2024-2026 IMPLEMENTATION STRATEGY/COMMUNITY HEALTH IMPROVEMENT PLAN

JUNE 2024
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A NOTE FROM
AVITA HEALTH SYSTEM &
RICHLAND PUBLIC HEALTH

Avita Health System and Richland Public Health strive to bring people and organizations together to improve community wellness. The community health needs assessment and implementation strategy/improvement plan process is one way we can live out our mission. To fulfill this mission, we must be intentional about understanding the health issues that impact residents and work together to create a healthy community.

A primary component of creating a healthy community is assessing and prioritizing needs for impact, and then addressing those needs. In 2023, Richland County conducted a comprehensive Community Health Needs Assessment (CHNA) to identify priority health issues and evaluate the overall current health status of the hospital and health department’s service area. These findings were then used to develop an Implementation Strategy/Improvement Plan (CHIP) to describe the response to the needs identified in the CHNA report. This Implementation Strategy/CHIP report was adopted by leadership of Avita Health System and Richland Public Health in June 2024.

The 2024-2026 Implementation Strategy/CHIP report is the third of these reports released, all following a CHNA. We want to provide the best possible care for our residents, and we can use this report to guide us in our strategic planning concerning future programs, clinics, and health resources.

The Richland County Implementation Strategy/CHIP would not have been possible without the help of numerous organizations. It is vital that assessments such as this continue so that we can know where to direct our resources and use them in the most advantageous ways.

More importantly, the possibility of this report relies solely on the participation of individuals in our community who committed to participating in interviews and completing health need prioritization surveys. We are grateful for those individuals who are committed to the health of the community, as we are, and take the time to share their health concerns, needs, praises, and behaviors.

The work of public health is a community job that involves individual facets, including our community members, working together to be a thriving community of health and well-being at home, work, and play.

Sincerely,

Cinda Kropka
Corporate Compliance & Privacy Officer

Dr. Julie Chaya
Health Commissioner
ACKNOWLEDGEMENTS

This Implementation Strategy/Improvement Plan (CHIP) was made possible thanks to the collaborative efforts of Avita Health System, Richland Public Health, community partners, local stakeholders, non-profit partners and community residents (listed below). Their contributions, expertise, time and resources played a critical part in the completion of this strategic plan.

AVITA HEALTH SYSTEM & RICHLAND PUBLIC HEALTH WOULD LIKE TO RECOGNIZE THE FOLLOWING INDIVIDUALS AND ORGANIZATIONS FOR THEIR CONTRIBUTIONS TO THIS REPORT:

- Area Agency on Aging
- Avita Health System
- Black/Brown Coalition of Mansfield
- Community Health Access Project (CHAP)
- Community Action/Capable Youth (CACY)
- DRM Productions
- Ignited
- Jobs & Family Services/Children’s Services
- Keim Farm
- Maddox Memorial Church of God in Christ
- Mansfield City Council
- Mansfield City School District
- Mansfield Richland County Public Library/First Call 211
- Mansfield Urban Minority Alcoholism and Drug Abuse Outreach Program (UMADAOP)
- Mansfield YMCA & YWCA
- Middle Ohio Education Service Center
- National Association for the Advancement of Colored People (NAACP)
- NAMI (National Alliance on Mental Illness)
- Richland County
- North End Community Improvement Collaboration (NECIC)
- OhioHealth Mansfield Hospital
- Ohio Community Action Board
- Ontario Schools
- Partners for Prevention Coalition of Richland County
- Pioneer Career and Technology Center School
- Richland Area Chamber & Economic Development
- Richland County Children's Services
- Richland County Commissioner
- Richland County Foundation
- Richland County Mental Health And Recovery Services Board
- Richland County Regional Planning Commission
- Richland County Youth & Family Council
- Richland NewHope
- Richland Public Health
- Shiloh Medical Center
- The Ohio State Mansfield
- Third Street Family Health Services
- United Way
An Implementation Strategy/Improvement Plan (CHIP) is part of a framework that is used to guide community benefit activities - policy, advocacy, and program-planning efforts. For hospitals, the Implementation Strategy describes their plan to respond to the needs identified through the previous Community Health Needs Assessment (CHNA) process. It also fulfills a requirement mandated by the Internal Revenue Service (IRS) in Section 1.501(r)(3). For health departments, the Improvement Plan (CHIP) fulfills the mandates of the Public Health Accreditation Board (PHAB) and outlines their plans to address priority community health needs identified through the previous Community Health Assessment (CHA).
OVERVIEW OF THE PROCESS

In order to develop an Implementation Strategy/Improvement Plan (CHIP), Avita Health System and Richland Public Health followed a process that included the following steps:

**STEP 1:** Plan and prepare for the Implementation Strategy/CHIP.

**STEP 2:** Develop goals/objectives and identify indicators to address health needs.

**STEP 3:** Consider approaches/strategies to address prioritized needs, health disparities, and social determinants of health.

**STEP 4:** Select approaches with community partners.

**STEP 5:** Integrate Implementation Strategy/CHIP with community partners, hospital, and health department plans.

**STEP 6:** Develop a written Implementation Strategy/CHIP.

**STEP 7:** Adopt the Implementation Strategy/CHIP.

**STEP 8:** Update and sustain the Implementation Strategy/CHIP.

Within each step of this process, the guidelines and requirements of both the state and federal governments are followed precisely and systematically.

THE 2024-2026 RICHLAND COUNTY IMPLEMENTATION STRATEGY/CHIP MEETS ALL OHIO DEPARTMENT OF HEALTH AND FEDERAL (IRS & PHAB) REGULATIONS.
DEFINING THE RICHLAND COUNTY SERVICE AREA

For the purposes of this report, Avita Health System and Richland Public Health define their primary service area as being made up of Richland County, Ohio. The Community Health Needs Assessment (CHNA) and this resulting Implementation Strategy/Improvement Plan (CHIP) identify and address significant community health needs and help guide community benefit activities. This Implementation Strategy/CHIP plans to address the selected priority health needs identified by the CHNA.

RICHLAND COUNTY SERVICE AREA

<table>
<thead>
<tr>
<th>GEOGRAPHIC AREA</th>
<th>ZIP CODE</th>
<th>GEOGRAPHIC AREA</th>
<th>ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fredericktown*</td>
<td>43019</td>
<td>Plymouth*</td>
<td>44865</td>
</tr>
<tr>
<td>Ashland*</td>
<td>44805</td>
<td>Shelby</td>
<td>44875</td>
</tr>
<tr>
<td>Belville</td>
<td>44813</td>
<td>Shiloh</td>
<td>44878</td>
</tr>
<tr>
<td>Butler</td>
<td>44822</td>
<td>Mansfield</td>
<td>44901</td>
</tr>
<tr>
<td>Crestline*</td>
<td>44827</td>
<td>Mansfield</td>
<td>44902</td>
</tr>
<tr>
<td>Galion*</td>
<td>44833</td>
<td>Mansfield</td>
<td>44903</td>
</tr>
<tr>
<td>Greenwich*</td>
<td>44837</td>
<td>Mansfield</td>
<td>44904</td>
</tr>
<tr>
<td>Lucas</td>
<td>44843</td>
<td>Mansfield</td>
<td>44905</td>
</tr>
<tr>
<td>Ontario</td>
<td>44862</td>
<td>Mansfield</td>
<td>44906</td>
</tr>
<tr>
<td>Perrysville*</td>
<td>44864</td>
<td>Mansfield</td>
<td>44907</td>
</tr>
</tbody>
</table>

*While portions of these communities lie outside of Richland County, the associated ZIP Codes are at least partially contained within Richland County and form part of Avita Health System’s service area.

WE CURRENTLY SERVE A POPULATION OF 125,195

1
The population of Ohio is increasing. The Richland County population is increasing at a slightly lower rate.

- +0.8% RICHLAND COUNTY
- +2.1% OHIO

The % of males and females is nearly equal.

- 49%
- 51%

7% of Richland County residents are veterans, the same as the state.

Youth ages 0-19 and seniors 65+ make up 44% of the population.

- Over half of veterans in the service area are aged 65+
- In the Richland County service area:
  - 1 in 5 Richland County residents are age 65+

The majority (85%) of the population in Richland County identifies as white as their only race, while Black/African Americans number nearly 10%.

- 85.1% WHITE
- 9.3% BLACK/AFRICAN AMERICAN
- 2.2% HISPANIC OR LATINO
- 0.2% AMERICAN INDIAN/ALASKA NATIVE
- 0.8% ASIAN
- 0.01% NATIVE HAWAIIAN/PACIFIC ISLANDER
- 2.4% MULTI RACIAL/OTHER

96% of the population in the Richland County service area speaks only English and only 2% are foreign-born.

1 in 213 Richland County residents will die prematurely, which is higher than the Ohio state rate.

Richland county is ranked in the bottom half of healthiest counties in Ohio based on health factors that we can modify.

The age-adjusted mortality rate in Richland County is 4% higher than the state of Ohio.

85% of the population in the Richland County service area speaks only English and only 2% are foreign-born.

2.4% of the population in the Richland County service area is multi-racial/other.

The major race in Richland County is white, followed by Black/African American, Hispanic, and American Indian/Alaska Native.

1 in 213 Richland County residents will die prematurely, which is higher than the Ohio state rate.
STEP 1
PLAN AND PREPARE FOR THE IMPLEMENTATION STRATEGY/IMPROVEMENT PLAN (CHIP)

IN THIS STEP, AVITA HEALTH SYSTEM AND RICHLAND PUBLIC HEALTH:

• DETERMINED WHO WOULD PARTICIPATE IN THE DEVELOPMENT OF THE IMPLEMENTATION STRATEGY/CHIP

• ENGAGED BOARD AND EXECUTIVE LEADERSHIP

• REVIEWED COMMUNITY HEALTH NEEDS ASSESSMENT
The implementation strategy/improvement plan (CHIP) deals with the “how and when” of addressing needs. While the community health needs assessment considers the “who, what, where and why” of community health needs, the CHIP takes care of the how and when components.
STEP 2
DEVELOP GOALS AND OBJECTIVES AND IDENTIFY INDICATORS FOR ADDRESSING COMMUNITY HEALTH NEEDS

IN THIS STEP, AVITA HEALTH SYSTEM AND RICHLAND PUBLIC HEALTH:

• DEVELOPED GOALS FOR THE IMPLEMENTATION STRATEGY/IMPROVEMENT PLAN (CHIP) BASED ON THE FINDINGS FROM THE CHNA

• SELECTED INDICATORS TO ACHIEVE GOALS
The following image shows the framework from ODH that this report followed while also adhering to federal requirements and the community’s needs.

Avita Health System and Richland Public Health desired to align with the priorities and indicators of the Ohio Department of Health (ODH). To do this, they used the following guidelines when prioritizing the health needs of their community.

First, Avita Health System and Richland Public Health used the same language as the state of Ohio when assessing the factors and health outcomes of their community in the 2023 Richland County Community Health Needs Assessment.

**Figure 1: Ohio State Health Improvement Plan (SHIP) Framework**

<table>
<thead>
<tr>
<th>Equity Priorities</th>
<th>Health equity is achieved when all people in a community have access to affordable, inclusive and quality infrastructure and services that, despite historical and contemporary injustices, allows them to reach their full health potential.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What shapes our health and well-being?</strong></td>
<td>The SHIP identifies three priority factors and three priority health outcomes that affect the overall healthy and well-being of children, families and adults of all ages.</td>
</tr>
</tbody>
</table>
| **Community Conditions** | • Housing affordability and quality  
• Poverty  
• K-12 student success  
• Adverse childhood experiences |
| **Health Behaviors** | • Tobacco/nicotine use  
• Nutrition  
• Physical activity |
| **Access to care** | • Health insurance coverage  
• Local access to healthcare providers  
• Unmet need for mental healthcare |
| **Mental health/addiction** | • Depression  
• Suicide  
• Youth drug use  
• Drug overdose deaths |
| **Chronic disease** | • Heart disease  
• Diabetes  
• Childhood conditions (asthma, lead) |
| **Maternal and infant health** | • Preterm births  
• Infant mortality  
• Maternal morbidity |
| **How will we know if health is improving in Ohio?** | The SHIP is designed to track and improve these 3 SHIP priority health outcomes: |
| **All Ohioans achieve their full health potential** | • Improved health status  
• Reduced premature death |

Vision: Ohio is a model of health, well-being, and economic vitality

Strategies

The SHIP provides state and local partners with a menu of effective policies and programs to improve Ohio’s performance on these priorities.

*These factors are sometimes referred to as the social determinants of health or the social drivers of health.*
Next, with the data findings from the community health needs assessment process, Richland County used the following guidelines/worksheet to choose priority health factors and priority health outcomes. Using the guidance from ODH’s State Health Improvement Plan (SHIP) strengthened the ability to align with the state in order to strengthen the efforts to improve the health, well-being, and economic vitality of both the Richland County service area and the state of Ohio (worksheet/guidelines continued to next page).

ALIGNMENT WITH PRIORITIES AND INDICATORS

**Figure 3. Alignment with priorities and indicators**

**STEP 1** Identify at least one priority factor and at least one priority health outcome

<table>
<thead>
<tr>
<th>PRIORITY FACTORS</th>
<th>PRIORITY HEALTH OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Conditions (strongly recommended)</td>
<td>Mental Health and Addiction</td>
</tr>
<tr>
<td>Health Behaviors</td>
<td>Chronic Disease</td>
</tr>
<tr>
<td>Access to Care</td>
<td>Maternal and Infant Health</td>
</tr>
</tbody>
</table>

**STEP 2** Select at least 1 indicator for each identified priority factor

<table>
<thead>
<tr>
<th>COMMUNITY CONDITIONS</th>
<th>INDICATOR NAME*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing affordability and quality (X)</td>
<td>CC1. Affordable and Available Housing Units</td>
</tr>
<tr>
<td>Poverty (X)</td>
<td>CC2. Child Poverty</td>
</tr>
<tr>
<td></td>
<td>CC3. Adult Poverty</td>
</tr>
<tr>
<td>K-12 student success (X)</td>
<td>CC4. Chronic Absenteeism (K-12 students)</td>
</tr>
<tr>
<td></td>
<td>CC5. Kindergarten Readiness</td>
</tr>
<tr>
<td>Adverse childhood experiences (X)</td>
<td>CC6. Adverse Childhood Experiences (ACEs)</td>
</tr>
<tr>
<td></td>
<td>CC7. Child Abuse and Neglect</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTH BEHAVIORS</th>
<th>INDICATOR NAME*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco/nicotine use (X)</td>
<td>HB1. Adult Smoking</td>
</tr>
<tr>
<td></td>
<td>HB2. Youth All-Tobacco/Nicotine Use</td>
</tr>
<tr>
<td>Nutrition (X)</td>
<td>HB3. Youth Fruit Consumption</td>
</tr>
<tr>
<td></td>
<td>HB4. Youth Vegetable Consumption</td>
</tr>
<tr>
<td>Physical Activity (X)</td>
<td>HB5. Child Physical Activity</td>
</tr>
<tr>
<td></td>
<td>HB6. Adult Physical Activity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACCESS TO CARE</th>
<th>INDICATOR NAME*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurance Coverage (X)</td>
<td>AC1. Uninsured Adults</td>
</tr>
<tr>
<td></td>
<td>AC2. Uninsured Children</td>
</tr>
<tr>
<td>Local Access to Healthcare Services (X)</td>
<td>AC3. Primary Care Health Professional Shortage Areas</td>
</tr>
<tr>
<td></td>
<td>AC4. Mental Health Professional Shortage Areas</td>
</tr>
<tr>
<td>Unmet Need for Mental Health Care (X)</td>
<td>AC5. Youth Depression Treatment Unmet Need</td>
</tr>
<tr>
<td></td>
<td>AC6. Adult Mental Health Care Unmet Need</td>
</tr>
</tbody>
</table>
**ALIGNMENT WITH PRIORITIES AND INDICATORS (CONTINUED)**

**STEP 2 CONTINUED** Select at least 1 indicator for each identified priority factor

<table>
<thead>
<tr>
<th>PRIORITY HEALTH OUTCOMES</th>
<th>MENTAL HEALTH AND ADDICTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOPIC</strong></td>
<td><strong>INDICATOR NAME</strong></td>
</tr>
<tr>
<td>Depression</td>
<td>MHA1. Youth Depression</td>
</tr>
<tr>
<td></td>
<td>MHA2. Adult Depression</td>
</tr>
<tr>
<td>Suicide Deaths</td>
<td>MHA3. Youth Suicide Deaths</td>
</tr>
<tr>
<td></td>
<td>MHA4. Adult Suicide Deaths</td>
</tr>
<tr>
<td>Youth Drug Use</td>
<td>MHA5. Youth Alcohol Use</td>
</tr>
<tr>
<td>Drug Overdose Deaths</td>
<td>MHA6. Youth Marijuana Use</td>
</tr>
<tr>
<td></td>
<td>MHA7. Unintentional drug overdose deaths</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHRONIC DISEASE</th>
<th><strong>INDICATOR NAME</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOPIC</strong></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td>CD1. Coronary Heart Disease</td>
</tr>
<tr>
<td></td>
<td>CD2. Premature Death - Heart Disease</td>
</tr>
<tr>
<td></td>
<td>CD3. Hypertension</td>
</tr>
<tr>
<td>Diabetes</td>
<td>CD4. Diabetes</td>
</tr>
<tr>
<td>Harmful Childhood Conditions</td>
<td>CD5. Child Asthma Morbidity</td>
</tr>
<tr>
<td></td>
<td>CD6. Child Lead Poisoning</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MATERNAL AND INFANT HEALTH</th>
<th><strong>INDICATOR NAME</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOPIC</strong></td>
<td></td>
</tr>
<tr>
<td>Preterm Births</td>
<td>MIH1. Uninsured Adults</td>
</tr>
<tr>
<td>Infant Mortality</td>
<td>MIH2. Infant Mortality</td>
</tr>
<tr>
<td>Maternal Morbidity/Mortality</td>
<td>MIH3. Severe Maternal Morbidity</td>
</tr>
</tbody>
</table>
The 2023 Community Health Needs Assessment (CHNA) identified the following significant health needs from an extensive review of the primary and secondary data. The significant health needs were ranked:

<table>
<thead>
<tr>
<th>#1</th>
<th>Mental health and access to mental healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>#2</td>
<td>Substance use</td>
</tr>
<tr>
<td>#3</td>
<td>Income/poverty and Employment</td>
</tr>
<tr>
<td>#4</td>
<td>Crime and violence</td>
</tr>
<tr>
<td>#5</td>
<td>Adverse childhood experiences (e.g. child abuse, mental health, family issues, trauma)</td>
</tr>
<tr>
<td>#6</td>
<td>Food insecurity (e.g. not being able to access and/or afford healthy food)</td>
</tr>
<tr>
<td>#7</td>
<td>Access to childcare</td>
</tr>
<tr>
<td>#8</td>
<td>Access to healthcare (e.g. doctors, hospitals, specialists, medical appointments, etc.)</td>
</tr>
<tr>
<td>#9</td>
<td>Housing and homelessness</td>
</tr>
<tr>
<td>#10</td>
<td>Nutrition and physical health/exercise</td>
</tr>
<tr>
<td>#11</td>
<td>Chronic diseases (e.g. heart disease, diabetes, cancer, asthma)</td>
</tr>
<tr>
<td>#12</td>
<td>Education (e.g. early childhood education, elementary school, post-secondary education)</td>
</tr>
<tr>
<td>#13</td>
<td>Transportation (e.g. public transit, cars, cycling, walking)</td>
</tr>
<tr>
<td>#14</td>
<td>Tobacco and nicotine use/smoking</td>
</tr>
<tr>
<td>#15</td>
<td>Preventive care and practices (e.g. mammograms, vaccinations)</td>
</tr>
<tr>
<td>#16</td>
<td>Environmental conditions (e.g. air and water quality)</td>
</tr>
<tr>
<td>#17</td>
<td>Internet/Wi-Fi access</td>
</tr>
<tr>
<td>#18</td>
<td>Maternal, infant and child health (e.g. pre-term births, infant mortality, maternal mortality)</td>
</tr>
<tr>
<td>#19</td>
<td>HIV/AIDS and Sexually Transmitted Infections (STIs)</td>
</tr>
</tbody>
</table>
From the significant health needs, Avita Health System and Richland Public Health chose health needs that considered the health department’s capacity to address community needs, the strength of community partnerships, and those needs that correspond with the health department’s priorities.

THE 3 PRIORITY HEALTH NEEDS THAT WILL BE ADDRESSED IN THE 2024-2026 IMPLEMENTATION STRATEGY/IMPROVEMENT PLAN (CHIP) ARE:

Priority Area 1: Mental Health & Addiction
Priority Area 2: Chronic Disease
Priority Area 3: Maternal & Infant Health
STEPS 3 & 4
CONSIDER AND SELECT APPROACHES/STRATEGIES TO ADDRESS PRIORITIZED NEEDS, HEALTH DISPARITIES, AND SOCIAL DETERMINANTS OF HEALTH WITH COMMUNITY PARTNERS

IN THESE STEPS, AVITA HEALTH SYSTEM AND RICHLAND PUBLIC HEALTH:

• SELECTED APPROACHES/STRATEGIES TO ADDRESS BUTLER COUNTY SERVICE AREA PRIORITIZED HEALTH NEEDS, HEALTH DISPARITIES, AND SOCIAL DETERMINANTS OF HEALTH

• DEVELOPED A WRITTEN IMPLEMENTATION STRATEGY/IMPROVEMENT PLAN (CHIP) REPORT
#1 PRIORITY AREA
MENTAL HEALTH & ADDICTION

Includes adverse childhood experiences

54% OF YOUTH
in Ohio with major depressive episodes in the past year did not receive mental health services

39% OF YOUTH
in Ohio with major depressive episodes in the past year received some consistent mental health services (7+ visits)

21% OF ADULTS
in BRFSS* Region 3 have been diagnosed with depression and suicidal ideation by a mental health professional, compared to 29% for Ohio

17% OF ADULTS
in Richland County experienced frequent mental distress (2+ weeks/month in the past year), compared to 16% for Ohio

Richland County’s suicide rate of 22 per 100,000 is higher than Ohio’s rate of 19 per 100,000

The drug poisoning death rate in Richland County was 49 per 100,000 from 2018-2020, higher than the state (39 per 100,000)

**OUTCOMES**

EDUCATION AND AWARENESS ON MENTAL HEALTH
MENTAL HEALTH SIGMA
ACCESS TO MENTAL HEALTH AND SUBSTANCE ABUSE CARE AND SUPPORT

MENTAL HEALTH AND SUBSTANCE ABUSE EMERGENCY DEPARTMENT VISITS AND HOSPITALIZATIONS
OVERDOS DEATHS
SUICIDES
PSYCHOLOGICAL DISTRESS AND DEPRESSION

DESIRRED OUTCOMES OF STRATEGIES

OVERALL IMPACT OF STRATEGIES

Mental health
Quality of life
Substance abuse

YOUTH

Expand Mental Health Education to Parents and Youth (e.g. through implementation of public awareness and social media campaigns, school programs).

Entire list of Richland County mental health and substance use partners (see page 23).

ADULTS

Expand Mental Health Education to Parents and Youth (e.g. through implementation of public awareness and social media campaigns, community courses and programs).

Entire list of Richland County mental health and substance use partners (see page 23).

ALL RICHLAND COUNTY RESIDENTS ACHIEVE THEIR FULL HEALTH POTENTIAL

*Treatment Effectiveness for Adolescents and Young Adults who Receive Help with Major Depression

*Behavioral Risk Factor Surveillance System; BRFSS Region 1 contains Richland County.
**PRIORITY AREA CHRONIC DISEASE**

*Includes nutrition and physical health, overweight and obesity, food security, preventive care and practices*

---

**ADULTS WITH HEART DISEASE AND AT RISK OF HEART DISEASE**

- 4% of both Richland County and Ohio adults reported they have had a stroke.
- 8% of Richland County adults reported having had a heart attack, angina, or coronary heart disease, compared to 7% for Ohio.
- 38% of Richland County adults have hypertension, compared to 35% for Ohio adults.
- 32% of Richland County adults have high cholesterol, compared to 31% of Ohio adults.
- 9% of Richland County adults have diabetes.

**OUTCOMES**

- 4% of both Richland County and Ohio adults have had a stroke.
- 8% of Richland County adults reported having had a heart attack, angina, or coronary heart disease, compared to 7% for Ohio.
- 38% of Richland County adults have hypertension, compared to 35% for Ohio adults.
- 32% of Richland County adults have high cholesterol, compared to 31% of Ohio adults.
- 9% of Richland County adults have diabetes.

---

**YOUTH**

- Provide free A1C screenings (e.g. evaluate cost and consider providing at health fairs).

**OVERALL IMPACT OF STRATEGIES**

- Mental and physical health
- Quality of life
- Health status
- Overweight & obesity
- Chronic disease
- Premature mortality

---

**DIVERSE POPULATIONS WITH HEALTH DISPARITIES**

- Expand access to health care providers, especially specialists (e.g. implement promotional campaigns to invite new specialists and advertise openings).
**#2 PRIORITY AREA**

**CHRONIC DISEASE (CONTINUED)**

Includes nutrition and physical health, overweight and obesity, food security, preventive care and practices

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**STRATEGIES**

- **Disproportionately Affected Population, Seniors, Youth, Adults, Families with Kids, Trauma Population, Under-insured, People with History or Family History of Chronic Conditions**
  - Increase awareness of and access to preventative screenings (e.g. implement more screening location, such as in workplaces, and coordinate and implement public education campaign to increase awareness).

- **Youth, Families, Seniors, Adults**
  - Promote healthy habits (healthy eating, physical activity, not smoking/ quitting smoking). (e.g. explore possibility of making parks more accessible and opening more parks and sports facilities, adding bike lanes, implementing a bike to work day, providing healthy food in schools, etc.).

- **Women, Youth, Parents, Seniors**
  - Promote healthcare literacy & importance of primary care providers (to avoid emergency department visits) (e.g. apply for grants for healthcare navigators/liasons to provide outreach to women, youth, parents, seniors, etc.)

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**PARTNERS**

Richland Public Health (RPH), Third Street Family Health Services, Avita Health System, OhioHealth, Cleveland Clinic, University, Veterans Affairs, First Call 211, Richland Source & media, Area Agency on Aging, Richland County Homeless Coalition, North End Community Improvement Collaborative (NECIC), food pantries, senior centers, YMCA, Richland County Safety Council, Mansfield Interdenominational Ministerial Alliance (MIMA), Goshenfield & churches, Richland County Transit & transportation partners, employers (on-site screenings), health coalitions (e.g. diabetes prevention, community health workers)

RPH, Richland County Park District, Physicians, grocers/farmers markets, County parks, city parks, local state parks, Muskingum Watershed Conservancy District, North Central Ohio Land Conservancy, YMCA, land trusts, Ohio Bird Sanctuary, SNAP Educators, Richland County Regional Planning, chefs, garden clubs

Mansfield Richland County Public Library, RPH, managed care organizations, school systems, Supplemental Nutrition Assistance Program (SNAP) Educators, Lucas Community Center, Lexington Senior Center

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**POPULATIONS**

- **These strategies will positively impact all residents, but data shows these populations are in the most need:**
  - Children and youth, adults, older adults, low-income residents, Black/African American, Multiracial, Latino/a, Asian, American Indian and Alaska Native, and Native Hawaiian and Pacific Islander residents, LGBTQ+ residents

---

**OUTCOMES**

- **Desired Outcomes of Strategies**
  - Education on chronic diseases & risk factors
  - Chronic disease prevention, screening & management
  - Sedentary youth & adults
  - Opportunities for physical activity
  - Food insecurity
  - Nutrition, including fruit and vegetable consumption

- **Overall Impact of Strategies**
  - Mental and physical health
  - Quality of life
  - Health status
  - Overweight & obesity
  - Chronic disease
  - Premature mortality

**All Richland County Residents Achieve Their Full Health Potential**

---

"Behavioral Risk Factor Surveillance System; BRFSS Region 1 contains Richland County."
#3 PRIORITY AREA
MATERNAL & INFANT HEALTH

IN OUR COMMUNITY

PRIORITY AREA MATERNAL & INFANT HEALTH

STRATEGIES

PREGNANT WOMEN, POSTPARTUM WOMEN, NEWBORNS, AND INFANTS
Increase the number of prenatal and newborn home visits by Community Health Workers (CHWs) and public health nurses in Richland County (e.g. implement a public awareness campaign on home visiting program).

TEENS AND WOMEN OF CHILDBEARING AGE
Increase awareness of women’s health and preconception health, prenatal care, healthy pregnancies, and family planning (e.g. implement sexual health education in schools).

PARTNERS

Richland Public Health, Women, Infants, and Children (WIC), Third Street Family Health Services, Community Health Access Project (CHAP), OhioHealth, Richland Pregnancy Services, managed care companies

Third Street Family Health Services, Cornerstone OB/GYN, OhioHealth Mansfield, Avita Health System, Richland Pregnancy Services, Women, Infants, and Children (WIC), Local schools, Planned Parenthood, Women’s Care

POPULATIONS

THESE STRATEGIES WILL POSITIVELY IMPACT ALL RESIDENTS, BUT DATA SHOWS THESE POPULATIONS ARE IN THE MOST NEED:
Women, low-income residents, Black/African American, Multiracial, Latino/a, Asian, American Indian and Alaska Native, and Native Hawaiian and Pacific Islander residents, LGBTQ+ residents, rural residents

Black/African women and infants in the service area will significantly benefit, as experience the highest rates of maternal mortality, morbidity, infant mortality, and other negative health outcomes related to maternal and infant health.

OUTCOMES

DESIRED OUTCOMES OF STRATEGIES
Access to pre- and post-natal care
Access to primary care, screening, and routine checkups
Access to culturally and linguistically appropriate care
Breastfeeding
Delayed care

OVERALL IMPACT OF STRATEGIES
Health status
Quality of life
Unmet care needs
Infant mortality
Maternal mortality and morbidity
Low birth weight and pre-term births

ALL RICHLAND COUNTY RESIDENTS ACHIEVE THEIR FULL HEALTH POTENTIAL
CURRENT RESOURCES
ADDRESSING PRIORITY HEALTH NEEDS

Information was gathered on assets and resources that currently exist in the community. This was done using feedback from the community and an overall assessment of the service area. While this list strives to be comprehensive, it may not be complete.

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Disabilities</th>
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<tbody>
<tr>
<td>American Cancer Society</td>
<td>Catalyst Life Services</td>
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<td>Avita Health System</td>
<td>Chiropractor</td>
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<td>Breast Cancer Group Krocker</td>
<td>Free Yoga for Veterans</td>
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<td>Cancer Services for Richland Counties</td>
<td>Opportunities for Ohioans With Disabilities</td>
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<tr>
<td>Cleveland Clinic</td>
<td>Pain-Management Specialists</td>
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<td>Mansfield Cancer Foundation</td>
<td>Physical Therapists</td>
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<td>Mansfield Radiation Oncology</td>
<td>Richland County Mental Health and Recovery Services Board</td>
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<td>OhioHealth</td>
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<td>Support Groups</td>
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<td>Liberty Nursing Center</td>
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<td>Mansfield Place</td>
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<td>Bike Trail</td>
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<td>Community Health Educators</td>
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<td>Diabetes Association</td>
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<td>Diabetes Prevention Program</td>
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<td>Good Samaritan Hospital</td>
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<td>Collaborative (NECIC)</td>
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<td>Richland Public Health</td>
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<td>Third Street Family Health Services</td>
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<tr>
<td>YMCA</td>
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**Family Planning**
- Avita Health System
- Catalyst Life Services
- CHAP – Community Health Access Project
- Community Action Commission of Erie, Huron & Richland
- OhioHealth
- Planned Parenthood
- Richland Pregnancy Services
- Richland Public Health
- Third Street Family Health Service

**Heart Disease**
- Akron Children’s Hospital
- Avita Health System
- Cleveland Clinic
- Community Health Workers
- From the Heart
- OhioHealth
- Richland Public Health
- Third Street Family Health Services

**Social Services, Injury and Violence**
- 211
- Avita Health System
- Catalyst Life Services
- Community Action Commission of Erie, Huron & Richland
- Crisis Line
- Harmony House
- Law Enforcement
- Mansfield Peace Coalition
- Metrich Crime Reporting Line
- North End Community Improvement Collaborative (NECIC)
- OhioHealth
- Richland County Community Alternative Center
- Volunteers of America
- Women's Shelter
- Youth and Family Council
CURRENT RESOURCES
ADDRESSING PRIORITY HEALTH NEEDS

Information was gathered on assets and resources that currently exist in the community. This was done using feedback from the community and an overall assessment of the service area. While this list strives to be comprehensive, it may not be complete.

Kidney Disease
Avita Health System
Dialysis Centers
Fresenius Kidney Care Central Ohio East
Richland Public Health

Mental Health
Behavioral Health Services
Catalyst Life Services
Counseling Centers
Faith-Based Organizations
Family Life Counseling
Mansfield Urban Minority Alcoholism and Drug Abuse Outreach Program (UMADAOP)
Mental Health and Recovery Board
National Alliance on Mental Illness (NAMI)
New Day
OhioHealth
Richland County Mental Health and Recovery Services Board
Substance Abuse Programs
The Center
The Oasis
Third Street Family Health Services
Veteran's Outpatient Clinic

Nutrition, Physical Activity, and Weight
Avita Health System
Bellville Neighborhood Outreach Center
Bike Trail
City/County Parks
Community Gardens
Farmers Markets
Fitness Center/Gyms
Food Banks
North End Community Improvement Collaborative
OhioHealth
Parks and Recreation
Planet Fitness
Richland County Health Department
Third Street Family Health Services

Oral Health
Catholic Charities
North End Community Improvement Collaborative
Richland Public Health
Third Street Family Health Services

Respiratory Disease
Avita Health System Pulmonary Rehab

Sexual Health
Planned Parenthood
Richland Public Health
Third Street Family Health Services

Substance Use
Abraxas
Alcoholics Anonymous
Ashland County Council on Drug Addictions
Avita Health System
Catalyst Life Services
Celebrate Recovery
Court Assisted/Ordered Recovery Programs
Crossroads Community Church
Department of Mental Health
Domestic Violence Center
Drug Court Family Health Services
Family Life Counseling
First Responders
Healing Hearts
Law Enforcement
Mansfield Urban Minority Alcoholism and Drug Abuse Outreach Program (UMADAOP)
Mental Health and Recovery Board
National Alliance on Mental Illness (NAMI)
New Beginnings
New Directors
Richland County Mental Health and Recovery Services Board
Richland County Community Alternative Center
Starfish Project
Suboxone Clinics
Substance Abuse Treatment Centers
The Center
Third Street Family Health Services

Tobacco Use
Avita Health System
Richland County Health Department
Smoking Cessation Programs
STEPS 5-8
INTEGRATE, DEVELOP, ADOPT, AND SUSTAIN IMPLEMENTATION STRATEGY/IMPROVEMENT PLAN (CHIP)

IN THIS STEP, AVITA HEALTH SYSTEM AND RICHLAND PUBLIC HEALTH WILL:

• INTEGRATE IMPLEMENTATION STRATEGY/CHIP WITH COMMUNITY PARTNERS AND HOSPITAL AND HEALTH DEPARTMENT PLANS

• ADOPT THE IMPLEMENTATION STRATEGY/CHIP

• UPDATE AND SUSTAIN THE IMPLEMENTATION STRATEGY/CHIP
The Community Health Needs Assessment (CHNA) and this resulting Implementation Strategy/Improvement Plan (CHIP) identify and address significant community health needs and help guide community benefit activities. This Implementation Strategy/CHIP explains how Avita Health System and Richland Public Health plan to address the selected priority health needs identified by the CHNA.

This Implementation Strategy/CHIP report was adopted by Avita Health System and Richland Public Health leadership in June 2024.

This report is widely available to the public on the hospital and health departments’ websites:

Avita Health System: [https://avitahealth.org/about-us/#community-wellness](https://avitahealth.org/about-us/#community-wellness)
Richland Public Health: [https://richlandhealth.org/](https://richlandhealth.org/)

Written comments on this report are welcomed and can be made by emailing: ckropka@avitahs.org or jchaya@richlandhealth.org.

**EVALUATION OF IMPACT**

Avita Health System and Richland Public Health will monitor and evaluate the programs and actions outlined above. We anticipate the actions taken to address significant health needs will improve health knowledge, behaviors, and status, increase access to care, and overall help support good health. Avita Health System and Richland Public Health are committed to monitoring key indicators to assess impact. Our reporting process includes the collection and documentation of tracking measures, such as the number of people reached/served and collaborative efforts to address health needs. A review of the impact of Avita Health System and Richland Public Health’s actions to address these significant health needs will be reported in the next scheduled CHNA.

**ADDITIONAL HEALTH NEEDS NOT DIRECTLY ADDRESSED**

Since Avita Health System and Richland Public Health cannot directly address all the health needs present in the community, we will concentrate our resources on those health needs where we can effectively impact our region given our areas of focus and expertise. Taking existing organization and community resources into consideration, Avita Health System and Richland Public Health will not directly address the remaining health needs identified in the CHNA, including but not limited to crime and violence, environmental conditions, internet access, access to childcare, education, access to healthcare, HIV/AIDS and STIs, economic stability, and COVID-19. We will continue to look for opportunities to address community needs where we can make a meaningful contribution. Community partnerships may support other initiatives that the health department cannot independently lead in order to address the other health needs identified in the 2023 CHNA.
MEETING THE IRS REQUIREMENTS FOR THE IMPLEMENTATION STRATEGY

The Internal Revenue Service (IRS) requirements for an Implementation Strategy serve as the official guidance for IRS compliance. The following pages demonstrate how this Implementation Strategy/ Improvement Plan meets those IRS requirements.
## INTERNAL REVENUE SERVICE REQUIREMENTS FOR IMPLEMENTATION STRATEGIES

<table>
<thead>
<tr>
<th>YES</th>
<th>PAGE #</th>
<th>IRS REQUIREMENTS CHECKLIST</th>
<th>REGULATION SUBSECTION NUMBER</th>
<th>NOTES/RECOMMENDATIONS</th>
</tr>
</thead>
</table>
| ✓   | 18-23  | (2) Description of how the hospital facility plans to address the health needs selected, including:  
    i. Actions the hospital facility intends to take and the anticipated impact of these actions;  
    ii. Resources the hospital facility plans to commit; and  
    iii. Any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need. | (c)(2) |                         |
| ✓   | 25     | (3) Description of why a hospital facility is not addressing a significant health need identified in the CHNA.  
    Note: A "brief explanation" is sufficient. Such reasons may include resource constraints, other organizations are addressing the need, or a relative lack of expertise to effectively address the need. | (c)(3) |                         |
| ✓   | Throughout report | (4) For those hospital facilities that adopted a joint CHNA report, a joint IS may be adopted that meets the requirements above. In addition, the joint IS must:  
    i. Be clearly identified as applying to the hospital facility;  
    ii. Clearly identify the hospital facility’s role and responsibilities in taking the actions described in the IS and the resources the hospital facility plans to commit to such actions; and  
    iii. Include a summary or other tool that helps the reader easily locate those portions of the strategy that relate to the hospital facility. | (c)(4) | Strategies that Avita Health System is leading/collaborating on are indicated throughout the report. |
| ✓   | 3, 25  | (5) An authorized body adopts the IS on or before the 15th day of the fifth month after the end of the taxable year in which the CHNA was conducted and completed, regardless of whether the hospital facility began working on the CHNA in a prior taxable year.  
    Exceptions (if applicable):  
    Transition Rule (if applicable): | (c)(5) |                         |
MEETING THE PHAB REQUIREMENTS FOR THE CHIP

The Public Health Accreditation Board (PHAB) Standards & Measures serve as the official guidance for PHAB national public health department accreditation and includes requirements for the completion of Community Health Assessments (CHAs) and CHIPs for local health departments. The following page demonstrates how this CHIP meets the PHAB requirements.
### Community health improvement planning process that includes:

- **i.** Broad participation of community partners.
- **ii.** Information from community health assessments.
- **iii.** Issues and themes identified by stakeholders in the community.
- **iv.** Identification of community assets and resources.
- **v.** A process to set health priorities.

### Implementation of the plan, in partnership with others, including:

- **i.** Process to track actions taken to implement strategies in the plan.
- **ii.** Examples of plan implementation.

### Evaluation reports, including:

- **i.** Progress related to health improvement indicators.
- **ii.** Review and revision, as necessary, of the health improvement plan strategies based on results of the assessment.

### Desired measurable outcomes or indicators of health improvement and priorities for action.

### Policy changes needed to accomplish health objectives.

### Individuals and organizations that have accepted responsibility for implementing strategies.

### Consideration of state and national priorities.

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A detailed workplan (living document) has been developed that included strategies, SMART objectives, annual activities, indicators, partners, and priority populations.

Indicators are included in both the CHIP report and workplan.

Detailed activities and policy changes needed to accomplish health objectives are included in the workplan.

Partners are included in both the CHIP report and workplan. A lead organizational contact has been identified to be accountable for each strategy.

This CHIP report aligns with the Ohio and national priorities including health needs, indicators, priority populations, and evidence-based strategies.
APPENDIX C
REFERENCES
APPENDIX C: REFERENCES

11. Community Member Survey
17. Community Member Survey