



LAFAYETTE COUNTY

COMMUNITY HEALTH IMPROVEMENT PLAN JUNE 2018 - DECEMBER 2023

Revised May 2019



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Lafayette Community Health Improvement Plan 2018-2023

AT-A-GLANCE: LAFAYETTE COMMUNITY HEALTH IMPROVEMENT PLAN STRATEGIC PRIORITIES, GOALS AND STRATEGIES

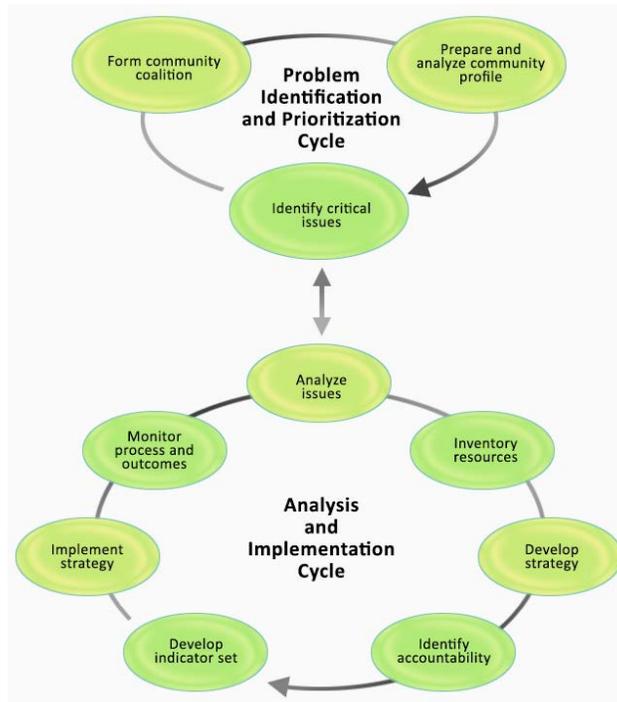
Strategic Priority 1: Maternal and Child Health
Goal 1: Improve the Health of Women and Babies
Strategy 1.1: Remove barriers to education/information, services and support for women and families
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Strategy 5.1.1: Improve communication about Community Health Improvement Plan initiatives and events

Overview of Community Health Improvement Planning

COMMUNITY HEALTH NEEDS ASSESSMENT AND HEALTH IMPROVEMENT PLANNING

In the Institute of Medicine’s (IOM) 1997 publication *Improving Health in the Community*, the community health improvement planning process was described as the required framework within which a community takes a comprehensive approach to improving health. That framework includes assessing the community’s health status and needs, determining health resources and gaps, identifying health priorities, and developing and implementing strategies for action. Notably, in this comprehensive approach there are two cycles; that is, an assessment or problem identification and prioritization cycle followed by an implementation cycle. By 2000 the National Association of County and City Health Officials (NACCHO) in conjunction with the Centers for Disease Control and Prevention’s (CDC) Public Health Practice Office had developed Mobilizing for Action through Planning and Partnerships (MAPP) as a strategic approach to community health improvement.

FIGURE 1: COMMUNITY HEALTH IMPROVEMENT PLANNING FRAMEWORK, IOM, 1997



J.S. Durch, L.A. Bailey, and M.A. Stoto, eds. (1997) *Improving Health in the Community*, Washington, DC: National Academy Press. Retrieved: <https://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/chip/main>

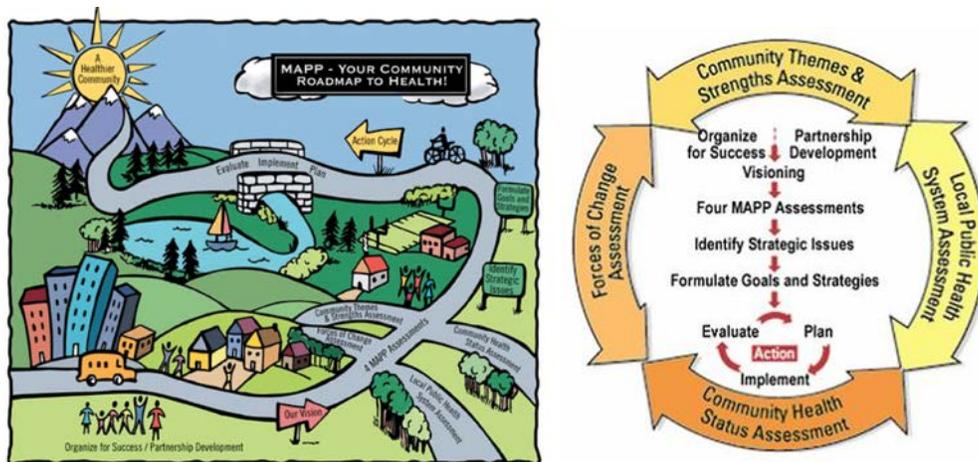
NACCHO and the CDC’s vision for implementing MAPP remains today as "Communities achieving improved health and quality of life by mobilizing partnerships and taking strategic action."

At the heart of the MAPP process are the following core MAPP assessments:

- Community Health Status Assessment
- Community Themes and Strengths Assessment
- Forces of Change Assessment
- Local Public Health System Assessment

The findings from four MAPP assessments inform the detection of common themes and issues in order to identify and prioritize the key community health needs. Prioritized strategic community health issues are documented and addressed in the MAPP action cycle phase to complete the comprehensive health improvement planning cycle.

FIGURE 2: MOBILIZING FOR PLANNING THROUGH PLANNING AND PARTNERSHIPS (MAPP)



National Association of County and City Health Officials (N.D.). *Community Health Assessment and Improvement Planning*. Retrieved June 21, 2018, <https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment>

The Public Health Accreditation Board (PHAB), the voluntary accrediting body for public health agencies in the United States, deems community health community health assessment and health improvement planning as foundational functions and core to the mission of public health. Community health assessment is defined in the PHAB Standards and Measures as a tool “to learn about the community: the health of the population, contributing factors to higher health risks or poorer health outcomes of identified populations, and community resources available to improve the health status.” The community health improvement plan is described as a “long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process.” Further, the

community health improvement process “involves an ongoing collaborative, community-wide effort to identify, analyze and address health problems; assess applicable data; develop measurable health objectives and indicators; inventory community assets and resources; identify community perceptions; develop and implement coordinated strategies; identify accountable entities; and cultivate community ownership of the process.” Public Health Accreditation Board (December 2013). *PHAB Standards and Measures*. Retrieved June 21, 2018, <http://www.phaboard.org/wp-content/uploads/SM-Version-1.5-Board-adopted-FINAL-01-24-2014.docx.pdf>

THE ROLE OF SOCIAL DETERMINANTS OF HEALTH AND HEALTH EQUITY IN COMMUNITY HEALTH IMPROVEMENT PLANNING

FIGURE 3: SOCIAL DETERMINANTS OF HEALTH (SDOH)



Healthy People 2020: Social Determinants of Health, Office of Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Retrieved June 21, 2018, <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

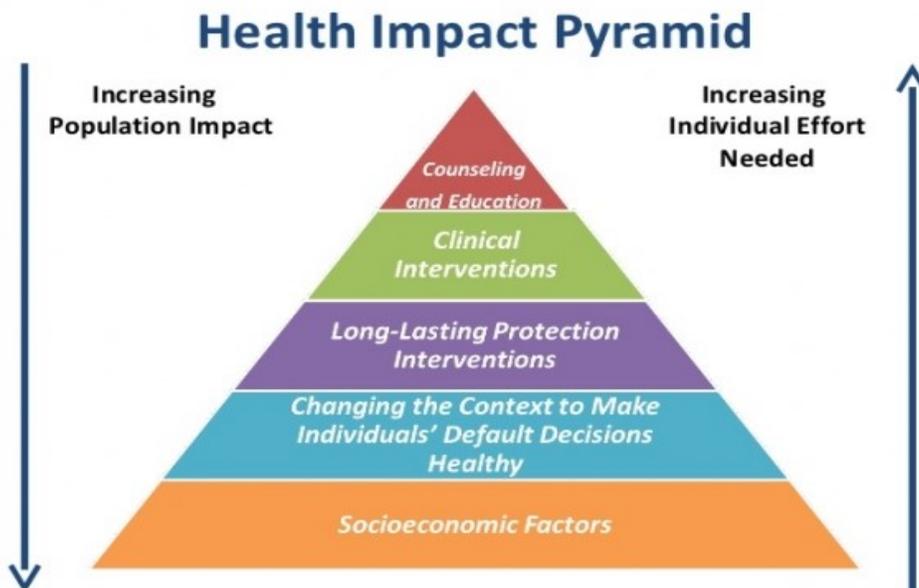
According to the World Health Organization and depicted above by the Centers for Disease Control and Prevention (CDC), the social determinants of health (SDOH) include the “conditions in the environments in which people are born, live, learn, work, play and age that shape and affect a wide range of health,

functioning, and quality of life outcomes and risks”.

(http://www.who.int/social_determinants/sdh_definition/en/ About Social Determinants of Health,” World Health Organization, accessed June 21, 2018). The SDOH include factors such as socioeconomic status, education, neighborhood and physical environment, employment and social networks as well as access to health care. Addressing social determinants of health is important for improving health and reducing health disparities. Research suggests that health behaviors such as smoking and diet and exercise, are the most important determinants of premature death. There is growing recognition that social and economic factors shape individuals’ ability to engage in healthy behaviors. Evidence shows that stress negatively affects health across the lifespan and that environmental factors may have multi-generational impacts. Addressing social determinants of health is not only important for improving overall health, but also for reducing health disparities that are often rooted in social and economic disadvantages.

The five-tier health impact pyramid depicts the potential impacts of different types of public health interventions. Efforts that address the SDOH are at the base of the pyramid, indicating their higher potential for positive impact. Interventions at the pyramid base tend to be effective because of their broad societal reach. CHIP interventions are targeted at all levels to attain the best and most sustainable health benefits.

FIGURE 4: HEALTH IMPACT PYRAMID



Frieden, T.R. (2010). A framework for public health action: The health impact pyramid. *American Journal of Public Health*, 100(4):590-595. Retrieved June 21, 2018, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/>

Lafayette Community Health Improvement Plan (CHIP) Process

METHODOLOGY

Development of the Lafayette CHIP is a continuation of the community health assessment process using the MAPP model. Community health assessment work began in August 2017, wrapped up in January 2018 and soon after launched into the CHIP process, or MAPP phases 4 through 6, i.e., identifying strategic issues, formulating goals and strategies and implementation. Led by the Florida Department of Health in Lafayette County and members of the Lafayette Health Improvement Partnership (LHIP), the strong commitment to better understand the health status and health needs of the community followed by impactful action and accountability are the hallmarks of the Lafayette CHIP process. Enhancements to the 2018 CHIP include an emphasis on the social determinants of health and health equity with concerted efforts to involve, include and understand diverse perspectives; inclusion of policy and environmental change strategies; and direct involvement of key community partners and citizens in identifying, formulating and implementing solutions. This also aligns with recommendations and guidance provided by the Public Health Accreditation Board (PHAB). The Florida Department of Health in Lafayette County (DOH-Lafayette) provides an administrative role in the CHIP by scheduling and facilitating meetings, writing reports, and identifying potential evidence-based or best-practice initiatives to address the identified objectives. DOH-Lafayette also maintains the Community Health Assessment and ensures all data collected and utilized to develop and measure success of the CHIP is updated annually and shared with the community. LHIP members are responsible for developing the CHIP, identifying and including community partner agencies and citizens for assistance in implementation efforts, and assuring accountability to the community for health improvement actions. A list of LHIP members can be found in the Appendix.

To refine and reconfirm the strategic priorities and potential strategies that emerged from the community health needs assessment process, at their April 10th meeting the LHIP reviewed the data and key findings from the four MAPP assessments; specifically, these included community health status data, local public health system capacity, community themes and strengths findings from the community survey, and forces of change issues. Please see below for a brief review of these key findings and refer to two companion documents, the Lafayette County Community Health Needs Assessment 2018 and Lafayette County Technical Appendix for extensive data reporting. After the LHIP's review, discussion, and identification of common themes, members participated in a facilitated consensus workshop process to identify the final strategic priorities. Towards developing an implementation-ready CHIP, the LHIP set a timeline of activities including a sequence of online work via surveys and email correspondence, proposed conference calls and in-person meetings.

LHIP members conducted three in-person work sessions (April 10, May 21 and July 12, 2018) to formulate a plan to address the five strategic priorities with goals, strategies, objectives and accountability measures. In addition to in-person deliberations and consensus-building, the LHIP members utilized an online survey

application to develop goal statements, identify strategies, and construct objectives. The WellFlorida Council provided technical and administrative assistance as well as facilitation for the LHIP work sessions.

At the May 21 and July 12, 2018 workshops, LHIP members dissected the proposed goal statements, enhanced and added strategies and refined the objectives collected via the online survey. Discussions were enriched by referring to findings and data in the Community Health Assessment and Technical Appendix documents, supplemental information provided by subject matter experts, and prioritization by consensus. In selecting the final goals and objectives, LHIP members considered the magnitude of the health problems, the immediacy of the need, impact on vulnerable and priority populations, the potential contribution to elimination of health disparities, and the likelihood that the identified issues could be substantially and positively impacted through collaborative local efforts.

In March 2019, the LHIP met and discussed the current plan, goals, data sources, baselines, targets, achievability of objectives, shifting priorities, as well as rebranding the group to be more of a community-driven group. The revisions to the Goals, Strategies, and Objectives are found in the Appendix. Additionally, the group defined health and a healthy community as:

Healthy habits and education reaching all populations

With this definition in mind, the group decided to change their name from Lafayette Health Improvement Partnership (LHIP) to **Lafayette Forward** as it better supports the definition of a healthy community and the purpose and role of the group.

KEY ASSESSMENT FINDINGS

Data and findings from the community health assessment informed the selection of the strategic priorities in this Lafayette CHIP. Through the completion of the four MAPP assessments, multiple data sets from a variety of sources, including both primary and secondary data, generated a wealth of data. These data were reviewed, analyzed and discussed to identify common themes across assessments, persistent health problems, health and quality of life issues that have worsened, and timely opportunities. The key findings that emerged are highlighted below.

SOCIAL DETERMINANTS OF HEALTH

As described above, the SDOH have been shown to have impacts on overall health. In addition, the SDOH can reduce health disparities that are often rooted in social and economic disadvantages. Data show Lafayette County has continuing challenges with the following SDOH-related issues:

- Generational poverty
- Limited employment opportunities
- Lack of affordable housing
- Low health literacy

HEALTH STATUS

Disease and death rates are the most direct measures of health and well-being in a community. In Lafayette County, as in Florida and the rest of the United States, premature disease and death are primarily attributable to chronic health issues. That is, medical conditions that develop throughout the life course and typically require careful management for prolonged periods of time. While Lafayette County is similar to Florida in many health indicators, some differences exist. In Lafayette County, the leading causes of death rates that are higher than state rates include the first four conditions listed below.

- Cancer
- Diabetes
- Unintentional injuries
- Influenza and Pneumonia
- Infant mortality

HEALTH BEHAVIORS AND CONDITIONS THAT CONTRIBUTE TO POOR HEALTH OUTCOMES

Health behavior data pointed to serious challenges facing Lafayette County residents. The issues listed below require multi-faceted approaches to improve existing health problems with simultaneous primary prevention strategies to help ensure healthy futures for all segments of the population. The chronic conditions that were considered as priority health issues include the following:

- Teen pregnancy
- Mental health problems
- Oral health issues
- Overweight and obesity
- Late entry into prenatal care
- Drug and substance abuse
- Tobacco use
- Poor nutrition and food choices

GEOGRAPHIC, RACIAL AND ETHNIC DISPARITIES

Some disparities were found in the course of Lafayette County's community health assessment process and these preventable differences were given serious consideration and importance in CHIP discussions. Areas of particular concern include:

- Poverty rate differences between Whites and Blacks
- Differences in mortality rates from Cancer and Heart Disease for Whites, from Heart Disease, Diabetes and HIV for Blacks, and Unintentional Injuries for Hispanics
- Low Birth Weight births among Blacks and lagging first trimester care rates among Whites and Hispanics

HEALTH CARE RESOURCES AND UTILIZATION

Although health insurance and access to health care do not necessarily prevent illness, early intervention and long-term management resources can help to maintain quality of life and minimize premature death and disability. Rural communities like Lafayette County face many barriers in accessing health care services. Utilization and health professional shortage data illuminated the depth of access to care issues in Lafayette County. The major issues fall into the four groups as listed below.

- Inappropriate use of Emergency Departments for routine primary, mental health, and dental care
- Lack of healthcare providers and services, specialty care physicians, and dentists
- Lack of affordable health insurance with sufficient coverage
- Limited Emergency Medical Services (EMS) and all volunteer fire services

COMMUNITY INFRASTRUCTURE AND ENVIRONMENT

Threats to the natural environment in Lafayette County emerged as pressing concerns including the degradation of natural resources, encroachment on agricultural land and impacts from natural disasters. In the forefront of community concerns are Lafayette County residents' lack of full understanding, sense of urgency, and engagement in addressing local health issues. Issues include:

- Challenges in mobilizing partners and the community to address health problems
- Need for better monitoring and communications about health and health status in Lafayette County
- Need for better community health education and health information dissemination
- Elections at state and local levels
- Threats to natural resources, the environment, rural setting and agricultural economy

Lafayette CHIP Priorities, Goals, Strategies, and Objectives

The Lafayette 2018-2023 CHIP focuses on five strategic priorities. For each priority, two goals have been set and will be addressed by strategies. Objectives provide the basis for performance and outcome tracking, measuring and reporting. Each goal area has its own work plan with activities, baseline and target data, accountability measures, and progress reporting mechanisms (see Appendix).

Strategic Priority 1: Maternal and Child Health	
Goal 1.1: Improve the Health of Women and Babies	
Strategy 1.1.1: Remove barriers to education/information, services and support for women and families	
Objectives:	Lead
A. By December 31, 2020 establish and promote a mobile care unit with Pregnancy Care Centers (2017 baseline = no mobile unit).	Pregnancy Care Centers
B. By December 31, 2023 increase the number of women receiving first trimester care by 3% (baseline to be established in 2020 after implementation of mobile unit).	Pregnancy Care Centers
C. By December 31, 2019 expand reach of DOH-Lafayette’s education and advertising campaign to regions outside the town limits of Mayo by working with community partners to share educational materials at a minimum of one event annually (2017 baseline = no events outside of Mayo).	DOH-Lafayette Healthy Start
Goal 1.2: Improve Healthy Teen Behavior	
Strategy 1.2.1: Policy change, awareness/education campaigns	
Objectives:	Lead
A. By December of 2019, Lafayette Forward will survey Lafayette teens to identify top teen healthy behavior issues.	DOH-Lafayette Health Educator
B. By January 2020, Lafayette Forward will identify one policy change or awareness/education campaign to address the identified teen healthy behavior issue (2017 baseline = 0).	DOH-Lafayette Health Educator and Meridian Behavioral Health
C. By January 2021, Lafayette Forward will have at least two teen partners to annually review progress on teen healthy behaviors and provide a teen perspective (2017 baseline = 0).	DOH-Lafayette Health Educator
Strategic Priority 2: Healthy Behaviors	
Goal 2.1: Improve Access to Mental Health Services	
Strategy 2.1.1: Improve access to services and resources, provide health education, institute policy change for funding to support expanded services	
Objectives:	Lead
A. By January 31, 2019 increase access to mental health services Lafayette County by increasing the availability (days) of Meridian Behavioral Health in Lafayette County from 0 to at least 2 days per week (2017 baseline = no office days in Lafayette).	Meridian Behavioral Health

<p>B. By June 30, 2019 partner with local law enforcement to provide education on drug and substance abuse to middle school/teen students of Lafayette County School (2017 baseline = no program in schools).</p>	<p>DOH-Lafayette Health Educator, Lafayette Sheriff's Office</p>
<p>Goal 2.2: Prevent Unintentional Injuries</p>	
<p>Strategy 2.2.1: Provide education and awareness campaigns, support safety enforcement activities</p>	
<p>Objectives:</p>	
<p>A. By May 31, 2021, provide 2 farm equipment safety seminars (2017 baseline = no safety seminars).</p>	<p>UF IFAS</p>
<p>B. By June 30, 2020 develop and implement an educational and skills development campaign on safe driving for adults and high school students (grades 9-12) (2017 baseline = no educational campaign).</p>	<p>Lafayette Sheriff's Office</p>
<p style="text-align: center;">Strategic Priority 3: Chronic Health Conditions</p>	
<p>Goal 3.1: Promote Healthy Weight for Lafayette County Residents</p>	
<p>Strategy 3.1.1: Institute primary prevention approaches to healthy lifestyles including education and access to services and resources</p>	
<p>Objectives:</p>	
<p>A. By December 31, 2022 decrease the percentage of adult obesity by 3% points from 35% to 32% (data source: County Health Ranking Adult obesity, 2017 baseline = 35%).</p>	<p style="text-align: center;">Lead</p> <p>DOH-Lafayette Health Educator</p>
<p>B. By December 31, 2021 increase recreational activities for residents of Lafayette County as evidenced by:</p> <ul style="list-style-type: none"> a. Hosting at least one healthy hike annually b. Offering quarterly healthy events like fun runs, park obstacle courses for children and adults (2017 baseline = one annual event). 	<p>DOH-Lafayette Health Educator</p>
<p>C. By December 31, 2023 Maintain a full-time health educator for chronic disease prevention at DOH-Lafayette (2017 baseline = no full-time health educator).</p>	<p>DOH-Lafayette Administration</p>
<p>D. By December 31, 2019 increase time spent in providing health education to Lafayette County residents (2017 baseline = one days at DOH-Lafayette).</p>	<p>DOH-Lafayette Health Educator</p>
<p>Goal 3.2: Reduce the Impact of Chronic Diseases</p>	
<p>Strategy 3.2.1: Provide education on disease management, provide support and resources</p>	
<p>Objectives:</p>	
<p>A. By December 31, 2019 Chronic disease health educator to set up community lunch and learns at least 3 times a year (2017 baseline = one lunch and learn annually).</p>	<p>DOH-Lafayette Health Educator</p>
<p>B. By December 31, 2023 decrease the percentage of adults who have ever had a heart attack, angina, or coronary heart disease, or stroke by 3% points from 18.2% to 15.2% (BRFSS 2016 baseline = 18.2%).</p>	<p>DOH-Lafayette Health Educator</p>

<p>C. By December 31, 2023 decrease the percentage of adults who have ever been told they had diabetes by 3% points from 21% to 18% (BRFSS 2016 baseline = 21%).</p>	<p>DOH-Lafayette Health Educator</p>
<p>Strategic Priority 4: Access to Health Care Services</p>	
<p>Goal 4.1: Improve Access to Health Care Services</p>	
<p>Strategy 4.1.1: Eliminate barriers to health care services</p>	
<p>Objectives:</p>	<p>Lead</p>
<p>A. By October 31, 2018 increase dental clinic days at DOH-Lafayette to 2 per week (2017 baseline = one day per week).</p>	<p>DOH-Lafayette Dental and Administration</p>
<p>B. By December 31, 2021 bring mobile dental clinics that are no or low cost for Lafayette County adults by December 31, 2021 (2017 baseline = no adult dental mobile clinic).</p>	<p>DOH-Lafayette Health Educator, Florida Baptist Association</p>
<p>C. By December 31, 2023 increase the percentage of adults had a medical checkup in the past year by 3% points from 79.1% to 82.1% (BRFSS 2016 baseline = 79.1%).</p>	<p>DOH-Lafayette Health Educator, Shepherds Hands Clinic</p>
<p>D. By December 31, 2023 implement a dental screening and sealant program for students in Grade 2 at Lafayette County elementary schools (2017 baseline = no sealant program).</p>	<p>DOH-Lafayette Dental, Lafayette Schools</p>
<p>Goal 4.2: Reduce Health Care Costs and Improve Efficient Use of Existing Services</p>	
<p>Strategies: Improve health literacy and encourage self-management of health</p>	
<p>Objectives:</p>	<p>Lead</p>
<p>A. By December 31, 2021 provide a health literacy/healthy lifestyles program/training to adults in Lafayette County (2017 baseline = no health literacy/healthy lifestyles program/training for adults).</p>	<p>DOH-Lafayette Health Educator, UF IFAS</p>
<p>B. By December 31, 2022 reduce preventable hospitalizations under 65 by Lafayette County residents by 10% from 47 to 43 (2017 AHCA baseline = 47).</p>	<p>DOH-Lafayette Health Educator, United Way</p>
<p>C. By December 31, 2023 secure staff in order to place into service a second ambulance in Lafayette County (2018 baseline = one ambulance).</p>	<p>Lafayette EMS</p>
<p>Strategic Priority 5: Community Engagement</p>	
<p>Goal 5.1: Improve Community Commitment to Improving Health in Lafayette County</p>	
<p>Strategy 5.1.1: Improve communication about Community Health Improvement Plan initiatives and events</p>	
<p>Objectives:</p>	<p>Lead</p>
<p>A. By November 30, 2018 increase participation of faith-based organizations in Lafayette Forward by one organization (2017 baseline = no faith-based organization).</p>	<p>DOH-Lafayette Health Educator</p>
<p>B. By July 1, 2019 create a community health improvement (Lafayette Forward) website to share Community Health Improvement Plan initiatives, events, and data (2017 baseline = no website).</p>	<p>DOH-Lafayette Health Educator</p>

C. Increase the number of new community partners who participate in outreach events by December 31, 2019. Increase from 12 current community partners to 14 community partners (2018 baseline=12).	DOH-Lafayette Health Educator
D. By December 31, 2020 increase number of community participants in outreach activities offered by Lafayette County community partner organizations. Increase from 12 current community participates to 14 community participates (2018 baseline=12).	DOH-Lafayette Health Educator

Lafayette CHIP Alignment with State and National Priorities

The strategic priorities, goals, strategies and objectives in the Lafayette CHIP align with several state and national initiatives. These include the Florida Department of Health’s State Health Improvement Plan for 2017-2021, Healthy People 2020, the U.S. Department of Health and Human Services (HHS) Surgeon General’s Office National Prevention Strategy 2017, and HHS Office of Minority Health National Stakeholder Strategy for Achieving Health Equity. These shared priorities present opportunities for collaboration and collective impact in improving health outcomes and quality of life for Lafayette County residents.

<p>Lafayette County CHIP Objectives</p>	<ul style="list-style-type: none"> • HP 2020 = Healthy People 2020 (bold = exact match of objectives) • Florida SHIP = Florida State Health Improvement Plan, 2017 - 2021 • NPS = National Prevention Strategy • NSS Health Equity: National Stakeholder Strategy for Achieving Healthy Equity
<p>Strategic Priority: Maternal and Child Health</p>	
<p>By December 31, 2020 establish and promote a mobile care unit with Pregnancy Care Centers (2017 baseline = no mobile unit).</p>	<p>HP 2020: MICH-10 (10.1-10.2)</p> <p>NPS: Reproductive and Sexual Health</p>
<p>By December 31, 2023 increase the number of women receiving first trimester care by 3% (baseline to be established in 2020 after implementation of mobile unit).</p>	<p>HP 2020: MICH-10 (10.1-10.2)</p> <p>NPS: Reproductive and Sexual Health</p>
<p>By December 31, 2019 expand reach of DOH-Lafayette’s education and advertising campaign to regions outside the town limits of Mayo by working with community partners to share educational materials at a minimum of one event annually (2017 baseline = no events outside of Mayo).</p>	<p>HP 2020: HC/HIT-13 (13.1)</p>
<p>By December of 2019, Lafayette Forward will survey Lafayette teens to identify top teen healthy behavior issues.</p>	<p>HP 2020: HC/HIT 13, EMC 4, EMC 4.3, ECBP 2, ECBP 3, ECBP 3.3</p>
<p>By January 2020, Lafayette Forward will identify one policy change or awareness/education campaign to address the identified teen healthy behavior issue (2017 baseline = 0).</p>	<p>NPS: Reproductive and Sexual Health</p>
<p>By January 2021, Lafayette Forward will have at least two teen partners to annually review progress on teen healthy behaviors and provide a teen perspective (2017 baseline = 0).</p>	<p>HP 2020: HC/HIT 13, EMC 4, EMC 4.3, ECBP 2, ECBP 3, ECBP 3.3</p>

Strategic Priority: Health Behaviors	
By January 31, 2019 increase access to mental health services Lafayette County by increasing the availability (days) of Meridian Behavioral Health in Lafayette County from 0 to at least 2 days per week (2017 baseline = no office days in Lafayette).	<p>HP 2020: MHMD 5, MHMD 6, MHMD 9, MHMD 9.1, MHMD 9.2, MHMD 11, ECBP 10.3</p> <p>Florida SHIP HE 3.5.1, HE 3.5.2</p> <p>NPS: Mental and Emotional Well-Being</p>
By June 30, 2019 partner with local law enforcement to provide education on drug and substance abuse to middle school/teen students of Lafayette County School (2017 baseline = no program in schools).	<p>HP 2020: EMC 4, ECBP 2.6, ECBP 10.5</p> <p>NPS: Preventing Drug Abuse and Excessive Alcohol Use</p>
By May 31, 2021, provide 2 farm equipment safety seminars (2017 baseline = no safety seminars).	<p>HP 2020: ECBP2, ECBP 2.2</p> <p>NPS: Injury and Violence Free Living</p>
By June 30, 2020 develop and implement an educational and skills development campaign on safe driving for adults and high school students (grades 9-12) (2017 baseline = no educational campaign).	<p>HP 2020: SA 1</p> <p>Florida SHIP ISV 1.1.1, ISV 1.1.2, ISV 1.2.1, ISV 1.2.2</p> <p>NPS: Injury and Violence Free Living</p>
Strategic Priority: Chronic Health Conditions	
By December 31, 2022 decrease the percentage of adult obesity by 3% points from 35% to 32% (data source: County Health Ranking Adult obesity, 2017 baseline = 35%).	<p>HP 2020: NWS 9, NWS 8, NWS 11, NWS 11.5, PA 2.2</p> <p>Florida SHIP HW 1.1.5</p> <p>NPS: Healthy Eating and Active Living</p>
By December 31, 2021 increase recreational activities for residents of Lafayette County as evidenced by: <ul style="list-style-type: none"> • Hosting at least one healthy hike annually • Offering quarterly healthy events like fun runs, park obstacle courses for children and adults (2017 baseline = one annual event).	<p>HP 2020: PA 1, PA 2, PA 2.1, PA 2.2, PA 2.3, PA 2.4, PA 10, PA 15, PA 15.1,</p> <p>NPS: Active Living</p>
By December 31, 2023 Maintain a full-time health educator for chronic disease prevention at DOH-Lafayette (2017 baseline = no full-time health educator).	<p>HP 2020: MHMD 5</p> <p>NPS: Healthy Eating and Active Living</p>
By December 31, 2019 increase time spent in providing health education to Lafayette County residents (2017 baseline = one days at DOH-Lafayette).	<p>HP 2020: HC/HIT 13</p>
By December 31, 2023 decrease the percentage of adults who have ever had a heart attack, angina, or coronary heart disease, or stroke by 3% points	<p>HP 2020: HDS 2, HDS 3, NWS 17</p>

from 18.2% to 15.2% (BRFSS 2016 baseline = 18.2%).	Florida SHIP 1.3.4
By December 31, 2023 decrease the percentage of adults who have ever been told they had diabetes by 3% points from 21% to 18% (BRFSS 2016 baseline = 21%).	HP 2020: D 1, D 16 (16.1-16.3), NWS 6, NWS 6.1, NWS 7 Florida SHIP CD1.1.2, CD 1.3.3
By December 31, 2019 Chronic disease health educator to set up community lunch and learns at least 3 times a year (2017 baseline = one lunch and learn annually).	NPS: Healthy Eating and Active Living, Tobacco Free Living, Preventing Drug Abuse and Excessive Alcohol Use
Strategic Priority: Access to Health Care Services	
By December 31, 2023 implement a dental screening and sealant program for students in Grade 2 at Lafayette County elementary schools (2017 baseline = no sealant program).	HP 2020: OH 9.1, OH 12.1, OH 1, OH 2.1, AHS 1.2
By December 31, 2021 bring mobile dental clinics that are no or low cost for Lafayette County adults by December 31, 2021 (2017 baseline = no adult dental mobile clinic).	HP 2020: AHS 6, AHS 6.3,
By December 31, 2023 increase the percentage of adults had a medical checkup in the past year by 3% points from 79.1% to 82.1% (BRFSS 2016 baseline = 79.1%).	HP 2020: PA 11 NSS Health Equity: Goal 3 Health System and Life Experience
By October 31, 2018 increase dental clinic days at DOH-Lafayette to 2 per week (2017 baseline = one day per week).	HP 2020: OH 3, OH 7, OH 8, OH 10, OH 14, OH 17, AHS 6.1, AHS 6.3
By December 31, 2023 secure staff in order to place into service a second ambulance in Lafayette County (2018 baseline = one ambulance).	HP 2020: AHS-6, AHS-8
Strategic Priority: Community Engagement	
By July 1, 2019 create a community health improvement (Lafayette Forward) website to share Community Health Improvement Plan initiatives, events, and data (2017 baseline = no website).	HP 2020: HC/HIT-13
By December 31, 2020 increase number of community participants in outreach activities offered by Lafayette County community partner organizations.	HP 2020: ECBP 10
Increase the number of new community partners who participate in outreach events by December 31, 2019	HP 2020: ECBP 10 Florida SHIP, Goal HE 2 NSS Health Equity: Goal 1
By November 30, 2018 increase participation of faith-based organizations in Lafayette Forward by	

one organization (2017 baseline = no faith-based organization).	
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Appendix

This Appendix includes the following sections:

- Plan Development Steering Committee Members
- Lafayette Forward Member list
- Revision Tracking
- Lafayette CHIP Implementation Template
- Health Improvement and Strategic Plan Tracking System

PLAN DEVELOPMENT STEERING COMMITTEE MEMBERS

- Children’s Home Society of Florida – Jennifer Anchors
- Community Member – Samantha Land
- Elder Options – Bianca Blackshear, Lauren Dean, Velma Chandler
- Florida Department of Children and Families - Cindy Bishop
- Florida Department of Corrections - Julie Eveslage, Kelly Stephenson
- Florida Department of Health, Child Protection Team – Stephanie Cox
- Haven Hospice – Debbie French
- Homewood Lodge Assisted Living Facility – Ashley Morgan
- Lafayette County Board of County Commission – Anthony Adams, Earnest Jones, Lance Lamb, Thomas Pridgeon, Lisa Walker, Donnie Hamlin (Retired)
- Lafayette County Chamber of Commerce – Leeta Hawkins
- Lafayette County Clerk of Court – Steve Land
- Lafayette County Extension Office – Eva Bolton, Jana Hart
- Lafayette County Property Appraiser – Tim Walker
- Lafayette County School Board – Darren Driver, Jeff Walker, Robby Edwards
- Lafayette County Supervisor of Elections – Travis Hart
- Lafayette County Youth Advocacy – Mary Taylor
- Lafayette Health Care Nursing Home – Rich Wisdahl
- Lutheran Services of Florida Health Systems - Lesley Hersey
- Meridian Behavioral Health Care – Anita Scarborough, Debra Wright, Nancy Collins, Natasha Fredericks Klein, Pamela Hester, Sharon Simons
- North Florida Community College – Takiyah Randolph, John Walt Boatright
- North Florida Medical Centers – A. Harris
- Oakridge Assisted Living Facility - Heather Lock
- Rural Women’s Health Project – Fran Ricardo
- St. Luke’s Episcopal Church - Father George Hinchliffe
- Suwannee River Area Health Education Center – Fran VanElla
- Suwannee River Economic Council - Frances Terry, Janis Owens, Matt Pearson
- Three Rivers Library – Cheryl Pulliam
- UF IFAS, Public Health Coordinator - Mike Swain
- United Way - Nancy Roberts

LAFAYETTE FORWARD COMMUNITY MEMBERS

- Alton Church of God
- Another Way, Inc.
- Children’s Home Society of Florida
- Community Member
- Do Good Media
- Elder Options
- Florida Department of Children and Families
- Florida Department of Corrections
- Florida Department of Health in Lafayette County
- Florida Department of Health, Child Protection Team
- Florida Department of Health, Healthy Start
- Haven Hospice
- Homewood Lodge Assisted Living Facility
- Lafayette County Board of County Commission
- Lafayette County Chamber of Commerce
- Lafayette County Clerk of Court
- Lafayette County Extension Office
- Lafayette County Property Appraiser
- Lafayette County School Board
- Lafayette County Supervisor of Elections
- Lafayette County Youth Advocacy
- Lafayette Health Care Nursing Home
- Lutheran Services of Florida Health Systems
- Meridian Behavioral Health Care
- Fredericks Klein, Pamela Hester, Sharon Simons
- North Florida Community College
- North Florida Medical Centers
- Oakridge Assisted Living Facility
- Rural Women’s Health Project
- St. Luke’s Episcopal Church
- Suwannee River Area Health Education Center
- Suwannee River Economic Council
- Suwannee Valley 4 Cs
- Three Rivers Library
- UF IFAS, Public Health Coordinator
- United Way



REVISION TRACKING

Date	Revision	Page Number
May 30, 2019	Added community definition of health and healthy community	8
	Renamed hierarchy of Priority, Goal, Strategy, and Objective to align with Department of Health Strategic Plan hierarchy, added numbers and letters to better identify Priorities, Goals, Strategies, and Objectives.	11-14
	Priorities, Strategies, Objectives to align with Lafayette Forward meeting March 2019, edited Teen Pregnancy to become Teen Healthy Behavior, edited Mental Health to include Mental Health First Aid Certification	11-14, 16-18
	Assigned lead roles to objective and initiative implementation	11-14
	Included list of Lafayette Forward Community Partners	21
	Updated (2019) Implementation Plan Template	23-25
	Health Improvement and Strategic Plan Tracking System	26-29



LAFAYETTE CHIP IMPLEMENTATION PLAN TEMPLATE

IMPLEMENTATION PLAN

Please select from the drop down menu which plan this is for:

Division/Office/CHD: _____
 Bureau: _____
 Reported by: _____
 Last Update Reported: _____

Priority Area: Enter priority number and name as listed in plan: _____
 Goal: Enter goal number and name as listed in plan: _____
 Strategy: Enter strategy number and name as listed in plan: _____
 Objective: Enter objective number and name as listed in plan: _____

Description	Plan Beginning Baseline	Direction of Change	Unit of Measure	Reporting Frequency	Previous YTD	Current Measurement				Current YTD	Current Status	2019 Target	Plan Target	National Benchmark Figure	National Benchmark Source	Data Source	Measure Notes
						Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec								
Description of the measures, those things that are numerical in showing that success has been reached	Baseline set at beginning of plan	Direction in which measure should change	Unit of measurement for objective	Frequency in which data are available	Annual figure from 2018, if available	Non-cumulative numerical value for each quarter. Use provisional data for strategic plan objectives when final data is not available. Only use final data for SHIP objectives.				Year-to-date figure for 2019, if available. The sum of Q1-Q4 if measured quarterly.	Status of the indicator (Please see bottom of page for descriptions of selection choices)	Target expected to be reached by 12/31/2019	Target expected to be reached by the end of the plan	Figure set by a national organization, a standard states are expected to meet or strive for, if applicable	Source that set national benchmark figure (Example: Healthy People 2020), if applicable	Data source used to collect and measure data	Any information helpful in knowing more about the measure. Include a comment about any provisional data.
		DROP DOWN MENU	DROP DOWN MENU	DROP DOWN MENU							DROP DOWN MENU						

SUR/PROCESS INDICATORS (INTERNAL USE ONLY)																	
Description	Baseline	Direction of Change	Unit of Measure	Reporting Frequency	Previous YTD	Current Measurement				Current YTD	Status	2019 Target	Plan Target	National Benchmark Figure	National Benchmark Source	Data Source	Measure Notes
						Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec								
This section is optional and is to list sub or process indicators for the objective. Indicators are those data that will adequately show measure of progress for the objective	Baseline set at beginning of plan	Direction in which measure should change	Direction in which measure should change	Frequency in which data are available	Annual figure from 2018, if available	Non-cumulative numerical value for each quarter				Year-to-date figure for 2019, if available. The sum of Q1-Q4 if measured quarterly.	Status of the indicator (Please see bottom of page for descriptions of selection choices)	Target expected to be reached by 12/31/2019	Target expected to be reached by the end of the plan	Figure set by a national organization, a standard states are expected to meet or strive for	Source that set national benchmark figure (Example: Healthy People 2020)	Data source used to collect and measure data	Any information helpful in knowing more about the measure
		DROP DOWN MENU	DROP DOWN MENU	DROP DOWN MENU							DROP DOWN MENU						

ACTIVITY 1					
Activity Description	Person Responsible	Anticipated Completion Date	Activity Status	Activity Progress Notes	
Activity/Intervention being carried out to address objective	Staff position responsible for carrying out or accountable for activity	Anticipated completion date of activity	Status of the indicator (Please see bottom of page for descriptions of selection choices)	Any notes about the progress of the activity	
			DROP DOWN MENU		

ACTIVITY 1 - ACTION STEPS						
Action Step Description	Action Status	Deliverables/Outputs of Action		Key Partners/Responsible Persons/Groups	Start Date	Finish/End Date
Description of the action needed in order to complete the activity (action plan)	Status of the indicator (Please see bottom of page for descriptions of selection choices)	Description of any products or results of the action		Names of internal and external individuals or groups who helped carry out the action	Actual start date of action described	Actual finish/end date of action described
	DROP DOWN MENU					



ACTIVITY 2				
Activity Description	Person Responsible	Anticipated Completion Date	Activity Status	Activity Progress Notes
Activity/Intervention being carried out to address objective	Staff position responsible for carrying out or accountable for activity	Anticipated completion date of activity	(Please see bottom of page for descriptions of selection choices)	Any notes about the progress of the activity
			DROP DOWN MENU	

ACTIVITY 2 - ACTION STEPS						
Action Step Description	Action Status	Deliverables/Outputs of Action		Key Partners/Responsible Persons/Groups	Start Date	Finish/End Date
Description of the action needed in order to complete the activity (action plan)	Status of the indicator (Please see bottom of page for descriptions of selection choices)	Description of any products or results of the action		Names of those who helped carry out the action	Actual start date of action described	Actual finish/end date of action described
	DROP DOWN MENU					

QUARTER 1		
Activity Progress and Comments		
Contributing Partners	List of partners who contributed to the completion of the activities during the quarter.	
Partner Contributions	Any resources provided by partners (funding, meeting space, assistance, etc.) during the quarter.	
Key Accomplishments	Description of any factors that contributed to the successful completion of the activities and any products or results due to the activities during the quarter.	
Barriers/Issues Encountered	Description of any barriers/issues/problems encountered during the completion of the activities during the quarter.	
Plans to Overcome Barriers/Issues	Description of what was done to overcome any barriers/issues/problems encountered during the completion of the activities during the quarter.	
Unanticipated Outcomes (optional)	Description of any unanticipated outcomes of the activities during the quarter.	

QUARTER 2		
Activity Progress and Comments		
Contributing Partners	List of partners who contributed to the completion of the activities during the quarter.	
Partner Contributions	Any resources provided by partners (funding, meeting space, assistance, etc.) during the quarter.	
Key Accomplishments	Description of any factors that contributed to the successful completion of the activities and any products or results due to the activities during the quarter.	
Barriers/Issues Encountered	Description of any barriers/issues/problems encountered during the completion of the activities during the quarter.	
Plans to Overcome Barriers/Issues	Description of what was done to overcome any barriers/issues/problems encountered during the completion of the activities during the quarter.	
Unanticipated Outcomes (optional)	Description of any unanticipated outcomes of the activities during the quarter.	



QUARTER 3		
Activity Progress and Comments		
Contributing Partners	List of partners who contributed to the completion of the activities during the quarter.	
Partner Contributions	Any resources provided by partners (funding, meeting space, assistance, etc.) during the quarter.	
Key Accomplishments	Description of any factors that contributed to the successful completion of the activities and any products or results due to the activities during the quarter.	
Barriers/Issues Encountered	Description of any barriers/issues/problems encountered during the completion of the activities during the quarter.	
Plans to Overcome Barriers/Issues	Description of what was done to overcome any barriers/issues/problems encountered during the completion of the activities during the quarter.	
Unanticipated Outcomes (optional)	Description of any unanticipated outcomes of the activities during the quarter.	

QUARTER 4		
Activity Progress and Comments		
Contributing Partners	List of partners who contributed to the completion of the activities during the quarter.	
Partner Contributions	Any resources provided by partners (funding, meeting space, assistance, etc.) during the quarter.	
Key Accomplishments	Description of any factors that contributed to the successful completion of the activities and any products or results due to the activities during the quarter.	
Barriers/Issues Encountered	Description of any barriers/issues/problems encountered during the completion of the activities during the quarter.	
Plans to Overcome Barriers/Issues	Description of what was done to overcome any barriers/issues/problems encountered during the completion of the activities during the quarter.	
Unanticipated Outcomes (optional)	Description of any unanticipated outcomes of the activities during the quarter.	

Drop Down Menu Options

Status
 During the tracking of the objective or activity, select "On Track", "Not on Track", or "Decision Required":

- **On Track** = Progress is exceeding expectations or is performing as expected at this point in time.
- **Not on Track** = Progress is below expectations at this point in time.
- **Decision Required** = At risk of not completing/meeting goal. Management decision is required on mitigation/next steps.

At completion of the date on the objective, select "Completed" OR "Not Completed":

- **Completed** = Completed or has been met and the target date has passed.
- **Not Completed** = Not completed or has not been met and the target date has passed.

SHIP ACCOMPLISHMENTS	
ACTIVITY 1	
ACTIVITY 2	

Template Updated: 02-01-2019

HEALTH IMPROVEMENT AND STRATEGIC PLAN TRACKING SYSTEM

Health Improvement and Strategic Plan Tracking System

Page 1 of 4

FLORIDA DEPARTMENT OF HEALTH Division of Public Health Statistics & Performance Management



Plan Review

Print

Lafayette CHD CHIP 2018-2022

Select Year:

Priority: Maternal and Child Health [Edit](#)

Goal: 1 Improve the Health of Women and Babies [Edit](#)

Strategy: 1.1 Remove Barriers to education/information, services, and support for women and families [Edit](#)

Objectives:

- 1.1.1.1 Reduce teen birth rate amongst young women aged 13-19 by 5% from a rate of 15.6 to 14.82 by December 31, 2021 [Edit](#)
- 1.1.1.2 Increase the percent of women who receive prenatal care in their first trimester by 5% points from 70.1% to 75.1% by December 31, 2021 [Edit](#)

Goal: 2 Institute Sexual Health Education for Youth and Teens [Edit](#)

Strategy: 2.1 Policy change at public schools, awareness/education campaigns [Edit](#)

Objectives:

- 1.2.1.1 A task force on teen sexual health and comprehensive sex education will be foremed and hold its first meeting by December 31, 2018 [Edit](#)
- 1.2.1.2 Launch an educational and advertising campaign targeting middle and high school students, featuring radio ads, community bulletin boards, and print ads in local media will be launched to outline key factors in reponsible parenting and sexual behaviors by December 31, 2019 [Edit](#)

Priority: Healthy Behaviors [Edit](#)

Goal: 2.1 Reduce Substance Abuse [Edit](#)

Strategy: 2.1.1 Improve access to services and resources, provide health education, policy change for funding to support expanded services [Edit](#)

Objectives:

- 2.1.1.1 Increase access to mental health services in Lafayette County by increased mental health visits by January 31, 2019 [Edit](#)

- 2.1.1.2 Partner with local law enforcement to provide education on drug and substance abuse to middle school/teen students of Lafayette County Schools by June 30, 2019
Edit

Goal 2 Prevent Unintentional Injuries Edit

Strategy 2.1 Provide education and awareness campaigns and support enforcement activities
Edit

Objectives:

- 2.2.1.1 Provide two farm equipment safety seminars by May 31, 2020 Edit
- 2.2.1.2 Develop and implement an educational and skills development campaign on safe driving for adults and high school students by June 30, 2019 Edit

Priority Chronic Health Conditions Edit

Goal 3.1 Promote Health Weight for Lafayette County Residents Edit

Strategy 3.1.1 Institute primary prevention approaches to healthy lifestyles including education and access to services and resources Edit

Objectives:

- 3.1.1.1 Increase time spent in providing health education to Lafayette County residents by having a DOH Health Educator spend at least two days per week in Lafayette by December 31, 2019 Edit
- 3.1.1.2 Decrease the percent of adults who are obese by 3% points from 35.5% to 32.5% by December 31, 2021 Edit
- 3.1.1.3 Increase recreational activities for residents of Lafayette County by hosting at least three Healthy Hikes and at minimum bimonthly health events (i.e.: fun runs, park obstacle courses, etc.) by December 31, 2021 Edit
- 3.1.1.4 Maintain a full-time Health Educator for Chronic Disease Prevention at DOH-Lafayette by December 31, 2022 Edit

Goal 3.2 Reduce the Impact of Chronic Diseases Edit

Strategy 3.2.1 Provide education on disease management and provide support services Edit

Objectives:

- 3.2.1.1 DOH Chronic Disease Health Educator will set up community Lunch and Learns at least 3 times per year by December 31, 2019 Edit
- 3.2.1.2 Increase availability of counseling services and health education classes for health risks by establishing a health education class schedule by December 31, 2020 Edit
- 3.2.1.3 Decrease the percent of adults who have ever had a heart attack, angina, or coronary heart disease, or stroke by 5% points from 18.2% to 13.2% by December 31, 2022 Edit
- 3.2.1.4 Decrease the percent of adults who have ever been told they had diabetes by 5% points from 21% to 16% by December 31, 2022 Edit

Priority 4: Access to Health Care Services [Edit](#)

Goal 4.1: Improve access to health care services [Edit](#)

Strategy 4.1.1: Eliminate barriers to health care services-including dental and mental health- and to use technology to bring enhanced services to Lafayette County [Edit](#)

Objectives:

- 4.1.1.2 Increase the percentage of patient visits to mobile health clinics by 5% by December 31, 2019 [Edit](#)
- 4.1.1.3 Establish mobile dental clinics that are no/low cost for Lafayette County adults by December 31, 2021 [Edit](#)
- 4.1.1.4 Implement a dental screening and sealant program for students in Grade 2 at Lafayette County elementary schools by December 31, 2022 [Edit](#)

Goal 4.2: Reduce Health Care Costs and Improve Efficient Use of Existing Services [Edit](#)

Strategy 4.2.1: Improve health literacy [Edit](#)

Objectives:

- 4.2.1.1 Provide health literacy/healthy lifestyles program/training to adults in Lafayette County by December 31, 2021 [Edit](#)
- 4.2.1.2 Reduce avoidable ER visits by Lafayette County residents by 2% from 702 to 688 by December 31, 2022 [Edit](#)

Priority 5: Community Engagement [Edit](#)

Goal 5.1: Ensure Adequate EMS Service [Edit](#)

Strategy 5.1.1: Policy change, revenue generation, awareness [Edit](#)

Objectives:

- 5.1.1.1 Place into service a second ambulance in Lafayette County by December 31, 2022 [Edit](#)
- 5.1.1.2 Increase public awareness of transportation services offered by Lafayette County by December 31, 2022 [Edit](#)
- 5.1.1.3 Increase usage of public transportation services by 2% by December 31, 2022 [Edit](#)

Goal 5.2: Improve community commitment to improving health in Lafayette County [Edit](#)

Strategy 5.2.1: Plan and implement health-related community events [Edit](#)

Objectives:

- 5.2.1.2 Increase the number of new community partners who participate in outreach events by five by December 31, 2019 [Edit](#)
- 5.2.1.3 Implement Friday Night Done Right campaign and hold first event by January 31, 2020 [Edit](#)



- 5.2.1.4 Increase number of community participants in outreach activities offered by Lafayette County community partners by five participants by December 31, 2020 [Edit](#)

