Lorain County
Community Health Improvement Plan

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Note: Throughout the report, hyperlinks will be highlighted in bold, gold text. If using a hard copy of this report, please see Appendix I for links to websites.

Executive Summary

Introduction

A community health improvement plan (CHIP) is a community-driven, long-term, systematic plan to address issues identified in a community health assessment (CHA). The purpose of the CHIP is to describe how hospitals, health departments, and other community stakeholders will work to improve the health of the county. A CHIP is designed to set priorities, direct the use of resources, and develop and implement projects, programs, and policies. The CHIP is more comprehensive than the roles and responsibilities of health organizations alone, and the plan's development must include participation of a broad set of community stakeholders and partners. This CHIP reflects the results of a collaborative planning process that includes significant involvement by a variety of community sectors.

The Lorain County Health Partners, an organized group of community partners that also makes up the CHIP Steering Committee, have been conducting CHAs since 2011 to measure community health status. The most recent Lorain County CHA was cross-sectional in nature and included a written survey of adults and electronic survey of youth within Lorain County. The adult questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention (CDC) for their national and state Behavioral Risk Factor Surveillance System (BRFSS). The youth survey was completed by Communities That Care (CTC) of Lorain County, as required by the Drug Free Communities Support Program. This has allowed Lorain County to compare their CHA data to national, state and local health trends. Community stakeholders were actively engaged in the early phases of CHA planning and helped define the content, scope, and sequence of the project.

Lorain County Public Health contracted with the Hospital Council of Northwest Ohio (HCNO), a neutral, regional, nonprofit hospital association, to facilitate the CHA and CHIP. The health department invited various community stakeholders to participate in community health improvement process. Data from the most recent CHA was carefully considered and categorized into community priorities with accompanying strategies. This was done using the National Association of County and City Health Officials' (NACCHO) national framework, Mobilizing for Action through Planning and Partnerships (MAPP). Over the next three years, these priorities and strategies will be implemented at the county-level with the hope to improve population health and create lasting, sustainable change. It is the hope of the Lorain County Health Partners that each agency in the county will tie their internal strategic plan to at least one strategy in the CHIP.

Public Health Accreditation Board (PHAB) Requirements

National Public Health Accreditation status through the Public Health Accreditation Board (PHAB) is the measurement of health department performance against a set of nationally recognized, practice-focused and evidenced-based standards. The goal of the national accreditation program is to improve and protect the health of the public by advancing the quality and performance of Tribal, state, local, and territorial public health departments. PHAB requires that CHIPs be completed at least every five years; however, Ohio state law (ORC 3701.981) requires that health departments and hospitals collaborate to create a CHIP every 3 years. Additionally, PHAB is a voluntary national accreditation program; however the State of Ohio requires that all local health departments become accredited by 2020, making it imperative that all PHAB requirements are met. Lorain County Public Health was awarded accreditated status in August 2016.

PHAB standards also require that a community health improvement model is utilized when planning CHIPs. This CHIP was completed using NACCHO's MAPP process. MAPP is a national, community-driven planning

process for improving community health. This process was facilitated by HCNO in collaboration with various local agencies representing a variety of sectors.

Inclusion of Vulnerable Populations (Health Disparities)

Approximately 13.7% of Lorain County residents were below the poverty line, according to the 2013-2017 American Community Survey 5-year estimates. For this reason, data is broken down by income (less than $25,000 and greater than $25,000) throughout the report to show disparities.

Mobilizing for Action through Planning and Partnerships (MAPP)

NACCHO's strategic planning tool, MAPP, guided this community health improvement process. The MAPP framework includes six phases which are listed below:

1. Organizing for success and partnership development
2. Visioning
3. The four assessments
4. Identifying strategic issues
5. Formulate goals and strategies
6. Action cycle

The MAPP process includes four assessments: community themes and strengths, forces of change, local public health system assessment, and the community health status assessment. These four assessments were used by the Lorain County Health Partners to prioritize specific health issues and population groups which are the foundation of this plan. Figure 1.1 illustrates how each of the four assessments contributes to the MAPP process.

Figure 1.1 The MAPP model

Alignment with National and State Standards

The 2020-2022 Lorain County CHIP priorities align with state and national priorities. Lorain County will be addressing the following priorities: chronic disease, maternal and child health, mental health, substance abuse, and cancer.

Ohio State Health Improvement Plan (SHIP)

Note: This symbol will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2017-2019 SHIP. Since the release of the Lorain County CHIP, the Ohio Department of Health updated the SHIP. See Appendix III: 2020-2022 SHIP Strategy Quick Guide.

SHIP Overview

The 2017-2019 State Health Improvement Plan (SHIP) serves as a strategic menu of priorities, objectives, and evidence-based strategies to be implemented by state agencies, local health departments, hospitals and other community partners and sectors beyond health including education, housing, employers, and regional planning.

The SHIP includes a strategic set of measurable outcomes that the state will monitor on an annual basis. Given that the overall goal of the SHIP is to improve health and wellbeing, the state will track the following health indicators:

- Self-reported health status (reduce the percent of Ohio adults who report fair or poor health)
- Premature death (reduce the rate of deaths before age 75)

SHIP Priorities

In addition to tracking progress on overall health outcomes, the SHIP will focus on three priority topics:

1. Mental Health and Addiction (includes emotional wellbeing, mental illness conditions and substance abuse disorders)
2. Chronic Disease (includes conditions such as heart disease, diabetes and asthma, and related clinical risk factors-obesity, hypertension and high cholesterol, as well as behaviors closely associated with these conditions and risk factors- nutrition, physical activity and tobacco use)
3. Maternal and Infant Health (includes infant and maternal mortality, birth outcomes and related risk and protective factors impacting preconception, pregnancy and infancy, including family and community contexts)

Cross-cutting Factors

The SHIP also takes a comprehensive approach to improving Ohio's greatest health priorities by identifying cross-cutting factors that impact multiple outcomes. Rather than focus only on disease-specific programs, the SHIP highlights powerful underlying drivers of wellbeing, such as student success, housing affordability and tobacco prevention. This approach is built upon the understanding that access to quality health care is necessary, but not sufficient, for good health. The SHIP is designed to prompt state and local stakeholders to implement strategies that address the Social determinants of health and health behaviors, as well as approaches that strengthen connections between the clinical healthcare system, public health, community-based organizations and sectors beyond health.

SHIP planners drew upon this framework to ensure that the SHIP includes outcomes and strategies that address the following cross-cutting factors:

- **Health equity**: Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

- **Social determinants of health**: Conditions in the social, economic and physical environments that affect health and quality of life.

- **Public health system, prevention and health behaviors**:
  - The public health system is comprised of government agencies at the federal, state, and local levels, as well as nongovernmental organizations, which are working to promote health and prevent disease and injury within entire communities or population groups.
  - Prevention addresses health problems before they occur, rather than after people have shown signs of disease, injury or disability.
  - Health behaviors are actions people take to keep themselves healthy, such as eating nutritious food and being physically active, or actions people take that harm their health or the health of others, such as smoking. These behaviors are often influenced by one's family; the community; and the broader social, economic, and/or physical environment.

- **Healthcare system and access**: Health care refers to the system that pays for and delivers clinical health care services to meet the needs of patients. Access to health care means having timely use of comprehensive, integrated and appropriate health services to achieve the best health outcomes.

CHIP Alignment with the 2017-2019 SHIP

The 2020-2022 Lorain County CHIP is required to select at least 2 priority topics, 1 priority outcome indicator, 1 cross cutting strategy and 1 cross-cutting outcome indicator to align with the 2017-2019 SHIP. The following Lorain County CHIP priority topics, outcomes and cross cutting factors very closely align with the 2017-2019 SHIP priorities:

Figure 1.2 2020-2022 Lorain CHIP Alignment with the 2017-2019 SHIP

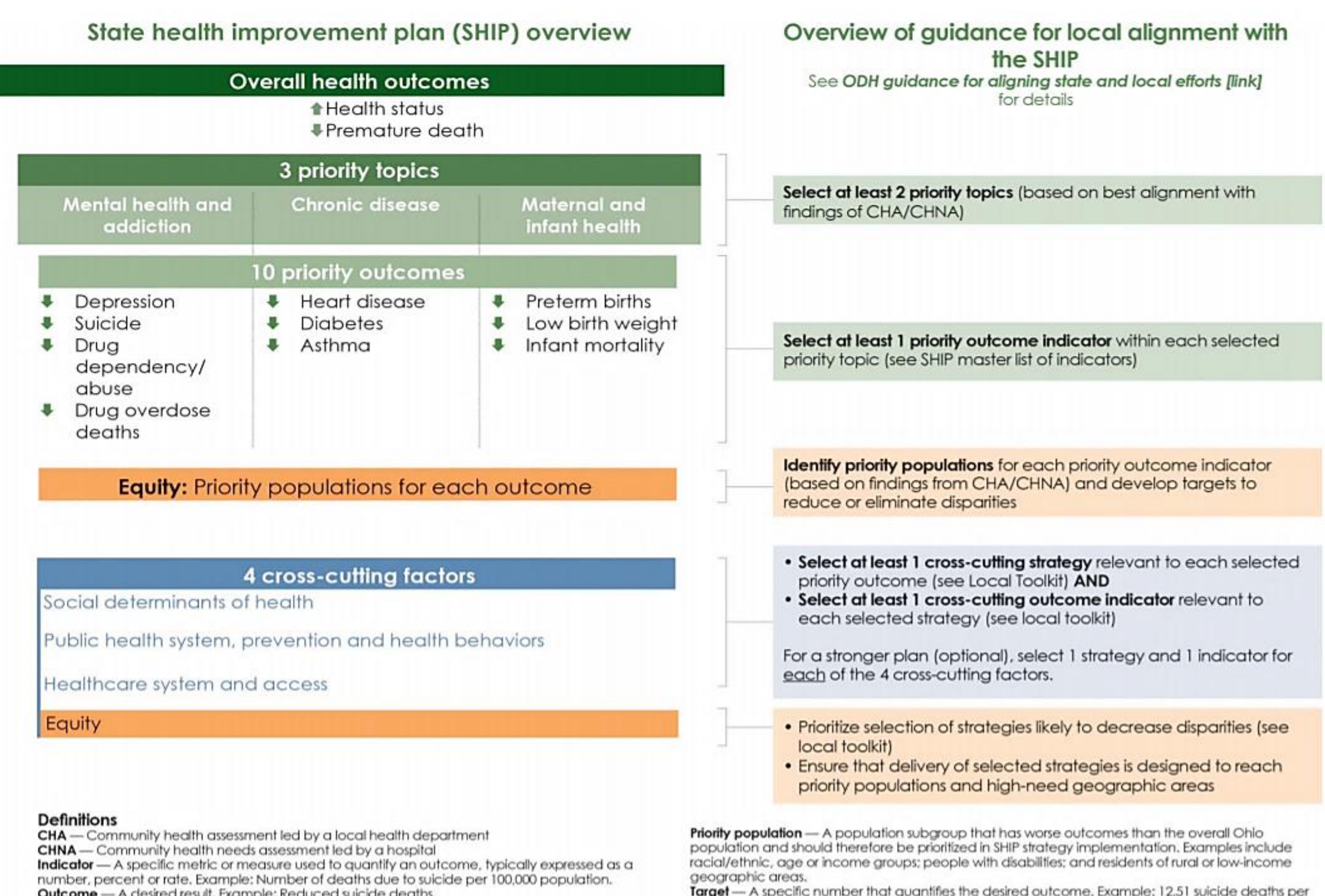
<table>
<tr><th colspan="4">2020-2022 Lorain CHIP Alignment with the 2017-2019 SHIP</th></tr>
<tr><th>Priority Topic</th><th>Priority Outcome</th><th>Cross-Cutting Strategy</th><th>Cross-Cutting Outcome</th></tr>
<tr><td>Mental health</td><td>• Reduce depression
• Reduce suicide deaths</td><td rowspan="4">• Public Health System, Prevention, and Health Behaviors
• Healthcare System and Access
• Social Determinants of Health
• Health Equity</td><td rowspan="4">• Adult smoking
• Adult fruit consumption
• Adult vegetable consumption
• Early childhood supports/kindergarten readiness</td></tr>
<tr><td>Addiction (Substance Abuse)</td><td>• Reduce unintentional overdose deaths</td></tr>
<tr><td>Chronic Disease</td><td>• Reduce heart disease
• Reduce diabetes</td></tr>
<tr><td>Maternal and Infant Health (Maternal and Child Health)</td><td>• Reduce preterm births</td></tr>
</table>

U.S. Department of Health and Human Services National Prevention Strategies

The Lorain County CHIP also aligns with seven of the National Prevention Priorities for the U.S. population: tobacco free living, preventing drug abuse and excessive alcohol use, healthy eating, active living, injury and violence free living, reproductive and sexual health, and mental and emotional well-being. For more information on the national prevention priorities, please go to **surgeongeneral.gov**.

Alignment with National and State Standards, continued

Figure 1.4 2017-2019 State Health Improvement Plan (SHIP) Overview



Vision and Mission

Vision statements define a mental picture of what a community wants to achieve over time while the mission statement identifies why an organization/coalition exists and outlines what it does, who it does it for, and how it does what it does.

The Vision of the Lorain County Health Partners

Working together to create a healthy Lorain County

The Mission of the Lorain County Health Partners

Improving health and quality of life by mobilizing partnerships and taking strategic action in Lorain County

Community Partners

The CHIP was planned by various agencies and service-providers within Lorain County. From June to July 2019, the Lorain County Health Partners reviewed many primary and secondary data sources concerning the health and social challenges that Lorain County residents are facing. They determined priority issues which, if addressed, could improve future outcomes, determined gaps in current programming and policies, examined best practices and solutions, and determined specific strategies to address priority issues. We would like to recognize these individuals and thank them for their dedication to this process.

Lorain County CHIP Steering Committee (Lorain County Health Partners)

Cleveland Clinic Avon Hospital
Lorain County Health & Dentistry
Lorain County Metro Parks
Lorain County Public Health
Mental Health, Addiction and Recovery Services Board of Lorain County
Mercy Health Allen Hospital
Mercy Health Lorain Hospital
Specialty Hospital of Lorain
University Hospitals Elyria Medical Center

Lorain County CHIP Acknowledgements

Amherst Exempted Village School District
Avon RH, LLC
Cleveland Clinic
Community Foundation of Lorain County
El Centro de Servicios Sociales, Inc.
Firelands Counseling & Recovery Services
French Creek YMCA
Linking Employment, Abilities, and Potential (LEAP)
Lorain County Board of Developmental Disabilities - Murray Ridge Center
Lorain County Drug Task Force
Lorain County Office on Aging
Silver Maple Recovery
The LCADA Way
The Nord Center
The Nord Family Foundation

United Way of Greater Lorain County
University Hospitals Avon Health Center

Hospital Council of Northwest Ohio (HCNO)

The Lorain County Health Partners retained HCNO to facilitate the community health improvement process. HCNO facilitated four community health improvement meetings and provided partial assistance with the development and selection of final strategies and their accompanying goals, objectives, and indicators, which were completed and finalized by the Lorain County Health Partners.

Community Health Improvement Process

Beginning in June 2019, the Lorain County Health Partners and other community partners met four (4) times and completed the following planning steps:

1. Initial Meeting
   - Review the process and timeline
   - Finalize committee members
   - Create or review vision
2. Choose Priorities
   - Use of quantitative and qualitative data to prioritize target impact areas
3. Rank Priorities
   - Rank health problems based on magnitude, seriousness of consequences, and feasibility of correcting
4. Community Themes and Strengths Assessment
   - Open-ended questions for committee on community themes and strengths
5. Forces of Change Assessment
   - Open-ended questions for committee on forces of change
6. Local Public Health Assessment
   - Review the Local Public Health System Assessment with committee
7. Gap Analysis
   - Determine discrepancies between community needs and viable community resources to address local priorities
   - Identify strengths, weaknesses, and evaluation strategies
8. Quality of Life Survey
   - Review results of the Quality of Life Survey with committee
9. Strategic Action Identification
   - Identification of evidence-based strategies to address health priorities
10. Best Practices
    - Review of best practices, proven strategies, evidence continuum, and feasibility continuum
11. Resource Assessment
    - Determine existing programs, services, and activities in the community that address specific strategies
12. Draft Plan
    - Review of all steps taken
    - Action step recommendations based on one or more of the following: enhancing existing efforts, implementing new programs or services, building infrastructure, implementing evidence-based practices, and feasibility of implementation

Community Health Status Assessment

Phase 3 of the MAPP process, the Community Health Status Assessment, or CHA, is a 150+ page report that includes primary data with over 100 indicators and hundreds of data points related health and well-being, including social determinants of health. Over 50 sources of secondary data are also included throughout the report. The CHA serves as the baseline data in determining key issues that lead to priority selection. The full report can be found at **https://www.loraincountyhealth.com/cha**. Below is a summary of county primary data and the respective state and national benchmarks.

Adult Trend Summary

Adult Variables	Lorain County 2011	Lorain County 2015	Lorain County 2018	Ohio 2017	U.S. 2017
Health Status					
Rated general health as good, very good, or excellent	88%	86%	89%	81%	83%
Rated health as excellent or very good	48%	47%	49%	49%	51%
Rated health as fair or poor	12%	14%	11%	19%	18%
Rated physical health as not good on four or more days (in the past 30 days)	18%	21%	18%	22%*	22%*
Rated mental health as not good on four or more days (in the past 30 days)	20%	27%	29%	24%*	23%*
Average days that physical health not good (in the past 30 days)	N/A	3.1	3.6	4.0‡	3.7‡
Average days that mental health not good in past month	N/A	4.1	4.7	4.3‡	3.8‡
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past 30 days)	18%	27%	25%	22%*	22%*
Health Care Access and Utilization					
Visited the doctor's office when needed health care services or advice	75%	80%	73%	N/A	N/A
Had one or more persons they thought of as their personal doctor or health care provider	83%	81%	84%	81%	77%
Did not see a doctor in the past year due to cost	20%	18%	14%	11%	13%
Visited a doctor for a routine checkup (in the past 12 months)	55%	64%	71%	72%	70%
Visited a doctor for a routine checkup (5 or more years ago)	12%	10%	7%	7%	8%
Health Care Coverage					
Uninsured	11%	11%	10%	9%	11%

N/A - Not Available
**2016 BRFSS*
‡2016 BRFSS Data as compiled by 2018 County Health Rankings
Indicates alignment with the Ohio State Health Assessment

Adult Variables	Lorain County 2011	Lorain County 2015	Lorain County 2018	Ohio 2017	U.S. 2017
Arthritis, Asthma & Diabetes					
Ever diagnosed with some form of arthritis	35%	34%	36%	29%	25%
Had ever been told they have asthma	14%	15%	16%	14%	14%
Ever been told by a doctor they have diabetes (not pregnancy-related)	13%	11%	13%	11%	11%
Ever been diagnosed with pregnancy-related diabetes	2%	3%	1%	1%	1%
Ever been diagnosed with pre-diabetes or borderline diabetes	N/A	6%	6%	2%	2%
Cardiovascular Health					
Ever diagnosed with angina or coronary heart disease	6%	6%	5%	5%	4%
Ever diagnosed with a heart attack, or myocardial infarction	6%	3%	5%	6%	4%
Ever diagnosed with a stroke	2%	4%	3%	4%	3%
Had been told they had high blood pressure	35%	36%	34%	35%	32%
Had been told their blood cholesterol was high	36%	33%	34%	33%	33%
Had their blood cholesterol checked within the past five years	N/A	82%	80%	85%	86%
Alcohol Consumption					
Current drinker (drank alcohol at least once in the past month)	59%	61%	62%	54%	55%
Binge drinker (defined as consuming more than four [women] or five [men] alcoholic beverages on a single occasion in the past 30 days)	23%	11%	21%	19%	17%
Drinking and driving in the past month (had driven after drinking too much)	4%	1%	8%	4%*	4%*
Tobacco Use					
Current smoker (smoked on some or all days)	22%	22%	12%	21%	17%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	26%	23%	24%	24%	25%
Drug Use					
Adults who used marijuana in the past 6 months	7%	10%	10%	N/A	N/A
Adults who used heroin in the past 6 months	1%	<1%	<1%	N/A	N/A
Adults who misused prescription drugs in the past 6 months	11%	11%	8%	N/A	N/A
Sexual Behavior					
Had more than one sexual partner in past year	6%	8%	7%	N/A	N/A
Weight Status					
Normal Weight (BMI of 18.5 – 24.9)	33%	31%	29%	30%	32%
Overweight (BMI of 25.0 – 29.9)	35%	32%	32%	34%	35%
Obese (includes severely and morbidly obese, BMI of 30.0 and above)	32%	37%	38%	34%	32%

N/A - Not Available
**2016 BRFSS*
Indicates alignment with the Ohio State Health Assessment

Adult Variables	Lorain County 2011	Lorain County 2015	Lorain County 2018	Ohio 2017	U.S. 2017
Quality of Life					
Limited in some way because of physical, mental or emotional problem	20%	36%	38%	21%*	21%*
Mental Health					
Considered attempting suicide (in the past 12 months)	4%	3%	4%	N/A	N/A
Attempted suicide (in the past 12 months)	<1%	1%	1%	N/A	N/A
Two or more weeks in a row felt sad, blue or depressed	13%	20%	13%	N/A	N/A
Oral Health					
Visited a dentist or a dental clinic (within the past year)	60%	66%	69%	68%*	66%*
Visited a dentist or a dental clinic (5 or more years ago)	14%	12%	10%	11%*	10%*
Had any permanent teeth extracted	N/A	N/A	47%	45%*	43%*
Had all their natural teeth extracted (ages 65 and older)	N/A	N/A	9%	17%*	14%*
Preventive Medicine					
Ever had a pneumonia vaccination (age 65 and older)	68%	82%	76%	76%	75%
Had a flu shot within the past year (age 65 and older)	68%	82%	80%	63%	60%
Ever had a shingles or zoster vaccine	N/A	13%	22%	29%	29%
Had a clinical breast exam in the past two years (age 40 & over)	N/A	69%	74%	N/A	N/A
Had a mammogram within the past two years (age 40 and older)	79%	75%	77%	74%*	72%*
Had a Pap smear in the past three years (ages 21-65)	N/A	68%**	70%	82%*	80%*
Had a PSA test within the past year	32%	27%	29%	N/A	N/A
Had a digital rectal exam within the past year	26%	17%	21%	N/A	N/A
Social Determinants of Health					
Firearms kept in or around their home	24%	31%	35%	N/A	N/A

N/A - Not Available
**2016 BRFSS*
***2015 BRFSS*

Youth Trend Summary

Youth Variables	Lorain County 2018 6th grade	Lorain County 2018 8th grade	Lorain County 2018 10th grade	Lorain County 2018 12th grade
Weight Control				
Physically active at least 60 minutes per day on every day in past week	27%	32%	25%	18%
Physically active at least 60 minutes per day on 5 or more days in past week	48%	56%	53%	38%
Did not participate in at least 60 minutes of physical activity on at least 1 day	10%	9%	7%	14%
Tobacco Use				
Used tobacco in the past year	1%	7%	11%	26%
Current smokers	1%	4%	3%	8%
Alcohol Consumption				
Youth who had alcohol in the past year	8%	17%	36%	59%
Current drinker	3%	8%	17%	32%
Rode with someone who was drinking	11%	12%	11%	11%
Drank and drove (of youth drivers)	N/A	N/A	1%	5%
Drug Use				
Used marijuana in the past month	1%	5%	13%	31%
Used methamphetamines in the past year	<1%	<1%	<1%	1%
Used cocaine in the past year	<1%	<1%	1%	3%
Used heroin in the past year	<1%	0%	0%	1%
Used steroids in the past year	2%	1%	1%	1%
Used inhalants in the past year	1%	3%	1%	2%
Used ecstasy/MDMA in the past year	<1%	1%	1%	3%
Used prescription drugs not prescribed for them in the past month	1%	2%	2%	6%
Mental Health				
Youth who had seriously considered attempting suicide in the past year	19%	20%	22%	28%
Youth who had attempted suicide in the past year	12%	13%	10%	12%
Youth who felt sad or hopeless almost every day for 2 or more weeks in a row	25%	32%	38%	48%
Safety and Violence				
Youth who carried a knife, club or other weapon at school	5%	8%	8%	7%
Youth who had been threatened with a handgun, knife or club	4%	6%	5%	3%
Youth who threatened to hurt another student by hitting, slapping or kicking	17%	25%	22%	16%
Youth who always wore a seatbelt when driving a car	N/A	N/A	43%	71%

N/A - Not Available

Key Issues

The Lorain County Health Partners reviewed the 2019 Lorain County Health Assessment. The detailed primary and secondary data for each identified key issue can be found in the section it corresponds to. Each member completed an "Identifying Key Issues and Concerns" worksheet. The following tables were the group results.

What are the most significant health issues or concerns identified in the 2019 assessment report? Examples of how to interpret the information include: 13% of Lorain County adults felt so sad or hopeless almost every day for 2 or more weeks in a row in the past year, increasing to 25% of those ages 30 and under.

Key Issue or Concern	Percent of Population At risk	Age Group, Income Level, or Race Most at Risk	Gender Most at Risk
Mental health (7 votes)			
Age adjusted suicide mortality (2013-2017) (Source: Lorain County Public Health via Ohio Department of Health)	15.3 per 100,00 population	Age: 20-39 years (21.5 per 100,000 population) Race: White (15.7 per 100,000 population)	Male (25.5 per 100,000 population)
Annual suicide deaths (2017) (Source: Lorain County Public Health via Ohio Department of Health)	61 deaths	Age: 40-64 (30 deaths) Race: White (55 deaths)	Male (47 deaths)
Adults who rated mental health as not good on four or more days (in the past month)	29%	Age: under 30 (41%)	Female (34%)
Adults average days that mental health not good (in the past month)	4.7 days	N/A	N/A
Youth who felt so sad or hopeless almost every day for 2 or more weeks in a row in the past year	48% (12th grade)	N/A	N/A
Adults who felt so sad or hopeless almost every day for 2 or more weeks in a row in the past year	13%	Age: Under 30 (25%) Income: <25K (16%)	Female (17%)
Adults limited in some way due to stress, depression, anxiety, or emotional problems	22%	N/A	N/A
Youth who seriously considered attempting suicide in the past year	28% (12th grade)	N/A	N/A
Adults who seriously considered attempting suicide in the past year	4%	N/A	N/A
Households in which resident age 65+ was living alone (2013-2017) (Source: Lorain County Public Health via US Census Bureau, American Community Survey 5-year estimates)	13,845 households	N/A	Female (9,719 households)

N/A - Not Available

Key Issue or Concern	Percent of Population At risk	Age Group, Income Level, or Race Most at Risk	Gender Most at Risk
Chronic disease (7 votes)			
Obesity	38%	Income: <$25K (44%) Age: 30-64 years (45%)	N/A
Ever been told by a doctor they have diabetes (not pregnancy related)	13%	Income: <$25K (26%) Age: 65 and over (25%)	Male (15%)
Age-adjusted diabetes mortality rate (2015-2017) (Source: Lorain County Public Health via Ohio Department of Health)	19.3 per 100,000 population	Age: 65-74 (76.7 per 100,000 population 5-year avg) Race: African American (45.9 per 100,000 population 5-year avg)	Male (26.4 per 100,000 population 5-year avg)
Age-adjusted heart disease mortality rate (2015-2017) (Source: Lorain County Public Health via Ohio Department of Health)	161.8 per 100,000 population	Age: Male 55-64 (239.3 per 100,000 population 5-year avg) Race: African American (194.1 per 100,000 population 5-year avg)	Male (208.3 per 100,000 population)
Number of deaths due to heart disease (2015-2017) (Source: Lorain County Public Health via Ohio Department of Health)	662 deaths	Age: 55-64 (73 deaths 5-year avg)	Male ages 55-64 (50 deaths 5-year avg)
Access to care (7 votes)			
Adults who visited a dentist or a dental clinic (within the past year)	69%	Income: <$25K (47%) Age: under 30 (61%)	Female (67%)
Adults who looked for a depression, anxiety, or mental health program for themselves or a loved one	25%	N/A	N/A
Cost prevented adults from seeing a doctor if they were sick, injured, or needed some kind of health care	30%	N/A	N/A
Doctor or health professional talked to adults about safe use of opiate-based pain medication	11%	N/A	N/A
Doctor or health professional talked to adults about substance abuse treatment options	3%	N/A	N/A
Adults reporting "don't know" in regard to what is included in their insurance coverage (example = alcohol & drug treatment)	58%	N/A	N/A
Adults who reported at least one transportation issue	8%	N/A	N/A

N/A - Not Available

Key Issue or Concern	Percent of Population At risk	Age Group, Income Level, or Race Most at Risk	Gender Most at Risk
Substance abuse (6 votes)			
Youth who used an e-cigarette, vape pen, or e-liquid rig in the past 30 days	37% (12th graders)	N/A	N/A
Adults average number of drinks consumed per drinking occasion	3.1	Income: <$25K (5.1 drinks) Age: Under 30 (5.1 drinks)	N/A
Adult binge drinker (consumed more than 4 [women] or 5 [men] alcoholic beverages on a single occasion in the past 30 days)	21%	N/A	N/A
Youth current drinkers (having had a drink at some time in the past month)	32% (12th graders)	N/A	N/A
Unintentional drug overdose deaths - 2018 (Source: Ohio Public Health Data Warehouse)	96 deaths	N/A	N/A
Maternal/child health (6 votes)			
Percent of births to mothers with BMI >30 (2014-2018) (Source: Lorain County Public Health via Ohio Department of Health)	28%	Race: African American (36%)	N/A
Percent of births to unmarried mothers (2014-2018) (Source: Lorain County Public Health via Ohio Department of Health)	48.2%	Race: African American (85.1%)	N/A
Preterm (<37 weeks gestation) birth rates (2013-2017) (Source: Lorain County Public Health via Ohio Department of Health)	97.3 per 1,000 live births	Race: African American (133 per 1,000 live births)	N/A
Women who had been pregnant within the past 5 years that had a prenatal appointment within the first 3 months	61%	N/A	N/A
Cancer (5 votes)			
Cancer mortality (Source: Ohio Public Health Data Warehouse 2015-2017)	22% of all deaths	N/A	N/A
Prostate cancer incidence (2011-2015) (Source: Ohio Public Health Data Warehouse)	1,139 cases	N/A	N/A
Breast cancer incidence (2011-2015) (Source: Ohio Public Health Data Warehouse)	1,268 cases	N/A	N/A
Women who had a mammogram in the past year	32%	Income: <$25K (16%) Urban area: (24%)	N/A
Women who had a Pap smear in the past year	36%	Income: <$25K (17%) Urban area: (21%)	N/A
Men who had a PSA test in the past year	29%	Income: <$25K (13%) Rural area: (26%)	N/A
Men who had DRE within the past year	21%	Income: <$25K (14%)	N/A

N/A - Not Available

Key Issue or Concern	Percent of Population At risk	Age Group, Income Level, or Race Most at Risk	Gender Most at Risk
STD's (1 vote)			
Chlamydia incidence rate (2014-2018) (Source: Lorain County Public Health via Ohio Department of Health)	429.1 per 100,000 population	N/A	N/A
Gonorrhea incidence rate (2014-2018) (Source: Lorain County Public Health via Ohio Department of Health)	131.7 per 100,000 population	N/A	N/A
New diagnoses of HIV infection – 2017 (Source: Ohio Department of Health, HIV Infections Annual Surveillance Statistics)	19 diagnoses	N/A	N/A
Hepatitis C rate (2017) (Source: Ohio Department of Health, Hepatitis Surveillance Program)	159.6 per 100,000 population	N/A	N/A
Infections present in mother at birth (2014-2018) (Source: Lorain County Public Health via Ohio Department of Health)	82.0	N/A	N/A
Preventive health (1 vote)			
Women who had a mammogram in the past two years (age 40 and over)	77%	N/A	N/A
Adults reported having been screened for colorectal cancer in the past 2 years	24%	N/A Age: 50+ (39%)	N/A

N/A - Not Available

Priorities Chosen

Based on the 2019 Lorain County Community Health Assessment, key issues were identified for adults and youth. Committee members then completed a ranking exercise, giving a score for magnitude, seriousness of the consequence and feasibility of correcting, resulting in an average score for each issue identified. Committee members' rankings were then combined to give an average score for the issue. The key issues and their corresponding votes are described in the table below.

Key Issues	Average Score
1. Chronic disease (obesity, diabetes, and heart disease)	24.3
2. Preventive health	22.6
3. Cancer	21.6
4. Maternal and child health	21.3
5. Mental health	21.0
6. Substance abuse	19.6
7. Access to care	19.5
8. STDs	16.6

Lorain County will focus on the following five priority areas over the next three years:

1. Chronic disease (includes heart disease, diabetes, and obesity)
2. Maternal and child health*
3. Mental health
4. Substance abuse*
5. Cancer

**Priority wording is slightly different than the Ohio SHIP*

Community Themes and Strengths Assessment (CTSA)

The Community Themes and Strengths Assessment (CTSA) provides a deep understanding of the issues that residents felt were important by answering the questions: "What is important to our community?" "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?" The CTSA consisted of two parts: open-ended questions to the committee and the Quality of Life Survey. Below are the results:

Open-ended Questions to the Committee

1. **What do you believe are the 2-3 most important characteristics of a healthy community?**
   - Optimal health for all
   - Quality schools and education
   - Healthy and accessible resources
   - Sense of belonging
   - Employment options
   - Resources for self-care
   - Accessible and affordable health care
   - Thriving community
   - Sense of safety
   - Generational interactions
   - Opportunities for families
   - Peer support
   - Lack of stigma for mental health issues and substance abuse
   - Diversity and inclusion
   - Support for re-entry
   - Built environment to support an active community
   - Access to healthy food
   - Thriving and engaged civic community
   - Environmental justice
2. **What makes you most proud of our community?**
   - Collaboration
   - Quality health care
   - Resilience and grit of community members
   - Community colleges
   - Diversity of population
   - Communities willingness to give
   - Metro Parks
   - Access to mental health and substance abuse support
   - Competent and caring practitioners
   - Availability of community services
   - Blending of private and public businesses and resources

3. **What are some specific examples of people or groups working together to improve the health and quality of life in our community?**
   - Lorain County Health Partners
   - Parks and recreation
   - Coalition for uninsured
   - Opiate collaboration
   - Homeless task force
   - Re-entry coalition
   - Libraries
   - United Way Community Collaboratives
   - Live Healthy groups
   - School systems

4. **What do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life in our community?**
   - Less emphasis on screen time and technology
   - Employment options with livable wages
   - Transportation
   - Mental health
   - Community connections
   - Universal and high-quality education for youth
   - Social isolation and loneliness
   - Racism
   - Improved housing stock
   - Linkage of Lorain County to broader/regional approaches

5. **What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?**
   - Lack of collaboration between municipal and county government
   - Turf and silos
   - Leveraging of public knowledge
   - Seeing the root causes of issues
   - Aligned funding
   - Unemployment
   - History
   - Fundamental attribution error
   - Clear and actionable goals
   - Sharing of "silent" work

6. **What actions, policy, or funding priorities would you support to build a healthier community?**
   - Research and data-driven approaches
   - Coordination of care across neighborhoods
   - Giving those with poor health a voice
   - Increased transportation
   - Local funding opportunities
   - Planning with sustainability in mind
   - Rural and urban strategies from the state

7. **What would excite you enough to become involved (or more involved) in improving our community?**
   - More private organization involvement
   - Sharing of data and information

- Continuous show of successes
- Mission and vision statements focused on collaboration
- Explanation of data-driven decisions

Quality of Life Survey

The Lorain County Health Partners urged community members to fill out a short Quality of Life Survey via SurveyMonkey. There were 394 Lorain County community members who completed the survey. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1. For all responses of "Don't Know," or when a respondent left a response blank, the choice was a non-response and was assigned a value of 0 (zero). The non-response was not used in averaging response or calculating

Quality of Life Questions	Likert Scale Average Response
1. Are you satisfied with the quality of life in our community? (Consider your sense of safety, well-being, participation in community life and associations, etc.) [IOM, 1997]	3.41
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.44
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.37
4. Is this community a good place to grow old? (Consider elder-friendly housing, transportation to medical services, churches, shopping; elder day care, social support for the elderly living alone, meals on wheels, etc.)	3.05
5. Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)	2.92
6. Is the community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?)	3.28
7. Are there networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, or organizations) during times of stress and need?	3.47
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.29
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.00
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.16
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.19
12. Is there an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments? (Are citizens working towards the betterment of their community to improve life for all citizens?)	3.14

Forces of Change Assessment

The Forces of Change Assessment focuses on identifying forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. This assessment answers the questions: "What is occurring or might occur that affects the health of our community or the local public health system?" and "What specific threats or opportunities are generated by these occurrences?" The Lorain County Health Partners were asked to identify positive and negative forces which could impact community health improvement and overall health of this community over the next three years. This group discussion covered many local, state, and national issues and change agents which could be factors in Lorain County in the future. The table below summarizes the forces of change agent and its potential impacts:

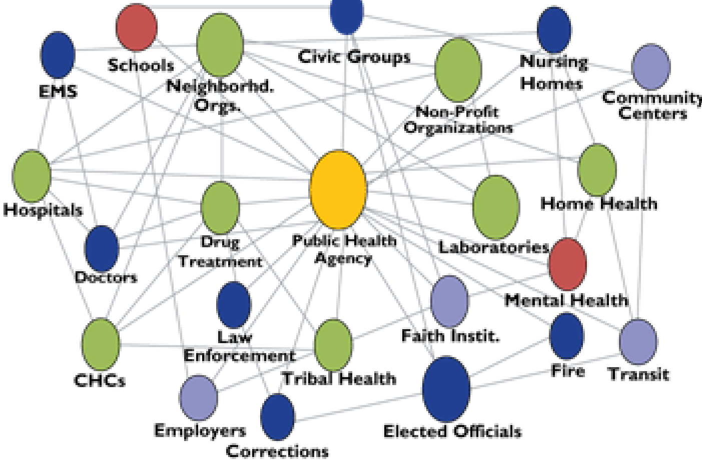
Force of Change	Threats Posed	Opportunities Created
1. Technology	• Decrease in job opportunities • Reduced access if technology is not available • Isolation • Sedentary lifestyles	• Improved access to care (efficient and affordable) • Telemedicine opportunities
2. Immigration	• Access to care • Access to affordable housing	• Strong sense of community • Work ethic
3. Opiate crisis/changes in drug epidemic	• Loss of parent(s) • Increase in number of children in foster care • Changes in drug of choice	• Education and awareness • Community support
4. Levy for community college	• Increase in tuition/reduced education options	• Affordable higher education
5. Growing elderly population	• Lack of public transportation • Increase in loneliness and isolation • Increase in older adults living alone • Reluctance to access preventive health care • Rise in health care costs	• Opportunities for generational connections • Increase acceptance/normalization of aging • Integrate physical/behavioral health care • Involvement with affordable child care • Neighborhood support
6. Disposable society	• Loss of community values • Loss of shared family values	• None noted
7. Social media/ programming	• Impact on youth (ex: increase in depression, suicide, bullying)	• Increased focus on youth to combat mental health issues
8. Stigma of seeking services	• Less service utilization	• Opportunity for continued conversations • Budget to address stigma issues • Harm reduction strategies

Force of Change	Threats Posed	Opportunities Created
9. Potential mayor change (Elyria and Lorain)	• Loss of connections, partnerships, relationships	• Opportunity for new relationships and collaboration • Fresh ideas
10. Retirement of Lorain police chief	• Loss of relationship with immigrant community/immigrants feeling unsafe	• Revisit gaps • Community support
11. Increased violence	• Often seen as common	• Continued community support • Parent education pieces
12. Abortion law changes	• Potential impact on infant mortality	• None noted
13. Deportation	• Populations may be afraid to seek services	• Opportunity to build relationships and strengthen community to calm fears
14. Aging workforce	• Lack of providers	• Community college pipeline programs • Increase job opportunities
15. Increase in e-cigarette use	• Increase in addiction	• Public policy changes
16. Governor's budget	• Potential decrease in funding • Ability to deliver promises may be threatened	• Increase in funding for addiction, foster care, etc.
17. Increase in fast food options	• Increase in chronic conditions	• Education
18. Single parenthood	• Childhood obesity • More criminal justice involvement	• Reduce stigma • Parenthood initiatives • Mentoring opportunities
19. Medicaid policy/work requirements	• Loss of coverage	• None noted
20. Marijuana legalization	• Addiction • Misperceptions of harm • Damage to developing brains	• Social and emotional learning • School and agency collaboration • Peer-to-peer exchanges
21. Water management/quality	• Highest Lake Erie water level • Environmental issues (pollution, flooding, etc.)	• Agency collaboration • Community education • Water management ideas
22. Segregation of neighborhoods	• Increase in disparities	• Redevelopment of neighborhoods
23. Merger of ADAS and Mental Health Board	• Competing priorities/political agendas • Potential loss of services	• Additional funding opportunities • Improved coordination of services • Potential to build new shared vision to make powerful impact

Force of Change	Threats Posed	Opportunities Created
24. Tax reform	• Less donations • Nonprofit/charities losing funding	• More money in family's pockets • Opportunity for fundraisers/events
25. Job mismatch	• No focus on trade opportunities	• Creation of meaningful jobs
26. School systems overloaded	• Lack of time to address issues during school hours	• Continued support
27. Impact of weather on economy/farmers	• Farmers cannot plant crops • Loss of work, especially for migrant population	• Action on stormwater management
28. Lack of livable wages	• Unemployment	• Creativity and problem solving
29. Increasing child care costs	• Financial stability	• None noted

Local Public Health System Assessment

The Local Public Health System



Public health systems are commonly defined as "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction." This concept ensures that all entities' contributions to the health and well-being of the community or state are recognized in assessing the provision of public health services.

The public health system includes:

- Public health agencies at state and local levels
- Healthcare providers
- Public safety agencies
- Human service and charity organizations
- Education and youth development organizations
- Recreation and arts-related organizations
- Economic and philanthropic organizations
- Environmental agencies and organizations

The 10 Essential Public Health Services

The 10 Essential Public Health Services describe the public health activities that all communities should undertake and serve as the framework for the NPHPS instruments.

Public health systems should:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

(Source: **Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services**)

The Local Public Health System Assessment (LPHSA)

The LPHSA answers the questions, "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services being provided to our community?"

This assessment involves the use of a nationally recognized tool called the **National Public Health Performance Standards Local Instrument.**

Members of Lorain County Public Health completed the performance measures instrument. The LPHSA results were then presented to the Lorain County Health Partners for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard was discussed and the group came to a consensus on responses for all questions. The challenges and opportunities that were discussed were used in the action planning process.

The CHIP committee identified 5 indicators that had a status of “minimal” and 0 indicators that had a status of “no activity.” The remaining indicators were all moderate, significant or optimal.

As part of minimum standards, local health departments are required to complete this assessment at least once every five years.

To view the full results of the LPHSA, please contact Lorain County Public Health at (440) 322-6367.

Lorain County Local Public Health System Assessment 2019 Summary

Summary of Average ES Performance Score

	Score
Average Overall Score	67.7
ES 1: Monitor Health Status	79.2
ES 2: Diagnose and Investigate	78.5
ES 3: Educate/Empower	72.2
ES 4: Mobilize Partnerships	65.6
ES 5: Develop Policies/Plans	75.0
ES 6: Enforce Laws	77.6
ES 7: Link to Health Services	56.3
ES 8: Assure Workforce	71.8
ES 9: Evaluate Services	53.8
ES 10: Research/Innovations	47.2

(Axis: 0.0, 20.0, 40.0, 60.0, 80.0, 100.0)

Note: The black bars identify the range of reported performance score responses within each Essential Service

Gap Analysis, Strategy Selection, Evidence-Based Practices, and Resources

Gaps Analysis

A gap is an area where the community needs to expand its efforts to reduce a risk, enhance an effort, or address another target for change. A strategy is an action the community will take to fill the gap. Evidence is information that supports the linkages between a strategy, outcome, and targeted impact area. The Lorain County Health Partners were asked to determine gaps in relation to each priority area, consider potential or existing resources, and brainstorm potential evidence-based strategies that could address those gaps. To view the completed gap analysis exercise, please view Appendix I.

Strategy Selection

Based on the chosen priorities, the Lorain County Health Partners were asked to identify strategies for each priority area. Considering all previous assessments, including but not limited to the CHA, CTSA, quality of life survey and gap analysis, Lorain County Health Partners determined strategies that best suited the needs of their community. Members referenced a list a of evidence-based strategies recommended by the Ohio SHIP, as well as brainstormed for other impactful strategies. Each resource inventory can be found with its corresponding priority area.

Evidence-Based Practices

As part of the gap analysis and strategy selection, the Lorain County Health Partners considered a wide range of evidence-based practices, including best practices. An evidence-based practice has compelling evidence of effectiveness. Participant success can be attributed to the program itself and have evidence that the approach will work for others in a different environment. A best practice is a program that has been implemented and evaluation has been conducted. While the data supporting the program is promising, its scientific rigor is insufficient. Each evidence-based practice can be found with its corresponding strategy.

Resource Inventory

Based on the chosen priorities, the Lorain County Health Partners were asked to identify resources for each strategy. The resource inventory allowed the Lorain County Health Partners to identify existing community resources, such as programs, policies, services, and more. The Lorain County Health Partners was then asked to determine whether a policy, program or service was evidence-based, a best practice, or had no evidence indicated. Each resource inventory can be found with its corresponding strategy.

Priority #1: Chronic Disease

Strategic Plan of Action

To work toward improving chronic disease outcomes, the following strategies are recommended:

Priority #1: Chronic Disease

Facilitating Organization: Lorain County Public Health

Goal 1: By 2022, stop the upward trend of female age-specific heart disease mortality (55-64 years) by staying at or below the last 5-year average (2013-2017, 103.3 deaths per 100,000 population).

Strategy 1: Prescriptions for physical activity

Objective 1: By July 30, 2022, implement exercise prescriptions in 2 communities and implement 3 new ways to promote exercise in underserved areas.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Research and recommend best practices for implementing and evaluating exercise prescriptions. Ensure focus on priority population (i.e. females aged 55-64, heart disease mortality) and underserved areas. Implement strategy through the Move Amherst pilot and work to enhance and evaluate systems changes made by local healthcare providers. Collect and summarize data to help expand similar model into another community.	2020	Females age 55-64 years.	Age adjusted heart disease mortality rate Female age-specific (55-64 years) Heart Disease Mortality Insufficient physical activity (adult)
Year 2: Analyze year 1 data from the Amherst area pilot. Make changes based on lessons learned. Ensure focus on priority population (i.e. females aged 55-64, heart disease mortality) and underserved areas. Establish exercise prescriptions and expanded exercise promotion in a second community.	2021		
Year 3: Analyze evaluation data from years 1 and 2. Make changes to implement in year 3. Continue to ensure focus on health disparities and underserved areas. Ensure plans to sustain systems, policy, and/or environmental changes completed over the last 3 years. Recommend a model to expand exercise prescriptions to specific demographics countywide.	July 30, 2022		

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ⊗ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

CHIP Priority Team Members: Amherst Exempted Village School District, CareSource, Cleveland Clinic, French

Priority #1: Chronic Disease			
Facilitating Organization: Lorain County Public Health			
Goal 1: By 2022, stop the upward trend of female age-specific heart disease mortality (55-64 years) by staying at or below the last 5-year average (2013-2017, 103.3 deaths per 100,000 population).			
Strategy 1: Prescriptions for physical activity			
Objective 1: By July 30, 2022, implement exercise prescriptions in 2 communities and implement 3 new ways to promote exercise in underserved areas.			
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Creek YMCA, LEAP, Lorain City School District, Lorain County Free Clinic, Lorain County Health & Dentistry, Lorain County Metro Parks, Mercy Health, Mercy Health Parish Nursing, Murray Ridge Center, Our FAMILY, Specialty Hospital of Lorain, University Hospitals Avon Health Center, University Hospitals Elyria Medical Center			
Resources to address strategy: United We Sweat free fitness classes & walking groups, Move Amherst route, Lorain County Metro Parks, local walking and bike maps, United We Sweat committee, collaboratives/coalitions in Lorain County Communities (i.e. Live Healthy Lorain)			

Priority #1: Chronic Disease

Facilitating Organization: Lorain County Public Health

Goal 1: By 2022, stop the upward trend of female age-specific heart disease mortality (55-64 years) by staying at or below the last 5-year average (2013-2017, 103.3 deaths per 100,000 population).

Strategy 2: Healthy food access (Healthy food initiative) *

Objective 1: By July 30, 2022, identify barriers to healthy food access and institute 2 initiatives to address barriers.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Establish inventory of healthy food access initiatives and subject matter experts (SMEs) in Lorain County. Identify best practice models that address food insecurity and healthy eating. Map Lorain County food deserts and healthy food access initiatives to identify barriers. Recommend policy, environmental and systems changes (PSEC) for improving healthy food access barriers based on inventory and data analysis. Prioritize tailored PSECs that impact groups facing health disparities. Produce and disseminate "Lorain County Food Access PSEC Recommendations" for implementation in Years 2-3.	2020	Females aged 55-64 yrs.	Fruit consumption: Percent of adults who report consuming fruits less than one time daily Vegetable consumption: Percent of adults who report consuming vegetables less than one time daily Percent of households that are food insecure Age adjusted heart disease mortality rate Female age-specific (55-64 years) Heart Disease Mortality
Year 2: Partner with existing community health collaboratives/ coalitions to implement at least 1 PSEC that is tailored to priority population. Evaluate the number of policy, systems, or environmental changes adopted as a result of recommendations formed in Year 1.	2021		
Year 3: Partner with existing community health collaboratives/ coalitions to implement at least 1 additional PSEC that is tailored to priority population. Evaluate the number of policy, systems, or environmental changes adopted from Year 1, Year 2, and Year 3.	July 30, 2022		

Type of Strategy:

- ○ Social determinants of health
- ⊗ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

CHIP Priority Team Members: Amherst Exempted Village School District, CareSource, Cleveland Clinic, French Creek YMCA, LEAP, Lorain City School District, Lorain County Free Clinic, Lorain County Health & Dentistry, Lorain County Metro Parks, Mercy Health, Mercy Health Parish Nursing, Murray Ridge Center, Our FAMILY, Specialty Hospital of Lorain, University Hospitals Avon Health Center, University Hospitals Elyria Medical Center

Resources to address strategy: GIS software, healthy eating best practices, local community collaboratives, Second Harvest Food Bank, Creating Healthy Communities grant

*Note: Strategy is identified as cross-cutting (impacts more than one priority area)

Priority #1: Chronic Disease

Facilitating Organization: Lorain County Public Health

Goal 2: By 2022, reduce age-adjusted incidence rate of diabetes from 9.2 new cases per 1,000 population to 6.3, the rate in Ohio (CDC).

Strategy 1: Prescriptions for physical activity

Objective 1: By July 30, 2022, implement exercise prescriptions in 2 communities and 3 new ways to promote exercise in underserved areas.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Determine methods for reaching populations affected adversely by diabetes and diabetes related mortality. Tailor exercise prescription programs to African American and Hispanic residents with risk factors for developing diabetes. Ensure healthcare providers make systems changes to prescribe exercise convenient for patients via United We Sweat tool. Partner with United We Sweat Committee to expand free fitness class offerings in census tracts with higher African American/ Hispanic populations (i.e. census tract 231). Summarize evaluation data.	2020	African American and Hispanic males and females	African American Diabetes Mortality Hispanic Diabetes Mortality Newly Diagnosed Diabetes, Adults Aged 18-76 years, age adjusted rate per 1000 (Incidence) Prediabetes: Percent of adults who have been told by a doctor they have prediabetes Diabetes: Percent of adults who have been told by a doctor they have diabetes
Year 2: Analyze year 1 data and make changes based on lessons learned. Continue implementation of tailored exercise prescription programs to African American and Hispanic residents with risk factors for developing diabetes. Continue partnership with United We Sweat Committee to sustain expanded fitness offerings in priority communities. Summarize Year 1 & Year 2 evaluation data.	2021		
Year 3: Analyze Year 1 & Year 2 data in order to make changes or sustain the completed policy, system or environmental changed completed in previous years. Summarize evaluation data.	July 30, 2022		

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ⊗ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

CHIP Priority Team Members: Amherst Exempted Village School District, CareSource, Cleveland Clinic, French Creek YMCA, LEAP, Lorain City School District, Lorain County Free Clinic, Lorain County Health & Dentistry, Lorain County Metro Parks, Mercy Health, Mercy Health Parish Nursing, Murray Ridge Center, Our FAMILY, Specialty Hospital of Lorain, University Hospitals Avon Health Center, University Hospitals Elyria Medical Center

Resources to address strategy: Pre-diabetes screenings in healthcare settings, United We Sweat free fitness classes & walking groups, Lorain County Metro Parks, local walking and bike maps, United We Sweat committee, collaboratives/coalitions in Lorain County Communities (i.e. Live Healthy Lorain, Elyria Health Partners)

Priority #1: Chronic Disease

Facilitating Organization: Lorain County Public Health

Goal 2: By 2022, reduce age-adjusted incidence rate of diabetes from 9.2 new cases per 1,000 population to 6.3, the rate in Ohio (CDC).

Strategy 2: Healthy food access

Objective 1: By July 30, 2022, identify gaps to healthy food access and institute 2 initiatives to address gaps.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Establish inventory of healthy food access initiatives and Subject Matter Experts (SMEs) in Lorain County. Identify best practice models that address food insecurity and healthy eating. Map Lorain County Food Deserts and healthy food access initiatives to identify barriers. Recommend policy, environmental and systems changes (PSEC) for improving healthy food access barriers based on inventory and data analysis. Tailor PSECs to priority populations. Produce and disseminate "Lorain County Food Access PSEC Recommendations" for implementation in Years 2-3.	2020	African American and Hispanic males and females	African American Diabetes Mortality Hispanic Diabetes Mortality Newly Diagnosed Diabetes, Adults Aged 18-76 years, age adjusted rate per 1000 (Incidence)
Year 2: Partner with existing community health collaboratives/ coalitions to implement at least 1 PSEC that is tailored to priority population. Evaluate the number of policy, systems, or environmental changes adopted as a result of recommendations formed in Year 1.	2021		
Year 3: Partner with existing community health collaboratives/ coalitions to implement at least 1 additional PSEC that is tailored to groups priority population. Evaluate the number of policy, systems, or environmental changes adopted from Year 1, Year 2, and Year 3.	July 30, 2022		

Type of Strategy:

- ○ Social determinants of health
- ⊗ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

CHIP Priority Team Members: Amherst Exempted Village School District, CareSource, Cleveland Clinic, French Creek YMCA, LEAP, Lorain City School District, Lorain County Free Clinic, Lorain County Health & Dentistry, Lorain County Metro Parks, Mercy Health, Mercy Health Parish Nursing, Murray Ridge Center, Our FAMILY, Specialty Hospital of Lorain, University Hospitals Avon Health Center, University Hospitals Elyria Medical Center

Resources to address strategy: diabetes screenings in healthcare settings, GIS software, healthy eating best practices, local community collaboratives, Lorain County Food Environment Index

Priority #1: Chronic Disease

Facilitating Organization: Lorain County Public Health

Goal 2: By 2022, reduce age-adjusted incidence rate of diabetes from 9.2 new cases per 1,000 population to 6.3, the rate in Ohio (CDC).

Strategy 3: Prediabetes screening and referral

Objective 1: By July 30, 2022, increase the number of people screened for prediabetes and establish referrals to culturally competent prevention programs.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Identify existing pre-diabetes screening systems in clinical and community settings. Identify existing clinical- and community-based programs for diabetes prevention. Establish coordinated system for prediabetes screening and referral to culturally competent prevention programs. Implement diabetes prevention program that reaches priority population. Collect baseline data on number of pre-diabetes screenings, referrals, and program completions.	2020	Black and Hispanic males and females	Baseline pre-diabetes screening (number screened) Newly Diagnosed Diabetes, Adults Aged 18-76 years, age adjusted rate per 1000 (Incidence) Baseline Diabetes and Pre-diabetes screening results
Year 2: Continue activities from Year 1 related to implementation of a coordinated system for pre-diabetes screening, program referral and evaluation of outcomes.	2021		
Year 3: Continue activities from Year 2 and evaluate outcomes. Sustain PSECs made in Year 1, Year 2, and Year 3 based on best model.	July 30, 2022		

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ⊗ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

CHIP Priority Team Members: Amherst Exempted Village School District, CareSource, Cleveland Clinic, French Creek YMCA, LEAP, Lorain City School District, Lorain County Free Clinic, Lorain County Health & Dentistry, Lorain County Metro Parks, Mercy Health, Mercy Health Parish Nursing, Murray Ridge Center, Our FAMILY, Specialty Hospital of Lorain, University Hospitals Avon Health Center, University Hospitals Elyria Medical Center

Resources to address strategy: Pre-diabetes screenings in healthcare settings, best practices for culturally competent diabetes prevention programs, agencies or organizations to conduct prevention programs

Priority #2: Maternal and Child Health

Strategic Plan of Action

To work toward improving maternal and child health outcomes, the following strategies are recommended:

Priority #2: Maternal and Child Health

Facilitating Organization: Lorain County Public Health

Goal 1: Decrease preterm birth rates by 10% in Lorain County.

Strategy 1: Progesterone treatment

Objective: By July 30, 2022, increase the use of progesterone for eligible pregnant women by 10% in Lorain County.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Gather data from hospital/health systems to identify how progesterone candidates are currently identified, as well as current barriers to progesterone distribution.	July 30, 2021	Pregnant women	Preterm births: Preterm (<37 weeks gestation) births per 1,000 live births.
Year 2: Based on data collected in year 1, develop and implement a plan to increase the use of progesterone for eligible pregnant women. Determine strategies to increase education for pregnant women regarding recognizing signs, symptoms, and risk factors of giving birth prematurely.	July 30, 2022		
Year 3: Continue efforts from years 1 and 2.	July 30, 2022		

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ⊗ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

CHIP Priority Team Members: Catholic Charities, Child Care Resource Center, Cleveland Clinic, Cornerstone Pregnancy Services, Horizon Education Centers, Lorain County Board of Developmental Disabilities, Lorain County Health & Dentistry, Lorain County Jobs and Family Services, Mercy Health Resource Mothers Program, University Hospitals Elyria Medical Center

Resources to address strategy: Lorain County hospitals and healthcare systems

Priority #2: Maternal and Child Health

Facilitating Organization: Lorain County Public Health

Goal 1: Decrease preterm births rates by 10% in Lorain County.

Strategy 2: Home visiting programs that begin prenatally

Objective: By July 30, 2022, identify 3 targeted at-risk areas to expand home visiting programs within Lorain County.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Identify all home visitation programs within the county that serve the prenatal population. Identify gaps in program reach within the county. Work with home visitation supervisors to work to develop the best way to coordinate which program is the best fit for different individuals. Ensure cultural competence training opportunities are available for home visitation providers. Work with home visitation programs to ensure education regarding food insecurity and its impact on health. Ensure there are protocols in place to ensure women are educated regarding their WIC eligibility.	July 30, 2021	Adult	Home visiting during pregnancy: percent of women wo had a home visit during their most recent pregnancy. Preterm births: Preterm (<37 weeks gestation) births per 1,000 live births.
Year 2: Continue efforts from year 1. Determine the feasibility of a joint communication plan or more neutral branding to market specific home visiting programs (ex: Mercy Health Resource Mothers Program). Increase referrals. Home visitation programs will enroll all pregnant women in Lorain County in need of services.	July 30, 2022		
Year 3: Continue efforts from years 1 and 2.	July 30, 2022		

Type of Strategy:

- ☐ Social determinants of health
- ☐ Public health system, prevention and health behaviors
- ☒ Healthcare system and access
- ☐ Not SHIP Identified

Strategy identified as likely to decrease disparities?

☒ Yes ☐ No ☐ Not SHIP Identified

CHIP Priority Team Members: Catholic Charities, Child Care Resource Center, Cleveland Clinic, Cornerstone Pregnancy Services, Horizon Education Centers, Lorain County Board of Developmental Disabilities, Lorain County Health & Dentistry, Lorain County Jobs and Family Services, Mercy Health Resource Mothers Program, University Hospitals Elyria Medical Center

Resources to address strategy: Help Me Grow, Mercy Health Resource Mothers Program, Ohio Guidestone, Lorain County Neighborhood Alliance, WIC services

Priority #2: Maternal and Child Health			
Facilitating Organization: Lorain County Public Health			
Goal 1: Decrease preterm birth rates by 10% in Lorain County			
Strategy 3: CenteringPregnancy			
Objective: Establish CenteringPregnancy within at least 2 Lorain County health systems by July 30, 2022.			
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Research current or potential pregnancy centering models to improve outcomes for both mothers and babies. Market current centering programs and determine the feasibility of expanding to additional health systems.	July 30, 2021	Adult	Preterm births: Preterm (<37 weeks gestation) births per 1,000 live births.
Year 2: Continue efforts of year 1. Work with partners to bring awareness of the centering model of prenatal care to county health care organizations. Reach out to surrounding counties to learn/share best practices from existing centering pregnancy programs.	July 30, 2022		
Year 3: Continue efforts of years 1 and 2.	July 30, 2022		

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ⊗ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

CHIP Priority Team Members: Catholic Charities, Child Care Resource Center, Cleveland Clinic, Cornerstone Pregnancy Services, Horizon Education Centers, Lorain County Board of Developmental Disabilities, Lorain County Health & Dentistry, Lorain County Jobs and Family Services, Mercy Health Resource Mothers Program, University Hospitals Elyria Medical Center

Resources to address strategy: Lorain County hospitals and healthcare systems, Lorain County Health and Dentistry, current pregnancy centering models, Mercy Health Resource Mothers Program

Priority #2: Maternal and Child Health

Facilitating Organization: Lorain County Public Health

Goal 2: Increase Kindergarten Readiness Assessment rates of students "demonstrating" and/or "approaching" by 10% in Lorain County.

Strategy 1: Interventions in language and literacy skills in children ages 1-5 through early childhood supports *

Objective: Increase language and literacy "on track" rates in at least 3 targeted communities by 10%.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Research current and/or potential evidence-based early childhood education programs/activities to improve language and literacy outcomes in at least 3 targeted communities in Lorain County.	July 30, 2021	Adult	Kindergarten readiness: Percent of children "on track" for language and literacy in Kindergarten Readiness Assessment (57.9% of Lorain County children were "on track" for language and literacy, KRA 2018-2019).
Year 2: Implement selected evidence-based programs identified in year 1.	July 30, 2022		
Year 3: Evaluate the interventions and outcomes from year 2 and make changes as necessary.	July 30, 2022		

Type of Strategy:

- ⊗ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ⊗ Not SHIP Identified

CHIP Priority Team Members: Catholic Charities, Child Care Resource Center, Cleveland Clinic, Cornerstone Pregnancy Services, Horizon Education Centers, Lorain County Board of Developmental Disabilities, Lorain County Health & Dentistry, Lorain County Jobs and Family Services, Mercy Health Resource Mothers Program, University Hospitals Elyria Medical Center

Resources to address strategy: Kindergarten Readiness Assessment, local preschools and daycares, best practices for improving language and literacy outcomes

*Note: Strategy is identified as cross-cutting (impacts more than one priority area)

Priority #2: Maternal and Child Health

Facilitating Organization: Lorain County Public Health

Goal 2: Increase Kindergarten Readiness Assessment rates of students "demonstrating" and/or "approaching" by 10% in Lorain County.

Strategy 2: Interventions in social foundations in children ages 1-5 through early childhood supports *

Objective: Increase social foundation overall score in at least 3 targeted communities by 10%.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Research current and/or potential evidence-based early childhood education programs/activities to improve social foundations and outcomes in at least three targeted at-risk areas in Lorain County.	July 30, 2021	Adult	Kindergarten readiness: Percent of children demonstrating readiness in Kindergarten Readiness Assessment (42.7% of Lorain County children were demonstrating readiness, KRA 2018-2019).
Year 2: Implement selected evidence-based programs identified in year 1.	July 30, 2022		
Year 3: Evaluate the interventions and outcomes from year 2 and make changes as necessary.	July 30, 2022		

Type of Strategy:

⊗ Social determinants of health
○ Public health system, prevention and health behaviors
○ Healthcare system and access
○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ⊗ Not SHIP Identified

CHIP Priority Team Members: Catholic Charities, Child Care Resource Center, Cleveland Clinic, Cornerstone Pregnancy Services, Horizon Education Centers, Lorain County Board of Developmental Disabilities, Lorain County Health & Dentistry, Lorain County Jobs and Family Services, Mercy Health Resource Mothers Program, University Hospitals Elyria Medical Center

Resources to address strategy: Kindergarten Readiness Assessment, local preschools and daycares, best practices for improving social foundations outcomes

*Note: Strategy is identified as cross-cutting (impacts more than one priority area)

Priority #2: Maternal and Child Health

Facilitating Organization: Lorain County Public Health

Goal 2: Increase Kindergarten Readiness Assessment rates of students "demonstrating" and/or "approaching" by 10% in Lorain County.

Strategy 3: Interventions in physical well-being and motor development in children ages 1-5 through early childhood supports *

Objective: Increase physical well-being and motor development overall score in at least 3 targeted communities by 10%.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Research current or potential evidence-based early childhood education programs/activities to improve well-being and motor development outcomes in at least three at-risk target areas in Lorain County.	July 30, 2021	Adult	Kindergarten readiness: Percent of children demonstrating readiness in Kindergarten Readiness Assessment (42.7% of Lorain County children were demonstrating readiness, KRA 2018-2019).
Year 2: Implement selected evidence-based programs identified in year 1.	July 30, 2022		
Year 3: Evaluate the interventions and outcomes from year 2 and make changes as necessary.	July 30, 2022		

Type of Strategy:

- ⊗ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ⊗ Not SHIP Identified

CHIP Priority Team Members: Catholic Charities, Child Care Resource Center, Cleveland Clinic, Cornerstone Pregnancy Services, Horizon Education Centers, Lorain County Board of Developmental Disabilities, Lorain County Health & Dentistry, Lorain County Jobs and Family Services, Mercy Health Resource Mothers Program, University Hospitals Elyria Medical Center

Resources to address strategy: Kindergarten Readiness Assessment, local preschools and daycares, best practices for well-being and motor development outcomes

*Note: Strategy is identified as cross-cutting (impacts more than one priority area)

Priority #3: Mental Health

Strategic Plan of Action

To work toward improving mental health outcomes, the following strategies are recommended:

Priority #3: Mental Health

Facilitating Organization: Mental Health, Addiction and Recovery Services Board of Lorain County

Goal 1: Arrest upward trend of overall suicide deaths by staying at or below the last 5-year average (2013-2017 average of 49 suicides per year, or 16 deaths per 100,000 population) for the period of 2018-2022.

Strategy 1: Community-based education to promote positive mental health

Objective: By December 31, 2022, provide QPR (Question Persuade Refer) basic suicide prevention training in two new identified settings determined by Year 1 data collection and Year 2 data analysis.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Informed by Psychological Autopsy techniques, increase # of data collection categories on the Lorain County Suicide Prevention Data Table by 25% (12 to 15), for approval by the Mental Health CHIP Priority Team and the Lorain County Suicide Prevention Coalition (SPC) on or before the December 7, 2020, SPC meeting.	December 7, 2020	Overall trends including adult and youth	Suicide deaths: Number of deaths due to suicide per 100,000 population (age adjusted) Note: Data based on information from the Lorain County Suicide Data Table and the Ohio Department of Health.
Year 2: By December 31, 2021, identify at least two new settings based on Year 1 data where suicide prevention training should be implemented.	December 31, 2021		
Year 3: By December 31, 2022, provide QPR (Question Persuade Refer) basic suicide prevention training in new identified settings.	December 31, 2022		

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ⊗ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

CHIP Priority Team Members: Cleveland Clinic, Far West Center, Firelands Counseling and Recovery Services, Horizon Education Center, Lorain County Children Services, Lorain County Health & Dentistry, Lorain County Jobs and Family Services, Lorain County Public Health, Mercy Health, The Nord Center

Resources to address strategy: Mental Health, Addiction and Recovery Services Board of Lorain County, existing community-based trainings (QPR, Working Minds, etc.), Lorain County Coroner's Office, Lorain County Suicide Prevention Coalition

Priority #3: Mental Health			
Facilitating Organization: Mental Health, Addiction and Recovery Services Board of Lorain County			
Goal 1: Arrest upward trend of overall suicide deaths by staying at or below the last 5-year average (2013-2017 average of 49 suicides per year, or 16 deaths per 100,000 population) for the period of 2018-2022.			
Strategy 2: Screen for clinical depression for all patients 12 or older using a standardized tool			
Objective: Informed by an environmental review of existing screening activities, increase the number of individuals who are screened by a minimum of 10% using standardized depression screening tools that are culturally and age-relevant, on or before December 31, 2022.			
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Create a sub-committee to work with county hospital systems and other health care providers (ex: primary care providers, OB-GYN offices, etc.) that currently screen for depression and determine what tool is used. Evaluate findings to both determine a baseline number of screenings happening among participating partners; and, share among mental health providers to determine what standardized tools are most helpful for identifying people at risk for suicidal thoughts or actions. Use the sub-committee to determine other community-based locations or programs that could integrate an approved screening tool to "catch" more people at risk.	July 30, 2020	Adult and youth	Suicide deaths: Number of deaths due to suicide per 100,000 population (age adjusted)
Year 2: Pilot the implementation of standardized screening tools (such as the **Patient Health Questionnaire (PHQ-9 and PHQ-A)**) and/or another chosen tool, within at least one new setting to increase the number of county residents being screened for depression (to be determined from assessment from year 1, approval by the Mental Health CHIP Priority Team and the Lorain County Suicide Prevention Coalition (SPC). Track the number of patients flagged for depression due to depression screening implementation. Work with both public and private providers, and community screeners, to ensure that clinicians have up to date community resources for mental health referrals.	July 30, 2021		
Year 3: Continue efforts from years 1 and 2. Possible future action: Determine a system of patient tracking to examine whether community referrals were acted upon.	Dec. 31, 2022		

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ⊗ Healthcare system and access
- ○ Not SHIP Identified

Priority #3: Mental Health

Facilitating Organization: Mental Health, Addiction and Recovery Services Board of Lorain County

Goal 1: Arrest upward trend of overall suicide deaths by staying at or below the last 5-year average (2013-2017 average of 49 suicides per year, or 16 deaths per 100,000 population) for the period of 2018-2022.

Strategy 2: Screen for clinical depression for all patients 12 or older using a standardized tool

Objective: Informed by an environmental review of existing screening activities, increase the number of individuals who are screened by a minimum of 10% using standardized depression screening tools that are culturally and age-relevant, on or before December 31, 2022.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

CHIP Priority Team Members: Cleveland Clinic, Far West Center, Firelands Counseling and Recovery Services, Horizon Education Center, Lorain County Children Services, Lorain County Health & Dentistry, Lorain County Jobs and Family Services, Lorain County Public Health, Mercy Health, The Nord Center

Resources to address strategy: Mental Health, Addiction, and Recovery Services Board of Lorain County, PHQ-9 or PHQ-A or other screening tool

<table>
<tr><td colspan="4">Priority #3: Mental Health</td></tr>
<tr><td colspan="4">Facilitating Organization: Mental Health, Addiction and Recovery Services Board of Lorain County</td></tr>
<tr><td colspan="4">Goal 1: Arrest upward trend of overall suicide deaths by staying at or below the last 5-year average (2013-2017 average of 49 suicides per year, or 16 deaths per 100,000 population) for the period of 2018-2022.</td></tr>
<tr><td colspan="4">Strategy 3: School-based prevention programs and policies</td></tr>
<tr><td colspan="4">Objective: By the start of the 2022-2022 school year, offer at least two new or expanded youth prevention programs proven to influence mental health outcomes for 8th to 12th grade students, reaching 10% more students in public school or pre- and after-school settings.</td></tr>
<tr><th>Action Step</th><th>Timeline</th><th>Priority Population</th><th>Indicator(s) to measure impact of strategy:</th></tr>
<tr><td>Year 1: Members of the Children's Subcommittee of the Lorain County Suicide Prevention Coalition, in partnership with the Educational Service Center, create an inventory of prevention programming and intervention services that are available to Lorain County school districts. Include pertinent information (grade levels, time commitment, cost).

Create a similar guide that lists which districts, schools, and grade levels are currently participating in the above programming, and develop an estimated baseline of the number of children served, by grade level. Ensure the information is easily accessible to Lorain County Health Partners.

Schedule a meeting with key stakeholders and the Educational Service Center to determine best ways to approach school districts/superintendents with program and service offerings. Discuss opportunities to incorporate or supplement information within current curriculums.</td><td>July 30, 2020</td><td rowspan="2">8th to 12th grade students</td><td rowspan="2">Number of youth enrolled in or experiencing youth school-based prevention programming offerings

Future outcomes measurement: PRIDE survey for 8th, 10th and 12th grades</td></tr>
<tr><td>Year 2: Continue efforts of year 1.

Research and determine the feasibility of launching or expanding the following or other identified programs/services:

• Teen Mental Health First Aid (tMHFA) across public high schools after pilot program
• Expanding Coping with Stress high-school program
• CAST (Coping and Support Training), a small-group 12-week program that can be offered in middle and high schools
• Mentoring programs and opportunities, for example: Ashland County's Multi-Generational Mentoring (MGM) program
• Expanding pre-school The PAX Good Behavior Game, The Incredible Years
• Trauma intervention services for all ages, like the Handle With Care Program</td><td>July 30, 2021</td></tr>
</table>

Priority #3: Mental Health

Facilitating Organization: Mental Health, Addiction and Recovery Services Board of Lorain County

Goal 1: Arrest upward trend of overall suicide deaths by staying at or below the last 5-year average (2013-2017 average of 49 suicides per year, or 16 deaths per 100,000 population) for the period of 2018-2022.

Strategy 3: School-based prevention programs and policies

Objective: By the start of the 2022-2022 school year, offer at least two new or expanded youth prevention programs proven to influence mental health outcomes for 8th to 12th grade students, reaching 10% more students in public school or pre- and after-school settings.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Secure funding, instructors, materials for any new programs selected.			
Year 3: Continue efforts of years 1 and 2. Launch or expand programs. Possible future action: use PRIDE Survey data to determine impacts in 8th, 10th and 12th grades.	August 15, 2022		

Type of Strategy:

- ○ Social determinants of health
- ⊗ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

CHIP Priority Team Members: Cleveland Clinic, Far West Center, Firelands Counseling and Recovery Services, Horizon Education Center, Lorain County Children Services, Lorain County Health & Dentistry, Lorain County Jobs and Family Services, Lorain County Public Health, Mercy Health, The Nord Center

Resources to address strategy: Lorain Public Health, Healthy Kids Achieve More Network, Educational Service Center of Lorain County, Communities That Care, local school districts, County MHARS/ADAMHS partners (Ashland, Stark), existing law enforcement partnerships, evidence-based social and emotional programs, ODE social and emotional instruction resources

Priority #4: Substance Abuse

Strategic Plan of Action

To work toward decreasing substance abuse, the following strategies are recommended:

Priority #4: Substance Abuse

Facilitating Organization: Mental Health, Addiction and Recovery Services Board of Lorain County

Goal 1: By December 31, 2022, Lorain County will see a decrease in adult tobacco use (20% or below of adults will be current smokers) and youth tobacco use (23% or below vaping and 10% or below smoking traditional tobacco).

Strategy 1: Policies to decrease availability of tobacco products

Objective: Adopt or improve at least 5 tobacco-free policies by December 31, 2022

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Raise awareness of the recently passed **Tobacco 21** initiative. Begin efforts to adopt or improve tobacco-free policies in schools, worksites and other public locations. Ensure all forms of tobacco are included (i.e. e-cigarettes). Reach out to other entities who have implemented these policies to learn best practices, strategies to approach decision makers, and to learn of potential barriers and challenges. Develop strategies to provide support to entities adopting tobacco-free policies	December 31, 2020	Adult and youth	Adult smoking: Percent of adults who currently smoke some or all days Youth smoking: Percent of youth who smoked cigarettes or vaped in the past 30 days Access to tobacco products: Number of tobacco retailers per 1,000 people)
Year 2: Continue efforts of year 1. Recruit additional entities for adoption or improvement of smoke-free policies. Develop evaluation strategies to evaluate policies and progress toward goal.	December 31, 2021		
Year 3: Continue efforts from years 1 and 2. Adopt or improve at least 5 total tobacco-free policies in county parks, fairgrounds, schools, or other public locations.	December 31, 2022		

Type of Strategy:

- ○ Social determinants of health
- ⊗ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

CHIP Priority Team Members: Cleveland Clinic, Communities That Care of Lorain County, Firelands Counseling and Recovery Services, Let's Get Real, Lorain County Children's Services, Lorain County Health & Dentistry, Lorain County Job and Family Services, Lorain County Opiate Action Team, Lorain County Public Health, Mercy Health, The LCADA Way, The Nord Center, University Hospitals Elyria Medical Center

Priority #4: Substance Abuse			
Facilitating Organization: Mental Health, Addiction and Recovery Services Board of Lorain County			
Goal 1: By December 31, 2022, Lorain County will see a decrease in adult tobacco use (20% or below of adults will be current smokers) and youth tobacco use (23% or below vaping and 10% or below smoking traditional tobacco).			
Strategy 1: Policies to decrease availability of tobacco products			
Objective: Adopt or improve at least 5 tobacco-free policies by December 31, 2022			
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Resources to address strategy: Current Lorain Public Health tobacco grant, Lorain Public Health, current tobacco ordinances, county tobacco cessation offerings, collaboration with Communities That Care of Lorain County *Note: Strategy is identified as cross-cutting (impacts more than one priority area)			

Priority #4: Substance Abuse			
Facilitating Organization: Mental Health, Addiction and Recovery Services Board of Lorain County			
Goal 2: Increase perception of risk of marijuana use in youth by 10% by December 31, 2022.			
Strategy 1: Community awareness and education of risky behaviors and substance abuse issues and trends			
Objective: Conduct at least 1 coordinated campaign among Lorain County organizations by December 31, 2022			
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1. Continue existing awareness campaigns to increase education and awareness of risky behaviors and substance abuse issues and trends. Work with organizations to determine best ways to educate community and parents (social media, newspaper, school websites or newsletters, television, church bulletins, etc.). Determine unified messaging approaches across organizations. Create a collaborative resource hub for partners and the community housing accurate and consistent information regarding marijuana, including facts about medical and recreational marijuana, sample policies for schools, employers and other entities, and local data.	December 31, 2020	Youth and adult	Youth perceptions: Percent of youth identifying a "great risk" of harm to smoke marijuana
Year 2: Continue efforts of Year 1. Continue to seek updated and consistent information for toolkits and expand access to the community.	December 31, 2021		
Year 3: Continue efforts of years 1 and 2.	December 31, 2022		

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ⊗ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

CHIP Priority Team Members: Cleveland Clinic, Communities That Care of Lorain County, Firelands Counseling and Recovery Services, Let's Get Real, Lorain County Children's Services, Lorain County Health & Dentistry, Lorain County Job and Family Services, Lorain County Opiate Action Team, Lorain County Public Health, Mercy Health, The LCADA Way, The Nord Center, University Hospitals Elyria Medical Center

Resources to address strategy: Communities That Care of Lorain County

Priority #4: Substance Abuse

Facilitating Organization: Mental Health, Addiction and Recovery Services Board of Lorain County

Goal 3: Decrease unintentional drug overdose deaths by 10% by December 31, 2022.

Strategy 1: Expand community efforts for education, identification, access to care and overdose prevention

Objective: Using a delineated process, implement SBIRT screenings within at least 3 new settings by July 30, 2022

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Increase coordination of existing treatment engagement efforts (e.g. Warm Handoff, QRT) to increase efficiency of access to care Expand existing efforts around naloxone distribution including proactive distribution to families Introduce or re-introduce a screening, brief intervention and referral to treatment model (**SBIRT**) to health care professionals. Pilot the screening tool with at least one additional location.	July 30, 2020	Adult and youth	Unintentional drug overdose deaths: Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted)
Year 2: Continue efforts of Year 1 Create and Implement marketing plan for stigma reduction	July 30, 2021		
Year 3: Continue efforts from year 2. Increase the number of Certified Peer Recovery Supports through training and support with the application processes	July 30, 2022		

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ⊗ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

CHIP Priority Team Members: Cleveland Clinic, Communities That Care of Lorain County, Firelands Counseling and Recovery Services, Let's Get Real, Lorain County Children's Services, Lorain County Health & Dentistry, Lorain County Job and Family Services, Lorain County Opiate Action Team, Lorain County Public Health, Mercy Health, The LCADA Way, The Nord Center, University Hospitals Elyria Medical Center

Resources to address strategy: Mental Health, Addiction and Recovery Services Board of Lorain County, Lorain County Opiate Action Team, Lorain County Public Health, OMHAS-Peer Support Training

Priority #4: Substance Abuse

Facilitating Organization: Mental Health, Addiction and Recovery Services Board of Lorain County

Goal 4: Decrease binge drinking in those under age 30 by 10% by December 31, 2022.

Strategy 1: Screening, brief intervention and referral to treatment (SBIRT)

Objective: Increase the number of healthcare providers using the SBIRT model by 25% from baseline.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Collect baseline data on the number of medical entities that currently screen for drug and alcohol abuse, and at what age they start screening. Introduce or re-introduce a screening, brief intervention and referral to treatment model (**SBIRT**) in medical locations. Pilot the screening tool with one additional location.	December 30, 2020	Adult	Binge drinking: Percent of adults/youth under age 30 who consumed 4 or more drinks on occasion (females) or 5 or more drinks on occasion (males) in the past 30 days
Year 2: Continue efforts from year 1. Determine feasibility of offering SBIRT screenings in additional (non-medical) settings (schools, Boys and Girls Club, etc.). Work with both public and private providers to ensure that clinicians have up to date community resources and processes for referral.	December 30, 2021		
Year 3: Continue efforts from year 1 and year 2. Increase the number of healthcare providers using the SBIRT model by 25% from baseline.	December 30, 2022		

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ⊗ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

CHIP Priority Team Members: Cleveland Clinic, Communities That Care of Lorain County, Firelands Counseling and Recovery Services, Let's Get Real, Lorain County Children's Services, Lorain County Health & Dentistry, Lorain County Job and Family Services, Lorain County Opiate Action Team, Lorain County Public Health, Mercy Health, The LCADA Way, The Nord Center, University Hospitals Elyria Medical Center

Resources to address strategy: Mental Health, Addiction and Recovery Services Board of Lorain County, Lorain County Public Health, OMHAS SBIRT resources

Priority #5: Cancer

Strategic Plan of Action

To work toward improving cancer outcomes, the following strategies are recommended:

Priority #5: Cancer			
Facilitating Organization: Lorain County Public Health			
Goal 1: Decrease late-stage diagnoses outcomes by 2% in three cancers with evidence-based screening recommendations in target high-risk subpopulations.			
Strategy 1: Increase screening and immunization rates in three cancers with evidence-based recommendations in target high-risk subpopulations			
Objective: Improve accessibility of screenings in identified subpopulations			
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Compile county baseline data regarding cancer stage diagnoses. Compile county baseline data regarding screening rates. Share data within Lorain County Health Partners to identify types of cancer and subpopulations of focus Inventory outreach efforts in the county Compile data on what screening guidelines are currently being utilized Explore feasibility of unified messaging across health systems	July 31, 2020 July 31, 2020 July 31, 2020 December 31, 2020 December 31, 2020 December 31, 2020	Adults (within age groups for recommended guidelines)	Late-stage diagnosis data Screening rate data
Year 2: Update data as it becomes available. Draft unified messaging if determined feasible. Suggest topics: insurance coverage, screening guidelines Identify channels for dissemination of messaging that reach identified subpopulations and professionals (primary care doctors)	March 31, 2021 March 31, 2021 June 30, 2021		

Priority #5: Cancer

Facilitating Organization: Lorain County Public Health

Goal 1: Decrease late-stage diagnoses outcomes by 2% in three cancers with evidence-based screening recommendations in target high-risk subpopulations.

Strategy 1: Increase screening and immunization rates in three cancers with evidence-based recommendations in target high-risk subpopulations

Objective: Improve accessibility of screenings in identified subpopulations

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Draft unified outreach plan Implement recommendations from outreach plan	December 31, 2021		
Year 3: Continue efforts from Years 1 and 2	July 30, 2022		

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ⊗ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

CHIP Priority Team Members: American Cancer Society, Cleveland Clinic, Lorain County Free Clinic, Lorain County Health & Dentistry, Mercy Health

Resources to address strategy: Informatics, data from hospital systems, screening and immunization rate data

Priority #5: Cancer			
Facilitating Organization: Lorain County Public Health			
Goal 2: Decrease number of eligible cases failing to initiate or continue treatment due to unmet needs by 2%.			
Strategy 1: Decrease barriers to treatment			
Objective: Improve accessibility to cancer treatment			
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:
Year 1: Inventory cancer resource sources Work with navigators and social workers to ensure inventory is complete. Update cancer resource sources as needed Identify gaps in resources	July 31, 2020 December 31, 2020 December 31, 2020 December 31, 2020	Adult	Number of cancer resources Number of channels receiving information Percent of needs that are unmet Percent of patients initiating or completing treatment after diagnosis
Year 2: Identify additional channels for dissemination of information. Provide channels with appropriate materials Select 1-2 gaps to improve services and resources	July 30, 2021 December 31, 2021 December 31, 2021		
Year 3: Continue efforts of Years 1 and 2 and implement resource improvements	December 31, 2022		

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ⊗ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

CHIP Priority Team Members: American Cancer Society, Cleveland Clinic, Lorain County Free Clinic, Lorain County Health & Dentistry, Mercy Health

Resources to address strategy: Oncology social workers, unmet needs data, loss to follow up data

Progress and Measuring Outcomes

Progress will be monitored with measurable indicators identified for each strategy, and most indicators align directly with the SHIP. The individuals or agencies working on strategies as part of CHIP Priority Teams will meet quarterly and can also meet more frequently as needed. The CHIP Steering Committee will meet quarterly to report and discuss progress. The Steering Committee will create a plan to disseminate the CHIP to the community. Strategies, responsible agencies, and timelines will be reviewed at the end of each year by the Steering Committee. As this CHIP is a living document, edits and revisions will be made accordingly.

Lorain County will continue facilitating CHAs every three years to collect data and determine trends. Primary data will be collected for adults and youth using national sets of questions to not only compare trends in Lorain County, but also be able to compare to the state and nation. This data will serve as measurable outcomes for each priority area. Indicators have already been defined throughout this report and are identified with the icon.

In addition to outcome evaluation, process evaluation will also be used on a continuous basis to focus on the success of the strategies. Areas of process evaluation that the CHIP committee will monitor include the following: number of participants, location(s) where services are provided, number of policies implemented, economic status and racial/ethnic background of those receiving services (when applicable), and intervention delivery (quantity and fidelity).

Furthermore, all strategies have been incorporated into a "Progress Report" template that can be completed at all future meetings, keeping the committee on task and accountable. This progress report may also serve as meeting minutes.

Contact Us

For more information about any of the agencies, programs, and services described in this report, please contact:

Lorain County Public Health
9880 South Murray Ridge Rd.
Elyria, OH 44035
440-322-6367
contact@loraincountyhealth.com

Appendix I: Gaps and Strategies

The following tables indicate gaps and potential strategies that were compiled by the Lorain County Health Partners. Gaps and potential strategies are compiled based on priority area.

Priority #1: Chronic Disease Gaps and Strategies

Gaps	Potential Strategies
1. Lack of transportation	• Access to medical appointments (Nord Family Foundation transportation initiatives) • Grants for Lyft/Uber • Advocacy opportunities • Managed care transportation plans
2. Lack of access to fresh fruits and vegetables (food deserts)	• Farmers markets • Prescriptions for healthy foods • Food insecurity screenings • Healthy food for Ohio fund (low interest rates to build new markets) • Cooking classes rather than recipes • City Fresh - many locations (LCCC, El Centro) • Second Harvest Food Bank • Farmers market at Cleveland Clinic • Testing out garden boxes • Food pantries • Community meal programs • SNAP • Resource guides - 211
3. Creating and promoting active communities	• Complete Streets • Promote knowledge of opportunities for active environments • Become a community that promotes being active • YMCA has many current opportunities - get the word out • Metroparks • Community based policing • Senior walking • Sidewalk/bike lanes (bike and pedestrian plans and street policies)
4. Lack of education regarding cultural appropriation (ex: beliefs, food culture) 5. Education biases against healthy eating practices (ex: political issues in rural areas)	• Food preparation education • Cultural competency education
6. Expense of diabetic supplies – limitations for those that are insured, uninsured or underinsured	• Ensure community is knowledgeable on what is available (insured and uninsured populations)
7. Lack of early diagnoses of chronic conditions (lack of preventive care)	• None noted

Priority #1: Chronic Disease Gaps and Strategies, continued

Gaps	Potential Strategies
8. Safety and affordability of outdoor physical activity opportunities	• United We Sweat (current successful program) • Community college as a potential resource • Silver Sneakers • Beat the Street in Lagrange (visit places by foot and bike)
9. Impact of emotional trauma on chronic conditions	• Trauma informed care trainings for ACEs
10. Patients not following through with post care after diagnoses of chronic illnesses (ex: heart attack)	• Follow through activities after diagnoses (access and motivation)

Priority #2: Maternal and Child Health Gaps and Strategies

Gaps	Potential Strategies
1. Lack of knowledge/data regarding support needs of single motherhood and the impact on maternal and child health	• None noted
2. Lack of cultural sensitivity and ability to engage communities	• Increase home visiting programs (Latino and African American populations, rural communities, southern areas (Oberlin)) • Cultural competence training to specific populations
3. Impact of financial stability on maternal and infant health	• None noted
4. Increase in drug use among pregnant mothers	• Screen all women (SBIRT) at 1st visit and at 28 weeks • Transfer to addictions specialist • Ensure health systems are following evidence-based screenings • Data warehouse within health partners and hospitals
5. Lack of access to contraceptive options to prevent unintended pregnancies	• None noted
6. Lack of following through on children after birth (ensure children are thriving)	• Home visiting programs
7. Poor pre-conception health (ex: obese mothers)	• Pregnancy centering and parent centering (potential to expand to Cleveland Clinic)
8. Transportation to prenatal care	• Increase transportation to prenatal care

Priority #2: Maternal and Child Health Gaps and Strategies, continued

Gaps	Potential Strategies
9. Pre-term births remain consistent within county	• Education on pregnancy spacing • Progesterone screening - cost of progesterone is high (look into Medicaid options) • Patient education to recognize symptoms/risk of giving birth prematurely • Safe sleep education
10. Women lack prenatal care within first trimester	• Home visiting programs (Mercy Resource Mothers) • Programs/advertisements could be neutrally branded (potentially Pubic Health) • Joint communication plan for all Lorain County women
11. Impact of trauma on maternal and infant health	• None noted
12. Difficulty accessing healthy food options at food banks/WIC	• Ensure WIC education is provided at discharge

Priority #3: Mental Health Gaps and Strategies

Gaps	Potential Strategies
1. Lack of coordination of care between providers (ex: lack of common language between outpatient providers, hospitals, ADAS, etc.) 2. Those dying by suicide seeing medical providers prior	• Zero suicide initiative • Clarifying levels of risk for providers and how to treat • Hospital warm hand offs • Stepping Up Program • Primary care free trainings for zero suicide • Assist with how to engage hospitals for trainings (ex: Zero Suicide Initiative) – need more engagement and attendance • Potential for Zero Suicide Initiative to be a required CME (use data to support need) • Tie trainings together (ex: Zero Suicide with SBIRT) • Research data regarding common themes of why residents are seeing doctor before committing suicide • Potential use of telemedicine for those in crisis
3. Lack of pipeline programs for careers in mental health field	• Courses at LCCC for certificates • Residential staff with complex cases could obtain certificate for additional training and education
4. Stigma in seeking mental health services 5. Lack of intentional engagement and communication approaches	• Working Minds – open the conversation about suicide • Reach more organizations with QPR trainings • "How we cope" commercials within community • Current train the trainer approaches

Priority #3: Mental Health Gaps and Strategies, continued

Gaps	Potential Strategies
6. Increase in loneliness and social isolation	• Current "You Belong" grant for schools for sense of belonging • Ashland County mentoring program
7. Lack of mental health counselors in schools	• Uniform approach for social workers in schools to better understand sequence of care
8. Lack of resiliency skills (social and emotional health standards are lacking in schools) 9. Costly for families/children to engage in extracurricular activities (good place to learn social/emotional skills)	• Many ODE resources to assist districts • Build upon mandates and reach out to superintendents • Research current social/emotional standards in local school districts • Approach schools with uniformity and offerings
10. Difficult to reach a large number of youth in county regarding programming (may be only reaching public schools)	• None noted

Priority #4: Substance Abuse Gaps and Strategies

Gaps	Potential Strategies
1. Substance abuse (vaping, alcohol use, marijuana use, etc.) has become normalized 2. Misinformation regarding substances (what is safe and what is not) 3. Lack of healthy coping mechanisms	• Focus on families that do not understand harm • Utilize perceptions from PRIDE data • Lorain Public Health 3-year grant to work on tobacco (ex: compliance checks, seller server trainings, tobacco 21). • Parent education piece- pathways to addiction • Work with city council to ban e-cigarettes • Expansion of social host laws
4. Easy access to substances (ex: vaping, alcohol, etc.)	• Hidden In Plain Sight currently available - opportunity for more engagement (curriculum to offer after included) • Operation Street currently available
5. Lack of provider education regarding safe prescribing practices	• Expand OARRS trainings to additional prescribing practices other than only opiates • Patient education regarding becoming their own advocate for pain management • Hold prescribers responsible
6. Increase promotion of drug take back days	• Promotion of drug take back days • Libraries, Public Health, churches, etc. giving out Deterra and medication safes
7. Lack of cross-sector collaboration (ex: educate businesses, workforce, etc.)	• Need for recovery friendly employers

Priority #4: Substance Abuse Gaps and Strategies, continued

Gaps	Potential Strategies
8. Lack of early substance abuse identification and referral	• SBIRT (parallels with suicide risk and provider education) • Screen at additional/unique settings (ex: Boys/Girls Club)
9. Stigma of seeking substance abuse services	• Relatable recovery stories needed • Education regarding stigma surrounding MAT
10. Fear of obtaining services for those with immigration status	• Outreach and connection – potentially give safe space (ex: federally qualified health center) • El Centro – currently screening for trauma and substance abuse
11. Lack of peer support programs (ex: peer support for recovery path)	• Grow recovery peer support for younger population • More peers need to be certified after recovery • Integrate peer support with treatment community to supplement process • State needs to expand training opportunities (supplement cost, provide support to obtain more peer support)

Priority #5: Cancer Gaps and Strategies

Gaps	Potential Strategies
1. Barriers to screenings	• Uniform practices on screening schedules • Insurance coverage understanding what is covered (navigators) • Transportation to screening
2. Lack of knowledge regarding screenings (ex: confusion regarding messages, age to begin screening, family history, etc.)	• Increase promotion of HPV vaccine for cervical cancer • Uniform communication regarding screenings • Determine list of cancers that have a screening criterion and have a better outcome with early detection (canned messaging for list of cancers)
3. Financial barriers (ex: uninsured or underinsured populations may not have access to screenings)	• Canned messaging - communication of insurance
4. Lack of early detection (ex: diagnosing at later stages)	• Uniform messaging- what does it look like in the community

Appendix II: Links to Websites

Title of Link	Website URL
Behavioral health workforce pipeline programs	https://www.ruralhealthinfo.org/project-examples/topics/health-workforce-pipeline
Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services	http://www.cdc.gov/nphpsp/essentialservices.html
Community-wide physical activity campaigns	https://www.thecommunityguide.org/findings/physical-activity-community-wide-campaigns
Culture, language and health literacy	https://www.hrsa.gov/cultural-competence/index.html
Exercise prescriptions	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/exercise-prescriptions
Federal Office of Rural Health Policy	https://www.hrsa.gov/rural-health/index.html
Grant opportunities	https://www.hrsa.gov/ruralhealth/programopportunities/fundingopportunities/default.aspx
Handle With Care Program	http://handlewithcaremi.org/index.php
Healthy Food for Ohio Program	http://www.financefund.org/userfiles/files/Program%20Fact%20Sheets/HFFO%20Fact%20Sheet.pdf
Hidden In Plain Sight	http://powertotheparent.org/be-aware/hidden-in-plain-sight/
https://www.loraincountyhealth.com/cha	https://www.loraincountyhealth.com/cha
Multi-Generational Mentoring (MGM) program	https://ccdocle.org/program/multi-generational-mentoring-mgm
Patient Health Questionnaire (PHQ-9)	http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf
PAX Good Behavior Game	https://www.hazelden.org/HAZ_MEDIA/gbg_insert.pdf
Prevent Diabetes STAT Toolkit	https://preventdiabetesstat.org/index.html
Prediabetes Risk Assessment	http://www.diabetes.org/are-you-at-risk/diabetes-risk-test/
SBIRT	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/alcohol-brief-interventions
SNAP/EBT at farmers markets	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/electronic-benefit-transfer-payment-at-farmers-markets
Surgeongeneral.gov	surgeongeneral.gov
The Incredible Years	http://www.incredibleyears.com/
Tobacco 21	https://tobacco21.org/state-by-state/

SHIP strategy quick guide

This is a high-level compilation of SHIP strategies. For more detail:
- See Appendix A for more information about indicators
- See topic sections in Parts 3-8 for more information about strategies

⊜ One or more specific strategies within this category are likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

★ Strategy is identified in two or more SHIP topic areas

▲ None of the strategies for this topic area met the criteria for featured strategies. These criteria are listed in Part 1 and Appendix C. Because no featured strategies are available, all strategies for this topic are displayed.

SHIP topic area	Featured strategies
Community conditions	
Housing affordability and quality ▲ Indicator CC1	• Rental assistance ⊜ • Affordable housing development and preservation ⊜ • Neighborhood improvements ⊜
Poverty Indicators CC2 and CC3	• Child care subsidies ⊜ • Adult employment programs ⊜ • High school equivalency programs ⊜
K-12 student success: Chronic absenteeism Indicator CC4	• Attendance interventions for chronically absent students ⊜ • Social-emotional learning and positive behavior initiatives • Middle and high school programs and policies that increase attendance ⊜
K-12 student success: Kindergarten readiness Indicator CC5	• Early childhood home visiting ⊜ ★ • Early childhood education ⊜ • K-12 and family resilience ⊜
Adverse childhood experiences Indicators CC6 and CC7	• Early childhood home visiting ⊜ ★ • Parenting, mentorship and school-based prevention ⊜ • Supports for system-involved children and youth • Violence prevention and crime deterrence ⊜ • Neighborhood conditions
Health behaviors	
Tobacco/nicotine use Indicators HB1 and HB2	• Increase the unit price of tobacco products ⊜ • Smoke-free policies ★ • Mass media campaigns against tobacco use • Tobacco cessation access ⊜
Nutrition Indicators HB3 and HB4	• Healthy meals served at schools ⊜ • Fruit and vegetable access and education • Outreach and advocacy to maintain or increase enrollment in federal food assistance programs • Healthy food in food banks ⊜ • Fruit and vegetable initiatives ⊜
Physical activity Indicators HB5 and HB6	• School-based programs to increase physical activity • Safe Routes to School • Transportation and land use policies (built environment changes and green space) ⊜ • Community fitness programs • Exercise prescriptions

SHIP strategy quick guide (cont.)

SHIP topic area	Featured strategies
Access to care	
Health insurance coverage Indicators AC1 and AC2	 • Outreach and advocacy to maintain Ohio Medicaid eligibility level and enrollment assistance • Insurance enrollment assistance for adults and children
Local access to healthcare providers Indicators AC3 and AC4	 • Comprehensive and coordinated primary care • Culturally competent workforce in underserved communities • Telehealth
Unmet need for mental health care Indicators AC5 and AC6	• Comparable insurance coverage for behavioral health (parity) • Telehealth for mental health
Mental health and addiction	
Depression Indicators MHA1 and MHA2	• Social and emotional instruction • Coordinated care for behavioral health • Digital access to treatment services and crisis response • Physical activity programs • Parenting programs
Suicide Indicators MHA3 and MHA4	• Suicide awareness, prevention and peer norm programs • Limits on access to lethal means
Youth drug use Indicators MHA5 and MHA6	• K-12 drug prevention education • Alcohol policy changes • Alcohol and other drug use screening (SBIRT)
Drug overdose deaths ▲ Indicator MHA7	• Naloxone education and distribution programs • Prescription drug monitoring programs (PDMPs) • Syringe services programs (SSPs) • Medication-assisted treatment (MAT) access • Comparable insurance coverage for behavioral health (parity) • Culturally competent workforce in underserved communities • Recovery communities and peer supports • Housing programs for people with behavioral health conditions

SHIP strategy quick guide (cont.)

	SHIP topic area	Featured strategies
Chronic disease		
	Heart disease and diabetes Indicators CD1, CD2, CD3 and CD4	 • Hypertension screening and follow up • Prediabetes screening, testing and referral to Diabetes Prevention Program (DPP) • DPP health insurance coverage and accessibility
	Childhood conditions: Asthma Indicator CD 5	 • Multicomponent asthma interventions • Housing improvements
	Childhood conditions: Lead poisoning ▲ Indicator CD 6	• Blood lead level screening for at risk pregnant women and children • Targeted outreach efforts in communities at risk of lead exposure • Public transparency regarding housing with or without lead hazards • Exposure to lead in homes and other settings to prevent lead poisoning
Maternal and infant health		
	Preterm birth and infant mortality Indicators MIH1 and MIH 2	• Smoke-free policies ★ • Early childhood home visiting • Group prenatal care ★
	Maternal morbidity ▲ Indicator MIH 3	• Paid leave • Early childhood home visiting ★ • Group prenatal care ★ • Tobacco cessation tailored for pregnant women • Care coordination and access to well-woman care • Clinical prevention, screening and treatment • Safety and quality improvement • Provider and cultural competency trainings