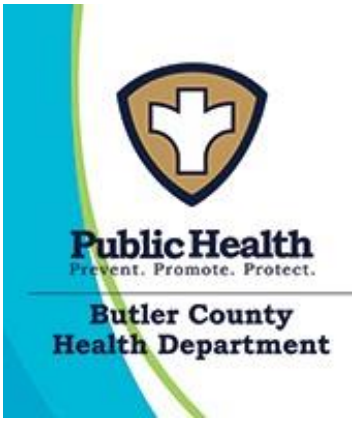
July 2017-December 2019

Butler County Community Health Improvement Plan



Letter to the Community

The Butler County Health Department, City of Hamilton Health Department, and City of Middletown Health Department are pleased to present to the community the 2017 -2019 Community Health Improvement Plan. This plan is the result of the work of numerous community members and stakeholders. The Community Health Improvement Plan is an action-oriented, living document to mobilize the community on areas where we can be most impactful in improving the health of all Butler County residents. It serves as a comprehensive guide to improve the health of the community.

The findings from our community health assessment helped identify significant health issues facing our community. Through collective input, action plans were developed to address these issues in order to reach our vision of a healthy and connected Butler County. The plan will be implemented over the next few years and will be reviewed annually to monitor the progress being made.

We would like to thank our community members and partners for their dedication and participation in the development of this countywide plan. We would also like to thank our Board of Health members and the staff of our organizations for their efforts in this process. The Community Health Improvement Plan along with the Annual Reports will be posted on each health department website. We invite you to visit our websites to follow along with the process and we encourage residents to provide comments and feedback.

Jenny Bailer, RN, MS
Health Commissioner
Butler County
Health Department

Kay Farrar, BSN, RN
Health Commissioner
City of Hamilton
Health Department

Jackie Phillips, MPH, BSN, RN
Health Commissioner
City of Middletown
Health Department

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Executive Summary

A Community Health Assessment (CHA) for Butler County was completed in July of 2017 to evaluate the health status of the county and its residents. This assessment provided data and information highlighting the health issues facing the community.

Out of that process, in an effort to improve the health of the community a broad set of stakeholders and partners gathered monthly to develop a Community Health Improvement Plan (CHIP), the first of its kind for Butler County. A CHIP is a long-term plan that identifies health priorities, goals, objectives, and action steps used by community organizations to guide them in the development of projects, programs, and policies aimed at improving the health of its residents. The purpose of the CHIP is to describe how the community will work together to address the prioritized issues.

Over 20 community organizations participated in the CHIP development process, and representatives from these organizations served as members of the Advisory Committee. These committee members used data gathered from the CHA to identify and prioritize issues that needed to be addressed. The priority areas selected were Mental Health and Addiction, Chronic Disease, and Maternal and Infant Health.

Three work groups were formed around these priority areas to develop an action plan with specific goals, objectives, and measures that will be used to address the issues and to monitor progress. Work groups were asked to consider some guiding principles in the development of their work plans which included the health impact pyramid, evidence-based strategies, and alignment with state and national improvement initiatives.

Implementation of the CHIP will begin in early 2018. Advisory committee members have planned to meet quarterly to update members on the status of their activities. An annual report will be published outlining the progress made towards achieving the goals detailed in the work plans, or any revisions that have been made. The improvement plan is to be implemented through 2019.

Community Health Assessment

Community Health Improvement Plan

Introduction

In 2016, Butler County, City of Hamilton, and City of Middletown health departments in collaboration with other community partners conducted a CHA to evaluate the health of its residents. From this assessment, major health issues were identified by an Advisory Committee. The Advisory Committee then embarked upon a process for developing a CHIP. They engaged a wide range of community partners able to provide insight and expertise to reach a vision for a healthy and connected Butler County. A CHIP is comprehensive and long term and includes action steps to be used by organizations as they implement projects, programs, and policies.

This CHIP is the first such county-wide collaborative health plan developed for Butler County. The Butler County Health Department is the lead agency in coordinating and guiding this process. The plan is an effort to utilize existing resources and to develop new collaborations in order to improve the health of all our residents.

Partners

The Butler County Community Health Improvement Plan would not have been successful without the dedication and hard work from community organizations and volunteers. The representatives below provided valuable knowledge and guidance in the development of this plan.

Mental Health and Addiction Participants

Alicia Ritchie	Registrar of Vital Statistics, Hamilton City Health Department
Amber Finkelstein	Manager Social Work and Case Management, West Chester Hospital

Angie Getz	Community Technician, Hamilton City Health Department
Charlie Chen	Intern, Butler County Health Department
Jenny Bailer	Health Commissioner, Butler County Health Department
Jim Bolen	Planning & Operations Manager, Butler County Emergency Management Agency
Joyce Kachelries	COO, LifeSpan
Kelly Hibner-Kalb	Chief Operating Officer, Community Health Alliance
Lauren Marsh	Director, Butler County Drug-Free Coalition
Lori Higgins	CEO, Envision Partnerships
Maria Laib	Executive Director, Sojourner Recovery Services
Melissa Ward Brown	Program Manager, Butler County Board of Developmental Disabilities
Nikki Taylor	Health Supervisor, Early Childhood Programs
Rachel Dillhoff	Prevention Specialist, Envision Partnerships
Scott Rasmus	Executive Director, Butler County Mental Health and Addiction Recovery Services
Tiffany Lombardo	Director of Addiction Services, Butler County Mental Health and Addiction Recovery Services Board
Valerie A. Ubbes	Associate Professor, Miami University, Department of Kinesiology and Health

Chronic Disease Participants

Alan Burley	Dentist, Butler County Health Department Board Member
Amy Macechko	Project Coordinator, Coalition-Oxford
Ann Munafo	Retired nurse and volunteer
Anna McKain	Program Director, YMCA

Bill Staler	CEO, LifeSpan
Darris Bohman	Trihealth
Donna Howard	Practice Navigator/Social Worker, Christ Hospital
Jackie Phillips	Health Commissioner, Middletown City Health Department
Jennifer Williams	Project Grant Coordinator, Bethesda Butler Trihealth
Kristina Yauch	LISW-S, Centerpoint Health
Krystal Tipton	VP Community Impact, Butler County United Way
Mallory Debo	Marketing/Outreach, Centerpoint Health
McKena Miller	Project Coordinator, Coalition-Middletown
Shawna Noble	Wellness Coordinator, Butler County Board of Commissioners
Stephen Roller	Medical Provider, Primary Health Solutions
Tanya Lowry	Executive Director, YMCA

Maternal and Infant Health Participants

Andrew Schwartz	Epidemiologist, Butler County Health Department/Hamilton County General Health District
Anita Scott Jones	Hospital Relations Manager, Atrium Medical Center
Cindy Meale	WIC Program Director, WIC, Primary Health Solutions
Cindy Price	Director of Nursing, Butler County Health Department
Daniel Maxwell	Coordinator Community Government Relations, UC Health
Gold-Marie Wontumi,	Co-lead Infant Mortality, Butler County Health Department
Jordan Kavanaugh	Community Building Institute, Middletown
Kathryn Yang	Co-lead Infant Mortality, Butler County Health Department
Katrina Wilson	Co-lead PRIM, Butler County Health Department

Kay Farrar	Health Commissioner, Hamilton City Health Department
Marie Augustin	Program Supervisor, Butler County Health Department
Mary Haubner	Envision Partnerships
Ryan Burke	Emergency Management Officer, West Chester Hospital
Sue Haines	Director of Nursing, Butler County Health Department
Tracey Szewczyk	OB Director, West Chester Hospital

Our Vision

"A CONNECTED AND HEALTHY BUTLER COUNTY "

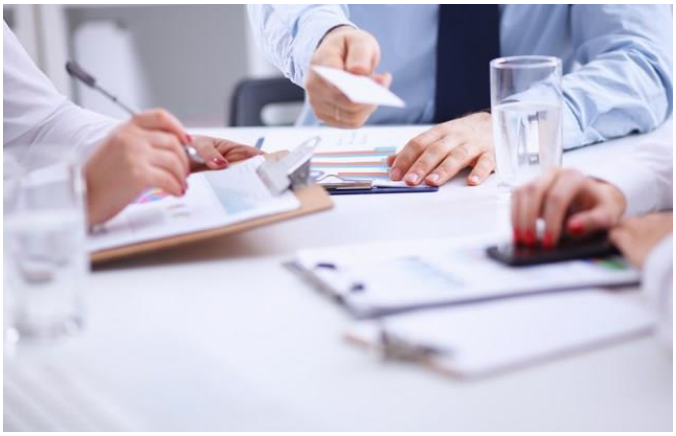
During the Community Health Assessment process, Advisory Committee members developed a vision statement to guide the process for the assessment and the improvement plan. Through community input, common themes, ideas, and values were identified and translated into a statement. This vision was used to provide focus, purpose and direction as community members gathered to work on improving the health of the community.

Our Vision Statement

"A healthy community is one in which members are connected to both physical resources and to each other. Necessary resources include access to quality primary, specialty, and preventative health care, as well as nutritious food and recreational opportunities. Connection to one another promotes a sense of belonging, supportive relationships, empowerment, and engagement. The well-being of a community is a reflection of physical, mental, emotional, spiritual, intellectual, and financial health. All members are responsible for the health of the community, and work in collaboration with one another, elected officials, first responders, the medical community, mental health and addiction treatment service providers, public health agencies, businesses, educators, government agencies, non-profit organizations, and the faith community. A connected community provides opportunity for all members to lead a healthy lifestyle and meet their full potential."

Community Health Improvement Process

The community health improvement process is a comprehensive approach to developing a plan to improve the health of the community. It first involves a CHA that engages community stakeholders and partners to participate in collecting and analyzing primary and secondary health-related data from a variety of sources. This analysis then guides the prioritization of health problems, leading into the development of the CHIP.



The CHIP is an action-oriented plan that focuses on the prioritized health issues outlined in the CHA. Committee members work to develop an action plan that includes goals and objectives with action steps to address the identified issues in order to improve the health of the community.

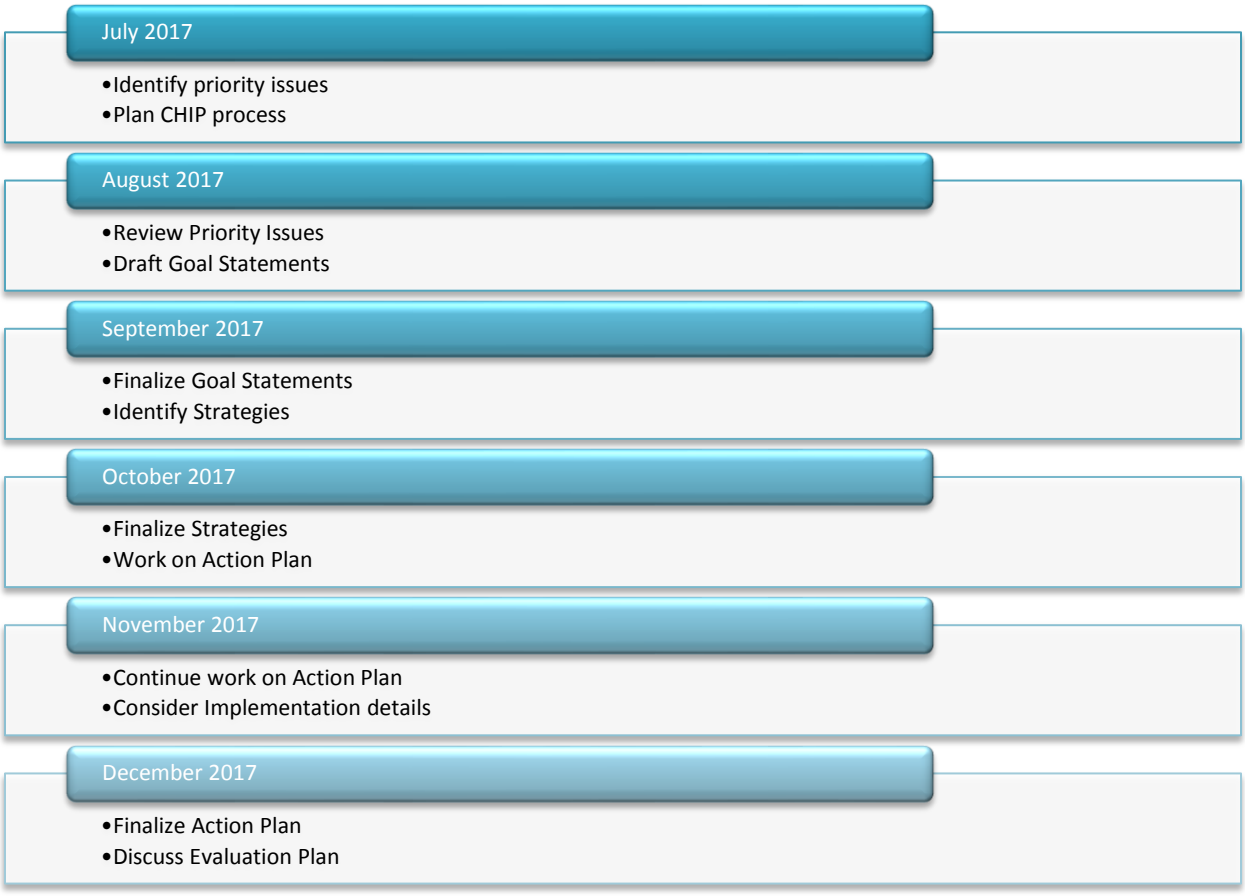
MAPP Process

Mobilizing for Action through Planning and Partnerships (MAPP) is a community driven framework for improving public health. Developed by the National Association of County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC), this model provides a structure for conducting the work for the health improvement process through community wide collaboration using information gathered from a variety of partners.

With the completion of the CHA the Advisory Committee continued with the MAPP process to facilitate the development of the CHIP for Butler County. This strategic approach focuses on identifying and using resources wisely, taking into account the unique circumstances and needs of the community, and forming effective partnerships for strategic action (NACCHO, n.d.).

CHIP Timeline

The timeline below outlines the planning stages of the CHIP.



Developing Priorities

The data and information gathered from the CHA, including findings from the four MAPP assessments, were used by committee members and stakeholders to select priority issues based upon the following criteria:

1. Size of the population: Assess what percent of the community is affected by the identified issue
2. Severity of the health issues: Degree to which the issue causes long-term illness, produces an above average mortality rate, an above average hospitalization rate, or public health interventions
3. Ability to evaluate outcomes: Assess the availability of data, benchmarks, tracking of trends, service counts, etc. to determine ability to evaluate outcomes
4. Current community capacity to address the health issue: The presence of facilities, organizations, agencies, groups, associations, etc. that address the identified health need.

Committee members identified 12 main issues that were found to be significant for the community. After reviewing and discussing the issues, the committee decided to consolidate drug use, tobacco use, and alcohol use and group them as Substance Abuse. Members then decided to incorporate access to care as a priority to be addressed by each work group. Later in the process, the Maternal and Infant Health work group decided to hold off on single-parent families and focus their efforts and resources to address infant mortality as that was more of a pressing health issue for the county. The Mental Health and Addiction group determined violent crime and bullying would be impacted by the strategies selected for mental health.

Finally, these issues were prioritized and then categorized into priority topic areas of Mental Health and Addiction, Chronic Disease, and Maternal and Infant Health which aligns with the State Health Improvement Plan.

12 Prioritized Issues for Butler County
Drug use
Tobacco use
Covering the cost of medical care
Alcohol abuse
Mental health issues
Single-parent families
Infant mortality
Obesity
Lung cancer
Violent crime
Hepatitis C virus
Bullying

Alignment of Prioritized Issues in Butler County with Ohio State Health Improvement Plan

Ohio 2017-2019 State Health Improvement Plan Priority Topics		
Mental Health and Addiction	**Chronic Disease**	**Maternal and Infant Health**

Butler County 2017 Priority Issues

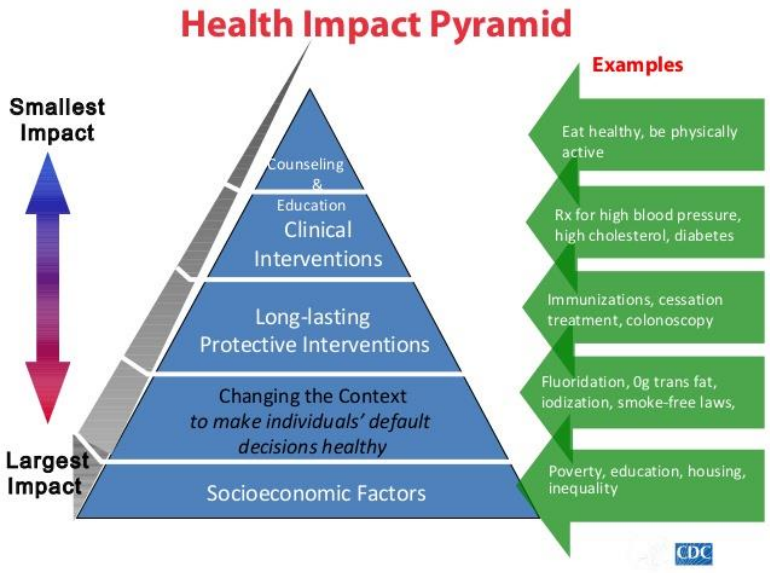
Mental Health and Addiction	Chronic Disease	Maternal and Infant Health
Substance Abuse	Obesity	Infant Mortality
Mental Health	Lung Cancer	
	Hepatitis C	

Guiding Principles

The next phase of the MAPP process involved formulating goals and strategies. Work groups were encouraged to consider the health impact pyramid, any policy changes needed to address social determinants of health, evidence based strategies already established, and alignment with the state and national health plans. Groups were provided with resource and assets lists to assist in selecting strategies that could utilize and build upon existing resources.

Health Impact Pyramid

Achieving lasting impact on health outcomes requires community-wide approaches focused on improving population health. The health impact pyramid describes the effectiveness of various public health interventions that have a wide reach in improving health. Interventions at the base of the pyramid are efforts to address social determinants of health which have the greatest potential impact. Lower level interventions reach the broader community and tend to be the most effective (Centers for Disease Control and Prevention [CDC], 2016).



Policy Changes

The conditions in which we live explain in part why some Americans are healthier than others and why some are not as healthy as they could be. By working to establish policies that positively influence social and economic conditions and those that support changes in individual behavior, we can improve the health of large numbers of people in ways that can be sustained over time (Office of Disease Prevention and Health Promotion [ODPHP], n.d.).

Evidence Based Strategies

Evidence based strategies are tested programs, policies, and interventions that are proven to be most effective in successfully changing behavior resulting in improved health. A list of evidence based strategies that addressed the priority issues were provided to each work group to guide their work in creating action plans that would help achieve their stated goals. Included in the lists were interventions and strategies aimed at affecting policy change at the local, state, and Federal levels.

Alignment with State and National Plans

Ohio's State Health Improvement Plan

The Ohio Department of Health's 2016 State Health Assessment (SHA) describes the current status of health and wellbeing in Ohio. It highlights many of the state's opportunities to improve health outcomes, reduce disparities and control healthcare spending. The 2017-2019 State Health Improvement Plan (SHIP) seizes upon those opportunities by laying out specific goals and

strategies designed to achieve measurable improvements on key priorities (Ohio Department of Health, 2017).

Healthy People 2020

The Healthy People initiative of the Office of Disease Prevention and Health Promotion provides science-based, 10-year national objectives for improving the health of all Americans. The focus is to identify nationwide health improvement priorities, increase public awareness of the social determinants of health, provide measureable objectives and goals, and engage organizations to strengthen policies and practices driven by evidence and knowledge. For many years, Healthy People has established benchmarks and monitored progress over time to encourage collaboration across communities as well as measure the impact of prevention activities (ODPHP, 2018).

National Prevention Strategy

The National Prevention Strategy from the Office of the Surgeon General, aims to guide our nation in the most effective and achievable means for improving health and well-being. The Strategy focuses on prevention by integrating recommendations and actions across multiple settings to improve health and save lives. Within the Strategy, the Priorities provide evidenced-based recommendations that are most likely to reduce the burden of the leading causes of preventable death and major illness. The Priorities are designed to improve health and wellness for the entire U.S. population, including those groups disproportionately affected by disease and injury (U.S. Department of Health and Human Services [DHHS], n.d.).

The table below demonstrates alignment of CHIP priority topic areas with state and national improvement initiatives.

Butler County CHIP	State Health Improvement Plan	Healthy People 2020	National Prevention Strategy
Mental Health and Addiction	Mental Health and addiction	Access to Health Services Substance Abuse Tobacco Use	Mental and Emotional Well-Being Preventing Drug Abuse and Excessive Alcohol Use
Chronic Disease	Chronic Disease	Nutrition, Physical Activity, and Obesity	Healthy Eating Active Living
Maternal and Infant Health	Maternal and Infant Health	Maternal, Infant, and Child Health	

Work groups were formed around the 3 priority areas (Mental Health and Addiction, Chronic Disease, and Maternal and Infant Health) and were tasked with developing goal statements for each priority issue. After goal statements were adopted, the groups completed a root cause analysis of their issues to help identify effective strategies for implementation. Strategy considerations were reviewed with committee members regarding social determinants of health, policy changes, and health inequities in order to have a broader impact in the community.

Transitioning into the action cycle of the MAPP process, committee members came together to develop objectives for their goals and create action plans for their strategies. Work groups were provided an action plan template with guidelines to help determine specific activities, timeframes, responsible leads, and resources needed for their activities. Upon completion of the action plans, work groups presented their strategies and action plans to the full committee for coordination of activities.

Priorities

Priority 1: Mental Health and Addiction

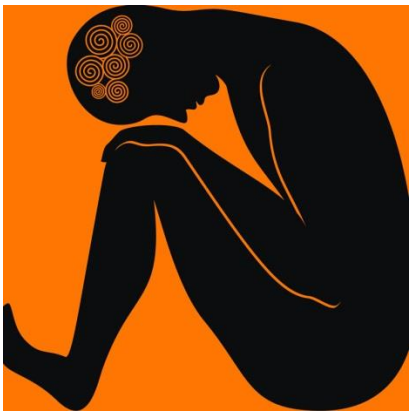
Some of the most common causes of disability and poor health are due to mental health disorders. Mental and emotional well-being are essential to overall health. Adverse early childhood experiences can have lasting, measurable, and negative consequences on health later in life. By fostering emotional well-being from the earliest stages of life, a foundation for overall good health and well-being can be formed.

Mental Health

Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services

- *Increase access by children to school based health centers (SBHC) that include behavioral health services*
- *Implement a Suicide Prevention Task Plan*
- *Ensure access to all mental health services by increasing NO WRONG DOOR (NWR) participating agencies*

In Butler County, the rate of frequent mental distress rose to 12% from 11% in 2016, and it was the fourth highest rated community health problem by survey participants. The resulting disease burden of mental illness is among the highest of all diseases with an estimated 18.1% of U.S. adults suffering from mental illness (Butler County CHA, 2017). In addition, suicide is the tenth leading cause of death in Butler County and in the U.S (Butler County CHA, 2017). A combination of individual, relationship, community, and societal factors contribute to the risk of suicide. Measures to prevent suicide include effective clinical care, access to a variety of interventions and support, family and community support, support from ongoing medical and mental health care, skills in problem solving, and nonviolent ways of handling situations.



Increase access by children to school based health centers (SBHC) that include behavioral health services

School-based health centers (SBHCs) provide students with a variety of health care services on school premises or at offsite centers linked to schools (County Health Rankings [CHR], 2016). Teams of nurses, nurse practitioners, and physicians often provide primary and preventive care and mental health care. The implementation and maintenance of SBHCs can lead to improved educational and health outcomes. Community programs can assist children and their families to unite with the right team to provide mental health solutions. SBHCs have been shown to improve students' health behaviors and may reduce barriers to mental health services (CHR, 2016).

Implement a Suicide Prevention Task Force

Suicide prevention requires a comprehensive approach with efforts that work together to address the problem. Increased coordination of suicide prevention activities among various partners could help improve services and outcomes, while promoting the greater sustainability of suicide prevention efforts over the long term (Substance abuse and Mental Health Services Administration [SAMHSA], 2017).

Ensure access to all mental health services by increasing NO WRONG DOOR (NWR) participating agencies

The traditional approach to service delivery often results in services and supports that do not work for people, drive costs higher, and, in some cases, contribute to poor outcomes In "No Wrong Door" systems, multiple state and community agencies coordinate to ensure that regardless of which agency people contact for help, they can access information and one-on-one counseling about the options available across all the agencies in their community. The goal is to enable people to make informed decisions based on the full range of available services. No

Wrong Door systems also provide assistance in accessing services, including help in completing applications for various programs (Administration for Community Living, 2017).

Substance Abuse:

Goal: Reduce substance abuse to protect the health, safety, and quality of life of all citizens of Butler County

- *Increase evidence based prevention programs, practices, and policies in schools*
- *Increase early childhood and prenatal home visiting programs and services*
- *Increase naloxone distribution*
- *Implement an Overdose Alerting System*
- *Provide trainings for health professionals on Trauma Informed Care and SBIRT*

Respondents from the Butler County Community Health Survey 2017 rated drug sales and/or use as one of the most problematic issues for Butler County. Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. The rate of drug overdose deaths continues to rise in Ohio. In 2015, Butler County had the third highest number of unintentional fentanyl-related drug overdose deaths in the state. The drug-induced mortality rate for Butler County was almost twice that of the state. Preventing drug abuse and excessive alcohol use increases people's chances of living long, healthy, and productive lives (Butler County Community Health Assessment, 2017). In 2017, the number of deaths due to opioid related overdoses surpassed any previous year (Butler County Coroner, 2018).

Increase Evidence based prevention programs, practices, and policies in schools

When evidence based substance use prevention programs are properly implemented by schools and communities, the use of alcohol, tobacco, and illegal drugs is reduced. The term evidence-based means that these programs have been rationally designed based on current scientific

evidence, rigorously tested, and shown to produce positive results. Scientists have developed a broad range of programs that positively alter the balance between risk and protective factors for drug abuse in families, schools, and communities. Such programs help teachers, parents, and health care professionals shape youths' perceptions about the risks of substance use. Studies have shown that research-based programs can significantly reduce early use of tobacco, alcohol, and illicit drugs (National Institute on Drug Abuse, 2014).

Increase prenatal and early childhood home visiting programs and services

Home visiting provides voluntary, evidence-based services to at-risk pregnant women and parents with young children. Home visiting is a service and support delivery strategy for families that can be an effective mechanism to reach those at highest risk. Evidence-based home visiting models address physiological, social, psychological, economic, family and other factors that influence children's health and development. Outcomes include less maternal behavioral impairment attributable to alcohol and drug abuse. The observed effect of home visitation programs seems to be greatest in high-risk populations, such as mothers who are teenagers, unmarried, poor, or have been abused, and in children who are preterm or low birth weight (American Academy of Pediatrics, 2018).

Increase naloxone distribution

Naloxone is a prescription drug that can reverse the effects of opioid overdose (prescription or illicit), and can be life-saving if administered in time. Expanding the availability of naloxone rescue kits to bystanders, family members, and first responders is a crucial element of the strategy to reduce opioid overdose deaths. Wider availability of naloxone is likely to reduce the number of opioid overdose deaths, and state laws and policies to encourage its distribution and use are essential (Oregon Health & Science University, 2015).

Implement an Overdose Alerting System

The National Drug Early Warning System (NDEWS) was designed to monitor emerging drug use trends to enable health experts, researchers, and concerned citizens across the country to respond quickly to potential outbreaks of illicit drugs such as heroin and to identify increased use of designer synthetic compounds (University of Maryland, n.d.). Developing and implementing a local overdose alerting system can raise local community awareness and advise first responders, healthcare providers, and substance users and their families of the increased risk for overdose in the community. Local Public Health Alerts can be issued to allow for surging personnel and resources to community hotspots.

Provide trainings for health professionals on Trauma Informed Care and SBIRT

Trauma is an emotional response to a terrible event that affects trauma survivors. Continued exposure to trauma can result in a complex array of social, emotional, and behavioral challenges.

The latest trauma programs and related practices can help individuals experience healing and resiliency. Two such practices include Screening, Brief Intervention, Referral to Treatment (SBIRT) and Trauma Informed Care. SBIRT is an approach to screening and early intervention for substance use disorders and people at risk for developing substance use disorders lives (SAMHSA, n.d.). Trauma-Informed Care is an approach that can be used by all caring professionals that recognizes the widespread presence of trauma symptoms in many people's lives, and acknowledges the role that trauma has played in their lives (SAMHSA, 2015).

Priority 2: Chronic Disease

Chronic diseases and conditions are the major factors of sickness, disability, and health care costs in the nation. Diseases such as heart disease, stroke, diabetes, cancer, chronic lung disease and others account for most deaths in the United States and globally (CDC, 2015). Many of these conditions are attributable to some primary factors such as tobacco use and exposure to secondhand smoke, obesity, physical inactivity, diets low in fruits and vegetables, and diets high in sodium and saturated fats. Just as these factors contribute to or worsen chronic disease, they can be prevented by many of the same strategies and interventions.

Obesity:

Goal: Promote health and reduce chronic disease risk and improve quality of life through the consumption of healthful diets and through daily physical activity

- *Increase the number of community gardens*
- *Offer nutritious food options to low-income families in food banks*
- *Implement healthy vending machine options*
- *Establish walking clubs*

Obesity is directly related to poor nutrition and insufficient physical activity. It is associated with some of the leading preventable chronic diseases, including heart disease, stroke, type 2 diabetes, and some cancers. In Butler County, 30.1% of adults and 14.6% of children age 2-5 have obesity, and 17.5% of children are considered overweight (Butler County CHA, 2017). It was the second highest rated community health problem from survey participants. A healthful diet and physical activity can help reduce the risks for many of these health conditions.

Increase the number of community gardens

Community gardens are collaborative projects on shared open spaces where participants share in the maintenance and products of the garden (CDC, 2010). They are a suggested strategy to increase fruit and vegetable availability in food deserts, promote healthy eating, reduce obesity and improve participant's mental health and social connectedness. Placing gardens in low income areas can reduce disparities in access to healthy foods, especially fruits and vegetables (What Works For Health, 2017). Community gardens can reduce barriers to healthy food associated with transportation, cost, and food preference, and may increase food security (What Works For Health, 2017).

Offer nutritious food options to low-income families in food banks

Food banks are central building blocks to the US emergency food system and although the main goal is to relieve hunger, the rise in obesity among food insecure individuals has encouraged food banks to endorse more nutritious options. Food banks and food pantries that use healthy

food initiatives may increase fruit and vegetable consumption, improve diet quality, and increase food security more than traditional food banks and pantries. Food banks that provide nutrition education and recipe demonstrations may improve the variety of fruits and vegetables clients consume, as well as their food knowledge and home cooking habits (CHR, 2017).

Implement healthy vending machine options

There are a variety of mechanisms to increase healthy options in vending machines, including reducing the price of healthy choices and increasing the number of healthy choices compared to unhealthy choices. There is some evidence that increasing healthy options in vending machines improves dietary behaviors especially when healthy options are made relatively less expensive than unhealthy options (CHR, 2017). Price discounts for healthier foods have been shown to increase consumption of healthier foods. Vending machine nutrition standards and increased healthy vending options are suggested strategies to improve nutrition.

Establish walking clubs

Community-based social support interventions for physical activity focus on changing physical activity behavior through building, strengthening, and maintaining social networks that provide supportive relationships for behavior change (e.g., setting up a buddy system or a walking group to provide friendship and support) (CHR, 2017). There is strong evidence that community-based social support interventions for physical activity increase physical activity and physical fitness among adults (CHR, 2017). Walking is one of the simplest ways to get active and maintain a healthy lifestyle.

Lung Cancer:

Goal: Reduce the number of new lung cancer cases as well as illness, disability, and death caused by lung cancer

- *Develop a resource list of tobacco cessation programs*
- *Promote screening for lung cancer*
- *Implement tobacco-free policies*

Cancer is the second leading cause of death in Butler County, the state, and the nation. From 2010-2014, lung and bronchus cancer was the leading cause of cancer incidence and mortality in Butler County, accounting for 16.0 percent of cancer cases and 31.1 percent of cancer deaths (Butler County CHA, 2017). Tobacco use is estimated to cause 80 percent of lung cancer deaths among men and women, and is the largest preventable cause of death and disease in the U.S. (CDC, 2014). Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for people of all ages. Effective strategies to reduce the tobacco use involve enacting comprehensive smoke-free policies, expanding cessation treatment and providing access to proven cessation treatment centers to all smokers.

Develop a resource list of tobacco cessation programs

Evidence-based interventions that are key components of a comprehensive tobacco prevention and control effort provide tobacco users with information on resources on how to quit (CDC, 2014). Promoting cessation is a core component of a comprehensive state tobacco control program's efforts to reduce tobacco use. Encouraging and helping tobacco users to quit is the quickest approach to reducing tobacco-related disease, death, and health care costs. Quitting smoking has immediate and long-term health benefits. Although quitting smoking at any age is beneficial, smokers who quit by the time they are 35 to 44 years of age avoid most of the risk of dying from a smoking-related disease.

Promote screening for lung cancer

The American Lung Association found that awareness of lung cancer and the lifesaving potential of lung cancer screening is critically low. Greater awareness of lung cancer screening for those considered at high risk is essential to saving lives (American Lung Association, 2018). The goal of lung cancer screening is to identify the cancer at an early stage so it can be successfully treated. Most screening programs focus on detecting the most common type of lung cancer, which can be cured if found and treated early (U.S. Preventive Service Task Force, 2015). Many lung cancer deaths can be prevented every year by screening high-risk people.

Implement tobacco-free policies

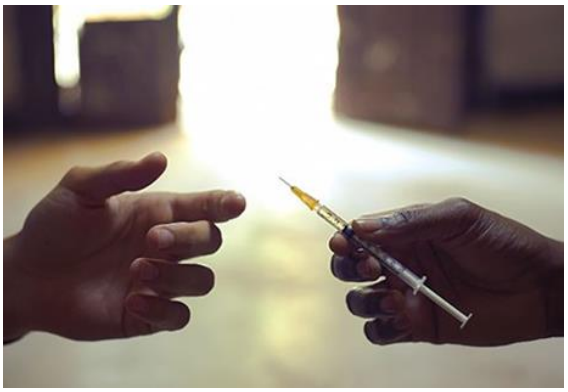
There is no safe level of exposure to secondhand smoke, and exposure to secondhand smoke is a danger even in outdoor areas. Recent studies have shown that secondhand smoke in outdoor areas can reach concentrations found indoors where smoking is permitted, particularly in places where multiple smokers gather, such as near entryways and in outdoor eating areas (Public Health and Tobacco Policy Center, n.d.). Comprehensive smoke-free policies have been shown to significantly improve indoor air quality, reduce secondhand smoke exposure, change social norms regarding the acceptability of smoking, prevent smoking initiation by youth, help smokers quit and decrease hospitalizations for heart attack and asthma among nonsmokers (CDC, 2016).

Hepatitis C:

Goal: Increase awareness of the prevalence of Hepatitis C throughout Butler County

- *Create a partnership to increase awareness of Hepatitis C*
- *Implement a syringe exchange program in Butler County*
- *Increase screening for those at risk for Hepatitis C*

Hepatitis C (HCV) is a leading cause of chronic liver disease, cirrhosis, and need for liver transplantation. Despite preventive measures and treatment availability, new HCV infections have increased in recent years due to an increase in injection drug use. In Ohio, reported cases of acute hepatitis C increased by 1000% between 2011 and 2015. However, the majority of infected persons are unaware of their status since they do have any symptoms of the infection, therefore actual rates are most likely higher. In 2010, there were zero acute cases of HCV and 129 cases of chronic HCV in Butler County, compared to 7 cases of acute HCV and 840 cases of chronic HCV in 2016. This rate is slightly lower than the state incident rate, but higher than the Healthy People 2020 target (Butler County CHA, 2017).



Create a partnership to increase awareness of Hepatitis C

Prevention of Hepatitis C is possible using a strategic approach that includes education, testing, and treatment for those infected. Outreach efforts to expand partnerships can reach a broad range of groups affected by HCV and decrease stigma related to hepatitis. Talking about hepatitis in classrooms, community settings, and faith based communities is an avenue to increase HCV awareness and provide education. Sharing experiences about hepatitis can help decrease stigma and normalize testing and treatment (Department of Health and Human Services [DHHS], 2017).

Implement a syringe exchange program in Butler County

Syringe exchange programs (SEP) provide intravenous drug users with sterile syringes to reduce the use of sharing dirty needles and spreading disease. A large body of research demonstrates that SEP participants are less likely to engage in high-risk injection behavior that can transmit Hepatitis C. These changes in behavior can reduce the risk of Hepatitis C and other blood borne diseases among intravenous drug users who use SEPs. SEPs also educate drug users about Hepatitis C risks and prevention and link drug users to screening and treatment. Harm reduction programs do not condone or stop intravenous drug use, but they are proven ways to prevent infections spread through needle sharing. Providing users with clean needles is an evidence based approach to reduce the occurrence of new Hepatitis C infections (Hepatitis Central, 2017).

Increase screening for those at risk for Hepatitis C

The best way to reduce deaths associated with viral hepatitis and improve the health of people living with HCV infection is to expedite the diagnoses, care, treatment, and/or cure of all individuals living with chronic viral hepatitis (DHHS, 2017). A major area of opportunity is leveraging the health care system through the use of electronic health record prompts. In a study conducted by the University of Michigan in Ann Arbor, HCV screening increased dramatically through implementation of prompts in electronic health records in primary care settings. These types of strategies are a cost effective and efficient way to increase screening and access to care for those living with HCV (Jernstedt, 2017).

Priority 3: Maternal and Infant Health

The infant mortality rate in Butler County has been declining the past four years, and is currently 6.9, which is below the state rate of 7.4, but above the national rate of 5.8 and Healthy People 2020 target of 6.0. Despite the recent overall decline, inequalities exist primarily for black infants as the mortality rate is almost double the rate for white infants. One of the greatest contributors to infant mortality is preterm birth, defined as the birth of an infant before 37 weeks of gestation. The earlier an infant is born, the higher the risk of morbidity and mortality. In efforts to address disparities in maternal and infant health, health initiatives have been aimed at

improving the health of women and infants before and during pregnancy through evidence-based interventions (Butler County Community Health Assessment, 2017).

<u>Infant Mortality</u>:

Goal: To improve the health and well-being of mothers and infants in our community by addressing the health and social needs of infants, mothers, and families.

- *Increase mothers breastfeeding at discharge from hospitals*
- *Increase awareness of progesterone treatment for preterm labor*
- *Provide educational trainings for community health workers*
- *Increase enrollment in a smoking cessation program for pregnant women and their partners*



Increase mothers breastfeeding at discharge from hospitals

The health effects of breastfeeding are well recognized and apply to all mothers and children. Breast milk is uniquely suited to the human infant's nutritious needs and can protect against a host of illnesses and diseases for both mothers and children. The U.S. Preventive Services Task Force has determined that education on breastfeeding is the most effective intervention for increasing breastfeeding initiation and for short-term duration (CDC, 2005).

Increase awareness of progesterone treatment for preterm labor

Preterm, or premature, birth is the number one leading cause of newborn death in Ohio with black infants experiencing higher rates than white infants. Multiple research studies have shown that progesterone treatment of women with certain risk factors can reduce their risk of preterm

birth by about one third. Ohio Perinatal Quality Collaborative (OPQC) chartered sites are implementing ways to reduce preterm births through the appropriate use of progesterone in women at risk of preterm birth. Health Care providers can partner with the OPQC to establish a Progesterone Team in the county.

Provide educational trainings for community health workers

The Ohio Community Health Workers Association defines Community Health Workers as individuals who as community representatives, advocate for individuals and groups in the community by assisting them in accessing community health and supportive resources through the provision of education, role modeling, outreach, home visits and referral services. Improvements over usual care were demonstrated to be associated with CHWs who were provided with opportunities for continued education (Evidence Report/Technology Assessment, 2009).

Increase enrollment in a smoking cessation program for pregnant women and their partners

Smoking during pregnancy remains one of the most common preventable causes of pregnancy complications, illness, and death among infants. Compared with nonsmokers, women who smoke before pregnancy are about twice as likely to experience an ectopic pregnancy and problems with the placenta. Babies born to women who smoke during pregnancy are more likely to have a premature birth, low birth weight, certain birth defects, and a higher risk of SIDS (Sudden Infant Death Syndrome). Women who quit smoking before or during pregnancy can reduce their risk of poor pregnancy outcomes. Effective behavioral interventions for pregnant women who smoke include counseling, feedback, health education, and social support (CDC, 2017). Providing access to smoking cessation programs can help reduce poor pregnancy outcomes.

Next Steps

The Action cycle of the MAPP process is a continuous cycle of planning, implementing, and evaluating action plans. Workgroups for the three priority areas have planned to meet quarterly to update committee members on the progress of the strategies and in achieving the goals outlined in the action plan. Work group leaders will coordinate and oversee implementation of their strategies, and set up meetings with their specific groups as needed.

As plans are implemented, community partnerships will be expanded as needed, ongoing data will be gathered, and the three priority areas will be evaluated on a regular basis. An annual report will be published to provide updates outlining the progress made and revisions needed to any areas of the improvement plan.

Appendix A: Action Plans

PRIORITY AREA: ***Mental Health and Addiction***
GOAL #1: ***Mental Health*: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services**

PERFORMANCE MEASURES **How We Will Know We are Making a Difference**		
Short Term Indicators	**Source**	**Frequency**
The rate of Frequent Mental Distress reported will decrease from 12% to 11%	*County Health Rankings*	*Annually*
Long Term Indicators	**Source**	**Frequency**
BY 2020, 75% of Butler County students will have access to Behavioral Health Services within the school setting.	*Butler County Coalition-drug free and safe communities*	*Annually*
By 2019, the rate of suicide deaths will decrease by 5%	*Vital Statistics Records*	*Annually*

OBJECTIVE #1:
By 2019, Increase access by children to school based health centers (SBHC) that include behavioral health services from 2 to 5.

Source: http://journals.sagepub.com/doi/full/10.1177/1059840515590607 **and** https://www.sbh4all.org/school-health-care/aboutsbhcs/

Evidence Base*:* School-based health centers (SBHCs) provide students with a variety of health care services on school premises or at offsite centers linked to schools (County Health Rankings [CHR], 2016). Teams of nurses, nurse practitioners, and physicians often provide primary and preventive care and mental health care. The implementation and maintenance of SBHCs can lead to improved educational and health outcomes. Community programs can assist children and their families to unite with the right team to provide mental health solutions. SBHCs have been shown to improve students' health behaviors and may reduce barriers to mental health services (CHR, 2016).

Policy Change (Y/N): Y

ACTION PLAN

Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**	**Progress Notes**
Assess Assess the number of Butler County school districts with	May 2018	Staff Time Research	TBD/Butler County Coalition-for Healthy, Safe, and Drug Free	Behavioral Health Service needs	

school-based health centers that include behavioral health.			Communities (BC Coalition) Beth Race/Butler County Families and Children First Council (FCFC), Lori Higgins /Envision Partnerships	identified	
Build Convene a stakeholder group to review assessment results and determine capacity for expansion.	September 2018	Staff Time Research Travel Collaboration	TBD/Butler County Coalition, Beth Race/FCFC, Lori Higgins/Envision Partnerships	Capacity determined	
Plan Develop a county wide plan based on current needs and capacity.	November 2018	Staff Time	TBD/Butler County Coalition, Beth Race/FCFC, Lori Higgins/Envision Partnerships	County wide plan developed	
Implement Partner with school districts and stakeholders to implement plan.	March 2019	Staff Time Collaboration Travel	TBD/Butler County Coalition, Beth Race/FCFC, Lori Higgins/Envision Partnerships	Plan implemented in schools	
Evaluate Evaluate implementation and determine next steps to achieve success.	May 2019	Staff Time Collaboration Travel	TBD/Butler County Coalition, Beth Race/FCFC, Lori Higgins/Envision Partnerships	Evaluation data obtained and examined	

OBJECTIVE #2:
By 2019, decrease suicides by 5% by developing and implementing a Butler County Suicide Prevention Plan.

Source: Strategic Prevention Framework (SPF) **www.samhsa.gov/capt/applying-strategic-prevention-framework**
Evidence Base: Suicide prevention requires a comprehensive approach with efforts that work together to address the problem. Increased coordination of suicide prevention activities among various partners could help improve services and outcomes, while promoting the greater sustainability of suicide prevention efforts over the long term (Substance abuse and Mental Health Services Administration [SAMHSA], 2017).
Policy Change (Y/N): Y

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Approve funding to support Suicide Prevention Plan proposed by Envision Partnerships to BCMHARS Board.	January 2018	Staff Time	Lori Higgins/Envision Partnerships, Tiffany Lombardo/BCMHARS Board	Funding	
Assess Analyze collected data Conduct environmental scan Assess Community Readiness	March 2018	Staff Time Travel Administrative Support	Lori Higgins/Envision Partnerships	Community Assessment Document	

Build Creation of Butler County Suicide Prevention Task Force Interface with the Ohio Suicide Prevention Foundation Training for staff and community partners	March 2018	Staff Time Travel Collaboration	Lori Higgins/Envision Partnerships	Task Force Trainings	
Plan Identify EBPs for suicide prevention Create a prevention model for specified populations and communities determined through risk factor and data analysis	May 2018	Staff time Collaboration	Lori Higgins/Envision Partnerships, Tiffany Lombardo/BCMHARS	Logic Model	
Implement Pilot evidence-based suicide prevention programs/practices/policies in select groups within existing agency programming	June 2018	Staff time Collaboration Travel Support	Lori Higgins/Envision Partnerships	Preliminary results of pilot project(s)	
Evaluate Evaluate the data, results, costs, ease of implementation and readiness	October 2018	Staff time Support	Lori Higgins/Envision Partnerships	Final Written Action Plan to include findings and recommendations	

OBJECTIVE #3:

By 2019, ensure access to all mental health services by increasing NO WRONG DOOR (NWR) participating agencies from 17 to 20.

Source: www.acl.gov/news-and-events/announcements-latest-news/acl-no-wrong-door-system-grants-help-streamline-access **and https://nwd.acl.gov/**

Evidence Base: The traditional approach to service delivery often results in services and supports that do not work for people, drive costs higher, and, in some cases, contribute to poor outcomes. In "No Wrong Door" systems, multiple state and community agencies coordinate to ensure that regardless of which agency people contact for help, they can access information and one-on-one counseling about the options available across all the agencies in their community. The goal is to enable people to make informed decisions based on the full range of available services. No Wrong Door systems also provide assistance in accessing services, including help in completing applications for various programs (Administration for Community Living, 2017).

Policy Change (Y/N): Y

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Assess Evaluate current No Wrong	August 2018	Staff time	Beth Race/Butler County Families and	Barriers and successes	

Door implementation to determine areas of improvement and opportunities for expansion Identify agencies with frequent public contact who may wish to adopt No Wrong Door approach			Children First Council (FCFC)	identified. List of possible new partners developed	
Build Create an annual training calendar for on-boarding of new NWD participating agencies	June 2018	Staff time Financial support of training events	Beth Race/FCFC	Calendar developed	
Plan Present NWD approach to 3 new agencies for adoption Assist new agencies in planning for implementation including identification of navigator and gateway staff, adjustment of policies and procedures if necessary	October 2018	Staff time	Beth Race/FCFC, No Wrong Door Agencies	3 new agencies sign the statement of commitment indicating their inclusion as No Wrong Door agencies	
Implement No Wrong Door (NWD) agencies participate in training event NWD agencies engage in Cureo communication forum for resources and problem solving Distribute yellow/orange Resource Cards in the community	November 2018	Staff time Cureo Resource Cards Training Events	Beth Race/FCFC, No Wrong Door Agencies	Navigator and Gateway staff have the information and communication mechanism needed for implementation	
Evaluate Conduct “Secret Shopper” phone calls of NWD agencies in order to evaluate implementation and provide feedback Convene NWD agency Navigator staff at least 2 times per year to monitor implementation and make adjustments	July 2019 and annually April 2019 and bi-annually on-going	Volunteer secret shoppers Staff time	Beth Race/FCFC, No Wrong Door Agencies	Independent assessment of implementation will be completed. Modifications and additional resources identified in response to needs/deficits.	

ALIGNMENT WITH STATE/NATIONAL PRIORITIES			
Obj #	**State Health Improvement Plan**	**Healthy People 2020**	**National Prevention Strategy**
1	*State Plan Strategy to create School Based health center with behavioral health services and Multi-tiered systems of support*	*Improve the healthy development, health, safety, and wellbeing of adolescents and young adults through programs that address school based health care services, mental health and substance use interventions.* *Increase the proportion of children with mental health problems who receive treatment*	*Ensure students have access to comprehensive health services, including mental health and counseling* *The Community Preventive Services Task Force (CPSTF) recommends the implementation and maintenance of school-based health centers (SBHCs) in low-income communities to improve educational and health outcomes.*
2	*State Plan Strategy to increase Local Suicide Prevention Coalitions*	*Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.* *Reduce the suicide rate*	*Train key community members to identify the signs of depression and suicide and refer people to resources*
3	*State Plan goals increasing care coordination*	*Improve access to comprehensive, quality health care services.* *Increase the proportion of adults with mental health disorders who receive treatment*	*Expand access to mental health services and enhance linkages between mental health, substance abuse, disability, and other social services*

PRIORITY AREA: ***Mental Health and Addiction***

GOAL #2:
Substance Abuse : Reduce substance abuse to protect the health, safety, and quality of life of all citizens of Butler County

PERFORMANCE MEASURES How We Will Know We are Making a Difference		
Short Term Indicators	**Source**	**Frequency**
Number of trauma trainings conducted	*Butler County Families and Children First*	*Annually*

	Council	
Number of Naloxone kits distributed	*Butler County Health Department*	*Annually*
Long Term Indicators	**Source**	**Frequency**
By 2019, decrease the deaths by overdose in Butler County by 10%.	*Butler County Coroner*	*Annually*
By 2019,Percent of persons age 12+ reporting illicit drug dependence or abuse will decrease by 10%	*National Survey on Drug Use and Health (NSDUH)*	*2019*

OBJECTIVE #1:
By 2019, Increase the number of schools implementing evidence based prevention programs, practices and policies by 2.

Source: **https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/preventing-drug-abuse-best-strategy**

Evidence Base: When evidence based substance use prevention programs are properly implemented by schools and communities, the use of alcohol, tobacco, and illegal drugs is reduced. The term evidence-based means that these programs have been rationally designed based on current scientific evidence, rigorously tested, and shown to produce positive results. Scientists have developed a broad range of programs that positively alter the balance between risk and protective factors for drug abuse in families, schools, and communities. Such programs help teachers, parents, and health care professionals shape youths' perceptions about the risks of substance use. Studies have shown that research-based programs can significantly reduce early use of tobacco, alcohol, and illicit drugs (National Institute on Drug Abuse, 2014).

Policy Change (Y/N): Y

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Assess Conduct survey of all school districts to establish which, if any evidence-based prevention curricula are already in place. Compile master list.	July 2018	Staff time	Lori Higgins/Envision Partnerships, Tiffany Lombardo/Mental Health and Addiction Services Recovery Board (MHARS)	List of schools with evidence-based prevention curricula	
Build Provide training to districts about evidence-based prevention curricula available for use, evidence base, cost Establish a quarterly prevention meeting for all county school district reps to share successes and barriers in implementing evidence-based prevention curricula programs	February 2019	Staff time funding	Lori Higgins/Envision Partnerships, Tiffany Lombardo/MHARS	Evidence-based prevention curricula trainings Quarterly prevention meetings	

Identify potential funding sources to support expansion				Funding sources	
Plan Each district uses a district-wide evidence-based prevention curricula policy, approved by the school board and established in written policy.	August 2019	Staff time	Lori Higgins/Envision Partnerships, Tiffany Lombardo/MHARS , Individual school districts	District wide evidence-based prevention curricula policy	
Implement Pilot and monitor evidence-based prevention curricula programs in select high risk districts Each district implements a evidence-based prevention curricula	August 2020	Staff time	Lori Higgins/Envision Partnerships, Tiffany Lombardo/MHARS Miami University (MU) Researchers Individual school districts	Evidence-based prevention curricula implemented	
Evaluate Evaluate piloted evidence-based prevention curricula Evaluate quarterly prevention meeting	October 2020	Staff time	Lori Higgins/Envision Partnerships, Tiffany Lombardo/MHARS, MU Researchers	Evaluation data on evidence-based prevention curricula programs	

OBJECTIVE #2:
By 2019, Increase the number of county residents served by prenatal and early childhood home visiting programs and services by 10%.

Source: http://www.apa.org/pi/families/resources/newsletter/2012/07/home-visiting.aspx **and** **http://pediatrics.aappublications.org/content/101/3/486**

Evidence Base*:*

Home visiting provides voluntary, evidence-based home visiting services to at-risk pregnant women and parents with young children. Home visiting is a service and support delivery strategy for families that can be an effective mechanism to reach the highest risk families. Evidence-based home visiting models address physiological, social, psychological, economic, family and other factors that influence children's health and development. Outcomes include less maternal behavioral impairment attributable to alcohol and drug abuse. The observed effect of home-visitation programs seems to be greatest in high-risk populations, such as mothers who are teenagers, unmarried, poor, or have been abused, and in children who are preterm or low birth weight (American Academy of Pediatrics, 2018).

Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Assess Identify current number of children served and programs offered Make a master list of all early	March 2018	Staff Time	Nikki Taylor/ Educational Service Center (ESC), Marie Augustin/Moms and Babies First	Complete assessment of early childhood services and numbers of children served	

childhood and prenatal home visiting programs for county					
Build Identify key stake holders & coordinate a collaborative	January 2019	Staff Time Travel Collaboration	Nikki Taylor/ Educational Service Center (ESC), Marie Augustin/Moms and Babies First	Collaborative Meeting	
Plan Identify barriers and needs to increasing number served Develop plan to address barriers	July 2019 January 2020	Staff Time Travel	Nikki Taylor/ Educational Service Center (ESC), Marie Augustin/Moms and Babies First	Need and Barriers List Barrier Removal Plan	
Implement Create implementation plan and execute	January 2021	Staff Time Travel	Nikki Taylor/ Educational Service Center (ESC), Marie Augustin/Moms and Babies First	Implementation Plan	
Evaluate Create and execute evaluation criteria and plan	January 2021	Staff Time Travel	Nikki Taylor/ Educational Service Center (ESC), Marie Augustin/Moms and Babies First	Evaluation Plan	

OBJECTIVE #3:
By 2019, Increase the distribution of naloxone in the county by 100%.

Source: **https://www.ohsu.edu/xd/research/centers-institutes/evidence-based-policy-center/evidence/med/upload/MED_best_practices_naloxone_report_final.pdf**
Evidence Base*:* Naloxone is a prescription drug that can reverse the effects of opioid overdose (prescription or illicit), and can be life-saving if administered in time. Expanding the availability of naloxone rescue kits to bystanders, family members, and first responders is a crucial element of the strategy to reduce opioid overdose deaths. Wider availability of naloxone is likely to reduce the number of opioid overdose deaths, and state laws and policies to encourage its distribution and use are essential (Oregon Health & Science University, 2015).
Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Assess Develop master list for county of all agencies/entities distributing and receiving naloxone from state supported, and private sources	March 2018	Resources for naloxone kits, staff time, outreach plan	Sue Haines/Butler County Health Department (BCHD), Tiffany Lombardo/Mental Health and Addiction Recovery Services Board (MHARS)	List of agencies distributing and receiving naloxone	
Build Link with additional existing programs to expand reach and	June 2018	Resources for naloxone kits, staff time,	Sue Haines/BCHD, Tiffany Lombardo/ MHARS	Classes conducted outside the	

increase number of classes conducted outside the health department (jails, churches, libraries, etc.)		outreach plan		health department	
Plan Ensure those at highest risk of OD have access to naloxone kits.	June 2018	Resources for naloxone kits, staff time, outreach plan	Sue Haines/BCHD, Tiffany Lombardo/ MHARS	High risk users have access to naloxone	
Evaluate Meet quarterly to evaluate: number of doses dispensed and used, barriers and successes.	Quarterly in 2018, 2019	staff time, evaluation plan template	Sue Haines/BCHD, Tiffany Lombardo/ MHARS	Increased OD reversals, Decreased OD deaths	

OBJECTIVE #4:
By 2019, implement a countywide Overdose Alerting System.

Source: https://ndews.umd.edu/about-us/project-overview

Evidence Base*:* The National Drug Early Warning System (NDEWS) was designed to monitor emerging drug use trends to enable health experts, researchers, and concerned citizens across the country to respond quickly to potential outbreaks of illicit drugs such as heroin and to identify increased use of designer synthetic compounds (University of Maryland, n.d.). Developing and implementing a local overdose alerting system can raise local community awareness and advise first responders, healthcare providers, and substance users and their families of the increased risk for overdose in the community. Local Public Health Alerts can be issued to allow for surging personnel and resources to community hotspots.

Policy Change (Y/N): Y

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Assess Establish whether a need exists for a county-wide Alerting System	January 2018	Staff time	Jenny Bailer/Butler County Health Department, City of Hamilton Health Department, City of Middletown Health Department, MHARS, Coroner, Quick Response Teams, EMS, dispatches	Expressed need	
Build Bring key stakeholders on board so all data is reported to centralized source Establish Overdose Alerting Network made up of key partners	February 2018	Staff time	Jenny Bailer/Butler County, City of Hamilton Health Department, City of Middletown Health Department, MHARS, Coroner, Quick Response Teams, EMS, dispatches, Hamilton Co. Public Health	Established Overdose Alerting Network meeting regularly	

Plan Discuss use of LIvestories for website Develop press release template for Public Health Advisories and criteria for release Obtain training on how to use The Communicator data bases.	April 2018	Staff time (project is grant funded)	Jenny Bailer/Butler County, City of Hamilton Health Department, City of Middletown Health Department, MHARS, Coroner, Quick Response Teams, EMS, dispatches, Hamilton Co. Public Health	Livestories on multiple website of agencies throughout county	
Implement Publicize roll out of Alerting System and its use Announce Livestories and encourage links on partner's websites Utilize The Communicator to send out alerts	April 2018	Staff time (project is grant funded)	Jenny Bailer/Butler County, City of Hamilton Health Department, City of Middletown Health Department, MHARS, Coroner, Quick Response Teams, EMS, dispatches, Hamilton Co. Public Health	Template for releasing alerts, List of recipients of alerts	
Evaluate Meet quarterly to evaluate barriers, successes, number of alerts, number of deaths, number of EMS runs, number of ER visits, satisfaction by key stakeholders	Quarterly, 2018, 2019	Staff time (project is grant funded)	Jenny Bailer/Butler County, City of Hamilton Health Department, City of Middletown Health Department, MHARS, Coroner, Quick Response Teams, EMS, dispatches, Hamilton Co. Public Health	Evaluation shows successful program	

OBJECTIVE #5:

By 2019, two trainings on trauma informed care and SBIRT will be provided for health, social service, or mental health providers.

Source: https://www.thinkculturalhealth.hhs.gov/clas/what-is-clas https://www.samhsa.gov/nctic/trauma-interventions https://www.integration.samhsa.gov/clinical-practice/sbirt

Evidence Base: Trauma is an emotional response to a terrible. Continued exposure to trauma can result in a complex array of social, emotional, and behavioral challenges. The latest trauma treatment programs and related practices can help individuals experience healing and resiliency. Two such practices include Screening, Brief Intervention, Referral to Treatment (SBIRT) and Trauma Informed Care. SBIRT is an approach to screening and referral to early intervention for substance use, depression or suicide risk. (SAMHSA, n.d.). Trauma-Informed Care is an approach that can be used by all caring professionals that recognizes the widespread presence of trauma symptoms in many people's lives, and acknowledges the role that trauma has played in their lives (SAMHSA, 2015).

Policy Change (Y/N): Y

ACTION PLAN

Activity	Target Date	Resources	Lead Person/	Anticipated	Progress

		Required	Organization	Product or Result	Notes
Offer two trainings on the use of SBIRT	January 2019	Staff Time	Beth Race/Butler County Families and Children First Council (FCFC), Tiffany Lombardo/Mental Health and Addiction Services Board (MHARS)	Increased identification of those at risk. Increased referrals and numbers of people in treatment.	
Offer two trainings on Trauma Informed Care	January 2019	Staff Time, Trainer costs, facility rental, publicity, materials	Beth Race/FCFC, Tiffany Lombardo /MHARS	Providers will be able to give care that is appropriate for those who have experienced trauma	

ALIGNMENT WITH STATE/NATIONAL PRIORITIES			
Obj #	**State Health Improvement Plan**	**Healthy People 2020**	**National Prevention Strategy**
1	*School-based health that includes universal prevention programs to promote mental wellbeing, and prevent alcohol, tobacco or other drug use.*	*Improve the healthy development, health, safety, and well-being of adolescents and young adults through programs that address school based health care services, mental health and substance use interventions.*	*The Community Preventive Services Task Force (CPSTF) recommends electronic screening and brief intervention (e-SBI) based on strong evidence of effectiveness in reducing self-reported excessive alcohol consumption and alcohol-related problems among intervention participants.*
2	*n/a*	*Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.*	*Educate parents on normal child development and conduct early childhood interventions to enhance mental and emotional well-being and provide support.*
3	*Training and access to naloxone*	*n/a*	*Development of a Nationwide community-based prevention system involving governments and partners*
4	*Implement enhanced overdose surveillance of opioid fatalities*	*To ensure that Federal, State, Tribal, territorial, and local health agencies have the necessary infrastructure to effectively provide essential public health services.*	*Enhance linkages between drug prevention, substance abuse, mental health, and juvenile and criminal justice agencies to develop and disseminate effective models of prevention and care*

5	*Multi-tiered systems of support training*	*n/a*	*Educate health care professionals on referral and treatment (SBIRT)*

PRIORITY AREA: ***Chronic Disease***

GOAL: #1

Obesity: ***Promote health and reduce chronic disease risk and improve quality of life through the consumption of healthful diets and through daily physical activity***

PERFORMANCE MEASURES **How We Will Know We are Making a Difference**		
Short Term Indicators	**Source**	**Frequency**
By 2019, increase in partners working towards the Obesity goal from 6 to 8.	*Butler County Commissioner's Office, Centerpoint*	*Annually*
By 2019, those with limited access to healthy foods will decrease from 6% to 5%	*County Health Rankings*	*Annually*
Long Term Indicators	**Source**	**Frequency**
By 2019, reduce the rate of physical inactivity from 25% to 24%	*County Health Rankings*	*Annually*
By 2019, reduce the rate of adult obesity from 33% to 32%	*County Health Rankings*	*Annually*

OBJECTIVE #1:
By 2019, establish 2 new community gardens in Butler County.

Source: http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/community-gardens

Evidence Base*:* Community gardens are collaborative projects on shared open spaces where participants share in the maintenance and products of the garden (CDC, 2010). They are a suggested strategy to increase fruit and vegetable availability in food deserts, promote healthy eating, reduce obesity and improve participant's mental health and social connectedness. Placing gardens in low income areas can reduce disparities in access to healthy foods, especially fruits and vegetables (What Works For Health, 2017). Community gardens can reduce barriers to healthy food associated with transportation, cost, and food preference, and may increase food security (What Works For Health, 2017).

Policy Change (Y/N): N

ACTION PLAN

Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**	**Progress Notes**
Research development of community garden	Spring 2018	Web search	Shawna Smith/ Butler County Commissioner's	Knowledge and data on development of	

			Office, Master Gardener Program	community garden	
Identify resources for creating a garden	Spring 2018	Land, tools, supplies to build it , water, seed	Shawna Smith/ Butler County Commissioner's Office, Site coordinator at each garden	Built gardens	
Provide education at each site	Dec 2018	Staff / volunteer	Shawna Smith/ Butler County Commissioner's Office, OSU extension	Curriculum	
Monitor growth and use of community garden	Spring 2019	Land, supplies, coordinator	Shawna Smith/ Butler County Commissioner's Office, OSU extension/Site coordinator	Fresh produce (2 Community gardens)	

OBJECTIVE #2:
By 2019**,** provide nutritious food options to low-income families in 2 food banks in Butler County

Source: ***http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/healthy-food-initiatives-in-food-banks***
Evidence Base: Food banks are central building blocks to the US emergency food system and although the main goal is to relieve hunger, the rise in obesity among food insecure individuals has encouraged food banks to endorse more nutritious options. Food banks and food pantries that use healthy food initiatives may increase fruit and vegetable consumption, improve diet quality, and increase food security more than traditional food banks and pantries. Food banks that provide nutrition education and recipe demonstrations may improve the variety of fruits and vegetables clients consume, as well as their food knowledge and home cooking habits (CHR, 2017).
Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Evaluate the current gaps in food banks to determine nutritious food offerings	May 2018	Time / volunteers	Tina Yauch/Centerpoint, Krystal Tipton (BC United Way)	Identified nutritious food gaps	
Determine nutritious food offerings that are available for donations to food banks	June 2018	Time/volunteers	Tina Yauch/Centerpoint Health	Viable nutritious food products for donation	
Get donated nutritious food offerings to food banks	August 2018	Time / volunteers	Tina Yauch/Centerpoint Health	Viable nutritious food products available in local food banks	
Integrate nutrition education opportunities in the food banks (i.e. recipes for products, demonstrations,	October 2018	Staffing, food donations, supplies	Tina Yauch/Centerpoint Health , OSU Extension/Miami	Educational opportunities at each food bank	

taste demonstrations, kid-friendly opportunities)			University Dietetics		
Evaluate the process for next cycle	February 2019	Time/volunteers	Tina Yauch/Centerpoint Health , OSU Extension/Miami University Dietetics	Ongoing plan	

OBJECTIVE #3:
By 2019, implement healthy vending options with 2 local employers in Butler County

Source: http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/healthy-vending-machine-options
Evidence Base: There are a variety of mechanisms to increase healthy options in vending machines, including reducing the price of healthy choices and increasing the number of healthy choices compared to unhealthy choices. There is some evidence that increasing healthy options in vending machines improves dietary behaviors especially when healthy options are made relatively less expensive than unhealthy options (CHR, 2017). Price discounts for healthier foods have been shown to increase consumption of healthier foods. Vending machine nutrition standards and increased healthy vending options are suggested strategies to improve nutrition.
Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Identify 2 employers with unhealthy vending choices	May 2018	Staff/volunteer, time	Shawna Smith/ Butler County Commissioner's Office	2 employers identified	
Survey employees on their desires/demands for healthy food preferences	July 2018	Staff/volunteer, survey	Shawna Smith/ Butler County Commissioner's Office	Healthy foods desired by employees	
Develop contract with vending supplier to implement healthy food options for vending machines	September 2018	Staff/volunteer	Shawna Smith/ Butler County Commissioner's Office	Healthy food in vending machines	
Evaluate the outcome	February 2019	Staff/volunteer	Shawna Smith/ Butler County Commissioner's Office	Healthy foods consumed	

OBJECTIVE #4:
By 2019, Establish 2 walking clubs in Butler County

Source: http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/community-based-social-support-for-physical-activity
Evidence Base: Community-based social support interventions for physical activity focus on changing physical activity behavior through building, strengthening, and maintaining social networks that provide supportive relationships for behavior change (e.g., setting up a buddy system or a walking group to provide friendship and support) (CHR, 2017). There is strong evidence that community-based social support interventions for physical activity increase physical activity and

physical fitness among adults (CHR, 2017). Walking is one of the simplest ways to get active and maintain a healthy lifestyle.

Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Research/assess current walking clubs for development	April 2018	Time, Staff	Shawna Smith/ Butler County Commissioner's Office, Anna McKain/YMCA	Knowledge on forming walking clubs	
Create info sheet including: -benefits of walking -how to start a walking club -outdoor walking areas in BC -indoor walking areas in BC -pet friendly trails, prayer walks, senior walks, kid walks	April 2018	Time, Staff, handouts	Shawna Smith/ Butler County Commissioner's Office, Anna McKain/YMCA	Information sheet	
Plan 1 mile walk kickoff for Butler County	April 2018	Time, Staff	Shawna Smith/ Butler County Commissioner's Office, Anna McKain/YMCA	Kickoff walk	
Develop schedule for walking clubs	June 2018	Time, Staff	Shawna Smith/ Butler County Commissioner's Office, Anna McKain/YMCA	Schedule of walks	
Promote walking club through community organizations and businesses	Ongoing	Time, Staff	Shawna Smith/ Butler County Commissioner's Office, Anna McKain/YMCA	Community awareness	

ALIGNMENT WITH STATE/NATIONAL PRIORITIES

Obj #	State Health Improvement Plan	Healthy People 2020	National Prevention Strategy
1	*Community healthy food access: community gardens*	*n/a*	*Increase access to healthy and affordable foods in communities.*
2	*Community healthy food access: Healthy food initiatives in food banks*	*Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables*	*Increase access to healthy and affordable foods in communities.* *Help people recognize and make healthy food and beverage choices*
3	*Community healthy food access*	*n/a*	*Increase access to healthy and affordable foods in communities.* *Improve nutritious quality of the food supply.*

4	*n/a*	*Increase the proportion of trips made by walking*	*Facilitate access to safe, accessible, and affordable places for physical activity.*

PRIORITY AREA: ***Chronic Disease***

GOAL #2

Lung Cancer: Reduce the number of new lung cancer cases as well as illness, disability, and death caused by lung cancer

PERFORMANCE MEASURES **How We Will Know We are Making a Difference**		
Short Term Indicators	**Source**	**Frequency**
By 2019 Develop a resource list of tobacco cessation programs in Butler County	*City of Middletown Health Department*	*Ongoing(for updates)*
By 2019, Develop a handout on lung cancer for Butler County	*City of Middletown Health Department*	*Ongoing(for updates)*
Long Term Indicators	**Source**	**Frequency**
By 2019, decrease the adult smoking rate from 19% to 18%	*County Health Rankings*	*Annually*

OBJECTIVE #1:
By 2019, develop a resource list of tobacco cessation programs to distribute in Butler County.

Source: https://www.cdc.gov/policy/hst/hi5/tobaccointerventions/index.html
https://www.cdc.gov/sixeighteen/docs/6-18-evidence-summary-tobacco.pdf
Evidence Base*:* Evidence-based interventions that are key components of a comprehensive tobacco prevention and control effort provide tobacco users with information on resources on how to quit (CDC, 2014). Promoting cessation is a core component of a comprehensive state tobacco control program's efforts to reduce tobacco use. Encouraging and helping tobacco users to quit is the quickest approach to reducing tobacco-related disease, death, and health care costs. Quitting smoking has immediate and long-term health benefits. Although quitting smoking at any age is beneficial, smokers who quit by the time they are 35 to 44 years of age avoid most of the risk of dying from a smoking-related disease.
Policy Change (Y/N): N

ACTION PLAN

Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**	**Progress Notes**
Research/assess current tobacco cessation treatments and resources in Butler County	April 2018	Time, Staff	Nancy McKillop/City of Middletown Health Department, Ann Munafo/Volunteer	Knowledge of current cessation resources	
Create a list of tobacco cessation resources	April 2018	Time, Staff	Nancy McKillop/City of Middletown Health Department, Ann	List of resources	

			Munafo/Volunteer		
Develop a plan to distribute and promote resource list	June 2018 ongoing	Time, Staff,	Nancy McKillop/City of Middletown Health Department, Ann Munafo/Volunteer	Distribution plan	
Distribute the resource list to: - Agency websites, social media outlets - Community events - Outreach to Employee Newsletters and websites encouraging tobacco cessation programs - CHW to educate and promote tobacco cessation programs to pregnant moms	July 2018	Time, Staff	Nancy McKillop/City of Middletown Health Department, Ann Munafo/Volunteer	Community aware of cessation programs	
Evaluate resource list quarterly for updates and changes to programs and additional distribution outlets	October 2018, ongoing quarterly	Time, Staff	Nancy McKillop/City of Middletown Health Department, Ann Munafo/Volunteer	Updated resource list	

OBJECTIVE #2:
By 2019, develop a Lung Cancer informational handout to distribute in Butler County.

Source: ***https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/lung-cancer-screening***
Evidence Base: The American Lung Association found that awareness of lung cancer and the lifesaving potential of lung cancer screening is critically low. Greater awareness of lung cancer screening for those considered at high risk is essential to saving lives (American Lung Association, 2018). The goal of lung cancer screening is to identify the cancer at an early stage so it can be successfully treated. Most screening programs focus on detecting the most common type of lung cancer, which can be cured if found and treated early (U.S. Preventive Service Task Force, 2015). Many lung cancer deaths can be prevented every year by screening high-risk people.

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Research and assess current screening guidelines and risk factors for Lung Cancer	April 2018	Time, Staff	Nancy McKillop/City of Middletown Health Department, Ann Munafo/Volunteer	Updated information on Lung Cancer	
Obtain a handout on Lung Cancer which includes: - Current screening guidelines - Risk factors - Local statistics	April 2018	Time, Staff	Nancy McKillop/City of Middletown Health Department, Ann Munafo/Volunteer	Handout on Lung Cancer	
Develop a plan to distribute handout - Agency website, social	July 2018	Time, Staff	Nancy McKillop/City of Middletown Health Department, Ann	Distribution Plan	

media - Community events - Outreach to Employee Newsletters and websites regarding Lung Cancer			Munafo/Volunteer		
Distribute the handout to: - Agency websites, social media outlets - Community events - Outreach to Employee Newsletters and websites encouraging lung cancer screening	July 2018	Time, Staff	Nancy McKillop/City of Middletown Health Department, Ann Munafo/Volunteer	Community awareness of lung cancer	
Evaluate for updates and for additional distribution outlets	October 2018, ongoing quarterly	Time, Staff	Nancy McKillop/City of Middletown Health Department, Ann Munafo/Volunteer		

OBJECTIVE #3:
By 2019, Increase the number of government agencies with a tobacco-free policy in Butler County by 2.

Source: https://www.cdc.gov/policy/hst/hi5/tobaccointerventions/index.html
Evidence Base: There is no safe level of exposure to secondhand smoke, and exposure to secondhand smoke is a danger even in outdoor areas. Recent studies have shown that secondhand smoke in outdoor areas can reach concentrations found indoors where smoking is permitted, particularly in places where multiple smokers gather, such as near entryways and in outdoor eating areas (Public Health and Tobacco Policy Center, n.d.). Comprehensive smoke-free policies have been shown to significantly improve indoor air quality, reduce secondhand smoke exposure, change social norms regarding the acceptability of smoking, prevent smoking initiation by youth, help smokers quit and decrease hospitalizations for heart attack and asthma among nonsmokers (CDC, 2016).
Policy Change (Y/N): Y

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Assess current tobacco policies within county/government agencies	April 2018	Time, Staff	Shawna Smith/ Butler County Commissioner, Kay Farrar/City of Hamilton Health Department	Knowledge of current tobacco policy	
Schedule meeting to discuss tobacco free policy with key county policy makers, administrators, and stakeholders	July 2018	Time, Staff, Meeting space	Shawna Smith/ Butler County Commissioner, Kay Farrar/City of Hamilton Health Department	Meeting held	
Develop a tobacco free policy for county/government agencies	September 2018	Time, Staff, Legal input	Shawna Smith/ Butler County Commissioner, Kay Farrar/City of Hamilton Health	Tobacco free policy	

			Department		
Implement tobacco free policy	January 2019 ongoing	Staff, Time,	Shawna Smith/ Butler County Commissioner, Kay Farrar/City of Hamilton Health Department	Tobacco free policy adopted	

ALIGNMENT WITH STATE/NATIONAL PRIORITIES			
Obj #	**State Health Improvement Plan**	**Healthy People 2020**	**National Prevention Strategy**
1	*Expand access to and referral to evidence-based tobacco cessation treatments including individual, group and phone counseling (including Quitline) and cessation medications*	*n/a*	*Expand use of tobacco cessation services.*
2	*n/a*	*Lung Cancer: Screening in Adults Ages 55 to 80 Years*	*n/a*
3	*Smoke-free policies (including maintenance of smoke-free workplace law and increased policy adoption for multi-unit housing, schools and other settings*	*n/a*	*Support comprehensive tobacco free and other evidence-based tobacco control policies.*

PRIORITY AREA: ***Chronic Disease***

GOAL #3

<u>Hepatitis C:</u> Identify new Hepatitis C infections in Butler County through increased screening.

PERFORMANCE MEASURES **How We Will Know We are Making a Difference**		
Short Term Indicators	**Source**	**Frequency**
By 2019, form a partnership to address Hepatitis C in Butler County	*City of Hamilton Health Department, City of Middletown Health Department Butler County Health Department (BCHD)*	*Ongoing*
By 2019, implement a needle exchange program in Butler County	*BCHD*	

Long Term Indicators	Source	Frequency
Increase the number of persons screened for Hepatitis C by 10%	*Butler County Health Department (BCHD), City of Hamilton Health Department, City of Middletown Health Department*	*Annually*

OBJECTIVE #1:
By 2019, form a partnership to increase awareness of Hepatitis C in Butler County.

Source: National Viral Hepatitis Action Plan 2017–2020
https://www.hhs.gov/sites/default/files/National%20Viral%20Hepatitis%20Action%20Plan%202017-2020.pdf
Evidence Base*:* Prevention of Hepatitis C is possible using a strategic approach that includes education, testing, and treatment for those infected. Outreach efforts to expand partnerships can reach a broad range of groups affected by HCV and decrease stigma related to hepatitis. Talking about hepatitis in classrooms, community settings, and faith based communities is an avenue to increase HCV awareness and provide education. Sharing experiences about hepatitis can help decrease stigma and normalize testing and treatment (Department of Health and Human Services [DHHS], 2017).

Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Participate in the observance of Hepatitis Awareness Month, Hepatitis Testing Day (May 19), and World Hepatitis Day (July 28).	May 2018, July 2018 May 2019, July 2019	Time, staff	Kay Farrar/City of Hamilton Health Department, Nancy McKillop/City of Middletown Health Department, Mita Patel/Butler County Health Department (BCHD)	Increase awareness of Hepatitis C within the community	
Educate those at risk about hepatitis C, the benefits of getting tested, risk factors for HCV, and about other health dangers associated with injection drug use (website, social media)	July 2018 ongoing	Time, Staff,	Kay Farrar/City of Hamilton Health Department, Nancy McKillop/City of Middletown Health Department, Mita Patel/Butler County Health Department (BCHD),	Community of patients and providers will be knowledgeable about Hepatitis C	
Partner with community groups to increase opportunities to educate about viral hepatitis and share facts, recommendations, and personal stories at work, school, faith-based	September 2018 ongoing	Time, Staff	Kay Farrar/City of Hamilton Health Department, Nancy McKillop/City of Middletown Health Department, Mita Patel/Butler County	Community will be knowledgeable about Hepatitis C which will reduce stigma and	

organizations, and other settings			Health Department (BCHD),	discrimination	

OBJECTIVE #3:
By 2019, increase screening for those at risk for Hepatitis C by 10%

Source: National Viral Hepatitis Action Plan 2017–2020
https://www.hhs.gov/sites/default/files/National%20Viral%20Hepatitis%20Action%20Plan%202017-2020.pdf
Evidence Base: The best way to reduce deaths associated with viral hepatitis and improve the health of people living with HCV infection is to expedite the diagnoses, care, treatment, and/or cure of all individuals living with chronic viral hepatitis (DHHS, 2017). A major area of opportunity is leveraging the health care system through the use of electronic health record prompts. In a study conducted by the University of Michigan in Ann Arbor, HCV screening increased dramatically through implementation of prompts in electronic health records in primary care settings. These types of strategies are a cost effective and efficient way to increase screening and access to care for those living with HCV (Jernstedt, 2017).
Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Assess hospital corporations' current process to screen those at risk for Hepatitis C.	June 2018	Staff time, development of questions to ask	Nancy McKillop/City of Middletown Health Department, hospital corporation coordinators	Data on current screening process for at risk Hepatitis C clients	
Discuss and plan the use of electronic health record prompts and other activities to screen those at risk for Hepatitis C.	August 2018	Staff time, data on electronic prompts	Nancy McKillop/City of Middletown Health Department, hospital corporation coordinators	Plan to implement electronic health record prompts and other activities for screening Hepatitis C clients	
Implement prompts in hospital electronic record systems to screen those at risk for Hepatitis C	January 2019	Staff time,	Nancy McKillop/City of Middletown Health Department, hospital corporation coordinators	At risk clients screened for Hepatitis c, for increased access to care for treatment	

OBJECTIVE #2:
By 2019, Implement an additional syringe exchange program in Butler County.

Source: ***http://harmreduction.org/wp-content/uploads/2012/01/SEPandHCVFactSheet2006.pdf***
http://www.hepatitiscentral.com/news/needle-exchange-for-halting-new-hep-c-infections/
Evidence Base:
Syringe exchange programs (SEP) provide intravenous drug users with sterile syringes to reduce the use of sharing dirty

needles and spreading disease. A large body of research demonstrates that SEP participants are less likely to engage in high-risk injection behavior that can transmit Hepatitis C. These changes in behavior can reduce the risk of Hepatitis C and other blood borne diseases among intravenous drug users who use SEPs. SEPs also educate drug users about Hepatitis C risks and prevention and link drug users to screening and treatment. Harm reduction programs do not condone or stop intravenous drug use, but they are proven ways to prevent infections spread through needle sharing. Providing users with clean needles is an evidence based approach to reduce the occurrence of new Hepatitis C infections (Hepatitis Central, 2017).

Policy Change (Y/N): Y

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Evaluate the need for additional needle/syringe and education sites in Butler County	September 2018	Staff, Time, Data collection	Jenny Bailer/Butler County Health Department (BCHD), Opioid Task Forces	Data on the additional need and capacity for needle/syringe exchange program and education sites in Butler County	
Convene a stakeholder group to review the need for needle/syringe exchange sites	September 2018	Staff, Time	Jenny Bailer/BCHD, Opioid Task Forces	Stakeholder meeting	
Develop a plan for implementation of needle/exchange program	February 2019	Staff, Time	Jenny Bailer/BCHD, Opioid Task Forces	Needle/syringe exchange program plan	
Implement needle/syringe exchange program	May 2019	Staff, Time	Jenny Bailer/BCHD, Opioid Task Forces	Needle/syringe exchange program implemented	

ALIGNMENT WITH STATE/NATIONAL PRIORITIES

Obj #	State Health Improvement Plan	Healthy People 2020	National Prevention Strategy
1	*n/a*	*Reduce new hepatitis C infections*	*Build awareness of substance use as a public health problem*
2	*n/a*	*Increase the proportion of persons aware they have a hepatitis C infection*	*n/a*
3	*n/a*	*n/a*	*Implement interventions to reduce harms associated with alcohol and drug misuse.*

PRIORITY AREA: ***Maternal and Infant Health***

GOAL:

To improve the health and well-being of mothers and infants in our community by addressing the health and

social needs of infants, mothers, and families.

PERFORMANCE MEASURES **How We Will Know We are Making a Difference**		
Short Term Indicators	**Source**	**Frequency**
By 2019, increase % of African American mothers breastfeeding at discharge	*Vital Statistics (Birth Certificates)*	*Annually*
By 2019, increase %of all women in Butler Country breastfeeding at discharge	*Vital Statistics (Birth Certificates)*	*Annually*
By 2019, increase % of providers at surveyed facilities in Butler County with knowledge of where to refer eligible clients for progesterone treatment (to reduce risk of preterm births)	*Partnership to Reduce Infant Mortality (PRIM)*	*Annually*
By 2019, increase % of women of childbearing age who are aware of the use of progesterone for prevention of preterm births	*PRIM*	*Annually*
By 2019, increase the number of meetings per year for Community Health Workers Community of Learners (CoL)	*PRIM*	*Annually*
By 2019, increase % of CHWs attending CHWs Community of Learners (CoL) meetings per year	*PRIM*	*Annually*
Long Term Indicators	**Source**	**Frequency**
By 2019, reduce percentage of preterm births by 1%	*Vital Statistics (Birth Certificates*	*Annually*
By 2019, reduce infant mortality rate for African American mothers by 0.05 %	*Vital Statistics (Birth Certificates*	*Annually*
By end of 2019, the ratio between black infant mortality and white infant mortality will be reduced to no greater than 2/1	*Vital Statistics (Birth Certificates*	*Annually*

OBJECTIVE #1:
By end of 2019, Increase % of breastfeeding African American mothers at discharge by 5%
By end of 2019, increase % of all breastfeeding mothers at discharge in Butler County by 5%

Source: https://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf
Evidence Base: The health effects of breastfeeding are well recognized and apply to all mothers and children. Breast milk is uniquely suited to the human infant's nutritious needs and can protect against a host of illnesses and diseases for both mothers and children. The U.S. Preventive Services Task Force has determined that education on breastfeeding is the most effective intervention for increasing breastfeeding initiation and for short-term duration (CDC, 2005).
Policy Change (Y/N): N

ACTION PLAN

Activity	**Target Date**	**Resources Required**	**Lead Person/ Organization**	**Anticipated Product or Result**	**Progress Notes**
Provide breastfeeding education seminars/ sessions for Community Health Workers (CHW), support staff (home visitation, social workers etc.) and interested	April 2018 Fall 2018	Meeting Space/educational speaker/invites and or flyers to alert community	Cindy Meale/Women, Infants and Children (WIC)	Increased capacity for breastfeeding support to moms in community Increased	

community members. (i) Breastfeeding 101 for all groups (ii) Breastfeeding seminar for dads				support of breastfeeding mothers by partners.	
Shadowing opportunity will be provided for CHWs at WIC	Summer2018	Schedule for shadowing/CHW and WIC employee time	Cindy Meale/WIC	Build capacity of CHWs, social workers etc. to provide breastfeeding support	
Supply educational resources on Breastfeeding/ Breastfeeding support to 2 Butler County Obstetrical providers and 2 Pediatric providers	Fall 2018	Informational resource kits for providers/provider WIC representative to visit offices.	Cindy Meale/WIC	Increase Healthcare Provider understanding of and support for breastfeeding	

OBJECTIVE #2:
By end of 2019 increase Butler County community awareness of progesterone treatment for decreasing risk of preterm birth rate by 5%

Source: https://www.opqc.net/
https://opqc.net/sites/bmidrupalpopqc.chmcres.cchmc.org/files/Progesterone/opqc_progesterone%20case_studies%20FINAL%2010-30.pdf
Evidence Base: Preterm, or premature, birth is the number one leading cause of newborn death in Ohio with black infants experiencing higher rates than white infants. Multiple research studies have shown that progesterone treatment of women with certain risk factors can reduce their risk of preterm birth by about one third. Ohio Perinatal Quality Collaborative (OPQC) chartered sites are implementing ways to reduce preterm births through the appropriate use of progesterone in women at risk of preterm birth. Health Care providers can partner with the OPQC to establish a Progesterone Team in the county.
Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Develop and conduct survey of PRIM priority population to assess knowledge of use of progesterone for preterm birth prevention	March 2018	Survey questionnaire,	Goldie Wontumi//Butler County Partnership to Reduce Infant Mortality (BC PRIM)/Butler County Health Department (BCHD)	Gain understanding of knowledge base of priority population.	
Assess facilities/providers in Butler County that provide	June 2018	Contact persons at local	Goldie Wontumi/BC Prim/BCHD	A list of providers/instituti	

screening for and treatment with progesterone for prevention of preterm birth		facilities		ons that provide progesterone treatment for preterm birth prevention	
Develop and administer a survey to assess provider knowledge of facilities/institutions where eligible clients can be referred for progesterone treatment for prevention of preterm births	June 2018	Sample survey,	Goldie Wontumi/BC Prim/BCHD	Gain understanding of knowledge base of providers.	.
Analyze and interpret survey results for priority population survey	May 2018	Epidemiologist, Data analysis software	Goldie Wontumi/BC Prim/BCHD	Understand whether priority population has appropriate understanding of use of progesterone for preterm birth prevention	
Analyze and interpret survey results from provider survey	July 2018	Epidemiologist, Data analysis software	Goldie Wontumi/BC Prim/BCHD	Understand whether providers have knowledge of where to refer clients for progesterone treatment	
Develop educational/awareness campaign using information obtained from provider and community surveys	August 2018	Stakeholders at OB facilities	Goldie Wontumi/BC Prim/BCHD	Increase in providers' knowledge of institutions that provide progesterone treatment for prevention of preterm births, increase community knowledge of the use of progesterone to prevent preterm births	
Implement educational/awareness campaigns to address knowledge gaps identified	Decembe r 2018	OPQC, Co leads, field experts, stakeholders at	Goldie Wontumi/BC Prim/BCHD	Increase provider knowledge of institutions that provide	

from provider and community surveys		OB facilities		progesterone treatment for prevention of preterm births, increase community knowledge of use of progesterone to prevent preterm births	
Repeat surveys to assess improvement	April 2019	Sample survey, Field Experts (OPQC), Major OB facilities	Goldie Wontumi/BC Prim/BCHD	Effectiveness of progesterone education/awareness campaign	

OBJECTIVE #3:
By end of 2018, Provide two educational/training sessions per calendar year for Butler County Community Health workers Community of Learning

Source: https://www.ahrq.gov/downloads/pub/evidence/pdf/comhealthwork/comhwork.pdf
Evidence Base: The Ohio Community Health Workers Association defines Community Health Workers as individuals who act as community representatives, advocate for individuals and groups in the community by assisting them in accessing community health and supportive resources through the provision of education, role modeling, outreach, home visits and referral services. Improvements over usual care were demonstrated to be associated with CHWs who were provided with opportunities for continued education (Evidence Report/Technology Assessment, 2009).
Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
CHWs develop a list of suggestions for education topics to be covered at COL monthly meetings	March 2018	CHW time	Sarah Barnett/Butler County Educational Service Center (BCESC),	List of Topics for COL meetings	
Select from list educational topics to cover, Identify appropriate speakers from community to present on topics.	April 2018	CHW time/community speakers	Sarah Barnett/BCESC,	Speaker list for Educational presentations	
Establish calendar of educational topics with scheduled presenters.	April 2018	CHW time/community speakers	Sarah Barnett/BCESC,	Schedule of speakers.	
Develop a survey to assess CHW satisfaction with	June 2018	CHW time	Sarah Barnett/BCESC,	Satisfaction survey.	

education sessions					
Administer satisfaction survey to CHW to track program success.	June 2018	CHW time	Sarah Barnett/BCESC,	Satisfaction survey.	

OBJECTIVE #4:
By 2019, increase the number of women enrolled in Moms Quit for Two smoking cessation program from 20 to 25 clients per year.

Source: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/tobaccousepregnancy/providers.htm
Evidence Base: Smoking during pregnancy remains one of the most common preventable causes of pregnancy complications, illness, and death among infants. Compared with nonsmokers, women who smoke before pregnancy are about twice as likely to experience an ectopic pregnancy and problems with the placenta. Babies born to women who smoke during pregnancy are more likely to have a premature birth, low birth weight, certain birth defects, and a higher risk of SIDS (Sudden Infant Death Syndrome). Women who quit smoking before or during pregnancy can reduce their risk of poor pregnancy outcomes. Effective behavioral interventions for pregnant women who smoke include counseling, feedback, health education, and social support (CDC, 2017). Providing access to smoking cessation programs can help reduce poor pregnancy outcomes.
Policy Change (Y/N): N

ACTION PLAN

Activity	Target Date	Resources Required	Lead Person/ Organization	Anticipated Product or Result	Progress Notes
Contact main referring agencies	March 2018	Staff Time	Mary Beth Haubner/Envision Partnerships, Kathryn Yang/Butler County Partnership to Reduce Infant Mortality (BC PRIM)	Contact List for referring agencies	
Set up in-service for each agency or go over program details with contact person	April 2018	Staff Time	Mary Beth Haubner/Envision Partnerships, Kathryn Yang/BC PRIM	Increased awareness of services and referral process for Moms Quit for Two.	
Send out brochures to OBGYN/Pediatrician offices and to other agencies in hot spot areas	April 2018	Brochures/staff time	Mary Beth Haubner/Envision Partnerships, Kathryn Yang/BC PRIM	Increased awareness among providers of Moms Quit for Two program	
Develop posters that will be placed at locations where the target group gathers including partner agencies and providers locations	April 2018	Posters/staff time	Mary Beth Haubner/Envision Partnerships, Kathryn Yang/BC PRIM	Increased awareness in community of Moms Quit for Two program.	

Identify and ensure representation of Mom's Quit for Two at major community events	May 2018, September 2018	Staff time/educational resources/incentives for community events	Mary Beth Haubner/Envision Partnerships, Kathryn Yang/BC PRIM	Increased awareness in community of Moms Quit for Two program.	
Develop slides with information on smoking in pregnancy and Moms Quit for Two- to be shown in provider and agency waiting rooms	July 2018	Staff time/contacts at offices/screen time.	Mary Beth Haubner/Envision Partnerships, Kathryn Yang/BC PRIM	Increased awareness in community of Moms Quit for Two program.	

ALIGNMENT WITH STATE/NATIONAL PRIORITIES			
Obj #	**State Health Improvement Plan**	**Healthy People 2020**	**National Prevention Strategy**
1	Breastfeeding promotion programs	Increase the proportion of infants who are ever breastfed	Support policies and programs that promote breastfeeding.
2	*Increase access to standardized screening and evidence-based treatment services: Progesterone Treatment*	*n/a*	*Educate communities, clinicians, pregnant women, and families on how to prevent infant mortality*
3	*Increase access to standardized screening and evidence-based treatment services: Home visiting program that begins prenatally*	*n/a*	*Support community health workers, patient navigators, patient support groups, and health coaches.* *Educate communities, clinicians, pregnant women, and families on how to prevent infant mortality*
4	*Access to and use of tobacco cessation services: Baby & Me Tobacco Free Program, Moms Quit for Two* *and Quit Line pregnancy protocol implementation*	*Increase smoking cessation during pregnancy*	*Expand use of tobacco cessation services*

Appendix B: Key Terms and Abbreviations

Community Health Assessment (CHA) - collaborative process of collecting and analyzing data and information for use in educating and mobilizing communities, developing priorities, garnering resources or using resources in different ways, adopting or revising policies, and planning actions to improve the population's health.

Community Health Improvement Plan (CHIP) - is a long-term, systematic plan to address issues identified in the Community Health Assessment.

Community Health Worker - a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served

Health Impact Pyramid - A 5-tier pyramid that describes the impact of different types of public health interventions and provides a framework to improve health

Health Inequity - a difference in the distribution or allocation of a resource between groups

Healthy People 2020 - a program of a nationwide health-promotion and disease-prevention goals set by the United States Department of Health and Human Services

Infant Mortality Rate – the number of deaths that occur for every 1,000 live births per year

Mobilizing for Action through Planning and Partnerships (MAPP) – An approach to improve health and quality of life through community-wide and community-driven strategic planning

Naloxone – a medication "opioid antagonist" medication used to counter the effects of opioid overdose

National Prevention Strategy - aims to guide our nation in the most effective and achievable means for improving health and well-being

No Wrong Door – a program that provides information about services and resources with one call to any of the member agencies

Overdose Alerting System – a community-based effort to collect and monitor data related to overdoses that alerts individuals and community partners to respond to overdose events

Progesterone – a hormone that helps your uterus grow during pregnancy and keeps it from having contractions

School based Behavioral Health Center (SBHC) – a primary care clinic located in or near a school facility that provides a combination of primary care, mental health care, substance abuse counseling, dental health, health education and health promotion.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) – an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

Social Determinants Of Health - Conditions in the social, economic and physical environments that affect health and quality of life

State health Improvement Plan - a long-term, systematic plan to address issues identified in the State Health Assessment

Trauma Informed Care – an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma

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