

Mcintosh County Health Improvement Plan

Appendix: Community Health Needs Assessment

2014 - 2018











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## Community Health Needs Assessment Supporters

August 18 – October 31, 2013

*Conducted by College of Coastal Georgia – McIntosh County Health Department*

McIntosh County Health Department

The Darien News

McIntosh County Board of Education

McIntosh County Board of Commissioners

McIntosh County Recreation Department

McIntosh County SEED

Senior Citizens Center, Eulonia

Senior Citizens Center, Darien

McIntosh County Industrial Development Authority

McIntosh High School

McIntosh County Health Department Rabies Clinic

McIntosh Family Connections Partnership

McIntosh County Extension Office

McIntosh County Board of Health

Coastal Regional Commission

McIntosh County Chamber of Commerce

Elm Grove Baptist Church

Barbara Foster Hurst

Mandy Harrison

Piggy Wiggly

Health Care Providers in McIntosh

Darien Pharmacy

College of Coastal Georgia School of Business and Public Affairs

College of Coastal Georgia Public Affairs and Health Informatics students: Maurice Mason, Maurey Moss, Jannronn Bradford, Jay Moreno, April Davis, Suncica Beba, Stephanie Basey, Corliss Wade, and John Lander

## Community Health Improvement Planning Participants

December 2013 – May 15, 2014

*Community Collaborative Participants*

Mandy Harrison, Executive Director, Darien/McIntosh Chamber of Commerce

Members of the Darien/McIntosh Chamber of Commerce

John K. Littles, McIntosh SEED

Board Members, McIntosh SEED

Members of the McIntosh Rotary Club

Genevieve Wynegar, Family Connection McIntosh

Board Members of McIntosh Family Connection

Bonnie Caldwell, McIntosh County Board of Education

Lewis Persons and Inez Maddox, McIntosh County DFCS

Petula Gomillian, Atlantic Area CASA

Ellen Post, Communities of Coastal Georgia Foundation

Chandra Mahony, America’s Second Harvest

Jan Durrence

C. Paige Lightsey, McIntosh County Health Department

Michelle Walcdaz, Southeastern Bank

Russ Toal, McIntosh County Board of Health, Georgia Southern University

Robert E. Hudley, McIntosh SEED

Karulynn Koelliker, C3 – Community Cares Café

Ann Mason, Volunteer for McIntosh Literacy

Cathy Maulden, Todd-Grant Principal

Terrance Haywood, Mcintosh County Academy Principal

Carolyn Smith, Oak Grove Intermediate School Principal

Diane Richardson, Board of Education

Terri Lilies, Helen’s Haven

Sharon Brandt, McIntosh Family Connection

Greg Hickey, McIntosh County Extension Service

Diane Martin, McIntosh Family Connection

Greg Hickey, McIntosh County Extension Service

## Elected/Public Officials Who Provided Support/Input

*McIntosh County Board of Commissioners*

Kelly Spratt, Commissioner-at-Large, Chair

Joel Williams, District 1

David Stevens, District 2

Charles Jordan, District 3

Bill Watson, District 4

Brett Cook, McIntosh County Manager *and* Darien City Manager

County Clerk, Patrick Zoucks

## Invited Plan Reviewers

Cliff Sowell, Ph.D., McIntosh Resident, Retired Economist

Wally T. Orrel, Executive Director, McIntosh Industrial Development Authority

Mandy Harrison, Executive Director, Darien/McIntosh Chamber of Commerce

Paige Lightsey, Nurse Manager, McIntosh County Health Department

Eric Rumer, Environmental Health, McIntosh County Health Department

DeCalvin Hughes

Ann Mason

Bill and Jan Chamberlain

Mike Hardy

Greg Hickey, McIntosh County Extension Service

## Steering Committee

*Board of Health Members*

Kelly Spratt, Chair of the McIntosh County Commission

Dr. Diane J. Richardson, Deputy Superintendent, McIntosh Board of Education

Griffin Lotson, Darien City Council

Jane Walker, R.N.

Russ Toal, Consumer Representing the County’s Needy, Underprivileged and Elderly

Barbara Hurst, Consumer Advocate

*Public Health Leaders*

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

Saroyi Morris, Program Manager, Coastal Health District

Paige Lightsey, Nurse Manager, McIntosh County Health Department

Eric Rumer, Environmental Health Director, McIntosh County Health Department

*Community Members*

Wally Orrel, Executive Director, McIntosh Economic Development Authority

Mandy Harrison, Executive Director, Darien/McIntosh Chamber of Commerce

Cliff Sowell, Ph.D., Retired Economist

# Executive Summary

## A Roadmap for Action

Between August and December 2013, McIntosh County Health Department, a division of 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 McIntosh Family Connection, members of the McIntosh Rotary Club, members of the Darien/McIntosh Chamber of Commerce, and members of McIntosh Sustainable Environment and Economic Development (hereafter SEED), 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 McIntosh County. The plan that follows represents findings from public and survey data (See results of Community Health Needs Assessment), 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, McIntosh Family Connection 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 impacts 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 long-term impacts. This document was widely circulated to all participants and invited community stakeholders in March for feedback and commentary. Feedback helped refine the goals, and new activities and partners were added.
* In late March, the plan was reviewed and final input was obtained from the Steering Committee, composed of Board of Health, Public Health, and Community leaders.
* Beginning in June 2014, a Community Health Coalition of stakeholders will begin the process of implementing the CHIP and will create more formal timelines and assigned responsibilities and set up a plan 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. McIntosh 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. 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 social-economic barriers to good health;
* Work with the elected officials, schools, and the media to ensure that community health is considered as 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 Paige Lightsey, [cplightsey@dhr.state.ga.us](mailto:cplightsey@dhr.state.ga.us), (912) 832-5473, Extension 110.

# McIntosh 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 and results shared with the community beginning in November 2013 (See results of Community Health Needs Assessment). 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. Indicators have been set. In the next phase, beginning in June 2014, the Community Health Coalition for McIntosh 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 typing budget, community, and evaluation . . . . (2001, p. 2).

## MAPP Themes Guided Planning

Coastal Health District and McIntosh 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 factors 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 jobs, insurance status, poverty, recreation, the environment, and social concerns including drug and alcohol abuse and family issues like child abuse.
2. *Increase the visibility of Public Health within the community.* The community survey and publicity surrounding the survey provided a kick-off for efforts to increase the visibility of the role of Coastal Health District and McIntosh County Health Department. Once the assessment was complete, data and analysis were shared with individuals, elected officials, and organizations that were asked to engage in developing a CHIP 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 county Health Department website and on the College of Coastal Georgia website, and provided in digital form to community leaders. Other organizations including McIntosh Family Connection, McIntosh SEED, and the McIntosh Chamber of Commerce shared the data with their members. 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 that could help ensure a more representative sample. 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 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 and appointed officials has also reinforced the role of Public Health in meeting community needs that would otherwise not be met. The relationship between literacy, health, and economic development, for example, has been of special interest in McIntosh and has attracted the interest of diverse participants who have volunteered to engage in implementation of the CHIP. 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 officials and representatives from 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, school system, and elected officials. Discovering, for example, the population most likely to smoke or binge drink or those most often using the emergency room in the neighboring county 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 willing to partner with Public Health to address these issues.

## The Process

### *The First Phase: Community Health Needs Assessment*

The Community Health Needs Assessment (See results of 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 251 residents of McIntosh County (95% confidence level with a margin of error of plus/minus 6) 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 participation of 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; and
* 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, digitized copies 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 the local library. 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. Along with the information from 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.

Because there was no single collaborative group in the community willing to take on a leadership role in the Community Health Improvement Planning process, a decision was made to conduct broad outreach to four groups representing various community demographics: McIntosh Family Connection, a group composed of representatives of school and social service organizations already engaged in planning for major issues like child health, literacy, improving graduating rates, and stable families; McIntosh SEED, a collaborative dedicated to improving the community by tackling social issues through economic development and creating a sustainable environment; McIntosh Rotary Club, a group of leading citizens who are engaged in community issues; and the Darien-McIntosh Chamber of Commerce. A team from Public Health shared the CHNA results with these community groups and engaged each group in the planning process.

Brief descriptions from the websites of participating groups follow:

McIntosh Family Connection: “Our Family Connection collaborative serves as the local decision-making body, bringing community partners together to develop, implement, and evaluate plans that address the serious challenges facing Georgia’s children and families” (<http://mcintosh.gafcp.org/>).



McIntosh SEED: “McIntosh SEED (Sustainable Environment and Economic Development) is a grass-roots, community-based organization working in McIntosh County, Georgia. Our work is guided by the social, economic, environmental, and cultural interest of the community. We provide quality education, better housing, recreational facilities, business opportunities, and environmental protection and restoration. We are committed to creating and sustaining a healthy and diverse community through community development, community organizing, and advocacy.

“McIntosh SEED works to strengthen low-wealth families and improve neglected rural communities through asset-based economic development, education reform, empowerment, and environmental preservation. SEED acts as the ‘bridge’ between community members and local decision makers, ensuring that all citizens' voices are heard while strengthening cross-sector relationships and trust to help sustain our efforts over time. Our vision is one of a strong, spiritual, healthy community where all members develop their potential in a safe and clean environment, to become productive, contributing community members who enjoy an enhanced quality of life through educational achievement, economic growth and empowerment. McIntosh SEED is committed to improving not only the lives of the citizens of McIntosh County but also the lives of citizens regionally and nationally” (<http://www.mcintoshseed.org/about.html>).



McIntosh Chamber of Commerce: “The mission of the Darien-McIntosh County Chamber of Commerce is to promote economic growth, represent the business community and enhance the quality of life while protecting our cultural and natural resources” (<http://www.visitdarien.com/home.html>).



McIntosh County Rotary Club: “The Rotary Club of McIntosh County was founded May 26, 1995. For the last 18 years this club has been involved in many projects to improve our community . . . . We are a small club that does big things. We are a part of something that makes a difference that changes peoples’ lives for the better and will continue to do everything that we can to be there for our community” (<http://rotaryclubofmcintosh.yolasite.com/about-us.php>).



Among the organizations represented in the community meetings were the following: Darien/McIntosh Chamber of Commerce, McIntosh Economic Development Authority, McIntosh County Commission, Darien City Council, McIntosh SEED, McIntosh Rotary Club, McIntosh Board of Education, McIntosh County DFCS, Atlantic Area CASA, Communities of Coastal Georgia Foundation, America’s Second Harvest, McIntosh County Health Department, Board Members of McIntosh Family Connections; McIntosh County Board of Education; McIntosh County Department of Family and Children Services; Southeastern Bank; McIntosh County Board of Health; C3 – Community Cares Café; McIntosh Literacy; Todd-Grant School, McIntosh County Academy, Oak Grove Intermediate School, Helen’s Haven, McIntosh County Extension Service, McIntosh Family Connection and others.

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 impacts 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 long-term 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.
* With input from the community, the CHIP was further revised and the draft document shared with Steering Committee members in late March for a final review. The Steering Committee included community stakeholders, McIntosh 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 meeting in Summer 2014.

|  |  |  |  |
| --- | --- | --- | --- |
| Broad-based community input from survey/focus groups/community meetings | Priorities/partner identification set by community partners that create vision and broad goals  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 |  |  |

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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. McIntosh 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 Paige Lightsey, cplightsey@dhr.state.ga.us, (912) 832-5473, Extension 110.

### *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 McIntosh 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;
* assurance 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 time line 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 impacts. Each of these problem statements and goals were derived from a collaborative approach, which was the basis for the McIntosh County Community Health Improvement Plan.

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| Vision for McIntosh County |
| A healthy community that takes care of its children and older adults, a community that is educated and employed, and a community where citizens are no longer overweight or addicted to drugs, alcohol, and cigarettes. |

## Our Values

* A community that challenges itself to adopt healthy lifestyles
* A community with the resources necessary to create change
* A community where education is the key to improving life and health
* A community where poverty is not a barrier to good health

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| **Problem Statements and Goals Identified Through the Collaborative Process** |
| Problem Statement: Safety issues and risk taking affect the health and well-being of McIntosh families. |
| * Goal #: 1 Prevent initiation of drug abuse that causes poor judgment and links to violence and injury. * Goal #2: Increase the use of seat belts and child safety seats. * Goal #3: Reduce violence in McIntosh County, including criminal acts and family violence. * Goal #4: Provide swimming lessons to children to reduce the risk of drowning, the second leading cause of injury-related morbidity. * Goal #5: Reduce the incidence of sexually transmitted diseases. |
| Problem Statement: The high level of obesity in McIntosh increases risks to health. |
| * Goal #1: Reduce the proportion of residents who are obese. * Goal #2: Decrease the proportion of residents who are physically inactive. * Goal #3: Increase access to healthy foods and information about nutrition. * Goal #4: Reduce the prevalence of diabetes and hypertension. |
| Problem Statement: McIntosh residents face barriers in accessing medical, dental, and mental health care. |
| * Goal #1: Increase the proportion of residents who have access to primary care, dental care, and mental health care. * Goal #2: Increase the proportion of residents who have health insurance. * Goal #3: Improve access to care and services for special populations. |
| Problem Statement: County Health Rankings reports that 22% of McIntosh residents smoke. |
| * Goal #1: Prevent initiation of smoking/tobacco/nicotine use among youth. * Goal #2: Decrease the total number of people who smoke/use tobacco/nicotine. |
| Problem Statement: McIntosh’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: All children live in safe homes. * Goal #3: Parents know about effective care and nurturing of children.   Goal #4: Increase affordable and safe housing alternatives for low-income families and others with special needs. |
| Problem Statement: Increase the proportion of McIntosh residents who have at least a high school diploma and both basic literacy and health literacy skills. |
| * Goal #1: Build a community in which all residents are high school graduates, thereby increasing the opportunity for higher education and health literacy. * 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 jobs that include benefits and enable residents to move out of poverty. |
| Problem Statement: According to County Health Rankings, 9% of McIntosh adults binge drink. |
| * Goal #1: Prevent/delay initiation of drinking among people under 21. * Goal #2: Decrease the percentage of McIntosh residents who binge drink. * Goal #3: Reduce the number of deaths/injuries of McIntosh residents related to driving or boating under the influence. |

## Alignment with National Goals

It is important to note the alignment of the McIntosh 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** **McIntosh County CHIP Goals**

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| **Healthy People 2020 Overarching Goals** | **McIntosh County Health Improvement Plan** |
| Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death. | * Increase the use of seatbelts and child safety seats. * Reduce the number of deaths/injuries of McIntosh residents related to driving or boating under the influence. * Decrease the percentage of McIntosh County adults who are obese. * Decrease the proportion of McIntosh residents who are physically inactive. * Reduce the prevalence of diabetes and hypertension. * 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 McIntosh residents who binge drink. * Reduce drug abuse that causes poor judgment and links to violence and injury. * Provide swimming lessons to children to reduce the risk of drowning, the second leading cause of injury-related morbidity. |
| 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 McIntosh 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 McIntosh 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 McIntosh County, including family violence and criminal acts. * 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: Safety issues and risk-taking affect the health of McIntosh County residents.

County Health Rankings indicates that the rate of violent crime in McIntosh County in 2013 was 505/100,000, higher than the Georgia rate of 437. Between 2008 and 2012, there were 6 murders, 5 rapes, 30 robberies, 178 assaults, 688 burglaries, 1295 cases of larceny, and 140 vehicle thefts. There were 60 men and 15 women charged as aggressors in family violence cases in 2012. According to the Department of Juvenile Justice, in 2011, 75 children had interactions with the Juvenile Justice system.

Motor vehicle crashes were the 8th leading cause of death in McIntosh between 2007 and 2011 and the fifth major cause of emergency room visits. From 2007 – 2011, there were 22 deaths from Motor Vehicle Accidents in McIntosh. Of 2011 fatalities from motor vehicle accidents, 80% were not restrained. The MVA crash death rate for McIntosh in 2013 was 20/100,000 compared with 16/100,000 for the state. From 1999 – 2010, the top three leading causes of mortality from injuries were motor vehicle accidents, firearms, and drowning.

According to the Georgia Drug and Narcotics Agency, during the first 8 months of 2013, there were 1.01 controlled substance prescriptions per capita for residents. According to the Georgia Department of Education 2013 High School Survey, almost 3% of McIntosh 7th graders, 2.4% of 8th graders, 5.6% of 9th graders; 7% of 10th graders, 8% of 11th graders, and 5% of 12th graders used marijuana in the past 30 days. Only 18 students in grades 6 – 12 reported using some drug other than marijuana in the last 30 days, according to the survey.

**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. Drug and alcohol abuse are often related to risk-taking.

**Assumptions:**

* Providing a safe environment for reporting and offering alternative housing for stressed families can reduce harm from family violence.
* Wearing seatbelts saves lives.
* Drug abuse is a risky behavior that is linked to violence, illness, and injury.
* Education and resources about risky sexual behavior can reduce risk.
* **Goal #1:** Prevent initiation of drug abuse that causes poor judgment and links to violence and injury.
  + *McIntosh Primary Performance Indicator*: Using 2013 Georgia Department of Education School Health Survey Data for benchmarking, by 2018 reduce by 25% reports by students of use of marijuana and other drugs in the last 30 days.
* **Goal #2:** Increase the use of seatbelts and child safety seats.
  + In 2011 in McIntosh, there were 5 traffic fatalities, 72 injuries, and 86 crashes. 48% of deaths in 2011 motor vehicle accidents were unrestrained persons.
  + *McIntosh Primary Performance Indicator*: Using county data from the Governor’s Office of Highway Safety for benchmarking, between 2014 and 2018, turn the trend line downward for injuries and fatalities from MVAs.
* **Goal #3:** Reduce violence in McIntosh County, including family violence and criminal acts.
  + McIntosh’s violent crime rate is higher than that of the state. Death from firearms was the second leading cause of death in McIntosh between 1999 and 2010.
  + *McIntosh Primary Performance Indicator*: Using County Health Rankings for benchmarking, reduce violent crime to below the state rate by 2018.
* **Goal #4:** Make swimming lessons accessible to McIntosh residents to reduce the risk of drowning, the second leading cause of injury-related morbidity.
  + Drowning was the third leading cause of death, after motor vehicle accidents and firearms, in McIntosh between 1999 and 2010.
  + *McIntosh Primary Performance Indicator:* All children will have access to swimming lessons.
* **Goal #5:** Reduce the incidence of sexually transmitted diseases.
  + According to Public Health, in 2010, there were 67 cases of sexually transmitted diseases.
  + *McIntosh Primary Performance Indicator:* Using Public Health data for benchmarking, by 2018, reduce the annual number of reported cases of sexually transmitted diseases from 67 to less than 44.

### Goal #1: 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 at Individual Level | **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  4-H  Youth leaders, pastors  Parents  Head Start  Law enforcement  Family Connection/Communities in Schools | Continue with state-mandated curriculum on risk behaviors for middle school students  Create the social norm that drug abuse is not socially acceptable; conduct social norms campaign (Family Connection)  School counselors/nurses notify parents of suspected drug abuse  State Department of Education tracks and trends marijuana, alcohol, and other drug use among students (HS Student Health Survey)  Conduct simulations of drug use and driving (need partner)  Existing laws enforced (law enforcement)  Teen Maze (need sponsor) | Review performance annually by creating and distributing a report to state officials  Conduct social norms campaign annually  Notify parents weekly  Create a report and distribute quarterly  Conduct 4 simulations per year  Conduct a quarterly assessment on citations  Develop partnerships | 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 #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 at Individual Level | **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  SGHS | Public health provides seat safety checks  WIC provides training to mothers  Law enforcement tracks and trends seatbelt and child safety seat use  Law enforcement enforces seatbelt laws  All new parents are required to have a safety seat installed before leaving the hospital (SGHS) | Conduct 30-50 safety checks per month  Offer weekly trainings  Create and distribute report quarterly  Stop 50-75 people at a check point monthly  Law enforcement will ensure parents have a safety seat installed before leaving the hospital | 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: Reduce violence in McIntosh County, including reducing family violence and criminal acts.

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| Planned Work | | | Intended Results | | |
| Reduce violence in McIntosh County, including reducing 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 at Individual Level | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Juvenile court  Gateway/Other behavioral health providers  Prisoner re-entry work programs  Schools  Law enforcement  Sheriff’s Office Victim Advocate  Brunswick Judicial Victim Assistance  Family Violence Shelters in Glynn County - Glynn Community Crisis Center, Amity House, Hope House  Georgia Family Violence Commission  Mandated reporters  Department of Juvenile Justice  Domestic Violence Task Force in Glynn County  Emergency Room  DFCS  Churches | Schools/school counselors/school nurses identify and refer for treatment cases of family/school violence (schools)  Campaign to increase citizen reporting of crime to hotline; law enforcement track and trend (law enforcement, local governments)  In-school telepsychiatry/  telepsychology in place for counseling (future effort)  Mandatory reporters encouraged to take online training through Georgia Office of Children and Families (schools, DFCS, medical personnel, Public Health)  Change attitudes toward victims through information campaign (Family Violence Organizations that serve McIntosh)  Provide additional services to victims through victim’s program/shelters (family violence agencies)  DFCS tracks and trends family violence, substantiated cases of child abuse for McIntosh (DFCS, Child Maltreatment Report)  Referrals to drug abuse/alcohol abuse counseling for abusers (DFCS)  Task Force on Family Violence, shelters provide education through media, to organizations to build awareness of family violence  Tracking and trending by local shelter | Refer 10-15 cases per month  At least 1 Family Violence Prevention Program presented annually in McIntosh  Implement in 3 schools per month  Complete online training before 90 day period  Assess attitudes using surveys; conduct information campaign annually  Select 4 additional services  Create and distribute monthly report  Refer 10-15 clients weekly  Disseminate press releases monthly  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  Increased awareness of domestic violence | 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; and
* Provide a continuum of care among social service providers.

### Goal #4: Make swimming lessons accessible to McIntosh residents to reduce the risk of drowning, the county’s third leading cause of injury-related mortality.

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| Planned Work | | | Intended Results | | |
| Make swimming lessons accessible to children to reduce the risk of drowning, the third leading cause of death in McIntosh County. | **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 | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| YMCA  4-H  Schools  Parents  Parent-Teacher Organizations  Recreation Department  Local Motels | YMCA, recreation department, 4-H collaborate to provide opportunities for swimming lessons for youth  Media messages on importance of learning to swim reinforce need for lessons (media)  Adult swimming lessons made available through YMCA/recreation department  Work with local motels to use pools off-hours for swimming lessons | Provide swimming lessons weekly  Disseminate 4 press releases monthly  Offer 5 adult swimming lessons weekly  Develop partnership | More opportunities for physical fitness  Greater safety on and around boats  More opportunity for jobs on water  If more adults can swim, their children will be more likely to swim | Fewer deaths from drowning  Healthier community |

Policy changes needed:

* Recreation personnel understands and knowingly accepts responsibility for the well-being and safety of youth members; and
* Recreation personnel are trained on Safe Swim Defense.

### Goal #5: 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 at Individual Level | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Public Health  Schools  Medical Providers  Parents  Parent-Teacher Organizations  DFCS  Gateway/Other behavioral health providers | Remove embarrassment from asking for condoms (Public Health)  Provide ready access at Public Health to condoms for those who cannot afford them  Provide STD information to DFCS case managers for sharing with clients (Public Health)  Educate WIC clients about STDs  Gateway provides education to clients  Provide sex education to middle and high school students (as mandated by state)  Provide education to parents about STDs | Distribute 3 condoms to clients in a secluded office  Distribute 3 condoms to clients  Provide 5 trainings per year to case managers  Educate each WIC client after lab work is completed  Provide monthly education to clients and distribute education materials  Offer 3 sex education classes during the semester  Provide 2 monthly classes to parents; distribute educational materials | Less disease, less worry  Ease of obtain condoms improves  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.

## Problem Statement: The high level of obesity in McIntosh increases risks to health.

According to County Health Rankings, 32% of McIntosh citizens are obese. Of McIntosh survey respondents, 40% of residents report that they are overweight, 52% say that they do not eat a healthy diet, and 32% say that they “seldom or never” exercise. These figures closely correlate with 2009 Centers for Disease Control Data that indicate that 31.3% of the population was obese and 29% were physically inactive.

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. Obesity is also 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. Community members suggested that lack of access to healthy foods and nutritional information compound the problem of obesity.

Heart disease and stroke are the number two and three causes of non-accidental death in McIntosh. The hospital discharge rate for hypertension for African-American residents in McIntosh was 194.5/100,000 and hypertension was ranked 8th in overall hospital discharges in 2010. Of Community Health Needs Assessment respondents, nearly 19% report diagnosed hypertension, though the percentage may be higher, since the rate for Georgia, according to the Centers for Disease Control, is about 31%.

According to County Health Rankings, 13% of McIntosh residents had diabetes in 2013.

County Health Rankings reports that McIntosh has fewer parks than the mean for Georgia and the nation. Access to safe parks in neighborhoods and to safe places for riding bikes can increase opportunities for exercise. McIntosh County Schools participate in the state-mandated FitnessGram® program, in which student progress in physical fitness is measured each year. Department of Education standards require only one quarter of physical education in high school. Middle schools average almost 4 hours per week, and some teachers are incorporating physical activity into teaching other subjects.

**Best Practice Resources and Recommendations:**

*Obesity -* From the Centers for Disease Control and Prevention: “CDC’s MMWR report ‘Recommended Community Strategies and Measurements to Prevent Obesity in the United States’ 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 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>.

*Active lifestyles* - 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).

*Diabetes, hypertension and heart disease* - 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 parks, walking and bike trails, and other recreation can increase exercise opportunities.
* **Goal #1:** Reduce the percentage of McIntosh County adults who are obese.
  + Healthy People 2020 reports that in 2009, only 31% of adults were at a healthy weight. The U.S. target for 2020 is 34%.
  + County Health Rankings reports that 32% of McIntosh adults are obese.
  + *McIntosh Primary Performance Indicator:* Using County Health Rankings 2013 data as the benchmark, McIntosh seeks to reduce the proportion of obese adults from 32% to 27% by 2018.
* **Goal #2:** Decrease the proportion of McIntosh residents who are physically inactive.
  + County Health Rankings reports that 30% of McIntosh residents are physically inactive. CHNA survey data indicates that 29% never exercise.
  + County Health Rankings reports that there are there are fewer parks per capita in McIntosh than the mean for the state. Community members urged the development of “active-play” neighborhood parks, additional walking/biking trails to enhance the county’s exercise options, and to expand recreation opportunities.
  + *McIntosh Primary Performance Indicator*: By 2018, add at least one biking/walking trail that is accessible to the community.
  + *McIntosh Primary Performance Indicator:* By 2018, the county will have at least two additional active play areas for children.
  + *McIntosh Primary Performance Indicator*: Using County Health Rankings data as the benchmark, McIntosh will reduce the proportion of citizens who are physically inactive from 30% to 25% by 2018.
  + *McIntosh Primary Performance Indicator: Between 2014 and 2018, i*ncrease the percentage of students in McIntosh who demonstrate physical fitness on the FitnessGram® test that is mandated by the State of Georgia for all students.
* **Goal #3:** Increase access to healthy foods and information about nutrition.
  + According to County Health Rankings, 30% of McIntosh restaurants are fast-food outlets with few choices for healthy meals. County Health Rankings also reports that 4% of McIntosh residents are low-income and do not live close to a grocery store.
  + *McIntosh Primary Performance Indicator:* Establish at least 5 community gardens at schools, churches, public areas by 2018.
  + *McIntosh Primary Performance Indicator:* By 2015, nutrition education will be offered by Public Health and its partners at least annually.
* **Goal #4:** Decrease the prevalence of diabetes and hypertension among McIntosh residents.
  + *McIntosh Primary Performance Indicator:* By 2018, using County Health Rankings for benchmarking, reduce from 13% to 11% the proportion of residents with diabetes.
  + *McIntosh Primary Performance Indicator:* By 2018, using OASIS data for benchmarking, reduce by 10% from 2013 levels the number of hospital discharges for hypertension.

### Goal #1: Reduce the percentage of McIntosh County adults who are obese.

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| Planned Work | | | Intended Results | | |
| Reduce the percentage of McIntosh 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 at Individual Level | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Public Health  WIC  Senior centers  McIntosh SEED  Parent-teacher organizations  Leisure/Recreation Services  Hospital  Community volunteers with interest in wellness/nutrition  4-H  Girl Scouts  Grant funding to pay for BP cuffs, scales, training for FD and laypersons  Medical providers  Housing Authority  Schools  County/city governments  Elected officials/local celebrities  Fire departments  Grocery stores  Chamber of Commerce | Create awareness of link between obesity and chronic disease through education provided  WIC consults with new mothers on nutrition  Public Health offers nutrition classes  YMCA will track/trend participation  School will track/trend FitnessGram® results  Health fairs with BP, cholesterol checks, weight, blood sugar screens (near partner)  Community food and fitness events (Chamber, businesses, recreation department)  Classes offered by recreation department on nutrition, exercise  Help clarify what obesity is (people do not realize that they are obese) through media (local media)  Limit unhealthy snacks in classrooms/for parties via school wellness policies/enforcement of policies (school system)  Chamber of Commerce promotes healthy workplace initiatives  Food distribution sites offer weigh-in and blood pressure checks (McIntosh SEED)  Classes in which children teach parents (4-H, Girl Scouts)  Information distributed through Extension Service Newsletters  Weight/scales available at fire departments  Schools track, trend, and compare BMI | Conduct annual health fair and distribute 100 pamphlets on health complications of obesity  Conduct 4 consultations with new mothers per week  Offer 3 nutrition classes per month  Create and distribute participation report  Conduct 4 health fairs per year  At least 1 community wellness event is held annually  Develop partnerships  Offer 4 classes per month  Disseminate 4 press releases per month  Implement school policies  Implement workplace initiatives  Conduct weigh-in an blood pressure checks twice a week  Two classes per month  Distribute monthly newsletters  Fire departments have 2 weight/scales  Create and distribute report annually | 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 snacks (including outside foods for parties) are publicized, enforced, and evaluated;
* Changes in government food assistance programs to encourage healthy eating;
* Businesses/local governments should offer incentives for healthy behaviors;
* State should reevaluate the requirement of only 1 quarter of physical education for high school students; and
* Seek grant funding for church outreach programming.

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

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| Planned Work | | | Intended Results | | |
| Decrease the proportion of McIntosh 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 at Individual Level | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Public Health  City/county governments  Recreation department  WIC  Parent-teacher organizations  Hospital/volunteers  YMCA and YMCA after-school programs and summer day camps  4-H  Girl Scouts/Boy Scouts  Grant funding/donations  Volunteers  Medical providers  Housing Authority  Schools  School nurses | Recreation department, city/county will identify opportunities for more active playgrounds (local governments)  Recreation department will identify more opportunities for adult physical activity (not team based) (recreation department)  City/county governments will identify and plan for areas where sidewalks are needed for biking/walking or create an accessible biking trail  Local governments will create policies that include requirements for open/play areas in new developments  Conduct an assessment of the walkability/bikeability within a two mile radius of all McIntosh Schools (seek grant funding)  Attendance at YMCA will increase  Schools will track/trend success on FitnessGram®  Schools will track and trend average BMI for comparison to national norms for age group  More teachers will include physical activity in learning (school policies)  After-school programs will include some form of physical activity (YMCA, other)  Community fitness event (need partner)  Churches offer exercise classes or group walk and talk time for adults/children (churches) | McIntosh County will have at least 1 community-wide fitness/health event per year  Identify 3 opportunities per month and inform 20-30 adults  Conduct 3 assessments per month  County will have at least two new active playgrounds annually    Conduct 3 assessments per month; At least one walking/biking trail that is accessible annually  Recruit 5 new members for YMCA  Create and distribute FitnessGram report  Create and distribute quarterly report to school board officials and parents  25 teacher will develop and implement curriculum  Conduct 3 after-school programs per week  Develop partnership  Offer classes once a week | County has fewer overweight individuals  Years of potential life lost decreases  Rates of hypertension, diabetes decrease  Less chronic disease | Community engagement  Culture of physical fitness  Healthier community  More productive workforce |

Policy changes needed:

* All new housing developments/apartment complexes require consideration of sidewalks;
* Make playground/play areas a requirement for new housing developments/apartments; and
* Assess walkability/bikeability near schools to see if changes need to be made in infrastructure; plan for new biking/walking trails to meet need.

### 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 at Individual Level | **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  Community gardens  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  Grant funds for training laypersons to visit churches | Offer at least one nutrition class in the community per year (Public Health)  WIC consults with new mothers on nutrition, exercise  Community food and fitness event to promote wellness  Promote a Farmers’ Market that accepts EBT cards (Chamber)  Ensure access to healthy snacks at school (school policies)  Food distribution sites offer weigh-in and blood pressure checks (McIntosh SEED)  4-H offer nutrition education and share with others  Extension Service continues health promotion newsletters  Weight/scales available at fire departments  Health laypersons visit churches to check blood pressure/take weights, offer nutrition classes (dependent on grant funding)  Schools will collect BMI from FitnessGram® data for trending  More businesses will provide incentives for healthy eating habits (Chamber promotion)  Establish community gardens program (need partner, schools and Extension) | Conduct 4 consultations with new mothers per week  Conduct 4 times a year  Recruit one farmer per month  Implement school policies of healthy snacks  Twice a week  Twice a month; develop curriculum  Distribute 30 copies per month  Fire departments should have 2 weight/scales  At least 10 churches are visited each year about layperson to talk about nutrition and do blood pressure checks, cooking demonstrations  Distribute quarterly reports to parents and school board officials  Recruit 2 businesses per month  Develop partnerships | Individuals will distinguish between healthy and unhealthy foods  Healthy foods, including fresh fruits and vegetables, are available and accessible  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:

* Remove sugary snacks from schools;
* Add healthy snacks to schools; and
* Remove unhealthy alternatives from business vending machines and replace with better alternatives.

### Goal #4: Decrease the prevalence of diabetes and hypertension among McIntosh residents**.**

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| Planned Work | | | Intended Results | | |
| Decrease the prevalence of diabetes among McIntosh 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- and Long-term Outcomes**  Benefits to Participants, Often at Individual Level | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Public Health  WIC  Medical providers  Churches  Fire departments  Grant for blood pressure cuffs, training of laypersons  McIntosh SEED  Case managers  Southeast Georgia Health System | Nutrition classes available at least annually (Public Health)  WIC consults with new mothers on diabetes and hypertension  Diabetes support group available (SGHS  Diabetes screening available at no or low cost at Health Department  Food distribution sites offer diabetes screenings (McIntosh SEED)  Fire departments will do BP checks/weight checks  Lay persons will visit churches to do BP checks and talk about need to diabetes screening (pending grant funding)  Refer to case management at-risk and non-compliant persons with hypertension and diabetes | Conduct consultations with new mothers after delivery  Conduct support groups once a month  Provide diabetes screenings twice a month  Offer two diabetes screenings per month  Fire departments conduct 2 BP/weight checks per month  At least 10 churches are visited each year by layperson to talk diabetes awareness (pending grant funding)  Refer 10-15 clients to case management per week | Pre-diabetics increase awareness  Diabetics better manage disease through better nutrition and exercise  Churches will take leadership role in improving health status of members  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  Reduce long-term disability  Reduce number of strokes | Healthier community  More active community  Less chronic disease  More productive workforce  Lower health care costs |

Policy changes needed:

* Make case management/disease management available to non-compliant and high-risk persons; and
* Work with Community Care, SOURCE, and additional waiver programs on expanding case management services.

## Problem Statement: McIntosh residents face barriers in accessing medical, dental, and mental health care.

McIntosh County is considered by the Health Resources Services Administration to be a Health Professional Shortage Area in primary care, mental health, and dental care. According to County Health Rankings, in 2013, McIntosh County had a population-physician ratio of 7,145:1, compared to 1,611:1 for Georgia. County Health Rankings 2013 reports that 18% of McIntosh residents had not seen a doctor in the past two years due to cost. The proportion of McIntosh residents without insurance in 2013, according to County Health Rankings, was 23% for all residents, though the percentage rises to a more startling 28% when only adults are considered. Of survey respondents without insurance, 50% had not seen a doctor in the last two years. For Medicaid recipients, 10% of respondents had not seen a doctor in two years. Of CHNA survey respondents, 33% of the uninsured seek care at a hospital emergency room, 20% depend on an out-of-town free care clinic, and 12% use an urgent care clinic. Access is further limited by the fact that some doctors do not accept Medicaid or new Medicaid patients.

The ratio of mental health providers to residents is 14,289:1 compared to the Georgia ratio of 3,504:1, evidence of a shortage in mental health services. Collaborative members and focus groups also expressed concern about lack of mental health access and continuity between physical and mental health services.

McIntosh County has a dentist-population ratio of 1:14,360, compared to the Georgia rate of 1:2249. Of survey respondents, about 41% had not seen a dentist in the past two years. Survey results indicate a direct correlation between dentist visits and higher income. Of survey respondents who identified a specific gap in care in McIntosh, 16% identified dental services

McIntosh focus group members identified transportation as a barrier to access to health services. The major barriers to accessing health services in McIntosh identified by survey respondents were the following: finding free or reduced health care services, co-payments and deductibles too expensive, cost of prescription medications, inability to pay, and tied were and lack of a regular medical provider and finding an office or clinic open during non-work hours. The following gaps in care identified by survey respondents in priority order were: free care for people who can’t afford it, primary care physicians, and dentists.

Special populations may require additional support to increase access. According to the Social Security Administration, McIntosh has 465 residents who receive SSI or SSI Disability. Of survey respondents, 15% say that they need assistance with activities of daily living. The proportion of 65 and older McIntosh residents grew from 12.82 to 17.3 percent between 2003 and 2010.

According to Healthy People 2020, “Access to health care Long-Term 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 McIntosh 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 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 more challenges in getting access to care.
* Continuity of care is essential for saving money and improving quality.
* **Goal #1:**  Increase the proportion of McIntosh residents who have access to primary care, dental care, and mental health care.
  + According to County Health Rankings, in 2013, 18% of McIntosh residents had not seen a doctor due to cost.
  + *McIntosh Primary Performance Indicator:* Using County Health Rankings for benchmarking, the proportion of population that has not seen a doctor for two years due to cost will decrease between 2013 and 2018.
  + *McIntosh Primary Performance Indicator:* Using County Health Rankings 2013 data as the benchmark, by 2018, decrease by 50% the population to primary care physician ratio.
  + *McIntosh Primary Performance Indicator:* Using County Health Rankings 2013 data as the benchmark, by 2018, reduce by 25% the population to mental health provider ratio in McIntosh County.
  + *McIntosh Primary Performance Indicator:* Using County Health Rankings 2013 data as the benchmark, by 2018, reduce by 25% the population to dentist ratio in McIntosh County.
* **Goal #2:**  Increase the proportion of McIntosh families that have health insurance.
  + According to County Health Rankings, 23% of McIntosh residents are uninsured.
  + *McIntosh Primary Performance Indicator*: Using County Health Rankings 2013 data for benchmarking, by 2018, decrease to 10% the residents who do not have health insurance coverage.
* **Goal #3**: Improve access to care and services for special populations.
  + *McIntosh Primary Performance Indicator*: Using County Health Rankings for benchmarking, the proportion of uninsured residents will decrease from 17% to 10% by 2018.
  + *McIntosh Primary Performance Indicator*: By 2018, the percentage of persons accessing WIC, immunizations, and other preventive services at McIntosh’s Public Health clinics will increase by 10% over 2013.
  + *McIntosh Primary Performance Indicator*: By 2018, McIntosh will have a Federally Qualified Health Center or services available from a Federally Qualified Health Center that will accept all-comers, including those with special needs and without insurance coverage.

### Goal #1: Increase the proportion of McIntosh residents who have access to primary care, dental care, and mental health care.

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| Planned Work | | | Intended Results | | |
| Increase the proportion of McIntosh residents who have access to primary care, dental care, and mental health care. | **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 Goals**  Benefits to Participants, Often at Individual Level | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Primary care community of providers  Southeast Georgia Health System/Discharge planners  Gateway/Other Behavioral Health Providers  Citizens interested in attracting a Federally Qualified Health Center  Community Case Management Programs, including Community Care, Area Agency on Aging, SOURCE  School system  Public Health  Media | Encourage sign-up for insurance, access to Navigators (Providers, SGHS)  Increase community awareness of insurance solutions (Public Health, SGHS, Media)  School nurses will make referrals to available providers (schools)  Information provided through hospital, nonprofits/Public Health about navigators  “Frequent fliers” to Emergency Room identified by hospitals with referrals to physicians (SGHS)  Hospital will track/trend inappropriate ER visits  Recruitment of primary care providers/mid-levels (SGHS, FQHC)  Recruitment of dentists willing to accept Medicaid/insurance  Recruitment/retention of mental health professionals (Gateway)  Work to have FQHC services in McIntosh or full-fledged FQHC  Case Management through Community Care, Source, other programs and through nonprofits to link residents to primary care providers  Increase number of offices/clinics that are available after normal office hours (SGHS, AppleCare, Optim) | Recruit 10-15 clients per week  Conduct annual health fair  Make 4 referrals per month  Provide 100 pamphlets  Distribute 5 frequent fliers monthly  Distribute 1 monthly report to the ER  Recruit 3 primary care providers per year  Recruit 5 dentists per year  Recruit 3 mental health professionals per year  Develop a strategic plan to obtain FQHC services  Refer 25 individuals monthly  Ensure 3 offices/clinics are available after normal office hours | More patients will seek primary care first  Fewer patients will use the ER inappropriately  More doctors, dentists, and mental health providers will accept Medicaid and other insurance on the Exchange  More clinics open after hours  New providers attracted to the community, leading to greater access | Less waste and redundancy in care provided as tests are not repeated, due to primary care coordination  Improved access to primary care  Improved continuity of care for better outcomes  Increase 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;
* Retain short-term increases in pay in Medicaid to encourage providers to accept Medicaid patients;
* Integrate behavioral health checks with physical health checks in school sports and activities; and
* Implementation of telemedicine/telepsychiatry/telepsychology in schools.

### Goal #2: Increase the proportion of McIntosh residents who have health insurance coverage.

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| Planned Work | | | Intended Results | | |
| Increase the proportion of McIntosh 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- and Long-Term Outcomes**  Benefits to Participants, Often at Individual Level | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Southeast Georgia Health System  Community non-profit organizations including churches, Family Connection, Area Agency on Aging, McIntosh Seed  Benefits managers at area businesses  Doctor offices  Navigators  Department of Family and Children Services  Public Health  Citizens interested in working on a FQHC for McIntosh  Libraries  Medicaid managed care plans | Case managers/nurses at DFCS/nonprofits/Public Health will provide resources about insurance coverage to all uninsured clients  Community groups/Public Health will engage with Navigators during 2014 and 2015  Local media outlets will publish articles/run public service announcements about insurance options  Public Health and nonprofit websites will include link to navigators/ agencies that can help link uninsured to insurance  Emergency room referrals to navigators/case managers/insurance resources  Those not eligible for exchange, access available services through CMAP, Public Health, and, if realized, FQHC | Distribute 100 pamphlets  to uninsured clients per month  Develop partnerships  Disseminate 4 press releases per month  Add links to each website  ERs refer 4 clients per week  Inform 20 clients about access to available services weekly | Increase knowledge of insurance options, access to free/affordable care  Increase 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 McIntosh 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;
* Expand Medicaid to 138% of FPL;
* Expansion of FQHC into McIntosh County; and
* Promote telehealth in schools.

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

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| 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- and Long-term Outcomes**  Benefits to Participants, Often at Individual Level | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Coastal Regional Coaches  Local physicians  Gateway/Other behavioral health providers  FQHC (if achieved)  Churches  Medicaid  Health benefits managers  Southeast Georgia Health System  School nurses  Volunteers  Law enforcement agencies  Area Agency on Aging,  Medicaid waiver programs case managers  Public Health | Law enforcement will collect and trend data of persons jailed with a diagnosis of mental illness  Medicaid Care Management Organizations/transportation companies will coordinate with media on talking points about transportation, access to providers  Make appropriate referrals for mental health at ER, provider offices  Make referrals for substance abuse at ER, doctors’ offices, jail  School nurses will make referrals for appropriate services including mental health  Increased training for school nurses on psychiatric issues  Telepsychiatry available in schools  Elderly/disabled/persons with chronic diseases will have access to appropriate case management/disease management  Implement system of volunteer lay people to visit churches to provide information about health resources, answer questions, take blood pressures, etc. (pending grant funding) | Distribute data report monthly  Disseminate 3 press releases monthly  5 patient referrals per month  4 patient referrals per month  Nurses will make referrals as needed  Offer 6 trainings per year  Available in 4 schools per district  Train case managers  Train 2 lay people in each church | 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 informational role to expand outreach  Hospitals will make appropriate referrals  Proposed FQHC will allow for integration of care with Gateway and other mental health providers  Transportation will be available to those who need it  Veterans will find resources for care within community  Aging population will be able to access disease management support | 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 and accountability courts;
* Provide vouchers for Coastal Regional Coaches for those who cannot afford even minimal fees;
* Add adult day health program that provides nursing services;
* Train lay people to work with elderly/disabled/mentally ill in navigator role as volunteers, outreach to churches and disenfranchised; and
* Establish means of providing case management to non-compliant and high-risk persons with chronic disease.

## Problem Statement: County Health Rankings reports that in 2011, 28% of McIntosh residents smoked.

The 2013 McIntosh County Community Health Needs Assessment found that 24% of all respondents and 39% of male respondents smoke. The survey demonstrates a direct correlation between smoking and self-described poor/fair health status. Nearly a third of respondents who smoke make less than $25,000 per year. Public Health Data indicates that in 2011, 18% of births were to mothers who smoke. Hospital discharge rates for lung cancer for whites in 2010 were 102/100,000, the highest in the southeast Georgia region.

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.

Cancer is the third major non-injury cause of death in McIntosh County.

**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 can reduce smoking.
* **Goal #1**: Prevent initiation of smoking/tobacco/nicotine use among 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%.
  + The 2013 Georgia Department of Education High School Student Survey indicates that nearly 10% of 9th graders, 10.5% of 10th graders, 12% of 11th graders, and just over 10% of 12th graders have used tobacco in some form in the past 30 days (Georgia Department of Education).
  + *McIntosh Primary Performance Indicator:* Using the GDOE survey for benchmarking, by 2018, reduce by 25% the 2013 proportion of high school students in grades 9 - 12 who have used tobacco in the last 30 days.
* **Goal #2**: Decrease the total number of people who smoke/use tobacco/nicotine.
  + 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.
  + According to the Community Health Needs Assessment survey, in 2013, 24% of McIntosh adults smoked.
  + *McIntosh Primary Performance Indicator:* By 2018, using County Health Rankings for benchmarking, reduce to 20% the percentage of McIntosh County residents who smoke.

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

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|  | Planned Work | | Intended Outcomes | | |
| Prevent initiation of smoking/tobacco use 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 and Long-term Outcomes**  Benefits to Participants, Often at Individual Level | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Parents  Schools  Students  Public health  Law enforcement  Convenience stores, other places that sell cigarettes  Physicians/medical providers  American Cancer Society  Relay for Life  Physical education teachers  Funding for billboards, campaigns  YMCA  Churches | Law enforcement upholds existing laws  Compliance checks at stores selling cigarettes (law enforcement)  Social norms campaign to make tobacco use uncool (need partner, Family Connection)  Demonstration of lung from smoker (need funding)  Testimonials from former smokers with lung disease (schools)  Increase “no smoking” areas where young people gather (Chamber)  Schools continue with state mandated education on high-risk behaviors  Treat nicotine delivery systems like tobacco products | Develop partnerships with stores  Conduct monthly compliance checks  Conduct social norms campaign; develop partnership with Family Connection  Conduct 5 demonstrations per year  Recruit 5-7 former smokers  Designate 8-10 no smoking areas annually  Implement state policies; create and distribute report to state officials  Have a monthly nicotine delivery class | Healthier and more active students  Fewer younger students start smoking  Students will influence their parents to quit smoking  Younger students delay experimentation | Lower rate of lung disease  As fewer young people smoke, social norms will have more influence  Fewer “years of potential life lost” |

Policy changes needed:

* More smoking prohibited areas;
* Increase cigarette tax in Georgia to make cigarettes more expensive;
* Better enforcement of tobacco purchasing laws;
* More law enforcement compliance activities;
* Raise smoking age to 21; and
* Restrict E-nicotine delivery systems, align with tobacco and smoke free designated areas.

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

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|  | 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 and Long-term Outcomes**  Benefits to Participants, Often at Individual Level | **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 health risks, including tobacco (part of curriculum)  Social norms campaign to make tobacco use uncool (Public Health, Family Connection, schools)  Demonstration of lung with cancer/smoker (sponsored by health providers, community organizations)  Testimonials from former smokers with lung disease  Increase “no smoking” areas (Chamber of Commerce)  More businesses have “no smoking” policies on premises and no hire policies for smokers (Chamber of Commerce)  Treat nicotine delivery systems like tobacco (local government policies, business policies) | Implement mandatory education; Create and distribute annually 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  Conduct a monthly nicotine delivery class | 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;
* Enforcement of existing laws on sales; and
* Treat nicotine delivery systems like cigarettes.

## Problem Statement: McIntosh’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). Within this problem statement are goals that get straight to the heart of addressing social determinants of health.

According to the Family Connection Partnership, the rate of child abuse in McIntosh County was 7.4/1000 in 2012, which translates to 24 substantiated incidents of child abuse/neglect. Of all McIntosh CHNA survey respondents, 7% of all respondents expressed concern about child abuse and 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>).

In Georgia, the rate of abuse of girls was slightly higher than that of boys, 7.7 versus 7.4. Of all substantiated cases in Georgia, almost 73% were for forms of 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. Children with disabilities are more likely to be abused.

County Health Rankings reports that 51% of children in McIntosh County live in single-parent homes. Children who live in single parent households are more likely to be in poverty and, according to Office on Child Abuse and Neglect Researchers, are

• 77 percent greater risk of being physically abused

• 87 percent greater risk of being harmed by physical neglect

• 165 percent greater risk of experiencing notable physical neglect

• 74 percent greater risk of suffering from emotional neglect

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

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

Between 2007 and 2011, nearly 36% of McIntosh families with children lived in homes with annual incomes of less than 150% of the Federal Poverty Level (Kids Count Database). County Health Rankings reports that in 2013, 71% of children were eligible for free lunch. In 2011, 75 young people had contact with the Department of Juvenile Justice.

The teen birth rates (ages 15-19) in McIntosh was 58/1000 in 2013. (Younger children giving birth are not included in this data.) 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 that 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, McIntosh had 98 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 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/.

**Rationales:** 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 in the home place children at higher risk of abuse.
* **Goal #1:** Reduce the rate of teen pregnancy.
  + The Healthy People 2020 target for adolescent births (15 – 17) is 36.2/1000.
  + According to County Health Rankings, in 2013, the teen birthrate (ages 15-19) for McIntosh County was 58/1000, higher than that of Georgia at 50/1000.
  + *McIntosh Primary Performance Indicator:* Using 2013 County Health Rankings as the benchmark, by 2018 reduce from 58/1000 to 40/1000 births to teenage mothers, 15-19.
* **Goal #2:** Parents know about effective care and nurturing of children.
  + In 2013, according to County Health Rankings, 10.7% of babies born to McIntosh mothers were considered to be low birthweight babies, a risk factor for other problems.
  + *McIntosh Primary Performance Indicator:* Using 2013 County Health Rankings data for benchmarking, McIntosh will reduce by 2018 from 10.7% to 9.2% the proportion of low birthweight babies.
  + *McIntosh Primary Performance Indicator:* Using Public Health data for benchmarking, between 2014 and 2018, McIntosh will see a decline in the infant mortality rate.
* **Goal #3:** All children live in safe homes**.**
  + In 2013, according to County Health Rankings, 51% of children lived in single family households, compared to 36% for Georgia. 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; McIntosh’s rate was 7.4/thousand.
  + *McIntosh Primary Performance Indicator*: Using the Child Maltreatment Report for benchmarking, reduce the rate of substantiated child abuse in McIntosh from 7.4/1000 to 6.8/1000 or lower by 2018.
* **Goal #4:** Increase affordable and safe housing alternatives for low-income families and persons with special needs.
  + County Health Rankings reports that 29% of McIntosh residents pay more than 30% of their income for housing. According to the Urban Institute, in 2012, for every 100 low-income renter households there were only 23 affordable and available housing units (<http://www.urban.org/housingaffordability/>).
  + *McIntosh Primary Performance Indicator:* By 2018, using Urban Institute data for benchmarking, increase the number of affordable/available rental housing units for low-income residents from 2012 levels of 23 per 100 households.

### 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 | **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 in McIntosh Schools  Teen mothers  DFCS  Family Connection Collaborative  CareNet | Offer age-appropriate sex education in schools (already in curriculum)  Churches to speak out about the high teen pregnancy rate  Teen parenting classes offered by schools  After-school programs provide counseling (YMCA, schools)  Parental training on signs that a child is sexually active (schools)  Focus on at-risk youth (DFCS, Public Health)  Teen mothers invited to talk to student groups about challenges of teen pregnancy (schools)  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  Outreach to older teens about free/low cost birth control (Public Health)  DFCS makes referrals to Public Health/community partners for education and counseling | Continue age appropriate sex education  Train leaders from church settings to speak with teens  Offer classes monthly to teens  Offer 3 after-school programs  Offer monthly parental training  Implement programs for at-risk youth  Offer monthly discussions after school  Recruit 5-7 teens per month  Create and distribute monthly report  Reach 4 teens per month  Make 10 referrals 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)  Reduce rate of child abuse/neglect | 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 change needed:

* 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 | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Public Health  School system/school nurses  Day care providers  Faith-based providers  Churches  Glynn Family Violence Task Force  DFCS  Grant funding for in-home visits  Southeast Georgia Health System  Mandated reporters  Parent-teacher organizations  Babies Can’t Wait  Family Connection | 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 (in Glynn County)  In-home visits for new mothers in at-risk families (need funding)  Free parenting classes by faith-based groups, churches  Clear referral processes for at-risk families to parenting classes, nutrition classes offered by Public Health/community partners  Public Health follows positive pregnancy tests to offer services, counseling  Mandatory reporters complete online training through Georgia Office of Children and Families  All new mothers receive information on community resources for parenting classes while in the hospital  Parent-teacher organizations host annual meeting on helping children succeed in school  Offer peer mentorship programs for young or abusive parents (DFCS, Family Connection Partnership) | DFCS creates and distributes quarterly report to Public Health  Recruit 10 participants per month  Conduct 4 visits per month  At least one no-cost or low-cost parenting class available on a regular basis  At-risk families receive at least one home visit after birth of baby (dependent on grant funds)  Provide consultation after every positive test  At least 20 mandated reporters participate in training/updates each year through online training through Georgia Office of Children and Families  Distribute materials to mothers  Each school parent-teacher organization will offer at least one annual event on helping children succeed in school  Enroll 10-15 parents twice a year | 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  Family violence reduced  Less child abuse | 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 reported for child abuse/neglect (not just referrals);
* Annual training (for CEUs) for mandated reporters available locally/online;
* Resources for parenting provided to at-risk families while in the hospital;
* Peer Mentorship Program;
* Establish a help line; 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 | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Public Health  DFCS  YMCA after-school programs and summer day camps  Community organizations that work with family violence, including Task Force Against Family Violence  Georgia Commission on Family Violence  Georgia Bureau of Investigation/local law enforcement  CareNet (Brunswick)  Family Connection  Mandatory reporters  SGHS  Churches  Social service organizations like Salvation Army  Schools  Safe Harbor Children’s Center  CASA  Grant funding for training for mandatory reporters, in-home visits  Babies Can’t Wait  Georgia Department of Early Care and Learning  Head Start | DFCS requires parenting classes for families with reported child abuse/neglect  Community resource list given to parents when abuse/neglect suspected but not substantiated  GBI/local law enforcement handles criminal cases, but also makes referrals to community resources  Include resource material on Family Connection web pages  Churches/social service organizations provide family counseling as needed, appropriate  Churches/social service organizations publicize counseling options  Mandatory reporters take training online through Georgia Office of Children and Families  CareNet offers “learn to earn” classes for at-risk mothers  YMCA and other after-school programs work with parents  Schools offer classes on parenting  WIC includes component on child development | Parenting classes on a regular basis in McIntosh (PH/community partners/schools)  Resource list of community organizations readily available for law enforcement, hospital, DFCS, social service organizations – (Family Connection, community partners)  10 referrals per month  Make resource material readily available  Offer counseling once a week    Disseminate 4 press releases per month  At least 20 mandated reporters take training annually  Offer monthly classes  Develop partnerships  Offer monthly classes  Develop 3 components on child development | Fewer children in single parent homes (County Health Rankings)  Fewer children in foster care (Administration on Children and Families)  Fewer cases of child abuse/neglect (Administration on Children and Families)  Improved reporting of child abuse/neglect  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- and Long-term Outcomes**  Benefits to Participants, Often at Individual Level | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Developers  Financial institutions/lenders  Chamber of Commerce  Department of Community Affairs  Department of Housing and Urban Development  City/county home inspectors, code enforcement  Local governments  Coastal Regional Commission  Law enforcement  Coastal Georgia Community Action Authority  Churches  Social service organizations  Volunteers | More affordable housing starts  Home rehabilitation with DCA funding if available (grant dependent)  Identifying abandoned homes and taking action before they become blighted (local governments)  Home inspections to identify substandard housing and refer to community agencies, when appropriate (local governments)  CGCAA provides financial counseling to home buyers, provides weatherization services  Link persons who live in homes without adequate insulation and moisture barriers to CGCAA  Law enforcement shares information about sub-standard housing with city/county inspectors for follow-up  Churches assist in “missions at home” | Develop a partnership among housing developers and banks  Develop partnership  More substandard homes are identified and rehabilitated with available funds, volunteers (local governments)  Conduct 5 home inspections per month  Financial counseling is provided before customers purchase homes  Refer 20 individuals to CGCAA per month  Law enforcement meets monthly with city/county inspectors  Offer monthly programs | Fewer people live in substandard homes  Neighborhoods are more stable when housing is decent  Families have access to safe and affordable housing  More permanent residents who become a part of the community | Crime is reduced and more people venture out of their homes to use local parks, thus healthier community  Fewer abandoned, neglected homes  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: Raise the proportion of McIntosh residents who have at least a high school diploma and both basic literary and health literacy skills.

McIntosh’s graduation rate was 77% in 2013, according to County Health Rankings. 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 McIntosh County was 10.6% in late 2013. Many low-paying jobs in the county do not provide health insurance benefits.

**Best Practice Resources/Recommendations:** 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>). To enhance health literacy, low literacy materials must be available at the source of care delivery.

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

**Assumptions:**

* More education is related to ability to get better jobs that can lift people from poverty and help families with better understanding of practices that lead to good health.
* Increasing the proportion of McIntosh County residents who complete high school will provide more opportunities for post-secondary education and job placement.
* Persons with higher educational levels are 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 McIntosh residents who have at least a high school diploma and some post-secondary education.
  + According to County Health Rankings, McIntosh’s high school graduation rate was 77% in 2013.
  + *McIntosh Primary Performance Indicator:* By 2018, increase the graduation rate from 77% to 85%.
* **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% of the McIntosh population lacked basic literacy skills (https://nces.ed.gov/naal/estimates/).
  + *McIntosh Primary Performance Indicator:* By 2018, increase 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 benefits and enable residents to move out of poverty.
  + In late 2013, the unemployment rate in McIntosh County was 10.6%. In 2013, according to County Health Rankings, 23% of the population was uninsured.
  + *McIntosh Primary Performance Indicator*: By 2018, using County Health Rankings for benchmarking, reduce to 10% the percentage of population that is uninsured.
  + *McIntosh Primary Performance Indicator:* By raising the educational and skills level of McIntosh County residents, between 2014 and 2018, McIntosh will see a trend of increased recruitment/retention of businesses and industry resulting in lower unemployment and more people with insurance.

### Goal #1: Build a community in which all residents are high school graduates, which increases the opportunity for higher education and health literacy.

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| Planned Work | | | Intended Results | | |
| Build a community in which all residents are high school graduates, which increases the opportunity for higher education and health 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 at Individual Level | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Altamaha Tech  College of Coastal Georgia  Coastal Workforce Investment Board  Head Start  TANF  Department of Labor  Goodwill Service Center, Brunswick  Salvation Army, Brunswick  Churches  Wellcare of Georgia GED Benefits Program  Teachers/school counselors/principals | Publicize Wellcare’s offer to pay for GED for members of the health plan  Teachers/school counselors identify students are risk for referral to tutoring, resources  To encourage college, work with Altamaha Tech and CCGA to encourage joint enrollment  High schools will track college/tech school admission rate  Literacy programs will include components of health literacy (Family Connection, Public Health)  Outreach to parents of Head Start, TANF participants, DOL unemployed and job-seekers, county incarcerated with information about community resources | At least 30 Wellcare Patients will complete their GEDs through the Wellcare program (Wellcare data)  Refer students quarterly  At least 15 McIntosh County students will experience college through joint enrollment at an area technical school or college (Schools)  Create and distribute report annually  Restructure literacy programs as needed annually  Conduct 5 outreach events per year | More students graduating from high school (County Health Rankings)  Increased population with technical skills  More potential employers attracted to McIntosh County by the Long-term Impacts of a stronger workforce  More students furthering their education after high school (school data)  Greater numbers of McIntosh residents successfully completing GED exams (GED Testing Program, Altamaha Technical College, 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:

* College of Coastal Georgia and Altamaha Tech should develop articulation agreements to define short and long-term training options that create a “step-wise” process for individuals to transition from GED or high school diploma to Technical Certificates of Credit to Career Diplomas to Associate degrees and Bachelors’ degrees;
* Define parameters for parents utilizing Head Start services to simultaneously be enrolled in earning educational credits. Provide access to both direct and online instruction but link service to achievement of the parent;
* Increase service incentives for TANF recipients and DOL clients receiving unemployment benefits to be enrolled in earning educational credentials. Provide access to both direct and online instruction but link service to achievement of the parent; and
* 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.

### 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 at Individual Level | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Wellcare of Georgia  Public libraries  Altamaha Technical College  Hospital  4-H Club  CMAP, Brunswick  Family Connection  Public Health  McIntosh Literacy  Girl Scouts/Boy Scouts  School system  YMCA and YMCA Teen Achievers  New FQHC (if funded) | Increase number of persons without a high school diploma who complete the GED through Wellcare or Altamaha Technical College (Wellcare data, Altamaha Technical College)  Altamaha Technical College will track and trend students in literacy programs  Ferst Foundation will provide one free book a month to children under five years old in McIntosh County  Public Health/hospitals will provide low literacy materials for health education  4-H will include some aspects of health education in educational activities  Libraries will maintain low-literacy materials on health education  YMCA Teen Achievers program will continue to encourage graduation  Continue providing health education included in all schools according to state guidelines | At least 30 Wellcare members will complete GED through Wellcare program (Wellcare)  Create and distribute quarterly report on students in the literacy programs  Low literacy materials are available at public locations, including library, Public Health  Add 3 components of health education  Low literacy materials are available at public locations, including library, Public Health  Provide incentives to teens enrolled in the program  Create and distribute report to state officials annually | Adults who earn a GED credential improve health status  Children engaged in healthy living activities will transfer information to their parents  Low literacy materials will made health education more accessible | More residents go on to graduate from secondary educational programs  More people enroll in post-secondary education  Healthier community  Culture fosters self-awareness, personal responsibility for health  Improved collaboration among agencies |

Policy changes needed:

* Wellcare or Altamaha 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 jobs that include benefits and enable residents to move out of poverty.

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| Planned Work | | | Intended Results | | |
| Work collaboratively across all types of organizations to recruit and retain jobs that include benefits and enable residents to move out of poverty. | **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 | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Altamaha Technical College  College of Coastal Georgia Center for Economic Analysis  Department of Labor  Chamber of Commerce  Industrial Development Authority  Case managers/job coaches  Coastal Workforce Investment Board | Foster job placements through prisoner reentry programs (need partner)  Chamber/Industrial Development Authority joins with other organizations to collaborate on economic development, literacy campaign  Social service organizations provide skills training (need partner)  Job coaching by social service organizations, Job Corps  Provide opportunities for education credits associated with TANF, Headstart, other social programs | Ensure 15 job placements per month  Develop partnerships  Offer 2-3 skills training  Offer job coaching monthly  Develop partnerships | Better jobs mean income and benefits, access to health care | Healthier community  Lower crime rate as more people have jobs |

Policy changes needed:

* Providing equitable salaries; and
* Ongoing professional learning.

## Problem Statement: According to County Health Rankings, in 2013 9% of McIntosh adults were binge drinkers.

The McIntosh Community Health Needs Assessment survey indicates 13% of McIntosh men binge drink several times a week and another 8% binge drink several times a month. Of female respondents, about 6% binge at least a few times a month. According to County Health Rankings, 9% of residents are binge drinkers. 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 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.

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 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.

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 related to substance abuse available online at <http://www.nrepp.samhsa.gov/ViewAll.aspx>.

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

**Assumptions:**

* Awareness of the risks of binge drinking can reduce consumption.
* Preventing initiation among young people will reduce adult alcohol use and dependence.
* Enforcement of laws can reduce underage drinking and drinking/boating while driving.
* **Goal #1**: Prevent/delay initiation of drinking among people under 21.
  + According to the 2013 Georgia Student Health Survey, 2.56% of 6th graders, 8.82% of 7th graders, 2.41 of 8th graders, 9.86% of 9th graders, 12.28% of 10th graders, 10% of 11th graders, and 12.82% of 12th graders had used alcohol in the past 30 days (Georgia Department of Education).
  + *McIntosh Primary Performance Indicator:* Using the Georgia School Health Survey for benchmarking, by 2018, reduce by 10% the 2013 percentage of students in each grade who have used alcohol in the past 30 days.
* **Goal #2**: Decrease the percentage of McIntosh residents who binge drink.
  + According to County Health Rankings, 9% of McIntosh residents engage in binge drinking.
  + *McIntosh Primary Performance Indicator*: Using County Health Rankings as the benchmark, by 2018, reduce by 1% the proportion of McIntosh residents who binge drink.
* **Goal #3:** Reduce the number of deaths/injuries of McIntosh residents related to driving or boating under the influence.
  + 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 driving under the influence.
  + Between 2007 and 2011, motor vehicle accidents were leading injury-related cause of death of McIntosh residents. There were four DUI fatalities between 2007 and 2011. Between 1999 and 2010, motor vehicle accidents were the number one cause of death and ranked 5th in reasons for admission to the ER.
  + *McIntosh Primary Performance Indicator:* The number of DUI deaths between 2014 and 2018 will decline as compared to the period between 2007 and 2011, using benchmark data from the Georgia Governor’s Office of Highway Safety.

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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 at Individual Level | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Law enforcement  Public health  Schools  Parents  Scouts  4-H  Social service organizations that work with children  Stores that sell alcoholic beverages  Courts  Radio/billboards  Family Connection  McIntosh Recreation Department  YMCA | Implement social norms campaign to demonstrate that the majority of teens don’t drink  Schools, parents, 4-H, Family Connection work with students use social norms efforts to demonstrate that most teens don’t drink  Law enforcement conducts compliance checks with stores by sending out young looking people to purchase alcohol; publicizing 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  More alcohol-free community events (local governments)  Virtualization exercise for driving under the influence for students (need partner, funding)  Testimonials  Campaign to discourage parents from “social hosting” | Conduct formative research and implement campaign annually  100% of middle school students will participate in health education programs that include discussion of high-risk behaviors like alcohol use  Conduct monthly compliance checks  Create a program that will reduce the number of minor arrests  Create a program that will reduce DUIs among teens  Conduct an alcohol-free community event quarterly  Conduct virtualization exercise tour once a month to students  Recruit 5 individuals who would be willing to give testimonials per year  Conduct annually | 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; and
* Administrative loss of license.

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

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| --- | --- | --- | --- | --- | --- |
| Planned Work | | | Intended Results | | |
| Decrease the number of McIntosh residents who binge drink.  Decrease the percentage of McIntosh 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 at Individual Level | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Law enforcement  Public health  Gateway/Other behavioral health providers  DUI schools  Alcohol/drug abuse counselors  Medical community  Media  Bars  Radio/Billboards | Virtualization demonstrations of drinking and drinking campaign at health fairs, community events (need funding, partner)  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/deemed unhealthy (Family Connection)  Testimonials of binge drinkers involved in accidents, etc. | Implement virtualization demonstration at each community event  Implement daily  Implement daily  Conduct annually  Recruit 5-8 binge drinkers who will provide testimonials | 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.

### Problem #3: Decrease the number of deaths/injuries of McIntosh residents related to driving/boating under the influence.

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| --- | --- | --- | --- | --- | --- |
| Planned Work | | | Intended Results | | |
| Reduce the number of deaths/injuries of McIntosh residents  related to driving or boating 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- and Long-term Outcomes**  Benefits to Participants, Often at Individual Level | **Long-term Impacts**  Changes that will occur in organizations, community, or systems due to effort |
| Law enforcement  DUI schools  Churches  Public health  Bars  Organization that can host drunk driving simulation  Victims of DUI accidents  Family Connection  Georgia Department of Natural Resources | Wider use of interlock devices for those with previous DUI conviction (law enforcement, courts)  Frequent road/boater checks by law enforcement, DNR  Law enforcement will monitor and trend DUI arrests  Virtualization demonstrations of drinking and drinking for students, public (need partner)  Social norms campaign that makes binge drinking unacceptable/deemed unhealthy (Family Connection, partners) | Conduct 4 site visits per month with previous DUI conviction  Conduct twice a month  Create and distribute report quarterly  Conduct twice a month at schools  Conduct campaign annually | Fewer needless accidents  Fewer people put at risk of injury, death | Fewer auto accidents  Fewer alcohol related injuries and deaths |

Policy changes needed:

* Increase taxes on alcohol;
* Regulate marketing of alcoholic beverages; and
* Conducting information and educational campaigns in support of effective policy measures.

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