MADISON COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN

2022

Madison County Public Health
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Contents

Introduction

Purpose

The purpose of a Community Health Improvement Plan (CHIP) is to develop a clear community-wide plan to collaboratively address state- and community-identified needs through evidence-based and community-informed interventions. The CHIP is created through a series of state and county health assessments to identify specific needs in the community and implement evidence-based strategies in collaboration with community stakeholders to address these needs.

Process Overview

The Community Health Improvement Plan, known as the CHIP, is a collaborative three-year community-driven plan that outlines the goals and strategies used by coalitions, task forces, organizations, and community members to address the identified health priorities in the county. These health priorities are determined through a process called the Community Health Assessment (CHA), which evaluates health status and issues impacting the county's residents. Both the CHA and the CHIP are informed by the State Health Assessment (SHA) and State Health Improvement Plan (SHIP). The SHIP is the state's roadmap to address challenges identified in the SHA and calls for cross-sector partnerships and alignment to meet a manageable set of measurable goals. The SHIP outlines three priority factors: community conditions, health behaviors, and access to care, and three priority health outcomes: mental health and addiction, chronic disease, and maternal and infant health. To develop a CHIP, communities must identify at least one priority factor and at least one priority health outcome listed in the SHIP, as informed by the local CHA. CHIP best practice supports between 3-5 goals with 2-4 objectives for each goal.

The CHIP process is a collaborative approach to assessing community health and implementing action plans to improve community health through community member and partner engagement. The community health improvement process includes two parts. The Community Health Assessment (CHA) engages community members and partners to collect and analyze health-related data and information from a variety of sources. The findings of the CHA inform community decision-making, the prioritization of health problems, and the development and implementation of a community health improvement plan. The Community Health Improvement Plan (CHIP) is action-oriented and outlines the community health priorities based on the community health assessment, community leader input, and communitywide input. The plan presents community health priorities and how they will be addressed by specific activities to improve the health of the community. Selected activities are evidence-based solutions that best met the need, resources, and capacity of the community. The CHIP is one requirement for accreditation of the Madison Public Health Department and of these accreditation requirements, improvement strategy(ies) or activity(ies) may be evidence-based, practice-based, promising practices, or may be innovative to meet the needs of the population. This document presents the Madison County Community Health Improvement Plan which was developed by the Madison County CHIP Steering Committee and was facilitated by staff from Ohio State University's Center for Health Outcomes, Policy, and Evaluation Studies (HOPES).

Steering Committee

Madison County CHIP Steering Committee Representatives 2022	
Name	**Agency**
Allison Wenger	Madison Health
Alyssa Edley	Madison County Juvenile Court
Amanda Hampton	Madison County Prevention
Amanda Morgan	Family and Children First Council
Amber Snyder	WIC

Bridgett Shoemaker	Wilson's Printing
Cindy Holland	Madison Health
Claire Reinhofer	Madison County Public Health
Dan Kaffenbarger	Educational Services Center
Deetra Huntington	OSU Extension
Diane Ulrich	Chamber of Commerce
Donna Brown-Thompson	Rocking Horse Community Health Center
Edgar Solano	Madison County Public Health
Erika Watkinson	Crager Tobin Real Estate
Erin Fawley	Madison County Public Health
Fran Feehan	Madison Health
Frances Foos	OSU Extension
Greta Mayer	Mental Health & Recovery Board
Jen Smith	Madison County Public Health
Jesse Batarseh	Amazon
J'Nell Buehl	Sister's Elderly Care of London
John Swaney	Madison County Sheriff
Julie Harris	Protective Services/Board of Health
Kara Van Zant	United Way
Karen Wells	Madison County Prevention
Kelly Cooley	St. John's Lutheran Church London
Kent Youngman	Rocking Horse Community Health Center
Laura Dillard	Bridges Community Action
Levin Hutson	Township Association/Engineer's Office
Misty Bradley	Madison County Senior Center
Mayor Patrick Closser	City of London
Robin Bruno	Department of Job & Family Services
Susan Thompson	Board of DD
Tim Sharp	Amazon
Trisha Sparks	London Metropolitan Housing Authority

Description of Madison County

Community Description

Madison County borders Franklin County, where Columbus sits, and is a 30-to-90-minute drive from several major Midwestern metropolitan communities including Dayton, Cincinnati, and Columbus. Approximately 93% of the county's land area is cropland, pasture, and forest; about 6% of its land cover is considered developed.

Madison County's total population is estimated to be about 44,413 in 2018. Its largest community and city is London, with an estimated 10,271 residents. According to the U.S. Census Bureau, one third of Madison County's population is under the age of 18 and 15% of the population are age 65 and over. The Ohio Development Services Agency forecasts Madison County's overall population to increase by approximately 7% by the year 2030. The population over the age of 65 years of age is projected to increase by approximately 4% by the year 2040.

Compared to the State of Ohio, Madison County has a slightly higher proportion of children (33.4% versus 29.8%) with 8% of households with children in Madison County having grandparents as the head of household. About 15% of families with children are below the poverty line. Two-thirds of households in Madison County are without children.

A smaller proportion of the adult population in Madison County has college degrees (24.1%) versus the average for Ohio (35.7%) and the U.S. (39.2%); however, a higher percentage of Madison County adults have some college education (21.5%) compared to Ohio (20.5%) and the nation (20.8%). Approximately 13.4% of Madison County's adult population does not have a high school diploma.

Madison County's job growth rate has outpaced the state and national rates for most years from 2001 to 2019, with its forecasted rate to sustain a pace of 6% growth to 2029. Associated with that, Madison County's unemployment rate has been lower than Ohio's and the U.S. rate from 2014-2018. According to the American Community Survey, the median household income for Madison County is $62,897.

Community Assets

Multiple agencies successfully conduct a primary role in monitoring health status to identify community health problems, including Madison Health, Madison County Public Health (MCPH), Rocking Horse Community Health Center (FQHC), Madison County Prevention (MCP), Mental Health & Recovery Board (MHRB), etc.

MCPH, County Protective Services, & the Diversion Program play a primary role in diagnosing and investigating health problems and health hazards at the community level, while the hospital, FQHC, MHRB & their service providers, and FCFC play a secondary role. These agencies are supported by United Way, Sheriff, Township Trustees, & the school systems. The leadership and coordination among these agencies is a strength.

Madison County leaders define their performance as optimal in terms of informing, educating, and empowering people about health issues. Beyond the agencies cited above, each city/village has a community center playing a primary role in this effort along with libraries, schools, OSU Extension (via SNAP-Ed & 4H), local media, and the Mayors' offices. The Maternal/Infant Health focus group cited WIC as a strength in the community for overall child health and for lactation support for breastfeeding mothers. More information (e.g., about vaccines) and support for new mothers is welcomed for focus group participants. The Mental Health & Addiction focus group participants said more should be done to advertise the mental health services available in the County, including mental health services available at Madison Health. The Board of DD cited several foundational organizations that support community health and stated: "One of the benefits of living in a small county is that everybody knows somebody from one of these agencies where you can get fairly quick answers."

Developing policies and plans that support individual & community health efforts is considered a strength and is led by MCPH, Madison Health, Sheriff's Office, City of London & Mayor, Madison County Commissioners, FQHC, School districts, and MCP. Local government is "hands on" and partners with the local PH system.

Enforcing laws & regulations that protect health & ensure safety is carried out by the local government, partnering with MCPH, Madison Health, FQHC, Board of DD, Senior Care Agencies, & MHRB. Each of these agencies perceives this as a primary role.

Researching for new insights and innovative solutions to health problems is considered to be a strength. The FQHC created a new position in 2018 for an Innovations Research Coordinator—a doctor in Public Health who uses meaningful data to provide innovative care to the population served. Madison Health researches evidence-based practices such as telemedicine with OSU Medical Center regarding stroke

response. FCFC is involved in research into the CompDrug MOMS program, which provides a 'one-stop' shop of services to women throughout pregnancy to meet both their addiction treatment and pregnancy needs. CompDrug is a federally recognized Opioid Treatment Program licensed by the Ohio Department of Mental Health and Addiction Services (OMHAS) and nationally accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). The Ohio State University (OSU) is evaluating these Central Ohio interventions.

Priority Area Selection and Strategy Development Process

Community Health Assessment Summary

Based on the Community Health Assessment data, the following priority areas and goals were outlined in 2019. This information directly informed the selection of the priority areas for the CHIP in addition to the SHIP priorities and evidence-based strategies, the most recent 2017 CHIP, and steering committee discussion. For further information on the Madison County CHA, visit their website or view the 2019 CHA pdf file at https://www.co.madison.oh.us/document_center/Public%20Health/Community%20Health/CHA2019.pdf.

Preliminary CHIP Goal Statements from the 2019 CHA		
Priority Area	**Goals**	**Champions**
Maternal & Infant Health	Infant Mortality: Reduce the infant mortality rate by preventing the leading causes of infant mortality	Madison Health, MCPH, and the Healthy Child & Family Consortium (HCFC)
	Breastfeeding: Achieve improved breastfeeding rates in the community	Madison Health, MCPH, & the Rocking Horse Community Health Center (FQHC)
Chronic Disease	Overweight and obesity: Partner in delivering Food Pharmacies where patients can enhance their cooking skills through cooking demonstrations, receive nutrition and health tips, undergo health screenings, and get referrals to other food assistance programs.	Madison Health & the Rocking Horse Community Health Center (FQHC)
	Sleep deprivation: Increase public knowledge of how adequate sleep and treatment of sleep disorders improve health for adults and children	Madison Health and its partnership with the OSU/Mount Carmel Health Alliance, & MCPH
	High blood pressure and lung and bronchus cancer: Improve access to community-based pulmonary health support	Madison Health and its new pulmonologist
Mental Health & Addiction	Pregnancy and Drug Addiction: Increase Madison County's participation in the MOMS Program, which provides a 'one-stop' shop of services to women throughout pregnancy to meet both their addiction treatment and pregnancy needs	Nationwide Children's Hospital, Mount Carmel Health System, Ohio Health, Central Ohio Newborn Medicine, Maryhaven, and Amethyst.
	Substance abuse prevention programs for youth: Continue to deliver evidence-based prevention education and youth-led prevention.	Madison County Prevention - Department of Family and Children, & the Rocking Horse Community Health Center (FQHC)
Access to Health Care	Transportation: TBD	TBD
	Access to Food: TBD	TBD
	Housing: TBD	TBD
	Workforce Development: TBD	TBD

Alignment with State Health Improvement Plan

The CHIP process is informed by the Community Health Assessment, but it is also informed by the priorities defined in the State Health Improvement Plan as determined by the State Health Assessment. Among the requirements for the CHIP, communities must identify at least one priority *factor* and at least one priority health *outcome* as described in the SHIP. The priority health *factors* include community conditions, health behaviors, and access to care. The priority *outcomes* include mental health and addiction, chronic disease, and maternal and infant health. The 2022 CHIP incorporates the priority health factors of health behaviors and access to care and the priority health outcomes of mental health and addiction and maternal and infant health.

Summary of 2017 CHIP

The CHIP is a continuous process. In the development of this CHIP, the most recent previous CHIP from 2017 was used as a reference for continued CHIP efforts. The 2017 goals, summarized below, where source committee members were asked to consider within their CHIP development discussions to inform continued efforts, like updates, different approaches, areas for growth, and to reflect on the invested efforts of their community.

2017 CHIP Summary Table				
Priority Area	*Goal*	*Objective(s)*	*Evaluation Measure*	*Monitoring Method*
Chronic Disease	Promote healthy lifestyles to prevent and address Chronic Diseases.	Educate community members about chronic disease management.	Number of community members attending diabetes programs. Number of community members visiting the Hospital's wellness center.	The Hospital will provide counts for the evaluation measures quarterly to the Family Council. Dashboard will be used as a tracking system for all initiatives in this plan.
		Educate hospital patients and community members about proper nutrition.	Number of community members attending education programs. Number of recipes created for use by food pantry customers.	The Ohio State University Extension and the Hospital will provide counts for the evaluation measures quarterly to the Family Council. A Dashboard will be used as a tracking system for all initiatives in this plan.
	Develop a coordinated approach to tackle childhood hunger.	Increase coordinated participation in Summer Food Service Programs.	Number of summer food programs available. Number of meals served by summer food service programs. Retention of children served throughout the summer. Number of community organizations working together on summer food service programs. Number of enrichment programs provided at each site.	Team Vittles will provide counts for each allied site each fall to the Family Council as part of the Community Health Improvement Plan annual report. A Dashboard will be used as a tracking system for all initiatives in this plan.

			Number of organizations providing programs.	
Maternal & Infant Health	Reduce the percentage of women who smoke while pregnant.	By 2020, decrease the percent of women who smoke during the 3rd trimester by 2 percent in Madison County, which should impact the number of low-birth-weight infants.	Reduce the low-birth-weight percentage by 0.2% over a three-year planning period. Low Birth Weight is the percent of births in which the newborn weighed <2,500 grams. Data for this measure is provided by the Ohio Department of Health, Birth Data and Statistics.	The Infant Mortality and Morbidity Task Force will report to the Healthy Child and Family Consortium quarterly, and they will also report to the Family Council on an annual basis to ensure goals and objectives are being met. A Dashboard will be used as a tracking system for all initiatives in this plan.
	Increase collaboration and resource delivery to improve infant care.	By 2020, increase the percentage of women receiving first trimester prenatal care by 1% and provide targeted interventions for those at risk for a poor birth outcome.	A measure of first trimester prenatal care will be provided by the Ohio Department annual basis to ensure goals and objectives are being met. A Dashboard will be used as a tracking system for all initiatives in this plan.	The Infant Mortality and Morbidity Task Force will report to the Healthy Child and Family Consortium quarterly, and they will also report to the Family Council on an annual basis to ensure goals and objectives are being met. A Dashboard will be used as a tracking system for all initiatives in this plan.
	Promote infant safe sleep among all childcare providing organizations and among the public.	Promote infant safe sleep resulting in more childcare professionals being trained and increased knowledge among the public.	Action for Children childcare training data and the County's general population survey will provide measures for the objective.	The Infant Mortality and Morbidity Task Force will report to the Healthy Child and Family Consortium quarterly, and they will also report to the Family Council on an annual basis to ensure goals and objectives are being met. A Dashboard will be used as a tracking system for all initiatives in this plan.
Mental Health & Well-Being	Strengthen the Substance Abuse Coalition	Ensure representation of the 12 current sectors comprising the Coalition and branch out to include more youth, businesses, and the faith-based community.	MCSAC composition	MCSAC will provide counts regarding Coalition involvement on an annual basis to the Family Council as part of the Community Health Improvement Plan annual report.
	Mitigate or eliminate substance	Reduce access to substances by focusing on prescription drug	The number of disposal bags distributed, the number of pharmacies	MCSAC will provide counts on an annual basis to the Family Council as

	abuse in the community to protect the health, safety, and quality of life for all.	proper disposal and compliance checks.	participating, and the number of compliance awards distributed.	part of the Community Health Improvement Plan annual report.
	Reduce youth substance abuse and the early onset of use.	Reduce the percentage of students who drank alcohol or used tobacco or tried marijuana for the first time before the age of 13 years. Youth alcohol use (past 30 days); youth marijuana use (past 30 days); youth nonprescribed prescription use (past 30 days. Target Youth Population: 8th-12th graders.	Progress reporting tools are the Youth Risk Behavior Survey (YRBS) and OHYES! which collaborative effort of the Ohio Departments of Education, Health and Mental Health & Addiction Services.	MCSAC will provide counts on an annual basis to the Family Council as part of the Community Health Improvement Plan annual report.

Summary of Planning Sessions

Madison County CHIP Steering Committee representatives from a variety of organizations throughout Madison County met for four planning sessions to develop the Madison County CHIP. In the first CHIP session, steering members discussed the needs of the county as informed by the CHA, the priority health areas of intersection, and strategies to address these needs. In the second session, the CHIP steering members created workplans in small group separated by priority factor or outcome and their area of work or affiliation in the community. Steering members then voted based on the Madison County 2019 CHA and 2017 CHIP strategies, evidence-based practices, and the committee discussions from CHIP sessions to rank the these needs and their associated goals to identify three to five goals with two to four objectives for each goal. For this need-ranking process, members were asked to specifically consider equity, impact, need, political will, readiness, and resources around these needs and their associated goals (Health Resources in Action, Inc). At the third session, these results were discussed to confirm consensus of the top ranked needs and their associated goals, and the specific details of the interventions were developed. At the fourth session, steering members were presented with a draft CHIP implementation table where the strategies and details of achieving the CHIP goals were refined and clarified for more effective CHIP implementation.

Community Health Improvement Plan Implementation

Implementation

The 2022 Madison County CHIP Implementation Table summarizes the 2022 CHIP including the priority health area, specific topic area, goals, strategies, objectives, implementation activities, measures, and lead entities. Using S.M.A.R.T., or specific, measurable, attainable, relevant, and time-bound, goals were a priority in the CHIP development process. This table also includes the SHIP indicators and priority populations where applicable. Asterisks indicate a reference to SHIP evidence-based strategies and guidance. See Appendix A for the compiled 2022 CHIP implementation table. Immediately following, find a summary table and the implementation plans for the selected priority areas for 2022 which include Maternal & Infant Health, Mental Health & Addiction, Health Behaviors, and Access to Care.

2022 CHIP Summary Table				
Priority Area	*Goal*	*Objective(s)*	*Evaluation Measure*	*Monitoring Method*
Maternal & Infant Health	Reduce infant mortality	Early childhood home visiting (cross-cutting with access to care, community conditions)	Number of moms receiving home visits and screenings in Madison County. Data utilized from ODH.	The Healthy Child & Family Consortium meet monthly to plan, report, and revise as needed. The group will use a dashboard and provide updates to the FCFC monthly and provide a detailed report annually.
		Care coordination and access to well-woman care		
		Clinical prevention, screening, and treatment		
Mental Health & Addiction	Reduce depression	Coordinated care for behavioral health (cross-cutting with access to care, chronic disease)	Number of residents utilizing telehealth for mental health services and crisis texting services.	The Mental Health & Addiction Task Force will meet monthly. MCPH will create an interactive dashboard/SharePoint for partners to track progress. Will provide verbal reports to FCFC on a quarterly basis and written report annually.
		Digital access to treatment services and response *(cross-cutting with access to care, chronic disease)*		
		Parenting programs (*cross-cutting with maternal and infant health, community conditions)*	Number of residents enrolled in group-based parenting programs.	
		Sleep hygiene education and policy recommendations	Number of residents enrolled in sleep hygiene programs. Formation of a new policy.	
Health Behaviors	Increase physical activity	Physical activity programs	Number of residents enrolled in physical activity programs. Physical activity levels of people enrolled in physical activity programs.	The Health Behaviors Task Force will combine as a "chronic disease prevention" coalition and will meet monthly. MCPH will create an interactive dashboard/SharePoint for partners to track progress. This coalition will provide verbal reports to FCFC on a quarterly basis and a detailed written report annually.
	Improve nutrition	Fruit and vegetable access and education	Number of residents participating in community gardens. Number of residents attending education programs. Resident's distance from fresh fruits and vegetables.	
		Outreach and advocacy to maintain or increase enrollment in federal food assistance programs (WIC and SNAP)	Number of eligible residents enrolled in WIC and SNAP.	
		Create Local Food Council to investigate and provide policy recommendations to alleviate causes of health inequities	Formation of new food policies.	
		Coordinated care for behavioral health		

Access to Care	Reduce unmet need for mental health care	Complete evaluation of WeCare Coalition to guide relevant action plan and policy recommendations	Number of residents obtaining mental health care.	The Access to Care Task Force will meet monthly. MCPH will create an interactive dashboard/SharePoint for partners to track progress. This task force will provide verbal reports to FCFC on a quarterly basis and a detailed written report annually.
	Increase local access to healthcare services	Culturally competent workforce	Number of residents obtaining healthcare services. Numbers of local providers.	
		Comprehensive and coordinated primary care		
		Access support		
		Identify providers needed		
	Investigate community needs related to public transportation	Complete a needs assessment (ODOT Feasibility study) to inform approaches to address transportation issues	ODOT Feasibility study results. Number of residents who use the mobile clinic or non-emergency medical transportation.	
		Mobile clinic		
		Non-emergency medical transportation (NEMT) to improve care and prenatal care		

Maternal and Infant Health

- MIH Goal 1: Reduce infant mortality
    - Strategy 1: Early childhood home visiting (*cross-cutting with access to care and community conditions priority areas)**
    - Strategy 2: Care coordination and access to well-woman care*
    - Strategy 3: Clinical prevention, screening, and treatment*

- Evaluation Monitoring Method: The Healthy Child & Family Consortium meet monthly to plan, report, and revise as needed. The group will use a dashboard and provide updates to the FCFC informally on a monthly basis and provide a detailed report annually.

Reduce Infant Mortality Goal Implementation Plan					
Strategy	*Target Begin Date*	*Activity*	*Lead Entity*	*Resources Required*	*Anticipated Outcome*
Strategy 1: Early childhood home visiting	October 2022	*Early childhood home visiting, including prenatal and postnatal visits (*cross-cutting with access to care and community conditions)*	HCFC	Personnel	Increased number of moms receiving home visits
Strategy 2: Care coordination and access to well-woman care	March 2023	*Community Health Workers	HCFC	Personnel	Counseling & coordinated care to women
	June 2023	*Continuous support for women during pregnancy and childbirth, including certified doulas	HCFC	Funding, Volunteers & Personnel	More support for mothers & reduced stigma asking for help
	January 2023	*Optimizing postpartum care	Madison Health	Provider	Improved health & wellbeing for mothers
Strategy 3: Clinical prevention, screening, and treatment	September 2022	*Screening and referring mothers postpartum at pediatric visits	Madison Health & WIC	None	More support for moms
	January 2023	Free descriptive pamphlets with information on available programs/services	HCFC	None	Increased awareness of local services and resources; and increased number of clients using these services and resources

Asterisk (*) indicates evidence-based strategy from SHIP guidance

Mental Health and Addiction

- MHA Goal 1: Reduce depression
    - Strategy 1: Coordinated care for behavioral health, especially related to delays/interruptions in care due to Covid-19 pandemic *(cross-cutting with access to care, chronic disease)**

- Strategy 2: Digital access to treatment services and response *(cross-cutting with access to care, chronic disease)**
- Strategy 3: Parenting programs (*cross-cutting with maternal and infant health, community conditions)**
- Strategy 4: Sleep hygiene education and policy recommendations

- Evaluation Monitoring Method: The Mental Health & Addiction Task Force will meet quarterly. MCPH will create an interactive dashboard/SharePoint for partners to track progress. Will provide verbal reports to FCFC on a quarterly basis and written report annually.

Reduce Depression Goal Implementation Plan					
Strategy	*Target Begin Date*	*Activity*	*Lead Entity*	*Resources Required*	*Anticipated Outcome*
Strategy 1: Coordinated care for behavioral health	January 2023	*telehealth (telemental health services)	MHRB & Madison Health	Telehealth program, high speed internet across county, funding, coordination	Environments that support healthy behavior and mental wellbeing
		*chronic disease management programs *cross-cutting with chronic disease)*			
		*integration of behavioral health services into primary care *cross-cutting with chronic disease)*			
Strategy 2: Digital access to treatment services and response	September 2022	*Crisis texting lines	MHRB	Volunteers, time	Empowered individuals; increased knowledge about resources/support; reduce stigma
	September 2022	Peer support	MHRB	Volunteers, time	Reduced social isolation and stigma
Strategy 3: Parenting programs		*Group-based parenting programs	MCP	Referrals, coordinators	Sustained parent involvement
		Youth ambassador program	MCP	Volunteers	Sustained youth involvement
Strategy 4: Sleep hygiene education and policy recommendations		Community education campaign regarding sleep health and impacts	MCPH	Time	Increased knowledge, improved health and adequate sleep levels
		Outreach to schools to shift school start times and emphasize reducing screentime at night; outreach to businesses to improve work schedules through consistent hours to improve sleep and health	MCPH, MCP, OSUE, Madison Health	Coordination, time, policy changes	Increased knowledge about resources/support, health benefits, and productivity

Asterisk (*) indicates evidence-based strategy from SHIP guidance

Health Behaviors

- HB Goal 1: Increase Physical Activity
  - Strategy 1: Physical activity programs
- HB Goal 2: Improve Nutrition
  - Strategy 1: Fruit and vegetable access and education
  - Strategy 2: Outreach and advocacy to maintain or increase enrollment in federal food assistance programs (WIC and SNAP)
  - Strategy 3: Create local food council

- Evaluation Monitoring Method: The Health Behaviors Task Force will combine as a "chronic disease prevention" coalition and will meet quarterly. MCPH will create an interactive dashboard/SharePoint for partners to track progress. This coalition will provide verbal reports to FCFC on a quarterly basis and a detailed written report annually.

***Increase Physical Activity* Goal Implementation Plan**					
Strategy	*Target Begin Date*	*Activity*	*Lead Entity*	*Resources Required*	*Anticipated Outcome*
Strategy 1: Physical activity programs	March 2023	*Activity programs for older adults *Community-based social support for physical activity	Friends of Madison County Parks & Trails	Funding and partnerships	Increased knowledge of health, increased physical activity; seniors informed about health care choices
***Improve Nutrition* Goal Implementation Plan**					
Strategy	*Target Begin Date*	*Activity*	*Lead Entity*	*Resources Required*	*Anticipated Outcome*
Strategy 1: Fruit and vegetable access and education	March 2023	*Community and school fruit and vegetable gardens Streamline free/reduced school meal application: consistent between schools, accessible, easy to complete *Farm to institution programs, including farm-to-school programs	OSU Extension	Partnership with the schools	Increased availability of healthier foods and beverages in schools; creation of an active environment for students
Strategy 2: Outreach and advocacy to maintain or	January 2023	*Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), including coordination of outreach and enrollment with local WIC clinics, Share Table, and SNAP-ED. Coordination of outreach and enrollment with County	WIC	Time, coordination, referrals	Increased number of children served by supplemental nutrition programs

increase enrollment in federal food assistance programs (WIC and SNAP)		Department of Job and Family Services locations, and increase in # available vouchers			
	September 2022	*Increase outreach to caregivers, including pregnant women, parents and older adults (including free pamphlet describing available programs/services)	WIC, Madison Health	Partnerships, food sources, referrals	Increased number of children served by supplemental nutrition programs; Increased food access and number of people served by assistance programs
		*Food insecurity screening and referral by healthcare providers			
Strategy 3: Create Local Food Council to investigate and provide policy recommendations to alleviate causes of health inequities	November 2022	*Healthy food initiatives in food banks, such as Ohio Agricultural Clearance Program and produce distribution in partnership with food banks/pantries	WIC & OSU Extension	Time, partnerships, grants, volunteers	Environments that support healthy behavior; Additional expertise and community connections; Increased access to healthy food options
		*Farmers markets, including WIC and Senior Farmers' Market Nutrition Programs and Electronic Benefit Transfer (EBT) payment			
		*Place, present, and promote healthy foods in retailers, school, workplace, and other community settings			
		*Good Food Here policies (from the Ohio Food and Beverage Guidelines Toolkit) adopted and implemented in community settings CHC			
		*Multi-component school-based obesity prevention interventions			

Asterisk (*) indicates evidence-based strategy from SHIP guidance

Access to Care

- AC Goal 1: Reduce unmet need for mental health care, especially related to delays/interruptions in care due to Covid-19 pandemic
    - Strategy 1: Coordinated care for behavioral health
    - Strategy 2: Complete evaluation of WeCare Coalition to guide relevant action plan
- AC Goal 2: Increase local access to healthcare services, especially related to delays/interruptions in care due to Covid-19 pandemic
    - Strategy 1: Culturally competent workforce
    - Strategy 2: Comprehensive and coordinated primary care
    - Strategy 3: Access support
    - Strategy 4: Identify providers needed
- AC Goal 3: Investigate Community Needs Related to Public Transportation
    - Strategy 1: Complete a needs assessment (ODOT Feasibility study) to inform approaches to address transportation issues

- Strategy 2: Mobile clinic
- Strategy 3: Non-emergency medical transportation (NEMT) to improve care and prenatal care

- Evaluation Monitoring Method: The Access to Care Task Force will meet monthly. MCPH will create an interactive dashboard/SharePoint for partners to track progress. This task force will provide verbal reports to FCFC on a quarterly basis and a detailed written report annually.

Reduce Unmet Need for Mental Health Care **Goal Implementation Plan**					
Strategy	*Target Begin Date*	*Activity*	*Lead Entity*	*Resources Required*	*Anticipated Outcome*
Strategy 1: Coordinated care for behavioral health	December 2022	*telehealth (telemental health services) *integration of behavioral health services into primary care *cross-cutting with chronic disease)* *chronic disease management programs *cross-cutting with chronic disease)*	MHRB & Madison Health	Coordination, partners, time, personnel	A system for addressing substance misuse and related behavioral health problems
Strategy 2: Complete evaluation of WeCare Coalition to guide relevant action plan and policy recommendations	January 2023	Incentivize community feedback during community events	WeCARE *will partner with Access to Care Task Force	Volunteers, funding	A strengthened coalition
Increase Local Access to Healthcare Services **Goal Implementation Plan**					
Strategy	*Target Begin Date*	*Activity*	*Lead Entity*	*Resources Required*	*Anticipated Outcome*
Strategy 1: Culturally competent workforce	February 2023	*Cultural competence training for health care professionals and implicit bias training (*with focus on older adults*)	MCPH, Madison Health, Rocking Horse Community Health Center	Training, research, buy-in	Environments that support all individuals; Additional expertise; Customized care; Patient retention and increased rapport
Strategy 2: Comprehensive and coordinated primary care	June 2023	*medical homes (comprehensive primary care practices)	Madison Health & Rocking Horse Community Health Center	Personnel	Increase in routine and preventative care visits

	October 2022	*telemedicine	Madison Health & Rocking Horse Community Health Center	Personnel, internet infrastructure, program	Increase in routine and preventative care visits
Strategy 3: Access support	March 2023	*health literacy intervention/community education	MCPH, Madison Health, Rocking Horse Community Health Center	Training, research, coordination	Empowered individuals; increased knowledge of health and health care
Strategy 4: Identify providers needed	January 2023	Collaborate with Madison Health, Rocking Horse, and MCPH to identify need and plan to fill gaps OBGYN services	Madison Health & Rocking Horse Community Health Center	Personnel, funding, time	OB medical home for more pregnant women; increased number of women receiving care
***Investigate Community Needs Related to Public Transportation* Goal Implementation Plan**					
Strategy	*Target Begin Date*	*Activity*	*Lead Entity*	*Resources Required*	*Anticipated Outcome*
Strategy 1: Complete a needs assessment (ODOT Feasibility study) to inform approaches to address transportation issues	November 2022	Investigate possible incentive for warehouse employers to support provision of transportation and provide policy recommendation ODOT establish "Mobility Manager" for Madison County	DJFS, Board of DD, MORPHC	Time, coordination, funding	Mobility Management Plan
Strategy 2: Mobile clinic	January 2023	Expand partnerships with MCPH, Madison Health, and Rocking Horse to deliver mobile clinic services and RHW nurse practitioner Investigate possible incentive for warehouse employers to provide access to mobile health clinic	MCPH	Coordination	Increase number of screenings, increase number of clients receiving care
Strategy 3: Non-emergency medical transportation (NEMT) to improve care and prenatal care	August 2022	Expand resources to support Bridges Community Action "Navigator" which provides NEMT by appointment	Bridges Community Action	Coordination	Empower individuals in a supportive atmosphere to foster skill development and provide resources

Sustainability and Continuity of Efforts

Sustainability is woven into the plan primarily by aligning strategic partners to a community health improvement agenda. Involving partners with substantial resources such as higher education partners and the hospital infuses student interns, research and evidence-based practice knowledge, and foundation support among other supports. Hospital support is reinforced via their own IRS required Community Health Needs Assessment and Implementation strategy. During the creation of the plan, significant efforts were made to keep the strategies and actions "S.M.A.R.T." (specific, measurable, achievable, relevant, and time-bound). Generally, the strategies are not dependent upon applying for and being awarded grants, or other uncertain resources. Madison County Public Health is committed to convening strategic partners quarterly so that annual progress reports can be reported in multi-agency type meetings such as the Madison County Family and Children First Council meetings. Madison County Public Health is committed to repeating the CHIP process every five years.

Acknowledgements

Madison County Public Health and the CHIP Steering Committee would like to thank Ashley Short Mejia, Ella Lewie, and Anne Trinh, of the Center for Health Outcomes and Policy Evaluation Studies (HOPES) at the Ohio State University for their guidance with the Community Health Improvement Plan process. We would also like to thank the Board of Health for MCPH for their continued support through the entire accreditation process, Madison Health for laying the groundwork with their Community Health Assessment, and MCPH staff for all of the time they put into this process. Additionally, thank you to each member of the steering committee for your time, insight, and passion to serve the residents of Madison County.

Appendix

A: CHIP Implementation Matrix

Asterisk (*) indicates evidence-based strategy from SHIP guidance

2022 Madison County CHIP Implementation Table								
Priority Health Area	*Topic*	*SHIP Indicator*	*Goal*	*Strategies/Objectives*	*Implementation activities*	*Priority Population*	*Measures*	*Lead Entities/ Coalition*
Health Outcome: ***Maternal & Infant Health**	*Preterm birth and infant mortality	MIH2, MIH3, CC5, CC6, CC7	***Reduce infant mortality**	*Early childhood home visiting (*cross-cutting with access to care, community conditions)*	*Early childhood home visiting, including prenatal and postnatal visits (*cross-cutting with access to care and community conditions)*	Priority population(s): Black (non-Hispanic); Youth, ages 15-17; Women ages 18-24; Women ages 45+; Low educational attainment (no high school diploma); Residents of urban counties*	County-level data is available from the ODH Public Health Data Warehouse. See also, online SHA. The Task Force will measure # enrollees and # referrals.	Maternal and Infant Health Task Force, Healthy Child Family Consortium, WIC, Help Me Grow, Family Children First Council, DJFS/CPS, MVCDC
				*Care coordination and access to well-woman care	*Community Health Workers			
					*Continuous support for women during pregnancy and childbirth, including certified doulas			
					*Optimizing postpartum care			
				*Clinical prevention, screening, and treatment	*Screening and referring mothers postpartum at pediatric visits			Rocking Horse Community Health Center, Madison Health
					Free descriptive pamphlets with information on available programs/services			
Health Outcome: ***Mental Health & Addiction**	*Depression (Isolation)	MHA1, MH2	***Reduce Depression**	*Coordinated care for behavioral health *(cross-cutting with access to care, chronic disease)*	*telehealth (telemental health services)	SHIP: N/A. Senior citizens and working people	Yes, similar: County-level data for a similar indicator is available from County Health Rankings & Roadmaps. See also, online SHA.	WeCARE Coalition, Mental Health Services, Rocking Horse Community Health Center, MHRB, Senior Centers, DJFS/APS, Madison County Prevention
					*chronic disease management programs *cross-cutting with chronic disease)*			
					*integration of behavioral health services into primary care *cross-cutting with chronic disease)*			
				*Digital access to treatment services and response *(cross-cutting with access to care, chronic disease)*	*Crisis texting lines			
					Peer support			
					*Group-based parenting programs			

				*Parenting programs (*cross-cutting with maternal and infant health, community conditions)*	Youth ambassador program		Task force will measure participation rates.	
				Sleep hygiene education and policy recommendations	Community education campaign regarding sleep health and impacts		Task force will measure participation rates and number of adjusted schedules.	OSU Extension, 4H, Youth-Led Prevention, MCPH, Schools, FCFC, Chamber of Commerce
					Outreach to schools to shift school start times and emphasize reducing screentime at night; outreach to businesses to improve work schedules through consistent hours to improve sleep and health			
Health Factor: ***Health Behaviors**	*Physical Activity	HB5, HB6	***Increase physical activity**	*Physical activity programs	*Activity programs for older adults	Black (non-Hispanic), Hispanic Adults, age 65+Low-income (less than $25,000 annual household income), People with a disability	Yes, similar: County-level data for a similar indicator is available from County Health Rankings & Roadmaps.	OSU Extension, 4H and Youth-Led Prevention, Mt. Sterling Senior Center, WIC, Proctor Center, Mt Sterling Community Center, Madison County Public Health, Madison County Commissioner's Office: Economic Development, Madison-Champaign ESC, Healthy Behaviors Task Force (MCPH Lead)
					*Community-based social support for physical activity			
	*Nutrition	HB3, HB4	***Improve nutrition**	*Fruit and vegetable access and education	*Community and school fruit and vegetable gardens	SHIP: N/A		
					Streamline free/reduced school meal application: consistent between schools, accessible, easy to complete			
					*Farm to institution programs, including farm-to-school programs			
				*Outreach and advocacy to maintain or increase enrollment in federal food assistance programs (WIC and SNAP)	*Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), including coordination of outreach and enrollment with local WIC clinics, Share Table, and SNAP-ED. Coordination of outreach and enrollment with County Department of Job and Family Services			

					locations, and increase in # available vouchers			
					*Increase outreach to caregivers, including pregnant women, parents and older adults (including free pamphlet describing available programs/services)			
					*Food insecurity screening and referral by healthcare providers			
				Create Local Food Council to investigate and provide policy recommendations to alleviate causes of health inequities	*Healthy food initiatives in food banks, such as Ohio Agricultural Clearance Program and produce distribution in partnership with food banks/pantries			
					*Farmers markets, including WIC and Senior Farmers' Market Nutrition Programs and Electronic Benefit Transfer (EBT) payment			
					*Place, present, and promote healthy foods in retailers, school, workplace, and other community settings			
					*Good Food Here policies (from the Ohio Food and Beverage Guidelines Toolkit) adopted and implemented in community settings CHC			
					*Multi-component school-based obesity prevention interventions			
Health Factor: ***Access to care**	*Unmet need for mental health care	AC5, AC6	***Reduce unmet need for mental health care**	*Coordinated care for behavioral health *(cross-cutting with mental health, chronic disease)*	*telehealth (telemental health services)	SHIP: N/A. Isolated/rural populations, including older adults and warehouse employees, youth, and working people	Yes, similar: County-level data for a similar indicator is available from County Health Rankings & Roadmaps. See also online SHA.	Mount Sterling CCC, WeCare Coalition, Mental Health Services, Rocking Horse Community Health Center, Access to Care, JFS, MCPH, Commissioners, MORPC
					*integration of behavioral health services into primary care *cross-cutting with chronic disease)*			
					*chronic disease management programs *cross-cutting with chronic disease)*			
				Complete evaluation of WeCare Coalition to guide relevant action plan and policy recommendations	Incentivize community feedback during community events			

	*Local access to healthcare providers	AC3, AC4	***Increase local access to healthcare services**	*Culturally competent workforce (*cross-cutting with maternal and infant health)*	*Cultural competence training for health care professionals and implicit bias training (*with focus on older adults*)			Madison Health, Rocking Horse, United Way, 211 Directory, FCFC
				*Comprehensive and coordinated primary care)	*medical homes (comprehensive primary care practices)			
					*telemedicine			
				*Access support	*health literacy intervention/community education			
				Identify providers needed	Collaborate with Madison Health, Rocking Horse, and MCPH to identify need and plan to fill gaps OBGYN services			
	Transportation		Investigate community needs related to public transportation	Complete a needs assessment (ODOT Feasibility study) to inform approaches to address transportation issues	Investigate possible incentive for warehouse employers to support provision of transportation		SHIP: N/A. # referrals, # appointments	County Commissioners, Engineer's Office, Board of DD (Madison Ride)
					ODOT establish "Mobility Manager" for Madison County			
				Mobile clinic	Expand partnerships with MCPH, Madison Health, and Rocking Horse to deliver mobile clinic services and WH nurse practitioner			MCPH, Madison Health, Rocking Horse; Warehouses: Amazon, Target, Staples, Torrid, Restoration Hardware
					Investigate possible incentive for warehouse employers to provide access to mobile health clinic			
				*Non-emergency medical transportation (NEMT) to improve care and prenatal care (*cross-cutting with maternal and infant health, mental health and addiction)*	*Expand resources to support Bridges Community Action "Navigator" which provides NEMT by appointment			Bridges Community Action

B: Task Force Membership

Madison County Public Health
Prevent. Promote. Protect.

Community Health Improvement Plan Task Forces

Maternal & Infant Health	Chronic Disease	Mental Health & Addiction	Access to Health Care
Amanda Morgan (FCFC)	Cindy Holland (MH)	Alyssa Edley (Juv. Court)	Allison Wenger (MH)
Amber Snyder (WIC)	Deetra Huntington (SNAP-Ed)	Amanda Hampton (MCP)	Diane Ulrich (Chamber)
Anita Biles (MVCDC)	Elizabeth Devine (MCPH)	Dan Kaffenbarger (ESC)	Erin Fawley (MCPH)
Cindy Stout (MH)	Fran Feehan (MH)	Frances Foos (OSUE)	Laura Dillard (Bridges Community Action)
Jen Smith (MCPH)	Kara Van Zant (United Way)	Greta Mayer (MHRB)	Levin Hutson (Township Association/Engineer's Office)
Kelly Cooley (St. John Lutheran's)	Kent Youngman (RHCHC)	J'Nell Buehl (Sisters Elderly Care)	Robin Bruno (DJFS)
Pat Closser (Mayor of London)	Lauren Sweeney (MCPH)	John Swaney (Sheriff)	Susan Thompson (Board of DD)
Rebekah Petit (Early Childhood)	Marie Dunsten (Bridges Community Action)	Julie Harris (CPS)	Trisha Sparks (London Met. Housing)
	Misty Bradley (Senior Center)	Kelly Rigger (MHS)	

C: Task Force Representative Selection Process

The CHIP is the result of the work of many local residents, community members, and partner organizations helping to improve the health status of Madison County residents. The success of this plan depends on the Madison County community as a whole to embrace individual and community health. Steering Committee and task force representatives were selected as representatives of the community and the local public health system. Individuals were selected for their expertise necessary to develop the CHIP and ability to provide support to carry out action. Representation included agencies, elected officials, community residents, employers, and healthcare providers that serve Madison County residents. Residents were represented in all strategy selection; this includes those who are not agency paid.

Task Force representation was selected by the Steering Committee. The Health Child and Family Consortium (HCFC) was already formed to address maternal and child health outcomes. Members from HCFC were included in the steering committee and strategy development. Members from WeCARE, Madison County's mental health wellness and substance misuse prevention coalition, were also involved in the steering committee; coalition members agreed to participate in the task force that will be led by MCPH. DJFS, Board of DD, and Bridges were all working on actively working on transportation plans and were selected to serve on the task force and steering committee to provide expertise in infrastructure and resident needs. MCPH will also create a Chronic Disease task force as their mission is to prevent people from getting sick or injured. Healthcare organizations including Madison Health and Rocking Horse Community Health Center, and social service agencies were selected as representatives for the chronic disease task force.