Clark County, Ohio

Community Health Improvement Plan 2013

Partial Report – Priorities and Work Plans

Introduction

The Community Health Improvement Plan (CHIP) was developed through the leadership of the Clark County Combined Health District, Springfield Regional Medical Center, Rocking Horse Community Health Center and more than 45 community representatives from various organizations. These organizations partnered to assess the community's health via rigorous data analysis and to develop evidence-based solutions in response to findings.

This summarization is intended to be part of the full Community Health Improvement Plan Report, and focuses on the priorities selected for the CHIP, as well as the action plans as stated in 2013.

Additional detail of the process can be obtained through contacting the Clark County Combined Health District, 529 East Home Road, Springfield, OH 45503; (937) 390-5600.

Priorities Selected

The task forces were organized in accordance with the five strategic priorities:

1. Healthy Births and Sexuality—Identify and engage pregnant women in first trimester prenatal care
2. Obesity—Implement a multi-dimensional, school-wide, evidence-based program to address youth obesity issues
3. Chronic Disease Management—Improve access to care and optimize health care resources.
4. Mental Health—Promote the mental health and wellbeing of youth in Clark County for the near- and long-term.
5. Substance Abuse—Mobilize a community coalition to address substance use issues in Clark County.

The Steering Committee had been told from the beginning that identifying three to five priorities rather than ten or twenty priorities would engender success. Therefore, each task force was charged to identify one top priority health issue for the Plan.

Task forces began their work by reviewing the Community Health Assessment Data for their topic area and then carrying out the other three MAPP Assessments. After completing the assessments, task force members reflected on the themes uncovered and then brainstormed the challenges and solution areas. In each task force, many health issues were generated and considered against the same decision criteria described earlier. From this effort, the top priority issue was defined for each task force. Then Wright State University conducted evidence based practice research to recommend solutions, primarily using the following sources:

- The Guide to Community Preventive Services: http://thecommunityguide.org/index.html
- Cochrane Collaboration: http://www.cochrane.org/
- Cochrane Public Health Field Review: http://www.vichealth.vic.gov.au/cochrane/
- Community Toolbox: http://ctb.ku.edu/en/promisingapproach/databases_best_practices.aspx

- Healthy People 2020: http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx
- National Governor's Association Center for Best Practices: http://www.nga.org/portal/site/nga/menuitem.50aeae5ff70b817ae8ebb856a11010a0/
- Partnership for Prevention: http://www.prevent.org/
- Promising Practices Network: http://www.promisingpractices.net/
- U.S. Preventive Services Taskforce: http://www.ahrq.gov/clinic/uspstfix.htm
- Network of Care: http://networkofcare.org

The narrative below will present the original brainstormed list developed by each task force, then the rationale for selecting their top priority issue.

Healthy Births and Sexuality Task Force Discussions and Decisions

Original discussion of need

Communication/Education/Prevention

- How do we empower our moms? How do we get the information about services into the right hands? (We thought that the FQHC OB clinic was going to be the solution to pregnant mom needs but pregnant moms are still showing up in the ER and hospital for care.)
- How do we communicate the services that are available to the agency professionals as well as to potential clients?
- To affect better birth outcomes and sexuality, we have to have more focus on prevention--education; what information is available to our teens? What is our community open to?

Reproductive Health Curricula

- Two foci--prevention and what to do after you become pregnant
- Sexuality programs--it would be interesting to know what the outcomes are of the two different reproductive Health education programs developed by the LHD and its partners (one conservative and one liberal curriculum)
- Take the Reproductive Health programs developed for the urban school district to other school districts in the County
- Create a parent education course and disseminate it in the "learning cafe"

Priority Issue Selected

Prenatal care, especially in the first trimester

The gap analysis uncovered the need for better outreach to pregnant women to get them to the FQHC's OB program. A concerning proportion of pregnant women delay prenatal care, and this trend is especially evident among the growing Spanish speaking-only households, where it is not uncommon for pregnant women to get a confirmation of pregnancy at 4-6 months. There are several reasons why pregnant women may not be seen for first trimester care.

- The observation that some Hispanic women did not seem to understand the importance of beginning prenatal care early and attending regular visits
- Many pregnant women work or depend on a working person for transportation.
- There may be a shortage of evening and weekend appointment times.
- Uninsured patients had difficulty paying for ultrasounds and other prenatal testing.
- Very young women deny they are pregnant or they seem not to want to deal with it
- Some women think that their total cost of the birth of the child will be reduced if they see the doctor less. Women don't realize that they would have been eligible for services within the delivery cost.
- The culture thinks you go to prenatal care when something is wrong or in the last trimester. There is a generational lack of understanding of a wellness approach to childbirth.
- Lack of awareness of the Rocking Horse Center (FQHC) OB clinic

Obesity Task Force Discussions and Decisions

Original discussion of need

"Switch--how to make change when change is hard." Historically, the community takes on projects that are multifaceted. Perhaps there could be more change if we pick one focus at a time. Helping people to see the value in better diet and exercise, e.g., can avoid knee replacements; can eliminate meds due to better health. What do people already value? Understanding what people already value will help inform the approach.

Research how to motivate change.

Work with the Promise Neighborhoods and the community leaders, building upon those relationships, to determine what people value.

Is a partnership with the schools to reduce obesity and increase physical activity possible? Hospitals would be interested in partnering. This could build on the work already being done with Springfield schools where BMI is measured. --This is where we have a willing partner, with existing relationships with public health. Find the impactful interventions that change behaviors. School cafeteria changes--like eliminating soda machines. Some schools are better than others in offering good foods. (CATCH program is possible.) This will take manpower; resources; and multiple partnerships. How do we engage volunteers such as using senior volunteers?

Priority Issue Selected

The Obesity Task Force determined that a core criterion for their decision was prevention, and therefore their focus is on youth in schools, which also engages parents, via a multidimensional, school-wide, child health evidence-based program.

The competency and capacity assessment revealed that in Clark County, the Health Department measures BMI for the City Schools and conducts a youth risk behaviors survey. Data show that the overweight and obesity problem is worsening. There are many school-based obesity prevention programs being carried out across the country. The strengths assessment pointed out the important

coordination role of the Springfield Promise Neighborhoods given its strong relationships with the schools and the neighborhoods. The Task Force prefers presenting the various programs, which have an evidence base of effective outcomes, to school representatives and allowing them to select the program that best suits the school. The Task Force reviewed the "Just for Kids!" program, the CDC's CATCH program, and the Annapolis Valley Health Promoting School Project among other evidence-based programs.

- Just For Kids! was adapted from the SHAPEDOWN Pediatric Obesity Program, the nation's leading weight management program for children and adolescents. SHAPEDOWN is currently offered in over 400 hospitals, HMO's and clinics, and by hundreds of health professional private practitioners providing pediatric obesity care to families nationwide.
- CATCH stands for a Coordinated Approach To Child Health and is an evidence-based, coordinated school health program designed to promote physical activity, healthy food choices and the prevention of tobacco use in children. The CATCH Programs cover kids from preschool through 8th grade and has been implemented in thousands of schools and after-school organizations across America and Canada. For 25 years, the CATCH Programs have guided kids on how to be healthy for a lifetime and it is now the #1 health promotion and childhood obesity prevention program available.
- Annapolis Valley Health Promoting School Project (AVHPSP): Schools are the voice and the leaders in the program. Health Promoting School Teams are formed at each school. These are comprised of a cross-section of people including school staff, food service workers, students, parents, Public Health staff and community members (e.g. recreation directors). Their purpose is to assess needs and develop a plan for their school. At the high school level where Youth Health Centers are being established, the vision is that health promotion will be part of the Youth Health Centre role.

Chronic Disease Management Task Force Discussions and Decisions

Original discussion of need

<u>Diabetes Care</u>

Idea: Reduce the number of County residents obtaining their diabetes care from the hospital Emergency Department.

- Make diabetes education more accessible by establishing satellite offices of the hospital's Diabetes clinic (e.g., establishing an office at the Rocking Horse Center).
- Identify resources to take to scale the Exemplary project that was implemented by the hospital's Diabetes clinic, which focused on 10 diabetes patients in which the A1C test results improved and there was no admission to ED in the following year.

Idea: Maximize the use of donated diabetes supplies.

- Obtain a special licensure to distribute diabetes supplies and coordinate the distribution of supplies and other resources that are donated.
    - Identify a location in Springfield that can accept supplies. If pharmacies have nearly expired medicines, assign a place where they can donate (testing strips, insulin).

- Establish a "Giving Circle"[1] or some other donor fund so that dollars that are donated to Diabetes stay in the County rather than going elsewhere.

Diabetes Prevention

Idea: Provide screening and education to those with pre-diabetes (aka borderline diabetes), with education pertaining to both adults and youth.

- Borrow best practices from the National Diabetes Prevention Program and the Ohio Diabetes Prevention and Control Program.
- Obtain and disseminate information to pediatricians about the Lipid Clinic at Dayton Children's. Disseminate information from the American Academy of Nutrition and Diabetics to address youth obesity.
- Could the Medical Society fund this initiative? (Sources of funds are needed because pre-diabetes is not well covered by insurance.)

Chronic Disease and Indigent Care

Idea: Engage active and retired health professionals in contributing their time and talents locally toward establishing a free clinic in Clark County.

- Partner with the Medical Society and/or other associations of health professionals.
    - Learn more about physicians' perspectives regarding who meets the needs of the uninsured who have chronic needs.
    - Outreach to other health professionals--nurses
    - Clark County Medical Society may be a means of contacting retired physicians; consider partnership with Medical Society
    - Develop and use a HIEx type tracking system so as to measure the number of indigent individuals served.

Priority Selected

Chronic disease management—providing community education about what Medicaid expansion will mean for Clark County and especially its vulnerable populations, and clarifying and formalizing roles within the local public health system (LPHS) to get the word out and provide the necessary Medicaid enrollment assistance.

There are great forces of change that can have a bearing on chronic disease, including Medicaid changes through the Affordable Care Act and medical home policies being elevated at the State and federal levels. At the same time, changes in legislation resulting in less reimbursement for all of health care—for example, chemotherapy and radiation therapy; mean that more people are seeking treatment at the hospital. The hospital has programs to obtain lower cost medicines, but those options are not limitless.

[1] Giving circles are a form of philanthropy where groups of individuals donate their own money or time to a pooled fund, decide together where to give these away to charity or community projects and, in doing so, seek to increase their awareness of and engagement in the issues covered by the charity or community project. Many circles, in addition to donating their money, also contribute their time and skills to supporting local causes.

The hospital is also negotiating with physicians to provide free screenings, but what is done when diseases are found is another funding challenge.

The Task Force determined that there are many challenges in serving people with chronic diseases, but the most important aspect was determined to be managing the chronic disease. Many individuals who are eligible for Medicaid are not enrolled. Connecting with hard-to-reach, underserved populations to improve access to preventive and primary health care is a tall challenge and a priority concern given the possible Medicaid expansion on the horizon. Therefore, the goal and strategy are to improve access to care and optimize health care resources, by providing community education about what Medicaid expansion will mean for Clark County and defining the roles and responsibilities of the lead agencies in accomplishing the strategy.

Mental Health Task Force Discussion and Decisions

Original discussion of need

Can we agree that the County is working with the state with the medical MH home and managed care, so can we agree to focus on prevention?

<u>The prevention ideas:</u>

1. GBG (good behavior game)
2. Telepsych with children—the Hospital is the local expert on this.
3. Education with first responders--what are other options than going to hospital or not.
4. What are the best interventions and partnerships for serving that top 5-10% of youths that have need of mental health services? Another way of stating this is how does the community best engage chronic crisis families? Youth are presenting with more complex issues today, both physical and mental. The goal is for collaboration between the schools and mental health agencies to impact early in the child's life. Schools know where the need is, but don't have the resources to adequate treatment services with the most severe cases. Schools have good information about where the need is because they have been applying Positive School Climate and Search Institute model programs.

Priorities Selected

Mental Health (first strategy)—promoting the mental health and wellbeing of youth in Clark County for the near and long-term

The first goal is to promote the mental health and wellbeing of youth in Clark County for the near- and long-term. “The 2009 Report on the Prevention of Mental, Emotional and Behavioral Disorders from the Institute of Medicine represents a watershed in prevention research.” “One of the scientific findings singled out in the report involved the Good Behavior Game, (IOM, pages 158, 184, 209, 284).”

The Game is not a program that involves lessons that take up valuable curriculum time. Rather the Game is a “behavioral vaccine” or routine that is used every day. “The Good Behavior Game can be prescribed and reimbursed under health-care reform (both for Medicaid and private insurance), because

it is highly effective in preventing DSM-IV disorders or reducing the symptoms of DSM-IV disorders as well as or better than psychotropic medications (which have many adverse consequences and wear off in time). The potential of the Good Behavior Game to significantly impact rising costs of psychotropic medications for disturbing, disruptive and inattentive behavior and to reduce the abuse of stimulant drugs is quite large. It is noteworthy that the Good Behavior Game is one of the few things ever recorded to prevent suicide in later life. Thus, the Game has proven prevention effects for mental illness, school failure, substance abuse, adolescent and adult crime, suicide, violent crime as well as increasing high-school graduation and college entry in exemplary research studies cited by the IOM Report."[2]

Mental Health (second strategy)—redirecting EMS frequent users to appropriate care and reducing 911/EMS overuse and redirect those resources to where they are more effective

Data analysis shows that an inordinate number of EMS calls come from a very few number of people. The strategy is to establish a better clinical pathway management model to address the root causes of the frequent calls.

Substance Abuse Task Force Discussion and Decisions

Original discussion of need

Idea: formalize a substance abuse prevention and treatment coalition

- Organize the data—we need to calculate the rates of substance abuse by different demographic cohorts so that we know which populations to target and so we can assess where we can be most effective.
- Obtain more training opportunities so that substance abuse therapists obtain the credentials they need (certifications are currently lacking to meet the need).
- Obtain foundation support to provide scholarships to therapists to pursue certifications.
- Inventory the types of evidence based programs being implemented in Clark County.

Idea: focus on prevention modeling practices from the *Strategic Prevention Framework*[3] to assess community readiness, determine resources available, and to develop a data-driven method.

The Strategic Prevention Framework (SPF) uses a five-step process known to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the life span.

[2] http://www.ncbi.nlm.nih.gov/pubmed/12495270

[3] Another model program is *Drug free coalitions* funded by SAMHSA. Communities must provide substantial local match. A neighboring county has a 5-year $500k grant that they had to match dollar for dollar.)

- Convey the message that substance abuse prevention is the job of the whole community. Begin with education and a stigma reduction campaign, as a means toward community engagement.
- Determine a means of informing youth that if parents have drug and/or alcohol dependency, the child is at risk. Children should know the science of that risk factor.
- Assess prevention needs based on epidemiological data
- Build prevention capacity
- Implement effective community prevention programs, policies and practices, and evaluate outcomes.

Idea: Focus on treatment.

- The County is facing a crisis due to trends in the increase in opiate and other substance abuse, complicated by long-term declines in state and federal funding support for treatment services.
- Obtain sufficient funding support so that anyone motivated to seek treatment in response to opiate addiction immediately receives the treatment services needed.
- Ramp up the use of the Consumer Advocacy Model (CAM) for substance abuse treatment for those not severely addicted. CAM is a unique program offered by Wright State University.
- Address the misinformation about suboxone by educating the treatment and health care providing community about the ODADAS low-dose protocol procedures to address the problems of over-prescribing suboxone.
- Address the need for more substance abuse therapists. Clark County is a Health Professionals Shortage Area (HPSA).
- Train physicians, like ER doctors, about the Ohio Automated Rx Reporting System: OARRS and other issues such as the coordination of patients' prescriptions when multiple doctors are involved.

Priority Selected

Substance abuse prevention—following SAMHSA's evidence-based Strategic Prevention Framework guidance to mobilize a community prevention coalition

Clark County, like many communities in the country, is experiencing an increase in the use of heroin among other substance abuse trends. The community determined that the primary barrier to improving substance abuse prevention strategies is the overall lack of capacity in the County. To get to the point of targeting the highest priority strategies, the community first needs to build data collection and analysis capacity. Such capacity will enable the community to make a firm case for the need for more resources, then to obtain additional professionals, and to be able to prioritize and disseminate effective prevention interventions. In terms of community strengths, there is wide community support to follow the Strategic Prevention Framework and to pursue participation by the 12 partnering sectors recommended by SAMHSA.

Implementation Plan

The following goals and strategies are organized according to the five strategic areas.

Strategic Issue: Healthy Babies and Sexuality		
Goal: Identify and engage pregnant women in first trimester prenatal care.		
Indicators/Outcome	**Source**	**Resources**
12-month indicator: Develop a uniform message for all agencies to use (for both positive and negative pregnancy tests)	Annual progress report	Strat 1: In-kind & cost of marketing materials. Strat 2: $50,000+
24-month indicator: Time to assess capacity to meet the need that may grow as a result of better education and communication	Annual progress report	
Longer-term outcome: Healthier babies	LHD Birth Data	
Strategy 1: Increase the focus on outreach and education about early signs of pregnancy, and ways to improve access to pregnancy testing.		
Partnering Agencies: Clark County Combined Health District including its WIC program, Community Mercy Health Partners, the Community Foundation, the Pregnancy Resource Center, Clark County Department of Job and Family Services, Springfield's Women's Network, and Planned Parenthood Policy Component (Y/N): No		
Action Plan	Target Date: 2014	Lead Organization: Clark County Combined Health District's WIC Program
Action 1: Inventory the list of those agencies and/or programs that provide pregnancy tests and those who first come in touch with the target population. CCCHD will take the lead on this.		
Action 2: Help the community as well as teens to understand the need for prenatal care.		
Action 3: Develop a deepening and sustained relationship with the schools so that education about abstinence, contraception, pre-conception care, and prenatal care is delivered.		
Action 4: Engage Primary Care Providers in educating teens (beginning at about the age of 15).		
Strategy 2: Gradually build capacity to serve women if strategy 1 is successful.		
Source/Evidence Base: The Patient Navigator Program Policy Component (Y/N): No		
Action Plan	Target Date:	Lead Organization:
Action 1: Add capacity to the Patient Navigator Program. It currently has 2 full time community health workers and a half time worker to address the Hispanic population. To enable that program to serve other populations than the current grant funding allows, the program would need to add one community health worker. To enable the program to reach as many non-minority women as minority women, the program would need a $200,000 annual investment.		

Strategic Issue: Obesity Prevention		
Goal: Change school culture to impact child and family wellness by increasing knowledge about healthy food and exercise choices and modifying systems and programs that can aid such choices in the school.		
Indicators/Outcome	**Source**	**Resources**
12-month indicator: Select an evidence-based program to address nutrition and exercise in one school. Increased vegetable and fruit consumption and the amount of exercise, along with physical (such as BMI or better) measurements--pairing the pre and post results so that the school begins to see BMI reduction in the selected cohort(s)	Clark County Combined Health District will provide the BMI or better measure	The Ohio State University Cooperative Extension Service will offer 10 hours per week of time to provide health education to youth after school. Seek funding from the Foundation Forum. YMCA to provide space or incentives, and lead monthly meetings. Community Mercy Health Partners could provide space, dietetics specialists, and the hospital foundation may be pursued. CCCHD to provide data and evaluation support.
24-month indicator: Target activities to families with things like family walking clubs, healthy cooking. Holding a Recognition Ceremony at the end of year one is one means to engage parents.	Annual progress report	
Longer-term outcome: Test the efficacy of the program and take it to next level if results merit that, which would be taking it from one school to a school district. If this is effective, then the partners will look to see how they can align more resources.	Annual progress report	
Strategy: Implement a child health, multi-dimensional, school-wide, evidence-based program in Lincoln Elementary as a pilot program to determine what works and then scale up to additional schools.		
Partnering Agencies: Springfield Promise Neighborhoods, The OSU Cooperative Extension Service, Community Mercy Health Partners, Clark County Combined Health District (CCCHD), the YMCA, and the School Evidence-based Practice: Yes, the program selected will be from among EBP such as the CDC's CATCH Program, Just For Kids!, or Annapolis Valley Health Promoting School Project (AVHPSP) Policy Component (Y/N): Yes, school food program policies will need to be reviewed and possibly revised		
Action Plan	Target Date: 2014	Lead Organization: The Promise Neighborhood
Action 1: Establish a community-wide partnership with the selected school.		
Action 2: Establish a data baseline so that results can be measured.		
Action 3: Select a program that benefits all students like a community garden, family walking club, etc.) with some elements that support a cohort of students to embed peer support.		
Action 4: Engage all partners.		

Strategic Issue: Chronic Disease Management		
Goal: Improve access to care and optimize health care resources.		
Indicators/Outcome	**Source**	**Resources**
12-month indicator: Have a plan in place to assess eligibility and enroll people in Medicaid. Establish a method to track the impact of having more organizations and professions recognizing, agreeing to, and supporting the plan	Annual progress report	In-kind contributions of time; Clark County Combined Health District fund BRFSS
24-month indicator: Federal dollars coming into the community to support health care services are maximized	Annual progress report	
Longer-term outcome: Health homes for Medicaid beneficiaries with chronic conditions	Adult BRFSS	
Strategy 1: Provide community education about what Medicaid expansion will mean for Clark County.		
Partnering Agencies: Hospital (including physicians groups and the ER), the Rocking Horse Center (which is the FQHC), the CCCHD to assure access to care for the County's population, and the County Department of Job & Family Services Evidence-based Practice: Be alert to practices that will be studied by Enroll America Policy Component (Y/N): Internal policies to enable a joint effort among partnering agencies may have to be addressed		
Action Plan	Target Date: 2013-ongoing	Lead Organizations: Hospital, FQHC, and CCCHD
Action 1: Use national PR campaign material locally to convince people to sign up for Medicaid so they have a Medical home (physician) and get preventive care. The idea is that a patient will have a physician before an event occurs that requires an ER visit or admission that could have been prevented. Even after new beneficiaries are signed up, there are difficulties enrolling very low-income adults and keeping them enrolled, in part because some of them have "transient housing and other unstable social circumstances." The use of "culturally and linguistically competent outreach conducted through community-based providers" is considered a best practice.		
Action 2: Promote the Rocking Horse Center (FQHC) resources.		
Action 3: Conduct physician education so that physicians refer Medicaid eligible clients to the FQHC, because its Medicaid reimbursement rate is more favorable.		
Strategy 2: Articulate the role of lead agencies in the community that have a bearing on the goal.		
Action Plan	Target Date: 2013	Lead Organization: Hospital, FQHC, and CCCHD
Action 1: Define an agreed-upon role for the FQHC (e.g., supporting the FQHC and directing Medicaid patients to the FQHC as increases in capacity at the Rocking Horse Center allow)		
Action 2: Define the role of health professionals.		
Action 3: Define the role of the Department of Job and Family Services in directing people to care since that is where an individual will go to sign up for Medicaid. Ensure that assistance in completing paperwork. DJFS may also have an estimate of the number of people who would become eligible for Medicaid under Medicaid expansion in Clark County. DJFS has three people at the FQHC to determine Medicaid eligibility.		

Action 4: Define the role of the Hospital and its physicians who have taken a leadership role in speaking out about care for the uninsured. The Hospital medical assistants can identify patients who are newly eligible for Medicaid and could assist them with paperwork. The Hospital ER can identify ER patients who are newly eligible for Medicaid and help patients sign up so they have a medical home. The Hospital can do the same for inpatients.

<table>
<tr><th colspan="3">Strategic Issue: Mental Health Wellbeing</th></tr>
<tr><td colspan="3">Goal 1: Promote the mental health and wellbeing of youth in Clark County for the near- and long-term.</td></tr>
<tr><td>Indicators/Outcome</td><td>Source</td><td>Resources</td></tr>
<tr><td>12-month indicator: Significant reduction of externalizing problems at the end of the academic year for participating schools. GBG has a data package and districts/partnerships will be required to use that. Do want to be able to see office disciplinary and nurse data -- data collection points can be defined.</td><td>GBG data package implemented by the school(s)</td><td rowspan="3">The cost per school building is estimated to be $5000 for the toolkit, teacher training, and coaching.
In July of 2011, the renowned Washington State Institute for Public Policy reported on return on investments for evidence-based options to improve state-level protective and prevention outcomes. Among all general prevention programs, the Good Behavior Game is the single most cost-efficient strategy, returning $96.80 per dollar spent. The net benefit to the child for his or her lifetime is $10,371 and $4,137 for the taxpayers (see http://www.wsipp.wa.gov/rptfiles/11-07-1201.pdf).
Nearby in Greene County, Anya Senetra, is a National PAX GBG Trainer. The fact that Wright State University is integrating PAX/GBG into its curriculum means that schools will not have to invest in training for those teachers that it hires from the Wright State program</td></tr>
<tr><td>24-month indicator: More schools participating.</td><td>Annual progress report</td></tr>
<tr><td>Longer-term outcome: Participating students will have substantially lower prevalence of smoking, alcohol abuse, and drug use; and will have higher rates of high school completion.</td><td>Youth Risk Behavior Survey carried out by the CCCHD</td></tr>
<tr><td colspan="3">Strategy: Implement the Good Behavior Game (GBG) eventually in all school buildings in Clark County.</td></tr>
<tr><td colspan="3">Partnering Agencies: School Districts and MHRB. Later a kernels training program for all agencies that work with children, Promise Neighborhoods, CCCHD, Wright State University (because it is integrating PAX/GBG into its teacher education curriculum)
Evidence-based Practice: The 2009 Report on the Prevention of Mental, Emotional and Behavioral Disorders from the Institute of Medicine represents a watershed in prevention research.” “One of the scientific findings singled out in the report involved the Good Behavior Game, (IOM, pages 158, 184, 209, 284).”
Policy Component (Y/N): Yes, school policies will likely be affected</td></tr>
<tr><td>Action Plan</td><td>Target Date: 2014/2015</td><td>Lead Organizations: School Districts and the Mental Health & Recovery Board of Clark, Greene & Madison Counties</td></tr>
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Action 1: Create Nurturing Environments – The umbrella under which GBG stands		
Action 2: Use Kernels (fundamental units of behavioral influence that underlie effective prevention and treatment for the most common and costly problems of behavior and an increase in the prevalence of wellbeing).		
Goal 2: Redirect EMS frequent users to appropriate care and reduce 911/EMS overuse so as to direct resources to where they are more effective.		
Indicators/Outcome	**Source**	**Resources**
12-month indicator: Hospital and EMS data exchange process is developed	Annual progress report	In other communities there are substantial cost savings (e.g., Houston, Texas saved over $4 million dollars; San Diego saved $314,306 over two years). Estimates for Clark County show that 27 frequent users cost about $84,000 annually
24-month indicator: Data exchange system is implemented; clinical pathway management model is developed	Annual progress report	
Longer-term outcome: clinical pathway management model is implemented saving the County about $80,000 annually	Annual progress report & law enforcement EMS cost data	
Strategy: Develop and implement a Hospital/Clinic-EMS data exchange and a better clinical pathway management model.		
Partnering Agencies: Law enforcement including the Sheriff and City Police, the Fire Departments, courts, behavioral and homeless outreach teams, social workers, case managers, and housing providers along with primary care, home health, palliative care, and Hospice Evidence-based Practice: Savings from Emergency Communication Nurse System (ECNS) Nurse Navigator programs are evidence-based Policy Component (Y/N): Yes, data and clinical pathway management model policies will be necessary		
Action Plan	Target Date: 2014	Lead Organization: Law enforcement including the Sheriff's Office and City Police Department
Action 1: Establish a better clinical pathway management model vis-à-vis a 911 Emergency Communication Nurse System (ECNS) Nurse Navigator.		
Action 2: The ECNS takes a more detailed history of the complaint and determines the most appropriate response/destination Emergency medical dispatchers (EMD), using the computer-assisted medical priority dispatch system, interview callers in order to determine the location, nature, and priority of the caller's situation. The calls are then classified into EMS Event Types. There are 44 different EMS Event Types classified by the medical priority dispatch system. In Houston, Texas, there are currently 5 call types being used for referral to the triage nurse		
Action 3: Connect with the non-ED partners/services, and specifically with that patient's health network (PCP, medical home, and Urgent care clinics)		
Action 4: Educate the population about the 911 system. Houston, Texas experienced a measurable impact on call volume from doing so.		
Action 5: Establish face to face contact by a health and human service team which is shown to permanently reduce calls from frequent users.		

Strategic Issue: Substance Abuse Prevention		
Goal: Mobilize a community coalition to address substance use issues in Clark County.		
Indicators/Outcome	**Source**	**Resources**
12-month indicator: Build, coalesce, and develop the baseline data to drive insight to interventions needed and build the case for additional local funding	SAMHSA's SPF community readiness assessment	Hospital and CCCHD will build an information system. Year one will be in-kind contributions of time. A person will be needed to manage the Coalition after year one when the coalition moves into selecting and implementing interventions. The data will be used to make the case for funding.
24-month indicator: interventions are begun which are data-driven. Measurable outcomes may be available by this time.	Annual progress report	
Longer-term outcome: use the data to evaluate the effectiveness of the interventions; promote resilience and decrease risk factors in individuals, families, and communities; reduce the incidence of substance abuse	The new data system	
Strategy: Model practices from the Strategic Prevention Framework to assess community readiness, determine resources available, and to develop a data-driven method.		
Partnering Agencies: McKinley Hall, Reach, MHS, Criminal Justice System, Health Department, MHRB Evidence-based Practice: SAMHSA's Strategic Prevention Framework Policy Component (Y/N): Data confidentiality policies will have to be addressed; MOU's/MOA's will be necessary		
Action Plan	Target Date: 2014	Lead Organizations: McKinley Hall

Action 1: Assess prevention needs based on epidemiological data. Work toward a central clearinghouse of substance abuse data.

McKinley Hall, the MHRB, Reach and the Criminal Justice system each collect data, but data are not recorded or reported in a way that enables cross-system aggregation. Data at the interfaces is especially lacking. For example, a probation officer may refer a person to therapy, but doesn't have the data access to confirm the person's attendance at therapy. Furthermore, Police reports and physicians in the ER may not code an incident as drug and alcohol related because the crime or the medical condition are the focus.

Sub-strategy: Convene organizations to bring their data and their IT people together to determine what level of aggregation or consistency in reporting is possible. As a starting point, the community wants to know what data we have and what we already know, including:

- Who is being served—age, gender, race, geography
- Trends in numbers served
- Trends in diagnoses
- Services being provided

Sub-strategy: Organize the data—calculate the rates of substance abuse by different demographic cohorts so the community knows which populations to target and where it can be most effective. Build a relationship with the ER physicians group so that diagnosing of substance abuse is done consistently.

Action 2: Form an Adult death review committee to review mortality data.

Action 3: Build prevention capacity by addressing the need for more professionals, more data capacity, and more effective interventions.

Sub-strategy: Build capacity by addressing the need for more credentialed and licensed prevention and treatment professionals. The County has a Health Professions Shortage Area designation by HRSA in part due to an insufficient number of psychiatrists. Community leaders also state that there is an insufficient number of skilled therapists.

a. Obtain more training opportunities so that substance abuse therapists obtain the credentials they need (certifications are currently lacking to meet the need).
b. Obtain foundation support to provide scholarships to therapists to pursue certifications.

Sub-strategy: Build data application capacity. If data are collected and organized per strategy #1, then the community needs to build its capacity to use the data to determine where the greatest needs are and where the community lacks capacity to respond to those needs.

a. Consider conducting a systems analysis to accompany the data analysis as an objective view of system resources and gaps.
b. Use the data to make the case for more resources to build capacity.
c. Formalize organizational commitment to the coalition via MOUs/MOAs

Sub-strategy: Build the capacity to implement effective interventions.

a. Apply the improved data capacity to help the community target the right interventions toward defined needs.
b. Use data capacity to build evaluation capacity to determine the effectiveness of interventions and continuously improve them.

Action 4: Develop a strategic plan that uses data to inform priority strategies.

Sub-strategy: Identify evidence-based practices to address priority strategies. A couple programs reviewed by the Task Force and appear to meet the needs in the County are Project DAWN and the Ohio SOLACE Program.

a. Project DAWN— is a community-based drug overdose prevention and education project that helps people recognize and respond to the signs of an overdose
b. Ohio SOLACE Program--support that is often requested by people affected by someone else's drinking or drug abuse.

Action 5: Implement effective community prevention programs, policies and practices.

Action 6: Evaluate efforts for outcomes.

Alignment with State & National Priorities

Strategic Issue	Ohio's State Health Improvement Plan	Healthy People 2020	National Prevention Strategy (NPS)
Healthy Births and Sexuality: Identify and engage pregnant women in first trimester prenatal care.	Implement or provide access to an evidence-based care coordination model, emphasizing communities at highest risk, to public & private providers who impact birth outcomes, including patient-centered medical homes.	MICH-10.2 Increase the proportion of pregnant women who receive early and adequate prenatal care	Proportion of pregnant females who received early and adequate prenatal care is an NPS Indicator
Obesity: Implement a multi-dimensional, school-wide, evidence-based program to address youth obesity issues	Implement priority strategies to increase physical activity and improve nutrition in Ohio following the Institute of Medicine Accelerating Progress in Obesity Prevention report	NWS-2 Increase the proportion of schools that offer nutritious foods and beverages outside of school meals (NWS-2.1 Increase the proportion of schools that do not sell or offer calorically sweetened beverages to students AND NWS-2.2 NWS-2.2 Increase the proportion of school districts that require schools to make fruits or vegetables available whenever other food is offered or sold)	Proportion of adults and children and adolescents who are obese is tracked as an NPS indicator
Chronic Disease Management: Improve access to care and optimize health care resources.	Medical homes are central to the "Access to Care Priority" in the SHIP	AHS-5 Increase the proportion of persons who have a specific source of ongoing care	Improve the use of patient-centered medical homes is an NPS strategy
Mental Health: Promote the mental health and wellbeing of youth in Clark County for the near- and long-term.	Addressed as a priority by the Ohio Department of Health, the Ohio Department of Job & Family Services, and Ohio Department of Mental Health	EMC-1 Increase the proportion of children who are ready for school in all five domains of healthy development: physical development, social-emotional	Youth mental health is a priority in the NPS

Strategic Issue	Ohio's State Health Improvement Plan	Healthy People 2020	National Prevention Strategy (NPS)
		development, approaches to learning, language, and cognitive development	
Substance Abuse: Mobilize a community coalition to address substance use issues in Clark County.	No	The County strategy is aimed to address the Epidemiology and Surveillance objectives in the Substance Abuse portion of HP 2020	Preventing drug abuse and excessive alcohol use is an NPS—" Foster development of a nationwide community-based prevention system involving state, tribal, local and territorial governments and partners such as schools, health and social service systems, law enforcement, faith communities, local businesses, and neighborhood organizations."

APPENDIX				
Health Indicator	**Size (IP=In-patient)**	**Seriousness (Hospitalization or death)**	**Trend**	**Impacts on other health issues**
Percent of adults reporting a sedentary lifestyle	30.1%**	2 million deaths each year are attributed to physical inactivity, according to the World Health Organization (WHO)	Unfavorable	Increase all causes of mortality, 2x risk of CVD, diabetes, obesity, increase risk of colon cancer, HTN, osteoporosis, lipid disorders, depression, anxiety (WHO)
Simple BMI calculation; percent of adults overweight or obese	76.9%** vs. 65.7 and 64.5% for OH and US	Gateway to many deadly diseases	Unfavorable	NIH says: CHD, HTN, stroke, type 2 diabetes, abnormal cholesterol, metabolic syndrome, cancer, etc.
Percent of adults with diabetes; number of deaths due to diabetes; hospital/ER discharge diagnosis; mortality rate/100,000	13.5%** 2010:69 deaths 2011: ER 3064; IP 3088	#2 reason for ER; #3 or 4 reason for hospital visits; higher rate of death for County vs. OH & US** (37.9 vs. 26 and 20.8)	Somewhat erratic, but County mortality rate is 1.6x U.S. rate	CDC says: Adults 2-4x more likely to die of heart disease or experience a stroke
Percent of adults reporting high blood pressure (hypertension); hospital/ER discharge diagnosis	39.5%** 2011: ER 7284 IP 6708	#1 ER & hospitalization diagnoses is hypertension	Unfavorable 2009: ER 5715; IP 6688; 2010: ER 5949; IP 6567	Commonly known: Relationship to heart attack and stroke
Percent of adults reporting heart disease; mortality rate/100,000	5.7%^*	Mortality rate is higher than OH & U.S.**	Favorable	n/a
Percent of adults reporting that they have had a heart attack; hospital/ER discharge diagnosis	8%** 2010: 403 deaths	#8 hospital diagnosis in 2010 & 2011, #7 diagnosis in 2009 Heart is leading cause of death	Pretty consistent 2009: IP 1194 2010: IP 1070 2011: IP 1152	n/a
Percent of adults reporting having had a stroke; mortality rate/100,000	5.7** 2010: 94 deaths	Stroke mortality rate is 1.4x higher than U.S.*; 3rd leading cause of death	Recent unfavorable	n/a
Percent of adults reporting asthma; hospital/ER discharge diagnosis	17.2%** 2011: ER 1317	#7 ER diagnosis in 2011 (#8 in 2009)	Unfavorable 2009: ER 1036	CDC says: Contributes to CLRD; Days of work or school lost

**statistically significant difference between the County versus Ohio and the U.S. at the .01 level (<1% likelihood that the difference is due to chance)
^statistically significant at the .05 level (if ^ is listed first and * second, that means significance versus Ohio is at .05, and .01 vs. U.S.)

Health Indicator	Size (IP=In-patient)	Seriousness (Hospitalization or death)	Trend	Impacts on other health issues
Number & percent of unwed mothers	2010: 888; 52.9%		Unfavorable	SES
Number & percent of births to mothers who smoke	2010: 423; 25.2%	Possible relationship to infant mortality	Recent unfavorable	CDC says: LBW; SIDS risk factor; miscarriage; premature birth; birth defects
Number and percent of teen births	2011: 225; 48.9%		Favorable	SES
Percent of births w/out 1st trimester prenatal care	2010: 32.4%	Ohio rate of births w/out care=27%	Unfavorable	HHS: Possible relationship to infant mortality
Infectious Disease: Number of cases of Chlamydia	2011: 436 Cases	Possible relationship to birth outcomes	Unfavorable	CDC: PID/Damage a woman's reproductive organs
Infectious Disease: Number of cases of Gonorrhea	2011: 187 Cases	Disease can impact a woman's ability to have children if left untreated	Favorable	CDC: PID/Damage a woman's reproductive organs; in men, infertility; problems to prostate
Infectious Disease: Number of cases of Hepatitis C	2011: 40 Cases	Chronic infection can lead to scarring of the liver & to cirrhosis.	Favorable	NY Times: In some cases, those with cirrhosis will go on to develop liver failure, liver cancer or life-threatening esophageal and gastric varices
Infant mortality rate per 1,000	2010: 20 deaths	Mortality rate: 11.9 vs. OH 8.2	Unfavorable	n/a
Anxiety based on hospital/ER discharge diagnosis	2010: ER 937; IP 914 2011: ER 1095; IP 1100	#8 ER diagnosis in 2010; #9 diagnosis in 2011; #9 or 10 hospital diagnosis	Unfavorable	Stress impacts: high blood pressure, heart problems, diabetes, skin conditions, asthma, arthritis, depression

Health Indicator	Size (IP=In-patient)	Seriousness (Hospitalization or death)	Trend	Impacts on other health issues
Suicide number; mortality rate/100,000	2010: 21 deaths	16.2 CLK OH 12.3 US 11.9	Unfavorable	n/a
Mental Health hospital/ER discharge diagnosis	2011: 2040 ER; IP 3485	See left column	Not available	Diabetes, cancer, CVD, asthma, obesity. Related physical inactivity, smoking, drinking, and insufficient sleep
Number of deaths; rate/100,000 for Chronic Lower Respiratory Disease	47.8/100,000 2010: 85 deaths	Mortality rate > U.S.; < Ohio	Favorable	n/a
Hypertensive chronic kidney disease hospital/ER discharge diagnosis	2009: IP 1529 2010: IP 1562 2011: IP 1523 2010: 27 deaths	#6 hospital diagnosis	Pretty consistent	National Kidney Fdn: anemia, weak bones, poor nutritional health, nerve damage, heart & blood vessel disease
Number of deaths due to cancer	2010: 386 deaths		Unfavorable	n/a
Lung and Bronchus cancer rate per 100,000	Cancer rate of 89.0 vs. 69.5 and 64.3 for OH & US**	Statistically higher % of County adults smoke than U.S.	Unfavorable	Strongest predictor is cigarette smoke; secondhand smoke & radon too
Percent of adults reporting tobacco use; hospital/ER discharge diagnosis	21.2% of adults currently smoke vs. 17.3 for US*	ICD-9 code 305.1 can refer to tobacco use disorder. 2011: ER 2236; Hospital: 3225. #3 diagnosis for ER & Hospital	Unfavorable for hospital diagnoses	Leading predictor of lung & bronchus cancer;~90% of deaths from chronic obstructive lung disease are caused by smoking
Breast cancer rate per 100,000; number of cases	Cancer rate is 160.3 vs. 118.3 and 123.1 for OH & US**	2009: 145 cases	Unfavorable Rate 2000=155.5 Rate 2005=157.9	
Skin cancer rate per 100,000; number of cases	Rate is 33.4 vs. 19.3 and 19.4**	2009: 51 cases	Steady since the year 2000	

Youth Health Indicators	Size	Seriousness (Hospitalization or death)	Trend	Impacts on other health issues
Percent of sexually active students using certain contraceptives	91% vs. 82% for the US and 77% for OH not using certain contraceptives	A higher percentage of sexually activity Clark County students are not using birth control pills or Depo-Provera	Unfavorable	Teen pregnancy if no other contraceptive is used
Percent of youth overweight or obese as measured by simple BMI calculation and as self-reported	39% according to BMI; In youth survey, 35% described themselves as slightly or very overweight (vs. 29.2% US; 30.2% OH)	Among children today, obesity is causing a broad range of health problems that previously weren't seen until adulthood	Unfavorable	High blood pressure, type 2 diabetes, elevated blood cholesterol levels. More prone to low self-esteem, negative body image and depression
Percent of youth reporting sedentary/decreased physical activity	Did not play on sports teams=45% (41% in 2009) vs. 41.6% for U.S.	n/a	Unfavorable	Recent study shows relationship to poor motor coordination (9x > likelihood)
Percent of youth reporting they have asthma	16% vs. 14% in 2009; 11.9% for US	Nationally, asthma is the 3rd leading cause of hospitalization among children <15 years	Unfavorable	Days of school lost; vulnerability to respiratory infections and colds
Percent of youth reporting they used chewing tobacco; percent of youth that did not try to quit smoking	Used chewing tobacco on at least one day=10% in 2011 vs. 7.7% for US. Did not try to quit smoking =46% vs. 43.5% for US and 50.1% for Ohio	Addictive qualities lead to long-term serious health issues	Steady 2009 rate in county was also 10%	More colds, flu, bronchitis, and pneumonia