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DOUGLAS COUNTY
HEALTH DEPARTMENT

COMMUNITY HEALTH IMPROVEMENT PLAN

2023-2027

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Executive Summary

The 2023-2027 Douglas County Community Health Improvement Plan (CHIP) represents a strategic, long-term effort for communities and organizations across Region G to address the primary health priorities identified in the 2021 Region G Community Health Assessment (CHA).

Considering the influence of the social determinants of health, the various elements that may elevate health risks among specific populations, and the imperative of achieving health equity, multiple organizations collaborated under the guidance of the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework. This community-based approach engaged stakeholders at all levels to conduct the CHA and develop the CHIP.

Region G's CHA delved into the present health status of its communities, identifying needs as well as strengths and assets. For more details on the assessment, you can refer to the 2021 Region G Community Health Assessment.

Throughout this assessment and planning process, several issues were identified and three health priorities—Healthy Living, Opioid Misuse, and Maternal Child Health—were selected for focused attention during the implementation phase. These priorities laid the foundation for the CHIP's development.

The core purpose of the CHIP is to collaboratively address these health priority areas. This document outlines the process through which the community prioritized strategic concerns, established goals, and devised strategies. An emphasis is placed on addressing root causes, employing evidence-based methodologies, and ensuring health equity remains central to all initiatives. Our aim is to create an environment where everyone has an equal and just opportunity to achieve optimal health and well-being.

We invite you to join us in executing these strategies and contribute to making Douglas County and Region G a more accessible, inclusive, safe, and healthy community for growth and prosperity in Missouri.

DOUGLAS County Health DEPARTMENT

Mission

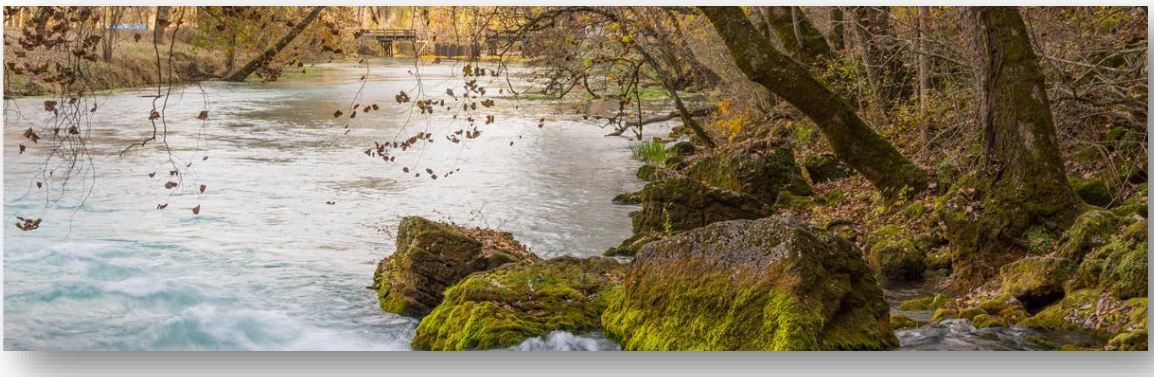
The Douglas County Health Department will protect and promote the public health of its residents by assessing their health status and needs, developing policies and priorities, and assuring appropriate county response, thus ultimately improving health as measured by reduced communicable disease and increased life expectancy.

Vision

Douglas County will become a county of healthy people in a healthy and safe environment.

Value Statement

The Douglas County Health Department employees and board members believe in a work environment and programs characterized by consistency, honesty, integrity, and trust. We are dedicated, straightforward professionals who are concerned and adaptable in dealing with a rapidly changing environment. Above all, we respect our county residents and their visitors, and attempt to maintain the highest standards of quality in our services to them.



About DOUGLAS County

Douglas County, Missouri, established in 1857, holds a wealth of history. Situated within the Ozarks of Missouri, it offers a distinctly rural experience with a population of roughly 11,800 residents. Ava, the county seat, is the only incorporated town in the county. Covering an expansive area of approximately 815 square miles and encompassing around 521,000 acres, the county is home to family-run farms, small businesses, and one Missouri's and the nation's top national forests. Located atop the Ozark Mountain Plateau, Douglas County enjoys a 4-season climate with much milder temperatures than the upland plains or prairie sections of the state plus an abundance of sunshine, low wind velocity, mild temperatures and favorable humidity.

Three designated "scenic highways" meet in Ava. Missouri Highway 5 connects points such as Missouri's Lake of the Ozark country to the north, and Arkansas to the south. State routes 14 and 76 merge in Ava and cover some of the most beautiful areas in the entire state. Our roads are the "Scenic Route to Branson!"

Ava is the world headquarters of the Missouri Fox Trotting Horse Breeders Association. In 2002, the Missouri Fox Trotting Horse officially was designated the State Horse of Missouri. The association's 150 acres include stables, arenas and 300 full-service campsites.

As of 2022, the demographic makeup of Douglas County reveals that Non-Hispanic White individuals constitute 94% of the population. Non-Hispanic Black representation stands at 0.7%, with 1.6% identifying as Hispanic, 0.3% as Asian, 2.4% as American Indian and Alaska Native, and 0% as Native Hawaiian/Other Pacific Islander. English serves as the primary language spoken by residents. For a breakdown of age distribution in Douglas County, please consult Table 1.

Table 1: Age, 2022

Age	Percent of Population
Under 5	5.7%
Under 18	22.9%
18-64	52%
65 and over	25.1%

Overview of MAPP 2.0

Developed by the National Association of County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC), Mobilizing for Action through Planning and Partnerships (MAPP) is a community-wide strategic planning process for improving community health. Facilitated by public health leaders and used by local health departments across the country, MAPP helps communities apply strategic thinking to prioritize public health issues and identify the resources needed to address them. All aspects of MAPP's newest version are centered on the following principles:

Equity: Encourages shared exploration of the social injustices including structural racism, class oppression, and gender oppression, that create and perpetuate inequities. Mobilizes community action to address these injustices through transformative change to the structures and systems that perpetuate inequities and creates the opportunity for all to achieve optimal health.

Inclusion: Fosters belonging and prevents othering by identifying and eliminating barriers to community participation and ensuring all stakeholders and community members, regardless of background or experience, can contribute to the MAPP process.

Trusted Relationships: Builds connection and trust by honoring the knowledge, expertise, and voice of community members and stakeholders.

Community Power: Actively builds community power to ensure those most impacted by the inequities and actions addressed through CHI are those that guide the process, make key decisions, and help drive action.

Strategic Collaboration & Alignment: Creates a community-wide strategy that appropriately aligns the missions, goals, resources, and reach of cross-sectoral partners to improve community health and address inequities.

Data & Community Informed Action: Identifies priorities, strategies, and action plans that are driven by the community's voice and grounded in community need as identified through timely qualitative and quantitative data.

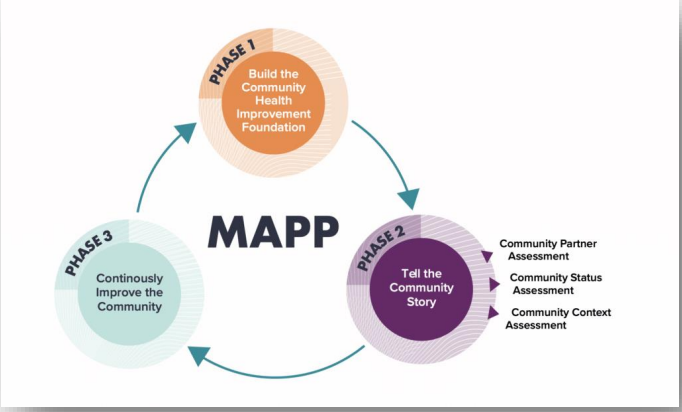
Full Spectrum Actions: Encourages community improvement through approaches ranging from provision of direct services to PSE (policy, systems, and environmental change), and community power building for supportive communities that enable health and well-being for all.

Flexibility: Meets the real-time, evolving, and unique needs of diverse MAPP communities, organizations, and sectors through an adaptable framework.

Continuous: Maintains continuous learning and improvement through iterative community assessment, planning, action, and evaluation cycles.

The newly released MAPP 2.0 version includes three phases:

1. Build the CHI Foundation
2. Tell the Community Story
3. Continuously Improve the Community



In Phase 1 of the MAPP process, the focus is on building strategic relationships with partners, analyzing stakeholder power and influence, and cultivating a shared understanding of the MAPP collaborative's mission and vision. This includes assessing the current community health infrastructure, scoping the MAPP process based on readiness and resources, and evaluating and improving the process over time with a focus on health equity.

In Phase 2, the focus is on conducting comprehensive community assessments to understand the health and well-being of the community. This phase involves ongoing assessments and data collection from multiple perspectives, including qualitative and quantitative data. The assessments are streamlined and include Forces of Change, integrated across all three revised MAPP assessments.

Phase 3 of the MAPP framework combines Phases 4-6 of the historical framework and emphasizes addressing upstream priorities through transactional and transformational approaches while building strategic partnerships for sustained action. It includes power analyses and partner profiles to appropriately engage partners to address inequities, employs continuous quality improvement and rapid cycle improvement, and provides a framework for shared measurement structures to monitor and evaluate impact on CHIP priorities.

What is a CHIP?

A Community Health Improvement Plan (CHIP) serves as a comprehensive framework that encapsulates the outcomes of the community's Mobilizing for Action through Planning and Partnerships (MAPP) process. It provides a concise summary of priority issues, goals, strategies, and activities aimed at systematically addressing public health challenges. A CHIP is distinguished by its long-term and systematic approach, driven by the results of Community Health Assessment (CHA) activities and the Community Health Improvement (CHI) process. Importantly, it operates as a collaborative effort involving health and various governmental, educational, and human services agencies, alongside community partners. The CHIP is a community-owned plan, representing the entire local public health system rather than a single agency.

Following the development of the CHIP, the next phase involves its implementation according to an action and evaluation plan, with continuous monitoring of its impact. While the effects on priority issues and goals may not be immediately visible, ongoing monitoring of strategy implementation and short-term outcomes is crucial. Effective monitoring and revision processes entail involving all responsible parties, establishing clear roles and responsibilities for partners, holding regular meetings for plan review and adjustment, and scheduling ongoing data assessments and discussions to track progress toward CHIP goals.

Implementing an evaluation plan involves collecting data on both process and outcome metrics to comprehensively evaluate intervention success and resource efficiency. Process metrics assess how intervention activities are being carried out as intended, while outcome metrics evaluate short-, intermediate-, and long-term intervention outcomes, acknowledging that some outcomes may take months or years to measure.

Upon studying intervention results, decisions should be made to adapt, adopt, or abandon elements of the intervention based on data or evidence-based strategies. Adaptations should be incremental and backed by data or evidence, while successful new elements can be adopted as official parts of the intervention. Ineffective practices should be abandoned. Any changes to the intervention should be tested incrementally on a small scale.

The Plan-Do-Study-Act cycle continues by making adjustments to the intervention and updating the data-collection plan as necessary. Monitoring the CHIP's impact can be achieved through various methods, and it is essential for all partners to contribute to data updates as outlined in the action plan. Regularly sharing CHIP results with the community is crucial to ensure transparency and accountability.

Douglas County Health Department (DCHD) will provide CHIP partners with updates via meetings and/or email, allowing them to receive and update on their progress concerning assigned CHIP activities. Additionally, a comprehensive evaluation or summary of the CHIP will be conducted every three to five years to assess strategy effectiveness and alignment with goals.

Community & Partner Engagement

To ensure inclusivity and transparency throughout the CHIP process, DCHD aimed to involve a diverse range of community residents and local public health system partners at every stage. The CHIP process was informed by contributions from the various partners listed below, who participated by attending collaborative meetings, providing feedback and data, and engaging in other ways throughout the process.

Ava School
City of Ava
Carter County Health Center
CHART, Ava
DOCO INC. Ava
Douglas County Health Department
Drury University, Ava
Howell County Health Department
Missouri Highlands Healthcare
Missouri Ozarks Community Health
Oregon County Health Department
Ozark County Health Department
Plainview R-8 School
Reynolds County Health Center
Shannon County Health Center
Texas County Health Department
University of Missouri Extension
Whole Kids Outreach
Whole Health
Wright County Health Department

DCHD expresses its gratitude for the expertise, dedication, and extensive time contributed by all the individuals listed above towards the CHIP process. Building on this foundation of community engagement and partnership, DCHD is determined to implement this community health improvement plan over the next five years.

CHA Highlights

The Region G Community Health Assessment (CHA) exhibits a mix of socio-economic and health challenges. About 20.8% of its residents live below the poverty line, with child poverty rates ranging from 28-36% and older adult poverty rates between 10.1% and 19.5%. The population has seen changes varying from a 7.01% decrease to a 30.4% increase. While educational metrics are strong, with nearly 0% school drop-out rates and high school graduation rates over 90%, there are infrastructure challenges: over 1% of homes lack plumbing and 5% don't have a telephone.

Diseases of the Heart is the leading cause of death in Douglas County residents under the age of 75. Thirty eight percent of adults in Douglas County are obese while twenty six percent smoke, both of which are known to contribute to various diseases of the heart. Substance abuse and mental health issues continue to challenge our community as resources to treat these problems continue to be scarce.

In 2019, chronic lower respiratory disease led in causes of death in Region G followed by accidental firearm discharges. Furthermore, a higher percentage of the region's population lacks health insurance compared to the state average.

Selecting Priorities

During an in-person gathering, representatives from the participating local public health agencies (LPHAs) analyzed the Region G CHA data. They deliberated over present concerns and potential initiatives to address the findings of the CHA. Together, they pinpointed three main priorities: Healthy Living, Opioid Misuse, and Maternal Child Health. These priorities were later presented at a hybrid meeting to community members from various sectors, including community benefit organizations, and other organizations throughout the region. Participants then affirmed these priorities, set an overarching goal for each, and brainstormed strategies for their realization.

Dedicated partners were then singled out to join focus groups centered on each priority. Within these sessions, CHIP partners reviewed 8-10 objectives for every strategy. They utilized the online tool, Padlet, to refine the objectives down to 1-2 per strategy. During these discussions, specific partners volunteered to spearhead individual objectives.

To conclude the decision-making process, a final meeting was held with each of the lead CHIP partners. This was to solidify activities and Key Performance Indicators (KPIs) associated with each objective.

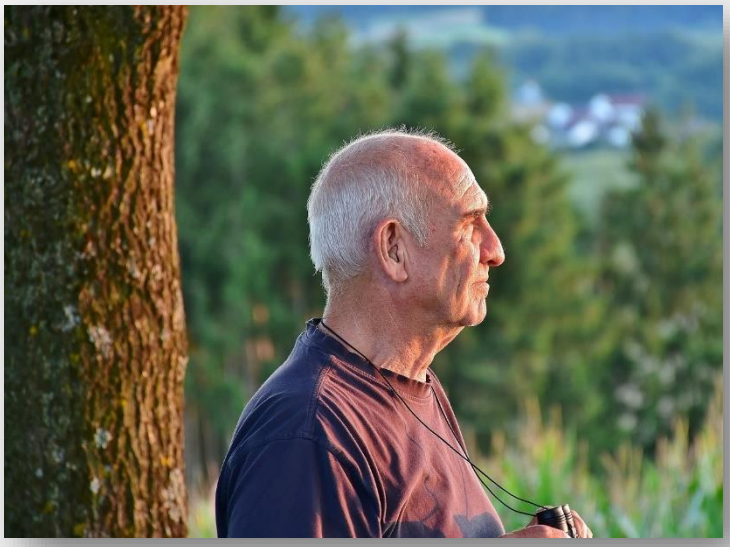
Throughout this third phase, the MAPP 2.0 framework was customized to be more feasible for collaborative participation, given Region G's predominantly rural landscape and the novelty of the community health improvement plan for many organizations.

Prioritized Issue #1: Healthy Living

Based on the information gathered from the community health assessment, the priority focus on Healthy Living has been chosen with careful consideration of several key factors. Firstly, the percentage of the population living below the poverty line in the range of 18.7% to 22.7% suggests a potential connection between economic disparities and health outcomes, underscoring the need to address health equity. Secondly, notable population changes, ranging from a 7.01% decrease to a 30.4% increase, indicate shifts in demographics that may impact health and wellness needs. Additionally, high-school graduation rates above 90% and a 0% school drop-out rate present an opportunity to leverage education as a foundation for healthier lifestyles. Furthermore, concerning statistics related to child homelessness, poverty rates, substance use, mental health, and chronic diseases highlight the multifaceted challenges faced by the community. By prioritizing Healthy Living, we aim to address these complex issues holistically, promoting healthier lifestyles, and mitigating the disparities revealed in the CHA.

When we talk about "Healthy Living," we are referring to a comprehensive approach to well-being that actively seeks to prevent and manage chronic diseases. This approach encompasses various facets:

Nutrition: Encouraging a balanced diet filled with whole foods, lean proteins, healthy fats, and fresh fruits and vegetables. Reducing the intake of processed foods, sugars, and saturated fats can decrease the risk of obesity and associated conditions like diabetes.



Physical Activity: Regular exercise, whether it's walking, cycling, or structured gym sessions, helps maintain a healthy weight, reduces the risk of heart disease, strengthens muscles and bones, and improves mental well-being.

Regular Health Screenings: Early detection of conditions like hypertension, diabetes, or heart anomalies can lead to more effective and less invasive treatments. Regular check-ups and monitoring are crucial.

Mental Well-being: Stress can be a significant factor in hypertension and heart disease. Mindfulness practices, adequate sleep, and stress-reducing techniques can play a role in preventing these conditions.

Limiting Harmful Habits: Reducing or eliminating the consumption of tobacco and excessive alcohol can dramatically decrease the risk of heart disease, hypertension, and other related illnesses.

Educational Initiatives: Providing the community with resources, workshops, and information on the risks of chronic diseases and ways to prevent them is key. This includes cooking classes, exercise groups, and informational seminars.

Community Engagement: Creating an environment where the community can come together in parks, community centers, or local events can foster physical activity, promote healthy eating, and build a supportive environment.

Access to Healthcare: Ensuring that every individual, regardless of their socio-economic status, has access to healthcare professionals, medications, and treatments is paramount. This includes affordable medications for conditions like diabetes and hypertension.

For Region G's CHIP, Healthy Living stands as a beacon of proactive healthcare, aiming to reduce the prevalence of obesity, diabetes, hypertension, heart disease, and other related conditions. By focusing on prevention and holistic well-being, we hope to foster a community that thrives in health and happiness.

Promoting Healthy Living: Our Plan

Overarching Goal: Promote and foster a culture of healthy living to reduce the prevalence of chronic disease in Region G.

Strategic Partners:

- Missouri Highlands Healthcare
- Missouri Ozarks Community Health (MOCH)
- Cox Health
- Plainview R-8 and Skyline Schools

Strategy 1: Enhance and expand upon existing diabetes education and support groups.

Lead Organization: DCHD

Objective 1: Within 12 months of CHIP initiation, increase participation in the existing diabetes education classes and/or support group by 10%.

Activities:

- **Class Promotion:** DCHD will build upon their current targeted outreach and awareness campaign to promote the diabetes education classes and support groups within the community, utilizing various communication channels such as social media, posters, and word of mouth.
- **Referrals:** DCHD will establish and continually foster partnerships with MOCH, other healthcare providers, and community organizations to refer individuals to the diabetes education classes and support group as well as facilitate the sharing of program information.
- **Virtual Option:** DCHD in coordination with Cox Health will offer virtual monthly support group meetings.

Key Performance Indicator (KPI):

- Class organizers will track participation in the diabetes education classes and/or support group meetings before and after the first 12 months of CHIP initiation. They will calculate the percent increase by comparing the number of participants before the CHIP initiation to the number of participants after 12 months of implementing the activities.
- This KPI target is to achieve a **10% or higher increase in participation** in the diabetes education classes and/or support group meetings, indicating a successful outcome of the activities aimed at enhancing and expanding the program.

Strategy 2: Strategically utilize pop-up screenings to enhance healthcare accessibility and increase referrals within the community.

Lead Organization: DCHD

Objective 1: Within 12 months of CHIP initiation, offer monthly pop up screenings at 3 partner locations to increase referrals to our diabetes classes and/or support group meetings, and health care providers by 20%.

Activities:

- **Determine 3 locations across the county:** DCHD will contact local schools, senior centers, and community organizations to organize on-site health fairs. We will create a database to compile this information, including event types, dates, locations, referrals, and participating organizations.
- **Data Collection:** DCHD will collect data on the frequency of pop-up healthcare events and referrals throughout the county and create a report summarizing the findings, which will serve as the baseline data for future comparisons and planning.

Key Performance Indicator (KPI):

- This KPI target is to achieve **100% completion** of number of health fairs offered monthly as well as a 20% increase in referrals and report creation within the specified 12-month timeframe, ensuring baseline data is available for strategic planning.

Prioritized Issue #2: Opioid Misuse

Opioid misuse is a pressing public health crisis with far-reaching effects on individuals, families, and communities. This priority is based on compelling data from our community health assessment, which revealed that three Region G counties rank among the top 5% nationwide at risk of HIV and hepatitis C outbreaks due to opioid use. Additionally, substance use-related hospitalizations among children and teens have risen significantly. Missouri has experienced an alarming epidemic of drug overdoses, with opioids implicated in over 70% of these deaths. These findings underscore the burden on families, communities, and healthcare systems, making opioid misuse a paramount priority in the Region G CHIP.

Overdoses: Opioids, whether prescription medications or illicit drugs like heroin, can slow down the body's essential functions, particularly breathing. Overconsumption or mixing with other substances can lead to an overdose, wherein breathing may stop entirely. This results in a lack of oxygen to the brain, leading to unconsciousness, permanent brain damage, or death. Reducing opioid overdoses is paramount in preserving the lives of individuals who may misuse these drugs, either knowingly or unknowingly.

Neonatal Abstinence Syndrome (NAS): NAS is a post-birth withdrawal syndrome that can occur in newborns exposed to opioids while in the womb. Babies with NAS can have a range of symptoms, including tremors, irritability, feeding difficulties, and respiratory distress. They often require specialized care in the neonatal intensive care unit. Reducing rates of NAS means ensuring that pregnant individuals have access to appropriate care and support to avoid opioid misuse during pregnancy.

Blood-borne Diseases: Sharing needles or other injection equipment is a common practice among some people who misuse opioids, particularly those who inject drugs. This practice can lead to the spread of blood-borne diseases like HIV and Hepatitis B and C. Reducing the rates of these diseases involves addressing the root causes of opioid misuse and ensuring access to clean needles and harm reduction services.

Additional Concerns: Beyond the immediate health risks, opioid misuse can result in job loss, family disruption, increased crime, and significant mental health challenges. Addressing opioid misuse in a comprehensive manner means not only focusing on the direct health consequences but also supporting broader social, economic, and mental health needs of affected individuals.

In response to these pressing concerns, our community health improvement plan will prioritize measures to reduce the impact of opioid misuse and its associated challenges. Collaborating with healthcare providers, community organizations, law enforcement, and individuals with lived experiences, we aim to continually develop comprehensive strategies that address prevention, treatment, recovery, and harm reduction.

Addressing Opioid Misuse: Our Plan

Overarching goal: Reduce opioid misuse and its associated harms in our region.

Strategic Partners:

- Region G LPHAs
- Emergency Managers
- Local Sheriff
- Plainview School
- Missouri Highlands
- Set Free Ministries
- MIMH / UMSL (providing Narcan and educational materials)
- Missouri Ozarks Community Health (Ava Clinic)
- Ava School District
- CHART
- Skyline School

Strategy 1: Increase awareness and accessibility of opioid overdose prevention education and resources.

Objective 1: Organize a community engagement event within 12 months of CHIP initiation to promote awareness of Drug disposal events and resources.

Lead Organizations: DCHD, CHART, and the Sheriff's office.

Activities:

- DCHD will collaborate with CHART to select and organize a community engagement event suitable for the target audience.
- The event hosts will present informative materials and to educate attendees about the risks of opioid misuse and proper drug disposal.

- They will create promotional materials such as posters, flyers, and social media posts to raise awareness and encourage community participation in the event.

Key Performance Indicator (KPI):

- The event hosts will create a concise post-event survey consisting of 3-5 questions to assess participants' understanding and knowledge acquired from the event.
- The target of this KPI is to attain a learning assessment rate of 75% or higher, signifying that participants have comprehended the key information presented during the event.

Objective 2: Within 12 months of CHIP initiation, create a point of contact for local schools, law enforcement, and local health department. This resource will be intended for healthcare professionals, school personnel, law enforcement, and the public.

Lead: DCHD

Activities:

- **Create Point of Contact:** Community navigator will initiate contact with MIMH to determine requirements for becoming the point of contact for Narcan Distribution. Once point of contact has been established for Narcan Distribution local agencies will be contacted about their need for Narcan.
- **Training:** The Community Navigator will coordinate training on the distribution and use of Narcan.
- **Process Development:** Develop a process by which other agencies can order Narcan through the point of contact.
- **Accessibility and Promotion:** Create an awareness campaign to promote Narcan distribution sites, utilizing various communication channels, such as social media, flyers, and word of mouth.

Key Performance Indicator (KPI):

- The target for this KPI is to successfully have 3 points of access in the county to obtain Narcan. This will ensure accessibility throughout the most rural parts of the county.

Objective 3: Develop a quarterly content media calendar with informative and engaging posts on opioid misuse prevention, treatment, and resources to be disseminated on social media platforms over the first 12 months of CHIP initiation.

Lead: DCHD

Activities:

- **Content Topics and Calendar Planning:** DCHD will identify key topics in collaboration with other partners related to opioid misuse prevention, treatment, and resources that are relevant to the audience. A quarterly content calendar will be created outlining the themes and topics for each month.
- **Content Creation:** DCHD will obtain or develop the content for each post, including informative text, visuals, and any multimedia elements. They will ensure that the content is accurate, engaging, and aligned with the messaging goals.
- **Platform Selection and Scheduling:** DCHD will choose the social media platforms where the target audience is most active. They will schedule the posts in advance using social media scheduling tools to ensure consistent dissemination.

Key Performance Indicator (KPI):

- This KPI target is to post a minimum of 4 informative and engaging posts on opioid misuse prevention, treatment, and resources on social media platforms each quarter of the first year after CHIP initiation.

Prioritized Issue #3: Maternal Child Health

Maternal Child Health (MCH) is a vital aspect of public health that focuses on the well-being of women of child-bearing age, infants, children, and families. Addressing the unique health challenges and needs of these groups lays the foundation for a healthier future generation. MCH emerged as a clear priority from the community health assessment due to several interconnected factors, including poverty rates, suboptimal living conditions, rising child homelessness, and concerning healthcare gaps. These challenges underscore the urgency of a holistic approach to improve the well-being of mothers and children in the community. Here are key focus areas under MCH:

Reducing Obesity Rates in Children: Childhood obesity is a pressing concern, linked to both immediate health problems and increased risk of chronic diseases in adulthood, such as diabetes and heart disease. By emphasizing nutrition, physical activity, and education, we aim to ensure children are provided with the tools and knowledge necessary to make healthy lifestyle choices.

Increasing Preventative Care Visits and Health Screenings: Women of child-bearing age benefit significantly from regular preventative care visits and health screenings. These checks help identify potential health risks before they become serious issues and ensure that women are in the best possible health both before and during pregnancy. Screenings can detect problems early when they are most treatable, leading to better outcomes for both mother and child.

Improving Access to Prenatal Care: Prenatal care is crucial for ensuring the health and well-being of both mother and baby. Regular check-ups during pregnancy can detect and address potential complications, provide essential health information, and ensure that babies have a healthy start in life. By enhancing access to such care, we aim to reduce birth complications and neonatal mortality rates.

Additional Areas of Focus: Beyond the immediate concerns, MCH encompasses a broad range of additional areas, including promoting breastfeeding, ensuring childhood immunizations, addressing mental health needs of mothers, and providing support for families in the early stages of a child's life. Each of these areas contributes to the overall well-being and long-term health outcomes of mothers and their children.

Prioritizing Maternal Child Health in our community health improvement plan signifies our commitment to nurturing the health of our most valuable assets: our mothers and their children. With coordinated efforts from healthcare providers, community agencies, and other stakeholders, we will continuously strive to create an environment where every woman and child can achieve optimal health and well-being.

Cultivating Maternal Child Health: Our Plan

Overarching Goal: To improve maternal and child health outcomes by ensuring access to comprehensive and equitable healthcare services, promoting healthy pregnancies, and supporting early childhood development.

Strategic Partners:

- Local Public Health Agencies (LPHAs)
- Missouri Ozarks Community Health
- Regional Hospitals
- Options Pregnancy Center
- HeadStart
- Early Childhood Centers

Strategy 1: Increase preventive care and health screenings for women of childbearing age.

Lead Organization: DCHD& Carter County Health Center

Objective 1: Obtain baseline data within the first 12 months of CHIP initiation on the awareness of family planning services among women of childbearing age.

Activities:

- **Survey Design**: The Carter County Health Center will provide a survey to gauge women's knowledge on family planning options.
- **Distribution**: Ensuring broad coverage across Douglas County, DCHD will distribute the survey, aiming to reach a diverse set of women in the targeted age bracket.
- **Data Collection**: DCHD will work with Carter County Health Center to gather and organize survey feedback.
- **Analysis**: Carter County Health Center will examine the feedback to identify patterns and set a baseline for awareness. The insights will be condensed into a concise report, informing the CHIP's subsequent phases.

Key Performance Indicator (KPI):

- The target for this KPI is to obtain survey feedback from a minimum of 383 women in the first year following the CHIP launch. This sample size aims to accurately represent the target audience with a 95% confidence interval and a 5% margin of error.

Strategy 2: Strengthen maternal mental health support through universal screening and promotion of resources.

Lead Organization: DCHD

Objective 1: Within 12 months of initiating the CHIP, enact a policy requiring maternal mental health screenings for all pregnant and postpartum individuals during their initial certification and exit counseling sessions. Furthermore, develop definitive referral protocols to ensure individuals identified with mental health concerns have immediate access to appropriate mental health resources.

Activities:

- **Screening Tool Adoption:** DCHD will research and identify a proven maternal mental health screening tool.
- **Policy & Screening Tool Integration:** DCHD will integrate the screening process into both the initial certification and exist counseling 4–6-week postpartum appointments.
- **Promotion**: Develop promotion materials to highlight existing resources and events such as 988, Community Navigiator, and suicide prevention.

Key Performance Indicator (KPI):

- This KPI measures the percentage of pregnant and postpartum individuals who undergo mental health screenings out of those who attend an initial certification or exit counseling session. The target is to achieve a mental health screening rate of at least 75% within the first 12 months of CHIP initiation.

Summary

As we conclude our CHIP planning, we must revisit our primary motivation: the health and well-being of our communities. We have thoroughly pinpointed significant health challenges and developed a strategic blueprint to tackle these crucial issues. A particular focus has been placed on mitigating health inequities by addressing barriers that disproportionately affect vulnerable populations.

When it comes to diabetes, education stands out as the cornerstone. With our targeted educational programs, we are on a mission to empower individuals. Our goal is to ensure they have the insights and tools to both manage and proactively prevent diabetes, leading to healthier life choices.

Our strategy to tackle the opioid crisis is layered. Not only are we equipping communities with immediate intervention tools like Narcan, but we are also driving an education-focused campaign on opioid misuse. Given the pressing nature of the national opioid epidemic, it is crucial to arm our community with both knowledge and resources.

Further emphasizing our commitment to health equity and preventive care, strategies like the pop up health clinics and Narcan availability come to the forefront. Our pop-up clinics aim to bridge the healthcare accessibility gap, ensuring every community member gets quality care. Additionally, a focus on free access to Narcan ensures that all individuals, regardless of income can obtain life saving Narcan.

The listed objectives and KPIs outline our roadmap and will measure progress towards each strategy. Collaboration with partners and the wider community will continue to be essential, and while we have established a solid foundation, we welcome feedback and will adjust our strategies to meet our community's changing needs.

To all residents of Douglas County and Region G: This CHIP is our formal commitment to addressing the identified health challenges. With clarity in our objectives and collaboration at the forefront, we're set to make meaningful improvements in our community's health landscape.