

Granville Vance Public Health COMMUNITY HEALTH IMPROVEMENT PLAN



2026-2028



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Granville Vance Public Health 2026-2028 Community Health Improvement Plan Executive Summary

Overview

The 2026–2028 Community Health Improvement Plan (CHIP) is GVPH's roadmap for improving the health and well-being of residents across Granville and Vance counties. Building on findings from the 2025 Community Health Assessment, this plan outlines coordinated strategies and goals to create lasting, measurable improvements in community health. This CHIP was developed with the support of Triangle North Healthcare Foundation.

Service Area

Granville County and Vance County, North Carolina

Health Priorities and Goals:

Through a community-driven process involving residents, leaders, and partner organizations, GVPH identified two priority areas for 2026–2028:

Physical Health



Physical Health: Chronic Disease & Healthy Lifestyle

Physical health encompasses the prevention and management of chronic conditions, such as diabetes, hypertension, heart disease, and cancer, as well as the behaviors that support overall wellness.

To address these needs, GVPH has established two goals:

Goal 1: Reduce Chronic Disease Burden

Goal 2: Strengthen Healthy Community Environments

Behavioral Health



Behavioral Health: Mental Health & Substance Use

Behavioral health encompasses mental health and substance use including the systems, services, and community supports that help people manage their emotional and psychological well-being.

To address these needs, GVPH has established two goals:

Goal 1: Build Community Capacity & Prevent Crises

Goal 2: Improve Care Coordination & Integration

Implementation Approach: Implementation begins in 2026, with strategies phased across the three-year cycle based on feasibility and impact.

Monitoring & Accountability: Progress will be tracked through quarterly implementation reviews and an annual report submitted to NCDHHS, ensuring strategies remain on track and responsive to community needs.

Who's Leading This Work: GVPH leads implementation in partnership with the WOW Coalition, Physical Health and Behavioral Health Action Teams, and a broad network of local organizations across both counties.

Key Terms and Acronyms

To support a shared understanding of the key components of this Community Health Improvement Plan (CHIP), this section provides definitions of important terms and acronyms used throughout the document. These definitions describe the essential elements that form the foundation of Granville Vance Public Health’s (GVPH) strategic approach to improving health outcomes in Granville and Vance Counties.

Key Terms

Action Plan A detailed, practical roadmap that outlines the specific steps, resources, timelines, and responsible parties needed to address identified health priorities within the community. Action plans translate the CHIP’s strategic goals into concrete, implementable activities with clear accountability measures.

Activity A specific action or intervention undertaken to achieve an objective within the CHIP. Activities are the concrete, tangible work that organizations and partners will implement to drive progress toward health improvement goals.

Goal A broad, high-level target that addresses a specific priority area identified through the Community Health Assessment process. Goals articulate the desired long-term health outcomes that GVPH and its partners aim to achieve for residents of Granville and Vance Counties. Goals are intentionally aspirational and provide overall direction for improvement efforts.

Objective A specific, measurable, and time-bound step toward achieving a stated goal. Objectives define how progress will be tracked and measured, serving as milestones along the path to accomplishing broader health improvement goals.

Acronyms

Acronym	Meaning
CHA	Community Health Assessment
CHIP	Community Health Improvement Plan
HNC 2030	Healthy North Carolina 2030
GVPH	Granville Vance Public Health
NCDHHS	North Carolina Department of Health and Human Services
PHAB	Public Health Accreditation Board
SDOH	Social Drivers of Health
SOTCH	State of the County Health Reports

Record of Changes

GVPH, in partnership with community stakeholders and health system partners, will review implementation progress and update this Community Health Improvement Plan (CHIP) annually. Substantive modifications to the document, including changes to goals, objectives, strategies, or activities detailed in the appendices, will be recorded in this section to maintain version control and ensure transparency with community partners.

Original Publication Date: March 2026

Implementation Timeline: March 2026 through December 2028

Scheduled Annual Review Periods:

- GVPH conducts review of CHIP implementation during the first quarter of each calendar year.
- GVPH annual SOTCH report submitted to NCDHHS by first Monday of March¹.

Date of Update	Description of Modification	Responsible Party

¹ [CHA CHIP SOTCH Submissions](#)

Introduction

This Community Health Improvement Plan (CHIP) serves as a strategic roadmap for addressing the most pressing health needs in Granville and Vance counties over the period of 2026-2028. Building on the findings of the 2025 Community Health Assessment (CHA), this CHIP outlines strategies intended to improve health outcomes and quality of life for all residents in the GVPH service area.

The vision underlying this CHIP reflects GVPH's commitment to inspiring a culture of health by improving **Your Environment, Your Community, and Your Health**. Through selected strategies, community partnerships, and a focus on health equity, this plan aims to create lasting positive change in both behavioral health and physical health outcomes while addressing the social drivers or factors that influence health across the region.

The 2026-2028 CHIP aligns with GVPH's mission to protect and promote health in Granville and Vance counties. The strategies included in this document represent a coordinated effort to leverage existing and new resources, expertise, and community strengths to achieve measurable improvements in population health.

Key Partners and Participants in the CHIP Development Process

With the support of [Triangle North Healthcare Foundation](#), Granville GVPH consulted with Ascendent to facilitate the assessment process for both CHA and CHIP. This 2026-2028 GVPH CHIP is the product of a collaborative process led by GVPH with input and insights provided by community members and organizations and agencies serving Granville and Vance county residents.

GVPH Internal CHA and CHIP Team

GVPH staff served in a leadership role in the CHIP's development, serving as the conveners of partners, key points of contact with the consultants hired to support the process, and final decision-makers on resulting report. A complete list of GVPH who offered their time, resources, and expertise throughout the CHA and CHIP processes are included in the [Acknowledgements](#) section of this report.

CHA and CHIP Steering Committee

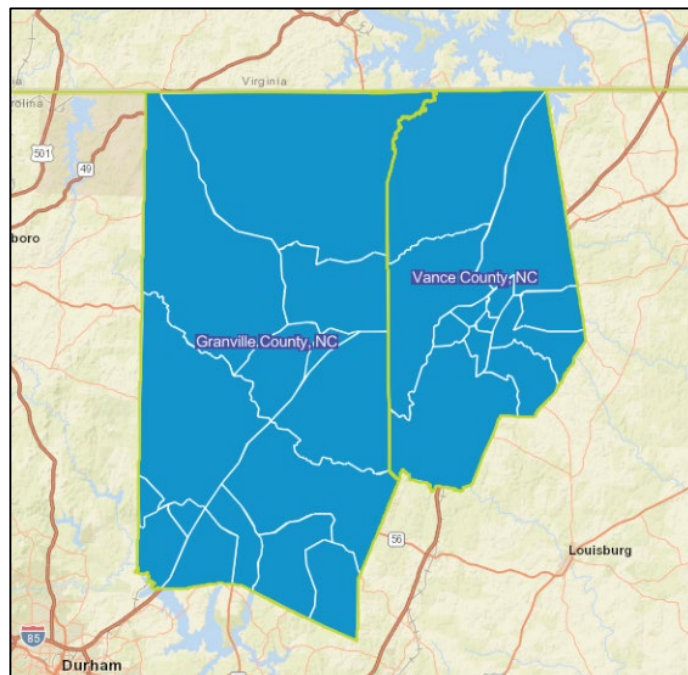
A Steering Committee comprised primarily of GVPH staff, leaders, and community partner organizations, served as the leadership for the 2025 GVPH CHA and subsequent CHIP, providing strategic oversight and support for CHA and CHIP-related activities throughout the multi-month process. The Steering Committee was responsible for providing feedback on CHA and CHIP process steps, offering input on goal, objective, and activity selections for the CHIP, and review of the final document. A complete list of Steering Committee members can be found in the [Acknowledgements](#) section of this report.

CHIP Action Teams and the WOW Coalition

During the CHIP development process, two Action Teams (the Behavioral Health Action Team and the Physical Health Action Team) were convened to develop and affirm draft issue profiles, goals, objectives, and activities for their respective priority health issue areas. These Action Teams included representatives from the WOW Coalition, partners from local community agencies and organizations, and residents with lived experience. Their participation and collaborative input was essential in shaping the key elements of this CHIP. A full listing of Action Team members and WOW Coalition Members can be found in the [Acknowledgements](#) section of this report.

Service Area Description

GVPH serves a two-county region in North Carolina's Northern Piedmont, located north of the Research Triangle. The service area features rolling hills, farmland, and forested areas typical of the Piedmont. Population centers are concentrated around the historic county seats of Oxford and Henderson, while large portions remain sparsely populated rural areas with extensive agricultural operations. Both counties border Virginia to the north, with Granville extending toward Wake County and Vance sitting along the I-85 corridor, maintaining their rural character despite proximity to major metropolitan areas.



GVPH Rural Academic Health Model

Since adopting a Rural Academic Health Department model, GVPH has cultivated partnerships with leading academic institutions including Duke University School of Nursing, the University of North Carolina Gillings School of Public Health, the Center for Health Promotion and Disease Prevention, and North Carolina Central University. These relationships strengthen the connection between research and practice, enhance grant funding capacity, and ensure evidence-based approaches to rural public health challenges.

Phase I: Assess the Situation

This phase involved conducting a comprehensive CHA that analyzed extensive secondary data on health indicators including length of life, quality of life, clinical care, health behaviors, physical environment, and social/economic factors. The assessment also gathered input from community members and key leaders through community health opinion surveys, key leader surveys, focus groups, and key leader interviews. From the assessment process, two categories of health needs were prioritized: behavioral health (including both mental health and substance use) and physical health (chronic disease and healthy lifestyle). Data and Steering Committee input also indicated special consideration of cross-cutting factors including transportation barriers, health equity concerns, and access to care challenges during the CHIP's development.

A full report of **2025 GVPH CHA findings** can be accessed via [GVPH's website](#) or via the North Carolina Department of Health and Human Services, Division of Public Health, State Center for Health Statistics Community Health Assessment [website](#).

Phase II: Development of Priority-Specific Action Plans

During Phase II, two Action Teams were engaged to develop issue profiles and issue statements, discuss possible goals, and brainstorm and prioritize corresponding objectives and activities for each of the two selected priority health needs. The Steering Committee worked collaboratively with Action Team members and a consulting firm to ensure goals, objectives, strategies, and their corresponding action plans reflected community priorities, considered existing local community assets and resources, and noted opportunities for new and innovative approaches to addressing priority health needs.

Phase III: Refine & Adopt CHIP

Phase III involved refining and finalizing issue profiles, goals, objectives, and activities with the Steering Committee. Action plans were established and further refined by the Steering Committee between November 2025 and January 2026. The final CHIP was reviewed and approved by GVPH leadership in February 2026.

Phase IV: Implementation & Monitoring

The last phase of the CHIP process focuses on action plan implementation, including a process for monitoring progress toward achievement of adopted CHIP goals and objectives. This phase includes regular review and reporting mechanisms to ensure accountability and continuous improvement throughout the implementation period. Details surrounding the CHIP's implementation and progress monitoring are detailed later in this report.

Conclusion

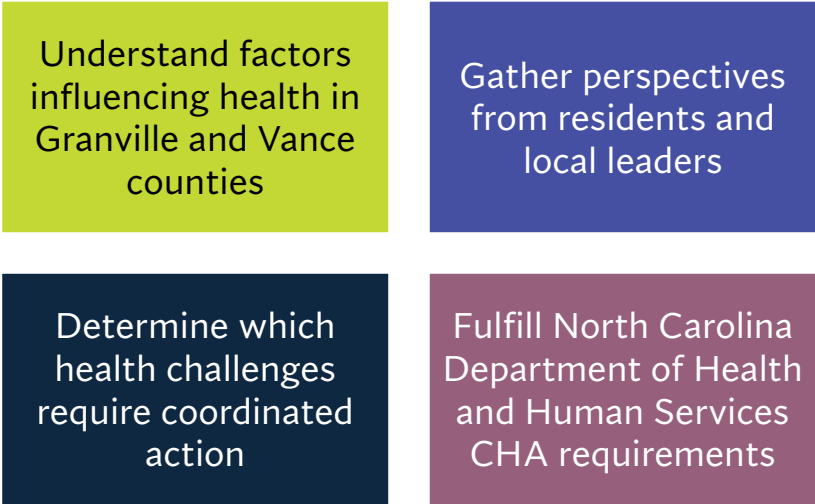
The 2026-2028 GVPH CHIP is designed to create meaningful, measurable improvements in the health and well-being of all service area residents and serves as the roadmap for coordinated community health improvement efforts led by GVPH and local partner organizations. Over the next several pages of this document, each of the CHIP 'phases', information and data reviewed through the CHA process, priorities selected, and decisions made by the Steering Committee and Action Teams are described in greater detail.

Phase I: Assess the Situation

Community Health Assessment Overview

GVPH conducted a CHA to understand the health status and needs of residents across both Granville and Vance counties in 2025. A Steering Committee composed of GVPH personnel and representatives from partner organizations directed this work with support from a consulting partner, Ascendient Healthcare Advisors. This Steering Committee guided decisions about how to collect information, interpreted existing and newly gathered data, and engaged the broader community – residents and stakeholders – throughout. Ultimately, the Steering Committee discussed and prioritized the health issues that became the focus for the **2026-2028 CHIP**.

The CHA aimed to accomplish several goals:



Gathering Community Input: GVPH used multiple data collection methods to hear directly from people living and working in the service area. Four distinct strategies were used to capture the voices, perspectives, and lived experiences from across both counties:

Table 1: Primary Data Collection for 2025 CHA	
Strategy	Participation
Community Health Opinion Survey	176 Responses
Key Leader Survey	48 community leaders
Key Leader Interviews	7 community leaders
Focus Groups	46 people across 6 sessions

1. **A Community Health Opinion Survey** was distributed widely throughout both counties to gather perspectives from residents about their health priorities and experiences. The survey captured what community members see as the most pressing health concerns, barriers they face in accessing care, and their perceptions of overall community health. Responses provided a broad view of health needs across different populations in Granville and Vance counties.
2. **The Key Leader Survey** engaged individuals in positions of community leadership and influence, including representatives from healthcare organizations, social services, education, faith communities, and local government. These leaders shared insights into health trends they observe, gaps in available services, and opportunities for addressing community health needs. Their perspectives offered a systems-level understanding of challenges and potential solutions.
3. **Key Leader Interviews** allowed for in-depth, one-on-one conversations with select community leaders who could provide detailed perspectives on specific health issues and community dynamics. These discussions explored root causes of health challenges, existing community resources, barriers to accessing care, and opportunities for strategic partnerships. The interviews revealed how health issues affect different populations and geographic areas across the service region.
4. **Focus groups** brought together specific populations whose perspectives were unique. Groups participating in focus groups were older adults, women, young people, Spanish speakers, and faith-based community leaders. These conversations revealed how people from these different populations experience health challenges in their daily lives and what makes it difficult to get the care they or their community needs.

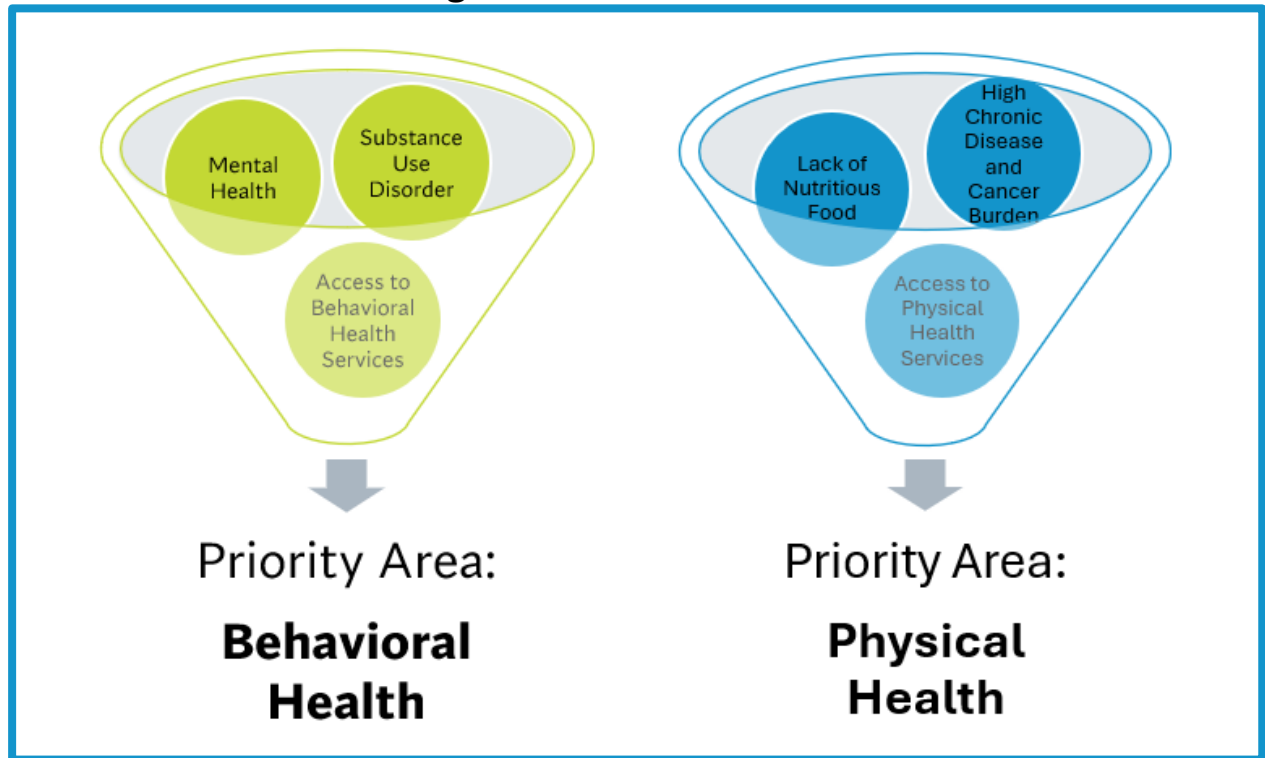
Analyzing Existing Data: The Steering Committee examined more than 100 health indicators from established data sources. Following the Robert Wood Johnson County Health Rankings framework², the secondary data analysis looked at factors ranging from how long people live to the conditions in which they live, work, and age. This included examining clinical care access, individual health behaviors, environmental conditions, and social and economic circumstances.

Connecting the Evidence: The CHA combined findings gathered from residents and leaders with existing data to identify where quantitative data trends aligned with lived experiences and perceptions. This helped to provide greater context for quantitative data findings and supported the Steering Committee in identifying which populations within the Granville Vance service area may face the greatest challenges. As a result, the Steering Committee was able to confirm selected priorities reflected genuine community needs.

² [County Health Rankings](#)

What the Assessment Revealed: After analyzing available information, two health priorities emerged: Behavioral Health (encompassing both mental health and substance use) and Physical Health (addressing chronic disease and healthy lifestyle factors). The CHA also identified cross-cutting themes in social drivers of health as necessary factors impacting health disparities that should be considered when developing approaches to addressing the priority health issues in this CHIP.

Figure 2: 2025 CHA Priorities



Accessing the Complete 2025 GVPH CHA Report: The 2025 GVPH Community Health Assessment contains further detail about the assessment methodology, primary and secondary data findings, and analysis that informed the selection of the 2026-2028 CHIP priorities for the Granville Vance service area.

This report can be accessed via [GVPH's website](#) or via the North Carolina Department of Health and Human Services, Division of Public Health, State Center for Health Statistics Community Health Assessment [website](#).

Phase II: Development of Action Plans

Lessons Learned, Continuing What Works

The previous GVPH CHIP cycle (2021-2024) focused on three key health priorities:

1. Enhancing Access to Healthcare
2. Promoting Mental Health and Addressing Substance Use
3. Engaging Youth for Community Health and Safety

The 2021 CHA identified mental health and substance use, access to healthcare, and youth well-being as top priority areas, with poverty and health equity recognized as cross-cutting themes affecting all priority areas. Several lessons learned from the previous CHIP cycle informed the development of the 2025 action plans.

1. Mental health and substance use remained the top priority in both the 2021 and 2025 assessments, indicating the need for sustained, long-term strategies rather than short-term interventions.
2. The importance of addressing social determinants of health became increasingly evident, as barriers such as transportation, food insecurity, and healthcare costs continued to prevent residents from accessing needed services and maintaining healthy behaviors.
3. The value of community partnerships and collaboration was reinforced, as many successful strategies from the previous cycle involved working across sectors with schools, faith organizations, community nonprofits, and healthcare providers.
4. The need to focus on priority populations - including rural residents, lower-income individuals, minority communities, youth, and older adults - emerged as essential for achieving health equity.
5. The previous cycle demonstrated that building upon existing programs and resources is more feasible and impactful than creating entirely new initiatives, suggesting that action plans should leverage and expand current community assets.

Action Team Process

Following the identification of priority health issues in August 2025, GVPH and partner organizations, with facilitation support from Ascendient Healthcare Advisors, established two Action Teams to develop and affirm goals, objectives, and strategies for each priority area. The Action Teams were convened to ensure that the resulting action plans would be grounded in community expertise, aligned with available resources, and implementable by the organizations and individuals who would ultimately carry out the work.

Physical Health Action Team

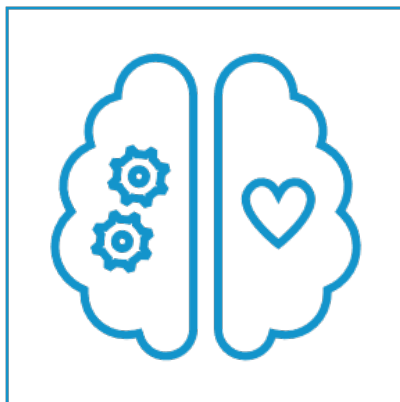
Physical Health



The Physical Health Action Team convened on October 1, 2025, to develop action plans addressing chronic disease and healthy lifestyle promotion. Participants engaged in a structured process that included reviewing CHA data specific to physical health, developing and refining the issue statement, examining previous CHIP goals, brainstorming potential activities, and prioritizing strategies based on feasibility and impact. Action Team participants represented diverse stakeholder groups and community sectors, ensuring multiple perspectives informed the action planning process.

Behavioral Health Action Team

Behavioral Health



The Behavioral Health Action Team convened on October 27, 2025, to develop action plans addressing mental health and substance use. This meeting followed a similar structured process to the Physical Health Action Team, with participants reviewing CHA findings related to behavioral health, refining the draft issue statement, examining previous CHIP accomplishments in this priority area, and collaboratively brainstorming and prioritizing potential strategies. Participants represented a broad cross-section of the behavioral health and social services community.

Establishing Issue Profiles & Issue Statements

A critical component of the action planning process involved developing comprehensive issue profiles and concise issue statements for each priority area, a concept adopted from the NACCHO Mobilizing for Action through Planning and Partnership (MAPP) 2.0 framework.³ Issue profiles provided a structured way to understand the current state of each health issue in the community by describing what the issue is, who is most impacted, how big the issue is, what contributes to the issue, and when and where the issue is most likely to occur. These profiles connected community health data to potential strategies for improvement and served as a foundation for understanding the current state and guiding the development of targeted interventions.

³ MAPP 2.0

Issue statements were developed as brief (one to two sentence) summaries that identify why and how each issue occurs in Granville Vance's service area, its severity, and its impacts on residents. Recognizing the importance of community accessibility and understanding, all issue statements were written at an 8th-grade reading level to facilitate sharing and understanding among residents. Action Team participants reviewed and provided feedback on draft issue statements, ensuring they accurately reflected the community's experience and priorities.

Physical Health (Chronic Disease and Healthy Lifestyle)

Issue Statement: Physical health is one of the top health concerns in Granville and Vance counties. More people living here have long-term health problems like diabetes and heart disease than in other parts of North Carolina and the United States. Physical health concerns especially hurt Vance County residents, people with low income, and people in rural areas who have trouble getting help. There are not enough doctors, people can't get rides to medical visits, many people don't have enough healthy food, and insurance problems stop people from getting care for long-term diseases. The main health problems are diabetes, high blood pressure, heart disease, and cancer. We need more doctors, cheaper healthcare, better transportation, and ways to help people get healthy food and learn about staying healthy.

Behavioral Health (Mental Health and Substance Use)

Issue Statement: Providing enough substance use and mental health treatment is one of the biggest challenges in Granville and Vance Counties. People in the community and their leaders say this is their main worry. Many factors contribute to these challenges, including poverty, social isolation, lack of transportation, and limited access to care. There are not enough substance use and mental health doctors and counselors. Eight out of ten leaders say we need more providers. Understanding what behavioral health services are available and how to pay for those services is an important role for leaders, health care providers, and public health partners to help with across the district. Young people, older adults, people who are alone, and minority groups need the most help but can't always get it.

Goal and Objective Development

Following the establishment of issue profiles and issue statements, both Action Teams engaged in goal and objective development. Action Teams reviewed draft goals that had been developed based on CHA findings, previous CHIP work, and best practices in public health. Participants provided feedback, suggested modifications, and affirmed or adjusted goals to ensure they aligned with community priorities and organizational capacity.

For each goal area, Action Teams brainstormed potential objectives and activities that could advance progress toward the stated goal. Facilitators presented lists of potential focus areas and activities derived from CHA qualitative data, previous CHIP strategies, and

evidence-based interventions. Action Team participants were encouraged to add new ideas, modify proposed activities to better fit local context, and identify existing programs or initiatives that could be leveraged or expanded. Discussions focused on ensuring that proposed activities were specific, actionable, and connected to measurable outcomes.

Brainstormed and Prioritized Objectives and Activities

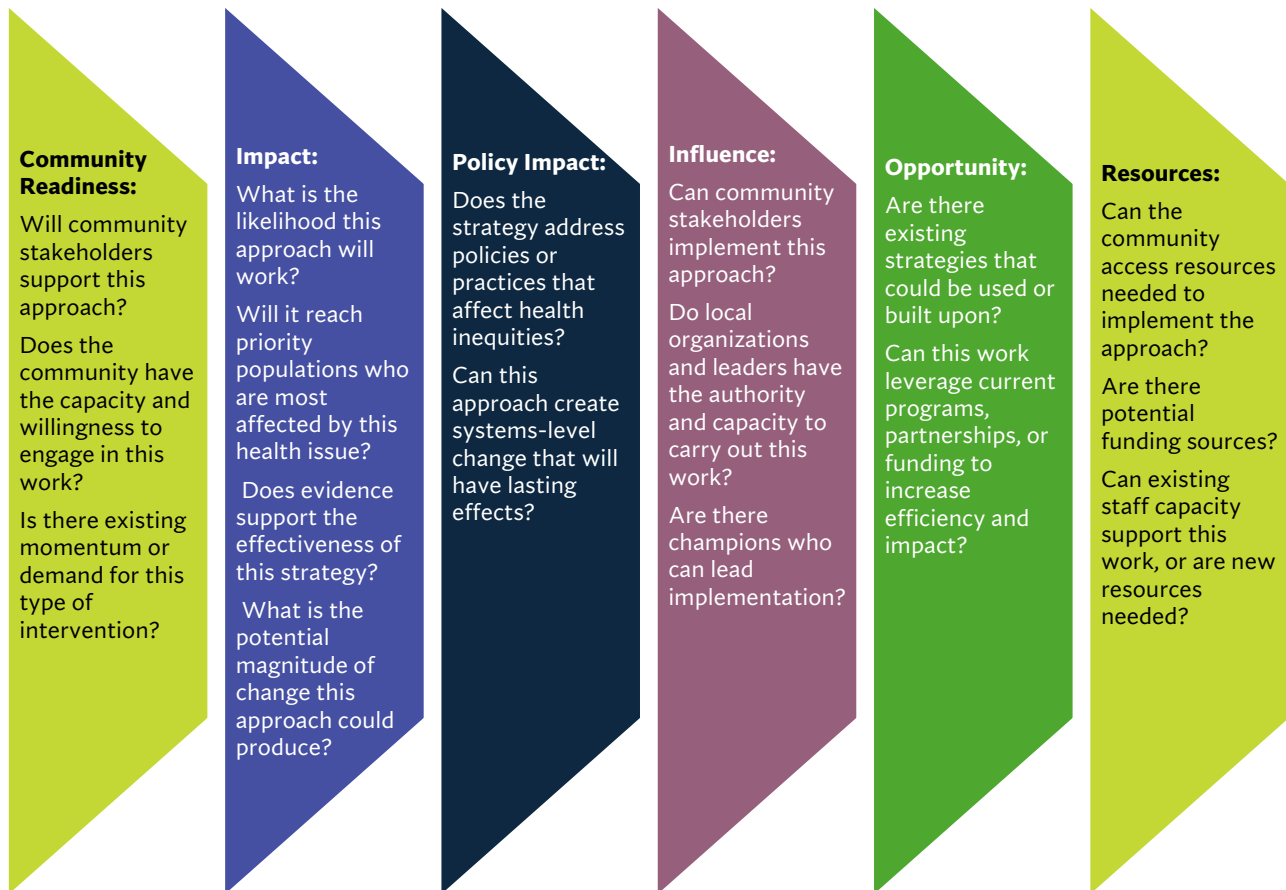
The action planning process employed interactive brainstorming and prioritization methods to ensure that final strategies reflected collective wisdom and priorities. Both Action Teams used virtual whiteboard tools and polling technology to facilitate real-time collaboration and decision-making.

Brainstorming sessions encouraged creative thinking about potential approaches to addressing each priority area. Facilitators emphasized that participants should not limit their thinking during initial brainstorming, recognizing that ambitious goals could be refined during prioritization. Participants were encouraged to identify both direct service strategies (such as health education programs and screening services) and upstream approaches that address social determinants of health and policy changes. The brainstorming process intentionally considered multiple levels of intervention, from individual behavior change to organizational practices to policy and systems change, reflecting the social-ecological model of health.

Discussions highlighted the importance of building upon existing community assets and programs rather than creating entirely new initiatives. Participants identified current programs that could be expanded, adapted, or better coordinated to achieve greater impact. The teams also discussed opportunities for cross-sector partnerships that could leverage resources and expertise from multiple organizations.

Prioritization Based on Feasibility, Impact, Equity, and Community Readiness

Following brainstorming, Action Teams engaged in structured prioritization processes to identify which objectives and activities should be included in the final CHIP. The prioritization process considered multiple criteria adapted from the MAPP 2.0 framework:



Action Teams used a prioritization matrix activity to systematically evaluate potential activities against selected criteria. Participants placed activities on a grid with two axis - **feasibility** (considering resources, influence, and community readiness) and **impact** (considering potential effectiveness and reach to priority populations). Activities were categorized into four quadrants:

- Activities that are both feasible and have high potential for impact (the "MUST" quadrant-highest priority for inclusion in CHIP)
- Activities that are feasible but have lower potential for impact (the "SHOULD" quadrant - consider for inclusion if resources allow)
- Activities that are less feasible but have high potential for impact (the "COULD" quadrant - may require additional planning, partnerships, or resources before implementation)
- Activities that are less feasible and have lower potential for impact (the "WON'T" quadrant - lowest priority)

Figure 3: Prioritization Matrix

		Potential for Community Impact	
		Low	High
Feasibility	High	Low	High
	Low		

This structured prioritization process ensured that the final action plans included strategies that were both ambitious and achievable, with the greatest potential to improve health outcomes for priority populations in Granville and Vance counties. The process resulted in goal areas with specific, prioritized objectives and activities that will guide health improvement work over the 2026-2028 CHIP cycle.

Throughout the action planning process, both Action Teams maintained focus on addressing health inequities by intentionally considering how strategies would reach and benefit priority populations, including rural residents, lower-income individuals, racial and ethnic minorities, youth, older adults, and other groups experiencing disproportionate health burdens. This equity lens ensures that the resulting CHIP will contribute to reducing health disparities and creating conditions for all Granville and Vance county residents to achieve optimal health.

Phase III: Refine & Adopt CHIP

Phase III involved refining and finalizing issue profiles, goals, objectives, and activities with the Steering Committee. During this phase, the Steering Committee engaged in strategic discussions about implementation priorities, resource allocation, and feasibility of proposed strategies across both Physical Health and Behavioral Health priority areas.

Following Action Team input gathered during Phase II, the Steering Committee reviewed draft goals, objectives, and activities through a comprehensive survey process in November 2025. Committee members evaluated each proposed activity on two key dimensions: **potential impact** on community health outcomes and **feasibility** of implementation given available resources and organizational capacity. This structured prioritization process allowed the committee to identify which strategies should be pursued immediately ("Do Now") versus those that would require additional planning, partnerships, or resources to implement in years 3-4 of the CHIP cycle ("Do Later").

Implementation Priorities and Phasing

The Steering Committee's prioritization process resulted in a phased implementation approach that balances ambition with feasibility:

- **"Do Now" Activities (Years 1-2, 2026-2027):** High-impact, high-feasibility strategies that leverage existing community assets, partnerships, and organizational capacity. These activities will be prioritized for immediate implementation and resource allocation.
- **"Do Later" Activities (Years 3-4, 2027-2028):** High-impact strategies that require additional planning, partnership development, funding acquisition, or infrastructure development before implementation can begin. These activities will be monitored and advanced through preparatory work in years 1-2.

The internal CHA team at GVPH identified two Physical Health goals and two Behavioral Health goals as top priorities for this CHIP cycle. This prioritization will inform resource allocation decisions and guide annual implementation planning throughout the CHIP cycle.

Goals and Objectives

This section lists the 2026-2028 GVPH CHIP goals and objectives by priority area. Additional detail for each priority area, including activities, timelines for implementation, measures of success, assets and resources, and responsible parties are included in **Appendices A and B** of this document.

Physical Health Priority Area

Table: Physical Health Priority Area Goals and Objectives - Chronic Disease Prevention
Goal 1: Reduce chronic disease burden through community-wide prevention programs, health education, and early detection initiatives that address the elevated rates of diabetes, hypertension, heart disease, and cancer in the service area.
Objective 1.1: By December 2028, increase community awareness and knowledge of chronic disease prevention and management through culturally appropriate education campaigns, health screenings, and partnership initiatives.
Objective 1.2: By December 2028, expand access to evidence-based chronic disease prevention and management programs through partnerships with community organizations, healthcare providers, and recreation facilities.
Objective 1.3: By December 2028, strengthen community capacity to support healthy behaviors and chronic disease self-management through peer support networks, community health worker programs, and collaborative partnerships.

Table: Physical Health Priority Area Goals and Objectives - Healthy Community Environments
Goal 2: Strengthen community environments that support healthy behaviors by improving access to physical activity opportunities, addressing food desert conditions, and creating supportive infrastructure for healthy lifestyle choices.
Objective 2.1: By December 2028, increase access to safe, affordable physical activity opportunities through community partnerships, mobile programming, and built environment improvements that support active living.
Objective 2.2: By December 2028, improve access to healthy, affordable food through community-based nutrition initiatives, food system development, and partnerships addressing food insecurity and nutrition education needs.
Objective 2.3: By December 2028, advocate for and support built environment improvements that promote walkability, safe recreation spaces, and access to healthy food retailers in underserved areas.

Behavioral Health Priority Area

Table: Behavioral Health Priority Area Goals and Objectives - Community Capacity and Prevention

Goal 1: Build community capacity to prevent behavioral health crises and reduce stigma through education, training, outreach, and partnership-based interventions that address mental health, substance use, and social isolation.

Objective 1.1: By December 2028, increase community awareness and reduce stigma related to mental health and substance use through culturally appropriate education campaigns and partnership initiatives

Objective 1.2: By December 2028, strengthen crisis response capacity through training and protocol development for first responders, community partners, and key stakeholders.

Objective 1.3: By December 2028, reduce social isolation and expand community-based behavioral health support through targeted outreach programs and peer networks.

Table: Behavioral Health Priority Area Goals and Objectives - Care Coordination and System Integration

Goal 2: Improve care coordination and integration between behavioral health providers, healthcare systems, and community organizations to create seamless pathways to appropriate mental health and substance use services while enhancing crisis response and access for residents experiencing barriers.

Objective 2.1: By December 2028, establish integrated behavioral health screening and referral systems across healthcare, schools, and community settings to improve early identification and linkage to services.

Objective 2.2: By December 2028, strengthen care coordination capacity through formalized protocols, navigation support, and technology infrastructure connecting behavioral health providers, primary care, emergency services, and community organizations.

Objective 2.3: By December 2028, enhance crisis response systems and improve access to behavioral health services through emergency department partnerships, resource navigation tools, and barrier reduction strategies.

Final Approval and Adoption

Action plans were established and further refined by the Steering Committee during November and December 2025. The final CHIP was reviewed and approved by GVPH leadership in January and February 2026, following a comprehensive review process that confirmed alignment with community priorities, regulatory requirements, and organizational capacity for implementation.

Phase IV: Implementation & Monitoring

The final phase of the CHIP process focuses on action plan implementation, including processes for monitoring progress toward achievement of adopted CHIP goals and objectives. This phase includes regular review and reporting mechanisms to ensure accountability, continuous improvement, and alignment with both PHAB requirements and North Carolina state mandates throughout the 2026-2028 implementation period.

Implementation Structure and Governance

GVPH will lead CHIP implementation through a collaborative governance structure that engages multiple community partners and maintains accountability for progress toward stated goals:

- **GVPH Internal CHA and CHIP Team:** Meets quarterly to review CHIP implementation progress, assess achievement of objectives, approve changes to strategies or timelines, and ensures alignment with GVPH priorities, resources, and capacities. The GVPH Internal CHA and CHIP Team is responsible for completing and submitting the annual SOTCH report to the NCDHHS each March during the current CHIP cycle.
- **Physical Health Action Team:** Continues to convene quarterly to coordinate implementation of physical health strategies, monitor progress on objectives, troubleshoot implementation challenges, and identify opportunities for enhanced collaboration across partner organizations.
- **Behavioral Health Action Team:** Continues to convene quarterly to coordinate implementation of behavioral health strategies, monitor progress on objectives, share resources and best practices, and address emerging behavioral health needs in the community.
- **WOW Coalition:** Serves as a key implementing partner for CHIP strategies, particularly those related to chronic disease prevention, healthy food access, and community wellness initiatives. The coalition provides community-level coordination and implementation support.

Monitoring Implementation Progress

GVPH employs a multi-tiered monitoring approach that tracks both process and outcome measures to ensure accountability and enable data-driven decision-making throughout the CHIP cycle:

- **Quarterly Progress Reviews:** The GVPH Internal CHA and CHIP Team and their partners on the WOW Coalition will document implementation activities, process measures/outputs (number of people reached, services provided, events held), and initial outcomes during quarterly meetings. Progress is tracked against established timelines and targets outlined in the action plans (**Appendices A and B**).

- **Annual Comprehensive Review:** The GVPH Internal CHA and CHIP Team and Steering Committee conducts an annual review of CHIP implementation progress, examining both process measures (activities completed, partnerships established) and outcome measures (changes in health indicators, progress toward objectives). This review informs adjustments to implementation strategies and resource allocation for the following year and provides the information required to submit the annual SOTCH report to the NCDHHS.

CHIP Performance Metrics

GVPH tracks both process and outcome measures aligned with North Carolina DHHS requirements and Healthy North Carolina 2030 (HNC 2030) indicators. These metrics enable the health department to monitor implementation progress, demonstrate impact, and contribute to statewide health improvement efforts.

Process Measures

Process measures track implementation activities and outputs, answering the questions "*How much did we do?*" and "*How well did we do it?*" These measures provide early indicators of progress and enable mid-course corrections.

Physical Health – Goal 1: Chronic Disease Prevention:

- Number of health awareness campaigns conducted and reach (people exposed)
- Number of health screenings provided and participants screened
- Number of culturally appropriate educational materials developed and distributed
- Number of evidence-based chronic disease programs implemented
- Number of peer support groups established and participants engaged
- Number of community partnerships established for chronic disease prevention

Physical Health – Goal 2: Healthy Environments:

- Number of physical activity programs offered and participants reached
- Number of community gardens, farmers markets, or food access initiatives supported
- Number of nutrition education programs delivered and participants reached
- Number of built environment improvement advocacy efforts initiated

Behavioral Health – Goal 1: Community Capacity:

- Number of anti-stigma campaigns conducted and estimated reach
- Number of individuals trained in Mental Health First Aid, Youth Mental Health First Aid, and crisis intervention
- Number of community education events on behavioral health topics
- Number of peer support programs established and participants engaged
- Number of substance use prevention trainings delivered

Behavioral Health – Goal 2: Care Coordination:

- Number of school-based behavioral health screenings conducted
- Number of warm handoff protocols established
- Number of individuals receiving behavioral health navigation services
- Number of crisis response protocols implemented
- Number of Stepping Up Initiative diversion protocols developed

Outcome Measures

Outcome measures assess whether community health status is improving, answering "Is anyone better off?" These measures align with NCDHHS health indicators and contribute to Healthy North Carolina 2030 (HNC 2030) goals.

HNC 2030 Alignment Note: The outcome measures aligning with HNC 2030 indicators are indicated as such, enabling GVPH to contribute to statewide health improvement goals while tracking local progress.

Physical Health Outcome Measures:

Physical Health Outcome Measure #1	
Data Source:	
Baseline:	
Target:	

Physical Health Outcome Measure #2	
Data Source:	
Baseline:	
Target:	

Physical Health Outcome Measure #3	
Data Source:	
Baseline:	
Target:	

Behavioral Health Outcomes:

Behavioral Health Outcome Measure #1	
Data Source:	
Baseline:	
Target:	

Behavioral Health Outcome Measure #2	
Data Source:	
Baseline:	
Target:	

Behavioral Health Outcome Measure #3	
Data Source:	
Baseline:	
Target:	

Continuous Quality Improvement

GVPH employs continuous quality improvement (CQI) principles throughout CHIP implementation to ensure strategies remain effective, responsive to community needs, and aligned with best practices:

- **Regular Assessment of Effectiveness:** The Internal GVPH CHA/CHIP Team reviews implementation quarterly to identify strategies that are achieving desired outcomes and those requiring modification. This includes assessing reach to priority populations, participant satisfaction, and early outcome indicators.
- **Annual Review and Adjustment Cycle:** Each year, the Internal GVPH CHA/CHIP Team conducts a comprehensive review of CHIP progress, examining what is working well, what requires adjustment, and whether objectives and activities remain aligned with community priorities. Based on this review, the Internal GVPH CHA/CHIP Team may modify strategies, timelines, or performance targets as documented in the Record of Changes. This information is then submitted to NCDHHS in March each year as part of the annual SOTCH report.
- **Community Engagement in Evaluation:** GVPH seeks input from community members, partner organizations, and program participants to understand whether strategies are meeting community needs and to identify opportunities for improvement. This feedback informs ongoing adjustments to implementation approaches.

Reporting and Communication

GVPH maintains transparency and accountability through regular reporting and communication about CHIP implementation progress:

- **Internal Reporting:** Quarterly progress reports are shared with GVPH leadership and the Board of Health, documenting implementation activities, performance metrics, and progress toward objectives.
- **Partner Communication:** Action Team meetings provide regular opportunities for partners to share updates, coordinate activities, and address implementation challenges collaboratively.
- **Community Updates:** GVPH provides annual updates to the community through multiple channels including the health department website, social media, community presentations, and the Board of Health. These updates highlight progress, celebrate successes, and invite ongoing community engagement.
- **State Reporting:** GVPH submits required reports to NCDHHS documenting CHIP implementation progress and outcomes, fulfilling state accreditation and oversight requirements. Community residents and key stakeholders can access the annual SOTCH reports via the [NCDHHS website](#).

Conclusion

Through systematic implementation, regular monitoring, and continuous quality improvement, GVPH and its community partners will work collaboratively to achieve the goals and objectives outlined in this CHIP. The monitoring framework ensures accountability while maintaining flexibility to adapt strategies based on emerging needs, evidence, and community feedback. By tracking progress toward both process and outcome measures aligned with state and national health improvement efforts, GVPH demonstrates its commitment to advancing health equity and improving health outcomes for all Granville and Vance County residents throughout the 2026-2028 CHIP cycle and beyond.

Acknowledgments

GVPH Internal CHA and CHIP Team

GVPH Team Member Name	Title
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Terry Jones, MPA	Health Promotion & Wellness Supervisor
Jesus Peralta, MSPH	Regional Foundational Capabilities Director
Gabriel Williams, MSPH, MBA	Communications & Staff Support Lead
Dr. Carmen Samuel-Hodge	Professor, Gillings School of Global Public Health and School of Medicine Department of Nutrition
Dr. Karl Johnson	Behavioral Health Integration Specialist
Tyzie Morning, MPH	Youth Integrated Care Lead
Abai Ikwechegh, MPH	Data Analyst
Anna Feng	MedServe Fellow
Cheryl L. Burton	Finance Officer

Steering Committee Members

Name	Organization
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Arneisha Crossen	Vaya Health
Carolyn Powell	Triangle North Healthcare Foundation
Chalis Henderson	Turning Point Community Development Corp.
Cortney M Phillips	Masonic Home for Children
Frank Sossamon	Community Citizen
Fransine Sanchez	Granville Vance Public Health
Gabriel Williams	Granville Vance Public Health
Jennifer Cufalo	Granville County Chamber of Commerce
Jessica Hawkins	Aim High Keep Pressing
Jesus Peralta	Granville Vance Public Health
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Lisa Macon Harrison	Granville Vance Public Health
Meredith Huffaker	Oxford Preparatory School
Samantha Branch	NC Guardian Ad Litem Program
Carmen Samuel-Hodge	UNC Chapel Hill
Sandra Wilkerson	Henderson Vance Chamber of Commerce
Tameeka Williams-Burchette	Vance County Schools
Terry Jones	Granville Vance Public Health
Tony Cozart	Franklin Granville Vance Smart Start, Inc.
Kimberly McCann	NC Harm Reduction Coalition

WOW Coalition Members

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Terry Jones	Granville Vance Public Health
Dr. Carmen Samuel-Hodge	UNC Gillings
Anna Feng	Granville Vance Public Health
Shaniya Boyd	Granville Vance Public Health
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Lina Howe	4H
Suzanne Thompson	988 Call Center
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Samantha Coleman	At Home Counseling
Jacqueline Robinson	Boys and Girls Club
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Angel Romero	Duke Population Health Management Office
Gabriela Sales	El Centro
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CHIP Consultants

GVPH commissioned Ascendent Healthcare Advisors to support this CHA and CHIP cycle. Ascendent works with healthcare organizations and public health departments nationwide to complete IRS and Public Health Accreditation Board (PHAB) conforming community health assessments, improvement plans, and progress tracking mechanisms.

Appendix A: Physical Health Action Plans

This appendix provides detailed action plans for the Physical Health priority area, including specific activities, implementation timelines, measures of success, responsible organizations and resources, and priority designations based on Steering Committee input.

Goal 1: Reduce Chronic Disease Burden

Goal Statement: Reduce chronic disease burden through community-wide prevention programs, health education, and early detection initiatives that address the elevated rates of diabetes, hypertension, heart disease, and cancer in the service area.

Objective 1.1: Increase Community Awareness and Knowledge

By December 2028, increase community awareness and knowledge of chronic disease prevention and management through culturally appropriate education campaigns, health screenings, and partnership initiatives.

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
Launch targeted health awareness campaigns using social media, local media, and community channels to promote chronic disease prevention	2026-2028 (Ongoing)	Number of campaigns conducted; Estimated reach/impressions; Community survey awareness metrics	GVPH Communications Team, WOW Coalition, Local media partners	Do Now
Host community health fairs offering free screenings for diabetes, hypertension, and cholesterol	2026-2028 (Quarterly)	Number of health fairs held; Number of participants screened; Number of abnormal results with follow-up referrals	GVPH, Healthcare partners, Community organizations, Volunteers	Do Now
Develop and distribute culturally appropriate educational materials in English and Spanish	2026-2027	Number of materials developed; Number of materials distributed; Feedback on cultural appropriateness	GVPH Health Education Team, Community partners, Translation services	Do Now
Integrate chronic disease prevention messaging into existing community events (festivals, farmers markets, recreation programs)	2026-2028 (Ongoing)	Number of community events with health education presence; Number of contacts made; Materials distributed	GVPH, WOW Coalition, Parks & Recreation, Community organizations	Do Now

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
Partner with faith-based organizations to deliver health education through trusted networks	2026-2028 (Ongoing)	Number of faith partnerships established; Number of educational sessions delivered; Participants reached	GVPH, Faith-based organizations, WOW Coalition	Do Now

Objective 1.2: Expand Evidence-Based Programs

By December 2028, expand access to evidence-based chronic disease prevention and management programs through partnerships with community organizations, healthcare providers, and recreation facilities.

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
Expand the NC Minority Diabetes Prevention Program and support programs with CHW support and peer mentoring	2026-2028 (Ongoing)	Number of MDPP programs offered; Participants enrolled and completing programs; A1C improvements among participants	NC Minority Diabetes Prevention Program, Community Health Workers, Healthcare partners	Do Now
Develop nutrition and physical activity education programs (Eat Smart, Move More NC)	2026-2028 (Ongoing)	Number of programs implemented; Participants reached; Pre/post behavior change assessments	GVPH, Cooperative Extension, Parks & Recreation, WOW Coalition	Do Now
Partner with healthcare systems, clinics, and FQHCs to co-locate chronic disease education and screening	2027-2028	Number of partnerships established; Co-located services provided; Patients reached through partnerships	GVPH, Local hospitals, FQHCs, Primary care practices	Do Later
Establish referral protocols between GVPH and primary care providers for chronic disease prevention	2026-2028	Documented referral protocols; Number of referrals exchanged; Feedback from providers on process	GVPH, Primary care providers, Healthcare systems	Do Now/ Later

Objective 1.3: Strengthen Community Capacity

By December 2028, strengthen community capacity to support healthy behaviors and chronic disease self-management through peer support networks, community health worker programs, and collaborative partnerships.

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
Develop peer support groups and networks for individuals managing chronic conditions	2026-2028	Number of Community and Barbershop conversations established; Active participants; Participant satisfaction and health outcome tracking	GVPH, Healthcare partners, Community organizations, Peer leaders	Do Now
Create shared resources, referral pathways, and communication systems among providers and organizations	2026-2028	Documented resource directory; Number of cross-referrals; Partner feedback on system effectiveness	GVPH, All CHIP partners, Healthcare providers	Do Now
Partner with local employers and worksites for workplace wellness initiatives	2026-2028 (Ongoing)	Number of workplace partnerships; Employees reached through wellness programs; Employer feedback	GVPH, Local employers, Chamber of Commerce	Do Now
Leverage the ICON model to address intersection of behavioral health and chronic disease	2026-2028 (Ongoing)	Patients served through integrated model; Documented care coordination; Health outcomes for dual-diagnosis patients	GVPH ICON program, Behavioral health providers, Primary care	Do Now

Goal 2: Strengthen Community Environments that Support Healthy Behaviors

Goal Statement: Strengthen community environments that support healthy behaviors by improving access to physical activity opportunities, addressing food desert conditions, and creating supportive infrastructure for healthy lifestyle choices.

Objective 2.1: Increase Access to Physical Activity Opportunities

By December 2028, increase access to safe, affordable physical activity opportunities through community partnerships, mobile programming, and built environment improvements that support active living.

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
Partner with community facilities to develop and expand accessible physical activity programs for diverse age groups and fitness levels	2026-2028 (Ongoing)	Number of partnerships established; Physical activity programs offered; Participants engaged; Program accessibility assessments	GVPH, Community centers, Recreation facilities, Senior centers, Faith-based organizations	Do Now
Establish mobile fitness and recreation programming targeting underserved rural areas and communities with limited access to exercise facilities	2026-2028	Mobile program schedule; Number of rural communities served; Participants reached; Program satisfaction; Continued participation rates	GVPH, Parks & Recreation, Mobile program partners, Community organizations	Do Now
Partner with schools, churches, senior centers, and community-based organizations to offer physical activity classes and wellness programming in accessible community spaces	2026-2028 (Ongoing)	Number of site partnerships; Physical activity classes offered; Total participants; Space utilization; Partnership sustainability	GVPH, Schools, Faith-based organizations, Senior centers, Community organizations	Do Now
Develop physical activity programming specifically designed for individuals managing chronic diseases (walking programs for diabetes management, cardiac rehabilitation-type activities, gentle exercise for seniors)	2027-2028	Disease-specific programs developed; Participants enrolled; Health outcome tracking; Healthcare provider referrals; Program adaptations	GVPH, Healthcare providers, Exercise professionals, Community partners	Do Later

Promote awareness and utilization of existing recreation facilities, parks, trails, and physical activity resources through marketing campaigns and community outreach	2026-2028 (Ongoing)	Marketing campaigns conducted; Reach/impressions; Facility utilization increases; Community awareness surveys; Resource guides distributed	GVPH, Parks & Recreation, Marketing partners, Community organizations	Do Now
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Objective 2.2: Improve Access to Healthy, Affordable Food

By December 2028, improve access to healthy, affordable food through community-based nutrition initiatives, food system development, and partnerships addressing food insecurity and nutrition education needs.

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
Support and expand community-based nutrition and food access initiatives including community gardens, farmers markets, food pantries, and mobile food distribution programs	2026-2028 (Ongoing)	Number of food access initiatives supported; Volume of food distributed; Households served; Partnership sustainability; Food security improvements	GVPH, WOW Coalition, Food banks, Farmers markets, Community gardens, Faith-based organizations	Do Now
Provide nutrition education programming addressing chronic disease prevention and management, healthy cooking on a budget, meal planning, and food preparation skills	2026-2028 (Ongoing)	Number of nutrition education sessions; Participants reached; Pre/post knowledge assessments; Behavior change reports; Recipe adoption	GVPH, Cooperative Extension, WOW Coalition, Healthcare partners	Do Now
Partner with local food producers, farmers markets, and mobile markets to increase availability and affordability of fresh produce in underserved areas	2027-2028	Partnerships with food producers; Mobile market schedules; Produce sales/distribution in underserved areas; Customer feedback; Food desert mapping	GVPH, Local farmers, Farmers markets, Mobile market vendors, WOW Coalition	Do Later
Conduct healthy cooking demonstrations and classes in partnership with community organizations, utilizing accessible community spaces	2027-2028	Number of cooking demonstrations; Participants attending; Recipe distribution; Skills adoption;	GVPH, Cooperative Extension, Culinary partners, Community organizations	Do Later

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
(churches, senior centers, recreation facilities)		Participant confidence assessments		

Objective 2.3: Support Built Environment Improvements

By December 2028, advocate for and support built environment improvements that promote walkability, safe recreation spaces, and access to healthy food retailers in underserved areas.

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
Advocate for built environment improvements supporting walkability including sidewalks, crosswalks, bike lanes, and pedestrian-friendly infrastructure, particularly in underserved rural and urban areas	2026-2028 (Ongoing)	Advocacy meetings held; Written comments submitted; Built environment assessments; Improvements tracked; Community input gathered	GVPH, Planning departments, Transportation departments, Advocacy organizations	Do Now
Partner with schools, parks and recreation departments, and community organizations to ensure safe, accessible recreation spaces are available during non-school hours	2026-2028 (Ongoing)	Partnership agreements; Extended access hours documented; Utilization tracking; Community feedback; Safety assessments	GVPH, Schools, Parks & Recreation, Community organizations	Do Now
Engage community residents in identifying barriers to physical activity and safe outdoor spaces, and advocate for solutions addressing these concerns	2026-2028 (Ongoing)	Community engagement events held; Barriers identified and documented; Solutions proposed; Advocacy actions taken; Policy changes tracked	GVPH, Community residents, Planning departments, Advocacy organizations	Do Now

Appendix B: Behavioral Health Action Plan

This appendix provides detailed action plans for the Behavioral Health priority area, including specific activities, implementation timelines, measures of success, responsible organizations and resources, and priority designations.

Goal 1: Build Community Capacity to Prevent Behavioral Health Crises

Goal Statement: Build community capacity to prevent behavioral health crises and reduce stigma through education, training, outreach, and partnership-based interventions that address mental health, substance use, and social isolation.

Objective 1.1: Increase Awareness and Reduce Stigma

By December 2028, increase community awareness and reduce stigma related to mental health and substance use through culturally appropriate education campaigns and partnership initiatives.

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
Create anti-stigma campaigns using local voices and testimonials with culturally appropriate messaging, building upon community forums model from 2023 ICON partnership	2026-2028 (Ongoing)	Number of campaigns conducted; Reach/engagement metrics; Community survey stigma assessment	GVPH, ICON partners, Faith-based organizations, Media partners	Do Now
Partner with churches and community groups to normalize behavioral health conversations through trusted networks	2026-2028 (Ongoing)	Number of faith partnerships; Educational sessions delivered; Community members reached	GVPH, Faith-based organizations, Community leaders	Do Now
Expand resource awareness campaigns beyond ICON network to highlight available behavioral health services	2026-2028 (Ongoing)	Campaign reach; Resource directory distribution; Service utilization increases	GVPH, THRIVE program, Behavioral health providers	Do Now
Host behavioral health resource fairs and community screening events	2027-2028	Number of events held; Participants screened; Follow-up referrals completed	GVPH, Behavioral health providers, Community organizations	Do Later

Objective 1.2: Strengthen Crisis Response Capacity

By December 2028, strengthen crisis response capacity through training and protocol development for first responders, community partners, and key stakeholders.

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
Implement Life Skills Training programming for children and adolescents through school and afterschool settings as part of THRIVE educational programming	2026-2028 (Ongoing)	Number of schools implementing LST; Students participating; Program completion rates; Skills assessments; Behavioral outcome tracking	GVPH THRIVE program, Schools, Afterschool programs, Youth organizations	Do Now
Provide community trainings on behavioral health, mental health, substance use, and overdose prevention (including naloxone training) through THRIVE workforce development initiatives	2026-2028 (Ongoing)	Number of trainings conducted; Community members trained; Naloxone kits distributed; Overdose reversals reported; Training satisfaction	GVPH THRIVE program, Community partners, Substance use prevention organizations	Do Now
Train youth, community members, school staff, and faith leaders in Teen Mental Health First Aid through THRIVE workforce training components	2026-2028 (Ongoing)	Number of Teen Mental Health First Aid trainings; Participants certified; Post-training confidence assessments; Intervention reports	GVPH THRIVE program, Schools, Faith-based organizations, Community organizations	Do Now
Implement evidence-based training programs for first responders and community partners in youth mental health crisis recognition and response, including Mental Health First Aid, Youth Mental Health First Aid, and crisis intervention protocols	2026-2028 (Ongoing)	Number of first responders trained; Crisis intervention protocols developed; Training evaluations; Crisis response improvements documented	GVPH, Law enforcement, Fire/EMS, Schools, THRIVE program	Do Now
Develop community-based crisis recognition and response protocols that integrate with existing emergency services, building upon Stepping Up Initiative's crisis intervention	2026-2028	Crisis protocols documented; Integration with emergency services; Number of crisis interventions; Outcomes tracked;	GVPH, Law enforcement, EMS, Crisis services, Stepping Up Initiative, Behavioral health providers	Do Now

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
infrastructure and case management model		System improvements identified		
Deliver behavioral health, mental health, and substance use training for all clinical staff and primary care providers through THRIVE continuing education programming	2026-2028 (Ongoing)	Number of clinical staff trained; Training topics delivered; Screening implementation; Referral rates; Provider satisfaction	GVPH THRIVE program, Healthcare systems, Primary care practices	Do Now

Objective 1.3: Reduce Social Isolation and Expand Support

By December 2028, reduce social isolation and expand community-based behavioral health support through targeted outreach programs and peer networks.

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
Develop social connection initiatives to address isolation affecting nearly half of residents, with targeted programming for high-risk populations, leveraging peer support models from THRIVE program's peer mentorship component and community-based organization partnerships	2026-2028 (Ongoing)	Social connection programs established; Participants engaged; Social isolation screening; Connection outcomes; Participant feedback	GVPH, THRIVE program, Community organizations, Senior centers, Faith-based organizations	Do Now
Create outreach programs specifically targeting socially isolated residents and high-risk youth identified through community screening, including outreach to seniors facing transportation barriers and youth identified through school-based screenings via THRIVE program	2027-2028	Outreach programs developed; High-risk individuals identified; Outreach contacts made; Service connections; Outcome tracking	GVPH, THRIVE program, Schools, Senior services, Transportation services, Community health workers	Do Later
Develop community education campaigns about substance use risks, prevention strategies, and pathways to treatment	2026-2028 (Ongoing)	Number of campaigns conducted; Reach/impressions; Treatment pathways promoted; Service	GVPH, Substance use prevention organizations, Treatment	Do Now

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
		utilization; Community knowledge assessments	providers, Media partners	
Expand peer support mentoring program for parents of children with behavioral health disorders through THRIVE program community partnerships, utilizing the Rural Child and Adolescent Behavioral Health Consortium and Regional Paraprofessional Consortium infrastructure	2026-2028 (Ongoing)	Number of parent mentors trained; Parents participating; Peer support sessions; Parent satisfaction; Family outcomes	GVPH THRIVE program, Rural Child and Adolescent BH Consortium, Regional Paraprofessional Consortium, Parent advocates	Do Now

Goal 2: Improve Care Coordination and Integration Between Behavioral Health Providers, Healthcare Systems, and Community Organizations

Goal Statement: Improve care coordination and integration between behavioral health providers, healthcare systems, and community organizations to create seamless pathways to appropriate mental health and substance use services while enhancing crisis response and access for residents experiencing barriers.

Objective 2.1: Establish Integrated Screening and Referral Systems

By December 2028, establish integrated behavioral health screening and referral systems across healthcare, schools, and community settings to improve early identification and linkage to services.

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
Develop cultural, age-appropriate, and evidence-based behavioral health, mental health, and substance use screenings in schools through THRIVE screening protocols, including implementation across multiple grade levels (5-17) and establishment of referral pathways for at-risk students	2026-2028 (Ongoing)	Number of schools implementing screening; Students screened; At-risk students identified; Referrals completed; Follow-up documentation	GVPH THRIVE program, Schools, School-based mental health specialists, School nurses	Do Now
Develop referral systems and warm handoff protocols between community organizations, schools, and behavioral health providers, leveraging THRIVE program's school-based mental health specialist providers and Health Care Navigator infrastructure	2027-2028	Warm handoff protocols documented; Number of warm handoffs completed; Follow-up appointment completion; Provider feedback; System improvements	GVPH THRIVE program, Schools, Behavioral health providers, Health Care Navigators, Community organizations	Do Later
Integrate behavioral health screening into existing health department services and programs, including maternal health, chronic disease programs, and	2026-2028 (Ongoing)	Screening tools implemented; Number of screenings conducted; Positive screens; Referrals	GVPH clinical staff, ICON program LCSW, Maternal health program, Chronic disease programs	Do Now

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
primary care touchpoints, building upon GVPH's integrated care model with on-site LCSW services that served 148 patients in 2024		completed; LCSW services utilization		

Objective 2.2: Strengthen Care Coordination Capacity

By December 2028, strengthen care coordination capacity through formalized protocols, navigation support, and technology infrastructure connecting behavioral health providers, primary care, emergency services, and community organizations.

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
Establish formal coordination protocols between the health department, primary care providers, and mental health providers to streamline communication and care transitions, building upon GVPH's integrated care model with embedded LCSW services and established primary care partnerships	2027-2028	Coordination protocols documented; Number of coordinated care cases; Communication system established; Provider satisfaction; Care transition outcomes	GVPH, ICON program, Primary care providers, Mental health providers, LCSW staff	Do Later
Develop peer navigation programs linking residents to ongoing support services and helping maintain engagement in treatment, leveraging THRIVE program's Health Care Navigator model and peer support mentorship infrastructure, with specific focus on youth and families navigating behavioral health services	2027-2028	Peer navigators trained; Residents receiving navigation; Treatment engagement rates; Service connection documentation; Navigator satisfaction	GVPH THRIVE program, Health Care Navigators, Peer mentors, Behavioral health providers	Do Later
Coordinate with existing telehealth programs to provide navigation assistance for behavioral	2027-2028	Telehealth navigation services established; Appointments facilitated; Technology	GVPH, Telehealth providers, Technology support,	Do Later

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
health appointments and reduce access barriers, particularly for rural residents and those facing transportation challenges, ensuring technology support and digital literacy assistance		assistance provided; Appointment completion rates; User feedback	Behavioral health providers, Community organizations	
Expand participation in the Rural Child and Adolescent Behavioral Health Consortium to implement initiatives and facilitate peer mentoring exchange of best practices, utilizing consortium infrastructure to coordinate care across the counties	2026-2028 (Ongoing)	Consortium participation; Initiatives implemented; Best practices exchanged; Cross-county coordination; Youth and family outcomes	GVPH, Rural Child and Adolescent BH Consortium, Schools, Behavioral health providers, Community partners	Do Now
Expand and strengthen participation in the Integrated Care Outreach Network (ICON) to improve access to and integration of behavioral health services within the broader public health framework, building on progress including on-site LCSW services, therapy room establishment, and partnerships with primary care and community providers across the counties	2026-2028 (Ongoing)	ICON network expansion; Services integrated; Patients served; Provider partnerships; Therapy room utilization; Integrated care outcomes	GVPH ICON program, LCSW staff, Primary care providers, Community partners, Healthcare systems	Do Now

Objective 2.3: Enhance Crisis Response Systems and Access

By December 2028, enhance crisis response systems and improve access to behavioral health services through emergency department partnerships, resource navigation tools, and barrier reduction strategies.

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
Explore partnerships with emergency departments to create warm handoff protocols for behavioral health crises, ensuring connection to community supports upon discharge	2027-2028	ED partnership agreements; Warm handoff protocols established; Post-discharge follow-up rates; Community support connections; Readmission tracking	GVPH, Hospital emergency departments, Behavioral health crisis services, Community support organizations	Do Later
Create and maintain comprehensive, updated behavioral health resource directories including youth services, substance use treatment options, crisis supports, and accessibility information, with user-friendly formats accessible via multiple channels (print, web, mobile) and available in English and Spanish	2027-2028	Resource directory completed; Distribution channels established; Directory usage tracking; Regular updates; Accessibility features; Translation quality	GVPH, Behavioral health providers, Community organizations, Translation services	Do Later
Develop crisis response protocols that connect individuals experiencing behavioral health emergencies to appropriate care levels and community resources	2026-2028	Crisis protocols documented; Crisis interventions conducted; Care level placements; Community resource connections; Protocol effectiveness	GVPH, Crisis services, Law enforcement, EMS, Behavioral health providers, Hospital emergency departments	Do Now
Partner with Stepping Up Initiative to develop diversion protocols and crisis response strategies for justice-involved individuals with behavioral health needs, coordinating with law enforcement and courts across the counties	2026-2028 (Ongoing)	Diversion protocols implemented; Justice-involved individuals diverted; Behavioral health services connected; Court coordination; Recidivism reduction	GVPH, Stepping Up Initiative, Law enforcement, Courts, Behavioral health providers, Case management	Do Now

Activity	Timeline	Measures of Success	Resources & Organizations	Priority
Provide crisis intervention training for law enforcement, first responders, and school personnel, building capacity for early de-escalation and appropriate referral, integrated with THRIVE program workforce training initiatives	2026-2028 (Ongoing)	Number of personnel trained; De-escalation techniques utilized; Crisis referrals completed; Training evaluations; Incident outcomes	GVPH THRIVE program, Law enforcement, Fire/EMS, Schools, Crisis intervention trainers	Do Now