Allen County
Community Health Improvement Plan
2014-2016

June, 2014

Partners

Allen County Public Health wishes to acknowledge the numerous contributions of the following partners and stakeholders. Their continued commitment to the mission of public health helps to make Allen County a great place to live, learn, work and play.

Kim Rieman, Director of Health Education, Allen County Public Health
Kathy Luhn, Health Commissioner, Allen County Public Health
Phyllis Montrose, Child Development Director, Lima/Allen Council on Community Affairs
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This CHIP planning process was facilitated by Britney Ward, MPH, Director of Community Health Improvement, and Michelle Von Lehmden, Health Assessment Coordinator, from the Hospital Council of Northwest Ohio.

Contact Us

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Executive Summary

Since 1995, Allen County has conducted community health assessments (CHA) for the purpose of measuring and addressing health status. The most recent Allen County Health Assessment began in 2013. In this assessment, already-existing data from sources such as Robert Wood Johnson Foundation's County Health Rankings, the Ohio Department of Health and our 2009 Allen County Health Risk and Community Needs Assessment were compiled to give us the most up-to-date information about 15 health topics. When possible, key data points were compared to state and national rates. This CHA also included information on our successes, our opportunities for improvement as well as what we are doing in the community to address our health issues.

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 study. Active engagement of community members throughout the planning process is regarded as an important step in completing a valid needs assessment.

The Allen County CHA has been utilized as a vital tool for creating the Allen County Community Health Improvement Plan (CHIP). The CHIP defines the vision for the health of the community. It is a long-term, systematic process of addressing health issues based on the results of assessment activities. This plan is used by health and other governmental, educational and human service agencies along with community partners, to set priorities and coordinate and target their resources. A CHIP is critical for developing policies and defining actions that promote health

To facilitate the Community Health Improvement Process, Allen County Public Health 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 Official's (NACCHO) strategic planning tool, Mobilizing for Action through Planning and Partnerships (MAPP), was used throughout this process.

The MAPP process includes four assessments, Community Themes & Strengths, Forces of Change, the Local Public Health System Assessment and the Community Health Status Assessment. These four assessments were used by the Allen County CHIP Committee to prioritize specific health issues and population groups which are the foundation of this plan.

Early in the CHIP Planning Process, the committee reviewed information from the CHA to identify the following Priority Areas for Allen County:

Priority Health Issues for Allen County
1. **Increase Wellness**
2. **Improve Maternal and Infant Health**
3. **Decrease Mental Health and Substance Abuse Issues**
4. **Increase Access to Care**

Desired Outcomes or Allen County Residents:

- Reduce risk for chronic disease
- Reduce poor birth outcomes e.g. Low Birthweight Babies and Preterm Deliveries

- Reduce infant mortality
- Reduce suicide rate
- Reduce substance abuse
- Increase access to health care

From these priority health issues and desired outcomes, the committee formulated a three-year plan with the recommended action steps. A summary follows and the complete three-year plan for 2014-2016 on page 4 of this report.

Allen County Community Health Improvement Plan 2014-2016
Action Plan Summary

Priority Area 1: Increase Wellness

Action Step Recommendations

To work toward **increasing wellness and reducing risk factors for chronic disease**, the following action steps are recommended:

1. Develop infrastructure for wellness activities and secure funding for prioritized initiatives
2. Increase businesses implementing formalized breastfeeding policies*
3. Increase businesses providing comprehensive wellness programs & insurance incentive programs to their employees*
4. Implement Ohio Hospital Association's Healthy Hospitals Initiative
5. Implement a county-wide school wellness council*
6. Implement a food policy council*
7. Implement a healthy housing initiative

Priority Area 2: Improve Maternal and Infant Health

Action Step Recommendations

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

1. Establish a maternal and infant health task force
2. Increase 1st trimester and preconception care*
3. Explore opportunities to implement The Pathways Model*

Priority Area 3: Decrease Mental Health and Substance Abuse Issues

Action Step Recommendations

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

1. Increase the number of primary care & specialty health care providers who screen and make referrals for depression during office visits
2. Increase the number of ER physicians and primary care providers who screen for alcohol and drug abuse
3. Implement evidence based substance abuse prevention programming for young children and their parents*

Priority Area 4: Increase Access to Care

Action Step Recommendations

To work toward increasing **access to care,** the following actions steps are recommended:

1. Increase public transportation
2. Increase physician recruitment for primary care and mental health providers
3. Increase cultural competence
4. Increase community education on health insurance opportunities and utilization

*** Indicates Best Practices, or Evidence-based or promising strategies.**

Allen County, Ohio
Community Health Improvement Plan
Action Plan 2014-2016

Priority Area 1: Increase Wellness		
Action Step	Responsible Person/Agency	Timeline
Develop infrastructure for wellness activities and secure funding for prioritized initiatives		
Year 1: Increase agency coordination and create a long term plan for wellness initiatives in Allen County.	**Activate Allen County Leadership Team**	December 2014
Year 2: Collaborate with agencies to implement the plan.		December 2015
Year 3: Continue efforts of years 1 and 2.		December 2016
Increase Businesses Implementing Formalized Breastfeeding Policies		
Year 1: Survey employers about current breastfeeding policies and provide education and sample policies.	**Breastfeeding Coalition**	December 2014
Year 2: Assist in implementing breastfeeding policies in at least 20 businesses/organizations in Allen County.		December 2015
Year 3: Assist in implementing breastfeeding policies in at least 25% of the businesses/organizations in Allen County.		December 2016
Increase Businesses Providing Comprehensive Wellness Programs & Insurance Incentive Programs to Their Employees		
Year 1: Collect baseline data on businesses and organizations offering comprehensive wellness and insurance incentive programs to employees. Develop a system of reporting outcomes eg. Staff participation, absenteeism, health care costs, return on investment	**WCORHA**	December 2014
Year 2: Increase the number of businesses/organizations that initiate wellness and/or insurance incentive programs or upgrade their current programs to best practices. Goal for 2014 will be set based on baseline information. Host a wellness summit to educate businesses about the benefits of implementing worksite wellness programs. Provide CEUs for human resource personnel. Aim to work with mid/large size employers.		December 2015
Year 3: Double the number of businesses/organizations providing wellness and insurance incentive programs from baseline.		December 2016

Priority Area 1: Increase Wellness, continued		
Implement Ohio Hospital Association's Healthy Hospitals Initiative		
Year 1: St. Rita's Medical Center and Lima Memorial Health System will explore opportunities to align with the Ohio Hospital Association's Good 4 You initiative. Create a focus group to set the parameters for the Good 4 You Initiative. Consider setting parameters in the following priority areas: • Balanced menus • Healthy beverages • Breastfeeding • Healthier Vending Create an action plan and begin implementing the Good 4 You Initiative in at least one priority area.	**St. Rita's Medical Center & Lima Memorial Health System**	December 2014
Year 2: The program will be introduced to area businesses and organizations. The hospital will assist others to adopt the guidelines and strategies, providing sample policies, signage and timeframes		December 2015
Year 3: The program will be introduced into other areas of the community (schools, churches, etc.)		December 2016
Implement a County-Wide School Wellness Council		
Year 1: Collaborate with the 9 school districts in Allen county to create a county-wide school wellness council that addresses physical and mental health. Obtain at least one appointee from each school district to serve on the council. Establish action steps to create more unified school wellness policies among Allen County school districts that include physical health and mental health. Meet with school district administrators from each school district to provide education on what a model school wellness policy should include. Review all 9 school districts current wellness policies.	**Activate Allen County Evaluation Team**	December 2014
Year 2: Make recommendations to school administrators on possible changes to improve current wellness policies. Initiate wellness policy revisions at 2 local school districts and have the new policies adopted by the school board.		December 2015
Year 3: Increase the number of schools adopting new/updated wellness policies by 50% from baseline.		December 2016

Priority Area 1: Increase Wellness, continued		
Implement a Food Policy Council		
Year 1: Organize a group of engaged citizens to create an Allen County Food Policy Council. Invite members from the following sectors: • the general public • government officials • community-based organizations and coalitions • institutions such as schools, churches, and hospitals • nonprofits • public agencies • the private sector Work to assess community needs, develop a strategic food policy plan and establish objectives of the food policy council.	**Allen County Economic Development Group & Lima-Allen County Chamber of Commerce**	December 2014
Year 2: Work to raise awareness of the food policy council. Begin addressing objectives identified by the council.		December 2015
Year 3: Continue efforts of years 1 & 2.		December 2016
Implement a Healthy Housing Initiative		
Year 1: Identify agencies/organizations to work together to identify housing issues that are impacting personal health. Identify what policy or legislative changes are needed.	**Allen County Regional Planning Commission**	December 2014
Year 2: Create a coordinated campaign of planned strategies and define interventions and resources. Search for grants and funding opportunities to support efforts.		December 2015
Year 3: Begin addressing strategies identified and implementing policy changes.		December 2016

Priority Area 2: Improve Maternal and Infant Health		
Action Step	Responsible Person/Agency	Timeline
Establish a Maternal and Infant Health Task Force		
Year 1: Work to gather and recruit volunteers dedicated to addressing maternal and infant health issues. Establish a multi-disciplinary task force and begin meeting on a regular basis. Develop goals and objectives to be addressed by the task force.	**Allen County Public Health, Nursing** **Activate Allen County**	December 2014
Year 2: Work to address the goals and objectives created by the task force.		December 2015
Year 3: Increase efforts of years 1 and 2.		December 2016
Increase 1st Trimester and Preconception Care		
Year 1: Enlist primary care providers, OB/GYN, and family physician offices to educate women of childbearing age on using prenatal vitamins and folic acid before getting pregnant; and send education on pregnancy do's and don'ts when patient calls in to confirm a pregnancy. Incorporate components of preconception health into existing local public health and related programs. Expedite the process of enrolling pregnant women in Medicaid. Increase education on retro-active payments and Paramount Advantage & Buckeye offering monetary incentives for prenatal care and well-baby visits.	**Maternal and Infant Health Task Force**	December 2014
Year 2: Double number of offices offering education.		December 2015
Year 3: Triple number of offices offering education.		December 2016
Explore Opportunities to Implement Pathways Model		
Year 1: Research the Community Pathways Model, which works to decrease poor birth outcomes in the high risk pregnant population. Determine interest and feasibility of implementing the Pathways Program in existing clinics and community centers throughout Allen County. Contact the Northwest Ohio Pathways HUB to present information on the Pathways Model to community stakeholders. Assess community readiness to implement a Pathways Program throughout various community centers, clinics and home visiting sites.	**Allen County Public Health, Nursing**	December 2014
Year 2: Research and secure start-up funding and select a pilot site to hire a community care coordinator. The selected site will complete Pathways training through the Northwest Ohio Pathways HUB and begin enrolling clients into the program.		December 2015
Year 3: Continue enrolling clients into the Pathways Program.		December 2016

Priority Area 3: Decrease Mental Health and Substance Abuse Issues		
Action Step	Responsible Person/Agency	Timeline
Increase the Number Primary & Specialty Health Care Providers Screening and Making Referrals for Depression During Office Visits		
Year 1: Collect baseline data on the number of primary care, specialty care providers and OBGYNs that currently screen and make referrals for depression and/or mental health issues during office visits.	**Mental Health and Recovery Services Board; St. Rita's Professional Services; Lima Memorial Professional Corporation, Health Partners of Western Ohio, Allen County Public Health**	December, 2014
Year 2: Determine what support is needed to screen patients. Determine what evidence-based models or tools are available.		December, 2015
Year 3: Increase the number of primary care physicians and OBGYNs using the evidence-based screening tool. Set goals based on baseline data.		December, 2016
Increase the Number of Emergency Department and Primary and Specialty Health Care Providers Screening for Alcohol and Drug Abuse		
Year 1: Collect baseline data on the number of Emergency Department and primary and specialty care providers that currently screen for drug and alcohol abuse, and at what ages. Determine which screening tool/model are being used.	**Mental Health and Recovery Services Board; St. Rita's Medical Center; Lima Memorial Health System, St. Rita's Professional Services, Lima Memorial Professional Corporation**	December, 2014
Year 2: Introduce a screening, brief intervention and referral to treatment model (SBIRT) to physicians' offices and hospital emergency room. Pilot the model with one primary care physician's office and the hospital emergency room.		December, 2015
Year 3: Increase the number of Emergency Department and primary care and specialty physicians using the SBIRT model by 25% from baseline.		December, 2016
Implement Evidence Based Prevention Programming for Young Children and Their Parents		
Year 1: Provide PAX training to an additional 50 elementary teachers. Investigate programs to educate/inform parents of young children about how to keep their children from using drugs and alcohol. Secure funding for programs.	**Mental Health and Recovery Services Board & PVFF**	December, 2014
Year 2: Provide PAX training to an additional 100 elementary teachers and educate 10 local agencies working with children about PAX Kernels and how to use in their programs. Promote and implement at least 10 parent training programs.		December, 2015
Year 3: Provide PAX training to new elementary teachers and PAX Kernel training to an additional 10 agencies working with children. Implement at least 10 additional parent training programs and evaluate programs.		December, 2016

Priority Area 4: Increase Access to Care		
Action Step	Responsible Person/Agency	Timeline
Increase Public Transportation		
Year 1: Create a survey to gather public input on identifying gaps in transportation services. Increase outreach efforts of the survey to include input from older adults, those with disabilities, low-income, and veterans. Implement the Building the Fully Coordinated Transportation System Self -Assessment Tool for Communities with Allen County stakeholders. Analyze the results from both surveys. Release the data to the public.	**RTA & Lima Allen County Regional Planning Commission**	December 2014
Year 2: Invite community stakeholders to attend a meeting to discuss transportation issues in Allen County. Create strategies to address gaps and increase efficiency in transportation. Address strategies to increase the use of public transportation and reduce stigma. Begin implementing strategies identified.		December 2015
Year 3: Increase efforts of years 1 and 2. Facilitate follow-up surveys to gauge the public's response to strategies that have been addressed and collect outcome measures.		December 2016
Increase Physician Recruitment for Primary Care & Mental Health Care Providers		
Year 1: Develop a marketing strategy focused on recruiting primary care physicians and mental health care providers.	**Allen County Chamber of Commerce, St. Rita's Medical Center, Lima Memorial Health System & Mental Health and Recovery Services Board, Allen Economic Development Group**	December 2014
Year 2: Implement strategy, increasing primary care physicians and mental health care providers by 25%.		December 2015
Year 3: Continue efforts of years 1 and 2		December 2016

Priority Area 4: Increase Access to Care, continued		
Increase Cultural Competence		
Year 1: Educate/inform local businesses, organizations and health care providers on county demographics and the importance of becoming culturally competent. Identify health disparities that may be a result of cultural incompetence.	**Allen County Chamber of Commerce, Allen County Public Health, Health Education, Lima Allen County Regional Planning Commission**	December 2014
Year 2: Offer a county-wide dialogue/training on cultural competence. Determine baseline of participating organizations who have adopted culturally competent principles, policies and/or practices within their organization.		December 2015
Year 3: Identify action steps to take to help organizations adopt culturally competent policies/practices. Increase the number of organizations adopting cultural competency policies/practices by 50% from baseline.		December 2016
Increase Community Education on Health Insurance Opportunities & Utilization		
Year 1: Research resources available to help consumers navigate the Health Insurance Marketplace. Utilize Federal Navigator grantees to provide an in-person resource for educating and enrolling community members in health insurance plans. Explore opportunities for employees to become certified application counselors. Begin educating and enrolling consumers. Create a list of physicians that accept Medicaid patients.	**St. Rita's Medical Center, Lima Memorial Health System & Health Partners of Western Ohio**	December 2014
Year 2: Continue efforts		December 2015
Year 3: Continue efforts		December 2016

Strategic Planning Model – Process Overview

MAPP – Mobilizing Action through Planning and Partnerships

The MAPP process includes four assessments, Community Themes & Strengths, Forces of Change, the Local Public Health System Assessment and the Community Health Status Assessment. These four assessments were used by the Allen County CHIP Committee 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.

The MAPP Framework includes the following six phases:

- Organizing for success and partnership development
- Visioning
- Conducting the MAPP assessments
- Identifying strategic issues
- Formulating goals and strategies
- Taking action: planning, implementing and evaluation

Beginning in April 2013, the Allen County Community Health Improvement Steering Committee met 5 times and completed the following planning steps which were facilitated by Allen County Public Health.

- Visioning- Create or review mission, vision and values

- Choosing Priorities- Use of quantitative and qualitative data to prioritize target impact areas

- Forces of Change and Community Themes and Strengths- Open-ended questions for committee on forces of change and community themes and strengths

Beginning in September 2013, the Allen County Community Health Improvement Planning Committee met 5 times and completed the following planning steps which were facilitated by The Hospital Council of Northwest Ohio.

- Local Public Health Assessment- Review the Local Public Health System Assessment with committee

- Ranking Priorities- Ranking the health problems based on magnitude, seriousness of consequences, and feasibility of correcting

- Resource Assessment- Determine existing programs, services, and activities in the community that address the priority target impact areas and look at the number of programs that address each outcome, geographic area served, prevention programs, and interventions

- Gap Analysis- Determine existing discrepancies between community needs and viable community resources to address local priorities; Identify strengths, weaknesses, and evaluation strategies; and Strategic Action Identification

- Best Practices- Review of best practices and proven strategies, Evidence Continuum, and Feasibility Continuum

- Draft Plan- Review of all steps taken; Action step recommendations based on one or more the following: Enhancing existing efforts, Implementing new programs or services, Building infrastructure, Implementing evidence based practices, and Feasibility of implementation.

Mission and Vision

The Allen County CHIP participants were asked to draft a vision and mission statement. Vision statements define a mental picture of what a community wants to achieve over time while the mission statement identifies why an organization/coalition exists and outlines what it does, who it does it for, and how it does what it does.

Vision: To improve the quality of life for residents of Allen County

Mission: Create a sustainable environment that promotes and supports the health and well-being of Allen County.

Value Statements:

- Enhance awareness and understanding of factors that contribute to the well- being of Allen County.
- Foster leadership collaboration to promote an aligned vision for improving Allen County.
- Mobilize community action and partnerships to build capacity for emerging opportunities.
- Emphasize the use of evidence based practices and interventions to promote effective outcomes.
- Commit to the prudent use of community resources in order to avoid redundancy and maximize results, outcomes and communication.

Overarching Approach:

- Continuing awareness
- Collaborative alignment
- Comprehensive action

Local Public Health System Assessment

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

The public health system includes:

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

The 10 Essential Public Health Services

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

Public health systems should

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

(Source: Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services; http://www.cdc.gov/nphpsp/essentialservices.html)

Local Public Health System Assessment, continued

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**.

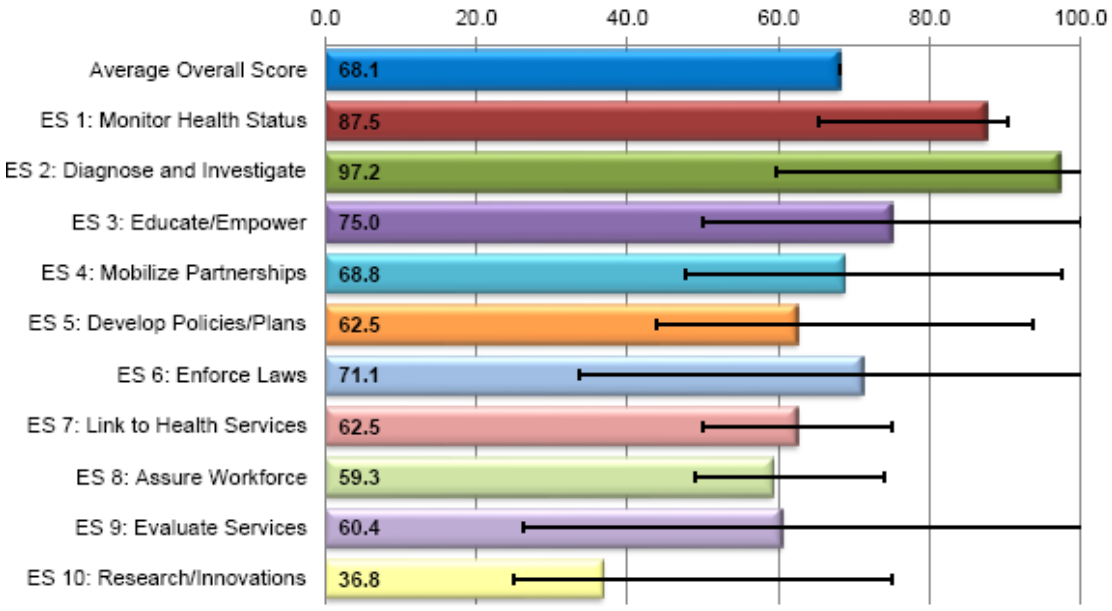
Members of the Allen County Health District completed the performance measures instrument. The LPHSA results were then presented to the full CHIP committee for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard was discussed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

The CHIP committee identified 11 indicators that had a status of "minimal". 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.

The overall score of each of the 10 Essential Services is listed in the graph below. To see the full results of the LPHSA, please contact Allen County Public Health.

Allen County Local Public Health System Assessment
2013 Summary



Community Health Status Assessment

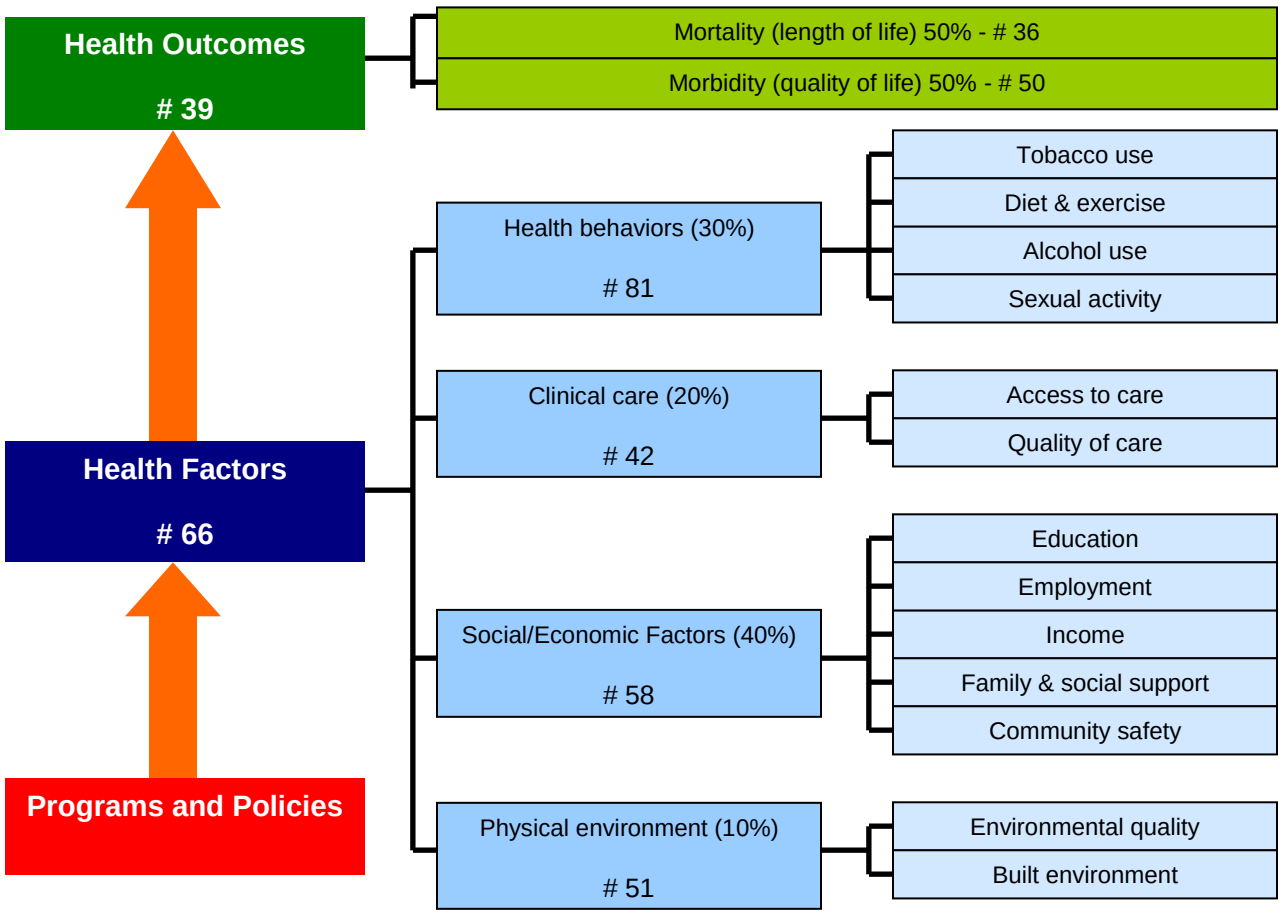
The Community Health Assessment provided us information to complete our Community Health Status Assessment. In this assessment, 15 health topics were reviewed to determine the health status of Allen County. The 15 health topics covered were:

- Access to Health Services
- Cancer
- Diabetes
- Disabilities
- Exercise, Nutrition and Weight
- Family Planning
- Heart Disease and Stroke
- Immunizations and Infectious Diseases
- Maternal, Fetal and Infant Health
- Mental Health and Mental Disorders
- Oral Health
- Prevention and Safety
- Respiratory Disease
- Substance Abuse
- Wellness and Lifestyle

The complete Community Health Assessment can be found on Allen County Public Health's website at: www.allencountypublichealth.org.

2013 County Health Rankings

Robert Wood Johnson's 2013 County Health Rankings show how Allen County's health status ranks with the other counties in Ohio. Information from this report also was used to determine the health status in our county. The information below shows a snapshot of Allen County's rankings and the measures used to determine our rankings.



County Health Rankings model © 2010 UWPHI For more specific information about the County Health Rankings visit: http://www.countyhealthrankings.org/

Forces of Change

Forces of Change identify forces that are or will be affecting the local public health system. An initial discussion of forces of change was held during a July 2013 discussion between local public health and hospital partners. The CHIP Committee also brainstormed and discussed forces of change impacting Allen County in the context of state and federal changes. Factors identified as a result of these discussions are listed below, organized by systems.

Social

- Aging population
- Population becoming more racially and ethnically diverse
- Aging healthcare workforce

Economic

- High unemployment
- Local government funds decreasing
- Unemployable workforce - substance abuse issues; job training
- Change in economic base

Political

- Affordable Care Act
- Medicaid expansion
- Sequester/federal budget impacting local grant funding
- State leadership changes

Environmental

- Health professional shortage area
- Declining housing conditions
- Weather events/Natural disasters - e.g. 2012 Derecho event
- Bike Pedestrian Task Force formed
- Active Transportation Plan being developed

Technological

- Electronic medical records
- Health information exchanges
- ICD 10 codes
- Increasing use of social media - agencies/individuals

Agency/Organizational

- Two-year Small Community Transformation Grant received (2012-2014)
- Hospital IRS requirements
- Public health accreditation requirements
- Annual mental health community summits - substance abuse, suicide, preventing mental illness and substance abuse in children
- Community health summits - Mark Fenton, Food Summit

After the Forces of Change were identified, the CHIP Committee reviewed them and identified through consensus which ones were considered "critical" and should be reflected in the Action Plan, as able.

"Critical" Forces of Change:

- Population – aging and more diverse
- Health care shortage area
- Changes with health care coverage
- Workforce – changes in economic base and workforce skills
- HIE/Technology

Community Themes and Strengths

Community Themes and Strengths
The CHIP Committee reviewed recent Allen County collaborative projects, community assessments, and community plans looking for overarching community themes and strengths. The committee also reviewed missions and work plans for existing community collaboratives. The following documents/collaboratives were included in this review:

- Allen 2020 Community Report
- Local Conversations on Minority Health - Health Disparity Reduction Plan
- Allen County Department of Jobs and Family Services' Prevention, Retention and Contingency Plan
- Activate Allen County
- Family and Children First Council

The committee then considered "energy areas" within the community - areas where there is strong collaboration, structure and planning/activities already in progress. The committee also reviewed the resources available as well as the gaps in community services. From these discussions and reviews, the committee identified the top community themes and strengths.

- "Energy Areas" include:
    - Substance abuse
    - Active transportation
    - Food policy
    - Education/workforce development
    - Economic development

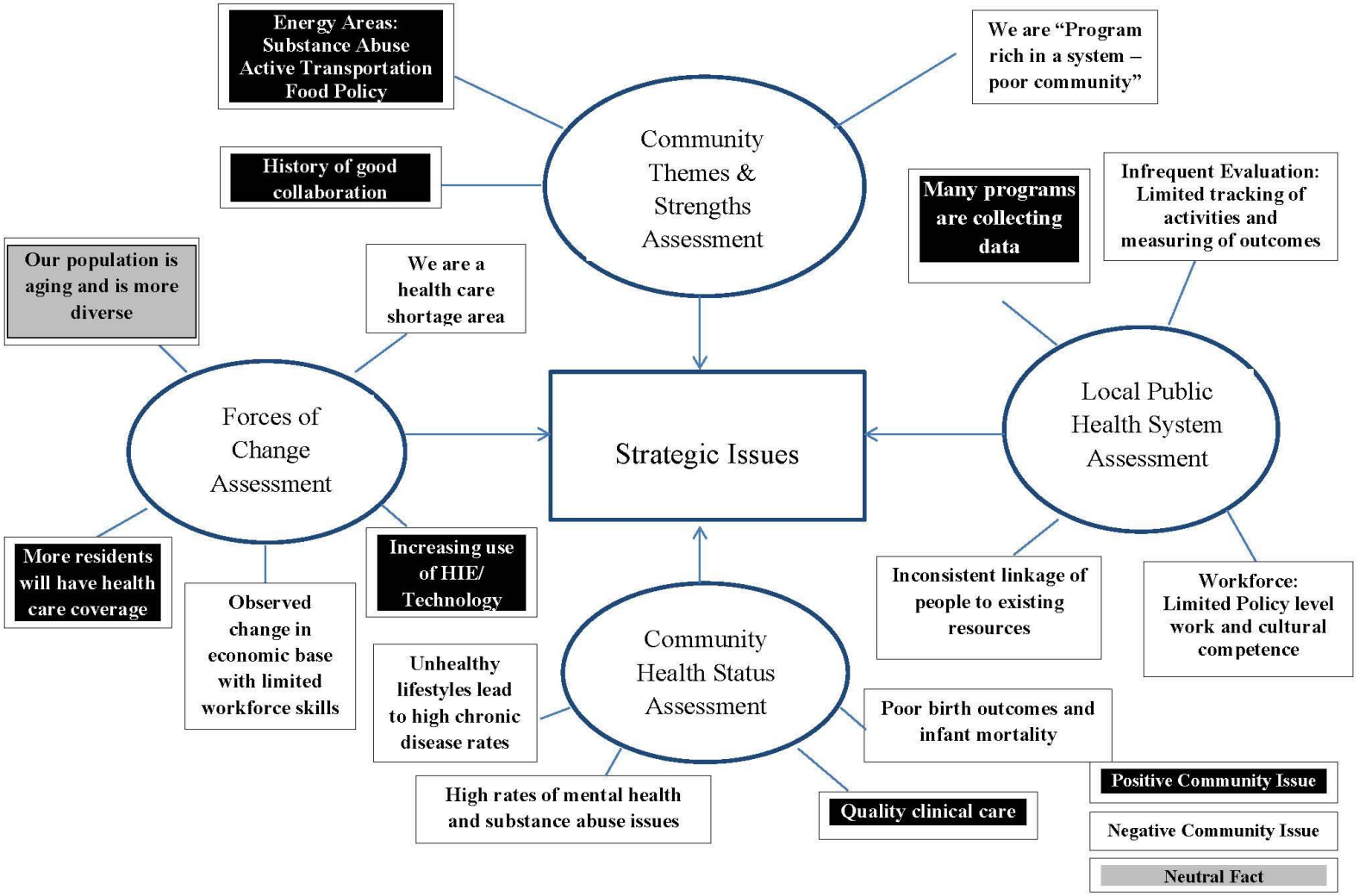
- A strong history of collaboration among agencies and organizations within the community

- We are "program rich in a system poor community" - while there are many programs and activities focused on improving health, programs and activities are not necessarily aligned and outcomes, particularly at the community level, are not tracked.

Finally, the CHIP Committee identified what they determined were the most critical themes that needed to be reflected in the Action Plan. These were determined through discussion and consensus agreement.

"Critical" themes:
- Energy areas: substance abuse, active transportation, food policy
- History of collaboration
- "Program rich in a system poor community"

Strategic Issues Relationship Diagram



Priorities Chosen

The Allen CHIP participants completed an exercise where they ranked the key issues based on the magnitude of the issue, seriousness of the consequence, and the feasibility of correcting the issue. A total score was given to each priority. The maximum score was 30. All committee members' scores were combined and then average numbers were produced.

The rankings were as follows:

Issue	Average Score
Exercise, Nutrition, Weight and Diabetes	25.3
Maternal and Infant Health	22.5
Mental Health and Substance Abuse	21.7
Access to Care	20.9
Wellness and Lifestyle	19.7

Allen County will focus on the following five priorities over the next 3 years:

- Wellness (including exercise, nutrition, weight and diabetes)
- Maternal and Infant Health
- Mental Health and Substance Abuse
- Access to Care

Alignment of Priorities with State and Nation

The priorities chosen are similar to those identified in Ohio and the nation. The table below highlights how Allen County's priorities align themselves with the state and national priorities.

Allen County Health Issues/Priorities	State Health Improvement Plan for Ohio	National Prevention Strategies	Healthy People 2020 Leading Health Indicators
Increase Wellness *Increase Fruit/Vegetable Intake* *Increase Physical Activity* *Increase Breastfeeding*	Prevent and reduce the burden of chronic disease	Healthy Eating Active Living Tobacco Free Living	Nutrition, Physical Activity and Obesity
Improve Maternal/Infant Health *Improve Preconception Health* *Increase Access to Early Prenatal Care*	Decrease Ohio's infant mortality rate and reduce disparities in birth outcomes	Reproductive and Sexual Health	Maternal/Infant and Child Health
Decrease Mental Health and Substance Abuse Issues *Decrease Suicide* *Decrease Substance Abuse*	Integration of physical and behavioral health	Preventing drug abuse and excessive alcohol use Mental and Emotional Well Being	Substance Abuse Mental Health
Increase Access to Care *Improve Access to Healthcare Providers* *Increase Insured Residents* *Improve Cultural Competence*	Establish, support and promote policies and systems to identify and reduce barriers that prevent access to appropriate healthcare		Access to Health Services

Best Practices

During the MAPP Process, Best Practices for programs to address our issues were identified. The list of Best Practices along with an explanation of each is in the appendices. When possible, these programs were included in our strategies and action steps. Best Practices are noted on the Action Plan Summary (page3).

Planning, Implementing and Evaluating

The progress of meeting the local priorities will be monitored with measurable indicators identified by the Allen County CHIP Committee. The individuals that are working on action steps will meet on an as needed basis. The full committee will meet quarterly to report out the progress in each area. The committee will form a plan to disseminate the Community Health Improvement Plan to the community. Action steps, responsible person/agency, and timelines will be reviewed at the end of each year by the committee. Edits and revisions will be made accordingly.

Appendices

Resource Assessment

For each of the priority areas chosen, the CHIP Participants determined existing programs, services, and activities in the community. The information on the following pages shows the resources available in Allen County in each priority area.

Strategy #1: Increase Wellness Resource Assessment				
Program/Strategy/ Service	**Responsible Agency**	**Population(s) Served**	**Continuum of Care** (prevention, early intervention, or treatment)	**Evidence of Effectiveness**
Summer Breakfast/Lunch Program	Lima City Schools	Elementary students	Prevention	Participation tracked
Back Pack Food Programs	West Ohio Food Bank & local school districts (Elida, Perry, Allen East, Bath)	Elementary students	Prevention	Participation tracked
Farmers Market	Multiple organizations & locations	All Ages	Prevention	Best practice
Mobile Produce Market	Activate Allen County, West Ohio Food Bank	Individuals in food deserts and low income	Prevention	Best practice
Genesis Garden (garden used to support the Mobile Produce Market)	Active Allen County, Lima Central Catholic, Knights of Columbus & West Ohio Food Bank	Individuals in food deserts and low income	Prevention	Best practice
Occupational Health Program (includes wellness program, produce market, Yoga, no sugar drink policy, healthy vending, weight loss program)	Lima Memorial Health System	All Ages and Associates	Prevention	Evidence based/ best practice
Primary Care	Coleman Professional Services	Individuals with mental illness/substance abuse issues Ages 18+	Prevention, early intervention, treatment	Best practice
Employee Wellness Programs/weight loss challenges	Lima Allen Council on Community Affairs (LACCA) and multiple other organizations	Employees	Prevention, early intervention, treatment	Outcomes tracked
Walk to the Cross (walking program)	West Central Ohio Health Ministries	All Ages	Prevention	Best practice
Recreation Programs	City and County Parks	All Ages	Prevention	Best practice
Food Banks, Food Pantries & Soup Kitchens	Various churches and organizations	All Ages	Prevention	Best practice
WIC Program	Allen County Health Department	Birth- Age 5 and Pregnant Women	Prevention, early intervention, treatment	Evidence based
Restaurant Healthy Menu Program, Active Transportation Plan, PECAT (evaluating	Activate Allen County	All Ages	Prevention, early intervention	

physical education curriculums/wellness plans for schools/Head Start)				
Breastfeeding Task Force (breastfeeding friendly hospitals, employee education, business breastfeeding policy modifications)	Activate Allen County	Breastfeeding women	Prevention	Best practice
Bike/Pedestrian Task Force	Multiple Agency Collaborative	All Ages	Prevention	Best practice
Ounce of Prevention	Health Partners of Western Ohio & other pediatric offices	Children	Prevention	Evidence based
Women's Wellness Center	St. Rita's Medical Center	10 County Area	Prevention, early intervention, treatment	Best practice
Creating Healthy Communities (CHC)	Allen County Health Department	City of Lima, those with mental illness, lower incomes, African Americans	Prevention	Evaluation Evidence based
Primary Medical/Dental Services	Health Partners of Western Ohio	Low income	Early intervention, treatment	Track Outcome
Employee Wellness Program	Lima City Schools	Staff and families	Prevention	Best practice
I am Moving, I am Learning (IML)	Head Start	Birth-5 years old	Prevention	Evidence Based Outcomes- track height & weight
Exercise programs, sponsored memberships, athletic leagues, personal training, classes, specialized exercise classes	YMCA	All ages	Prevention, early intervention, treatment	Best practice
National Diabetes Education Site	Activate Allen County/YMCA	Adults	Prevention, early intervention, treatment	Evidence Based
Healthy Vending	Ohio State Lima	Faculty/Staff, Students	Prevention	Evidence Based
Sports Medicine Program, Cardiac Rehabilitation, Farmers Market, Healthy Living Naturally Slim, D54U Diabetes program, Diabetes Clinic, Red Yellow Green Program	St. Rita's Medical Center	All Ages	Prevention, early intervention, treatment	Best practice
Elderly Daycare, Dance Programs, Caregivers Program, Diabetics are Us Program, Transportation	Council on Aging	Ages 60 + Allen County Residents	Prevention, early intervention, treatment	Best practice
Exercise Classes	Delphos Senior Center, Lima Senior Center, Bluffton Senior Center	Ages 50+/60+	Prevention, early intervention, treatment	Best practice
Chronic Disease Self-Management (diabetes, Healthy U, pain management, nutrition therapy, in home nutrition counseling)	Area Agency on Aging (AAA 3)	60 +	Treatment	Evidence Based
Tia-Chi. Steady U- Falls Prevention, Senior Farmers Markets, Home Meal Delivery	Area Agency on Aging (AAA 3)	60 +	Prevention	Evidence Based

Strategy #2: Improve Maternal and Infant Health Resource Assessment				
Program/Strategy/ Service	**Responsible Agency**	**Population(s) Served**	**Continuum of Care** (prevention, early intervention, or treatment)	**Evidence of Effectiveness**
Early intervention, home visits, Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)	Help Me Grow	Birth- Age 3/ Maternal, Birth- Age 5	Prevention, early intervention	Evidence based
Bridges, Excel, Women of Worth, Sleep & Ride, Ultrasounds	Heartbeat of Lima	Pregnant Women	Support Services	Evidence based
Education Programs	Teen Pregnancy Prevention Task Force (TPPTF)	Teens and parents of youth and adolescents	Prevention	
Homeless shelter for pregnant teens	Guiding Light	Homeless pregnant teens	Early intervention	Best practice
Parenting Classes	Allen County Children Services	Parents of children of all ages	Prevention, early intervention	
Early Child Coordinating Committee	Family and Children First Council	Birth- Age 5	Prevention and education	
The BABY Project	Connected Hands	Young pregnant females or young parents	Prevention	
Women Infants and Children (WIC) Breastfeeding support, mother and infant nutrition	Allen County Health Department	Birth- Age 5 and Pregnant Women	Prevention, early intervention and treatment	Evidence based
Reproductive Health and Wellness	Allen County Health Department	Teens through reproductive years	Prevention	Best practice
Bureau for Children with Medical Handicaps (BCMH)	Allen County Health Department	Birth- Age 21	Intervention, treatment	Best practice
Caring For Two	Allen County Health Department	Young African American Mothers and Infants to Age 2	Prevention	Evidence based
Happiest Baby Program	Health Partners of Western Ohio	Uninsured, low income patients	Prevention	Best practice
Child Immunization	Health Partners of Western Ohio	Uninsured, low income patients	Prevention	Best practice
Family Planning and STD Clinic	Allen County Health Department	Young and Middle Aged Men and Women	Prevention, Early Intervention and Treatment	
Breastfeeding Worksite Program	Allen County Health Department, CFHS, Creating Healthy Communities; Small Community Transformation Grant	Employers of Breastfeeding Women	Prevention	Best practice Policies Formed

Reducing the Risk Pregnancy Prevention Program	Lima City Schools	High school youth	Prevention	Evidence based
Incredible Years Preschool-Basic	Help Me Grow-ACBDD	Parents of Children Birth to 3 Years	Prevention	Evidence Based
Parents in Progress	Connected Hands Helping Others	Parents of young children	Prevention	Using the "1-2-3-4 Parents" Curriculum
Nurturing Parents Program	LACCA/Head Start	Parents of young children	Prevention	Evidence based
Incredible Years Parenting Program	Family Resource Center	Parents of young children	Prevention	Evidence based
Incredible Years Dinosaur Child Training	Family Resource Center	Children ages 4-7	Prevention	Evidence based
ACT Against Violence "Parents Raising Safe Kids"	Partnership for Violence Free Families	Young Parents	Prevention	Evidence based
Incredible Years	Lima City Schools	Kindergarten -1st grade	Prevention	Evidence based
Child Fatality Review Board	Allen County Health Department	Review deaths of children 17 and under for preventable strategies	Prevention	Best practice
Early Head Start	LACCA	Birth- Age 3	Prevention	Evidence based
Head Start	LACCA	Ages 3-5	Prevention	Evidence based
Fatherhood Program	LACCA & Allen County Health Department	Fathers of all ages	Prevention	
OB Services, Level 2 Nursery, Breastfeeding classes, Prenatal classes, Baby Fairs, Baby Friendly Initiatives	Lima Memorial Health System and St. Rita's Medical Center	All ages	Prevention, early intervention, treatment	Best practice
Children's Developmental Center	Lima Memorial Health System	Children with Special Needs Ages 2-5	Prevention, early intervention, treatment	Best practice

Strategy #2: Decrease Mental Health and Substance Abuse Issues Resource Assessment				
Program/Strategy/ Service	**Responsible Agency**	**Population(s) Served**	**Continuum of Care** (prevention, early intervention, or treatment)	**Evidence of Effectiveness**
Mental Health Counseling, SBIRT screening &, brief intervention, post-partum screenings	Health Partners of Western Ohio	Low- moderate complexity patients/low income mothers	Treatment	Outcomes measured Evidence based
Conscious Discipline	Head Start	Birth-Age 3/ Agency-wide training for employees	Prevention	Evidence based
Adult and Geriatric Psychiatric Unit, Mercy Hall-Addiction Services, Behavioral Access Center, Mobile Behavior Access Center, patient treatment intervention	St. Rita's Medical Center	Adults	Treatment	Outcomes monitored
Mental Health Evaluations	Lima City Schools	High school students	Prevention, early intervention	Best practice
Support Services	YMCA	All ages	Treatment	
Mental health counseling, youth substance abuse counseling, Incredible Years, PAX Good Behavior Game, Dina School, Life Skills Training	Mental Health and Recovery Services Board/ Specialized Alternatives for Families and Youth (SAFY), Family Resource Center	Youth and children	Prevention, early intervention, treatment	Evidence based
We Care at Work	Mental Health and Recovery Services Board	Working adults	Prevention, early intervention, treatment	Best practice
Adults and Children Together- Raising Safe Kids	PVFF	Parents	Prevention	Evidence based
Mental Health First Aid	PVFF	Adults	Prevention	Evidence based
Lifeline Suicide Prevention Program	PVFF	Teens/parents/staff	Prevention	Evidence based
Engaging Communities (AOD prevention group), support groups, LGBT support services, PFLAG	PVFF	Adults and youth	Prevention	Evidence based
Olweus Bullying Prevention Program	PVFF	Youth	Prevention	Evidence based
Safe Dates	PVFF	7th-12th grade youth	Prevention	Evidence based
Alcohol and drug addiction services, Resist Weed Group, prevention groups, social skills groups for youth with developmental disabilities, adolescent sexual intervention groups	SAFY	Youth	Prevention, early intervention, treatment	Outcomes monitored
Crisis Stabilization Unit, crisis/information referral hotline, Day Center, addiction/mental health services and programs, counseling, education, intervention, screening, treatment (multiple services)	Coleman Professional Services	All ages	Prevention, early intervention and treatment	Outcomes monitored
Child observation/screening	LACCA	Children ages 3-5	Screening/ prevention	Best practice

Intersystem Committee for youth (family centered support system)	Family and Children First Council and multiple agencies,	Families		
Adolescent Committee	Family and Children First Council		Prevention	
Child Advocacy Center	MHRSB/Hospitals CSB, Crime Victim Services	Children	Prevention and treatment	Evidence based
Court Appointed Special Advocate	Crime Victim Services	Children		
Alcoholics Anonymous, Al-Anon, Celebrate Recovery	Multiple Locations	Adults	Prevention, early intervention and treatment	Best practice
Substance abuse prevention programs, housing for women	UMADAOP	African American (predominantly) adults and youth	Prevention, early intervention and treatment	Evidence based program
Re-entry Program /Open-Gate Program	Coleman/MHRSB	Adults and families	Prevention, early intervention and treatment	
Healthy IDEAS depression screenings and referral (social work counseling)	Area Agency on Aging (AAA3)	60 +	Early intervention	Evidence based
Ohio Works- mental health and substance abuse screenings	Department of Jobs and Family Services	Adults who receive public assistance/child support delinquent	Early Intervention	Tracking participants
Day camps, adult weekend camps, social activities	ARC	Children & adults with developmental disabilities and their families	Early Intervention and Treatment	Tracking participants
AIDS Resources	AIDS Resource Center	All ages	Early intervention, treatment	Outcomes monitored
DMC Task Force	Juvenile Court	Youth		
Domestic violence shelter	The Crossroads Crisis Center	All ages (mostly women and children)	Prevention, early intervention, treatment	Best practice
Suicide Prevention Coalition	PVFF	All ages	Prevention, early intervention, treatment	Best practice
Safe Harbor	SAFY	Adolescents	Prevention, early intervention, treatment	
Numerous shelters	Multiple organizations	All ages		Best practice
Mental Health Counseling	Ohio Youth Advocacy Program	Children	Treatment	Best practice
Counseling and multiple programs	Lutheran Social Services	Families	Prevention, early intervention, treatment	Best practice
Counseling and multiple programs	Covenant Ministries and Counseling	Adults and youth	Prevention, early intervention, treatment	Best practice

Strategy #4: Increase Access to Care ***Resource Assessment***				
Program/Strategy/ Service	**Responsible Agency**	**Population(s) Served**	**Continuum of Care** (prevention, early intervention, or treatment)	**Evidence of Effectiveness**
Comprehensive Charity Care Policies	St. Rita's Medical Center/Lima Memorial Health System	10 County Area	Prevention, early intervention, treatment	Outcomes monitored
Financial Assistance Programs	St. Rita's Medical Center/Lima Memorial Health System	10 County Area	Prevention, early intervention, treatment	Outcomes monitored
Indigent Medication Program	St. Rita's Medical Center/Lima Memorial Health System	10 County Area	Prevention, early intervention, treatment	Outcomes monitored
Health Insurance Exchange Program	St. Rita's Medical Center/Lima Memorial Health System	10 County Area	Prevention, early intervention, treatment	Outcomes monitored
I-Triage	St. Rita's Medical Center/Lima Memorial Health System	10 County Area	Prevention, early intervention, treatment	Outcomes monitored
Primary Care Medical, Dental, Behavioral Health, Pharmacy, and Chiropractic Care	Health Partners of Western Ohio	Low Income	Prevention, early intervention, treatment	Outcomes monitored
Health Insurance Exchange Certified Application Counselors	Health Partners of Western Ohio	All Populations	Prevention, early intervention, treatment	Outcomes monitored
Ohio Benefits Bank Counselors	Health Partners of Western Ohio	Low Income (sliding fee discount offered)	Prevention, early intervention, treatment	Outcomes monitored
Transportation Assistance	Health Partners of Western Ohio	Current Patients	Prevention, early intervention, treatment	Best practice
School Based Dental Outreach Sealants Program	Health Partners of Western Ohio	School aged youth	Prevention	Best practice
Home Medication Deliveries	Health Partners of Western Ohio	Current Patients	Prevention, early intervention, treatment	Best practice
Pharmacy Discount Program (nine different inventories of meds at reduced price for people living up to 300% federal poverty standards)	Health Partners of Northwest Ohio	Current Patients	Prevention, early intervention, treatment	Best practice
HIV Screening	Health Partners of Northwest Ohio	Current Patients	Prevention, early intervention, treatment	Best practice
Good Rides	Good Will			Best practice
RTA	RTA	All ages		Best practice
RPC-Funded Vans	Council on Aging, Marimor	Elderly/disabled		Best practice
Transportation vouchers	Varies by funding ability			Best practice
Kids Clinic	Lima Memorial Health System	Sexually Abused Children	Treatment	Evidence based

Primary Care Via Patient Centered Medical Homes	Health Partners of Western Ohio	All Ages	Prevention, early intervention and treatment	Reduction in chronic illness numbers
Breast and Cervical Cancer Program	Allen County Health Department	Women: Ages 40-46 / Paps; Ages 50-64 For Mammograms	Early Intervention and/or treatment	Reduction in late stage diagnosis of breast and cervical cancers
Komen Community Grant	Lima Memorial Health System	Mammograms for Men and Women Below the Age of 50 Years Old	Early Intervention	Reduction in late stage diagnosis of breast cancer

Gap Analysis

The CHIP Committee also met to determine existing discrepancies between community needs and viable community resources to address local priorities. The group also developed potential strategies to address the identified gaps. The following tables show the Gaps and Potential Strategies identified for each priority area.

Strategy #1: Increase Wellness Gaps & Potential Strategies	
Gaps	**Potential Strategies**
Lack of policy level changes that impact wellness	• Creating a food policy council • Underwrite a Local Foods Plan • Coordinate a group such as our County Commissioners' to address wellness policies
Lack of awareness of wellness initiatives	• Increase awareness and communication
Not enough focus on prevention	• Increase focus on prevention
Active family programming	• Increase focus on family activities
County wide wellness initiatives	• Weight loss programs on bigger level
Lack of pediatric endocrinologists	• Increase providers/bring more doctors to area • Satellite offices • Tele-medicine
Lack of program evaluation data	• Increase community awareness of programs • Increase community awareness of successes • Increase evaluation of outcomes
Lack of resources for low-income populations (exercise)	• Community walking programs • Churches facilitating exercise classes • Increase free and/or low cost fitness opportunities • Increase parks & recreation capital improvement funding
Lack of stable funding- longevity (short-term grants not providing sustainability for programs)	• Work on leveraging local funds
Not enough people who want to work on policy making	• No guidance to work at that level • Coordinated group • County commissioners being champions
Difficulty getting physical activity in schools	• Activate Allen County is looking at schools wellness policies • Wellness Council (appointee from each school)
No system to connect all schools wellness policies together	• Tie it to outcomes that schools value • Create a school wellness council with appointees from each district

Culture not valuing wellness	• Reduce social stigma around modes of transportation
Lack of inner-agency coordination	• Increase programing collaboration • Need an agency "convener" someone to take charge • Continue going after funding jointly; collaborate • Create a Cooperation Model for agencies

Strategy #2: Improve Maternal and Infant Health ***Gaps & Potential Strategies***	
Gaps	**Potential Strategies**
Lack of focus on preconception health	• Increase health care focus on things you can do before and between pregnancies to increase the chances of having a healthy baby • Increase emphasis on the health of women before they become pregnant
Lack of focus on social determinants of health related to birth outcomes	• Looking at census tracts (Data from hospitals would be required) • Work to address disparities

Strategy #3: Decrease Mental Health and Substance Abuse Issues ***Gaps & Potential Strategies***	
Gaps	**Potential Strategies**
Shortage of trained/licensed providers	• No strategy identified
Funding eligibility for benefits	• No strategy identified
Detoxification and recovery housing for addiction	• No strategy identified
Transportation assistance	• Public Transit and paratransit services exist at RTA, Find-A-Ride supported by the Area Agency on Aging, and of course Black & White. However, RTA and AAA services are limited in terms of hours and funding. I was under the impression that under "Obama Care" Health Care Providers were required to provide transport for medical services. A Transportation Levy would be an option.
Transitional housing for youth ages 18-21	• No strategy identified
Integration of behavioral health into primary care	• Create a more holistic approach • "No Wrong Door" approach- increase referrals • Increase Healthy Homes
Lack of awareness of services and how to access them	• Increase awareness • Increase communication among providers • Explore opportunities for mental health/substance abuse screening be built into employment process especially temporary employment services
Behavioral health prevention program aimed at parents, caregivers and teachers of young children.	• Incorporate the PAX Program and Conscious Discipline Program into current programming

Comprehensive evidence based substance abuse prevention curriculum (grades 9-12)	• Strengthening Families Program • Too Good for Drugs • Michigan Model for Health
Culturally competent access to mental health care for youth ages 12-18	• Textable helpline • Online textable/chatable website for assistance

Strategy #4: Increase Access to Care Gaps & Potential Strategies	
Gaps	**Potential Strategies**
Transportation/ job access (scheduling and routes)	• Work with RTA to create efficient and more consistent routes • Address the cultural stigma around public transportation • The routes are constructed now using sophisticated software to serve the transit dependent and those most likely to need transit services. Increased efficiency will only come about as a result of increased frequency of trips. The City of Lima and ODOT provide the lone funding to support a federal stream for public transit services. We are maxed out on the amount of federal funds we can drawdown. Support from the County was terminated, no support was ever provided by the Townships or villages. A county-wide Transportation Levy that could be tapped by multiple sources under a brokerage-type of service would be a viable option.
Cultural Competency	• Provide relevant trainings on cultural competence • Create policies that reduce barriers to care
Quality Clinical Care	• Notify insurance providers when physicians are not providing all necessary components of physicals etc… • Increase clinical quality measures and quality improvement
Lack of awareness of services	• Increase awareness of available services. Increase communication among providers (No Wrong Door approach)

Best Practices

The following information shows the identified Best Practices that have been shown to be effective in addressing the prioritized areas.

Strategy #1: Increase Wellness
Best Practices

Best Practices

1. **Health Insurance Incentives & Penalties:** The number of employers offering financial rewards for participating in wellness programs rose by 50 percent from 2009 to 2011. In 2012, four out of five companies planned to offer some type of financial health incentive. The use of penalties among employers more than doubled from 2009 to 2011, rising from 8 percent to 19 percent. It could double again next year when 38 percent of companies plan to have penalties in place. Requiring smokers to pay a higher portion of the health insurance premium is among the most common penalties. A growing number of employers also base rewards on actual outcomes, such as reaching targeted healthy weights or cholesterol levels, rather than simply rewarding participation.
A provision in the federal health care reform law will let employers offer greater incentives for participating in wellness programs starting in 2014. Under current rules, employers can provide incentives of up to 20 percent of the total health insurance premium per person. The 2010 Patient Protection and Affordable Care Act boosts the threshold to 30 percent and, in cases approved by federal health and labor officials, up to 50 percent in 2014.
Employer programs often reward employees who exercise, lose weight or participate in disease management programs. Incentives may include cash awards, gift cards, higher employer contributions toward the health insurance premium, contributions toward employee health savings accounts, or the chance to compete in a sweepstakes. A lot of research shows people are very much motivated by the potential of a large prize. Some employers offer both individual awards and team awards.
Some employers have found rescission of a reward especially effective. For instance, an employer might offer a $500 health insurance premium discount to everyone and rescind the reward for employees who choose not to participate in the care management program.

2. **Worksite Obesity Prevention Interventions**: Worksite nutrition and physical activity programs use educational, environmental, and behavioral strategies to improve health-related behaviors and health outcomes. These programs may include written materials, skill-building (e.g., cue control), individual or group counseling, improved access to healthy foods (e.g., changing cafeteria or vending machine options), and opportunities to be more active at work (e.g., on-site facilities for exercise or standing/walking workstations) (CG-Obesity).

Expected Beneficial Outcomes

- Increased fruit & vegetable consumption
- Increased physical activity
- Increased weight loss

Evidence of Effectiveness

There is strong evidence that worksite nutrition and physical activity programs increase physical activity, weight loss (Verweij 2011, CG-Obesity), and fruit and vegetable consumption among employees (Verweij 2011).

Worksite nutrition and physical activity programs that utilize multiple components appear to be more successful than programs that utilize only one component (CG-Obesity). Successful programs have been

shown to enhance self-confidence for participants, and benefit employers through increased employee productivity and reduced medical care costs (CG-Obesity).

Worksite programs appear to be cost effective strategies to increase physical activity and improve weight status (CG-Obesity).

Impact on Disparities

No impact on disparities likely

3. Breastfeeding Promotion Programs: Breastfeeding promotion programs aim to increase breastfeeding initiation, exclusive breastfeeding, and duration of breastfeeding.

Evidence of Effectiveness

There is strong evidence that breastfeeding promotion programs increase initiation, duration and exclusivity of breastfeeding. Breastfeeding has also been shown to provide health benefits to mother and child, including reduced rates of breast and ovarian cancer for women; fewer ear infections, lower respiratory tract infections, and gastrointestinal infections for children; and lower likelihood of childhood obesity, type 2 diabetes, and asthma *(USPSTF-Breastfeeding, 2008)*. Education interventions increase breastfeeding initiation rates, particularly in low income women. Face to face support and tailored education increase the effectiveness of support efforts. Combining pre- and post-natal interventions increases initiation and duration more than pre- or post-natal efforts alone. Support from health professionals, lay health workers, and peers have demonstrated positive effects, including increasing initiation, duration, and exclusivity. Implementing components of the Baby Friendly Hospitals Initiative, as a whole or individually, has been shown to increase breastfeeding rates. This includes practices in maternal care such as rooming in, staff training to support breastfeeding, and maternal education. For employed mothers, supportive work environments increase the duration of breastfeeding.
The Affordable Care Act includes provisions to encourage breastfeeding, including requiring insurance coverage of supplies and support, and requiring employers to provide unpaid time and private space for nursing mothers to pump breast milk at work *(AMCHP-Breastfeeding, 2012)*. Forty-five states and Washington DC have laws that allow women to breastfeed in any public or private location *(NCSL-Breastfeeding*). For more information go to:
http://www.countyhealthrankings.org/policies/breastfeeding-promotion-programs

4. Healthy Hospitals Initiatives/Dietary Guidelines for Americans, 2010: The Dietary Guidelines for Americans are evidence-based recommendations intended to help people choose an overall healthy diet. The 2010 Dietary Guidelines include 23 key recommendations for the general population and 6 additional key recommendations for specific population groups, such as pregnant women.

Developed By: USDA/CNPP, HHS/OASH

For more information go to:
http://www.cnpp.usda.gov/Publications/DietaryGuidelines/2010/PolicyDoc/PolicyDoc.pdf

5. School-Based Obesity Prevention Interventions: School-based obesity prevention programs seek to increase physical activity and improve nutrition before, during, and after school. Programs combine educational, behavioral, environmental, and other components such as health and nutrition education classes, enhanced physical education and activities, promotion of healthy food options, and family education and involvement. Specific components vary by program.

Expected Beneficial Outcomes

- Increased physical activity
- Increased physical fitness
- Improved weight status
- Increased consumption of fruit & vegetables

Evidence of Effectiveness

There is strong evidence that multi-component school-based obesity prevention programs increase physical activity (Nixon 2012, Cochrane-Dobbins 2009, Demetriou 2012), improve weight status (Khambalia 2012, Cochrane-Waters 2011, Katz 2008), and improve dietary habits (Kropski 2008, Van Cauwenberghe 2012, Cawley J, Cisek-Gillman L, Roberts R, et al. Effect of HealthCorps, a high school peer mentoring program, on youth diet and physical activity. Childhood Obesity. 2011;7(5):364–71. Link to original source (journal subscription may be required for access)Cawley 2011). However, there is significant variability in program design and effect (Brown 2009, Harris 2009a, CG-Obesity). Additional evidence is needed to confirm effects on body mass index (BMI) and characteristics of successful programs.
For more information go to: http://www.countyhealthrankings.org/policies/school-based-obesity-prevention-interventions

Strategy #2: Improve Maternal and Infant Health
Best Practices

Best Practices

1. **Prenatal care in the first trimester** – Accessing prenatal care in the first trimester by 10 to 12 weeks is vital to improve pregnancy outcomes. HRSA recommends the way to increase the rate of early access to prenatal care is to increase awareness of the importance of prenatal care and to standardize preconception health as part of the routine health care for women of childbearing age. Adequate prenatal care includes counseling, education, along with identification and treatment of potential complications. There are no evidence-based guidelines regarding the content of prenatal visits, but they usually include evaluation of blood pressure, weight, protein levels in the urine, and monitoring fetal heart rate.
   For more information, go to:
   http://www.hrsa.gov/quality/toolbox/measures/prenatalfirsttrimester/part3.html

2. **Expand Use of Community Health Workers (CHW):** Community health workers (CHW), sometimes called lay health workers, serve a variety of functions, including: providing outreach, education, referral and follow-up, case management, advocacy and home visiting services. They may work autonomously or as part of a multi-disciplinary team; training varies widely with intended role and location. CHW services are often targeted at women who are at high risk for poor birth outcomes.

   #### Expected Beneficial Outcomes

   - Increased patient knowledge
   - Increased access to care
   - Increased use of preventive services
   - Improved health behaviors

   #### Evidence of Effectiveness

   - There is some evidence that CHWs improve patient knowledge and access to health care, especially for minority women and individuals with low incomes.

- CHWs have been shown to improve access to care for patients that my not otherwise receive care.
- CHWs appear as effective as, and sometimes more effective than, alternate approaches to disease prevention, asthma management, efforts to improve colorectal cancer screening, chronic disease management, and maternal and child health.

Impact on Disparities:
Likely to decrease disparities
For more information go to: http://www.countyhealthrankings.org/policies/expand-use-community-health-workers-chw

Strategy #3: Decrease Mental Health and Substance Abuse Issues
Best Practices

Best Practices

Through proven and promising best practices, effective programs will be better able to help achieve the Healthy People 2020 Mental Health and Mental Disorders Objectives to improve mental health through prevention and ensure access to appropriate, quality mental health services.
Healthy People 2020 goals include:

- Reduce the suicide rate
- Reduce suicide attempts by adolescents
- Reduce the proportion of adults aged 18 and older who experience major depressive episodes (MDEs)
- Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral
- Increase the proportion of persons with serious mental illness (SMI) that are employed
- Increase the proportion of adults aged 18 years and older with serious mental illness who receive treatment
- Increase the proportion of adults aged 18 years and older with major depressive episodes (MDEs) who receive treatment
- Increase the proportion of primary care physicians who screen adults aged 19 years and older for depression during office visits
- Increase the proportion of homeless adults with mental health problems who receive mental health services

The following evidence-based community interventions come from the Guide to Community Preventive Services, Centers for Disease Control and Prevention (CDC) and help to meet the Healthy People 2020 Objectives:
Collaborative care for the management of depressive disorders is a multicomponent, healthcare system-level intervention that uses case managers to link primary care providers, patients, and mental health specialists. This collaboration is designed to:

1. Improve the routine screening and diagnosis of depressive disorders
2. Increase provider use of evidence-based protocols for the proactive management of diagnosed depressive disorders
3. Improve clinical and community support for active patient engagement in treatment goal setting and self-management

1. **PHQ-9:** 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, and
- 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 Fourth Edition (DSM-IV).

For more information go to:
http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/

2. **Motivational Interviewing (MI)—**MI is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. MI has been applied to a wide range of problem behaviors related to alcohol and substance abuse as well as health promotion, medical treatment adherence, and mental health issues. The MI counseling style generally includes the following elements:
   - Establishing rapport with the client and listening reflectively.
   - Asking open-ended questions to explore the client's own motivations for change.
   - Affirming the client's change-related statements and efforts.
   - Eliciting recognition of the gap between current behavior and desired life goals.
   - Asking permission before providing information or advice.
   - Responding to resistance without direct confrontation. (Resistance is used as a feedback signal to the therapist to adjust the approach.)
   - Encouraging the client's self-efficacy for change.
   - Developing an action plan to which the client is willing to commit.

   For more information go to http://www.motivationalinterview.org

3. **Project ASSERT**- 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:
   1. 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).
   2. 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).
   3. 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.

For more information go to: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=222

4. **LifeSkills Training (LST):** LST is a school-based program that aims to prevent alcohol, tobacco, and marijuana use and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. LST is based on both the social influence and competence enhancement models of prevention. Consistent with this theoretical framework, LST addresses multiple risk and protective factors and teaches personal and social skills that build resilience and help youth navigate developmental tasks, including the skills necessary to understand and resist pro-drug influences. LST is designed to provide information relevant to the important life transitions that adolescents and young teens face, using culturally sensitive and developmentally and age-appropriate language and content. Facilitated discussion, structured small group activities, and role-playing scenarios are used to stimulate participation and promote the acquisition of skills. Separate LST programs are offered for elementary school (grades 3-6), middle school (grades 6-9), and high school (grades 9-12). For more information, go to http://www.lifeskillstraining.com.

5. **Too Good For Drugs (TGFD):** Too Good is a comprehensive drug and violence prevention program designed to mitigate risk factors and build protection against problem behaviors. *Too Good* is a framework of social and emotional skills that develops goal-setting, decision-making, and effective communication skills. *Too Good* also builds additional skills for peer pressure refusal, pro-social bonding, conflict resolution, and media literacy

A comprehensive body of evidence demonstrates the positive effects of Too Good on emotional competency skills, decision-making ability, intentions to use illicit substances, substance use behavior, and intentions to engage in aggressive behavior. Too Good programs have demonstrated effectiveness in third party evaluations.

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.

For more information: http://www.toogoodprograms.org/too-good/

Strategy #4: Increase Access to Care
Best Practices

Best Practices

1. **Systems Navigators and Integration (E.g., Patient Navigators):** Patient navigators provide culturally sensitive assistance and care-coordination, guiding patients through available medical, insurance, and social support systems. These programs seek to reduce racial, ethnic, and economic disparities in access to care and disease outcomes.

Expected Beneficial Outcomes:

- Increased use of preventive services
- Increased cancer screening
- Improved birth outcomes
- Improved maternal health

Evidence of Effectiveness

- There is strong evidence that patient navigator programs improve cancer screenings, especially for breast cancer. Additional evidence is needed to confirm effects for programs focused on other health outcomes.

Impact on Disparities:

Likely to decrease disparities

For more information go to: http://www.countyhealthrankings.org/policies/systems-navigators-and-integration-eg-patient-navigators

2. **Expand Use of Community Health Workers (CHW):** Community health workers (CHW), sometimes called lay health workers, serve a variety of functions, including: providing outreach, education, referral and follow-up, case management, advocacy and home visiting services. They may work autonomously or as part of a multi-disciplinary team; training varies widely with intended role and location. CHW services are often targeted at women who are at high risk for poor birth outcomes.

Expected Beneficial Outcomes

- Increased patient knowledge
- Increased access to care
- Increased use of preventive services
- Improved health behaviors

Evidence of Effectiveness

- There is some evidence that CHWs improve patient knowledge and access to health care, especially for minority women and individuals with low incomes.
- CHWs have been shown to improve access to care for patients that my not otherwise receive care.
- CHWs appear as effective as, and sometimes more effective than, alternate approaches to disease prevention, asthma management, efforts to improve colorectal cancer screening, chronic disease management, and maternal and child health.

Impact on Disparities:

Likely to decrease disparities

For more information go to: http://www.countyhealthrankings.org/policies/expand-use-community-health-workers-chw