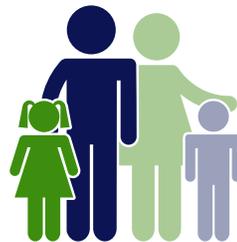


DELAWARE COUNTY | 2019-2022

COMMUNITY HEALTH IMPROVEMENT PLAN



COMMISSIONED BY THE DELAWARE GENERAL HEALTH DISTRICT
FOR THE PARTNERSHIP FOR A HEALTHY DELAWARE COUNTY

Table of Contents

Table of Contents.....	1
Executive Summary	2
Partners.....	4
Vision, Values, and Definition’s of Health	6
Alignment with National and State Standards	7
Strategic Planning Model.....	11
Action Steps.....	12
Needs Assessment.....	13
Priorities Chosen	17
Community Themes and Strengths Assessment.....	18
Local Public Health System Assessment	21
Forces of Change Assessment.....	23
Quality of Life Survey.....	25
Priority 1: Mental Health and Addiction.....	26
Priority 2: Chronic Disease.....	51
Cross-cutting Strategies.....	59
Progress and Measuring Outcomes	71
Appendix I: Links to Websites	72

*Note: Throughout the report, hyperlinks will be highlighted in **bold, gold text**. If using a hard copy of this report, please see Appendix I for links to websites.*

Executive Summary

In 2007, the Partnership for a Healthy Delaware County began conducting community health assessments (CHA) for the purpose of measuring and addressing health status. The most recent Delaware County Community Health Assessment was cross-sectional in nature and included a written survey of adults and parents. The Delaware County Youth Risk Behavior Survey (DCYRBS) was also cross-sectional in nature and included an anonymous online survey of adolescents within Delaware County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention for their national and state Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), and National Survey of Children's Health (NSCH). This has allowed Delaware County to compare the data collected in their CHA to national, state and local health trends.

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

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

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

The Delaware General Health District contracted with the Hospital Council of Northwest Ohio, a neutral regional non-profit hospital association, to facilitate the process. The Health District then invited key community leaders to participate in an organized process of strategic planning to improve the health of residents of the county. The National Association of County and City Health Officials (NACCHO) strategic planning tool, Mobilizing for Action through Planning and Partnerships (MAPP), was used throughout this process.

The MAPP Framework includes six phases which are listed below:

1. Organizing for success and partnership development
2. Visioning
3. Conducting the MAPP assessments
4. Identifying strategic issues
5. Formulating goals and strategies
6. Taking action: planning, implementing, and evaluation

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

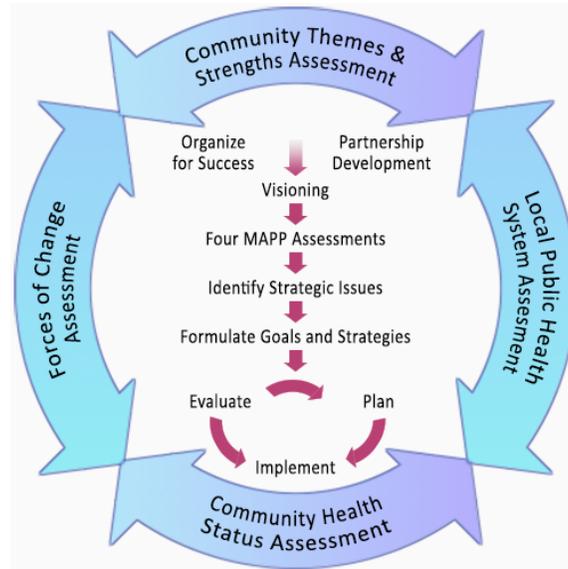


Figure 1.1 2019-2022 Delaware County CHIP Overview

Overall Health Outcomes	
↑ Increase Health Status	↓ Decrease Premature Death
Priority Topics	
Mental Health and Addiction	Chronic Disease
Priority Outcomes	
<ul style="list-style-type: none"> ↓ Decrease adult and youth suicide ↓ Decrease adult and youth depression ↓ Decrease adult and youth alcohol use ↓ Decrease youth and child bullying ↓ Decrease adult and youth tobacco use ↓ Decrease drug dependency/abuse ↓ Reduce unintentional drug overdose deaths 	<ul style="list-style-type: none"> ↓ Decrease adult, youth, and child obesity ↓ Decrease adult diabetes ↓ Decrease adult heart disease ↓ Decrease adult chronic pain

Partners

The 2019-2022 Community Health Improvement Plan was drafted by agencies, service providers, and community residents within Delaware County. From June to August 2018, the Partnership for a Healthy Delaware County reviewed many sources of information concerning the health and social challenges that Delaware County residents may be facing. They determined priority issues which if addressed, could improve future outcomes; determined gaps in current programming and policies; and examined best practices and solutions. The committee has recommended specific action steps they hope many agencies and organizations will embrace to address the priority issues in the coming months and years. We would like to recognize these individuals and thank them for their devotion to this process and body of work:

The Partnership for a Healthy Delaware County Planning Committee:

Bob Anderson, Delaware County Department of Job and Family Services

Tony Benishek, Preservation Parks of Delaware County

Allisha Berendts, Olentangy Local School District

Pat Blaney, Delaware County Board of Health

Randy Bournique, People In Need, Inc.

Deanna Brant, Delaware-Morrow Mental Health & Recovery Services Board

Mitchell Briant, Big Brothers, Big Sisters of Central Ohio

Amy Carlisle, Southeast Healthcare, Inc.

Kim Cooksey, Southeast Healthcare, Inc.

Mel Corroto, Andrews House

James Costillo, HelpLine

Jennifer Coy, Delaware County Jail

Daniel Cuciak, Southeast Healthcare, Inc.

Brandon Feller, United Way of Delaware County

Averee Fields, Columbus State Community College Delaware Campus

Christopher Fink, Ohio Wesleyan University (Partnership Co-Chair)

Kelsey Fox, United Way of Delaware County

Susan Hanson, HelpLine (Partnership Co-Chair)

Jamica Harper, Drug-Free Delaware

Officer Robert Hatcher, Delaware City Police Department

Amy Hawthorne, HelpLine

Judy Held, MD, Physician

Shelia Hiddleston, Delaware General Health District

Amy Hill, Delaware-Morrow Mental Health & Recovery Services Board

Sandy Honigford, Delaware County Department of Job and Family Services

Heidi Kegley, Delaware City Schools

Karen Kehoe, Buckeye Valley Local Schools

Tiffany Kocher, Recovery & Prevention Resources

Julie Krupp, Delaware County Sheriff's Office

Ian Lafferty, Mount Carmel Fitness Center

Kathy Laughlin, Delaware Area Transit Authority

Sheriff Russ Martin, Delaware County Sheriff's Office

Melissa Mason, Grace Clinic Delaware

Alan Matteson, Delaware Fire Department

Nicole McGarity, Mount Carmel Lewis Center

Captain Adam Moore, Delaware City Police Department

Amy Mosser, Delaware County YMCA

Kassandra Neff, Delaware County Sheriff's Office/Jail

The Partnership for a Healthy Delaware County Planning Committee, Continued:

Erin Nieset, OhioHealth Grady Memorial Hospital
Kristin Nietfeld, Nationwide Children's Hospital
Samantha Norman, Olentangy Local School District
Andrea Norris, Liberty Township/Powell YMCA
Tina Overturf, Delaware County Board of Developmental Disabilities
Melissa Pickelheimer, OhioHealth
Brian Pierson, Mount Carmel Healthcare
Benjamin Powers, Family Promise of Delaware County
Michelle Price, HelpLine
Scott Sanders, Delaware County Regional Planning Commission
Angie Santangelo, Cancer Support Community
Ruth Shrock, Genoa Township Resident
Nicole Steffani, Grace Clinic Delaware
Penny Sturtevant, Big Walnut Local Schools
Chase Sullivan, Syntero
Amea Sword, Wornstaff Memorial Public Library
Larry Walters, Lewis Center Resident/American Cancer Society Volunteer
Fara Waugh, SourcePoint
Lily Wiest, Delaware City Schools Family Resource Center
Lisa Williamson, Delaware County Juvenile Court
Laurie Winbigler, Delaware County Adult Court Services
Trustee Sandra Stults, Scioto Township Trustees
Tracey Sumner Sr., Second Ward Community Initiative/Word of Faith Church

Delaware General Health District (DGHD) Staff:

Josie Bonnette, Connie Codispoti, Abby Crisp, Adam Howard, Lori Kannally, Jen Keagy, Kelsey Kuhlman, Heather Lane, Susan Sutherland, Abbey Trimble, and Monica Wing.

The full Partnership roster can be found [HERE](#).

The community health improvement process was facilitated by Emily Stearns, MPH, Community Health Improvement Coordinator, and Britney Ward, MPH, Director of Community Health Improvement, from the [Hospital Council of Northwest Ohio](#).

Vision, Values, and Definitions of Health

Vision and value statements provide focus, purpose, and direction to the CHIP, so participants achieve a shared vision for the future. A shared community vision provides an overarching goal for the community. Values are fundamental principles and beliefs that guide a community-driven planning process. The Partnership's vision, values, and definitions of health are listed below.

The Vision of the Partnership for a Healthy Delaware County

A community where we work together to provide opportunities for complete health and well-being.

The Values of the Partnership for a Healthy Delaware County

Excellence: We believe in setting a high standard for all services provided to everyone within our community.

Respect: We value and acknowledge everyone in our community.

Family: We believe that all policies and programs directed at health and well-being must focus on the individual and their family, however they define it.

Stewardship: We carefully and responsibly make decisions about the health and well-being of our community.

Diversity: We recognize, embrace, and appreciate our differences.

Accountability: We take responsibility for participating in The Partnership, for prioritizing identified health problems in our community, for clearly communicating our findings to the community, and for stimulating action to create a healthier Delaware County.

Holistic: We recognize that health and well-being reflect the wholeness of a person or a community. **Social Justice:** Social Justice is attained when we achieve health equity, eliminate health disparities, and create social and physical environments that promote good health for all.

Collaboration: We work jointly with other partners to attain our vision.

Accessibility: We recognize our obligation to make The Partnership accessible to the community, and we believe that information and services must be easily available to provide everyone in our community the opportunity to achieve complete health and well-being.

Integrity: We maintain high ethical principles when assessing and planning for the health and well-being of our community.

Empowerment: We work to mobilize individuals and our community to act to improve its health and well-being.

The Partnership for a Healthy Delaware County's Definition of Health

A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

The Partnership for a Healthy Delaware County's Definition of a Healthy Community

One that continuously creates and improves both its physical and social environments, helping people to support one another in aspects of daily life and to develop to their fullest potential.

Alignment with National and State Standards

The 2019-2022 Delaware County CHIP priorities align with state and national priorities. Delaware County will be addressing the following priorities: mental health and addiction, and chronic disease.

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

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

Healthy People 2020

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

- Mental Health and Mental Disorders (MHMD)-1: Reduce the suicide rate
- Nutrition and Weight Status (NWS)-10: Reduce the proportion of children and adolescents who are considered obese.

For more information on the Healthy People 2020 objectives, please go to healthypeople.gov.

Ohio 2017-2019 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.

Delaware County Alignment with Ohio’s State Health Improvement Plan

The 2019-2022 Delaware County CHIP is required to align with two (2) priority topics, one (1) priority outcome indicator, one (1) cross cutting strategy and one (1) cross-cutting outcome indicator to align with the 2017-2019 SHIP. As outlined in figure 1.2, the following Delaware County CHIP priority topics, outcomes and cross cutting factors very closely align with the 2017-2019 SHIP priorities:

Figure 1.2 2019-2022 Delaware County CHIP Alignment

2019-2022 Delaware CHIP Alignment with the 2017-2019 SHIP			
Priority Topics	Priority Outcomes	Cross-Cutting Factors	Cross-Cutting Outcomes
Mental Health and addiction	<ul style="list-style-type: none"> Decrease depression Decrease suicide Decrease drug dependence or abuse Reduce unintentional drug overdose deaths 	<ul style="list-style-type: none"> Social Determinants of Health Public Health System, Prevention and Health Behavior Healthcare System and Access 	<ul style="list-style-type: none"> Reduce percentage of county residents with high housing costs Reduce severe housing problems Increase cultural understanding and skills Reduce food insecurity
Chronic Disease	<ul style="list-style-type: none"> Decrease diabetes Decrease heart disease 		

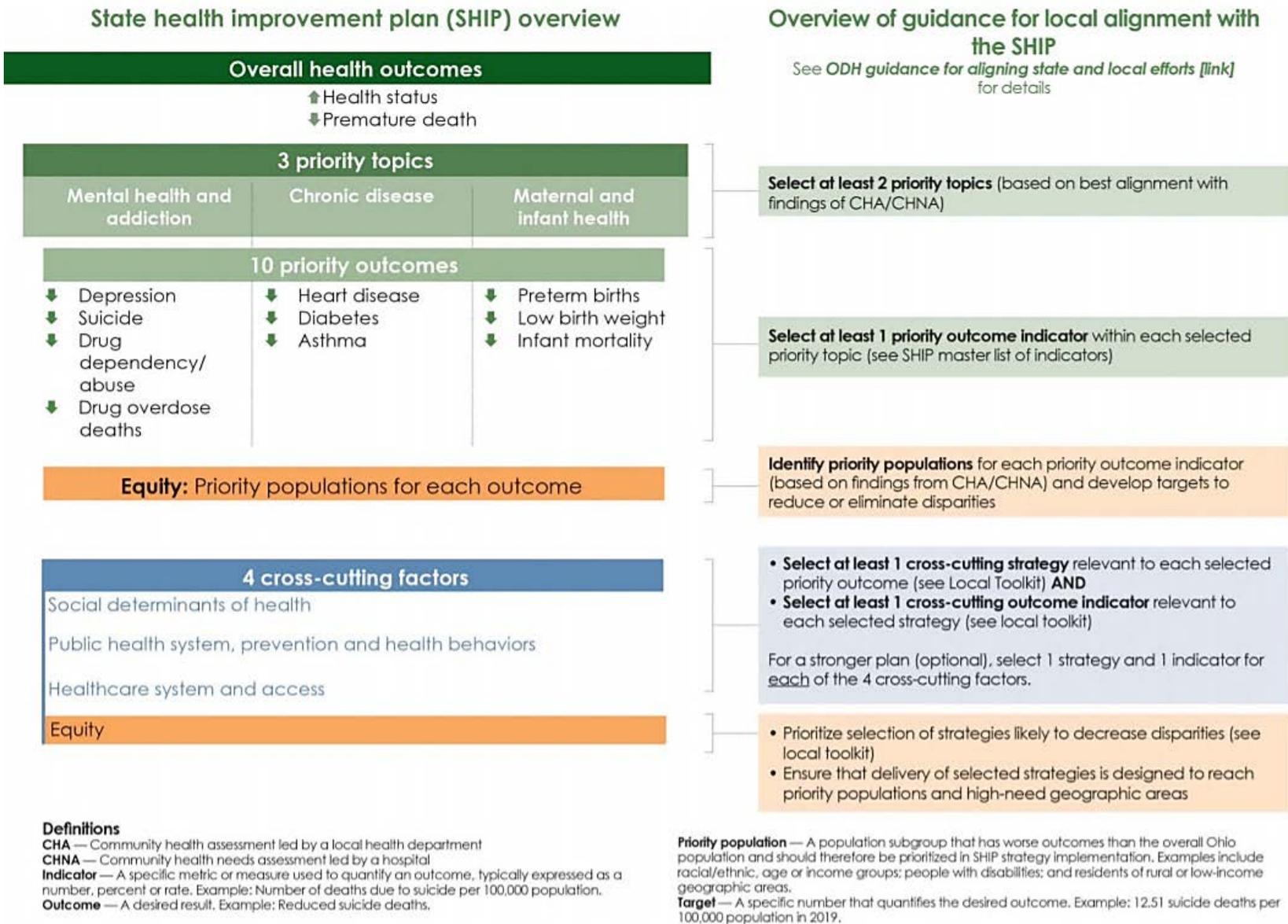
To align with and support *mental health and addiction*, Delaware County will work to implement school-based suicide awareness and education programs, school-based violence prevention programs, and school-based alcohol/other drug prevention programs. Delaware County will utilize suicide crisis hotlines and cell phone-based support programs and screen for clinical depression 12 or older using a standardized tool. Additionally, Delaware County will expand screening, brief intervention and referral to treatment (SBIRT) model; and increase policies to decrease availability of tobacco products. Lastly, Delaware County will provide cultural competence trainings for health care professionals and other service providers as a cross-cutting strategy.

To align with and support *chronic disease*, Delaware County will increase awareness of prediabetes using the prediabetes risk assessment and adopt healthy-food initiatives as a cross-cutting strategy.

Note: This symbol ✓ will be used throughout the report when a strategy has been rated by **What Works for Health** as “likely to decrease disparities” and/or recommended by the **Community Guide** as effective strategies for achieving health equity. These sources consider potential impacts on disparities and inequities by racial/ethnic, socioeconomic, geographic, or other characteristics.

Alignment with National and State Standards, continued

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



Definitions

CHA — Community health assessment led by a local health department

CHNA — Community health needs assessment led by a hospital

Indicator — A specific metric or measure used to quantify an outcome, typically expressed as a number, percent or rate. Example: Number of deaths due to suicide per 100,000 population.

Outcome — A desired result. Example: Reduced suicide deaths.

Priority population — A population subgroup that has worse outcomes than the overall Ohio population and should therefore be prioritized in SHIP strategy implementation. Examples include racial/ethnic, age or income groups; people with disabilities; and residents of rural or low-income geographic areas.

Target — A specific number that quantifies the desired outcome. Example: 12.51 suicide deaths per 100,000 population in 2019.

Strategic Planning Model

Beginning in June 2018, the Partnership for a Healthy Delaware County met four (4) times and completed the following planning steps:

1. **Initial Meeting:** Reviewed process and timeline, finalized committee members, created or reviewed vision
2. **Choosing Priorities:** Used quantitative and qualitative data to prioritize target impact areas
3. **Ranking Priorities:** Ranked the health problems based on magnitude, seriousness of consequences, and feasibility of correcting
4. **Resource Assessment:** Identified assets and resources to implementing each strategy
5. **Forces of Change and Community Themes and Strengths:** Answered open-ended questions by committee on community themes and strengths
6. **Gap Analysis:** Determined existing discrepancies between community needs and viable community resources to address local priorities; identify strengths, weaknesses, and evaluation strategies; and completed strategic action identification
7. **Local Public Health Assessment:** Reviewed the Local Public Health System Assessment with committee
8. **Quality of Life Survey:** Reviewed results of the Quality of Life Survey with committee
9. **Best Practices:** Reviewed best practices and proven strategies, evidence continuum, and feasibility continuum
10. **Draft Plan:** Reviewed all steps taken and made 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

Action Steps

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

Mental Health

1. Implement community-based education to promote positive mental health
2. Implement universal school-based suicide awareness and education programs
3. Research the use of technology to deliver mental health services (Suicide crisis hotlines and cell-phone based support programs)
4. Improve mental health and substance abuse referral process
5. Screen for clinical depression for all patients 12 or older using a standardized tool
6. Evaluate school district implementation of community-based prevention programming that supports PBIS (Positive Behavioral Interventions & Supports) (School-based violence prevention programs)

Addiction

1. Expand screening, brief intervention and referral to treatment (SBIRT) model
2. Expand community-based comprehensive program(s) to reduce alcohol abuse
3. Evaluate school district implementation of community-based prevention programming that supports PBIS (Positive Behavioral Interventions & Supports) (School-based alcohol/other drug prevention programs)
4. Increase community awareness and education of risky behaviors and substance abuse issues and trends
5. Increase safe disposal of prescription drugs
6. Increase policies to decrease availability of tobacco products

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

1. Develop partnership-based healthy lifestyle programming
2. Increase awareness of prediabetes (Prediabetes Risk Assessment)
3. Create a county wide physical activity collaboration
4. Research chronic pain management best-practices

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

1. Increase the amount of affordable housing required with new development and throughout the county
2. Provide cultural competence training for healthcare professionals and other service providers
3. Increase transportation opportunities and awareness
4. Support trauma-informed health care
5. Adopt healthy food initiatives
6. Promote healthy eating practices through education and skill building

Needs Assessment

The Partnership for a Healthy Delaware County reviewed the 2017 Delaware County Health Assessment along with the collective responses from community members and stakeholders who provided feedback at the CHA data release event in May 2018. Based on these two approaches, the community identified the following top key issues and concerns. Detailed primary data for each individual priority area can be found in the section it corresponds to.

What are the most significant health issues or concerns identified in the 2017 health assessment report? Examples of how to interpret the information include: 29% of Delaware County adults were obese: 34% of those ages 65 and older, and 31% of males.

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Mental Health (13 votes)			
Adults who considered attempting suicide in the past year	3%	N/A	N/A
Youth who considered attempting suicide in the past year (6 th -12 th grade)	11%	Grades: 9 th -12 th (13%)	Female (14%)
Adults who felt sad or hopeless almost every day for 2 or more weeks in a row in the past year	8%	N/A	N/A
Youth who felt sad or hopeless almost every day for 2 or more weeks in a row in the past year (6 th -12 th grade)	20%	Grades: 9 th -12 th (24%)	Female (27%)
Adult mental health not good on 4+ days in past month	23%	Age: <30 (53%), Income: <\$50K (38%)	Female (40%)
Children diagnosed with anxiety in their lifetime	7%	N/A	N/A
Alcohol Consumption (8 votes)			
Adult current drinkers	69%	Income: >\$100K (77%)	Male (74%)
Adults who binged in the past month (of current drinkers)	34%	N/A	N/A
Youth current drinkers (6 th -12 th grade)	14%	Age: 17+ (35%)	Female (16%)
Youth who binged in the past month (of current drinkers 9 th -12 th grade)	44%	Age: 17+ (56%)	Male (48%)

Key Issue or Concern	Percent of Population At Risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Social Determinates of Health (6 votes)			
Adults who experienced 4 or more ACEs in their lifetime	7%	N/A	N/A
Youth who experienced 3 or more ACEs in their lifetime (6 th -12 th grade)	15%	N/A	N/A
Children who experienced 2 or more ACEs in their lifetime	4%	N/A	N/A
Adults abused in the past year	2%	N/A	N/A
Adults spending above 30% of their household income on housing	36%	N/A	N/A
Adults needing help meeting general daily needs in the past 30 days	7%	N/A	N/A
Weight Status (4 votes)			
Adult obesity	29%	Age: 65+ (34%)	Male (31%)
Adult overweight	36%	Age: 30-64 (41%)	Male (43%)
Youth obesity (9 th -12 th grade)	9%	N/A	Male (13%)
Child obesity	13%	N/A	N/A
Access to Care (4 votes)			
Routine check-up in past year (adult)	73%	Income: > \$100K (65%)	N/A
Uninsured (adult)	5%	Income: < \$50K (12%)	N/A
Did not get medical care in past year due to cost (adult)	11%	N/A	N/A
Bullying (3 votes)			
Youth who were bullied in the past year (6 th -12 th grade)	43%	N/A	N/A
Youth bullied on school property in the past year (6 th -12 th grade)	25%	N/A	N/A
Children (age 6-11) bullied in the past year	43%	N/A	N/A
Chronic Disease (2 votes)			
Adults diagnosed with diabetes	7%	Age: 65+ (20%); Income: < \$50K (15%)	N/A
Adults diagnosed with coronary heart disease	2%	Age: 65+ (7%)	N/A

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Food Access (2 votes)			
Adults who experienced more than one food insecurity issue in the past year	4%	N/A	N/A
Parents who experienced at least one food insecurity issue in the past year	7%	N/A	N/A
Tobacco Use (2 votes)			
Adult current smoker	10%	Income: <\$50K (16%)	Male: (12%)
Youth current smoker (6 th -12 th grade)	3%	Age: 17+ (7%)	N/A
Youth who used an electronic vapor product in the past month (6 th -12 th grade)	15%	Age: 17+ (20%)	N/A
Prescription Drug Abuse (1 vote)			
Adult who used medication not prescribed for them/took more than prescribed to feel good/high in past 6 months	7%	Income: <\$50K (10%)	N/A
Youth who used prescription drugs not prescribed for them in the past month (6 th -12 th grade)	3%	Age: 17+ (5%)	N/A
Dental Health (1 vote)			
Adult dentist or dental clinic visit in the past year	80%	Age: 65+ (77%); Income: <\$50K (52%)	Male: (78%)
Child dentist or dental clinic visit in the past year	86%	Age: 0-5 (63%)	N/A
Men's Health (1 vote)			
Self-testicular exam in past year	36%	N/A	N/A
PSA test within the past 2 years	42%	Age: <40 (10%); Income: <\$50K (36%)	N/A
Adult Health Perceptions (1 vote)			
Rated general health as fair or poor in the past year	7%	Income: <\$50K (13%)	N/A
Immunizations (1 vote)			
Adults who received a flu vaccination in the past year	57%	Age: 65+ (83%)	N/A
Adults who received a pneumonia vaccination in their life	34%	Age: 65+ (82%)	N/A
Children who received a flu vaccine in the past year	66%	N/A	N/A

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Vehicle Safety (1 vote)			
Drivers in crashes* (ages 14-20)	1,004 drivers	Age: 17 (121 drivers)	N/A
Drivers in crashes resulting in injury* (ages 14-20)	345 drivers	Age: 17 (83 drivers)	N/A
Drivers cited for speed* (ages 14-20)	345 drivers	N/A	N/A

**Ohio Department of Public Safety, 2016 Driver Statistics, Updated 2/14/18*

Priorities Chosen

Based on the 2017 Delaware County Community Health Assessment, key issues were identified for adults, youth, and children. Partnership members then completed a ranking exercise via an online tool, giving a score for magnitude, seriousness of the consequence and feasibility of correcting, resulting in an average score for each issue identified. Partnership members' rankings were then combined to give an average score for the issue.

The rankings were as follows:

Health Issue	Average Score
Mental Health (includes depression and suicide)	22.2
Opiates	21.6
Chronic Pain	20.1
Access to Care	19.4
Chronic Disease (includes diabetes and heart disease)	19.2
Weight Status	18.1
Bullying	18.1
Alcohol Consumption	17.2
Food Access	16.8
Tobacco Use	16.4
Abuse/Trauma	16.0

Delaware County will focus on the following two priority areas over the next four years:

- 1. Chronic disease** 
Includes:
 - Adult, youth, and child obesity
 - Adult diabetes
 - Adult heart disease
 - Adult chronic pain
- 2. Mental health and addiction** 
Includes:
 - Adult and youth alcohol consumption
 - Adult and youth tobacco use
 - Adult and youth and opiates
 - Adult and youth depression
 - Adult and youth suicide
 - Youth and child bullying

Community Themes and Strengths Assessment

The Partnership for a Healthy Delaware County participated in an exercise to discuss community themes and strengths. The Community Themes and Strengths Assessment provides a deep understanding of the issues that residents feel are important by answering a broad set of questions. The results are as follows:

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

- Adequate access to services
- Space for addiction issues
- Collaboration and coordination of services within community (including healthcare, parks, social services, etc.)
- Economically vibrant
- Community considering health a priority
- Absence of disease
- Connectivity (neighborhoods, community groups, neighborhoods)
- Access to outdoor recreation spaces
- Engaged community members
- Access to affordable and plentiful primary/preventive care
- Availability of basic resources (housing, education, transportation)
- Knowledge and education regarding resources across all sectors
- Low incidence of chronic health conditions

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

- Health District
- Partnership for a Healthy Delaware County
- Family and Children First Council
- Chamber of Commerce
- Creating Healthy Communities
- Drug-Free Delaware
- SourcePoint
- Schools and local agencies
- Hunger Alliance
- Volunteerism within Delaware County
- Main Street Delaware
- Strengthening Families
- City of Delaware
- Service coordination in Delaware City
- Crisis Response Team
- Mental Health Board and SourcePoint providing in-home mental health care

3. What makes you most proud of our community?

- Sense of community
- Availability and quality of resources
- Collaboration
- Parks
- Libraries
- Schools
- Relationship between community and leaders
- #1 healthiest county in Ohio
- Great organizations
- Transparency
- Parks/outdoor spaces
- Culture of social responsibility

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?

- Substance abuse
- Addiction services
- Dental health
- Domestic violence
- Housing
- Public transportation access
- Emergency mental health services
- Support for addiction
- Chronic disease
- Available care for low income communities
- Affordable housing
- Ability to measure outcomes to drive hot spot interventions
- Localized opportunities to family-oriented activities
- Improve awareness of resource availability
- Early intervention for those in crisis

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

- Funding
- Volunteers/community involvement
- Lack of awareness
- Issues are not a quick fix
- Resistance to change
- Too busy or unwillingness to think outside the box
- Perception that health issues are not happening in Delaware County
- Improve transportation
- Population growth
- Lack of education and recognition of community needs
- Limited involvement from surrounding communities
- Obstacles to access including affordable transportation

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

- Create/promote community coalitions that are all encompassing
- Focus on prevention
- More money to support infrastructure for green space and trails
- Health equity and equal access to basic needs
- Addiction
- Transportation initiatives
- Healthy food access
- Funding innovative technology
- Identify better process for mental health and addiction crisis intervention

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

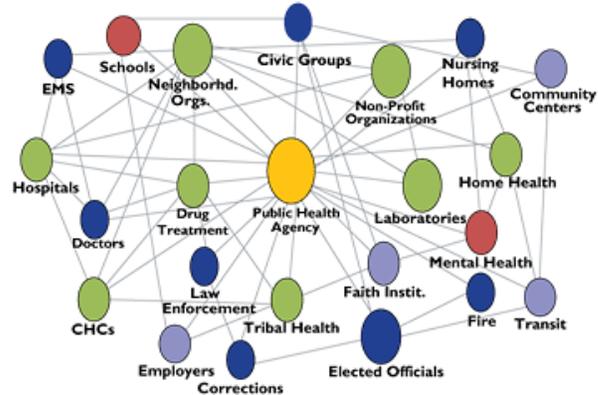
- Seeing results
- Community leaders making a call to action
- Ability to take action and implement an action step personally
- Sharing/communicating results more often
- Marketing opportunities
- Meaningful and impactful work
- More community member involvement/ability to understand their voices
- Continued collaboration

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.



Local Public Health System Assessment (LPHSA)

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

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

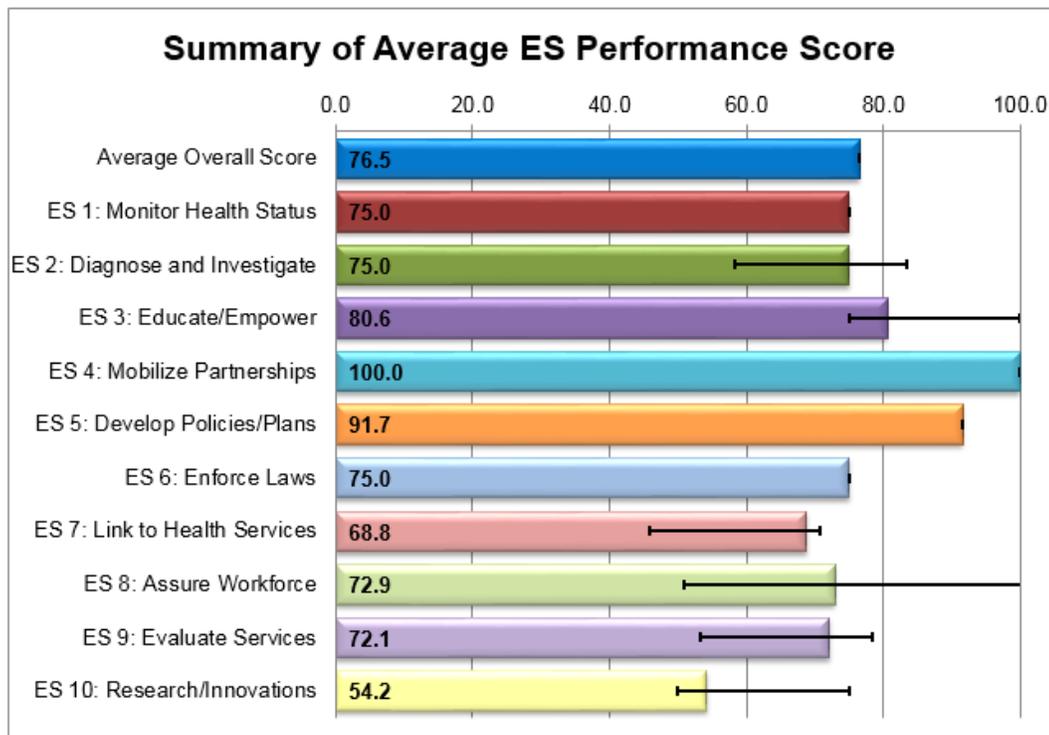
Members of the Delaware General Health District completed the performance measures instrument. The LPHSA results were then presented to the Partnership for a Healthy Delaware County for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard were 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.

The Partnership for a Healthy Delaware County identified 0 indicators that had a status of "minimal" and 0 indicators that had a status of "no activity." The remaining indicators were all moderate, significant or optimal.

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 the Delaware General Health District, Community Health Division, at (740) 368-1700.

Delaware County Local Public Health System Assessment 2018 Summary



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

Forces of Change Assessment

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

Force of Change	Potential Impact
1. Major development in county (Amazon, IKEA, Evans Farms, etc.)	<ul style="list-style-type: none"> • Increase in jobs • Many residents leaving the county for job opportunities (increase in turnover within county)
2. Aging population	<ul style="list-style-type: none"> • Increase in use of social services • Lack of affordable housing options • Increase in isolation • Aging in place becoming more common with larger homes
3. Lack of transportation	<ul style="list-style-type: none"> • Limited options available to access care • More difficult for those in outlying areas of county to access transportation • Lack of funding to address transportation • Lack of trust in the public transportation system • Difficult to use DATA bus for appointments
4. Population growth (school aged children, young families)	<ul style="list-style-type: none"> • Increase in need for resources (including child care) • Behind with levy-funded services • Disparity in resources between various areas of county • Schools will need additional resources due to growth • Increase in traffic
5. Increase in housing density	<ul style="list-style-type: none"> • Increase in housing costs • Changes in walkability
6. Cultural diversity	<ul style="list-style-type: none"> • Need for a greater understanding of diversity and cultural differences within the county • Language barriers
7. Affordable housing	<ul style="list-style-type: none"> • Certain populations being forced out because of increased costs
8. Loss of local government funds	<ul style="list-style-type: none"> • Lack of funds for transportation • Loss of necessary services • Limited access to services
9. Infectious diseases (locally and globally)	<ul style="list-style-type: none"> • No impact identified
10. Increase in technology use and social media	<ul style="list-style-type: none"> • Increase in non-traditional healthcare options (electronic consults) • Impact on bullying, mental health, and isolation • Great tool for dissemination of information
11. Weather/natural disasters	<ul style="list-style-type: none"> • No impact identified
12. Increase in substance/drug abuse	<ul style="list-style-type: none"> • Increase in use of health services • Additional resources needed • Negative impact on workforce

Force of Change	Potential Impact
13. Political environment	<ul style="list-style-type: none"> • Change in health care policies and practices • Changes in federal and state policies • Disillusionment with climate and constant changes
14. Economic drivers of care	<ul style="list-style-type: none"> • Economic model of medicine driven by sick care and economic outcomes versus health outcomes
15. Interpretation of HIPPA and privacy laws	<ul style="list-style-type: none"> • Difficult to share information for continuity of care
16. Need/desire for instantaneous care	<ul style="list-style-type: none"> • High use of emergency rooms/urgent care • Low use of preventive and primary care
17. Lack of availability of primary care when needed	<ul style="list-style-type: none"> • High use of emergency rooms/urgent care • Needs not being served

Quality of Life Survey

The Partnership for a Healthy Delaware County urged community members to fill out a short quality of life survey via Survey Monkey from July - August 2018. This tool will assist The Partnership in understanding the overall quality of life in Delaware County. There were **1,036** respondents who completed the survey. Ninety-five percent (95%) of survey respondents currently lived in Delaware County.

The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1. For all responses of "Don't Know," or when a respondent left a response blank, the choice was a non-response, was assigned a value of 0 (zero) and the response was not used in averaging response or calculating descriptive statistics.

Quality of Life Questions	Likert Scale Responses (1 to 5, with 5 being most positive)
<i>How satisfied or dissatisfied are you with the following statements?</i>	
1. The quality of life in our community? (Consider your sense of safety, well-being, participation in community life and associations, etc.)	4.53
2. The health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.97
3. This community is a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	4.46
<i>How much do you agree or disagree with the following statements?</i>	
4. This community is 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.)	3.96
5. There is 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.)	3.78
6. The community is a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, the mall. Do neighbors know and trust one another? Do they look out for one another?)	4.29
7. There are networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, organizations) during times of stress and need?	3.95
8. All Individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.92
9. All residents perceive that they, individually and collectively, can make the community a better place to live?	3.66
10. Community assets are broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.74
11. Levels of mutual trust and respect increase among community partners as they participate in collaborative activities to achieve shared community goals?	3.95
12. There is an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments? (Are citizens working towards the betterment of their community to improve life for all citizens?)	3.70

Priority 1: Mental Health and Addiction

Mental Health Indicators – 2017 Delaware County Community Health Assessment

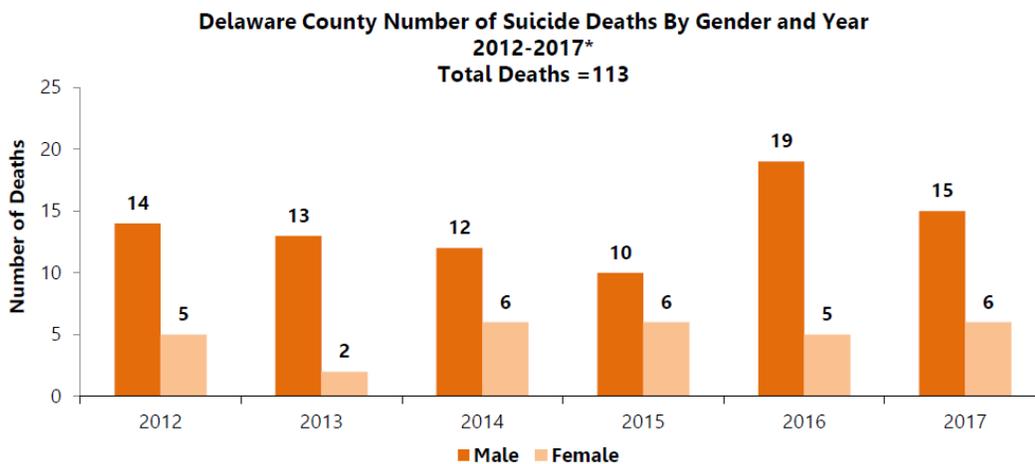
Adult Mental Health

In 2017, 3% of Delaware County adults considered attempting suicide in the past year. 🇺🇸

According to the Ohio Department of Health, there were 21* adult suicide deaths in Delaware County in 2017. 🇺🇸 *Years are considered partial and may be incomplete per Ohio Department of Health

In 2017, 8% of adults reported they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities.

In 2017, 23% of adults rated their mental health as not good on four or more days in the previous month.



*Data for 2017 are considered partial and may be incomplete, and should be used with caution
(Source: ODH, Ohio Public Health Data Warehouse, Mortality, Leading Causes of Death (all residents), Updated 12/18/17)

Youth Mental Health

In 2016/17, 20% of youth reported they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities (YRBS reported 26% for Ohio in 2013 and 30% for the U.S. in 2015). 🇺🇸

In 2016/17, 11% of youth reported they had seriously considered attempting suicide in the past year (2013 YRBS reported 14% for Ohio and 18% for the U.S. in 2015). 🇺🇸

According to the 2016/17 health assessment, 4% of Delaware County youth had attempted suicide in the past year. The 2015 YRBS reported 9% for U.S. youth and a 2013 YRBS rate of 6% for Ohio youth. 🇺🇸

According to the 2016/17 health assessment, 43% of youth had been bullied in the past year. In the past year, 25% of youth had been bullied on school property (YRBS reported 21% for Ohio in 2013 and 20% for the U.S. in 2015). 🇺🇸

Child Mental Health

In 2017, 7% of children were diagnosed with anxiety by a doctor, health professional or health educator.

In 2017, 43% of parents reported their child was bullied in the past year.

Mental Health: Gaps and Potential Strategies

The following tables indicate mental health gaps and potential strategies that were compiled by the Partnership for a Healthy Delaware County. The Partnership reviewed strategies from the 2014-2018 Delaware County CHIP and determined gaps and potential strategies relating to current CHIP priorities. Following the review, The Partnership discussed additional gaps and reviewed potential strategies that were not included in the 2014-2018 Delaware County CHIP. The results were as follows:

Previous 2014-2018 CHIP Strategies	Gaps:	Potential Strategies:
1. Increase by two the number of Signs of Distress trainings offered to the community and maintain the number of school buildings receiving Signs of Suicide training	<ul style="list-style-type: none"> Lack interest in training facilitators for Mental Health First Aid course Course is time consuming (8 hours) and poses time restrictions for training teachers and other first line employees 	<ul style="list-style-type: none"> Combine strategy with signs of distress strategy Identify other programs similar to mental health first aid courses Better identify gaps in existing services and determine who all is providing similar trainings
2. Implement community-wide campaign to promote positive mental health	<ul style="list-style-type: none"> No gaps identified 	<ul style="list-style-type: none"> Continue strategy but modify to a program that specifically addresses mental health stigma
3. Increase the number of primary care physician (PCP) offices that screen for depression	<ul style="list-style-type: none"> Lack of integration into electronic health records Limiting adherence to one screening tool has been difficult 	<ul style="list-style-type: none"> Continue strategy but do not limit to PCP offices. Include all health care offices and schools Promote health care offices to offer a modified depression screening tool Research PHQ-9 so providers can bill Combine with current strategies to broadly cover screenings

Mental Health: Gaps and Potential Strategies

Previous 2014-2018 CHIP Strategies	Gaps:	Potential Strategies:
<p>4. Evaluate the feasibility of implementing age-appropriate mental health screenings with the local school districts for preschool and elementary age students</p>	<ul style="list-style-type: none"> • Syntero is currently within all Delaware County schools, but nothing is universally implemented 	<ul style="list-style-type: none"> • Olentangy schools are looking into an RTI (Response to Intervention) type strategy to create a universal mental health screening • Research appropriate screening tools • Combine strategies to address mental health screening in general and make screening in preschools and elementary schools an action step
<p>5. Refer a minimum of 50% of clients annually who receive screenings for suicidal ideation at local hospital emergency rooms;</p> <p>6. Increase annually the number of referred suicidal clients who enter into public health treatment services</p>	<ul style="list-style-type: none"> • Changes in referral process among major hospital providers 	<ul style="list-style-type: none"> • Expand the process of screening and referral • Evaluate the current referral systems in place and identify gaps and areas for improvement with the changes that have taken place • Create messaging specifically targeting most at risk (i.e.: adult white middle-aged men at risk of obtaining lethal means) • Increase the use of HelpLine and referrals to treatment - track clients who enroll in the referred treatment • Highlight and improve process for HelpLine being first line of defense instead of Emergency Departments

Mental Health: Gaps and Potential Strategies

Previous 2014-2018 CHIP Strategies	Gaps:	Potential Strategies:
<p>7. Maintain the number of school buildings implementing anti-bullying curriculum;</p> <p>8. Implement community-wide anti-bullying curriculums;</p> <p>9. Implement community wide anti-bullying social media campaign</p>	<ul style="list-style-type: none"> • No gaps identified 	<ul style="list-style-type: none"> • Combine strategies into one strategy to address bullying overall and emphasize cyber bullying and social media • Expand the Too-Good Programs into high school or another age appropriate program • Use the PEACE prevention matrix to identify current programs being used in schools and any gaps in these programs • Focus on healthy and appropriate use of social media across all age groups (including adults/parents as well as youth) and highlight with positive messaging more than negative outcomes • Evaluate if there are any programs that focus on the relationship between social media and mental health

Mental Health: Best Practices

The following programs and policies have been reviewed and have proven strategies to **improve mental health**. Specific mental health strategies, selected by The Partnership, can be found following this section on page 33.

1. **Mental Health First Aid** is an adult public education program designed to improve participants' knowledge and modify their attitudes and perceptions about mental health and related issues, including how to respond to individuals who are experiencing one or more acute mental health crises (i.e., suicidal thoughts and/or behavior, acute stress reaction, panic attacks, and/or acute psychotic behavior) or are in the early stages of one or more chronic mental health problems (i.e., depressive, anxiety, and/or psychotic disorders, which may occur with substance abuse).

The intervention is delivered by a trained, certified instructor through an interactive 12-hour course, which can be completed in two 6-hour sessions or four 3-hour sessions. The course introduces participants to risk factors, warning signs, and symptoms for a range of mental health problems, including comorbidity with substance use disorders; builds participants' understanding of the impact and prevalence of mental health problems; and provides an overview of common support and treatment resources for those with a mental health problem. After completing the course and passing an examination, participants are certified for 3 years as a Mental Health First Aider. In the studies reviewed for this summary, Mental Health First Aid was delivered as a 9-hour course, through three weekly sessions of 3 hours each.

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

There are two components of the PHQ-9:

- Assessing symptoms and functional impairment to make a tentative depression diagnosis
- Deriving a severity score to help select and monitor treatment

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

3. **Universal school-based suicide awareness and education programs** deliver a curriculum-based approach to suicide prevention to all students, usually in middle or high school settings. Students learn to recognize warning signs of suicide in themselves and others. Programs are often based on a psychoeducational curriculum and use multimedia presentations, lectures, classroom discussion, interactive activities, and role-play.

Expected Beneficial Outcomes

- Reduced suicide
- Increased knowledge of suicide
- Improved coping skills

Other Potential Beneficial Outcomes

- Increased help-seeking behavior

Signs of Suicide (SOS) is an award-winning, nationally recognized program designed for middle and high school-age students. The program teaches students how to identify the symptoms of depression and suicidality in themselves or their friends and encourages help-seeking through the use of the ACT® technique (Acknowledge, Care, Tell).

The SOS High School program is the only school-based suicide prevention program listed on the Substance Abuse and Mental Health Services Administration’s National Registry of Evidence-based Programs and Practices that addresses suicide risk and depression, while reducing suicide attempts. In a randomized control study, the SOS program showed a reduction in self-reported suicide attempts by 40%.

4. **Universal school-based violence prevention programs** provide students and school staff with information about violence, change how youth think and feel about violence, and enhance interpersonal and emotional skills such as communication and problem-solving, empathy, and conflict management. These approaches are considered “universal” because they are typically delivered to all students in a grade or school. Focus may vary among prevention programs according to the ages of the target student population, and programs may focus on either general violence or specific forms of violence such as bullying or dating violence.

Ohio Positive Behavioral Interventions and Supports (PBIS) is a general education initiative that supports children and youth. PBIS is a decision-making framework that guides selection, integration and implementation of the best evidence-based academic and behavioral practices for improving academic and behavior outcomes for students. PBIS emphasizes data for decision making, measurable outcomes supported and evaluated by data, practices with evidence that the outcomes are achievable, and systems that support implementation of these practices. Public schools in Ohio are required to adopt policies and procedures regarding PBIS.

5. **Telemedicine**, sometimes called telehealth, uses telecommunications technology to deliver consultative, diagnostic, and health care treatment services. Services can encompass primary and specialty care, referrals, and remote monitoring of vital signs, and may be provided via videoconference, email, smartphones, wireless tools, or other modalities. Telemedicine can supplement health care services for patients who would benefit from frequent monitoring or provide services to individuals in areas with limited access to care.

Expected Beneficial Outcomes

- Increased access to care

Other Potential Beneficial Outcomes

- Improved mental health
- Reduced mortality
- Increased medication adherence

Cell phone-based support programs offer new opportunities to reach individuals with mental health concerns such as depression, anxiety, post-traumatic stress disorder, and substance abuse. Mobile phone applications (apps) can deliver a form of cognitive behavior therapy, link a user with a medical professional, or allow patients to regularly self-monitor their emotional state and easily share that information with a provider. Texting interventions can include provision of health information, automated reminders, or supportive messages sent to individuals participating in longer term mental health treatment.

Action Step Recommendations & Plan

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

1. Implement community-based education to promote positive mental health
2. Implement universal school-based suicide awareness and education programs
3. Research the use of technology to deliver mental health services (Suicide crisis hotlines and cell-phone based support programs)
4. Improve mental health and substance abuse referral process
5. Screen for clinical depression for all patients 12 or older using a standardized tool
6. Evaluate school district implementation of community-based prevention programming that supports PBIS (Positive Behavioral Interventions & Supports) (School-based violence prevention programs)

Action Plan

Priority Topic: Mental Health				
Strategy 1: Implement community-based education to promote positive mental health				
Action Step	Priority Outcomes & Indicators	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Obtain baseline information from county organizations offering community-based mental health trainings.</p> <p>Identify gaps in existing programs and determine additional programming needs.</p> <p>Determine goal to increase number of trainings.</p> <p>Brainstorm effective marketing techniques among community organizations that will promote identified trainings.</p> <p>Research social marketing programs that specifically address mental health stigma (ex: NAMI's CureStigma, OMHAS's Be Present Campaign) that can accompany community-based trainings.</p>	<p>Priority Outcomes:</p> <ol style="list-style-type: none"> 1. Reduce youth depression 2. Reduce adult depression <p>Priority Indicators:</p> <ol style="list-style-type: none"> 1. Percentage of youth who reported feeling sad or hopeless almost every day for 2 or more weeks in a row in the past year 2. Percentage of adults who reported feeling sad or hopeless almost every day for 2 or more weeks in a row in the past year 	Adult and youth	<p>Delaware-Morrow Mental Health & Recovery Services Board (Lead)</p> <p>HelpLine</p> <p>NAMI</p> <p>Delaware General Health District</p>	December 31, 2019
<p>Year 2: Create marketing tools that promote all offerings.</p> <p>Market community-based trainings to all sectors of society (ex: churches, schools, civic clubs, law enforcement, chambers of commerce, local government).</p> <p>Determine how community-based trainings can connect attendees to social marketing campaigns and local resources to help increase awareness of mental health.</p> <p>Provide at least three community-based trainings across the county.</p>				December 31, 2020
<p>Year 3: Continue efforts from year 2. Continue to increase number of trainings offered to community.</p>				December 31, 2021
<p>Year 4: Continue efforts from year 3. Continue to market community offering.</p>				December 31, 2022
<p>Identified Assets & Resources: DMMHRSB, Delaware & Morrow Counties NAMI, HelpLine, Syntero – these providers have funding to provide free trainings</p>				

Priority Topic: Mental Health

Strategy 2: Implement universal school-based suicide awareness and education programs

Action Step	Priority Outcomes & Indicators	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Establish baseline reach (from 2017/2018 school year) for number of middle school and high school buildings implementing Signs of Suicide (SOS)/depression.</p> <p>Create a reporting system for program reach to be reported within the CHIP.</p> <p>Work with school district staff to ensure program fidelity in screening students and identify district and building gaps.</p> <p>Determine a process within each district for student referrals.</p> <p>Work with YRBS sub-committee to determine if next assessment cycle (YRBS) is capturing data for youth anxiety rates, and what other data may be needed.</p>	<p>Priority Outcomes:</p> <ol style="list-style-type: none"> 1. Reduce suicide deaths 2. Reduce youth depression <p>Priority Indicators:</p> <ol style="list-style-type: none"> 1. Number of deaths due to suicide per 100,000 populations (age-adjusted) 2. Percentage of youth who reported feeling sad or hopeless almost every day for 2 or more weeks in a row in the past year 	Youth	<p>HelpLine (Lead)</p> <p>Syntero</p> <p>School Guidance Counselors/Nurses</p>	December 31, 2019
<p>Year 2: Continue program implementation efforts from year 1.</p> <p>Implement next cycle of YRBS within all districts.</p> <p>Share YRBS findings with community partners to evaluate data and assess program effectiveness.</p>				December 31, 2020
<p>Year 3: Continue efforts from years 1 and 2.</p>				December 31, 2021
<p>Year 4: Continue efforts from years 2 and 3.</p>				December 31, 2022
<p>Identified Assets & Resources: DMMHRSB currently funds HelpLine staff to implement Signs of Suicide across the county, support and communication with school district partners, each MS & HS has a school resource officer to provide additional support/referrals, Syntero provides school-based clinicians to each school district to assist with student referral process</p>				

Priority Topic: Mental Health

Strategy 3: Research the use of technology to deliver mental health services (Suicide crisis hotlines and cell-phone based support programs)

Action Step	Priority Outcomes & Indicators	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1 Establish a sub-committee to evaluate the need for mental health service reach via technology.</p> <p>Determine community need for each type of technology related service (ex: telemedicine, mental health apps, video, cell phone etc.).</p> <p>Research costs associated with technology needs to determine funding streams.</p> <p>Create a timeline for mental health technology improvements across the cycle of the CHIP.</p>	<p>Priority Outcomes:</p> <ol style="list-style-type: none"> 1. Reduce suicide deaths 2. Reduce youth depression 3. Reduce adult depression <p>Priority Indicators:</p> <ol style="list-style-type: none"> 1. Number of deaths due to suicide per 100,000 populations (age-adjusted) 2. Percentage of youth who reported feeling sad or hopeless almost every day for 2 or more weeks in a row in the past year 3. Percentage of adults who reported feeling sad or hopeless almost every day for 2 or more weeks in a row in the past year 	<p>Adult and youth</p>	<p align="center">Delaware-Morrow Mental Health & Recovery Services Board</p>	<p>December 31, 2019</p>
<p>Year 2: Continue efforts from year 1.</p> <p>Share sub-committee findings with community mental health funded organizations (ex: technology needed, funds to support, timeline for technology improvements).</p> <p>Identify marketing tactics for each technology service (ex: what populations are going to be targeted for use, evaluation measures, etc.).</p>				<p>December 31, 2020</p>
<p>Year 3: Continue efforts from years 1 and 2.</p>				<p>December 31, 2021</p>
<p>Year 4: Continue efforts from years 1, 2 and 3.</p>				<p>December 31, 2022</p>
<p>Identified Assets & Resources: DMMHR SB has already started researching possible technological services to deliver mental health services, HelpLine already has a successful crisis text line service, SourcePoint</p>				

Priority Topic: Mental Health

Strategy 4: Improve mental health and substance abuse referral process

Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Evaluate the current referral system within Grady Hospital (ED or inpatient) to public behavioral health providers and identify ways to make the process more effective and efficient for residents needing behavioral health services.</p> <p>Refine the behavioral health referral protocol to be used with other emergency rooms, including data collection to establish baseline measurements for behavioral health follow-up and referrals.</p>	<p>Priority Outcomes:</p> <ol style="list-style-type: none"> 1. Reduce youth depression 2. Reduce adult depression 3. Reduce suicide deaths <p>Priority Indicators:</p> <ol style="list-style-type: none"> 1. Percentage of youth who reported feeling sad or hopeless almost every day for 2 or more weeks in a row in the past year 2. Percentage of adults who reported feeling sad or hopeless almost every day for 2 or more weeks in a row in the past year 3. Number of deaths due to suicide per 100,000 populations (age-adjusted) 	<p>Adult and youth</p>	<p>Delaware-Morrow Mental Health & Recovery Services Board (Lead)</p> <p>HelpLine</p> <p>OhioHealth Grady Memorial Hospital</p> <p>Delaware General Health District</p>	<p>December 31, 2019</p>
<p>Year 2: Design a database to collect information and track activity regarding patient public behavioral health referral and follow-up.</p> <p>Evaluate the protocol based on the usage and satisfaction of those implementing it and the patients involved in the process.</p>				<p>December 31, 2020</p>
<p>Year 3: Explore implementing the referral protocol with other local emergency departments (ex: other OhioHealth sites, Mount Carmel Healthcare and Nationwide Children’s Hospital).</p> <p>Implement the referral protocol with other local emergency departments.</p>				<p>December 31, 2021</p>
<p>Year 4: Increase the number of discharged emergency room patients being contacted for post-visit follow-up by 25% from baseline.</p> <p>Increase the number of discharged emergency room and inpatient hospital patients engaged post-visit in public behavioral health services by 25% from baseline.</p>				<p>December 31, 2022</p>
<p>Identified Assets & Resources: DMMHRSB funds public providers and all agencies have Rapid Engagement Coordinators to improve referral process, HelpLine has crisis line already established, DGHD, OhioHealth, Mount Carmel Healthcare, Nationwide Children’s Hospital</p>				

Priority Topic: Mental Health

Strategy 5: Screen for clinical depression for all patients 12 or older using a standardized tool 

Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Create a sub-committee to work with county hospital systems and public mental health providers to collect baseline data on the number of emergency departments, urgent care centers, primary care providers (including pediatricians), and mental health public providers that currently screen for depression and determine what tool is used.</p> <p>Determine feasibility of gathering baseline measurements of the number of patients with major depressive episodes across all partners.</p> <p>Evaluate findings and share among mental health providers within The Partnership to determine need for standardizing the use of one tool.</p> <p>Work with both public and private providers to ensure that clinicians have up to date community resources for mental health referrals.</p>	<p>Priority Outcomes:</p> <ol style="list-style-type: none"> 1. Reduce youth depression 2. Reduce adult depression <p>Priority Indicators:</p> <ol style="list-style-type: none"> 1. Percentage of youth who reported feeling sad or hopeless almost every day for 2 or more weeks in a row in the past year 2. Percentage of adults who reported feeling sad or hopeless almost every day for 2 or more weeks in a row in the past year 	<p align="center">Adult and youth</p>	<p align="center">Delaware-Morrow Mental Health & Recovery Services Board (Lead)</p> <p align="center">Hospital Partners Delaware General Health District</p>	<p align="center">December 31, 2019</p>
<p>Year 2: Possibly pilot the implementation of an evidenced based screening tool (such as the Patient Health Questionnaire (PHQ-9)) within one new setting to increase the number of county residents being screened for depression (to be determined from assessment from year 1).</p> <p>Track the number of patients flagged for depression due to depression screening implementation.</p> <p>Determine a system of patient tracking to examine whether community referrals were acted upon.</p>				<p align="center">December 31, 2020</p>
<p>Year 3: Continue efforts from years 1 and 2.</p>				<p align="center">December 31, 2021</p>
<p>Year 4: Continue efforts from years 1, 2 and 3.</p>				<p align="center">December 31, 2022</p>
<p>Identified Assets & Resources: Hospital systems are willing partners to examine and share current screening processes, DGHD can be a new system to implement a depression screening with the Pre-Natal & Newborn Home Visiting Programs, many public serving mental health providers are already practicing in Delaware County</p>				

Priority Topic: Mental Health

Strategy 6: Evaluate school district implementation of community-based prevention programming that supports PBIS (Positive Behavioral Interventions & Supports) (School-based violence prevention programs 🗨️)

Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Conduct an evaluation of community-based violence programming in grades K-12 (across local public schools) using the PEACE prevention matrix to assess gaps across grades, districts and buildings.</p> <p>Compile report with above information to share within each district to assess student reach, review gaps, and learn about current PBIS models currently in place to determine future community service needs.</p> <p>Maintain number of buildings & districts implementing community-based violence prevention programming across grades K-12 (ex: Too Good for Violence/Drugs, Love all That & More, Safe Dates). Determine tracking system for monitoring student reach during CHIP.</p> <p>Discuss how districts utilized the 2016/2017 YRBS data to improve PBIS tiers of intervention.</p> <p>Set up YRBS planning committee for next cycle of YRBS data collection.</p>	<p>Priority Outcomes:</p> <ol style="list-style-type: none"> 1. Reduce youth electronic (cyber) bullying 2. Reduce youth bullying on school property 3. Reduce child electronic (cyber) bullying <p>Priority Indicators:</p> <ol style="list-style-type: none"> 1. Percent of youth who reported being cyber-bullied (teased, taunted or threatened by e-mail or cell phone) during the past 12 months 2. Percent of youth who reported being bullied on school property within the past 12 months 3. Parents who reported their child was cyber-bullied (teased, taunted or threatened by e-mail or cell phone) during the past 12 months 	Youth and child	<p>HelpLine (Lead)</p> <p>Delaware General Health District School Districts RPR</p>	December 31, 2019
<p>Year 2: Continue to evaluate community services/programming supporting PBIS framework within each district.</p> <p>Implement next cycle of YRBS within all districts and share YRBS findings with community partners to evaluate data and assess program effectiveness.</p>				December 31, 2020
<p>Year 3: Continue efforts from years 1 and 2.</p>				December 31, 2021
<p>Year 4: Continue efforts of years 1, 2 and 3.</p>				December 31, 2022
<p>Identified Assets & Resources: HelpLine, RPR, DMMHRB funds current prevention programming, supportive school administration</p>				

Priority 1: Mental Health and Addiction

Addiction Indicators – 2017 Delaware County Community Health Assessment

Adult Addiction

According to the Ohio Department of Health, there were 27* adult accidental drug overdose deaths in Delaware County in 2017.  *Years are considered partial and may be incomplete per Ohio Department of Health.

In 2017, 7% of adults had used medication not prescribed for them or they took more than prescribed to feel good or high and/or more active or alert during the past 6 months.

In 2017, adults who misused prescription medications obtained them from the following: primary care physician (87%), multiple doctors (14%), ER or urgent care doctor (3%), and free from a friend/family member (1%).

In 2017, 69% of adults had at least one alcohol drink in the past month, increasing to 74% of males (The 2016 BRFSS reported current drinker prevalence rates of 53% for Ohio and 54% for the U.S.).

In 2017, 22% of adults reported they had five or more alcoholic drinks (for males) or 4 or more alcoholic drinks (for females) on occasion in the last month and would be considered binge drinkers (The 2016 BRFSS reported 18% for Ohio and 17% for the U.S.). 

In 2017, 10% of adults were current smokers (The 2016 BRFSS reported current smoker prevalence rates of 24% for Ohio and 25% for the U.S.). 

In 2017, more than half (56%) of current smokers responded that they had stopped smoking for at least one day in the past year because they were trying to quit smoking. 

Youth Addiction

In 2016/17, 3% of youth reported using prescription drugs not prescribed for them in the past month, increasing to 5% of those over the age of 17. 

In 2016/17, 3% of youth smoked part or all of a cigarette in the past month, increasing to 7% of those 17 and older.

In 2016/17, 10% of youth used an electronic vapor product in the past 30 days, increasing to 20% of those 17 and older (YRBS reported 24% for the U.S. in 2015).

In 2016/17, 14% of youth had at least one drink in the past 30 days and would be defined as a current drinker, increasing to 35% of those ages 17 and older. 

In 2016/17, of those high school youth who drank, 44% had five or more alcohol drinks on an occasion in the last month and would be considered binge drinkers, increasing to 56% of those ages 17 and older. 

Addiction: Gaps and Potential Strategies

The following tables indicate addiction gaps and potential strategies that were compiled by the Partnership for a Healthy Delaware County. The Partnership reviewed strategies from the 2014-2018 Delaware County CHIP and determined gaps and potential strategies relating to current CHIP priorities. Following the review, The Partnership discussed additional gaps and reviewed potential strategies that were not included in the 2014-2018 Delaware County CHIP. The results were as follows:

Previous 2014-2018 CHIP Strategies	Gaps:	Potential Strategies:
1. A family-focused, multi-faceted educational campaign on the dangers of prescription drug abuse and heroin use will be implemented	<ul style="list-style-type: none"> • Olentangy School District is not currently providing the same comprehensive prevention program across all schools • Not one consistent prevention program being used in different school districts throughout county • Campaign only targets heroin and prescription drug abuse. Leads to time constraints with being able to get into the schools 	<ul style="list-style-type: none"> • Create multi-faceted age appropriate prevention plan targeting schools, parents, and youth to use consistent messaging about alcohol, and other drug use
2. Implement one comprehensive educational program on marijuana use to change normative perceptions	<ul style="list-style-type: none"> • Progress halted due to legalization of medical marijuana in Ohio 	<ul style="list-style-type: none"> • Continue strategy but focus on medical marijuana as the other strategies will address recreational use in the schools • Cover all age ranges and normative perceptions and misconceptions held by older adults • Cover impact on driving under the influence and the effects medical marijuana may have for employers and employees

Addiction: Gaps and Potential Strategies

Previous 2014-2018 CHIP Strategies	Gaps:	Potential Strategies:
<p>3. 10% of primary care physicians practicing in Delaware County will implement SBIRT screening tool</p>	<ul style="list-style-type: none"> • Not many private providers left in area-many are larger systems in which it is more difficult to implement change • Inability to bill screening tool • No universal screening tool currently being used • Providers do not have time – may take up to 30 minutes to complete 	<ul style="list-style-type: none"> • Expand screening within county - Prenatal & Newborn Home Visiting Program at DGHD will be implementing the SBIRT tool • Coordination with Mount Carmel to pilot SBIRT tool at Lewis Center location • Increase trainings (through DGHD ODH grant) to providers to include a “train the trainer” piece
<p>4. Provide age appropriate alcohol and other drug education to three populations not currently receiving education through structured and evidence-based programs (older adults, incarcerated adults, young adults)</p>	<ul style="list-style-type: none"> • The health assessment identified a concern regarding young adults and binge drinking. Binge drinking rates in Delaware County are above state and national averages • Difficult to identify a point person to implement program with incoming Ohio Wesleyan freshmen & their parents - there has been a consistent staff turnover over the past 4 years • Current strategy targeting young adults has been limited to one college 	<ul style="list-style-type: none"> • Modify strategy to specifically focus on binge drinking targeting adults aged 18-34 • Drug Free Delaware currently focuses mostly on youth, but they are considering an expansion • Increasing number of graduates attending Columbus State Community College - identify point person from other colleges • Reach out to young professional groups - although these groups may often be meeting where alcohol is served • Create a parental component to educate on parental beliefs (expand the “Parents Who Host” campaign) • Potentially reach parents during high school orientations and educate on drinking rates within the county. Potentially target the southern part of the county

Addiction: Best Practices

The following programs and policies have been reviewed and have proven strategies to **improve addiction**. Specific addiction strategies, selected by The Partnership, can be found following this section on page 45.

1. Project ASSERT (Alcohol and Substance Abuse Services, Education, and Referral to Treatment) is a **screening, brief intervention, and referral to treatment (SBIRT)** model designed for use in health clinics or emergency departments (EDs). Project ASSERT targets three groups:
 - Out-of-treatment adults who are visiting a walk-in health clinic for routine medical care and have a positive screening result for cocaine and/or opiate use. Project ASSERT aims to reduce or eliminate their cocaine and/or opiate use through interaction with peer educators (substance abuse outreach workers who are in recovery themselves for cocaine and/or opiate use and/or are licensed alcohol and drug counselors).
 - Adolescents and young adults who are visiting a pediatric ED for acute care and have a positive screening result for marijuana use. Project ASSERT aims to reduce or eliminate their marijuana use through interaction with peer educators (adults who are under the age of 25 and, often, college educated).
 - Adults who are visiting an ED for acute care and have a positive screening result for high-risk and/or dependent alcohol use. Project ASSERT aims to motivate patients to reduce or eliminate their unhealthy use through collaboration with ED staff members (physicians, nurses, nurse practitioners, social workers, or emergency medical technicians).

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

2. **Community Trials Intervention to Reduce High-Risk Drinking** is a multicomponent, community-based program developed to alter the alcohol use patterns and related problems of people of all ages. The program incorporates a set of environmental interventions including:
 - Using zoning and municipal regulations to restrict alcohol access through alcohol outlet density control.
 - Enhancing responsible beverage service by training, testing, and assisting beverage servers and retailers in the development of policies and procedures to reduce intoxication and driving after drinking.
 - Increasing law enforcement and sobriety checkpoints to raise actual and perceived risk of arrest for driving after drinking.
 - Reducing youth access to alcohol by training alcohol retailers to avoid selling to minors and those who provide alcohol to minors.
 - Forming the coalitions needed to implement and support the interventions that address each of these prevention components.

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

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

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

4. **Tobacco 21** is a national campaign aimed at raising the tobacco and nicotine sales age in the United States to 21. The Tobacco 21 campaign is produced and funded by the Prevention Tobacco Addiction Foundation, a public health nonprofit organization established in 1996. Tobacco 21 produces online content to promote anti-tobacco messages and helps communities around the United States raise the tobacco and nicotine sales to age 21.

In March 2015, the Institute of Medicine, on behalf of the Food and Drug Administration (FDA), released a seminal report detailing the potential public health benefits of enacting a nationwide Tobacco 21 policy. Among the results was a 25% drop in youth smoking initiation, a 12% drop in overall smoking rates and 16,000 cases of preterm birth and low birth weight averted in the first 5 years of the policy. The conservation estimate is that if age 21 were adopted throughout the U.S. it would prevent 4.2 million years of life lost to smoking in kids alive today. Age 21 reduces initiation in younger kids and inhibits consolidation of addiction in older teens.

Action Step Recommendations & Plan

To work toward **improving addiction outcomes**, the following strategies are recommended:

1. Expand screening, brief intervention and referral to treatment (SBIRT) model
2. Expand community-based comprehensive program(s) to reduce alcohol abuse
3. Evaluate school district implementation of community-based prevention programming that supports PBIS (Positive Behavioral Interventions & Supports) (School-based alcohol/other drug prevention programs)
4. Increase community awareness and education of risky behaviors and substance abuse issues and trends
5. Increase safe disposal of prescription drugs
6. Increase policies to decrease availability of tobacco products

Action Plan

Priority Topic: Addiction				
Strategy 1: Expand screening, brief intervention and referral to treatment (SBIRT) model				
Action Step	Priority Outcomes & Indicators	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Collect baseline data on the number of hospital emergency departments, urgent care centers, and primary care providers (including pediatricians) that currently screen for drug and alcohol abuse, and at what age they start screening.</p> <p>Introduce a screening, brief intervention and referral to treatment model (SBIRT) to healthcare providers. Pilot the screening tool with at least one hospital, urgent care center, or primary care office.</p>	<p>Priority Outcomes:</p> <ol style="list-style-type: none"> 1. Reduce adult binge drinking 2. Reduce youth binge drinking 3. Reduce unintentional drug overdose deaths <p>Priority Indicators:</p> <ol style="list-style-type: none"> 1. Percent of adults who had at least (5 for men/4 for women) drinks on an occasion in the past month 2. Percent of youth who had at least 5 drinks on an occasion in the past month 3. Number of deaths due to unintentional drug overdoses per 100,000 population (age adjusted) 	Adult and youth	<p>Delaware-Morrow Mental Health & Recovery Services Board (Lead)</p> <p>Delaware General Health District Mount Carmel Lewis Center</p>	December 31, 2019
<p>Year 2: Continue to introduce SBIRT model.</p> <p>Increase the number of healthcare providers using the SBIRT model by 25% from baseline.</p>				December 31, 2020
<p>Year 3: Continue efforts from year 2. Increase the number of healthcare providers using the SBIRT model.</p>				December 31, 2021
<p>Year 4: Continue efforts of year 3.</p>				December 31, 2022
<p>Identified Assets & Resources: DMMHRBSB funding, ODH contract in place, hospital system willing to implement (i.e. Mount Carmel), DGHD Home Visiting Program planning to implement in 2018, local primary care physicians implementing SBIRT</p>				

Priority Topic: Addiction

Strategy 2: Expand community-based comprehensive program(s) to reduce alcohol abuse

Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Research alcohol prevention programs or other like programs outside of law enforcement to address binge drinking. Focus on strategies that specifically target high use populations.</p> <p>Work with all area law enforcement agencies and Drug-Free Delaware to determine which components would be feasible to expand and/or implement.</p> <p>Collect baseline data on current environmental interventions being administered by law enforcement including: Compliance checks, Responsible Beverage Service, and Parents Who Host Lose the Most campaign.</p>	<p>Priority Outcomes:</p> <ol style="list-style-type: none"> 1. Reduce adult binge drinking 2. Reduce youth alcohol use <p>Priority Indicators:</p> <ol style="list-style-type: none"> 1. Percent of adults who had at least (5 for men/4 for women) drinks on an occasion in the past month 2. Percent of youth who drank one or more drinks of an alcoholic beverage in the past 30 days 	<p align="center">Adult and youth</p>	<p align="center">Drug-Free Delaware (Lead)</p> <p align="center">Delaware General Health District</p> <p align="center">Maryhaven</p>	<p align="center">December 31, 2019</p>
<p>Year 2: Determine feasibility of implementing/continuing the following programs:</p> <ul style="list-style-type: none"> • Sobriety checkpoints (working with law enforcement) • Compliance checks (working with the Ohio Investigative Unit) • Responsible Beverage Service (working with the Ohio Investigative Unit) • Parents Who Host Lose the Most campaign (educating parents on the laws for distributing alcohol to minors) • Use zoning and municipal regulations to control alcohol outlet density <p>Explore and expand alcohol use prevention programming at local college campuses.</p>			<p align="center">Law Enforcement: (Sherriff's Office, police departments)</p> <p align="center">SAFE Coalition</p> <p align="center">Year 2:</p> <p align="center">Ohio Wesleyan University</p> <p align="center">Columbus State</p>	<p align="center">December 31, 2020</p>
<p>Year 3: Expand strategies to all areas of the county and implement remaining strategies. Publicize the results.</p>			<p align="center">December 31, 2021</p>	
<p>Year 4: Continue efforts of year 3.</p>			<p align="center">December 31, 2022</p>	
<p>Identified Assets & Resources: Drug-Free Delaware Coalition (SAMHSA funding); DMMHRB funding; existing partnerships with law enforcement entities; Delaware County Law Enforcement Executives group; SAFE Coalition; Ohio Wesleyan University; Columbus State College; Southeast Healthcare, Inc.; Maryhaven; Syntero</p>				

Priority Topic: Addiction

Strategy 3: Evaluate school district implementation of community-based prevention programming that supports PBIS (Positive Behavioral Interventions & Supports) (School-based alcohol/other drug prevention programs 🗨)

Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Conduct an evaluation of community-based substance abuse programming in grades K-12 (across local public schools) using the PEACE prevention matrix and the Ohio Attorney General's <i>Drug Use Prevention Resource Guide</i> (including guidance from ORC 3313.60) to assess gaps across grades, districts and buildings.</p> <p>Compile report with above information to share within each district to assess student reach, review gaps, and learn about current PBIS models currently in place to determine future community service needs.</p> <p>Maintain number of buildings & districts implementing community-based substance abuse prevention programming across grades K-12 (ex: Too Good for Drugs).</p> <p>Discuss how districts utilized the 2016/2017 YRBS data to improve PBIS tiers of intervention. Set up YRBS planning committee for next cycle of YRBS data collection.</p>	<p>Priority Outcomes:</p> <ol style="list-style-type: none"> 1. Reduce youth non-prescribed prescription drug misuse 2. Reduce youth binge drinking <p>Priority Indicators:</p> <ol style="list-style-type: none"> 1. Percent of youth who misused prescription drugs not prescribed to them in the past 30 days 2. Percent of youth who had at least 5 drinks on an occasion in the past month 	Youth	<p align="center">HelpLine (Lead)</p> <p align="center">PEACE Collaborative Recovery & Prevention Resources School Districts</p>	December 31, 2019
<p>Year 2: Continue to evaluate community services/programming supporting PBIS framework within each district.</p> <p>Implement next cycle of YRBS within all districts and share YRBS findings with community partners to evaluate data and assess program effectiveness.</p>				December 31, 2020
<p>Year 3: Continue efforts from years 1 and 2.</p>				December 31, 2021
<p>Year 4: Continue efforts of years 1, 2 and 3.</p>				December 31, 2022
<p>Identified Assets & Resources: Big Brothers Big Sisters mentoring program, Recovery and Prevention Resources (RPR), HelpLine staff and programs, PEACE Collaborative, DMMHRSB funds current prevention programming, supportive school administration</p>				

Priority Topic: Addiction

Strategy 4: Increase community awareness and education of risky behaviors and substance abuse issues and trends

Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Plan a community awareness campaign to increase education and awareness of risky behaviors and substance abuse issues and trends.</p> <p>Include information focusing on: medical marijuana, e-cigarettes, binge drinking, and prescription drug abuse.</p> <p>Partner with Drug-Free Delaware and determine best ways to educate community and parents (social media, newspaper, school websites or newsletters, television, church bulletins, etc.).</p>	<p>Priority Outcomes:</p> <ol style="list-style-type: none"> 1. Reduce adult binge drinking 2. Reduce youth binge drinking 3. Reduce adult non-prescribed prescription drug misuse 4. Reduce youth non-prescribed prescription drug misuse 5. Reduce adult current smokers 6. Reduce youth current smokers 			December 31, 2019
<p>Year 2: Plan awareness programs and/or workshops focusing on different “hot topics”, risky behaviors, and substance abuse issues and trends (ex: severely mentally ill (SMI) population and high tobacco use rates).</p> <p>Attain media coverage for all programs and/or workshops.</p>	<p>Priority Indicators:</p> <ol style="list-style-type: none"> 1. Percent of adults who had at least (5 for men/4 for women) drinks on an occasion in the past month 2. Percent of youth who had at least 5 drinks on an occasion in the past month 	Adult and youth	<p>Delaware General Health District (Lead)</p> <p>Drug-Free Delaware</p> <p>Tobacco-Free Delaware Coalition</p>	December 31, 2020
<p>Year 3: Continue efforts of years 1 and 2.</p>	<ol style="list-style-type: none"> 3. Percent of adults who misused prescription drugs not prescribed to them in the past 6 months 		Delaware County Sheriff’s Office	December 31, 2021
<p>Year 4: Continue efforts of year 3.</p>	<ol style="list-style-type: none"> 4. Percent of youth who misused prescription drugs not prescribed to them in the past 30 days 5. Percent of adults who smoked at least 100 cigarettes in their lifetime and currently smoke some or all days 6. Percent of youth who smoked cigarettes in the past 30 days 			December 31, 2022
<p>Identified Assets & Resources: Drug-Free Delaware Coalition, Tobacco Free Delaware County Coalition, communications team, drug liaison position at Delaware County Sherris’s Office, school resource officers are in all school districts, several police departments in the county that work with Drug-Free Delaware</p>				

Priority Topic: Addiction

Strategy 5: Increase safe disposal of prescription drugs

Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Increase awareness of prescription drug abuse and expand the locations of existing prescription drug collection boxes.</p> <p>Work with local law enforcement to continue to sponsor and host prescription drug take-back days.</p> <p>Expand the number of local practitioners and pharmacies providing information on prescription drug abuse and collection locations.</p> <p>Promote the use of dissolvable prescription bags (i.e. Detera) and provide education regarding safe disposal (i.e. knowledge of safe needle disposal).</p>	<p>Priority Outcomes:</p> <ol style="list-style-type: none"> 1. Reduce adult non-prescribed prescription drug misuse 2. Reduce youth non-prescribed prescription drug misuse <p>Priority Indicators:</p> <ol style="list-style-type: none"> 1. Percent of adults who misused prescription drugs not prescribed to them in the past 6 months 2. Percent of youth who misused prescription drugs not prescribed to them in the past 30 days 	<p align="center">Adult and youth</p>	<p align="center">Drug-Free Delaware (Lead)</p>	<p align="center">December 31, 2019</p>
<p>Year 2: Host at least two additional prescription drug take-back-days and increase participation.</p>				<p align="center">December 31, 2020</p>
<p>Year 3: Continue efforts of year 2.</p>				<p align="center">December 31, 2021</p>
<p>Year 4: Continue efforts of year 3.</p>				<p align="center">December 31, 2022</p>
<p>Identified Assets & Resources: Drug-Free Delaware Coalition website and materials such as flyer "Be Smart with Sharps," county fire departments, SourcePoint, Delaware County Sherriff's Office, law enforcement agencies, hospital systems, pharmacies, DGHD</p>				

Priority Topic: Addiction

Strategy 6: Increase policies to decrease availability of tobacco products

Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Expand the Tobacco 21 Initiative. Raise awareness of Tobacco 21 and research the feasibility of additional jurisdictions adopting this policy.</p> <p>Continue efforts to adopt smoke-free policies in county parks, fairgrounds, schools and other public locations.</p> <p>Work with the City of Powell who has implemented this policy and determine barriers and challenges.</p> <p>Review the model Tobacco 21 policy to ensure all forms of tobacco use are included (i.e. e-cigarettes).</p>	<p>Priority Outcomes:</p> <ol style="list-style-type: none"> 1. Reduce adult current smokers 2. Reduce youth current smokers <p>Priority Indicators:</p> <ol style="list-style-type: none"> 1. Percent of adults who smoked at least 100 cigarettes in their lifetime and currently smoke some or all days 2. Percent of youth who smoked cigarettes in the past 30 days 	<p>Adult and youth</p>	<p>Tobacco Free Delaware County Coalition (Lead)</p> <p>Creating Healthy Communities Program (DGHD)</p>	<p>December 31, 2019</p>
<p>Year 2: Present information to City Councils on both the Tobacco 21 initiative and smoke free outdoor public locations. Focus on Delaware City and eventually on other villages that achieve city status.</p>				<p>December 31, 2020</p>
<p>Year 3: Continue efforts from years 1 and 2.</p>				<p>December 31, 2021</p>
<p>Year 4: Continue efforts from year 3.</p>				<p>December 31, 2022</p>
<p>Identified Assets & Resources: Tobacco-Free Delaware County Coalition, DGHD, relationship with political subdivisions within the county, recent adoption of Powell’s Tobacco 21 policy, solid infrastructure with law enforcement partners throughout the county, Drug-Free Delaware’s support of tobacco prevention efforts</p>				

Priority 2: Chronic Disease

Chronic Disease Indicators – 2017 Delaware County Community Health Assessment

Adult, Youth, and Child Obesity

In 2017, about two-thirds (65%) of Delaware County adults were either overweight (36%) or obese (29%) by Body Mass Index (BMI), putting them at an elevated risk for developing a variety of chronic diseases. 🇺🇸

In 2016/17, 9% of youth were classified as obese by Body Mass Index (BMI) calculations. Ten percent (10%) of youth were classified as overweight. 🇺🇸

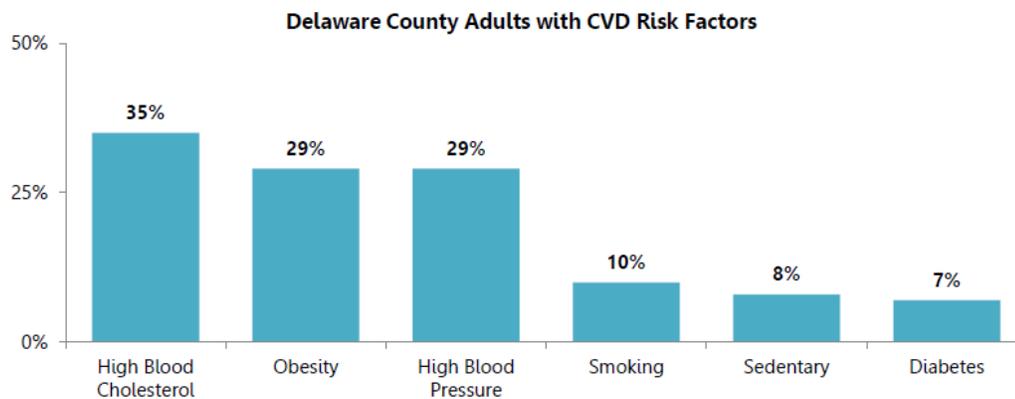
In 2017, 13% of children were classified as obese by Body Mass Index (BMI) calculations. Nine percent (9%) of children were classified as overweight, 68% were normal weight, and 10% were underweight. 🇺🇸

Adult Heart Disease

In 2017, 3% of Delaware County adults reported they had survived a heart attack or myocardial infarction, increasing to 7% of those over the age of 65. 🇺🇸

In 2017, 2% of adults reported they had angina or coronary heart disease, increasing to 7% of those over the age of 65. 🇺🇸

In 2017, 2% of Delaware County adults reported they had survived a stroke.



(Source: 2017 Delaware County Health Assessment)

Adult Diabetes

In 2017, 7% of Delaware County adults had been diagnosed with diabetes, increasing to 20% of those over the age of 65. 🇺🇸 Six percent (6%) of adults had been diagnosed with pre-diabetes or borderline diabetes. 🇺🇸

Adult Chronic Pain

In 2017, 22% of adults indicated they were limited in some way due to chronic pain.

In 2017, 29% of Delaware County adults were told by a doctor, nurse, or other health professional that they had some form of arthritis, increasing to 66% of those over the age of 65.

Chronic Disease: Gaps and Potential Strategies

The following tables indicate chronic disease gaps and potential strategies that were compiled by the Partnership for a Healthy Delaware County. The Partnership reviewed strategies from the 2014-2018 Delaware County CHIP and determined gaps and potential strategies relating to current CHIP priorities. Following the review, The Partnership discussed additional gaps and reviewed potential strategies that were not included in the 2014-2018 Delaware County CHIP. The results were as follows:

Previous 2014-2018 CHIP Strategies	Gaps:	Potential Strategies:
1. Implement a complete streets policy to enhance physical activity	<ul style="list-style-type: none"> • Powell and Sunbury Township currently lack complete street policies 	<ul style="list-style-type: none"> • Expand complete streets policy to Powell and/or Sunbury Village • Work with cities first as they may be more interested • Incorporate healthy living strategies into new planning or development
2. Implement one campaign to educate Delaware County residents on healthier eating and physical activity	<ul style="list-style-type: none"> • Difficult to measure outcomes • Need to emphasize active living 	<ul style="list-style-type: none"> • Continue 5321 Almost none campaign • Continue a Fast 500 campaign
3. Implement 2 evidence-based behavior weight management programs for Delaware County families	<ul style="list-style-type: none"> • Difficult to get enrollees for youth program • Only available at YMCAs • Availability of individual level interventions 	<ul style="list-style-type: none"> • Engage school nurses to identify at risk youth and connect to program • Involve PTOs to connect with sharing campaign information • Worksite wellness programs to further individual level interventions • Peer-run community wellness curriculum • Develop partnership based healthy life-style programming

Chronic Disease: Gaps and Potential Strategies

Gaps:	Potential Strategies:
4. More room to involve parks to promote physical activity and wellness	<ul style="list-style-type: none"> • Involve parks into physical activity campaign • Master trail plan to focus on educational awareness and public awareness around connectivity • Support parks through a coordinated campaign- possibly survey those using parks to get better information of what they would like to see/use at parks • Look into funding opportunities from trail committee • Explore feasibility of “park prescriptions” used by medical offices • Use local park imagery in doctor’s offices and waiting rooms • Use community branding to promote the many health resources in Delaware County
5. Lack of understanding surrounding chronic pain needs	<ul style="list-style-type: none"> • Research chronic pain management strategies • Understand individual experiences with chronic pain and how to better navigate resources and choices. Potentially share with doctor’s offices • Research feasibility and accessibility of online self-management programs • Explore SourcePoint resources
6. Lack of physical activity and knowledge of physical activity opportunities	<ul style="list-style-type: none"> • Create a community calendar of physical activity events/resources across the community (Campaign App [community hub], Eventbrite, Facebook, etc.)
7. Difficult to connect individuals with other organizations once programming ends	<ul style="list-style-type: none"> • Cancer Support Community would like to expand partnerships with local organizations • Offer more classes and connect individuals with additional resources after programs end – facilitate connections within organizations • Reach additional people by partnering events/programs with multiple organizations

Chronic Disease: Best Practices

The following programs and policies have been reviewed and have proven strategies to **reduce chronic disease**. Specific chronic disease strategies, selected by The Partnership, can be found following this section on page 55.

1. **Diabetes Risk Assessments CDC and American Diabetes Association (ADA) questionnaires**
Offers an educational opportunity for patients to learn about their risk for prediabetes and help physicians and care teams identify their patients at greater risk.
2. **Community-based Social Support for Physical Activity** Community-based social support interventions for physical activity combine physical activity opportunities and social support to build, strengthen, and maintain social networks that encourage positive behavior changes. Interventions can also include education, group or individual counseling, or plans tailored to individual needs. Examples of community-based social support interventions include walking groups, setting up an exercise buddy system, and making contracts, goals, or physical activity plans with others.
3. **Department of Health and Human Services Task Force on Best Practices for Pain Management**
The Task Force recommends that a broad spectrum of complementary, alternative and integrative therapies be used in the treatment of acute and chronic pain, while additional research be conducted to determine therapeutic value for particular pain conditions and syndromes, risks and benefits, and mechanisms of action. Patient education is recognized as an important and necessary best practice with the recommendation that a national panel of chronic pain patients, patient advocates, and clinicians be convened to develop a set of core competencies for patient education, and that creation of patient education programs based on these core competencies and disseminated widely to patients and their families.
4. **Clinical-Community Linkages for the Prevention and Control of Chronic Disease (CDC)**
Creating sustainable, effective linkages between the clinical and community settings can improve patients' access to preventive and chronic care services by developing partnerships between organizations that share a common goal of improving the health of people and the communities in which they live. These linkages connect clinical providers, community organizations, and public health agencies.

The goals of clinical-community linkages include:

- Coordinating health care delivery, public health, and community-based activities to promote healthy behavior.
- Forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services.
- Promoting patient, family, and community involvement in strategic planning and improvement activities.
- Types of clinical-community linkages include coordinating services at one location, coordinating services between different locations, and developing ways to refer patients to resources.

Action Step Recommendations & Plan

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

1. Develop partnership-based healthy lifestyle programming
2. Increase awareness of prediabetes (Prediabetes Risk Assessment )
3. Create a county wide physical activity collaboration
4. Research chronic pain management best-practices

Action Plan

Priority Topic: Chronic Disease				
Strategy 1: Develop partnership-based healthy lifestyle programming				
Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Recruit interested organizations/partners to form a partnership-based healthy lifestyle collaboration. Determine goals of the partnership.</p> <p>Complete a gap analysis of current healthy-lifestyle programming within the county and determine potential action steps focused on collaboration.</p>	<p>Priority Outcome:</p> <ol style="list-style-type: none"> 1. Reduce adult obesity 2. Reduce youth obesity 3. Reduce child obesity <p>Priority Indicator:</p> <ol style="list-style-type: none"> 1. Percent of adults that report body mass index (BMI) greater than or equal to 30 2. Percent of youth who were obese 3. Percent of children who were obese 	Adult, youth and child	<p>Cancer Support Community (Lead)</p> <p>Grace Clinics of Ohio</p> <p>Ohio Wesleyan University</p> <p>SourcePoint</p> <p>YMCA</p> <p>Mount Carmel</p>	December 31, 2019
<p>Year 2: Develop an evaluation process for tracking outcomes and progress of the partnership.</p> <p>Continue to recruit interested agencies and implement action steps determined from year 1.</p>				December 31, 2020
<p>Year 3: Continue efforts of years 1 and 2.</p>				December 31, 2021
<p>Year 4: Continue efforts of years 1, 2 and 3.</p>				December 31, 2022
<p>Identified Assets & Resources: YMCA Strong, Well, Fit and other classes; Mount Carmel classes; Cancer Support Community classes; Grace Clinics of Ohio Weight Loss and Nutrition classes; SourcePoint Healthy U and fitness and aquatic classes; Strengthening Families; Cooking Matters; OWU; OhioHealth Grady Memorial Hospital</p>				

Priority Topic: Chronic Disease

Strategy 2: Increase awareness of prediabetes (Prediabetes Risk Assessment )

Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Determine baseline of the number of organizations that currently provide prediabetes screening or risk assessments (ex: Diabetes Prevention Program (DPP)).</p> <p>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.</p> <p>Partner with local programs to administer the screening or raise awareness of pre-diabetes.</p>	<p>Priority Outcome:</p> <ol style="list-style-type: none"> 1. Reduce adult diabetes 2. Reduce adult prediabetes <p>Priority Indicator:</p> <ol style="list-style-type: none"> 1. Percent of adults who had been told by a doctor that they have diabetes 2. Percent of adults who had been told by a doctor that they have prediabetes 	Adult	<p align="center">Grace Clinics of Ohio (Lead)</p> <p align="center">SourcePoint</p> <p align="center">Mount Carmel</p> <p align="center">OhioHealth Grady Memorial Hospital</p> <p align="center">Delaware General Health District</p>	December 31, 2019
<p>Year 2: Increase awareness of prediabetes screening, identification and referral.</p> <p>Increase the number of individuals within Delaware County that are screened for prediabetes.</p> <p>If needed, increase the number of organizations that screen for diabetes.</p>				December 31, 2020
<p>Year 3: Continue efforts of years 1 and 2.</p>				December 31, 2021
<p>Year 4: Continue efforts of years 1, 2 and 3.</p>				December 31, 2022
<p>Identified Assets & Resources: SourcePoint, YMCA, Mount Carmel, Grace Clinics of Ohio, Ohio Department of Health, Delaware County food pantries, diabetes risk assessment screening tool (ODH), OhioHealth Grady Memorial Hospital</p>				

Priority Topic: Chronic Disease

Strategy 3: Create a county wide physical activity collaboration

Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Recruit interested organizations/partners who are working on improving and promoting Delaware County's physical activity opportunities.</p> <p>Determine goals of the physical activity collaboration.</p> <p>Engage county organizations to participate in a unified message to make Delaware County well-known as an active community.</p> <p>Create county branding.</p> <p>Explore the feasibility and challenges of creating a county physical activity app or calendar.</p>	<p>Priority Outcome:</p> <ol style="list-style-type: none"> 1. Reduce adult obesity 2. Reduce youth obesity 3. Reduce child obesity 4. Reduce coronary heart disease <p>Priority Indicator:</p> <ol style="list-style-type: none"> 1. Percent of adults that report body mass index (BMI) greater than or equal to 30 2. Percent of youth who were obese 3. Percent of children who were obese 4. Percent of adults ever diagnosed with coronary heart disease 	<p>Adult, youth and child</p>	<p>Preservation Parks (Lead)</p> <p>Delaware County Trail Committee</p> <p>Grace Clinics of Ohio</p> <p>Delaware General Health District</p> <p>YMCA</p>	<p>December 31, 2019</p>
<p>Year 2: Continue efforts of year 1.</p> <p>Increase awareness and dissemination of the unified message (created from year 1).</p> <p>Provide community organizations with ways to support the outreach campaign such as using social media, websites, flyers, etc.</p>				<p>December 31, 2020</p>
<p>Year 3: Continue efforts of years 1 and 2.</p>				<p>December 31, 2021</p>
<p>Year 4: Continue efforts of years 1, 2 and 3.</p>				<p>December 31, 2022</p>
<p>Identified Assets & Resources: Preservation Parks of Delaware County, park boards, Destination Delaware, Columbus Zoo, Delaware County Chambers of Commerce, local park systems, community park groups, Delaware County Trail Committee, Delaware County Friends of the Trail, Delaware County Tourism, Grace Clinics of Ohio Walk with a Doc, OhioHealth Grady Memorial Hospital, YMCA, SourcePoint (hiking group)</p>				

Priority Topic: Chronic Disease				
Strategy 4: Research chronic pain management best-practices				
Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Research and/or monitor chronic pain best practices (ex: Department of Health and Human Services Pain Management Best Practices Inter-Agency Task Force) and determine availability of local resources.</p> <p>Complete a needs assessment focused on individual experiences with chronic pain and the process of navigating resources.</p>	<p>Priority Outcome: Decrease adult chronic pain</p> <p>Priority Indicator: Percent of adults limited in some way due to chronic pain</p>	Adult	<p>Delaware General Health District (Lead)</p> <p>Mount Carmel</p> <p>Grace Clinics of Ohio</p> <p>OhioHealth Grady Memorial Hospital</p>	December 31, 2019
<p>Year 2: Determine action steps based on needs assessment (completed in year 1).</p>				December 31, 2020
<p>Year 3: Continue efforts from years 1 and 2.</p>				December 31, 2021
<p>Year 4: Continue efforts from years 1, 2 and 3.</p>				December 31, 2019
<p>Identified Assets & Resources: Mount Carmel, Grace Clinics of Ohio, Cancer Support Community, DHHS report (pending), Integrated Pain Solutions, OhioHealth Grady Memorial Hospital, HelpLine</p>				

Cross-cutting Indicators

Cross-Cutting Indicators – 2017 Delaware County Community Health Assessment

Adult Indicators

In 2017, 7% of adults had experienced three or more adverse childhood experiences (ACEs) in their lifetime.

In 2017, 3% of Delaware County adults considered attempting suicide in the past year. 🍷

In 2017, 2% of Delaware County adults were abused in the past year. They were abused by the following: a spouse or partner (50%), someone outside their home (17%), a child (17%), and someone else (33%).

Five percent (5%) of adults had transportation issues in 2017. They reported the following: limited public transportation available or accessible (50%), did not feel safe to drive (28%), disabled (28%), no public transportation available or accessible (22%), no car (17%), other car issues/expenses (11%), suspended/no driver's license (6%), and no car insurance (6%).

According to the 2017 health assessment, reasons for not getting medical care in the past 12 months included the following: no need to go (67%), cost/no insurance (11%), too long of a wait for an appointment (6%), office wasn't open when they could get there (2%), too long of a wait in the waiting room (2%), did not take their insurance (2%), inconvenient appointment times (2%), too embarrassed to seek help (1%), and other (7%).

Delaware County adults reported they looked for the following programs in 2017: depression, anxiety or mental health (14%); weight problem (5%); disability (5%); elderly assistance (4%); marital or family problems (4%); family planning (3%); end-of-life or hospice care (2%); cancer support group/counseling (2%); tobacco cessation (2%); alcohol abuse (2%); and drug abuse (1%).

According to the 2017 health assessment, adults experienced the following food insecurity issues during the past 12 months: had to choose between paying bills and buying food (5%), worried food would run out (3%), went hungry/ate less to provide more food for their family (3%), were hungry but did not eat because they did not have money for food (2%), loss of income led to food insecurity issues (2%), and food assistance was cut (<1%). 🍷

In 2017, 4% of adults ate 5 or more servings of whole vegetables per day. Twenty-nine percent (29%) ate 3 to 4 servings per day, 63% ate 1 to 2 servings per day, and 5% ate 0 servings per day.

In 2017, 3% of adults ate 5 or more servings of whole fruit per day. Nineteen percent (19%) ate 3 to 4 servings per day, 71% ate 1 to 2 servings per day, and 7% ate 0 servings per day.

According to the 2017 health assessment, in the past 30 days, 7% of Delaware County adults reported needing help meeting general daily needs such as food, clothing, shelter or paying utility bills.

In 2017, 9% of adults reported they spent 50% or more of their household income on housing.

Youth & Child Indicators

In 2016/17, 15% of youth had experienced three or more adverse childhood experiences (ACEs) in their lifetime.

In 2016/17, 11% of youth reported they had seriously considered attempting suicide in the past year (2013 YRBS reported 14% for Ohio and 18% for the U.S. in 2015). 🍷

In 2017, 4% of children had experienced three or more adverse childhood experiences (ACEs) in their lifetime. 🍷

According to the 2017 health assessment, 7% of parents had at least one food insecurity issue in the past year. They reported the following: they had to choose between paying bills or buying food (58%), they went hungry/ate less to provide more food for their family (46%), they were worried food would run out (35%), their food assistance was cut (19%), loss of income led to food insecurity issues (15%), and they were hungry but did not eat because they did not have money for food (8%). 🍷

In 2016/17, 4% of youth ate 5 or more servings of whole fruit per day. Thirty percent (30%) ate 3 to 4 servings of whole fruit per day and 61% ate 1 to 2 servings per day.

In 2016/17, 4% of youth ate 5 or more servings of whole vegetables per day. Twenty-four percent (24%) ate 3 to 4 servings of whole fruit per day and 65% ate 1 to 2 servings per day.

In 2017, 7% of children ate 5 or more servings of whole fruit per day. Thirty-four percent (34%) ate 3 to 4 servings of whole fruit per day, 58% ate 1 to 2 servings per day, and 1% ate 0 servings per day.

In 2017, 4% of children ate 5 or more servings of whole vegetables per day. About one-fifth (21%) ate 3 to 4 servings of whole fruit per day, 69% ate 1 to 2 servings per day, and 6% ate 0 servings per day.

Cross-Cutting: Gaps and Potential Strategies

The following tables indicate cross-cutting gaps and potential strategies that were compiled by the Partnership for a Healthy Delaware County. The Partnership reviewed strategies from the 2014-2018 Delaware County CHIP and determined gaps and potential strategies relating to current CHIP priorities. Following the review, The Partnership discussed additional gaps and reviewed potential strategies that were not included in the 2014-2018 Delaware County CHIP. The results were as follows:

Previous 2014-2018 CHIP Strategies	Gaps:	Potential Strategies:
1. Increase grades 6-8 students engaged in structured after-school activities	<ul style="list-style-type: none"> Lack of programming for elementary aged students 	<ul style="list-style-type: none"> Increase grades 1–5 students engaged in structured after-school enrichment activities
2. Provide a program designed to build knowledge, skills, and capacity among families	<ul style="list-style-type: none"> Lack of programming outside of Delaware City 	<ul style="list-style-type: none"> Assist families in crisis at Strengthening Families Willis Center (Common Ground, food pantry, Syntero) Appoint liaison to the Housing Coalition (run by Salvation Army local and regional group)
3. Establish readily-available resources to address mental health issues and make referrals to the appropriate supportive agencies	<ul style="list-style-type: none"> No gaps identified 	<ul style="list-style-type: none"> Strengthening Families Health Committee – Grace Clinic Mini Clinic, dental, speech & hearing
4. Increase the number of Delaware County residents using alternative transportation options for health-related trips by 20%	<ul style="list-style-type: none"> Lack of funding Schedule of bus routes Access to rural areas 	<ul style="list-style-type: none"> Explore options for alternate transportation (Uber, Lyft, rideshare, bikes) Appoint representative to Transportation Advisory Committee
5. Implement coordinated public health messages related to prenatal care, diabetes care, and access to prescription medication among county service agencies and community partners	<ul style="list-style-type: none"> Residents lack of awareness of available transportation options 	<ul style="list-style-type: none"> Implement awareness/education campaign related to available transportation options in the county

Cross-Cutting: Gaps and Potential Strategies

Previous 2014-2018 CHIP Strategies	Gaps:	Potential Strategies:
6. Implement a pilot mobile Integrated health care/community paramedicine program in Delaware County	<ul style="list-style-type: none"> • Many agencies could be involved with one client but not necessarily know which services are being provided – possible duplication of services • Communication barriers – inability to speak, foreign languages 	<ul style="list-style-type: none"> • Continue paramedicine program (EMS/social workers) • Develop system for service coordination for referrals and follow-up (ex. patient navigator) • Utilize FCFC – Interagency Youth Council
7. Staff of 10 community/public agencies will be trained in trauma-informed care with 50% percent of agencies trained completing the pre-and post-test assessment.	<ul style="list-style-type: none"> • Social service agencies have been the majority of providers who have been training in trauma informed care 	<ul style="list-style-type: none"> • Continue trauma informed care training – focus on big employers, not just social service agencies • Address ACES in daycares – Early Intervention Workgroup at Strengthening Families
8. Increase by 50% the supply of nutritious foods to food insecure Delaware County residents	<ul style="list-style-type: none"> • Lewis Center (Dooley’s Orchard), Worthington Arms • Growth in the county = new residents not aware of services 	<ul style="list-style-type: none"> • Increase the number of unique individuals accessing food pantries • Awareness campaign to promote pantry services & decrease stigma to accessing these services
9. 80% of participants will increase their knowledge of nutritional food after successfully completing the Cooking Matters Program	<ul style="list-style-type: none"> • Get outside the city to offer courses • Staffing for classes – Ohio Wesleyan University limited on how many students can participate • Difficultly to prepare food/access food for people with mobility issues (age <55, specifically 21-55-year-old group) 	<ul style="list-style-type: none"> • Continue Cooking Matters classes – both the 6-week and demos at pantries • Cancer Support Community cooking classes
10. Increase by 25% the number of stakeholders involved in the Delaware County Hunger Alliance	<ul style="list-style-type: none"> • Funded agencies are the only members of the Hunger Alliance 	<ul style="list-style-type: none"> • Recruit businesses and other employers to be involved in Hunger Alliance

Cross-cutting: Best Practices

The following programs and policies have been reviewed and have proven strategies to **improve health outcomes**. Specific cross-cutting strategies, selected by The Partnership, can be found following this section on page 65.

1. **Cooking Matters (No Kid Hungry Center for Best Practices)** hands-on courses empower families with the skills to be self-sufficient in the kitchen. In communities across America, participants and volunteer instructors come together each week to share lessons and meals with each other.

Courses meet for two hours, once a week for six weeks and are team-taught by a volunteer chef and nutrition educator. Lessons cover meal preparation, grocery shopping, food budgeting and nutrition. Participants practice fundamental food skills, including proper knife techniques, reading ingredient labels, cutting up a whole chicken, and making a healthy meal for a family of four on a \$10 budget. Adults and teens take home a bag of groceries after each class, so they can practice the recipes taught that day.

Community partners that serve low-income families offer six-week Cooking Matters courses to adults, kids and families. Share Our Strength provides seven specialized curricula that cover nutrition and healthy eating, food preparation, budgeting and shopping. Cooking Matters' culinary and nutrition volunteers teach these high-quality, cooking-based courses at a variety of community-based agencies—including Head Start centers, housing centers and after-school programs—with neighborhood locations that make it easy for families to attend.

2. **Trauma-informed care** (TIC) is a framework that requires change to organizational practices, policies, and culture that reflect an understanding of the widespread impact of trauma and potential paths for recovery, and actively seek to prevent re-traumatization. In health care, TIC usually includes universal trauma precautions and practice changes for patients with a known trauma history. Universal trauma precautions emphasize patient-centered communication and care, often with careful screening for trauma, safe clinical environments (e.g., quiet waiting areas), and shared decision making for all patients. Under a trauma-informed clinical approach, providers collaborate across disciplines, use streamlined referral pathways, and remain aware of their own trauma histories and stress levels when they know patients have experienced trauma.
3. **Cultural competence training for health care professionals** focuses on skills and knowledge to value diversity, understand and respond to cultural differences, and increase awareness of providers' and care organization's cultural norms. Trainings can provide facts about patient cultures or include more complex interventions such as intercultural communication skills training, exploration of potential barriers to care, and institution of policies that are sensitive to the needs of patients from culturally and linguistically diverse (CALD) backgrounds.

Expected Beneficial Outcomes

- Increased cultural understanding and skills

Other Potential Beneficial Outcomes

- Increased patient satisfaction
- Improved adherence to treatment
- Improved health outcomes

4. **Healthy food initiatives in food banks and food pantries** combine hunger relief efforts with nutrition information and healthy eating opportunities for low income individuals and families. Such initiatives offer clients healthy foods such as fruits, vegetables, whole grains, low-fat dairy products, and lean proteins. Healthy food initiatives can also modify the food environment via efforts such as on-site cooking demonstrations and recipe tastings, produce display stands, or point-of-decision prompts. Some food banks and food pantries establish partnerships with health and nutrition professionals to offer screening for food insecurity and medical conditions (e.g., diabetes), provide nutrition and health education, and health care support services as part of their healthy food initiatives.

Expected Beneficial Outcomes:

- Increased healthy food consumption
- Increased food security
- Improved nutrition
- Improved weight status

Cross Cutting: Action Step Recommendations & Plan

To work toward **improving health outcomes**, the following cross-cutting strategies are recommended:

1. Increase the amount of affordable housing required with new development and throughout the county
2. Provide cultural competence training for healthcare professionals and other service providers ✓
3. Increase transportation opportunities and awareness
4. Support trauma-informed health care ✓
5. Adopt healthy food initiatives ✓
6. Promote healthy eating practices through education and skill building

Action Plan

Cross-cutting Topic: Social Determinants of Health				
Strategy 1: Increase the amount of affordable housing required with new development and throughout the county				
Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Assure representation from The Partnership on the Housing Coalition.</p> <p>Utilize Collective Impact to identify housing issues that are impacting personal health.</p> <p>Identify policy or legislative changes that can impact affordable housing.</p>	<p>Cross-Cutting Outcome:</p> <ol style="list-style-type: none"> 1. Reduce percentage of county residents with high housing costs 2. Reduce severe housing problems <p>Cross-Cutting Indicator:</p> <ol style="list-style-type: none"> 1. Percent of households with monthly housing costs, including utilities, exceed 50% of monthly income (via U.S. HUD) 2. Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities (via Community Health Rankings) 	Adult, youth and child	United Way of Delaware County	December 31, 2019
<p>Year 2: Continue efforts from year 1.</p> <p>Create a strategic plan.</p>				December 31, 2020
<p>Year 3: Begin addressing strategies identified and implementing policy changes.</p>				December 31, 2021
<p>Year 4: Continue efforts of years 2 and 3.</p>				December 31, 2022
<p>Identified Assets & Resources: CHA data, Point in time count in January, "Out of Reach" Report, Delaware County Housing Coalition (chaired by Salvation Army), Region 10 Coalition, Family Promise, DelMor Dwellings, Andrews House, DACC, Habitat for Humanity, Building Industry Association, Regional Planning, Landlord Association</p>				

Cross-cutting Topic: Healthcare System and Access

Strategy 2: Provide cultural competence training for healthcare professionals and other service providers  

Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Assess county data related to demographics, determinants of health and health equity, measures of mortality, health behaviors, etc.</p> <p>Research evidence-based cultural competency training opportunities.</p> <p>Explore opportunities for a quarterly forum for social service providers to discuss agency information, policy/legislation, trends, challenges/barriers, training, etc.</p>	<p align="center">Cross-cutting Outcome: Increase cultural understanding and skills</p> <p align="center">Cross-cutting Indicator: Not currently available per Ohio SHIP</p>	<p align="center">Adult, youth and child</p>	<p align="center">Delaware General Health District</p>	<p align="center">December 31, 2019</p>
<p>Year 2: Educate/inform local businesses, organizations and health care providers on county demographics and the importance of becoming culturally competent (focuses may include: culture, language and health literacy).</p> <p>Explore needs and interest and offer trainings/workshops on cultural competence.</p> <p>Enlist 2 organizations to adopt culturally competent principles, policies and/or practices within their organization.</p> <p>Increase the number of training/workshops by 25%.</p>				<p align="center">December 31, 2020</p>
<p>Year 3: Increase the number of organizations adopting cultural competency policies by 50% from baseline.</p>				<p align="center">December 31, 2021</p>
<p>Year 4: Continue efforts of year 3.</p>				<p align="center">December 31, 2022</p>
<p>Identified Assets & Resources: CHA data, Bridges out of Poverty – STEP – Andrews House, Community Coalition (Second Ward), DGHD CLAS Plan, OWU Diversity Inclusion, Olentangy Schools Office of Diversity and Inclusion, HelpLine training for social workers, Chamber of Commerce, Greif, Local Scholars Program – all school districts, Columbus Council on World Affairs – offers global fluency training for businesses</p>				

Cross-cutting Topic: Healthcare System and Access				
Strategy 3: Increase transportation opportunities and awareness				
Action Step	Cross-cutting Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Conduct an environmental scan of all transportation opportunities, including public, regional, and private. Collect information regarding eligibility of services, cost, and other relevant information.</p> <p>Assure representation from The Partnership on the Transportation Advisory Committee.</p> <p>Research alternative transportation opportunities such as ride share, park and ride, biking/walking, Uber/Lyft.</p>	<p>Cross-cutting Outcome: Increase access to transportation opportunities</p> <p>Cross-cutting Indicator: None identified</p>	<p>Adult, youth and child</p>	<p>Delaware Area Transit Agency (DATA)</p>	<p>December 31, 2019</p>
<p>Year 2: Disseminate information regarding transportation opportunities in Delaware County.</p> <p>Target businesses and agencies that serve at-risk populations, as well as seniors.</p>				<p>December 31, 2020</p>
<p>Year 3: Continue awareness marketing and research into alternative transportation opportunities as they become available.</p> <p>Continue efforts from years 1 and 2.</p>				<p>December 31, 2021</p>
<p>Year 4: Continue efforts from years 1, 2 and 3.</p>				<p>December 31, 2022</p>
<p>Identified Assets & Resources: CHA data, DATA bus ridership data, DATA bus, Transportation Advisory Committee, DATA link with COTA, SourcePoint partnership with Lyft, Complete Streets policies</p>				

Cross-cutting Topic: Healthcare System and Access

Strategy 4: Support trauma-informed health care 

Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Obtain baseline of the number of trauma informed care trainings which have been administered within the county.</p> <p>Expand awareness and understanding of trauma informed care, including toxic stress and adverse childhood experiences, and secondary trauma. Focus specifically on large businesses and day-care staff.</p> <p>Implement the trauma informed care pre-assessment to participating organizations. Administer a training to increase education and understanding of trauma informed care to at least 2 organizations.</p>	<p align="center">Cross-cutting Outcomes:</p> <ol style="list-style-type: none"> 1. Reduce suicide ideation in adults 2. Reduce suicide ideation in youth <p align="center">Cross-cutting Indicators:</p> <ol style="list-style-type: none"> 1. Percent of adults who seriously considered attempting suicide in the past 12 months 2. Percent of youth who seriously considered attempting suicide in the past 12 months 	<p align="center">Adult and youth</p>	<p align="center">Delaware-Morrow Mental Health & Recovery Services Board</p>	<p align="center">December 31, 2019</p>
<p>Year 2: Continue to market and offer trainings.</p> <p>Implement the trauma informed care post-assessment to participating organizations.</p>				<p align="center">December 31, 2020</p>
<p>Year 3: Continue efforts from years 1 and 2. Enlist additional organizations to participate in the training.</p>				<p align="center">December 31, 2021</p>
<p>Year 4: Continue efforts of year 3.</p>				<p align="center">December 31, 2022</p>
<p>Identified Assets & Resources: Delaware-Morrow Mental Health & Recovery Services Board, school counselors (DACC holds regular counselor meetings), superintendents and principals, Strengthening Families</p>				

Cross-cutting Topic: Public Health System, Prevention and Health Behaviors

Strategy 5: Adopt healthy food initiatives  ✓

Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Work with the Hunger Alliance to increase awareness of available food pantries within the county. Continue to update GIS maps for location information on a quarterly basis.</p> <p>Research and create a campaign to decrease the stigma associated with obtaining pantry services.</p> <p>Recruit additional stakeholders, especially businesses, to join the Hunger Alliance. Invite stakeholder to a Hunger Alliance meeting.</p>	<p>Cross-Cutting Outcomes: Reduce food insecurity</p> <p>Cross-Cutting Indicators: Percent of adults who had experienced at least one food insecurity issue in the past year</p>	Adult, youth and child	Delaware County Hunger Alliance	December 31, 2019
<p>Year 2: Continue to market food pantries within the county. Address strategies to target the number of “unique” individuals receiving pantry services.</p> <p>Increase the number of locations offering food insecurity screening and referrals and continue to educate participating locations on existing community resource.</p>				December 31, 2020
<p>Year 3: Continue efforts of years 1 and 2.</p>				December 31, 2021
<p>Year 4: Continue efforts of years 2 and 3.</p>				December 31, 2022
<p>Identified Assets & Resources: Delaware County Hunger Alliance partners</p>				

Cross-cutting Topic: Public Health System, Prevention and Health Behaviors

Strategy 6: Promote healthy eating practices through education and skill building

Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
<p>Year 1: Continue to implement the Share Our Strength’s Cooking Matters program to eligible adults and families through OWU.</p> <p>Begin to implement the Cooking for Wellness program to adults and families through Cancer Support Community Central Ohio.</p> <p>Work with at least one new organization, specifically outside of Delaware City, such as a senior center or community center.</p> <p>Determine gaps and potential strategies to address those with mobility or transportation issues.</p> <p>Measure knowledge gained, and skills utilized through evaluations.</p>	<p>Cross-Cutting Outcomes:</p> <ol style="list-style-type: none"> Increase adult fruit/vegetable consumption Increase youth fruit/vegetable consumption Increase child fruit/vegetable consumption <p>Cross-Cutting Indicators:</p> <ol style="list-style-type: none"> Percent of adults who consumed whole fruit/vegetables less than one time daily Percent of youth who consumed whole fruit/vegetables less than one time daily Percent of children who consumed whole fruit/vegetables less than one time daily 	<p>Adult, youth and child</p>	<p align="center">Ohio Wesleyan University (Lead)</p> <p>Cancer Support Community Central Ohio</p> <p>Tracey Sumner</p>	<p align="center">December 31, 2019</p>
<p>Year 2: Continue to market and implement cooking classes, including demonstrations at local food pantries.</p> <p>Explore opportunities to offer grocery store tours.</p> <p>Measure knowledge gained, and skills utilized through evaluations.</p>				<p align="center">December 31, 2020</p>
<p>Year 3: Continue efforts from years 1 and 2.</p>				<p align="center">December 31, 2021</p>
<p>Year 4: Continue efforts of year 3.</p>				<p align="center">December 31, 2022</p>
<p>Identified Assets & Resources: OWU, Cancer Support Community Central Ohio, Delaware County Hunger Alliance, SNAP at farmer’s markets, school district hospitality programs (DACC), Andrews House – STEP meals, township buildings have kitchens, Grace Clinic waiting room</p>				

Progress and Measuring Outcomes

The progress on outcomes and indicators identified for each strategy under each priority will be monitored. Most indicators align directly with the SHIP. The organizations and individuals that are working on action steps will meet on an as needed basis. The full Partnership will meet quarterly to report out the progress. The Partnership will form a plan to disseminate the Community Health Improvement Plan to the community. Action steps, responsible agencies, and timelines will be reviewed at the end of each year by The Partnership. Edits and revisions will be made accordingly.

Delaware County will continue facilitating full Community Health Assessments in 2022 and thereafter every six years to collect and track data. However, the Youth Youth Risk Behavior Survey for middle and high-school aged youth will be conducted every three years. Primary data will be collected for adults, youth, and children using national sets of questions to not only compare trends in Delaware County, but also be able to compare to the state, the nation, and Healthy People 2020. This data will serve as measurable outcomes for each of the priority areas. Indicators that will be tracked by the state have already been defined throughout this report and are identified with the  icon.

In addition to outcome evaluation, process evaluation will also be used on an ongoing basis to focus on how well action steps are being implemented. Areas of process evaluation that The Partnership will monitor will include the following: number of participants, location(s) where services are provided, number of policies implemented, economic status and racial/ethnic background of those receiving services (when applicable), and intervention delivery (quantity and fidelity).

Furthermore, all action steps will be incorporated into a progress report template that can be shared at all future Partnership for a Healthy Delaware County 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:

Delaware General Health District

Community Health Division
1-3 W. Winter St.
Delaware, OH 43015
(740) 368-1700

Appendix I: Links to Websites

Title	Link
Be Present Campaign	https://bepresentohio.org/
Cell phone-based support programs	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/cell-phone-based-support-programs
Community-based comprehensive program(s) to reduce alcohol abuse	http://pire.org/communitytrials/index.htm
Community-based Social Support for Physical Activity	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/community-based-social-support-for-physical-activity
Community-Clinical Linkages for the Prevention and Control of Chronic Diseases	https://www.cdc.gov/dhds/pubs/docs/ccl-practitioners-guide.pdf
Community Guide	https://www.thecommunityguide.org/topic/health-equity?field_recommendation_tid=7476&items_per_page=All
Community Trials Intervention to Reduce High Risk Drinking	http://pire.org/communitytrials/index.htm
Cooking Matters (No Kid Hungry Center for Best Practices)	https://cookingmatters.org/courses
Cultural competence training for health care professions	http://countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/cultural-competence-training-for-health-care-professionals
Culture, language and health literacy	https://www.hrsa.gov/cultural-competence/index.html
CureStigma	https://www.curestigma.org/
Department of Health and Human Services Task Force on Best Practices for Pain Management	https://www.hhs.gov/ash/advisory-committees/pain/index.html
Diabetes Prevention Program (DPP)	www.cdc.gov/sixteen/docs/6-18-evidencere-summary-diabetes.pdf
Diabetes Risk Assessments CDC and American Diabetes Association (ADA) questionnaires	https://www.cdc.gov/diabetes/prevention/lifestyle-program/deliverers/screening-referral.html
Food insecurity screening and referral	www.aappublications.org/content/early/2015/10/23/aapnews.20151023-1
Food pantries	www.countyhealthrankings.org/policies/healthy-food-initiatives-food-banks

Title	Link
Healthy Food initiatives in food banks and food pantries	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/healthy-food-initiatives-in-food-banks
Healthypeople.gov	https://www.healthypeople.gov/
Hospital Council of Northwest Ohio	http://www.hcno.org/
Master list of SHIP indicators	http://www.odh.ohio.gov/sha-ship
Mental Health First Aid	http://www.mentalhealthfirstaid.org/cs/
Ohio Positive Behavioral Interventions and Supports (PBIS)	http://education.ohio.gov/Topics/Other-Resources/School-Safety/Building-Better-Learning-Environments/PBIS-Resources
ORC 3313.60	http://codes.ohio.gov/orc/3313.60
Partnership Roster	https://app.smartsheet.com/b/home
Patient Health Questionnaire (PHQ-9)	http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf
Policies to decrease availability of tobacco products	http://tobaccocontrolnetwork.org/wp-content/uploads/2016/07/TCN-2016-Policy-Recommendations-Guide.pdf
Prediabetes Risk Assessment	http://www.diabetes.org/are-you-at-risk/diabetes-risk-test/
Prevent Diabetes STAT Toolkit	https://preventdiabetesstat.org/index.html
School-based violence prevention programs	https://www.cdc.gov/policy/hst/hi5/violenceprevention/index.html
Screen for clinical depression for all patients 12 or older using a standardized tool	https://www.integration.samhsa.gov/clinical-practice/screening-tools#depression
Screening, brief intervention, and referral to treatment (SBIRT)	http://www.integration.samhsa.gov/clinical-practice/sbirt
Signs of Suicide (SOS)	https://mentalhealthscreening.org/programs/sos-signs-of-suicide?gclid=Cj0KCQjwof3cBRD9ARIsAP8x70MNRFtoLRbFK-peYeNsrihL9sxoAKVyXoEKAvkVoF7-XbUB_33rZNIaAsLgEALw_wcB
Surgeongeneral.gov	https://www.surgeongeneral.gov/priorities/prevention/strategy/index.html#The%20Priorities
Telemedicine	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/telemedicine
The 10 Essential Public Health Services	https://www.cdc.gov/stltpublichealth/nphps/index.html
The PHQ-9	http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression
Tobacco 21	https://tobacco21.org/
Too Good for Drugs	http://www.mendezfoundation.org/
Trauma-informed care	http://www.countyhealthrankings.org/policies/trauma-informed-health-care

Title	Link
Universal school-based suicide awareness and education programs	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/universal-school-based-suicide-awareness-education-programs
Universal school-based violence prevention programs	https://www.cdc.gov/policy/hst/hi5/violenceprevention/index.html
What Works For Health	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health