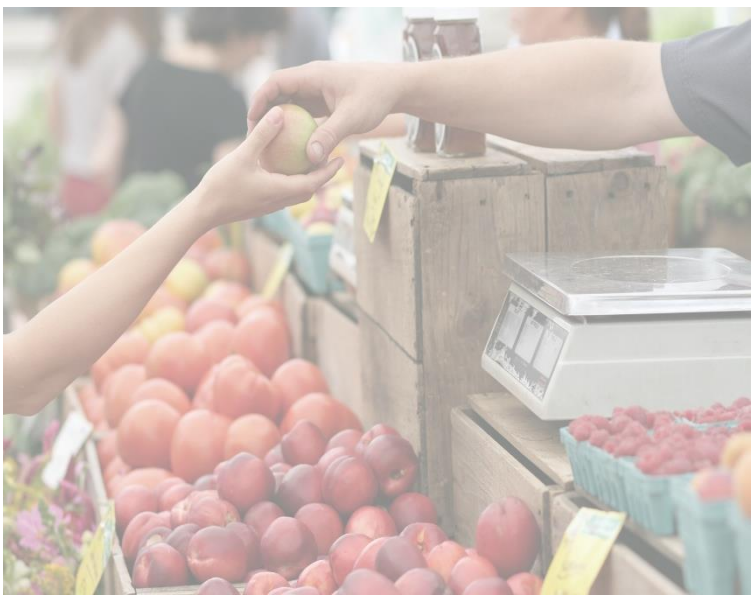
2019

Mitchell County Community Health Improvement Plan (CHIP)



TOE RIVER HEALTH DISTRICT

Avery · Mitchell · Yancey County Health Departments

2019 Community Health Improvement Plan - Mitchell County

Mitchell County CHA Overview Video

The 2018 Community Health Assessment priority areas are:

- **Substance Abuse and Increasing Availability/Access of Mental Health Services**
- **Healthy Living Behaviors/Lifestyles and Chronic Disease Prevention**
- **Access to Healthcare/Social Determinants**

The following CHIP Scorecard was created and submitted **September 9th, 2019** in order to meet the requirements for the **Mitchell County** Long and/or Short Term Community Health Improvement Plans.

Clear Impact Scorecard™ is a strategy and performance management software that is accessible through a web browser and designed to support collaboration both inside and outside organizations. WNC Healthy Impact is using Clear Impact Scorecard™ to support the development of electronic CHIPs, SOTCH Reports and Hospital Implementation Strategy scorecards in communities across the region.

Scorecard helps communities organize their community health improvement efforts:

- Develop and communicate shared vision
- Define clear measures of progress
- Share data internally or with partners
- Simplify the way you collect, monitor and report data on your results

The following resources were used/reviewed in order to complete the CHIP:

- WNC Healthy Impact
- WNC Healthy Impact Data Workbook
- NC DHHS CHA Tools
- NC DHHS County Health Data Book
- NC DHHS/ DPH CHA Data Tools
- National Institute of Drug Abuse

Substance Abuse and Mental Health - Long Term CHIP

	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
R Mitchell County is free from substance abuse, and residents have access to mental health services.				
I Mitchell Number of Unintentional Opioid Deaths	2017	1	↘ 2	-50% ↓
I Mitchell Rate of drug overdoses in Mitchell County	2013	19.4	→ 0	0% →

	Time Period	Current Actual Value	Current Trend	Baseline % Change
P Expansion of Youth to Youth into the High School				

What Is It?

Expanding youth to youth was identified by the Mitchell Community Health Partnership, that when combined with other actions in our community, that has a reasonable chance of making a difference in Mitchell County and in our community. This is an ongoing program in our community.

The priority population for this intervention are youth in the community, and the intervention also aims to make a difference at the individual and interpersonal level. Implementation will take place in the community through expanding the foundations of what is already happening in Mitchell County. This strategy addresses individuals in the school system.

Partners

The partners for this program include:

Agency	Person	Role
Mitchell Community Health Partnership	(Done as a group)	
Mitchell-Yancey Substance Abuse Task Force	Jeff Spargo	Collaborate
Toe River Health District	Jessica Farley and Drew Brown	Collaborate
Partners Aligned Toward Health	Schell McCall and Team	Collaborate
Mountain Community Health Partnership	Amber Dellinger	Collaborate
Blue Ridge Regional Hospital	Colby Boston	Collaborate

Work Plan

This work plan will begin by adding on to the things that are already being done within the community. This can be added on by beginning with youth to youth and thus taking the items being done in the middle schools into the local high school and teaching the students there the dangers of alcohol and other drugs.

Evaluation and Sustainability

Evaluation Plan:

We plan to evaluate the impact of our substance abuse programs through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures.

We will track our interventions through the use of straight forward and specific data. The data that will be used is through watching the youth to youth expand into the high school and seeing how many students are enrolled in this program and what activities they participate in. After that our team will take a look at the underage drinking statistics within the community to see if they have decreased once our programs were implemented.

We will also use our community partners to help track the data. Community partners such as the school system will be used to see if we reached the students that we sought out to reach by keeping tabs of the class size. The remaining evaluation will occur internally by checking what information was handed out and tracking that through the health department via surveys to employees. There will also be surveys used to evaluate customer satisfaction along with other things that can be evaluated based on pre and post surveys.

Sustainability Plan:

The following is our sustainability plan for the Youth to Youth expansion program:

- We will develop a sustainability plan by keeping track of the people reached through our interventions and making sure to keep the number of participants in the youth to youth program. This will show progress and help us keep track of our numbers to show community stakeholders and other individuals invested in our programs.
- We plan to collaborate with our local hospital to sustain the programs and initiatives that are being implemented in the community. By combining our resources along with other community partners we are able to greatly impact the community.

PM Y2Y Number of High School Students Reached — Sep 2019 — → 0 — No Data →

P Educate the community and professionals through events and initiatives (community and partner strategy)

Time Period | Current Actual Value | Current Trend | Baseline % Change

What Is It?

What is it?

Continuing education in the community was identified by the Mitchell Community Health Partnership, that when combined with other actions in our community, that has a reasonable chance of making a difference in Mitchell County and in our community. This is an ongoing program in our community.

The priority population for this intervention are all ages of individuals in the community, and the intervention also aims to make a difference at the individual and interpersonal level. Implementation will take place in the community through expanding the foundations of what is already happening in Mitchell County. This strategy addresses all types of individuals that reside in Mitchell County from people that live in poverty to every individual in the school system, while also targeting the families and individual's community members who aren't in the school system.

Partners

The partners for this program include:

Agency	Person	Role
Mitchell Community Health Partnership	(Done as a group)	
Mitchell-Yancey Substance Abuse Task Force	Jeff Spargo	Collaborate
Toe River Health District	Jessica Farley and Drew Brown	Collaborate
Partners Aligned Toward Health	Schell McCall and Team	Collaborate
Mountain Community Health Partnership	Amber Dellinger	Collaborate
Blue Ridge Regional Hospital	Colby Boston	Collaborate

Work Plan

This work plan will begin by adding on to the things that are already being done within the community. The education into the community can continue after the wonderful developments currently being made through Partners Aligned Towards Health (PATH). After the Tonier Cane event that is being held in Burnsville (open to neighboring counties) along with other events focused around Substance Abuse and how to deal with this trauma the Mitchell Community Health Partnership group can continue building this education into the community. This will create a more resilient community that knows how to deal with substance abuse among youth and adults.

Evaluation and Sustainability

Evaluation Plan:

We plan to evaluate the impact of our substance abuse programs through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures.

We will track our interventions through the use of straight forward and specific data. We will use a simple method of seeing how many educational events the community has that are geared to helping the substance abuse problem in the county.

We will also use our community partners to help track the data. Community partners such as the school system will be used to see if we reached the students that we sought out to reach by keeping tabs of the class size. The remaining evaluation will occur internally by checking what information was handed out and tracking that through the health department via surveys to employees. There will also be surveys used to evaluate customer satisfaction along with other things that can be evaluated based on pre and post surveys.

Sustainability Plan:

The following is our sustainability plan for the Youth to Youth expansion program:

- We will develop a sustainability plan by keeping track of the people reached through our intervention and making sure to keep the number of participants in the educational events held. This will show progress and help us keep track of our numbers to show community stakeholders and other individuals invested in our programs.
- We plan to collaborate with our local hospital to sustain the programs and initiatives that are being implemented in the community. By combining our resources along with other community partners we are able to greatly impact the community.

PM	Number of Events Hosted	Sep 2019	–	→ 0	No Data →

Healthy Living Behaviors and Chronic Disease - Long Term CHIP

		Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
R	Healthy living behaviors/lifestyles in Mitchell County. Mitchell County free from chronic disease.				
I	Mitchell Residents who meet physical activity recommendations	2018	16.9%	↘ 2	-66% ↓
P	Expand strategies to focus more on youth healthy living behaviors in the area	Time Period	Current Actual Value	Current Trend	Baseline % Change
PM	Healthy Living Number of high school students reached	–	–	–	–
P	Educate the community on the benefits of a healthy lifestyle	Time Period	Current Actual Value	Current Trend	Baseline % Change

What Is It?

Educating the community on the benefits of a healthy lifestyle will greatly impact the community. This was identified by Mitchell Community Health Partnership as an action, that when combined with other actions in our community, that has a reasonable chance of making a difference in healthy living behaviors in our community. This is an ongoing program in our community.

The priority population/customers for these initiatives is the community as a whole (school age children to the community in general), and the initiatives aim to make a difference at the individual and interpersonal level. Implementation will take place throughout the community.

Partners

The partners for these healthy behaviors and lifestyle interventions include:

Agency	Person	Role
Mitchell Community Health Partnership	(Done as a group)	Lead
Toe River Health District	Jessica Farley and Drew Brown	Collaborate
Partners Aligned Toward Health	Schell McCall and Team	Collaborate
Mountain Community Health Partnership	Amber Dellinger	Collaborate
Blue Ridge Regional Hospital	Colby Boston	Collaborate

Work Plan

This work plan will begin by first looking at the things being done in the community. This will be done by compiling the youth activities throughout the county. Once that is complete we will then collect the educational material throughout the county and compile the information throughout and estimated by the number of individuals that are approximately being reached. Once compiled the group will then look at the best ways to expand the material to reach a broader range of the community. This will be done as a community as a whole and then reassessed to focus on the youth in the county. The plan will be to try and use things such as afterschool programs and try to expand activities to teach youth the importance of a healthy diet along with physical activity. This will be with the hope of children taking this on to their family and help their family improve their quality of life and the youth take this knowledge on with them for future purposes. Overall this work plan will be to supply education broadly throughout the county via news releases and social media, while also going into the school and educating youth directly and letting this knowledge work into the family and increase their quality of life.

Evaluation and Sustainability

Evaluation Plan:

We plan to evaluate the impact of educating the community on the benefits of a healthy lifestyle through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Our evaluation activities will be tracked in the Work Plan table, above.

We will track our interventions through the use of straight forward and specific data. We will use a simple method of seeing how many educational events the community has that are geared to helping the healthy living behavior problems in the county. After that our team will look at the BMI of the county along with the physical activity that the individuals in the county participate in, this will be an approximate number and will be summarized to represent the county as a whole.

We will also use our community partners to help track the data. Community partners such as the school system will be used to see if we reached the students that we sought out to reach by keeping tabs of the class size. The remaining evaluation will occur internally by checking what information was handed out and tracking that through the health department via surveys to employees. There will also be surveys used to evaluate customer satisfaction along with other things that can be evaluated based on pre and post surveys.

Sustainability Plan:

The following is our sustainability plan for the education program:

- We will develop a sustainability plan by keeping track of the people reached through our interventions and making sure to keep the number of participants in the educational events held. This will show progress and help us keep track of our numbers to show community stakeholders and other individuals invested in our programs.
- We plan to collaborate with our local hospital to sustain the programs and initiatives that are being implemented in the community. By combining our resources along with other community partners we are able to greatly impact the community.

PM	Number of healthy diet educational materials disseminated into the community	–	–	–	–
PM	Number of physical activity educational materials disseminated into the community	–	–	–	–

P Implement fitness center in the area

Time Period | Current Actual Value | Current Trend | Baseline % Change

What Is It?

Implementing fitness center in the area while also educating the public on the benefits of healthy lifestyle will greatly impact the community. This was identified by Mitchell Community Health Partnership as an action, that when combined with other actions in our community, that has a reasonable chance of making a difference in healthy living behaviors in our community. This is an ongoing program in our community.

The priority population/customers for these initiatives is the community as a whole (school age children to the community in general), and the initiatives aim to make a difference at the individual and interpersonal level. Implementation will take place throughout the community.

Partners

The partners for these healthy behaviors and lifestyle interventions include:

Agency	Person	Role
Mitchell Community Health Partnership	(Done as a group)	Lead
Toe River Health District	Jessica Farley and Drew Brown	Collaborate
Partners Aligned Toward Health	Schell McCall and Team	Collaborate
Mountain Community Health Partnership	Amber Dellinger	Collaborate
Blue Ridge Regional Hospital	Colby Boston	Collaborate

Work Plan

This work plan will begin by first looking at the things being done in the community. This will be done by compiling the youth activities throughout the county. Once that is complete we will then collect the educational material throughout the county and compile the information throughout and estimated by the number of individuals that are approximately being reached. Once compiled the group will then look at the best ways to expand the material to reach a broader range of the community. This will be done as a community as a whole and then reassessed to focus on the youth in the county. The plan will be to try and use things such as afterschool programs and try to expand activities to teach youth the importance of a healthy diet along with physical activity. This will be with the hope of children taking this on to their family and help their family improve their quality of life and the youth take this knowledge on with them for future purposes. Overall this work plan will be to supply education broadly throughout the county via news releases and social media, while also going into the school and educating youth directly and letting this knowledge work into the family and increase their quality of life.

Evaluation and Sustainability

Evaluation Plan:

We plan to evaluate the impact of our healthy living behavior programs through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Our evaluation activities will be tracked in the Work Plan table, above.

We will track our interventions through the use of straight forward and specific data. Our team will look at the BMI of the county along with the physical activity that the individuals in the county participate in, this will be an approximate number and will be summarized to represent the county as a whole.

We will also use our community partners to help track the data, and most of the data that we are comparing can be found from the community health assessment and State of the County Reports. These will be used to track where we stand for our goals. There will also be surveys used to evaluate customer satisfaction along with other things that can be evaluated based on pre and post surveys.

Sustainability Plan:

The following is our sustainability plan for the fitness center:

- We will develop a sustainability plan by keeping track of the people reached through this intervention and making sure to keep the number of participants. This will show progress and help us keep track of our numbers to show community stakeholders and other individuals invested in our programs.
- We plan to collaborate with our local hospital to sustain the programs and initiatives that are being implemented in the community. By combining our resources along with other community partners we are able to greatly impact the community.

PM Program, Project, Initiative Performance Measure (Select 2-5 PMs) – – – –

Social Determinants and Access to Healthcare - Long Term CHIP

R Mitchell County residents are educated, gainfully employed, food secure, and have health insurance coverage.

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change

Alignment

Social determinants and access to healthcare and the related result of "Mitchell County residents are educated, gainfully employed, food secure, and have health insurance coverage" are aligned with the following Healthy NC 2020 Focus Areas/ Objectives.

- Decrease the percentage of individuals living in poverty
- Increase the four-year high school graduation rate

Experience and Importance

How would we experience a higher quality of life for those affected by social determinants in our community?

Mitchell County would experience a great increase in the quality of life of their citizens if the social determinants in the county were to be addressed. The quality of life for families would greatly increase and create a more sustainable and flourishing county where the citizens have a better opportunity to flourish in the county and aren't restrained because of determinants affecting their health. This in turn will create a higher quality of life for these community members and help them with achieving their goals for their family. This will not only help the present life of the family but in turn help the future of the children to have a better chance at a quality of life that is enjoyable and sustainable.

What information led to the selection of this health issue and related result?

This priority is of utmost importance to Mitchell County and the individuals who help lead the county to a healthier environment. Throughout Mitchell Community Health Partnership meetings there are multiple conversations held about the determinants that hinder the community members. The MCHP group as individual group members are also very deep into the issue itself and hold meetings specifically to address how to get healthy living behaviors in Mitchell County. This issue affects families of loved ones and even the individuals who deal with trying to fix this issue everyday by having people who aren't physically active and are unhealthy.

I Mitchell % Residents limited in activities due to a physical, mental or emotional problem

Time Period	Current Actual Value	Current Trend	Baseline % Change
2018	36.8%	↗ 1	23% ↑

P Create mapping guide of resources in the community

What Is It?

Creating a mapping guide of resources in the community was identified by the Mitchell Community Health Partnership as an action, that when combined with other actions in our community, that has a reasonable chance of making a difference in social determinants in our community. This is an ongoing program in our community.

The priority population/customers for these initiatives are the county as whole (school age children to the community in general), and the initiatives aim to make a difference at the individual, interpersonal, and community levels. Implementation will take place throughout the community.

Partners

The partners for these social determinant interventions include:

Agency	Person	Role
Mitchell Community Health Partnership	(Done as group)	Lead
Toe River Health District	Jessica Farley and Drew Brown	Collaborate
Partners Aligned Toward Health	Schell McCall and Team	Collaborate
Mountain Community Health Partnership	Amber Dellinger	Collaborate
Blue Ridge Regional Hospital	Colby Boston	Collaborate

Work Plan

This work plan will begin by first looking at the things being done in the community. This will first be done by compiling the data relevant to social determinants throughout the county. The data that will be compiled will include those affected by poverty, and other social determinants in the area. Food insecurity will be surveyed and attempted to be quantitatively summarized. Once compiled the group will then look at the best ways to expand the material to reach a broader community. This will focus on the community as a whole and see how to best affect the population. Overall this work plan will look to provide resources to the entire county and help families from the children to the grandparents.

Evaluation and Sustainability

Evaluation Plan:

We plan to evaluate the impact of creating mapping guide of resources in the community through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures.

We will also use our community partners to help track the data, and most of the data that we are comparing can be found from the community health assessment and State of the County Reports. These will be used to track where we stand for our goals. There will also be surveys used to evaluate customer satisfaction along with other things that can be evaluated based on pre and post surveys.

Sustainability Plan:

The following is our sustainability plan for social determinants:

- We will develop a sustainability plan by keeping track of the people reached through our intervention and making sure to keep track of the number individuals reached via asset mapping. Tracking this data will give us an idea of how the community has been affected before and after the interventions. This will also give us an idea of how to best continue the sustainability of these interventions. This will show progress and help us keep track of our numbers to show community

stakeholders and other individuals invested in our programs.

- We plan to collaborate with our local hospital to sustain the programs and initiatives that are being implemented in the community. By combining our resources along with other community partners we are able to greatly impact the community.

PM Performance Measure (select 2-5 performance measures)

	Time Period	Current Actual Value	Current Trend	Baseline % Change
P Continue expansion of meals on wheels to reach more individuals in the county/ try to provide more food to those in need	–	–	–	–

What Is It?

Continuing the expansion of meals on wheels to reach more individuals in the county was identified by the Mitchell Community Health Partnership as an action, that when combined with other actions in our community, that has a reasonable chance of making a difference in social determinants in our community. This is an ongoing program in our community.

The priority population/customers for these initiatives are the county as whole (school age children to the community in general), and the initiatives aim to make a difference at the individual, interpersonal, and community levels. Implementation will take place throughout the community.

Partners

The partners for these social determinant interventions include:

Agency	Person	Role
Mitchell Community Health Partnership	(Done as group)	Lead
Toe River Health District	Jessica Farley and Drew Brown	Collaborate
Partners Aligned Toward Health	Schell McCall and Team	Collaborate
Mountain Community Health Partnership	Amber Dellinger	Collaborate
Blue Ridge Regional Hospital	Colby Boston	Collaborate

Work Plan

This work plan will begin by first looking at the things being done in the community. This will first be done by compiling the data relevant to social determinants throughout the county. The data that will be compiled will include those affected by poverty, and other social determinants in the area. Food insecurity will be surveyed and attempted to be quantitatively summarized. Once compiled the group will then look at the best ways to expand the material to reach a broader community. This will focus on the community as a whole and see how to best affect the population. Overall this work plan will look to provide resources to the entire county and help families from the children to the grandparents.

Evaluation and Sustainability

Evaluation Plan:

We plan to evaluate the impact of social determinants and access to healthcare through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Our evaluation activities will be tracked in the Work Plan table, above.

We will track our interventions through the use of straight forward and specific data. The data that will be used is through watching the county and see what difference is made in the lifestyles of the ones that our intervention touches. We will also use a simple method of seeing how many interventions the community has that are geared to helping the problems with social determinants in the county. After that our team will look at food insecurity rates along with indicators of overall social determinants in the community.

We will also use our community partners to help track the data, and most of the data that we are comparing can be found from the community health assessment and State of the County Reports. These will be used to track where we stand for our goals. There will also be surveys used to evaluate customer satisfaction along with other things that can be evaluated based on pre and post surveys.

Sustainability Plan:

The following is our sustainability plan for social determinants:

- We will develop a sustainability plan by keeping track of the people reached through our interventions and making sure to keep track of the number individuals reached via food insecurity and asset mapping. Tracking this data will give us an idea of how the community has been affected before and after the interventions. This will also give us an idea of how to best continue the sustainability of these interventions. This will show progress and help us keep track of our numbers to show community stakeholders and other individuals invested in our programs.
- We plan to collaborate with our local hospital to sustain the programs and initiatives that are being implemented in the community. By combining our resources along with other community partners we are able to greatly impact the community.

PM Number of food insecure families reached

Time Period	Current Actual Value	Current Trend	Baseline % Change
–	–	–	–

P Expand services available to individuals at their local health department

What Is It?

Expanding services available to individuals at their local health department was identified by the Mitchell Community Health Partnership as an action, that when combined with other actions in our community, that has a reasonable chance of making a difference in social determinants in our community. This is an ongoing program in our community.

The priority population/customers for these initiatives are the county as whole (school age children to the community in general), and the initiatives aim to make a difference at the individual, interpersonal, and community levels. Implementation will take place throughout the community.

Partners

The partners for these social determinant interventions include:

Agency	Person	Role
Mitchell Community Health Partnership	(Done as group)	Lead
Toe River Health District	Jessica Farley and Drew Brown	Collaborate
Partners Aligned Toward Health	Schell McCall and Team	Collaborate
Mountain Community Health Partnership	Amber Dellinger	Collaborate
Blue Ridge Regional Hospital	Colby Boston	Collaborate

Work Plan

This work plan will begin by first looking at the things being done in the community. This will first be done by compiling the data relevant to social determinants throughout the county. The data that will be compiled will include those affected by poverty, and other social determinants in the area. Food insecurity will be surveyed and attempted to be quantitatively summarized. Once compiled the group will then look at the best ways to expand the material to reach a broader community. This will focus on the community as a whole and see how to best affect the population. Overall this work plan will look to provide resources to the entire county and help families from the children to the grandparents.

Evaluation and Sustainability

Evaluation Plan:

We plan to evaluate the impact of social determinants and access to healthcare through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Our evaluation activities will be tracked in the Work Plan table, above.

We will track our interventions through the use straight forward and specific data. The data that will be used is through watching the county and see what difference is made in the lifestyles of the ones that our intervention touches. We will also use a simple method of seeing how many interventions the community has that are geared to helping the problems with social determinants in the county. After that our team will look at food insecurity rates along with indicators of overall social determinants in the community.

Sustainability Plan:

The following is our sustainability plan for social determinants:

- We will develop a sustainability plan by keeping track of the people reached through the expanded services of the local health department. Tracking this data will give us an idea of how the community has been affected before and after the

health department. Tracking this data will give us an idea of how the community has been affected before and after the interventions. This will also give us an idea of how to best continue the sustainability of these interventions. This will show progress and help us keep track of our numbers to show community stakeholders and other individuals invested in our programs.

- We plan to collaborate with our local hospital to sustain the programs and initiatives that are being implemented in the community. By combining our resources along with other community partners we are able to greatly impact the community.

PM	Number of new families who received health services	–	–	–	–