



**Public Health**  
Prevent. Promote. Protect.

# 2021-2024 Community Health Improvement Plan

*Prepared By: Wayne County Health Department*

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# Executive Summary

The Wayne County Health Department is pleased to present the Wayne County Community Health Improvement Plan (CHIP) 2021-2024. A community's CHIP is developed collaboratively by a partnership of community members (individuals, organizations, agencies) and the local health department. A CHIP is a long-term, systematic effort to address health problems in a community based on results from a community health assessment (CHA). The plan recommends priorities for action and is used by health and other governmental, education, and social service agencies and organizations to implement policies and programs that promote health. The 2021-2024 Wayne County Community Health Improvement Plan reflects the understanding that the quality of the communities we live, work, and play is as important to achieving good health as going to the doctor for regular checkups, proper nutrition, and adequate physical activity. That is why the goals of the CHIP are:

- Ensure the members of the community have access to adequate resources that support health and well-being
- Motivate positive change by mobilizing community participation and improving the exchange of information
- Make certain all community members have equal opportunities to live healthy and productive lives

The Community Health Improvement Plan guides policy and program decisions that optimize health and well-being. Analysis of health, social and economic data as well as direct input from the community led to the identification of the top threats to community health and the selection of priorities that will address these threats. The CHIP is a realistic plan that will assist WCHD in its role to improve the health of Wayne County. It is designed to provide clear direction based on community and statewide goals. It includes evidence based strategies that are measurable and appropriate for influencing policies, systems, and environments to bring change to the county. At the same time, the 2021-2024 plan is flexible. It allows for adjustments in timing, leadership, strategy initiation, and tactical planning.

Because this plan focuses on a restricted number of priorities, not all health issues or community initiatives are identified in the plan. This does not negate the importance of other public health issues; nor does it imply that resources and services should not continue for other public health needs. The plan is intended to bring the community together around a limited number of issues with the greatest opportunity for health improvement through collective efforts.

# New Strategies and Revisions from 2016-2020 Community Health Improvement Plan

This CHIP marks the second iteration of a Community Health Improvement Plan for Wayne County. While some areas we excelled in the previous plan and will not be a part of this plan, we have also retained if not the same, similar goals and the associated strategies to achieve them. This new plan is based on yearly evaluations of the previous plan as well as the latest Community Health Assessment from late 2020.

In this version, we decided to keep similar priorities. We kept mental health as a priority. However, in the previous version substance use disorder was a separate priority. In this version we have included it with mental health. There are two reasons this change was made. First it was practical in that many of the community partners who work on mental health strategies also work on Substance Use Disorder strategies. Another reason this was made was because we wanted to elevate cross cutting factors for the health of Wayne County residents to giving it its own priority in this version. We retained a physical health as a priority but we also wanted to add chronic conditions to this priority.

In terms of strategies, we kept some of the same mental health strategies because of their success. We will continue to provide free naloxone distribution to the community as the number of overdoses continue to be high. We will also continue to provide drug use prevention education and awareness. We will continue to use schools as a vehicle for education on mental health and substance use prevention. Because Wayne County reported the most suicides (20) ever in 2019 and the suicides did not taper off much in 2020 (16), we have decided to continue strategies aimed at suicide prevention such as Mental Health First Aid (MHFA) and Question, Persuade, Refer (QFR) trainings. Underneath the mental health strategy, we have added new strategies aimed at reducing child abuse. This has become a newly prioritized health issue as the community survey identified this as a priority. The strategies with this new goal are related to parenting education being conducted by various community partners.

Within the physical health priority, there is a greater emphasis on this cycle with chronic conditions. We had focused on some strategies related to dental care that we did not retain because we really could not make much progress and the group decided to discontinue various related strategies for dental care throughout the previous CHIP cycle. We also discontinued promotion of breastfeeding strategy as this requires an in person component and at the time of deciding on focus areas, the Covid-19 pandemic presented and continues to present challenges. These activities will still occur but just did not make this iteration and will be tracked as such.

The various partners, especially our hospital systems and extension office, who are part of the steering committee will be looking to provide the community many educational opportunities to promote healthy lifestyles. These are not limited to a healthy diet and active living in terms of prevention of cancers, which was identified by the community and diabetes, which was identified by the steering committee. There will be an equal focus on living healthy with these conditions so they can be managed as much as possible. In the last CHIP we had cross cutting strategies aimed at access and equity and prevention. For this iteration, the steering committee decided to elevate cross cutting strategies to a priority. Health access as a priority will receive more attention in this iteration. In addition, it is necessary to make health equity a larger part of this CHIP. Many of the strategies related to access were housed in the physical health priority in the previous CHIP. In the previous CHIP we were unsuccessful with trying to increase the number of providers (medical and dental). While some of the providers that are part of the steering committee were engaged in recruiting providers, it was not really a strategy that there was much control and is not part of this particular plan. Access strategies related to increasing transportation availability had some successes and will continue with this next cycle as there is still opportunity. We will work on having a regular transit throughout the county. The benefits here go even beyond the health access aspect. In the previous cycle, the CHIP steering committee served as the de facto committee on issues around access. This cycle will see a development of a new task force dedicated specifically to take a deeper dive and come up with its own work plan and objectives into the healthcare access problems and health equity issues in Wayne County. While we are not a very diverse community, the level of diversity is increasing, especially among African American and Hispanic populations in Wayne County. This brings about the necessity to also give more focus on the social determinants of health.

There are two new cross cutting factors added to this version of the CHIP. One new cross cutting factor that we decided to focus on this time is trying to develop strategies to reduce Adverse Childhood Experiences. Adverse Childhood Experiences (ACE) can impact both those mental health and physical health priorities contained within. Consequently, many of the strategies used in Priorities 1 and 2 will serve to address this issue as well. The strategies specific for ACE are those aimed at positive parenting and breaking the cycle of abuse and greater community awareness. The second new cross cutting factor in this iterations is reducing obesity. While there certainly is a mental health component to the problem of obesity, many of the strategies correspond to many of the physical health strategies undertaken in the diabetes priority.

## Community Health Assessment

A community health assessment (CHA) is a process by which community members gain an understanding of the health concerns and needs of the community. Participation in the survey was voluntary, and care was taken to ensure that respondents' answers were confidential. The steps for conducting the CHA can be found within the 2020 Wayne County Community Health Assessment (available at [wayne-health.org](http://wayne-health.org)). The community health assessment provided

information for problem and asset identification, along with policy formulation, implementation, and evaluation. The data regarding demographic information and health outcomes for the residents of Wayne County gathered through the CHA, along with data from other community organizations needs assessments, guided the validation of the focal health issues that are addressed in the CHIP.

## Purpose of Plan

The purpose of this Community Health Improvement Plan is to inform Wayne county residents of goals and strategies for addressing the priority health issues identified in the Community Health Assessment. Initiated in 2020 and completed in 2021, this process is part of a broad community initiative to ultimately improve health and quality of life in Wayne County, Ohio. This plan will provide the strategic framework to guide the community to better health and wellness for all residents. It is a broad strategic framework for community health and should be modified and adjusted as conditions, resources and external environmental factors change.

It is important to recognize that multiple factors affect health and there is a dynamic relationship between people and their environments.

Where and how we live, work, play and learn are interconnected factors that are critical to consider. That is, not only do people's genes and lifestyle behaviors affect their health, but health is also influenced by more upstream factors such as employment status and quality of housing stock. The social determinants of health framework addresses the distribution of wellness and illness among a population; its patterns, origins, and implications. The CHIP uses this framework to determine who is healthiest and least healthy in the community, as well as examine the larger social and economic factors associated with good and ill health.



**Figure 1: Social Determinants of Health**  
*Source: National Association of County & City Health Officials*



This plan uses the assessment-planning-implementation-evaluation-reassessment process, which is a continuous cycle of improvement that seeks to “move the needle” on key health priorities over the course of time. The Ten Essential Public Health Services exist within this cycle and are informed and guided by the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHIP).



**Figure 2: 10 Essential Public Health Services**  
*Source: Centers for Disease Control (CDC)*

The CHIP is intended to help align and solidify each agency’s commitment to improving the health of the community. Through sustained, collective effort(s) on this overarching framework, a wide range of public health partners and stakeholders who are involved in assessment, planning, and implementation will be able to document measured improvement on these key health issues over the next several years. We encourage you to review the priorities and goals, reflect on the suggested intervention strategies, and consider how you can join this call to action: individually, within your organization, and collectively as a community.

## Relationship between CHIP and other Guiding Documents

The CHIP does not replace or supersede any concurrent action planning document produced by Wayne County Health Department or any of their community partners. It was designed to complement and build upon guiding documents, plans, and coalitions developed to shape the public health of the Wayne County community. Rather than conflicting with or duplicating the recommendations and actions of existing frameworks and coalitions, the participants of the CHIP developed process incorporated strategies and resource networks wherever possible. Wayne County Health Department does not own the process and is not the sole organization responsible for CHIP implementation.

# Vision and Values

The Steering Committee for the Wayne County Health Improvement Plan confirmed the same vision and values as the previous version of the Wayne County Community Health Improvement Plan.

## Vision

“We embrace the belief that health is more than the absence of disease. It aims to create an engaged, interconnected community that encourages and supports all of its members to achieve and maintain physical, mental and social wellness.”

## Values

- Trust – Ensuring transparency and doing what we should to serve the community
- Person-Centered – Promoting care and health of the individual with compassion
- Equity – Supporting and providing residents choices regardless of their situation
- Collaborative – Fostering relationships with the community
- Empowerment – Encouraging individuals to take ownership for their well-being
- Integrity – Giving community members respect so that it can be received in return
- Inclusion – Embracing diversity and cultural competency is paramount to achieving community wellness

# Process and Methodology

A Community Health Assessment (CHA) was completed in December 2020. The CHA provided the foundation for improving and promoting the health of the community. It identified and described factors that affect the health of a population, and factors that determine the availability of resources within the community to adequately address health concerns.

The CHIP steering committee used components of Mobilizing Action through Planning and Partnerships (MAPP), a nationally-recognized model for conducting community health assessments and strategic planning for community health improvement, supported by the Centers for Disease Control and Prevention (CDC) and the National Association of County and City Health Officials (NACCHO). The tool helps communities improve health and quality of life through community-wide and community-driven strategic planning. The MAPP assessments can be tailored to suit the needs of most communities. MAPP is the foundation of the planning process, and includes the identification of strategic issues and goal/strategy formulation as prerequisites for action. Through MAPP, communities can seek to achieve optimal health by identifying and using their resources wisely, taking into account their unique circumstances and needs and forming effective partnerships for strategic action.

Community partners and stakeholders were invited to participate in this effort based on their professional expertise and scope of work. Health needs are constantly changing as communities and its context evolve, just as the 10 Essential Public Health Services have a cyclical nature, MAPP is a cyclical 18 month process, which allows for the periodic identification of new priorities and the realignment of activities and resources to address them.

The process continued with a meeting of the steering committee which began in April 2016. The CHIP steering committee is comprised of members of Wayne County Health Department, local hospitals, and other stakeholders.



**Figure 3: Mobilization for Action through Planning and Partnerships**  
*Source: National Association of City & County Health Officials*

# Community Prioritization

Prioritization is a key step in creating the Community Health Improvement Plan. Using findings from the CHA, focus groups, and secondary data, the CHIP steering committee is able to identify the target priority areas where a population may have increased risk for poorer health outcomes. This information can be used to guide the strategies and programs that will improve health wellness in Wayne County. Prioritizing health issues enables the steering committee to focus efforts and funding to health areas where it is most able to have the greatest impact. It is important when prioritizing issues, that the steering committee keep in mind those strategies that will have the largest impact on the largest amount of people. Other criteria used to identify priorities are; cost/return on investment, availability of solutions, impact of problem, availability of resources to solve problem, urgency of problem, size of problem, and community interest of problem.<sup>1</sup> Once the priorities are selected, strategies and programs need to be defined to affect the priorities.

It is important when developing strategies and programs that the committee use SMART objectives. SMART is a mnemonic acronym giving the criteria to guide project management and objectives. It stands for specific, measurable, attainable, realistic, and time-bound.



**Figure 4:SMART**  
*Source: zoeticamedia.com*

The steering committee also assessed aspects such as:

1. Impact on Community Health
  - Affects a large portion of the population
  - Addresses an issue specifically identified in the CHA
2. Feasibility of Implementation
  - Has stakeholder support in the community
  - Supports existing initiatives without duplication of efforts
  - Engages available resources to undertake the effort
3. Contribution to Health Equity
  - Addresses the needs of high-risk or underserved groups directly or indirectly
  - Impacts social factors that influence health and the root causes of negative health outcomes.

The steering committee used the data gathered from the CHA and the criteria listed above to aid them in selecting priorities for the CHIP. The committee also considered State priorities listed in the Ohio State Health Improvement plan, along with National priorities such as the National Prevention Strategy and Healthy People 2030.

The priorities for the 2021-2024 Community Health Improvement Plan are:

Priority 1: Mental Health and Substance Use Disorder

Priority 2: Physical Health

Priority 3: Cross Cutting Factors (Access and Equity, Adverse Childhood Experiences, Obesity)

The strategies and key activities of the CHIP provide opportunities for resident, partner, and stakeholder engagement and participation. The CHIP is a tool to improve health equity and health outcomes: it is imperative that the Wayne County Public Health System take ownership of the CHIP and work collaboratively to advance community health.

# Priority #1: Mental Health and Substance Use Disorders

## ***Background***

Mental health includes emotional, psychological, and social well-being. It affects how people think, feel and act. It also helps determine how people handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Over the course of your life, mental health problems can affect thinking, mood, and behavior (USHHS, 2017). Many factors contribute to mental health problems:

- Biological factors, such as genes or brain chemistry
- Life experiences, such as trauma or abuse
- Family history of mental health problems

Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors (HP2020; Mental, 2017).

## **Why is Mental Health and Substance Use Disorders included as a Priority?**

Mental health problems are very common and often go undetected (USHHS, 2017):

- One in five American adults experienced a mental health issue
- One in ten young people experienced a period of major depression
- Suicide accounts for the loss of more than 41,000 American lives each year
- Less than 20% of children and adolescents with diagnosable mental health problems receive treatment

## **County Issues:**

- In Wayne County 38.5% of individuals surveyed stated they were diagnosed with depression/anxiety.
- When asked about community issues, community members acknowledged that mental health was most commonly listed health problem and child abuse was the third most common problem
- In 2019 there were 1010 reports of child abuse in Wayne County. In 2020 there were 870. There is a concern due to Covid-19 pandemic, child abuse was severely underreported.
- In 2020 there were 311 overdoses and 34 overdose deaths in Wayne County.
- In 2020, there were 14 suicides.



## **Mental Health & Substance Use Disorders**

### **Desired Outcome #1**

Reducing the number of overdoses (death from overdoses)

### **Contributing Partners**

Partnership for Drug Free Wayne/Holmes  
The Mental Health and Recovery Board of Wayne and Holmes Counties  
The Wayne County Health Department  
Prescribers

### **Indicator/Source**

The number of overdoses and overdose deaths/ Wayne County Health Department

2020 overdoses 311/2020 overdose deaths 34

### **Corresponding Strategies**

- Harm reduction through increased access to and availability of Naloxone; WCHD is retooling Project Dawn Classes
- Public education about the prevalence of Fentanyl in street drugs including "fake" prescription pills being sold
- Distribution of Deterra drug deactivation bags
- Promotion of drug-take back sites and events (perhaps an increase in these events in frequency, scale, or both)

- Continue to manage and provide education for patients related prescribing only as necessary, and limit quantity.
- Continued education and awareness. Continuing support and treatment services.

### **Priority Populations**

- Individuals with known substance use disorder
- Individuals identified as being at-risk for Substance Use Disorder (SUD)
- Prescribers of controlled substances individuals with friends/loved ones with SUD
- Community members who interact with the public (hospitality, recreation/tourism, public

### **Desired Outcome #2**

Reducing child abuse

### **Contributing Partners**

The Wayne County Children Services Board  
The Wayne County Family and Children First Council  
The Wayne County Child Advocacy Center

### **Indicator/Source**

Number of child abuse investigations 2019-1010, 2020-870/Wayne County Children Service Board

### **Corresponding Strategies**

- Essentially a measurable increase in the number of adult residents who are educated in/understand what child abuse is (what one family may identify as abusive, another family may identify as discipline, for example) - community/education (without stigma/shaming families who may have experienced corporal punishment in their upbringing) and data collection; increased education to mandated reporters; community education
- OSU Extension offers co-parenting classes that could be offered. Money management classes may also be important to reduce the stresses of parenting during times of financial hurdles.
- Continued & enhanced community education and awareness, including drug exposure to children when living in a home that has addiction concerns and higher complex needs of children. Expansion of prevention programs to positively support families.



- Implementation of Family First Prevention Services Act.
- Continue to enhance supports for kinship caregivers when children cannot remain in their original home safely.

### **Priority Populations**

- Child-serving entities (daycares, preschools, schools, before- and after-school programs, youth programs/recreation Pediatricians, and child PT/OT/SLP;
- Parent/caregiver organizations (PTOs, scout leaders, churches)
- Specific employers whose staff or clients may be identified as at-risk; early intervention
- Families with history of domestic violence

### **Desired Outcome**

Reducing suicide (and suicide attempts)

### **Contributing Partners**

Wayne/Holmes Suicide Prevention Coalition  
NAMI of Wayne/Holmes counties  
Wayne/Holmes Mental Health and Recovery Board

### **Indicator/Source**

2020 Suicides: 14 2020 Mental Health ER visits (Adults: 1,476/ Youth:216) /Wayne County Health Department

### **Corresponding Strategies**

- Promote 24hr Crisis team availability
- "No Wrong Door" Mental Health Provider approach/response
- Navigation/peer/mentoring services for those with complex social needs
- Continued education and awareness of suicide prevention through the Wayne Holmes Suicide Prevention Coalition and other entities.

### **Priority Populations**

- Individuals with a history of previous suicide attempt or loss of a loved one to suicide
- Individuals with complex social needs (employment, housing, child-rearing, substance use, financial stressors, relationship issues, history of mental health concerns)
- Marginalized populations or groups facing discrimination
- Individuals with justice system involvement
- Farming-families are experiencing a great deal of stressors. Ohio statistics show farmers die from suicide at double the rate of the general population.
- Middle aged men

# Priority 2#: Physical Health and Chronic Conditions

## *Background*

Physical health is connected to mental and emotional health. Taking care of your body is a powerful first step towards mental and emotional health. The mind and body are linked; when you improve your physical health, you'll automatically experience greater mental and emotional well-being. Physical health consists of many components:

- Physical activity
- Nutrition and diet
- Medical self-care – includes addressing minor ailments or injuries and seeking emergency care as necessary
- Rest and sleep

## **Why is Physical Health included as a Priority?**

- The leading causes of death in Wayne County are preventable diseases such as heart disease and cancer.
- In Ohio, chronic diseases account for up to 86% of all health care spending.
- When surveyed, 40.5% of residents stated they have been told by a healthcare professional that they are overweight or obese.
- 23% of residents claim they do not engage in physical activity for at least a half hour once during the week.
- When Wayne county community members were asked what are the leading health problems facing our community, cancer was the second highest rated.



## **Physical Health & Chronic Conditions**

### **Desired Outcome #4**

Reducing Cancer (mortality)

### **Contributing Partners**

Aultman Orrville  
Wooster Hospital  
Cleveland Clinic  
Wayne County Health Department  
Wayne County OSU Extension Office

### **Indicator/Source**

Wayne County Cancer mortality rate 2019 157.8/CDC Wonder.

### **Corresponding Strategies**

- Community education re: scheduling of routine screenings; physician encouragement to order routine screenings; (colonoscopy, mammogram)
- Take home FIT test; increase lung cancer screening); Promote HPV vaccines for ages 9-11
- Promotion of habits which may reduce or otherwise favorably impact cancer risk(s)
- Aultman Orrville Sports & Wellness- Expand Exercise is Medicine initiative to support cancer patients through Healthy Lifestyles and exercise prescription programming
- SNAP-Ed can provide nutrition education focusing on increase of fruits and vegetables and healthy eating patterns for low-income audiences.
- OSU Extension FCS can offer basic cooking classes in the community to promote good health habits. Food preservation might also be ways to encourage fruits and vegetables. The OSU Master Gardeners Program can provide programs to teach basic and advanced gardening techniques for homeowners

### **Priority Populations**

- Current smokers, men and women aged 45 and older for CRC screening
- Kids 9-11 for HPV vaccine.
- Women, children, people of color
- Those entering cancer screening age ranges

## **Desired Outcome #5**

Reducing Diabetes (Unmanaged)

### **Contributing Partners**

Aultman Orrville  
Wooster Hospital  
Cleveland Clinic  
Wayne County Health Department  
Wayne County OSU Extension Office

### **Indicator/Source**

Wayne County Diabetes prevalence 2018 11.7/CDC Wonder

### **Corresponding Strategies**

- Health Promotion to reduce shame and stigma associated with Type II Diabetes
- Increased community diabetes education: managing sugars, how to count carbs, meal plan options, diabetic-friendly cooking demonstrations
- Promoting low-intensity fitness options (parks and rec, YMCAs, Health Point/Planet Fitness/other gyms, walking clubs, etc.) to promote a healthy weight and daily activity; resources to assist with the costs of medications to manage diabetes
- Aultman Orrville Hospital continues to expand MEDs Clinic and collaborate with Exercise is Medicine initiative Healthy Lifestyles and exercise prescription programming at Sports & Wellness
- SNAP-Ed Nutrition Education programs for low-income audiences
- OSU Extension also offers a program called "Dining with Diabetes" that is very well received throughout the state and available for Wayne County. Also offered are FCS programs for exercise and balance to encourage activity.

### **Priority Populations**

- Those living with diabetes
- Those at risk for developing diabetes (pre-diabetic, family history, at risk, etc.)
- Health partners (physicians, diabetic educators, gyms/health promotion programs)
- African American and Hispanic populations tend to have higher rates of diabetes and hypertension.
- Low-income audiences tend to have increased complications from diabetes due to lack of treatment.

# Priority 3# Cross Cutting Factors

## *Background*

Cross cutting factors are those factors defined by the group as areas to focus as a community. These cross cutting factors impacts different types of health conditions. While the focus of this document will not cover the full complement of all cross cutting factors that impact all health, the CHIP committee has decided to focus on the following three

- Health Care Access and Equity
- Adverse Childhood Experiences
- Obesity

## **Cross Cutting Factors**

### **Desired Outcome #6**

Reducing the Number of people not seeking medical services due to access  
(Including mental health services)

### **Contributing Partners**

Community Action Wayne Medina  
Wooster Community Hospital  
Aultman Orrville Hospital  
Cleveland Clinic  
Wayne County Health Department  
Viola Startzman Clinic

### **Indicator/Source**

13.0% uninsured for 2019 /US Census ACS 5 year estimates

### **Corresponding Strategies**

- Aultman Orrville- Continue to expand Rural Health Clinic (RHC) and number of Providers
- Continue to work with Wayne/Holmes transportation to reduce transportation challenges that impact access to care

- Medical transportation is available through the Free Transportation Program offered by Community Action Wayne/Medina. This program can get people to transportation to medical services anywhere in Wayne County. The Wooster Transportation Program provides low-cost rides that can get people to medical services. Seniors and people with disabilities can get to services for \$1 per trip.
- CAW/M provides free out-of-county medical transportation to seniors, people with disabilities and low-income residents.
- In 2021, Stark Area Regional Transit Authority (SARTA) began providing medical transportation for seniors and people with disabilities for \$2.50 per one-way trip. This is to medical services in Wayne County.
- Convene a Wayne County Access to Care and Health Equity Workgroup
- Utilization and promotion of tele-health
- Wooster Hospital offers transportation for clients that see any of their providers.

### **Priority Populations**

Lower SES  
Minority populations  
Those with mobility issues

## **Desired Outcome #7**

Reducing the average number of Adverse Childhood Experiences (ACES)

## **Contributing Partners**

Wayne Resiliency Network  
Wayne County Family and Children First  
Wayne/Holmes Mental Health and Recovery Board

## **Indicator/Source**

Wayne County rate for 2 or more Adverse Childhood Experiences is 26.8% among adults/2016-2017 National Survey of Children's Health.

## **Corresponding Strategies**

- Increase awareness of Trauma/Trauma Informed Care/Resiliency through educating community, healthcare providers, schools, etc.
- Education regarding referral process for services
- Supports like Wraparound and Service Coordination attempting to get to families sooner.
- OSU provide the FCS Co-Parenting program that would be great for this.

## **Priority Populations**

Children, especially at risk youth.  
Adolescents and Adults with a history of ACES has a greater risk for chronic diseases.



## **Desired Outcome #8**

Reducing the problem of obesity

### **Contributing Partners**

Ohio State University Extension Office Wayne County  
Wooster Community Hospital  
Aultman Orrville Hospital  
Cleveland Clinic  
Wayne County Health Department/WIC  
Viola Startzman Clinic

### **Indicator/Source**

29.7% of Wayne County is obese in 2019/ Ohio Department of Health

### **Corresponding Strategies**

- Continue weight management programs at Aultman Orrville Sports and Wellness (i.e. Healthy Lifestyles & Transformation X-programming)
- Support community health & wellness through Growing Healthy Habits Coalition activities.
- Continue support of the Aultman Ambassador program (Student led Wellness programs) at Norwayne, Orrville, Rittman, and Waynedale High Schools
- SNAP-Ed Cooking Matters program for low income audiences and the basic SNAP-Ed programs would both address obesity
- All OSU FCS programs based on nutrition, Money 101 - basic budgeting, Mindfulness and Exercise would all apply
- Orrville Moves and Win a Ton, Lose a Ton programs as part of the Growing Healthy Habits team from Orrville is in place and very well received in Orrville.
- Adding walking challenges at housing areas or near apartments, advertising bike and walking paths throughout the county.

### **Priority Populations**

While we focus on adults it is critical, we focus on students to impact the upcoming generations to learn healthy lifestyles to reduce future risk.

# Policy Changes Needed for Success

Because of the diversity of the objectives contained in the CHIP, some of the goals and objectives may need additional policy changes for us to be successful.

For Priority 1: Mental Health and Substance Use Disorders, the following policy changes would be needed to help guarantee success of the CHIP

- Legislation that would provide more support for mental health and addiction services.
- Policy that would further destigmatize and decriminalize substance use disorders
- Policy that would allow for more funding for keeping families together and training for parents.

For Priority 2: Physical Health and Chronic Conditions, the following policy changes would be needed to help guarantee success of the CHIP

- Policies that encourage healthier food choices for those receiving food benefits through WIC, SNAP, etc.
- Policies that encourage insurance companies to offer more preventative screenings at lower out of pocket to customers.
- Continue to look at taxation on tobacco and other tobacco averse policies.

For Priority 3: Cross Cutting Strategies, the following policy changes would be needed to help guarantee success of the CHIP

- In addition to the strategies above, policies that would encourage ACEs assessment to better assess the depth and breadth of the problem of childhood trauma.

## Sustainability

Sustainability is an important consideration in plan development. Sustaining implementation efforts of the CHIP have been built into this plan by:

- 1) Creating a strong local public health system by maintaining and developing community partnerships. These partnerships create a platform for ongoing community health improvement.

- 2) Creating a coordinated health improvement effort that broadens and builds upon successful local initiatives. Engages partners to align efforts and resources to address identified priorities.
- 3) In creating the plan, significant efforts were made to keep the strategies and actions realistic and manageable for the community and its partners.
- 4) The CHIP is a living document that will be revised as resources, environment, and situations evolve.
- 5) Communication: Communication/Reports will be made available via the health department’s website and other social media to community members and stakeholders throughout the process.

The challenge of “moving the needle” on our health status is great, but together we are dedicated to a healthier community.

## Alignment with State and National Health Priorities

Wayne County Priorities	2020-2022 Ohio State Health Improvement Plan	Healthy People 2030 Priority
Mental Health and Substance Use Disorders (Priority One)	Suicide Drug Overdose Deaths	<ul style="list-style-type: none"> <li>• Reducing drug overdoses and deaths from overdose                             <ul style="list-style-type: none"> <li>• Reduce Suicide rate</li> </ul> </li> <li>• Reduce nonfatal child abuse and neglect</li> </ul>
Physical Health and Chronic Conditions (Priority Two)	Diabetes Tobacco/Nicotine Use Nutrition/Physical Activity	<ul style="list-style-type: none"> <li>• Reduce the number of diabetes cases diagnosed yearly</li> <li>• Reduce overall cancer death rate</li> </ul>
Cross Cutting Issues (Priority Three)	ACES Access to Care Nutrition Physical Activity	<ul style="list-style-type: none"> <li>• Reduce the number of young adults who report 3 or more ACES</li> <li>• Reduce the proportion of adults and children with obesity</li> <li>• Increase proportion of children and adults receiving preventative care</li> </ul>

# How to Use the CHIP

## Healthcare (County Hospitals, County Health Centers, and Private Physicians) can:

- Understand the priority health issues within Wayne County, remove barriers, and assist with the implementation of strategies or interventions
- Assist in coordinating programs to reduce redundancy or duplication of efforts
- Share evaluation data on programs that are addressing the prioritized health issues
- Assist with evaluation of strategies in the county

## Public Health Professionals/Government Agencies can:

- Use this document in preventative and educational efforts throughout the county
- Work with and collaborate with healthcare partners in evaluating and updating of strategies per health issue
- Evaluate strategies, outcomes and outputs
- Share public health data with partners that target the health issues identified in the county

## Community and Faith-Based Organizations can:

- Understand the prioritized health issues identified in the county, and get involved in improving community health
- Advocate with members of your organization about the importance of overall wellness and local community health improvement efforts
- Identify opportunities within your organization/agency where you can support and encourage participation in the strategies and interventions
- Provide information or evaluation data on efforts of strategies implementing to the steering committee on how your program or intervention is working in your organization

## Academia (Schools & Colleges) can:

- Understand the prioritized health issues identified in the county, and help by integrating them into your school or college program curriculum planning
- Create a healthier academic environment by aligning the CHIP strategies in your wellness plans or policies
- Assist in the promotion or creation of resources that promote community health

## Businesses can:

- Use the recommended strategies to make your business a healthy place to work
- Educate your workers on the link between employee health and productivity
- Provide opportunities for wellness and healthy eating for their employees

**Residents can:**

- Become familiar with the CHIP and prioritized health issues in the county
- Get involved in improving community health by volunteering to be part of an initiative or program targeting one of the health issues identified through a community or faith-based organization
- Take an active role in your health and well-being by eating healthy and getting the proper exercise and preventative screenings



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