Richland County Community Health Improvement Plan: 2017-20

The Richland County Community Health Partners
Richland County, Ohio · July 2017

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EXECUTIVE SUMMARY

In 2011, Richland County began conducting community health assessments (CHA) for the purpose of measuring and addressing health status. The most recent 2016 Richland County Community Health Assessment, released in 2017, was cross-sectional in nature and included a written survey of adults, including an oversample of Shelby City adults and African Americans; adolescents; and parents within Richland County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention for their national and state *Behavioral Risk Factor Surveillance System* (BRFSS), *Youth Risk Behavior Surveillance System* (YRBSS) and the *National Survey of Children's Health* (NSCH). This has allowed Richland County to compare the data collected in their CHA to national, state and local health trends.

The Richland County CHA also fulfills national mandated requirements for the hospitals in our county. H.R. 3590 Patient Protection and Affordable Care Act states that in order to maintain tax-exempt status, not-for-profit hospitals are required to conduct a community health needs assessment at least once every three years, and adopt an implementation strategy to meet the needs identified through the assessment.

From the beginning phases of the CHA, Richland County community leaders were actively engaged in the planning process and helped define the content, scope, and sequence of the project. Active engagement of community members throughout the planning process is regarded as an important step in completing a valid needs assessment.

The Richland County CHA has been utilized as a vital tool for creating the Richland County Community Health Improvement Plan (CHIP). The Public Health Accreditation Board (PHAB) defines a CHIP as a long-term, systematic effort to address health problems on the basis of the results of assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. This plan also meets PHAB Domain 5, Standard 5.2: Conduct a comprehensive planning process resulting in a Tribal/state/community health improvement plan. A CHIP is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community inclusively and should be done in a timely way.

The Richland County Community Health Assessment Partners hired the Hospital Council of Northwest Ohio, a neutral regional non-profit hospital association, to facilitate the Community Health Improvement Process. The Richland County Health Department and the Shelby City Health Department, along with the local hospital systems, then invited key community leaders to participate in an organized process of strategic planning to improve the health of residents of the county. The National Association of City County Health Officer's (NACCHO) strategic planning tool, Mobilizing for Action through Planning and Partnerships (MAPP), was used throughout this process.

The MAPP Framework includes six (6) phases which are listed below:

- Organizing for success and partnership development
- Visioning
- Conducting the MAPP assessments
- Identifying strategic issues
- Formulating goals and strategies
- Taking action: planning, implementing, and evaluation

The MAPP process includes four (4) assessments: Community Themes & Strengths, Forces of Change, the Local Public Health System Assessment and the Community Health Status Assessment. These four assessments were used by The Richland County Community Health Partners to prioritize specific health issues and population groups which are the foundation of this plan. The diagram below illustrates how each of the four assessments contributes to the MAPP process.

(Source: University of Kansas, Work Group for Community Health and Development, 2016)

Figure 1.1 2017-2020 Richland County CHIP Overview

Overall Health Outcomes	
↑ Increase Health Status	↓ Decrease Premature Death
Priority Topics	
Mental Health and Addiction	*Chronic Disease*
Priority Outcomes	
↓ Decrease adult and youth substance abuse ↓ Decrease youth depression ↓ Decrease youth suicide ↓ Child adverse childhood experiences	↓ Decrease adult, youth and child obesity ↓ Decrease adult and child asthma ↓ Decrease adult diabetes

STRATEGIC PLANNING MODEL

Beginning in April 2017, The Richland County Community Health Partners met four (4) times and completed the following planning steps:

1. **Initial Meeting**- Review of process and timeline, finalize committee members, create or review vision

2. **Choosing Priorities**- Use of quantitative and qualitative data to prioritize target impact areas

3. **Ranking Priorities**- Ranking the health problems based on magnitude, seriousness of consequences, and feasibility of correcting

4. **Resource Assessment**- Determine existing programs, services, and activities in the community that address the priority target impact areas and look at the number of programs that address each outcome, geographic area served, prevention programs, and interventions

5. **Forces of Change and Community Themes and Strengths**- Open-ended questions for committee on community themes and strengths

6. **Gap Analysis**- Determine existing discrepancies between community needs and viable community resources to address local priorities; identify strengths, weaknesses, and evaluation strategies; and strategic action identification

7. **Local Public Health Assessment**- Review the Local Public Health System Assessment with committee

8. **Quality of Life Survey**- Review results of the Quality of Life Survey with committee

9. **Best Practices**- Review of best practices and proven strategies, evidence continuum, and feasibility continuum

10. **Draft Plan**- Review of all steps taken; action step recommendations based on one or more the following: enhancing existing efforts, implementing new programs or services, building infrastructure, implementing evidence based practices, and feasibility of implementation.

PARTNERS

The 2017-2020 Community Health Improvement Plan was drafted by agencies and service providers within Richland County. During April 2017 – June 2017, the Richland County Community Health Partners reviewed many sources of information concerning the health and social challenges Richland County adults, youth and children may be facing. They determined priority issues which if addressed, could improve future outcomes, determined gaps in current programming and policies and examined best practices and solutions. The committee has recommended specific actions steps they hope many agencies and organizations will embrace to address the priority issues in the coming months and years. We would like to recognize these individuals and thank them for their devotion to this process and this body of work:

The Richland County CHIP Committee:

Teresa Alt, Richland County Youth and Family Council Director
Tracee Anderson, Community Action for Capable Youth (CACY)
Andrea Barnes, Shelby City Health Department
Teri Bernkus, Mayor, Village of Bellville
Elizabeth Blakley, Richland County Domestic Relations Court
Sherry Branham, Mental Health and Recovery Services Board of Richland County
Nyshia Brooks, North End Community Improvement Collaborative
Laura Burns, Mom's Clean Air Force
Terry Carter, First Call 2-1-1
Dr. Ajay Chawla, Health Commissioner, Shelby City Health Department
Ellen Claiborne, Richland Public Health
Marsha Coleman, Richland County Children Services
Amanda Crawford, United Way
Selby Dorgan, Richland Public Health
Deborah Dubois, Mansfield/Richland County Public Library
Heather Foley, Richland Public Health
Kerrick Franklin, Mansfield Area YMCA
Veronica Groff, Catalyst Life Services
Beth Hildreth, Community Health Access Project (CHAP)
Maggie Hoecker, Mansfield Memorial Homes
Martin Jones, Richland County Prosecutor's Office
Cinda Kropka, Avita Health System
Emily Leedy, Richland Public Health
Stacey Nolen, Third Street Family Health Services
Eugene Parkison, Mayor, Village of Lexington
Tina Picman, Richland Public Health
Karyl Price, Richland Public Health
Reed Richard, Richland Public Health
Seth Roberts, Mansfield Memorial Homes
Amy Schmidt, Richland Public Health
Jotika Shetty, Richland County Regional Planning
Geron Tate, National Association for the Advancement of Colored People (NAACP)
Martin Tremmel, Health Commissioner, Richland Public Health
Kari Westfield, Third Street Family Health Services
Dr. Terry Weston, OhioHealth Mansfield and Shelby Hospitals
Lisa Wintersteller, Catalyst Life Services

The strategic planning process was facilitated by Tessa Elliott, Community Health Improvement Coordinator from the Hospital Council of Northwest Ohio.

VISION

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 Richland County Community Health Partners:

Working together to improve the health of individuals, families, and our community by shifting our focus from treatment to prevention and wellness.

The Mission of The Richland County Community Health Partners:

Promoting overall wellness and empowering residents.

ALIGNMENT WITH NATIONAL AND STATE STANDARDS

The 2017-2020 Richland County Health Improvement Plan priorities align perfectly with state and national priorities. Richland County will be addressing the following priorities: chronic disease and mental health and addiction.

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

The Richland County Plan also aligns with six (6) of the National Prevention Strategies for the U.S. population: healthy eating, active living, injury and violence free living, mental and emotional well-being and preventing drug abuse and excessive alcohol use.

Healthy People 2020

Richland County's priorities also fit specific Healthy People 2020 goals. For example:

- ***Nutrition and Weight Status (NWS)-8:*** Increase the proportion of adults who are at a healthy weight. This plan also support goals *NWS 1-22*.
- ***Heart Disease and Stroke (HDS)*-5:** Reduce the proportion of persons in the population with hypertension**.** This plan also supports goals *HDS 1-8.*
- ***Mental Health and Mental Disorders (MHMD)-9:*** Increase the proportion of adults with mental health disorders who receive treatment. This plan also supports goals *MHMD 1-12*.
- ***Substance Abuse (SA)-2****:* Increase the proportion of adolescents never using substances. This plan also supports goals *SA 1-6, 8-11, 14, 16-17, & 20*.

ALIGNMENT WITH NATIONAL AND STATE STANDARDS, *continued*

Ohio State Health Improvement Plan

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 Ohio Department of Health contracted with the Health Policy Institute of Ohio (HPIO) to conduct the 2017-2018 State Health Improvement Plan. HPIO sub-contracted with the Hospital Council of Northwest Ohio to collect data, facilitate regional forums, and assist with the SHIP strategies.

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)

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)

The SHIP also takes a comprehensive approach to improving Ohio's greatest health priorities by identifying **cross-cutting factors** that impact multiple outcomes: health equity, social determinants of health, public health system, prevention and health behaviors, and healthcare system and access.

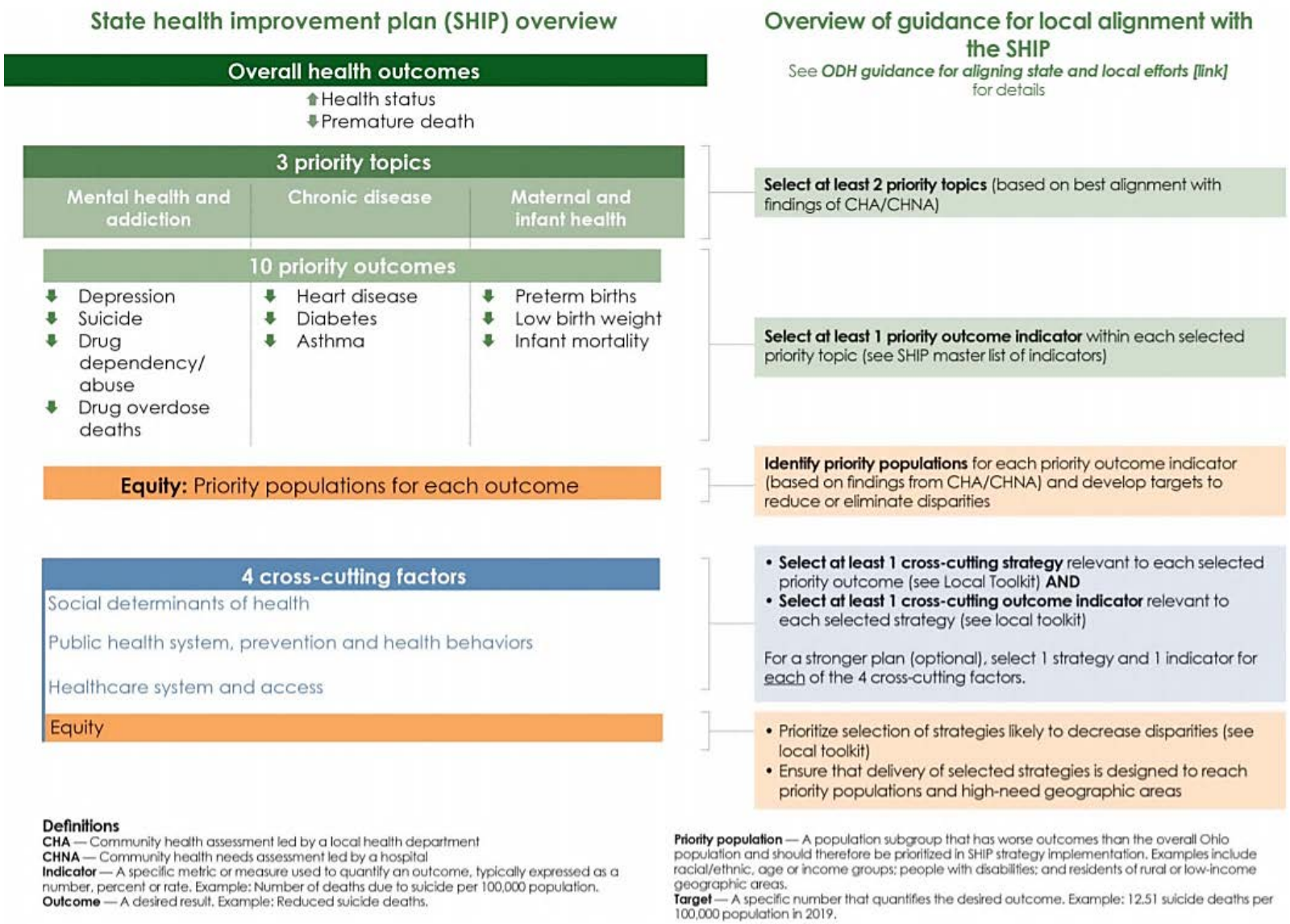
This symbol will be used throughout the report when a strategy or indicator directly aligns with the 2017-2019 SHIP

In order to align with the 2017-2019 SHIP, Richland County is encouraged to select at least *2 SHIP priority topics* to be addressed in the CHIP. Then for each priority topic, the county should select at least *1 priority outcome indicator, 1 cross cutting strategy and 1 cross-cutting outcome indicator*. The following Richland County CHIP priority topics, outcomes and cross cutting factors align with the 2017-2019 State Health Improvement Plan (SHIP) priorities:

2017-2020 Richland CHIP Alignment with 2017-2019 Ohio SHIP		
Priority topics	***Priority outcomes***	***Cross-cutting factors***
• Chronic disease	• Decrease diabetes • Decrease asthma	• Social determinants of health • Public health system, prevention and health behaviors • Healthcare system and access
• Mental health and addiction	• Decrease depression • Decrease suicide • Decrease drug dependence/ abuse • Decrease drug overdose deaths	

ALIGNMENT WITH NATIONAL AND STATE STANDARDS, *continued*

Figure 1.2 2017-2019 State Health Improvement Plan (SHIP) Overview



(Source: 2017-2019 State Health Improvement Plan)

Action Steps:

To work toward **decreasing chronic disease**, the following action steps are recommended:

1. Shared use (joint use agreements)
2. Smoke free policies
3. Food insecurity screening and referral
4. Nutrition prescriptions
5. Healthy food in convenience stores
6. Community gardens & famers' markets/stands
7. Healthy home environment assessments
8. Implement higher quality school lunch programs
9. Explore the possibility of recruiting a bariatric surgeon and creating a bariatric surgery program

To work toward **improving mental health and decreasing addiction,** the following actions steps are recommended:

1. Screening, brief intervention and referral to treatment
2. Screen for clinical depression for all patients 12 or older using a standardized tool
3. Provide mental health first trainings to community members
4. Trauma-informed healthcare
5. Provider training on opiod prescribing guidelines
6. Expand community collaboration to increase awareness and coordination of mental health and substance use services
7. School-based violence prevention programs
8. School-based alcohol/other drug prevention programs

To address all priority areas, the following cross-cutting strategies are recommended:

1. Cultural competence trainings for healthcare professionals
2. Complete streets
3. Public transportation
4. School-based nutrition education programs

NEEDS ASSESSMENT

The Richland County Community Health Partners reviewed the 2016 Richland County Health Assessment. The detailed primary data for each individual priority area can be found in the corresponding section. Each member completed an "Identifying Key Issues and Concerns" worksheet. The following tables illustrate the group results.

What are the most significant ADULT health issues or concerns identified in the 2016 health assessment report?

Key Issue or Concern *(self-reported)*	Percent of Population At risk	Age Group or Income Level Most at Risk	Gender Most at Risk	Race/Ethnicity Most at Risk
Chronic Disease (18 votes)				
Obesity	42%	Age: 30-64 Income: <25K	Female	African American
Overweight	31%	Age: 65+ Income: >25K	Male	African American
Diagnosed with diabetes	13%	Age: 65+ Income: <25K	Male	African American
Diagnosed with high blood pressure	40%	Age: 65+ Income: <25K	Male	African American
Diagnosed with high blood cholesterol	39%	Age: 65+ Income: <25K	Male	African American
Diagnosed with arthritis	35%	Age: 65+ Income: <25K	Female	African American
Substance Abuse (12 votes)				
Used medication not prescribed for them	7%	Age: 30-64 Income: <25K	Male	African American
Used recreational drugs in the past 6 months	1%	N/A	N/A	N/A
Opiate use	N/A	N/A	N/A	N/A
Overdose deaths	438 per 100,000	N/A	N/A	N/A
Binge alcohol drinker (among current drinkers)	41%	Age: Under 30 Income: <25K	Male	African American
Current alcohol drinker	50%	Age: Under 30	N/A	African American
Mental Health (11 votes)				
Made a plan to attempt suicide	3%	N/A	N/A	African American
Attempted suicide	1%	N/A	N/A	African American
Felt sad, blue or depressed	14%	N/A	N/A	N/A
Did not get enough rest or sleep	31%	N/A	N/A	N/A

NEEDS ASSESSMENT, *continued*

Key Issue or Concern *(self-reported)*	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk	Race/Ethnicity Most at Risk
Tobacco Use (5 votes)				
Current smoker	16%	Age: 30-64 Income: <25K	Female	African American
Former smoker	24%	Age: 30-64 Income: >25K	Male	African American
Cancer (2 votes)				
Prostate cancer	15%	N/A	N/A	N/A
Breast cancer	31%	N/A	N/A	N/A
Mammogram in the past year	39%	Age: 40+ Income: <25K	Female	N/A
Asthma (2 votes)				
Diagnosed with asthma	18%	Age: Under 30 Income: <25K	Female	African American
Health Insurance (2 votes)				
Uninsured	15%	Age: Under 30 Income: <25K	Male	African American
Health Perceptions (1 vote)				
Rated health as fair or poor	13%	Income: <25K	N/A	African American
Rated health as excellent or very good	45%	Age: Under 30 Income: >25K	N/A	N/A
Rated physical health as not good on 4+ days	27%	N/A	N/A	African American
Rated mental health as not good on 4+ days	34%	N/A	N/A	African American
Infant mortality (1 vote)				
Infant mortality	N/A	N/A	N/A	N/A

NEEDS ASSESSMENT, *continued*

What are the most significant YOUTH (ages 12-18) health issues or concerns identified in the 2016 health assessment report?

Key Issue or Concern *(self-reported)*	Percent of Population At risk	Age Group/Grade Most at Risk	Gender Most at Risk
Substance Abuse (16 votes)			
Used Inhalants	8%	Grade: 9-12	Male
Lifetime alcohol drinker	38%	Age: 17+	Female
Current alcohol drinker	17%	Age: 17+	N/A
Binge alcohol drinker (of current drinkers)	57%	Age: 14-16	Male
Current tobacco smoker	7%	Age: 17+	Male
Obesity/Overweight (12 votes)			
Obese	19%	Age: 13 or younger	Male
Overweight	20%	Age: 14-16	Female
Drank soda pop at least once in the past week	28%	N/A	N/A
Had a drink that was high in caffeine at least 1-3 times during the past week	27%	N/A	N/A
Violence (11 votes)			
Bullied in the past year	46%	Grade: 9-12	N/A
Carried a weapon in the past 30 days	12%	Age: 14-16	Male
Mental Health (10 votes)			
Felt so sad or hopeless almost every day for two weeks or more in a row	25%	Grade: 9-12	Female
Contemplated suicide	14%	Age: 14-16	Female
Attempted suicide	7%	Age: 14-16	Female
Risky Behaviors (9 votes)			
Had multiple sexual partners	53%	Grade: 9-12	N/A
They had been asked to meet someone they met online	18%	N/A	N/A
Teen birth rate (2 votes)			
Teen birth rate	51/1,000	N/A	N/A
Infant mortality rate (1 vote)			
Infant mortality	N/A	N/A	N/A

NEEDS ASSESSMENT, *continued*

What are the most significant CHILD (ages 0-11) health issues or concerns identified in the 2016 health assessment report?

Key Issue or Concern *(self-reported)*	Percent of Population At risk	Age Group Most at Risk	Gender Most at Risk
Overweight/Obese (12 votes)			
Obese	41%	N/A	N/A
Overweight	17%	N/A	N/A
Physically active every day of the week	17%	N/A	N/A
Bullied (7 votes)			
Bullied in the past year	43%	Age: 6-11	N/A
Adverse Childhood Experiences (7 votes)			
2+ adverse childhood experiences (ACE's)	20%	Income: <25K	N/A
Asthma (7 votes)			
Diagnosed with asthma	13%	Age: 0-5	N/A
ADD/ADHD (2 votes)			
Diagnosed with ADD/ADHD	7%	Age: 6-11	N/A
Parent Health (1 vote)			
Mother's mental or emotional health is fair/poor	6%	Age: 6-11	N/A
Father's mental or emotional health is fair/poor	4%	Age: 6-11	N/A
Head injury (1 vote)			
Diagnosed with a head injury	4%	Age: 6-11	N/A
Autism (1 vote)			
Diagnosed with autism	2%	Age: 6-11	N/A
Child Health (1 vote)			
Dental care visit within in the past year	43%	Age: 0-5	N/A
Diagnosed with vision problems that cannot be corrected	2%	Age: 0-5	N/A

PRIORITIES CHOSEN

Based on the 2016 Richland County Health Assessment, key issues were identified for adults, youth and children. Committee members then completed the 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 rankings were as follows:

Health Issue	Average Score
1. Child Overweight/Obese	25.0
2. Youth Overweight/Obese	24.3
3. Adult Chronic Disease	23.6
4. Youth Substance Abuse	23.0
5. Adult Substance Abuse	22.2
6. Adult Mental Health	22.1
7. Child ACE's	21.8
8. Youth Violence	21.6
9. Youth Risky Behaviors	21.6
10. Youth Mental Health	21.5
11. Child Bullying	20.2
12. Child Asthma	19.8

Richland County will focus on the following two (2) priorities over the next 3 years:

1. **Chronic Disease** *(includes adult, youth, and child obesity; adult and child asthma and adult diabetes)*

2. **Mental health & Addiction** *(includes adult and youth substance abuse; adult and youth depression and suicide and child adverse childhood experiences)*

FORCES OF CHANGE

The Richland County Community Health Partners was asked to identify positive and negative forces which could impact community health improvement and overall health of this community over the next three to five years. This group discussion covered many local, state, and national issues and change agents which could be factors in Richland County in the near future. The table below summarizes the forces of change agent and its potential impacts.

Force of Change	Impact
1. Medicaid & Medicare	o The number of individuals on these programs has increased over the past forty years. Because of this, there has been a lack funding at the state and federal level.
2. Public School System	o Schools in Richland County have a low retention rate and overall low enrollment; some schools have even closed. Because of this, it has been difficult to attract businesses to the county.
3. Economic Workforce	o There is a lack of presence from businesses in the county; businesses are leaving the county. o Employers are struggling to give healthcare to their employees.
4. Aging Population	o The aging population brings an increase in chronic disease and falls, etc. o Seniors may have low a socio-economic status (SES) (i.e. live in poverty).
5. Maternal & Infant Health	o Good maternal and infant health is the cornerstone of a healthy community.
6. Third Street Services	o Third Street Services is expanding and can access and provide services for more patients in the community.
7. Opiate Epidemic Response	o Richland County Opiate Task Force
8. Location	o Richland County is located between Columbus, Cleveland and Akron. While people may live in Richland County – they work in the areas surrounding the county.
9. Manufacturing & Refinery Jobs	o Manufacturing and refinery jobs are leaving Richland County causing workforce displacement. These jobs are being replaced by technology-based jobs. o Younger people are leaving the county after they graduate from high school or college to live and work and raise their families. o Older people need to be able to fill that gap and be properly trained for jobs in the available technology sector.
10. Civic Engagement	o There has been a decline in civic engagement over the years. People are uninterested and uninvolved in local government. People only care about politics during a presidential election.
11. Unfunded Mandates	o The federal government is becoming increasingly more involved in local politics. o Unfunded mandates at both the state and federal level is impeding the work being done at the local governmental level.
12. OhioHealth	o A new hospital system, Avita Health, has moved into Richland County in addition to both OhioHealth (Shelby & Mansfield) Hospitals.
13. Healthcare	o OhioHealth is opening a new emergency room (ER) in July 2017. o Various urgent cares throughout the county have opened rapidly over the last couple years.
14. State Government	o A new governor will lead to the appointment of new directors at the state level in 2018.
15. Environment Health/Emergency Planning	o The fear that a natural disaster (i.e. tornados and floods) could strike at any time. o Fracking and the uncertainty of what environmental and health effects that may cause.
16. US-30 Construction	o The re-directing of highway exits could negatively affect neighborhoods, but positively affect businesses.

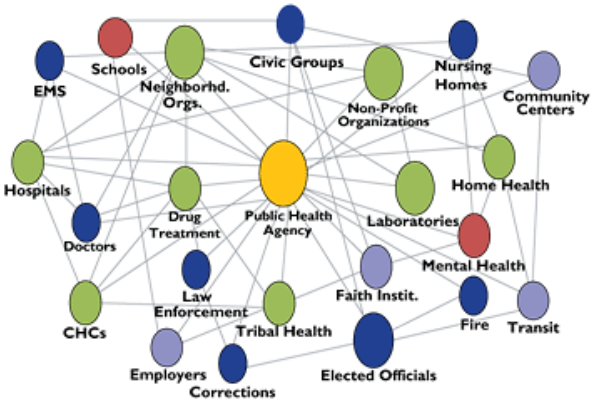
LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

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:

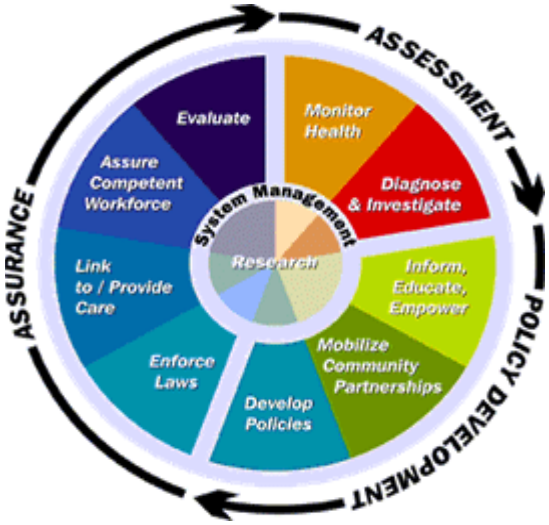
- Public health agencies at state and local levels
- Healthcare providers
- Public safety agencies
- Human service and charity organizations
- Education and youth development organizations
- Recreation and arts-related organizations
- Economic and philanthropic organizations
- Environmental agencies 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 and Prevention; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services; http://www.cdc.gov/nphpsp/essentialservices.html)

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT, continued

The Local Public Health System Assessment (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**.

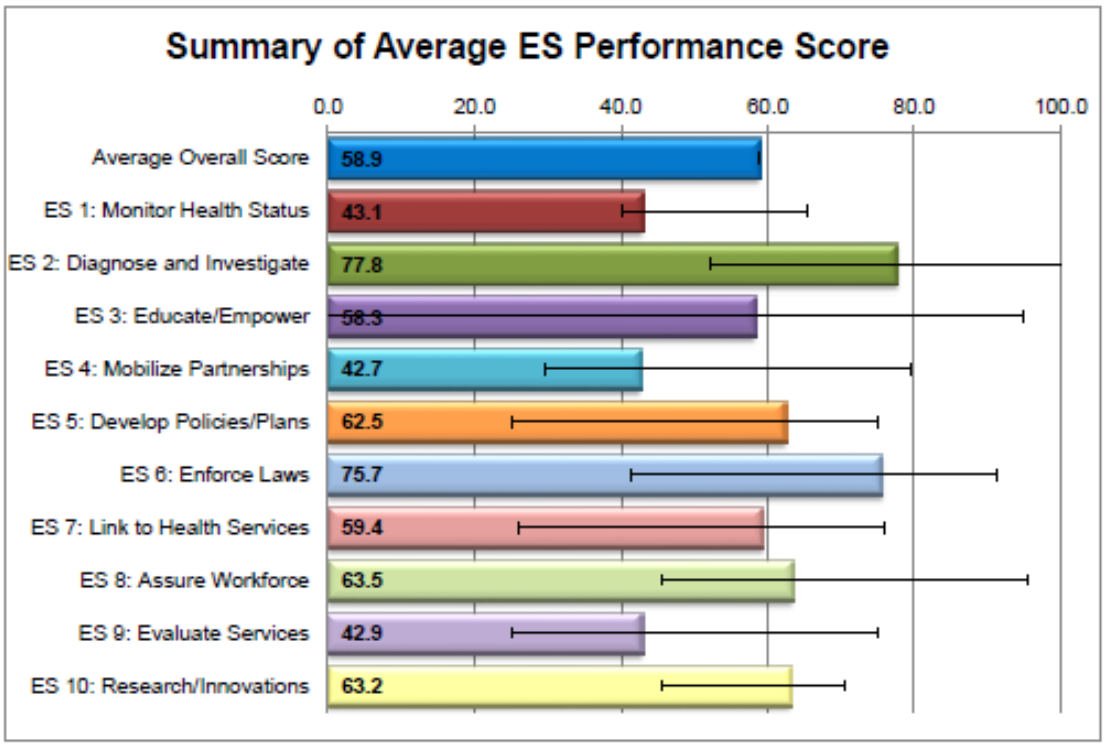
Members of Richland Public Health completed the performance measures instrument. The LPHSA results were then presented to the full CHIP committee for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard was discussed and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

The CHIP committee identified 14 indicators that had a status of "minimal" and one indicator that had a status of "no activity". The remaining indicators were all moderate, significant or optimal.

As part of Ohio's 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 Amy Schmidt from the Richland Public Health at aschmidt@richlandhealth.org

Richland County Local Public Health System Assessment
2017 Summary



COMMUNITY THEMES AND STRENGTHS

The Richland County Community Health Partners participated in an exercise to discuss community themes and strengths. The results are as follows:

Richland County community members believed the most important characteristics of a healthy community were:

- Access to nutritious foods and physical activity opportunities
- Residents in the community staying active
- Education on the available resources in the community
- Focus on The Social Determinants of Health (i.e. workforce, education, access to housing)
- Economic landscape – economic opportunities throughout the county
- Clean air, water, and overall physical environment
- Healthy people
- Strong leadership in the community
- Focus on prevention (i.e. vaccines)
- School support

Community members are most proud of the following regarding their community:

- How the community comes together in a time of crisis
- The ongoing partnerships throughout the county
- Abundant resources throughout the community
- Richland County is a beautiful place to live
- Good-hearted people in the community
- Feeling of safety
- Strong sense of pride
- Ample leadership initiatives throughout the county
- Creativity
- Perseverance of residents
- Reasonable cost of living
- Revitalization of downtown Mansfield

The following were specific examples of people or groups who have worked together to improve the health and quality of life in the community:

- CHIP Planning Committee
- CHAP (Community Health Access Program)
- Pathways HUB
- OhioHealth Mansfield and Shelby, Ohio
- Mental Health & Recovery Services Board
- Community of Care Network
- Opiate Response Team
- Richland Moves
- 2-1-1
- Richland Public Library
- United Way
- North End Community Improvement Collaborative, Inc. (NECI)
- Richland County Schools
- Avita Health System
- Nursing Students from Ashland University (i.e. provide blood pressure screenings, etc.)
- Richland Giving Professionals
- Catholic Charities
- Older Adult Consortium (Nursing Home & Home Health)
- YMCA
- Council on Aging
- Children's Services
- The Arts Community (i.e. Renaissance Playhouse)
- Richland County Banks
- Richland County Foundation
- County EMA
- Red Cross

COMMUNITY THEMES AND STRENGTHS, continued

The most important issues that Richland County residents believed must be addressed to improve the health and quality of life in their community are:

- Social Determinants of Health (i.e. access to transportation)
- Bringing additional organizations and sectors to the table
- Workforce education
- Food access
- Safety
- Environment
- Healthcare access to all community members
- Education (youth and adults)
- School support

The following were barriers that have kept the community from doing what needs to be done to improve health and quality of life:

- Lack of informal involvement from leaders in the community
- Funding
- A lack of people and organizations not taking initiative
- People and organizations working in "silos"
- Lack of/no money for programming
- Lack of efficiency at the leadership level
- Not viewing community members as "assets"
- Residents don't know about available community resources
- Areas surrounding the city of Mansfield, but are located within Richland County, feel separate from Mansfield

Richland County residents believed the following actions, policies, or funding priorities would support a healthier community:

- Re-direction of funds at the local level and leadership
- Research different frameworks for programmatic Quality Improvement (i.e. Six Sigma)

Richland County residents were most excited to get involved or become more involved in improving the community through:

- Seeing results
- Work on efforts making residents feel valued (i.e. community and customer service)
- People and organizations working together; dealing with "turf wars"
- Hold a forum with county commissioners, village mayors, town mayors on issues that need to be addressed in the community

QUALITY OF LIFE SURVEY

The Richland County CHIP committee urged community members to fill out a short Quality of Life Survey via Survey Monkey. There were ***572*** Richland 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, was assigned a value of 0 (zero) and the response was not used in averaging response or calculating descriptive statistics.

Quality of Life Questions	Likert Scale Average Response 2011 *n=676*	Likert Scale Average Response 2017 *n=572*
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]	3.12	3.36
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.25	3.46
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.25	3.36
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.)	3.13	3.31
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.)	2.29	2.87
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?)	2.98	3.03
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?	3.24	3.51
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.14	3.32
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	2.76	2.86
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	2.79	3.06
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	2.81	3.24
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?)	2.78	3.11

RESOURCE ASSESSMENT

Based on the chosen priorities, The Richland County Community Health Partners was asked to complete a resource inventory for each priority. The resource inventory allowed the committee to identify existing community resources, such as programs, exercise opportunities, free or reduced cost health screenings, etc. The committee was then asked to determine whether a program or service was evidence-based, a best practice, or had no evidence indicated based on the following parameters:

An **evidence-based** practice has compelling evidence for its 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. A **non-evidence based** practice has either no documentation that it has ever been used (regardless of the principals it is based upon) nor has been implemented successfully with evaluation.

The resource assessment can be found at the following links:
https://www.richlandhealth.org/

www.richlandmentalhealth.com

Priority #1 Chronic Disease

Chronic Disease Indicators

**Additional data can be found in the complete 2016 Richland County Community Health Assessment*

Adult Chronic Disease

In 2016, the health assessment indicated that nearly three-fourths (73%) of Richland County adults were either overweight (31%) or obese (42%) by Body Mass Index (BMI).

In 2016, 18% of Richland County adults had been diagnosed with asthma, increasing to 23% of those with incomes less than $25,000 and 26% of those under the age of 30.

The 2016 health assessment has identified that 13% of Richland County adults had been diagnosed with diabetes, increasing to 27% of those over the age of 65.

Adult Comparisons	Richland County 2011	Richland County 2016	Ohio 2015	U.S. 2015
Obese	35%	42%	30%	30%
Overweight	38%	31%	37%	36%
Has been diagnosed with asthma	15%	18%	14%	14%
Has been diagnosed with diabetes	10%	13%	11%	10%

Youth Chronic Disease

In 2016, 19% of youth were classified as obese by Body Mass Index (BMI) calculations (2013 YRBS reported 13% for Ohio and 14% for the U.S. in 2015). 20% of youth were classified as overweight.

2% of Richland County youth ate 5 or more servings of fruits and vegetables per day. 26% ate 3 to 4 servings of fruits and vegetables per day. 61% ate 1 to 2 servings of fruits and vegetables per day.

Youth Comparisons	Richland County 2011 (6th-12th)	Richland County 2016/17 (6th-12th)	Richland County 2016/17 (9th-12th)	Ohio 2013 (9th-12th)	U.S. 2015 (9th-12th)
Obese	14%	19%	22%	13%	14%
Overweight	13%	20%	26%	16%	16%
Ate 1 to 4 servings of fruits and vegetables per day	81%	88%	90%	N/A	N/A

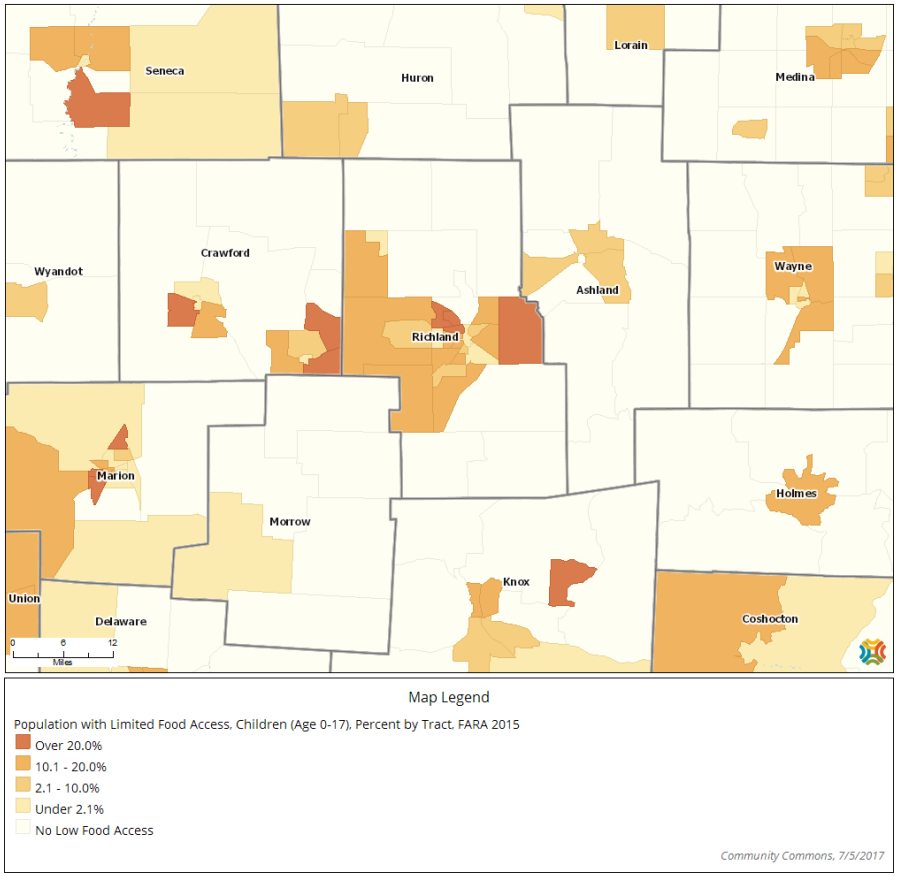
Child Chronic Disease

About two-fifths (41%) of children were classified as obese by Body Mass Index (BMI) calculations. 17% of children were classified as overweight, 37% were normal weight, and 5% were underweight.

Child Comparisons	Richland County 2011 Ages 0-5	Richland County 2016 Ages 0-5	Ohio 2011/12 Ages 0-5	U.S. 2011/12 Ages 0-5	Richland County 2011 Ages 6-11	Richland County 2016 Ages 6-11	Ohio 2011/12 Ages 6-11	U.S. 2011/12 Ages 6-11
Diagnosed with asthma	9%	13%	6%	6%	16%	10%	10%	10%

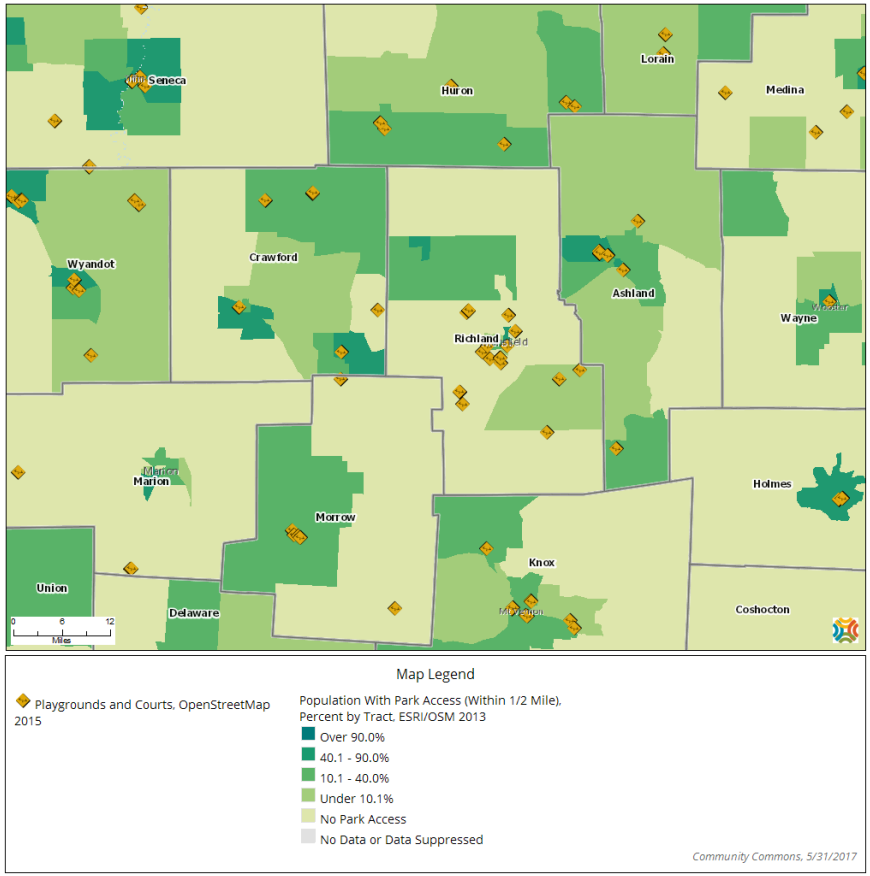
Priority #1 Chronic Disease

Population with Limited Food Access, Children (Age 0-17), Percent by Tract, FARA 2015



(Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas: 2015, as compiled by Community Commons)

Population with Park Access (Within ½ Mile). Total by Tract, ESRI/OSM 2013



(Source: ESRI Map Gallery and OpenStreetMap: 2013. OpenStreetMap: 2013, as compiled by Community Commons)

Priority #1 Chronic Disease

Gaps and Potential Strategies

Gaps	Potential Strategies
1. Pedestrian infrastructure	o Consider a "Complete Streets" policy o Introduce better street lighting throughout county
2. Transportation	o Connect and promote transportation services to those that are currently available o Introduce rural car sharing o Plan an education campaign around transportation services in the county o Introduce a voucher transportation program o Research grants and other funding opportunities to increase transportation
3. A focus on prevention	o Focus on increasing education and awareness for different chronic diseases including obesity and asthma o Pin point food deserts in Richland County and develop a plan to increase access to healthier foods in those areas o Revamp food assistance programs o Provide different types of rewards, incentives or travel vouchers to those who participate in different types of engagement programs
4. Lack of healthy food and grocery stores in certain neighborhoods	o Introduce year-round Farmer's Markets
5. Safety	o Parks are unsafe and unclean which causes limited access to be able to participate in physical activity outdoors
6. Lack of resources for childhood asthma	o Provide consistent programming in schools and school health programming o Increase awareness of environments and air control
7. Asthma integrated therapy	o Increase parental education on asthma - focus on the reasons why children are being diagnosed (i.e. second hand smoke, use of pesticides) o Promote how to safely use different cleaning supplies and recommend using organic alternatives
8. Second hand smoke	o Provide education to family and friends of smokers on the harmful effects of second hand smoke, especially to children and the risk of developing asthma
9. Afterschool fitness opportunities	o Introduce facilitated after school physical activity programs including yoga, dance, aerobics, etc. for all community members including adults and seniors
10. Healthy eating in schools	o Provide *edible* healthy food options. Provide lunches that aren't just "fat free" and "low calorie"

Priority #1 Chronic Disease

Best Practices

The following programs and policies have been reviewed with proven strategies to **reduce chronic disease**:

1. **Nutrition Prescriptions:** Nutrition prescriptions are a way for physicians and other health care providers to outline a healthy, balanced eating plan for patients. Based on US Dietary Guidelines for adults, children, and adolescents, nutrition prescriptions establish achievable goals for the patient and their family. Health care providers review progress at each office visit and a nutrition specialist is consulted for dietary advice as needed. Some nutrition prescription programs partner with local farmers' markets (FVRx programs); in these programs, prescriptions for fruit and vegetables are redeemed or invited at participating markets. Such prescriptions typically support the purchase of at least one serving of produce per day for each patient and their family members.

   For more information go to: http://www.countyhealthrankings.org/policies/nutrition-prescriptions

2. **Food Insecurity Screening and Referral:** Hospitals and clinics can play a central role in screening and identifying patients at risk for food insecurity and connecting families with needed community resources. It is important to advocate for federal and local policies that support access to adequate healthy food for an active and healthy life.

   For more information go to:
   https://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Resources/InstantDownloads/FoodInsecurityAssessTool.pdf

   http://pediatrics.aappublications.org/content/early/2015/10/20/peds.2015-3301

3. **Healthy Food in Convenience Stores:** In many neighborhoods that lack supermarkets and grocery stores, families depend on corner stores and other small-scale stores to purchase food. The choices at these stores are often limited to packaged food and very little, if any, fresh produce. Improving the product mix at smaller stores and addressing other issues of viability — such as pricing, food quality/ freshness, and customer service — strategies that build upon existing community resources to enhance access to healthy food in underserved communities. Corner stores are also frequent destinations for children, many of whom stop daily on the way to and from school for snacks. Corner stores are, therefore, a great place to make healthy food choices available and easy.

   For more information go to:
   http://www.healthylucascounty.org/initiatives/healthy-eating/

   http://www.countyhealthrankings.org/policies/healthy-food-convenience-stores

4. **Healthy Home Environment Assessments** Healthy home environment assessments engage home visitors, sometimes community health workers (CHWs), similarly trained asthma outreach workers, other professionals, paraprofessionals, or volunteers to assess and remediate environmental health risks within the home. Programs typically focus on improving asthma management via low cost changes such as improved ventilation, integrated pest management, and other forms of allergen control. Programs may also provide low emission vacuums, allergen-impermeable bedding covers, air filters, cleaning supplies, and supplies for roach abatement.

   Expected Beneficial Outcomes:
   - Reduced exposure to allergens
   - Reduced hospital utilization

   Evidence of Effectiveness
   - There is strong evidence that health home environment assessments encourage household behaviors that reduce asthma triggers and exposure to allergens and decrease use of urgent care and related health care costs.
   - Health home environment assessments conducted by CHW's or trained asthma outreach workers have been shown to improve asthma self-management, increase the number of asthma symptom free days, and improve quality of life for participating children and caregivers. Such interventions can also improve asthma symptoms for those living in lower quality housing.
   - Economic evaluations indicate healthy home environment assessments achieve high cost savings largely due to averted urgent care clinics visits, emergency room visits, and hospitalizations.

   Impact on Disparities
   - Likely to decrease disparities

   For more information go to: http://www.countyhealthrankings.org/policies/healthy-home-environment-assessments

Priority #1 Chronic Disease

Action Step Recommendations & Plan

To work toward decreasing **chronic disease**, the following action steps are recommended:

1. Shared use (joint use agreements)
2. Smoke free policies
3. Food insecurity screening and referral
4. Nutrition prescriptions
5. Healthy food in convenience stores
6. Community gardens & famers' markets/stands
7. Healthy home environment assessments
8. Implement higher quality school lunch programs
9. Explore the possibility of recruiting a bariatric surgeon and creating a bariatric surgery program

Action Plan

Priority Topic: Chronic Disease				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy: Shared use (joint use agreements)				
Year 1: Assess how many schools, churches, businesses and other organizations currently offer shared use of their facilities (gyms, tracks, etc.). Create an inventory of known organizations that possess physical activity equipment, space, and other resources.	**Priority Outcome:** Reduce diabetes **Priority Indicator:** Percent of adults who have been told by a health professional that they have diabetes	Adults and youth	**Ellen Claiborne** Richland Public Health	July 2018
Year 2: Collaborate with local organizations to create a proposal for a shared-use agreement. Initiate contact with potential organizations from the inventory. Implement at least one shared-use agreement for community use. Publicize the agreement and its parameters.				July 2019
Year 3: Continue efforts from year 1. Implement 2-3 shared-use agreements for community use in Richland County.				July 2020

Priority Topic: Chronic Disease				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy: Smoke-free policies				
Year 1: Collect baseline data on which organizations, multi-unit housing facilities, schools and other businesses currently have tobacco-free policies. Hire/appoint 1 Tobacco Prevention Health Educator to build partnerships with the local public housing authority and multi-unit housing complexes. Provide education to residents to assist with the transition of multi-unit housing complexes to a smoke-free policy and create a resident advisory council. Implement a smoke-free policy in at least 2 multi-unit housing complexes.	**Priority Outcomes:** Reduce child asthma hospitalization **Priority Indicators:** Hospital admissions for pediatric asthma, per 100,000 children ages 2-17	Adult, youth and children	**Tracee Anderson** Community Action for Capable Youth (CACY)	July 2018
Year 2: Continue efforts of year 1. Implement the smoke-free policy in at least 2 multi-unit housing complexes. Begin efforts to adopt smoke-free policies in parks, fairgrounds, schools and other public locations. Continue education efforts.				July 2019
Year 3: Continue efforts of years 1 and 2. Target 3 additional multi-unit housing complexes to adopt a smoke-free housing policy.				July 2020
Strategy: Food insecurity screening and referral				
Year 1: Research the 2-item Food Insecurity (FI) Screening Tool and determine feasibility of implementing a food insecurity screening and referral program. Educate hospitals and clinics on food insecurity, its impact on health, and the importance of screening and referral. Address food insecurity as part of routine medical visits on an individual and systems-based level. Implement the screening model in at least 1 location with accompanying evaluation measures.	**Priority Outcome:** Reduce diabetes **Priority Indicator:** Percent of adults who have been told by a health professional that they have diabetes	Adult, youth and children	**Nyshia Brooks** North End Community Improvement Collaborative (NECIC) **Terry Carter** 2-1-1 **Beth Hildreth** CHAP **Kari Westfield** Third Street Family Services (TSFS)	July 2018
Year 2: Educate participating locations on existing community resources such as 2-1-1, WIC, SNAP, school nutrition programs, food pantries, etc. Continue efforts of year 1.				July 2019
Year 3: Double the number of organization offering food insecurity screening and referrals.				July 2020

Priority Topic: Chronic Disease				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy: Nutrition prescriptions				
Year 1: Research nutrition prescriptions programs. Obtain baseline data to document need for a nutrition prescription program. Contact potential clinic and farmer's market partners. Schedule and attend meetings with potential partners – discuss the program and requirements for participation. Finalize clinic and program partners. Decide what program materials are needed. Develop program materials.	**Priority Outcome:** Reduce diabetes **Priority Indicator:** Percent of adults who have been told by a health professional that they have diabetes	Adults and youth	**Nyshia Brooks** North End Community Improvement Collaborative (NECIC) **Terry Carter** 2-1-1 **Beth Hildreth** CHAP **Kari Westfield** Third Street Family Services (TSFS)	July 2018
Year 2: Implement a nutrition prescription program in at least 1 location (i.e. hospital, doctors' office, etc.) with accompanying evaluation measures.				July 2019
Year 3: Double the number of locations offering a nutrition prescription program.				July 2020
Strategy: Healthy food in convenience stores				
Year 1: Research the Healthy Food Retail Initiative. Survey customers and community members to assess community needs for healthy food items.	**Priority Outcome:** Reduce diabetes **Priority Indicator:** Percent of adults who have been told by a health professional that they have diabetes	Adults and youth	**Emily Leedy** Richland Public Health **Nyshia Brooks** North End Community Improvement Collaborative (NECIC)	July 2018
Year 2: Initiate contact with local corner stores. Recruit at least 2 corner stores to participate in the Healthy Food Retail Initiative. Consider hiring/appointing a health educator to lead the Healthy Food Retail Initiative.				July 2019
Year 3: Continue efforts of years 1 and 2. Recruit at least 3 additional corner stores to participate in the Healthy Food Retail Initiative.				July 2020

Priority Topic: Chronic Disease				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy: Healthy home environment assessments				
Year 1: Research Healthy Home Environment Assessments. Partner with local community organizations and hospitals. Determine what organizations and hospitals will conduct Healthy Home Environment Assessments. Train Community Health Worker's (CHW's) on the different aspects of asthma management. Utilize CHW's and/or community volunteers to do the following using the assessment: • Identify health hazards in the home (i.e. dust, lead, household chemicals, mold and other air pollutants). • Use low cost methods to reduce risks • Train families on the different ways to improve their home environment. • Provide education and resources to control asthma and allergen triggers in the home. Integrate lead assessments into the Healthy Home Environment Assessments. Focus on low-income families with small children who have asthma. Search for grants and funding opportunities to support efforts.	**Priority Outcome:** Reduce child asthma hospitalizations **Priority Indicator:** Hospital admissions for pediatric asthma per 100,000 children ages 2-17	Children	**Laura Burns** Moms Clean Air Force **Beth Hildreth** CHAP **Nyshia Brooks** North End Community Improvement Collaborative (NECIC) **Andrea Barns** Shelby City Health Department	July 2018
Year 2: Continue efforts from year 1.				July 2019
Year 3: Continue efforts from years 1 and 2.				July 2020

Priority Topic: Chronic Disease				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy: Community gardens & famers' markets/stands				
Year 1: Obtain baseline data regarding which cities/towns, school districts, churches, and organizations currently have community gardens and/or farmer's markets. Obtain baseline data regarding which farmer's markets are open year-round. Research grants and funding opportunities to increase the number of community gardens and/or farmer's markets.	**Priority Outcome:** Reduce diabetes **Priority Indicator:** Percent of adults who have been told by a health professional that they have diabetes	Adults, youth and children	**Nyshia Brooks** North End Community Improvement Collaborative (NECIC) **Karyl Price** Richland Public Health **Andrea Barns** Shelby City Health Department **Teri Brenkus, Mayor** Village of Bellville **Kerrick Franklin** Mansfield YMCA	July 2018
Year 2: Help school districts and other organizations apply for grants to obtain funding to start a community garden or farmer's market. Recruit at least one farmer's market to stay open year-round. Consider placing any additional farmer markets and community gardens in more rural locations throughout the county. Encourage the use of SNAP/EBT (electronic benefit transfer) at farmer's markets.				July 2019
Year 3: Implement community gardens in all school districts and double the number of organizations with community gardens and/or farmer's markets from baseline. Implement the use of WIC and SNAP/EBT benefits in all farmer's markets.				July 2020
Strategy: Implement a higher quality school lunch program				
Year 1: Work with school wellness committees to introduce the idea of implementing a higher quality school lunch program (i.e. lunches that are healthy *and* taste good). Obtain baseline data on the types of foods that are currently being served. Consider holding a local training for food service directors and cooks. Develop a healthier school lunch program.	**Priority Outcome:** Reduce youth obesity **Priority Indicator:** Percent of youth who were obese (>95th percentile for BMI, based on sex-and age-specified reference data from the 2000 CDC growth charts) (YRBS and Richland County CHA)	Youth	**Nyshia Brooks** North End Community Improvement Collaborative (NECIC)	July 2018
Year 2: Pilot new school lunch program in at least 1 building from each district.				July 2019
Year 3: Implement in all districts and buildings county-wide.				July 2020

Priority Topic: Chronic Disease				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy: Explore the possibility of recruiting a bariatric surgeon and creating a bariatric surgery program				
Year 1: Collect baseline data on the feasibility of creating a bariatric surgery program in Richland County. Explore the idea of recruiting a bariatric surgeon.	**Priority Outcome:** Reduce adult obesity **Priority Indicator:** Percent of adults that report body mass index (BMI) greater than or equal to 30 (BRFSS and Richland County CHA)	Adults	**Cinda Kropka** Avita Health System	July 2018
Year 2: Raise awareness of the bariatric surgery program if implemented. Continue efforts from year 1				July 2019
Year 3: Continue efforts from year 1 & 2				July 2020

Priority #2 Mental Health & Addiction

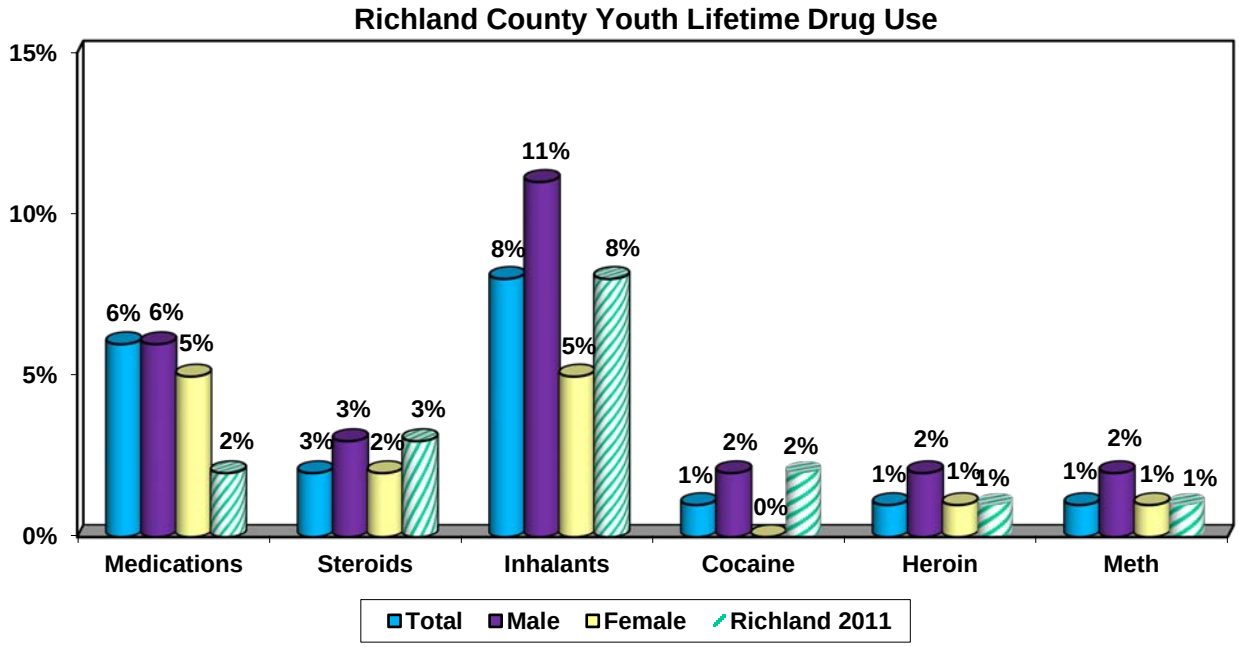
Mental Health and Addiction Indicators

**Additional data can be found in the complete 2016 Richland County Community Health Assessment*

Adult Substance Abuse
7% of Richland County adults had used medication not prescribed for them or they took more than prescribed to feel good or high and/or more active or alert during the past 6 months, increasing to 10% of those with incomes less than $25,000.

In 2016, 50% of Richland County adults had at least one alcoholic drink in the past month, increasing to 60% of those under the age of 30.

Youth Substance Abuse
8% of youth used inhalants in their life (YRBS reports 9% for Ohio in 2013 and 7% for the U.S. in 2015)



Adult Mental Health
Three percent (3%) of Richland County adults made a plan to attempt suicide in the past year.

One percent (1%) of adults reported attempting suicide in the past year.

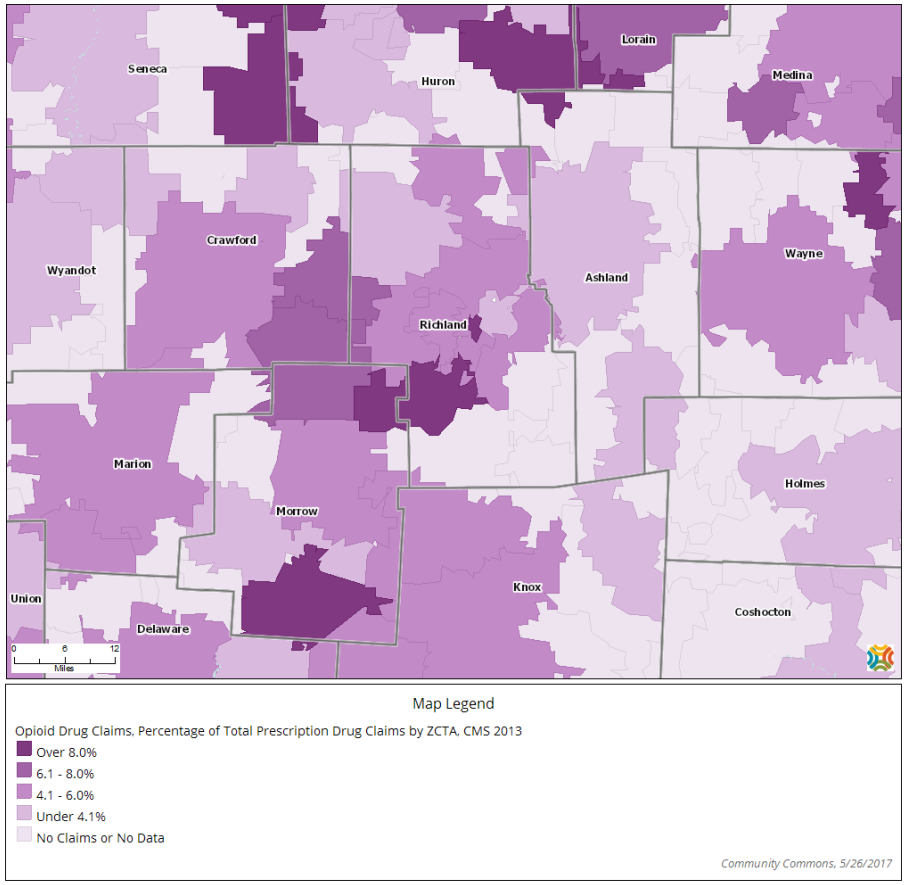
Youth Mental Health
One-quarter (25%) of youth reported they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities, increasing to 33% of females (YRBS reported 26% for Ohio in 2013 and 30% for the U.S. in 2015).

14% of youth reported they had seriously considered attempting suicide in the past 12 months, increasing to 19% of females. 20% of high school youth had seriously considered attempting suicide, compared to the 2015 YRBS rate of 18% for U.S. youth and the 2013 YRBS rate of 14% for Ohio youth.

Child Mental Health
20% of Richland County parents reported their child had 2 or more Adverse Childhood Experiences (ACEs), increasing to 26% of those with income less than $25,000.

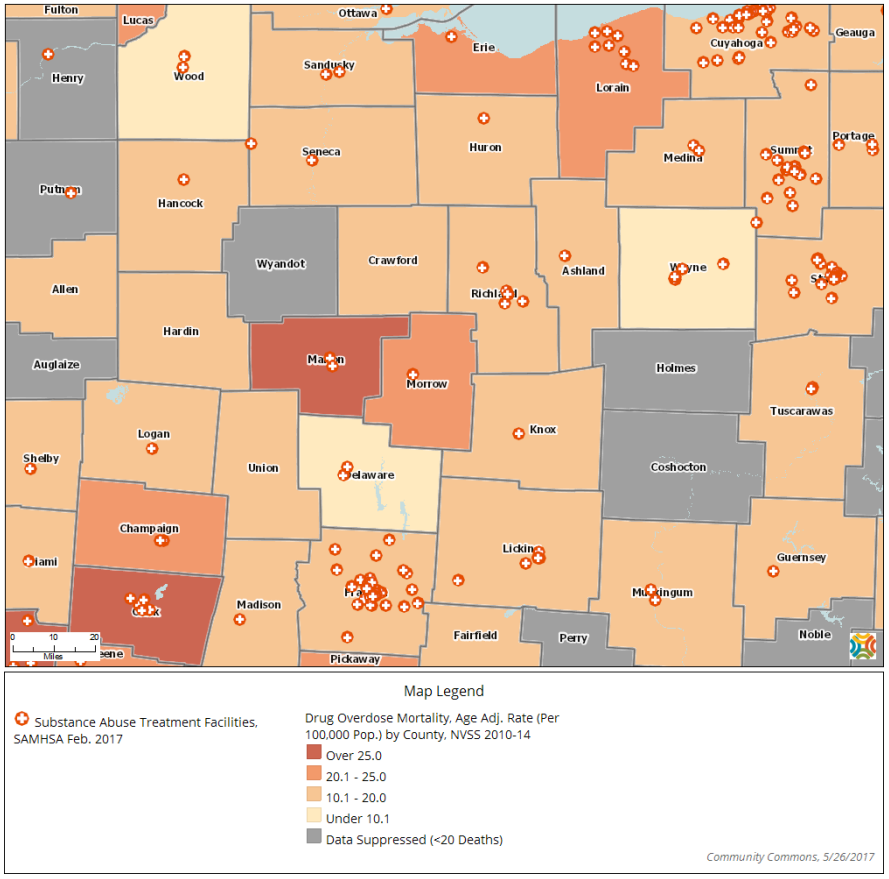
Priority #2 Mental Health & Addiction

Opioid Drug Claims, Percentage of Total Prescription Drug Claims by ZCTA, CMS 2013



(Source: Centers for Medicare and Medicaid Services: 2013, as compiled by Community Commons)

Drug Overdose Mortality, Age Adj. Rate (Per 100,000 Pop.) by County, NVSS 2010-14



(Source: National Vital Statistics System Mortality component (NVSS-M) 2010-14, as compiled by Community Commons)

Priority #2 Mental Health & Addiction

Gaps and Potential Strategies

Gap	Potential Strategies
1. Transportation	o Connect and promote transportation services that are currently available o Introduce rural car sharing o Plan an education campaign around transportation services in the county o Introduce a voucher transportation program o Research grants and other funding opportunities to increase transportation
2. Mental healthcare for adolescents and young adults	o Partner/increase conversation with Akron Children's Hospital and Nationwide Children's for linkage to different services
3. Detox program	o Increase support of current and future efforts
4. Acute mental healthcare for adults	o Increase bed capacity and facilities throughout the county
5. In home crisis services (foster homes, kinship providers, schools)	o Provide telemedicine o Promote *Live Health* on-line telemedicine (on similar) o Provide on-call crisis intervention and de-escalation o Crisis diversion for special populations
6. Mental health services available at businesses	o Expand use of EAP or similar intervention being offered universally by Richland County businesses
7. Social media intervention	o Provide prevention and early intervention education in schools o Encourage schools to enact stricter policies against using social media during school hours o Provide clinical intervention services for youth and adults
8. Geriatric psychiatric services	o Lack of services and places for the geriatric population to go to if they are struggling with Alzheimer's, Dementia, or other mental illnesses. o Provide trainings to nursing home staff on mental health issues in the geriatric population o Contact and partner with Catalyst Life Services to see if they would have beds available for geriatric patients

Priority #2 Mental Health & Addiction

Mental Health & Addiction Best Practices

1. **PHQ-9:** The PHQ-9 is the nine-item depression scale of the Patient Health Questionnaire. The PHQ-9 is a powerful tool for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment. The primary care clinician and/or office staff should discuss with the patient the reasons for completing the questionnaire and how to fill it out. After the patient has completed the PHQ-9 questionnaire, it is scored by the primary care clinician or office staff.

   There are two components of the PHQ-9:
   - Assessing symptoms and functional impairment to make a tentative depression diagnosis
   - Deriving a severity score to help select and monitor treatment

   The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV).

   For more information go to: http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression

2. **Project ASSERT**- Project ASSERT (Alcohol and Substance Abuse Services, Education, and Referral to Treatment) is a screening, brief intervention, and referral to treatment (SBIRT) model designed for use in health clinics or emergency departments (EDs). Project ASSERT targets three groups:

   a. Out-of-treatment adults who are visiting a walk-in health clinic for routine medical care and have a positive screening result for cocaine and/or opiate use. Project ASSERT aims to reduce or eliminate their cocaine and/or opiate use through interaction with peer educators (substance abuse outreach workers who are in recovery themselves for cocaine and/or opiate use and/or are licensed alcohol and drug counselors).
   b. Adolescents and young adults who are visiting a emergency department for acute care and have a positive screening result for marijuana use. Project ASSERT aims to reduce or eliminate their marijuana use through interaction with peer educators (adults who are under the age of 25 and, often, college educated).
   c. Adults who are visiting an ED for acute care and have a positive screening result for high-risk and/or dependent alcohol use. Project ASSERT aims to motivate patients to reduce or eliminate their unhealthy use through collaboration with ED staff members (physicians, nurses, nurse practitioners, social workers, or emergency medical technicians).

   On average, Project ASSERT is delivered in 15 minutes, although more time may be needed, depending on the severity of the patient's substance use problem and associated treatment referral needs. The face-to-face component of the intervention is completed during the course of medical care, while the patient is waiting for the doctor, laboratory results, or medications.

   For more information go to: http://www.integration.samhsa.gov/clinical-practice/sbirt

3. **Prescription Drug Monitoring Programs (PDMP's):** Prescription drug monitoring programs are electronic databases, housed in state agencies, that track prescribing and dispensing of controlled substances. Most states monitor drugs on Schedules II - IV of the Drug Enforcement Administration's drug schedule; many also include drugs on Schedule V and other controlled substances. Schedule I drugs (e.g., heroin) are not included. PDMPs can be used by prescribers and pharmacists to view prescriptions written for and dispensed to individual patients, by law enforcement agencies to identify drug diversion or pill mills, or by state medical boards to identify potentially problematic prescribers. Drugs monitored, individuals authorized to use the system, functionality, and use varies from state to state.

   For more information go to: http://www.countyhealthrankings.org/policies/prescription-drug-monitoring-programs-pdmps

4. **Expect Respect®**: Engages youth, parents, schools and community organizations in promoting healthy teen relationships and preventing dating abuse.

   Serving Austin schools since 1988, Expect Respect is built on an ecological, trauma-informed model and offers a comprehensive prevention program for youth in middle and high schools. Expect Respect has 3 primary program components that 1) support boys and girls who have been exposed to violence, 2) mobilize youth as leaders and 3) engage schools, parents and community organizations in creating safe and healthy environments.

   Expect Respect provides counseling and weekly, curriculum-based support group sessions at school for youth exposed to violence or abuse. Expect Respect educates and empowers teens with the knowledge and skills they need to design and lead prevention efforts in their schools and communities. Expect Respect works with parents, teachers, coaches, nurses and other important adults in teens' lives to promote safe and healthy relationships.

   Recognized by the U.S. Department of Justice, National Resource Center on Domestic Violence, National Sexual Violence Resource Center, National Center for Victims of Crime, Texas Association Against Sexual Assault and others as a model program.

   For more information go to http://www.expectrespectaustin.org/about/

5. **Ending Violence:** Ending Violence is an innovative dating violence prevention curriculum. The program teaches teens how to:
   - Prevent and safely end abusive relationships
   - Understand their legal rights and responsibilities
   - Create a framework for building healthy relationships in the future

   Ending Violence focuses on dating violence prevention from a law and justice perspective, Content includes basic information about dating abuse in addition to legal definitions, rights and responsibilities under the law and information about accessing the civil and criminal justice system.

   For more information go to:
   http://www.violencepreventionworks.org/public/ending_violence.page

6. **Shifting Boundaries:** Shifting Boundaries: Lessons on relationships for students in middle school is an evidence-based, multi-level prevention program for middle school students on sexual harassment and precursors to dating violence. The program is unique in that it embraces an environmental approach that identifies multiple strategies to support young people – both school-wide interventions and classroom lessons.

   For more information go to: http://www.preventconnect.org/2013/05/shifting_boundaries/

7. **Dating Matters®:** *Dating Matters Strategies to Promote Healthy Teen Relationships* is the Centers for Disease Control and Prevention's teen dating violence prevention Initative. The CDC developed Dating Matters as a comprehensive teen dating violence prevention Initative based on current evidence about what works in prevention. Dating Matters focuses on 11-to-14-year-olds in high risk, urban communities. It includes preventive strategies for individuals, peers, families, schools, and neighborhoods.

   The CDC based Dating Matters: Strategies to Promote Healthy Teen Relationships is on three important facts:

   1. Dating violence has important negative effects on the mental and physical health of youth, as well as on their school performance.
   2. Violence in an adolescent relationship sets the stage for problems in future relationships, including intimate partner violence and sexual violence perpetration and/or victimization throughout life. Therefore, early intervention is needed to stop violence in youth relationships before it begins and keep it from continuing into adult relationships.
   3. Although evidence suggests dating violence is a significant problem in economically disadvantaged urban communities, where often times due to environmental factors an accumulation of risk factors for violence exists, there have been few attempts to adapt the developing evidence base for prevention of dating violence within these communities.

   For more information go to: https://www.cdc.gov/violenceprevention/datingmatters/

8. **LifeSkills Training (LST) –** LST is a school-based program that aims to prevent alcohol, tobacco, and marijuana use and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. LST is based on both the social influence and competence enhancement models of prevention. Consistent with this theoretical framework, LST addresses multiple risk and protective factors and teaches personal and social skills that build resilience and help youth navigate developmental tasks, including the skills necessary to understand and resist pro-drug influences. LST is designed to provide information relevant to the important life transitions that adolescents and young teens face, using culturally sensitive and developmentally and age-appropriate language and content. Facilitated discussion, structured small group activities, and role-playing scenarios are used to stimulate participation and promote the acquisition of skills. Separate LST programs are offered for elementary school (grades 3-6), middle school (grades 6-9), and high school (grades 9-12).

   For more information go to: http://www.lifeskillstraining.com

9. **Too Good For Drugs:** Too Good for Drugs (TGFD) is a school-based prevention program for kindergarten through 12th grade that builds on students' resiliency by teaching them how to be socially competent and autonomous problem solvers. The program is designed to benefit everyone in the school by providing needed education in social and emotional competencies and by reducing risk factors and building protective factors that affect students in these age groups. TGFD focuses on developing personal and interpersonal skills to resist peer pressures, goal setting, decision making, bonding with others, having respect for self and others, managing emotions, effective communication, and social interactions. The program also provides information about the negative consequences of drug use and the benefits of a nonviolent, drug-free lifestyle. TGFD has developmentally appropriate curricula for each grade level through 8th grade, with a separate high school curriculum for students in grades 9 through 12. The K-8 curricula each include 10 weekly, 30- to 60-minute lessons, and the high school curriculum includes 14 weekly, 1-hour lessons plus 12 optional, 1-hour "infusion" lessons designed to incorporate and reinforce skills taught in the core curriculum through academic infusion in subject areas such as English, social studies, and science/health. Ideally, implementation begins with all school personnel (e.g., teachers, secretaries, janitors) participating in a 10-hour staff development program, which can be implemented either as a series of 1-hour sessions or as a 1- or 2-day workshop.

   Five studies conducted by an independent evaluator have examined TGFD's effectiveness in reducing adolescents' intention to use tobacco, alcohol, and marijuana; reducing fighting; and strengthening protective and resiliency factors. Each of the five studies showed positive effects on risk and protective factors relating to alcohol, tobacco, illegal drug use, and violence, including significant positive effects on the following:

   - Attitudes toward drugs
   - Attitudes toward violence
   - Perceived peer norms
   - Peer disapproval of use
   - Emotional competence
   - Social and resistance skills
   - Goals and decision making
   - Perceived harmful effects

   For more information go to: http://www.toogoodprograms.org/

Priority #2 Mental Health & Addiction

Action Step Recommendations & Action Plan

To work toward **improving mental health and decreasing addiction,** the following actions steps are recommended:

1. Screening, brief intervention and referral to treatment
2. Screen for clinical depression for all patients 12 or older using a standardized tool
3. Provide mental health trainings to community members
4. Trauma-informed healthcare
5. Provider training on opiod prescribing guidelines
6. Expand community collaboration to increase awareness and coordination of mental health services
7. School-based violence prevention programs
8. School-based alcohol/other drug prevention programs

Action Plan

Priority Topic: Mental Health and Addiction				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy: Screening, brief intervention and referral to treatment				
Year 1: Introduce Project ASSERT. Collect baseline data on the number of emergency department, primary care and specialty care providers that currently screen for drug and alcohol abuse (and at what age they start screening).	**Priority Outcome:** Reduce drug abuse **Priority Indicator:** Percent of persons age 12+ who report past-year illicit drug dependence or abuse*	Adult and youth	**Dr. Terry Weston** OhioHealth **Cinda Kropka** Avita Health System **Kari Westfield** Third Street Family Services (TSFS)	July 2018
Year 2: Introduce a screening, brief intervention and referral to treatment model (SBIRT) to physicians' offices and hospital emergency departments. Pilot the model with one primary care physician's office and hospital ER.				July 2019
Year 3: Increase the number of ER and primary care physicians using the SBIRT model by 25% from baseline.				July 2020

*For adults, use *6-month drug use (2016 Richland County CHA)* as the primary indicator; for youth, use *30-day marijuana use (YRBS)* as priority indicator (per Master List of SHIP indicators).

Priority Topic: Mental Health and Addiction				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy: Screen for clinical depression for all patients 12 or older using a standardized tool				
Year 1: Collect baseline data on the number of primary care physicians that currently screen for depression during office visits. Continue to introduce the PHQ-2 and PHQ-9 to physicians' and OBGYN offices.	**Priority Outcome:** Reduce adolescent depression **Priority Indicator:** Percent of youth who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities (YRBS)	Adults and youth	**Dr. Terry Weston** OhioHealth **Cinda Kropka** Avita Health System **Kari Westfield** Third Street Family Services (TSFS)	July 2018
Year 2: Increase the number of primary care physicians using the PHQ-2 and PHQ-9 screening tool by 10% from baseline.				July 2019
Year 3: Continue efforts from year 1 and 2.				July 2020
Strategy: Provide mental health trainings to community members				
Year 1: Obtain baseline data on the number of trainings that have taken place. Market the training to Richland County area churches, schools, coaches, Rotary Clubs, Law Enforcement, Chamber of Commerce, City Councils, college students majoring in social work/mental health, college campuses, nursing homes, nurses, etc. Include trainings that cover ethics, geriatric mental health issues, etc. Provide at least 2 trainings.	**Priority Outcome:** Reduce suicide deaths **Priority Indicator:** Number of deaths due to suicide per 100,000 populations (age adjusted)	Adults and youth	**Joe Trolian** Mental Health & Recovery Services Board of Richland County **Sherry Branham** Mental Health & Recovery Services Board of Richland County	July 2018
Year 2: Provide 3 additional trainings and continue marketing efforts.				July 2019
Year 3: Continue efforts from year 2.				July 2020

Priority Topic: Mental Health and Addiction				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy: Trauma-informed healthcare				
Year 1: Facilitate an assessment among clinicians in Richland County on their awareness and understanding of toxic stress, trauma informed care, and trauma informed recovery orientated community of care. Survey community members, social workers, pastors, etc. on their awareness and understanding of toxic stress and trauma. Facilitate a training to increase education and understanding of toxic stress and trauma.	**Priority Outcome:** Reduce suicide deaths **Priority Indicator:** Number of deaths due to suicide per 100,000 populations (age adjusted)	Adults and youth	**Joe Trolian** Mental Health & Recovery Services Board of Richland County	July 2018
Year 2: Facilitate trainings for Richland County teachers on trauma and Adverse Childhood Experiences. Develop and implement a trauma screening tool for social service agencies who work with at risk youth.				July 2019
Year 3: Continue efforts of years 1 and 2 Increase the use of trauma screening tools by 25%.				July 2020
Strategy: Provider training on opiod prescribing guidelines and use of OARRS				
Year 1: Develop a training on opiod prescribing guidelines and the use of OARRS (Ohio Automated Rx Reporting System). Offer the training to local healthcare providers.	**Priority Outcome:** Sales of opiod pain relievers **Priority Indicator:** Kilograms of opioid pain relievers sold per 100,000 population	Adults	**Dr. Terry Weston** OhioHealth **Cinda Kropka** Avita Health System	July 2018
Year 2: Continue to market the training to local healthcare providers. Increase the number of trainings by 10%.				July 2019
Year 3: Continue efforts from year 2. Increase the number of trainings by 15%.				July 2020

Priority Topic: Mental Health and Addiction				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy: Expand community collaboration to increase awareness and coordination of mental health and substance use services				
Year 1: Invite faith-based leaders, local businesses, community organizations and mental health service providers to a round table discussion and gather baseline data on what programs and services are offered within or near Richland County. Collaborate with local organizations to address gaps in services. Increase awareness and coordination of existing mental health services between all sectors involved. Measure progress based on number of clients served.	**Priority Outcome:** Reduce depression **Priority Indicator:** Percent of adults and youth who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities	Adults and youth	**Joe Trolian** Mental Health & Recovery Services Board of Richland County **Sherry Branham** Mental Health & Recovery Services Board of Richland County	July 2018
Year 2: Expand collaboration efforts to continue filling mental health service gaps. Continue to coordinate services between one another. Measure progress based on number of clients served.				July 2019
Year 3: Continue efforts of Years 1 and 2.				July 2020
Strategy: School-based violence prevention programs				
Year 1: Gather baseline data on which types of dating violence prevention programs are currently being implemented in which districts and grade levels. Research different evidence based programs specifically aimed at reducing and preventing dating violence including Expect Respect, Dating Matters, Shifting Boundaries and Ending Violence. Decide which program(s) will be offered and are sustainable.	**Priority Outcome:** Reduce adolescent depression **Priority Indicator:** Percent of youth who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities (YRBS)	Youth	**Tracee Anderson** Community Action for Capable Youth (CACY) **Joe Trolian** Mental Health & Recovery Services Board of Richland County	July 2018
Year 2: Introduce the evidence based program(s) to the school districts. Pilot the program(s) in at least one district.				July 2019
Year 3: Expand programming to additional districts and grade levels.				July 2020

Priority Topic: Mental Health and Addiction				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy: School-based alcohol/other drug prevention programs				
Year 1: Continue to expand both the Life Skills and Too Good for Drugs programs to additional school districts and grade levels. Discuss program/service needs and gaps with school personnel at all schools within the county. Work with school administrators, guidance counselors and other school personnel to raise awareness of the programs.	**Priority Outcome:** Reduce marijuana use **Priority Indicator:** Youth marijuana use (past 30 days) (YRBS)*	Youth	**Tracee Anderson** Community Action for Capable Youth (CACY) **Joe Trolian** Mental Health & Recovery Services Board of Richland County	July 2018
Year 2: Continue efforts from year 1. Double the number schools offering either the Life Skills or Too Good for Drugs programs.				July 2019
Year 3: Continue efforts from year 1 and 2.				July 2020

*For adults, use *6-month drug use (2016 Richland County CHA)* as the primary indicator; for youth, use *30-day marijuana use (YRBS)* as priority indicator (per Master List of SHIP indicators).

Cross-Cutting Strategies

Cross-cutting Outcomes

In addition to tracking progress on the CHIP priority outcome objectives, Richland County will evaluate the impact of strategies implemented by also measuring progress on a set of cross-cutting outcome objectives. Examples of cross-cutting outcomes are listed below. See the **master list of SHIP indicators** for the complete list of the SHIP cross-cutting outcome indicators and the community toolkits for a recommended set of aligned community indicators to track progress related to each CHIP strategy.

Social determinants of health: Examples of crosscutting outcomes that address all priorities

- Improve third grade reading proficiency
- Reduce chronic absenteeism in school
- Reduce high housing cost burden
- Reduce secondhand smoke exposure for children

Prevention, public health system and health behaviors: Examples of cross-cutting outcomes that address all priorities

- Increase adult vegetable consumption
- Reduce adult physical inactivity
- Reduce adult smoking
- Reduce youth all-tobacco use

Healthcare system and access: Examples of cross-cutting outcomes that address all priorities

- Reduce percent of adults who are uninsured
- Reduce percent of adults unable to see a doctor due to cost
- Reduce primary care health professional shortage areas

Specific, measurable objectives for selected cross-cutting outcomes will be included in the following action plans.

Cross-Cutting Strategies Best Practices

1. **Complete Streets:** Complete streets are designed and operated to enable safe access for all users, including pedestrians, bicyclists, motorists and transit riders of all ages and abilities. Complete Streets make it easy to cross the street, walk to shops, and bicycle to work.

   Creating Complete Streets means transportation agencies must change their approach to community roads. By adopting a Complete Streets policy, communities direct their transportation planners and engineers to **routinely design and operate the entire right of way to enable safe access for all users,** regardless of age, ability, or mode of transportation. This means that every transportation project will make the street network better and safer for drivers, transit users, pedestrians, and bicyclists – making your town a better place to live.

   Changing policy to routinely include the needs of people on foot, public transportation, and bicycles would make walking, riding bikes, riding buses and trains safer and easier. People of all ages and abilities would have more options when traveling to work, to school, to the grocery store, and to visit family.

   For more information go to: https://smartgrowthamerica.org/program/national-complete-streets-coalition/

2. **Building the Fully Coordinated Transportation System**: Leaders in communities and states across the country have greatly improved mobility for millions of people over the last several decades. The shift away from providing rides to managing mobility is driving the success of fully coordinated transportation systems.

   The strategy coordinates human service agencies that support transportation with public and private transit providers. Such systems have gone far in meeting the needs of consumers who must have access to healthcare, jobs or job training, education and social networks. Coordinated transportation systems also increase the ability of government officials, at all levels, to make the most efficient and effective use of limited resources.

   The Framework for Action: Building the Fully Coordinated Transportation System helps stakeholders realize a shared perspective and build a roadmap for moving forward together. The Framework for Action was developed by analyzing the transportation coordination efforts in states and communities and successful models, with the advice and guidance of an expert panel. The assessment tool can be used by itself, or it can be an essential element of developing a work plan, a strategic plan, or some other plan.

   For more information go to:
   http://www.incog.org/transportation/coordinatedplan/UnitedWeRideFramework.pdf

3. **Serving Up MyPlate: A Yummy Curriculum** (USDA Nutritional Guidelines): Serving Up MyPlate is a collection of classroom materials that helps elementary school teachers integrate nutrition education into Math, Science, English Language Arts, and Health. This "yummy curriculum" introduces the importance of eating from all five (5) food groups using the MyPlate icon and a variety of hands–on activities. Students also learn the importance of physical activity to staying healthy. Serving Up MyPlate provides teacher lesson plans, activities, posters, parent education handouts, and additional games and resources.

   For more information go to: http://www.fns.usda.gov/tn/serving-myplate-yummy-curriculum

4. **Cultural Competence Training for Health Care Professionals:** Cultural competence training for health care professionals focuses on skills and knowledge to value diversity, understand and respond to cultural difference, and increase awareness of providers' and care organizations cultural norms. Trainings can provide facts about patient cultures or include more complex interventions such as intercultural communication skills training, exploration of potential barriers to care, and institution of policies that are sensitive to the needs of patients from culturally and linguistically diverse (CALD) backgrounds.

   For more information go to: http://www.countyhealthrankings.org/policies/cultural-competence-training-health-care-professionals

Action Step Recommendations & Plan

1. Cultural competence trainings for healthcare professionals
2. Complete streets
3. Public transportation
4. School-based nutrition education programs

Cross-cutting factor: Healthcare System and Access			
Action Step	**Cross-cutting Outcome & Indicator**	**Person/Agency Responsible**	**Timeline**
Cross-cutting strategy: Cultural competence trainings for healthcare professionals			
Year 1: Educate/inform local businesses, organizations and health care providers on county demographics and the importance of becoming culturally competent. Offer a county-wide training/workshop on cultural competence.	**Cross-cutting Outcome:** Adult smoking **Cross-cutting Indicator:** Percent of adults that are current smokers	**Nyshia Brooks** North End Community Improvement Collaborative (NECIC)	July 2018
Year 2: Enlist 2 organizations to adopt culturally competent principles, policies and/or practices within their organization. Increase the number of training/workshops by 25%.			July 2019
Year 3: Increase the number of organizations adopting cultural competency policies by 50% from baseline.			July 2020
Cross-cutting factor: Social Determinants of Health			
Cross-cutting strategy: Complete streets			
Year 1: Raise awareness of Complete Streets Policies and recommend that all local jurisdictions adopt comprehensive complete streets policies for villages. Gather baseline data on all the Complete Streets Policy objectives.	**Cross-cutting Outcome:** Adult physical inactivity (no leisure time physical activity) **Cross-cutting Indicator:** Percent of adults aged 18 and over reporting no leisure time physical activity	**Ellen Claiborne** Richland Public Health **Andrea Barns** Shelby City Health Department **Teri Brenkus, Mayor** Village of Bellville **Jotika Shetty** Richland County Regional Planning	July 2018
Year 2: Begin to implement the following Complete Streets Objectives: • Increase in total number of miles of on-street bicycle facilities, defined by streets and roads with clearly marked or signed bicycle accommodations. • Increase in local jurisdictions which adopt complete streets policies. Increase in number of jurisdictions achieving or pursuing Bike-Friendly Community status from the League of American Bicyclists, or Walk-Friendly Community status from www.walkfriendly.org			July 2019
Year 3: Continue efforts from years 1 and 2.			July 2020

Cross-cutting factor: Healthcare System and Access			
Action Step	**Cross-cutting Outcome & Indicator**	**Person/Agency Responsible**	**Timeline**
Cross-cutting strategy: Public transportation			
Year 1: Collaborate with community organizations, local government, churches and schools to create a transportation coalition. Invite the Transportation Director to sit on the committee. Complete the Building the Fully Coordinated Transportation System Self -Assessment Tool for Communities with stakeholders. Create a survey to gather public input on identifying gaps in transportation services. Increase outreach efforts of the survey to include input from older adults, those with disabilities, low-income, and veterans. Analyze the results from the survey and the self-assessment tool. Release the data to the public.	**Priority Outcome:** Reduce transportation as a barrier to health care **Priority Indicator:** No transportation or difficult to find transportation to receive health care (Richland County CHA)	**Tony Vero, Esp.** Commissioner	July 2018
Year 2: Invite community stakeholders to attend a meeting to discuss transportation issues. Create strategies to address gaps and increase efficiency in transportation. Address strategies to increase the use of public transportation and reduce stigma. Begin implementing strategies identified.			July 2019
Year 3: Increase efforts of Years 1 and 2. Fully implement the Coordinated Transportation System. Facilitate follow-up surveys to gauge the public's response to strategies that have been addressed and collect outcome measures.			July 2020
Cross-cutting factor: Public Health System, Prevention and Health Behaviors			
Cross-cutting strategy: School-based nutrition education programs			
Year 1: Conduct an assessment of schools to determine which schools are currently utilizing the *Serving Up MyPlate* program. Continue to introduce the program to schools. By utilizing the *Serving up MyPlate* framework, implement various educational activities and programming in 2 additional schools.	**Cross-cutting Outcome:** Reduce youth obesity **Cross-cutting Indicator:** Percent of youth who were obese (>95th percentile for BMI, based on sex- and age-specific reference data from the 2000 CDC growth charts)	**Nyshia Brooks** North End Community Improvement Collaborative (NECIC) **Teri Brenkus, Mayor** Village of Bellville	July 2018
Year 2: Continue efforts from Year 1. Work with schools to offer "Try it Tuesday" fruit and vegetable taste testing for children *and/or* work with at least 1-2 schools to host a taste-testing event or family education night.			July 2019
Year 3: Continue efforts from Years 1and 2.			July 2020

PROGRESS AND MEASURING OUTCOMES

The progress of meeting the local priorities will be monitored with measurable indicators identified for each strategy found within the action step and recommendation tables within each of the priority sections. Most indicators align directly with the SHIP. The individuals/agencies that are working on action steps will meet on an as needed basis. The full committee will meet bi-annually to report progress. The committee will form a plan to disseminate the Community Health Improvement Plan to the community. Action steps, responsible person/agency, and timelines will be reviewed at the end of each year by the committee. Edits and revisions will be made accordingly.

Richland County will continue facilitating a Community Health Assessment every 3 years to collect and track data. The next Community Health Assessment is scheduled to take place in 2019. Primary data will be collected for adults, youth and child using national sets of questions to not only compare trends in Richland County, but also be able to compare to the state, the nation, and Healthy People 2020. This data will serve as measurable outcomes for each of the priority areas. 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 an ongoing basis to focus on how well action steps are being implemented. Areas of process evaluation that the CHIP committee will monitor will 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 action steps have been incorporated into a Progress Report template that can be completed at all future Richland County CHIP meetings, keeping the committee on task and accountable. Progress reports 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:

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