STARK COUNTY
COMMUNITY HEALTH IMPROVEMENT PLAN
2017-2019

Public Health
Prevent. Promote. Protect.

Stark County Community Health Needs Assessment Advisory Committee

MARCH 2017

ACKNOWLEDGEMENTS

Input for this report provided by staff from all four local health departments in Stark County. This includes: Alliance City Health Department, Canton City Health Department, Massillon City Health Department and Stark County Health Department.

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PROTECTING HEALTH SINCE 1920 SCHD

Public Health
Prevent. Promote. Protect.
Canton City Health District

Alliance City Health Department

Massillon
City of Champions
Health Department

Ohio Department of Health

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LETTER TO THE COMMUNITY

This has been a most significant year in regards to population health planning in Stark County. Partnerships and collaborations are of vital importance in promoting health within a community. The public health departments, hospitals, social service agencies, and private health practitioners in Stark County are committed to making measurable improvements in the health of our community.

The development of the Stark County Health Improvement Plan (CHIP) is the result of collaboration with many community partners. The Stark County Community Health Assessment (CHA) was the foundation for determining the health priorities for the CHIP. The CHA data is a representation of the Stark County population that resides within the four local health districts of Alliance, Canton, Massillon and the Stark County Combined General Health District. This report summarizes the health status of the 375,165 residents who call Stark County home. This data includes: overall health data, behavioral health risks, health outcomes, the built environment and access to medical and dental care.

These partnerships and collaborations have identified significant social disparities and health inequities that are impacting socioeconomic groups within our communities. Together we are combating these factors that influence health by building public health policies, programs, and services to promote health equity and significantly decrease poor health outcomes.

The health of our community is our number one priority. We are committed to providing excellent public health services to the residents of Stark County. These services are built on the foundation of 10 Essential Services. These services are extremely important in guiding public health activities, as well as providing a structure for public health accreditation. Working with our community partners and aligning our resources will be essential to achieving our health priorities. We will all work together to improve the health of our neighbors and achieve a healthier and safer Stark County.

Together, we begin achieving health today.

James M. Adams, RS, MPH
Health Commissioner
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Terri Argent, RS, REHS
Health Commisioner
Massillon, OH

Randall M. Flint, RS, MPH
Health Commissioner
Alliance, OH

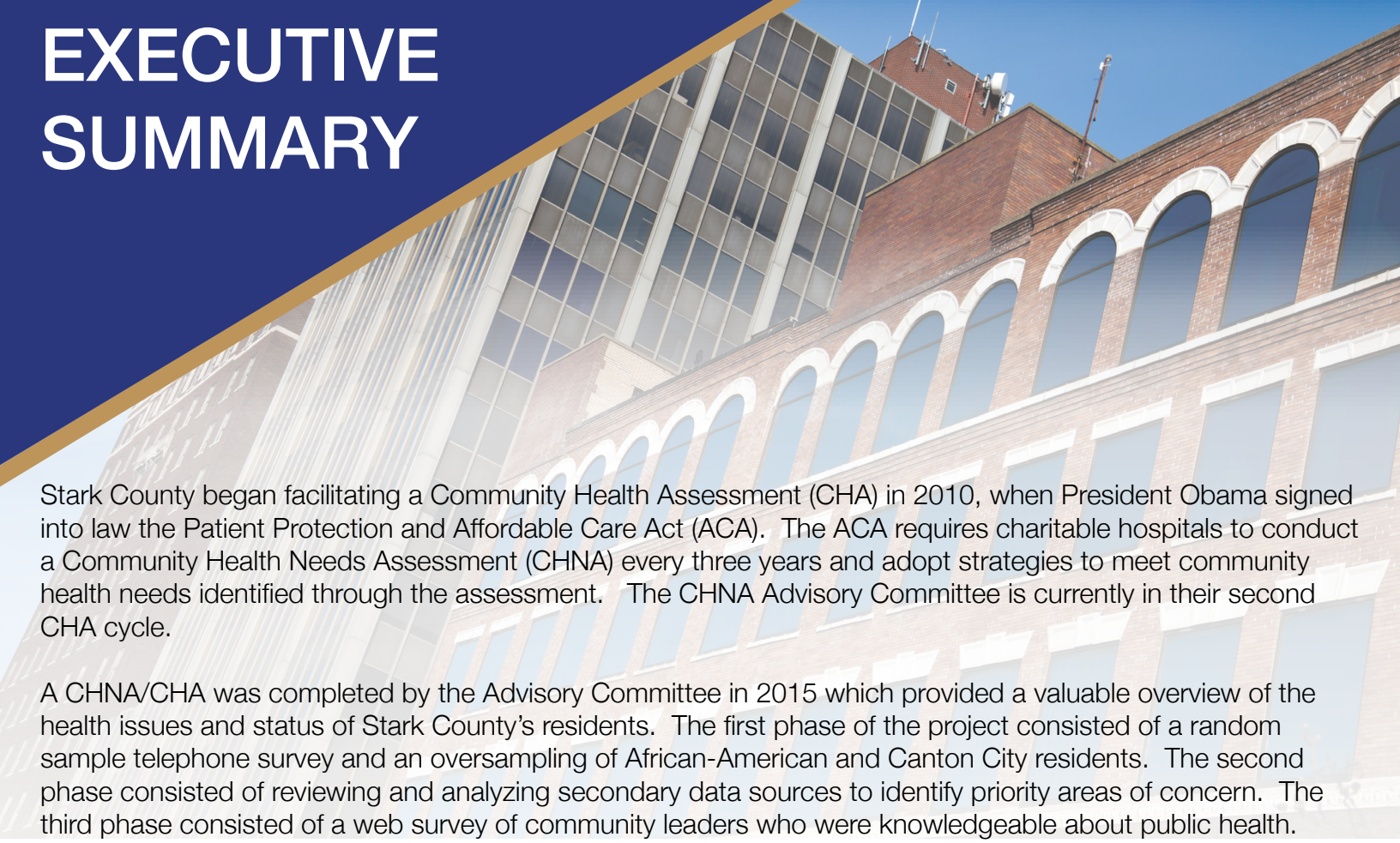
Kirkland K. Norris, RS, MPH
Health Commissioner
Stark County, OH

THE 10 ESSENTIAL SERVICES

The below framework provides a foundation for public health activities at the state and local level, and includes the 10 Essential Services. It is used as the foundation for the National Public Health Performance Standards (NPHPS), and provides structure for public health accreditation.

CDC. (2014, May). National Public Health Performance Standards. Retrieved from http://www.cdc.gov/nphpsp/essentialservices.html

EXECUTIVE SUMMARY



Stark County began facilitating a Community Health Assessment (CHA) in 2010, when President Obama signed into law the Patient Protection and Affordable Care Act (ACA). The ACA requires charitable hospitals to conduct a Community Health Needs Assessment (CHNA) every three years and adopt strategies to meet community health needs identified through the assessment. The CHNA Advisory Committee is currently in their second CHA cycle.

A CHNA/CHA was completed by the Advisory Committee in 2015 which provided a valuable overview of the health issues and status of Stark County's residents. The first phase of the project consisted of a random sample telephone survey and an oversampling of African-American and Canton City residents. The second phase consisted of reviewing and analyzing secondary data sources to identify priority areas of concern. The third phase consisted of a web survey of community leaders who were knowledgeable about public health. Using all available data, the top five priority health areas were identified as part of the CHNA/CHA process.

An annual Health Improvement Summit has been organized each year since 2011. The 2016 Health improvement Summit was held Wednesday, February 24th at Walsh University. The purpose of the 2016 Summit was to narrow down the top five priority health areas identified within the 2015 CHNA and to create the framework for Stark County's 2017-2019 Community Health Improvement Plan (CHIP). Over 100 advocates with representatives from healthcare, mental health, non-profit organizations, public health, local business, governmental leaders, and community members attended the 2016 Summit to discuss the assessment findings and vote on the top three priority areas to be addressed within Stark County's CHIP. The three priority health areas voted the most important for Stark County were:

1. Access to Health Care
2. Mental Health
3. Infant Mortality

Additionally, the city of Canton has developed an annex for the plan, prioritizing Obesity and Healthy Lifestyles.

Stark County's CHIP is a plan that identifies health priorities, goals and long-term key measures that will be used by community partners to guide project development, programs, and policies targeted to improve the health outcomes of Stark County residents. Community advocates were closely involved in the development of Stark County's 2017-2019 CHIP. A lead agency was identified to facilitate a subcommittee for each priority area. The three subcommittees will create and work on action plans outlining how the long-term key measures will be accomplished through strategies and activities.

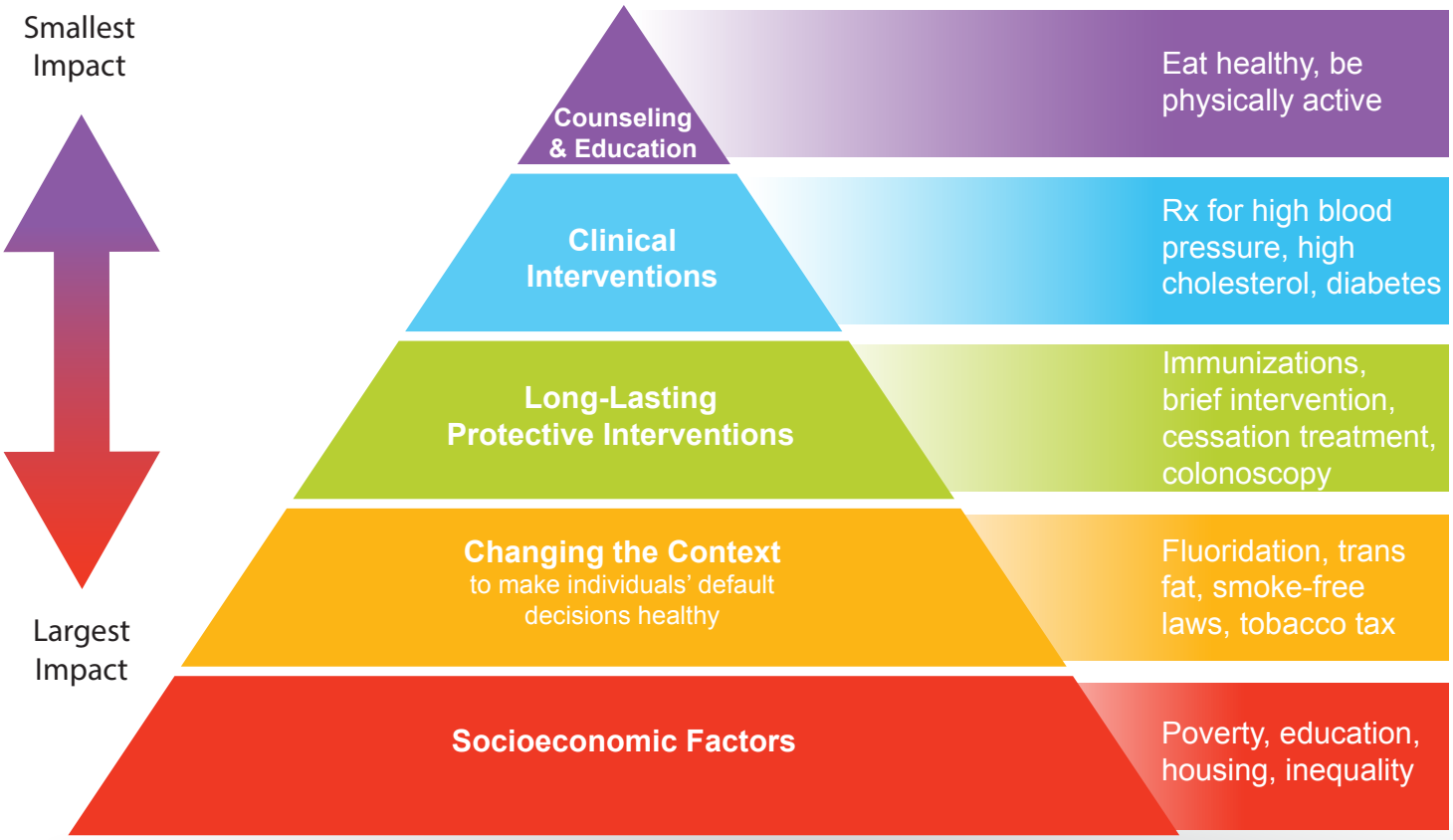
Implementation and monitoring of the CHIP will begin in mid-2017. Annually, the Advisory Committee will publish an evaluation report outlining the progress of the three priority health areas. Revisions to the plan will be based on the annual evaluation report. Following the next CHA in 2018 the community health improvement planning process will begin again.

ABOUT THE PLAN

This document, the Community Health Improvement Plan (CHIP), provides a long-term vision and describes the goals and long–term key measures that will be addressed in the community as organizations and initiatives implement projects, programs, and policies. This plan is used by public health, health care, and other governmental, education and human service agencies, in collaboration with community partners, to set priorities, coordinate services, and target resources.

A Community Health Improvement Plan is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community through a collaborative process and should address the gamut of strengths, weaknesses, challenges, and opportunities that exist in the community to improve the health status of that community.

The Health Impact Pyramid, below, serves as a guide to identify the most effective strategies, or those with the largest impact.



The Health Impact Pyramid (Frieden, 2010)

STARK COUNTY CHNA/CHA PROCESS

CHNA Advisory Committee: Facilitated By Stark County Health Department

CHA Model Used: Community Health Improvement Cycle (CHIC)

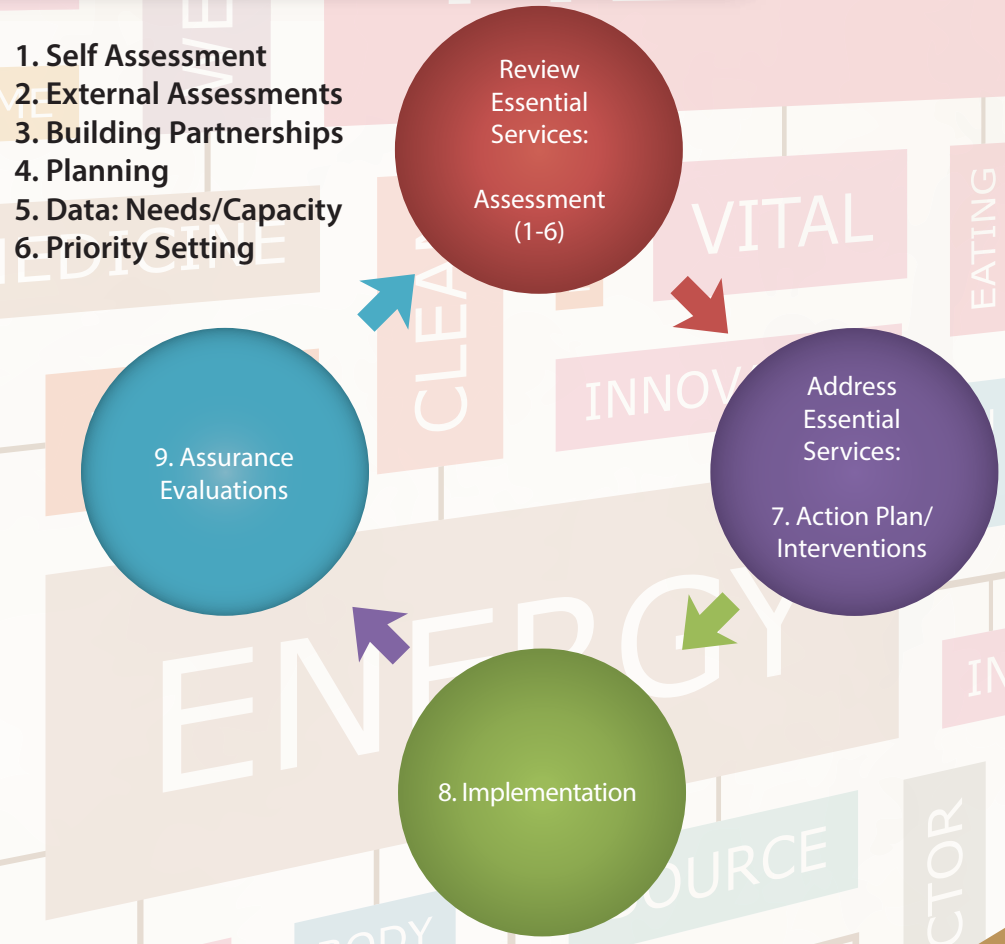
Stark County uses the Community Health Improvement Cycle (CHIC), provided by the Ohio Department of Health, through the Child and Family Health Services (CFHS) program. This process includes performing ongoing community health assessment and planning by: building partnerships, coordinating a consortium, conducting planning, assessing data needs and capacity, conducting prioritization, planning interventions, planning implementation and conducting evaluation.

Cycle: Every 3-5 Years

Participants:
- ✔ Health Departments
- ✔ Hospitals
- ✔ Social Service Agencies
- ✔ Non-Profit Organizations
- ✔ Community Advocates/Volunteers
- ✔ Foundations

Health Improvement Summits:

Since 2011, an Annual Health Improvement Summit has been held to provide updates to the CHNA process, as well as to provide information andpresentations on topics addressedin the CHIP.



COMMUNITY HEALTH IMPROVEMENT PLAN TIMELINE

July 2015	Community Health Assessment (CHA) - Telephone Poll, Stakeholder Web Survey, Secondary Data Analysis
September 2015	SWOT Analysis
February 2016	Prioritization at Health Improvement Summit
Summer/Fall 2016	Community Health Improvement Plan (CHIP) Development; strategies and interventions identified
February 2017	CHIP Reviewed at Health Improvement Summit; begin CHIP implementation
March 2017	CHIP Finalized; begin to update, review and monitor CHIP implementation
January 2018	Evaluate CHIP; review and revise goals and objectives regularly; continue implementation
Spring 2018	CHA; data collection begins again

SWOT ANALYSIS

The Advisory Committee also conducted a SWOT Analysis in 2015 to identify the committee's strengths, weaknesses, opportunities for improvement, and threats/challenges (SWOT); in order to improve the current CHA cycles outcomes. The Advisory Committee's SWOT Analysis identified the following:

STRENGTHS

- ✔ Agency participation and support.
- ✔ More awareness and understanding of the process, programs and interventions.
- ✔ More targeted programs.
- ✔ Comprehensive data.
- ✔ Good participation and cooperation between hospitals and local health departments.
- ✔ Alignment of shared priorities.

WEAKNESSES

- ✔ Lack of diversity to membership team (minority groups and community members).
- ✔ Lack of measureable goals/objectives/ activities within CHIP.
- ✔ Lack of youth data.
- ✔ Gaps in services not identified.
- ✔ Relying only on data to identify health problems/issues.
- ✔ Lack of current data.
- ✔ Data analysis capacity.
- ✔ Acknowledging barriers that are out of our control/limitations.

OPPORTUNITIES

- ✔ Increase referral processes and getting individuals the services they need.
- ✔ Increase community engagement.
- ✔ Have a shared sense of engagement (all moving in the same direction).
- ✔ Increase more secondary data regarding youth.
- ✔ Increase investment in complex health issues (opportunity to receive funding from local organizations).
- ✔ Process allows each individual/agency to breakout of existing silos.

THREATS/CHALLENGES

- ✔ Increase awareness of referral process.
- ✔ Reporting progress toward goals/ objectives/activities.
- ✔ Better system to disseminate findings/ progress being made.
- ✔ Each individual/agency working in their own silos.
- ✔ Policy barriers.

SOCIAL DETERMINANTS OF HEALTH

Many factors affect the health of individuals, namely diet, exercise, and smoking status. However, social determinants of health are better predictors of health outcomes. “Social determinants of health are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.” The social determinants of health include the neighborhood and the built environment in which you live, work, worship, etc; availability and quality of healthcare; the type of support available to you from your community and social groups; access to and quality of education; and economic stability. Unfortunately, better social and economic opportunities are afforded to some groups of people more than others contributing to health inequalities. Therefore, when looking at community health and developing plans for its improvement, considering social determinants of health is very important.

https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

EQUALITY VS. EQUITY

Social Determinants of health are addressed throughout each of the priority areas identified in this report. Like a ribbon that is weaved throughout this plan, social determinants have been considered in selecting many of the strategies, interventions and/or programs identified. There will be a focus on increasing cultural awareness and competency of health care and social service providers, addressing environmental factors and barriers, and connecting to communities at risk for poor health outcomes in a respectful and appropriate manner. This is essential in order to make positive health outcomes to our community as a whole. Many of the goals and strategies identified in this plan aim to provide "equity" for individuals who are at a higher risk for poor health outcomes, as opposed to "equality" as illustrated below.

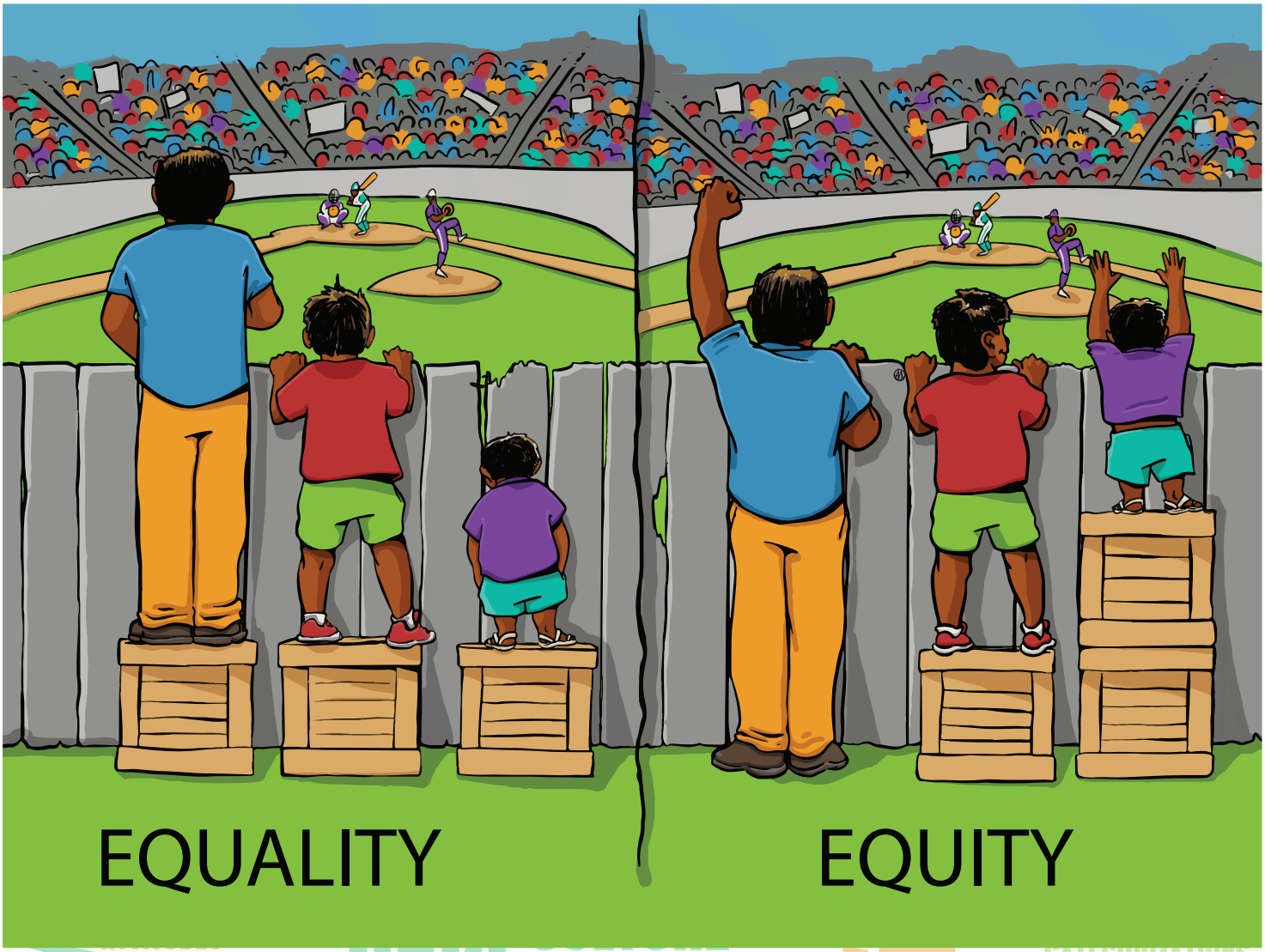


Image Credit: Interaction Institute for Social Change | Artist: Angus Maguire.

HEALTH PRIORITY SELECTION/ACTION PLAN DEVELOPMENT

At the Health Improvement Summit in February, 2016, after voting for the top three health priorities, participants who attended were asked to indicate their interest in helping to develop an action plan to address each health priority. Volunteers were obtained from the Summit evaluation and from the regular CHNA Advisory Committee to work on one of the three priorities. From June until September of 2016, three separate groups met and created a framework for addressing the health priorities for the CHIP. More than 100 community partners representing hospitals and healthcare providers, city and county government, law enforcement, and not-for-profits participated in the development of the CHIP.

ACCESS TO HEALTH CARE

Goal 1

All people have equitable access to healthcare services.

Key Measures:

- ✔ Increase use of community health workers (CHW's) in Stark County by 75%.
- ✔ Reduce barriers to accessing health care for vulnerable populations.
- ✔ Decrease the percentage of respondents from vulnerable populations who report not having a primary care provider from 16% to 10%.
- ✔ Decrease the percentage of respondents from vulnerable populations who report not having health insurance from 10% to 5%.

Goal 2

All people have the ability to live their healthiest life.

Key Measure:

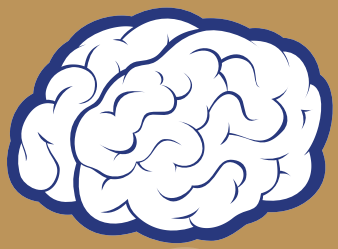
- ✔ Decrease the percentage of respondents from vulnerable populations who report their health as being poor or very poor from 7.7% to 5%.

Why is this Important?

Mercy Medical Center, Canton, OH

A large portion of county residents still do not have access to basic health care services.

- Lack of affordable insurance/health care was identified as the most important health issue by Stark County residents, with 27.9% of survey respondents citing this to be the case (Community Survey).
- 25% of community survey respondents receive health care most often from a place other than a primary care or family doctor. This includes 8.3% who receive health care most often at the emergency room and 6.5% at an urgent care center. Groups of respondents most likely to use a place other than a primary care doctor for health care include unemployed respondents, urban residents, those ages 18 to 44, minorities and those with an annual income under $50,000 (Community Survey).
- 73% of community health leaders reported that community residents have difficulty getting needed medical services. The most common barriers to getting needed medical care were transportation, cost, and lack of understanding/knowledge of available services and programs (Community Health Leader Web Survey).
- 12% of Stark County residents reported not being able to see a doctor because of cost in the past year (County Health Ranking. Original Source: Behavioral Risk Factor Surveillance System, 2006- 2012).



MENTAL HEALTH

Goal 1

All people have equitable access to behavioral health services and supports.

Key Measures:

- ✔ Decrease the average appointment wait time for clients with referrals for behavioral health services and supports by 10%.
- ✔ Increase the number of mental health and substance abuse treatment and prevention programs and supports by 25%.

Goal 2

All people are aware of mental health services and substance abuse prevention.

Key Measures:

- ✔ Increase the use of the Mental Health First Aid Training by 50%.
- ✔ Increase the awareness of suicide prevention by increasing the utilization of the crisis text line by 10%.
- ✔ Decrease Prescription Drug Overdose deaths by 15%.

Goal 3

All people have the opportunity to receive behavioral and physical health services at the same time and the same place.

Key Measure:

- ✔ Increase the number of co-locations that support and provide mental health and physical health services by 10%.

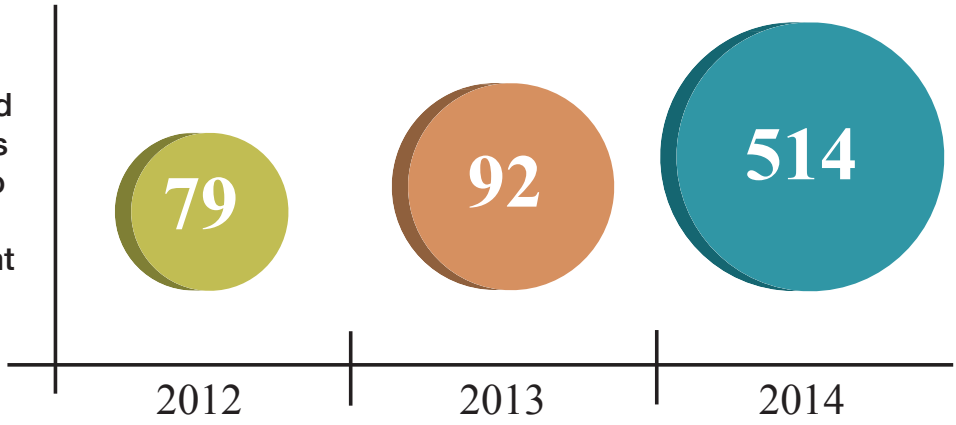
The need for mental health treatment and intervention continues to increase, especially for youth. High diagnosis rates of depression, as well as, a high percentage of youth with suicidal thoughts; substantiates this issue.

- More than two-thirds, 69%, of community health leaders felt that people with mental illness are not being adequately served by local health services (Community Health Leader Web Survey).
- Stigma, lack of mental health providers, and transportation were identified as the top 3 barriers that prevent residents from receiving needed mental health services (Community Health Leader Web Survey).

Number of Unintentional Stark County Overdose Deaths

2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
25	25	30	21	39	40	35	42	59	75

Fentanyl Related Drug Overdoses per year in Ohio according to Ohio Department of Health



The Stark County suicide rate for 2015 is 59, two more than the previous year. Based on the average of 25 attempts for each suicide completion, Stark County had an estimated 1,475 suicide attempts in 2015.

Stark County's 2015 statistics above show that 45.7% of the individuals who completed suicide had one or more mental disorders, with depression the most common disorder. However, most of the information about mental illness (MI) was provided by surviving family members or friends. Stark County's 2015 statistics above also show that 30.5% of the individuals who completed suicide in 2015 tested positive for either alcohol and/or drugs (AoD) at the time of their deaths.

INFANT MORTALITY

Goal 1

All babies in Stark County will celebrate their first birthday.

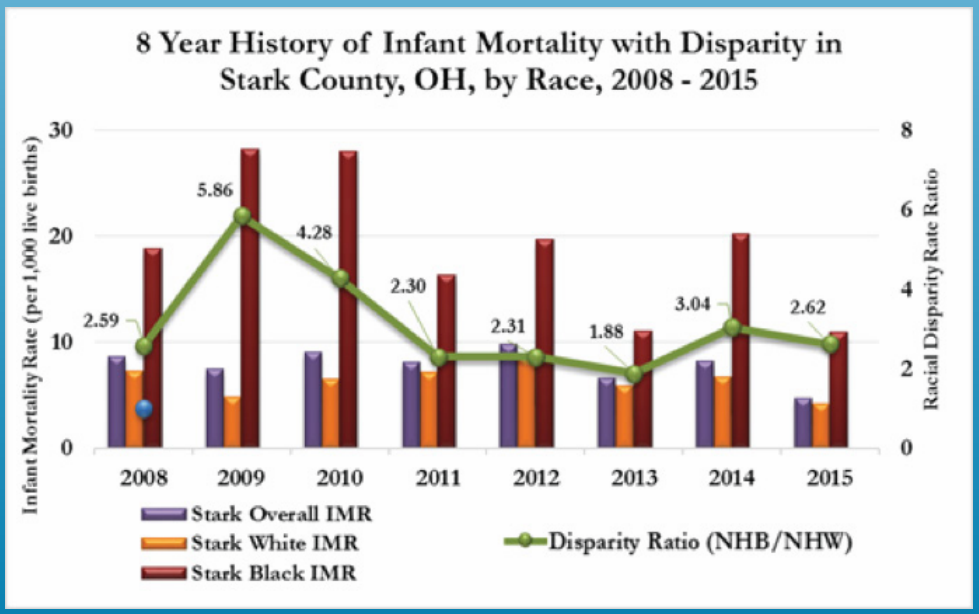
Key Measures:

- ✔ Decrease the overall infant mortality rate to less than 6.0 (Healthy People 2020).
- ✔ Decrease the disparity in the infant mortality rate between white and black babies by more than 50%.
- ✔ Decrease the disparity in the gestational age between white and black babies by more than 50%.
- ✔ Decrease the disparity in the birth weight between white and black babies by more than 50%.
- ✔ Complete the evaluation of THRIVE Project and disseminate results of the project impacts

Why is this Important?

Infant mortality rates in Ohio are very high and not getting better. The situation is even more serious considering the disparity between white and black babies. Stark County has one of the highest disparities in birth outcomes of any large urban center in Ohio. Although some local rates show improvement, sustainable change and progress has not been demonstrated.

- As of 2013, Ohio ranks 46th in the nation in overall infant mortality and 48th in infant mortality for black babies. The disparity in infant mortality between white infants and black infants in Ohio is among the worst in the nation (National Vital Statistics Reports, Vol. 64, No. 9, August 6, 2015, Table 2)
- 10.4% of community survey respondent reported that either they or an immediate family member had a child that had low birthweight (Community Survey).
- 17.3% of community survey respondents reported that either they or an immediate family member had a child that was born prematurely (Community Survey).
- The Infant Mortality Rate (IMR) in Stark County is more than twice as high for black babies compared to white babies - 11.0 compared to 4.2, creating an infant death disparity of 2.62 by races. (Ohio Department of Health, Infant Mortality, 2015 Report)



NEXT STEPS

Community Health Improvement Plan Implementation will begin in 2017.
An agency or community partner has been identified to lead each priority sub-committee; they will be responsible for continued planning and implementation with community partners.

Conduct an annual review of the Community Health Improvement Plan.
The public health departments will review the CHIP and work plans annually and report to the CHNA Advisory Committee. Based on CHIP progress, revisions to the implementation plans may be needed, as well as updates to who will be responsible and appropriate time frames for completion.

A Community Health Improvement Plan is a long-term plan.
This CHIP describes the goals and long-term key measures to be implemented over the next three years (2017-2019). At the end of 2019, the Stark County Health Advisory Committee will initiate the next prioritization process, and will begin the Community Health Improvement Planning process again.

The most effective strategies are those that are Evidence-Based, Best Practice, Scientifically Supports or those that are Expert Opinion Programs. Evidence-based practice involves making decisions on the basis of the best available scientific evidence, using data and information systems systematically, applying program-planning frameworks, engaging the community in decision making, conducting sound evaluation, and disseminating what is learned. (This definition was adopted by the Public Health Accreditation Board (PHAB)).

The following 3 pages outline Evidence-Based strategies and policies that relate to the 3 priority areas selected for this CHIP.

Access to Health Care

Evidence based strategies from What Works For Health
http://www.countyhealthrankings.org/policies?f[0]=field_program_health_factors%3A12068

- Community Health Workers: Engage professional or lay health workers to provide education, referral and follow-up, case management, home visiting, etc. for those at high risk for poor health outcomes. (What Works in Health)
- Cultural Competence Training for Health Care Professionals: Increase health care providers' skills and knowledge to understand and respond to cultural differences, value diversity, etc. via factual information, skills training, and other efforts. (What Works for Health)
- Telemedicine: Deliver consultative, diagnostic, and treatment services remotely for patients who live in areas with limited access to care or would benefit from frequent monitoring; also called telehealth. (What Works for Health)
- Federally Qualified Health Centers (FQHCs): Increase support for non-profit health care organizations and deliver comprehensive care to uninsured, underinsured, and vulnerable patients regardless of ability to pay; often called community health centers (CHCs). (What Works in Health)
- Individual Incentives for Public Transportation: Offer incentives such as free or discounted bus, rail, or transit passes, reimbursements, partial payments, or pre-tax payroll deductions to encourage individuals' use of existing public transit. (What Works for Health)

Aultman Hospital, Canton, OH

Evidence-Based, Best Practice, Scientifically Supported, Expert Opinion Programs

Infant Mortality

Evidence based strategies from What Works For Health
http://www.countyhealthrankings.org/policies?f[0]=field_program_health_factors%3A12068

- CenteringPregnancy: Provide prenatal care in a group setting, integrating health assessment, education, and support. (What Works for Health)
- Reproductive Life Plans: Establish plans consistent with personal values and current life circumstances that set goals related to having or not having children; goals often change over time. (What Works for Health)
- Breastfeeding Promotion Programs: Engage health care professionals, lay health workers, and others to increase breastfeeding initiation, exclusive breastfeeding, and duration of breastfeeding. (What Works for Health)
- Community Health Workers: Engage professional or lay health workers to provide education, referral and follow-up, case management, home visiting, etc. for those at high risk for poor health outcomes (What Works in Health)
- Cultural Competence Training for Health Care Professionals: Increase health care providers' skills and knowledge to understand and respond to cultural differences, value diversity, etc. via factual information, skills training, and other efforts. (What Works for Health)
- Father Involvement Programs: Support fathers' active involvement in child rearing via various father-focused or family focused interventions.
- Individual Incentives for Public Transportation: Offer incentives such as free or discounted bus, rail, or transit passes, reimbursements, partial payments, or pre-tax payroll deductions to encourage individuals' use of existing public transit. (What Works for Health)

Mental Health

Evidence based strategies from What Works For Health
http://www.countyhealthrankings.org/policies?f[0]=field_program_health_factors%3A12068

- Mental Health Benefits Legislation: Regulate mental health insurance to increase access to mental health services, including treatment for substance use disorders. (What Works for Health)
- Text Message-Based Health Interventions: Provide reminders, education, or self-management for health conditions, especially chronic disease, via text message. (What Works for Health)
- Behavioral Health Primary Care Integration: Revise health care processes and provider roles to integrate mental health and substance abuse treatment into primary care.
- Care Academies: Establish small learning communities in high schools focused on fields such as health care, finance, technology, communications, or public service. (What Works for Health)
- Cell Phone-Based Support Programs: Deliver real-time ongoing or crisis support to individuals with mental health concerns via mobile phone applications (apps) or texts. (What Works for Health)
- Community Health Workers: Engage professional or lay health workers to provide education, referral and follow-up, case management, home visiting, etc. for those at high risk for poor health outcomes (What Works in Health)
- Cultural Competence Training for Health Care Professionals: Increase health care providers' skills and knowledge to understand and respond to cultural differences, value diversity, etc. via factual information, skills training, and other efforts. (What Works for Health)
- Drug Courts: Use specialized courts to offer criminal offenders with drug dependency problems an alternative to adjudication or incarceration. (What Works for Health)
- Naloxone Access: Train and authorize all first responders to administer naloxone and permit prescribing to people likely to encounter those who might overdose. (What Works for Health)
- Prescription Drug Monitoring Programs: Use databases, housed in state agencies, to track prescription and dispensing of Schedule II, III, IV, and V drugs and other controlled substances. (What Works for Health)
- Individual Incentives for Public Transportation: Offer incentives such as free or discounted bus, rail, or t ransit passes, reimbursements, partial payments, or pre-tax payroll deductions to encourage individuals' use of existing public transit. (What Works for Health)

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Melinda Wiles, Aultman Hospital
Kathy Wise, Mercy Medical Center

PARTICIPANTS – CHIP COMMITTEES/WORK GROUPS

Access to Health Care Workgroup Co-chairs: Kellie Johnson & Kay Conley

Kay Conley, Stark County Health Department
Julie Elkin, North Canton Medical Foundation
Kellie Johnson, Access Health Stark County
Carol Lichtenwalter, Pegasus
Janice Houchins, Family Council
John Humphrey, North Canton Medical Foundation
Amanda Kelly, Stark County Health Department
Bethany Perkowski, Massillon City Health Department
Kelly Potkay, Stark County Health Department
Laura Roach, Canton City Health Department
Courtney Styffeler, Aultman Hospital
Down Sultzbach, Austin-Bailey
John Sutton, My Community Health Center
Gayle Walters, Access Health Stark County

Infant Mortality Workgroup Co-chairs: Dawn Miller & Jim Adams

Jessica Zavala, Stark MHAR
Takeysha Cheney, Molina Health Care
Ashley Scott, Ohio Guidestone
Jim Adams, Canton City Health Department
Inese Alvarez, Molina Health Care
Amanda Archer, Canton City Health Department
Tiffany Belknap, Stark County Health Department
Danielle Bunner, THRIVE
Annie Butusov, Canton City Health Department
Deborah Crable-Snell, JRC
Emily Edwards, Alliance City Health Department
Christine Frank, Help Me Grow
Yvette Graham, OSU
Carrie Hensel, Akron Children's Hospital
Jen Hostetler, Aultman Hospital
Delight Howells, Stark County Health Department
Danielle Hugg, Care Source
Peter Leahy, Kent State University
Cleo Lucas, THRIVE
Sandy Marincheck, Stark County Health Department
John McGrath, Health Foundation
Audrey Merrit, OSU
Dawn Miller, THRIVE
Robin Mingo Miles, Stark Metro Housing Authority
Elaine Olives, Pregnancy Choices
Kelly Potkay, Stark County Health Department
Rochelle Reamy, THRIVE
Margaret Reaves, Turnaround Community Outreach
Laura Roach, Canton City Health Department
Susan Ross, Canton City Schools
Lisa Seeden, Stark Metro Housing Authority
Sherry Smith, Stark County Health Department
Tricia Warner, Stark County Health Department
Melinda Wiles, Aultman Hospital
Diana Wood, Massillon City Health Department

Mental Health Workgroup Co-Chairs: John Aller & Linda Morckel

John Aller, Stark MHAR
Kay Conley, Stark County Health Department
Amanda Kelly, Stark County Health Department
Sarah Hayden, Stark MHAR
Linda Morckel, Canton City Health Department
Kelly Potkay, Stark County Health Department
Vicki Theis, Massillon City Health Department
Chanitta Westbrooks, Volunteer

STATE & NATIONAL ALIGNMENT

STARK COUNTY PRIORITY AREAS	STATE PRIORITY AREAS Ohio 2017-2019 State Health Improvement Plan	HEALTHY PEOPLE 2020 PRIORITY AREAS
Access to Healthcare *(Priority One)*	Healthcare system and access: Improve healthcare outcomes through increased access to patient-centered, community connected, high-value clinical care. *(Third Strategy)*	Access to Health Services
Mental Health *(Priority Two)*	Mental Health & Addiction *(Priority One)*	Mental Health and Mental Disorders Substance Abuse
Infant Mortality *(Priority Three)*	Maternal & Infant Health *(Priority Three)*	Maternal, Infant and Child Health

CANTON CITY HEALTH DEPARTMENT COMMUNITY HEALTH IMPROVEMENT PLAN 2017-2019 ANNEX

INTRODUCTION AND PURPOSE

The Canton City Health Department is pleased to offer this annex to the Stark County Community Health Improvement Plan. Canton, the largest city and county seat of Stark County, presents several unique challenges and opportunities for health improvement. Canton has an urban population that is older, poorer, and more ethnically diverse than the rest of Stark County. Poverty rates are higher, housing is older, and access to health care is generally less than the surrounding areas.

Although Canton City Health Department actively participated in the development of the Stark County Community Health Improvement Plan, this annex outlines the challenges and opportunities that make Canton distinctly different. Included in the annex are descriptions of the priority areas, objectives, and activities for health improvement for the City of Canton.

Where Receive Health Care by Selected Demographics, 2015

		Primary Care Doctor	Something Else	Valid Responses
All respondents		75.0%	25.0%	795
Group	Subgroup			
General Location*	Alliance/Canton/Massillon	67.6%	32.4%	787
	Suburbia	80.1%	19.9%	

Health Insurance Coverage by Selected Demographics, 2015

		Not insured	Employer paid	Private insurance	Medicare or Medicaid
All respondents		4.8%	38.5%	11.9%	42.9%
Group	Subgroup				
General Location*	Alliance/Canton/Massillon	5.5%	30.9%	11.6%	52.0%
	Suburbia	4.3%	45.3%	12.1%	38.3%

Tobacco Use by Selected Demographics, 2015

		Everyday	Some days	Not at all
All respondents		22.0%	7.6%	70.4%
Group	Subgroup			
General Location*	Alliance/Canton/Massillon	27.4%	7.8%	64.8%
	Suburbia	17.8%	7.4%	74.8%

Personal Health Rating by Selected Demographics, 2015

		Excellent/ Good	Fair	Poor/Very Poor
All respondents		74.4%	20.6%	5.0%
Group	Subgroup			
General Location*	Alliance/Canton/Massillon	67.5%	25.3%	7.2%
	Suburbia	79.6%	17.2%	3.3%

METHODS

The Canton City Health Department convened the Canton City Health Improvement Advisory Group. Members represent city departments, residents, social service organizations, and the faith community. The advisory group provided feedback about the improvement plan to the Canton City Health Department.

A series of meetings were held on 2/18/2016, 3/23/2016, 7/7/2016, 7/21/2016, 8/25/2016, and 10/18/2016, the advisory group identified four priority areas for health improvement:

- Infant Mortality
- Mental Health
- Access to Health Care
- Obesity and Healthy Lifestyles

The members of the Canton City Health Improvement Advisory Group are:

- **Jim Adams**, Canton City Health Commissioner
- **Krista Allison**, Canton City School District
- **Amanda Archer**, Canton City Health Department
- **Darrell Austin**, resident of southeast Canton
- **Maureen Austin**, Community Building Partnership
- **Mary Gates**, Live Well Stark County, Stark County Parks
- **Debbie Mazzocca**, Canton City Health Department
- **Dawn Miller**, THRIVE, Canton City Health Department
- **Ryan Miller**, owner of Deli Ohio
- **Linda Morckel**, Canton City Health Department
- **Walter Moss**, Stark County Prosecutor's Office
- **Darlene Moss**, faith community
- **Ed Pabin**, Canton City Health Department
- **Don Patterson**, Canton City Parks Department
- **Tom Phillips**, StarkFresh
- **Laura Roach**, Canton City Health Department
- **Susan Ross**, Canton City School District
- **Jay Spencer**, Stark County Crime Lab

Priority Areas for Health Improvement

The Canton City Health District endorses the three priority areas selected for the Stark County Community Health Improvement Plan, Infant Mortality, Mental Health, Access to Care. In addition, specific to the city of Canton, a fourth priority was identified – Obesity/Healthy Lifestyles.

Priority Area: Obesity/Healthy Lifestyles

Every person will have access to and utilize the resources and services necessary to achieve and maintain a healthy weight and a healthy lifestyle.

Long Term Indicators

- ✔ Decrease the prevalence of obesity among adults (ages 18 and over) by 5%. (Ohio's Plan to Prevent and Reduce Chronic Disease, 2014-2019)
- ✔ Decrease the prevalence of obesity among high school students (grades 9-12) by 5%. (Ohio's Plan to Prevent and Reduce Chronic Disease, 2014-2019)
- ✔ Decrease the prevalence of current tobacco use among middle school students (grades 6-8) by 4.4%
- ✔ Decrease the prevalence of tobacco use among adults ages 18 and over by 3.3%.
- ✔ Increase the prevalence of students (grades 9-12) engaging in 60 minutes or more of physical activity per day by 5%.
- ✔ Increase the prevalence of adults consuming 5 or more servings of fruits/vegetable per day by 5% (Stark County Community Health Assessment)
- ✔ Increase the prevalence of adults meeting physical activity guidelines for aerobic activity and muscle strengthening by 5%. (Stark County Community Health Assessment)

Objective #1

Increase the number of outdoor areas in Canton that are designated as tobacco free areas.

Activities

- ✔ Establish tobacco free outside areas in at least three (3) public spaces (such as parks, neighborhood areas, public venues).
- ✔ Develop a model smoke free policy for congregate housing areas (housing, Stark Metropolitan Housing Authority, condominiums) and implement policy in at least three new locations.
- ✔ Increase utilization of tobacco cessation services.
- ✔ Encourage tobacco free sporting venues at schools and parks.

Objective #2

Increase access to outdoor recreation areas.

Activities

- ✔ Improve the walking areas of city parks by resurfacing the walking trail, adding ramps for accessibility, and cleaning park area.
- ✔ Conduct walkability assessments in at least 10 neighborhoods in the City of Canton to identify safe routes, potential improvements for walking routes, and appropriate signage.
- ✔ Develop a program targeting physicians that encourages them to offer their patients a "walking prescription" as a means to increase activity levels.
- ✔ Publish a city map that identifies "safe" walking routes.
- ✔ Participate in community planning efforts for community development, streets, sidewalks, parks, neighborhoods, and other community planning efforts.
- ✔ Increase amount of nutritional foods and level of physical activity in early pre-school and primary school settings.
- ✔ Implement the Safe Routes To Schools program in at least one Canton city school.

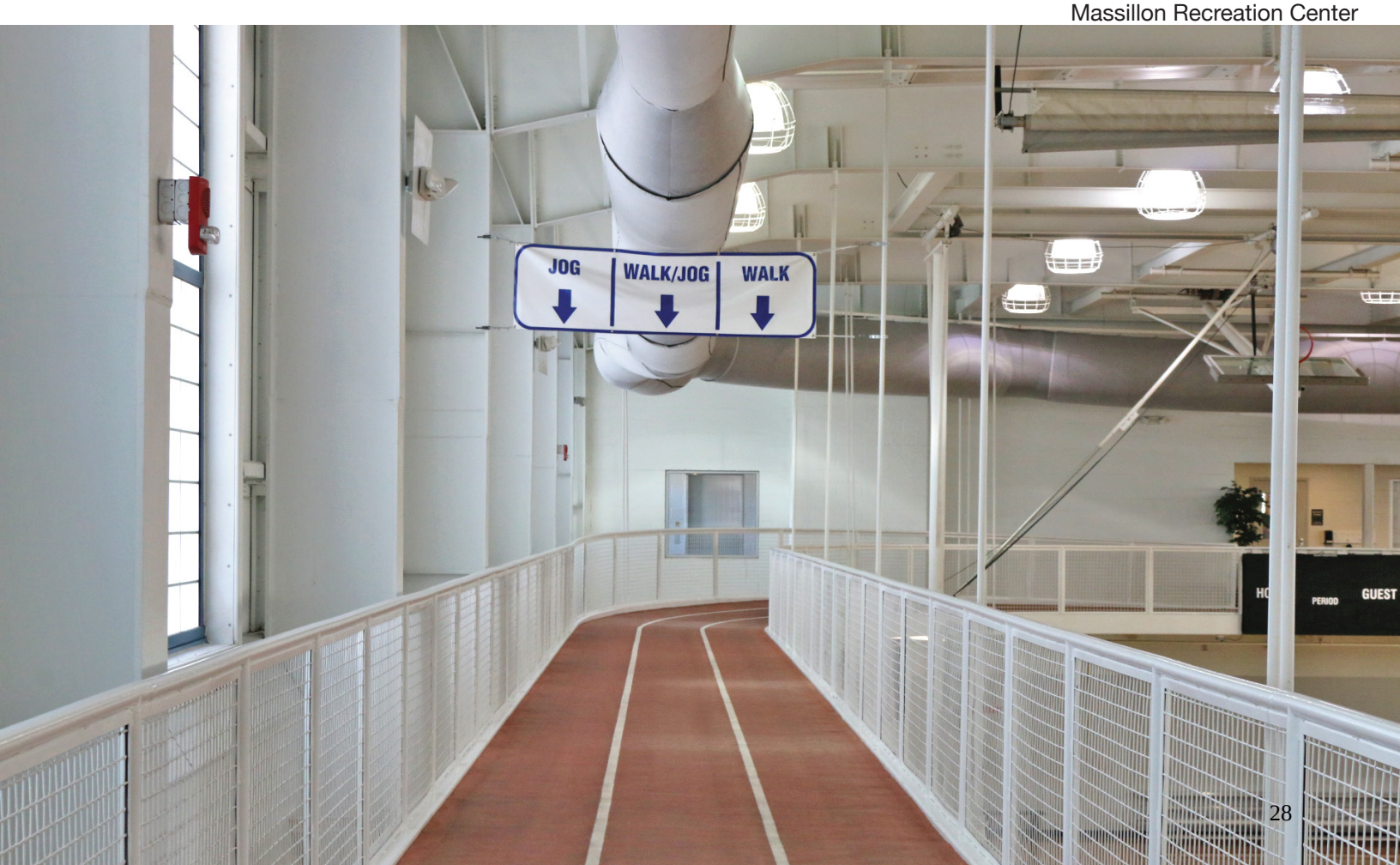
Objective #3
Increase access to fresh foods in neighborhoods identified as food deserts in Canton.

Activities
- ✔ Implement a mobile farmers market to at least three additional locations in identified food desert areas in Canton.
- ✔ Develop and promote a "Prescriptions for Fresh Food" program for area physicians.
- ✔ Develop at least one (1) permanent store that provides fresh food in identified food desert.
- ✔ Identify three convenience store locations in identified food desert areas and implement the sale of fresh foods at these locations.
- ✔ Expand the use of mobile fresh food delivery van to all year (from summer only).
- ✔ Expand distribution of fresh food into at least on non-traditional setting. (FQHC, schools, culinary training programs, etc.)

Next Steps
The Stark County Health Department convened an advisory group to develop a Community Health Improvement Plan. This advisory group has representation from the Canton City Health Department. This document represents the first step in the development of an action plan to implement priority areas, objectives, and activities that will result in the improvement of the health of the community. Over the next six of months, this advisory group will develop a work plan assigning responsibilities for various activities to community partners and monitoring progress toward outcomes. This work plan will be published as a separate document to this health improvement plan.

As part of that process, the Canton City Health Department will maintain the Canton City Health Improvement Advisory Group to ensure that the unique needs of Canton are addressed in the work plan.

Massillon Recreation Center



DEFINITIONS/GLOSSARY/ACRONYMS

Definitions/Glossary

Evidence-based strategy — A policy, program or service that has been evaluated and demonstrated to be effective based on the best available research evidence, rather than personal belief or anecdotal information.
Goal – The larger overarching outcome of a the project – the end toward which effort is directed.
Health disparities — Differences in health status among distinct segments of the population, including differences that occur by gender, race, ethnicity, education, income, disability or living in various geographic localities.
Health equity — Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.
Health inequity — A subset of health disparities that are a result of systemic, avoidable and unjust social and economic policies and practices that create barriers to opportunity.
Key measure – A type of performance measurement used to determine the success of a program or intervention.
Population health — The distribution of health outcomes across a geographically-defined group that results from the interaction between individual biology and behaviors; the social, familial, cultural, economic and physical environments that support or hinder wellbeing; and the effectiveness of the public health and healthcare systems (as defined by HPIO's Population Health Definition Workgroup and published in the HPIO publication "What is 'Population Health?'")

Acronyms

State assessments and plans
SHA — State health assessment
SHIP — State health improvement plan

Hospital assessments and plans
CHNA — Community health needs assessment
IS — Implementation strategy

Local health department (LHD) assessments and plans
CHA — Community health assessment
CHIP — Community health improvement plan

Organizations
PHAB — Public Health Accreditation Board

Miscellaneous
CHR — County Health Rankings
PCMH — Patient-Centered Medical Home