drivers;
* Parental notification required if student caught while drinking;
* Administrative loss of license;
* Recommendation for changing any zoning that allows for high numbers of businesses that sell alcohol (stores, bars) in neighborhoods; and
* Recommendation for changing zoning or city/county ordinances that allow for prominent outside display of cigarettes and alcohol advertisements in store windows.

### Goal #2: Decrease the number of Glynn residents who binge drink.

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| Planned Work | | | Intended Results | | | |
| Decrease the number of Glynn residents who binge drink.  Decrease the percentage of Glynn adults  Who binge drink. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Law enforcement  Public health  Gateway  DUI schools  Alcohol/drug abuse counselors  Medical community  Media  Bars  SafeRide Program  Radio/Billboards  Taxi companies | Virtualization demonstrations of drinking and drinking campaign (need sponsor, funding)  Bars limit sales to patrons who are obviously inebriated  Bars ask about designated drivers/call taxis for people who have had too much to drink  Social norms campaign that makes binge drinking unacceptable/unhealthy  Testimonials of binge drinkers involved in accidents, etc. (DUI schools, schools, civic groups)  Establish connection between drinking and risk taking through victim impact board | | Conduct virtualization demonstrations at each community event  Implement policy daily  Implement policy daily  Conduct campaign annually  Recruit 5-8 binge drinkers to provide testimonials  Presentation of findings to Glynn residents at community forums | Fewer people with addictions  Fewer accidents  Less family violence | Less risky behavior  Less family violence  Healthier residents |

Policy changes needed:

* Local government regularly conduct policy checklist for best community practices and set goals based on the assessment;
* Increase taxes on alcohol; and
* Regulate marketing of alcoholic beverages.

### Goal #3: Decrease the number of deaths/injuries of Glynn residents related to driving under the influence.

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| --- | --- | --- | --- | --- | --- |
| Planned Work | | | Intended Results | | |
| Reduce the number of deaths/injuries of Glynn residents  related to driving under the influence. | **Resources/**  **Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Law enforcement  DUI schools  Churches  Public health | Wider use of interlock devices for those with previous DUI conviction (courts, law enforcement)  Frequent road checks by law enforcement  Law enforcement will monitor and trend DUI arrests  Virtualization demonstrations of drinking and drinking for those arrested (need sponsor)  Social norms campaign that makes binge drinking unacceptable/unhealthy (need sponsors)  Establish victim impact panels to talk to offenders (partners?, DUI schools) | Conduct 4 site visits per month with previous DUI conviction  Conduct twice a month  Create and distribute report quarterly to law officials  Conduct twice a month at DUI schools  Conduct campaign annually  Conduct victim impact panels annually | Fewer needless accidents  Fewer people put at risk of injury, death | Fewer auto accidents  Fewer alcohol related injuries and deaths |

Policy changes needed:

* Link education, engineering, encouragement, and enforcement strategies;
* Increase taxes on alcohol;
* Regulate marketing of alcoholic beverages; and
* Conducting information and educational campaigns in support of effective policy measures.

## Problem Statement: County Health Rankings reported in 2013 that 17% of Glynn residents smoked.

According to County Health Rankings, in 2013, 17% of Glynn residents smoked. In 2010, Georgia Public Health data indicates that 10% of births were to mothers who smoke. Of Community Health Needs Assessment survey respondents, 17% of women and 23% of men use tobacco in some form, and 26% of African-American survey respondents reported that they smoke. The Community Health Needs Assessment survey demonstrates a strong correlation between smoking and income, that is, the lower the income, the greater the likelihood that the respondent smoked. There was also a clear correlation between those who smoked and poor or fair health. Between 1999 and 2010, cancer was the leading cause of non-injury death in Glynn County.

HealthyPeople.gov reports that every year, 443,000 people die of smoking-related diseases. “Tobacco use is the single most preventable cause of disease, disability, and death in the United States, yet more deaths are caused each year by tobacco use than by all deaths from human immunodeficiency virus (HIV), illegal drug use, alcohol use, motor vehicle injuries, suicides, and murders combined” (HealthyPeople.gov). Tobacco use is related to cancer of the lung, bronchus, esophagus, and mouth, lung disease (including emphysema, and bronchitis), heart disease, premature and low birthweight babies, and still births. Secondhand smoke endangers children and may cause asthma attacks, respiratory infections, ear infections, and SIDS. Tobacco-related diseases cost the health care system over $200 billion each year.

**Best Practice Resources and Recommendations:** Proven prevention strategies can be found at the CDC Tobacco Control website at <http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm?source=govdelivery>.

**Rationale:** Reducing tobacco use can save lives and improve health.

**Assumptions:**

* Education about the risks of tobacco will reduce use.
* Preventing initiation will reduce long-term tobacco use.
* A cultural shift that makes tobacco unacceptable.
* **Goal #1**: Prevent initiation of smoking/tobacco use among children and youth.
  + According to Healthy People 2020, 26% of adolescents in grades 9 through 12 used some form of tobacco in the past 30 days. The national target is 21%. According to the Georgia Department of Education Student Health Survey, in 2013 in Glynn County, almost 7% of ninth graders, almost 10% of 10th graders, almost 15% of 11th grades, and 18% of 12th graders used tobacco in some form. In the same survey, on average, almost 4% of 6th – 8th graders have used tobacco in some form in the past 30 days.
  + *Glynn Primary Performance Indicator:* Using Georgia DOE Student Health Survey data for benchmarking, reduce by 25% from 2013 levels the percentage of high school students using tobacco in the past 30 days.
  + *Glynn Primary Performance Indicator:* Using Georgia DOE Student Health Survey data for benchmarking, reduce to less than 2% the percentage of 6th through 8th graders who have used tobacco in the past 30 days.
* **Goal #2**: Decrease the total number of people who smoke/use tobacco.
  + According to Healthy People 2020, almost 21% of Americans ages 18 and over smoke. The goal for Healthy People 2020 is to reduce smoking to 12% of adults by 2020.
  + *Glynn Primary Performance Indicator:* By 2018, with County Health Rankings data as the benchmark, reduce to 12% the proportion of Glynn County residents who smoke/use tobacco.

### Goal #1: Prevent initiation of smoking/tobacco among youth.

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|  | Planned Work | | Intended Outcomes | | |
| Prevent initiation of smoking/tobacco among youth. | **Resources/Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Parents  School  Students  Public health  Law enforcement  Convenience stores, other places that sell cigarettes  Physicians/medical providers | Law enforcement upholds existing laws  Compliance checks at stores selling cigarettes (law enforcement)  Social norms campaign to make tobacco use uncool (grant funding?)  Demonstration of lung with cancer (grant funding, Public Health, schools)  Testimonials from former smokers with lung disease (schools, youth groups, Boys and Girls Club, 4-H)  Increase “no smoking” areas where young people gather (businesses, local governments) | Develop partnerships with stores  Conduct monthly compliance checks  Conduct campaign annually  Conduct 5 demonstrations per year  Recruit 5-7 former smokers to give testimonials  Designate 8-10 no smoking areas annually | Healthier and more active students  Fewer younger students start smoking  Students will influence their parents to quit smoking | Lower rate of lung disease  As fewer young people smoke, social norms will have more influence |

Policy changes needed:

* More smoking prohibited areas;
* Increase cigarette tax in Georgia to make cigarettes more expensive;
* More businesses refuse to hire smokers;
* Limit number of tobacco retailers; and
* Enforcement of existing laws on sales.

### Goal #2: Decrease the total number of people who smoke/use tobacco.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Planned Work | | Intended Outcomes | | |
| Decrease the total number of people who smoke/use tobacco. | **Resources/Inputs**  Resources essential to conduct this program/effort including community partners | **Activities**  How we will accomplish our planned activities and who will be engaged. | **Outputs**  The amount of service delivered or number of people served | **Short-term Outcomes**  Benefits to participants, often an individual level within 5 years | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Children of parents who smoke/use tobacco  Schools  Relay for Life  American Cancer Society  Public health  Physicians/medical providers  Churches  Businesses | Schools continue mandatory education on risks of tobacco  Social norms campaign to make tobacco use uncool (need partner, funding)  Demonstration of lung with cancer (sponsored by hospital, providers, etc.)  Testimonials from former smokers with lung disease (schools, wellness education)  Increase “no smoking” areas (Chamber of Commerce)  More businesses have “no smoking” policies on premises and no hire policies for smokers (Chamber of Commerce) | Create and distribute annual reports on mandatory education  Conduct campaign annually  Conduct 5 demonstrations per year  Recruit 5 individuals who will provide testimonials  Designate 8-10 no smoking areas yearly  Implement 2-3 policies for no smoking | Healthier and more active adults  Fewer people start smoking  Students will influence their parents to quit smoking | Lower rate of lung disease  Fewer “years of potential life lost”  Social norms will influence adults |

Policy changes needed:

* Raise taxes on tobacco products;
* More smoke-free places;
* More businesses refuse to hire smokers;
* Limit number of tobacco retailers; and
* Enforcement of existing laws on sales.

# References

American Public Health Association. (n.d.). *Ten Essential Public Health Services.* http://www.apha.org/programs/standards/performancestandardsprogram/resexxentialservices.htm.

Annie E. Casey Foundation. (n.d.). Kids Count Data Center. http://datacenter.kidscount.org/.

Avery, Lacy. (2012). *Public Health Nurses: Vital to Georgia, But All Too Few*. Georgia Health News (August 30). <http://www.georgiahealthnews.com/2012/08/public-health-nurses-vital-georgia>.

Bureau of Labor Statistics. (n.d.). <http://www.bls.gov/lau/>.

Center for Nutrition Policy and Promotion. (n.d.). <http://www.cnpp.usda.gov/>.

Centers for Disease Control and Prevention. (n.d.). *Effective HIV and STD Prevention Programs for Youth.* <http://www.cdc.gov/healthyyouth/sexualbehaviors/effective_programs.htm>.

Centers for Disease Control and Prevention. (2013). *Effective Public Health Strategies to Prevent and Control Diabetes: A Compendium.* <http://www.cdc.gov/diabetes/pubs/pdf/PublicHealthCompedium.pdf>.

Centers for Disease Control and Prevention. (n.d.). *Fast Stats A to Z.* <http://www.cdc.gov/Nchs/fastats/>.

Centers for Disease Control and Prevention. (n.d.). *Health Literacy.* <http://www.cdc.gov/healthliteracy/developmaterials/index.html>.

Centers for Disease Control and Prevention. (n.d.). *Injury Prevention and Control: Motor Vehicle Safety.* [www.cdc.gov/motorvehiclesafety/seatbelts/facts/html](http://www.cdc.gov/motorvehiclesafety/seatbelts/facts/html).

Centers for Disease Control and Prevention. (n.d.). *Best Practices for Tobacco Control and Prevention.* <http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm?source=govdelivery>.

Centers for Disease Control and Prevention. (n.d.). *Violence Prevention.* <http://www.cdc.gov/violenceprevention/pdf/cm-data-sheet--2013.pdf>.

County Health Rankings. (n.d.). *University of Wisconsin and Robert Wood Johnson Foundation.* <http://www.countyhealthrankings.org>.

FRIENDS National Resource Center for Community-Based Child Abuse Prevention (CBCAP). (2009). *Evidence‐Based and Evidence-Informed Programs:  Prevention Program Descriptions Classified by CBCAP.* Grant-funded publication by U.S. Department of Health and Human Services, Administration for Children, Youth and Families, Office on Child Abuse and Neglect, under discretionary Grant 90CA1707.

Georgia Bureau of Investigation. (n.d.). *GBI Crime Statistics Database.* https://gbi.georgia.gov/gbi-crime-statistics-database.

Georgia Department of Education. (2013). *Student Health Survey II.* <http://www.gadoe.org/Curriculum-Instruction-and-Assessment/Curriculum-and-Instruction/GSHS-II/Pages/Georgia-Student-Health-Survey-II.aspx>.

Georgia Department of Juvenile Justice. (n.d.). *County Statistics.* <http://www.djj.state.ga.us/ResourceLibrary/resStatisticsMainCounty.shtml>.

Georgia Drug and Narcotics Agency. (2013). *Report on Controlled Substances for First Eight Months of 2013.*

Georgia Family Connection Partnership. (n.d.). <http://www.gafcp.org/>.

Go, A. S., Bauman, M., King, S., Fonarow, G., Lawrence, W., Williams, K., & Sanchez, E. (2013). An Effective Approach to Blood Pressure Control: A Science Advisory from the American Heart Association, the American College of Cardiology, and the Centers for Disease Control and Prevention. *Hypertension*. http://hyper.ahajournals.org/content/early/2013/11/14/HYP.0000000000000003.full.pdf.

Goldman, J., Salus, M.K., Wolcott, D., & Kennedy, K.Y. (2003). A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice. Office on Child Abuse and Neglect, Children’s Bureau, <https://www.childwelfare.gov/pubs/usermanuals/foundation/foundatione.cfm>.

Governor’s office of Highway Safety. (n.d.). *Georgia Highway Safety Statistics.* https://www.gahighwaysafety.org/research/.

Hayslett, C. (2012). Partner Up! for Public Health Connects the Dots between Community Health, Economic Health. *Health Voices*. Healthcare Georgia Foundation, Issue 1, 2012, Publication #592012.

Healthy People.gov. (n.d.). <http://www.healthypeople.gov/2020/default.aspx>.

Hood, E. (2005.) “Dwelling Disparities: How Poor Housing Leads to Poor Health.” *Environmental Health Perspectives,* 113(5), A310-A317.

Kendall, J., & Sullivan, J. (2012). Best Practices in Outreach and Enrollment for Health Centers. *Enroll America.* http://www.enrollamerica.org/best-practices-in-outreach-and-enrollment-for-health-centers/.

Kreiger, J., & Higgins, D. (2002). Housing and Health: Time Again for Public Health Action. *American Journal of Public Health*, 92(5), 758-768.

Leadership for Healthy Communities. (n.d.). *Action Strategies for Healthy Communities.* http://www.leadershipforhealthycommunities.org/action-strategies-toolkitmenu-122/open-spaces-parks-a-rec-toolkitmenu-129?task=view&id=298

McLeroy, K. R., Steckler, A., & Bibeau, D. (1988). The Social Ecology of Health Promotion Interventions. *Health Education Quarterly,* 15(4), 351-495.

Millar, A., Simeone, R., & Carnevale, J. (2001). Logic Models: A Systems Tool for Performance Management. *Evaluation and Program Planning,* 24, 73-81.

National Center for Education Statistics. (2003). *State and County Estimates of Low Literacy.*  <https://nces.ed.gov/naal/estimates/>.

National Campaign to Prevent Teen Pregnancy. (n.d.). <http://www.thenationalcampaign.org/why-it-matters/pdf/child_well-being.pdf>.

National Campaign to Prevent Teen Pregnancy. (2011). *A Summary of Effective Interventions.* <http://thenationalcampaign.org/sites/default/files/resource-primary-download/Briefly_Effective_Interventions.pdf>.

National Dropout Prevention Center/Network. (n.d.). *Effective Strategies for Increasing Graduation Rates.* <http://www.dropoutprevention.org/customized-seminars/effective-strategies-increasing-graduation-rates>.

National Institute on Alcohol and Alcoholism. (n.d.). *Alcohol and Health.* <http://www.niaaa.nih.gov/alcohol-health>.

Office of Juvenile Justice. (n.d.). *Model Programs Guide.* <http://www.ojjdp.gov/mpg/>.

Office of Juvenile Justice. (2013). *Safe Start: Promising Approaches – Improving Outcomes for Children Exposed to Violence.* This publication is supported by Contract No. GS-10F-0285K awarded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), Office of Justice Programs, U.S. Department of Justice. <http://www.safestartcenter.org/sites/default/files/documents/publications/PDF_SSCImprovingOutcomes.pdf>.

Substance Abuse and Mental Health Services Administration. (n.d.). *SAMHSA’s National Registry of Evidence-Based Programs and Practices.* <http://www.nrepp.samhsa.gov/ViewAll.aspx>.

Stokols, Daniel. (1996). Translating Social Ecological Theory into Guidelines for Community Health Promotion. *American Journal of Health Promotion,* 10(4), 282-283.

The Urban Institute. (n.d.). Housing Assistance Matters Initiative. http://www.urban.org/housingaffordability.

U.S. Department of Agriculture, USDA Economic Research. (n.d.). *County Level Data Sets/Poverty.* <http://www.ers.usda.gov/data-products/county-level-data-sets/poverty.aspx?reportPath=/State_Fact_Sheets/PovertyReport&stat_year=2009&stat_type=0&fips_st=37#.UyXKPPldXQQ>.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children’s Bureau. (2012). *Child Maltreatment Report 2012*. <http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf>.

U.S. Department of Health and Human Services. (2012). *HHS Environmental Justice Strategy.* <http://www.hhs.gov/environmentaljustice/strategy.htm>.

U.S. Department of Transportation, Office of Proven Highway Safety. (2012). *Guidance Memorandum of Promoting the Implementation of Proven Safety Measures.* http://www.safety.fhwa.dot.gov/provencountermeasures/.