2019 Community Health Improvement Plan

HEALTHY TETON COUNTY

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HEALTHY TETON COUNTY
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Dear Community Members,

The completion of the second Healthy Teton County (HTC) Community Health Needs Assessment (CHNA) marked a momentous step forward toward improving the health and quality of life for Teton County residents.

The CHNA report, released in July 2018, provided our community with a comprehensive overview of the primary health needs we face today. The CHNA findings indicated that while Teton County is very healthy in certain categories, there is still work to be done in other areas. The full HTC report can be found at www.healthytetoncounty.org.

The CHNA identifies a host of critical, community-wide health issues that impact our local health. The following document, the Community Health Improvement Plan (CHIP), includes the strategic framework that will guide the ongoing interventions among our local government agencies, service delivery providers and advocacy groups.

This year, we embarked on a new process for developing the CHIP action plans. Recognizing the impressive efforts already underway to address our local health needs, we convened respective groups of service providers and advocates who work in the same priority area to update the HTC Core Committee on their current and future initiatives to address health disparities. These meetings were facilitated, enabling the groups to synthesize their current action plans.

As was the case in 2015, the goal remains to follow a collective impact model, which allows health issues to be addressed by diverse sectors working towards the shared HTC vision of "a vibrant Greater Teton community where opportunities for excellent health are available to all."

The involvement of multiple stakeholders in each action plan also allows interventions to be implemented at different levels of influence: personal, interpersonal, organizational, the social environment, and the physical environment. With this approach, HTC and the community of Teton County, Wyoming, will continue to work together to focus on what's important, choose effective policies and programs, and implement evaluation strategies. Similarly, we hope that by addressing health issues from a multifactorial perspective, we will see improved health outcomes that are sustained over time.

The HTC Core Committee thanks all of our community partners for your continued dedication to this initiative and the improvement of health and quality of life in Teton County. We could not do it without you.

Sincerely,
Jodie Pond, MPH, MCHES, Director, Teton County Health Department
Julia Heemstra, Director, Wellness, St. John's Medical Center

Background

In May 2018, the Healthy Teton County (HTC) coalition completed its second comprehensive community health improvement plan (CHIP) on the health status of Teton County, Wyoming. This project — led by Teton County Health Department (TCHD) and St. John's Medical Center (SJMC), in partnership with over 35 community organizations — identified and prioritized the primary health issues facing Teton County.

After examining both qualitative and quantitative data, the list of key health issues included both traditional clinical indicators as well as social determinants of health. The full CHNA report, including methodology and results, can be found at www.healthytetoncounty.org.

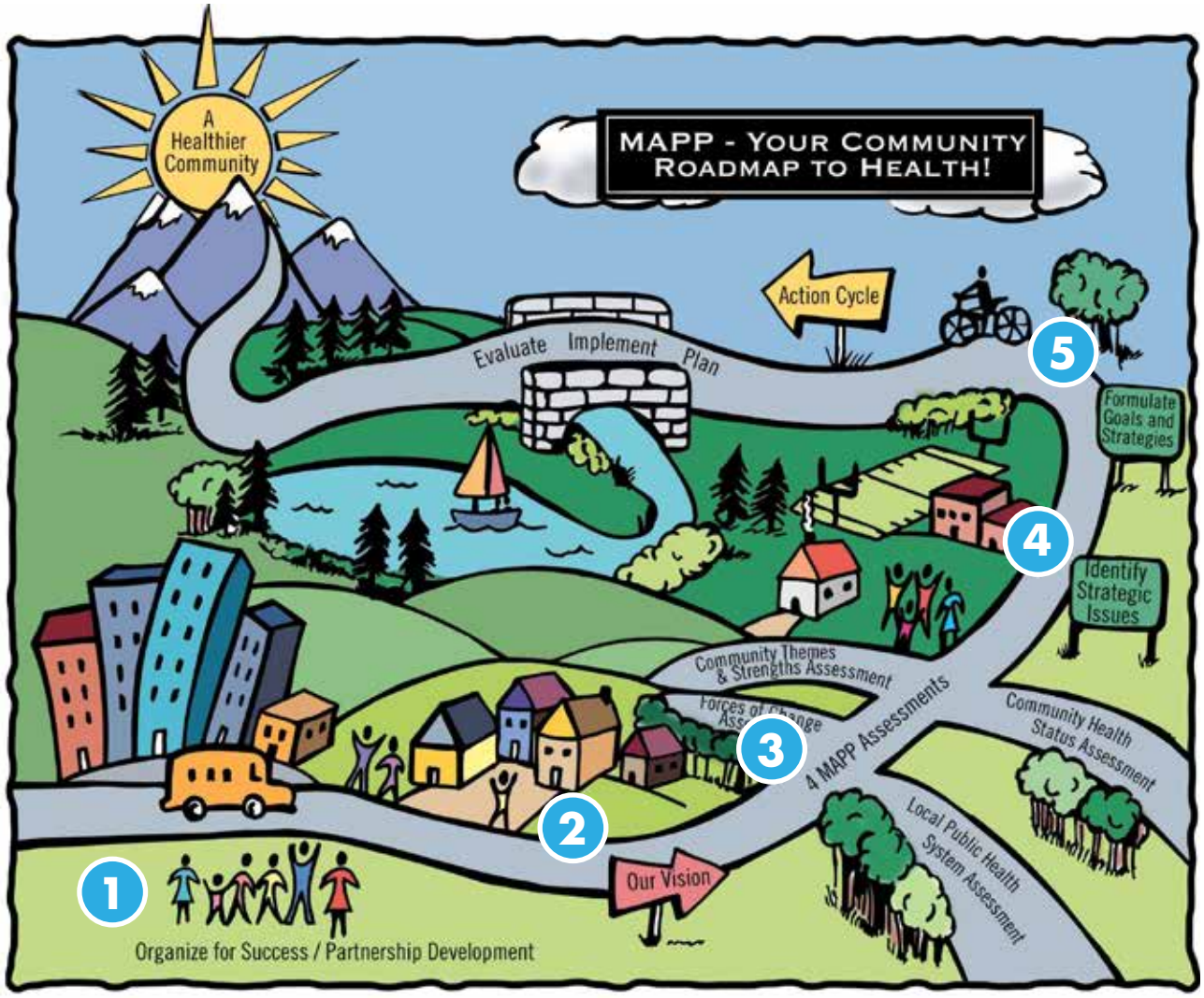

Figure 1

Strategic Planning Framework

Phases 1–3

The 2018 CHNA again used the strategic framework Mobilizing for Action through Planning and Partnerships (MAPP). Some of the work completed for the 2015 CHNA still held true for the 2018 iteration of the CHNA, so all six phases of the MAPP framework, as seen in Figure 1, were not repeated. The HTC Core Committee voted to use the same methods for Phase 1, Organizing for Success, and for Phase 2, Visioning. The HTC vision of "a vibrant Greater Teton area where opportunities for health are available to all" has continued to guide this project. The Core Committee decided to continue to use this vision statement again for the 2018 CHNA. Phase 3 is comprised of the four MAPP Assessments (Community Health Status Assessment, Community Themes and Strengths Assessment, Forces of Change Assessment, and the Local Public Health System Assessment). In 2018, the Local Public Health System Assessment was not conducted, as there are no significant systems changes since 2015. More detail on the initial phases of the HTC project can be found in the 2018 CHNA document.

Phases 4–6

This document contains HTC's Community Health Improvement Plan (CHIP) and provides a summary of HTC's work following Phases 4-6 of the MAPP framework.

Phases 4-6 included:
Phase 4: Identification of Strategic Issues;
Phase 5: Formulating Goals and Strategies; and
Phase 6: The Action Cycle (Planning, Implementation, and Evaluation).

These phases allow HTC to strategically plan for action around the most important health issues identified in Phases 1-3, ultimately bringing the community together to galvanize around the implementation of evidence-based solutions using a collective impact model.

Methodology

The primary health needs in Teton County were prioritized by the HTC Steering Committee, a diverse advisory committee made up of over 18 community stakeholders. Findings from the three assessments in Phase 3 were presented to the Steering Committee at a meeting in November 2017. The presentation included information on whether quantitative indicators were statistically significant, whether specific health issues had been identified in the community quality of life survey, and whether the Teton County data met Healthy People 2020 (HP2020) goals. HP2020 is a national framework for health improvement that sets quantitative targets for community health indicators.

Following the data presentation, attendees prioritized the primary health issues with a weighted voting system. Attendees were prompted to consider three primary criteria: what value the issue has to the community, whether there are proven solutions available for implementation, and if there is a consequence of inaction. Other important criteria that were assessed during the data analysis phase included: number of people affected, seriousness of the health issue, whether there was an observed data trend, and if certain groups were disproportionately affected. In addition, the feasibility of interventions was considered. All criteria utilized during the data analysis and issue prioritization phases were adopted from a list provided by MAPP.

Primary Health Issues

The prioritized health issues for Teton County, which include health behaviors and conditions and the social determinants of health, are on page 7. This year, the social determinants of health were prioritized separately from the health behaviors and conditions because they require different strategies and a multisectoral approach. The priorities from the 2015 CHNA continue to be monitored and addressed, even though some do not meet the criteria to be included for prioritization in the 2018 CHNA. Emerging issues within the community are being pro-actively addressed by local providers. At this time, the emerging issues did not meet the criteria to be included in the prioritization process for the 2018 CHNA, but HTC will continue to monitor these issues in future iterations of the CHNA. Positive indicators are areas where Teton County performs better than either the state of Wyoming or the United States.

Lists

2018 Health Behaviors and Conditions

Mental Health

Alcohol Use

Sexual/Reproductive Health

Chronic Disease/Cancer Screenings

Nicotine Use

Immunizations 65+

2018 Social Determinants of Health

Severe Housing

Access to Care

Food Insecurity

2015 Priorities Continuing to be Addressed

Transportation

Radon

Emerging Issues

Opioid Use

Domestic Violence

Positive Indicators

Adult Obesity

Physical Inactivity (Age 20+)

Poor or Fair Health

Poor Physical Health Days

Frequent Physical Distress

Poor Mental Health Days

Frequent Mental Distress

Teen Births

Low Birthweight

Preventable Hospital Stays

Prostate Cancer Incidence

Diabetic Monitoring

Diabetes Prevalence

Radon

HTC PREVENTION STRATEGY

To address the top nine health issues in a strategic and organized manner, HTC turned to the National Prevention Strategy (NPS). The NPS, created by the Office of the Surgeon General of the United States, "envisions a prevention-oriented society where all sectors recognize the value of health for individuals, families, and society and work together to achieve better health for Americans." Figure 2 is a visual representation of the NPS incorporating the goal, strategic directions and priorities. This framework provides evidence-based solutions to common health problems and was developed "to guide the United States in the most effective and achievable means for improving health and well-being."

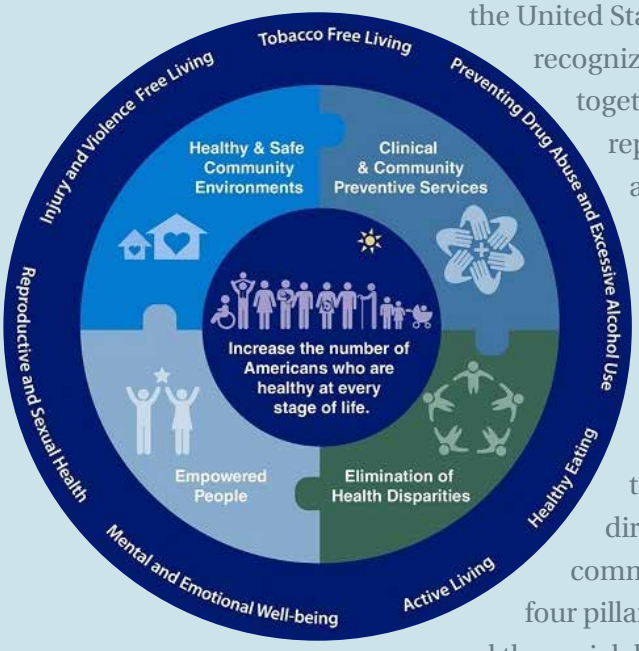

Figure 2

The HTC Prevention Strategy (Figure 3), a modification of the NPS, is centered around the HTC vision of "a vibrant Greater Teton community where opportunities for excellent health are available to all." This customized prevention strategy contains three strategic directions: healthy and safe community environments, clinical and community preventive services, and access to health services. It is based on four pillars: health equity, elimination of health disparities, empowered people, and the social determinants of health (shown in the four corners of Figure 3).

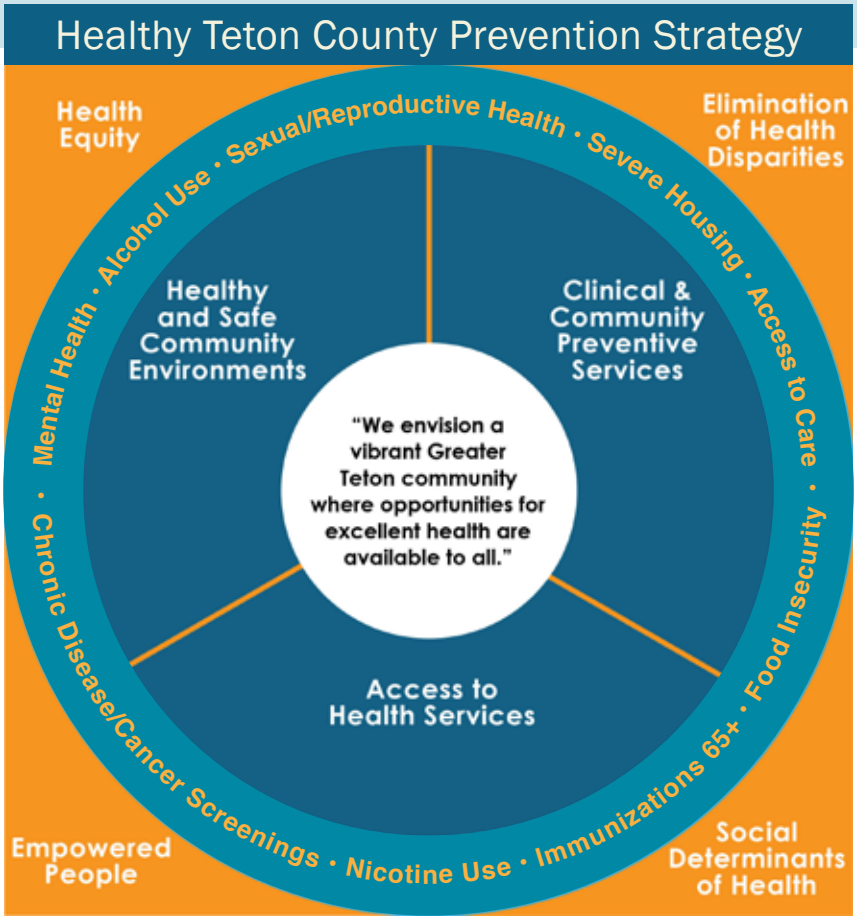

Figure 3

Health Equity

Health equity is defined by the Center for Disease Control (CDC) as the, "attainment of the highest level of health for all people." The CDC goes on to say that when health equity exists, no one is "disadvantaged from achieving their highest potential because of social position or other socially determined circumstances." Health inequities are reflected through differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment. Health equity is achieved when health disparities, described below, are eliminated.

Elimination of Health Disparities

The NPS describes health disparities as, "differences in health outcomes across subgroups of the population, often linked to social, economic, or environmental disadvantages (e.g., less access to good jobs, unsafe neighborhoods, and lack of affordable transportation options). Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health on the basis of their racial or ethnic groups, religion, socioeconomic status, gender, age, mental health, cognitive, sensory or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

Empowered People

HTC also recognizes that individuals must be supported in taking an active role to improve their health. The NPS states that, "people become empowered when they have the knowledge, ability, resources, and motivation to identify and make healthy choices. When people are empowered, they are better able to improve their health, support their families and friends in making healthy choices, and lead community change."

Social Determinants of Health

HTC aims to create social and physical environments that create good health for all. Understanding the relationship between how population groups experience "place" and the impact of "place" on health is fundamental to the social determinants of health — including both social and physical influences. The term Social Determinants of Health (SDOH) is defined by the World Health Organization as, "the conditions in which people are born, grow, live, work and age." SDOH include factors such as the built environment, access to health services, social connections, education, housing, and economic stability.

THE ACTION PLAN

Following the identification of the 2018 HTC priority areas, service providers and advocates addressing each priority area met to discuss their current and future service goals. Through these meetings, each group was tasked with completing an action plan related to their respective issue of focus. Each action plan includes a broad primary goal, general strategies, and specific tactics for each strategy. Action plans also list target measures and indicate which organizations or individuals will be participating in each tactic. The basic action plan framework is shown below in Figure 4, with each component labeled for reference. This model will be followed for each of the top 9 issues on the following pages.

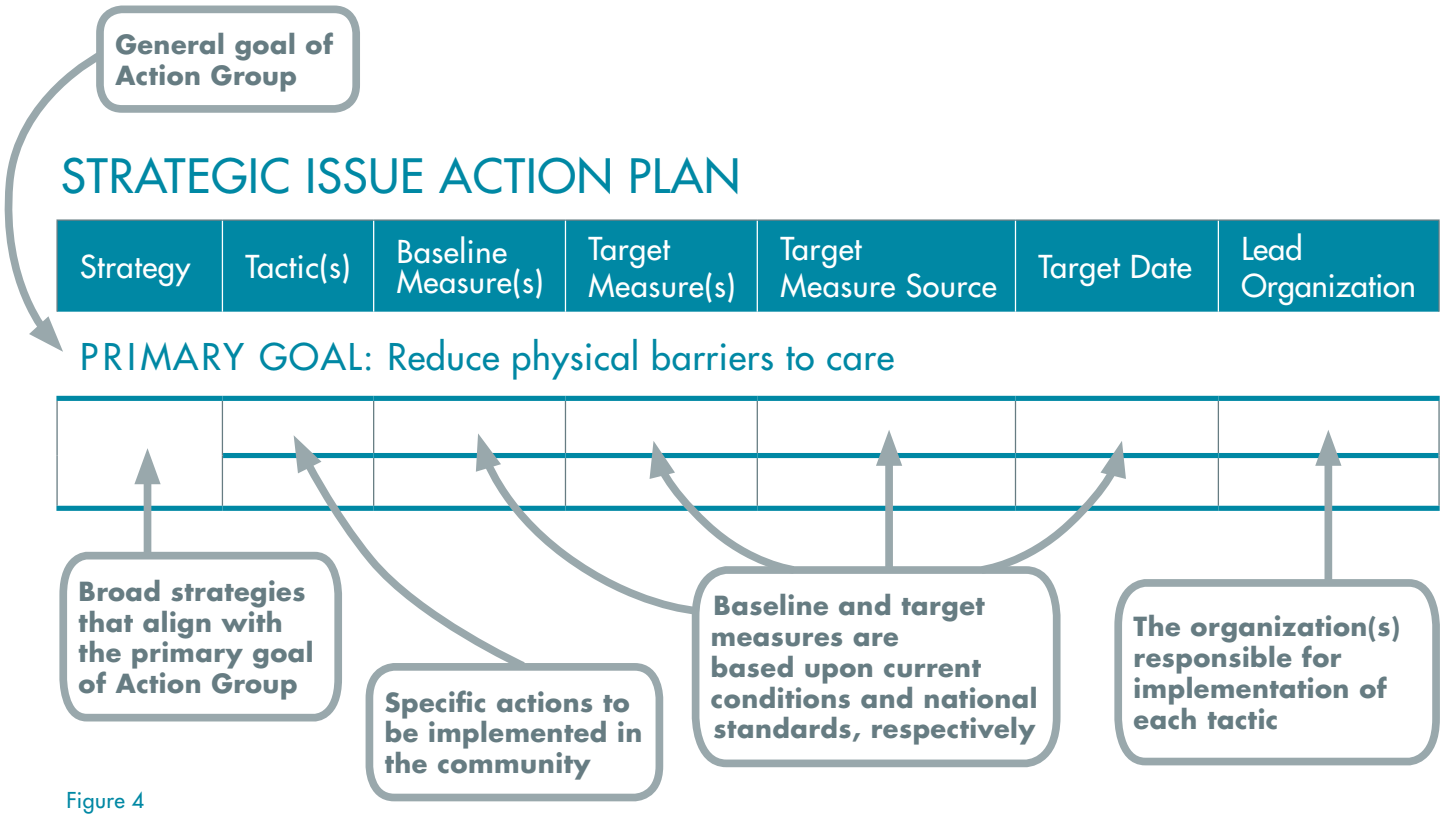

Figure 4

Action Plan Components

All HTC action plans were guided by three primary community development principles: evidence-based best practices, standardized national target measures, and Collective Impact. These guiding principles utilize proven health improvement strategies and are explained in detail below.

1) Evidence-based Best Practices

The action plans that follow include interventions identified by local experts as those proven to be effective in similar community settings and also effective for our community's make-up and resources. Some interventions are being carried forward from the 2015 CHIP process, and some are being launched. Many of the interventions are grounded in peer-reviewed research that was identified in the 2015 MAPP process. The primary resources used during the 2015 selection of these services included: County Health Rankings and Roadmaps, The Community Guide, and the Center for Disease Control's Community Health Improvement Navigator.

2) National Target Measures

Data from the HTC Community Health Improvement Plan report were analyzed against state and national data sets as often as possible. This data analysis strategy provided a broad context for Teton County's health indicators and allowed local results to be compared to similar data across the nation. Similarly, the HTC Action Groups are working toward the Healthy People 2020 (HP2020) target measures if available. HP2020 is a federal program focused on, "providing science-based, 10-year national objectives for improving the health of all Americans." The HP2020 target measures are the end goal for each action plan. These target measures may take multiple iterations of the CHNA to achieve. Due to this, the 2018 action plan target measures focus on smaller goals that will move Teton County closer to the HP2020 target measures.

3) Collective Impact

The Collective Impact (CI) framework provides guidelines for organizations or individuals who are working together towards a common goal. CI was first introduced in an article of the Stanford Social Innovation Review by researchers who observed, "that large-scale social change comes from better cross-sector coordination rather than from the isolated intervention of individual organizations." This community development model emphasizes: setting a common agenda, using common performance measures, implementing mutually-reinforcing activities, focusing on clear communications, and utilizing a backbone organization.

Mental Health Action Plan

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society.

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Reduce cost as a barrier to mental health care		
Offset costs of mental health care services.	Maintain a dedicated mental health care fund at the St. John's Hospital Foundation to provide funding for mental health appointments.	$2,900 in funds were disbursed.
	Provide scholarships and fee adjustments for all JHCCC services (case management, peer specialists, medication management, job counseling).	1068 clients served. 923 clients received additional fee adjustment. 860 clients qualified for the sliding fee scale.
	Maintain Medication Case Manager to assist clients with applying for financial assistance for medication.	1 Full-time equivalent (FTE)
Provide low-cost options for mental health care services.	Provide services on a sliding scale, based on ability to pay.	1068 clients served. 99.8% patients pay less than full cost of service.

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Reduce physical barriers to care		
Provide telephone-based referrals to local mental health resources.	Maintain SJMC Mental Health Resource Line.	40 callers served.
Address mental health concerns during primary care visits.	Employ a mental health professional in the SJMC outpatient clinics to reduce barriers and increase access to mental health care.	1 FTE

Key Actions:

- Reduce cost as a barrier to mental health care.
- Reduce physical barriers to mental health care.
- Ensure availability of services in crisis situations
- Ensure community education, awareness, prevention and stigma reduction services.

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
Maintain level.	Mental Health Fund at St. John's Hospital Foundation	Implemented	St. John's Medical Center (SJMC)
All clients that apply for sliding fee will be served. All fee adjustment applications will be approved.	Jackson Hole Community Counseling Center (JHCCC) offers a sliding fee scale as well as additional fee adjustments for those that apply.	Implemented	JHCCC
1 FTE	Ongoing service provided for enrolled clients.	Implemented	JHCCC
Maintain service level.	Sliding fee scale and additional fee adjustments	Implemented	JHCCC

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
80 callers served.	Mental Health Resource Line Log	Implemented	SJMC
1 FTE	SJMC	Implemented	SJMC

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Ensure availability of services in crisis situations		
Ensure timely response to crisis situations.	Provide open access/walk-in intake for crisis services.	206 individuals came in for crisis services.
	Partner with schools to provide services to any students in mental health crisis (i.e. suicide).	Students in need of this service are sent from the schools in coordination with the schools and family.
	Maintain 24/7 crisis hotline for daytime and after-hours needs.	Calls are relayed through the JHCCC answering service and answered each time by a licensed therapist.
	Provide assessments and discharge planning for clients referred to psychiatric hospitals outside of Teton County.	100% of inpatients seen at SJMC have a discharge plan.
	Coordinate Crisis Intervention Team Training for law enforcement.	One training per year
	Provide Mental Health First Aid training for youth and adults (8-hour course on how to respond in crisis situations).	3 trainings per a year
	Provide SafeTalk suicide prevention program in schools.	3 trainings per a year

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Ensure community education, awareness, prevention and stigma reduction services		
Ensure community awareness, understanding and normalization of local mental health resources.	Publicize mental health services through advertising, social media, and regular newspaper columns.	Continue with monthly mental health column, monthly advertising, and social media.
	Coordinate two annual mental health campaigns in September (suicide awareness month) and May (mental health awareness month).	Facilitate awareness campaign and hold events in May for mental health and in September for suicide.
	Provide two support groups: one for survivors of suicide and one for friends and family who have individuals in their lives who are facing a significant mental health challenge.	This initiative is in development.

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
Maintain walk-in crisis appointments during office hours and maintain 24/hr crisis hotline.	Jackson Hole Community Counseling Center (JHCCC) schedule/outcomes measures and crisis log	Implemented	JHCCC
Maintain service level.	JHCCC outcomes measures	Implemented	JHCCC
Maintain 24/7 crisis hotline.	JHCCC call logs	Implemented	JHCCC
100% of inpatients and any patients referred from clinics.	JHCCC/SJMC	Implemented	JHCCC/SJMC
Maintain service level.	JHCCC	Implemented	JHCCC
Maintain service level.	JHCCC/Community Prevention Coalition of Teton County	Implemented	JHCCC/Community Prevention Coalition of Teton County
Maintain service level.	JHCCC, in collaboration with the Children's Mental Health Initiative	Implemented	JHCCC, in collaboration with the Children's Mental Health Initiative

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
Maintain outreach efforts.	JHCCC	Implemented	JHCCC
Maintain outreach efforts.	JHCCC	Implemented	JHCCC
Plan, schedule, and advertise a support group for friends/family of those with mental illness and another for Survivors of Suicide.	Mark Houser/JHCCC	Ongoing	Mark Houser/ JHCCC

Alcohol Action Plan

According to Healthy People 2020, substance abuse, including alcohol, "has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include: teenage pregnancy, or Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) and other Sexually Transmitted Diseases (STDs), domestic violence, child abuse, motor vehicle crashes, physical fights, crime, homicide, and suicide."

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Reduce alcohol and other substance use among teens		
Educate youth and parents about the risks associated with the substances they are using.	Continue Teton County School District (TCSD) Parent Connections Nights.	65 parent attendees per event and 3 events per year
	Continue substance use prevention curriculum in all Teton County Schools.	Educated 1,200 students in 2017.
	Provide education/seminars about risks associated with substances.	3 educational seminars per year, or as issues arise
Decrease youth accessibility to alcohol.	Decrease selling to minors in liquor stores and serving in restaurants.	In 2017, there were 61 alcohol compliance checks completed in the Town of Jackson. 84% of establishments passed, while 16% failed.
	Educate parents about the prevalence of youth accessing alcohol at home with or without parents' knowledge, also known as "social hosting," during parent connection nights/events.	65 parent attendees per event and 3 events per year
	Increase awareness of TIPS training among restaurant and bar owners and managers. Encourage alcohol vendors to support TIPS training.	185 TIPS-trained employees in 2017. 5 trained instructors in 2018.

Key Actions:

- Reduce alcohol and other substance use among teens.
- Change social norms around alcohol and other substance use.
- Increase access to prevention & addiction care services.

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
Increase parent attendees by 10%.	TCSD Parent Night attendance records	2019	Teton County School District (TCSD)
Annually educate all students in grades 4 through 9.	TCSD grade level enrollment records	2019	Curran Seeley Foundation
9 educational seminars in 3 years	TCSD schools	2019	TCSD contacting Curran Seeley as issues arise
Maintain or decrease the percentage of compliance check failures (even if the overall number of compliance checks increases).	Town/County Clerks	2019	Town of Jackson Police Department
Increase parent attendees by 10%.	TCSD Parent Night attendance records	2019	Curran Seeley, Community Prevention Coalition of Teton County (CPCTC), TCSD
Increase the number of TIPS trained employees and number of trained TIPS instructors.	Jackson Police Department/ Town Clerk Data	2019	Town of Jackson Police Department

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Change social norms around alcohol and other substance use		
Educate the community about the connection between alcohol/substance-positive culture and youth substance use and abuse.	Use social media, newspaper ads, and movie preview advertising to raise awareness of the problem of an alcohol/ substance-positive culture.	Community Prevention Coalition of Teton County (CPCTC) Facebook page had 47 likes in December of 2017. No video or newspaper advertisements at this time.

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Increase access to prevention & addiction care services		
Increase access to prevention & addiction care services.	Free consultations at Curran Seeley	10 people a month for free consultations

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
Increase Facebook likes to 500 by 2020. Video advertisements to run prior to every movie at MovieWorks and Jackson Hole Twin Cinema for at least 6 months in 2019. Advertise in 3 issues of the JH Daily per week for at least 3 months.	CPCTC FB insight data.	2020	Community Prevention Coalition of Teton County (CPCTC)

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
Increase consultations to 13 per month and see referrals within two days of phone call request.	Curran Seeley schedules	2019	Curran Seeley

Sexual/Reproductive Health Action Plan

According to Healthy People 2020, "Reproductive and sexual health is a key component to the overall health and quality of life for both men and women. Improving reproductive and sexual health is crucial to eliminating health disparities, reducing rates of infectious diseases and infertility, increasing educational attainment, career opportunities, and financial stability."

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Decrease STI transmission among ages 12-24		
Increase STI screening	All adult and teen family planning clients at Teton County Health Department (TCHD) complete sexual risk assessment form and are offered screening at low to no cost. When appropriate, refer to a provider.	New initiative, so no baseline established.
	Create a teen/young adult friendly environmentat TCHD. Youth focus groups will be used to obtain information on how best to access and serve that population. Review teen-friendly clinic checklist.	Youth focus groups scheduled for August 2015.
	Increase availability for screening at TCHD by extending hours to accommodate urgent walk-ins and youth.	8 hours of clinic time
	Continue to provide low to no-cost testing through Knowyo.org voucher program and other funds.	All clients requesting STD screening have access to low to no-cost screening at TCHD.
Make additional clinic services available	Mid-level provider care available at TCHD at low to no-cost for reproductive and sexual health care services.	1 Family Nurse Practioner for 8 hours once a week, and 1 FNP for 4 hours once a week.

Key Actions:

- Increase STI screening.
- Increase community awareness of available STI prevention services.
- Make additional clinic services available.
- Maintain STI prevention activities.

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
90% of clients complete risk assessment and offered screening.	Risk assessments completed and in client charts.	January 2020	Teton County Health Department (TCHD)
Youth-focused groups completed and data analyzed.	Annually review youth friendly clinic checklist.	Annually	Teton County Health Department
12 hours of clinic time	At least one late clinic established thru TCHD.	Completed	Teton County Health Department
Maintain service level.	Public Health Nursing Report	January 2019	Teton County Health Department
1 FNP full day Tuesday and 1 FNP 4 hours for extended clinic hours.	Public Health Nursing Report	January 2019	Teton County Health Department

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Decrease STI transmission among ages 12-24 *(continued)*		
Increase community awareness of available STI prevention services	Health messaging and advertising regarding STI testing and screening	Ads placed in START bus, Women's section of the News and Guide.
	Educational booths and presentations throughout the community	Currently being implemented.
Maintain STI prevention activities	Continue to develop messaging and advertising to target populations in culturally/age sensitive manner.	Brainstorm during communicable disease meetings at TCHD.
	Evidence-based School Sexual Health Curriculum taught to students.	Currently teaching school sexual health at Jackson Hole High School, Red Top Meadows, Van Vleck House, and other schools.
	Offer HPV and Hepatitis B vaccines at no to low cost through TCHD clinic by utilizing VFC (vaccine for children) and VUA (vaccine for uninsured adults) vaccines.	In 2018, 44 Hep B vaccines were given for individuals 18 and under (VFC). 44 adult Hep B vaccines were given (VUA). 71 HPV vaccines were given to individuals 18 and under (VFC). 20 adult HPV vaccines were given (VUA).

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
Maintain level.	Public Health Nursing Report	Ongoing	Teton County Health Department
Maintain level.	Teton County Health Department	Ongoing	Teton County Health Department
Meeting once/month	Public Health Nursing Report	Ongoing	Teton County Health Department
Maintain level.	School District Curriculum Plan	January 2019	Teton County Health Department
Maintain level.	Public Health Nursing Report	January 2021	Teton County Health Department

Chronic Disease Prevention Action Plan

Routine preventive screenings such as mammograms, colorectal screenings, and diabetic screenings have the potential to catch the development of disease before it progresses.

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Increase rates of mammography, colonoscopy and diabetic screening		
Increase rates of routine colorectal screenings	Increase community awareness efforts about colorectal screening and enhanced online scheduling.	573 colorectal screenings performed at SJMC on Teton County residents during FY 18. Note: colorectal screenings are only recommended once per a decade for asymptomatic patients.
Increase rates of routine mammography screenings	Increase capacity to schedule and perform mammograms through purchase of a breast tomosynthesis mammography machine to be located at SJMC.	In FY 2018, 2,061 mammograms were performed at SJMC for Teton County residents
	Provide financial assistance specifically for mammography screenings.	$11,330 of financial assistance was provided in 2018, covering 45 screenings.
Increase rates of routine diabetic screenings.	Provide evidence-based free screenings, including A1C, at annual Health Fair. Provide low-cost or no-cost A1c screening to community members on a walk-in basis and at other outreach events. Refer those at risk for diabetes to the Diabetes Self-Management Program for further consultation.	45 screenings were financially assisted in 2018. 28 walk-in screenings were conducted during diabetes awareness month.
Empower individuals with and without chronic disease to play a more active role in their health and disease management.	Provide ongoing education and training through Stanford University's Healthy U curriculum and locally developed Whole Health program.	Four iterations of Healthy U and two iterations of Whole Health have been completed in the community.

Key Actions:

» Increase screening rates via education, increased services, and financial assistance

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
Maintain or increase baseline.	St. John's Medical Center	Ongoing	St. John's Medical Center (SJMC)
Maintain or increase baseline.	St. John's Medical Center	Ongoing	St. John's Medical Center
Maintain or increase baseline.	St. John's Medical Center	Ongoing	St. John's Medical Center
Increase the number of screenings provided in 2019 by 1%.	St. John's Medical Center	Ongoing	St. John's Medical Center
Continue providing these programs as needed.	St. John's Medical Center	Ongoing	St. John's Medical Center

Nicotine Action Plan

The use of any kind of tobacco is associated with cancer, diseases of the mouth, increased risk of heart attack and stroke and may cause nicotine addiction. Nicotine exposure during periods of significant brain development, such as adolescence, can disrupt the growth of brain circuits that control attention, learning, and susceptibility to addiction. The effects of nicotine exposure during youth and young adulthood can be long-lasting, including lowering impulse control and increasing mood disorders. The nicotine in e-cigarettes and other tobacco products can prime young brains for addiction to other drugs, such as cocaine and methamphetamine.

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Primary Goal: Reduce and prevent nicotine use		
Provide resources to the community to prevent uptake and reduce all types of nicotine use	Distribute cessation quit kits and educational brochures.	In 2018, 400 quit kits were distributed to 4 medical facilities.
	Mayo Clinic certified tobacco cessation specialist on SJMC Wellness staff provides free nicotine quit services.	1 FTE
Reduce and prevent use of nicotine vaping among middle school and high school age youth.	Use social media, newspaper, and theater advertising to raise awareness and educate the public about the recent significant prevalence of youth nicotine vaping in Teton County and its associated risks.	CPCTC Facebook page had 47 likes in December of 2017. No video or newspaper advertisements at this time.
	Expand substance use prevention curriculum in all Teton County Schools to include all forms of nicotine use.	Educated 1,200 students this year.

Key Actions:

» Provide resources to the community to prevent uptake and reduce all types of nicotine use.

» Reduce and prevent use of nicotine vaping among middle school and high school age youth.

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
800 quit kits distributed to 7 medical facilities.	Community Prevention Specialist distribution records	December 31, 2019	Community Prevention Coalition of Teton County (CPCTC)
1 FTE	St. John's Medical Center	Ongoing	St. John's Medical Center (SJMC)
Increase Facebook likes to 250 by 2020. Run video advertisements prior to every movie at MovieWorks and Jackson Hole Twin Cinema for at least 6 months in 2019. Advertise in 3 issues of the JH Daily per week for at least 3 months in 2019.	CPCTC FB insight data and other social media detailed reports. Impressions, reach, engagement, likes, followers etc. Theatre attendance logs JH Daily readership data	2020	Community Prevention Coalition of Teton County
Educate all students in grades 4 through 9 annually.	TCSD and Curran Seeley	Ongoing	Teton County School District (TCSD) and Curran Seely

Immunizations 65+ Action Plan

Immunizations for individuals over the age of 65 can reduce the spread of communicable diseases. Seniors, youth, and those with compromised immune systems are all populations who are vulnerable to common illnesses such as influenza and pneumonia.

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Increase immunizations for community members aged 65+		
Increase number of seniors seeking flu and pneumococcal vaccinations.	Place Senior-friendly newspaper ads in the Daily and Weekly newspapers advertising for 'flu season'; advertise Senior flu shot clinics in Senior Center newsletter	1 ad during or before each flu season showing an active and/ or healthy senior with reference to clinics and need for flu and pneumonia vaccines
	Distribute paper flyers around Teton County in centers/buildings frequently visited by the 65+ population.	Article in Senior Center newsletter. Flyers posted in Senior Center, Recreation Center, library and other sites.
Increase communication with clients about vaccine availability and routine follow-ups.	Share information from vaccine distributors regarding immunization brands available as supplies change throughout the season	Calls to other providers made at least once during the flu season.
	Increase entities that use the WyIR (Wyoming Immunization Registry) since legislation passed in February 2018 mandating that all vaccine providers must enter in WyIR.	TCHD and pharmacies are entering into the WyIR.
Improve education surrounding flu and pneumococcal vaccinations.	Provide educational material at TCHD walk-in and offsite mass clinics.	Distribute flu and pneumonia vaccine brochures to 100 clients per year.
Increase volume of flu and pneumococcal vaccination.	Provide offsite mass vaccination clinics	2-3 Senior Center Clinics and 1 other clinic targeting Seniors (possibly at Assisted Living Center) will be held by TCHD each year.
	Maintain stock of Pneumonia 23 VUA (vaccine for uninsured adults), which is state supplied. Maintain private stock of Pneumonia 23 and Prevnar.	Keep VUA Pneumonia 23 and private stock of Prevnar and Pneumonia 23 vaccine in stock at TCHD all times.
	Recall clients who are due for a second pneumonia vaccine (Pneumonia 23 and Prevnar).	Recall system designed and implemented for Pneumonia vaccines by January 2019.

Key Actions:

» Increase number of seniors seeking and receiving flu and pneumococcal vaccinations.

» Increase communication with/education of clients about vaccine availability and routine follow-ups.

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
(influenza and pneumococcal)			
Ad is placed and newsletter article published.	*News and Guide* and Senior Center newsletter noted in PHN report; BRFSS data on flu vaccination rates per year. Pneumococcal data not currently available.	Annually during flu season	Teton County Health Department (TCHD), Senior Center
Flyers are posted in multiple sites during the fall.	Public Health Nursing (PHN) Report.	Annually during flu season	Teton County Health Department, Senior Center
Regular communication with providers about stock and availability.	PHN Report	Annually during flu season	Teton County Health Department, Community Health Care Providers and Pharmacies
Ensure all Teton County providers and all SJMC providers are entering data into WyIR.	WyIR database	Ongoing	Teton County Health Department, all immunization providers
Number of handouts/brochures distributed	PHN Report	Yearly	Teton County Health Department
Number of targeted clinics held	PHN Report	Yearly	Teton County Health Department
Stock supplies adequate for demand.	PHN Report	Ongoing	Teton County Health Department
Recall system established at TCHD.	PHN Report	Ongoing	Teton County Health Department

Severe Housing Action Plan

Severe housing is defined by County Health Rankings as "A household that has one or more of the following: Housing unit lacks complete kitchen facilities; lacks complete plumbing; severely overcrowded (1.5 persons or more per room); severely cost burdened (monthly costs including utilities exceed 50% of monthly income)." According to the Robert Wood Johnson Foundation, physical conditions of the home, neighborhood conditions, and housing affordability have the potential to affect health both directly and indirectly. Good health depends on having homes that are affordable, safe and free from physical hazards.

This social determinant of health has fewer strategies than the others, not because this issue is less important, but because the Jackson/Teton Workforce Housing Action Plan, which has already been developed, is so thorough. The severe housing issue is complex in nature and demands a community-wide approach to truly solve the problem. The Workforce Housing Action Plan involved community members and stakeholders to identify the initiatives used to work on severe housing.

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Increase capacity for Teton County workforce to live locally		
Create, manage, and promote cross-sector collaboration of joint Town of Jackson/Teton County initiatives and agencies to address local housing issues.	Implement the Jackson/Teton County Housing Action Plan. http://www.tetonwyo.org/DocumentCenter/View/1835/Workforce-Housing-Action-Plan-November-2015-PDF	59% of local workforce live locally.
Provide housing for homeless individuals in Teton County.	Provide free/low-cost nightly shelter for Teton County residents and transient individuals.	9,164 nightly bed stays per year.

Key Actions:

» Create, manage, and promote cross-sector collaboration of joint Town of Jackson/ Teton County initiatives and agencies to address local housing issues.

» Provide housing for homeless individuals in Teton County.

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
Minimum 65% of workforce lives locally.	Town and County Annual Indicator Report (produced by joint long-range planning department).	2022	Jackson/Teton County Affordable Housing Department
10,700 nightly bed stays per year.	Good Samaritan Mission	2021	Good Samaritan Mission

Access to Care Action Plan

Access to Health Services encompasses four components: 1) insurance coverage; 2) cost as a barrier to care; 3) information as a barrier to care; and 4) language as a barrier to care. Individuals or families without adequate insurance coverage may delay or completely forgo preventive care, leading to more complex health needs and therefore higher health care costs down the road. Similarly, if cost, information or language are barriers to receiving care, both the insured and uninsured may not visit providers as often as they should for optimal health. The Access to Care Action Plan addresses each of these issues.

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Increase insurance coverage of the uninsured		
Coordinate health insurance enrollment for those without insurance	Ensure widespread, community awareness of 6-week marketplace plan enrollment period.	# people enrolled in Affordable Care Act (ACA) plans in Teton County: 2014: 1574 2015: 2615 2016: 2812 2017: 2825 2018: 2782
	Increase # of ACA navigators available to assist with enrollment procedures and re-enrollment processes.	Four total ACA navigators
	Enroll clients eligible for Medicare/Medicaid/KidCare CHIP or refer to appropriate resources.	255 families were assisted with Medicaid/KidCare CHIP enrollment through One22 in 2017. 187 families were assisted with Medicaid/KidCare CHIP enrollments through TCHD in FY18. 43 clients assisted with Medicare sign ups through WYSHIIP.

Key Actions:

- Coordinate health insurance enrollment for those without insurance.
- Eliminate cost as a barrier to health care services. Provide financial assistance and related counseling on how to manage hardship associated with major medical bills.
- Maintain and expand wellness programs throughout the community.
- Provide interpretation services at medical appointments throughout the community.

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
Expand the number of ACA navigators, including working with large employers to train navigators in their agencies.	St. John's Medical Center	Ongoing	St. John's Medical Center
Maintain current enrollment trend for ACA plans.	St. John's Medical Center	Ongoing	St. John's Medical Center
Enrollment level to remain steady in the coming years, unless there are changes in KidCare CHIP or Medicaid at the federal or state level.	One22, Teton County Health Department, Wyoming State Health Insurance Information Program (WYSHIIP)	Ongoing	One22, Teton County Health Department, Wyoming State Health Insurance Information Program (WYSHIIP)

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Eliminate cost as a barrier to health care services		
Provide financial assistance to patients who meet criteria to assist with payment of medical bills. Provide medications and services to individuals who otherwise have no/little access to health care.	Raise and distribute funds for patients in need of care. Patients who meet eligibility guidelines can qualify for patient assistance for all SJMC services and at all SJMC clinics.	In fiscal year 2017, St. John's Medical Center patient assistance funds totaled $3,900,528, which served 1,553 SJMC patients. In addition, patients accessed $204,346 from St. John's Hospital Foundation Patient Assistance funds.
Provide financial assistance and/or counseling on how to manage hardship associated with major medical bills (rent, transportation, medication).	Provide one-time financial assistance for major, non-medical expenses that limit ability to pay for health care services (e.g. rent, transportation).	548 financial assistance clients served in 2017. $156,021.73 in financial assistance awards provided through One22's Emergency Assistance Fund, Salvation Army, and Community Service Block Grant.
Teton County Health Department provides many health care services at free or reduced costs based on a client's income and family size. Teton County Health Department services include: family planning, immunizations, prenatal care, HIV and TB case management, STD testing.	TCHD to provide financial assistance for services based on a client's income and family size.	Current service level
Maintain low-cost services at Teton Free Clinic.	Teton Free Clinic is a grant-funded clinic that serves individuals that do not have any health insurance and meet their guidelines for service. To be served, clients must have a photo ID of some kind, proof of employment or residence in Teton County and make under 200% of the federal poverty level. Clients are also asked to make a $5 donation.	An average of 25 patients/week or ~1300 patients per year are served by the Teton Free Clinic. Some individuals are turned away due to capacity.

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
Level funding in 2018-2019. Anticipated level patient loads	St. John's Medical Center; St. John's Hospital Foundation	Ongoing	St. John's Medical Center; St. John's Hospital Foundation
Maintain service level.	One22, Salvation Army, and Community Services Block Grant (CSBG)	Annually	One22
Maintain service level.	Teton County Health Department	Ongoing	Teton County Health Department
Maintain service level.	Teton Free Clinic	Ongoing	Teton Free Clinic

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Reduce information gap as a barrier to health care services		
Establish Buen Corazón/Good Heart Patient Guide Program to provide patient support and financial assistance for: paying bills associated with St. John's Medical Center; researching and referring for appropriate clinical services; and referring out to community resources where appropriate.	Establish the position of Bilingual Financial and Customer Care Navigator (currently under the SJMC Finance/Billing Dept).	Create Buen Corazón/Good Heart Patient Guide Program for patients.
Maintain ongoing Wellness Center Programs.	Provide ongoing customized Wellness Programs for community employers and a la carte wellness services to businesses	1,400 current individual clients
Expand St. John's Medical Center Wellness Program	Wellness Center staff to offer free follow-up to patients who receive blood screening results outside the reference range and who do not have a primary care provider. Wellness staff then refer patients to appropriate clinical service and lifestyle-related programs.	In 2017, 3,920 wellness blood screenings were performed.
	Expand prevention classes such as Healthy U (Stanford University's chronic disease self-management program) in partnership with other local agencies.	Completed 4 Healthy U classes to date (in English).

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
Continue to provide Buen Corazón/Good Heart Patient Guide Program for patients.	St. John's Medical Center	2018-2019	St. John's Medical Center
Continue to explore options for increasing number of Teton County individuals served.	St. John's Medical Center	Ongoing	St. John's Medical Center
Anticipated wellness blood screening volume to remain the same.	St. John's Wellness Center	Ongoing	St. John's Medical Center
Continue to meet the demand for Healthy U and expand Healthy U program to Spanish-speaking population if need is demonstrated.	St. John's Wellness Center	Ongoing	St. John's Medical Center

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Reduce language as a barrier to health care services		
Train St. John's Medical Center staff as interpreters.	Outreach to SJMC staff who may be interested in pursuing interpretation certification for the needs of their particular scope of work/department.	No baseline available because tactic is currently being developed.
Provide patient interpretation through St. John's Medical Center Language Line.	Ensure patient safety by providing multiple tools to address each patient need most effectively (e.g. phone interpreter or interactive iPad service).	No baseline available because tactic is currently being developed.
	Staff are trained to ensure effective use of interpretation technology in both administrative and clinical settings.	No baseline available because tactic is currently being developed.
Teton County Health Department provides interpretation services for clients.	Teton County Health Department employs one translator. The medical registration receptionist and medical administrative assistant position are both bilingual positions.	Provide translation services for clients.

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
SJMC will identify target measures once tactic is fully developed.	NA	NA	St. John's Medical Center
SJMC will identify target measures once tactic is fully developed.	NA	NA	St. John's Medical Center
SJMC will identify target measures once tactic is fully developed.	NA	NA	St. John's Medical Center
Continue to provide translation services.	Teton County Health Department	Ongoing	Teton County Health Department

Food Insecurity Action Plan

Food insecurity is defined by Feeding America as, "Lack of access, at times, to enough food for an active, healthy life for all household members, and limited or uncertain availability of nutritionally adequate food." Individuals or families that suffer from food insecurity may experience more stress and more negative health outcomes.

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Reduce number of households considered food insecure		
Increase awareness and participation in programming and support for food-insecure children	Teton County School District (TCSD) to promote summer lunch programs.	Served at least 2,000 meals per summer in partnership with 8 summer programs.
	Assist in enrollment for free/reduced lunch program in schools.	23% of student population
	Increase access to food for children through partnering with summer programs.	Partner with 7 summer programs, reaching 165 children.
Provide free food for food-insecure children, seniors and families	Provide funding for meals to children who apply for free/reduced meals and are denied due to established financial requirements.	100 total students, approximately $50,000 per calendar year
	Continue dissemination of "Friday backpacks" to food-insecure children.	31 backpacks are distributed each week.
	Provide subsidized meals in all public schools through USDA's National School Lunch Program during the school year.	12% of all TCSD students receive free meals and 8% receive reduced price meals. The number of students with negative cafeteria balances has doubled in the past year. TCSD continues to allow children to purchase food even if their accounts have negative balances.

Key Actions:

» Increase awareness of and participation in programming and support for food-insecure children, families, and seniors.

» Provide free food for food-insecure children and seniors.

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
Maintain level of meals served/ participating programs.	Teton County School District	Annual assessment	Teton County School District
Maintain service level. Note: To compensate for the high cost of living in Teton County, wages may be higher than national averages.Thus service level may not be truly reflective of the need.	Teton County School District	Annual assessment	Teton County School District
Maintain level of participating programs and children enrolled.	Hole Food Rescue (HFR)	Annual assessment	Hole Food Rescue
Maintain level.	Teton County School District	Annual assessment through 2021	Teton County School District, funded by a local private donor at least through 2021
Maintain or increase numbers of backpacks distributed.	Hole Food Rescue will receive numbers from Holland & Hart	ongoing	Hole Food Rescue, Holland & Hart
Approximately 30% of TCSD students (projected actual need).	Teton County School District	ongoing	Teton County School District

Strategy	Tactic(s)	Baseline Measure(s)
PRIMARY GOAL: Reduce number of households considered food insecure *(continued)*		
(continued) Provide free food for food-insecure children, seniors and families	Provide subsidized meals in all public schools during summer months.	Meals were provided to 180 students.
	Provide snacks for children who visit school nurses or participate in after-school programs, school clubs, morning meetings, school dances, etc.	Snacks were provided to a total of 1000 students, about 1/3 of the total student population.
	Provide free after-school snacks at Teton County Library.	200 children per week
	Provide weekly food to families at Children's Learning Center who are identified as food insecure.	40 bags of food each week during the school year. Each bag is approximately 12 to 15 pounds.
	Provide food boxes for food insecure families in need when Jackson Cupboard is closed.	Approximately 5-10 bags of food per week.
	Use JH Food Help as a visual platform for community members to know where free or reduced meals are available in the community.	Website for JH Food Help and distributed brochures around the community.
	WIC to provide monthly food package to pregnant or postpartum mothers, infants and children up to age 5. For people below 185% of the poverty level.	173 participants. Benefits are credited onto a WYO WEST card, which is used like a credit card at Smith's or Albertson's in Jackson.
	Provide food to Senior Center of Jackson Hole for food insecure seniors.	200 lbs. of food delivered Monday-Friday throughout the year.
	Provide home-delivered meals to people ages 60+ who qualify as homebound.	5,575 home delivered meals/year.
	Provide "Satellite Cupboard" at Pioneer Homestead senior facility.	Approximately 80 elderly and disabled individuals who don't access free food elsewhere.

Target Measure(s)	Target Measure Source	Target Date	Lead Organization
Maintain level.	Teton County School District	ongoing	Teton County School District
Maintain level.	Teton County School District	ongoing	Teton County School District
Maintain level.	Hole Food Rescue (HFR), St. John's Episcopal Church, and Teton County Library	ongoing	Hole Food Rescue, Jackson Cupboard, St. John's Episcopal Church, Teton County Library
Maintain level.	Good Samaritan Mission	ongoing	Good Samaritan Mission
Maintain level.	Good Samaritan Mission	ongoing	Good Samaritan Mission
Continue to advertise JH Food Help materials around the community.	Hole Food Rescue	ongoing	Hole Food Rescue
Maintain level.	WIC (Women, Infants and Children)	ongoing	WIC (Women, Infants and Children)
Maintain level.	Hole Food Rescue	ongoing	Hole Food Rescue
Maintain level.	Senior Center of Jackson Hole	ongoing	Senior Center of Jackson Hole
Maintain service level.	HFR and Cupboard feedback surveys from Pioneer residents	ongoing	Hole Food Rescue, Jackson Cupboard

NEXT STEPS

It will be a progressive process to evaluate the extent to which the HTC Action Plans have improved health behaviors, health conditions, and social determinanats of health. Outcome measures will be reassessed when HTC begins its third iteration of the MAPP process at the end of 2020.

Evaluation Timeline

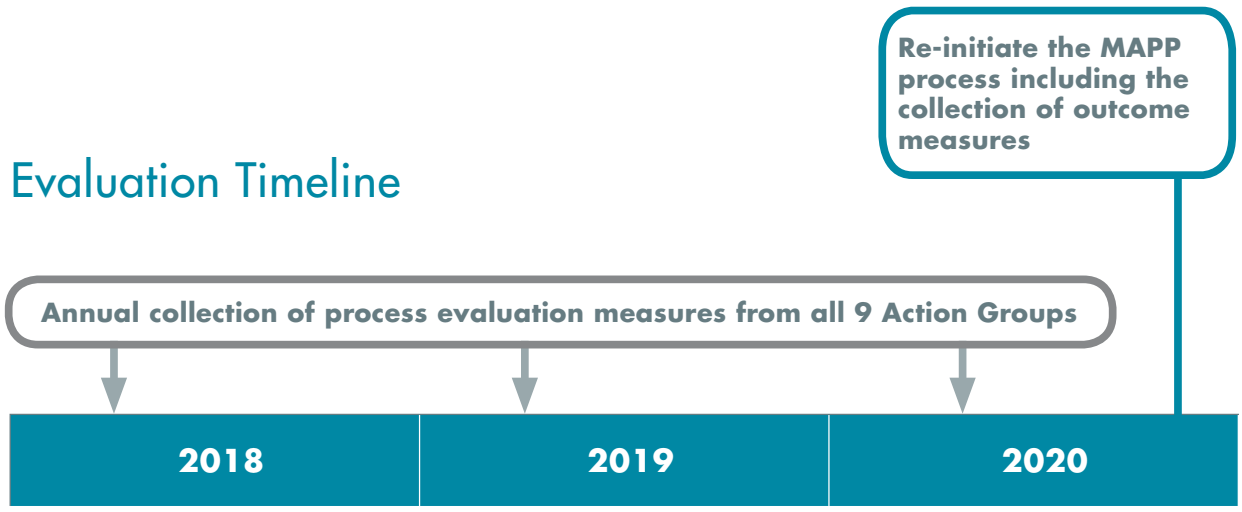

Figure 5