2020  2022

Geauga County

Community Health Improvement Plan

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Foreword

The members of the Partnership for a Healthy Geauga understand that to build a culture of health in Geauga County requires not only a diverse set of committed partners but also a solid plan to guide our work. This 2020-2022 Community Health Improvement Plan is the culmination of a robust planning process that sought to be inclusive in its approach, evidence-based in its strategy selection, realistic in its ambition, and opportunistic in its evolution of the work that has come before by so many who are still at the table as committed as ever to assure that Geauga County remains one of Ohio's healthiest counties.

We recognize that while we are a relatively healthy county, we have populations who experience disparities in their access to good health. Barriers exist that interfere with access to the many social conditions that support health. These barriers include adverse childhood experiences and trauma, housing, food, and financial insecurity, limited access to transportation, disability status, and inability to afford quality health care when needed. It is our intent to continue to grow our coalition to include partners that can help address an increasing number of these social determinants of health. We will also continue to identify those populations within Geauga County whose optimal health is disproportionately vulnerable, to remove or mitigate those barriers to health and to work to build resilience. It is the vision of the Partnership for a Healthy Geauga that we strive to achieve optimal health for all through diverse community partnerships and a robust and sustainable public health system. We believe this plan will advance that vision.

On behalf of the Partnership for a Healthy Geauga, we recommend this plan to all who read it and invite you to consider joining us in our work.

Respectfully,

Donald DeCarlo, MD, MBA
President
University Hospitals Geauga Medical Center

Thomas Quade, MA, MPH, CPH, FRSPH
Health Commissioner
Geauga County Public Health

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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.

Partnership for a Healthy Geauga has been conducting CHAs since 2011 to measure community health status. The most recent Geauga County CHA was cross-sectional in nature and included a written survey of adults within Geauga 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 has allowed Geauga 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.

Geauga County Health Partners contracted with the Hospital Council of Northwest Ohio (HCNO), a neutral, regional, nonprofit hospital association, to facilitate the CHA and CHIP. Partnership for a Healthy Geauga then invited various community stakeholders to participate in community health improvement 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). Over the next three years, these priorities and strategies will be implemented at the county-level with the hope to improve population health and create lasting, sustainable change. It is the hope of Partnership for a Healthy Geauga that each agency in the county will tie their internal strategic plan to at least one strategy in the CHIP.

Public Health Accreditation Board (PHAB) Requirements

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

PHAB standards also require that a community health improvement model is utilized when planning CHIPs. This CHIP was completed using NACCHO's MAPP process. MAPP is a national, community-driven planning process for improving community health. This process was facilitated by HCNO in collaboration with various local agencies representing a variety of sectors.

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 steering committee 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, steering committee 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 occurs during the prioritization process of the CHA/CHIP. The committee considers the results of the assessments, including data collected from community members (primary data) and existing statistics (secondary data) to identify key health issues. Upon identifying the key health issues, an objective ranking process is used to prioritize health needs for the CHIP.

In order to identify strategic issues, the steering community considers findings from the visioning process and the MAPP assessments in order to understand why certain issues remain constant across the assessments. The steering committee uses 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 the community and/or needed, to accomplish. The steering committee 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 steering committee members considered the urgency of issues and the consequences of not addressing certain items.

5. Formulate goals and strategies

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

6. Action cycle

The steering committee begins 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. As the end of the CHIP cycle, partners review progress to select new and/or updated strategic priorities based on progress and the latest health statistics.

Inclusion of Vulnerable Populations (Health Disparities)

The Geauga collaborative, which includes UH Geauga, intentionally elected to use a random household survey to incorporate a broad range of perspectives across the county. The data is de-identified and aggregated in such a way to show several demographic categories such as income, gender, age, etc. to further identify populations experiencing adverse conditions. It is described more fully in the Primary Data Collection Methods section of this report. Additionally, the planning committee itself includes a variety of human service organizations working collaboratively to complete the assessment.

Alignment with National and State Standards

The 2020-2022 Geauga County CHIP priorities align with state and national priorities. Geauga County will be addressing the following priorities: mental health, addiction and chronic disease.

Ohio State Health Improvement Plan (SHIP)

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

SHIP Overview

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

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

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

SHIP Priorities

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

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

Cross-cutting Factors

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

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

- **Health equity**: Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.
- **Social determinants of health**: Conditions in the social, economic and physical environments that affect health and quality of life.
- **Public health system, prevention and health behaviors**:
    - The public health system is comprised of government agencies at the federal, state, and local levels, as well as nongovernmental organizations, which are working to promote health and prevent disease and injury within entire communities or population groups.
    - Prevention addresses health problems before they occur, rather than after people have shown signs of disease, injury or disability.
    - Health behaviors are actions 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 Geauga 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 Geauga County CHIP priority topics, outcomes and cross cutting factors very closely align with the 2017-2019 SHIP priorities:

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

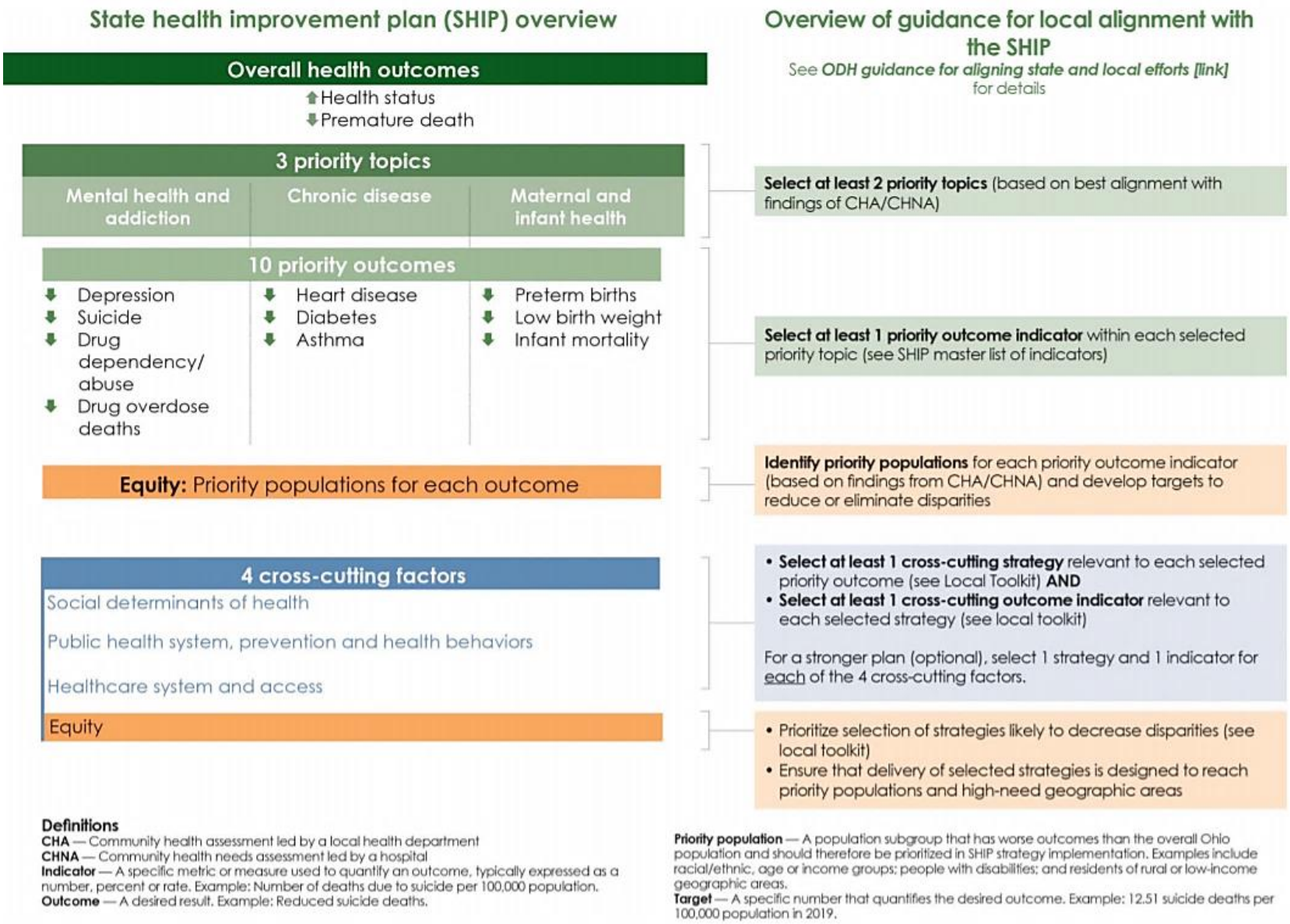
2020-2022 Geauga CHIP Alignment with the 2017-2019 SHIP			
Priority Topic	***Priority Outcome***	***Cross-cutting Factor***	***Cross-Cutting Outcome***
Mental health and addiction	• Decrease adult suicide ideation • Decrease suicide deaths • Decrease drug overdose deaths	• Public Health System, Prevention and Health Behaviors • Healthcare system and access • Social determinants of health	• Decrease current smokers • Decrease uninsured adults • Increase cigarette quit attempts • Decrease poverty
Chronic Disease	• Decrease diabetes • Decrease coronary heart disease		

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

The Geauga County CHIP also aligns with five of the National Prevention Priorities for the U.S. population: tobacco free living, preventing drug abuse and excessive alcohol use, healthy eating, active 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 outcomes**, the following action steps are recommended:

1. Trauma-informed care
2. Mental health first aid
3. Campaign to increase awareness of behavioral health warning signs
4. School-based social and emotional instruction

To work toward **decreasing substance abuse**, the following action steps are recommended:

1. School-based alcohol/other drug prevention programs
2. Medication Assisted Treatment (MAT)
3. Naloxone Access

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

1. Prediabetes screening and referral
2. Diabetes prevention program (DPP)
3. Hypertension screening and follow up
4. Wellness navigation
5. Screening events

To develop **cross-cutting strategies that address multiple priorities**, the following action steps are recommended:

<u>Public Health System, Prevention and Health Behaviors</u>

1. Mass-reach communications
2. Integrate public health data and healthcare system clinical data

<u>Healthcare System and Access</u>

1. Health insurance enrollment, literacy and outreach
2. Expand access to evidence-based tobacco cessation treatments including individual, group and phone counseling (including Quitline) and cessation medications

<u>Social Determinants of Health</u>

1. Outreach to increase uptake for earned income tax credits

Vision

Vision statements define a mental picture of what a community wants to achieve over time.

The Vision of Geauga County:

Geauga County strives to achieve optimal health for all through diverse community partnerships and a robust and sustainable public health system.

Community Partners

The CHIP was planned by various agencies and service-providers within Geauga County. From September 2019 to December 2019, Partnership for a Healthy Geauga reviewed many data sources concerning the health and social challenges that Geauga 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:

Partnership for a Healthy Geauga

- CASA for KIDS of Geauga County
- Catholic Charities Community Services
- Chagrin Falls Park Community Center
- DDC Clinic
- Family Planning Association of Northeast Ohio, Inc. (A Division of Signature Health)
- Family Pride
- Geauga County Board of Developmental Disabilities
- Geauga County Board of Health
- Geauga County Board of Mental Health & Recovery Services
- Geauga County Clerk of Courts
- Geauga County Commissioners
- Geauga County Department on Aging
- Geauga County Educational Service Center: (Representing all Geauga County School Districts)
- Geauga Public Health
- Geauga County Health District Advisory Council
- Geauga County Hunger Task Force
- Geauga County Job and Family Services
- Geauga County Public Library System
- Geauga County Residents
- Geauga County Sheriff
- Geauga County Township Association
- Geauga Family First Council
- Geauga Park District
- Lake-Geauga Head Start
- Lake Geauga Recovery Centers
- Life Act
- Middlefield Care Center
- NAMI Geauga
- Ohio Department of Health
- Ravenwood Mental Health Center
- Starting Point
- Torchlight Youth Mentoring Alliance
- United Way Services of Geauga County
- University Hospitals Geauga Medical Center
- WomenSafe, Inc.

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 Partnership for a Healthy Geauga met four (4) times and completed the following planning steps:

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

Community Health Status Assessment

Phase 3 of the MAPP process, the Community Health Status Assessment, or CHA, is a 141-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.

Geauga County Adult Trend Summary

Adult Variables	Geauga County 2011	Geauga County 2016	Geauga County 2019	Ohio 2017	U.S. 2017
Healthcare Coverage, Access, and Utilization					
Uninsured	12%	6%	6%	9%	11%
Visited a doctor for a routine checkup (in the past 12 months)	57%	59%	68%	72%	70%
Had one or more persons they thought of as their personal health care provider	86%	89%	89%	81%	77%
Preventive Medicine					
Ever had a pneumonia vaccination (age 65 and older)	N/A	81%	78%	76%	75%
Had a flu shot within the past year (age 65 and older)	41%	83%	76%	63%	60%
Ever had a shingles or zoster vaccine	N/A	18%	27%	29%	29%
Had a colonoscopy or sigmoidoscopy within the past 5 years (age 50 and older)	67%	54%	58%	72%*	74%*
Women's Health					
Had a clinical breast exam in the past two years (age 40 and older)	N/A	75%	71%	N/A	N/A
Had a mammogram within the past two years (age 40 and older)	77%	78%	79%	74%*	72%*
Had a pap test in the past three years (ages 21-65)	N/A	69%	80%	82%*	80%*
Men's Health					
Had a PSA test within the past two years (age 40 and older)	N/A	56%	54%	39%*	40%*
Oral Health					
Visited a dentist or dental clinic (within the past year)	68%	79%	78%	68%*	66%*
Visited a dentist or dental clinic (5 or more years ago)	10%	6%	7%	11%*	10%*
Health Status Perceptions					
Rated general health as good, very good, or excellent	94%	91%	91%	81%	83%
Rated general health as excellent or very good	67%	63%	60%	49%	51%
Rated general health as fair or poor	6%	9%	9%	19%	18%
Rated physical health as not good on four or more days (in the past 30 days)	16%	19%	23%	22%*	22%*
Average number of days that physical health not good (in the past 30 days) (County Health Rankings)	N/A	3.8	3.3	4.0¥	3.7¥
Rated mental health as not good on four or more days (in the past 30 days)	18%	28%	25%	24%*	23%*
Average number of days that mental health not good (in the past 30 days) (County Health Rankings)	N/A	4.8	3.6	4.3¥	3.8¥
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past 30 days)	18%	21%	22%	22%*	22%*

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	Geauga County 2011	Geauga County 2016	Geauga County 2019	Ohio 2017	U.S. 2017
Weight Status					
Obese (includes severely and morbidly obese, BMI of 30.0 and above)	22%	27%	24%	34%	32%
Overweight (BMI of 25.0 – 29.9)	38%	37%	41%	34%	35%
Normal weight (BMI of 18.5 – 24.9)	39%	35%	33%	30%	32%
Tobacco Use					
Current smoker (currently smoke some or all days)	14%	10%	10%	21%	17%
Former smoker (smoked 100 cigarettes in lifetime & now do not smoke)	30%	27%	34%	24%	25%
Tried to quit smoking (on at least one day in the past year)	42%	51%	41%	N/A	N/A
Current e-cigarette user (vaped on some or all days)	N/A	N/A	6%	5%	5%
Former e-cigarette user	N/A	N/A	12%	19%	16%
Alcohol Consumption					
Current drinker (drank alcohol at least once in the past month)	65%	69%	71%	54%	55%
Binge drinker (defined as consuming more than four [women] or five [men] alcoholic beverages on a single occasion in the past 30 days)	18%	26%	24%	19%	17%
Drove after having perhaps too much alcohol to drink	6%	5%	5%	4%**	4%**
Drug Use					
Adults who used recreational marijuana or hashish in the past 6 months	5%	5%	4%	N/A	N/A
Adults who misused prescription medication in the past 6 months	5%	5%	5%	N/A	N/A
Sexual Behavior					
Had more than one sexual partner in past year	5%	2%	5%	N/A	N/A
Mental Health					
Considered attempting suicide in the past year	2%	3%	3%	N/A	N/A
Attempted suicide in the past year	1%	0%	1%	N/A	N/A
Cardiovascular Health					
Ever diagnosed with angina or coronary heart disease	2%	3%	3%	5%	4%
Ever diagnosed with a heart attack or myocardial infarction	2%	4%	4%	6%	4%
Ever diagnosed with a stroke	2%	2%	2%	4%	3%
Had been told they had high blood pressure	30%	27%	30%	35%	32%
Had been told their blood cholesterol was high	36%	36%	39%	33%	33%
Had their blood cholesterol checked within last five years	82%	86%	84%	85%	86%
Arthritis, Asthma and Diabetes					
Had ever been told they have asthma	12%	14%	14%	14%	14%
Ever been told by a doctor they have diabetes (not pregnancy-related)	6%	9%	7%	11%	11%
Ever been diagnosed with pregnancy-related diabetes	1%	N/A	<1%	1%	1%
Even been diagnosed with pre-diabetes or borderline diabetes	N/A	5%	5%	2%	2%

N/A – Not Available

Indicates alignment with the Ohio State Health Assessment

***2015 BRFSS*

Key Issues

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

What are the most significant health issues or concerns identified in the 2019 assessment report? Examples of how to interpret the information include: 75% of Geauga County adults were overweight or obese, increasing to 78 of those ages 65+ and under 30, as well as 80% of males.

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			
Adult seriously considered attempting suicide in the past 12 months (suicide ideation)	3%	Income <$25K (10%)	Female (4%)
Age-adjusted mortality rates per 100,000 population for death by suicide (2013-2017) *(Source: ODH, Ohio Public Health Data Warehouse, Mortality, Leading Causes of Death)*	11.5	Age 85+ (25.7)	Male (20.5)
Adult rated mental health as not good on 4 or more days in the past month	25%	Income <$25K (40%)	Female (41%)
Adult average number of days that mental health was not good (in the past 30 days)	3.6	N/A	N/A
Addiction			
Adult current smoker (smoked on some or all days)	10%	Ages 30-64 (11%) Income <$25K (11%) Amish* (17%)	Female (14%)
Adult current e-cigarette user (vaped on some or all days)	6%	Income <$25K (7%)	Female (6%)
Adult current drinker (had at least one drink of alcohol within the past 30 days)	71%	Income $25K+ (76%)	Male (76%)
Adult binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	24%	N/A	N/A
Geauga County Number of Opiate Related Overdose Deaths 2007-2017 *(Source: Ohio Department of Health, Unintentional Drug Overdose Data, 2007-2017)*	111	N/A	N/A
Geauga County Number of Heroin Related Overdose Deaths 2007-2017 *(Source: Ohio Department of Health, Unintentional Drug Overdose Data, 2007-2017)*	57	N/A	N/A
Geauga County Number of Fentanyl Related Overdose Deaths 2007-2017 *(Source: Ohio Department of Health, Unintentional Drug Overdose Data, 2007-2017)*	50	N/A	N/A
Geauga County overdose deaths (age-adjusted) per 100,000 population, 2012-2017 *(Source: Ohio Department of Health, 2017 Ohio Drug Overdose Data: General Findings)*	21.1	N/A	N/A

**Amish survey was a convenience sample and is not generalizable to the entire Amish population. Use data with caution.*

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
Adult used marijuana (in the past 6 months)	4%	Ages 30-64 (6%) Income $25K+ (5%)	Male (8%)
Adult used drugs not prescribed for them or took more than prescribed to feel good, high, and/or more active or alert (in the past 6 months)	5%	Income <$25K (10%)	Female (7%)
Chronic Disease			
Overweight (BMI of 25.0 – 29.9)	41%	Ages 30-64 (47%) Income $25K+ (43%)	Male (48%)
Obese (BMI of 30.0 and above)	24%	Ages <30 (44%) Income <$25K (31%)	Male (26%)
Geauga County 2015-2017 Age-adjusted mortality rates for Chronic Lower Respiratory Diseases (COPD) *(Source: ODH, Ohio Public Health Data Warehouse, Mortality, Leading Causes of Death)*	34.7	N/A	N/A
Ever been told by a doctor they have diabetes (not pregnancy-related)	7%	Ages 65+ (15%) Income $25K+ (6%)	Male (12%)
Diagnosed with high blood pressure	30%	Ages 65+ (55%) Income <$25K (33%)	Male (34%)
Coronary heart disease	3%	Ages 65+ (7%)	N/A
Social determinants of health			
Geauga County residents were living in poverty *(Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-year Estimates)*	7%	N/A	N/A
Unemployment rate for Geauga County July 2019 *(Source: Ohio Department of Job and Family Services, July 2019)*	4.4	N/A	N/A
Owner-occupied housing unit rate for Geauga County *(Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-year Estimates)*	86%	N/A	N/A
Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities *(Source: 2019 County Health Rankings)*	13%	N/A	N/A
Adults and their loved ones needed transportation assistance in the past year	2%	N/A	N/A
Food insecurity rate for Geauga County *(Source: Feeding America, Map the Meal Gap 2018)*	9%	N/A	N/A
Child food insecurity rate for Geauga County *(Source: Feeding America, Map the Meal Gap 2018)*	16%	N/A	N/A
Adults experienced 4 or more ACEs	9%	N/A	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
Access to healthcare			
Uninsured	6%	N/A	Male (7%)
Had Medicaid or medical assistance	2%	N/A	N/A
Had a flu shot in the past year	54%	Income 25K+ (52%)	Male (50%)
Had a colonoscopy/sigmoidoscopy in the past 5 years (of those 50 and older)	41%	N/A	N/A
Did not see a dentist in the past year due to cost	38%	N/A	N/A
Had one or more persons they thought of as their personal healthcare	89%	Income <25K (87%)	Male (84%)
Visited a doctor for a routine checkup (in the past 12 months)	68%	Income 25K+ (68%)	Male (62%)
Visited a dentist or a dental clinic (within the past year)	78%	Ages 30-64 (76%) Income <25K (52%)	Male (72%)

Priorities Chosen

Nine key issues were identified by the committee based on the 2019 Geauga County Health Assessment. Each organization 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 Geauga 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	22
2. Access to health care	22
3. Chronic disease	18
4. Adverse childhood experiences (ACEs)	15
5. Food insecurity	10
6. Housing	9
7. Domestic violence	9
8. Transportation	5

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

1. Mental health
2. Addiction
3. Chronic disease

Geauga County will focus on the following cross-cutting factors over the next three years:

1. Social determinants of health
2. Access to healthcare

Community Themes and Strengths Assessment (CTSA)

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

Open-ended Questions to the Committee

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

- Access to primary are
- Access to behavioral health care
- Reliable shelter
- Basic needs being met
- Access to clean drinking water
- Environment
- Social connectedness
- Community in itself
- Tolerance/acceptance
- Intentional community commitment to health
- Access/availability/awareness of resources
- Proximity to resources
- Alignment of resources in the community
- Being proactive rather than reactive
- Employment/job opportunities
- Economically healthy community
- Educational attainment
- Early childhood education
- Faith-based community
- Access to physical activity opportunities
- Built environment/infrastructure
- Buy-in from the community
- Having community champions
- Political will

2. What makes you most proud of our community?

- Collaboration among agencies
- Approachability/willingness to listen
- Willingness to help
- Commitment to children
- Abundance of generational families living in the county
- Abundance/availability of parks that offer a wide variety of opportunities
- Abundance of resources
- Safety
- Community cares for and supports one another
- Public servants in Geauga County
- Strong civic commitment
- Positive attitude in the community
- General commitment to prevention—over 500 community outreach events a year
- Education opportunities in Geauga County
- Good place to grow up
- Strong religious community
- Strong medical community

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

- Amish outreach
- Partnership for a Healthy Geauga
- Suicide Prevention Coalition
- Prevention Hub
- Marijuana prevention coalition
- Geauga Growth Partnership
- Leadership Geauga
- Safe Community Coalition
- Youth led prevention groups
- Aware Group
- Senior Center
- Citizen's Circle
- Housing Coalition
- Ad Hoc groups
- 4H
- GDP
- Faith-based groups
- Habitat for Humanity
- Bridges Out of Poverty
- Rising Scholars Program
- Geauga Safety Council

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?

- Mental health
- Addiction
- Chronic Disease
- Social Determinants of Health
- Access to Health Care
- Transportation/Driving to work in the community
- Quality/affordable health care coverage
- Cost of medication
- Lack of education regarding medication
- Dental care/Dentists accepting Medicaid
- Cross-county partnerships sometimes take services out of Geauga County
- Accommodating the aging population
- Affordable housing

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

- Fear and stereotypes of changing zoning possibly changing the community
- Affordable access to health care/Rx
- Lack of a livable wage
- Lack of affordable housing
- Lack of transportation
- Hidden poverty areas
- Negative perception of needing help
- Stigma/fear of using available resources
- Cost of living

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

- Including healthy equity when creating policies
- Awareness of available mental health services
- Funding for mental/behavioral health acute services
- Increased access to health care services
- Funding for affordable medications
- Education of health insurance coverage and importance of understanding it
- Campaigns to reduce stigma
- Development of more tobacco/drug free agencies
- Drug court
- Succession planning
- Advocacy for policy change

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

- Return on investment (health-wise, economically)
- Demonstrable results of community health improvement actions
- Improve awareness of community health improvement results
- Peer outreach

Quality of Life Survey

Partnership for a Healthy Geauga urged community members to fill out a short Quality of Life Survey via SurveyMonkey in 2019. There were 78 Geauga County community members who completed the survey. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1. For all responses of "Don't Know," or when a respondent left a response blank, the choice was a non-response and was assigned a value of 0 (zero). The non-response was not used in averaging response or calculating descriptive statistics.

Quality of Life Questions	2015-2018 CHIP	2018-2019 CHIP	2020-2022 Current CHIP
1. Are you satisfied with the quality of life in our community?	4.24	4.33	4.22
2. Are you satisfied with the health care system in the community?	3.86	3.65	3.88
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.87	4.43	4.18
4. Is this community a good place to grow old?	3.24	3.98	3.64
5. Is there economic opportunity in the community?	3.44	3.49	3.57
6. Is the community a safe place to live?	4.07	4.25	4.38
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?	3.46	3.63	3.95
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	N/A	N/A	3.92
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.91	3.94	3.66
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	N/A	N/A	3.70
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	N/A	N/A	3.58
12. Is there an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments?	3.46	3.48	3.58

Forces of Change Assessment

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

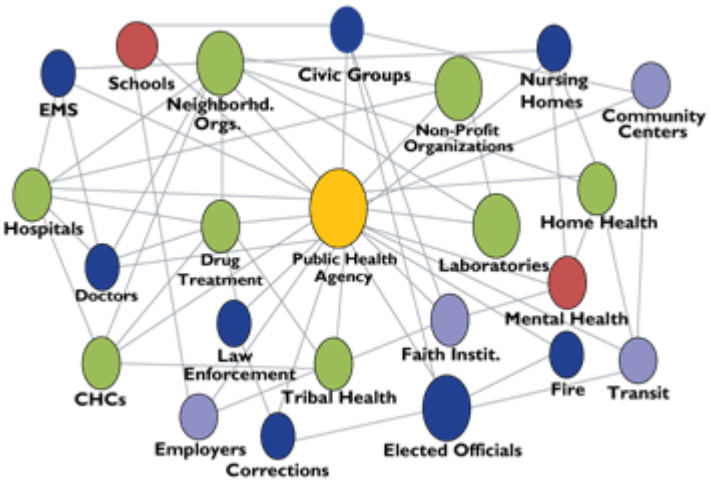
Force of Change	Threats Posed	Opportunities Created
1. Tobacco 21	• Untold effects	• Decrease smoking rate long term
2. Lawsuits with drug companies	• Increase in price of other Rx medications	• Funding for addiction
3. Technology	• Hackers/threat to privacy • People might not have computers • At home or resist technology	• Telemedicine • Increase access to care • Make monitoring health easier
4. State mandates/requirements	• Need to check boxes • Lose focus on prevention and other programming • Hard to provide service within required parameters • Funding changes frequently	• Public health accreditation
5. Staff changes at the local level	• People with certain backgrounds moving into a different arena • Catching new employees up to speed	• Succession planning • Build training programs • Internships • Pipeline programs • Build connection with universities
6. Nursing shortage	• Negative impact on health care	• Recruitment • Pipeline programs • Internships • Tuition reimbursement • Build connection with universities
7. Aging Community	• Lack of resources to meet needs of the aging population	• Increase availability of retirement communities • Increase programming/outreach/education within senior centers
8. Lack of social workers	• Limits ability to treat those with mental health/substance abuse disorders • State sets standards on what licenses you can have and what treatment you can provide	• Recruitment • Pipeline programs • Internships • Tuition reimbursement • Build connection with universities • Increase in wages

Force of Change	Threats Posed	Opportunities Created
9. Migration out of county	• Can't fill jobs • Impacts businesses • Businesses might begin to close • Relying on other communities, such as Amish, for resources	• Recruitment • Build connection with universities • Increase in wages
10. High school population declining (under 1,000 graduating seniors in county in 2020)	• Impacts hiring for health care positions • Impacts businesses • Having less children • Businesses might begin to close • Relying on other communities, such as Amish, for resources	• Increase in homeschooling
11. Shortage of physicians	• Lack of access to health care in the county	• Recruitment • Tuition reimbursement • Increase nurse practitioners and other midlevel providers • Telemedicine
12. Education	• Unaffordable • Low wages that do not offset student loan debt • Graduates are getting married later, having kids later, and buying homes later • Lack of competitive wages	• Education among youth concerning tobacco prevention • Universal pre-K and early childhood education • Affordable college
13. Transportation	• Access to resources (health care, grocery store, jobs, etc.)	• Transportation assessment • Use data from upcoming Census • Public version of ride share programs • Involve transportation stakeholders in CHIP planning
14. Expensive property	• Lack of affordable housing for low income populations	• How tax revenue is calculated for public programs
15. Politics at all levels	• Politicians/party have own agendas, beliefs and values and that directs funding and opportunities • Difficult to decipher facts from opinion • Lack of trust with government	• Local level can deliver facts to residents • Organized advocacy plans • Have politicians involved in community health improvement planning

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)

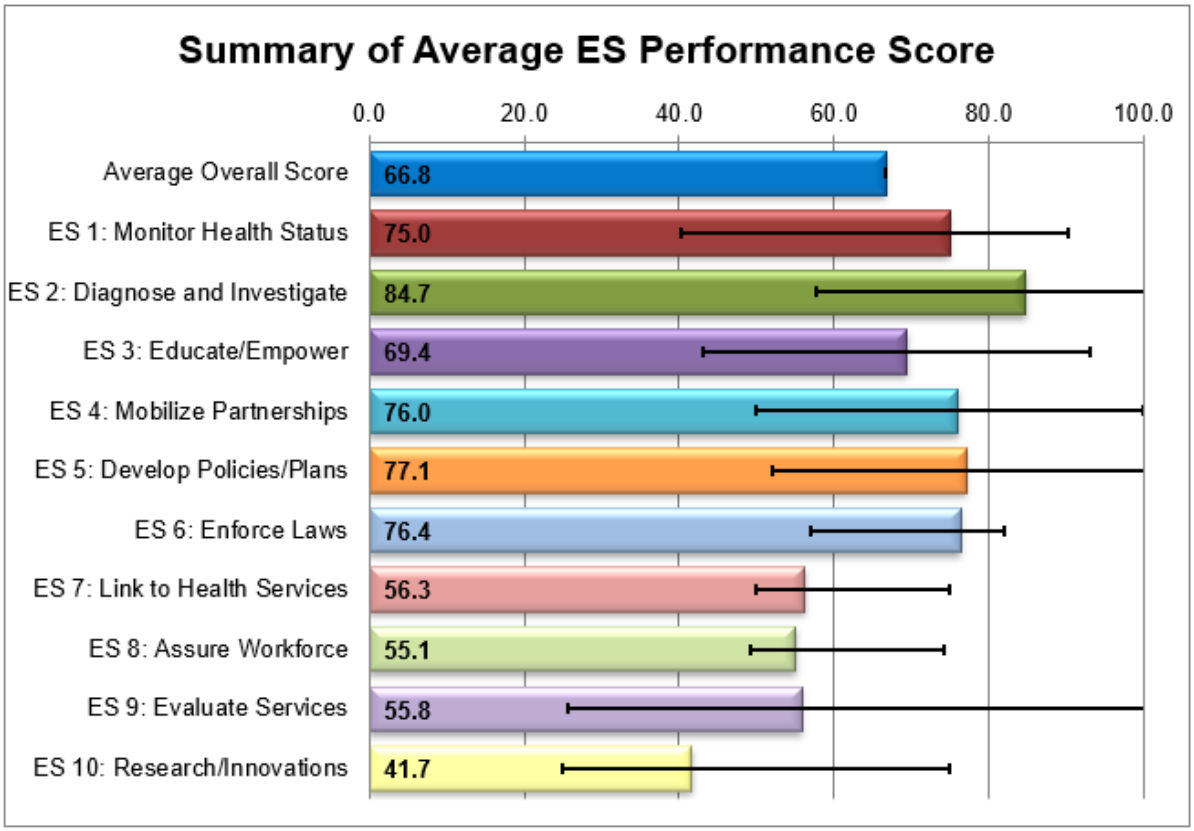
The LPHSA answers the questions, "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services being provided to our community?"

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

Members of Partnership for a Healthy Geauga completed the performance measures instrument in July 2019. 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.

Geauga 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. Partnership for a Healthy Geauga was asked to determine gaps in relation to each priority area, consider potential or existing resources, and brainstorm potential evidence-based strategies that could address those gaps. To view the completed gap analysis exercise, please view Appendix I.

Strategy Selection

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

Evidence-Based Practices

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

Resource Inventory

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

Priority #1: Mental Health

Strategic Plan of Action

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

Priority #1: Mental Health				
Strategy 1: Trauma-informed care				
Goal: Improve mental health outcomes.				
Objective: Conduct at least two trauma-informed care trainings (per year) 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 four **trauma-informed care** trainings 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.	December 31, 2020	Adult	1. Adult suicide ideation: Decrease the percent of adults who report that they ever seriously considered attempting suicide within the past 12 months by 1% (Baseline: 3%, 2019 Geauga County CHNA) 2. Suicide deaths: Decrease the number of age-adjusted deaths due to suicide per 100,000 population by 2 (Baseline: 11.5, 2013-2017 ODH Data Warehouse)	Geauga County Board of Mental Health and Recovery Services Ravenwood Health
Year 2: Continue efforts from year 1. Administer at least two trauma-informed care trainings 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.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Administer at least two trauma-informed care trainings 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.	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 ○ Unknown/No Data ○ Not SHIP Identified				
Resources to address strategy: MHRB, Ravenwood Health, schools, Lake Geauga Recovery Center, NAMI Geauga County, Geauga Public Health, Partnership for a Healthy Geauga.				

Priority #1: Mental Health

Strategy 2: Mental health first aid

Goal: Improve mental health outcomes.

Objective: Conduct one mental health first aid training (per quarter) 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, law enforcement, social service providers, and other community members on their ability to identify, understand and respond to signs of mental illnesses and substance use disorders. Continue to offer mental health first aid. Administer at least four **mental health first aid** trainings (one per quarter) to increase education and understanding of mental illnesses and substance use disorders. Target trainings towards those who live in or serve economically disadvantaged, aging, and/or minority populations.	December 31, 2020	Adult	1. Adult suicide ideation: Decrease the percent of adults who report that they ever seriously considered attempting suicide within the past 12 months by 1% (Baseline: 3%, 2019 Geauga County CHNA) 2. Suicide deaths: Decrease the number of age-adjusted deaths due to suicide per 100,000 population by 2 (Baseline: 11.5, 2013-2017 ODH Data Warehouse)	NAMI Geauga County
Year 2: Continue efforts from year 1. Administer at least four mental health first aid trainings (one per quarter) to increase education and understanding of mental illnesses and substance use disorders. Target trainings towards those who live in or serve economically disadvantaged, aging, and/or minority populations.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Administer at least four mental health first aid trainings (one per quarter) to increase education and understanding of mental illnesses and substance use disorders. Target trainings towards those who live in or serve economically disadvantaged, aging, 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 ○ Unknown/No Data ○ Not SHIP Identified

Resources to address strategy: MHRB, Ravenwood Health, schools, Lake Geauga Recovery Center, NAMI Geauga County, Partnership for a Healthy Geauga, Geauga Public Health, UH Geauga Medical Center (will provide Stop the Bleed training).

Priority #1: Mental Health

Strategy 3: Campaign to increase awareness of behavioral health warning signs

Goal: Improve mental health outcomes.

Objective: By December 31, 2022, create and implement a written implementation plan to increase awareness of mental health warning signs in Geauga County.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Work with school administrators, guidance counselors, hospitals, churches, and other community agencies to research mental health social marketing programs that specifically address stigma such as NAMI's **Cure Stigma** or OHMAS's **Be Present Campaign**). Secure funding for campaign and create a written implementation plan focusing on awareness and outreach. Target outreach to specific audiences, such as low-income, Amish, and school-age populations.	December 31, 2020	Adult	1. Adult stigma: Decrease the percentage of adult who did not use a program or service for themselves or a loved one to help with depression, anxiety, or emotional problems due to stigma (Baseline: 3%, 2019 Geauga County CHNA) 2. Adult suicide ideation: Decrease the percent of adults who report that they ever seriously considered attempting suicide within the past 12 months by 1% (Baseline: 3%, 2019 Geauga County CHNA) 3. Suicide deaths: Decrease the number of age-adjusted deaths due to suicide per 100,000 population by 2 (Baseline: 11.5, 2013-2017 ODH Data Warehouse)	Geauga County Board of Mental Health and Recovery Services
Year 2: Target campaign to specifically address demographics most at risk. Include information on warning signs and symptoms of mental health issues and where to seek help. Launch campaign. Continue to promote local community events that aim to reduce stigma. Promote and raise awareness of the Crisis Text Line (Text **4hope** to 741741) throughout the county, as well as other mental health trainings, such as **QPR (Question, Persuade, Refer)**.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Evaluate campaign effectiveness.	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 ○ Unknown/No Data ○ Not SHIP Identified

Resources to address strategy: MHRB, Ravenwood Health, schools, Lake Geauga Recovery Center, NAMI Geauga County, Partnership for a Healthy Geauga, Geauga Public Health, UH Geauga Medical Center will work with other partners to raise awareness.

Priority #1: Mental Health

Strategy 4: School-based social and emotional instruction

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

Objective: Implement a school-based social-emotional learning program in at least three additional Geauga County school districts by December 31, 2022.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Collect baseline data on the number of school districts that implement **The PAX Good Behavior Game**. Introduce PAX to Geauga County school districts that primarily serve economically disadvantaged and/or 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 PAX, or another evidence-based program, with the school(s).	December 31, 2020	Youth	TBD by Geauga County	Geauga County Board of Mental Health and Recovery Services
Year 2: Evaluate outcomes from year one. Obtain a MOU with at least one additional school district that primarily serves economically disadvantaged and/or 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 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 ○ Unknown/No Data ○ Not SHIP Identified

Resources to address strategy: MHRB, Ravenwood Health, schools, Lake Geauga Recovery Center, NAMI Geauga County, Partnership for a Healthy Geauga, Geauga Public Health, Torchlight Youth Mentoring Alliance (after school programs based on 40 developmental assets that improve social, emotional and resiliency in youth).

Priority #2: Addiction

Strategic Plan of Action

To work toward decreasing addiction, the following strategies are recommended:

Priority #2: Addiction

Strategy 1: School-based alcohol/other drug prevention programs

Goal: Decrease substance use.

Objective: By December 31, 2022, all school districts will have at least one school-based alcohol/other drug prevention program.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Continue to implement the **BOTVIN Life Skills** Training. Develop a marketing plan to recruit instructors and/or volunteers to assist in implementing/teaching the program. Implement Life Skills Training in all Geauga County school districts.	December 31, 2020	Youth	TBD by Geauga County	Ravenwood Health Lake Geauga Recovery
Year 2: Continue efforts from years 1. Determine the feasibility of expanding the program to additional classrooms. Secure funding for program (if applicable).	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Expand program service area where necessary.	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
- ○ Unknown/No Data
- ○ Not SHIP Identified

Resources to address strategy: MHRB, Ravenwood Health, schools, Lake Geauga Recovery Center, Torchlight Youth Mentoring Alliance, Geauga Public Health, Partnership for a Healthy Geauga.

Priority #2: Addiction

Strategy 2: Medication Assisted Treatment (MAT)

Goal: Decrease drug overdose deaths.

Objective: By December 31, 2022, create a plan to continue and expand MAT programming.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Responsible Person/ Agency
Year 1: Collect baseline data on the number of agencies offering MAT and how many clients have been served. Create a plan to continue and expand MAT services.	December 31, 2020	Adult	Unintentional drug overdose deaths: Decrease the number of age-adjusted deaths dues to unintentional drug overdoses per 100,000 population by 2 (Baseline: 21.1, 2012-2017 ODH Data Warehouse)	Ravenwood Health
Year 2: Continue efforts from year 1.	December 31, 2021			
Year 3: Continue efforts from 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
- ○ Unknown/No Data
- ○ Not SHIP Identified

Resources to address strategy: MHRB, Ravenwood Health, Lake Geauga Recovery Center, Geauga Public Health, Partnership for a Healthy Geauga, UH Geauga Medical Center (will work with partners to refer patients for the appropriate treatment).

Priority #2: Addiction

Strategy 3: Naloxone access

Goal: Decrease drug overdose deaths.

Objective: Expand naloxone distribution to include three additional distribution sites by December 31, 2022

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to implement Project DAWN and provide/distribute naloxone and increase awareness of free naloxone distribution for lay responders. Expand naloxone distribution to distribute 250 naloxone kits by end of year.	December 31, 2020	Adult	Unintentional drug overdose deaths: Decrease the number of age-adjusted deaths dues to unintentional drug overdoses per 100,000 population by 2 (Baseline: 21.1, 2012-2017 ODH Data Warehouse)	Geauga Public Health Ravenwood Health Lake Geauga Recovery
Year 2: Continue efforts from year 1. Expand naloxone distribution to include one additional distribution strategy.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Expand naloxone distribution to include one additional distribution strategy.	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
- ○ Unknown/No Data
- ○ Not SHIP Identified

Resources to address strategy: MHRB, Ravenwood Health, Lake Geauga Recovery Center, Geauga Public Health, Partnership for a Healthy Geauga.

Priority #3: Chronic Disease

Strategic Plan of Action

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

Priority #3: Chronic Disease				
Strategy 1: Prediabetes screening and referral				
Goal: Prevent diabetes in adults.				
Objective: By December 31, 2022, increase prediabetes screening and referral by 15%.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to screen for prediabetes and refer patients to resources. 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, aging and/or minority populations. Increase screening and referral by 5%.	December 31, 2020	Adult	Diabetes: Decrease the percent of adults who have been told by a health professional that they have diabetes by 2% (Baseline: 7%, 2019 CHA)	University Hospitals Geauga Medical Center
Year 2: Continue efforts from year 1. Increase screening and referral by 5%.	December 31, 2021			
Year 3: Continue efforts of years 1 and 2. Increase screening and referral 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 ○ Unknown/No Data ○ Not SHIP Identified				
Resources to address strategy: Geauga Public Health, YMCA, Area Office on Aging, OSU Extension, Partnership for a Healthy Geauga, UH Geauga Medical Center Community Outreach Staff and supplies.				

Priority #3: Chronic Disease

Strategy 2: Diabetes prevention program (DPP)

Goal: Prevent diabetes in adults.

Objective: By December 31, 2022, increase enrollment in diabetes education programs by 25%

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to implement the **National Diabetes Prevention Program (DPP)** at the YMCA. Increase awareness of the program among community agencies and health care providers. Create a referral process for admission to the program. Increase enrollment by 5% from baseline.	December 31, 2020	Adult	Diabetes: Decrease the percent of adults who have been told by a health professional that they have diabetes by 2% (Baseline: 7%, 2019 CHA)	Linda McVey, YMCA
Year 2: Continue efforts from year 1. Increase enrollment by 15% from baseline.	December 31, 2021			
Year 3: Continue efforts of years 1 and 2. Increase program participation by 25%.	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
- ○ Unknown/No Data
- ○ Not SHIP Identified

Resources to address strategy: Geauga Public Health, YMCA, Area Office on Aging, Partnership for a Healthy Geauga, OSU Extension.

Priority #3: Chronic Disease				
Strategy 3: Hypertension screening and follow up				
Goal: Prevent coronary heart disease in adults.				
Objective: By December 31, 2022, increase hypertension screening by 15%.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Continue to screen for hypertension and refer patients to resources. 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, aging and/or minority populations. Increase screening and referral by 5%.	December 31, 2020	Adult	Coronary heart disease: Decrease the percent of adults ever diagnosed with coronary heart disease by 1% (Baseline: 3%, 2019 CHA)	University Hospitals Geauga Medical Center
Year 2: Continue efforts from year 1. Increase screening and referral by 5%.	December 31, 2021			
Year 3: Continue efforts of years 1 and 2. Increase screening and referral 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 ○ Unknown/No Data ○ Not SHIP Identified				
Resources to address strategy: Geauga Public Health, YMCA, Area Office on Aging, OSU Extension, Partnership for a Healthy Geauga, UH Geauga Medical Center Community Outreach staff and supplies.				

Priority #3: Chronic Disease

Strategy 4: Wellness navigation

Goal: Increase wellness screenings.

Objective: By December 31, 2019, screen 1,200 patients a year for necessary wellness screenings and services.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to implement wellness navigation at UH Geauga. The Wellness Navigator will continue to screen inpatients and outpatients and facilitate scheduling services that are identified (i.e. mammogram, colonoscopy, calcium scoring, etc.) Screen 1,200 patients a year for necessary wellness screenings and services.	December 31, 2020	Adult	1. Mammography: Increase the percentage of women ages 40 and older who received a mammogram in the past year by 2% (Baseline: 62%, 2019 CHA) 2.Colonoscopy/ Sigmoidoscopy: Increase the percentage of adults ages 50 and older who received a colonoscopy/sigmoidoscopy in the past 5 years by 2% (Baseline: 58%, 2019 CHA)	University Hospitals Geauga Medical Center
Year 2: Continue efforts from year 1. Screen 1,200 patients a year for necessary wellness screenings and services.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Screen 1,200 patients a year for necessary wellness screenings and services.	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
- ⊗ Unknown/No Data
- ⊗ Not SHIP Identified

Resources to address strategy: Geauga Public Health, YMCA, Area Office on Aging, OSU Extension, Partnership for a Healthy Geauga, UH Geauga Medical Center Wellness Navigator.

Priority #3: Chronic Disease

Strategy 5: Screening events

Goal: Increase prevention and early detection.

Objective: By December 31, 2019, host 175 screening events per year in Geauga County.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to provide screening events though University Hospitals Geauga Medical Center. Community Outreach will provide 175 chronic disease screening events during the year to facilitate early detection and mitigate chronic disease progression.	December 31, 2020	Adult	1. Diabetes: Decrease the percent of adults who have been told by a health professional that they have diabetes by 2% (Baseline: 7%, 2019 CHA) 2. Coronary heart disease: Decrease the percent of adults ever diagnosed with coronary heart disease by 1% (Baseline: 3%, 2019 CHA)	University Hospitals Geauga Medical Center
Year 2: Continue efforts from year 1. Provide 175 chronic disease screening events per year.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Provide 175 chronic disease screening events 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
- ⊗ Unknown/No Data
- ⊗ Not SHIP Identified

Resources to address strategy: Geauga Public Health, YMCA, Area Office on Aging, OSU Extension, Partnership for a Healthy Geauga, UH Geauga Medical Center Community Outreach Staff and supplies.

Cross-Cutting Strategies (Strategies that Address Multiple Priorities)

Cross-Cutting Factor: Public Health System, Prevention and Health Behaviors

Cross-Cutting Factor: Public Health System, Prevention and Health Behaviors

Strategy 1: Mass-reach communications

Goal: Improve health behaviors.

Objective: By December 31, 2022, Geauga County will implement at least two mass-reach communication initiatives.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Establish the framework for **Mass-reach communication** initiatives: • Share messages and engage audiences on social networking sites like Facebook and Twitter. • Deliver messages through different websites and stakeholders communications. • Generate free press through public service announcements. • Pay to place adds on TV, radio, billboards, online platforms and/or print media. • Community wellness calendar	December 31, 2020	Adult	1. Diabetes: Decrease the percent of adults who have been told by a health professional that they have diabetes by 2% (Baseline: 7%, 2019 CHA) 2. Coronary heart disease: Decrease the percent of adults ever diagnosed with coronary heart disease by 1% (Baseline: 3%, 2019 CHA) 3. Current smoker: Percentage of adults who are current smokers (Baseline: 10% 2019 CHA) 4. Current vaper: Percentage of adults who are current vapers (Baseline: 6% 2019 CHA) 5. Adult suicide ideation: Decrease the percent of adults who report that they ever seriously considered attempting suicide within the past 12 months by 1% (Baseline: 3%, 2019 Geauga County CHNA) 6. Suicide deaths: Decrease the number of age-adjusted deaths due to suicide per 100,000 population by 2 (Baseline: 11.5, 2013-2017 ODH Data Warehouse) 7. Unintentional drug overdose deaths: Decrease the number of age-adjusted deaths dues to unintentional drug overdoses per 100,000 population by 2 (Baseline: 21.1, 2012-2017 ODH Data Warehouse)	Geauga Public Health Lake Geauga Recovery
Year 2: Continue efforts from year 1. Implement one mass-reach communication strategy.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Implement one mass-reach communication strategy.	December 31, 2022			

Priority area(s) the strategy addresses:

⊗ Mental Health and Addiction ⊗ Chronic Disease Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Unknown/No Data ○ Not SHIP Identified

Resources to address strategy: Geauga Public Health, YMCA, Area Office on Aging, OSU Extension, Partnership for a Healthy Geauga, MHRB, Ravenwood Health, Lake Geauga Recovery Center, NAMI Geauga County.

Cross-Cutting Factor: Public Health System, Prevention and Health Behaviors

Strategy 2: Employ strategies of intentional inclusion in the collection of population health data to assure representation of populations who experience health disparities and health inequities

Goal: Increase data collection regarding under-represented populations in Geauga County.

Objective: By December 31, 2022, create a comprehensive health assessment that is inclusive of our Amish community and people living with developmental and intellectual disabilities.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Responsible Person/ Agency
Year 1: Recruit additional partnership members who are able to represent the Amish community and the population who live with developmental and intellectual disabilities.	December 31, 2020	Adult, youth, child, Amish community, and People living with IDD.	1. The Partnership for a Healthy Geauga will include at least two members who are willing and able to represent the Amish population and two members who are willing and able to represent people who live with developmental and intellectual disabilities. 2. The next iteration of the Community Health Needs Assessment will include actionable data specific to these two populations.	Geauga Public Health
Year 2: Continue to engage new members, Work with local agencies, including Amish leaders and the Metzenbaum Center, to discuss appropriate strategies of data collection and topics of particular need/interest.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Create a create a comprehensive health assessment that consists of county-level data regarding the health risk behaviors, health status, and access to health needs for the general population as well as specifically as well as the Amish population and the population living with IDD.	December 31, 2022			

Type of Strategy:

○ Mental Health, Substance Use and Addiction ○ Chronic Disease ⊗ Not SHIP Identified

Strategy identified as likely to decrease disparities?

⊗ Yes No ○ Unknown/No Data ○ Not SHIP Identified

Resources to address strategy: Access to Amish community leadership, Access to the Geauga Board of Developmental Disabilities, UH Geauga Medical Center.

Cross-Cutting Factor: Healthcare System and Access

Cross-Cutting Factor: Healthcare System and Access				
Strategy 1: Health insurance enrollment, literacy and outreach				
Goal: Increase health insurance enrollment.				
Objective: Enroll 20% of identified uninsured UH Geauga patients to a health insurance option by December 31, 2022.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Refer the uninsured resident and enroll them in the Health Insurance Marketplace, Medicaid, or another health insurance option. Refer resident to health insurance literacy classes and promote the classes throughout the county. Enroll 10% of identified uninsured residents into a health insurance option.	December 31, 2020	Adult	Uninsured adults: Decrease the percent of adults who are uninsured by 2% (Baseline: 6%, 2019 CHA)	University Hospitals Geauga Medical Center
Year 2: Continue efforts from year 1. Enroll 15% of identified uninsured residents into a health insurance option.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Enroll 20% of identified uninsured residents into a health insurance option.	December 31, 2022			
Priority area(s) the strategy addresses: ⊗ Mental Health and Addiction ⊗ Chronic Disease ○ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Unknown/No Data ○ Not SHIP Identified				
Resources to address strategy: Geauga Public Health, Partnership for a Healthy Geauga, UH Geauga Medical Center Patient Access Staff.				

Cross-Cutting Factor: Healthcare System and Access

Strategy 2: 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: Collect baseline data on the number of evidence-based tobacco cessation treatments available in Geauga 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. Conduct activities to help increase the number of providers and/or provider referrals. Obtain at least 1 Letter of Commitment from providers and provider referrals	December 31, 2020	Adults	1. Current smoker: Decrease the percentage of adults who are current smokers by 2% (Baseline: 10% 2019 CHA) 2. Quit attempts: Increase the percent of adult smokers who have made a quit attempt in the past year by 2% (Baseline: 41% 2019 CHA)	Lake Geauga Recovery
Year 2: 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 providers. Encourage providers to share resources with patients who are current smokers, encourage them to quit, and refer them to treatment. Continue to conduct trainings and obtain at least 1 Letter of Commitment from providers and/or provider referrals.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Explore the feasibility of offering additional evidence-based tobacco cessation treatments to underserved areas.	December 31, 2022			

Priority area(s) the strategy addresses:

⊗ Mental Health and Addiction ⊗ Chronic Disease ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Unknown/No Data ○ Not SHIP Identified

Resources to address strategy: Geauga Public Health, Partnership for a Healthy Geauga, MHRB, Ravenwood Lake Geauga Recovery Center.

Cross-Cutting Factor: Healthcare System and Access				
Strategy 3: Amish outreach programs				
Goal: Increase positive health outcomes among Amish.				
Objective: By December 31, 2019, host 30 Amish outreach programs per year.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to do Amish outreach programs. Community Outreach will provide at least 30 Amish-specific outreach programs per year (well-baby clinic, immunizations clinic, health screens, etc.) during the year.	December 31, 2020	Adult	TBD by Geauga county	University Hospitals Geauga Medical Center
Year 2: Continue efforts from year 1.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2.	December 31, 2022			
Priority area(s) the strategy addresses: ○ Mental Health, Substance Use and Addiction ○ Chronic Disease ⊗ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Unknown/No Data ⊗ Not SHIP Identified				
Resources to address strategy: Geauga Public Health, Partnership for a Healthy Geauga, UH Geauga Medical Center Community Outreach staff and supplies.				

Cross-Cutting Factor: Social Determinants of Health

Cross-Cutting Factor: 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, 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: 6%, 2018 Census Quick Facts)	Geauga County Public Library
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			
Priority area(s) the strategy addresses: ⊗ Mental Health and Addiction ⊗ Chronic Disease ○ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Unknown/No Data ○ Not SHIP Identified				
Resources to address strategy: Geauga County Public Library, Geauga Public Health, Partnership for a healthy Geauga.				

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 on an as-needed basis. The full committee will meet quarterly to report out progress. The committee will create a plan to disseminate the CHIP to the community. Strategies, responsible agencies, and timelines will be reviewed at the end of each year by the committee. As this CHIP is a living document, edits and revisions will be made accordingly.

Geauga County will continue facilitating 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 Geauga County, but also be able to compare to the state and nation. This data will serve as measurable outcomes for each priority area. Indicators have already been defined throughout this report and are identified with the icon.

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

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

Contact Us

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

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Appendix I: Gaps and Strategies

The following tables indicate gaps and potential strategies that were compiled by the Partnership for a Healthy Geauga.

Mental Health Gaps

Gaps	Potential Strategies
1. Mental Health Stigma	• Outreach/education – "Finding your own audience," such as low-income or Amish, or schools. • QPR training
2. Lack of diversity of available programs	• Explore multilingual services, education, and availability
3. Lack of mental health prevention/coping skills for K-12 (Get all schools on board with PAX)	• Educate not PAX schools about return on investment • Expand life skill (e.g. addiction)
4. Lack of mental health counselors in schools and do not utilize school nurses	• Provide mental health services in schools to kids with violent behaviors • Educate parents on youth mental health
5. Lack of youth data	• Youth health assessment/OHYES
6. Rising suicide numbers in the aging population	• Early identification through Meals on Wheels • Case management through Area on Aging • Referrals through health department • UH Age Well Be Well • Expand PHQ-2
7. Hidden issues among Amish we don't know about concerning depression, domestic violence, etc.	• Build relationship with Amish to establish trust • Target Amish in health assessment • Home visits
8. Lack of technology skills among aging population to access certain resources	• Tech help/training at senior centers • Provide print information through senior programs or libraries • Yearly calendar
9. Social anxiety among youth	• Youth mentoring programs • YAC

Addiction Gaps

Gaps	Potential Strategies
10. Lack of education/prevention around addiction at the youth-level concerning tobacco, vaping, drinking, drug use, etc. (Life skills in certain schools in some capacity only in select grades)	• Life skills • No comprehensive health education standards
11. Lack of awareness of resources that are available in the county	• County level resource guide • Promote 2-1-1 (online database available) • Pathways HUB
12. Addiction Stigma	• Routine screening • More education to primary care providers • Naloxone treatment • Gambling education
13. Lack of detox beds and most insurance won't cover it	• Advocacy plan
14. Funding for alcohol, amphetamines and cocaine. Funding going towards opiates.	• Advocacy plan
15. Lack of smoking cessation services	• Increase cessation services • Smoke-free policies
16. Hidden issues among Amish we don't know about concerning drug use	• Build relationship with Amish to establish trust • Target Amish in health assessment • Home visits
17. Rx misuse among aging population	• Rx assistance
18. Lack of technology skills among aging population to access certain resources	• Tech help/training at senior centers • Provide print information through senior programs or libraries • Yearly calendar

Chronic Disease Gaps

Gaps	Potential Strategies
1. Lack of education for adults and youth around healthy eating and physical activity	• Expand Age Well Be Well • Increase community gardens • Physical education programs for aging population • Expand SNAP education • SNAP/WIC at farmers markets
2. Lack of awareness of resources	• Resource guide/Facebook page/Amish newsletter • Resource fairs
3. Lack of awareness of programs/activities/senior centers available for the aging population	• Expand Aging Agency newsletter
4. Expense of healthy foods	• Healthy food at food banks • Healthy convenience stores • Cooking matters
5. Lack of gym/affordability of gyms	• Shared use agreement • County worker access to YMCA at discount
6. Apathy/Lack of buy-in	• Campaign to change perceptions • Expand efforts of wellness clinic • Patient centered medical homes
7. Lack of self-efficacy	• Cooking matters • Community education and motivation • Target churches, school, and transportation for messaging

Cross-Cutting Factor: Access to Health Care Gaps

Gaps	Potential Strategies
Lack of health care providers (primary care [or long wait list], mental health, and behavioral health)	• Behavioral health pipeline program • Physician recruitment – UH, to address nursing/physician shortage
Only one dentist in the county accepts Medicaid	• None noted
Long waitlists to see behavioral health counselors	• Recruit psychiatrists/psychiatric nurse practitioners
Lack of acute behavioral health care inpatient beds	• Advocacy plan
Not enough resources to meet the demand of behavioral health issues—locations that will take patients for acute care	• None noted
Some health care agencies do not accept certain types of health care, such as Tri-Care	• None noted
Limitations in serving those with Medicare	• Advocacy plan
Understanding insurance coverage and what is covered	• Ohio Department – insurance • Health Insurance Policy • UH to explain insurance prior to services • Expand Amish outreach of health insurance
Lack of awareness of screenings such as mammograms	• Expand wellness navigator • More community outreach
Lack of screenings/immunizations with the Amish	• Amish well-being clinic • Increase Amish outreach events (include free transportation)
Misinformation around vaccines	• Increase social media campaign • Increase awareness regarding vaccines

Cross-Cutting Factor: Social Determinants of Health Gaps

Gaps	Potential Strategies
Lack of coping/social emotional learning in relation to ACEs	• None noted
Food insecurity on East side	• None noted
Transportation	• None noted
Lack of data concerning domestic violence	• None noted