2020 2022

Mahoning County

Community Health Improvement Plan

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Foreword

Dear Mahoning County Residents,

It is with great excitement that we present the Mahoning County 2020-2022 Community Health Improvement Plan. It is the culmination of many months of collaborative work that exceeds, in comprehensiveness, any community health planning done in Mahoning County to date. Health is not merely the absence of disease, it is a state of physical, social and emotional well-being which occurs when the environment in which an individual lives, works and plays provides sufficient support and opportunities to make these conditions possible.

Driven by the vision of Mahoning County truly being a healthy, thriving and equitable community for ALL residents, throughout the fall of 2018 and the winter, spring, and summer of 2019, a diverse group of individuals from numerous sectors across the county met, reviewed data, and discussed what needed to be done to improve well-being of Mahoning County. This group, known as the Community Health Assessment and Community Health Improvement Planning Team (the CHA/CHIP Team) was comprised of representatives from education, health care, aging, business, individuals with disabilities, members of the LGBTQ+ community, civic organizations, neighborhood associations, youth, pregnant at-risk women, experts in housing, zoning, parks and recreation, the faith community, employers, public health and organizations serving individuals reentering society following incarceration.

Following the MAPP process (Mobilizing for Action through Planning and Partnerships), the CHA/CHIP Team reviewed a number of assessments, identified strategic issues and formulated the CHIP goals and strategies contained herein.

This plan would not exist without the financial support and collaborative work of Mercy Health, Mercy Health Foundation Mahoning Valley, Mahoning County Public Health, Healthy Community Partnership-Mahoning Valley, Mahoning County Mental Health & Recovery Board, and the Youngstown City Health District. We would also like to thank the Hospital Council of Northwest Ohio for facilitating the community health improvement planning process, and Akron Children's Hospital for their participation.

However, the publication of the Mahoning County 2020-2022 Community Health Improvement Plan is just the first step. The CHA/CHIP Team will continue to work, and with the community will implement the plan's Action Steps. We sincerely hope that this Plan will be the catalyst to stimulate new collaborations between public and private sectors to address health concerns, measure the impact of our collective efforts and guide the most effective use of our resources to maximize the health and well-being of ALL residents of Mahoning County.

Patricia M. Sweeney, JD, MPH, RN
Health Commissioner,
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Erin Bishop, MPH
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Table of Contents

Executive Summary 5
- Introduction 5
- Public Health Accreditation Board (PHAB) Requirements 5
- Inclusion of Vulnerable Populations (Health Disparities) 7
- Alignment with National and State Standards 7
- Strategies 12
- Vision and Mission 13
- Community Partners 13

Community Health Status Assessment 16
Key Issues 20
Priorities Chosen 23
Community Themes and Strengths Assessment (CTSA) 24
Forces of Change Assessment 28
Local Public Health System Assessment 30
Gap Analysis, Strategy Selection, Evidence-Based Practices, and Resources 32
Priority #1: Mental Health and Addiction 33
Priority #2: Chronic Disease 42
Priority #3: Maternal and Infant Health 51
Priority #4: Social Determinants of Health 56
Priority #5: Health Equity 65
Progress and Measuring Outcomes 69
Appendix I: Gaps and Strategies 73

Note: Throughout the report, hyperlinks will be highlighted in bold, gold text.

Executive Summary

Introduction

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

Mahoning County CHA/CHIP Team has been conducting CHAs since 2011 to measure community health status. The most recent Mahoning County CHA was cross-sectional in nature and included a written survey of adults and adolescents within Mahoning County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention (CDC) for their national and state Behavioral Risk Factor Surveillance System (BRFSS). This allowed Mahoning County to compare their CHA data to national, state and local health trends. Community stakeholders were actively engaged in the early phases of CHA planning and helped define the content, scope, and sequence of the project.

A committee made up of Mahoning and Trumbull County Health partners contracted with the Hospital Council of Northwest Ohio (HCNO), a neutral, regional, nonprofit hospital association, to facilitate the CHA and CHIP in both counties. The Mahoning County CHA/CHIP Team then invited cross-sector community stakeholders to participate in the community health improvement planning process. Data from the most recent CHA were carefully considered and categorized into community priorities with accompanying strategies. This was done using the National Association of County and City Health Officials' (NACCHO) national framework, Mobilizing for Action through Planning and Partnerships (MAPP). The following priorities were selected in Mahoning County:

1. Improving mental health status and reducing substance abuse and addiction
2. Reducing chronic disease
3. Improving maternal and infant health
4. Improving the economic and social issues impeding health (the social determinants of health)
5. Improving health equity

Over the next three years, to address these priorities, strategies and action steps will be implemented at the county-level with the intent to improve population health and well-being and create lasting, sustainable change. It is the hope of Mahoning County CHA/CHIP Team that every organization in the county will tie their internal strategic plan to at least one strategy in the CHIP.

Public Health Accreditation Board (PHAB) Requirements

National Public Health Accreditation status through the Public Health Accreditation Board (PHAB) is the measurement of health department performance against a set of nationally recognized, practice-focused and evidenced-based standards. The goal of the national accreditation program is to improve and protect the health of the public by advancing the quality and performance of Tribal, state, local, and territorial public health departments. PHAB requires that CHIPs be completed at least every five years, however, Ohio state law (ORC 3701.981) requires that health departments and hospitals collaborate to create a CHIP every 3 years. Additionally, PHAB is a voluntary national accreditation program, however

the State of Ohio requires that all local health departments become accredited by 2020, making it imperative that all PHAB requirements are met.

PHAB standards also require that a community health improvement model is utilized when planning CHIPs. This CHIP was completed using NACCHO's MAPP process. MAPP is a national, community-driven planning process for improving community health. This process was facilitated by HCNO in collaboration with Mahoning County Public Health and the Youngstown City Health District and numerous local agencies and individuals representing a broad cross sector of community stakeholders.

Mobilizing for Action through Planning & Partnerships (MAPP) Process Overview

This 2020-2022 CHIP was developed using the Mobilizing Action through Partnerships and Planning (MAPP) process, which is a nationally adopted framework developed by the National Association of County and City Health Officials (NACCHO) (see Figure 1.1). MAPP is a community-driven planning process for improving community health and is flexible in its implementation, meaning that the process does not need to be completed in a specific order. This process was facilitated by HCNO in collaboration with a broad range of local agencies representing a variety of sectors of the community. This process involved the following six phases:

1. Organizing for success and partnership development

During this first phase, community partners examined the structure of its planning process to build commitment and engage partners in the development of a plan that could be realistically implemented. With a CHA/CHIP Team (Team) already in place, members examined current membership to determine whether additional stakeholders and/or partners should be engaged, its meeting schedule (which occurs on a quarterly basis and more frequently as needed), and responsibilities of partnering organizations for driving change. The steering committee ensured that the process involved local public health, health care, faith-based communities, schools, local leadership, businesses, organizations serving minority populations, and other stakeholders in the community health improvement process.

Figure 1.1 The MAPP Framework

2. Visioning

Next, Team members re-examined its vision and mission. Vision and values statements provide focus, purpose, and direction to the CHA/CHIP so that participants collectively achieve a shared vision for the future. A shared community vision provides an overarching goal for the community—a statement of what the ideal future looks like. Values are the fundamental principles and beliefs that guide a community-driven planning process.

3. The four assessments

While each assessment yields valuable information, the value of the four MAPP assessments is multiplied considering results as a whole. The four assessments include: The Community Health Status Assessment (CHSA), the Local Public Health System Assessment (LPHSA), the Forces of Change (FOC) Assessment, and the Community Themes and Strengths Assessment (CTSA).

4. Identifying strategic issues

The process to formulate strategic issues occurred during the prioritization process of the CHA/CHIP. The Team considered the results of the assessments, including data collected from community members (primary data) and existing statistics (secondary data) to identify the county's key health issues. Upon identifying the key health issues, an objective ranking process was used to prioritize health needs for the CHIP.

In order to identify strategic issues, the Team considered findings from the visioning process and the MAPP assessments in order to understand why certain issues remain constant across the assessments. They used a strategic approach to prioritize issues that would have the greatest overall impact to drive population health improvement and would be feasible, given the resources available in Mahoning County and/or needed, to accomplish the goal. The Team also arranged issues that were related to one another, for example, chronic disease related conditions, which could be addressed through increased or improved coordination of preventative services. Finally, the Team considered the urgency of issues and the consequences of not addressing them.

5. Formulate goals and strategies

Following the prioritization process, a gap analysis was completed in which Team members identified gaps within each priority area, identified existing resources and assets, and potential strategies to address the priority health needs. Following this analysis, the committee formulated goals, objectives, and strategies to meet the prioritized health needs.

6. Action cycle

The Team will begin implementation of strategies as part of the next community health improvement cycle. Both progress data to track actions taken as part of the CHIP's implementation and health outcome data (key population health statistics from the CHA) are continually tracked through ongoing meetings. Annually, and at the end of every CHIP cycle, the Team reviews progress to select new and/or update strategic priorities based on progress and the latest health statistics.

Inclusion of Vulnerable Populations (Health Disparities)

According to the 2017 American Community Survey 1-year estimates, Mahoning County is 80% Caucasion, 14% African American, 6% Hispanic/Latino, 1% Asian, and <1% American Indian and Alaska Native. Approximately 18% of Mahoning County residents were below the poverty line. For this reason, Community Health Assessment data was broken down by race and ethnicity, as well as by income. Data was carefully considered and prioritized based on needs of vulnerable populations living in Mahoning County.

Alignment with National and State Standards

The 2020-2022 Mahoning County CHIP priorities align with state and national priorities. Mahoning County will be addressing the following priorities: mental health and addiction, chronic disease, maternal and infant health, social determinants of health, and health equity.

Ohio State Health Improvement Plan (SHIP)

Note: This symbol is used throughout the report to denote that a Mahoning County priority, indicator, or strategy directly aligns with the 2017-2019 SHIP.

SHIP Overview

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

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

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

SHIP Priorities

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

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

Cross-cutting Factors

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

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

- **Health equity**: Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.
- **Social determinants of health**: Conditions in the social, economic and physical environments that affect health and quality of life.
- **Public health system, prevention and health behaviors**:
    - The public health system is comprised of government agencies at the federal, state, and local levels, as well as nongovernmental organizations, which are working to promote health and prevent disease and injury within entire communities or population groups.
    - Prevention addresses health problems before they occur, rather than after people have shown signs of disease, injury or disability.
    - Health behaviors are actions that people take to keep themselves healthy (such as eating nutritious food and being physically active) or actions people take that harm their health or the health of others (such as smoking). These behaviors are often influenced by family, community and the broader social, economic and physical environment.
- **Healthcare system and access**: Health care refers to the system that pays for and delivers clinical health care services to meet the needs of patients. Access to health care means having timely use of comprehensive, integrated and appropriate health services to achieve the best health outcomes.

CHIP Alignment with the 2017-2019 SHIP

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

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

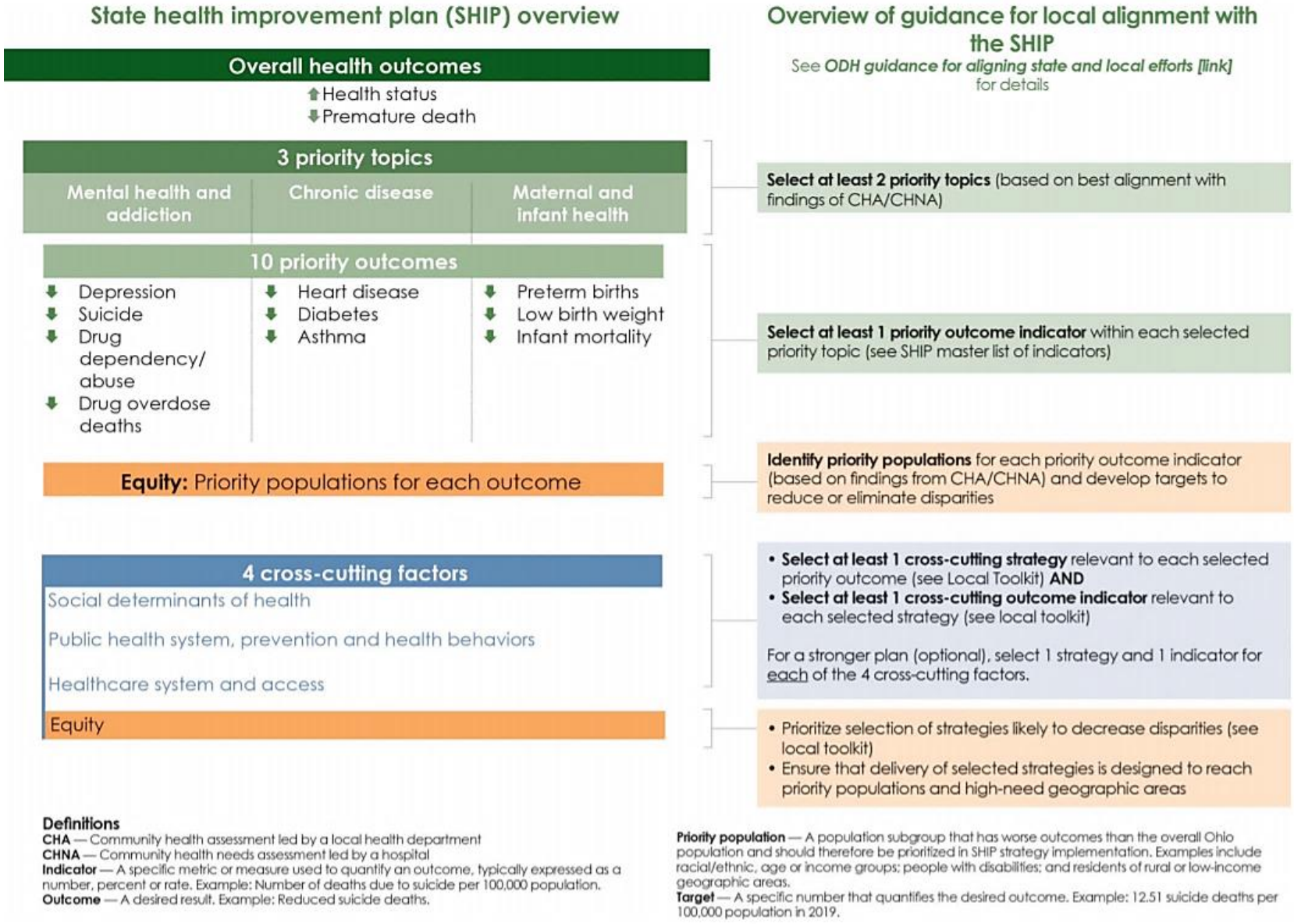
2020-2022 Mahoning CHIP Alignment with the 2017-2019 SHIP			
Priority Topic	***Priority Outcome***	***Cross-cutting Factor***	***Cross-Cutting Outcome***
Mental health and addiction	• Decrease adult depression	• Social determinants of health • Health equity	• Decrease poverty • Decrease severe housing problems • Increase kindergarten readiness • Increase third grade reading levels • Increase high school graduation rate • Increase physical activity • Increase access to exercise opportunities • Increase access to transportation • Increase health equity • Reduce racial inequality • Reduce LBGTQ quality
Chronic Disease	• Decrease diabetes • Decrease coronary heart disease		
Maternal and Infant Health	• Reduce preterm births • Reduce infant mortality • Reduce low birthweight		

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

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

Alignment with National and State Standards, continued

Figure 1.3 2017-2019 State Health Improvement Plan (SHIP) Overview



Strategies

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

1. Trauma-informed care
2. Behavioral health workforce pipeline programs
3. Provider education to primary care and behavioral health providers regarding depression/suicide and substance use screening tools and evidence-based treatments
4. Advocate to state and local policy makers
5. Mental health first aid
6. Crisis Intervention Team (CIT)
7. Implement evidence-based programming in schools
8. Expand access to evidence-based tobacco cessation treatments including individual, group and phone counseling (including Quitline) and cessation medications

To work toward reducing **chronic disease**, the following actions steps are recommended:

1. Food insecurity screening and referral
2. Grocery development and improvement in underserved areas
3. Prediabetes screening and referral
4. Hypertension screening and follow up
5. Nutrition prescriptions
6. Healthy food initiatives
7. Healthy food in convenience stores
8. Community-wide physical activity campaign

To work toward improving **maternal and infant health,** the following actions steps are recommended:

1. Progesterone treatment
2. Home visiting programs that begin prenatally
3. Provider counseling with patients about preconception health and reproductive life plans
4. Expand enrollment in care coordination, home visiting and community support programs for at-risk prenatal and parenting women

To work toward improving **social determinants of health,** the following actions steps are recommended:

1. Outreach to increase uptake for earned income tax credits
2. Vocational training for adults
3. Housing Improvement
4. Early childhood education (ECE) opportunities
5. School-based health centers
6. Green space and parks
7. Community-scale urban design land use policies and streetscape design (Complete Streets
8. Access to transportation
9. Screening for social determinants of health (SDOH) using a standardized tool

To improve **health equity**, the following action steps are recommended:

1. Cultural competency training for healthcare professionals
2. Dialogue on racism
3. Implicit bias training
4. Nondiscrimination policies in the workplace

Vision and Mission

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

The Vision of Mahoning County:

Create a healthy, thriving, and equitable community for all Mahoning County residents.

The Mission of Mahoning County:

To bring people and organizations together to improve the quality of life for all residents of Mahoning County.

Community Partners

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

Mahoning County CHA/CHIP Team

- Abby Webb, Americorp Vista, Common Wealth, Inc.
- Allysa Covert, HChoices
- Angela Divito, Director, Coalition for a Drug Free Mahoning County
- Anthea Mickens, Director of Nursing, Youngstown City Health District
- Austine Duru, Mercy Health Youngstown
- Bobbe Reynolds, Northeast Homeowners Association
- Brenda Heidinger, Associate Director, Mahoning County Mental Health & Recovery Board
- Bridget Lackey, Mercy Health Youngstown
- Chris Tennant, Executive Director and Co-Founder, Thrive Mahoning Valley
- Christine Haynish, Mahoning County Educational Service Center
- Crystal Jones, Executive Director, Grants and Contracts, Mercy Health Foundation
- Daniel Tirabassi, Full Spectrum LGBTQ+ Community Outreach
- Dawn Turnage, City of Youngstown, Parks and Recreation
- Deanna Ford, Director of Mission and Values, Mercy Health Youngstown
- Deatrice Traylor, Resource Mothers Program, Mercy Health Youngstown
- Deborah Hlad, Mercy Health Youngstown
- Dianea Moss, Meridian Care MOMS Programs.

- Dionne Dowdy, United Returning Citizens
- Dior Williams, Kent State University
- Doris Bullock, Mercy Health Youngstown Community Outreach
- Dr. Nicolette Powe, Assistant Professor, Department of Health Professions, Youngstown State University
- Duane J. Piccirilli, Executive Director, Mahoning County Mental Health & Recovery Board
- Ellen Ford, Manager of Community Health Education, Mercy Health Youngstown
- Ericka Clark, Mahoning County Public Health
- Erin Bishop, Health Commissioner, Youngstown City Health District
- Heather Wuensch, Director, Community Benefit, Advocacy & Outreach, Akron Children's Hospital
- John Luellen, MD, Market President, Mercy Health Youngstown.
- John Woods, President, Insurance Navigators Agency
- Joseph Caruso, President and CEO, Compass Family Services
- Katherine Komara, VP Behavioral Health Integration at Catholic Charities USA, Director of Operations, Behavioral Health Institute, Mercy Health Youngstown
- Kathy Harley, President, Mercy Health St. Elizabeth Hospital Youngstown
- Kim Johnson, Mahoning County Educational Services Center
- Kurt Williams, Director of Community Health, Mercy Health Youngstown
- Lauren Trohman, Community Benefit & CHNA Coordinator, Akron Children's Hospital
- Leah Merritt,, President and CEO, YWCA Mahoning Valley
- Leigh Greene, Director, Office of Minority Health, Youngstown City Health District
- Lisa Argiro,, Direction Home of Eastern Ohio (formerly known as Area Agency on Aging)
- Lisa Taafe, Clinical Administrative Director, Akron Children's Hospital Mahoning Valley
- Marie Mayberry, Epidemiologist, Mahoning County Public Health
- Melissa LaManna, Community Education Manager, Planned Parenthood of Greater Ohio
- Meri Fetkovich, YMCA of Youngstown
- Michelle Comanescu, Americorps Vista
- Michelle Clarke, United Returning Citizens
- Michelle Edison, Mahoning Valley Pathways HUB
- Mirta Arrowsmith, Mercy Health Youngstown, Community Health Education
- Nicole Mansky, Akron Children's Hospital Mahoning Valley
- Paige Eckman, Mercy Health Youngstown
- Patricia M. Sweeney, Health Commissioner, Mahoning County Public Health
- Paul S. Homick, President, Mercy Health Foundation Mahoning Valley and Interim VP, Mission Integration, Mercy Health Youngstown
- Robin Adams, Ohio State University Extension Office
- Rose Carter, Executive Director of ACTION – Alliance for Congregational Transformation Influencing our Neighborhoods
- Sarah J. Lowry, Director, Healthy Community Partnership-Mahoning Valley
- Shari Harrell, President, Community Foundation of the Mahoning Valley
- Sharon Hrina, VP of Mahoning Valley Enterprises, Akron Children's Hospital
- Sheila Triplett, Executive Director, Mahoning Youngstown Community Action Partnership
- Steve Pelton, HChoices
- Tara Cioffi,, Director of Environmental Health, Youngstown City Health District
- Tracy Behnke, American Heart Association
- Tracy Styka, Community Health Education Specialist, Mahoning County Public Health
- Vince Brancaccio, CEO, Help Network of Northeast Ohio
- William Whitacre, Superintendent, Mahoning County Board of Developmental Disabilities

The community health improvement process was facilitated by Emily Golias, Community Health Improvement Coordinator, from Hospital Council of Northwest Ohio.

Community Health Improvement Process

Beginning in June 2019, the Mahoning County CHA/CHIP Team met five times and completed the following planning steps:

1. Initial Meeting
    - Review the process and timeline
    - Finalize committee members
    - Create or review vision

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

Community Health Status Assessment

Phase 3 of the MAPP process, the Community Health Status Assessment, or CHA, is a 218-page report that includes primary data with over 100 indicators and hundreds of data points related health and well-being, including social determinants of health. Over 50 sources of secondary data are also included throughout the report. The CHA serves as the baseline data in determining key issues that lead to priority selection. The full report can be found at **www.hcno.org/community-services/community-health-assessments/**. Below is a summary of county primary data and the respective state and national benchmarks.

Mahoning County Adult Trend Summary

Adult Variables	Youngstown City 2018-2019	Mahoning County 2018-2019	Ohio 2017	U.S. 2017
Health Status				
Rated general health as good, very good, or excellent	75%	79%	81%	83%
Rated general health as excellent or very good	39%	45%	49%	51%
Rated general health as fair or poor	25%	21%	19%	18%
Rated mental health as not good on four or more days (in the past 30 days)	36%	30%	24%*	23%*
Rated physical health as not good on four or more days (in the past 30 days)	35%	30%	22%*	22%*
Average number of days that physical health was not good (in the past 30 days)	6.5	5.3	4.0**	3.7**
Average number of days that mental health was not good (in the past 30 days)	6.1	5.5	4.3**	3.8**
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past 30 days)	34%	34%	22%*	22%*
Healthcare Coverage, Access, and Utilization				
Uninsured	7%	6%	9%	11%
Had one or more persons they thought of as their personal healthcare provider	86%	87%	81%	77%
Visited a doctor for a routine checkup (in the past 12 months)	75%	72%	72%	70%
Visited a doctor for a routine checkup (5 or more years ago)	5%	7%	7%	8%
Chronic Disease				
Ever been told by a doctor they have diabetes (not pregnancy-related)	16%	16%	11%	11%
Ever diagnosed with arthritis	32%	33%	29%	25%
Had ever been told they have asthma	16%	15%	14%	14%
Ever diagnosed with Chronic Obstructive Pulmonary Disease (COPD), emphysema or chronic bronchitis	9%	10%	8%	6%
Ever been told they had skin cancer	3%	4%	6%	6%
Ever been told they had other types of cancer (other than skin cancer)	7%	8%	7%	7%
Cardiovascular Health				
Ever diagnosed with angina or coronary heart disease	4%	4%	5%	4%
Ever diagnosed with a heart attack, or myocardial infarction	5%	5%	6%	4%
Ever diagnosed with a stroke	3%	3%	4%	3%
Had been told they had high blood pressure	40%	40%	35%	32%
Had been told their blood cholesterol was high	39%	40%	33%	33%
Had their blood cholesterol checked within the last five years	82%	80%	85%	86%
Weight Status				
Overweight (BMI of 25.0 – 29.9)	33%	33%	34%	35%
Obese (includes severely and morbidly obese, BMI of 30.0 and above)	39%	40%	34%	32%
Alcohol Consumption				
Current drinker (had at least one drink of alcohol within the past 30 days)	51%	52%	54%	55%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	15%	20%	19%	17%

N/A – Not Available

Indicates alignment with the Ohio State Health Assessment

**2016 BRFSS*

***2016 BRFSS as compiled by 2018 County Health Rankings*

Adult Variables	Youngstown City 2018-2019	Mahoning County 2018-2019	Ohio 2017	U.S. 2017
Tobacco Use				
Current smoker (smoked on some or all days)	20%	16%	21%	17%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	25%	23%	24%	25%
Drug Use				
Adults who used marijuana in the past 6 months	5%	3%	N/A	N/A
Adults who misused prescription drugs in the past 6 months	8%	6%	N/A	N/A
Preventive Medicine				
Ever had a pneumonia vaccination (ages 65 and older)	N/A	71%	76%	75%
Had a flu shot within the past year (ages 65 and older)	N/A	75%	63%	60%
Had a clinical breast exam in the past two years (age 40 and older)	N/A	73%	N/A	N/A
Had a mammogram within the past two years (ages 40 and older)	N/A	76%	74%*	72%*
Had a pap test in the past three years (ages 21-65)	N/A	72%	82%*	80%*
Had a PSA test within the past two years (ages 40 and older)	N/A	56%	39%*	40%*
Had a digital rectal exam within the past year	20%	19%	N/A	N/A
Quality of Life				
Limited in some way because of physical, mental or emotional problem	28%	29%	21%**	21%**
Mental Health				
Felt sad or hopeless for two or more weeks in a row in the past year	12%	12%	N/A	N/A
Seriously considered attempting suicide in the past year	3%	3%	N/A	N/A
Attempted suicide in the past year	<1%	<1%	N/A	N/A
Sexual Behavior				
Had more than one sexual partner in past year	5%	5%	N/A	N/A
Oral Health				
Visited a dentist or a dental clinic (within the past year)	63%	63%	68%*	66%*
Visited a dentist or a dental clinic (5 or more years ago)	10%	8%	11%*	10%*
Had any permanent teeth extracted	46%	47%	45%*	43%*
Had all their natural teeth extracted (ages 65 and older)	7%	8%	17%*	14%*

N/A – Not Available

Indicates alignment with the Ohio State Health Assessment

**2016 BRFSS*

***2015 BRFSS*

Mahoning and Trumbull County African American Adult Trend Summary

Adult Variables	Mahoning and Trumbull County African American 2018-2019	Mahoning County 2018-2019*	Ohio African American 2017	U.S. African American 2017
Health Status				
Rated general health as good, very good, or excellent	72%	79%	76%	78%
Rated general health as excellent or very good	30%	45%	40%	43%
Rated general health as fair or poor	28%	21%	24%	22%
Rated mental health as not good on four or more days (in the past 30 days)	40%	30%	26%	25%
Rated physical health as not good on four or more days (in the past 30 days)	37%	30%	26%	26%
Average number of days that physical health was not good (in the past 30 days)	7.6	5.3	N/A	N/A
Average number of days that mental health was not good (in the past 30 days)	6.7	5.5	N/A	N/A
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past 30 days)	37%	34%	26%	24%
Healthcare Coverage, Access, and Utilization				
Uninsured	4%	6%	11%	11%
Had one or more persons they thought of as their personal healthcare provider	83%	87%	78%	83%
Visited a doctor for a routine checkup (in the past 12 months)	80%	72%	81%	84%
Chronic Disease				
Ever been told by a doctor they have diabetes (not pregnancy-related)	16%	16%	14%	20%
Ever diagnosed with arthritis	43%	33%	27%	33%
Had ever been told they have asthma	18%	15%	18%	16%
Ever diagnosed with Chronic Obstructive Pulmonary Disease (COPD), emphysema or chronic bronchitis	9%	10%	8%	7%
Ever been told they had skin cancer	0%	4%	<1%	<1%
Ever been told they had other types of cancer (other than skin cancer)	0%	8%	6%	7%
Cardiovascular Health				
Ever diagnosed with angina or coronary heart disease	1%	4%	4%	5%
Ever diagnosed with a heart attack, or myocardial infarction	4%	5%	7%	5%
Ever diagnosed with a stroke	5%	3%	5%	6%
Had been told they had high blood pressure	58%	40%	40%	52%
Had been told their blood cholesterol was high	32%	40%	28%	38%
Had their blood cholesterol checked within the last five years	72%	80%	88%	93%
Weight Status				
Overweight (BMI of 25.0 – 29.9)	23%	33%	32%	33%
Obese (includes severely and morbidly obese, BMI of 30.0 and above)	47%	40%	42%	42%
Alcohol Consumption				
Current drinker (had at least one drink of alcohol within the past 30 days)	39%	52%	50%	42%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	21%	20%	17%	26%

N/A – Not Available
**Mahoning County 2018-2019 does not directly compare to Mahoning and Trumbull County African American 2018-2019, Ohio African American 2017, or U.S. African American 2017. Please compare with caution.*

Adult Variables	Mahoning and Trumbull County African American 2018-2019	Mahoning County 2018-2019*	Ohio African American 2017	U.S. African American 2017
Tobacco Use				
Current smoker (smoked on some or all days)	23%	16%	25%	17%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	18%	23%	19%	19%
Drug Use				
Adults who used marijuana in the past 6 months	4%	3%	N/A	N/A
Adults who misused prescription drugs in the past 6 months	15%	6%	N/A	N/A
Preventive Medicine				
Had a pap test in the past three years (ages 21-65)	64%	72%	83%**	84%**
Had a digital rectal exam within the past year	19%	19%	N/A	N/A
Quality of Life				
Limited in some way because of physical, mental or emotional problem	32%	29%	24%***	25%***
Mental Health				
Felt sad or hopeless for two or more weeks in a row in the past year	25%	12%	N/A	N/A
Seriously considered attempting suicide in the past year	8%	3%	N/A	N/A
Attempted suicide in the past year	1%	<1%	N/A	N/A
Sexual Behavior				
Had more than one sexual partner in past year	12%	5%	N/A	N/A
Oral Health				
Visited a dentist or a dental clinic (within the past year)	51%	63%	63%**	60%**
Visited a dentist or a dental clinic (5 or more years ago)	13%	8%	12%**	13%**
Had any permanent teeth extracted	63%	47%	52%**	62%**
Had all their natural teeth extracted (ages 65 and older)	10%	8%	24%**	20%**

N/A – Not Available
**Mahoning County 2018-2019 does not directly compare to Mahoning and Trumbull County African American 2018-2019, Ohio African American 2017, or U.S. African American 2017. Please compare with caution.*
***2016 BRFSS*
****2015 BRFSS*

Key Issues

On June 27, 2019, Mahoning County CHA/CHIP Team reviewed the 2018-2019 Mahoning County Health Assessment. The detailed primary data for each identified key issue can be found in the section to which it corresponds. Each member completed an "Identifying Key Issues and Concerns" worksheet. The following tables were the group results.

What are the most significant health issues or concerns identified in the 2018-2019 assessment report? Examples of how to interpret the information include: 12% of Mahoning County adults felt sad or hopeless for two or more weeks in a row, increasing to 25% of African Americans, 18% of those with incomes less that $25k, 16% of females and 15% of those ages 30-64.

Key Issue or Concern	Percent of Population At risk	Age Group, Income Level, Race/Ethnicity, and/or Geography Most at Risk	Gender Most at Risk
Mental Health & Addiction			
Felt sad or hopeless for two or more weeks in a row in the past year	12%	African American (25%) Income <$25K (18%) Ages 30-64 (15%)	Female (16%)
Seriously considered attempting suicide in the past 12 months (suicide ideation)	3%	African American (8%) Income <$25K (5%)	N/A
Attempted suicide in the past 12 months	<1%	African American (1%)	N/A
Current smoker (smoked on some or all days)	16%	Income <$25K (32%) African American (23%) Youngstown City (20%)	Female (19%)
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	20%	African American (21%)	N/A
Mental health was not good on 4 or more days in the past month	30%	African American (40%) Youngstown City (36%)	N/A
Rate of Mahoning County overdose deaths (age-adjusted) per 100,000 population, 2012-2017 *(Source: Ohio Department of Health, 2017 Ohio Drug Overdose Data: General Findings)*	30	Age 35-44 (62) Caucasian (31)	Male (44)
Rate of Mahoning County suicide deaths (age-adjusted) per 100,000 population, 2007-2017 *(Source: ODH, Ohio Public Health Data Warehouse, Mortality, Leading Causes of Death)*	13	Age 35-64 (19) Caucasian (14)	Male (20)
Current drinker (had at least one drink of alcohol within the past 30 days)	52%	Income $25k (61%) Youngstown City (51%)	N/A
Infant Mortality			
Mahoning County infant mortality rate (per 1,000 live births)	7.8	African American (16.4)	N/A
Chronic Disease			
Ever been told by a doctor they have diabetes (not pregnancy-related)	16%	Ages 65+ (25%) Income <$25K (23%)	Female (21%)

Key Issue or Concern	Percent of Population At risk	Age Group, Income Level, Race/Ethnicity, and/or Geography Most at Risk	Gender Most at Risk
Ever diagnosed with arthritis	33%	Ages 65+ (59%) Income <$25K (51%) African American (43%)	Female (42%)
Had ever been told they have asthma	15%	Income <$25K (19%) African American (18%) Ages 30-64 (16%) Youngstown City (16%)	Female (19%)
Experienced more than one food insecurity issue	11%	Youngstown City (14%)	N/A
Did not exercise in the past week	32%	African American (38%) Youngstown City (34%)	N/A
Obesity	40%	African American (47%) Ages 30-64 (46%) Income <$25K (46%) Youngstown City (39%)	Female (46%)
Diagnosed with high blood pressure	40%	Ages 65+ (65%) African American (58%) Income <$25K (52%) Youngstown City (40%)	Female (43%)
Diagnosed with high blood cholesterol	40%	Ages 65+ (56%) Income <$25K (45%)	Male (40%)
Coronary heart disease	4%	Ages 65+ (9%)	N/A
Congestive heart failure	3%	Ages 65+ (10%)	N/A
Social determinants of health			
Transportation issues	8%	African American (21%) Youngstown (10%)	N/A
Housing	N/A	N/A	N/A
Unable to meet daily needs	12%	African American (32%) Youngstown City (15%)	N/A
Total number of persons point-in-time homelessness data for Youngstown/Mahoning County, sheltered and unsheltered counts *(Source for graphs: Mahoning County Homeless Continuum of Care, 2018)*	148	White (83)	Male (117)
Systemic Inequality			
Treated worse than other races at work	6%	African American (9%)	N/A
When seeking healthcare, adults felt their experiences were worse than other races	3%	African American (12%) Youngstown City (4%)	N/A
ACEs			
Experienced 4 or more ACEs	19%	African American (24%) Youngstown City (21%)	N/A

Key Issue or Concern	Percent of Population At risk	Age Group, Income Level, Race/Ethnicity, and/or Geography Most at Risk	Gender Most at Risk
Oral Health			
Visited a dentist or a dental clinic (within the past year)	63%	Ages 30-64 (62%) African American (51%) Income <25K (38%)	Female (62%)
Visited a dentist or a dental clinic (5 or more years ago)	8%	African American (13%) Youngstown City (10%)	Female (4%)
Had any permanent teeth extracted	47%	African American (63%)	N/A
Had all their natural teeth extracted (ages 65 and older)	8%	African American (10%)	N/A
Sexual Behavior			
Had more than one sexual partner in the past year	5%	African American (12%) Ages <30 (7%) Income $25K+ (6%)	N/A
Cultural Bias			
Reported feeling upset, angry, sad, or frustrated as a result of how they were treated based on their race	9%	African American (30%)	N/A
Access to Health Care			
Uninsured	6%	Ages <30 (28%) Income <$25k (8%) Youngstown City (7%)	Male (6%)
Had one or more persons they thought of as their personal healthcare	87%	Youngstown City (86%) African American (83%) Income <25k (78%)	Male (81%)
Visited a doctor for a routine checkup (in the past 12 months)	72%	Income $25k+ (71%) Ages <30 (63%)	Male (67%)
Lack of transportation kept them from medical appointments, meetings, work, or from getting things needed for daily living.	5%	African American (9%) Youngstown City (8%)	N/A

Priorities Chosen

On June 27, 2019, 10 key issues were identified by the Team based on the 2018-2019 Mahoning County Health Assessment. Each organization/agency /sector represented then completed a ranking exercise, giving a score for magnitude, seriousness of the consequence and feasibility of correcting, resulting in an average score for each issue identified. Afterwards, each organization was given 5 votes to place next to their 5 key issues that ranked the highest. The committee then voted and came to a consensus on the priority areas Mahoning County will focus on over the next three years. The key issues and their corresponding votes are described in the table below.

Key Issues	Votes
1. Mental Health and Addiction	13
2. Infant Mortality	12
3. Chronic Disease	10
4. Social determinants of health	10
5. Cultural Bias	6
6. Systemic Inequality	6
7. ACE's	5
8. Oral Health	3
9. Access to health care	0
10. Sexual behavior	0

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

1. Mental health and addiction

2. Chronic Disease

3. Maternal and Infant Health

4. Social Determinants of Health

5. Health Equity

Community Themes and Strengths Assessment (CTSA)

The Community Themes and Strengths Assessment (CTSA) provided a deeper understanding of the issues of concern to residents by asking the questions: "What is important to our community?" "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?" The CTSA consisted of two parts: open-ended questions to the CHA/CHIP Team and the Quality of Life Survey distributed widely throughout the community. Below are the results:

Open-ended Questions to the Team (June 8, 2019)

1. What do you believe are the 2-3 most important characteristics of a healthy community?

- Safety
- Equal access to health care/resources
- Economic stability
- Collaboration
- Inclusion for all
- Encouraging use of resources
- Trust in resources
- Built environment
- Access to healthy food
- Environment that supports health
- People who feel valued
- Employment/living wages
- Community engagement
- Education/strong school systems
- Good health coverage
- Social opportunities
- Community support/connectedness
- Youth engagement
- Affordable housing
- Responsive/influential community leaders
- More inclusive/diverse community
- Civic engagement
- Strong faith-based community
- Access to transportation
- Community events
- Ethics events

2. What makes you most proud of our community?

- Engaged organizations
- Collaboration
- Successful leaders
- People who come back and give back
- Pride
- Outdoor activities
- Parks and recreation
- Melting pot heritage
- Resiliency/grit
- Good, hardworking people
- YSU
- Mercy Health
- Downtown Youngstown is evolving
- Strong young people
- Community support
- A lot of small businesses
- Museums and visitor activities
- Arts and culture
- Local theater groups
- Food/restaurants
- Partnerships with African American community
- Minority outreach
- Willingness to adapt
- Excitement for revitalization efforts
- Rural/farming community
- School support
- Sporting community

3. What are some specific examples of people or groups working together to improve the health and quality of life in our community?

- My Baby's First Infant Mortality Prevention Coalition
- Healthy Community Partnership
- Family and Children First Council
- Nonviolence committee
- MLK committee
- Food bank network
- Youngstown Neighborhood Development Center
- Homelessness continuum of care
- Western Reserve Transit Authority
- Coalition for a Drug-free Mahoning County
- Youngstown Urban Minority Alcoholism Drug Abuse Outreach Program YUMADOAP
- Greater Youngstown Dialogue on Racism (GYDOR)
- Behavioral health partnerships/system of care
- Broadcasting (health coverage & special news)
- Vindicator
- TIC (trauma informed county)
- Aging community groups
- Mental health crisis team
- Hoarding coalition
- PTA in school districts
- Health expo
- Full spectrum collaboration with HIV testing
- Summer food program
- Libraries
- Access Health
- Pathways HUB
- Juvenile court system
- United Way
- SAFE Kids Coalition
- OSU Extension
- Ohio Means Jobs
- Senior Center
- Small business Development Center
- Center for the Arts
- TAB

4. What do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life in our community?

- Lack of grocery stores
- Lack of trust between healthcare providers and population
- Mental Health and addiction
- Chronic disease
- Maternal and infant health
- Social determinants of health
- Equity
- Transportation access
- Economic stability/employment
- Community education on health and wellness
- Aging population and services
- Opiate epidemic
- Mental illness/depression/ anxiety/suicide
- Education about healthy relationships

5. What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?

    - Money/funding
    - Unemployment/lack of jobs
    - Lack of people recognizing effects of systemic racism
    - Lack of trust
    - Lack of empowerment
    - Generational poverty
    - Area rooted in tradition/keeps area from evolving
    - Stigma about mental health and addiction
    - Power dynamics in community
    - Reactive vs. Proactive
    - Volume of need in community
    - Lack of living wage jobs
    - Hopelessness
    - Lack of law enforcement and people feeling safe

6. What actions, policy, or funding priorities would you support to build a healthier community?

    - Transportation
    - Housing
    - Complete streets
    - Food insecurity strategies
    - County-wide nondiscrimination policy
    - Health in all policies/health equity in all policies
    - Better coordination between community partners
    - More support in obtaining medications/for people rationing Rx

7. What would excite you enough to become involved (or more involved) in improving our community?

    - Funding
    - Seeing the needle move
    - Fruits of labor
    - Bringing people back to the community
    - Generate momentum
    - Support for all communities
    - Bringing arts back to community
    - More awareness of resources & programs
    - Breaking down silos
    - Increase awareness of groups in Mahoning County
    - Socialization

Quality of Life Survey (June-August 2019)

Mahoning County CHA/CHIP Team widely distributed a short Quality of Life Survey via SurveyMonkey. 137 Mahoning County community members completed the survey. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1. For all responses of "Don't Know," or when a respondent left a response blank, the choice was a non-response and was assigned a value of 0 (zero). The non-response was not used in averaging response or calculating descriptive statistics.

Quality of Life Questions	2020-2022 Likert Scale Average Response
1. Are you satisfied with the quality of life in our community? (Consider your sense of safety, well-being, participation in community life and associations, etc.) [IOM, 1997]	3.43
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.32
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.49
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.)	3.51
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.)	2.77
6. Is the community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?)	3.29
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?	3.50
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.27
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.03
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.18
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.18
12. Is there an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments? (Are citizens working towards the betterment of their community to improve life for all citizens?)	3.15

Forces of Change Assessment

The Forces of Change Assessment focused on identifying factors such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. This assessment answers the questions: "What is occurring or might occur that affects the health of our community or the local public health system?" and "What specific threats or opportunities are generated by these occurrences?" On June 8, 2019, Mahoning County CHA/CHIP Team was asked to identify positive and negative forces which could impact community health improvement and the overall health of this community over the next three years. This group discussion covered local, state, and national issues and change agents which could be factors in Mahoning County in the future. The table below summarizes the forces of change occurring in Mahoning County and their potential impact:

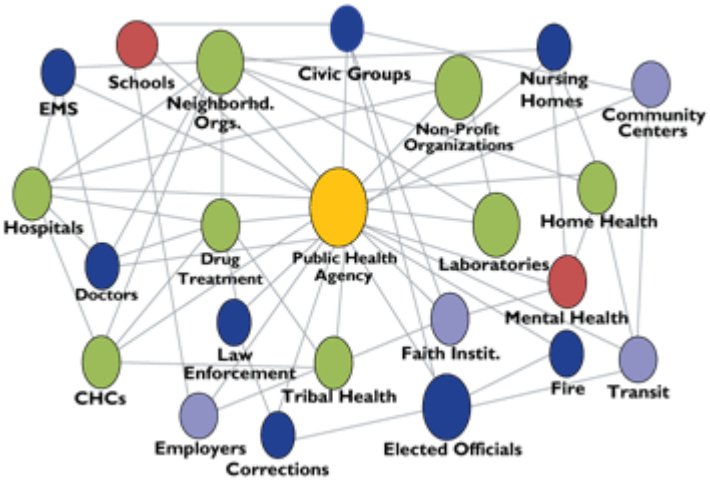
Force of Change	Threats Posed	Opportunities Created
1. Opiate/drug use	• Decrease in employment • Affecting workplace • Infant mortality	• Policy change with overdose fatality review board • Obtaining more information
2. Medical marijuana	• Decrease in employment • Affecting workplace • Increase in traffic deaths • Infant mortality • Increase in vaping	• None identified • Economic opportunity for growers and dispensaries.
3. Youngstown State University	• Alcohol outlets resurface • Residential drug uses higher than on campus	• New housing • New businesses • Transportation
4. Dialogue on racism	• LGBTQ+ community marginalized	• Solution focused • Inclusivity
5. Youngstown Business Incubator	• None identified	• Promotes innovation • Provides offices to young entrepreneurs
6. Air quality	• Commission closed • Potential to impact respiratory health	• None identified
7. Infrastructure	• Old infrastructure deteriorating • Sinkholes • No political will/resources to address	• Rehabilitation of historic buildings
8. Young people	• Leaving the area • Aging population	• Young people are speaking out more • Coalition building • Young people want to improve Mahoning County
9. Fracking	• Injection wells—small seismic activity • Increase in radium • Possible threat to water quality	• Potential economic opportunity for residents who lease land for fracking
10. Lead	• Problem with old pipes • Repairs needed • Threat to water quality • Demolition results in lead spreading into soil	• New focus of the Ohio Department of Health • Additional funding for remediation

Force of Change	Threats Posed	Opportunities Created
11. Human trafficking	• Safety • Threats facing LGBTQ youth • Increased drug and alcohol trafficking • Increased STIs and HIV • Those affected not empowered to seek help	• Education to assist in identification of victims
12. Lordstown plant closing	• Loss of jobs • Unemployment • People relocated • Families being split up/anxiety/insecurity/anger	• New partnerships to support families
13. Hospital closing	• Lack of insurance for those who lost jobs • Lack of women/reproductive health care • Lack of health care • Increased demand for safety net providers	• Reproductive Health Care options outside of a hospital facility.
14. Daily Locally owned Newspaper closing	• Loss of reporters • Lack of awareness for services • Loss of local news	• Expansion of other media venues
15. Political Climate	• Historically democratic voter base • More polarized tenor/division of people • Funding changes (state/federal) • Affects healthcare for minorities • Poverty threshold may be lowered • Gerrymandering is an issue—made this area more Republican • Less trust in government • Partisan census administration • Threats to women's reproductive freedoms • Lack of trust	• Commitment of young leaders in the community
16. Climate change	• Sewer problems • Flooding • Housing problems • Mold in housing	• Opportunities for new partnerships to address new challenges
17. People leaving the County	• Less federal funding • Reimbursement struggle for health care • Harder to attract businesses • Trickle down effects to other businesses • Not enough population to build • Lack of workforce • Aging population	• Opportunities for new partnerships to address new challenges

Local Public Health System Assessment

The Local Public Health System

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



The public health system includes:

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

The 10 Essential Public Health Services

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

Public health systems should:

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

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

The Local Public Health System Assessment (LPHSA)

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

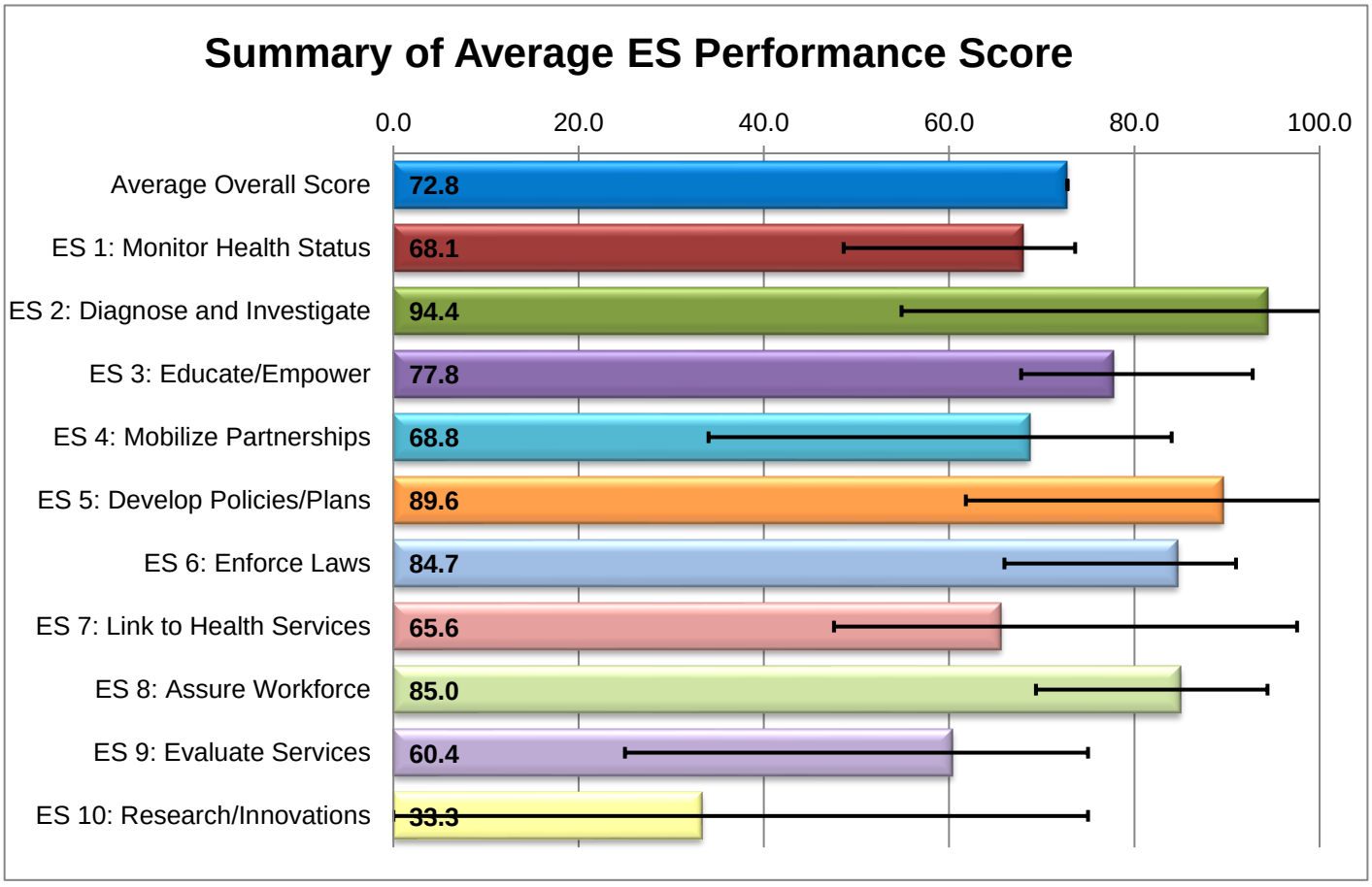
This assessment involves the use of a nationally recognized tool called the **National Public Health Performance Standards Local Instrument.**

Members of Mahoning County CHA/CHIP Team 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 challenges and opportunities that were discussed were used in the action planning process.

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

To view the full results of the LPHSA, please contact Patt Sweeney from Mahoning County Public Health at (330) 270-2855

Mahoning County Local Public Health System Assessment 2019 Summary



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

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

Gaps Analysis

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

Strategy Selection

Based on the chosen priorities, the Mahoning County CHA/CHIP Team identified strategies for each priority area. They considered all previous assessments, including but not limited to the CHA, CTSA, quality of life survey and gap analysis, and then determined which strategies best suited the needs of Mahoning County. Members referenced a list of evidence-based strategies recommended by the Ohio SHIP, as well as brainstormed for other impactful strategies.

Evidence-Based Practices

As part of the gap analysis and strategy selection, the Mahoning County CHA/CHIP Team considered a wide range of evidence-based practices, including best practices. An evidence-based practice has compelling evidence of effectiveness. Participant success can be attributed to the program itself and there is evidence that the approach will work for others in a different environment. A best practice is a program that has been implemented and an evaluation has been conducted. While the data supporting the program is promising, its scientific rigor is insufficient.

Resource Inventory

Also based upon the chosen priorities, the Mahoning County CHA/CHIP Team identified resources for each strategy. The resource inventory allowed the Team to identify existing community resources, such as programs, policies, services, and more. The committee then determined whether a policy, program or service was evidence-based, a best practice, or had no evidence indicated. Each resource inventory can be found with its corresponding strategy.

Priority #1: Mental Health and Addiction

Strategic Plan of Action

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

Priority #1: Mental Health and Addiction				
Strategy 1: Trauma-informed care				
Goal: Improve mental health outcomes.				
Objective: Conduct one trauma-informed care training (per semester) by December 31, 2022.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Responsible Person/ Agency
Year 1: Facilitate an assessment among healthcare providers, teachers, coaches, social service providers, and other community members on their awareness and understanding of trauma, including toxic stress and adverse childhood experiences. Administer at least two **trauma-informed care** trainings (one per semester) to increase education and understanding of trauma and the lifelong impact of untreated adverse childhood experiences. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations. Develop a baseline listing of Trauma Aware, Trauma Informed and Trauma Certified Organizations. Develop a list of Trauma Certified Clinicians currently practicing and determine trainings needed to get more clinicians certified.	December 31, 2020	Adult	1. Increase number of Mahoning County entities that are Trauma Aware, Trauma Informed and Trauma Certified (Baseline: 0, Mahoning County Mental Health & Recovery Board, 2019) 2. Increase number of persons that attend trauma informed care trainings (Baseline: TBD, Mahoning County Mental Health & Recovery Board, 2019) 3. Increase number of Trauma Certified Clinicians practicing in Mahoning County (Baseline: TBD, Mahoning County Mental Health & Recovery Board, 2019)	Mahoning County Mental Health and Recovery Board
Year 2: Continue efforts from year 1. Administer at least two trauma-informed care trainings (one per semester) to increase education and understanding of trauma and the lifelong impact of untreated adverse childhood experiences. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations. Continue to develop Trauma Aware, Trauma Informed and Trauma Certified Organizations. Increase by 5% the number of Trauma Certified Clinicians practicing in Mahoning County.	December 31, 2021			

Year 3: Continue efforts from years 1 and 2. Administer at least two trauma-informed care trainings (one per semester) to increase education and understanding of trauma and the lifelong impact of untreated adverse childhood experiences. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations. Continue to develop Trauma Aware, Trauma Informed and Trauma Certified Organizations. Increase by 5% the number of Trauma Certified Clinicians practicing in Mahoning County.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

- ○ Yes
- ⊗ No
- ○ Not SHIP Identified

Resources to address strategy: Mahoning County Mental Health and Recovery Board; the Mahoning County Trauma Informed Care Team; Mahoning County Juvenile Court; Common Please and Municipal Courts, treatment agencies; schools, and Mahoning County Public Health.

Priority #1: Mental Health and Addiction

Strategy 2: Behavioral health workforce pipeline programs

Goal: Increase availability of mental health providers.

Objective: Develop a written plan to implement a behavioral health pipeline program by December 31, 2022.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Explore **behavioral health workforce pipeline programs**, sometimes referred to as a "Grow-Your-Own" model of care, and determine the feasibility of implementing a pipeline program in Mahoning County.	December 31, 2020	Adult and youth	Provider availability - mental health providers: Ratio of population to mental health providers (baseline: 590:1, County Health Rankings, 2019)	Mahoning County Mental Health and Recovery Board
Year 2: Secure funding that would support the implementation of a behavioral health workforce pipeline program, such as **grant opportunities** from HRSAs **Federal Office of Rural Health Policy**.	December 31, 2021			
Year 3: Develop a written plan to implement a behavioral health workforce pipeline program in Mahoning County. Target the pipeline program towards those who live in economically disadvantaged and/or minority populations.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy: Youngstown State University counseling programs, Mahoning County Board of Mental Health and Addiction Services, Coalition for a Drug Free Mahoning County, Easter Ohio, and AHEC.

Priority #1: Mental Health and Addiction

Strategy 3: Provider education to primary care and behavioral health providers regarding depression/suicide and substance use screening tools and evidence-based treatments

Goal: Improve behavioral health outcomes.

Objective: By December 31, 2022, increase the number of individuals who have successfully completed an appointment based on a behavioral health referral by ≥5%.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Work with Mercy Health primary care and behavioral health providers and county's infant and maternal health home visiting programs to collect baseline information on the number of individuals who received a standardized screening tool, such as PHQ-2, PHQ-9, C-SSRS and/or SBIRT, that are utilized for depression, suicide and/or substance use.	December 31, 2020	Adult and youth	Adult depression: Percent of adults had a period of two or more weeks when they felt so sad or hopeless nearly every day that they stopped doing usual activities (baseline: 12%, 2018-2019 CHA)	MY Baby's 1st Infant Mortality Prevention Coalition Mercy Health Youngstown
Year 2: Increase baseline numbers of individuals receiving a standardized screening tool from Year 1 by ≥ 5%. Collect baseline number of individuals who were referred to behavioral health based on identified need from the standardized tool.	December 31, 2021			
Year 3: Increase the number of referrals based on identified need from the standardized assessment in Year 2 by ≥5%. Increase the number of individuals who have successfully completed an appointment based on a behavioral health referral in Year 2 by ≥5%.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Mercy Health Youngstown Primary Care Practices and Behavioral Health Institute, Mahoning County Behavioral Health Providers, Help Network of Northeast Ohio, Akron Children's Hospital, Belmont Pines Hospital, and the County's Home Visiting Programs: Help Me Grow, Nurse Family Partnership, Pathways HUB,

Priority #1: Mental Health and Addiction

Strategy 4: Advocate to state and local policy makers

Goal: Improve behavioral health outcomes.

Objective: By December 31, 2022, create and implement a written advocacy plan.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Collaborate with local stakeholders and other partners to identify the biggest policy needs surrounding mental health and addiction, such as increasing funding for long-term recovery, increasing capacity for residential and recovery housing, and making specific personal health information available for fatality review boards. Create a written advocacy plan detailing specific activities and follow-up actions for each policy need.	December 31, 2020	Adult and youth	1. Advocacy plan written and approved by the Mahoning County Mental Health and Recovery Board (Baseline: TBD, Mahoning County Mental Health and Recovery Board, 2019) 2. Number of contacts with lawmakers (Baseline: TBD, Mahoning County Mental Health and Recovery Board, 2019) 3. Number of legislation and policy changes accomplished (Baseline: TBD, Mahoning County Mental Health and Recovery Board, 2019)	Mahoning County Mental Health and Recovery Board
Year 2: Continue efforts from year 1. Implement the advocacy plan.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Implement the advocacy plan.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Partnerships with state and local policymakers; Mahoning County Mental Health and Recovery Board, Youngstown City Health District, Mahoning County Public Health.

Priority #1: Mental Health and Addiction

Strategy 5: Mental health first aid

Goal: Improve behavioral health outcomes.

Objective: Conduct one mental health first aid training (per semester) by December 31, 2022.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Responsible Person/ Agency
Year 1: Administer at least two **mental health first aid** trainings (one per semester) to increase education and understanding of mental illnesses and substance use disorders. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations.	December 31, 2020	Adult and youth	Posttest change in attitudes (Baseline: TBD by Mahoning County Mental Health and Recovery Board, 2019)	Mahoning County Mental Health and Recovery Board
Year 2: Continue efforts from year 1. Administer at least two mental health first aid trainings (one per semester) to increase education and understanding of mental illnesses and substance use disorders. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Administer at least two mental health first aid trainings (one per semester) to increase education and understanding of mental illnesses and substance use disorders. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

- ○ Yes
- ○ No
- ⊗ Not SHIP Identified

Resources to address strategy: Mahoning County Mental Health and Recovery Board and child trainings by Alta.

Priority #1: Mental Health and Addiction

Strategy 6: Crisis Intervention Team (CIT)

Goal: Improve behavioral health outcomes.

Objective: By December 31, 2022, increase the number of officers trained in CIT by 10%.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Work with Mahoning County law enforcement to collect baseline data on the number of law enforcement officers that have received CIT training. Discuss the importance of CIT training and encourage Mahoning County law enforcement to have all newly hired law enforcement officers receive CIT training.	December 31, 2020	Adult and youth	1. Pretest and Posttest change (Baseline: TBD by Mahoning County Mental Health and Recovery Board, 2019) 2. Number of Mahoning County Officers who have received CIT training (Baseline: TBD by Mahoning County Mental Health and Recovery Board, 2019) 3.Numbers of CIT activation (Baseline: TBD by Mahoning County Mental Health and Recovery Board, 2019)	Mahoning County Mental Health and Recovery Board
Year 2: Continue efforts from year 1. Arrange and implement a biannual CIT training for all newly hired law enforcement officers as well as officers that have not previously attended the training.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Arrange and implement a biannual CIT training for all newly hired law enforcement officers as well as officers that have not previously attended the training.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Mahoning County Mental Health and Recovery Board and Mahoning County law enforcement agencies.

Priority #1: Mental Health and Addiction

Strategy 7: Implement evidence-based programming in schools

Goal: Improve social competence, behavior, and resiliency in youth.

Objective: Implement an evidence-based prevention program in at least three Mahoning County school districts by December 31, 2022.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Introduce **The PAX Good Behavior Game**, **Second Step**, **LifeSkills Training**, **Generation Rx**, or another evidence-based program to Mahoning County school districts that primarily serves economically disadvantaged and/or large minority populations. Obtain a memorandum of understanding (MOU) with at least one school district to support the implementation of the program. Work with the school district(s) to develop policies for implementation. Pilot the social-emotional learning program with the school(s).	December 31, 2020	Youth	1. Number of Mahoning County Schools who introduce an evidence-based program (Baseline: TBD by Mahoning County Mental Health and Recovery Board, 2019) 2. Number of students who participate in the program (Baseline: TBD by Mahoning County Mental Health and Recovery Board, 2019) 3. Pre and Post test data to measure impact of program (Baseline: TBD by Mahoning County Mental Health and Recovery Board, 2019) 4. Reduce the number of 11th grade students who reported using a substance in the past 30 days (Baseline: See 2018 PEP survey data #1) 5. Reduce the number of 11th grade students who report planning to use a substance in the next 30 days (Baseline: See 2018 PEP survey data #2) 6. Increase the number of 11th grade students who report a perception of harm with use of substances (Baseline: See 2018 PEP survey data #3)	Mahoning County Mental Health and Recovery Board
Year 2: Evaluate outcomes from year one. Obtain a MOU with at least one additional school district that primarily serves economically disadvantaged and/or large minority populations. Work with the school district(s) to develop policies for implementation. Implement the social-emotional learning program with the school(s).	December 31, 2021			
Year 3: Continue efforts from year 2. Obtain a MOU with at least one additional school district that primarily serves economically disadvantaged and/or large minority populations. Work with the school district(s) to develop policies for implementation. Implement the social-emotional learning program with the school(s).	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Mahoning County Schools; Prevention Providers; Mahoning County Mental Health and Recovery Board; Coalition for a Drug Free Mahoning County.

Priority #1: Mental Health and Addiction

Strategy 8: Expand access to evidence-based tobacco cessation treatments including individual, group and phone counseling (including Quitline) and cessation medications

Goal: Reduce cigarette smoking.

Objective: Develop a county-wide resource guide for evidence-based tobacco cessation treatments by December 31, 2022.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Establish a Task Force to create a county wide strategy and seek funding for the collection of baseline data on the number of evidence-based tobacco cessation treatments available in Mahoning County, including individual, group and phone counseling (including Quitline) and cessation medications. Include information regarding cost, population (such as expectant mothers), insurance, transportation options and geography.	December 31, 2020	Adults	1. Current smoker: Percentage of adults who are current smokers (Baseline: 16% 2018-2019 CHA) 2. Quit attempts: Percent of adult smokers who have made a quit attempt in the past year (Baseline: 36% 2018-2019 CHA)	Youngstown City Health District
Year 2: Collect baseline data on the number of evidence-based tobacco cessation treatments available in Mahoning County, including individual, group and phone counseling (including Quitline) and cessation medications. Include information regarding cost, population (such as expectant mothers), insurance, transportation options and geography.	December 31, 2021			
Year 3: Create a county-wide resource guide for evidence-based tobacco cessation treatments, highlighting cost, population, insurance, transportation options and geography. Disseminate the resource to healthcare, behavioral health care, and social service program providers. Encourage providers to share resources with patients/clients who are current smokers, encourage them to quit, and refer them to treatment.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy: MHY Regional Tobacco Treatment Center, Local chapter of American Health Association, Local Chapter of the American Lung Association, Mahoning County Public Health Tobacco Cessation Program, Youngstown City Health District.

Priority #2: Chronic Disease

Strategic Plan of Action

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

Priority #2: Chronic Disease				
Strategy 1: Food insecurity screening and referral				
Goal: Reduce food insecurity.				
Objective: Implement a food insecurity screening tool in at least three additional locations by December 31, 2022.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Continue to implement the **2-item Food Insecurity (FI) Screening Tool**, or another screening tool, and determine the feasibility of implementing the food insecurity screening and referral program in another location. Inform participating locations on existing community resources and referral options such as 2-1-1, WIC, SNAP, school nutrition programs, food pantries, transportation and other resources. Implement a screening tool in at least one additional location with accompanying referral options and evaluation measures. Target screenings towards those who live in or serve economically disadvantaged populations.	December 31, 2020	Adult, youth	Food insecurity: Percent of households that are food insecure (Baseline: 16%, Map the Meal Gap, 2017)	Healthy Community Partnership American Heart Association Mahoning County Public Health YMCA/JCC Full Spectrum Youngstown City Health District Food Insecurity Taskforce Mercy Health Youngstown Help Network of NEO United Returning Citizens
Year 2: Continue efforts from year 1. Implement the screening tool in at least one additional location with accompanying referral options and evaluation measures.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Implement the screening tool in at least one additional location with accompanying referral options and evaluation measures.	December 31, 2022			
Type of Strategy: ○ Social determinants of health ○ Public health system, prevention and health behaviors ⊗ Healthcare system and access ○ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Mercy Health Youngstown, Healthy Community Partnership; Mahoning County Public Health; American Heart Association; United Returning Citizens, Help Network of NEO ;Youngstown City Health District, ACTION; YNDC; and Alpha & Omega First Baptist; Antonine Sisters; Austintown Community Church; Beatitude House; Beulah Baptist Church; Boys & Girls Club of Youngstown; Bunker Hill United Methodist Pantry ; Christ Community Church; Christian Life Center; Christ Our Savior; Concordia Lutheran Church; Difference Makers (St. Lucy); Doris Burdman Home; E.B. Family Life; Evergreen SDA Pantry; Faith Community Church; First				

Federated Church; Free Methodist Community Church; Good Hope Lutheran Church; High Pointe Assembly of God; Holy Rosary Parish; Horizon House; Lakeview Assembly of God; Mt. Calvary Pentecostal Church; Mt. Zion Baptist Church; Needles Eye Christian Counsel; New Beginning Assembly of God; New Bethel Baptist Church; New Hope Church of God; New Life Assembly of God; North Jackson Church of the Nazarene; O.C.C.H.A., Inc.; Oak Baptist Church; People's Chapel Church of God; Poland Interfaith Pantry; Positive Impact; Price Memorial; Protestant Family Service; Red Door Pantry St Johns; Representatives of Christ; Richard Brown Memorial; Salvation Army Youngstown; South Range Council; Spanish Seventh Day Adventist; St. Angela Merici Pantry and Kitchen; St. Edwards Conference; St. John the Baptist Catholic Church; Temple Emmanuel SDA Church; The Concern Inc.; United Methodist Community Center; Ursuline Sisters HIV/Aids Ministry; Victory Christian Center; Yost Community Center; Zion Lutheran Church; Full Spectrum Community Outreach.

Priority #2: Chronic Disease

Strategy 2: Grocery development and improvement in underserved areas

Goal: Reduce food insecurity.

Objective: By December 31, 2022, collaborate with at least one local grocery store to improve access to fresh food.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Assess county data related to food deserts and food insecurity. Research and review requirements of the **Healthy Food for Ohio Program**, which aims to encourage the development and/or improvement of grocery stores and other retail outlets selling fresh food in underserved areas.	December 31, 2020	Adult	Food insecurity: Percent of households that are food insecure (Baseline: 16%, Map the Meal Gap, 2017)	Healthy Community Partnership
Year 2: Continue efforts of year 1. Determine feasibility of providing technical assistance to local grocery stores or future grocery stores to develop/improve fresh food access in underserved areas.	December 31, 2021			
Year 3: Continue efforts of year 2. Provide technical assistance to at least one local grocery store to improve access to fresh food.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: American Heart Association; Mahoning County Public Health; Healthy Community Partnership; YMCA; JCC; Full Spectrum; Youngstown City Health District.

Priority #2: Chronic Disease

Strategy 3: Prediabetes screening and referral

Goal: Prevent diabetes in adults.

Objective: By December 31, 2022, increase the number of prediabetes screenings by 15%.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Raise awareness of prediabetes screening, identification and referral through dissemination of the **Prediabetes Risk Assessment** (or a similar assessment) and/or the **Prevent Diabetes STAT Toolkit**. Promote free/reduced cost screening events within the county, such as health fairs, hospital screening events, etc. Target screenings towards those who live in or serve economically disadvantaged and/or minority populations. Increase the number of screenings by 5%.	December 31, 2020	Adult	Diabetes: Percent of adults who have been told by a health professional that they have diabetes (Baseline: 16%, 2018-2019 CHA)	Mercy Health Youngstown
Year 2: Continue efforts from year 1. Increase awareness of prediabetes screening, identification and referral. Increase the number of screenings by 5%.	December 31, 2021			
Year 3: Continue efforts of years 1 and 2. Increase the number of screenings by 5%.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Resources to address strategy: <Insert resources here>Mercy Health Youngstown Primary Care Practices, Community Health Education, Hispanic Health, Neighborhood Health Watch and Diabetes Education Programs, Mahoning County Public Health, Healthy Community Partnership, YMCA, , Youngstown City Health District.

Priority #2: Chronic Disease

Strategy 4: Hypertension screening and follow up

Goal: Prevent coronary heart disease in adults.

Objective: By December 31, 2022, increase the number of hypertension screenings by 15%.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Increase provider education on hypertension screening, treatment, and the importance of routine follow up with patients diagnosed with hypertension. Promote free/reduced cost screening events within the county, such as health fairs, hospital screening events, etc. Target screenings towards those who live in or serve economically disadvantaged and/or minority populations. Increase the number of screenings by 5%.	December 31, 2020	Adult	1. Coronary heart disease: Percent of adults ever diagnosed with coronary heart disease (Baseline: 4%, 2018-2019 CHA) 2. Hypertension management: Percent of adults with hypertension who report currently taking medicine for their high blood pressure (Baseline: N/A)	Mercy Health Youngstown American Heart Association
Year 2: Continue efforts from year 1. Increase awareness of hypertension screening, treatment, and follow up. Increase the number of screenings by 5%.	December 31, 2021			
Year 3: Continue efforts of years 1 and 2. Increase the number of screenings by 5%.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: American Heart Association, Mahoning County Public Health, Healthy Community Partnership, YMCA, , Youngstown City Health District, Mercy Health Youngstown Primary Care Practices, Community Health Education, Neighborhood Health Watch, Hispanic Health Program and Know Your Numbers Program.

Priority #2: Chronic Disease

Strategy 5 Nutrition prescriptions

Goal: Increase fruit and vegetable consumption.

Objective: Implement nutrition prescription programs into three additional primary care offices by December 31, 2022.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to implement **nutrition prescription programs**. at Mercy Health Youngstown. Seek additional nutrition prescription program providers such as FQHC's.	December 31, 2020	Adult	1. Fruit consumption: Percent of adults who report consuming 0 servings of fruit per day (Baseline: 13%, 2018-2019 CHA) 2. Vegetable consumption: Percent of adults who report consuming 0 servings of vegetables per day (Baseline: 6%, 2018-2019 CHA)	Healthy Community Partnership Mahoning County Public Health Mercy Health Youngstown
Year 2: Continue efforts from year 1. Implement a nutrition prescription program into one additional primary care office with accompanying referral options and evaluation measures. Target the program towards those who serve economically disadvantaged and/or minority populations.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Implement a nutrition prescription program into two additional primary care offices with accompanying referral options and evaluation measures. Target the program towards those who serve economically disadvantaged and/or minority populations.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: MHY fruit and vegetable prescription program, healthy community partners, farmers markets in the area, FINI grant collaboration between YNDC and MHY, MHY primary care physicians, and food banks.

Priority #2: Chronic Disease

Strategy 6: Healthy food initiatives

Goal: Increase fruit and vegetable consumption.

Objective: By December 31, 2022, Mahoning County will implement at least three healthy food initiatives in local food banks or farmers markets.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Raise awareness of the available food banks and **farmers markets** within the county (locations, offerings, transportation routes, etc.). Continue to distribute information on where to obtain fresh fruit and vegetables. Update information on a quarterly basis. Encourage local **food banks** to offer more fresh, healthy food (versus shelf stable foods). Obtain baseline information of who currently accepts SNAP/EBT at local farmers markets. Determine the feasibility of **SNAP/EBT at farmers markets** and meet with market managers to determine readiness. Educate vendors regarding food deserts and the benefits of accepting SNAP/EBT at farmers markets.	December 31, 2020	Adult	1. Fruit consumption: Percent of adults who report consuming 0 servings of fruit per day (Baseline: 13%, 2018-2019 CHA) 2. Vegetable consumption: Percent of adults who report consuming 0 servings of vegetables per day (Baseline: 6%, 2018-2019 CHA)	Healthy Community Partnership
Year 2: Continue efforts of year 1. Implement at least one of the following in local food banks or farmers markets: • Cooking demonstrations and recipe tastings • **WIC and senior farmers market programs** • Nutrition, diabetes, Fresh Start and other health education classes • Healthcare support services	December 31, 2021			
Year 3: Continue efforts of year 2. Implement at least two items above within local food banks or farmers markets.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy: Healthy Community Partnership; American Heart Association; Mahoning County Public Health; YMCA; JCC; Full Spectrum; Youngstown City Health District; Mercy Health Youngstown.

Priority #2: Chronic Disease

Strategy 7: Healthy food in convenience stores

Goal: Increase fruit and vegetable consumption.

Objective: By December 31, 2022, recruit at least three convenience stores to participate in the Healthy Food Retail Initiative.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research "**healthy food in convenience stores**" initiatives, such as the **Healthy Food Retail Initiative**. Collaborate with local organizations to implement the initiative in local convenience stores by working with stores to offer an assortment of affordable fresh fruits and vegetables as a means to eliminate food desert areas. Appoint a coordinator to lead the Healthy Food Retail Initiative. Survey customers and community members to assess community need for healthy food items.	December 31, 2020	Adult	1. Fruit consumption: Percent of adults who report consuming 0 servings of fruit per day (Baseline: 13%, 2018-2019 CHA) 2. Vegetable consumption: Percent of adults who report consuming 0 servings of vegetables per day (Baseline: 6%, 2018-2019 CHA) 3. Food insecurity: Percent of households that are food insecure (Baseline: 16%, Map the Meal Gap, 2017)	Healthy Community Partnership
Year 2: Initiate contact with local convenience stores. Recruit at least one convenience stores to participate in the Healthy Food Retail Initiative. Target convenience stores that are in food desert areas. Design nutrition education materials, such as healthy recipe cards or healthy shopping lists, to accompany fresh produce being offered in convenience stores. Promote the program within the community.	December 31, 2021			
Year 3: Continue efforts of Years 1 and 2. Recruit an additional two convenience stores to participate in the initiative. Promote the programs within the community.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy: American Health Association; Mahoning County Public Health; YMCA; JCC; Full Spectrum; Youngstown City Health District.

Priority #2: Chronic Disease

Strategy 8: Community-wide physical activity campaign

Goal: Increase physical activity.

Objective: Implement a community-wide physical activity campaign in collaboration with at least five Mahoning County agencies by December 31, 2022

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Create a community-wide physical activity campaign. Recruit at least five agencies who are working to improve and promote Mahoning County's physical activity opportunities. Determine the goals and objectives of the physical activity campaign. Engage community agencies to coordinate a unified message to increase awareness of Mahoning County physical activity opportunities, such as **community fitness programs** and **activity programs for older adults**, and create a culture of health. Brand the campaign and explore the feasibility of creating a county physical activity resource that houses all physical activity opportunities.	December 31, 2020	Adult	Physical inactivity: Percentage adults reporting no leisure time physical activity (Baseline: 32%, 2018-2019 CHA)	Mahoning County Public Health Healthy Community Partnership YMCA/JCC Full Spectrum Youngstown City Health District YSU Mercy Health Youngstown
Year 2: Continue efforts of year 1. Using the coordinated message, all participating agencies will increase awareness of physical activity opportunities and promote the use of them at least once a week. Provide non-participating community agencies with materials to support the campaign, such as social media messages, website information, infographics, maps of activities, booklets, flyers, etc.	December 31, 2021			
Year 3: Continue efforts of years 1 and 2.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: AARP Livable Communities; Walk [Your City]; National Walk/Bike to School Day; American Heart Association; Mahoning County Public Health; YSU; Healthy Community Partnership; YMCA; JCC; Full Spectrum; Youngstown City Health District; Mercy Health Youngstown.

Priority #3: Maternal and Infant Health

Strategic Plan of Action

To work toward improving Maternal and Infant Health outcomes, the following strategies are recommended:

Priority #3: Maternal and Infant Health

Strategy 1: Progesterone treatment

Goal: Improve birth outcomes.

Objective: By December 31, 2022, develop and implement a plan to increase by 10% the use of progesterone for eligible pregnant women.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Gather data from health systems to identify how progesterone candidates are currently identified, as well as current barriers to progesterone distribution.	December 31, 2020	Adult	1. Total preterm births: Percent of live births that are preterm: <37 weeks gestation (Baseline: 14%, Ohio Department of Health, 2018) 2. Infant mortality: Rate of infant deaths per 1,000 live births (Baseline: 7.8, Ohio Department of Health, 2013-2017)	Mercy Health Youngstown
Year 2: Based on data collected in year 1, develop and implement a plan to increase by 5% the use of progesterone for eligible pregnant women. Determine strategies to increase education for pregnant women regarding recognizing signs, symptoms, and risk factors of giving birth prematurely. Target strategies towards economically disadvantaged and/or minority populations.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Increase by 5% from Year 2.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy: Mercy Health Youngstown; Akron Children's Hospital, OB/Gyn and Maternal Fetal Medicine physicians, Ohio Perinatal Quality Collaborative.

Priority #3: Maternal and Infant Health

Strategy 2: Home visiting programs that begin prenatally

Goal: Improve birth outcomes.

Objective: By December 31, 2022, increase referrals to home visiting programs by 20%.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Identify all home visitation and community support programs within the county that serve prenatal populations. Identify gaps in program reach within the county. Work with home visitation supervisors to determine the best way to coordinate which program is the best fit for different individuals and populations. Ensure cultural competence and implicit bias training opportunities are available for home visitation providers.	December 31, 2020	Adult	1. Total preterm births: Percent of live births that are preterm: <37 weeks gestation (Baseline: 14%, Ohio Department of Health, 2018) 2. Low birth weight births: Percent of births in which the newborn weighed <2,500 grams (Baseline: 12%, Ohio Department of Health, 2018) 3. Infant mortality: Rate of infant deaths per 1,000 live births (Baseline: 7.8, Ohio Department of Health, 2013-2017)	My Baby's 1st Infant Mortality Prevention Coalition
Year 2: Continue efforts from year 1. Develop a joint communication plan to market all available support programs for pregnant women in Mahoning County Target economically disadvantaged and/or minority populations. Increase referrals by 10%.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Increase referrals by 10%.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy: Ohio Department of Medicaid Managed Care Organizations; Mercy Health Resource Mothers; Mahoning Valley Pathways HUB; Help Me Grow; Nurse Family Partnership; Ohio Department of Health; Ohio Equity Institute 2.0; Health Moms Healthy Babies; Meridian MOMS (Maternal Opiate Medical Support program); CenteringPregnancy® community support groups and Fatherhood programs.

Priority #3: Maternal and Infant Health				
Strategy 3: Provider counseling with patients about preconception health and reproductive life plans				
Goal: Improve birth outcomes.				
Objective: By December 31, 2022, increase the number of women enrolled in community home visiting and prenatal and/or parenting support groups that have a reproductive health plan by 20% from baseline.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Develop a community based Advisory Group to identify barriers to implementation of reproductive health plans. Determine the number of women currently enrolled in community home visiting and prenatal and/or parenting support groups that have a reproductive health plan. (establish a baseline). Work with community health workers (CHWs) and home visitors to connect women of childbearing age to health insurance and a medical home and remove barriers to care. Determine the baseline number of partners of pregnant women that are being served by appropriate support systems and/or Fatherhood programs. Work with community health workers (CHWs) and home visitors to connect partners of pregnant women to needed support systems and/or Fatherhood programs in the community. Educate CHWs regarding how to discuss reproductive life plans and long-acting reversible contraception with their clients to encourage the client to discuss these issues with their health care provider during preventive care and postpartum visits	December 31, 2020	Adult	1. Total preterm births: Percent of live births that are preterm: <37 weeks gestation (Baseline: 14%, Ohio Department of Health, 2018) 2. Low birth weight births: Percent of births in which the newborn weighed <2,500 grams (Baseline: 12%, Ohio Department of Health, 2018) 3. Infant mortality: Rate of infant deaths per 1,000 live births (Baseline: 7.8, Ohio Department of Health, 2013-2017)	My Baby's 1st Infant Mortality Prevention Coalition
Year 2: Increase efforts from year 1. Increase the number of women enrolled in community home visiting and prenatal and/or parenting support groups that have a reproductive health plan by 10% from baseline. Increase the number of partners of pregnant women that are being served by appropriate support systems and/or Fatherhood programs by 5% from baseline.	December 31, 2021			

Year 3: Increase efforts from years 1 and 2. Increase the number of women enrolled in community home visiting and prenatal and/or parenting support groups that have a reproductive health plan by 10% from baseline. Increase the number of partners of pregnant women that are being served by appropriate support systems and/or Fatherhood programs by 5% over baseline.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy: Mercy Health Resource Mothers; Mahoning Valley Pathways HUB; Help Me Grow; Nurse Family Partnership; Ohio Department of Health Ohio Equity Institute 2.0, Healthy Moms, Healthy Babies; Meridian MOMS (Maternal Opiate Medical Support program; CenteringPregnancy® community support groups; and Fatherhood programs; Kappa Alpha Psi Fraternity.

Priority #3: Maternal and Infant Health

Strategy 4: Expand enrollment in care coordination, home visiting and community support programs for at-risk prenatal and parenting women

Goal: Improve birth outcomes.

Objective: By December 31, 2022, increase participation in home visiting and community support programs by 20%.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Implement the county-wide coordinated referral process developed in 2019. Work with local organizations to create and implement a marketing plan with consistent messaging targeting African American women most at-risk for poor birth outcomes.	December 31, 2020	Adult	1. Total preterm births: Percent of live births that are preterm: <37 weeks gestation (Baseline: 14%, Ohio Department of Health, 2018) 2. Low birth weight births: Percent of births in which the newborn weighed <2,500 grams (Baseline: 12%, Ohio Department of Health, 2018) 3. Infant mortality: Rate of infant deaths per 1,000 live births (Baseline: 7.8, Ohio Department of Health, 2013-2017) 4. Without usual source of care: Percent of adults who don't have one (or more) persons they think of as their personal healthcare provider (Baseline: 13%, 2018-2019 CHA)	My Baby's 1st Infant Mortality Prevention Coalition
Year 2: Continue efforts from year 1. Increase program participation by 10%.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Increase program participation by 10%.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy: Ohio Department for Medicaid; Western Reserve Health Foundation Community Legal Aid of Northeast Ohio Marketing Director; MY Baby's 1st Infant Morality Prevention Coalition; The Mahoning Valley Pathways HUB; Meridian Health Care, Eagle's Nest Life Equipping Center.

Priority #4: Social Determinants of Health

Strategic Plan of Action

Priority #4: Social Determinants of Health				
Strategy 1: Outreach to increase uptake for earned income tax credits				
Goal: Decrease poverty.				
Objective: By December 31, 2022, implement two CDC-recommended awareness strategies to increase uptake in earned income tax credits.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collaborate with county agencies, such as Job and Family Services, libraries and United Way, to increase awareness about **earned income tax credits (EITC),** how it can reduce the tax burden for low-to-moderate income working people, and who is eligible.	December 31, 2020	Adult	Poverty: Percent individuals who live in households at or below the poverty threshold (Baseline: 18%, 2018 Census Quick Facts)	TBD
Year 2: Continue efforts from year 1. Continue to collaborate with county partners to implement at least one of the following CDC-recommended awareness strategies: • Offer free tax assistance to EITC-eligible families in primary care settings to take advantage of clinic wait times. • Provide tax services at no charge to economically disadvantaged residents, which are funded by non-profit organizations, such as United Way.	December 31, 2021			
Year 3: Continue efforts from year 1 and year 2. Implement both awareness strategies identified in Year 2. Advocate for state polices to increase awareness of EITC, such as laws requiring states to notify potentially qualified families and individuals of the credit, and Laws requiring employers to give notice of the federal and any state EITC to potentially qualified employees.	December 31, 2022			
Type of Strategy: ⊗ Social determinants of health ○ Public health system, prevention and health behaviors ○ Healthcare system and access ○ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: Vita program.				

Priority #4: Social Determinants of Health

Strategy 2: Vocational training for adults

Goal: Decrease poverty.

Objective: By December 31, 2022, increase enrollment to vocational/technical school by 10%.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collect baseline data on the number of organizations offering vocational and technical training, including which organizations offer scholarships, paid tuition, financial compensation, personal development resources, job placement, job search assistance, and/or other comprehensive support services (e.g., child care during training).	December 31, 2020	Adult	Poverty: Percent individuals who live in households at or below the poverty threshold (Baseline: 18%, 2018 Census Quick Facts)	TBD
Year 2: Identify and collaborate with at least one organization offering vocational and technical training. Discuss the importance of this training as a means to increase earnings and employment and reduce recidivism among Mahoning County residents. Create a plan for recruitment to vocational and technical training, targeting high schools and economically disadvantaged populations.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Increase enrollment to the vocational/technical school by 10%.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

- ⊗ Yes
- ○ No
- ○ Not SHIP Identified

Resources to address strategy: Flying High Inc, trade schools, community colleges, manufacturers coalition, Mahoning County Workforce Development, Ohio Means Jobs, and reentry programs.

Priority #4: Social Determinants of Health

Strategy 3: Housing improvement

Goal: Decrease severe housing problems.

Objective: By December 31, 2022, develop and implement a plan to address housing priorities in Mahoning County.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Convene housing concerned agencies/individuals to create or broaden a current housing task force to comprehensively assess the scope of housing needs and assets in the community.	December 31, 2020	Adult	Severe housing problems: Percent of households that have one or more of the following problems: 1) housing unit lacks complete kitchen facilities; 2) housing unit lacks complete plumbing facilities; 3) household is severely overcrowded; and 4) monthly housing costs, including utilities, exceed 50% of monthly income (Baseline: 15%, 2019 County Health Rankings)	The SDOC Housing Committee of MY Baby's 1st
Year 2: Develop a plan to address the identified housing priorities in Mahoning County.	December 31, 2021			
Year 3: Implement the plan to address the identified housing priorities in Mahoning County.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

- ○ Yes
- ○ No
- ⊗ Not SHIP Identified

Resources to address strategy: YWCA Mahoning Valley, Taft Promise neighborhood, YNDC, The Metropolitan Housing Authority; the Mahoning County Homeless Continuum; Catholic Charities; The Mahoning County Land Bank.

Priority #4: Social Determinants of Health

Strategy 4: Early childhood education (ECE) opportunities

Goal: Increase early childhood education (ECE) opportunities.

Objective: By December 31, 2022 increase the number of children enrolled in an ECE program by 15%.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Conduct an environmental scan of all **early childhood education (ECE)** opportunities that are available in the county, including school-based ECE, program-based ECE, universal preschool, Head Start, and others. Collect information regarding eligibility and cost. Gather baseline data on the number of children enrolled in a Head Start, Early Head Start or pre-kindergarten, and other ECE opportunities. Increase public awareness regarding access to ECE opportunities.	December 31, 2020	Adult	Kindergarten readiness: Percent of kindergarten students demonstrating readiness (entered kindergarten with sufficient skills, knowledge and abilities to engage with kindergarten-level instruction) (Baseline: TBD by Mahoning County School Districts)	The Mahoning County Educational Service Center
Year 2: Continue efforts from year 1. If there is a need for additional ECE opportunities in the county, apply for an **early childhood education grant** through the Ohio Department of Education (ODE). Increase the number of children enrolled in an ECE program by 10% from baseline.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Increase the number of children enrolled in an ECE program by 15% from baseline.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy: Alta, United Way and the educational service center.

Priority #4: Social Determinants of Health

Strategy 5: School-based health centers

Goal: Increase access to health care.

Objective: By December 31, 2022, pilot a school-based health center in one school.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Explore the school-based health center being implemented in the Warren City School District in Trumbull County. Explore failure of school-based health center previously operated in the Austintown School system.	December 31, 2020	Youth and children	1. Third grade reading: Percent of third graders at least proficient in reading (Baseline: TBD by Mahoning County School Districts) 2. High school graduation: Four-year graduation rate: Percent of incoming 9th graders who graduate in 4 years from a high school with a regular degree, as calculated using the AFGR (Baseline: TBD by Mahoning County School Districts)	Akron Children's Hospital Mahoning Valley
Year 2: Collaborate with community leaders to determine the feasibility of implementing a **school-based health center** in Mahoning County. Continue efforts from year 1. Create an implementation plan and obtain funding for a school-based health center.	December 31, 2021			
Year 3: Pilot a school-based health center in at least one school with accompanying evaluation measures.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy: Mercy Health Youngstown; Akron Children's; Promise Neighborhoods; Warren City School District; MCPH and YCHD.

Priority #4: Social Determinants of Health

Strategy 6: Green space and parks

Goal: Increase physical activity

Objective: By December 31, 2022, create a written plan to create additional green space in Mahoning County.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collaborate with local partners to advertise local parks, playgrounds, trails, walking paths and other green space available in Mahoning County.	December 31, 2020	Adult	1. Physical inactivity: Percentage adults reporting no leisure time physical activity (Baseline: 32%, 2018-2019 CHA) 2. Access to exercise opportunities: Percent of individuals who live reasonably close to a location for physical activity, defined as parks or recreational facilities (Baseline: 76%, 2019 County Health Rankings)	TBD
Year 2: Continue efforts from year 1. Identify an area in Mahoning County and either renovate under-used recreation areas, rehabilitate vacant lots, or abandoned infrastructure to create additional green space. Target spaces that are in economically distressed and/or minority population areas.	December 31, 2021			
Year 3: Continue efforts from year 1 and year 2. Create a written plan to create the additional green space.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy: Partnership with CHC, Metroparks, and HCP.

Priority #4: Social Determinants of Health

Strategy 7: Community-scale urban design land use policies and streetscape design (Complete Streets)

Goal: Increase physical activity.

Objective: By December 31, 2022, pass Complete Streets policy in at least one jurisdiction in Mahoning County.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Meet with city council to discuss readiness to develop a **Complete Streets** policy. Raise awareness of Complete Streets policy and recommend that all local jurisdictions adopt comprehensive Complete Streets policies.	December 31, 2020	Adult	Physical inactivity: Percentage adults reporting no leisure time physical activity (Baseline: 32%, 2018-2019 CHA)	TBD
Year 2: Evaluate readiness for Complete Streets policy. Compile results and identify needs related to complete streets policy adoption. Identify a champion from Mahoning County to assist in technical assistance and the creation of a draft policy.	December 31, 2021			
Year 3: Implement/pass Complete Streets policy at Council level. Communicate and market existing and new Complete Streets policies throughout the community. Continue to communicate and market Complete Streets policy throughout the community. Evaluate policy utilization.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Partnership with CHC, elected officials, and zoning/planning/engineers.

Priority #4: Social Determinants of Health

Strategy 8: Access to transportation

Goal: Increase access to transportation.

Objective: By December 31, 2022, support WRTA in the implementation of strategies from the transportation plan.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Support the strategies being implemented by WRTA to improve access to transportation services for all residents of Mahoning County (e.g., write letters of support for WRTA funding applications, participate/facilitate WRTA service-related community meetings). Share information about WRTA service expansion to all county residents. Administer evaluation surveys to gauge the public's response to strategies that have been implemented and collect outcome measures.	December 31, 2020	Adult	Increase transportation (Baseline: TBD by Mahoning County)	TBD
Year 2: Administer evaluation surveys to gauge the public's response to strategies that have been implemented and collect outcome measures. Provide WRTA with data regarding gaps.	December 31, 2021			
Year 3: Increase efforts of years 1 and 2.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: The Western Reserve Transit Authority (WRTA); Youngstown State University; Eastgate Regional Council of Governments; Mercy Health Youngstown.

Priority #4: Social Determinants of Health

Strategy 9: Screening for social determinants of health (SDOH) using a standardized tool

Goal: Increase health equity.

Objective: Implement a SDOH screening in at least four Mercy Health Primary Care Practices by December 31, 2022.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Assess the extent to which social determinants of health (SDOH) screenings are currently taking place in health care settings across Mahoning County. Collect baseline data on the number of schools, primary care offices, FQHC's, home visiting programs, or other entities that are screening for SDOH. 1. Align assessment tools to enable outcome analysis. 2. Evaluate the screening process and develop a referral process. 3. Determine the feasibility of implementing the screening in **no less than two** Mercy Health Primary Care Practices or other organizations in the county.	December 31, 2020	Adult	Increase health equity (Baseline: TBD by Mahoning County)	Mercy Health Youngstown Mahoning County Public Health Youngstown City Public Health
Year 2: Implement the SDOH screening in two additional organizations or practices that serve economically disadvantaged and/or minority populations. Implement a mechanism to collect and analyze the SDOH screening outcomes. Collect and analyze data on the number of screenings for SDOH completed by participating organizations Assess most frequently identified needs and barriers to resolution.	December 31, 2021			
Year 3: Continue efforts of year two. Increase the number of SDOH screenings from Year 2 by ≥5%.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Mercy Health Youngstown, Help Network of Northeast Ohio, Mahoning County Public Health, Youngstown City Health District.

Priority #5: Health Equity

Strategic Plan of Action

Priority #5: Health Equity				
Strategy 1: Cultural competency training for healthcare professionals				
Goal: Increase cultural competency among healthcare organizations.				
Objective: By December 31, 2022, increase the number of individuals trained in cultural competency by 25% from baseline.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collect data on the number of healthcare organizations that offer comprehensive cultural competency trainings and how often they are conducted. Collect baseline data on the numbers of individuals these programs have trained to date.	December 31, 2020	Adults	1. Racial inequality in health care: Felt their experience was worse than other races when seeking healthcare (of African American residents) Baseline: 12%, 2018-2019 CHA) 2. LBGTQ inequality in health care (TBD by Mahoning County)	Office of Minority Health Full Spectrum Mercy Health Youngstown
Year 2: Educate and inform healthcare providers (and support staff) on Mahoning County demographics and the importance of becoming culturally competent. Education/training must include: diversity and inclusion, implicit bias, gender identity, sexual orientation and expression, trauma informed care and **culture, language and health literacy**). Increase the number of individuals trained by 15% from baseline	December 31, 2021			
Year 3: Continue to offer trainings/workshops on cultural competence. Increase the number of training/workshops by 50%. Increase the number of individuals trained by 25% from baseline Encourage healthcare organizations to offer cultural competency trainings annually and adopt culturally competent policies.	December 31, 2022			
Type of Strategy: ○ Social determinants of health ○ Public health system, prevention and health behaviors ⊗ Healthcare system and access ○ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: Mercy Health Youngstown Leadership Council for Diversity and Inclusion; Youngstown City Health District Office of Minority Health; Full Spectrum Community Outreach Program; Mahoning County Public Health; Mahoning County Mental Health and Recovery Board.				

Priority #5: Health Equity

Strategy 2: Dialogue on racism

Goal: Decrease racism.

Objective: By December 31, 2022, host at least two dialogue sessions per year.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to implement the Dialogue on Racism program. Collect baseline data on the number and type of places the dialogue has taken place. Expand the program to host at least two community dialogues per year in spaces such as churches, hospitals, schools, community events etc. Dialogues will include the following topics racism, diversity and inclusion, implicit bias, gender identity, sexual orientation and expression.	December 31, 2020	Adult	1. Racial inequality: Felt upset, angry, sad, or frustrated as a result of how they were treated based on their race (of African American residents) Baseline: 30%, 2018-2019 CHA) 2. LBGTQ inequality (TBD by Mahoning County)	Office of Minority Health Full Spectrum
Year 2: Continue efforts from year 1. Host at least two dialogues per year.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Host at least two dialogues per year.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: GYCDOR (Greater Youngstown Community Dialogue on Racism). Youngstown Office of Minority Health; Full Spectrum Community Outreach.

Priority #5: Health Equity

Strategy 3: Implicit bias training

Goal: Decrease racism.

Objective: By December 31, 2022, implement at least two implicit bias trainings per year.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Work with local stakeholders to create a formal implicit bias training detailing the association between implicit bias and racial/LBGTQ inequity. Pilot the training in one location, such as a school, church, hospital, or local business. Evaluate the training and make necessary changes.	December 31, 2020	Adult	1. Racial inequality: Felt upset, angry, sad, or frustrated as a result of how they were treated based on their race (of African American residents) Baseline: 30%, 2018-2019 CHA) 2. LBGTQ inequality (TBD by Mahoning County)	Office of Minority Health Full Spectrum
Year 2: Continue efforts from year 1. Implement the training at least twice per year.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Implement the training at least twice per year.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Mercy Health Youngstown Leadership Council on Diversity and Inclusion and GYCDOR (Greater Youngstown Community Dialogue on Racism). Full Spectrum, YWCA, Planned Parenthood Ohio Center for Sex Education; Full Spectrum community Outreach YCHD; MCPH.

Priority #5: Health Equity

Strategy 4: Nondiscrimination policies in the workplace

Goal: Decrease inequality.

Objective: By December 31, 2022, increase outreach for nondiscrimination policies by 10% from baseline.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collaborate with local leaders to create county-wide standards for nondiscrimination policies in the workplace. Work with local government agencies to collect baseline data on the number and types of local businesses in Mahoning County.	December 31, 2020	Adult	1. Racial inequality: Felt upset, angry, sad, or frustrated as a result of how they were treated based on their race (of African American residents) Baseline: 30%, 2018-2019 CHA) 2. LBGTQ inequality (TBD by Mahoning County)	Full Spectrum
Year 2: Continue efforts from year 1. Approach local business to and ask to review their nondiscrimination policies against the new standards. Work with businesses to revise their policies if needed, and if they do not have policies, adopt them. Increase outreach to businesses regarding nondiscrimination policies by 5% from baseline.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Approach local business to and ask to review their nondiscrimination policies against the new standards. Work with businesses to revise their policies if needed, and if they do not have policies, adopt them. Increase outreach to businesses regarding nondiscrimination policies by 10% from baseline.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: MCPH; YCHD; The Youngstown Office on Minority Health; Full Spectrum Community Outreach.

Progress and Measuring Outcomes

Progress will be monitored with measurable indicators identified for each strategy. Most indicators align directly with the SHIP. The individuals or agencies that are working on strategies will meet to implement the action steps. The CHA/CHIP Team meets quarterly to review plan implementation progress Annually, the CHA/CHIP Team publishes a "report card" that is shared with the public and all partners to demonstrate progress toward goal achievement. Strategies, responsible agencies, and timelines are also reviewed annually by the CHA/CHIP Team. As this CHIP is a living document, edits and revisions will be made accordingly.

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

In addition, to ensure that trends and/or new threats are recognized and addressed as timely as possible, Mahoning County will annually monitor the following key community health status indicators.

Annual Community Health Status Indicators

DEMOGRAPHICS

1. Population Size
2. Population Density
3. Percent Below Poverty Line
4. Race / Ethnicity
5. Age Distribution

SOCIAL AND ECONOMIC INDICATORS

6. High School Graduation Rate
7. Some College
8. Unemployment
9. Children in Poverty
10. Inadequate Social Support/Associations
11. Children in Single-Parent Households
12. Homicide Rate
13. Rank – Overall Social and Economic Factors

ENVIRONMENTAL INDICATORS

14. Air Pollution – Particulate Matter
15. Grocery Stores per 1,000 Population
16. Fast Food Restaurants per 1,000 Population
17. Transportation access/WRTA ridership
18. Rank – Overall Physical Environment

CLINICAL CARE AND RELATED CONDITIONS

19. Uninsured Adults
20. Primary Care Physicians
21. Dentists
22. Mental Health Providers
23. Diabetic HbA1c Monitoring
24. Preventable Hospital Stay Rate
25. Mammography Screening
26. Rank – Overall Clinical Care
27. MHY HBA1c Testing
28. Number of Acute Medical Detox Facilities

HEALTH BEHAVIOR INDICATORS

29. Adult Smoking
30. Adult Obesity
31. Chlamydia Rate
32. Gonorrhea Rate
33. Syphilis Rate
34. Persons Living with HIV/AIDS
35. Food Environment Index
36. Adults Who are Physically Inactive
37. Access to Exercise Opportunities
38. Adults Reporting Eating <5 Servings of Fruits and Vegetables per day
39. Rank – Overall Health Behaviors
40. Minutes/week Children Active in School
41. WIC Breastfeeding Initiation Rates
42. MHY Breastfeeding Initiation Rates
43. MHY Exclusive Breastfeeding at Discharge
44. Baby and Me Tobacco Cessation Training Hours– MCDBOH

45. Baby and Me Tobacco Cessation Participant Numbers– MCDBOH
46. Regional Tobacco Cessation Adult Participant Numbers
47. Number of Pregnant Women from High Risk Census Tracks Referred to Tobacco Treatment
48. Number of Health Care Providers Educated on Tobacco Cessation Programs
49. Number of Newly Adopted 100% Tobacco Free Policies
50. Number of 5 A's Trainings Conducted
51. YMCA Diabetes Prevention Program Participation Numbers
52. YMCA Diabetes Prevention Program Participation Evaluation
53. CDSMP Participation Numbers
54. DEEP Participation Numbers
55. Stepping Out Participation Numbers
56. Percent Voucher Usage of the MHY Fruit and Vegetable Prescription Program
57. Well-Being Collaborative of Ohio Participation Numbers
58. Number of Farm Markets that Accept Nutrition Assistance Benefits
59. Percentage of HUB Participants Receiving BF Education
60. Fitness Lifestyle Challenge Participation Numbers
61. Eat Right and Move School Walking Challenge School Participation Numbers
62. YMCA Childhood Obesity Program Participation Numbers

MORTALITY INDICATORS

63. Premature Deaths (Years Potential Life Lost)
64. Heart Disease Deaths
65. Suicide Deaths
66. Stroke Deaths
67. Lung Cancer Deaths
68. Colon Cancer Deaths
69. Breast Cancer Deaths
70. Unintentional Injury Deaths
71. Diabetes Deaths
72. Tuberculosis Case Mortality Rate
73. Rank - Overall Mortality

MORBIDITY INDICATORS

74. Poor or Fair Health
75. Poor Physical Health
76. Poor Mental Health
77. Rank – Overall Morbidity
78. Child Lead Poisoning - Number Tested
79. Child Lead Poisoning – Numbers and Percentage of Lead Poisoned Children
80. Incidence of Diabetes Among Adults

DRUG AND ALCOHOL RELATED INDICATORS

81. Heroin Poisonings
82. Drug Poisoning Deaths
83. Rx Opioid Related Poisonings
84. Liquor Stores
85. Excessive Drinking
86. Evidence Based Programming Adoption
87. Opiate Prescriptions Per Capita
88. Naloxone Distribution - First Responders
89. Naloxone Distribution – Community
90. Number of Pharmacies Offering Naloxone
91. Students Reporting Opiate/Heroin use
92. Membership of the Prescription Drug and Opiate Task Force
93. SBIRT Implementation
94. Numbers of Schools Implementing Start Talking
95. Drug Death Review Recommendations
96. Percentage of Physicians Prescribing Opioids and Benzodiazepines
97. Percentage of Physicians Utilizing OARRS
98. Number of Emergency Rooms Adopting the Ohio ED Opioid Guidelines
99. Number of HUB Clients Receiving SBIRT Screening

MATERNAL AND CHILD HEALTH INDICATORS

100. Infant Mortality
101. Infant deaths in an unsafe sleep environment
102. Black Infant Mortality Rate
103. White Infant Mortality Rate
104. Low Education (HS diploma or less) Infant Mortality Rate
105. Infant Mortality Rate for Deliveries Paid by Medicaid
106. Teen Birth Rate
107. Mothers Who Reported Smoking during Pregnancy
108. Births with First Trimester Prenatal Care
109. Low Birth Weight
110. Very Low Birth Weight
111. Pre-Term Births
112. Percentage of Mothers Becoming Pregnant Within 18 Months of a Prior Delivery
113. Number of NICU 17P Eligible Mothers Educated
114. Percentage of HUB enrollees that receive post-partum health care following delivery
115. Number of Health Care Providers Educated on 17P
116. Percent of Eligible Mothers Who Receive 17P

117. Number of FIMR Recommendations
118. Black to White Infant Mortality Ratio
119. Number of Newborn with Neonatal Abstinence Syndrome
120. Number of Health Care Providers Trained in NAS
121. Percent of MCDBOH WIC Staff with CLC
122. Number of HUB CHWs Trained in BF Support Strategies
123. HUB enrollees with open and closed housing pathways
124. Number of Health Care Providers Trained in Birth Spacing and LARC
125. Number of Birth Spacing and LARC Education Materials Distributed
126. Number of CHWs Assigned to the HUB
127. Number of HUB Clients Enrolled During 1st Trimester
128. Number of At-Risk Pregnant and Parenting Women Served by CHWs
129. Number of HUB Referrals
130. Number of HUB Care Coordinating Agencies
131. Number of Crib For Kids Cribettes Distributed
132. Number of Place Based Safe Sleep Trainings Conducted
133. Number of CenteringPregnancy Sites
134. Number of First Responder Agencies Trained in Safe Sleep
135. Percentage of Premature Birth Reoccurrence
136. On-demand Transportation Utilization Numbers

HEALTH INEQUITY INDICATORS

137. Number of Community Members Educated on Health Inequity
138. Number of Health Care Providers Educated on Health Inequity
139. Number of Foundations Prioritizing Funding Based on Health Inequity
140. Percentage of GYCDR Action Plans Implemented
141. Number of Zip Codes with Formal Linkages Formed
142. Number Individuals Trained in Cultural Competency

Partners will also be asked to provide data relating to trends they may be seeing in their respective sectors that may be impacting the health and wellbeing of Mahoning County residents.

Lastly, in addition to outcome evaluation, process evaluation will also be used on a continuous basis to focus on the success of the strategies. Areas of process evaluation that the CHIP committee will monitor include the following:

- number of participants, location(s) where services are provided,
- number of policies implemented,
- economic status and racial/ethnic background of those receiving services (when applicable),
- and intervention delivery (quantity and fidelity).

Contact Us

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

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Appendix I: Gaps and Strategies

The following tables indicate gaps and potential strategies that were compiled by the Mahoning Community Health Improvement Partnership on July 25, 2019.

Mental Health and Addiction Gaps

Gaps	Potential Strategies
Lack of mental health and substance abuse providers (psychiatrists who can prescribe, pediatric providers, lack of racial/ethnic diversity in providers, Spanish-speaking providers)	• Higher education financial incentives for health professionals serving underserved areas (such as tuition reimbursement and loan repayment programs for behavioral health professionals • Health care recruiting for minority student and focus on behavioral health professional • Telehealth • Behavioral health workforce pipeline programs • Mass reach communication
Lack of quality mental health services for incarcerated individuals	• Increase access to care once screened
Lack of continuum of care and coordination between child and adult services	• Mass reach communication • Need for educate vs strategies
Stigma and how it is a barrier to treatment	• Mass reach communication • Peer recovery support specialist • Culture competency training for health care professionals with a focus on behavioral health professional
Lack of mental health education, particularly in youth	• Screening for clinical depression for all patients 12 or older using a standardized tool • Screening for suicide for patients 12 or older • School based social and emotional instructions
Lack of community mental health/suicide awareness and resources	• Mass reach communication • Screening for suicide for patients 12 or older using standardized tool (such as CSSR-S) when indicated positive
How to address and assess ACEs	• Trauma informed care
Increased awareness of trauma for law enforcement	• Trauma informed care • CIT • Mental health 1st aide
Lack of detox and inpatient addiction treatment beds/facility	• Mass awareness for detox resources • Advocate at state/federal level to increase capacity – residential
Lack of data (HIPAA protocol for Overdose Fatality Review Board)	• Legislation to allow demographics to identify preventable deaths • Same rules need as in infant mortality
Lack of education on alcohol/binge drinking	• School based alcohol/other drug prevention programs including youth led prevention and specific universal • Provide education to primary care and behavioral health providers regarding depression/suicide screening tools and drug/alcohol, anxiety

Chronic Disease Gaps

Gaps	Potential Strategies
Lack of physical activity options	• Community Fitness Programs • Activity Programs for Older Adults • Individually adapted health behavior change programs • Community-scale urban design land use policies and streetscape design Green spaces and parks
Lack of physical activity /motivation for physical activity	• Community based social support for physical activity • Community-scale urban design land use policies and streetscape design • Green spaces and parks
Access to healthy and affordable food (food insecurity)	• Farmer's Markets • SNAP/EBT infrastructure at Farmer's markets • Nutrition prescriptions (including fruit and veg prescription programs) • Healthy food initiatives in food banks Food insecurity screening and referral
Lack of education, understanding, awareness, and efficacy	• Campaigns and information approaches to increase physical activity: Community wide campaigns Nutrition education at farmers markets, fresh start for resource mothers' clients
Lack of trust with vulnerable populations and health providers	• Incorporate community health workers into health career recruitment for minority students • Health career recruitment for minority students Cultural competency training for healthcare professionals
Lack of targeted outreach	Screenings and education for hypertension, diabetes, high cholesterol with a focus on minority and underserved populations
Lack of health coverage	Prescription assistance program

Maternal and Infant Health Gaps

Gaps	Potential Strategies
Substance use during pregnancy	• MOMS – Maternal opiate medical support • Offering CP @ Meridian Health
Lack of preconception, prenatal, and postnatal awareness and education, and prevention	• Education and encourage providers about CHW
Lack of understanding and utilizing services	• Marketing (billboards), social media, HUB, CHW
Lack of providers (OB/GYN)/Lack of diverse providers	• Higher education incentive • Other incentive (malpractice allowance) • Urban birthing center
Lack of trust/Negative care experiences as a barrier to seeking future care	• Cultural competence training for health care professionals and front office staff
Agency policies that act as barriers to prenatal/contraceptive care	• Raise the conversation since now the only provider is Mercy Health
Lack of birth spacing	• Continue to strengthen the current birth/space LARK program • Consistent messaging
Lack of social support	• Expansion of Empowering Moms • Improved marketing
Lack of fatherhood initiatives	• Dads Matter • Fast Track – the male CHW (Medicaid family) • Healthy moms/healthy babies • Continue to support the African American walk

Social Determinants of Health Gaps

Gaps	Potential Strategies
Poverty/Unemployment	• Policy change for hiring practices for individuals with criminal records • SAW program (school-at-work) • Jobs for individuals in recovery/vocational training • Scholarships for underrepresented populations in trades and professions
Transportation	• Full assessment of transportation options • Rideshare • All individuals receiving public benefits has a transportation voucher
Lack of affordable, safe, quality housing/Slum Lords	• Home Improvement loans and grants • Housing for homeless and pregnant women • Healthy homes • Healthy families • Landlord registration • Revitalize housing located on active bus lines
Homelessness	• Policy change for criminal history affecting Housing options • Permanent, supportive housing • Community health workers
Generational learned behaviors	• Cultural competence training for healthcare professionals • Home visiting program

Health Equity Gaps

Gaps	Potential Strategies
Lack of cultural competency	• Cultural competence training for healthcare professionals
Cultural bias/Lack of open-mindedness and understanding	• School based education • Community based events and education • REI training • Inclusion of community individuals • Change organization structure
Systemic racism	• Start at the top – corporate, families, churches, organizations • Look at policies • Review county policies/review business policies
Segregation/No race-mixed neighborhoods	• Review and change county policies • Nondiscrimination policies • Zero tolerance • Ordinances • Work environment
Rural needs and access to services are not often addressed	• Internet access (telehealth) • Satellite medical centers • Education of internet, computer basic skills
Lack of advocacy for policy change	• Getting all organizations to adapt policies and zero tolerances • Managed care insurance case management • CHWs • Trauma informed care