

Fort Riley
Kansas
Department of
Public Health

United States Army
Medical Activity

2014-2018
Community
Health
Improvement
Plan



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An Invitation to the Fort Riley Community

The health of our community has a direct result in how effective we train and equip a fighting force who calls Fort Riley home. Health extends well beyond the clinic or aid station. The threats to our health are varied and unique. For example, select few communities deal with the effects of over 10 years of direct involvement in war. Additionally, in an all-volunteer army the challenge exists in collecting and training risk taking individuals and then managing risky behaviors to promote health. Many challenges exist in improving the health of our community. What is required is a focused, coordinated effort that is evidence based and followed through in order to improve our community. Some health challenges are formidable and will require bravery on our part as community members to overcome. This plan is aimed at bringing together all resources and assets that support our community in order to make change and to see improvement in our community's health.

You are encouraged to review this plan, take action, and to be responsible in your role in making this community a safe and healthy place to live, work, train, and play. Where we are headed is better than where we have been. Onward!

Executive Summary

The Fort Riley Community Health Improvement Plan (CHIP) is the result of following a process that used compiled data from various sources and is interpreted by the USA MEDDAC Fort Riley Department of Public Health and its Community Partners in order to develop an overall plan to improve the health of the community. The community health improvement process is not one of a single department that serves the needs of a few but one that synergizes the efforts of many to make a lasting change. The intent is for the CHIP to be a road map for improvement and one that changes based on the overall needs of our community. The needs of the community are determined by the Community Health Assessment(CHA) which is conducted periodically.

The CHA identifies health related issues that adversely impact the health of the Fort Riley community and identifies demographic groups that are at higher risks. This plan provides a “snapshot” of the current health status of the community and assists us in developing solutions for improving the health status of our community.



These improvements will be spearheaded by the Community Health Promotion Council and assisted by the Department of Public Health and other community partners.

Mobilizing for Action through Planning and Partnerships (MAPP) was the strategic method used in the development of the CHIP. It is a community-driven strategic planning process for improving community health. This process was facilitated by the Department of Public Health. The first phase of MAPP involved two main phases. The first was organizing the planning process and developing the planning partnership. The purpose of this phase was to make a planning process that built commitment, engaged participants as active contributors, showed concern for their other commitments and resulted in a plan worthy of implementation. The second part of the MAPP process is visioning. The visioning will guide the community through a collaborative, creative process that leads to a shared, community vision and common values.

Statistical profile: statistical information was gathered from the following sources and provided indicators of current health status in our community:

- Community Health Assessment
- Public Health System Assessment
- Forces of Change Assessment
- Community Themes and Strengths Assessment
- Community Health Promotion Council

The importance of gathering this information is to use it in developing long-term, strategic health plans with goals and objectives directed at addressing the most significant health issues. This is particularly important due to the many needs and the limited and steadily decreasing amount of funding available to the United States Army and neighboring Kansas communities which provide resources to the military population, their families, retirees, and civilian workers. We welcome your feedback and encourage you to learn more about the DPH and its other Community Partners at <http://iach.amedd.army.mil/sections/clinics/pubHealthMain.asp> or call 785.239.7344 to learn how you can be a part of implementing our CHIP on Fort Riley.

Description of Fort Riley

Summary of Population: Fort Riley, KS

First Infantry Division is America's most storied division, an expeditionary–modular division headquarters, with nine brigade-sized units assigned to Fort Riley and three additional installations. The Big Red One has a distinguished history of “firsts.” The proud history of the 1st Infantry Division shaped its legendary motto: “No Mission too Difficult, No Sacrifice too Great, Duty First.” Since 2003, Fort Riley has deployed over 65,000 Soldiers to Iraq, Kuwait, Afghanistan and the Horn of Africa.

The Garrison Command is composed of dedicated Soldiers and civilian employees who play a critical role in supporting the Fort Riley mission. Their focus is to provide training, readiness, and support the ability of troops to deploy for active, component combat brigades and support for mobilization and deployment of active and reserve component units. The Garrison Command also provides effective, support services for the Soldiers and Family members. Garrison Command provides the services found in most local and city governments.

The focus of the CHIP is to improve the health of those Soldiers stationed at Fort Riley and the families living or on Fort Riley. There are many more people that may receive services from on-



post organizations but are not the focus of the CHIP. This is no different than other communities that have visitor coming from outside of the area to get products or services.

Located in the Central Flint Hills Region of Northeast Kansas, on the Kansas River, between Junction City and Manhattan, Fort Riley covers 152 square miles in Geary and Riley

counties and includes two census-designated places; Fort Riley North and Fort-Riley-Camp Whiteside. Fort Riley is located one hour west of Topeka, the State Capital, and two hours driving distance westward from Kansas City. The area is a predominantly rural area with an outstanding, public school system and a variety of universities and colleges.

Description of CHIP Process

The USA MEDDAC Fort Riley Department of Public Health (DPH) Accreditation Team engaged community partners to complete a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). Initial planning was completed by the DPH Accreditation Team through bi-weekly Team meetings, with the assistance of online and in-person training and tools from the Public Health Accreditation Board, US Army Public Health Command, Kansas Department of Health and Environment and Kansas Health Institute. Team members attended basic workshops in order to gain a better understanding of how to traverse the process of developing a CHIP. Once the basic plan was developed, the DPH embarked on gaining community buy-in and support. The Community Health Promotion Council (CHPC) was engaged to determine how best to impact the overall health of the community. This council is represented by various units and support organizations that represent the people and services of Fort Riley. The senior commander of Fort Riley is:

Commanding General, 1st Infantry Division, Major General Paul E. Funk II

The DPH participation members include:

Chief, DPH – COL Paul Benne
Administrative Officer - Kristen Bourland
Chief, Industrial Hygiene – Eric Coates
Chief, Occupational Health – Karen Culbertson
Chief, Army Public Health Nursing – LTC Yvette Malmquist
Chief, Environmental Health – 1LT Jessica Morley
Manager, Army Hearing Program – CPT Virginia Bailey
Director, Army Wellness Center – Kendra Seat

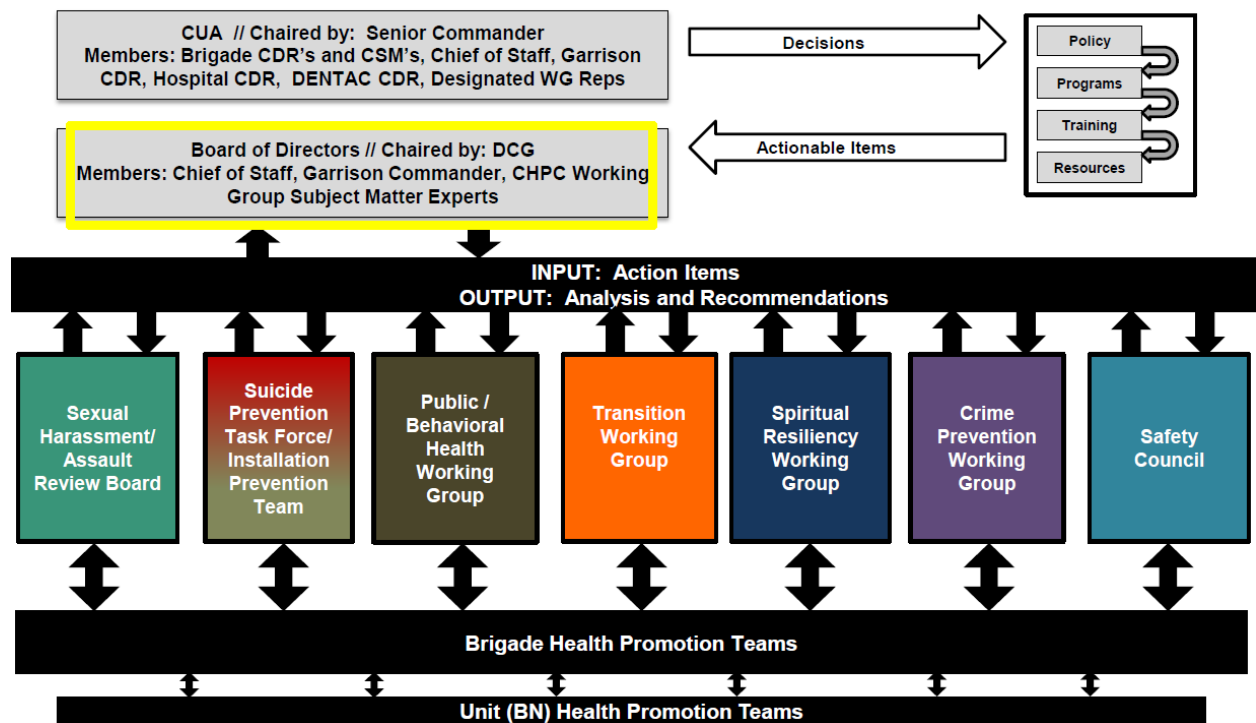
Other on post partners:

1st Infantry Division and Fort Riley Health Promotions Officer – Judith Woodward
Fort Riley Veterinary Services Clinic Officer in Charge – CPT Cole Wenzel

The Community Health Promotion Council (CHPC) consists of seven pillars. Each pillar is a working group, consisting of members from various organizations. These pillars provide information and plans to the CHPC Board of Directors. Each pillar of the CHPC provides updates to the Commanding General during the Commanders Update Assessment on a monthly basis. The seven pillars are:

Sexual Harassment / Assault Review Board
 Suicide Prevention Task Force/Installation Prevention Team
 Public/Behavioral Health Working Group
 Installation Prevention Team

Transition Working Group
 Spiritual Resiliency Working Group
 Crime Prevention Working Group
 Safety Council



CHPC Board of Directors

Deputy Commanding General (Support) –
 Brigadier General, Patrick Frank
 Garrison Commander – COL Andrew Cole
 Chief of Staff - Colonel Peter Minalga
 Irwin Army Community Hospital (IACH)
 Commander – COL Risa Ware

Division/United States Army Garrison
 Chaplain – MAJ Christian Goza
 Deputy Garrison Commander - Mr Timothy
 Livsey
 Division Safety Director – Mr. Paul Inman

Special thanks go to others that have been involved but have left for other assignments:

CPT Madeline McAlister
Mr. Tom Tessendorf

MAJ Catharina Lindsey

We would especially like to thank Ms. Lauren Shirey, Accreditation Lead and Lead Program Evaluator, Public Health Assessment Program, US Army Public Health Command for her guidance and assistance throughout this process. Having personnel from outside our community who understands both the National and Army priorities is a great asset.

Selecting Strategic Priorities

The Department of Public Health Accreditation Team along with the Community Health Promotion Council went through a process of reviewing Community Health Assessment Data, the Public Health System Assessment, and input from the Community Health Promotion Council in order to develop a list of strategic health issues. Seventeen possible health issues were identified by the team:

- Addictions(Alcohol/Drug/Gambling/
Sexual)
- Poly-Pharm
- Stress
- Suicide
- Alcohol Use
- Sleep
- Tobacco Use
- Drug Use
- Sexual Assault
- Obesity
- Family/Marriage Strength
- Domestic Violence
- Injury Prevention
- Financial Management
- Lack of coping skills
- Crimes Against Persons
- Conducting Research for new insights

A prioritization matrix was developed by DPH and CHPC to focus our efforts. Each of the seventeen possible health issues were ranked based upon magnitude, seriousness, concern, and feasibility. The team members were provided the following evaluation guidance:

Magnitude

- 1 less than 20% of population
- 2 20-40% of population
- 3 41-60% of population
- 4 61-80% of population
- 5 >80% of population

Seriousness

- 1 No health implications
- 2 Minor health impact
- 3 Serious reduction in quality of life
- 4 Taking years of life expectancy
- 5 Death

Concern

- 1 Public not concerned
- 2 Public not aware of the issue
- 3 Concern at local level without policy
- 4 Socially unacceptable or government regulations to reduce
- 5 Outrage by public and governmental agencies

Feasibility / Strategies

- 1 No possibility of fixing / no known strategies
- 2 Requires significant resources / costs greater than \$100K
- 3 Requires coordination of resources from multiple commands, agencies, or departments / Possible strategies exist to correct issue
- 4 Requires significant work from one group with costs less than \$10K
- 5 Easy fix that requires very little resources / known proven studies to correct issue

Feasibility and Known Strategies was weighted 20% more than the other criteria as it was felt the ability to have an impact on health issues was important to the CHPC.

After reviewing all seventeen health issues and agreeing on criteria for prioritizing, the team voted on the top three health issues to include in the CHIP. While everyone agreed that these were not the only important health issues to Fort Riley, these are the issues supported by consensus:

- Stress
- Suicide
- Alcohol Abuse

Once established, they were each priority was assigned to one of the pillars of the CHPC in order to develop the goals and evidence-based intervention strategies. Each working group conducted root cause analysis using brainstorming and fishbone diagrams, included in Appendix A. The action plans associated with each intervention strategy will designate the individuals or organizations that have accepted the responsibility for implementing these strategies.

Each of the priorities and their associated goals were compared to Army, State and National Health Priorities. Healthy Kansans 2020 was chosen as the State improvement priorities and the Healthy People 2020 along with National Prevention Strategy was chosen and the National improvement priorities. Army Medicine 2020 and Army 2020 Generating Health & Discipline in the Workforce were used as comparisons since the population on Fort Riley is somewhat unique compared to the State and the US population.

Comparison of Army, State and National Priorities					
Priorities	Army Medicine 2020	Army 2020	Healthy Kansans 2020	Healthy People 2020	National Prevention Strategy
Stress		✓			
Suicide	✓	✓		✓	✓
Alcohol Abuse		✓			

While only three priorities were selected at this time, there are many other improvements being made by individual organizations and/or groups of organizations. The priorities of our community may change as improvements are made and as the population changes. We realized that not all individuals may be impacted by the three priority areas and which is why our community partners and resources will continue to offer services meant to meet the needs of those in our community with specific issues. A list of community assets and resources is included in Appendix B.

CHIP Revision Process Description

In March 2016, the Fort Riley Department of Public Health (DPH) led the first annual review of the Fort Riley CHIP. These annual reviews and reports are scheduled to occur each fiscal year (1 OCT-30 SEP) after the initial CHIP is published.

Based on the annual CHIP report, the DPH led a process to revisit the Fort Riley CHIP to update it to reflect changes in priorities, strategies to address identified priorities, and metrics. It is vital that the CHIP be a living document that guides the Fort's health improvement efforts and reflects its achievements and changing priorities and resources.

This document reflects the updated Fort Riley CHIP.

Stress

Stress was identified as the health issue with the greatest level of concern on Fort Riley. As an occupationally based community, we in some ways are comparable to a "factory town." Yet the type of work is unique in that the product from our Army's efforts is freedom. This has come with a cost to the community due to long and repeated deployments, re-acclimatization, single parenthood and the mental and physical effects of war. Stress is an understood part of our culture which we should not expect to make go away. Our goals, as stated, are towards stress management and a decrease in stress where possible. When it is not possible to reduce stress, our goal is to improve our resilience as a community. Resilience is a practice supported by both academia and professional organizations such as the University of Pennsylvania (1) and American Psychiatric Foundation (2). Another root cause of stress discovered on in depth analysis of suicides occurring in our Fort Riley community has been that due to personal relationship. This stress may also manifest itself as domestic violence or child abuse occurring at rates above that expected in the US Army (3) and has given rise to a desired goal of minimizing this outcome. Early childhood visitation intervention is supported in the management of child abuse and may play a role in intimate partner violence (4). The US Army's Medical Command and the Army's Surgeon General has chosen healthy sleep to be the greatest priority to improve performance and we consider the lack of adequate sleep to be a chronic and underlying potential contributor of stress at Fort Riley due responses on the Unit Risk Inventory.

References:

- (1) Master Resiliency Training
- (2) Employer Practices for Addressing Stress and Building Resilience
- (3) Fort Riley Community Health Assessment, 2014
- (4) The Community Guide to Clinical Preventive Services, US Preventive Task Force

Priority Area: Stress	
Working Group Lead: Public Health/Behavioral Health	
Team Members	
COL Donald Robinson, Chief, DPH MAJ Gordon Lyons MAJ (P) Kimberli Matthews, Chief, Army Public Health Nursing SFC Bill Collins, Resilience Coordinator CPT Corina Tortora, Nurse Educator and Integrative Health Coach Mr. Ted Freeman, Army Substance Abuse Program (ASAP) Manager	Ms. Cheryl Erickson, Director, Army Community Services LTC Jeff Mrochek, Operations Research Systems Analyst (ORSA) Danielle Holliday, Health Promotions Officer MAJ Christian Goza, Division Chaplain Mr. Shawn Perry, Training Center Manager Comprehensive Soldier and Family Fitness (CSF2)

Goal #1: Decrease stress due to poor personal relationships	
<p>1.1. Objective: Abuse and Violence Free Living. Decrease rate of substantiated child abuse and domestic violence cases to lower (statistically significant) than the Army average by 2017.</p> <p>1.1.1 Intervention Strategy: Work with partners to coordinate effective in home, early childhood (3 years and under) visitation through the New Parent Support Program.</p> <p>1.1.2. Intervention Strategy: Increase awareness on the topics of child abuse and domestic violence through training.</p>	<p>Outcome measure(s)</p> <ul style="list-style-type: none"> • Increase in home visitation to families with a child(ren) under 3 years of age by 20% as measured by total visits and deliveries • Decrease the Fort Riley domestic violence and child abuse rate to lower than that of the Army's as measured by the Installation Prevention Team metric • Increase in the percent completing training on abuse and violence by 15% as measured by the Defense Training Module (DTMS) by 2016
<p>1.2. Objective: Strong and Valued Relationships. Increase participation by 10% by 2016 year in relationship building events.</p> <p>1.2.1. Intervention Strategy: Work with leaders and the community to strengthen involvement in Army</p>	<p>Outcome measure(s)</p> <ul style="list-style-type: none"> • By 2016, increase the participation in Army Community Service relationship education by 10% as measured by total enrollment

<p>Community Service relationship education.</p> <p>1.2.2. Intervention Strategy: Coordinate with spiritual leaders (Chaplains) to increase participation in marriage strengthening events.</p>	<ul style="list-style-type: none"> • Increase the participation in spiritual marriage strengthening events by 10% as measured by total enrollment of first time attendees by 2017 • Decrease the percentage of Soldiers reporting a relationship ending by 15% by the end of 2016 compared to calendar year 2014 based on unit risk inventory summary results.
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Goal #2: Increase ability to handle workplace stress	
<p>2.1. Objective: Create a Ready and Resilient Community.</p> <p>2.1.1. Intervention Strategy: Implement policy ensuring Comprehensive Soldier and Family Fitness (CSF2) training in post wide training guidance Within one year, 85% of Soldiers will be trained using CSF2 by Master Resilience Trainers.</p> <p>2.1.2. Intervention Strategy: Implement the Master Resilience Trainer program effectively.</p>	<p>Outcome measure(s)</p> <ul style="list-style-type: none"> • 100 % of units have official guidance by the end of 2014 as measured by operations distribution • By 2016, 85% of all Soldiers CSF2 trained as measured by DTMS • By end of 2014, train, maintain and assure quality of Master Resilience Trainer staffing to an annual average of 90% as measured by Army defined standard over 3 consecutive years • A decrease in the number of prescribed serotonin release inhibitors per 1000 beneficiaries by 15% by 2017 as measured by the Composite Health Care System (CHCS)
<p>2.2. Objective: Assure Effective Sleep.</p> <p>2.2.1. Intervention Strategy: Increase awareness of the importance of sleep by education through the Performance Triad campaign.</p>	<p>Outcome measure(s)</p> <p>Increase participation in Sleep Education as measured by the Army Wellness Center enrollment statistics by 10% per year for 2 years</p>

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Suicide

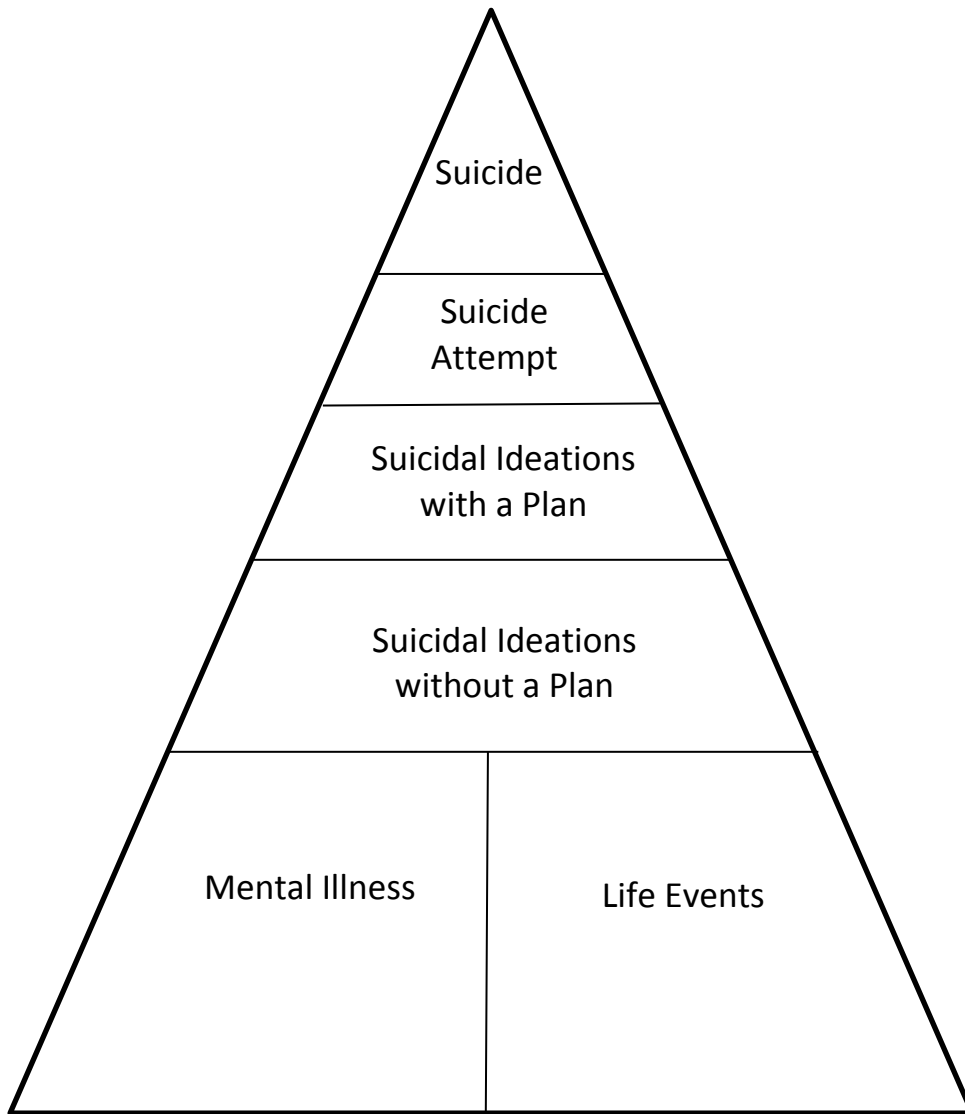
Suicide is of great concern to the military. Beginning in 2005, rates increased from a baseline of 10.3 to 11.3 per 100,000 to a increased rate stabilizing at 18 per 100,000 since 2009 (1). Although not adjusted for gender, the comparison to age adjusted rates nationally of 11.8 to 12.3 per 100,000 from 2009-11 reveals great disparity (2). For Fort Riley, suicide is the leading cause of death (3). Prevention of this unfortunate event is challenging and dependent on great part to the mental health of our community. Evidence does support the model of "First Aid" for mental health (4). The Applied Suicide Intervention Skills Training (ASIST) program was accepted by the Army in 2009. Individuals that are trained are able to identify warning signs and intervene in effective ways while then linking at risk personnel to professional resources. This program is soon to be fully operationalized by policy on Fort Riley. Evidence base also supports collaborative care models especially for the treatment and identification of depression (5). In the near future, complete mental health teams will be located within each Brigade area alongside Soldiers and linked to primary care by dedicated case managers. Additional services will be added as well for family members. Suicide attempts data has been monitored on posts for years and recently a Unit Risk Inventory is conducted at least annually that measures suicidal ideation with and without a plan. Improved access to behavioral healthcare should result in rapid care and a decrease in those that that have developed a plan. Effective "First Aid" should result in lowered suicide attempts and completions.

References:

- (1) LeardMann et al. Risk factors associated with suicide in current and former military personnel. JAMA. 2013;310(5):496-506
- (2) National Vital Statistics Report (NVSr) Deaths: Final Data for 2011 (NVSr Volume 63, Number 3), Table 9. Death rates by age and age-adjusted death rates for the 15 leading causes of death in 2011: United States, 1999-2011
- (3) Fort Riley Community Health Assessment, August 2013
- (4) Substance Abuse and Mental Health Services Administration (SAMSHA) National Registry of Evidence- based Programs and Practices, June 2014
- (5) Guide to Community Preventive Services, Improving Mental Health and Addressing Mental Illness: Collaborative Care for the Management of Depressive Disorders, Recommended June, 2010

During the brainstorming sessions and root cause analysis of suicide, the team members developed what they considered a path to suicide. Intervention strategies were designed to focus on strategies at multiple levels in the path. The diagram below depicts the basic areas of the path to suicide.

Path to Suicide



Priority Area: Suicide	
Working Group Lead: Suicide Prevention	
Team Members	
Mr. David Easterling, Suicide Prevention Program Manager Mr. Ted Parks, Suicide Prevention Program Manager COL Peter Minalga, Chief of Staff MAJ Gordon Lyons, Chief, Behavioral Health	LTC Jeff Mrochek, ORSA Danielle Holliday, Health Promotions Officer MAJ Christian Goza, Division Chaplain

Goal #1: Decrease the number of suicide attempts	
<p>1.1. Objective: A trained and ready environment with skill at preventing suicide. Increase suicide prevention training for active duty personnel.</p> <p>1.1.1. Intervention Strategy: Create and issue policy mandating the five day Applied Suicide Intervention Skills Training (ASIST) train the trainer program.</p> <p>1.1.2. Intervention Strategy: Create and issue policy mandating the two day ASIST Gatekeeper training.</p>	<p>Outcome measure(s)</p> <ul style="list-style-type: none"> • Decrease in number of suicide attempts by 15% by 2017 • By 2015, issue policy mandating ASIST train the trainer training • By 2015, issue policy mandating ASIST Gatekeeper training • By 2017 have a 10% reduction in “of those having suicidal thoughts made a plan” as measured by the unit risk inventory 2014 baseline.
<p>1.2. Objective: An environment saturated with those aware and able to intervene to prevent a suicide. Increase levels of trained individuals equally throughout the post.</p> <p>1.2.1. Intervention Strategy: Implement train the trainer ASIST training at the battalion level.</p> <p>1.2.2. Intervention Strategy: Implement Gatekeeper ASIST training at the Soldier level.</p>	<p>Outcome measure(s)</p> <ul style="list-style-type: none"> • Increase ASIST train the trainers to 2 per battalion by 2015 • Increase Gatekeepers to 5% of platoon size and rear deployed elements, 10% of barracks personnel by gender, and 85% of all Chaplaincy, Military Police, Unit Medical Assets and Green tab military leaders at the Company level by 2016

Goal #2: Increase access to Behavioral Health services	
<p>2.1. Objective: Professional skills and collaborative care effective within the Soldier area. Increase access to behavioral health services for active duty service members.</p> <p>2.1.1. Intervention Strategy: Develop and implement embedded behavioral health teams for each brigade.</p> <p>2.1.2. Intervention Strategy: Increase Behavioral Health resources and capabilities at Irwin Army Community Hospital.</p>	<p>Outcome measure(s)</p> <ul style="list-style-type: none"> • Maintain a 95% staffing rate of embedded behavioral health year over year. • Decrease those answering yes to the end of an important relationship that experienced anger and frustration by 15% by 2016.
<p>2.2. Objective: An army family well supported by local mental health care resources. Increase access to behavioral health services available to family members.</p> <p>2.2.1. Intervention Strategy: Increased hiring of Child, Adolescent and Adult Mental Health practitioners.</p>	<p>Outcome measure(s)</p> <ul style="list-style-type: none"> • Increase in the number of family members seen for behavioral health services by 10% per year • By 2016, have at least two active agreements resulting in mental health care students being trained at Fort Riley

Alcohol Abuse

Alcohol abuse was identified by our community when surveyed as the greatest threat to health on Fort Riley (1). Statistics lay foundation to this public sentiment. During the five year period between 2009 and 2013, alcohol related offenses were more than twice that expected (1). Hours of sale of alcohol are allowed on post beyond that allowed by state law (2). An evidence based strategy to reduce alcohol abuse has been to limit the hours of sale (3). The extended effect would be a reduction in alcohol related offenses. Also recommended in high performance, job settings are workplace policies that require alcohol and drug testing (4). A well-functioning and comprehensive, surveillance system is necessary to appropriately identify individuals. When surveyed, many of the Fort Riley community responded that increased consequences to the abuse of alcohol would be the best way to solve this problem (1). Designated rides are prevalent and effective in this unique community where an Army post is in such close proximity to a major university (Kansas State University). As in the university setting, many in our ranks are below the legal drinking age of 21 years old. From a primary prevention standpoint, school based programs to dissuade young community members from abusing alcohol have been supported by evidence (5). Military traditions have at times glamorized the use of alcohol. The "Dining In" is an event that is meant to spur comradery. At the center of this event, though, is the "Grog Bowl" which is a collection of various types of drinking alcohol.

(1) Fort Riley Community Health Assessment, August 2014

(2) Kansas Department of Revenue, Alcohol Beverage Control, Hours and Days When Alcoholic Liquor and CMB May Be Sold/Served, September 24, 2012

(3) Guide to Community Preventive Services, Maintaining Limits on Hours of Sale Recommended February 2009

(4) Center for Disease Control, Alcohol and Substance Abuse Guidelines, August 2014

(5) Substance Abuse and Mental Health Services Administration (SAMSHA) National Registry of Evidence- based Programs and Practices, June 2014

Priority Area: Alcohol Abuse

Working Group Lead: Installation Prevention Team

Team Members

Ms. Nicole Sizemore, Prevention Branch Chief
 Mr. Christopher Bowman, Prevention Coordinator
 Ms. Dani Holliday, Health Promotion Officer
 Mr. Eric Coates, Industrial Hygienist

Goal #1: Reduce the number of alcohol offenses

1.1. Objective:

Create a safe and healthy environment. Reduce the number of alcohol offenses for the military and local communities over the next two years.

1.1.1. Intervention Strategy: Implement a policy change on Fort Riley to prevent alcohol sales from 2300-0700 hours and demonstrate its effectiveness.

1.1.2 Intervention Strategy (New): Standardize Alcohol Training into 3 modules (overview Kansas Laws, Social influences on drinking, and alcohol interaction with the body and blood alcohol content) and provide to Soldiers and to Family Readiness Groups.

Outcome measure(s)

- Decrease alcohol offenses to lower than the Army average within 2 years
- Decrease alcohol offenses from an equivalent time period prior to limits on hours of sale by at least 15% within a year
- Increase the number of Fort Riley Soldiers and family members that have participated in standardized alcohol training (all 3 modules completed) by 10% each year.

Goal #2: Deglamorize the use of alcohol on Fort Riley

2.1. Objective A culture of responsibility where moderate, lawful or no use of alcohol is accepted as the norm. Increase primary prevention efforts and incentive awards.

2.1.1 Intervention Strategy (New): Conduct alcohol free events at least one per month. An increase from twice per

Outcome measure(s)

- Decrease the proportion of 6th and 8th grade students that have used alcohol in the last 30 days by 10% by 2016 as measured by the Communities That Care (CTC)

<p>year.</p> <p>2.2.2 Intervention Strategy (New): Develop and distribute information book to all Soldiers and family members stationed at Fort Riley, KS about broad spectrum of activities available at and around Fort Riley and Kansas.</p>	<p>survey</p> <ul style="list-style-type: none"> • Decrease the proportion of those drinking 6 or more drinks on one occasion by 15% as measured by the Unit Risk Inventory by 2016
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Getting Involved

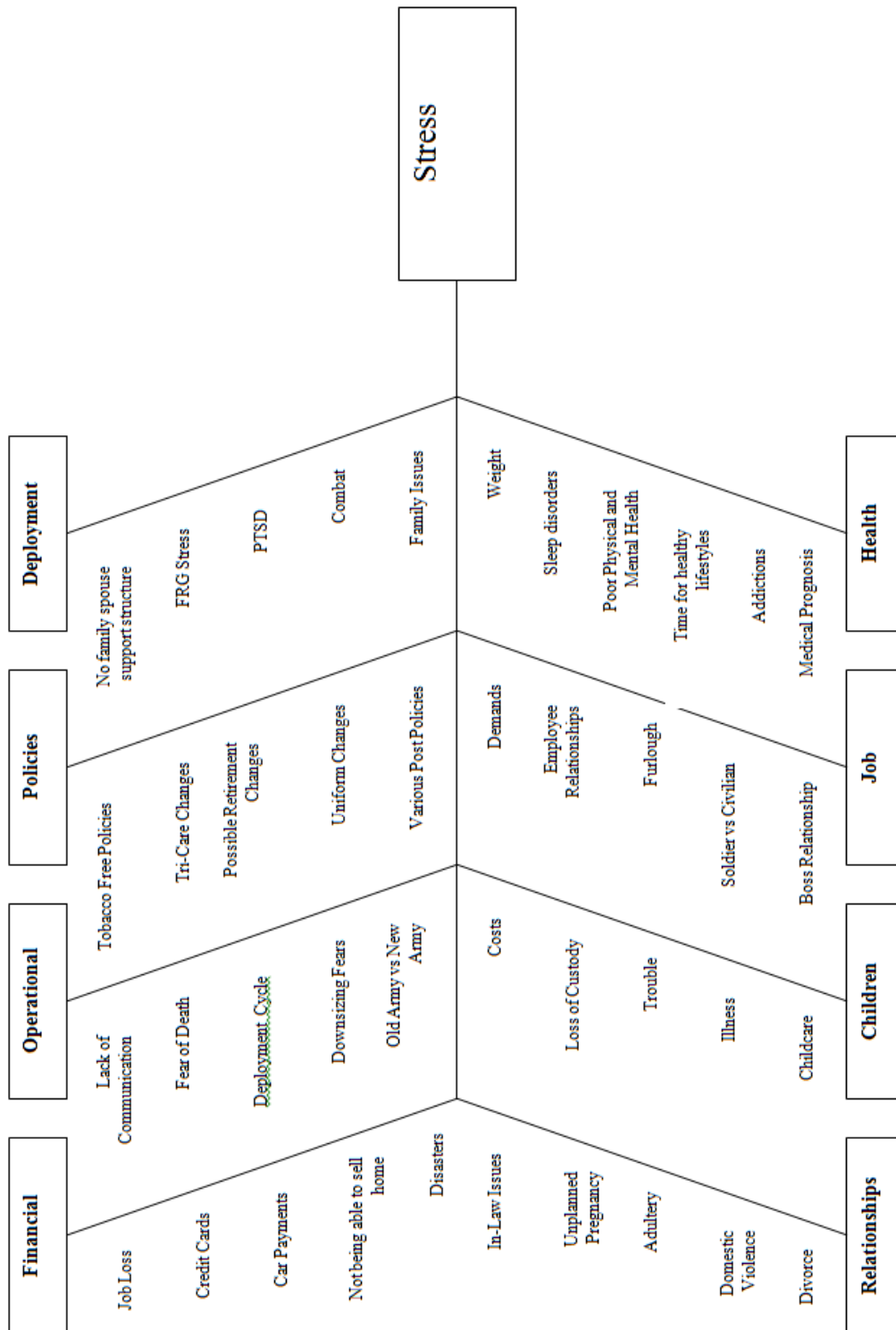
The Fort Riley CHIP was developed in order to improve the health of those working and living on Fort Riley. It is designed to get engagement from all those that have an impact on the health of our community. There are many ways that you can become involved in this effort.

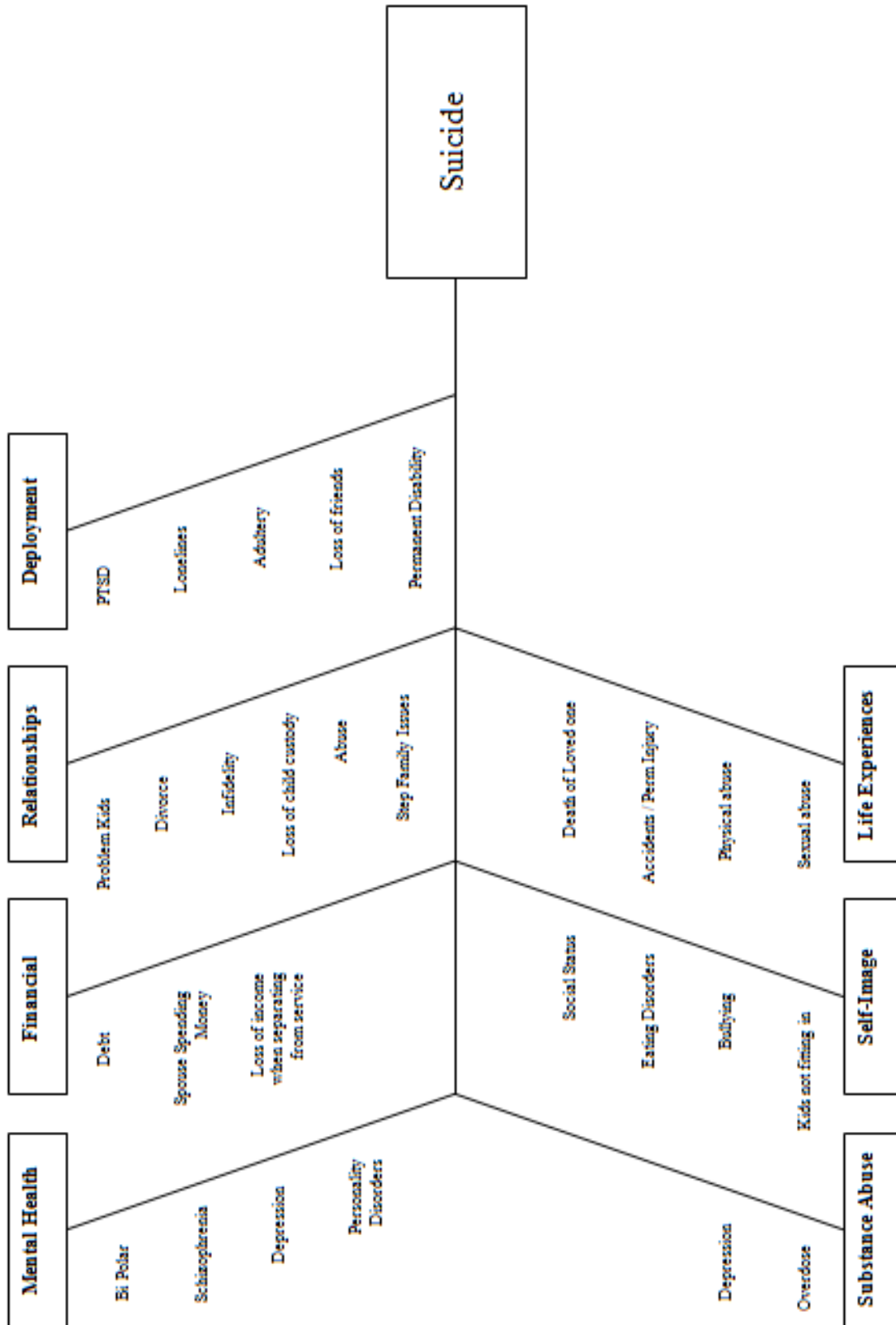
If you would like to get involved with the CHIP, or have a question or comment, please contact the Department of Public Health or the Fort Riley Health Promotions Officer by e-mailing:

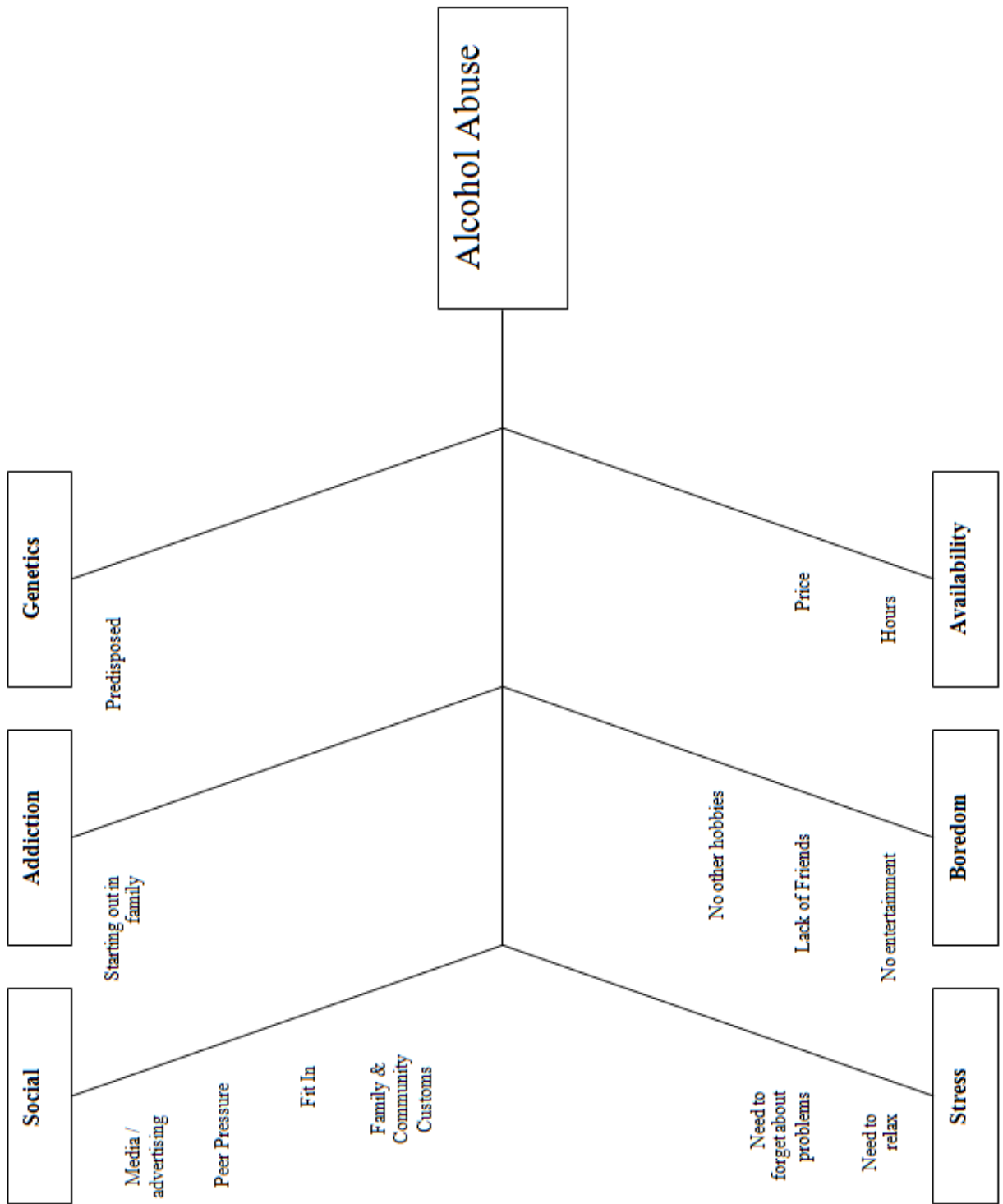
usarmy.riley.medcom-iach.list.public-health@mail.mil

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Appendix A: Fishbone Diagrams







Appendix B: Community Assets and Resources

Fort Riley

Army Community Service

 Exceptional Family Member Program (EFMP)

 Family Advocacy Program (FAP) Abuse and Neglect

 Social Work Services

 Survivor Outreach Services

 Casualty Assistance Center

Irwin Army Community Hospital

Army Substance Abuse Program

Sexual Harassment / Assault Response and Prevention (SHARP)

Child Youth and School Services

Resiliency Campus

Women, Infants and Children (WIC) Program

Dental Corps

Veterinary Services

Geary County

USD 475 - Geary County Schools

Geary County Community Hospital

Geary County Health Department

Riley County

Riley County Health Department

USD 383 – Manhattan-Ogden Schools

USD 378 – Riley County Schools

Pottawatomie County

Pottawatomie County Health Department