2022

Mahoning-Trumbull

Community Health Improvement Plan – **Mahoning & Youngstown**

August 2022

Trumbull County Public Health
Mahoning County Public Health
Warren City Health District
Youngstown City Health District

SIGNATURES

This plan has been approved and adopted by the following individuals: This CHIP document is reflection of the priorities and strategies for Mahoning County and Youngstown City only. Trumbull County and Warren City strategies were removed for clarity of the work being performed with community partners in Mahoning County. Please contact the Trumbull County Health District for strategies as they relate to Trumbull County and Warren City.

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ACKNOWLEDGMENTS

The Mahoning Trumbull Community Health Partners (MTCHP) is a collaborative effort started in 2021, among health and human services agencies in the two counties. MTCHP expresses gratitude to all the partners and community members who contributed their time, expertise, and passion to this project.

CONTRACTORS

The North Carolina Institute for Public Health at the UNC Gillings School of Global Public Health in Chapel Hill was contracted to provide facilitation and development services for the Mahoning Trumbull Community Health Needs Assessment and Community Health Improvement Plan.

ACRONYMS USED IN THIS REPORT

CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
CHOS	Community Health Opinion Survey
MTCHP	Mahoning Trumbull Community Health Partners
NCIPH	North Carolina Institute for Public Health
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual
SHIP	State Health Improvement Plan

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FOREWORD

Dear Mahoning and Trumbull County Community Members,

In keeping with our shared goal of improving community health through collaboration and community action, it is the pleasure of Mahoning Trumbull Community Health Partners (MTCHP) to present the 2022-2024 Mahoning Trumbull Community Health Improvement Plan (CHIP). This plan will serve as a roadmap to improving the health and well-being of all residents of our two counties.

The CHIP process was conducted in four sessions with both health and human service organizations as well as community members and facilitated by the North Carolina Institute for Public Health at the UNC Gillings School of Global Public Health. The collaborative process involved many weeks of work with many community contributors. Using data from the 2022 Mahoning Trumbull Community Health Needs Assessment (CHNA), a Results-Based Accountability model was utilized to guide the partnership in the development of purpose statements, population-level indicators, organizational-level strategies, and performance measures that will serve as the blueprint for improving health outcomes in our community over the next three years.

The CHIP is meant to be concise, accessible, data-driven, feasible, up-to-date, and equitable with established metrics to track our progress and hold us accountable for our strategies. As such, this plan is a "living document" that will be monitored and implemented over the next three years. The plan will be reviewed at least annually to reflect our progress and new areas of need, and changes made as needed. To that end, by addressing our most significant health challenges through a comprehensive, collaborative approach, we can ensure the residents of Mahoning and Trumbull counties that our available resources are most effectively utilized to improve the health of our communities.

We would like to thank our partners and engaged community members for their dedication to this effort and invite everyone to stay active in this process as we go forward in bettering our communities in the coming years.

Sincerely
Mahoning Trumbull Community Health Partners

INTRODUCTION

WHAT IS A CHIP?

CHIP stands for Community Health Improvement Plan. Through the CHIP, the community establishes a shared set of priorities, and identifies appropriate projects, programs and policies that will be implemented to advance these priorities. The CHIP is a collaborative process, drawing on organizations and community members varied expertise and experiences to inform the planning process and identify and uplift community resources and assets. This CHIP sets forth the strategic plan for improving health and well-being in Mahoning and Trumbull counties from 2023-2025. Although The CHA and CHIP is performed collaborative between Trumbull Mahoning County, this document reflects the strategies and initiatives for Mahoning and Youngtown City.

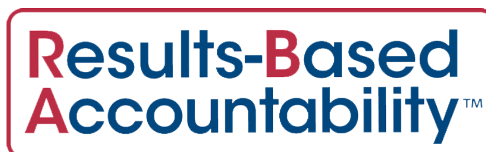
According to the Centers for Disease Control and Prevention, a CHIP is a "long-term, systematic effort to address public health problems based on results of community health assessment activities and the community health improvement process." {CDC}

WHY IS A CHIP IMPORTANT?

The CHIP establishes common priorities and courses of action in order to improve community health. A CHIP can serve as a roadmap guiding many different entities and organizations to contribute to the selected priority area improvements and, in turn, grow the community's health. While Mahoning and Trumbull counties have previously worked separately to formulate and implement their CHIP, the 2022 process is especially important because the Mahoning and Trumbull Community Health Partners (MTCHP) collaborative brought together partners across both counties to work together, leveraging overlapping resources and assets to address opportunities shared by both counties.

HOW IS A CHIP DEVELOPED?

The MTCHP collaborative represents Mahoning County Public Health, Trumbull County Combined Health District, Warren City Health District, Youngstown City Health District, the Mercy Health Foundation Mahoning Valley, the Mahoning Mental Health and Recovery Board, the Trumbull Mental Health and Recovery Board, and Healthy Community Partnership- Mahoning Valley. Many other health and human service organizations engaged in the CHNA and CHIP processes. Community members in both Mahoning and Trumbull counties were specifically invited to participate in the CHIP, with over 50 community members joining the hybrid community meeting that set the stage for the proceeding priority-focused planning meetings. The process was facilitated by the North Carolina Institute for Public Health at the UNC Gillings School of Global Public Health using a Results-Based Accountability™ (RBA) approach for improvement planning.



HOW WILL THE CHIP BE IMPLEMENTED?

Through the CHIP process, community partners selected evidence-based and community-appropriate program or policy strategies. Each priority area has multiple strategies outlined in its Action Plan. Next, community partners identified organizations and individuals who will be responsible for coordinating and

supporting the implementation of these interventions, as well as the timeline for implementation. Finally, the CHIP establishes a plan to track the impact of the proposed interventions over time.

*TBD (to be determined) notes within the original action plans here will be resolved in early meetings of the workgroups to further refine planned work.

IMPORTANT CONSIDERATIONS

PHAB REQUIREMENTS

The Public Health Accreditation Board is the national accrediting body for public health departments. PHAB accreditation demonstrates that health departments meet a common set of standards, have the capacity to conduct and deliver core public health services, and are working to improve services, value and accountability to their stakeholders. Mahoning County Health Department received PHAB re-accreditation in 2021, and Trumbull County Combined Health District received initial accreditation in 2019. In order to receive or maintain their accreditation status, health departments must fulfill a variety of requirements, including completing a Community Health Assessment and CHIP in alignment with PHAB accreditation standards (specifically 1.1 for Assessment and 5.2 CHIP) {Reaccreditation Guide}. While PHAB standards specify that CHIP should be completed at least every five years, Ohio state law requires CHIPs to be developed every three years {ORC 3701.981}. A checklist of how this CHIP meets PHAB requirements can be found in Appendix 1.

THE IMPORTANCE OF LANGUAGE AND EQUITY

In developing priorities, the MTCHP desired a strong CHIP focus on incorporating health equity and addressing root causes of issues throughout the process. To assist, the Vibrant Valley Health Equity Project revised the previous CHIPs with a health equity lens and provided feedback and suggestions on improving the process (ECO, personal communication, April 4, 2022). Suggestions and how they were addressed included:

Add an iterative process to verify that language aligns with intent of strategy, realistic expectation for who is in charge so it can continue in the face of staff succession.
Within the process, utilizing RBA guided the group in clearly linking strategy to population-level purpose and indicators. The action plans clearly define who is the lead agency, who are contributing agencies, and who is the lead for monitoring/evaluation.

Identify different roles for accountability partners and champion organizations so that we can reduce the burden of CHIP strategy implementation.
The action plans clearly define who is the lead agency, who are contributing agencies, and who is the lead for monitoring/evaluation.

WHAT IS HEALTH EQUITY?

While the term health equity is used widely, a common understanding of what it means is lacking.

According to the Robert Wood Johnson Foundation, "health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." {Robert Wood Johnson}

Consider limiting the number of CHIP strategies, mapping/organizing all strategies, or culling strategies when needed.
Only three priorities were chosen for this CHIP, with a total of 11 main strategies, many of which align with local organization strategic plans.

Be as specific as possible when referring to target population.
How each strategy addresses health equity is included in the action plans. A concerted approach was made in developing purpose statements that also took health equity into strong consideration.

There is continuing opportunity to continue to address health equity throughout the next three years and community organizations, partners, and individuals are encouraged to identify issues and contribute to these improvements during annual evaluation.

ALIGNMENT WITH SHIP

The Ohio State Health Improvement Plan (SHIP) 2020-2022 was created as a roadmap to respond to the challenges and opportunities identified in the 2019 State Health Assessment. Just as the CHIP guides local health improvement at the county level, the Ohio Department of Health and other agencies utilize the SHIP to organize entities across the state to guide policy, programmatic, and funding efforts to improve the health of Ohioans. The 2020-2022 SHIP vision is that the state of Ohio is a model of health, well-being and economic vitality. (Ohio Department of Health, 2020)

2020-2022 State Health Improvement Plan (SHIP) framework

Equity
Health equity is achieved when all people in a community have access to affordable, inclusive and quality infrastructure and services that, despite historical and contemporary injustices, allows them to reach their full health potential.

Priorities
The SHIP identifies three priority factors and three priority health outcomes that affect the overall health and well-being of children, families and adults of all ages.

What shapes our health and well-being?
Many factors, including these
3 SHIP priority factors*:

Community conditions
- Housing affordability and quality
- Poverty
- K-12 student success
- Adverse childhood experiences

Health behaviors
- Tobacco/nicotine use
- Nutrition
- Physical activity

Access to care
- Health insurance coverage
- Local access to healthcare providers
- Unmet need for mental health care

How will we know if health is improving in Ohio?
The SHIP is designed to track and improve these
3 SHIP priority health outcomes:

Mental health and addiction
- Depression
- Suicide
- Youth drug use
- Drug overdose deaths

Chronic disease
- Heart disease
- Diabetes
- Childhood conditions (asthma, lead)

Maternal and infant health
- Preterm births
- Infant mortality
- Maternal morbidity

All Ohioans achieve their full health potential
- Improved health status
- Reduced premature death

Vision
Ohio is a model of health, well-being and economic vitality

Strategies
The SHIP provides state and local partners with a menu of effective policies and programs to improve Ohio's performance on these priorities.

* These factors are sometimes referred to as the social determinants of health or the social drivers of health

The Ohio Department of Health and other agencies utilize the SHIP to organize entities across the state so that the work being done is complimentary and that "everyone is rowing in the same direction"; the SHIP is intended to guide policy and funding decisions. In order to achieve its statewide goals, the state recommends CHIP strategic planning at the local level align with several aspects of the SHIP.

ALIGNMENT GUIDANCE

The Ohio Department of Health offers guidance to local health departments undertaking the CHIP process to ensure local goals can be tracked and contribute to statewide progress. The following items indicate the areas of alignment between the Mahoning and Trumbull CHIP and the Ohio SHIP 2020-2022. (Ohio Department of Health, 2020)

Identify at least one priority factor and at least one priority health outcome. Selection of community conditions is strongly recommended. Priorities should be informed by the CHNA and/or CHA.

Priority factors	Priority health outcomes
✓ Community conditions	✓ Mental health and addiction
☐ Health behaviors	☐ Chronic disease
✓ Access to care	☐ Maternal and infant health

Select at least one health indicator for each identified priority factor and priority health outcome.

Priority factors		
Community Conditions and Safety		
Topic	Indicator name (per SHIP)	Indicator CHIP
Housing affordability and quality	CC1. Affordable and available housing units	Percent of population cost-burdened by housing (spending more than 30% of income on housing), stratified by homeowners and renters
Poverty	CC3. Adult poverty	Percent of population living below the poverty line
Access to Care		
Screening (*does not align with example topic)	*does not align with SHIP topics/indicators	Percent of Mahoning and Trumbull County population accessing recommended preventive screenings: Cervical cancer screening among women ages 21-65
	*does not align with SHIP topics/indicators	Percent of Mahoning and Trumbull County population accessing recommended preventive screenings: Cholesterol screening among adults 18+
	*does not align with SHIP topics/indicators	Percent of Mahoning and Trumbull County population accessing recommended

		preventive screenings: Colorectal cancer screening among adults 50-75
	*does not align with SHIP topics/indicators	Percent of Mahoning and Trumbull County population accessing recommended preventive screenings: Mammography among women ages 50-74
Priority health outcome		
Mental Health and Substance Use		
Topic	Indicator name (per SHIP)	Indicator CHIP
Depression	MHA 2. Adult depression	Average number of mentally unhealthy days reported in past 30-days
Drug overdose deaths	MHA7. Unintentional drug overdose deaths	Unintentional drug overdose mortality
	MHA7. Unintentional drug overdose deaths	Incidence of emergency department visits for suspected drug overdose

Select at least one strategy for each priority factor and priority outcome

See the action plans for strategies – each priority factor and outcome include at least one strategy.

Equity: Whenever possible, identify priority populations for objectives and select strategies likely to reduce disparities and inequities. Resources should be allocated and tailored to communities where need is greatest.

Health equity and root causes of inequities were a key part of the initial discussion with community members during the hybrid session. Additionally, each action plan was examined and revised using an equity lens by the MTCHP workgroup members, with guidance from the Vibrant Valley Health Equity Project. Members worked to identify priority populations, tailor interventions to alleviate inequities, and allocate resources where they are most needed.

COMMUNITY PARTNERS

Developing and implementing the CHIP with a wide and diverse array of partners and engaged community members is critical to its relevance to the community and its success. This

IMPORTANT DEFINITIONS

According to Community Catalyst, "*a **coalition** is an alliance of individuals and/or organizations working together to achieve a common purpose. When this type of alliance forms to address the needs and concerns of a particular community, it is often referred to as a community coalition.*"

A **community-based organization** is defined by the US Department of Health and Human Services as, "*a public or private non-for-profit resource hub that provides specific services to the community or targeted population within the community that works to address the health and social needs of populations. These organizations are trusted entities that know their clients and communities, want to be engaged, and have the infrastructure/systems in place to work on various community issues.*"

process engaged not just the MTCHP, but a multitude of other health and human services agencies across the two counties, as well as a number of community members. These agencies and individuals are listed in Appendix 2.

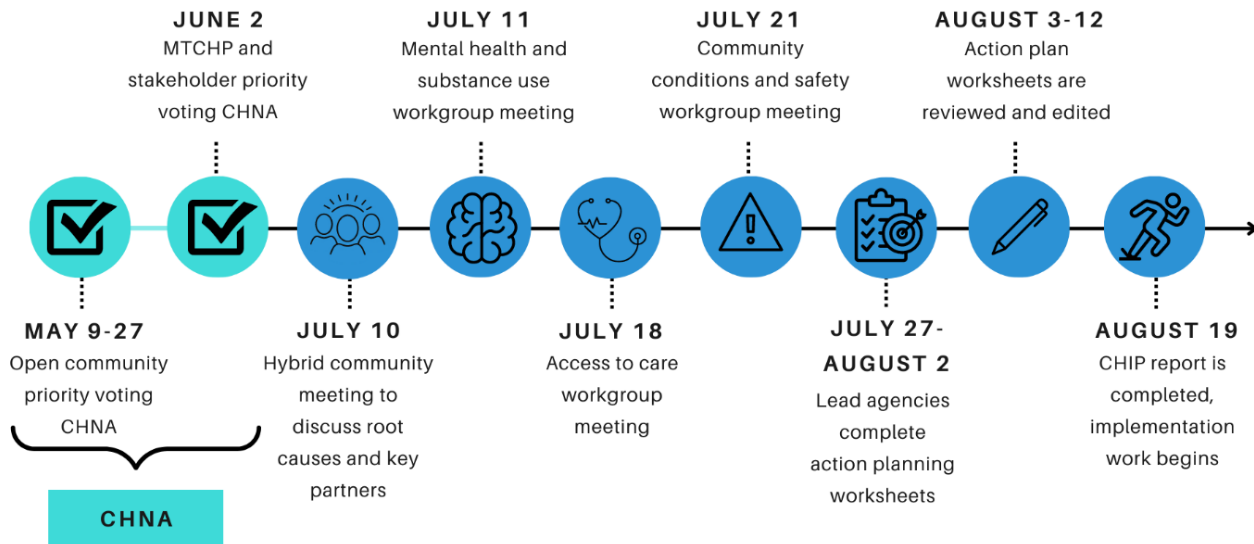
It should also be noted that engaging with community coalition and community-based organizations is crucial to implementation of CHIP strategies, though expectations for their level of involvement/ responsibilities should not be assumed as they are often under-resourced.

COMMUNITY HEALTH IMPROVEMENT PROCESS

The CHIP Process was conducted in July and August of 2022. After the completion of the CHNA, the MTCHP members participated in a Results-Based Accountability Workshop. In early July, the MTCHP hosted a hybrid meeting (online and in-person in Youngstown and Warren) for community members to discuss their vision for the future of health in Mahoning and Trumbull counties as it related to the three priority areas. The community discussed their vision for each priority in three years, what root causes they identify with each priority, and what key partners are currently involved with addressing the issue or where partner gaps were in planning and implementing intervention and policy changes. This discussion was synthesized by NCIPH and provided to each of the priority area working groups.

Subsequently, the MTCHP held three meetings, with each meeting focused on one of the priority topic areas. In these topic-specific meetings, MTCHP partners built on the community discussions and applied the RBA framework to identify/refine population-level purpose statements and indicators and organizational-level strategies and performance measures. Each workgroup included dedicated time to discuss equity concerns related to the strategies they generated. After each meeting, the lead agency responsible for each intervention or policy developed an action plan, including timeline and evaluation/monitoring strategy. An initial draft of the action plans was shared with the working groups and interested community partners for feedback before being incorporated into the CHIP.

After the CHIP was completed in August, several Mahoning County partners raised questions about gaps that remained in the CHIP strategies. In November, the Vibrant Valley Health Equity Project hosted three workshops (one per priority topic area) to revise the CHIP and address these gaps. This revision process included adding detail about who would be implementing each strategy, as well as clarifying what metrics would be used to track progress and health outcomes. The resulting Mahoning County CHIP was presented to the public at a Community Health Open House and Resource Fair in February 2023.



COMMUNITY HEALTH NEEDS ASSESSMENT SUMMARY

ABOUT

The Community Health Needs Assessment is a systematic process for evaluating community health in which data is gathered and analyzed that describes the state of health and wellbeing within a community. During this process, community members and the assessment team work to identify community needs, areas for improvement, resources, and strengths. Using this information, priority areas are selected to be the focus of strategic planning, ensuring a data and community-informed approach to health improvement. The community assessment process and the final report set the stage for the CHIP by promoting collaboration and resource sharing between local leaders, community-serving organizations, and community members as they work to improve community health in the priority areas.

COMMUNITY INVOLVEMENT

Community members across counties were engaged in this assessment process in a variety of ways. Community members were invited to take the Community Health Opinion Survey, participate in Community Conversations, attend assessment data presentations, and vote during prioritization. Community Conversations were held among specific populations in the counties who historically have been underserved and underrepresented. These conversations groups were: community members experiencing homelessness, Black/African American community members, community members in rural areas, LGBTQIA+ community members, and Latinx community members.

Community Prioritization Voting was conducted online from May 9th to May 27th, 2022, and was open to all adults living in Mahoning and Trumbull County. In total, 844 community members participated, 591 from Mahoning and 253 from Trumbull County. In both counties, a disproportionate number of respondents were women (76%). Regarding race and ethnicity, 83% of participants identified as white, compared to 10% Black/African American, and 3% Hispanic/Latino. While these demographics roughly align with the racial/ethnic makeup of Trumbull County, Black/African American and Hispanic/Latino voices

were underrepresented in priority voting in Mahoning County. The top five priorities selected by respondents in Mahoning and Trumbull County were mental health, community safety, access to care, access to healthy food and physical activity, and substance use. There was considerable alignment in priorities among respondents in both counties, apart from substance use, which was voted as a priority by 25% of respondents in Mahoning County (making it #5 in ranked priorities) compared to 37% of respondents in Trumbull County (making it #2 in ranked priorities). Among respondents who identify as Black/African American, community safety, community conditions, and education were more often selected as priorities. Among Hispanic/Latino respondents, access to care, community conditions, and mental health were more often selected.

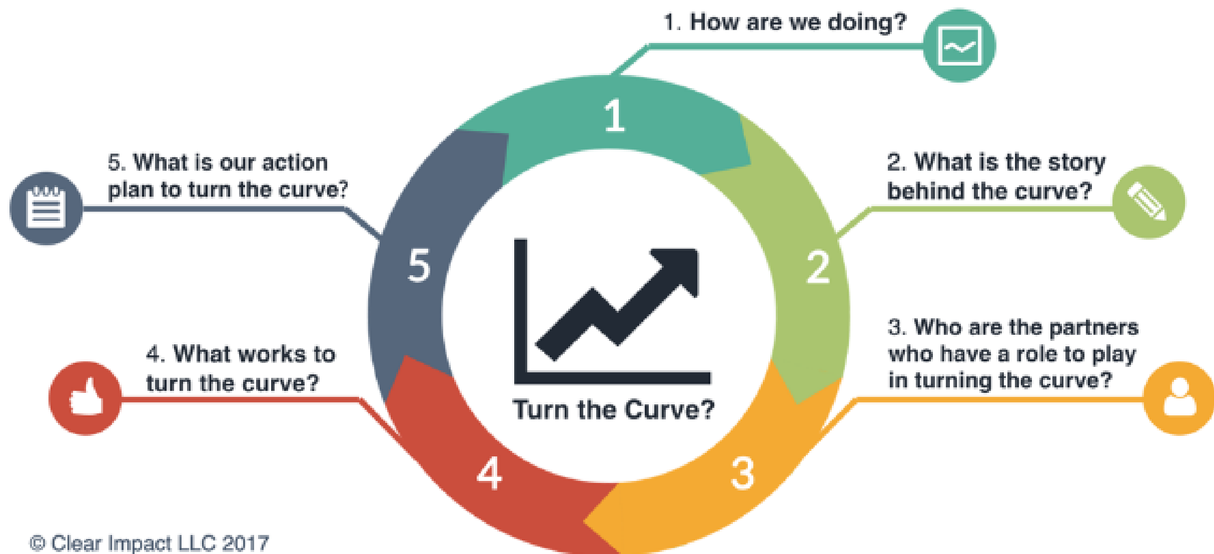
On June 2nd, 2022, the steering group and additional community stakeholders met to review the prioritization voting and relevant data and to cast votes live as community representatives using the Mentimeter voting platform. Thirty-five community stakeholders in attendance cast votes. The most votes were cast for mental health, followed by community safety, access to care, and community conditions. Further discussion suggested consensus around combining mental health and substance use as a single priority, acknowledging that there is alignment in services and existing efforts, although strategies to approach each will differ. Stakeholders also emphasized the need to center the voices of those most affected by poor outcomes in the priority selection, as well as to address root causes of health disparities.

After reviewing the community voting, the stakeholder voting, the relevant data, and the reflections from the prioritization meeting, the CHNA leadership team synthesized the priority areas into three: mental health and substance use, community conditions with an emphasis on community safety, and access to care. Health equity was also identified as a cross-cutting issue to incorporate into the community health improvement planning process in all three priorities.

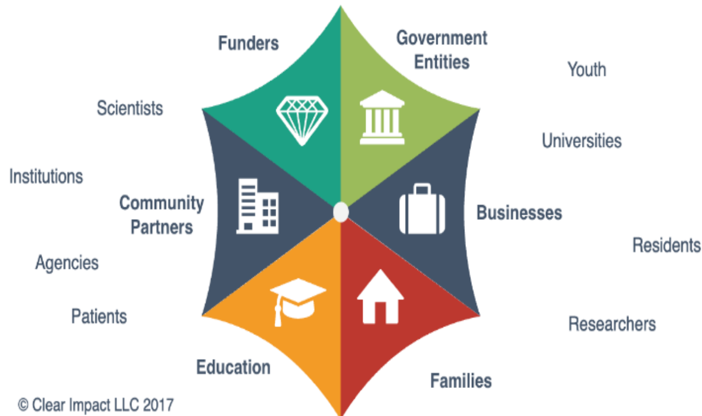
RESULTS-BASED ACCOUNTABILITY

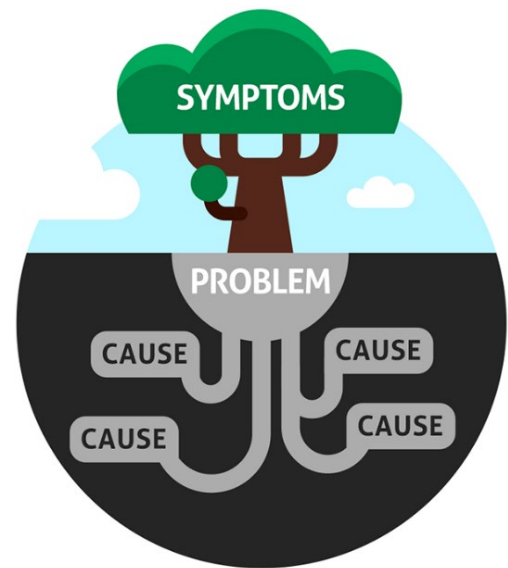
NCIPH facilitated a Results-Based Accountability™ (RBA) approach to the CHIP strategic planning. RBA is a methodology for problem-solving developed by Mark Friedman and Clear Impact LLC {Clearimpact website}. RBA is a simple approach that starts with determining the desired end-state and works backward to identify the best means of achieving that vision. RBA ensures decision-making is data-driven and transparent.

"Turn the curve thinking" is foundational to RBA. Turning the curve for CHIP means first understanding the current state of the community's health, and exploring the contributing factors driving the data, then using this information to generate partnerships and strategies that, when applied will change the trajectory of the health outcomes.



In this case, the desired end-state was a happier and healthier community in Mahoning and Trumbull counties. By examining the current data collected in the Community Health Needs Assessment, community partners gained a picture of the state of health in both counties and the contributing factors to current trends. In community meetings, participants discussed best practices and evidence-based solutions that have been successful at influencing the root causes and brainstormed how these efforts could be best applied in Mahoning and Trumbull counties. After selecting the most appropriate strategies, plans were made for strategy implementation, a lead entity or person was selected to be responsible for the effort's coordination, a timeline was set, supportive partners were identified, and action steps were proposed. Continuous monitoring and assessment are an essential part of the RBA process to see if there is new data, additional information on best practices, or new potential partners. Communities participating in RBA are encouraged to meet regularly for status updates and to track their progress.





RBA works to turn the curve by leveraging the work being done by existing partners and by identifying new partners that serve the community's common goals. A key concept of RBA relevant here is the concept of Population and Performance Accountability which demonstrates the complementary and collaborative efforts of many partners to total improvement and which also set a framework for measuring progress.

- Population accountability: A group of partners takes responsibility for the well-being of the population. In this case the MTCHP partners and community organizations and members who participated in the CHIP process.
- Performance accountability: A single partner is responsible for the well-being of their customer population rather than the whole. For instance, a hospital may be responsible for looking after patients within its own catchment area.

These two concepts are important because entities participating in broader population health improvement can do so in ways that align with their programmatic responsibilities. While performance accountability can be a contributing part of population accountability, it is important to distinguish if an aim is for accountability for the whole population or a client population because this has an impact on the language used to evaluate progress.

While data-informed and partner-driven action are necessary to turn the curve, progress must also be measured consistently to determine the effectiveness of the interventions. In Population Accountability, Results are measured by key Indicators. In Performance Accountability, organizational efforts or programs make contributions that serve their clients and are quantified by Performance Measures. The performance measures identify the quantity and quality of effort and determine the effect the intervention has had on the clients.

To learn more about Results-Based Accountability™ visit https://clearimpact.com/results-based-accountability/ (Belflower Thomas, 2022).

COMMUNITY INVOLVEMENT IN CHIP

Community involvement was an essential part of shaping the CHIP. As part of the CHNA, 844 community members voted on a set of 12 priorities to select the top five most important. The community selections provided the base for the MTCHP prioritization discussion and final voting. On July 10th a hybrid CHIP meeting was hosted with in-person locations in Youngstown and Warren, with an option to join online. NCIPH facilitated the community discussion and synthesized using Google Jamboards. As part of the activity community members generated Results Statements for each of the priority areas, discussed the story behind the priorities, and brainstormed existing and needed partners.

Results/Purpose Statement

- A result is something we want for our whole population, such as:
  - A community with adequate affordable housing for all.
  - An environment which is....
  - Children who are...
  - Families that are...
  - Communities that are....

Results Statements

Access to Care

Results/Purpose Statement

- To do this, it should:
  - Use simple, plain language
  - Be positively stated
  - Avoid referencing data or improvement
  - Avoid referencing services or programs

Community where providers can be reached and patients can get care in an adequate time.

Everyone in the community, regardless of their insurance can get the care they need

Community with more facilities to provide treatment.

Families that can overcome insurance issues to receive adequate treatment.

Community that improves access to all types of health screenings.

Communities that encourage screenings at faith-based organizations.

Community with referral system and central location to access health needs.

Increase knowledge of FQHCs in the area

Understanding the 988 Suicide Line.

Community with public transportation.

Figure 1: Jamboard from 7/10/22 Community Meeting, Results Statements.

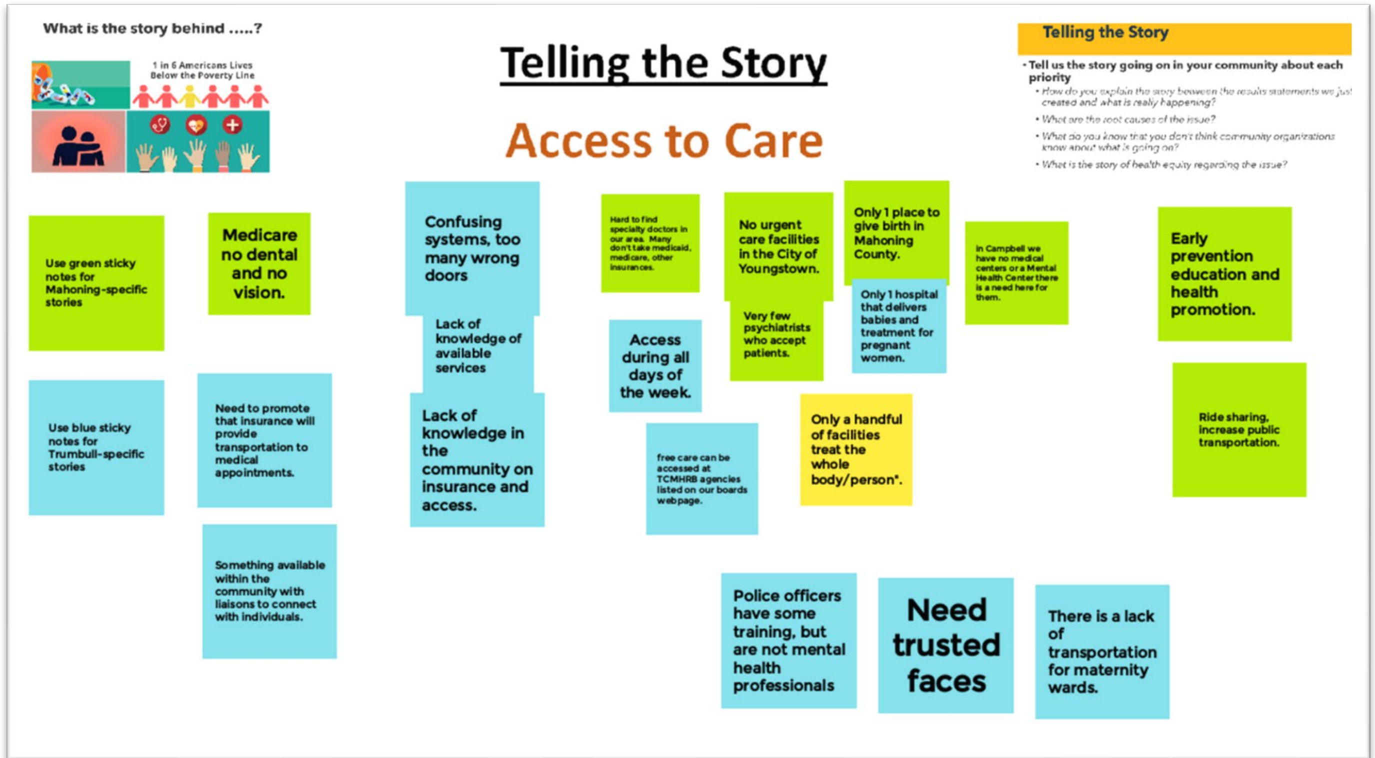


Figure 2: Jamboard from 7/10/22 Community Meeting, Story Behind the Curve

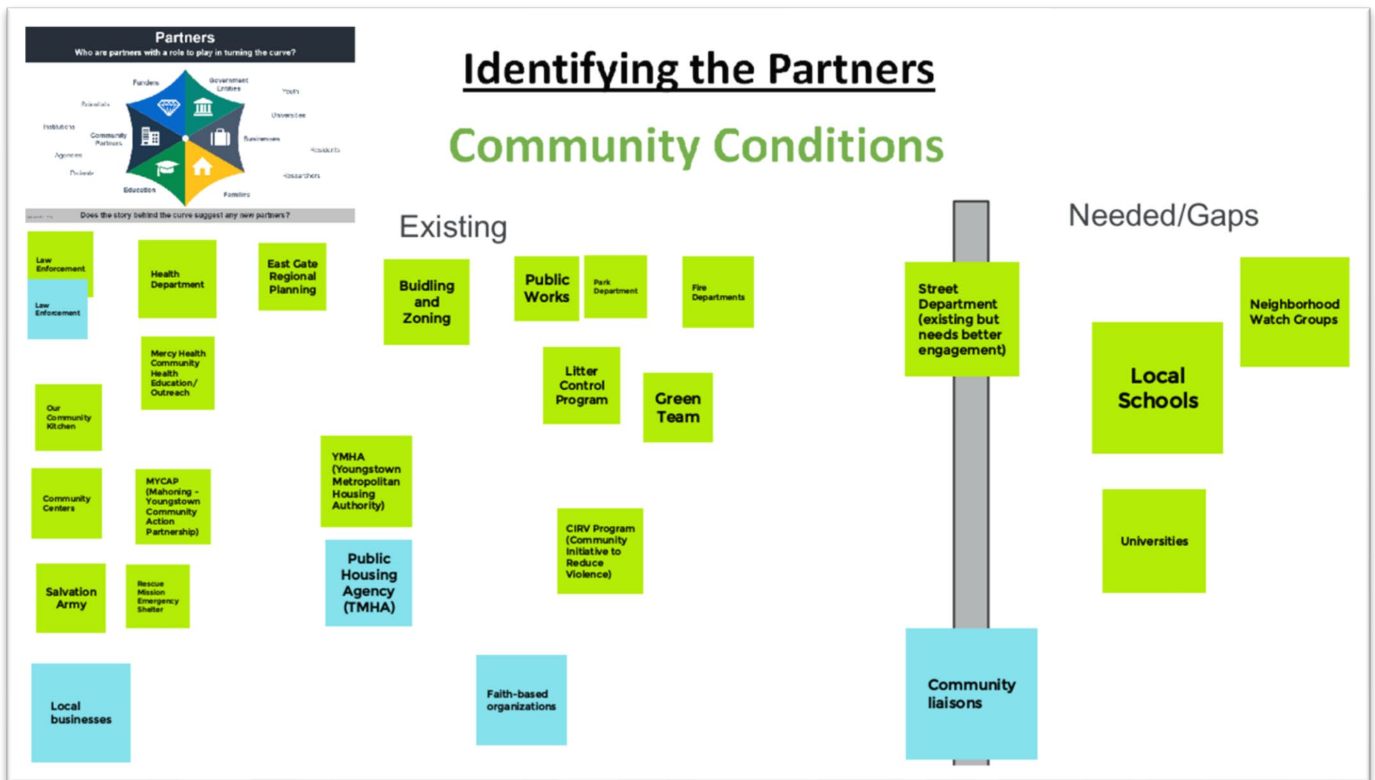


Figure 3 Jamboard from 7/10/22 Community Meeting, Identifying Partners

A community free of stigma around mental health & substance use where there are no barriers to accessing and utilizing affordable, culturally relevant, holistic care when and where and how they need it.

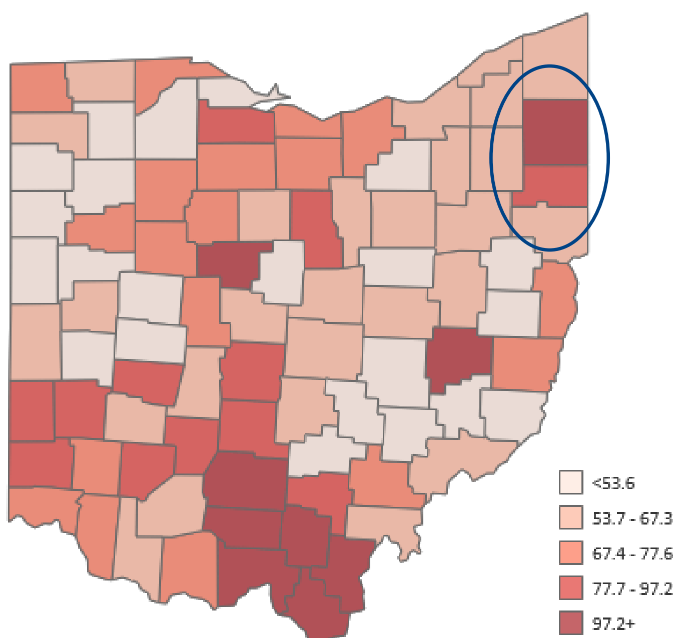
POPULATION-LEVEL INDICATORS:

1. Incidence of emergency department visits for suspected drug overdose (Ohio Department of Health EpiCenter, data available to health departments)
2. Unintentional drug overdose mortality (Ohio VDRS) (Ohio Department of Health, 2021)
3. Average number of mentally unhealthy days reported in past 30-days (County Health Rankings & Roadmaps, publicly available) (University of Wisconsin Population Health Institute, 2022)

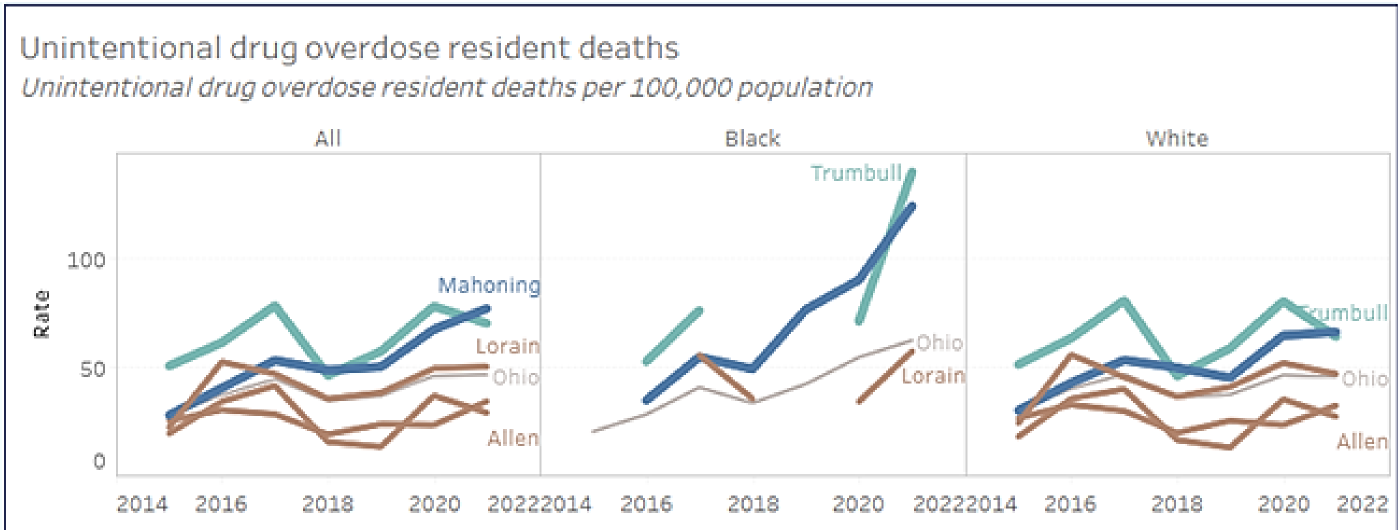
These population-level indicators will be used as the best overall proxies for Mental Health and Substance Use state-of-being at the Mahoning and Trumbull county-level. Though they may not be directly applicable to each strategy, they will provide a population-based measure for tracking overall Mental Health and Substance Use throughout the next three years.

HOW ARE WE DOING?

Emergency Department Visits for Suspected Drug Overdose Rates per 10,000 ED Visits by Year



Overdose Incidence:
In 2021, Mahoning County reported a rate of 78.9/10,000 emergency department visits for suspected drug overdoses compared to 112.6 for Trumbull County. This trend has been consistent since at least 2017. Mahoning County has higher overall numbers of people experiencing overdose, but relative to its population size, Trumbull has a higher rate.



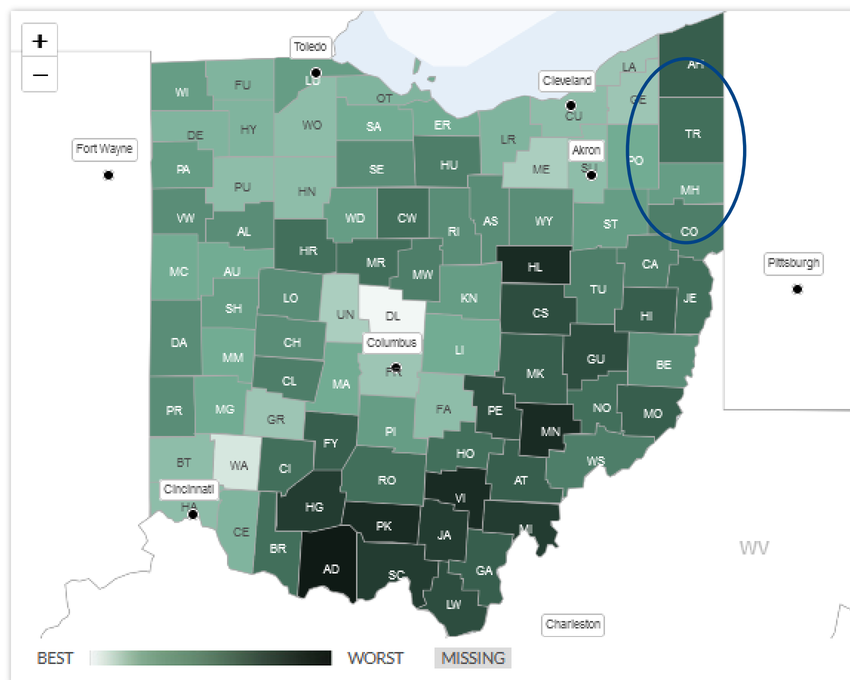
Overdose Deaths:
Mahoning and Trumbull overdose death rates are higher than in peer counties and the state of Ohio. There is a notable increase in the overdose death rate among Black/African Americans in recent years.

Poor Mental Health Days

Average number of mentally unhealthy days reported in past 30 days (age-adjusted).

The 2022 County Health Rankings used data from 2019 for this measure.

Map | Data | Description | Data Source



Mental Distress:
2019 BRFSS data indicate that the average number of mentally unhealthy days reported in the past 30 days for Mahoning County was 5.3 and was 5.6 for Trumbull County. The state average was 5.2 days.

- Existing coalitions of service providers and stakeholders
- Narcan distribution
- Strong faith communities

What is helping?

- Stigma around mental health and substance use
- Lack of trust in service providers
- Limited availability of services (waitlists)
- Lack of affordable options (insurance and cost barriers)
- Decreased community connectivity

What is Hurting?

- Continued and perhaps increased lack of community connection and trust between service providers and community members
- Limited resources, yet influx of funding coming for Behavioral Health as result of Opioid Settlement

What might be coming in the near future?

- Primary data collection about barriers to care

What research/data is stilled needed to better address?

WHO ARE THE PARTNERS WHO HAVE A ROLE TO PLAY IN ADDRESSING THIS ISSUE?

Sector	Entities
School Systems	Teachers
	Coaches
	School nurses
	Bus drivers
	Administrators
	School counselors
	Secretaries
Faith Communities	Neighborhood churches
	Salvation Army
	Basement Ministries
Hispanic/Latinx outreach	OCCHA
Substance Use/Mental Health Providers	Alta Behavioral Health
	Cadence Care Network
	ONE Health Ohio/RISE Recovery
	Mahoning County Mental Health & Recovery Board
	Trumbull County Mental Health & Recovery Board
	Meridian Health Services
	Brightview
	Coleman Health Services
	COMPASS Family and Community Services
	Valley Counseling Services
	TRAVCO
	New Day Recovery
	On Demand Counseling
	First Step Recovery
	Parkman Recovery
	Glenbeigh
	Belmont Pines
	New Start
	YUMADAOP
Higher Ed	Kent State University Trumbull
	Eastern Gateway Community College
	Youngstown State University
Law enforcement	Police and Sheriff's departments
Re-entry	Coleman Health Services
Healthcare	Trumbull County Combined Health District
	Warren City Health Department
	Trumbull Regional Medical Center
	Mercy Health
Community outreach	Community Educator- Mercy Health
	Community organizers
	Parent Advocacy Connection- NAMI
	NAMI
	Family and Children First Council

	Amish communities
	Community Liaisons from MH providers
	Barber shops and beauty salons
	NAACP Trumbull Chapter
	Medical Society Alliance
	Trumbull Neighborhood Partnerships
	United Way Trumbull County
	SCOPE
Referral Services	211 Help Network
Coalitions	ASAP (Alliance for Substance Abuse Prevention)
	Trumbull County Suicide Prevention Coalition
LGBTQIA+ Support	Full Spectrum Community Outreach
Politicians	Public officials
Social Services	TMHA
	Children Services
	Developmental Disabilities
	Direction Home of Eastern Ohio
Military	Youngstown Air Reserve Station

WHAT ARE SOME OF THE THINGS THAT COULD WORK TO ADDRESS THIS ISSUE?

- Harm reduction strategies HHS Resources
- Narcan distribution
- Needle exchange
- CIT Training for Police officers NAMI Resources
- Mental Health First Aid MHFA Resources
- Assertive Community Treatment Case Western Resources
- Permanent Supportive Housing SAMHSA Resources
- Barbershop and Salon Interventions Systematic Review
- Directory of resources for specific populations (e.g. this resource for women of color, or LGBTQ+-affirming providers, as suggested in community conversations)
- Set up satellite sites for delivering mental health and recovery services
- at community sites (such as churches)

Mental Health and Substance Use - MHSU

A community free of stigma around mental health and substance use where there are no barriers to accessing and utilizing affordable, culturally relevant, holistic care when and where and how they need it.

Indicator

Population Level

1. Incidence of emergency department visits for suspected drug overdoses
2. Unintentional drug overdose mortality
3. Average number of mentally unhealthy days reported in past 30 days.

Strategies

Program Level

MHSU1 - Leverage community resources to implement evidence-based mental health & substance use preventative practices. Over the long term, reduce fatalities related to overdose & suicide, and build protective factors in communities to strengthen resilience.

MHSU2 - Implement training programs to reduce unnecessary hospitalizations/ incarcerations and to improve outcomes of crisis situations for community members with mental illness.

MHSU3 - Develop workplace wellness & support programs.

MHSU4 - Develop behavioral health workforce pipeline programs.

<table>
<tr><td colspan="2">STRATEGY MHSU1: Leverage community resources to implement evidence-based mental health & substance use preventative practices. Over the long term, reduce fatalities related to overdose & suicide, and build protective factors in communities to strengthen resilience.</td></tr>
<tr><td colspan="2">Sub-Strategy MHSU1a Work with educational leadership to implement social-emotional learning (SEL) program in one school district, to address non-academic barriers to academic success.</td></tr>
<tr><td colspan="2">Mahoning Agency Lead: Mahoning County Mental Health and Recovery Board (suicide), Mahoning County Public Health (overdose)</td></tr>
<tr><td colspan="2">Timeline: January 2023-December 2025</td></tr>
<tr><td>Implementation Planning:
• <u>Year 1:</u> Gather data on previous successes in Struthers. Work with ESC to meet with educational leadership across districts. Identify one school district to focus efforts for the next 3 years. Meet separately with school leadership & with teachers to identify barriers to implementation.

• <u>Years 2-3:</u> Implement SEL programming (PBIS, PAX or other) in one school district. Track progress & outcomes in this district for comparison to other districts.</td><td>Assisting Agencies/Groups:
• Educational Service Center of Eastern Ohio, Drug-Free Mahoning County, Alta Care Group, COMPASS, Meridian, YUMADAOP Coalition for Health Promotion, Struthers City Schools, target school districts</td></tr>
<tr><td>Performance Measures:
• # of students impacted by SEL programming
    • PEP survey results (TBD based on results from Struthers)
    • ASCD Whole Child survey results
Goal for Each Year:
• To be determined in Year 1</td><td>Target Population:
Kindergarten – 6th Grade students who are at risk of mental illness and substance use.</td></tr>
</table>

STRATEGY MHSU1: Leverage community resources to implement evidence-based mental health & substance use preventative practices. Over the long term, reduce fatalities related to overdose & suicide, and build protective factors in communities to strengthen resilience.	
Sub-Strategy MHSU1b: Increase offerings of Mental Health First Aid trainings, targeting recruitment to barbers & stylists.	
Mahoning Agency Lead: Mahoning County Mental Health and Recovery Board (suicide), Mahoning County Public Health (overdose)	
Timeline: January 2023-December 2025	
Implementing Planning: • Years 1-3 -Offer 2 youth and 3 adult Mental Health First Aid training each year. • Year 1 - recruit barbers and stylists for training. • Years 2 and 3 - provide training to at least 5 barbers/stylists per year. *Consider offering additional trainings for RAs at YSU.	**Assisting Agencies/Groups:** • Mahoning County Public Health (MCPH) CPH; Lynn & Keland Bilal*; YSU NAMI chapter*; YSU Department of Residential Life* * = not yet contacted
Performance Measures: • # of participants in MHFA training (categorize if barbers/stylists) • # of suicide deaths • # of overdose deaths • # of homicide deaths **Goal for Each:** • Successfully complete 2 youth and 3 adult trainings per each year; • Successfully train 5 barbers/stylists participating each year in Years 2 & 3	**Target Population**: Community members at risk of mental illness & substance use

<table>
<tr><td colspan="2">STRATEGY MHSU1: Leverage community resources to implement evidence-based mental health & substance use preventative practices. Over the long term, reduce fatalities related to overdose & suicide, and build protective factors in communities to strengthen resilience.</td></tr>
<tr><td colspan="2">Sub-Strategy MHSU1c Work with coalitions and/or providers to implement additional evidence-based practices.</td></tr>
<tr><td colspan="2">Mahoning Agency Lead: Mahoning County Mental Health and Recovery Board, Mahoning County Public Health</td></tr>
<tr><td colspan="2">Timeline: January 2023-December 2025</td></tr>
<tr><td>Implementing Planning:
<u>Year 1</u> - determine whether to select additional evidence-based practices to incorporate into CHIP. Additional practices may include: suicide prevention presentations, overdose prevention presentations, Narcan trainings & kit distribution, call outs for LOSS and DOSS teams, QPR trainings, etc. If new initiatives are implemented, set up specific metrics to track each over time.</td><td>Assisting Agencies/Groups:
• Help Network of Northeast Ohio
• Coalitions:
1) Overdose Prevention Coalition
2) Overdose Fatality Review Board
3) Suicide Prevention Coalition
4) Suicide Fatality Review Board
5) Coalition for Drug Free Mahoning County
6) Coalition for Health Promotion (YUMADAOP)</td></tr>
<tr><td>Performance Measures:
• # Activities conducted by coalitions.
• Assure demographics of coalition members are diverse to assure services are provided with cultural responsiveness.

Goal for Each:
• TBD in year 1</td><td>Target Population:
Community members at risk of mental illness & substance use</td></tr>
</table>

<table>
<tr><td colspan="2">STRATEGY MHSU2: Implement training programs to reduce unnecessary hospitalizations/ incarcerations and to improve outcomes of crisis situations for community members with mental illness.</td></tr>
<tr><td colspan="2">Sub-Strategy MHSU2a Conduct Crisis Intervention Team Training for local police departments.</td></tr>
<tr><td colspan="2">Mahoning Agency Lead: Mahoning County Mental Health and Recovery Board</td></tr>
<tr><td colspan="2">Timeline: January 2023-December 2025</td></tr>
<tr><td>Implementation Planning:
• Conduct at least 3 training courses per year. Each training will consist of 20 officers and optionally 2 police chaplains. Aim for at least 10 police departments participating each year. Target trainings toward school resource officers to align with MHSU1a.</td><td>Assisting Agencies/Groups:
• Mahoning County Police Departments (participation in training)</td></tr>
<tr><td>Performance Measures:
• # Law enforcement officers participating in CIT trainings
• # of police departments with at least one trained officer on the force (TBD in Year 1 based on data availability)

Goal for Each:
• 3 training courses conducted each year.
    ○ 20 officers + 2 police chaplains.
    ○ 10 police departments participating</td><td>Target Population:
Community members in Mahoning County who are experiencing mental illness & substance use.</td></tr>
</table>

STRATEGY MHSU2: Implement training programs to reduce unnecessary hospitalizations/ incarcerations and to improve outcomes of crisis situations for community members with mental illness	
Sub-Strategy MHSU2b Work with Mahoning County Dispatch to develop a system to measure impact of Crisis Intervention Training on emergency response outcomes.	
Mahoning Agency Lead: Mahoning County Mental Health and Recovery Board	
Timeline: January 2023-December 2025	
Implementation Planning: • Track how many 911 calls request a CIT trained officer and whether a CIT officer is dispatched based on the situation. Work with Dispatch and police jurisdictions to establish trust, with the goal of eventually tracking outcomes such as use-of-force complaints to demonstrate effectiveness of CIT training.	**Assisting Agencies/Groups:** • Dispatch staff, police officers • Help Network of Northeast Ohio (additional data around mental health crisis response)
Performance Measures: • # of times when CIT officer is dispatched (intentionally & by chance) • # of arrests or hospitalizations resulting from a 911 call (TBD in Year 1 based on availability of data) **Goal for Each:** • Increase in the # of times a CIT officer is dispatched; start to track outcomes	**Target Population**: Community members in Mahoning County experiencing mental illness & substance use.

STRATEGY MHSU2: Implement training programs to reduce unnecessary hospitalizations/ incarcerations and to improve outcomes of crisis situations for community members with mental illness	
Sub-Strategy MHSU2c Work to develop Mobile Response & Stabilization Service (MRSS) Team that can lead emergency response efforts for mental health-related crisis calls.	
Mahoning Agency Lead: Mahoning County Mental Health and Recovery Board	
Timeline: January 2023-December 2025	
Implementation Planning: • Year 1 - form action group to assess current conditions and identify next steps toward developing Mobile Response & Stabilization Service team. • Years 2 and 3 - Implement Mobile Response & Stabilization Service MRSS training and any relevant next steps identified in Year 1.	**Assisting Agencies/Groups:** • Dispatch staff, police officers • Help Network of Northeast Ohio (additional data around mental health crisis response)
Performance Measures: • TBD Year 1 **Goal for Each:** • TBD Year 1	**Target Population**: Community members within Mahoning County experiencing mental illness & substance use

<table>
<tr><td colspan="2">STRATEGY MHSU3: Develop workplace wellness & support programs.</td></tr>
<tr><td colspan="2">Sub-Strategy MHSU3a Develop & carry out an awareness campaign regarding existing workplace wellness resources for employees.</td></tr>
<tr><td colspan="2">Mahoning Agency Lead: Mahoning County Mental Health and Recovery Board</td></tr>
<tr><td colspan="2">Timeline: January 2023-December 2025</td></tr>
<tr><td>Implementation Planning:
• Educate employees regarding the benefits that Employee Assistance Programs (EAPs) can provide. Highlight the resources that EAPs generally provide at no cost to employees and their families, such as short-term counseling, locating other mental or general health resources or services, and financial or legal assistance.
• In Year 1, develop a strategy and plan for awareness activities, including building in funding for activities.
• In Years 2-3, implement activities.</td><td>Assisting Agencies/Groups:
• Alta, COMPASS & Meridian (Providers offering EAP programs and informal employee support programs)
• MC MHRB (funding)
• Clever* / WKBN* / WFMJ* (communications, outreach & social media);
• YUMADAOP (education & outreach)
• MCTA WIB (Maryann Pachelko - employer outreach & marketing)

* = not yet contacted</td></tr>
<tr><td>Performance Measures:
• TBD Year 1

Goal for Each:
• TBD Year 1
• At employers with EAPs, 15-20% of employees engage in program</td><td>Target Population:
Employees whose work interests is with helping people, such as healthcare & education whose work and health has been impacted by stress due to the pandemic.</td></tr>
</table>

STRATEGY MHSU3: Develop workplace wellness & support programs.	
Sub-Strategy MHSU3b Develop & carry out an awareness campaign regarding the benefits that employers get from investing in workplace wellness and support.	
Mahoning Agency Lead: Mahoning County Mental Health and Recovery Board	
Timeline: January 2023-December 2025	
Implementation Planning: • Educate employers regarding the benefits of wraparound EAP services and workplace wellness & support programs. Highlight the returns on investment that come from investing in employee wellness, such as reduced turnover and increased productivity. Target the education and healthcare sectors (including school district from MHSU1). • In Year 1, develop a strategy and plan for awareness activities, including building in funding for activities. In Years 2-3, implement activities.	**Assisting Agencies/Groups:** • Alta, COMPASS & Meridian (Providers offering EAP programs and informal employee support programs) • MC MHRB (funding); Clever* / WKBN* / WFMJ* (communications, outreach & social media) • YUMADAOP (education & outreach) • MCTA WIB (Maryann Pachelko - employer outreach & marketing) * * = not yet contacted
Performance Measures: • # of awareness activities initiated • # of employers interested in offering expanded EAP benefits **Goal for Each:** • TBD in Year 1 • At employers with EAPs, 15-20% of employees engage in program	**Target Population**: Employees whose work involves helping people, such as healthcare & educational workforce whose career has been impacted by stress due to the pandemic.

STRATEGY MHSU3: Develop workplace wellness & support programs.	
Sub-Strategy MHSU3c Local service providers expand the number of employers at which they offer wraparound Employee Assistance Program (EAP) services	
Mahoning Agency Lead: Mahoning County Mental Health and Recovery Board, Alta Behavioral Healthcare, COMPASS Family and Community Services	
Timeline: January 2023-December 2025	
Implementation Planning: • Year 1: Alta and COMPASS determine the number of additional employers they could offer EAP services to. • Year 2: Alta and COMPASS select and initiate contracts with employers. Minority-owned or minority-employing businesses as well as the education and healthcare sectors are prioritized. • Year 3: Alta and COMPASS expand wraparound EAP services to the number of employers determined in Year 1.	**Assisting Agencies/Groups:** • Mahoning County Schools that express interest in wraparound EAP services • Identified employers In Mahoning County that express interest in wraparound EAP
Performance Measures: • # of new employers with wraparound EAP services • Workplace retention & productivity at new employers (before & after intervention), including % of employees engaging in program **Goal for Each:** • Enroll 1 school system and 2 other employers to programs by Year 3	**Target Population**: Employees whose work involves helping people, such as healthcare & educational workforce whose career has been impacted by stress due to the pandemic.

<table>
<tr><td colspan="2">STRATEGY MHSU4: Develop behavioral health workforce pipeline programs</td></tr>
<tr><td colspan="2">Sub-Strategy MHSU4a Implement a behavioral health pipeline program to eventually increase the availability of mental health providers in Mahoning County.</td></tr>
<tr><td colspan="2">Mahoning Agency Lead: Mahoning County Mental Health and Recovery Ba, AHEC, MyPath</td></tr>
<tr><td colspan="2">Timeline: January 2023-December 2025</td></tr>
<tr><td>Implementation Planning:
<u>Year 1:</u> Meet with community partners to assess the current landscape of workforce pipeline programs. Develop a plan for outreach about behavioral health career opportunities to high school & college students and recent graduates.
<u>Years 2-3:</u> Implement outreach program. Activities may involve classroom visits, shadowing opportunities, scholarships, advising, and educational programs.</td><td>Assisting Agencies/Groups:
Mahoning County Area Health Education Center (AHEC)*
MyPath Mahoning Valley (Gerri Jenkins)*
Mahoning County school districts (school counselors/social workers) *
Informal educational programs*
* = not yet contacted</td></tr>
<tr><td>Performance Measures:
# of students reached
Ratio of population to mental health providers (County Health Rankings or local data source)
Goal for Each:
At least 50 students reached over 3-year period</td><td>Target Population:
High school students, college students, and recent graduates of high school & college.</td></tr>
</table>

How do these strategies address the cross-cutting priorities of addressing health equity and root causes of substance use and poor mental health?

MHSU1

- Coalitions include all sectors of the community and can review data to determine any disparities and create plans to address these disparities.

MHSU2

- Based on research to date, CIT training can be considered an EBP for improving officers' cognitive and attitudinal outcomes, including knowledge, attitudes, and self-efficacy. Additionally, evidence supports CIT as an EBP for officers' behavioral intentions and decision-making. There is growing evidence of CIT's effectiveness for impacting officers' behavior in terms of actual use of force and call resolutions, including several studies with strong comparison groups. Depending on the criteria used, CIT may be considered an EBP for these outcomes. https://www.citinternational.org/page-18451.
- More trained police officers can better serve the community. They are more equipped to refer to services, rather than putting people in the criminal justice system. Training diverse officers can allow equity response throughout the community.

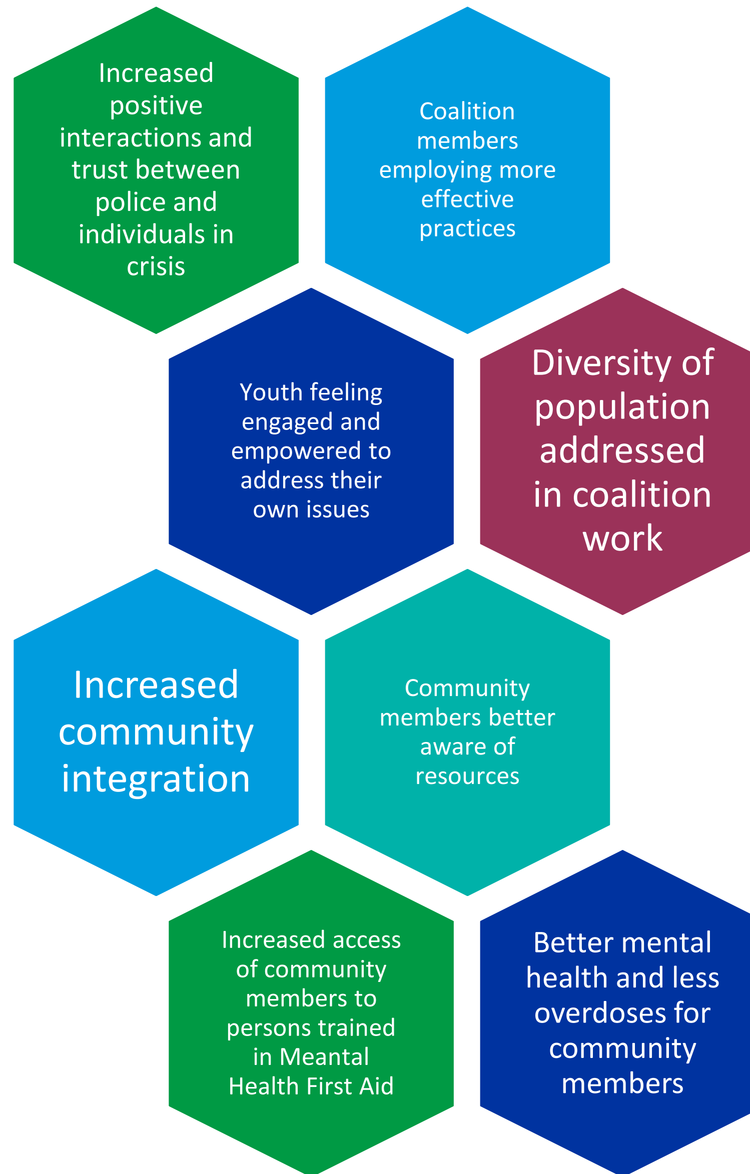
MHSU3

- The State of the Workplace Mental Health in the U.S. in 2021 by Mind Share Partners showed that 76% of workers report experiencing at least one symptom of a mental health condition in the last year. While 50% of full time U.S. workers have left a previous role due, at least in part, to mental health reasons, that percentage rises to 81% of Gen Z respondents and 68% of Millennial respondents. The most desired "resource" for mental health was an open culture about mental health at work. (2021 Mental Health at Work Report—The Stakes Have Been Raised (mindsharepartners.org))
- Workplace wellness and support programs can reach a large portion of the adult population. The programs can assist the individual employee as well as their family members.

MHSU4

- Workforce shortages in mental health and addiction counseling have been an ongoing issue for several years across the United States, with Ohio having 1 counselor for every 330 people in the 2023 County Health Rankings & Roadmaps. In an effort to address these workforce shortages we need to approach students earlier than college to educate them on positions in behavioral health.

How will we know that we are better off around Mental Health and Substance Use in our communities?



A community that meets the needs of each individual with services that are high-quality, accessible, effective, and well-communicated for all, and delivered in an equitable way by addressing barriers to care.

POPULATION-LEVEL INDICATORS:

Percent of Mahoning and Trumbull County population accessing recommended preventive screenings: (Centers for Disease Control and Prevention, 2021)

- Cervical cancer screening among women ages 21-65
- Cholesterol screening among adults 18+
- Colorectal cancer screening among adults 50-75
- Mammography among women ages 50-74

These population-level indicators will be used as the best overall proxies for Access to Care state-of-being at the Mahoning and Trumbull county-level. Though they may not be directly applicable to each strategy, they will provide a population-based measure for tracking overall Access to Care throughout the next three years.

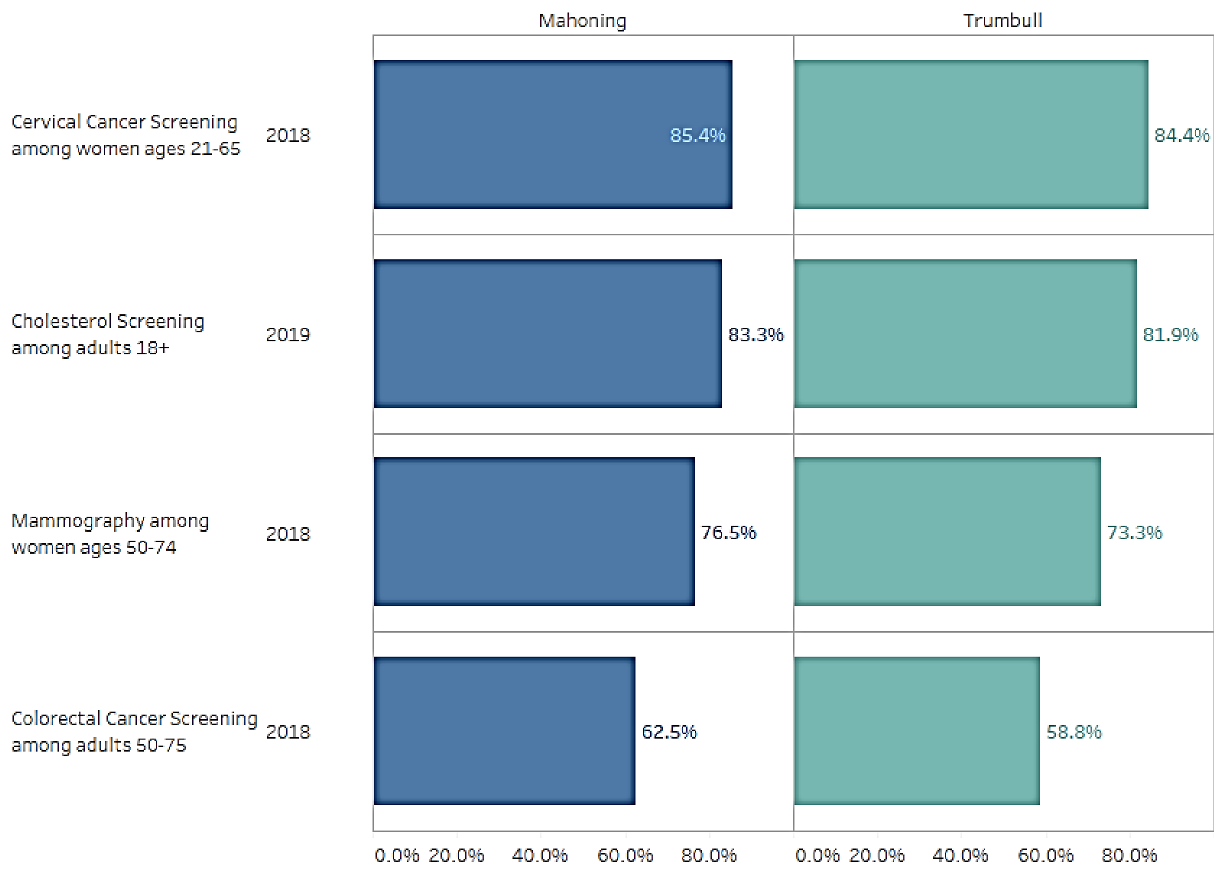
HOW ARE WE DOING?

Cervical Cancer Screening among women ages 21-65:
Mahoning 85.4%, Trumbull 84.4% (2018)

Cholesterol Screening among adults 18+:
Mahoning 83.3%, Trumbull 81.9% (2019)

Colorectal Cancer Screening among adults 50-75:
Mahoning 62.5%, Trumbull 58.8% (2018)

Mammography among women ages 50-74:
Mahoning 76.5%, Trumbull 73.3% (2018)

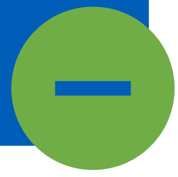

Health Seeking Behaviors
Mahoning
Trumbull
Cervical Cancer Screening among women ages 21-65
2018
85.4%
84.4%
Cholesterol Screening among adults 18+
2019
83.3%
81.9%
Mammography among women ages 50-74
2018
76.5%
73.3%
Colorectal Cancer Screening among adults 50-75
2018
62.5%
58.8%
0.0% 20.0% 40.0% 60.0% 80.0%
0.0% 20.0% 40.0% 60.0% 80.0%

- Major healthcare providers (Mercy, Steward, Health departments, FQHCs)
- Mahoning Valley Pathways HUB
- Home visiting programs in Warren and Trumbull County
- Family Planning/Reproductive Health program with Trumbull/ Steward Health
- Resource Mothers program with Mercy Health

What is helping?

- Accessibility problems: locations, hours of operation, red tape, limited availability of local service-providers or appointments
- Transportation barriers
- Cost/insurance hurdles
- Unequal treatment of patients

What is Hurting?



- Policies that impact access to care and health equity (Medicaid access, gender-affirming care, funding)

What might be coming in the near future?

- More frequent data collection on barriers to care
- Data tools for visualizing accessibility of services

What research/data is stilled needed to better address?

WHO ARE THE PARTNERS WHO HAVE A ROLE TO PLAY IN ADDRESSING THIS ISSUE?

Mercy Health
Trumbull County Combined Health District
Mahoning County Combined Health District
Warren City Health District
Youngstown City Health District
VA Hospital
Steward Health
Kent State University Trumbull Campus
Eastern Gateway Community College
Youngstown State University
Churches/pastors in every neighborhood
Faith-based organizations
OneHealth

WHAT ARE SOME OF THE THINGS THAT COULD WORK TO ADDRESS THIS ISSUE?

- Mahoning Valley Pathways HUB
- Home visiting programs in Warren and Trumbull County
- Family Planning/Reproductive Health program with Trumbull/Steward Health
- Resource Mothers program with Mercy Health
- Mobile clinic Warren/Trumbull County
- Barber shop and beauty salon outreach

Access to Care - AC

A community that meets the needs of each individual with services that are high quality, accessible, effective and well-communicated for all, and delivered in an equitable way by addressing barriers to care.

Indicator

Percent of population accessing recommended preventive screenings:

- Cervical cancer screening among women ages 21-65
- Cholesterol screening among adults18+
- Colorectal cancer screening among adults 50-75
- Mammography among women ages 50-74

Population Level

Strategies

AC1 - Increase culturally congruent connection to services for Mahoning Valley residents in high SVI areas.

AC2: Increase health screenings, primary care services, & maternal health programs for underserved areas and populations.

AC3: Develop stronger data tools to track access to care.

AC4: Monitor state legislative efforts that would impact access to care.

Program Level

<table>
<tr><td colspan="2">STRATEGY AC1: Increase culturally congruent connection to services for Mahoning Valley residents in high SVI areas</td></tr>
<tr><td colspan="2">Sub-Strategy AC1a Train Community Health Workers (CHWs) in the Pathways Community Hub Institute (PCHI) Model. Training should include 75% of the Youngstown Health Improvement Zones Community Health Advocates, as well as any other currently untrained Mahoning County CHWs.</td></tr>
<tr><td colspan="2">Mahoning Agency Lead: Mahoning County Public Health (Mahoning Valley Pathways HUB Division)</td></tr>
<tr><td colspan="2">Timeline: Yearly goals (1-3)</td></tr>
<tr><td>Implementation planning:
Training will be conducted by Mahoning Valley Pathways HUB. PCHI training focuses on methods to coordinate care and eliminate risks for community residents.</td><td>Assisting Agencies/Groups:
• YCHD
• Mercy Health</td></tr>
<tr><td>Performance Measures:
• The % of Community Health Workers trained for each year under the PCHI model. The number will be based on the number of CHWs hired and onboarded through the PCHI model.
Goal for Each:
• Of the untrained CHWs, train 80% each year under the PCHI model. (Each CHW needs to be trained once.)</td><td>Target Population: Residents of areas with a high Social Vulnerability Index will have a PCHI trained CHW.</td></tr>
</table>

<table>
<tr><td colspan="2">STRATEGY AC1: Increase culturally congruent connection to services for Mahoning Valley residents in high SVI areas</td></tr>
<tr><td colspan="2">Sub-Strategy AC1b: Work with CHW supervisors to develop a strategy for a comprehensive approach to reaching pregnant people earlier in their pregnancy.</td></tr>
<tr><td colspan="2">Mahoning Agency Lead: Mahoning County Public Health (Mahoning Valley Pathways HUB Division)</td></tr>
<tr><td colspan="2">Timeline: Yearly goals (1-3)</td></tr>
<tr><td>Implementation planning:
• Of the total pregnant clients enrolled in the Pathways HUB, enroll at least 50% in the 1st trimester, 30% by their 2nd trimester, and 20% by the 3rd trimester.</td><td>Assisting Agencies/Groups:
• YCHD,
• Mercy Health</td></tr>
<tr><td>Performance Measures:
• Data entered within the HUB data platform as reported to OCMH:
    • # of referrals / enrollments, categorized by trimester in which they were enrolled
    • Tracking SVI related data for pregnant clients enrolled.
Goal for Each:
  • For each year (1-3) the HUB will target 50% enrollment of pregnant clients in their first trimester, 30%: second trimester, 20%: third trimester.</td><td>Target Population: Targeted Pregnant clients with a focus on residents of high SVI census tracts.</td></tr>
</table>

<table>
<tr><td colspan="2">STRATEGY AC1: Increase culturally congruent connection to services for Mahoning Valley residents in high SVI areas</td></tr>
<tr><td colspan="2">Sub-Strategy AC1c: By Year 3, hire 1 CHW to specialize in the care coordination of pregnant people with mental health & substance use issues, as well as individuals that have been impacted by human trafficking.</td></tr>
<tr><td colspan="2">Agency Lead: Mahoning County Public Health (Mahoning Valley Pathways HUB Division</td></tr>
<tr><td colspan="2">Timeline: Yearly goals (1-3)</td></tr>
<tr><td>Methods/Implementation planning:
• HUB Director will work with the HUB Special Projects Fiscal Manager to secure funding by Year 3 to support the hire of 1 CHW with a focus on mental health and substance use of pregnant clients and human trafficking.</td><td>Assisting Agencies/Groups:
• Mercy Health
• Additional community partners TBD</td></tr>
<tr><td>Performance Measures:
• HUB data records from HUB data platform

Goal for Each:
MCPH will contract with an agency to hire CHWs for the two identified specialized areas by year 3</td><td>Target Population: Pregnant people with mental health & substance use disorders; people who have been trafficked</td></tr>
</table>

STRATEGY AC2: Increase health screenings, primary care services, & maternal health programs for underserved areas and populations

Sub-Strategy AC2a Mercy Community Health will provide primary healthcare, including preventative screenings, to at-risk populations via the Mobile Medical Clinic.

Mahoning Agency Lead: Mercy Health

Timeline: Years 1-3

Implementation Planning:

- Year 1: Secure grant funding and make improvements to mobile unit. Train behavioral health nurse. Launch program by April.
- Years 1-3: Mobile Clinic is deployed on a rotating weekly schedule to four locations. Staff will include a behavioral health nurse, nurse practitioner, resident physician, resident instructor, RN, and community health worker. Referrals will be made for patients whose needs exceed the scope of the clinic.
- Years 2-3: Based on patient surveys, pursue funding to provide taxi vouchers, cell phones, or other service to address barriers to care access.

Assisting Agencies/Groups:

- MCPH (support & data)
- YCHD (coordination with CHWs)
- Mercy Health Residency Program (working to include mobile clinic in resident rotation program)

Performance Measures:

# of patients per clinic.

% of patients seeing a behavioral health provider. % of patients accessing services for Mental Health, Substance Use, or both.

# of patients referred to Family Practice / Resident Practice vs. number of completed referrals

Goals:

- In Years 1-2: establish baseline data for # of patients and # of referrals.
- In Year 3: Increase the number of patients seen by the mobile clinic by 5% and the number of referrals to Family Practice / Resident Practice.

Target Population: Wider population without current access to healthcare, living near 4 South Side & East Side locations (OCCHA, Spanish Evangelical, Price Memorial, Rockford Village)

<table>
<tr><td colspan="2">STRATEGY AC2: Increase health screenings, primary care services, & maternal health programs for underserved areas and populations</td></tr>
<tr><td colspan="2">Sub-Strategy AC2b Mercy Health will open new clinics in Cornersburg (maternal health, family support) and on the North Side of Youngstown focused on primary care, maternal health, and behavioral health services.</td></tr>
<tr><td colspan="2">Mahoning Agency Lead: Mercy Health</td></tr>
<tr><td colspan="2">Timeline: Years 1-3</td></tr>
<tr><td>Implementation Planning:
• Cornersburg Nurturing Families Clinic and Belmont Clinic to open in 2023. Collaborate with data cohort (AC3) to track clinic success over time.</td><td>Assisting Agencies/Groups:
• MCPH (support & data),
• YCHD (coordination with CHWs),
• Mercy Health Residency Program (working to include mobile clinic in resident rotation program)</td></tr>
<tr><td>Performance Measures:
# of patients per clinic.

Of the patients enrolled in maternal & family programs, % of births that are premature. Compare to County average.

Goals:
• Year 1 - Cornersburg Nurturing Families Clinic and Belmont Clinic to open in 2023. Establish baseline enrollment at both Centering sites.
• Year 2 – Increase the number of enrollments by 5% at each of the Centering sites.
• Year 3 - Increase the number of enrollment by 5% and the number of individuals completing Centering programs and other maternal/family support programs at each site.</td><td>Target Population: Wider population without current access to healthcare or lacking maternal/family health support in Youngstown area</td></tr>
</table>

<table>
<tr><td colspan="2">STRATEGY AC3: Develop stronger data tools to track access to care</td></tr>
<tr><td colspan="2">Sub-Strategy AC3a Convene a team to develop a data collection, sharing, and communication strategy to track health outcomes related to health equity & access to care.</td></tr>
<tr><td colspan="2">Mahoning Agency Lead: Mahoning County Public Health, Vibrant Valley, ECO</td></tr>
<tr><td colspan="2">Timeline: Years 1-3</td></tr>
<tr><td>Implementation Planning:
• In Year 1, develop data collection & funding strategy.
• In Year 2, collect data related to other Access to Care strategies, targeting at-risk populations.
• In Year 3, share results & develop data continuation plan for next CHA/CHIP.</td><td>Assisting Agencies/Groups:
• Vibrant Valley Data Cohort
• HCP Data Team Members</td></tr>
<tr><td>Performance Measures:
# of Data Cohort members / partners

Health outcomes & health disparities: select metrics related to other AC strategies.

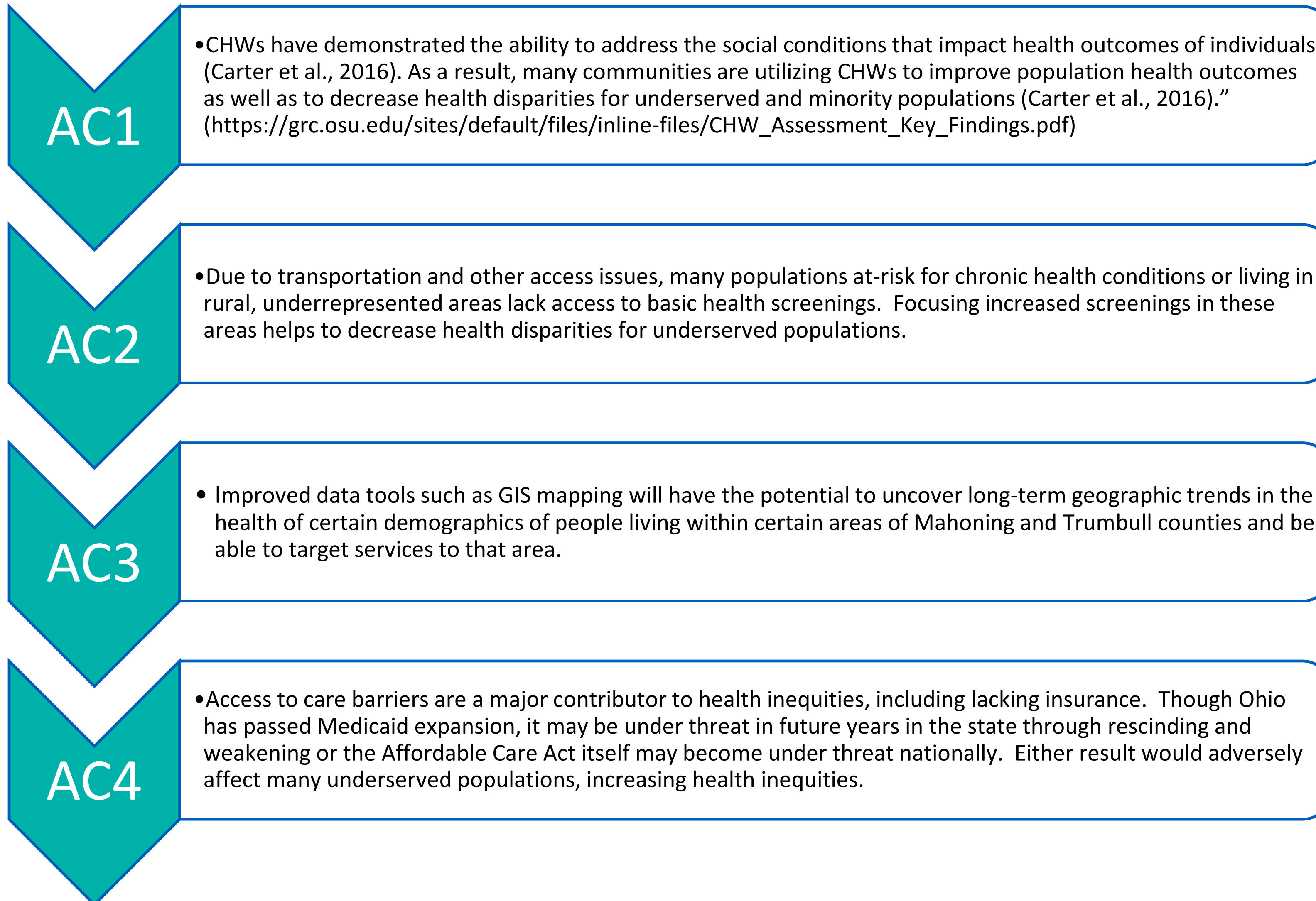
Goals:
The Development CHIP Dashboards which will be public facing for data transparency on all CHIP related Data and progress for each strategy.</td><td>Target Population: At-risk populations facing barriers to accessing care & impacted by other AC strategies</td></tr>
</table>

<table>
<tr><td colspan="2">STRATEGY AC4: Monitor state legislative efforts that would impact access to care</td></tr>
<tr><td colspan="2">Sub-Strategy AC4a Track legislative efforts related to access to care. Implement educational & policy-focused efforts as needed.</td></tr>
<tr><td colspan="2">Agency Lead: Vibrant Valley Health Equity Project</td></tr>
<tr><td colspan="2">Timeline: As needed per AC4a</td></tr>
<tr><td>Implementation Planning:
• Vibrant Valley Data Cohort to track state legislative efforts on a quarterly basis. If a relevant state legislative effort comes up, HCP to assist with educational and policy-focused efforts.</td><td>Assisting Agencies/Groups:
Healthy Community Partnership
Vibrant Valley agencies & partners</td></tr>
<tr><td>Performance Measures
# of initiatives responding to local & state legislative efforts as they relate to Health outcomes

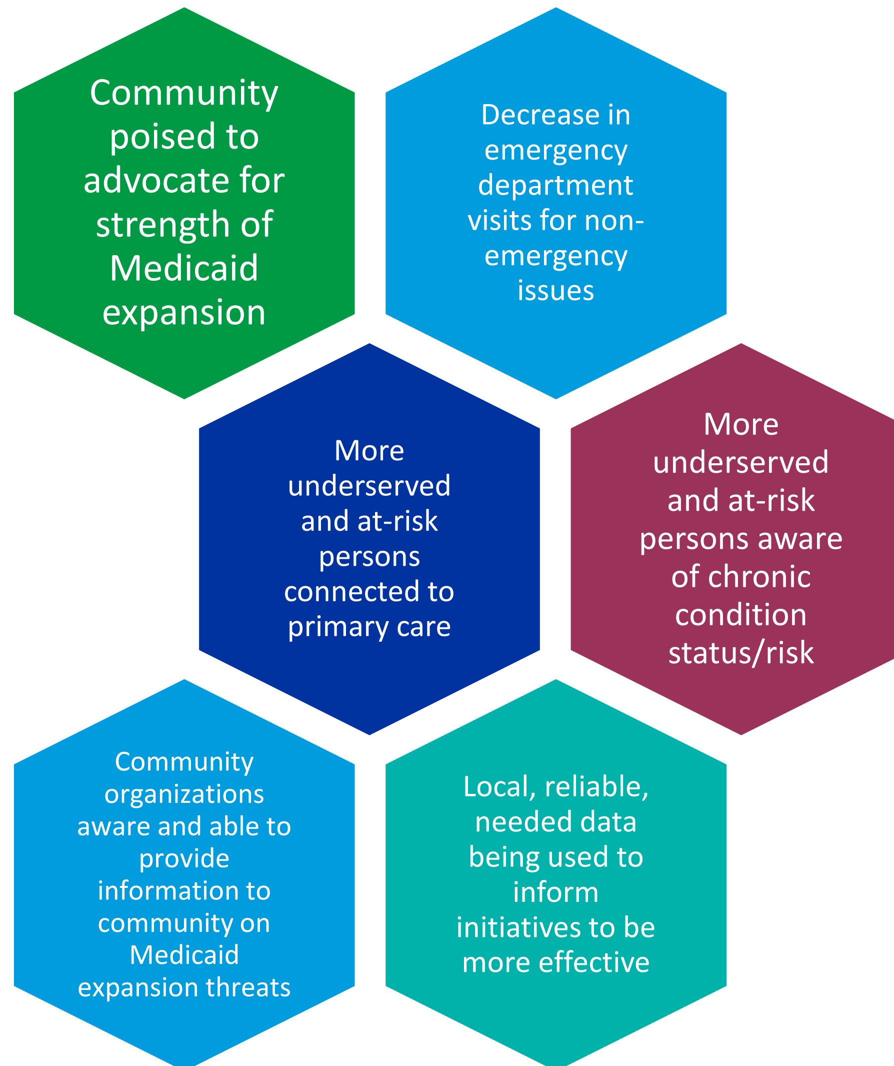
Data
• # of initiatives responding to local & state legislative efforts and the impact on health.</td><td>Target Population Program: Local & state legislators representing Mahoning County; voter populations.

Target Population: At-risk populations facing barriers to accessing care & impacted by other AC strategies</td></tr>
</table>

How do these strategies address the cross-cutting priorities of addressing root causes of lack of access to care in the community and health equity?



How will we know that we are better off around Access to Care in our communities?



A thriving region where organizations and individuals work together in trusting, community-driven relationships to crate a safe, healthy, prosperous, and inclusive environment.

POPULATION-LEVEL INDICATORS:

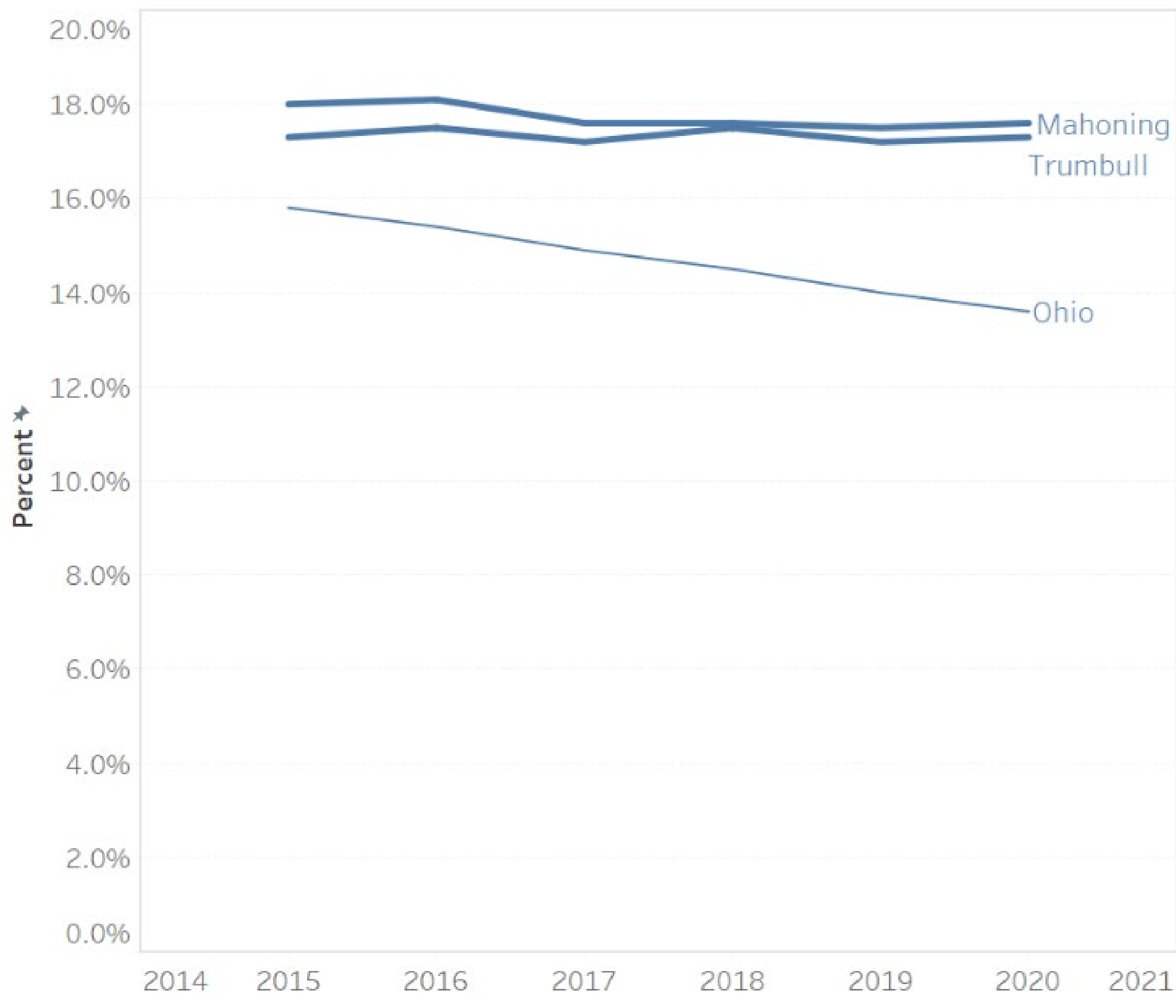
1. Percent of population living below the poverty line (U.S. Census Bureau, 2022)
2. Percent of population cost-burdened by housing (spending more than 30% of income on housing), stratified by homeowners and renters (U.S. Census Bureau, 2022)

These population-level indicators will be used as the best overall proxies for Community Conditions & Safety state-of-being at the Mahoning and Trumbull county-level. Though they may not be directly applicable to each strategy, they will provide a population-based measure for tracking overall Community Conditions & Safety throughout the next three years.

HOW ARE WE DOING?

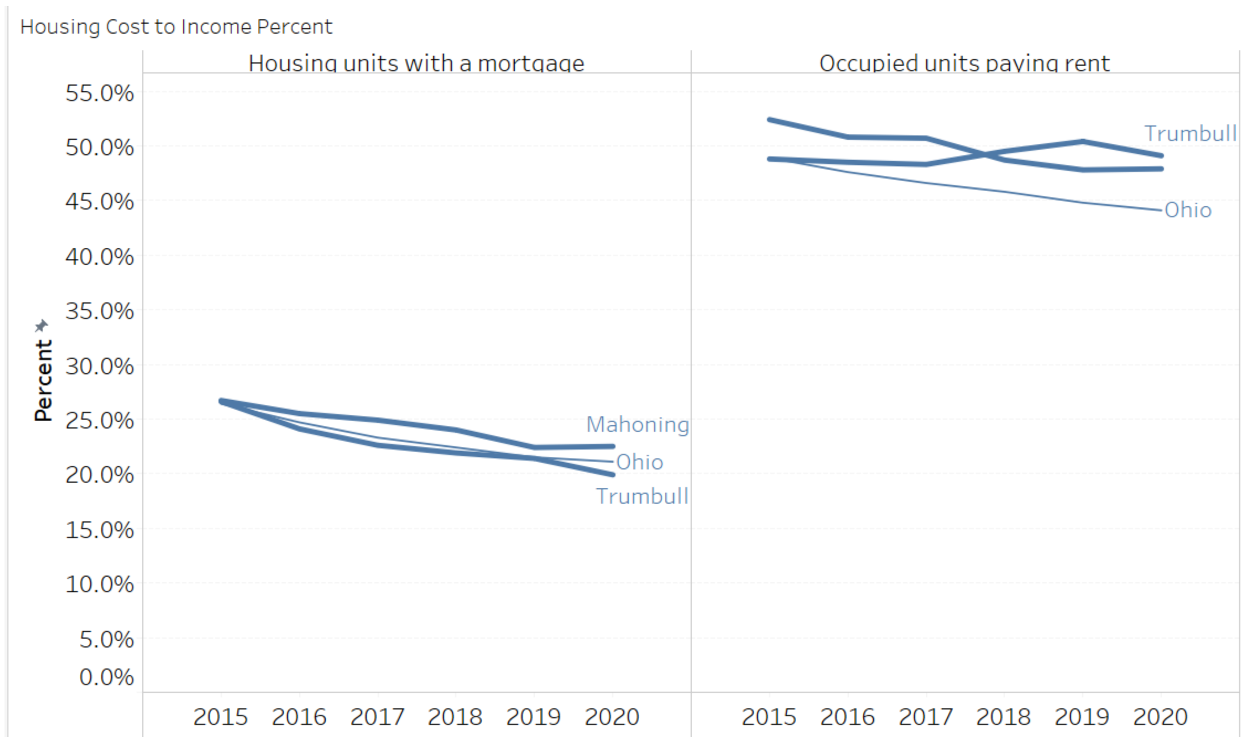
POVERTY STATUS

Mahoning and Trumbull have similar poverty levels in 2020 estimates, with 17.6% of people living below the federal poverty level in Mahoning and 17.3% in Trumbull. About one in three people live below 200% of the poverty line in both counties: 36.3% in Mahoning and 36.6% in Trumbull. A breakdown of the poverty status by race and age reveals even greater disparities, among groups and between counties. In Mahoning County, 37.6% of Black/African American community members and 36.9% of Hispanic/Latino community members were living below the poverty level in 2020 estimates, and 38.0% of Black/African American and 37.9% of Hispanic/Latino community members in Trumbull County. These are higher percentages than in peer counties and the state. In contrast, 11.7% of non-Hispanic White community members were living below the poverty level in 2020 estimates in Mahoning County and 14.4% in Trumbull County.


Poverty status in the past 12 months, *Below poverty level, 2015 to 2020*
Percent
20.0%
18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
2014
2015
2016
2017
2018
2019
2020
2021
Mahoning
Trumbull
Ohio

HOUSING COSTS

About one in five homeowners spend 30% or more of their income on housing, but nearly half of all renters spend 30% or more.



WHAT IS THE STORY BEHIND THE CURVE, INCLUDING ROOT CAUSES?

- Community-based organizations and non-profits
- Existing coalitions and partnerships

What is Helping?

- Lack of economic opportunity
- Neighborhood blight
- Violence and crime
- Lack of trust between police and communities
- Staffing shortages on police force
- Redlining and systemic barriers to housing
- Resource shortages for housing enforcement efforts

What is Hurting?

- Continued systemic barriers
- Lack of funding
- Unintended consequences of some initiatives

What might be coming in the near future?

- More locally-sourced housing data, particularly on vacant or abandoned residencies
- Mapping of concentrations of vacancies and green space
- Data to quantify and monitor jobs with livable wage and benefits

What research/data is stilled needed to better address?

WHO ARE THE PARTNERS WHO HAVE A ROLE TO PLAY IN ADDRESSING THIS ISSUE?

Health Departments
Mercy Health
Community Initiative to Reduce Violence
Mahoning County Healthy Homes & Lead Hazard Control Program
Mahoning-Youngstown Community Action Partnership
Trumbull Mahoning Housing Authority
Community Development Corporations
Land Banks
Our Community Kitchen
Creating Healthy Communities Coalition
Eastgate Regional Planning
Rescue Mission Emergency Shelter
Salvation Army

Parks Department
Public Works
Fire Departments
Universities
Schools
Neighborhood Watch
Street Department
Law enforcement
Child welfare agencies
Green Team
Trumbull County Land Bank
City of Warren, Community Development Dept.

WHAT ARE SOME OF THE THINGS THAT COULD WORK TO ADDRESS THIS ISSUE?

What is Working Now

- Residential rental lead ordinances
- Rental registry programs and relationship building with landlords
- Active transportation plans accounting for sidewalk improvements and multi-modal connectivity
- Action plans for Parks and Recreation Departments and stewardship agreements
- Food hubs and food delivery programs

What is Working, but Needs Improving

- Lead inspection and monitoring programs led by county or state authorities
- Increase networking with large funders/foundations to invest in local initiatives
- Additional arts and cultural programs
- Reviving a local version of the Ohio Benefits Bank to connect people with needed economic resources
- Policies to support minority- and LGBTQ-owned businesses in governmental contracts

Additional Research Needed

- Housing retrofit program using hemp materials
- Housing resources for co-living spaces for group homes

Community Conditions & Safety - CCS

A thriving region where organizations and individuals work together in trusting, community-driven relationships to create a safe, healthy, prosperous, and inclusive environment.

Indicator

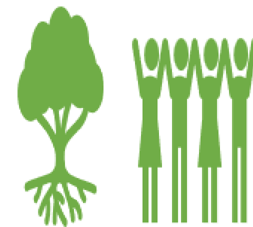
1. Percent of population living below the poverty line
2. Percent of population cost-burdened

Population Level

Strategies

CCS1 – Address housing quality issues
CCS2 – Expand active transportation safety through infrastructure and community engagement, focusing on pedestrian and bicycle safety.
CCS3 – Invest in expanding greenspace and safe parks.
CCS4 – Increase access to healthy foods.
CCS5 – Gather information about community safety concerns.

Program Level



<table>
<tr><td colspan="2">STRATEGY CCS1: Address housing quality issues</td></tr>
<tr><td colspan="2">Sub-Strategy CCS1a Coordinate Community Housing Impact and Preservation Program between City and County to assist with home repairs.</td></tr>
<tr><td colspan="2">Mahoning Agency Lead: Mahoning County Healthy Homes & Lead Hazard Control</td></tr>
<tr><td colspan="2">Timeline: Ongoing</td></tr>
<tr><td>Implementation Planning:
• Implement Community Housing Improvement & Preservation Program. Coordinate funding & programs between City & County.
This program conducts home repairs primarily in Campbell & Struthers, as these cities co-fund the program, but also works in the rest of the county, except Youngstown (see CCS1c for Youngstown home repair program).</td><td>Assisting Agencies/Groups:
• Youngstown Neighborhood Development Corporation
• Mahoning County Public Health,
• Youngstown City Health District</td></tr>
<tr><td>Performance Measures
• # of homes assisted including the types of improvements made to the structures.
*Will include the occupants: age, incomes, race/ethnicity, census tracts.
Data
• Asthma rates in Mahoning County.
• % of people reporting housing issues or concerns
• Number of homes repaired</td><td>Target Population: Mahoning County residents, primarily in Campbell & Struthers, with home repair needs</td></tr>
</table>

<table>
<tr><td colspan="2">STRATEGY CCS1: Address housing quality issues</td></tr>
<tr><td colspan="2">Sub-Strategy CCS1b Coordinate interagency collaboration and data collection & analysis for the Healthy Homes & Lead Hazard Control Program.</td></tr>
<tr><td colspan="2">Mahoning Agency Lead: Mahoning County Healthy Homes & Lead Hazard Control</td></tr>
<tr><td colspan="2">Timeline: Ongoing</td></tr>
<tr><td>Implementation Planning:
Assess and implement remediation & repair for eight basic home hazards: allergies, asthma, carbon monoxide, home safety, integrated pest management, lead, mold, and radon. Track health data related to hazards.

Develop procedures for effective coordination with Water Department on lead hazard control.</td><td>Assisting Agencies/Groups:
• Mahoning County Public Health
• Youngstown City Water District</td></tr>
<tr><td>Performance Measures:
CHA question: % of residents experiencing critical home safety concerns; asthma rates; child blood lead levels.

Data
• # of homes tested & remediated for 8 hazards,
• types of improvements,
• occupants: age, incomes, race/ethnicity, census tracts</td><td>Target Population:
Mahoning County residents with potential home hazards</td></tr>
</table>

<table>
<tr><td colspan="2">STRATEGY CCS1: Address housing quality issues</td></tr>
<tr><td colspan="2">Sub-Strategy CCS1c Gather data and track outcomes from the YNDC Emergency Home Repair Program.</td></tr>
<tr><td colspan="2">Mahoning Agency Lead: Youngstown Neighborhood Development Corporation</td></tr>
<tr><td colspan="2">Timeline: see Implementation Planning</td></tr>
<tr><td>Implementation Planning:
• YNDC to implement program as it corresponds with the Youngstown Citywide Housing Strategy.
• Years 1-3: Complete 100 roof replacements and 135 emergency home repairs each year for low-income homeowners in Youngstown and Mahoning County.

Other implementation notes: This strategy aligns with the Youngstown Housing Analysis and Strategy to Improve Housing Conditions, adopted by Youngstown City Council in 2021. The Strategy calls for incorporating its recommendations into the CHIP, as housing is a social determinant of health, and the Strategy aims to improve housing quality for Mahoning County's most vulnerable populations.</td><td>Assisting Agencies/Groups:
• Audrey Tillis and Phil Puryear, Mahoning County (resources & referrals)
• Mike Durkin and Nikki Posterli, City of Youngstown (resources & referrals)
• Darrell Harrison, Building Neighborhoods of Youngstown (complete home repairs)</td></tr>
<tr><td>Performance Measures:
• # of homes repaired, categorized by types of repairs initiated
• % of residents experiencing critical home safety concerns
• Data
  • Minimum of 235 home repairs each year
  • 5% reduction in # of owner-occupied houses with significant exterior deficiencies over 3 years</td><td>Target Population Program:
Low-income Youngstown and Mahoning County homeowners with home repair needs</td></tr>
</table>

STRATEGY CCS1: Address housing quality issues	
Sub-Strategy CCS1d Implement Managing Asthma Triggers at Home (MATH) program.	
Mahoning Agency Lead: Mahoning County Public Health	
Timeline: See Implementation Planning	
Implementation Planning: 1. **Year 1 -** The managing pediatric asthma program/plan will be developed by the multiagency partnership. 2. **Year 2 and Year 3 –** Implementation of the program within the Mahoning County and Youngstown city	**Assisting Agencies/Groups:** • Youngstown City Health District • Akron Children's Hospital • Mahoning County Healthy Homes Program • Legal Aid
Performance Measures: • # of high-risk clients identified in the Akron Children's Hospital High Risk Asthma Clinic **Data** • Point increase in client's self-assessment scores of symptoms. • Percent decrease in hospital admissions among clients • Percent decrease in ED visits among clients	**Target Population**: # of high-risk asthma patients/participants enrolled in program, with demographics (age, race/ethnicity, income, census tract)

STRATEGY CCS1: Address housing quality issues	
Sub-Strategy CCS1e Gather baseline data from other programs to determine feasibility of homeownership assistance program in Mahoning County.	
Mahoning Agency Lead: City of Youngstown Health District	
Timeline: TBD	
Implementation Planning: • Track Trumbull County HOME assistance program to see if it can be implemented in Mahoning County. • Gather baseline data related to barriers to homeownership, e.g. low/unestablished credit.	**Assisting Agencies/Groups:** • Mahoning County Land Bank, • Financial Stability Partnership
Performance Measures: • Data indicators identified; funding strategies; partners identified. **Data** • % of households cost-burdened by housing; % of low-income homeowners	**Target Population**: Long-term low-income renters facing barriers to homeownership

STRATEGY CCS1: Address housing quality issues	
Sub-Strategy CCS1f Assign and publish grades for rental properties to assist prospective renters. Collect and track data collected by the licensing & inspection program to track outcomes of program.	
Mahoning Agency Lead: City of Youngstown Code Enforcement	
Timeline: Ongoing	
Implementation Planning: • Continue registering properties & property owners. Continue implementing inspection program. Assign and publish grades for rental properties to assist prospective renters.	**Assisting Agencies/Groups:** • Youngstown Municipal Court, • Mahoning County Lead Hazard Agency, • YMHA, • Mahoning County & City of Youngstown Land Banks, • Legal Aid
Performance Measures: • % of renters experiencing housing quality / safety issues **Data** • % of properties / landlords registered in system; • % of properties given a grade	**Target Population**: Current and prospective renters with Youngstown City jurisdiction

<table>
<tr><td colspan="2">STRATEGY CCS1: Address housing quality issues</td></tr>
<tr><td colspan="2">Sub-Strategy CCS1g Formalize procedures to ensure objective & equitable practices around granting zone variances, to reduce spot zoning & substitution zoning.</td></tr>
<tr><td colspan="2">Mahoning Agency Lead: Youngstown City Health District</td></tr>
<tr><td colspan="2">Timeline: See Implementation Planning</td></tr>
<tr><td>Implementation Planning:
• Year 1: Review past zoning variances to understand baseline and develop policy.
• Year 2: Formalize and implement spot zoning prevention policy in Youngstown.
• Year 3: Explore possibility of similar policies in other municipalities.</td><td>Assisting Agencies/Groups:
• Mahoning County Healthy Home
• Neighborhood Leadership Council</td></tr>
<tr><td>Performance Measures:
# of identified spot zoning locations
Data
• # of variance requests & approvals, reasons for approval of variances</td><td>Target Population: Youngstown Residents</td></tr>
</table>

STRATEGY CCS2: Expand active transportation safety through infrastructure and community engagement, focusing on pedestrian and bicycle safety	
Sub-Strategy CCS2a Support pedestrian safety projects and initiatives	
Trumbull Agency Lead: Healthy Community Partnership (HCP)'s Active Transportation Coordinator and Action Team	
Timeline: August 2022 – December 2023	
Implementation Planning: 1. Organize safer street demonstrations. 2. Expand municipalities' participation in ODOT's Safe Routes to School program. 3. Expand community walking programs, including those funded through Mercy Health and YSU. 4. Advocate for / implement local or MPO-level Complete and Green Streets Policy. 5. Support Pedestrian Safety and Outreach Coordinator Position.	**Assisting Agencies/Groups:** • Responsible/Accountable: HCP AT Team, HCP AT Coordinator, Eastgate for data storage and mapping, Stepping Out for walking programs/physical activity data, Youngstown Engineering Dept (Jordan Karim) for SRTS and infrastructure installations, YCHD (Erin Bishop) to assist other municipalities in applying for SRTS funding, Mercy Health (Doris Bullock) for community walking programs. • Consulted/Informed: Walking program leaders, YNDC (Jack Daugherty)
Performance Measures: 1. Area of sidewalks installed or improved 2. Funds invested in active transportation projects with pedestrian safety focus 3. Number of walking programs offered 4. Number of schools or community partners engaged **Data** • Increased % people walking for transportation. • Decrease number of traffic crashes • Increased % people reporting regular physical activity	**Target Population**: Residents living in areas with insufficient pedestrian infrastructure. Focus on Youngstown in years 1-2 and if feasible, support expansion across county in years 2-3.

<table>
<tr><td colspan="2">STRATEGY CCS2: Expand active transportation safety through infrastructure and community engagement, focusing on pedestrian and bicycle safety</td></tr>
<tr><td colspan="2">Sub-Strategy CCS2b Support bicycle safety projects and initiatives</td></tr>
<tr><td colspan="2">Trumbull Agency Lead: Healthy Community Partnership (HCP)’s Active Transportation Coordinator and Action Team</td></tr>
<tr><td colspan="2">Timeline: August 2022 – December 2023</td></tr>
<tr><td>Implementation Planning:
Years 1-2: Activities may include: Youngstown CHWs and community members document locations of existing bike racks and identify locations for new bike racks. Contact businesses to sponsor new bike racks. Identify local artists for creative bike rack design. Apply for additional funding. Explore the possibility of expanding bike lane infrastructure. Explore the possibility of bike giveaway programs based on existing community assets. Consider integrating GoOhio Commute tool in community engagement efforts. Advocate for local or MPO-level Complete and Green Streets Policy.

Years 2-3: Activities may include: Install new bike racks. Install new bike infrastructure. Implement bike giveaway programs if possible.</td><td>Assisting Agencies/Groups:
Responsible/Accountable: HCP AT Team, Eastgate for data storage (Tricia D'Avignon), Adam Lee - Bicycle Safety Project, YCHD (Erin Bishop - CHWs collect bike rack data)
Consulted/Informed: CycWard, Outspokin Wheelmen, Rust Belt Revival Trail Coalition
Informed: YoGo Bike Share - Ronnell Elkins - they will be collecting use data once they launch; Jacob Harver; Justin Arroyo
Funding possibilities: HCP mini-grants, local businesses, local foundations, Eastgate, ODOT SRTS</td></tr>
<tr><td>Performance Measures:
1. Area of bicycle lanes/dedicated trails installed or improved
2. $ invested in active transportation projects with a bicycling safety focus
3. Number of cycling programs offered
4. Number of schools or community partners engaged

Data
Increased % people biking for transportation.
Decrease number of traffic crashes
Increased % people reporting regular physical activity</td><td>Target Population:
Residents living in areas with insufficient bicycle infrastructure</td></tr>
</table>

<table>
<tr><td colspan="2">STRATEGY CCS3: Invest in expanding greenspace and safe parks</td></tr>
<tr><td colspan="2">Sub-Strategy CCS3a Invest in City of Youngstown and Mahoning County Parks to increase park usage.</td></tr>
<tr><td colspan="2">Mahoning Agency Lead: Youngstown parks staff, HCP staff, PGS team members</td></tr>
<tr><td colspan="2">Timeline: TBD</td></tr>
<tr><td>Implementation Planning :
• Continue Youngstown parks planning & prioritization process. Establish relationships with Mahoning County Park districts. Continue holding annual Mahoning Valley Park leadership summits. Support Mahoning Valley Outside 365 initiatives to encourage outdoor recreation year-round.</td><td>Assisting Agencies/Groups:
• Healthy Community Partnerships (HCP)
• City of Youngstown</td></tr>
<tr><td>Performance Measures:
• # of participants in outreach activities
Data
• Park usage data (especially in the off season) (need data source); % people reporting regular physical activity</td><td>Target Population: Mahoning County residents, especially in City of Youngstown</td></tr>
</table>

STRATEGY CCS3: Invest in expanding greenspace and safe parks	
Sub-Strategy CCS3b Enhance open spaces to benefit local ecology.	
Mahoning Agency Lead: Youngstown parks staff, HCP staff, PGS team members	
Timeline: TBD	
Implementation Planning: • Support partners leading open space projects or initiatives. Activate the Youngstown Tree Coalition and expand into other communities. Identify opportunities for open space promotion, preservation, or conservation with a focus on tree canopy or waterways	**Assisting Agencies/Groups:** • MCLB, • Operation Pollination, • ODNR, • Treez Please, • Plant Ahead Ohio, • City of Youngstown parks staff, • HCP staff, • Eastgate
Performance Measures: • # of participants in outreach activities **Data** • Air quality (PM2.5); % of people reporting regular physical activity	**Target Population Program** Residents interested in engaging in open space projects. **Target Population**: Residents living in areas lacking greenspace

STRATEGY CCS4: Increase access, affordability, and consumption of healthy foods.

Sub-Strategy CCS4a Expand neighborhood-focused food access efforts.

Mahoning Agency Lead: Mahoning Food Access Coordinator; HCP HFR team

Timeline: TBD

Implementation Planning:

1. Continue work to establish a Food Hub.
2. Maintain and expand availability of Mobile Markets.
3. Increase the number of neighborhood food access points.
4. Continue to support current community stores, farmers markets, etc. and enhance their capacity.
5. Implement voucher programs at mobile markets
6. Expand voucher programs at community stores.
7. Assess progress and community reception.

Assisting Agencies/Groups:

Mobile Markets

- Responsible/Accountable: ACTION, Mercy Health Foundation
- Consulted/Informed: ACTION, HFR Team

Community Stores

- Responsible: Mahoning Food Access Coordinator
- Accountable: Trumbull Neighborhood Partnership
- Consulted/Informed: HCP Staff / HFR Team

Glenwood Fresh Market

- Responsible/Accountable: YNDC
- Consulted: Mercy Health / USDA / Nutrition Incentive Hub / Market Members
- Informed: HCP Staff, HCP HFR Team, Funding Partners

Performance Measures:

- # of locations
- # of participants served (YNDC can provide for fresh market) including demographics of participants
- $ value of fruits and veggies distributed (or by weight)

Data:

- # of locations increased in most impacted neighborhoods
- Decrease in barriers to food access.
- % of folks enrolled in program who feel more food secure
- Increase in consumption of fruits and vegetables among participants

Target Population:

Residents facing barriers to healthy food consumption.

<table>
<tr><td colspan="2">STRATEGY CCS4: Increase access, affordability, and consumption of healthy foods.</td></tr>
<tr><td colspan="2">Sub-Strategy CCS4b Address other barriers to healthy food access by supporting and tracking initiatives related to affordability and healthy food education. These initiatives may include Double Up nutrition incentives, produce prescriptions, volunteer support, and education program support..</td></tr>
<tr><td colspan="2">Mahoning Agency Lead: Mahoning Food Access Coordinator; HCP HFR team</td></tr>
<tr><td colspan="2">Timeline: TBD</td></tr>
<tr><td>Implementation Planning:
1. Implement voucher programs at mobile markets
2. Expand voucher programs at community stores
3. Assess progress and community reception</td><td>Assisting Agencies/Groups:
Responsible: Mercy Health Foundation (Jessica) / Food Access Coordinator / Produce Perks Midwest / MYCAP

Accountable: Mercy Health / ACTION / Food Access Coordinators / Produce Perks Midwest

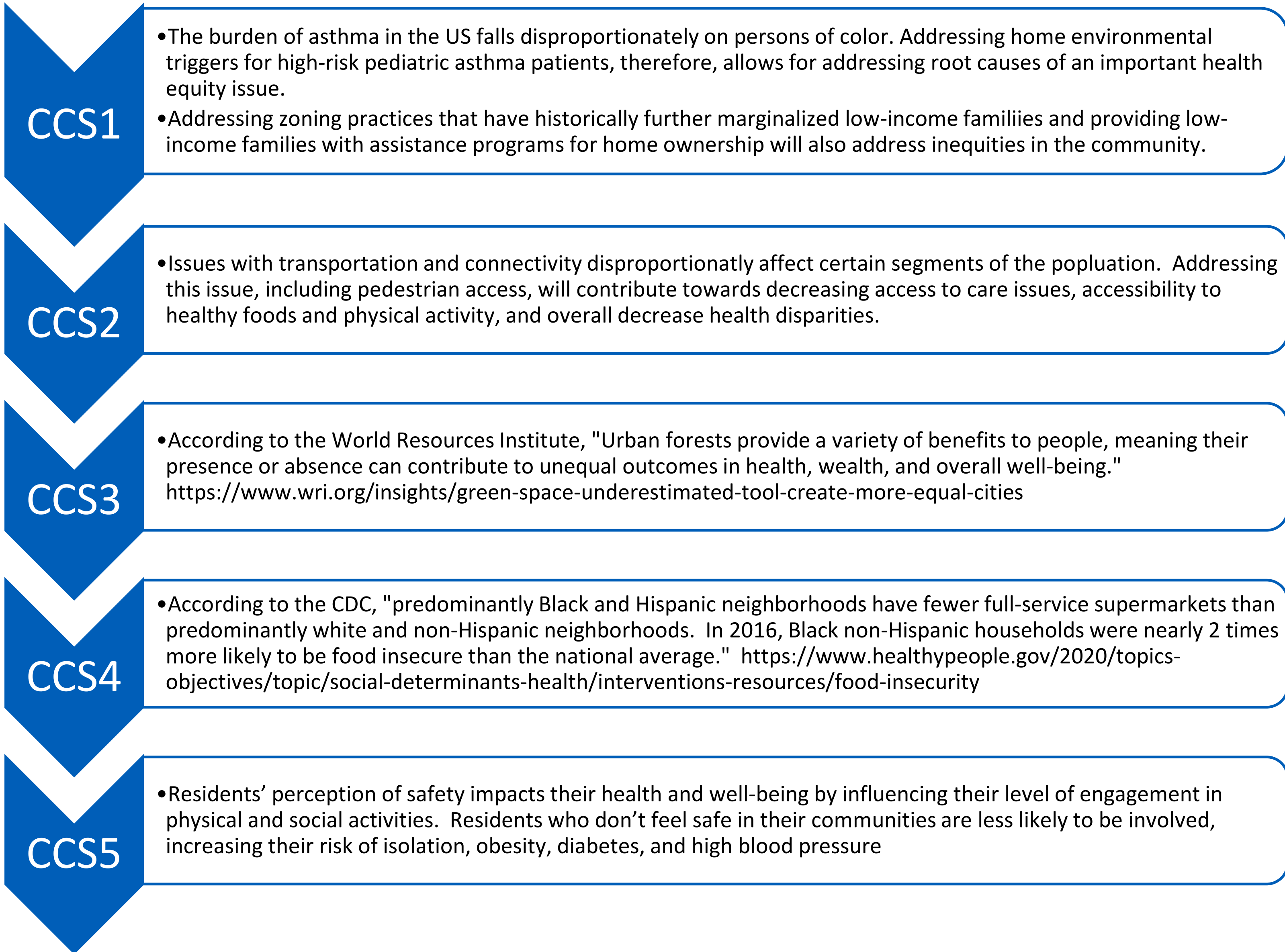
Consulted: YNDC / Produce Perks Midwest

Informed: HFR Team</td></tr>
<tr><td>Performance Measures:
• Increased consumption of healthy foods
Data:
• # of redemptions
• # of locations using incentive programs
• # of participants including demographics</td><td>Target Population:
Residents facing barriers to healthy food consumption.</td></tr>
</table>

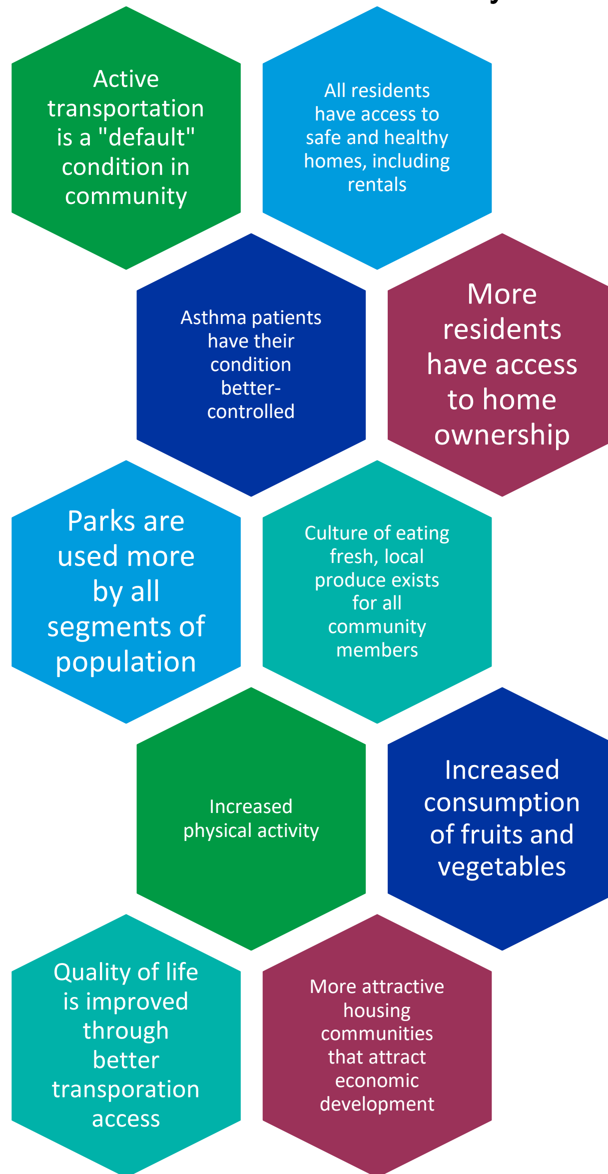
STRATEGY CCS4: Increase access, affordability, and consumption of healthy foods.	
Sub-Strategy CCS4c Increase contact points or opportunities for participation in healthy food education programming	
Mahoning Agency Lead: Mahoning Food Access Coordinator; HCP HFR team	
Timeline: TBD	
Implementation Planning: 1. Expand programming/partnerships (i.e., partner with the local libraries). 2. Continue and expand current educational opportunities.	**Assisting Agencies/Groups:** _None
Performance Measures: • Change in behavior reported by participants (Increased consumption of healthy foods) - Qualitative **Data:** • Increase in number of community partners/programming. • # of participants (Mercy Health Foundation and OSU) • # of locations (Mercy Health Foundation and OSU)	**Target Population:** Residents facing barriers to healthy food consumption.

STRATEGY CCS5: Gather information about community safety and concerns.	
Sub-Strategy CCS5a Collect community data and build partnerships to understand what community safety means and how it can be improved.	
Mahoning Agency Lead: Mahoning County Public Health and Vibrant Valley	
Timeline: TBD	
Implementation Planning: **Years 1-2:** Develop a plan to collect qualitative & quantitative data to refine and deepen understanding of what safety means to our community. Find a partner to develop a preliminary strategy related to safety. **Year 3:** If applicable, implement strategy developed in Years 1-2. Create a plan for prioritizing community safety strategies in next CHA/CHIP.	**Assisting Agencies/Groups:** Vibrant Valley data team partners; additional partners TBD in Year 1
Performance Measures: • TBD in year 1 **Data:** **TBD in year 1** •	**Target Population:** Mahoning County residents, particularly BIPOC, who were more likely to report community safety as a concern in prioritization survey

How do these strategies address the cross-cutting priorities of addressing health equity and root causes of poor community conditions and lack of safety?



How will we know that we are better off around Community Conditions in our area?



GET INVOLVED

Community members are invited to get involved and join MTCHP and community partners in implementing the CHIP.

1. Identify a priority to be involved with
2. Identify a Sub-strategy to support
3. Contact the Agency Lead for the selected strategy

Sub-strategy	Lead Agency	Contact
Mental Health and Substance Use		
MHSU1a	Mahoning County Mental Health and Recovery Board (suicide), Mahoning County Public Health (overdose), Trumbull County Mental Health and Recovery Board	
MHSU1b	Mahoning County Mental Health and Recovery Board (suicide), Mahoning County Public Health (overdose), Trumbull County Mental Health and Recovery Board	
MHSU1c	Mahoning County Mental Health and Recovery Board (suicide), Mahoning County Public Health (overdose), Trumbull County Mental Health and Recovery Board	
MHSU1d	Mahoning County Mental Health and Recovery Board (suicide), Mahoning County Public Health (overdose), Trumbull County Mental Health and Recovery Board	
MHSU1e	Mahoning County Mental Health and Recovery Board (suicide), Mahoning County Public Health (overdose), Trumbull County Mental Health and Recovery Board	
MHSU1f	Mahoning County Mental Health and Recovery Board (suicide)	
MHSU2a	Mahoning and Trumbull County Mental Health and Recovery Boards	
MHSU2c	Mahoning County Mental Health and Recovery Board	
MHSU2b	Trumbull County Mental Health and Recovery Board	
Access to Care		
AC1a	Mahoning County Public Health	
AC1b	Mahoning County Public Health	
AC2a	Mercy Health	
AC3a	Mahoning County Public Health	
AC4b	Vibrant Valley Health Equity Project	
AC2b	Trumbull County Combined Health District	
AC4a	Trumbull County Mental Health and Recovery Board (TCMHRB)	

Community Conditions and Safety		
CCS1a	Mahoning County Healthy Homes & Lead Hazard Control	
CCS1b	Mahoning County Public Health	
CCS1c	Mahoning County Healthy Homes and Lead Hazard Control Program	
CCS1d	City of Youngstown	
CCS1e	City of Youngstown	
CCS1f	City of Youngstown Code Enforcement, Warren City	
CCS1g	City of Youngstown	
CCS1h	City of Youngstown	
CCS1i	City of Youngstown	
CCS1j	City of Youngstown	
CCS2a	Trumbull County Combined Health District, Healthy Community Partnership (HCP)'s Active Transportation Action Team	
CCS3a	Trumbull County Combined Health District	
CCS4a	Healthy Community Partnership (HCP)'s Health Retail Action Team	

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APPENDICES

1. CHIP ALIGNMENT WITH PHAB STANDARDS AND MEASURES

Community Health Improvement Planning for PHAB Accreditation
(Based on Standards & measures for Reaccreditation Version 2022)

<table>
<tr><td colspan="4">Community Health Improvement Planning</td></tr>
<tr><td colspan="4">STANDARD 5.2 Develop and implement community health improvement strategies collaboratively.</td></tr>
<tr><td colspan="4">The purpose of a CHIP is to describe how the health department and community will work together to improve community health
The CHIP can be used to set priorities, allocate resources and develop and implement projects, programs and policies
CHIP development and implementation must include participation from community stakeholders and partners
Planning process is community-driven and collaborative
The CHIP will address the needs of community residents in the Health Department's jurisdiction</td></tr>
<tr><td>Measure</td><td>Requirement</td><td>Notes</td><td>Completion Notes</td></tr>
<tr><td>5.2.1.A</td><td>Adopt a community health plan</td><td>A health improvement plan looks at population health across the jurisdiction. While programs in the health department may have program-specific plans, those plans do not fulfill the purpose of the health improvement plan to address the jurisdiction's priorities.</td><td>Full plan</td></tr>
<tr><td>5.2.1.A</td><td>a. At least two health priorities.</td><td></td><td>Three priorities were chosen</td></tr>
<tr><td></td><td>b. Measurable objective(s) for each priority.</td><td>Establishing one or more measurable objective(s) for each of the health priorities will enable the CHIP collaborative to determine if progress is being made towards addressing each priority. The objectives could be contained in another document.</td><td>At least one population - level indicator was developed for each priority</td></tr>
<tr><td></td><td>c. Improvement strategy(ies) or activity(ies) for each priority.</td><td>Improvement strategy(ies) or activity(ies) may be evidence-based, practice-based, promising practices, or may be innovative to meet the needs of the population.</td><td>Multiple strategies were developed for each priority</td></tr>
</table>

		National guidance (e.g., the National Prevention Strategy, Guide to Community Preventive Services, and Healthy People 2030) could be used as sources of strategies or activities,	
	C i. Each activity or strategy must include a timeframe **and** a designation of organizations or individuals that have accepted responsibility for implementing it.	For i: Time-framed strategies or activities may be contained in another document, such as an annual work plan. If communities are using innovation processes (e.g., design thinking) or quality improvement processes, the CHIP or workplan may describe the timelines for putting in place the process rather than specific actions. Designation of responsible parties may include, assignments to staff or agreements between partners. Agreements do not need to be formal.	Lead organizations as well as contributing organizations as well as a general timeframe were developed for each strategy
	C ii. At least two of the strategies or activities must include a policy recommendation, one of which must be aimed at alleviating causes of health inequities.	For ii: CHIP will include recommendations related to policy—either new policies or changes to existing policies. The CHIP will include at **least two** policy recommendations. One of those policy recommendations is designed to alleviate causes of health inequities. Policy recommendations may be developed by involving communities impacted by health inequities in the identification, development, and implementation of policy changes to improve conditions impacting their health.	Policy change strategies and sub-strategies are identified in AC4 and CCS1. Both strategies aim at alleviating causes of health inequities.
	d. Identification of the assets or resources that will be used to address at least one of the specific priority areas.	Assets and resources could be, but are not limited to, those identified as part of the CHA process. It is not necessary to include an asset or resource for each priority area. They may be included as part	Lead organizations as well as contributing organizations and resources were identified

		of the CHIP, as an addendum, or in a separate document (as long as the link to the CHIP is indicated).	for each strategy
	e. Description of the process used to track the status of the effort or results of the actions taken to implement CHIP strategies or activities.	This may be included as part of the CHIP, as an addendum, or in a separate document.	Monitoring and evaluation information was developed for each priority
5.2.2A	Encourage and participate in collaborative implementation and revision of the community health improvement plan.	Effective CHIP should not be stagnant, but dynamic to reflect the evolving needs of the population served. Health departments should continuously work with multi-sector partnerships to evaluate and improve the community health improvement plan.	Information for implementation of the CHIP is presented on p. 7.
	The CHIP process must address the jurisdiction as described in the description of Standard 5.2.		This CHIP covers the jurisdictions of Mahoning and Trumbull counties as well as the towns of Warren and Youngstown, with representation from each health department on the MTCHP.
	If the plan was adopted less than a year before it was submitted to PHAB, the health department may provide implementation from an earlier CHIP.	(Documentation must demonstrate the linkage between the activity or strategy and the prior CHIP. Although the prior CHIP may be more than 5 years old, the implementation must have occurred within 5 years.)	N/A
	1. Implementation of a community health improvement plan (CHIP) strategy or activity, including:	The intent of the requirement is to provide documentation of the implementation of a (CHIP) strategy or activity, rather than a full review of progress on all CHIP strategies or activities. The example could be of a success or unsuccessful implementation,	TBD in 2023

		including what was learned based on the implementation of a specific community health improvement strategy or activity. The example could include a news article, meeting materials, excerpt of an annual report, a grant that was received, or presentation demonstrating how the strategy or activity was implemented.	
	1a. Which CHIP priority the example addresses. (This may be indicated in the Documentation Form.)		TBD in 2023
	1b. The health department's role in the implementation.	The health department does not need to have led the strategy, but the health department's role will be indicated to show how the department participated in implementing the strategy.	TBD in 2023
	1c. Results of the strategy or activity.	What was accomplished as a result of the activities	TBD in 2023
	2. Community health improvement plan (CHIP) strategy or activity that was revised, in collaboration with partners.	Provide a specific example demonstrating how the CHIP is a living document that continues to evolve after it is released. An example about how a strategy or activity from one cycle of the CHIP was improved in the second cycle **would not** meet the intent of the requirement Changes will be developed in collaboration with partners and stakeholders involved in the planning process. The intent is that at least some of the partners involved in the CHIP (e.g., one of the workgroups) are engaged when making changes. It is not necessary for the entire CHIP partnership to be involved. Documentation could include, for example, an addendum to the CHIP showing the revision, meeting minutes or a presentation showing the change, or a revised workplan.	TBD in 2023

5.2.3 A	Address factors that contribute to specific populations' higher health risks and poorer health outcomes.	The purpose is to assess the health department's efforts to address factors that contribute to specific populations' higher health risks and poorer health outcomes, inequities, as well as to build environmental resiliency. Differences in populations' health outcomes are well documented. These differences in health outcomes require engagement of the community in strategies that develop community resources, capacity, and strength.	TBD in 2023
	1. Implementation of one strategy, in collaboration with stakeholders, partners, or the community, to address factors that contribute to specific populations' higher health risks and poorer health outcomes, or inequities. The documentation must define the health department's role in the strategy as well as the roles of stakeholders, partners, or the community	Could be related to a CHIP strategy but does not have to be. The Health Department does not have to have led the strategy. A plan would not be sufficient for this requirement. Documentation could include, for example, a press release; report to the governing entity or the community; or other document that outlines efforts, achievements, or implementation updates.	TBD in 2023
	2. Efforts taken that contribute to building environmental resiliency.	Efforts may be led by the health department, or the health department might participate in efforts in partnership with others. Could include successful or unsuccessful examples.	TBD in 2023

2. COMMUNITY PARTNERS

MTCHP PARTNERS

Organization	Representative
Mahoning County Public Health	Ryan Tekac
Mercy Health	Leigh Greene
Trumbull County Combined Health District	Frank Migliozzi
Warren City Health District	John May
Youngstown City Health District	Erin Bishop
Health Community Partnership	Sarah Lowry
Environmental Collaborative	Courtney Boyle
Mahoning County Mental Health & Recovery Board	Brenda Heidinger
Trumbull County Mental Health & Recovery Board	April Caraway

COMMUNITY STAKEHOLDERS

The following community stakeholders contributed to the CHIP process.

Representative	**Organization**
Golie Stennis	Access Health Mahoning Valley
Jodi Mitchell	Aetna OhioRISE Health Equity Specialist for NE Ohio
Sarah Brown	AmeriHealth Caritas Ohio
Allic Bora	Bright View Health
Doug Franklin	City of Warren, Mayor
Sarah Lowry	Community Foundation of the Mahoning Valley
Traci Hostetler	Educational Service Center of Eastern Ohio
Courtney Boyle	Environmental Collaborative
Rachel Evans	Green Tree Counseling
John Gargano	Job and Family Services
Colleen Kosta	Mahoning County Government
Phillip O. Puryear	Mahoning County Government
Duane Piccirilli	Mahoning County Mental Health & Recovery Board
Michelle Edison	Mahoning County Public Health
Tracy Styka	Mahoning County Public Health
Erica Horner	Mahoning County Public Health
Leigh Greene	Mercy Health
Stephanie Oakes	Mercy Health - Community Outreach
Mirta Pacheco Arrowsmith	Mercy Health - Hispanic Program
Doris Bullock	Mercy Health - Stepping Out Program
Bishop David Herron	Monument of Faith Church of God in Christ
Bobbe Reynolds	Northeast Homeowners & Concerned Citizens Association

Mandy Shina	OneHealth Ohio
Stephanie Bardash	OneHealth Ohio
Hannah Haynie	OneHealth Ohio
Rev. Gayle Catinella	St. John's Episcopal Church, Youngstown Ohio
Jenna Amerine	Trumbull County Combined Health District
Daniel Bonacker	Trumbull County Combined Health District
Frank Migliozzi	Trumbull County Combined Health District
Jessica King	Trumbull County Land Bank
John Myers	Trumbull County Mental Health & Recovery Board
Lauren Thorp	Trumbull County Mental Health & Recovery Board
Miles Jay	Trumbull Neighborhood Partnership
Lydia Walls	Trumbull Neighborhood Partnership
Lisa Ramsey	Trumbull Neighborhood Partnership
Cheryl Strother	Warren City Health District
Rose Leonhard	Warren City Health District
John May	Warren City Health District
Eric Merkel	Warren Police Department, Chief
Erin Bishop	Youngstown City Health District
Adam Lee	Youngstown City Scape
Nicolette Powe	Youngstown State University
Dr. Nicole Kent-Strollo	Youngstown State University
Junious Williams	Organization?
Sydney Williams	Community Member
Miquel	Community Member
Christopher Colven	Community Member