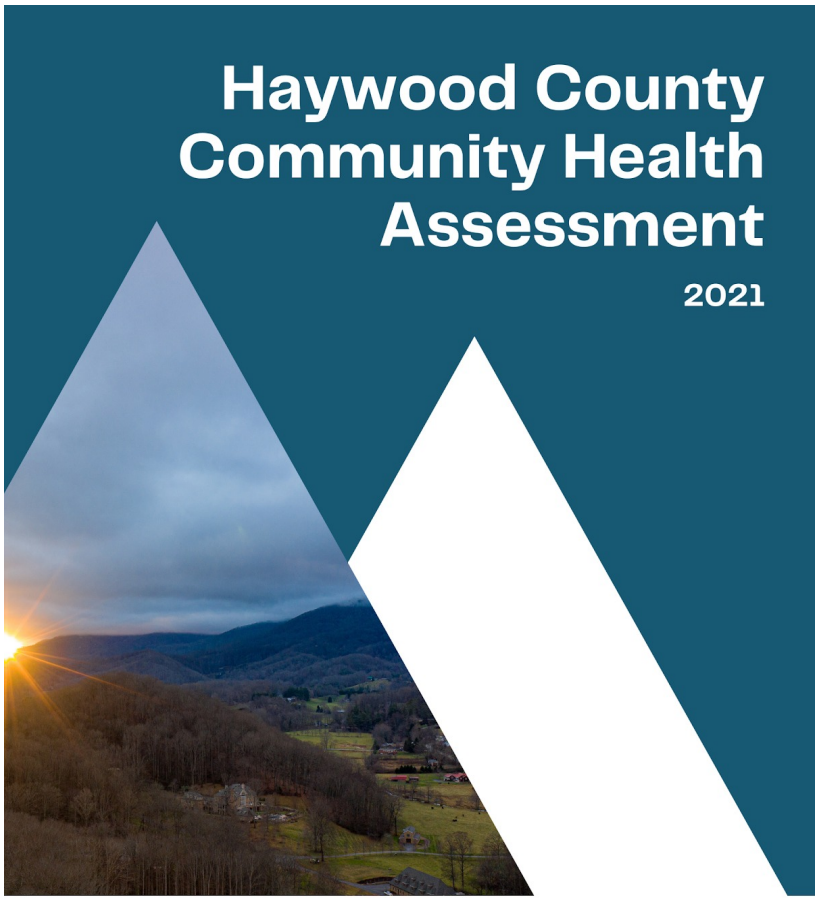
HNC 2030 Scorecard: Haywood County (2021-2023)

2021 Haywood County Community Health Assessment



Haywood County's 2021 Community Health Assessment priority areas are:

- **Mental health**
- **Obesity**

- **Substance use**

Clear Impact Scorecard™ is a strategy and performance management software that is accessible through a web browser and designed to support collaboration both inside and outside organizations. WNC Healthy Impact is using Clear Impact Scorecard™ to support the development of electronic community health improvement plans (eCHIP), State of the County Health Reports and Hospital Implementation Strategy scorecards in communities across the region. The 2022 Haywood County Community Health Improvement Plan (eCHIP) was submitted by Friday, September 30, 2022.

Scorecard helps communities organize their community health improvement efforts by:

- Developing and communicating shared vision
- Defining clear measures of progress
- Sharing data internally or with partners
- Simplifying the way you collect, monitor and report data on your results

A key to navigating this scorecard:

CA Community Health Assessment

R Result – A condition of well-being for an entire population.

I Indicator – A measure that helps quantify the achievement of a population result.

S Strategy – A collection of actions that have a reasoned chance of improving results.

PM Performance Measure – A measure of how well a program is working, the quality of a program or whether clients or customers of the program are better off.

SR SOTCH Report – An annual report and update on the Community Health Improvement Plan.

The following link displays the resources used/reviewed to complete this scorecard:

Community Health Improvement Plan Resources

An additional resource related to the CHIP is the CHA tools located at: https://publichealth.nc.gov/lhd/.

A list of Community Health Improvement Process partners is located at this link.

Community Health Assessment (CHA) Report

CA 2021 Haywood County Community Health Assessment

Most Recent Period | Current Actual Value | Current Trend | Baseline % Change

Executive Summary

Haywood County 2021 Community Health Assessment Executive Summary

Community Results Statement

The ultimate goal for Haywood County is to build a healthy and resilient community.

Leadership for the Community Health Assessment Process

A data team of community partners and the public health education team from Haywood County Health and Human Services led the CHA process. Following internal review of both primary and secondary data, the data team received a condensed list. This team provided input to public health staff on which data to review during the prioritization process.

Name	Agency	Title	Agency Website
Megan Hauser	Haywood County Health and Human Services	Public Health Education Supervisor	https://www.haywoodcountync.gov/615/Health-Human-Services
Jeanine Harris	Haywood County Health and Human Services	Public Health Education Specialist/Preparedness Coordinator	https://www.haywoodcountync.gov/615/Health-Human-Services

Darion Vallerga	Haywood County Health and Human Services	Public Health Educator	https://www.haywoodcountync.gov/615/Health-Human-Services
Vicky Gribble	Mountain Projects, Inc.	Certified Application Counselor	https://mountainprojects.org/
Tobin Lee	MountainWise	Region 1 Tobacco Prevention Manager/Interim Project Manager	http://mountainwise.org/
Libby Ray	Mountain Projects, Inc.	Preventionist	https://mountainprojects.org/
Lindsey Solomon	Haywood Regional Medical Center	Marketing and Communications Coordinator	https://www.myhaywoodregional.com/
Jennifer Stuart	Haywood County Public Library	Branch Librarian	https://www.haywoodlibrary.org/

Partnerships

Name	Agency	Title	Agency Website
Greg Caples	Haywood Regional Medical Center	CEO	https://www.myhaywoodregional.com
Greg Christopher	Haywood County Sheriff's Office	Sheriff	https://www.haywoodncsheriff.com
Travis Donaldson	Haywood County Emergency Services	Emergency Services Director	https://www.haywoodcountync.gov/185/Emergency-Services
Shelly Foreman	Vaya Health	Community Relations Regional Director	https://www.vayahealth.com
Vicky Gribble	Mountain Projects, Inc.	Certified Application Counselor	https://mountainprojects.org
Mandy Haithcox	Haywood Pathways Center	Executive Director	https://www.haywoodpathwayscenter.org
Norm Hoffman	Evince Clinical Assessments	President/CHA Prioritization	www.evinceassessment.com
Tobin Lee	MountainWise	Region 1 Tobacco Prevention Manager/Interim Project Manager/CHA Data Team	https://mountainwise.org
Courtney Mayse	Meridian Behavioral Health Services	Haywood County Director of Services/CHA Prioritization	https://meridianbhs.org/
Jody Miller	Region A Partnership for Children	Community Engagement Coordinator/CHA Prioritization	https://rapc.org/
Debbie Ray	Great by Eight	Faith-Based Guiding Team Member/CHA Prioritization	Not applicable
Libby Ray	Mountain Projects, Inc.	Preventionist/CHA Data Team and Prioritization	https://mountainprojects.org

Jessica Rodriguez	Vecinos, Inc.	Farmworker Health Program Manager/ CHA Prioritization	https://www.vecinos.org
Julie Sawyer	Haywood County Cooperative Extension	Extension Agent/ CHA Prioritization	https://haywood.ces.ncsu.edu
Lindsey Solomon	Haywood Regional Medical Center	Marketing and Communications Coordinator/CHA Data Team and Prioritization	https://www.myhaywoodregional.com
Jennifer Stuart	Haywood County Public Library	Branch Librarian/CHA Data Team and Prioritization	https://www.haywoodlibrary.org
Florence Willis	Blue Ridge Community Health Services	Patient Navigator/CHA Prioritization	https://www.brchs.com
Mary Ann Widenhouse	National Alliance on Mental Illness/ Vaya Health	President/Member/CHA Prioritization	namihaywood.com
Christy Yazan	NC Department of Health and Human Services	Infant Toddler Program Supervisor/CHA Prioritization	https://beearly.nc.gov/index.php

Regional/Contracted Services

Our county received support from **WNC Healthy Impact**, a partnership and coordinated process between hospitals, public health agencies, and key regional partners in western North Carolina working towards a vision of improved community health. We work together locally and regionally to assess health needs, develop collaborative plans, take action, and evaluate progress and impact. This innovative regional effort is coordinated and supported by **WNC Health Network**. WNC Health Network is the alliance of stakeholders working together to improve health and healthcare in western North Carolina. Learn more at www.WNCHN.org.

Theoretical Framework/Model

WNC Health Network provides local hospitals and public health agencies with tools and support to collect, visualize, and respond to complex community health data through Results-Based Accountability™ (RBA). RBA is a disciplined, common-sense approach to thinking and acting with a focus on how people, agencies, and communities are better off for our efforts.

Collaborative Process Summary

Haywood County's collaborative process is supported on a regional level by WNC Healthy Impact.

Locally, our process began with an internal public health education team reviewing a large list of primary (newly collected) and secondary data (existing). The team narrowed the list before sharing with a data team of community partners. The data team further reviewed the information and arrived at a 'short list.' Before and during prioritization meetings, participants received opportunities to review this data. Following a data presentation, participants used a 'Local Rating and Prioritization' worksheet to rate the relevance, impact, and feasibility of addressing the key issues presented. After arriving at their top three scores, each participant selected their top three key issues using an online poll. The three top-scoring areas overall are the county's new health priorities.

Phase 1 of the collaborative process began in January, 2021 with the collection of community health data. For more details on this process see Chapter 1 – Community Health Assessment Process.

Key Findings

Findings that were particularly telling included:

- **Chronic Disease**
    - Over 72% of individuals are experiencing overweight or obesity (WNC Health Network, 2021), root causes for many chronic diseases. This was an increase from 2018.

- **Substance Use and Mental Health**
    - Over 88% reported feeling hopeful, but 23% of individuals experienced more than seven days of poor mental health in the past month, an increase from 2018. In addition, over 18% were unable to get necessary mental health care in the past year, also an increase from 2018 (WNC Health Network, 2021).
    - A decrease in all opioid use (prescription and non-prescription) was reported: 15.3% vs. 12.4% (WNC Health Network, 2021).
    - Alcohol continues to be a widely misused substance, with over 12% of adults reporting past-month binge drinking, an increase from 2018 This was defined as five or more drinks for a man or four or more for a woman during any occasion (WNC Health Network, 2021). In addition, Haywood County residents made over 500 emergency department visits in 2021 for 'alcohol abuse and dependence,' a decrease from over 600 visits in 2018 (North Carolina Disease Event Tracking and Epidemiologic Detection Tool*, 2022). **NC DETECT is a statewide public health syndromic surveillance system, funded by the NC Division of Public Health (NC DPH) Federal Public Health Emergency Preparedness Grant and managed through collaboration between NC DPH and UNC-CH Department of Emergency Medicine's Carolina Center for Health Informatics. The NC DETECT Data Oversight Committee does not take responsibility for the scientific validity or accuracy of methodology, results, statistical analyses, or conclusions presented.
- **Violent Crime**
    - A larger number of survivors were served by domestic violence shelters: 413 vs 320 (NC Department of Administration, 2021).
    - The community has experienced an increase in violent crime: 342.7 vs 326.8 per 100,000 (NC Department of Justice, 2021).
- **Social Determinants of Health**
    - Over 12% reported a loss of health Insurance during the pandemic, with 24% losing work hours or wages (WNCHN, 2021), affecting access to care. This is a point-in-time figure.
    - In spite of a pandemic, fewer people reported experiencing food insecurity: 3.4% vs. 18.9% (WNC Health Network, 2021).
    - While over 13% of residents live below the poverty level, this figure sharply increases to 33% for those under age 5. This data point is unchanged, as we reviewed a 2015-2019 estimate (U.S. Census, 2021).
- The top three health priorities identified through the Online Key Informant Survey were the same as those emerging from health prioritization meetings.

Health Priorities

1. Mental Health
2. Obesity
3. Substance Use

*Obesity and substance use received an equal number of votes during prioritization meetings.

Next Steps

- Monthly action team meetings based on each health priority;
- Engage existing and new partners in health priority action teams;
- Select priority strategies and performances measures to help us evaluate community health improvement progress;
- The evidence-based strategy, Results-based Accountability (RBA), will be utilized to guide decision-making to create swift and effective health improvements;
- The county's health action teams will hold 'Getting to Strategies' meetings during spring 2022. These meetings will include discussing the quality of life conditions desired for the county, the county's progress on related data points, partners with a role to play, and possible evidence-based strategies.
- Following completion of strategy development for each priority area, the Community Health Improvement Plan (CHIP) will be published using electronic scorecard software. The scorecard allows anyone to monitor progress of the CHIP, the current plan shown here. A CHIP, built from evidence-based strategies, is submitted to the North Carolina Division of Public Health.
- To access the full data set(s) (primary and secondary data), community members are encouraged to contact megan.hauser@haywoodcountync.gov.

CHA Priorities

1. **Mental Health**
2. **Obesity**

3. **Substance Use**

*Obesity and substance use received an equal number of votes during prioritization meetings.

Obesity

R Obesity: Helping Haywood residents live well and live long by promoting physical activity, healthy eating, and quality healthcare.

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change

Experience and Importance

How would we experience improved physical activity, healthy eating, and quality healthcare in our community?

- **Physical activity**
  - Emphasis on physical activity; community is more physically active
  - Increasing mobility
  - Active lifestyles
  - Less screen time
  - Regular physical exercise
- **Decreased barriers**
  - Access to care/access to nutritional services
  - Access to information
- **Socioeconomics**
  - Affordable housing
- **Built environment**
  - More resources for more people to walk, outdoor recreation options
  - People using recreational options
- **Happier community**

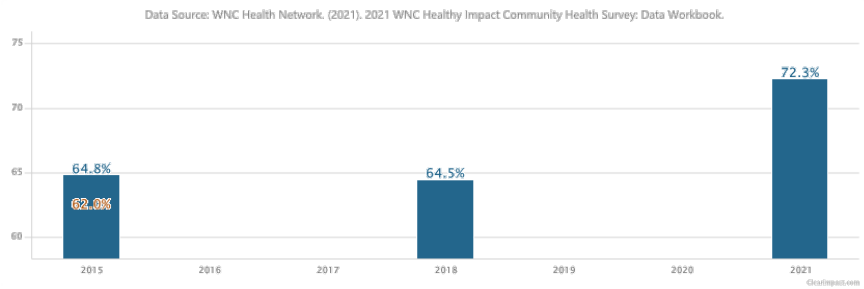
What information led to the selection of this health issue and related result?

The Healthy Haywood Coalition and Wellness Action Group received Community Health Assessment data. Both groups discussed the relevance, impact, and feasibility around obesity, specifically considering weight, physical activity, chronic disease, nutrition, economic (poverty), insurance/access to care and stress data. The community members in attendance then unanimously voted to move forward with the obesity priority as a result of evaluating the primary and secondary community health data. This is a continuation from previous years' health priorities.

- **Weight**
  - Adult overweight/obesity- 72% (WNC Health Network, 2021)
  - Adult healthy weight- 26.3% (WNC Health Network, 2021)
  - Child overweight/obesity (ages 2-18)- 29.9% (Eat Smart, Move More, 2017)
  - Challenges to accessing affordable food: 'Foods found at convenience stores and 'dollar' stores in less populated geographic areas tend to be highly processed, high in sodium & sugar, etc.' -Community Leader (Online Key Informant Survey-WNCHN, 2021)
- **Physical activity**
  - No past-month leisure-time physical activity- 21.7% (WNC Health Network, 2021)
  - Meeting physical activity recommendations- 22.2% (WNC Health Network, 2021)
  - Strengthening activity- 31.7% (WNC Health Network, 2021)
  - Qualities of a healthy community: 'Access to free or low-cost healthy activities, such as walking trails, community parks, etc.' -Community Leader (OKIS-WNCHN, 2021)

- **Chronic disease**
  - Diabetes- 18.6% (WNC Health Network, 2021)
  - Pre-diabetes- 2.9% (WNC Health Network, 2021)
  - Heart Disease- 10.9% (WNC Health Network, 2021)
  - High Blood Pressure- 40.2% (WNC Health Network, 2021)
  - High Cholesterol- 31.8% (WNC Health Network, 2021)
- **Nutrition**
  - Fruit and Vegetable intake- 5.1% (WNC Health Network, 2021)
  - Food and Nutrition Services (SNAP) participation- 8,930 individuals (UNC-CH Jordan Institute for Families, 2021)
  - Free/reduced lunch participation- 7,131 (average daily membership) (NC Department of Public Instruction, 2021)
  - Food Insecurity- 18.9% (WNC Health Network, 2021)
  - Access to nutritional/healthy food- 23% have difficulty buying fresh produce (WNC Health Network, 2015)
  - Strengths- 'The amazing network of people who ensure that food is consistently available. During COVID the flexibility and creativity that included food being delivered to homes without transportation, strong partnerships to move food to reduce waste.' -Community Leader (OKIS-WNCHN, 2021)
- **Economics: Poverty (2015-2019 estimate) (US Census Bureau, 2021)**
  - Total Population (~60,256)
    - 8,087 residents below poverty [13.4%]
  - Children under 18 (~10,743)
    - 2,423 residents below poverty [22.6%] (down)
  - Children under 5 (~2,962)
    - 2,962 residents below poverty [33.4%] (up)
  - Populations impacted- 'Low income, working-class and historically marginalized communities' and 'Older adults on fixed incomes and families with low income jobs or multiple jobs.' -Community Leader (OKIS-WNCHN, 2021)
- **Insurance/access to care**
  - No health insurance coverage- 20.2% (WNC Health Network, 2021)
  - Lost health insurance during pandemic- 12.1% (WNC Health Network, 2021) (point-in-time)
  - Qualities of a healthy community: Ability to see a provider when needed—insurance and free/reduced cost clinics, pop-up free clinics including dental/vision clinics.' -Community Leader (OKIS-WNCHN, 2021)
- **Stress**
  - Typical day is extremely/very stressful- 12.0% (down)
  - Confident in ability to manage stress- 87.3%

Overweight & Obesity prevalence in Haywood County (BMI 25.0 or higher)



2021	72.3%	1	18%
2018	64.5%	1	5%
2015	64.8%	1	6%
2012	61.4%	0	0%

Story Behind the Indicator

The "Story Behind the Indicator" helps us understand why the data on overweight & obesity is the way that it is in our community. When we understand the root causes of our community problems, we have a better chance of finding the right solutions, together.

What's Helping? *These are the positive forces are work in our community and beyond that influence this issue in our community.*

- Grant funding to Haywood County HHSA administered by NC State University provides free Diabetes Prevention Program classes with incentives.
- Double Up Food Bucks provides bonus dollars to Supplemental Nutrition Assistance Program recipients at Haywood's Historic Farmer's Market.
- More adults are meeting fruit and vegetable recommendations- 5.1% (WNC Health Network, 2021)
- More adults are meeting physical activity recommendations- 22.2% (WNC Health Network, 2021)
- Physical activity is supported by free use of school tracks and playgrounds. They are available after school hours when no other activities are scheduled.

What's Hurting? *These are the negative forces are work in our community and beyond that influence this issue in our community.*

- Challenges accessing affordable foods: 'Foods found at convenience stores and 'dollar" stores in less populated geographic areas tend to be highly processed high in sodium & sugar, etc.' -Community Leader (Online Key Informant Survey- WNCHN, 2021)
- Typical day is extremely stressful- 12% (WNC Health Network, 2021)
- Loss of health insurance during pandemic- 12.1% (WNC Health Network, 2021)
- Increase in diabetes- 18.6% (WNC Health Network, 2021)
- Fewer individuals are receiving leisure-time physical activity- 21.7% (WNC Health Network, 2021)
- Transportation is a barrier for many residents. While public transportation exists and is making great strides, it is still difficult for some residents to access.

Partners With A Role To Play

Partners With a Role in Helping Our Community Do Better on This Issue:

Agency	Person	Role
Haywood County Health and Human Services	Darion Vallerga/Megan Hauser/Jeanine Harris	Collaborate
Haywood County Cooperative Extension	Julie Sawyer/Sally Dixon	Lead
Haywood Regional Medical Center	Dietetics and Fitness Staff	Support
Mountain Projects, Inc.	Vicky Gribble	Collaborate
MountainWise	Lauren Wood/Paige Robinson	Support
Haywood County Public Library	Jennifer Stuart	Support
Blue Ridge Health	Florence Willis	Support

What Works to Do Better

The following actions have been identified by our Wellness Action Group and community members as ideas for what can work for our community to make a difference on overweight and obesity.

Actions and Approaches Identified by Our Partners *These are actions and approaches that our partners think can make a difference on overweight and obesity.*

- 5-2-1-Almost None health messaging

- Four-week walking challenge
- Access to professional counseling

What is Currently Working in Our Community *These are actions and approaches that are currently in place in our community to make a difference on overweight and obesity.*

- Steps to Health: pre-k, kindergarten, 3rd grade, 4th grade
  - Color Me Healthy
- Cook Smart, Eat Smart
- Med Instead of Meds
- Canton Library- emphasis on community gardening
- Food Policy Council- supported by Empowering Mountain Food Systems

Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference on overweight and obesity.*

Name of Strategy Reviewed	Level of Intervention
Obesity Prevention and Control: Digital Health Interventions for Adolescents with Overweight or Obesity	Individual
Worksite Digital Health and Telephone Interventions to Increase Healthy Eating and Physical Activity	Individual, Organizational
Obesity: Multicomponent Interventions to Increase Availability of Healthier Foods and Beverages in Schools	Organizational, Policy

Process for Selecting Priority Strategies

Haywood County used a process planning tool refered to as the "Getting to Strategies: Process Plan" designed to move from health priorities to Community Health Improvement Plan strategies. This tool assisted in facilitation when discussing priorites and strategies with work groups. Seven questions were presented to identify: Our ideal vision of Haywood County; What in our community would require change to accomplish our vision; What are the most important measures to reflect positive change; Who plays a role in creating change; What past and current strategies work to make positive change; and What we propose to do this Community Health Imporvement Plan cycle (questions below). Once all of our work groups, partners, and community members in attendance agreed on proposed strategies (keeping in mind feasibility, sustainability, level of impact in regard to current resources and capacity) the group voted for their top three obesity strategies.

- Questions:
  - What are the quality-of-life conditions we want for the people who live in our community?
  - How can we measure these conditions?
  - What would these conditions look like if we could see them?
  - How are we doing on the most important of these measures?
  - Who are the partners who have a role to play in doing better?
  - What works to do better?
  - What do we propose to do?

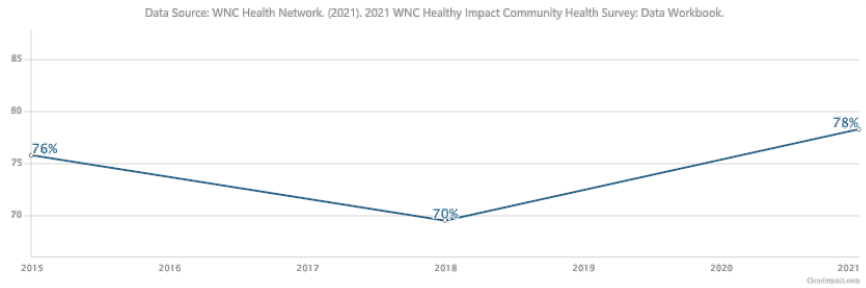
Data Holes

We are keeping an eye on overweight and obesity as a way of telling how we are doing as a community in addressing obesity and build a community where 'Haywood residents live well and live long by promoting physical activity, healthy eating, and quality healthcare.' We have also identified other data that is not currently available, but that we would like to develop to help us monitor progress on this result:

- Child obesity data (more current)

- Activity limitations (prevalence and reasons)

Past-month Leisure Time Physical Activity



2021	78%	1	-6%
2018	70%	2	-17%
2015	76%	1	-9%
2012	84%	0	0%

Story Behind the Indicator

The "Story Behind the Curve" helps us understand why the data on leisure-time physical activity is the way that it is in our community. When we understand the root causes of our community problems, we have a better chance of finding the right solutions, together.

What's Helping? *These are the positive forces are work in our community and beyond that influence this issue in our community.*

- Grant funding to Haywood County HHSA administered by NC State University provides free Diabetes Prevention Program classes with incentives.
- More individuals meeting physical activity recommendations- 22.2%
- Physical activity is supported by free use of school tracks and playgrounds. They are available after school hours when no other activities are not scheduled.
- School programs- Girls on the Run and walking/biking programs

What's Hurting? *These are the negative forces are work in our community and beyond that influence this issue in our community.*

- Fewer individuals are receiving leisure-time physical activity- 21.7%
- Transportation is a barrier for many residents. While public transportation exists and is making great strides, it is still difficult for some residents to access.

Partners With A Role To Play

Partners With a Role in Helping Our Community Do Better on This Issue:

Agency	Person	Role
Haywood County Health and Human Services	Darion Vallerga/Megan Hauser/Jeanine Harris	Collaborate
Haywood County Cooperative Extension	Julie Sawyer/Sally Dixon	Lead
Haywood Regional Medical Center	Fitness Center and Dietetic Staff	Support
MountainWise	Lauren Wood/Paige Robinson	Support
Haywood County Public Library	Jennifer Stuart	Support
Haywood County Recreation and Parks	Ian Smith	Lead
Canton Parks and Recreation	Ben Williams	Lead
Waynesville Parks and Recreation	Luke Kinsland	Lead

What Works to Do Better

(A) Actions and Approaches Identified by Our Partners *These are actions and approaches that our partners think can make a difference on the leisure-time physical activity total.*

- Existing Programs- **Take Control programs**
- Canton Library- emphasis on community gardening
- 5,2,1 Almost None- 5 servings of fruit and vegetables; 2 hours of screen time; 1 hour of exercise; almost no sugary drinks
- 4 week walking challenge- inexpensive community resource to motivate participants to get active

(B) What is Currently Working in Our Community *These are actions and approaches that are currently in place in our community to make a difference on the leisure-time physical activity total.*

- Diabetes Prevention Program
- Haywood County Greenway
- Girls on the Run

(C) Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference on the leisure-time physical activity total.*

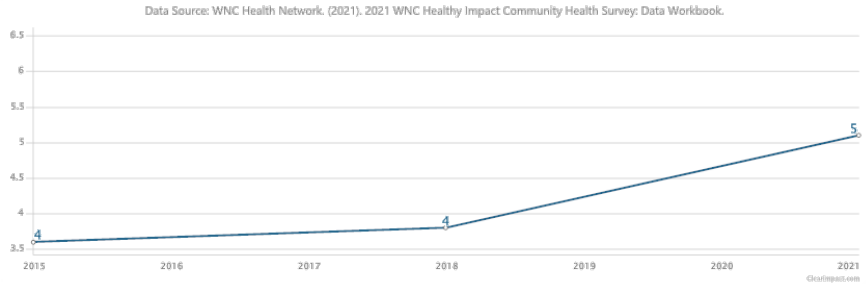
- Faithful Families Thriving Communities- individual and policy levels
- Walk with a Doc- individual level
- Safe Routes to School- individual and organizational levels

Process for Selecting Priority Strategies

Haywood County used a process planning tool referred to as the "Getting to Strategies: Process Plan" designed to move from health priorities to Community Health Improvement Plan strategies. This tool assisted in facilitation when discussing priorities and strategies with work groups. Seven questions were presented to identify: Our ideal vision of Haywood County; What in our community would require change to accomplish our vision; What are the most important measures to reflect positive change; Who plays a role in creating change; What past and current strategies work to make positive change; and What we propose to do this Community Health Improvment Plan cycle (questions below). Once all of our work groups, partners, and community members in attendance agreed on proposed strategies (keeping in mind feasibility, sustainability, level of impact in regard to current resources and capacity) the group voted for their top three obesity strategies.

- Questions:
  - What are the quality-of-life conditions we want for the people who live in our community?
  - How can we measure these conditions?
  - What would these conditions look like if we could see them?
  - How are we doing on the most important of these measures?
  - Who are the partners who have a role to play in doing better?
  - What works to do better?
  - What do we propose to do?

Five daily servings of fruits and vegetables	2021	5	2	-19%	



2018	4	1	-40%
2015	4	1	-43%
2012	6	0	0%

Story Behind the Indicator

What's Helping? *These are the positive forces are work in our community and beyond that influence this issue in our community.*

- Grant funding to Haywood County HHSA administered by NC State University provides free Diabetes Prevention Program classes with incentives.
- Double Up Food Bucks provides bonus to Supplemental Nutrition Assistance Program recipients at Haywood's Historic Farmer's Market.
- The Canton Library cultivates a 'Giving Garden.'
- Participating Farmer's Market vendors donate extra produce to Haywood Gleaners. Grant funding compensates the vendors for these donations.

What's Hurting? *These are the negative forces are work in our community and beyond that influence this issue in our community.*

- Challenges accessing affordable foods: 'Foods found at convenience stores and 'dollar" stores in less populated geographic areas tend to be highly processed high in sodium & sugar, etc.' -Community Leader (Online Key Informant Survey- WNC Health Network, 2021)
- Typical day is extremely stressful- 12% (WNCHN, 2021)
- Increase in diabetes- 18.6% (WNCHN, 2021)
- Transportation is a barrier for many residents. While public transportation exists and is making great strides, it is still a gap for some individuals.

Partners With A Role To Play

Partners With a Role in Helping Our Community Do Better on This Issue:

Agency	Person	Role
Haywood County Health and Human Services	WIC, Health Education, and Food and Nutrition Services Staff	Lead, Collaborate
Haywood County Cooperative Extension	Julie Sawyer/Sally Dixon	Lead
MountainWise	Lauren Wood/Paige Robinson	Support
Haywood County Public Library	Jennifer Stuart	Support
Food Security Network	Participating Food Providers	Lead
Food Policy Council	Blake Hart	Lead

What Works to Do Better

(A) Actions and Approaches Identified by Our Partners *These are actions and approaches that our partners think can make a difference on fruit and vegetable consumption.*

- **Existing Programs**
  - Steps to Health: pre-k, kindergarten, 3rd grade, 4th grade
  - Color Me Healthy
  - Take Control programs
  - Cook Smart, Eat Smart
  - Med Instead of Meds
- Canton Library- emphasis on community gardening
- Food Council- upstream solutions to creating accessible healthy food
- 5,2,1 Almost None- 5 servings of fruit and vegetables; 2 hours of screen time; 1 hour of exercise; almost no sugary drinks

(B) What is Currently Working in Our Community *These are actions and approaches that are currently in place in our community to make a difference on fruit and vegetable consumption.*

- Diabetes Prevention Program
- Med Instead of Meds
- Women, Infants, and Children (WIC)

(C) Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference on fruit and vegetable consumption.*

- Cook Smart, Eat Smart- individual level
- Faithful Families Thriving Communities- individual and policy levels
- Have a Plant (create a habit, eat fruits and vegetables first, cultivate enjoyment)- individual and organization levels

Process for Selecting Priority Strategies

Haywood County used a process planning tool referred to as the "Getting to Strategies: Process Plan" designed to move from health priorities to Community Health Improvement Plan strategies. This tool assisted in facilitation when discussing priorities and strategies with work groups. Seven questions were presented to identify: Our ideal vision of Haywood County; What in our community would require change to accomplish our vision; What are the most important measures to reflect positive change; Who plays a role in creating change; What past and current strategies work to make positive change; and What we propose to do this Community Health Improvement Plan cycle (questions below). Once all of our work groups, partners, and community members in attendance agreed on proposed strategies (keeping in mind feasibility, sustainability, level of impact in regard to current resources and capacity) the group voted for their top three substance use and mental health strategies.

- Questions:
  - What are the quality-of-life conditions we want for the people who live in our community?
  - How can we measure these conditions?
  - What would these conditions look like if we could see them?
  - How are we doing on the most important of these measures?
  - Who are the partners who have a role to play in doing better?
  - What works to do better?
  - What do we propose to do?

Data Holes

We are keeping an eye on fruit and vegetable consumption as a way of telling how we are doing as a community in addressing obesity and build a community where 'Haywood residents live well and live long by promoting physical activity, healthy eating, and quality healthcare.' We have also identified other data that is not currently available, but that we would like to develop to help us monitor progress on this result:

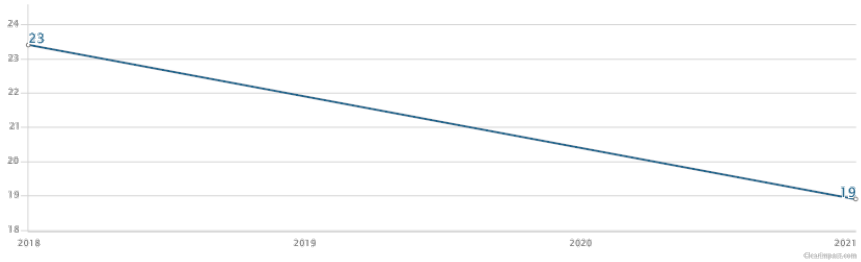
- Proximity of restaurants to grocery stores (more current)

- Access to and utilization of fast food restaurants (more current)

Food Insecurity

2021	19	1	-19%
2018	23	0	0%

Data Source: WNC Health Network. (2021). 2021 WNC Healthy Impact Community Health Survey: Data Workbook.



Story Behind the Indicator

What's Helping? *These are the positive forces are work in our community and beyond that influence this issue in our community.*

- Women, Infants and Children and Supplemental Nutrition Assistance Program facilitated by Haywood County Health and Human Services.
- Double Up Food Bucks provides bonus to SNAP recipients at Haywood's Historic Farmer's Market.
- Regular food distribution events, including special back-to-school and Thanksgiving events. Some food distributions are paired with community resources and school supplies.
- A newly-formed food policy council exists in the county and is facilitated by a local food provider.
- Outdoor pantries provide support for those unable to visit a pantries during scheduled hours.

What's Hurting? *These are the negative forces are work in our community and beyond that influence this issue in our community.*

- Over 20% of individuals report not having someone to rely on for help, if needed.
- Over 22% of individuals say that it is very or somewhat difficult to afford fresh produce.
- Challenges accessing affordable foods: 'Foods found at convenience stores and 'dollar" stores in less populated geographic areas tend to be highly processed high in sodium & sugar, etc.' -Community Leader
- Transportation is a barrier for many residents. While public transportation exists and is making great strides, it is still difficult for some residents to access.

Partners With A Role To Play

Partners With a Role in Helping Our Community Do Better on This Issue:

Agency	Person	Role
Haywood County Health and Human Services	WIC, Health Education, and Food and Nutrition Services Staff	Collaborate
Haywood County Cooperative Extension	Julie Sawyer/Sally Dixon	Lead
MountainWise	Lauren Wood/Paige Robinson	Support
Haywood County Public Library	Jennifer Stuart	Support
Food Security Network	Participating Food Providers	Lead
Food Policy Council	Blake Hart	Lead

What Works to Do Better

(A) Actions and Approaches Identified by Our Partners *These are actions and approaches that our partners think can make a difference on fruit and vegetable consumption.*

- **Existing Programs**
  - Take Control programs
  - Steps to Health: pre-k, kindergarten, 3rd grade, 4th grade
  - Color Me Healthy
  - Cook Smart, Eat Smart
  - Med Instead of Meds
- Canton Library- emphasis on community gardening
- Food Council- upstream solutions to creating accessible healthy food
- 5,2,1 Almost None- 5 servings of fruit and vegetables; 2 hours of screen time; 1 hour of exercise; almost no sugary drinks

(B) What is Currently Working in Our Community *These are actions and approaches that are currently in place in our community to make a difference on fruit and vegetable consumption.*

- Supplemental Nutrition Assistance Program
- Double Up Food Bucks
- Women, Infants, and Children (WIC)

(C) Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference on fruit and vegetable consumption.*

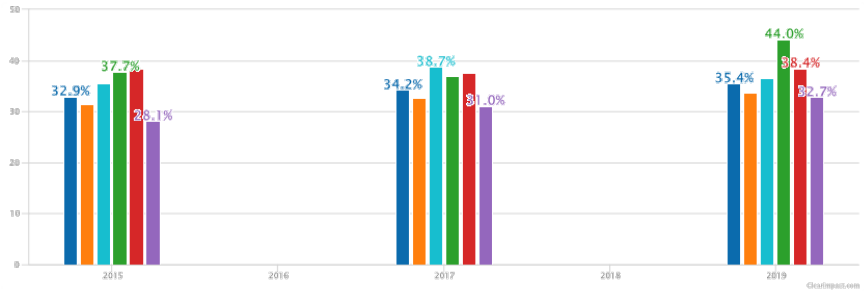
- Cook Smart, Eat Smart: individual level
- Faithful Families Thriving Communities: individual and organizational levels
- Have a Plant (create a habit, eat fruits and vegetables first, cultivate enjoyment): individual and organization levels
- National School Lunch Program: individual and organizational levels

Process for Selecting Priority Strategies

Haywood County used a process planning tool referred to as the "Getting to Strategies: Process Plan" designed to move from health priorities to Community Health Improvement Plan strategies. This tool assisted in facilitation when discussing priorities and strategies with workgroups. Seven questions were presented to identify: Our ideal vision of Haywood County; What in our community would require change to accomplish our vision; What are the most important measures to reflect positive change; Who plays a role in creating change; What past and current strategies work to make positive change; and What we propose to do this Community Health Improvement Plan cycle (questions below). Once all of our workgroups, partners, and community members in attendance agreed on proposed strategies (keeping in mind feasibility, sustainability, level of impact in regard to current resources and capacity) the group voted for their top three substance use and mental health strategies.

- Questions:
  - What are the quality-of-life conditions we want for the people who live in our community?
  - How can we measure these conditions?
  - What would these conditions look like if we could see them?
  - How are we doing on the most important of these measures?
  - Who are the partners who have a role to play in doing better?

I	FHLI-NC HNC2030	Adult Sugar-Sweetened Beverages (SSBs) Total	2019	35.4%	2	8%



2017	34.2%	1	4%
2015	32.9%	0	0%

RM FHLI-NC HNC2030 County Health Ranking Map - Limited Access to Healthy Foods

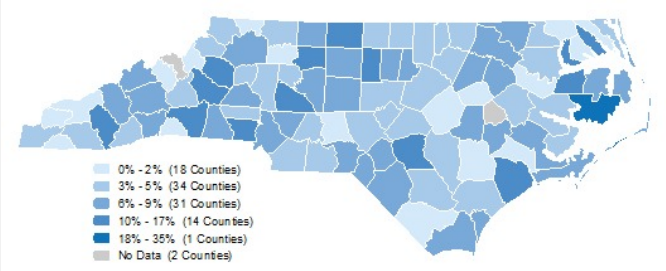
Most Recent Period | Current Actual Value | Current Trend | Baseline % Change

County Health Ranking Map

Limited access to healthy foods

Percentage of population who are low-income and do not live close to a grocery store.

The 2020 County Health Rankings used data from 2015 for this measure.



CHR Link to County Level Data

P Haywood 4 Good Community Wellness Program

Most Recent Period | Current Actual Value | Current Trend | Baseline % Change

What Is It?

Haywood 4 Good is a free wellness initiative that addresses physical, spiritual, emotional, and community wellness. The program operates in six-month sessions and offers continuous enrollment. Participants have the opportunity to participate in at least three wellness challenges each month. Unlike the typical heart health or weight loss challenge, Haywood 4 Good is more broad and inclusive. Challenges such as screen time, water consumption, and volunteerism are accessible by a wider range of people and ability levels.

Haywood 4 Good was identified by the Healthy Haywood Welllness Action Group as an action, that when combined with other actions in our community, that has a reasonable chance of making a difference in adult overweight and obesity prevalence in our community. This is an ongoing program in our community.

The current intervention shows promise. Of participants registered for the first 2022 program, zero participants reported getting at least 30 minutes of flexibility or balance training per week. During the closing survey, over nine percent of participants reported meeting this goal. Vegetable consumption was also a challenge, as zero participants in the first program reported not regularly eating two to three cups of daily vegetables. The closing survey showed that nearly 13% reported meeting this goal. The primary limitation for the program's evaluation is that fewer participants completed the closing survey, demonstrating a gap in behavior change data.

The priority population/customers for this community wellness program are Haywood County residents, and the Haywood 4 Good aims to make a difference at the individual level. Implementation will take place in a virtual format, as all activities are able to be done individually.

This strategy addresses health disparities by providing a free program that does not require transportation or internet access to complete.

Partners With A Role To Play

The partners for this community wellness program include:

Agency	Person	Role
Haywood County Health and Human Services Agency	Megan Hauser, Darion Vallerga	Lead
Haywood Regional Medical Center	Lindsey Solomon	Support, Collaborate
Wellness Action Group	Team Members	Support, Collaborate

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Challenge Runner (account updates and payment)	Staff time, funding	Haywood County Health and Human Services/Megan Hauser	Ongoing
Marketing	Staff time	Haywood County Health and Human Services (Darion Vallerga)/Wellness Action Group members	Ongoing
Participant E-mail Listserv	Staff time	Haywood County Health and Human Services/Megan Hauser	Ongoing
Participant assessments (beginning, midpoint, and closing)	Staff time	Haywood County Health and Human Services/Megan Hauser/Darion Vallerga	Ongoing

Evaluation & Sustainability

Evaluation Plan:

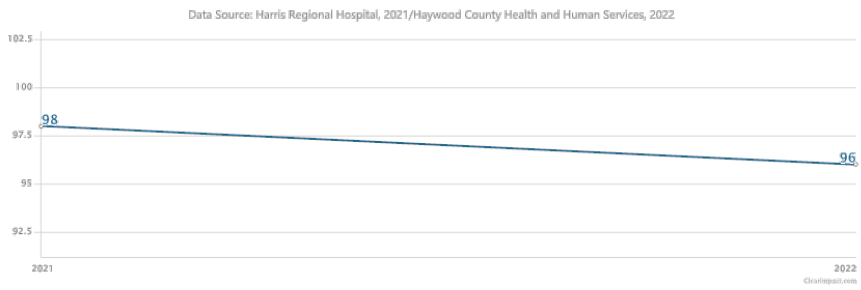
We plan to evaluate the impact of the community wellness challenge through the use of Results-Based Accountability™ to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Our evaluation activities will be tracked in the Work Plan table,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

Sustainability Plan:

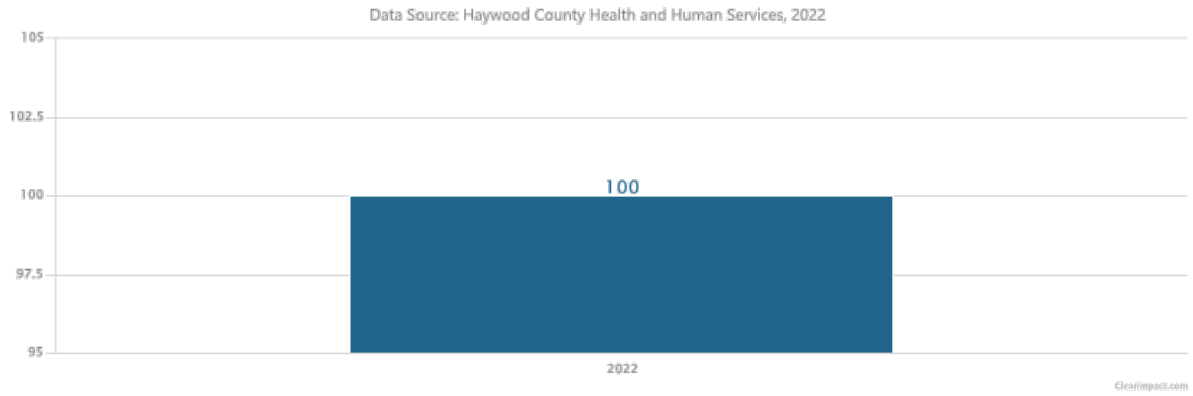
The following is our sustainability plan for the community wellness challenge:

- Sustainability Components
  - Participant registration numbers, percent of participants following recommended health behaviors, and participant feedback will be evaluated. This information will be used to determine the future of the program and justify necessary funding to stakeholders.
  - The challenge is not a typical nutrition or weight loss program, but will instead have a comprehensive focus of physical, spiritual, emotional, and community wellness. Unlike previous programs, the wellness challenge will not focus on gym membership or have a cost, increasing the likelihood that participants will continue healthy habits over time. These features will allow us to engage a more diverse group of community members.
  - Haywood County Health and Human Services Agency (HHSA) has a history of conducting a community fitness challenge and has strong support from community partners. The HHSA is committed to providing staff time for this program.

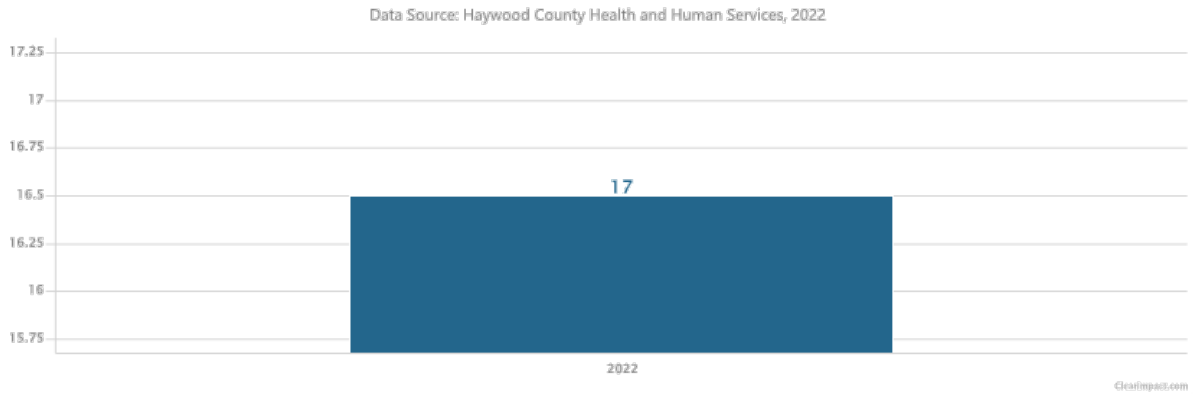
PM	How Much	Number of registered participants in the community wellness program	2022	96	1	-2%
			2021	98	0	0%



PM	How Well	Percent of participants who report satisfaction with the program	2022	100	0	0%



PM | Better Off | Percent of participants who eat 2-3 cups of vegetables per day | 2022 | 17 | 0 | 0%



Customers

Customers:

- School staff
- County employees
- Clients served by Community Health Workers

Clients served by community health workers are often part of groups that are historically underserved.

Story Behind the Curve

The "Story Behind the Curve" helps us understand the causes and forces at work that explain the data behind recommended daily vegetable intake and the resources that Healthy Haywood plans to commit to address the health issue.

What's Helping What We Do? *These are the positive forces at work in our community wellness program that influence how much we do or how well we do it.*

- A program employee oversees regular food resource guide updates
- Community organizations have dedicated staff and volunteers who distribute food.
- A food policy council formed in 2022.

What's Hurting What We Do? *These are the negative forces at work in our community wellness program that influence how much we do or how well we do it.*

- Food providers face increased food and fuel costs.
- Program staff balance many competing priorities.

What's Helping Communities Served/Customer Change? *These are the positive forces at work in our community wellness program that influence customer change.*

- Access to outdoor food pantries
- Drive-through food distribution events
- Low-cost programs offered by Haywood County Cooperative Extension

What's Hurting Communities Served/Customer Change? *These are the negative forces at work in our community wellness program that influence customer change.*

- Difficulty accessing brick and mortar pantries during scheduled hours
- Transportation
- Poverty

What Works to Do Better?

The following actions have been identified by the Wellness Action Group as ideas for what can work for this performance measure to make a difference on overweight and obesity.

Actions and Approaches Identified by Our Wellness Action Group *These are actions and approaches that we think can make a difference for this performance measure.*

- Steps to Health programs- pre-k, kindergarten, 3rd grade, 4th grade
- Med Instead of Meds
- Four-week walking challenge

No-cost and Low-cost Ideas Identified by Our Wellness Action Group *These are no-cost and low-cost actions and approaches that we think can make a difference for this performance measure.*

- 5-2-1-Almost None health messaging
- Community garden

P Offer evidence-based nutrition programming

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change

What Is It?

Faithful Families Thriving Communities (FFTC) was identified by members of the Wellness Action Group as an action, that when combined with other actions in our community, that has a reasonable chance of making a difference in fruit and vegetable consumption and overweight/obesity prevalence in our community. This is a new program in our community.

FFTC is led by program facilitators and lay leaders. The curriculum features nine sessions addressing topics such as nutrition, meal preparation, and becoming more physically active. The program encourages changes at the organization and community levels, such as having a policy to serve water during events.

The priority population/customers for this educational program are members of faith communities, and the educational program aims to make a difference at the individual and organizational levels. Implementation will take place in churches and other faith-based organizations.

This strategy addresses health disparities by connecting individuals with free, evidence-based education in a convenient setting.

FAITHFUL FAMILIES Thriving Communities

Cook Smart, Eat Smart (CSES) was identified by members of the Wellness Action Group as an action, that when combined with other actions in our community, that has a reasonable chance of making a difference in fruit and vegetable consumption and overweight/obesity prevalence in our community. This is an ongoing program in our community.

CSES is led by a trained instructor through North Carolina Cooperative Extension. This four-session program provides recipes demonsrations and instruction about simple cooking techniques.

The priority population/customers for this educational program are adults and older teenagers, and the educational program aims to make a difference at the individual level. Implementation will take place in a community organization.

This strategy addresses health disparities by demonstrating that a healthy diet is accessible even when funds are limited.

Both programs were identified by Haywood County Cooperative Extension as priorities and programs with potential. CSES was offered successfully in the past.

Partners With A Role To Play

The partners for evidence-based nutrition programs include:

Agency	Person	Role
Haywood County Cooperative Extension	Julie Sawyer/Sally Dixon	Lead
Haywood County Health and Human Services	Health Education/WIC/Food and Nutrition Services Staff	Collaborate

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Cook Smart Eat Smart (CSES) marketing and recruitment	Staff time, social media, printed materials	Cooperative Extension/Julie Sawyer Haywood County Health and Human Services/Health Education, WIC, and Food and Nutrition Services' staff	Spring 2023
CSES program instruction	Funding, class materials, staff time	Cooperative Extension/Julie Sawyer	Spring 2023

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
CSES program evaluation and reporting	Staff time	Cooperative Extension/Julie Sawyer	Summer 2023

PM How Much Number of adult participants who increased their consumption of fruits and vegetables

Customers

Customers:

- Women, Infants and Children participants (WIC)
- Supplemental Nutrition Assistance Program (SNAP) recipients
- Community members

Customers include groups at risk for poor nutrition and/or who meet income guidelines to participate in public assistance programs.

Story Behind the Curve

The "Story Behind the Curve" helps us understand the causes and forces at that work that explain the data behind number of participants who complete the evidence-based nutrition curricula and the resources that Haywood County Cooperative Extension plans to commit to address the health issue.

What's Helping What We Do? *These are the positive forces at work in our nutrition education program that influence how much we do or how well we do it.*

- Buy-in from community programs
- Skilled facilitators
- Access to evidence-based programs

What's Hurting What We Do? *These are the negative forces at work in our nutrition education program that influence how much we do or how well we do it.*

- Difficulty recruiting participants
- Limited staff capacity
- Limited funding

What Works to Do Better?

The following actions have been identified by Healthy Haywood as ideas for what can work for this performance measure to make a difference on obesity.

Actions and Approaches Identified by Healthy Haywood *These are actions and approaches that we think can make a difference for this performance measure.*

- Recruitment through SNAP and WIC offices
- Media promotion
- Faith community outreach

No-cost and Low-cost Ideas Identified by Healthy Haywood *These are no-cost and low-cost actions and approaches that we think can make a difference for this performance measure.*

- Recruitment through SNAP and WIC offices
- Media promotion
- Faith community outreach

What communities served/customers think would work to do better *These are actions and approaches that our communities served/customers think can make a difference for this performance measure.*

- Free programs
- Expanded public transportation

Action Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Cook Smart Eat Smart (CSES)/Faithful Families marketing and recruitment	Staff time, social media, printed materials	Cooperative Extension/Julie Sawyer Haywood County Health and Human Services/Health Education, WIC, and Food and Nutrition Services' staff	Spring 2023
CSES/Faithful Families program instruction	Funding, class materials, staff time	Cooperative Extension/Julie Sawyer	Spring 2023
CSES/Families program evaluation and reporting	Staff time	Cooperative Extension/Julie Sawyer	Summer 2023

PM How Much Number of adult participants who increased their physical activity

PM How Much Number of adult participants who indicated they consume less sodium in their diet

PM How Much Number of adult participants who indicated they consume less sugar in their diet

PM How Much Number of participants who increased their knowledge of how to prepare foods, including home food preservation techniques

PM How Much Number of individuals who intend to use local foods when cooking, preparing, or preserving Number of participants who increased their knowledge of safe home food handling, preservation, or preparation practices

R Substance Use: Advance health and resilience by advocating for prevention, treatment, risk mitigation, and recovery for people affected by substance use disorders.

Most Recent Period | Current Actual Value | Current Trend | Baseline % Change

Experience and Importance

How would we experience improved health and resiliency in our community?

Haywood County would be healthier and happier as a result of reduction of substance misuse. According to previous community partner meetings, community members would experience the following:

- A community that offers support to people experiencing substance use disorder (SUD).
- Overall health, optimizing well-being, a community in which all are supported doing those things.
- Stigma-free environment: people feel comfortable and no ashamed by reaching out for help.
- Access to and affordable primary care.
- Whole-person focus from providers.

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

- Opioid Use/Substance Use
  - 12.4% Used Opiates/Opioids in the Past Year, With or Without a Prescription (WNC Health Network, 2021)
  - "Story" Data (Online Key Informant Survey-WNCHN, 2021)
    - Qualities of a healthy community: 'Having a 'no wrong door' approach. If you cannot help someone, you offer a warm handoff and connect them with someone who can help.' -Public Health Representative
    - Challenges from COVID-19: 'The drug prevention education classes normally offered to eighth-grade students at public middle schools in Haywood County were unable to be held due to the COVID-19 pandemic.' 2020 State of the County Health report
- Alcohol Use
  - 12.5% Binge drinking[Single Occasion - 5+ Drinks Men, 4+ Women] (WNCHN, 2021)
  - 17.4% Excessive drinking (WNCHN, 2021)
- Tobacco Use
  - 13.3% Currently smoke (WNCHN, 2021)
  - 3.2 % Use vaping products (such as e-cigarettes) (WNCHN 2021)
- Secondary (Hospital/EMS) Data (NC Opioid Action Plan Dashboard, 2021)
  - Accidental Overdose Death
    - 14 in 2018 (22.6 per 100,000 residents); 17 in 2019 (27.3 per 100,000 residents)
  - Emergency department visits with an Opioid Overdose Diagnosis
    - 54 in 2019 (86.7 per 100,000 residents); 63 in 2020 (101.1 per 100,000 residents)

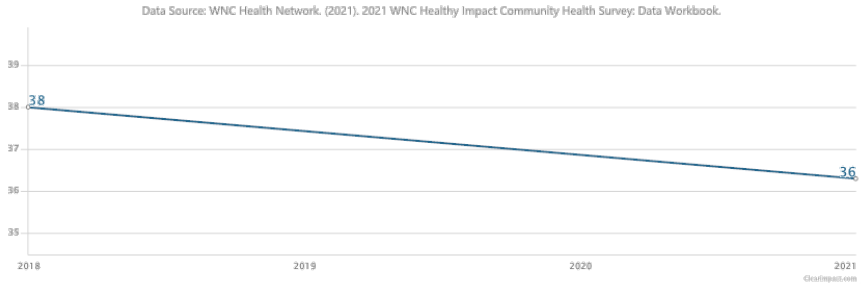
The Healthy Haywood Coalition and Substance Use Prevention Alliance were presented with relevant community health assessment data (above). Both groups received information about the relevance, impact, and feasibility around substance misuse, specifically looking at opioid, tobacco/vaping, and alcohol data. Social determinants of health data such as poverty, community resiliency estimates, and other community-based data were also provided. The community members in attendance then unanimously voted to move forward with the substance abuse priority as a result of evaluating the primary and secondary community health data. This is a continuation from previous years' health priorities.

Known risk factors for this issue are as follows:

- Family
- Social Network/Support Networks
- Adverse Childhood Experiences (ACEs)
- Income Level/ Experiencing Poverty

- Educational Attainment

I	SU	Life has been negatively affected by substance use (self or someone else)	2021	36	1	-4%
			2018	38	0	0%



Story Behind the Indicator

The "Story Behind the Curve" helps us understand why the data on is the way that it is in our community. When we understand the root causes of our community problems, we have a better chance of finding the right solutions, together.

What's Helping? *These are the positive forces at work in our community and beyond that influence this issue in our community.*

- All law enforcement agencies carry Naloxone, a reversal medication for opioid overdoses. This project is overseen by Haywood County EMS. Many lay citizens have also been trained to use this medication.
- Mountain Area Health Education Center provides trainings on topics such as Medication-Assisted Treatment, Substance Use Disorder, and Stimulant Use Disorder.
- The Community Linkages to Care (CLC) grant- this program aims to connect Haywood County residents to treatment and support for substance use disorder. Support includes risk mitigation, and linkage to housing, food, and jobs.
- 211: It's a free, easy-to-remember phone number connecting callers with health and human services in their community.

What's Hurting? *These are the negative forces at work in our community and beyond that influence this issue in our community.*

- Fentanyl is often found in Heroin and increases the likelihood of an overdose.
- Local data about youth substance use is lacking, which hinders the community's ability to apply for federal funding.
- Stigma exists surrounding drug use and Medication-Assisted Treatment (MAT), such as Suboxone.
- Many residents lack adequate housing, living-wage employment, and Medicaid access, making it difficult to achieve and sustain recovery from substance use and mental health disorders.
- In 2021, 15.8%, or 9,849 Haywood County residents were prescribed opioids (NC Opioid Dashboard, 2021).

Partners With A Role To Play

Partners With a Role in Helping Our Community Do Better on This Issue:

Agency	Person	Role
Haywood County Health and Human Services	Megan Hauser, Darion Vallerga, Jeanine Harris	Lead
Haywood Connect	Lynn Carlson	Support
Haywood Regional Medical Center	Lindsey Solomon	Collaborate
Haywood County Sheriff's Office	Christina Esmay	Support
Haywood County Emergency Services	Travis Donaldson	Support
Vaya Health	Shelly Foreman	Collaborate
Mountain Projects, Inc.	Libby Ray	Collaborate
MountainWise	Tobin Lee	Collaborate
Meridian Behavioral Health Services	Courtney Mayse	Collaborate/Lead

Region A Partnership for Children	Jody Miller	Support
Vecinos, Inc.	Yolanda Pinzon Uribe	Support
Great by Eight	Debbie Ray	Support
Haywood County Cooperative Extension	Julie Sawyer	Support
Haywood County Public Library	Jennifer Stuart	Support
Blue Ridge Community Health Services	Florence Willis	Collaborate
National Alliance on Mental Illness/Vaya Health	Mary Ann Widenhouse	Collaborate

What Works to Do Better

The following actions have been identified by our Substance Use Prevention Alliance and community members as ideas for what can work for our community to make a difference on unintentional medication and drug overdose.

(A) Actions and Approaches Identified by Our Partners *These are actions and approaches that our partners think can make a difference on unintentional medication and drug overdose.*

- Adverse Childhood Experiences/Trauma- seveloping a Community Resilience Plan
- Conduct community education about overdose prevention and reversal.
- Provide risk mitigation services, including naloxone and post-overdose response.

(B) What is Currently Working in Our Community *These are actions and approaches that are currently in place in our community to make a difference on unintentional medication or other drug overdose.*

- Education about safer prescribing practices and naloxone administration
- Community Linkages to Care (CLC): The CLC program aims to connect Haywood County residents to treatment and support for substance use disorder. The goal is to reduce overdose and deaths in Haywood County. The program focuses on people who have Substance Use Disorder.
- Medication-Assisted Treatment- MAT is an evidence-based method for treating substance use disorders. Several agencies in the county provide MAT. Clinics also exist in nearby counties.

(C) Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference on unintentional medication or other drug overdose.*

Name of Strategy Reviewed	Level of Intervention
Medication-Assisted Treatment	Individual, Interpersonal, Community, Organizational
Decreasing stigma	Community, Organizational
Trauma-Informed System of Care	Community, Organizational, Societal

What Community Members Most Affected by Unintentional Medication and Drug Overdose Say *These are the actions and approaches recommended by members of our community who are most affected by unintentional medication and drug overdose.*

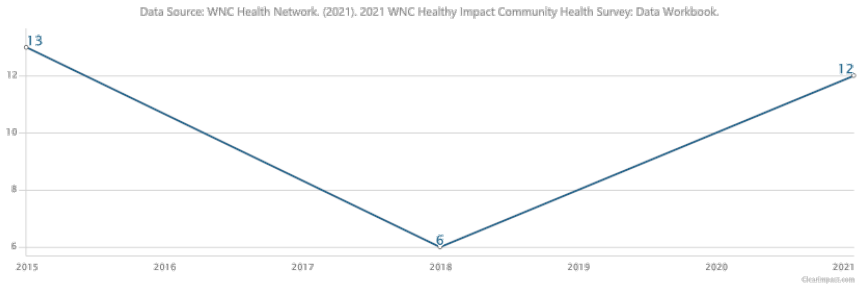
- Implement the Pride survey to obtain youth substance use data
- Hold community listening sessions to determine barriers receiving substance use treatment
- Offer community education about overdose signs and symptoms, as well as how to reverse an overdose

Process for Selecting Priority Strategies

Haywood County used a process planning tool refered to as the "Getting to Strategies: Process Plan" designed to move from health priorities to Community Health Improvement Plan strategies. This tool assisted in facilitation when discussing priorities and strategies with work groups. Seven questions were presented to idenifty: Our ideal vision of Haywood County; What in our community would require change to accomplish our vision; What are the most important measures to reflect positive change; Who plays a role in creating change; What past and current strategies work to make positive change; and What we propose to do this Community Health Improvement Plan cycle (questions below). Once all of our work groups, partners, and community members in attendance agreed on proposed strategies (keeping in mind feasibility, sustainability, level of impact in regard to current resources and capacity) the group voted for their top three substance use and mental health strategies.

- Questions:
  - What are the quality-of-life conditions we want for the people who live in our community?
  - How can we measure these conditions?
  - What would these conditions look like if we could see them?
  - How are we doing on the most important of these measures?
  - Who are the partners who have a role to play in doing better?
  - What works to do better?
  - What do we propose to do?

I SU Past-year opioid use (with or without a prescription)



2021	12	1	38%
2018	6	1	-31%
2015	13	1	49%
2012	9	0	0%

Story Behind the Indicator

The "Story Behind the Curve" helps us understand why the data on is the way that it is in our community. When we understand the root causes of our community problems, we have a better chance of finding the right solutions, together.

What's Helping? *These are the positive forces at work in our community and beyond that influence this issue in our community.*

- All law enforcement agencies carry Naloxone, a reversal medication for opioid overdoses. This project is overseen by Haywood County EMS. Many lay citizens have also been trained to use this medication.
- Mountain Area Health Education Center provides trainings on topics such as Medication-Assisted Treatment, Substance Use Disorder, and Stimulant Use Disorder.
- The Community Linkages to Care (CLC) grant- this program aims to connect Haywood County residents to treatment and support for substance use disorder. Support includes risk mitigation and linkage to housing, food, and jobs.
- 211: It's a free, easy-to-remember phone number connecting callers with health and human services in their community.

What's Hurting? *These are the negative forces at work in our community and beyond that influence this issue in our community.*

- Fentanyl is often found in Heroin and increases the likelihood of an overdose.
- Local data about youth substance use is lacking, which hinders the community's ability to apply for federal funding.
- Stigma exists surrounding drug use and Medication-Assisted Treatment (MAT), such as Suboxone.
- Many residents lack adequate housing, living-wage employment, and Medicaid access, making it difficult to achieve and sustain recovery from substance use and mental health disorders.
- In 2021, 15.8%, or 9,849 Haywood County residents were prescribed opioids (NC Opioid Dashboard, 2021).

Partners With A Role To Play

Partners With a Role in Helping Our Community Do Better on This Issue:

Agency	Person	Role
Haywood County Health and Human Services	Megan Hauser, Darion Vallerga, Jeanine Harris	Lead
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Haywood Regional Medical Center	Lindsey Solomon	Collaborate
Haywood County Sheriff's Office	Christina Esmay	Support
Haywood County Emergency Services	Travis Donaldson	Support
Vaya Health	Shelly Foreman	Collaborate
Mountain Projects, Inc.	Libby Ray	Collaborate
MountainWise	Tobin Lee	Collaborate
Meridian Behavioral Health Services	Courtney Mayse	Collaborate
Region A Partnership for Children	Jody Miller	Support
Vecinos, Inc.	Yolanda Pinzon Uribe	Support
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Haywood County Cooperative Extension	Julie Sawyer	Support
Haywood County Public Library	Jennifer Stuart	Support
Blue Ridge Community Health Services	Florence Willis	Collaborate
National Alliance on Mental Illness/Vaya Health	Mary Ann Widenhouse	Collaborate

What Works to Do Better

The following actions have been identified by our Substance Use Prevention Alliance and community members as ideas for what can work for our community to make a difference on unintentional medication and drug overdose.

(A) Actions and Approaches Identified by Our Partners *These are actions and approaches that our partners think can make a difference on unintentional medication and drug overdose.*

- Adverse Childhood Experiences/Trauma- developing a Community Resilience Plan
- Conduct community education about overdose prevention and reversal.
- Provide risk mitigation services, including naloxone and post-overdose response.
- Coordinate presentations by first responders and risk mitigation staff for the Substance Use Prevention Alliance. Presentations will include post-overdose response protocol and information about harm reduction interventions.

(B) What is Currently Working in Our Community *These are actions and approaches that are currently in place in our community to make a difference on unintentional medication or other drug overdose.*

- Education about safer prescribing practices and naloxone administration.
- Community Linkages to Care (CLC): this CLC program aims to connect Haywood County residents to treatment and support for substance use disorder. The goal is to reduce overdose and deaths in Haywood County. The program focuses on people who have substance use disorder.
- Medication-Assisted Treatment- MAT is an evidence-based method for treating Substance Use Disorder. Haywood County has several agencies that provide MAT. Clinics also exist in nearby counties.

(C) Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference on unintentional medication or other drug overdose.*

Name of Strategy Reviewed	Level of Intervention

Medication-Assisted Treatment	Individual, Interpersonal, Community, Organizational
Decreasing stigma	Community, Organizational
Trauma-Informed System of Care	Community, Organizational, Societal

What Community Members Most Affected by Unintentional Medication and Drug Overdose Say *These are the actions and approaches recommended by members of our community who are most affected by unintentional medication and drug overdose.*

- Implement the Pride survey to obtain youth substance use data
- Hold community listening sessions to determine barriers receiving substance use treatment
- Offer community education about overdose signs and symptoms, as well as how to reverse an overdose

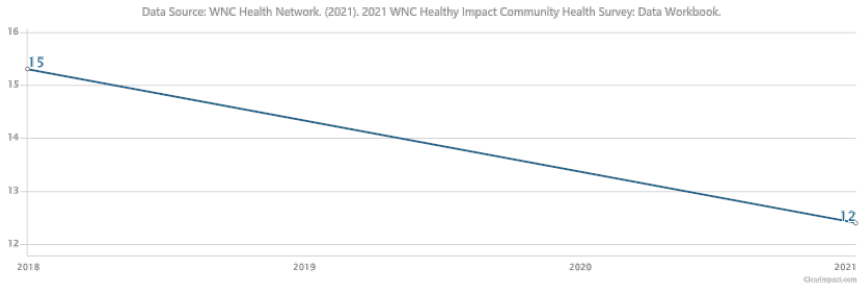
Process for Selecting Priority Strategies

Haywood County used a process planning tool refered to as the "Getting to Strategies: Process Plan" designed to move from health priorities to Community Health Improvement Plan strategies. This tool assisted in facilitation when discussing priorities and strategies with work groups. Seven questions were presented to idenifty: Our ideal vision of Haywood County; What in our community would require change to accomplish our vision; What are the most important measures to reflect positive change; Who plays a role in creating change; What past and current strategies work to make positive change; and What we propose to do this Community Health Imporvement Plan cycle (questions below). Once all of our work groups, partners, and community members in attendance agreed on proposed strategies (keeping in mind feasibility, sustainability, level of impact in regard to current resources and capacity) the group voted for their top three substance use and mental health strategies.

- Questions:
  - What are the quality-of-life conditions we want for the people who live in our community?
  - How can we measure these conditions?
  - What would these conditions look like if we could see them?
  - How are we doing on the most important of these measures?
  - Who are the partners who have a role to play in doing better?
  - What works to do better?
  - What do we propose to do?

I SU Past-month binge drinking

2021	12	1	-19%
2018	15	0	0%



Story Behind the Indicator

The "Story Behind the Curve" helps us understand why the data on is the way that it is in our community. When we understand the root causes of our community problems, we have a better chance of finding the right solutions, together.

What's Helping? *These are the positive forces at work in our community and beyond that influence this issue in our community.*

- Several outpatient facilities in Haywood County offer treatment for Alcohol Use Disorder, including counseling and support, information about employment resources, health education services.
- Community support groups

- Non-privatized alcohol retail stores (only liquor) and limited hours of sale.
- Law enforcement leadership, combined with government and healthcare leadership, make it possible tackle the issue as a community.

What's Hurting? *These are the negative forces at work in our community and beyond that influence this issue in our community.*

- Alcohol consumption increased during the COVID-19 pandemic due to various factors, such as coping with pandemic-related stressors and disrupted treatment access.
- Local data about youth substance use is lacking, which hinders the community's ability to apply for federal funding.
- Many residents lack adequate housing, living-wage employment, transportation barriers and Medicaid access, making it difficult to achieve and sustain recovery from substance use and mental health disorders.

Partners With A Role To Play

Partners With a Role in Helping Our Community Do Better on This Issue:

Agency	Person	Role
Haywood County Health and Human Services	Megan Hauser, Darion Vallerga, Jeanine Harris	Lead
Haywood Connect	Lynn Carlson	Collaborate
Haywood Regional Medical Center	Lindsey Solomon	Collaborate
Haywood County Sheriff's Office	Christina Esmay	Support
Haywood County Emergency Services	Travis Donaldson	Support
Vaya Health	Shelly Foreman	Collaborate
Mountain Projects, Inc.	Libby Ray	Collaborate
MountainWise	Tobin Lee	Collaborate
Meridian Behavioral Health Services	Courtney Mayse	Collaborate
Region A Partnership for Children	Jody Miller	Support
Vecinos, Inc.	Yolanda Pinzon Uribe	Support
Great by Eight	Debbie Ray	Support
Haywood County Cooperative Extension	Julie Sawyer	Support
Haywood County Public Library	Jennifer Stuart	Support
Blue Ridge Community Health Services	Florence Willis	Collaborate
National Alliance on Mental Illness/Vaya Health	Mary Ann Widenhouse	Collaborate

What Works to Do Better

The following actions have been identified by our trauma-informed system of care community advocates, the Substance Use Prevention Alliance, and community members as ideas for what can work for our community to make a difference on Substance Use and Mental Health using a trauma-informed system of care.

(A) Actions and Approaches Identified by Our Partners *These are actions and approaches that our partners think can make a difference on substance use disroder and the long-term impacts of trauma.*

- Adverse Childhood Experiences/Trauma- developing a Community Resilience Plan
- Conduct community education about overdose prevention and reversal.
- Provide risk mitigation services, including naloxone and post-overdose response.
- Coordinate presentations by first responders and risk mitigation staff for the Substance Use Prevention Alliance. Presentations will include post-overdose response protocol and information about risk mitigation interventions.

- Maintaining long-term provider & patient relationships: continuity of care

(B) What is Currently Working in Our Community *These are actions and approaches that are currently in place in our community to make a difference on substance use disroder and the long-term impacts of trauma.*

- Education about safer prescribing practices and naloxone administration.
- Education about the effects along the lifespan that trauma may cause.
- Medication-Assisted Treatment- MAT is an evidence-based method for treating Substance Use Disorders. Haywood County has several agencies that provide MAT. Clinics also exist in neighboring counties.

(C) Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference on substance use disroder and the long-term impacts of trauma.*

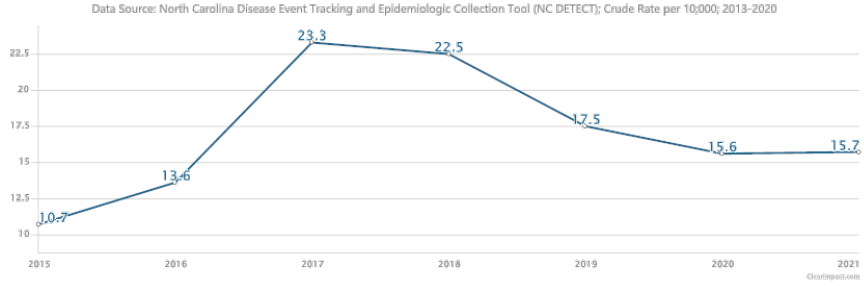
Name of Strategy Reviewed	Level of Intervention
Trauma-Informed System of Care	Organizational, Community, Societal
Medication-Assisted Treatment	Individual, Interpersonal, Community, Organizational
Decreasing stigma	Community, Organizational

Process for Selecting Priority Strategies

Haywood County used a process planning tool refered to as the "Getting to Strategies: Process Plan" designed to move from health priorities to Community Health Improvement Plan strategies. This tool assissted in facilitation when discussing priorities and strategies with work groups. Seven questions were presented to identify: Our ideal vision of Haywood County; What in our community would require change to accomplish our vision; What are the most important measures to reflect positive change; Who plays a role in creating change; What past and current strategies work to make positive change; and What we propose to do this Community Health Improvement Plan cycle (questions below). Once all of our work groups, partners, and community members in attendance agreed on proposed strategies (keeping in mind feasibility, sustainability, level of impact in regard to current resources and capacity) the group voted for their top three substance use and mental health strategies.

- Questions:
  - What are the quality-of-life conditions we want for the people who live in our community?
  - How can we measure these conditions?
  - What would these conditions look like if we could see them?
  - How are we doing on the most important of these measures?
  - Who are the partners who have a role to play in doing better?
  - What works to do better?
  - What do we propose to do?

I SU Emergency department visits for unintentional medication or drug overdoses



2021	15.7	1	71%
2020	15.6	3	70%
2019	17.5	2	90%
2018	22.5	1	145%
2017	23.3	2	153%
2016	13.6	1	48%
2015	10.7	1	16%
2014	12.5	1	36%

Story Behind the Indicator

The "Story Behind the Curve" helps us understand why the data on is the way that it is in our community. When we understand the root causes of our community problems, we have a better chance of finding the right solutions, together.

What's Helping? *These are the positive forces at work in our community and beyond that influence this issue in our community.*

- All law enforcement agencies carry Naloxone, a reversal medication for opioid overdoses. This project is overseen by Haywood County EMS. Many lay citizens have also been trained to use this medication.
- Mountain Area Health Education Center provides trainings on topics such as Medication-Assisted Treatment, Substance Use Disorder, and Stimulant Use Disorder.
- The Community Linkages to Care (CLC) grant- this program aims to connect Haywood County residents to treatment and support for substance use disorder. Support includes risk mitigation and linkage to housing, food, and jobs.
- 211: It's a free, easy-to-remember phone number connecting callers with resources in their communities.

What's Hurting? *These are the negative forces at work in our community and beyond that influence this issue in our community.*

- Fentanyl is often found in Heroin and increases the likelihood of an overdose.
- Local data about youth substance use is lacking, which hinders the community's ability to apply for federal funding.
- Stigma exists surrounding drug use and Medication-Assisted Treatment (MAT), such as Suboxone.
- Many residents lack adequate housing, living-wage employment, and Medicaid access, making it difficult to achieve and sustain recovery from substance use and mental health disorders.
- In 2021, 15.8%, or 9,849 Haywood County residents were prescribed opioids (NC Opioid Dashboard, 2021).

Partners With A Role To Play

Partners With a Role in Helping Our Community Do Better on This Issue:

Agency	Person	Role
Haywood County Health and Human Services	Megan Hauser, Darion Vallerga, Jeanine Harris	Lead
Haywood Connect	Lynn Carlson	Support
Haywood Regional Medical Center	Lindsey Solomon	Collaborate
Haywood County Sheriff's Office	Christina Esmay	Support
Haywood County Emergency Services	Travis Donaldson	Support
Vaya Health	Shelly Foreman	Collaborate
Mountain Projects, Inc.	Libby Ray	Collaborate
MountainWise	Tobin Lee	Collaborate
Meridian Behavioral Health Services	Courtney Mayse	Collaborate
Region A Partnership for Children	Jody Miller	Support
Vecinos, Inc.	Yolanda Pinzon Uribe	Support
Great by Eight	Debbie Ray	Support
Haywood County Cooperative Extension	Julie Sawyer	Support
Haywood County Public Library	Jennifer Stuart	Support
Blue Ridge Community Health Services	Florence Willis	Collaborate
National Alliance on Mental Illness/Vaya Health	Mary Ann Widenhouse	Collaborate

What Works to Do Better

The following actions have been identified by our Substance Use Prevention Alliance and community members as ideas for what can work for our community to make a difference on unintentional medication and drug overdose.

(A) Actions and Approaches Identified by Our Partners *These are actions and approaches that our partners think can make a difference on unintentional medication and drug overdose.*

- Adverse Childhood Experiences/Trauma- developing a Community Resilience Plan
- Conduct community education about overdose prevention and reversal.
- Provide risk mitigation services, including naloxone and post-overdose response.
- Coordinate presentations by first responders and risk mitigation staff for the Substance Use Prevention Alliance. Presentations will include post-overdose response protocol and information about risk mitigation interventions.

(B) What is Currently Working in Our Community *These are actions and approaches that are currently in place in our community to make a difference on unintentional medication or other drug overdose.*

- Education about safer prescribing practices and naloxone administration
- Community Linkages to Care (CLC): this program aims to connect Haywood County residents to treatment and support for substance use disorder. The goal is to reduce overdose and deaths in Haywood County. The program focuses on people who are at risk for substance use disorder.
- Medication-Assisted Treatment- MAT is an evidence-based method for treating Substance Use Disorders. Haywood County has several agencies that provide MAT. Clinics also exist in neighboring counties.

(C) Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference on unintentional medication or other drug overdose.*

Name of Strategy Reviewed	Level of Intervention
Medication-Assisted Treatment	Individual, Interpersonal, Community, Organizational
Decreasing stigma	Community, Organizational
Trauma-Informed System of Care	Community, Organizational, Societal

What Community Members Most Affected by Unintentional Medication and Drug Overdose Say *These are the actions and approaches recommended by members of our community who are most affected by unintentional medication and drug overdose.*

- Implement the Pride survey to obtain youth substance use data.
- Hold community listening sessions to determine barriers receiving substance use treatment.
- Offer community education about overdose signs and symptoms, as well as how to reverse an overdose.

Process for Selecting Priority Strategies

Haywood County used a process planning tool referred to as the "Getting to Strategies: Process Plan" designed to move from health priorities to Community Health Improvement Plan strategies. This tool assisted in facilitation when discussing priorites and strategies with work groups. Seven questions were presented to identify: Our ideal vision of Haywood County; What in our community would require change to accomplish our vision; What are the most important measures to reflect positive change; Who plays a role in creating change; What past and current strategies work to make positive change; and What we propose to do this Community Health Improvment Plan cycle (questions below). Once all of our work groups, partners, and community members in attendance agreed on proposed strategies (keeping in mind feasibility, sustainability, level of impact in regard to current resources and capacity) the group voted for their top three substance use and mental health strategies.

- Questions:
  - What are the quality-of-life conditions we want for the people who live in our community?
  - How can we measure these conditions?
  - What would these conditions look like if we could see them?
  - How are we doing on the most important of these measures?
  - Who are the partners who have a role to play in doing better?
  - What works to do better?
  - What do we propose to do?

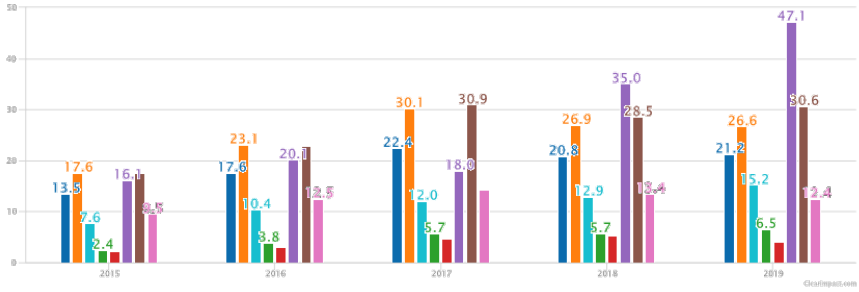
Data Holes

We are keeping an eye on medication and other drug overdoses as a way of telling how we are doing as a community in addressing substance use. We also strive to build a community where we ''advance health and resilience by advocating for prevention, treatment, harm reduction and recovery.'' We have identified other data that is not currently available, but that we would like to develop to help us monitor progress on this result:

- Youth tobacco use
- Youth vape use
- Youth alcohol use
- Youth illicit drug use

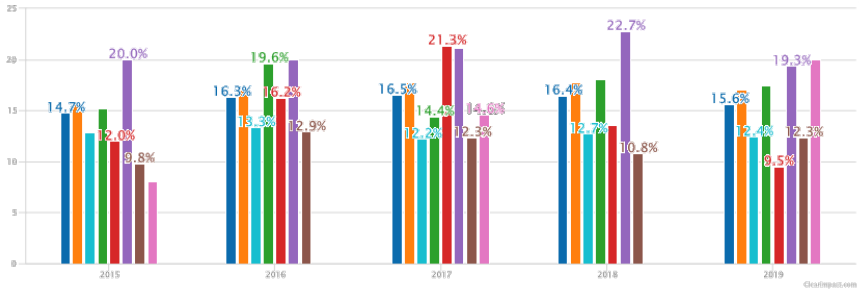
These data points can be collected from youth by conducting the Pride survey in local schools. Pride collects data such as perceptions surrounding drug use, past 30-day drug use and the locations where drugs are used. Additionally, Haywood County created a voluntary youth survey designed to gain feedback from individuals under 18 about their media communication preferences around vaping.

I FHLI-NC HNC2030 Drug Poisoning Deaths Total



2019	21.2	1	57%
2018	20.8	1	54%
2017	22.4	2	66%
2016	17.6	1	30%
2015	13.5	0	0%

I FHLI-NC HNC2030 Binge or Heavy Drinking Total



2019	15.6%	2	6%
2018	16.4%	1	12%
2017	16.5%	2	12%
2016	16.3%	1	11%
2015	14.7%	0	0%

P Participate in anti-stigma communications project

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change

What Is It?

WNC Anti-Stigma Messaging Campaign was identified by community members and the Substance Use Prevention Alliance as an action. When the WNC Anti-Stigma Campaign is combined with other actions in our community, it has a reasonable chance of making a difference in 'Life has been negatively affected by substance use (self or someone else)', 'Past-year opioid use (with or without prescription), 'Emergency department visits for unintentional medication or drug overdoses' in our community. This is a new program in our community.

The priority population for this anti-stigma messaging campaign is individuals living in Haywood County misusing substances, living with substance use disorder (SUD), and those who are indirectly affected by SUD. The anti-stigma messaging campaign aims to make a difference at the interpersonal, community, and organizational levels. Implementation will take place at the community and organizational levels.

Partners With A Role To Play

The partners for this campaign include:

Agency	Person	Role
Western North Carolina Health Network	Adrienne Ammerman, Emily Kujawa	Lead
Haywood County Health and Human Services	Megan Hauser, Darion Vallerga, Jeanine Harris	Collaborate
SHARE Project	Michele Rogers, Lisa Falbo	Collaborate
Vaya Health	Shelly Foreman	Collaborate
Mountain Projects, Inc.	Libby Ray	Collaborate
MountainWise	Tobin Lee	Collaborate
Meridian Behavioral Health Services	Penelope Rollins	Collaborate
Appalachian Community Services	Tabatha Brafford	Collaborate
Haywood County Public Library	Jennifer Stuart	Collaborate
Blue Ridge Community Health Services	Florence Willis	Collaborate
National Alliance on Mental Illness/Vaya Health	Mary Ann Widenhouse	Collaborate
Haywood Regional Medical Center	Lindsey Solomon	Support
Haywood County Sheriff's Office	Christina Esmay	Support
Haywood County Emergency Services	Travis Donaldson	Support

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Planning [advisory meetings and listening sessions]	All individuals/organizations in advisory group & Haywood County residents (for listening sessions)	WNC Health Network [Adrienne Ammerman/Emily Kujawa], Megan Hauser, Darion Vallerga	10/31/2022
Planning [Create campaign toolkit that includes tailored strategies for focused target audiences, resources, template materials, key data, printable materials, a video library, etc.]	Individuals with subject matter expertise, individuals with lived experience, third-party media partner	WNCHN	10/31/2022
Identify or create a website to hold resources, content, and information needed to support the campaign goals.	Website host, domain name, dashboard sfotware	WNCHN	10/31/2022

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Implementation (TBD)	Media for messaging/platforms willing to display messaging (e.g. radio, billboard, news outlets, etc.)/funding	Adrienne Ammerman, Megan Hauser, Darion Vallerga	TBD
Ongoing Evaluation	TBD	TBD	Ongoing

Evaluation & Sustainability

Evaluation Plan:

We plan to evaluate the impact of the anti-stigma messaging campaign through the use of Results-Based AccountabilityTM to monitor specific performance measures. We will monitor How Much, How Well and Better Off Performance Measures. Currently, we plan to evaluate the 'number of advertisements placed,' 'Number of advertisement engagements,' 'Number of clicks from online advertisements,' and 'Number of Haywood County residents reached.' We will track evaluation activities using the draft Work Plan table.

Results	Measures	Methods
Campaign materials are reaching [target audiences]. How much	» Extent to which campaign materials are disseminated through channels that reach a significant proportion of the population » Extent to which efforts are made to touch historically marginalized populations	» Reporting data - Reach - Demographics
Campaign materials are engaging. How well	» Appeal of materials » Perceived likelihood of materials to shift behavior	» Reporting data - Engagement rate » Survey of participant leads
Western NC residents have increased awareness, attitudes, and practices around the identified health practice [name here]. How well and Better off	» Frequency of sharing of positive attitudes and practices associated with campaign among social media participants	» Reporting data - Impressions - Engagement rate - Link clicks - Video views » Public Survey - % who report seeing the ads had an affect on their [topic]-related behaviors - % who report the ads led them to seek more information about [topic] and related preventive behaviors
Local health communicators have increased capacity to create and disseminate health communication materials. Better off	Extent to which participants experienced changes in: » Knowledge and skills to create [topic-related] materials » Ability to disseminate materials » Knowledge of how and where to obtain support	» Survey of participant leads: % who agree with the statements: - "My participation in this campaign helps me to build my capacity to support my agency/facility or community to address [health topic]" - "Participation in this campaign increases my capacity to create and/or disseminate communications materials related to [health topic]"

Campaign participants believe that the collaboration was a positive experience. How well	Ways that the campaign was experienced by the participants related to: » Communication with WNCHN and others in the campaign » Respect » Valuable use of time	» Survey of participant leads - % of participants who agree with the statement: "I feel respected" and "participation in this campaign is a valuable use of my time"

Sustainability Plan:

The following is our sustainability plan for Haywood County's anti-stigma messaging campaign:

- Sustainability Component:
  - Consistent evaluation of program performance measures to ensure ongoing effectiveness and demonstrate successes to funders and other key stakeholders.
  - Participate in monthly meetings with WNCHN and stakeholders to ensure all are in agreement and concerns are addressed.
    - Consistent efforts in identifying new community partners/stakeholders.
  - Ensuring we have the capacity to accomplish documented goals

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PM How Much Number of advertisements placed

Customers

Customers:

- All Haywood County residents
- Anyone affected by substance use disorder or misuse

Story Behind the Curve

The "Story Behind the Curve" helps us understand the causes and forces at that work that explain the data behind the number of advertisements placed and the resources the Substance Use Prevention Alliance plans to commit to address the health issue.

What's Helping What We Do? *These are the positive forces at work in our anti-stigma messaging campaign that influence how much we do or how well we do it.*

- Anti-stigma campaign messaging using local platforms
- Linkage and referral to resources, such as through the Community Linkages to Care program

What's Hurting What We Do? *These are the negative forces at work in our anti-stigma messaging campaign that influence how much we do or how well we do it.*

- Barriers to treatment
- Limited organizational/provider training
- Access to stable housing and employment

What Works to Do Better?

The following actions have been identified by our Substance Use Prevention Alliance as ideas for what can work for this performance measure to make a difference on stigma related to substance use.

Actions and Approaches Identified by Our Agency and Healthy Haywood Coalition *These are actions and approaches that we think can make a difference for this performance measure.*

- Including people with lived experience of Substance Use Disorder into the conversations/community collaboration

- Increasing provider recruitment and retention
- Working with college students in healthcare and social science fields

No-cost and Low-cost Ideas Identified by Our Agency and Healthy Haywood Coalition *These are no-cost and low-cost actions and approaches that we think can make a difference for this performance measure.*

- Including people with lived experience into the conversations/community collaboration
- Working with college students in healthcare and social science fieldse
- Policy change

What communities served/customers think would work to do better *These are actions and approaches that our communities served/customers think can make a difference for this performance measure.*

- Comprehensive list of resources
- Use of evidence-based communication strategies/campaigns
- Expanding peer support services in the community

List of Questions/Research Agenda *These are questions to follow-up on for this performance measure. If you still need more information about what works to do better, make these questions part of your information & research agenda.*

- Are we using the correct platforms to reach our desired audience?
- Are the messages compelling and appropiate?

PM How Much Number of advertisement engagements

PM How Much Number of clicks from online advertisements

PM How Much Number of Haywood County residents reached

R Mental Health: Advance health and resilience by advocating for prevention, treatment, and recovery for people affected by mental health disorders.

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change

Experience and Importance

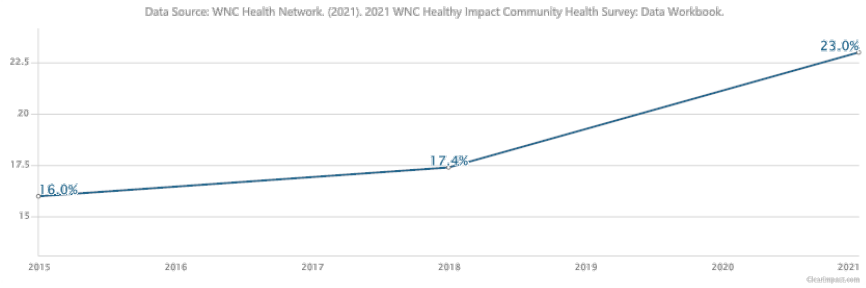
How would we experience improved mental health in our community?

Decreased stigma and barriers to care, injury/self-harm prevention, those with mental health challenges obtain the care they need from reliable mental health practitioners, increased mental health care support for families, and improvements in the broader mental health care system that ensure seamless and continuity of care.

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

Since 2018, self-reported data from Haywood County adults shows increases in the following areas: past-30 day poor mental health, an inability to access needed mental health care or counseling in the last year, not receiving needed social and/or emotional support, and being dissatisfied or very dissatisfied with life. Prioritization team members attributed increases to: nearly 21% of individuals reporting no health care insurance, an increase in the number of individuals reporting homelessness, and stigma for seeking mental health care (WNC Health Network, 2021).

I MH >7 days of poor mental health in the past month in Haywood County | 2021 | 23.0% | 3 | 67%



2018	17.4%	2	26%
2015	16.0%	1	16%
2012	13.8%	0	0%

Story Behind the Curve

The "Story Behind the Curve" helps us understand why the average number of days of poor mental health among adults is the way that it is in our community. When we understand the root causes of our community problems, we have a better chance of finding the right solutions, together.

What's Helping? *These are the positive forces are work in our community and beyond that influence this issue in our community.*

- Approximately 88% of adults reported that they remain hopeful, even in difficult times (WNC Health Network, 2021, point-in-time figure).
- Strong partnerships with mental health providers

What's Hurting? *These are the negative forces are work in our community and beyond that influence this issue in our community.*

- More adults reported having greater than seven days of poor mental health within the past month (WNCHN, 2021).
- 6.7% of individuals reported considering suicide in past year (WNC Health Network, 2021, point-in-time figure).
- Nearly 8% of adults were unable to get needed mental health counseling in the past year (WNCHI, 2021).

What Works to Do Better?

The following actions have been identified as ideas for what can work for our community to make a difference on mental health in Haywood County.

(A) Actions and Approaches Identified by Our Partners *These are actions and approaches that our partners think can make a difference on mental health.*

- Action/Approach 1: Continue providing Question, Persuade, Refer (QPR) training
- Action/Approach 2: Provide Trauma-Informed Care/Adverse Childhood Experiences training

(B) What is Currently Working in Our Community *These are actions and approaches that are currently in place in our community to make a difference on mental health.*

- 211 is available
- Mountain Projects, Inc. provides prevention and early intervention services.
- Vaya Health serves those with mental health and substnace use challenges and developmental disabilities.
- Meridian Behavioral Health Services provides mental health and substance use treatment services, working with both adults and children.
- Reach of Haywood County provides services for survivors of domestic violence and sexual assault, including an emergency shelter and legal assistance (reachofhaywood.org).
- 30th Judicial District Domestic Violence-Sexual Assault Alliance, Inc. - This organization serves survivors of domestic violence and sexual assault
- Kids Advocacy Resource Effort focuses on preventing child abuse and neglect. They also provide advocacy services for survivors.
- Haywood Pathways Center - a non-profit organization that transformed a former jail into a soup kitchen, halfway house and homeless shelter, including a family dorm.
- Haywood Regional Medical Center has a behavioral health unit.

- The Sheriff's Office operates a tip line. Individuals may report calls about underage drinking and drug use, such as drug parties, or for mental health concerns.

(C) Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference on mental health.*

- Question, Persuade, Refer (QPR)
- Trauma Informed Care/Adverse Childhood Experiences (ACES)
- Mental Health First Aid

Process for Selecting Priority Strategies

Haywood County used the process planning tool "Getting to Strategies: Process Plan" which helped move from health priorities to Community Health Improvement Plan strategies. This tool facilitated priority and strategy discussions with work groups. Seven questions were used to identify Our ideal vision of Haywood County; What in our community would require change to accomplish our vision; What are the most important measures to reflect positive change; Who plays a role in creating change; What past and current strategies work to make positive change; and What we propose to do this Community Health Improvement Plan cycle (questions below). Once all work groups, partners, and community members in attendance agreed on proposed strategies (keeping in mind feasibility, sustainability, level of impact in regard to current resources and capacity) the group voted for their top three substance use and mental health strategies.

- Questions:
  - What are the quality-of-life conditions we want for the people who live in our community?
  - How can we measure these conditions?
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  - What works to do better?
  - What do we propose to do?

Partners With A Role To Play

Partners With a Role in Helping Our Community Do Better on This Issue:

Agency	Person	Role
30th Judicial District Domestic Violence and Sexual Assault Alliance	Lynn Carlson	Lead, Collaborate, Support, or Represent Target Population
Haywood County Health and Human Services Agency	Megan Hauser	Collaborate, Support
Haywood County Schools	Joan Kennedy	Collaborate, Support, Represent Target Population
Haywood County Sheriff's Office	Christina Esmay	Collaborate, Support
Haywood Regional Medical Center	Linsey Solomon	Collaborate, Support
Meridian Behavioral Health Services	Courtney Mayse, Penelope Rollins	Lead, Collaborate, Represent Target Population
Mountain Projects, Inc.	Libby Ray	Collaborate, Support
Vaya Health	Shelly Foreman	Lead, Collaborate, Support, or Represent Target Population

Data Holes

We are keeping an eye on number of individuals reporting more than seven days of poor mental health in past month as a way of telling us how we are doing as a community in addressing poor mental health and strides to build a community with increased access to trained mental health providers. We have also identified other data that is not currently available, but that we would like to develop to help us monitor progress on this result:

- Indicator 1: number of individuals who access mental health programs
- Indicator 2: the number of those individuals who accessed mental programs and remain in programs when indicated

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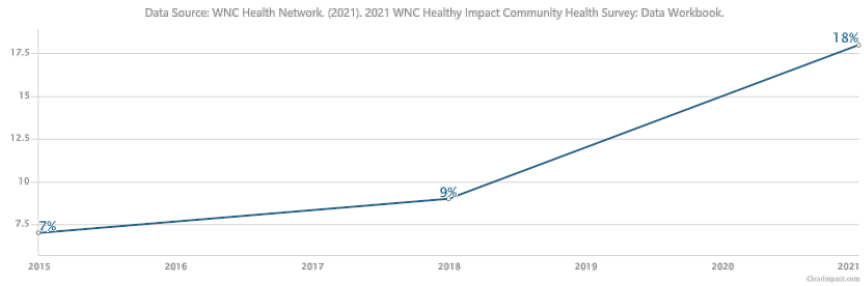
I MH Did not get mental health care or counseling needed in the last year



2021	18%	3	200%
2018	9%	2	50%
2015	7%	1	17%
2012	6%	0	0%

Story Behind the Indicator

What's Helping? *These are the positive forces are work in our community and beyond that influence this issue in our community.*

- Approximately 88% of adults reported that they remain hopeful, even in difficult times (WNC Health Network, 2021, point-in-time figure).
- Strong partnerships with mental health providers.

What's Hurting? *These are the negative forces are work in our community and beyond that influence this issue in our community.*

- More adults reported having greater than seven days of poor mental health within the past month (WNCHN, 2021).
- 6.7% of individuals reported considering suicide in past year (WNCHN, 2021, point-in-time figure).
- Nearly 8% of adults were unable to get needed mental health counseling in the past year (WNCHN, 2021).

What Works to Do Better?

(A) Actions and Approaches Identified by Our Partners *These are actions and approaches that our partners think can make a difference on mental health care access.*

- Action/Approach 1: Improving access to timely, quality care for the uninsured
- Action/Approach 2: Utilize Trauma-Informed Care, including a focus on Adverse Childhood Experiences (ACEs)
- Action/Approach 3: Decrease stigma

(B) What is Currently Working in Our Community *These are actions and approaches that are currently in place in our community to make a difference on mental health care access.*

- Question, Persuade, Refer training
- Trauma-Informed Systems of Care training
- Wellness Recovery Action Plan training

(C) Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference on overweight & obesity rate.*

- Mental Health First Aid
- Crisis Intervention Teams

Process for Selecting Priority Strategies

Haywood County used a process planning tool refered to as the "Getting to Strategies: Process Plan" designed to move from health priorities to Community Health Improvement Plan strategies. This tool assisted in facilitation when discussing priorities and strategies with work groups. Seven questions were presented to idenifty: Our ideal vision of Haywood County; What in our community would require change to accomplish our vision; What are the most important measures to reflect positive change; Who plays a role in creating change; What past and current strategies work to make positive change; and What we propose to do this Community Health Improvement Plan cycle (questions below). Once all of our work groups, partners, and community members in attendance agreed on proposed strategies (keeping in mind feasibility, sustainability, level of impact in regard to current resources and capacity) the group voted for their top three substance use and mental health strategies.

- Questions:
  - What are the quality-of-life conditions we want for the people who live in our community?
  - How can we measure these conditions?
  - What would these conditions look like if we could see them?
  - How are we doing on the most important of these measures?
  - Who are the partners who have a role to play in doing better?
  - What works to do better?
  - What do we propose to do?

Partners With A Role To Play

Partners With a Role in Helping Our Community Do Better on This Issue:

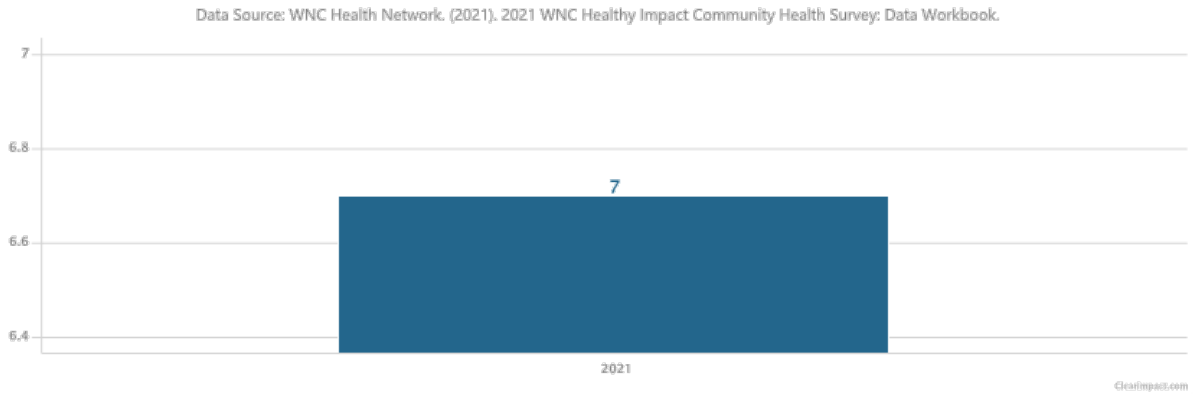
Agency	Person	Role
Vaya Health	Shelly Foreman	Lead, Collaborate, Represent Target Population
Meridian Behavioral Health Services	Courtney Mayse	Lead, Collaborate, Represent Target Population
Haywood County Health and Human Services	Megan Hauser	Collaborate, Support

Data Holes

We are keeping an eye on access to care as a way of telling how we are doing as a community in mental health and build a community where we 'advance health and resilience by advocating for prevention, treatment, and recovery for people affected by mental health disorders,' We have also identified other data that is not currently available, but that we would like to develop to help us monitor progress on this result:

- Indicator 1: number of individuals who access mental health programs
- Indicator 2: the number of those individuals who accessed mental programs and remain in programs when indicated

I	MH Have considered suicide in the past year	2021	7	0	0%



Story Behind the Indicator

What's Helping? *These are the positive forces are work in our community and beyond that influence this issue in our community.*

- Approximately 88% of adults reported that they remain hopeful, even in difficult times (WNC Health Network, 2021, point-in-time figure).
- Strong partnerships with mental health providers.
- Increased awareness through Question, Persuade, Refer (QPR) training sessions
- Dedicated efforts of the Substance Use Prevention Alliance
- Trauma-Informed Care/Adverse Childhood Experiences (ACES) awareness training sessions

What's Hurting? *These are the negative forces are work in our community and beyond that influence this issue in our community.*

- More adults reported having greater than seven days of poor mental health within the past month (WNCHN, 2021).
- 6.7% of individuals reported considering suicide in past year (WNCHN, 2021, point-in-time figure).
- Nearly 8% of adults were unable to get needed mental health counseling in the past year (WNCHN, 2021).
- Lack of accurate suicide data
- Limited access to health care, especially mental health care, for uninsured
- Lack of trauma-informed care and awareness of ACES

Partners With A Role To Play

Partners With a Role in Helping Our Community Do Better on This Issue:

Agency	Person	Role
Vaya Health	Shelly Foreman	Lead, Collaborate, Represent Target Population
Meridian Behavioral Health Services	Courtney Mayse	Lead, Collaborate, Represent Target Population
Haywood County Health and Human Services	Megan Hauser	Collaborate, Support
Blue Ridge Community Health Services	Florence Willis	Colloborate, Support, Represent Target Population
Evince Clinical Assessments	Norm Hoffman	Collaborate, Support, Represent Target Population
National Alliance on Mental Illness/Vaya Health	Mary Ann Widenhouse	Collaborate, Support, Represent Target Population

What Works to Do Better

(A) Actions and Approaches Identified by Our Partners *These are actions and approaches that our partners think can make a difference on suicide prevention.*

- Action/Approach 1: Improving access to timely, quality care for those without insurance

- Action/Approach 2: Utilize Trauma-Informed Care, including a focus on Adverse Childhood Experiences (ACES)
- Action/Approach 3: Decrease stigma
- Action/Approach 4: QPR training for social workers, law enforcement
- Action/Approach 5: Trauma-Informed Care/ACES training for wide range of professionals who are likely to encounter individuals with mental health concerns

(B) What is Currently Working in Our Community *These are actions and approaches that are currently in place in our community to make a difference on suicide prevention.*

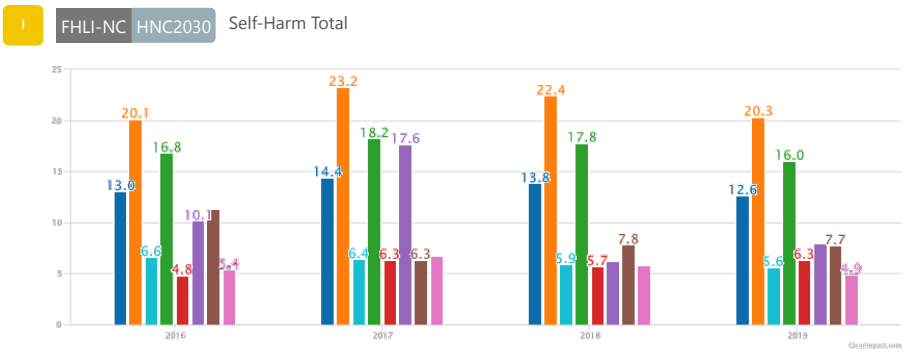
(C) Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference on suicide prevention.*

Name of Strategy Reviewed	Level of Intervention
Question, Persuade, Refer (QPR)	Individual, Interpersonal, Organizational
Trauma Informed Care/Adverse Childhood Experiences (ACES)	Individual, Interpersonal, Organizational, Community, and Policy

Process for Selecting Priority Strategies

Haywood County used a process planning tool refered to as the "Getting to Strategies: Process Plan" designed to move from health priorities to Community Health Improvement Plan strategies. This tool assisted in facilitation when discussing priorities and strategies with work groups. Seven questions were presented to identify: Our ideal vision of Haywood County; What in our community would require change to accomplish our vision; What are the most important measures to reflect positive change; Who plays a role in creating change; What past and current strategies work to make positive change; and What we propose to do this Community Health Improvement Plan cycle (questions below). Once all of our work groups, partners, and community members in attendance agreed on proposed strategies (keeping in mind feasibility, sustainability, level of impact in regard to current resources and capacity) the group voted for their top three substance use and mental health strategies.

- Questions:
  - What are the quality-of-life conditions we want for the people who live in our community?
  - How can we measure these conditions?
  - What would these conditions look like if we could see them?
  - How are we doing on the most important of these measures?
  - Who are the partners who have a role to play in doing better?
  - What works to do better?
  - What do we propose to do?



2019	12.6	2	-3%
2018	13.8	1	6%
2017	14.4	1	11%
2016	13.0	0	0%

What Is It?

Establishing a Trauma-Informed System of Care was identified by various community members and the Substance Use Prevention Alliance as an action, when combined with other actions in our community, that has a reasonable chance of making a difference in 'Life has been negatively affected by substance use (self or someone else)', 'Past-month binge drinking', and 'Emergency department visits for unintentional medication or drug overdoses in our community. This is a new program in our community.

The priority population for establishing a trauma-informed system of care are all Haywood County residents using health, human, or public services (any organization serving Haywood County residents) and the establishment of a trauma-informed system of care aims to make a difference in the community, organizational, and policy levels. Implementation will take place at the organizational level.

Although anyone can experience trauma and especially adverse childhood experiences, this strategy addresses health disparities due to the higher prevalence of trauma in populations experiencing poor social determinants of health such as unstable housing, low income, and racism. Addressing trauma at the socio-ecological level mentioned above will create a more equitable environment to access quality healthcare, access to education, and increase social and community support among all Haywood County residents.

Partners With A Role To Play

The partners for establishing a trauma-informed system of care include:

Agency	Person	Role
Haywood County Health and Human Services	Megan Hauser, Darion Vallerga, Jeanine Harris	Lead
Haywood Connect	Lynn Carlson	Collaborate
Haywood Regional Medical Center	Lindsey Solomon	Support
Haywood County Sheriff's Office	TBD	Support
Haywood County Emergency Services	Travis Donaldson	Support
Vaya Health	Shelly Foreman	Collaborate
Mountain Projects, Inc.	Libby Ray	Collaborate
MountainWise	Tobin Lee	Support
Meridian Behavioral Health Services	Courtney Mayse	Collaborate
Region A Partnership for Children	Jody Miller	Collaborate
Vecinos, Inc.	Yolanda Pinzon Uribe	Support
Great by Eight	Debbie Ray	Support
Haywood County Public Library	Jennifer Stuart	Collaborate
Blue Ridge Community Health Services	Florence Willis	Collaborate
National Alliance on Mental Illness/Vaya Health	Mary Ann Widenhouse	Collaborate

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Develop *Road Map To Success* for Organizational and Commmunity Awareness for Trauma Informed Care/ACES	HHSA developed Trauma Informed Care/ACES materials	Darion Vallerga, Public Health Education Specialist	12/31/2022
Train all Haywood County Health and Human Services Staff (HCHHSA) (Internal HCHHSA trauma-informed systemm of care initative)	Presentation Slideshow, Trainers (Health Education Staff), Mobile Technology [e.g. portable projector]	HCHHSA Health Education Team	10/15/2022
Administer Process Evaluation to HCHHSA staff	Process evaluation (survey), contact information	Darion Vallerga	10/15/2022
Outcome Evaluation	Outcome evaluation (survey), contact information	Darion Vallerga	10/15/2022
Six-month Impact Evaluation	Impact evaluation (survey), contact information, attrition mitigation strategy	HCHHSA Health Education Team	TBD

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
Implement *Road Map To Success* for Organizational and Commmunity Awareness for Trauma Informed Care/ACES	Haywood Connect Particpants and Staff	Haywood Connect, Darion Vallerga	8/31/2025

Evaluation & Sustainability

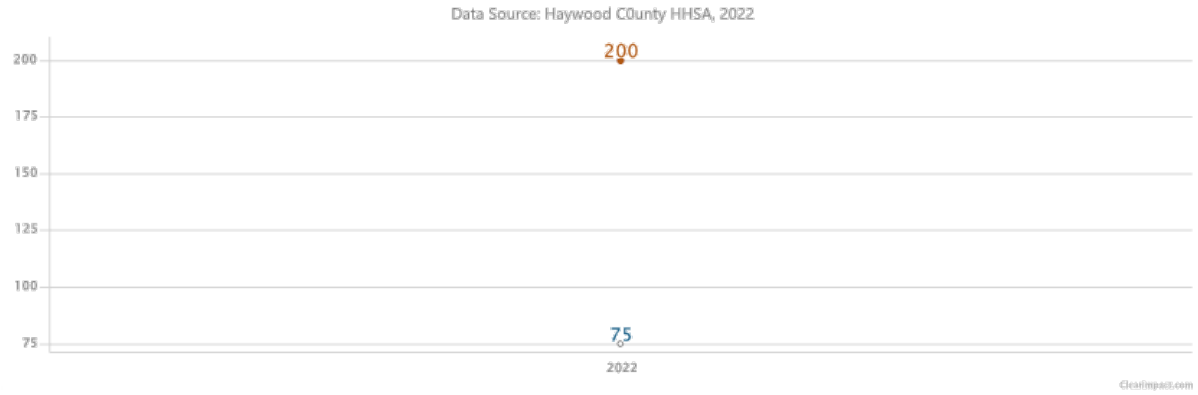
Evaluation Plan:

We plan to evaluate the impact of the trauma-informed system of care initative through the use of Results-Based AccountabilityTM to monitor specific performance measures. We will be monitoring How Much, How Well and Better Off Performance Measures. Currently, we plan to evaluate 'Number of HHSA staff who complete training sessions about trauma-informed care and ACEs', 'Number of members who participate in the ACES Collaborative group (Haywood Connect)', and 'Number of organizations who complete training session about trauma-informed care and ACEs'. Our evaluation activities will be tracked in the Work Plan table, above (ongoing).

Sustainability Plan:

- Sustainability Component:
  - Consistent evaluation of program performance measures to ensure ongoing effectiveness and demonstrate successes to funders and other key stakeholders.
  - Monthly meetings with Haywood Connect and stakeholders to ensure all are in agreement and concerns are addressed.
    - Consistent efforts in identifying new community partners/stakeholders.
  - Ensuring we have the capacity to accomplish documented goals.

PM | How Much | Number of HHSA staff who complete training sessions about trauma-informed care and ACEs | 2022 | 75 | 0 | 0%



Customers

Customers:

- Haywood County Health and Human Services Agency (HHSA) Staff
- Haywood County residents served by HHSA

It is not only important to recongize the benefits of fostering resilience in our community, but also our HHSA staff serving our community.

Story Behind the Curve

The "Story Behind the Curve" helps us understand the causes and forces at that work that explain the data behind the number of HHSA staff who complete training sessions about trauma-informed care and ACEs and the resources Haywood County Health and Human Services Agency plans to commit to address the health issue.

What's Helping What We Do? *These are the positive forces at work in our Trauma-Informed and ACEs Education Initiative that influence how much we do or how well we do it.*

- Ongoing trainings
- Building resiliency skills
- Creating a shared understanding and language of trauma

What's Hurting What We Do? *These are the negative forces at work in our Trauma-Informed and ACEs Education Initiative that influence how much we do or how well we do it.*

- Difficult to measure individual resilience in staff

What Works to Do Better?

The following actions have been identified by our Healthy Haywood Coalition as ideas for what can work for this performance measure to make a difference on trauma and adverse childhood experiences.

Actions and Approaches Identified by Our Agency and Healthy Haywood Coalition *These are actions and approaches that we think can make a difference for this performance measure.*

- Internal-agency training
- External community-based, faith-based, and provider or organization trainings
- Marekting campaign designed to promote the awareness of adverse childhood experiences and related outcomes.

No-cost and Low-cost Ideas Identified by Our Agency and Healthy Haywood Coalition *These are no-cost and low-cost actions and approaches that we think can make a difference for this performance measure.*

- Trauma-Informed System of Care Initiative
- Community collaboration

What communities served/customers think would work to do better *These are actions and approaches that our communities served/customers think can make a difference for this performance measure.*

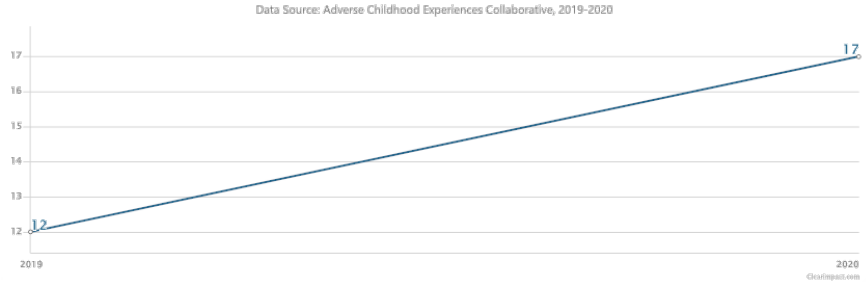
- Maintaining long-term provider & patient relationship/continuity of care
- Increase access to inpatient treatment
- Allowing initiation of medication assisted treatment in detention centers

List of Questions/Research Agenda *These are questions to follow-up on for this performance measure. If you still need more information about what works to do better, make these questions part of your information & research agenda.*

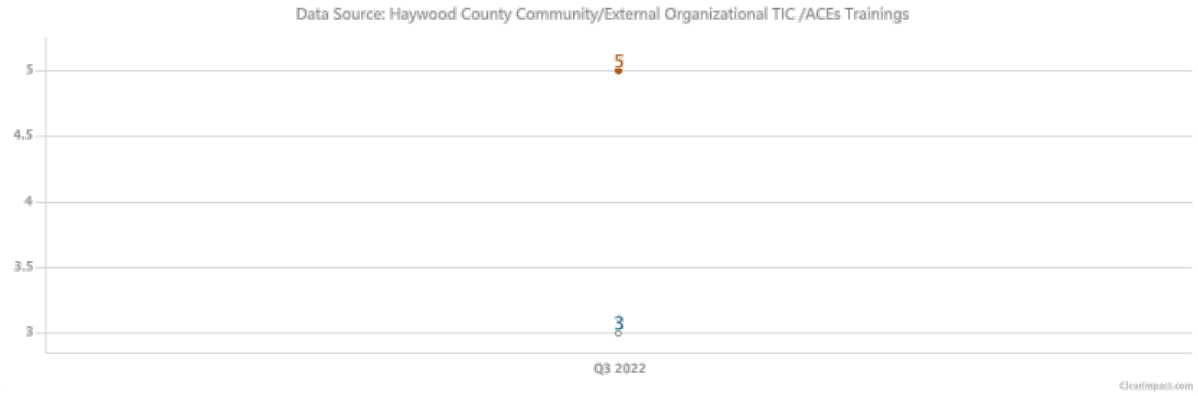
- Is your organization guided by the SAMSHA Trauma-Informed Approach principles?

PM | How Much | Number of members who participate in the ACES Collaborative group (Haywood Connect)

2020	17	1	42%
2019	12	0	0%



PM	How Much Number of organizations who complete training session about trauma-informed care and ACEs	Q3 2022	3	0	0%



P Promote and coordinate mental health trainings and awareness

Most Recent Period | Current Actual Value | Current Trend | Baseline % Change

What Is It?

Trauma-Informed Care (Adverse Childhood Experiences) and Question, Persuade, Refer suicide prevention training (QPR) programs are existing programs being utilized and promoted by our Substance Use Prevention Alliance (SUPA) coalition. Coalition partners recommend continuing these programs and think that when combined with other actions in our community, they have a reasonable chance of making a difference to improve mental health and mental health care in our community.

The priority population/customers for Trauma-Informed Care and QPR-Suicide Prevention Training are health care and social work professionals. The goal is to make a difference at the individual/interpersonal behavior level for staff and the clients they serve. The intent of this goal is to develop a community-wide workforce skilled at recognizing suicidal ideations and individuals affected by adverse outcomes, resulting in quick, appropriate services and care for at-risk populations they serve.

Partners With A Role To Play

The partners for Trauma-Informed Care and QPR include:

Agency	Person	Role
Vaya Health- QPR	Shelly Foreman	Lead, Collaborate, Support, and Represent Target Population
Haywood County HHSA- Trauma-Informed Care	Darion Vallerga	Lead, Collaborate, Support, and Represent Target Population
Mountain Projects- QPR and Trauma Informed Care	Vicky Gribble	Collaborate, Support, and Represent Target Population

Work Plan

Activity	Resources Needed	Agency/Person Responsible	Target Completion Date
QPR Classes	QPR program materials	Vaya Health/Shelly Forman	On-going
Trama Informed Care/ACES	HHSA-developed materials	Haywood County HHSA/Darion Vallerga	On-going

Evaluation & Sustainability

Evaluation Plan:

We plan to evaluate the impact of QPR and Trauma-Informed Care/ACES through the use of Results-Based AccountabilityTM to monitor specific performance measures. We will be monitoring How Much, How Well and/or Better Off Performance Measures. Our evaluation activities will be tracked in the Work Plan table, above.

Sustainability Plan:

The following is our sustainability plan for QPR and Trauma Informed Care/ACES trainings:

- Sustainability: Performance measures will be used to assess the effectiveness of the programs to communicate to community partners and leaders that advocating for and investing in a workfoce trained to recognize and quickly provide appropriate mental health care improves the well being of all residents.
  - Numbers of professional staff attending training will be maintained as well as assessing
    - Staff acknowledgement training enhanced their ability to recognize and care for clients with mental health concerns
    - Staff satisfaction with the training
    - Their willingness to recommend other staff and agencies for this training
    - Si- month follow up that programs have made a difference in their behavior and the behavior of clients they serve

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PM How Much Number of individuals participating in trainings

PM Better Off Percent of individuals participating who indicate positive influence on their life, life of clients they serve

Customers

The ending target population is the clients served by mental health providers in Haywood County, NC. The immediate target population is the mental health care providers and social service workers in Haywood County, NC, including, but not limited to Head Start; Public Health staff: WIC, Clinic, and School Nurses; Meridian Behavioral Health Services, Mountain Projects, Inc.; and MountainWise staff. The goal is to incresase awareness, skills, and comfort level of mental health providers to assess and develop clinical and behavioral improvement plans for their clients.

Customers:

- Haywood County HHSA staff
- Head Start Staff
- Public Health Staff: WIC, Clinic, School Nurses

All identified customers have well established programs for which the majority of their services target the underserved and at-risk and/or vulnerable populations in Haywood County.

Story Behind the Curve

The "Story Behind the Curve" helps us understand the causes and forces at work that explain the data behind Improving Access and Treatment for Mental Health Needs and the resources the Haywood County Health and Human Services Agency (HHSA) plans to commit to address this health issue.

Training up a skilled workforce, using evidenced-based programs such as Question, Persuade, Refer and Trauma Informed Care/ACEs, will improve skills and competency levels when working with clients facing mental health issues and help strengthen referral networks for quick and seamless access to care.

What's Helping What We Do? *These are the positive forces at work with* Mental Health Care *that influence how much we do or how well we do it.*

- Buy-in from community partners
- Skilled, professional facilitators
- Access to evidence-based programs

What's Hurting What We Do? *These are the negative forces at work in our* Mental Health Care *that influence how much we do or how well we do it.*

- High turnover/loss of workforce providing mental health care
- Limited recruitment of participants

- Limited staff capacity for additional training

What Works to Do Better

The following actions have been identified by our Substance Use Prevention Alliancie and community members as ideas for what can work for our community to make a difference mental health care.

- Meridian Behavioral Health Services provides services to both adults and children.
- Reach of Haywood County provides services for survivors of domestic violence and sexual assault, including an emergency shelter and legal assistance.
- 30th Judicial District Domestic Violence-Sexual Assault Alliance, Inc. - This organization serves victims of domestic violence and sexual assault
- Kids Advocacy Resource Effort focuses on preventing child abuse and neglect. They also provide advocacy services for victims.
- Haywood Pathways Center - a partnership that transformed a former jail into a soup kitchen, halfway house and homeless shelter, including a family dorm.
- Haywood Regional Medical Center has a behavioral health unit.
- The Haywood County Sheriff's Office operates a tip line. Individuals may report calls about underage drinking and drug use, such as drug parties, or for mental health concerns.

(C) Evidence-Based Strategies *These are actions and approaches that have been shown to make a difference with mental health issues.*

- Question, Persuade, Refer (QPR)
- Trauma Informed Care/Adverse Childhood Experiences (ACES)
- Mental Health First Aid

What Community Members Most Affected by Mental HealthSay *These are the actions and approaches recommended by members of our community who are most affected by mental health issues*

- Decrease stigma about accessing mental health care
- Secure/retain a well-trainined mental health care workforce
- Increase mental health care support for families

Process for Selecting Priority Strategies

The Healthy Haywood Coalition and Substance Use Prevention Alliance were presented with relevant Community Health Assessment data (above). Both groups were provided information about the relevance, impact, and feasibility around substance misuse, specifically looking at opioid, tobacco/vaping, and alcohol data. Social determinants of health data such as poverty, community resiliency estimates, and other community-based data were also provided. The community members in attendance then unanimously voted to move forward with the substance abuse priority as a result of evaluating the primary and secondary community health data. This is a continuation from previous years' health priorities.

Strategy Prioritization Worksheet; Identifying Priority Strategies Worksheet.

PM How Well Percent of individuals participating who recommend this training for co-workers and other agencies

State of the County Health Reports (SOTCHs)

		Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
SR	2022 State of the County Health Report				