2020  2022

Trumbull County

Community Health Improvement Plan

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Signature Page

This plan has been approved and adopted by the following individuals:

Robert Beiry, Jr., President — Date: 11/20/19

Frank J. Migliozzi, MPH, REHS, RS, Health Commissioner — Date: 11-20-19

Kris Wilster, MPH, REHS, RS, Director of Environmental Health — Date: 11/20/19

Sandra Swann, RN, BSN, Director of Nursing — Date: 11/20/2019

Foreword

Dear Trumbull County Resident,

In keeping with the objective of improving community health through collaboration and community action, it is my pleasure to present the 2019-2021 Trumbull County Community Health Improvement Plan (CHIP). This plan will serve as a roadmap to improving the health and wellbeing of all residents of Trumbull County.

The CHIP process was conducted in four sessions with Trumbull Community Health Improvement Partnership members and facilitated by Hospital Council of Northwest Ohio (HCNO). The collaborative process involved over 4 months of work from at least 12 community partners and agencies listed in the executive summary of this document. Using data from the 2019 Trumbull County Community Health Needs Assessment and access to care addendum, the Mobilizing for Action through Planning & Partnerships (MAPP) process was utilized to guide the partnership in the development of priorities, goals and strategies that will serve as the blueprint for improving health outcomes in our community.

The CHIP is data driven with baselines and metrics to evaluate our progress. As such, this plan is a "living document" and will be implemented over the next three years. The plan will be reviewed annually to reflect our accomplishments and new areas of need.

To that end, by addressing our most significant health challenges through a comprehensive collaborative approach, we can ensure the residents of Trumbull County that our available resources are most effectively utilized to improve health outcomes.

I would like to personally thank our partners for their dedication to this effort and invite everyone to stay active in this process as we go forward.

Sincerely,

Frank Migliozzi, MPH, REHS/RS
Health Commissioner
Trumbull County Combined Health District

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

Executive Summary

Introduction

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

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

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

Public Health Accreditation Board (PHAB) Requirements

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

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

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

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

1. Organizing for success and partnership development

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

Figure 1.1 The MAPP Framework

2. Visioning

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

3. The four assessments

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

4. Identifying strategic issues

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

In order to identify strategic issues, the steering community considers findings from the visioning process and the MAPP assessments in order to understand why certain issues remain constant across the assessments. The steering committee uses a strategic approach to prioritize issues that would have the greatest overall impact to drive population health improvement and would be feasible, given the

resources available in the community and/or needed, to accomplish. The steering committee also arranged issues that were related to one another, for example, chronic disease related conditions, which could be addressed through increased or improved coordination of preventative services. Finally, the steering committee members considered the urgency of issues and the consequences of not addressing certain items.

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

6. Action cycle
The steering committee begins implementation of strategies as part of the next community health improvement cycle. Both progress data to track actions taken as part of the CHIP's implementation and health outcome data (key population health statistics from the CHA) are continually tracked through ongoing meetings. As the end of the CHIP cycle, partners review progress to select new and/or updated strategic priorities based on progress and the latest health statistics.

Inclusion of Vulnerable Populations (Health Disparities)

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

Alignment with National and State Standards

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

Ohio State Health Improvement Plan (SHIP)

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

SHIP Overview

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

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

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

SHIP Priorities

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

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

Cross-cutting Factors

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

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

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

CHIP Alignment with the 2017-2019 SHIP

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

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

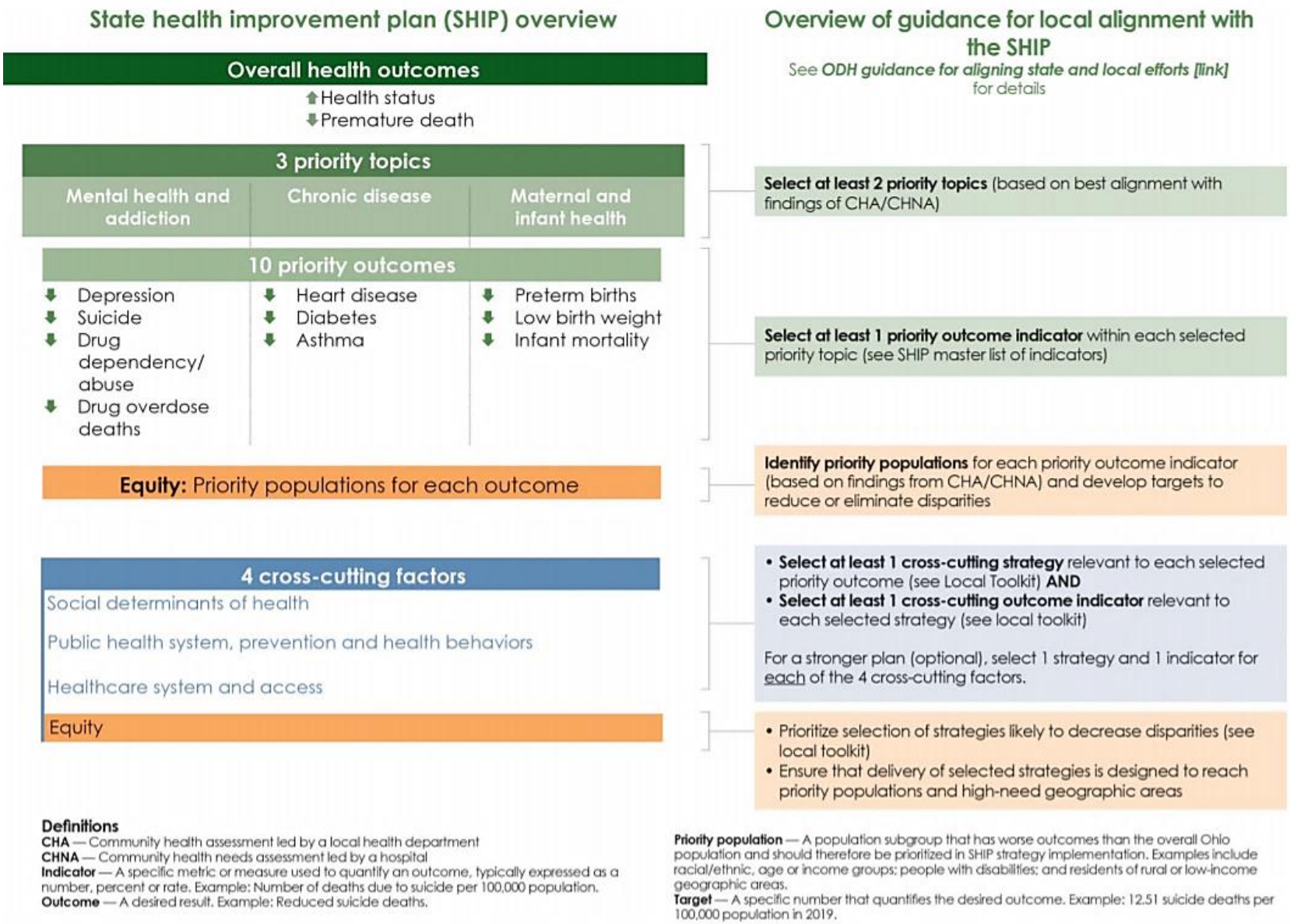
2020-2022 Trumbull CHIP Alignment with the 2017-2019 SHIP			
Priority Topic	***Priority Outcome Indicator***	***Cross-cutting Factor***	***Cross-Cutting Outcome Indicator***
Mental health and addiction	• Suicide ideation • Suicide deaths • Unintentional drug overdose deaths	• Public health system, prevention and health behaviors • Healthcare system and access • Social determinants of health	• Current smoker • Quit attempts • Fruit consumption • Vegetable consumption • Physical inactivity • Access to exercise opportunities • Food insecurity • Poverty
Chronic Disease	• Diabetes • Coronary heart disease		
Maternal and Infant Health	• Total preterm births • Low birth weight births • Infant mortality		

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

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

Alignment with National and State Standards, continued

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



Strategies

To work toward **increasing mental health and decreasing substance abuse**, the following action steps are recommended:

1. Trauma-informed care
2. Advocate to state and local policy makers
3. Mental health first aid
4. Crisis Intervention Team (CIT)
5. Provider education to primary care and behavioral health providers regarding depression and substance use screening tools and evidence-based treatments
6. Implement evidence-based programming in schools

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

1. Food insecurity assessment
2. Prediabetes screening and referral
3. Hypertension screening and follow up
4. Community gardens
5. Prescriptions for physical activity

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

1. Progesterone treatment
2. Home visiting programs that begin prenatally
3. Infant mortality taskforce

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

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

1. Mass-reach communications
2. Healthy food in convenience stores

<u>Healthcare System and Access</u>

1. Cultural competency training for healthcare professionals
2. Expand access to evidence-based tobacco cessation treatments including individual, group and phone counseling (including Quitline) and cessation medications

<u>Social Determinants of Health</u>

1. Outreach to increase uptake for earned income tax credits
2. Lead awareness taskforce
3. Green space and parks
4. Active transportation planning (Complete Streets policies)
5. Access to transportation
6. Screening for social determinants of health (SDOH) using a standardized tool

Vision and Mission

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

The Vision of Trumbull County:

Create a healthy, thriving, and equitable Trumbull County for all.

The Mission of Trumbull County:

Improving overall health and well-being across the lifespan by mobilizing partnerships, empowering residents, and taking strategic action in Trumbull County.

Community Partners

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

Trumbull Community Health Improvement Partnership

- Abby Webb, Americorp Vista, Common Wealth, Inc.
- Angie Mackey, Strategic Account Executive, United Healthcare
- April J. Caraway, Executive Director, Trumbull County Mental Health & Recovery Board
- Bonnie Wilson, Coordinator, Family and Children First Council
- Bridget Lackey, RDN, Mercy Health
- Cassandra Clevenger, GROW Program Director, Trumbull Neighborhood Partnership
- Cheryl Strother, Director of Nursing, Warren City Health District
- Crystal Jones, Executive Director, Grants and Contracts, Mercy Health Foundation
- Deanna Ford, Director of Mission and Values, Mercy Health Youngstown
- Deatrice Traylor, LSW-RSM Supervisor, Mercy Health
- Debbie Hlad, Diabetes Education, Mercy Health
- Doris Bullock, Community Health, Mercy Health
- Ellen Ford, Manager of Community Health Education, Mercy Health Youngstown
- Frank J. Migliozzi, Health Commissioner, Trumbull County Combined Health District
- Ginny Pasha, President, Trumbull County United Way
- Jenna Amerine, Health Educator, Creating Healthy Communities Program Director, Trumbull County Combined Health District
- John Luellen, President, Mercy Health
- John Myers, Director of Planning and Evaluation, Trumbull County Mental Health & Recovery Board
- Johnna Ben, Administrative Secretary, Trumbull County Combined Health District
- Julie Green, Grants Manager, Trumbull County Commissioners
- Kathy Komara, Director of Operations Behavioral Health, Mercy Health
- Kathy Parilla, Public Health Nurse, Trumbull County Combined Health District
- Kelly Brown, RN Community Health, Mercy Health
- Kimberly Billings, CC Director, Meridian Healthcare

- Kris Wilster, Director of Environmental Health, Trumbull County Combined Health District
- Lauren Thorp, ASAP Project Director, Trumbull County Mental Health & Recovery Board
- Lauren Webb, Shelter Manager, Someplace Safe
- Leslie Markulin, Maternal Opioid Medical Support Program, Meridian Healthcare
- Lisa Cocca, Chief Executive Officer, Belmont Pines
- Lisa Ramsey, Deputy Director, Trumbull Neighborhood Partnership
- Melissa Lamanna, Community Education Manager, HMHB/PPGOH
- Mirta P. Arrowsmith, RN Supervisor, Mercy Health
- Natalie Markusic, Accreditation Coordinator, Trumbull County Combined Health District
- Paige Eckman, AOD Navigator, Mercy Health
- Pam Davies, Educator, Western Reserve Independent Living Center
- Paul S. Homick, President, Mercy Health Foundation Mahoning Valley and Interim VP, Mission Integration, Mercy Health Youngstown
- Robert R. Pinti, Deputy Health Commissioner, Warren City Health District
- Sandra Swann, Director of Nursing, Trumbull County Combined Health District
- Sarah J. Lowry, Director, Healthy Community Partnership-Mahoning Valley
- Sarah Ridel, Quality, Monitoring, Planning Manager, Direction Home
- Shelly Turner, Prevention Navigator, Equitas Health
- Tammy Shells, Director of A&R, Belmont Pines
- Tracy Behnke, Executive Director, American Heart Association
- Vincent Peterson II, Community Affairs, Congressman Tim Ryan's Office

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

Community Health Improvement Process

Beginning in June 2019, the Trumbull Community Health Improvement Partnership met four (4) times and completed the following planning steps:

1. Initial Meeting
    - Review the process and timeline
    - Finalize committee members
    - Create or review vision
2. Choose Priorities
    - Use of quantitative and qualitative data to prioritize target impact areas
3. Rank Priorities
    - Rank health problems based on magnitude, seriousness of consequences, and feasibility of correcting
4. Community Themes and Strengths Assessment
    - Open-ended questions for committee on community themes and strengths
5. Forces of Change Assessment
    - Open-ended questions for committee on forces of change
6. Local Public Health Assessment
    - Review the Local Public Health System Assessment with committee
7. Gap Analysis
    - Determine discrepancies between community needs and viable community resources to address local priorities
    - Identify strengths, weaknesses, and evaluation strategies

Community Health Improvement Process (cont.)

8. Quality of Life Survey
    - Review results of the Quality of Life Survey with committee
9. Strategic Action Identification
    - Identification of evidence-based strategies to address health priorities
10. Best Practices
    - Review of best practices, proven strategies, evidence continuum, and feasibility continuum
11. Resource Assessment
    - Determine existing programs, services, and activities in the community that address specific strategies
12. Draft Plan
    - Review of all steps taken
    - Action step recommendations based on one or more of the following: enhancing existing efforts, implementing new programs or services, building infrastructure, implementing evidence-based practices, and feasibility of implementation

Community Health Status Assessment

Phase 3 of the MAPP process, the Community Health Status Assessment, or CHA, is a 191-page report that includes primary data with over 100 indicators and hundreds of data points related health and well-being, including social determinants of health. Over 50 sources of secondary data are also included throughout the report. The CHA serves as the baseline data in determining key issues that lead to priority selection. The full report can be found at **www.hcno.org/community-services/community-health-assessments/**. Below is a summary of county primary data and the respective state and national benchmarks.

Trumbull County Adult Trend Summary

Adult Variables	Warren City 2018-2019	Trumbull County 2018-2019	Ohio 2017	U.S. 2017
Health Status				
Rated general health as good, very good, or excellent	78%	81%	81%	83%
Rated general health as excellent or very good	49%	47%	49%	51%
Rated general health as fair or poor	22%	19%	19%	18%
Rated mental health as not good on four or more days (in the past 30 days)	34%	29%	24%*	23%*
Rated physical health as not good on four or more days (in the past 30 days)	26%	21%	22%*	22%*
Average number of days that physical health was not good (in the past 30 days)	5.8	4.6	4.0**	3.7**
Average number of days that mental health was not good (in the past 30 days)	6.0	5.0	4.3**	3.8**
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past 30 days)	35%	28%	22%*	22%*
Healthcare Coverage, Access, and Utilization				
Uninsured	7%	6%	9%	11%
Had one or more persons they thought of as their personal healthcare provider	91%	90%	81%	77%
Visited a doctor for a routine checkup (in the past 12 months)	67%	73%	72%	70%
Visited a doctor for a routine checkup (5 or more years ago)	4%	4%	7%	8%
Chronic Disease				
Ever been told by a doctor they have diabetes (not pregnancy-related)	18%	15%	11%	11%
Ever diagnosed with arthritis	35%	36%	29%	25%
Had ever been told they have asthma	21%	21%	14%	14%
Ever diagnosed with Chronic Obstructive Pulmonary Disease (COPD), emphysema or chronic bronchitis	17%	12%	8%	6%
Ever been told they had skin cancer	2%	4%	6%	6%
Ever been told they had other types of cancer (other than skin cancer)	9%	11%	7%	7%
Cardiovascular Health				
Ever diagnosed with angina or coronary heart disease	4%	6%	5%	4%
Ever diagnosed with a heart attack, or myocardial infarction	5%	6%	6%	4%
Ever diagnosed with a stroke	6%	5%	4%	3%
Had been told they had high blood pressure	41%	39%	35%	32%
Had been told their blood cholesterol was high	38%	40%	33%	33%
Had their blood cholesterol checked within the last five years	78%	80%	85%	86%
Weight Status				
Overweight (BMI of 25.0 – 29.9)	27%	35%	34%	35%
Obese (includes severely and morbidly obese, BMI of 30.0 and above)	46%	40%	34%	32%
Alcohol Consumption				
Current drinker (had at least one drink of alcohol within the past 30 days)	53%	52%	54%	55%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	19%	18%	19%	17%

N/A – Not Available

Indicates alignment with the Ohio State Health Assessment

**2016 BRFSS*

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

Adult Variables	Warren City 2018-2019	Trumbull County 2018-2019	Ohio 2017	U.S. 2017
Tobacco Use				
Current smoker (smoked on some or all days)	20%	18%	21%	17%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	32%	30%	24%	25%
Drug Use				
Adults who used marijuana in the past 6 months	4%	4%	N/A	N/A
Adults who misused prescription drugs in the past 6 months	8%	9%	N/A	N/A
Preventive Medicine				
Ever had a pneumonia vaccination (ages 65 and older)	N/A	68%	76%	75%
Had a flu shot within the past year (ages 65 and older)	N/A	77%	63%	60%
Had a clinical breast exam in the past two years (age 40 and older)	N/A	59%	N/A	N/A
Had a mammogram within the past two years (ages 40 and older)	N/A	72%	74%*	72%*
Had a pap test in the past three years (ages 21-65)	N/A	65%	82%*	80%*
Had a PSA test within the past two years (ages 40 and older)	N/A	56%	39%*	40%*
Had a digital rectal exam within the past year	35%	29%	N/A	N/A
Quality of Life				
Limited in some way because of physical, mental or emotional problem	34%	28%	21%**	21%**
Mental Health				
Felt sad or hopeless for two or more weeks in a row in the past year	24%	16%	N/A	N/A
Seriously considered attempting suicide in the past year	6%	5%	N/A	N/A
Attempted suicide in the past year	2%	1%	N/A	N/A
Sexual Behavior				
Had more than one sexual partner in past year	6%	7%	N/A	N/A
Oral Health				
Visited a dentist or a dental clinic (within the past year)	56%	62%	68%*	66%*
Visited a dentist or a dental clinic (5 or more years ago)	12%	11%	11%*	10%*
Had any permanent teeth extracted	45%	52%	45%*	43%*
Had all their natural teeth extracted (ages 65 and older)	N/A	13%	17%*	14%*

N/A – Not Available

Indicates alignment with the Ohio State Health Assessment

**2016 BRFSS*

***2015 BRFSS*

Mahoning and Trumbull County African American Adult Trend Summary

Adult Variables	Mahoning and Trumbull County African Americans 2018-2019	Trumbull County 2018-2019*	Ohio African Americans 2017	U.S. African Americans 2017
Health Status				
Rated general health as good, very good, or excellent	72%	81%	76%	78%
Rated general health as excellent or very good	30%	47%	40%	43%
Rated general health as fair or poor	28%	19%	24%	22%
Rated mental health as not good on four or more days (in the past 30 days)	40%	29%	26%	25%
Rated physical health as not good on four or more days (in the past 30 days)	37%	21%	26%	26%
Average number of days that physical health was not good (in the past 30 days)	7.6	4.6	N/A	N/A
Average number of days that mental health was not good (in the past 30 days)	6.7	5.0	N/A	N/A
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past 30 days)	37%	28%	26%	24%
Healthcare Coverage, Access, and Utilization				
Uninsured	4%	6%	11%	11%
Had one or more persons they thought of as their personal healthcare provider	83%	90%	78%	83%
Visited a doctor for a routine checkup (in the past 12 months)	80%	73%	81%	84%
Chronic Disease				
Ever been told by a doctor they have diabetes (not pregnancy-related)	16%	15%	14%	20%
Ever diagnosed with arthritis	43%	36%	27%	33%
Had ever been told they have asthma	18%	21%	18%	16%
Ever diagnosed with Chronic Obstructive Pulmonary Disease (COPD), emphysema or chronic bronchitis	9%	12%	8%	7%
Ever been told they had skin cancer	0%	4%	<1%	<1%
Ever been told they had other types of cancer (other than skin cancer)	0%	11%	6%	7%
Cardiovascular Health				
Ever diagnosed with angina or coronary heart disease	1%	6%	4%	5%
Ever diagnosed with a heart attack, or myocardial infarction	4%	6%	7%	5%
Ever diagnosed with a stroke	5%	5%	5%	6%
Had been told they had high blood pressure	58%	39%	40%	52%
Had been told their blood cholesterol was high	32%	40%	28%	38%
Had their blood cholesterol checked within the last five years	72%	80%	88%	93%
Weight Status				
Overweight (BMI of 25.0 – 29.9)	23%	35%	32%	33%
Obese (includes severely and morbidly obese, BMI of 30.0 and above)	47%	40%	42%	42%
Alcohol Consumption				
Current drinker (had at least one drink of alcohol within the past 30 days)	39%	52%	50%	42%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	21%	18%	17%	26%

N/A – Not Available

**Trumbull County 2018-2019 does not directly compare to Mahoning and Trumbull County African Americans 2018-2019, Ohio African Americans 2017, or U.S. African Americans 2017. Please compare with caution.*

Adult Variables	Mahoning and Trumbull County African Americans 2018-2019	Trumbull County 2018-2019*	Ohio African Americans 2017	U.S. African Americans 2017
Tobacco Use				
Current smoker (smoked on some or all days)	23%	18%	25%	17%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	18%	30%	19%	19%
Drug Use				
Adults who used marijuana in the past 6 months	4%	4%	N/A	N/A
Adults who misused prescription drugs in the past 6 months	15%	9%	N/A	N/A
Preventive Medicine				
Had a pap test in the past three years (ages 21-65)	64%	65%	83%**	84%**
Had a digital rectal exam within the past year	19%	29%	N/A	N/A
Quality of Life				
Limited in some way because of physical, mental or emotional problem	32%	28%	24%***	25%***
Mental Health				
Felt sad or hopeless for two or more weeks in a row in the past year	25%	16%	N/A	N/A
Seriously considered attempting suicide in the past year	8%	5%	N/A	N/A
Attempted suicide in the past year	1%	1%	N/A	N/A
Sexual Behavior				
Had more than one sexual partner in past year	12%	7%	N/A	N/A
Oral Health				
Visited a dentist or a dental clinic (within the past year)	51%	62%	63%**	60%**
Visited a dentist or a dental clinic (5 or more years ago)	13%	11%	12%**	13%**
Had any permanent teeth extracted	63%	52%	52%**	62%**
Had all their natural teeth extracted (ages 65 and older)	10%	13%	24%**	20%**

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

Key Issues

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

What are the most significant health issues or concerns identified in the 2018-2019 assessment report? Examples of how to interpret the information include: 75% of Trumbull County adults were overweight or obese, increasing to 78 of those ages 65+ and under 30, as well as 80% of males.

Key Issue or Concern	Percent of Population At risk	Age Group, Income Level, Race/Ethnicity, and/or Geography Most at Risk	Gender Most at Risk
Obesity			
Overweight or obese	75%	Under 30 (78%) Age 65+ (78%)	Males (80%)
Obese	40%	African Americans (47%) Warren City (46%)	N/A
Overweight	35%	Age 65+ (44%)	Males (43%)
Adults who lived 2+ miles away from healthy food	27%	African Americans (28%) Warren City (27%)	N/A
Adults who experienced more than one food insecurity issue	9%	Warren City (9%)	N/A
Did not exercise in the past week	34%	African Americans (38%) Warren City (37%)	N/A
Chronic Disease			
High blood pressure	39%	Age 65+ (63%) African Americans (58%) Income <$25k (47%)	Males (43%)
High blood cholesterol	40%	Age 65+ (55%)	N/A
Ever diagnosed with angina or coronary heart disease	6%	Age 65+ (14%)	N/A
Ever diagnosed with a heart attack, or myocardial infarction	6%	Age 65+ (12%)	N/A
Congestive heart failure	6%	Age 65+ (9%)	N/A
Ever been told by a doctor that they have diabetes (not pregnancy-related)	15%	Age 65+ (25%) Income <$25k (22%) Warren City (18%) African Americans (16%)	Males (18%)
Ever been told they have asthma	21%	Age under 30 (39%) Warren City (21%)	N/A
Ever diagnosed with some form of arthritis	36%	Age 65+ (49%) Income <$25k (46%) African Americans (43%)	Females (40%)
Ever been told they had skin cancer	4%	N/A	N/A

Key Issue or Concern	Percent of Population At risk	Age Group, Income Level, Race/Ethnicity, and/or Geography Most at Risk	Gender Most at Risk
Ever been told they had other types of cancer (other than skin cancer)	11%	Warren City (9%)	N/A
Males who had a PSA at some time in their life	45%	African Americans (49%) Warren City (44%)	N/A
Males who had a PSA test in the past year	33%	African Americans (32%)	N/A
Males who had a digital rectal exam in the past year	51%	African Americans (19%)	N/A
Sexual Behavior			
Adults who had sex without a condom	32%	Warren City (30%) African American (25%)	N/A
Adults tested for an STD	5%	African American (6%)	N/A
Adults treated for an STD	1%	African American (3%) Warren City (2%)	N/A
Adults who had more than one sexual partner in the past year	7%	Age under 30 (33%) African American (12%)	Males (9%)
Adults who had 4 or more sexual partners in the past year	1%	African American (1%)	N/A
Addiction			
Adults who misuse prescription medication in past 6 months	9%	Income <$25K (19%) African American (15%)	N/A
Binge drinker	18%	African American (21%) Warren City (19%)	N/A
Current drinker	52%	Warren City (53%)	N/A
Current smoker	18%	Income <$25K (30%) African American (23%) Warren City (20%)	Females (19%)
Trumbull County unintentional drug overdose death rate (age-adjusted) per 100,000 population, 2012-2017 *(Source: Ohio Department of Health, 2017 Ohio Drug Overdose Data: General Findings)*	42	Caucasian (43) Age 25-34 (98)	Male (59)
Infant Mortality			
Infant mortality rate	8.1	African American (18.1)	N/A
Transportation			
Adults who reported having transportation issues	13%	African American (21%) Warren City (16%)	N/A
More than 1 transportation issue	57%	Warren City (64%)	N/A
Racial Inequality			
Treated worse than other races at work	3%	African American (9%)	N/A
When seeking healthcare, adults felt their experiences were worse than other races	2%	African American (12%)	N/A

Key Issue or Concern	Percent of Population At risk	Age Group, Income Level, Race/Ethnicity, and/or Geography Most at Risk	Gender Most at Risk
Reported feeling upset, angry, sad, or frustrated as a result of how they were treated based on their race	7%	African American (30%) Warren City (10%)	N/A
Mental Health			
Felt sad or hopeless for two or more weeks in a row in the past year	16%	African American (25%) Warren City (24%)	N/A
Mental health not good 4+ days in past month	29%	Income <$25k (48%) African American (40%) Warren City (34%)	Females (38%)
Average number of days mental health not good	5.0	African American (6.7) Warren City (6.0)	N/A
Seriously considered attempting suicide in the past 12 months (suicide ideation)	5%	African American (8%) Warren City (6%)	N/A
Trumbull County suicide death rate (age-adjusted) per 100,000 population, 2007-2017 *(Source: ODH, Ohio Public Health Data Warehouse, Mortality, Leading Causes of Death)*	17	Age 45-54 (29) Caucasian (19)	Male (28)
Access to Healthcare			
Uninsured	6%	Ages <30 (12%) Income <$25k (9%) Warren City (7%)	Female (7%)
Had one or more persons they thought of as their personal healthcare	90%	African Americans (83%)	N/A
Visited a doctor for a routine checkup (in the past 12 months)	73%	Income $25k+ (70%) Ages <30 (44%) Warren City (67%)	Female (72%)
Visited a dentist or dental clinic is the past year	62%	African American (51%) Income <$25k (40%)	N/A
Quality of Life			
Adults limited in some way because of physical, mental, or emotional problem	28%	Income <$25k (47%) Age 65+ (42%) Warren City (34%) African American (32%)	N/A
Poor physical or mental health kept adults from doing usual activities on at least one day in the past month	28%	African American (37%) Warren City (35%)	N/A
Average number of days physical health was not good in past month	4.6	African American (7.6) Warren City (5.8)	N/A
Average number of days mental health was not good in past month	5.0	African American (6.7) Warren City (6.0)	N/A
Adults who needed help meeting general daily needs in the past month	13%	Income <$25k (42%) African American (32%) Warren City (21%)	N/A

Priorities Chosen

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

Key Issues	Votes
1. Access to health care	12
2. Infant Mortality	11
3. Chronic Disease	8
4. Mental Health	7
5. Addiction	7
6. Obesity	7
7. Transportation	4
8. Racial Inequality	4
9. Quality of Life	0

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

1. Mental Health and Addiction

2. Chronic Disease

3. Maternal and Infant Health

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

1. Access to Health Care

2. Social Determinants of Health

3. Public Health System, Prevention and Health Behaviors

Community Themes and Strengths Assessment (CTSA)

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

Open-ended Questions to the Committee (July 8, 2019)

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

    - Access to healthcare
    - Safety
    - Economic stability
    - Absence of poverty
    - Community resources
    - People able to be active
    - Consistent civic engagement
    - Environment that supports health and wellbeing/Built environment
    - Responsive community leaders
    - Education
    - Prevention
    - Trust within community
    - Connectedness

2. What makes you most proud of our community?

    - Ability to collaborate
    - History—a lot of "firsts"
    - Cultural diversity
    - Food—various ethnicities
    - Resiliency
    - Community pride
    - Spirit of residents
    - Hardworking people
    - Caring people
    - Social capital
    - Committed leaders dedicated to improving the county
    - Amish population
    - Packard Music Hall
    - So many positive people wanting a better community

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

    - Trumbull County Creating Healthy Community coalition
    - Healthy Community Partnership
    - Family and Children First Council
    - Alliance for Substance Abuse Prevention
    - Trumbull Community Health Improvement Partnership
    - Trumbull County Visitors Bureau
    - Overdose Fatality Review Committee
    - County Commissioners/Sanitary Engineers Office/BOH
    - Suicide Prevention Coalition
    - Ministerial alliances
    - Domestic Violence Task Force
    - Housing Collaborative
    - Farmers Market Collaborative
    - Neighborhood success grants
    - Financial Stability Partnership
    - Women United
    - Maternal Opiate Medical Support Coalition
    - Wellness Committee
    - OSU Extension
    - Ohio Means Jobs
    - Senior Center
    - Small Business Development Center
    - Center for the Arts
    - TAB

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

- Mental health and addiction
- Chronic disease
- Homelessness
- Employment/economic stability
- Diet
- Safe neighborhoods
- Education
- Transportation
- Trust
- Obesity
- Access
- Infant mortality
- Inequity
- Smoking rates

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

- Lack of funding
- Buy-in from community
- Poverty
- Lack of political will to change
- Risk aversion
- Silos in political community
- Narrative of Trumbull County and how people perceive Trumbull County
- Lack of equality
- Institutional racism
- Income inequality
- Transportation barriers
- Lack of young people/talent leaving Trumbull County
- Negative gentrification
- Social injustice
- Trumbull County viewed as weak
- Desperation
- Drug epidemic
- Lack of morality in some cases
- Raising minimum wage

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

- Raising minimum wage
- Supporting Medicaid expansion
- Strengthening relationships with community
- Lack of equality
- Make it easy to find resources
- Help network website
- Better healthcare resources
- Increase in affordable transportation
- Complete streets policies
- Open dialogues about gangs
- Reduce supply/demand for drugs
- Funding priorities at St. Joes
- Policy for demolition

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

- Empowerment of residents
- Seeing results of efforts
- Seeing representation of diversity
- Police representation in community
- Clergy representation
- Willingness to confront things you wish to sweep under the rug
- Seeing young people involved
- More elected officials involved
- Involvement of local businesses
- Make health improvement interactive
- Elimination of silos
- Youth engagement
- Monetary incentives
- Health-focused policy agenda

Quality of Life Survey (June-August 2019)

Trumbull Community Health Improvement Partnership urged community members to fill out a short Quality of Life Survey via SurveyMonkey. There were 241 Trumbull County community members who completed the survey. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1. For all responses of "Don't Know," or when a respondent left a response blank, the choice was a non-response and was assigned a value of 0 (zero). The non-response was not used in averaging response or calculating descriptive statistics.

Quality of Life Questions	2020-2022 Likert Scale Average Response
1. Are you satisfied with the quality of life in our community? (Consider your sense of safety, well-being, participation in community life and associations, etc.) [IOM, 1997]	3.24
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.04
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.24
4. Is this community a good place to grow old? (Consider elder-friendly housing, transportation to medical services, churches, shopping; elder day care, social support for the elderly living alone, meals on wheels, etc.)	3.11
5. Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)	2.48
6. Is the community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?)	3.07
7. Are there networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, or organizations) during times of stress and need?	3.36
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.20
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	2.81
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	2.96
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	2.94
12. Is there an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments? (Are citizens working towards the betterment of their community to improve life for all citizens?)	2.92

Forces of Change Assessment

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

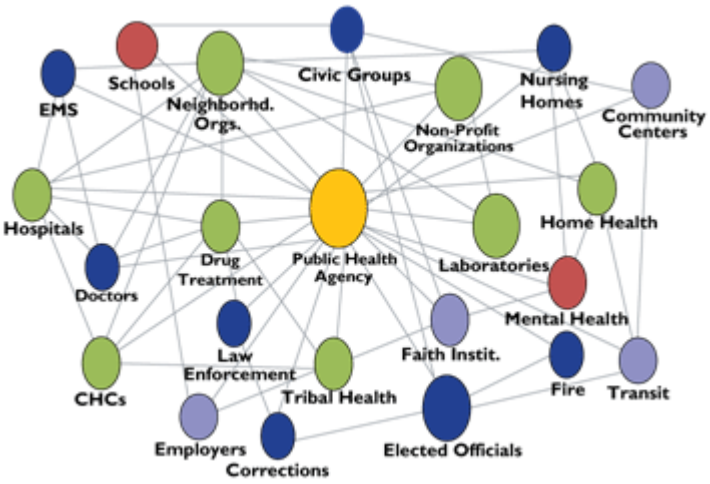
Force of Change	Threats Posed	Opportunities Created
1. Loss of population (particularly young people)	• Less ability to receive grants • Less working class • Low tax base • Increasing elderly population relying on social services	• Business Journal is working on a project to identify causes and possible solutions • Increase workforce development opportunities
2. Major industries closing	• Worse mental health outcomes • Negative economic impact • Loss of health insurance/healthcare • Bigger reliance of Medicaid expansion—challenging for hospitals	• TCDJFS has over 1 million dollars for workforce development for displaced workers
3. Gerrymandering	• People don't have a voice • Needs not represented via voting	• None identified.
4. New governor	• No budget for Ohio yet • New department heads—lots of change • Trickle down impact	• TC schools received $5,660,488 in new funding from the governor for BH supports
5. Hospital closed (north side)	• Lack of access to health care • Lack of employment/leave area for work	• None identified.
6. Substance use disorder	• Repercussions from epidemic—can't get jobs because of felonies • Increase in methamphetamine use	• Help people with felonies to get jobs • Create campaign on dangers of meth
7. Newspaper going out of business	• Lack of awareness via print	• Tribune Chronicle hired many Vindicator employees and developed a Youngstown Tribune edition
8. Many injection well in Trumbull County	• Dumping waste water from fracking in Trumbull County • Contains radium • Increase truck traffic/possible accidents • Could affect water wells • Increased community stress, which can lead to increased cardiovascular disease	• Advocate for taxes • Increase taxes/regulation

Force of Change	Threats Posed	Opportunities Created
9. Revitalization of downtown Warren	• Perceived safety fears by other community residents	• Increase jobs • Encourage residents to go downtown
10. Expansion of Akron Children's Hospital	• None identified.	• Increase access to health care • Increase jobs
11. Poverty	• Depression/anxiety/substance abuse • Hopelessness	• TCDJFS should advertise all programs available to help people.
12. Lack of transportation	• Lack of access • Depression/anxiety/substance abuse	• Community leaders should expand WRTA throughout Trumbull County
13. Arconic	• Fear of losing it	• Largest employer in Trumbull County • Increase employment
14. Loss of income for famers due to weather/tariffs	• Increased suicide • Increased drug use • Loss of income	• TCMHRB implemented ManTherapy campaign
15. Built environment	• Development trends inside/outside center city	• None identified.
16. National media	• Increased negativity about area	• None identified.
17. KSU Trumbull/YSU campus/TC TC/Plumbing School	• None identified.	• Increased education • Affordable college education • Adult education programs • Getting kids interested in trades

Local Public Health System Assessment

The Local Public Health System

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



The public health system includes:

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

The 10 Essential Public Health Services

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

Public health systems should:

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

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

The Local Public Health System Assessment (LPHSA)

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

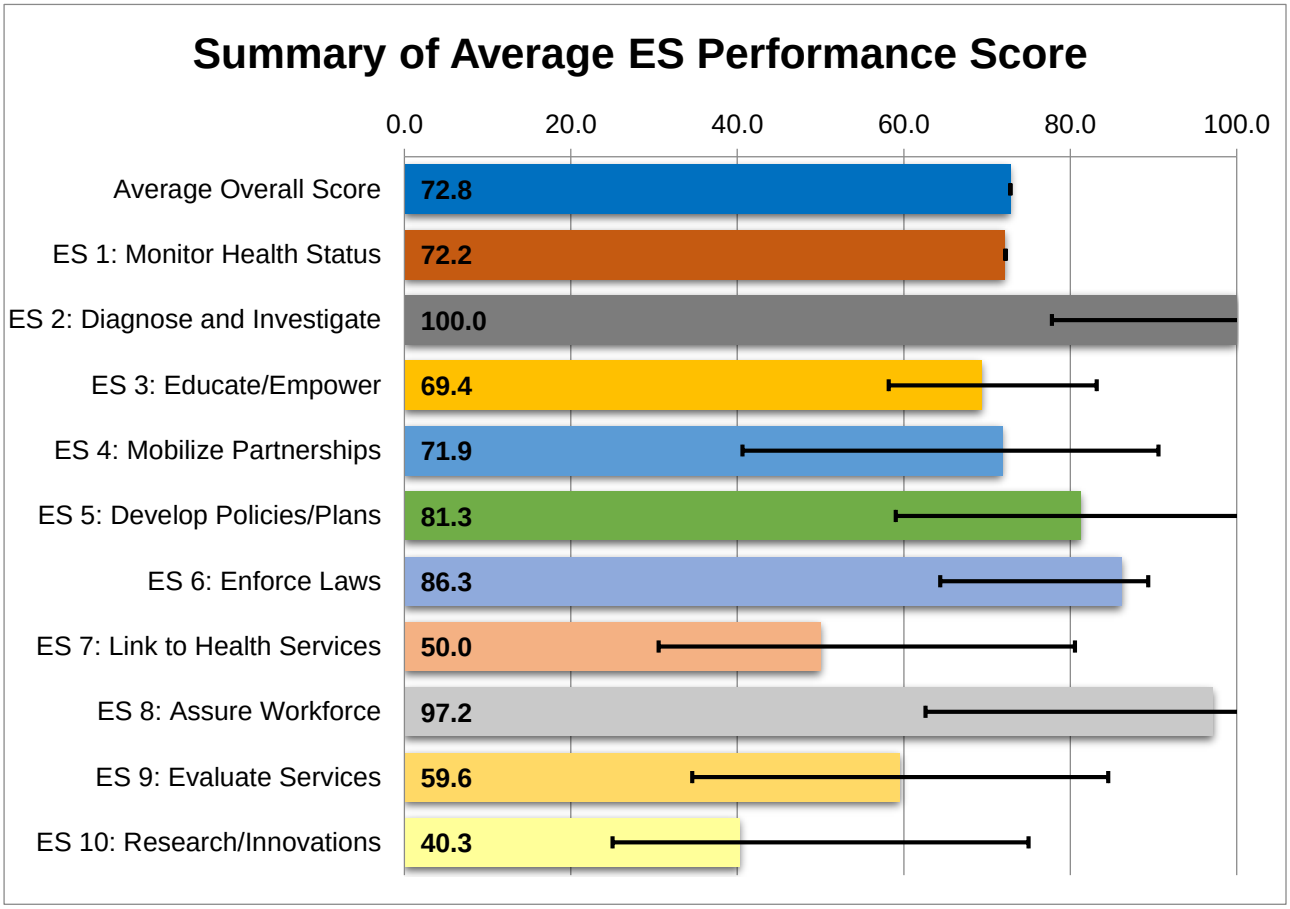
This assessment involves the use of a nationally recognized tool called the **National Public Health Performance Standards Local Instrument.**

Members of Trumbull Community Health Improvement Partnership completed the performance measures instrument in July 2019. The LPHSA results were then presented to the full CHIP committee for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard was discussed and the group came to a consensus on responses for all questions. The challenges and opportunities that were discussed were used in the action planning process.

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

To view the full results of the LPHSA, please contact Frank J. Migliozzi from Trumbull County Combined Health District at 330-675-7805

Trumbull County Local Public Health System Assessment 2019 Summary



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

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

Gaps Analysis

A gap is an area where the community needs to expand its efforts to reduce a risk, enhance an effort, or address another target for change. A strategy is an action the community will take to fill the gap. Evidence is information that supports the linkages between a strategy, outcome, and targeted impact area. On July 8, 2019, Trumbull Community Health Improvement Partnership was asked to determine gaps in relation to each priority area, consider potential or existing resources, and brainstorm potential evidence-based strategies that could address those gaps. To view the completed gap analysis exercise, please view Appendix I.

Strategy Selection

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

Evidence-Based Practices

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

Resource Inventory

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

Priority #1: Mental Health and Addiction

Strategic Plan of Action

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

Priority #1: Mental Health and Addiction				
Strategy 1: Trauma-informed care				
Goal: Improve mental health outcomes.				
Objective: Conduct one trauma-informed care training (per quarter) by December 31, 2022.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Facilitate an assessment among healthcare providers, teachers, coaches, social service providers, and other community members on their awareness and understanding of trauma, including toxic stress and adverse childhood experiences. Administer at least four **trauma-informed care** trainings (one per quarter) to increase education about and understanding of childhood trauma and the potential lifelong impact of untreated adverse childhood experiences. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations.	December 31, 2020	Adult	1. Suicide ideation (adult): Percent of adults who report that they ever seriously considered attempting suicide within the past 12 months (baseline: 5%, 2018-2019 CHA) 2. Suicide deaths: Number of deaths due to suicide per 100,000 populations (age-adjusted) (baseline: 22.9, 2017 ODH Data Warehouse)	Family & Children First Council of Trumbull County
Year 2: Continue efforts from year 1. Administer at least four trauma-informed care trainings (one per quarter) to increase education about and understanding of childhood trauma and the potential lifelong impact of untreated adverse childhood experiences. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Administer at least four trauma-informed care trainings (one per quarter) to increase education about and understanding of childhood trauma and the potential lifelong impact of untreated adverse childhood experiences. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations.	December 31, 2022			
Type of Strategy: ○ Social determinants of health ○ Public health system, prevention and health behaviors ⊗ Healthcare system and access ○ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Partnership with health departments, schools, home visiting programs, and mental health and recovery services board; time; funding.				

Priority #1: Mental Health and Addiction

Strategy 2: Advocate to state and local policy makers

Goal: Improve behavioral health outcomes.

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

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Collaborate with local stakeholders to identify the biggest policy needs surrounding mental health and addiction, such as increasing funding for long-term recovery, increasing capacity for residential and recovery housing, and making specific personal health information available for fatality review boards. Create a written advocacy plan detailing specific activities and follow-up actions for each policy need.	December 31, 2020	Adult and youth	1. Suicide deaths: Number of deaths due to suicide per 100,000 populations (age-adjusted) (baseline: 22.9, 2017 ODH Data Warehouse) 2019 CHA) 2. Unintentional drug overdose deaths: Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted) (baseline: 77.9, 2017 ODH Data Warehouse)	Trumbull County Mental Health and Recovery Board Trumbull County Alliance for Substance Abuse Prevention Trumbull County Combined Health District
Year 2: Continue efforts from year 1. Implement the advocacy plan.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Implement the advocacy plan.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Partnership with state and local policymakers; mental health and recovery services board; funding.

Priority #1: Mental Health and Addiction

Strategy 3: Mental health first aid

Goal: Improve behavioral health outcomes.

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

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Facilitate an assessment among healthcare providers, teachers, coaches, law enforcement, social service providers, and other community members on their ability to identify, understand and respond to signs of mental illnesses and substance use disorders. Continue ManTherapy Campaign. Identify and implement increased prevention efforts in schools. Administer at least four **mental health first aid** trainings (one per quarter) to increase education and understanding of mental illnesses and substance use disorders. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations.	December 31, 2020	Adult and youth	1. Suicide ideation (adult): Percent of adults who report that they ever seriously considered attempting suicide within the past 12 months (baseline: 5%, 2018-2019 CHA) 2. Suicide deaths: Number of deaths due to suicide per 100,000 populations (age-adjusted) (baseline: 22.9, 2017 ODH Data Warehouse) 3. Unintentional drug overdose deaths: Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted) (baseline: 77.9, 2017 ODH Data Warehouse)	Trumbull County Mental Health and Recovery Board
Year 2: Continue efforts from year 1. Administer at least four mental health first aid trainings (one per quarter) to increase education and understanding of mental illnesses and substance use disorders. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Administer at least four mental health first aid trainings (one per quarter) to increase education and understanding of mental illnesses and substance use disorders. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: TCMHRB levy funds; state suicide prevention funds if they become available.

Priority #1: Mental Health and Addiction

Strategy 4: Crisis Intervention Team (CIT)

Goal: Improve behavioral health outcomes.

Objective: By December 31, 2022, train at least 20 law enforcement officers in CIT per year.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Work with Trumbull County law enforcement to collect baseline data on the number of law enforcement officers that have received CIT training. Discuss the importance of CIT training and encourage Trumbull County law enforcement to have all law enforcement officers receive CIT training.	December 31, 2020	Adult	1. Suicide ideation (adult): Percent of adults who report that they ever seriously considered attempting suicide within the past 12 months (baseline: 5%, 2018-2019 CHA) 2. Suicide deaths: Number of deaths due to suicide per 100,000 populations (age-adjusted) (baseline: 22.9, 2017 ODH Data Warehouse) 3. Unintentional drug overdose deaths: Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted) (baseline: 77.9, 2017 ODH Data Warehouse)	Trumbull County Mental Health and Recovery Board
Year 2: Continue efforts from year 1. Arrange and implement an annual CIT training for law enforcement officers. Train at least 20 officers in CIT.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Arrange and implement an annual CIT training for law enforcement officers. Train at least 20 officers in CIT.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: TCMHRB levy and NAMI Ohio funds.

Priority #1: Mental Health and Addiction

Strategy 5: Provider education to primary care and behavioral health providers regarding depression and substance use screening tools and evidence-based treatments

Goal: Improve behavioral health outcomes.

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

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Work with Mercy Health primary care and behavioral health providers to collect baseline information on the number of individuals who received a standardized screening, such as PHQ-2, PHQ-9, C-SSRS and/or SBIRT, that are utilized for depression, suicide and/or substance use.	December 31, 2020	Adult and youth	1. Adult depression: Percent of adults had a period of two or more weeks when they felt so sad or hopeless nearly every day that they stopped doing usual activities (baseline: 12%, 2018-2019 CHA) 2. Suicide ideation (adult): Percent of adults who report that they ever seriously considered attempting suicide within the past 12 months (baseline: 3%, 2018-2019 CHA) 3. Suicide deaths: Number of deaths due to suicide per 100,000 populations (age-adjusted) (baseline: 14.8, 2017 ODH Data Warehouse) 4. Unintentional drug overdose deaths: Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted) (baseline: 52.7, 2017 ODH Data Warehouse)	Mercy Health Youngstown
Year 2: Increase baseline number of individuals receiving a standardized screening tool from year 1 by ≥5%. Collect the baseline number of individuals who were referred to behavioral health based on identified need from the standardized tool.	December 31, 2021			
Year 3: Increase the number of referrals based on identified need from the standardized assessment in Year 2 by ≥ 5%. Increase the number of individuals who have successfully completed an appointment based on a behavioral health referral in Year 2 by ≥5%.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Mercy Health Youngstown Primary Care Practices and Behavioral Health Institute, Mahoning County Behavioral Health Providers, Help Network of Northeast Ohio, Akron Children's Hospital, Belmont Pines Hospital

Priority #1: Mental Health and Addiction

Strategy 6: Implement evidence-based programming in schools

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

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

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Introduce **The PAX Good Behavior Game**, **Second Step**, **Botvin LifeSkills** , Too Good for Drugs, **Generation Rx**, or another evidence-based program to Trumbull County school districts that primarily serves economically disadvantaged and/or large minority populations. Obtain a memorandum of understanding (MOU) with at least one school district to support the implementation of the program. Work with the school district(s) to develop policies for implementation. Pilot the social-emotional learning program with the school(s).	December 31, 2020	Youth	Pre and Post tests will be completed to measure risk factors and protective factors/resiliency.	Trumbull County Mental Health and Recovery Board
Year 2: Evaluate outcomes from year one. Increase services with at least one additional school district that primarily serves economically disadvantaged and/or large minority populations. Work with the school district(s) to develop policies for implementation. Implement the social-emotional learning program with the school(s).	December 31, 2021			
Year 3: Continue efforts from year 2. Increase services with at least one additional school district that primarily serves economically disadvantaged and/or large minority populations. Work with the school district(s) to develop policies for implementation. Implement the social-emotional learning program with the school(s).	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: TCMHRB.

Priority #2: Chronic Disease

Strategic Plan of Action

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

Priority #2: Chronic Disease				
Strategy 1: Food insecurity assessment				
Goal: Reduce food insecurity.				
Objective: Facilitate a food insecurity assessment by December 31, 2022.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Facilitate an assessment on food insecurity in Trumbull County. Assess topics such as food desserts, grocery store development, etc. Create maps, such as HEAL maps, to identify food desert areas.	December 31, 2020	Adult, youth	Food insecurity: Percent of households that are food insecure (Baseline: 16%, Map the Meal Gap, 2017)	Healthy Community Partnership
Year 2: Continue efforts from year 1.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2.	December 31, 2022			
Type of Strategy: ○ Social determinants of health ○ Public health system, prevention and health behaviors ○ Healthcare system and access ⊗ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: Trumbull County Creating Healthy Communities Coalition, Healthy Community Partnership Retail Action Team, OSU Extension HEAL Mapping.				

Priority #2: Chronic Disease

Strategy 2: Prediabetes screening and referral

Goal: Prevent diabetes in adults.

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

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Raise awareness of prediabetes screening, identification and referral through dissemination of the **Prediabetes Risk Assessment** (or a similar assessment) and/or the **Prevent Diabetes STAT Toolkit**. Promote free/reduced cost screening events within the county, such as health fairs, hospital screening events, etc. Target screenings towards those who live in or serve economically disadvantaged and/or minority populations. Increase the number of screenings by 5%.	December 31, 2020	Adult	Diabetes: Percent of adults who have been told by a health professional that they have diabetes (Baseline: 15%, 2018-2019 CHA)	Mercy Health Youngstown
Year 2: Continue efforts from year 1. Increase awareness of prediabetes screening, identification and referral. Increase the number of screenings by 5%.	December 31, 2021			
Year 3: Continue efforts of years 1 and 2. Increase the number of screenings by 5%.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Mercy Health Youngstown Primary Care Practices, Community Health Education and Diabetes Education Departments, St. Joe's at the Mall, partnerships with community agencies, churches, businesses and other organizations.

Priority #2: Chronic Disease

Strategy 3: Hypertension screening and follow up

Goal: Prevent coronary heart disease in adults.

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

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Increase provider education on hypertension screening, treatment, and the importance of routine follow up with patients diagnosed with hypertension. Promote free/reduced cost screening events within the county, such as health fairs, hospital screening events, etc. Target screenings towards those who live in or serve economically disadvantaged and/or minority populations. Increase the number of screenings by 5%.	December 31, 2020	Adult	1. Coronary heart disease: Percent of adults ever diagnosed with coronary heart disease (Baseline: 6%, 2018-2019 CHA) 2. Hypertension management: Percent of adults with hypertension who report currently taking medicine for their high blood pressure (Baseline: N/A)	American Heart Association Mercy Health Youngstown
Year 2: Continue efforts from year 1. Increase awareness of hypertension screening, treatment, and follow up. Increase the number of screenings by 5%.	December 31, 2021			
Year 3: Continue efforts of years 1 and 2. Increase the number of screenings by 5%.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: American Heart Association, Mercy Health Primary Care Practices and Community Health Education Department, St. Joe's at the Mall, partnerships with community agencies, churches, businesses, and other organizations.

Priority #2: Chronic Disease

Strategy 4: Community gardens

Goal: Increase fruit and vegetable consumption.

Objective: By December 31, 2022, implement three new community gardens in Trumbull County.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Obtain baseline data regarding how many school districts, churches, and other community organizations currently have **community gardens** and where they are located. Identify demographic need for additional community gardens. Determine the need for additional community gardens and to secure volunteers and/or Master Gardeners (ex: potential partnership with OSU Extension).	December 31, 2020	Adult	1. Fruit consumption: Percent of adults who report consuming 0 servings of fruit per day (Baseline: 16%, 2018-2019 CHA)	Trumbull County Combined Health District
Year 2: Research grants and funding opportunities to increase the number of community gardens. Develop a sustainability plan to maintain existing and future community gardens year-round. Identify which local food banks are in need of fresh produce. Work with food pantries to offer fresh produce and assist pantries in seeking donations from local grocers. Market current and future community gardens within the county (i.e. location, offerings, etc.). Update the marketing information on an annual basis. Implement 1 new community garden.	December 31, 2021		2. Vegetable consumption: Percent of adults who report consuming 0 servings of vegetables per day (Baseline: 6%, 2018-2019 CHA)	
Year 3: Continue efforts from year 2. Implement 2 new community gardens. Explore partnership opportunities to educate community members and families on gardening and healthy eating practices.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Trumbull County Creating Healthy Communities Coalition, Healthy Community Partnership Healthy Retail Action Team. OSU Extension Master Gardeners.

Priority #2: Chronic Disease

Strategy 5: Prescriptions for physical activity

Goal: Increase physical activity.

Objective: Create an exercise prescription plan by December 31, 2022.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Explore the feasibility of implementing **exercise prescriptions**, such as the Parks Rx program, and collect data.	December 31, 2020	Adult	Physical inactivity: Percentage adults reporting no leisure time physical activity (Baseline: 34%, 2018-2019 CHA)	Healthy Community Partnership Parks and Greenspaces Team
Year 2: Continue efforts from year 1. Create a plan to implement exercise prescriptions.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Creating Healthy Communities, primary care physicians, YMCA, and parks district.

Priority #3: Maternal and Infant Health

Strategic Plan of Action

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

Priority #3: Maternal and Infant Health

Strategy 1: Progesterone treatment

Goal: Improve birth outcomes.

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

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Gather data from health systems to identify how progesterone candidates are currently identified, as well as current barriers to progesterone distribution.	December 31, 2020	Adult	1. Total preterm births: Percent of live births that are preterm: <37 weeks gestation (Baseline: 10%, Ohio Department of Health, 2018) 2. Infant mortality: Rate of infant deaths per 1,000 live births (Baseline: 8.1, Ohio Department of Health, 2013-2017)	Mercy Health Youngstown
Year 2: Based on data collected in year 1, develop and implement a plan to increase by 5% the use of progesterone for eligible pregnant women. Determine strategies to increase education for pregnant women regarding recognizing signs, symptoms, and risk factors of giving birth prematurely. Target strategies towards economically disadvantaged and/or minority populations.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Increase by 5% from Year 2.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

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

Priority #3: Maternal and Infant Health

Strategy 2: Home visiting programs that begin prenatally

Goal: Improve birth outcomes.

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

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Identify all home visitation programs within the county that serve prenatal populations. Identify gaps in program reach within the county. Establish a multi-disciplinary coalition as a sub-committee of the ECCC and begin meeting on a regular monthly basis. Work with home visitation supervisors to determine the best way to coordinate which program is the best fit for different individuals and populations. Ensure cultural competence training opportunities are available for home visitation providers.	December 31, 2020	Adult	1. Total preterm births: Percent of live births that are preterm: <37 weeks gestation (Baseline: 10%, Ohio Department of Health, 2018) 2. Low birth weight births: Percent of births in which the newborn weighed <2,500 grams (Baseline: 9%, Ohio Department of Health, 2018) 3. Infant mortality: Rate of infant deaths per 1,000 live births (Baseline: 8.1, Ohio Department of Health, 2013-2017)	Early Childhood Coordinating committee; a Committee of the TCFCFC
Year 2: Continue efforts from year 1. Determine the feasibility of a joint communication plan or more neutral branding to market specific home visiting programs in Trumbull County (ex: Mercy Resource Mothers). Target economically disadvantaged and/or minority populations. Increase referrals by 10%.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Increase referrals by 10%.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy: Mercy Health Resource Mothers Program, Trumbull County Health Department home visiting program, Healthy Moms Healthy Babies, Help Me Grow, Family and Children First Council of Trumbull County, Meridian Healthcare, Trumbull County WIC, and Warren City Health District..

Priority #3: Maternal and Infant Health

Strategy 3: Infant mortality taskforce

Goal: Improve birth outcomes.

Objective: By December 31, 2022, create an infant mortality taskforce in Trumbull County.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Recruit local stakeholders dedicated to addressing maternal and infant health issues. Establish a multi-disciplinary coalition and begin meeting on a regular basis (weekly, biweekly, monthly, etc.). Develop goals and objectives to be addressed by the coalition.	December 31, 2020	Adult	1. Total preterm births: Percent of live births that are preterm: <37 weeks gestation (Baseline: 10%, Ohio Department of Health, 2018) 2. Low birth weight births: Percent of births in which the newborn weighed <2,500 grams (Baseline: 9%, Ohio Department of Health, 2018) 3. Infant mortality: Rate of infant deaths per 1,000 live births (Baseline: 8.1, Ohio Department of Health, 2013-2017)	Mercy Health Youngstown Family and Children First Council of Trumbull County MOMS Trumbull County WIC Trumbull County Combined Health District Warren City Health District
Year 2: Work to address the goals and objectives created by the coalition.	December 31, 2021			
Year 3: Increase efforts from years 1 and 2.	December 31, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Trumbull County Combined Health District, Mercy Health Resource Mothers Program and Maternal-Child Services, Healthy Moms, Healthy Babies, Family and Children First Council of Trumbull County, Meridian Healthcare, Warren City Health District, Trumbull County WIC, OH Child Injury Action Group, Tri-County Safe Kids, Safe Kids Mahoning Valley, TCCHD Home Visiting Program.

Cross-Cutting Strategies (Strategies that Address Multiple Priorities)

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

Cross-Cutting Factor: Public Health System, Prevention and Health Behaviors				
Strategy 1: Mass-reach communications				
Goal: Reduce cigarette smoking.				
Objective: By December 31, 2022, Trumbull County will implement at least two mass-reach communication initiatives.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Consider implementing the following **Mass-reach communication** initiatives: • Share messages and engage audiences on social networking sites like Facebook and Twitter. • Deliver messages through different websites and stakeholders communications. • Generate free press through public service announcements. • Pay to place adds on TV, radio, billboards, online platforms and/or print media. The **strategies** should focus on motivating tobacco users to quit, protecting people from the harm of secondhand smoke exposure, and preventing tobacco use and vaping initiation.	December 31, 2020	Adult	Current smoker: Percentage of adults who are current smokers (Baseline: 18% 2018-2019 CHA)	Trumbull County Combined Health District
Year 2: Continue efforts from year 1. Promote and raise awareness of the **Ohio Tobacco Quit Line**. Promote the available cessation services and programs in the county.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Implement one mass-reach communication strategy.	December 31, 2022			
Priority area(s) the strategy addresses: ⊗ Mental Health and Addiction ⊗ Chronic Disease ⊗ Maternal and Infant Health ○ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Tobacco Use Prevention Cessation Program.				

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

Strategy 2: Healthy food in convenience stores

Goal: Increase fruit and vegetable consumption.

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

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

Priority area(s) the strategy addresses:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy: Partnership with CHC; time; and funding.

Cross-Cutting Factor: Healthcare System and Access

Cross-Cutting Factor: Healthcare System and Access				
Strategy 1: Cultural competency training for healthcare professionals				
Goal: Increase cultural competency among healthcare organizations.				
Objective: Increase the number of cultural competency trainings offered to healthcare professionals by December 31, 2022.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collect baseline data on healthcare organizations that offer cultural competency trainings and how often they are conducted. Recruit healthcare organizations to offer cultural competency trainings.	December 31, 2020	Adults	Cultural perceptions in health care: Felt their experience was worse than other races when seeking healthcare (of African American residents) Baseline: 12%, 2018-2019 CHA)	Mercy Health Youngstown Trumbull County Combined Health District
Year 2: Continue to recruit healthcare organizations. Educate and inform healthcare providers (and support staff) on Trumbull County demographics and the importance of becoming culturally competent (focuses may include: diversity and inclusion, implicit bias, and **culture, language and health literacy**). Recruited organizations will conduct cultural competency trainings annually.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Recruited organizations will conduct cultural competency trainings annually.	December 31, 2022			
Priority area(s) the strategy addresses: ⊗ Mental Health and Addiction ⊗ Chronic Disease ⊗ Maternal and Infant Health ○ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: Partnerships with hospitals and FQHCs.				

Cross-Cutting Factor: Healthcare System and Access

Strategy 2: Expand access to evidence-based tobacco cessation treatments including individual, group and phone counseling (including Quitline) and cessation medications

Goal: Reduce cigarette smoking.

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

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collect baseline data on the number of evidence-based tobacco cessation treatments available in Trumbull County, including individual, group and phone counseling (including Quitline) and cessation medications. Include information regarding cost, population (such as expectant mothers), insurance, transportation options and geography.	December 31, 2020	Adults	1. Current smoker: Percentage of adults who are current smokers (Baseline: 18% 2018-2019 CHA) 2. Quit attempts: Percent of adult smokers who have made a quit attempt in the past year (Baseline: 42% 2018-2019 CHA)	Trumbull County Combined Health District Mercy Health—Youngstown Tobacco Treatment Center
Year 2: Create a county-wide resource guide for evidence-based tobacco cessation treatments, highlighting cost, population, insurance, transportation options and geography. Disseminate the resource to healthcare providers. Encourage providers to share resources with patients who are current smokers, encourage them to quit, and refer them to treatment.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Explore the feasibility of offering additional evidence-based tobacco cessation treatments to underserved areas.	December 31, 2022			

Priority area(s) the strategy addresses:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy: MHY Regional Tobacco Treatment Center, Tobacco Use Prevention Cessation Program.

Cross-Cutting Factor: Social Determinants of Health

Cross-Cutting Factor: Social Determinants of Health				
Strategy 1: Outreach to increase uptake for earned income tax credits				
Goal: Decrease poverty.				
Objective: By December 31, 2022, implement two CDC-recommended awareness strategies to increase uptake in earned income tax credits.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collaborate with county agencies, such as Job and Family Services, to increase awareness about **earned income tax credits (EITC),** how it can reduce the tax burden for low-to-moderate income working people, and who is eligible.	December 31, 2020	Adult	Poverty: Percent individuals who live in households at or below the poverty threshold (Baseline: 16%, 2018 Census Quick Facts)	United Way
Year 2: Continue efforts from year 1. Continue to collaborate with county partners to implement at least one of the following CDC-recommended awareness strategies: • Offer free tax assistance to EITC-eligible families in primary care settings to take advantage of clinic wait times. • Provide tax services at no charge to economically disadvantaged residents, which are funded by non-profit organizations, such as United Way.	December 31, 2021			
Year 3: Continue efforts from year 1 and year 2. Implement both awareness strategies identified in Year 2. Advocate for state polices to increase awareness of EITC, such as laws requiring states to notify potentially qualified families and individuals of the credit, and Laws requiring employers to give notice of the federal and any state EITC to potentially qualified employees.	December 31, 2022			
Priority area(s) the strategy addresses: ⊗ Mental Health and Addiction ⊗ Chronic Disease ⊗ Maternal and Infant Health ○ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: United Way Worldwide, free income tax work, AARP's free tax program, Policy Matters Ohio and the Ohio CASH Coalition.				

Cross-Cutting Factor: Social Determinants of Health

Strategy 2: Lead awareness taskforce

Goal: Increase awareness of lead hazards

Objective: By December 31, 2022, create a lead awareness taskforce.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Work with local stakeholders to create a lead awareness taskforce. Share information on the dangers of elevated blood lead levels particularly in small children. Collect data and assess resources.	December 31, 2020	Adult, youth, and children	TBD by Trumbull County	Mercy Health—Youngstown Family and Children First Council of Trumbull County Trumbull Neighborhood Partnership Warren City Health District
Year 2: Establish a plan to improve lead screening and abatement.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2.	December 31, 2022			

Priority area(s) the strategy addresses:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Mercy Health Youngstown, Trumbull County Combined Health District, Warren City Health District, Trumbull Neighborhood Partnership, Family and Children First Council of Trumbull County, Ohio Department of Health, Jobs and Family Services, Warren City Health District.

Cross-Cutting Factor: Social Determinants of Health

Strategy 3: Green space and parks

Goal: Increase physical activity

Objective: By December 31, 2022, create a written plan to improve and maintain green space in Trumbull County.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collaborate with local partners to advertise local parks, playgrounds, trails, walking paths and other green space available in Trumbull County.	December 31, 2020	Adult	1. Physical inactivity: Percentage adults reporting no leisure time physical activity (Baseline: 34%, 2018-2019 CHA) 2. Access to exercise opportunities: Percent of individuals who live reasonably close to a location for physical activity, defined as parks or recreational facilities (Baseline: 82%, 2019 County Health Rankings)	Trumbull County Combined Health District Healthy Community Partnership Trumbull Neighborhood Partnership
Year 2: Continue efforts from year 1. Identify an area in Trumbull County and either renovate under-used recreation areas, rehabilitate vacant lots, or abandoned infrastructure to create additional green space. Target spaces that are in economically distressed and/or minority population areas.	December 31, 2021			
Year 3: Continue efforts from year 1 and year 2. Create a written plan to improve and maintain green space.	December 31, 2022			

Priority area(s) the strategy addresses:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

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

Cross-Cutting Factor: Social Determinants of Health

Strategy 4: Active transportation planning (Complete Streets policies)

Goal: Increase physical activity.

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

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Work with the City of Warren to implement Complete Streets policy.	December 31, 2020	Adult	Physical inactivity: Percentage adults reporting no leisure time physical activity (Baseline: 34%, 2018-2019 CHA)	Trumbull County Combined Health District
Year 2: Evaluate readiness for Complete Streets policy and reach out to additional jurisdictions.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2.	December 31, 2022			

Priority area(s) the strategy addresses:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

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

Cross-Cutting Factor: Social Determinants of Health

Strategy 5: Access to transportation

Goal: Increase access to transportation.

Objective: Create a transportation coordination plan by December 31, 2022.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collaborate with local transportation and community stakeholders to build a fully coordinated transportation system. Create a survey to gather public input on identifying gaps in transportation services. Increase outreach efforts of the survey to include input from older adults, those with disabilities, economically disadvantaged, veterans and minority populations. Analyze the results from the survey. Create a proposed transportation coordination plan.	December 31, 2020	Adult	Increase transportation (Baseline: TBD by Trumbull County)	Trumbull County Transit
Year 2: Invite community stakeholders to attend a meeting to discuss transportation issues in the county. Utilizing the proposed transportation coordination plan, select strategies to implement across the county. Address strategies that increase the use of public and other transportation sources. Begin implementing strategies identified.	December 31, 2021			
Year 3: Increase efforts of years 1 and 2. Continue to implement transportation strategies. Administer evaluation surveys to gauge the public's response to strategies that have been implemented and collect outcome measures.	December 31, 2022			

Priority area(s) the strategy addresses:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Trumbull County Commissioners, Trumbull County Transit Board, WRTA

Cross-Cutting Factor: Social Determinants of Health

Strategy 6: Screening for social determinants of health (SDOH) using a standardized tool

Goal: Increase health equity.

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

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research social determinants of health (SDOH) screenings and determine the feasibility of implementing the screening in Mercy Health Primary Care Practices.	December 31, 2020	Adult	Increase health equity (Baseline: TBD by Trumbull County)	Mercy Health Youngstown
Year 2: Collect baseline data on the number of screenings for SDOH completed by Mercy Health Primary Care Practices.	December 31, 2021			
Year 3: Evaluate the screening process and develop a referral process. Increase the number of SDOH screenings from Year 2 by ≥5%.	December 31, 2022			

Priority area(s) the strategy addresses:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Mercy Health Youngstown Primary Care Practices, Help Network of Northeast Ohio, any agency that addresses SDOH.

Progress and Measuring Outcomes

Progress will be monitored with measurable indicators identified for each strategy. Most indicators align directly with the SHIP. The individuals or agencies that are working on strategies will meet on an as-needed basis. The full committee will meet annually to report out progress. The committee will create a plan to disseminate the CHIP to the community. Strategies, responsible agencies, and timelines will be reviewed at the end of each year by the committee. As this CHIP is a living document, edits and revisions will be made accordingly.

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

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

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

Contact Us

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

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Health Commissioner
Trumbull County Combined Health District
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Appendix I: Gaps and Strategies

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

Mental Health and Addiction Gaps

Gaps	Potential Strategies
1. Lack of mental health and substance abuse providers (lack of psychiatrists who can prescribe, lack of clinicians, long wait lists)	• Higher education financial incentives for health professionals serving underserved areas (such as tuition reimbursement and loan repayment programs for behavioral health professionals • Monitor implementation of behavioral health parity legislation • Improve access to comprehensive primary care - Telehealth
2. Recovery housing (need more oversight and credentialing)	• Strengthen current Trumbull County credentialing process through state regulation
3. Residential care (lack of inpatient beds, lack of political will for creation of long-term residential care including follow-up and follow-through with MAT plans)	• Home and Community Based Waivers unlimited funding for individuals
4. Mental health and addiction prevention education in schools	• School based alcohol/other drug prevention programs including youth-led prevention and specific universal prevention curricula, or programs reviewed and found to be effect by credible sources • Develop policies to incorporate such programs and commitment with schools to follow policies.
5. Increase mental health outreach in African American Populations	• Cultural competence training for healthcare professionals, with a focus on behavioral health professions • Health career recruitment for minority students (can also include rural/Appalachian regions of the state and other underrepresented population groups), with focus on behavioral health professions
6. Suicide prevention in vulnerable/high-risk populations	• Provider education to primary care and behavioral health providers regarding depression/suicide screening tools and evidence-based treatments for depression (such as cognitive behavioral therapy), especially focusing on providers of services to those most at risk. • Screening for ACES, parent survey & RAT for all families in HV program & provide referral. • Provider education to Primary Care and Behavioral Health • Screening for suicide for patients 12 or older C-SSRS
7. Stigma	• Positive behavioral interventions and supports (PBIS Tier 1)
8. Lack of awareness of resources	• Promote and expand 211 programs
9. Lack of coping skills and healthy relationships	• Screening for ACES, parent survey & RAT for all families in HV program and provide referral • School-based social and emotional instruction

Gaps	Potential Strategies
10. Support for care givers, especially older adults	• PASSPORT program
11. Lack of awareness on traumatic impact of families and children who experience a loved one's addiction or overdose	• School-based social and emotional instruction • School-based violence prevention programs • Positive Behavioral Interventions and Supports (PBIS Tier 1) • Trauma-informed health care
12. Affordability of behavioral health care	• Health insurance enrollment and outreach • Monitor implementation of behavior health parity legislation
13. SBIRT education and training	• Screening during HV at family and provide referral resources • And Provider education to PC and BH providers…. Under standardized care
14. Lack of ability to sustain a continuum of care	• Onsite provision of evidence-based treatment in PCMH and/or specialty behavioral health settings using a model such as COMPASS
15. More funding resources for long term mental health and addiction recovery	• Health insurance enrollment and outreach • Advocate to State and local policy makers

Chronic Disease Gaps

Gaps	Potential Strategies
Lack of physical activity infrastructure (safe and accessible parks, recreational spaces)	• Green spaces and parks • Community Fitness Programs • Activity Programs for Older Adults • Individually adapted health behavior changes programs
Lack of pedestrian infrastructure (sidewalks)	• Bike and pedestrian master plans • Complete streets • Active Transportation Planning
Lack of resources for diet, nutrition, and cooking healthy meals	• Community gardens • Farmer's markets/stands • Healthy food in convenience stores • Recruit and promote OHP implementation in childcare centers • Nutrition education at farmer's markets, fresh start for resource mothers' clients, diabetes education classes
Lack of access to affordable healthy food (food deserts/food insecurity)	• Healthy food in convenience stores • WIC and senior farmers market nutrition programs • SNAP infrastructure at farmers markets/EBT payment • Nutrition prescriptions (including fruits and vegetables prescription programs) • Food insecurity screening and referral
More screening opportunities and outreach (promote free screenings in a community setting, collaboration/ communication	• Prediabetes screening and referral • Hypertension screening and follow up • Implement needle exchange program • Develop collaborative committee to oversee projects to recruit services

Gaps	Potential Strategies
Lack of workplace wellness programs	• Develop model policy and recruit businesses to adopt policy • Healthy vending • Healthy cafeterias • Shared use agreements
Lack of health knowledge, efficacy and education	• OHP • Specific evidence-based home visiting models supported by ODH • Early childhood education • Provider training and education prediabetes and education
Lack of awareness in health care providers	• Health insurance enrollment and outreach • Provider training and education
Lack of CPR training in minority populations	• Provide training and education to these communities • Identify high arrest neighborhoods (evidence based) after CPR
Lack of prescription education/medication compliance	• Improved access and adherence to antihypertensive medications, including medication therapy management by pharmacists
Other (if applicable):	• Expand access to evidence-based tobacco cessation treatment including individual, group, and phone counseling and cessation medications.
Other (if applicable):	• Health insurance enrollment and outreach • Prescription assistance program

Maternal and Infant Health Gaps

Gaps	Potential Strategies
Smoking during pregnancy	• Provide ABCs to pregnant moms that smoke during HV and referral to cessation program • Expand access to evidence-based tobacco cessation treatment including individual, group, and phone counseling and cessation medications. • Assess pregnancy moms • Educate and refer to smoking cessation programs
Lack of prenatal care	• Recruit program moms to HV program • HV provide education & follow up to promote healthy pregnancy • Pre-conception education and intervention • Education and outreach to vulnerable population (combine birth spacing, lack of health and reproductive education) • Preconception intervention • Public school-based education • Home visiting programs
Birth spacing	• Provide counseling with patients about preconception health and productive life plans • Preconception intervention
Stigma with women's health care	• Provide education guidelines for women health screening and promote these using various models

Gaps	Potential Strategies
Lack of awareness and access of programs and services, especially in vulnerable populations	• Promote types of programs available and provide access to the programs (i.e. transportation or in community) • Assess and plan to media/marketing to vulnerable population • HV list of transportation options
Lack of health and reproductive education	• Provider counseling w/ patients about preconception health and reproductive life plans • Preconception intervention
Lack of education and outreach to vulnerable populations	• Preconception intervention • Home visiting (programs that start prenatally)
Lack of continuum of care/medical follow-up	• HV provide education and follow up to promote health pregnancy
Lack of screening for prenatal and postnatal health issues	• Recruit program moms to HV program • HV provide education and follow up to promote healthy pregnancy

Cross-Cutting Factor: Access to Health Care Gaps

Gaps	Potential Strategies
Lack of cultural competency	• Cultural competence training for healthcare professionals • Develop CLAS/Strategic Plan • Health career recruitment of minority students
Lack of insurance	• Health insurance enrollment and outreach
Lack of trust in health institutions and resources	• Cultural competence training for healthcare professionals • Health career recruitment of minority students
Lack of knowledge of health services	• Promote 211 and evaluate info provided
Prevention/screening education	• Prediabetes screening and referral • Hypertension screening and follow up • Screening for clinical depression • Screening for suicide, child abuse and neglect, domestic violence, and human trafficking
Lack of providers in rural areas	• Higher education financial incentive for health professionals serving underserved areas

Cross-Cutting Factor: Social Determinants of Health Gaps

Gaps	Potential Strategies
Poverty/Unemployment	• Transitional jobs
Systemic racial inequality	• Transitional jobs • Vocational training for adults
Housing	• Complete Streets • Recruit/prioritize referrals for HV programs and other TCCHD programs
Lack of child care	• Home improvement loans and grants • Housing rehabilitation loans and grants