LOGAN COUNTY

Community Health Improvement Plan

EXECUTIVE SUMMARY

The Logan County 2020-22 Community Health Improvement Plan (CHIP) is the result of a collaborative planning process led by the Logan County Health District (LCHD), Mary Rutan Hospital (MRH), Community Health and Wellness Partners (CHWP), United Way of Logan County, and the Mental Health, Drug and Alcohol Services Board of Logan and Champaign Counties (MHDAS Bd.) that involved more than 50 representatives from local organizations and community members dedicated to improving the health of Logan County residents. The priorities, goals, and objectives that were collectively developed are aimed at several of the community's most important health concerns: **chronic diseases, housing and homelessness, suicide and mental health, and substance use**. These issues were selected based on the 2020 Community Health Assessment (CHA) that was conducted. The CHA included data and input from community residents, local health care organizations, as well as state and national data repositories.

The process engaged the existing coalitions and the Coalition Advisory Board (CAB) that were established to implement the 2015 and 2018 CHIPs to review progress made since then and select priorities for the 2020-22 CHIP. The priority selection process involved discussions and voting based on the magnitude of the problem, the community's capacity to address the problem, and the availability of effective interventions. In addition, social factors that contribute to the problem and population groups most at risk were taken into consideration in developing health improvement strategies and objectives. Finally, this CHIP aligns with Ohio's 2020-2022 State Health Improvement Plan (SHIP), utilizing strategies and objectives recommended by the State.

What follows is the result of the community's deliberation and planning to address health concerns in a strategic way that aligns resources with needs to make a measurable impact on the health of Logan County residents.

Adopted June 2021

Logan County 2020-2022 Community Health Improvement Plan At a Glance

Priorities	Goals	Objectives
Chronic Diseases	Reduce obesity and chronic disease risk through the consumption of healthful diets and increased physical activity.	- Reduce the percent of adults diagnosed with Coronary Heart Disease. - Reduce the percent of adults diagnosed with Hypertension. - Reduce the percent of adults diagnosed with Diabetes.
Housing and Homelessness	Create a housing environment in Logan County that promotes good health for all.	- Increase affordable and available housing units for renters with income below 50% of Area Median Income (very low income). - Increase the number of at-risk children tested for lead poisoning.
Suicide and Mental Health	Improve mental health across the lifespan through prevention and postvention by utilizing evidenced-based strategies.	- Reduce the number of youths, 8-17 years, treated at the Mary Rutan Hospital ED for suicide - Reduced the number of deaths due to suicide for adults ages 18 years and older.
Substance Use	Reduce substance use to protect the health, safety, and quality of life for all, especially children.	- Reduce the number of high school students who have used alcohol. - Reduce the number of high school students who have used marijuana. - Reduce the number of deaths due to unintentional drug overdoses.

OUR CHIP PROCESS

WHAT IS A COMMUNITY HEALTH IMPROVEMENT PLAN?

The U.S. Centers for Disease Control and Prevention defines a Community Health Improvement Plan (CHIP) as "a long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process."[1] In Ohio, local health departments (LHDs) and non-profit or government-owned hospitals are required to work together to conduct an assessment of the health needs of the community(ies) they serve (otherwise known as a Community Health Assessment (CHA), as well as prepare a plan (CHIP) for addressing those needs in order to improve the health of the population. In addition, the State requires that LHDs and hospitals submit their CHA and CHIP every three years.[2]

Although LHDs and hospitals are designated by the State as the lead organizations for assessing and addressing community health needs, this can only be successfully accomplished through a collaborative effort that engages other organizations in the community whose work impacts the health of residents. A CHIP serves as a planning tool to guide these organizations as they implement programs and deliver services in their community in such a way that the health of residents improves over time. To ensure that these efforts are effective, the collaborating partners select strategies based on evidence and/or prior experience that has demonstrated their effectiveness in addressing the priority health problems.

The main components of a CHIP are:

- **Health Improvement Priorities**: Description of specific health problems that must be addressed if the overall health of residents is to be improved. The CHA is the primary data source used to develop health improvement priorities.
- **Outcome Objectives**: Health improvement targets for each of the health priorities that can be measured over time.
- **Strategies:** Programs and activities that the collaborating organizations will implement to reduce and prevent the priority health problems.
- **Monitoring Mechanism**: Data collection process to measure progress toward and report to the community.

STATE HEALTH IMPROVEMENT PLAN

The Ohio Department of Health led a similar health improvement planning

[1] ttps://www.cdc.gov/publichealthgateway/cha/plan.html

[2] Ohio Revised Code section 3701.981.

process that resulted in the State Health Improvement Plan (SHIP) of 2020-2022. The SHIP includes health improvement priorities, objectives, strategies, and guiding principles that local communities are expected to include in their CHIP. Specifically, local communities are required to include at least two (2) SHIP priorities, related objectives, and strategies in their CHIP. In this way, each community in Ohio will contribute to reducing and preventing the priority health problems across the State.

Two guiding principles that are included in the SHIP are *Health Equity* and *Social Determinants of Health*. "**Health equity** is achieved when all people in a community have access to affordable, inclusive and quality infrastructure and services that, despite historical and contemporary injustices, allows them to reach their full health potential."[3] There are two components to health equity: disparities and inequities. Health disparities refers to differences in health outcomes that may exist within a community when comparing one population group with another such as minorities compared to the general population. Health inequities refers to differences in access to health resources between one group and another such as access to health care or healthy food. Local communities are required to address health equity in their CHIP by including strategies to reduce disparities and health inequities.

Social Determinants of Health (SDOH) refers to factors in a community that contribute to and influence the health of its residents. Examples of SDOH include access to health care services, poverty, housing, and education. It is a well-known fact that these and other social conditions affect the health of individuals and families in either positive or negative ways. For example, those who have higher incomes and educational levels are more likely to be healthier, while those with lower incomes and educational levels are more likely to have poorer health. Local communities must consider these factors when developing health improvement strategies so that those with the greatest health needs receive the services and assistance necessary to improve their health.

Figure 1 illustrates how social and economic conditions interact with individual behaviors to impact the health of residents in a community.

Fig. 1 - SOCIAL DETERMINANTS OF HEALTH

[3] State Health Improvement Plan: Ohio 2020-2022, p.9.

Social determinants are often best addressed through **policy changes**, such as the strategies included in this CHIP.

Community Support and Involvement

The Logan County CHIP was developed by a collaborative team that consisted of a number of community health and social service organizations that serve Logan County residents. The team was led and funded by Mary Rutan Hospital (MRH), Logan County Health District (LCHD), United Way of Logan County, Community Health and Wellness Partners (CHWP), and Mental Health Drug and Alcohol Services (MHDAS) Board for Logan and Champaign Counties. In addition, over 55 community leaders and residents provided extensive input to the plan.

The Priority Selection Process

The Logan County CHIP process began by conducting a community needs assessment (CHA). The CHA was conducted in 2020 and involved an extensive data collection process. Primary data was collected via a community survey, key informant interviews, and focus groups of Logan County residents. In addition, a number of secondary data sources were also used to develop a profile of the health needs in the county.[4]

The findings of the CHA were presented at a virtual Community Call-to-Action meeting that consisted of more than 50 community stakeholders on February 9th, 2021. Stakeholders included the leadership team, community leaders, residents, and professionals from organizations serving Logan County residents. The CHA analysis identified several health and social issues that impact residents of Logan County including chronic diseases, safe and affordable housing, homelessness, mental health, substance use, and child safety. These findings served as the principal data source that was used to identify the priorities for the 2020-2022 Logan County CHIP.

In addition, each coalition that was established to implement the 2018 Logan County CHIP presented the stakeholders with a progress report concerning the current status of each of the 2018 health improvement priorities. Finally, a team from Kent State University's College of Public Health discussed state and national health priorities, as well as the importance of addressing social determinants and health equity issues in a health improvement plan. The team also explained the priority selection criteria and voting process to be used to select health improvement priorities for the 2020-22 CHIP period (see Table 1).

Meeting participants were then polled to identify the priorities to be included in the 2020-22 CHIP. As a result of the voting, the following priorities were selected:

- **Reducing chronic diseases**
- **Increasing the availability of safe and affordable housing**
- **Addressing mental health issues to prevent suicide**
- **Reducing substance use**

[4] Secondary data sources are from 2020 Logan County CHA

It was also decided that child safety and maltreatment would be addressed by the existing Early Childhood Collaborative and considered under the work of each coalition.

Immediately after the Call-to-Action meeting, the Coalition Advisory Board (CAB) that was established in 2015 met to decide how to restructure the existing coalitions to address the new priorities. The CAB decided to charge four (4) of the existing six (6) coalitions to develop logic models and implementation plans with specific goals and outcome objectives, and to oversee the implementation of those plans: *Healthy Living Coalition, Housing and Homelessness Coalition, Suicide Prevention Coalition, and Coalition for Ongoing Recovery Efforts (CORE)*.

Table 1 - Priority Selection Criteria

Consequential	Community Support	Pragmatic
Will it make a difference?	*Are there resources to dedicate?*	*Can we do something to address this priority?*
Will there be consequences if not done?	*What resources exist that are being or could be directed to this issue?*	*What can realistically be achieved and over what timeframe?*
How many people are affected?	*Is there a willingness to collaborate on addressing selected issues?*	*Is it susceptible to proven and affordable interventions?*
Could there be a serious consequence, and does it address wide disparity?	*Does the community recognize the issue as an important need?*	*Does this issue identify a strength that can be replicated throughout the community?*
Will the issue have wide implications and long-term health improvements?		*Is ongoing monitoring of this issue possible?*
Will addressing this issue create a breakthrough in community health?		
Has this issue been persistent, nagging, and seemingly unsolvable?		

Each of the coalitions then met with the Kent State team to select specific goals, outcome objectives, and strategies to address the priorities selected by the community representatives. Each coalition chose to adopt at least one of the SHIP goals, objectives, and/or strategies.

Logic models and implementation plans were developed for each priority. A logic model is a graphical depiction that shows the relationship between specific strategies or activities that a community will implement and the health improvements (i.e., outcomes) that can be expected as a result of successfully executing the strategy.

A strategy or implementation plan is a management tool designed to guide organizations in their efforts to address community health problems. The plan includes a goal statement, the strategies that will be implemented to achieve the goal, the organization(s) responsible for implementing the strategies, and specific measurable outcome objectives that will be monitored over time to determine if the strategies are effective in achieving the goals. The strategy plans and logic models are included below.

NEXT STEPS

The CHIP will be posted for community review to the websites of the Mary Rutan Hospital, Logan County Health District, United Way of Logan County, Community Health and Wellness Partners, and Mental Health Drug & Alcohol Services Board for Logan and Champaign Counties. It will also be sent to the CAB for review.

The four coalitions will be responsible for implementing the strategies associated with the CHIP priorities. The CAB will serve as the oversight body that will monitor progress toward achievement of the goals and objectives included in the CHIP. The CAB membership consists community leaders representing businesses, city and county government, schools, the court systems, health care providers, social service agencies, and the chair(s) of each of the coalitions. The CAB is charged with providing guidance and support to coalition work by impacting and implementing policy change, as well as, identifying financial support and local resources for the work of the coalitions.

Quarterly each coalition will provide an update to the CAB regarding progress toward meeting their goals and objectives. The Logan County Health District in collaboration with the coalitions and CAB will prepare a report for the community annually documenting progress made toward the CHIP goals and objectives.

Objectives will be tracked in Clear Impact, a dashboard to measure the impact of community efforts and show trends towards improving the health of Logan County. CHIP partners will provide data as available that will be input into the Clear Impact dashboard. The dashboard will be made available to all partners and the public on the Health District website - www.loganhealth.org beginning the fourth quarter of 2021.

On an annual basis, the coalitions and the CAB will review and update the CHIP as needed.

PRIORITY #1
CHRONIC DISEASES

CURRENT SITUATION

In Logan County, **chronic diseases** related to obesity and other behavioral risk factors continue to affect many residents. Data from the 2020 CHA shows that in 2019 Mary Rutan Hospital treated: 2,770 adults for hypertension; 1,302 for diabetes; and 920 for coronary heart disease. With the exception of diabetes, these numbers have improved since 2016. These gains can, in part, be attributed to the efforts of the Healthy Living Coalition to increase residents' consumption of healthy foods and engagement in physical activities. Unfortunately, the CHA data also showed that between 48-49% of adult residents are obese and nearly 27% use tobacco products.

For 2020-22, the Healthy Living Coalition has developed an Implementation Plan that includes a number of effective strategies designed to address the risk factors associated with these diseases to build on the success that has been made. These strategies including:

- Health Habits, Healthy YOU
- Hypertension screening and follow-up
- Prediabetes screening, testing, and referral to the Diabetes Prevention Program
- Vaping and tobacco cessation program
- Wholesome Rx and Nature Rx programs
- Walk with a Doc/Play with a Doc and Winter Walking programs
- Preventative care and exercise prescriptions delivered through Patient-Centered Medical Homes
- Bellefontaine Joint Recreation District's activity program
- Using website, blogs, and telehealth technologies
- Educational classes on healthy living in the schools

Logan County 2020-2022 CHIP

Priority	Goals	Objectives
Chronic Diseases	Reduce obesity and chronic disease risk through the consumption of healthful diets and increased physical activity.	- Reduce the percent of adults diagnosed with Coronary Heart Disease. - Reduce the percent of adults diagnosed with Hypertension. - Reduce the percent of adults diagnosed with Diabetes.

GOAL: REDUCE CORONARY HEART DISEASE, HYPERTENSION, AND DIABETES

GUIDING PRINCIPLES
• Priority populations to be targeted include low-income and minority individuals and families, as well as census tracts with health disparities/inequities or vulnerable populations. • Social determinants to be considered include neighborhood and built environment, uninsured and under-insured, household income. • Policy change strategies to be implemented include restaurant and grocery store labeling.

STRATEGY	LEAD PARTNERS	SHORT-TERM OBJECTIVE	INTERMEDIATE OBJECTIVE	LONG-TERM OBJECTIVE
1. Implement Healthy Habits, Healthy YOU program. 2. Implement Exercise Prescription from Health Care Providers program. 3. Implement MRH vaping program.	1. Healthy Living Coalition Members 2. MRH, CHWP, Maple Leaf, Local Primary Care Providers 3. MRH	- By 12/31/2022, reduce the percent of adults, ages 18 and older diagnosed with **Coronary Heart Disease** by 1.5% (prevalence of CHWP, MRH Inpatient and observation, & MRH ED patients).	- By 12/31/2025, reduce the percent of adults, ages 18 and older diagnosed with **Coronary Heart Disease** by an additional 2% (prevalence of CHWP, MRH Inpatient and observation, & MRH ED patients).	- By 12/31/2028, reduce the percent of adults, ages 18 and older diagnosed with **Coronary Heart Disease** by an additional 2% (prevalence of CHWP, MRH Inpatient and observation, & MRH ED patients).
4. Implement CHWP tobacco cessation program. 5. Develop and implement new tobacco/vaping programs offered in conjunction with CORE coalition	4. CHWP 5. Healthy Living Coalition Members	- By 12/31/2022, Reduce the percent of adults, ages 18 and older diagnosed with **Hypertension** by 1.5% (prevalence of CHWP, MRH Inpatient and observation, & MRH ED patients).	- By 12/31/2025, Reduce the percent of adults, ages 18 and older diagnosed with **Hypertension** by an additional 2% (prevalence of CHWP, MRH Inpatient and observation, & MRH ED patients).	- By 12/31/2028, Reduce the percent of adults, ages 18 and older diagnosed with **Hypertension** by an additional 2% (prevalence of CHWP, MRH Inpatient and observation, & MRH ED patients).
6. Reassess restaurant labeling and grocery store labeling projects. 7. Update and use Healthy Habits website to blog and deliver health education messaging.	6. Healthy Living Coalition Members 7. Healthy Living Coalition Members	- By 12/31/2022, Reduce the percent of adults, ages 18 and older, diagnosed with **Diabetes** by 1.5% (prevalence of CHWP, MRH Inpatient and observation, & MRH ED patients).	- By 12/31/2025, Reduce the percent of adults, ages 18 and older diagnosed with **Diabetes** by an additional 2% (prevalence of CHWP, MRH Inpatient and observation, & MRH ED patients).	- By 12/31/2028, Reduce the percent of adults, ages 18 and older diagnosed with **Diabetes** by an additional 2% (prevalence of CHWP, MRH Inpatient and observation, & MRH ED patients).

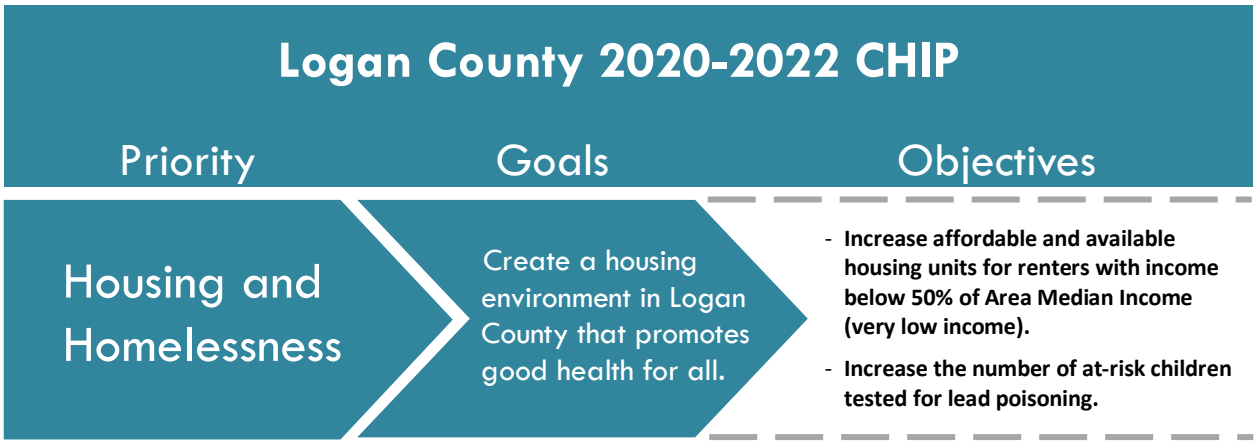
PRIORITY #2
HOUSING AND HOMELESSNESS

CURRENT SITUATION

In Logan County, the need for more **safe and affordable housing options** is evident by the fact that nearly a quarter (23.7%) of the respondents to the CHA survey stated housing and homelessness was a high need for them. In addition, 41.8% of respondents indicated housing was a challenge. This was the second most listed challenge behind mental health and addiction. Respondents who reported not having sufficient funds for housing indicated that the lack of affordable housing in Logan County as one of the most common reasons given. Five (5) percent of the respondents said they had been homeless at least once in the past six (6) months. In the last quarter of 2019, the greatest needs recorded by the County's 211 service were for emergency shelter and assistance with paying electric bills and rent. Data from Mary Rutan Hospital showed that treatment for asthma increased in 2019, as did treatment for lead poisoning, according to the Ohio Department of Health.

For 2020-22, the Housing Coalition has developed an Implementation Plan that includes a number of effective strategies designed to increase the availability of safe and affordable housing options. These strategies include:

- Rental assistance programs and increased Investment in rental housing assistance for low - income residents
- Affordable housing development and preservation
- Incentives for housing developers
- Neighborhood improvement
- Develop and expand land banking programs
- Prioritize Community Block Grant
- Lead paint education and abatement



GOAL: INCREASE AFFORDABLE HOUSING OPTIONS

GUIDING PRINCIPLES
• Priority populations to be targeted include the homeless, low-income renters, as well as census tracts with health disparities/inequities or vulnerable populations. • Social determinants to be targeted include neighborhood and built environment, employment access, uninsured and under-insured individuals and families, household income. • Policy change strategies to be implemented include Community Block Grant and land bank programs.

STRATEGY	LEAD PARTNERS	SHORT-TERM OBJECTIVE	INTERMEDIATE OBJECTIVE	LONG-TERM OBJECTIVE
1. Implement rental assistance programs	1. Metro Housing (MH), Residential Administrator (RA), other com-munity assistance agencies	- By 12/31/2022, increase the number of affordable and available units for renters with income below 50% of Area Median Income (very low income) by 10 units per year.	- By 12/31/2025, increase the number of affordable and available units for renters with income below 50% of Area Median Income (very low income) by 10 units per year	- By 12/31/2028, increase the number of affordable and available units for renters with income below 50% of Area Median Income (very low income) by 10 units per year.
2. Increase investment in rental and housing assistance solutions for low-income families.	2. MH, RA, other agencies			
3. Affordable housing development and preservation.	3. MH, RA, other agencies			
4. Maintain/increase incentives for affordable housing developers that partner w/ health-care & social services agencies to leverage federal funding, (e.g., the Low-Income Housing Tax Credit, HOME Investment Partnerships , etc.	4. MH, RA, other agencies; Housing Coalition			
5. Neighborhood Improvement	5. LCHD, County/City Govt, Housing Coal.			
6. Develop/expand land banking programs	6. County/City Govt, Housing Coalition			
7. Prioritize Community Development Block Grant	7. County/City Govt, Housing Coalition			
8. Reduce evictions	8. Legal Aid Society, Housing Coalition			

GOAL: INCREASE SAFE HOUSING OPTIONS

GUIDING PRINCIPLES
• Priority populations to be targeted include children on Medicaid and SCHIP, low-income households, as well as census tracts with health disparities/inequities or vulnerable populations. • Social determinants to be targeted include neighborhood and built environment, uninsured and under-insured individuals and families, household income. • Policy change strategies to be implemented include public disclosures of lead hazards.

STRATEGY	LEAD PARTNERS	SHORT-TERM OBJECTIVE	INTERMEDIATE OBJECTIVE	LONG-TERM OBJECTIVE
1. Implement targeted outreach efforts in communities at-risk of lead exposure 2. Ensure public transparency regarding housing with or without lead hazards 3. Real estate disclosures about potential lead hazards 4. Lead paint remediation programs to control lead-based paint hazards. 5. Increase enforcement of the federal renovation, repair, and painting rule at the state level	1. ODH, Logan County Health District, Housing Coalition 2. Logan County Health District, Housing Coalition 3. Housing Coal., County/City Govt., Building Authority, Realtors Assoc. 4. Logan County Health District, Housing Coalition, 5. ODH, Logan County Health District, Housing Coalition, County/City Govt., Building Authority	- By 12/31/2022, increase the percentage of at-risk children tested for lead poisoning by 1.5%.	- By 12/31/2025, increase the percentage of at-risk children tested for lead poisoning by an additional 2%.	- By 12/31/2028, increase the percentage of at-risk children tested for lead poisoning by an additional 2%.

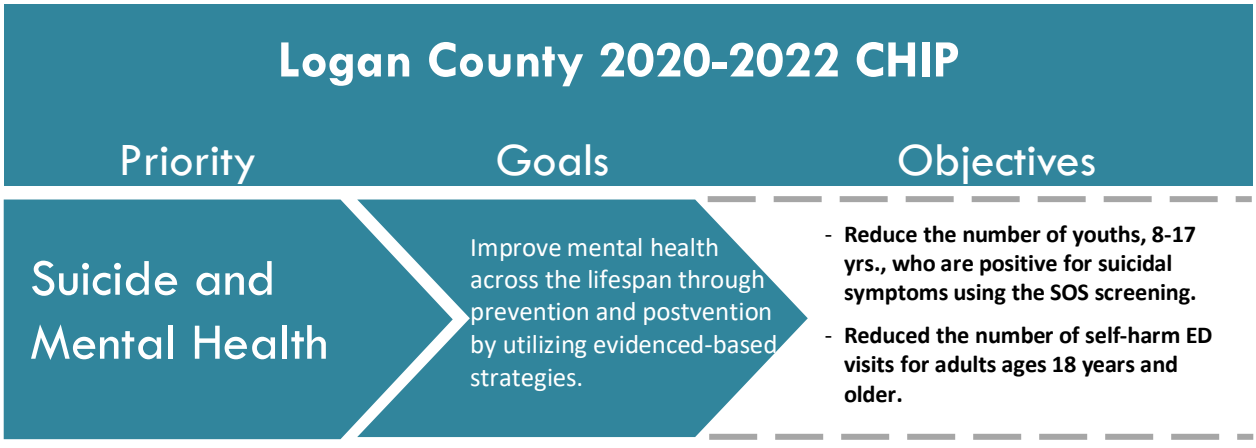
PRIORITY #3
SUICIDE & MENTAL HEALTH

CURRENT SITUATION

Data from the 2020 CHA indicates that there is a continuing need to address mental health issues among youth and adults in Logan County to **prevent suicides**. Between 2017 and 2019, harm-related emergency room visits at Mary Rutan Hospital increased by 36% and the number of patients and patient visits for behavioral and mental health issues increased more than threefold. In the first three quarters of 2020, there were over 3,100 patients who said they were "better off dead" or were hurting themselves in some way. This was up from about 1,800 similar responses in 2019 suggesting that the pandemic likely contributed to the spike. In addition, 43.5% of respondents to the CHA survey ranked mental health as a high need and 64% of respondents listed mental health and addiction as a challenge. The number of patients treated for suicide at Mary Rutan Hospital increased for all age groups, including 0–17-year-old youths, and for both males and females from 2017 – 2019. For school-age children, data from the Logan County public schools indicates that between 16-21% of students screened for suicide risk were positive.

For 2020-22, the Suicide Prevention Coalition (SPC) has developed an Implementation Plan that includes a number of effective strategies designed to prevent suicides. These strategies include:

- School-based suicide education
- Peer mentoring program
- Integrating behavioral health and primary care
- Zero Suicide and Mental Health First Aid programs
- Use of telehealth
- Training in motivational interviewing & Question Persuade Refer
- Limiting access to lethal means



GOAL: REDUCE YOUTH SUICIDE

GUIDING PRINCIPLES
• Priority populations to be targeted include school-age children, low-income and minority individuals and families, as well as census tracts with health disparities/inequities or vulnerable populations. • Social determinants to be considered include education access, social and community support, uninsured and under-insured, household income. • Policy change strategies to be implemented include integrating behavioral and primary care.

STRATEGY	LEAD PARTNERS	SHORT-TERM OBJECTIVE	INTERMEDIATE OBJECTIVE	LONG-TERM OBJECTIVE
1. Conduct universal school-based suicide awareness and education programs	1. MHDAS Board, TCN, Logan County School Districts (LCSD)	- By 12/31/2022, reduce the number of youths, ages 8-17 yrs., who are positive for suicidal symptoms using the SOS screening by 1.5%.	- By 12/31/2025, reduce the number of youths, ages 8-17 yrs., who are positive for suicidal symptoms using the SOS screening by an additional 2%.	- By 12/31/2028, reduce the number of youths, ages 8-17 yrs., who are positive for suicidal symptoms using the SOS screening by an additional 2%.
2. Implement peer mentoring program	2. LCSD, SPC			
3. Limit access to lethal means	3. TCN, MRH, Coleman, CHWP			
4. Integrate behavioral health care in primary care settings	4. Logan County primary care providers, SPC, CHWP, MRH			
5. Utilize telehealth for screening, counseling	5. TCN, CHWP, MRH-Coleman			
6. Implement Zero Suicide program	6. TCN			
7. Implement Mental Health First Aid program	7. TCN			
8. Provide Question Persuade Refer (QPR) training	8. TCN, MHDAS Board			
9. Expand use of Motivational Interviewing	9. SPC, TCN, CHWP, MHDAS Board			

GOAL: REDUCE ADULT SUICIDE

GUIDING PRINCIPLES
• Priority populations to be targeted include low-income and minority individuals and families, men, as well as census tracts with health disparities/inequities or vulnerable populations. • Social determinants to be considered include access to behavioral health care, social and community support, uninsured and under-insured, household income. • Policy change strategies to be implemented include integrating behavioral and primary care.

STRATEGY	LEAD PARTNERS	SHORT-TERM OBJECTIVE	INTERMEDIATE OBJECTIVE	LONG-TERM OBJECTIVE
1. Limit access to lethal means 2. Integrate behavioral health care in primary care settings Integrate behavioral health care in primary care settings 3. Utilize telehealth for screening, counseling 4. Implement Zero Suicide program 5. Implement Mental Health First Aid program 6. Provide Question Persuade Refer training 7. Expand use of Motivational Interviewing	1. TCN, MRH, CHWP, Coleman 2. Logan primary care providers, SPC, CHWP, MRH 3. TCN, CHWP, MRH, Coleman 4. TCN 5. MHDAS Board 6. TCN, MHDAS Board 7. SPC, TCN, CHWP, MHDAS Board	- By 12/31/2022, reduce the number of self-harm ED visits for adults, ages 18 and older by 1.5%.	- By 12/31/2025, reduce the number of self-harm ED visits for adults, ages 18 and older by an additional 2%.	- By 12/31/2028, reduce the number of self-harm ED visits for adults, ages 18 and older by an additional 2%.

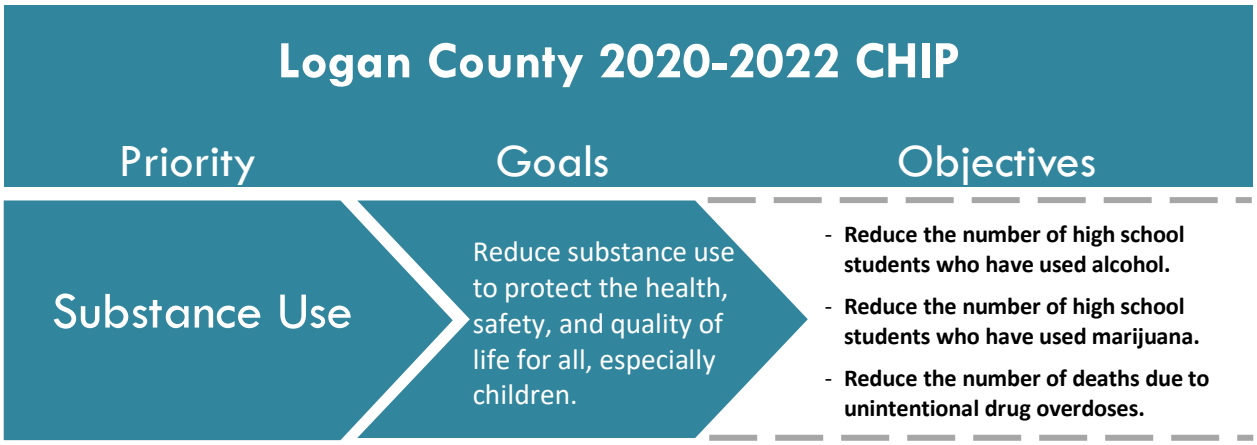
PRIORITY #4
SUBSTANCE USE

CURRENT SITUATION

The need to address **substance use** in Logan County was documented in the 2020 CHA based on several data sources. Naloxone administrations were higher in 2020 than they were in 2018-2019 that likely contributed to a reduction in overdose deaths in 2020. Data from the 2020 CHA showed that 28% of respondents know someone who uses illicit drugs, while drug overdose and alcohol use treatments at Mary Rutan Hospital rose between 2016-2019 by 65% and 37% respectively. Another indicator of concern is that the percent of cases where children were removed from the home because of substance use increased from 35% to 62% from 2019-2020, though the total number of out-of-home placements decreased. Smoking and use of smokeless tobacco is also a concern as 26.7% of respondents to the CHA survey indicated they use tobacco products. Among teens, data from the schools shows that 10.9% reported they currently use E-cigarettes and 18.9% reported experimenting with vaping.

For 2020-22, the Coalition for Ongoing Recovery Efforts (CORE) has developed an Implementation Plan that includes a number of effective strategies to reduce substance abuse in the county. These strategies include:

- School-based prevention program
- SBIRT alcohol & drug screening
- Tobacco and vaping programs
- Parental Engagement program
- Naloxone education and distribution
- Prescription drug monitoring, syringe service & medication assistance programs
- Alcohol and drug policy changes



GOAL: REDUCE YOUTH ALCOHOL USE

GUIDING PRINCIPALS
• Priority populations to be targeted include low-income and minority individuals and families, as well as census tracts with health disparities/inequities or vulnerable populations. • Social determinants to be considered include uninsured and under-insured, household income, and geographic areas with disparities. • Policy change strategies to be implemented include alcohol advertising restrictions.

STRATEGY	LEAD PARTNERS	SHORT-TERM OBJECTIVE	INTERMEDIATE OBJECTIVE	LONG-TERM OBJECTIVE
1. Universal school-based alcohol prevention programs	1. Prevention and Education Team	- By 12/31/2022, reduce the percent of high school students who have used alcohol within the past 30 days by 1.5%.	- By 12/31/2025, reduce the percent of high school students who have used alcohol within the past 30 days by an additional 2%.	- By 12/31/2028, reduce the percent of high school students who have used alcohol within the past 30 days by an additional 2%.
2. SBIRT (Alcohol Screening) in healthcare settings, schools, etc.	2. Prevention and Education Team			
3. Alcohol policy changes re: advertising restrictions	3. Legal and Advocacy Team			

GOAL: REDUCE YOUTH MARIJUANA USE

GUIDING PRINCIPALS
• Priority populations to be targeted include low-income and minority individuals and families, as well as census tracts with health disparities/inequities or vulnerable populations.. • Social determinants to be considered include uninsured and under-insured, household income. • Policy change strategies to be implemented include drug policy/advertising restrictions.

STRATEGY	LEAD PARTNERS	SHORT-TERM OBJECTIVE	INTERMEDIATE OBJECTIVE	LONG-TERM OBJECTIVE
1. K-12 drug prevention education: K-12 Social Emotional Learning and positive behavior initiatives	1. Prevention and Education Team	- By 12/31/2022, reduce the percent of high school students who have used marijuana within the past 30 days by 1.5%.	- By 12/31/2025, reduce the percent of high school students who have used marijuana within the past 30 days by an additional 2%.	- By 12/31/2028, reduce the percent of high school students who have used marijuana within the past 30 days by an additional 2%.
2. SBIRT (Drug Screening) in healthcare settings, schools, etc.	2. Prevention and Education Team, CHWP, TCN			
3. Parental engagement/Group-based parenting programs	3. Prevention and Education Team, CHWP, TCN			
4. Drug policy changes/ advertising restrictions	4. Legal and Advocacy Team			

GOAL: REDUCE UNINTENTIONAL DRUG OVERDOSES

GUIDING PRINCIPALS
• Priority populations to be targeted include low-income and minority individuals and families, as well as census tracts with health disparities/inequities or vulnerable populations..
• Social determinants to be considered include uninsured and under-insured, household income.
• Policy change strategies to be implemented include prescription monitoring, syringe service, and criminal justice system collaboration.

STRATEGY	LEAD PARTNERS	SHORT-TERM OBJECTIVE	INTERMEDIATE OBJECTIVE	LONG-TERM OBJECTIVE
1. Naloxone education and distribution programs	1. Logan County Health District	- By 12/31/2022, reduce the number of deaths due to unintentional drug overdose by 1.5%.	- By 12/31/2025, reduce the number of deaths due to unintentional drug overdose by an additional 2%.	- By 12/31/2028, reduce the number of deaths due to unintentional drug overdose by an additional 2%.
2. Prescription Drug Monitoring programs / OARRS Peer Review	2. All prescribers in Logan County			
3. Syringe Service Programs (SSP)	3. CHWP, MHDAS Board, Treatment & Recovery Services Team			
4. Medication Assisted Treatment (MAT) Access	4. CHWP, TCN, MRH ED, Treatment and Recovery Services Team			
5. Recovery communities and peer supports.	5. Recovery Zone, TCN, Treatment and Recovery Services Team			
6. Address Mental Health and Substance Use Disorders within the criminal justice system	6. Legal and Advocacy Ream			

LOGIC MODELS

Healthy Living Coalition: Logic Model

GOAL: Reduce obesity and chronic disease risk through the consumption of healthful diets and increased physical activity.

GUIDING PRINCIPLES:

- Priority populations to be targeted include low-income and minority individuals and families, as well as census tracts with health disparities/inequities or vulnerable populations.
- Social determinants to be considered include neighborhood and built environment, uninsured and under-insured, and household income.
- Policy change strategies to be implemented include restaurant and grocery store labeling.

Inputs	Activities	Outputs	Outcomes
Partnership Staffing: • Logan County Health District (LCHD) • Mary Rutan Hospital (MRH) • Community Health and Wellness Partners (CHWP) • Bellefontaine Joint Recreation District (BJRD) • Logan County Board of DD (LCBDD) • Logan Acres Senior Community • Midwest Regional Educational Service Center • Riverside Schools • Mary Rutan Foundation	1. Promotion of physical activity through Community Fitness Programs: • Healthy Habits, Healthy YOU program • Partner activity programs 2. Delivery of preventative care through Patient Centered Medical Homes: • Exercise Prescription from Health Care Providers • Screening and follow-up for Hypertension and Pre-Diabetes;	1. Promotion of physical activity through Community Fitness Programs: a. Expanded access to Walk with a Doc/ Play with a Doc b. Extended number of days for the Winter Walking program c. Increased access to Chronic Disease self-management classes d. New BJRD activity program at Harmon field 2. Delivery of preventative care through Patient Centered Medical Homes: a. Distribution of Nature RX promotion pieces to community providers (Maple Leaf, MRH outpatient and weight management, CHWP)	• **Reduced number of adult residents diagnosed with Coronary Heart Disease.** • **Reduced number of adult residents diagnosed with Hypertension.** • **Reduced number of adult residents diagnosed with Diabetes.**

Inputs	Activities	Outputs	Outcomes
Funding via: • United Way Support • Partner in-kind support • Mary Rutan Foundation support • Bellefontaine Joint Recreation District support	referral to Diabetes Prevention Program	b. Hypertension and Diabetes screening campaigns at local primary care offices c. If screenings occur outside of the healthcare setting, education on how to receive treatment will be provided. d. Resumption of MRH diabetes screenings	
	3. Promotion of combined diet and physical activity strategies to prevent Type 2 diabetes among people at increased risk.	3. Promotion of combined diet and physical activity strategies to prevent Type 2 diabetes among people at increased risk. a. Increased access to Diabetes Prevention Programs via MRH and CHWP b. Increased participation in educational classes and distribution of coupons for free fruits and vegetables	
	4. Delivery of tobacco/nicotine use reduction strategies: • MRH vaping program • CHWP tobacco cessation program • New programs offered in conjunction with CORE coalition	4. Delivery of tobacco/nicotine use reduction strategies. a. Increased involvement in education of students grades 6 through 12 on hazards of vaping. b. Increased targeted prevention activities. c. Increased involvement of residents receiving medication and behavioral therapy via CHWP program.	

Inputs	Activities	Outputs	Outcomes
		d. Increased education of students on vaping hazards in lieu of school consequences. e. Increased SBIRT (Screening, Brief Intervention, Referral to Treatment) practices used. f. Increased use of evidence-based treatments for tobacco cessation	
	5. Delivery of nutrition programs: • Healthy Habits, Healthy YOU program	5. Delivery of nutrition programs. a. Reassessment of restaurant labeling and grocery store labeling projects.	
	6. Delivery of healthy behaviors information through technology	6. Delivery of healthy behaviors information through technology. a. Blogs on updated Healthy Habits website	

Housing Coalition: Logic Model

GOAL: Create a housing environment in Logan County that promotes good health for all.

GUIDING PRINCIPLES:

- Priority populations to be targeted include the homeless, low-income renters, and at-risk neighborhoods, as well as census tracts with health disparities/inequities or vulnerable populations.
- Social determinants considered include neighborhood and built environment, employment access, uninsured and under-insured, household income.
- Policy change strategies to be implemented include Community Block Grant and land bank programs.

Inputs	Activities	Outputs	Outcomes
Partnership Staffing: ● Residential Administrators ● First Lutheran Church - Bellefontaine ● Mental Health Drug and Alcohol Services Board for Logan and Champaign Counties ● TCN ● Community Health and Wellness Partners ● Logan County Health District ● Mary Rutan Hospital Staff ● Bridges To Community Action ● United Way of Logan County ● Recovery Zone ● Metropolitan Housing Authority ● Campbell Landing Housing Authority ● Logan County Land Bank	1. Rental Assistance Programs 2. Investment in rental and housing assistance solutions for Ohioans with low incomes. 3. Affordable housing development and preservation. 4. Work with the city/county to establish connections with local developers to increase communication and potential relationship development. 5. Neighborhood Improvement - Neighborhood stabilization practices; Winter weatherization program (Bridges	1. Increased community member access to Metro Housing Association assistance, financial assistance through local agencies, Residential Administrators Funding will continue to assist those residents in need of assistance. 2. Increased investment in rental and housing assistance solutions for Ohioans with low incomes. 3. Increased development and preservation of affordable housing. 4. Increased communication and relationships with local developers. 5. Increased awareness of neighborhood improvement opportunities in Logan County.	• **Increased number of affordable housing units for renters with income below 50% of Area Median Income (very low income)**

Inputs	Activities	Outputs	Outcomes
• Other community housing authorities/agencies **Funding via:** • Partner organizations through in-kind support • State and Federal allocated funding • Allocated funding from Residential Administrators	to Community Action); Home improvements grants through city/county 6. Develop and/or expand land banking programs. 7. Promote Community Development Block Grant 8. Expand the footprint of legal aid society assistance for local renters to improve housing conditions	6. Increased awareness of land banking programs. 7. Increased agency awareness of the community development block grant. 8. Reduced evictions and improve housing conditions.	
Partnership Staffing: • Residential Administrators • First Lutheran Church - Bellefontaine • Mental Health Drug and Alcohol Services Board for Logan and Champaign Counties • TCN • Community Health and Wellness Partners • Logan County Health District • Mary Rutan Hospital Staff • Local pediatricians • Ohio Department of Health • Logan County Building Authority • Realtors Association **Funding via:**	1. Targeted outreach efforts in communities at risk of lead exposure 2. Public transparency regarding housing with or without lead hazards 3. Rental real estate disclosures about potential lead hazards	1. Increased outreach in neighborhoods identified as most at risk. Increase blood lead level screenings in children under 6 years of age. 2. Increased education to residents regarding lead hazards in Logan County. 3. Increased use of real estate disclosures in rental properties about potential lead hazards. To be considered is The Ohio Lead Hazardous Properties dataset contains a searchable list of properties in Ohio whose owners have refused to comply with an order from the ODH or its delegated local board of health to correct known lead hazards.	• **Increased number of at-risk children tested for lead poisoning.**

Inputs	Activities	Outputs	Outcomes
● Potential Grants in Future ● Logan County Health District ● Partner organizations through in-kind support	4. Lead paint remediation programs to control lead-based paint hazards.	The Ohio Housing Locator allows the sorting of available rental units for those that are lead-safe 4. A lead paint remediation program in Logan County. Exposure to lead paint can be addressed by eliminating the paint or mitigating and controlling by enclosure or encapsulation. Must be performed by a certified professional.	
Progress/Action taken in 2021:			
Progress/Action taken in 2022:			
Progress/Action taken in 2023:			

Suicide Coalition: Logic Model

GOAL: To improve mental health across the lifespan through prevention and postvention by utilizing evidence-based strategies.

GUIDING PRINCIPLES:

- Priority populations to be targeted include school-aged children, low-income and minority individuals, and families, as well as census tracts with health disparities/inequities or vulnerable populations.
- Social determinants considered include quality education access, social and community support, uninsured and under-insured, and household income, and men.
- Policy change strategies to be implemented include integrating behavioral and primary care.

Inputs	Activities	Outputs	Outcomes
Partnership Staffing: ● Mental Health Drug and Alcohol Services Board for Logan and Champaign Counties ● TCN ● Community Health and Wellness Partners ● Logan County Health District ● Mary Rutan Hospital Staff ● Family and Children First Council ● Logan County School Districts ● Coleman Professional Services **Funding via:** ● Mental Health Drug and Alcohol Services Board funding	1. Universal school-based suicide awareness and education programs.	1. More students will have received doses in these programs: - 40 Developmental Assets - Search Institute (40 key ingredients to healthy youth development and local youth asset and risk levels/behaviors) -ACT - Acknowledge, Care, Tell (a part of SOS - Signs of Suicide helps students identify depression, self-injury, suicide in themselves or others and how to respond) -Botvins LifeSkills Training (school-based prevention SUD and violence by targeting major social and psychological factors that promote the initiation of Substance Use and risky behaviors) all school levels -CAST - Coping and Support Training (for at-risk or high-risk youth in middle school and high school - 12 55-minute sessions to reduce suicide risk	● **Reduced number of youths, ages 8-17, who are positive for suicidal symptoms using the SOS screening.**

Inputs	Activities	Outputs	Outcomes
• In-kind support from community partners • United Way funding		behaviors, anxiety, depression, substance use and increases problem solving, coping, personal control, and family support -PAX Tools/Good Behavior Game (teaches students self-regulation, self-control, and self-management) -SOS Signs of Suicide Prevention Program (school-based depression awareness and suicide prevention program for middle and high school) -Trauma 101 (2-3 hour training provides an intro to trauma and trauma-informed approaches) - Mental Health First Aid – Youth (training for school staff) -ASQSE Initiative – early childhood and kindergarten	
	2. Peer mentoring	2. More students participate in Kognito Friend2Friend (training simulations designed to prepare middle and high school educators, staff, and students to recognize when someone is in distress and manage a conversation with the goal of connecting them to support)	
	3. Limit access to lethal means	3. Increased number of at-risk students screened using the following: use of COLUMBIA by TCN and counselors; Use of ASQ/BSSA/Brown Safety Plan by CHWP	
	4. Behavioral health integration in primary care	4. Increased access to behavioral health within p4imary care agencies;	

Inputs	Activities	Outputs	Outcomes
		continued integration efforts at local primary care agencies	
	5. Telehealth	5. Increased access to mental health telehealth visits by community residents	
	6. Zero Suicide trained	6. Increased number of community members/agencies trained in Zero Suicide practices	
	7. Mental Health First Aid training	7. Increased number of community members/agencies trained in Mental Health First Aid	
	8. Question Persuade Refer training	8. Increased number of community members/agencies trained in Question Persuade Refer.	
	9. Motivational Suicide Interviewing training	9. Increased number of community members/agencies/school personnel trained in Motivational Interviewing	
Partnership Staffing: ● Mental Health Drug and Alcohol Services Board for Logan and Champaign Counties ● TCN ● Community Health and Wellness Partners ● Logan County Health District ● Mary Rutan Hospital Staff ● Family and Children First Council ● Coleman Professional Service	1. Limit access to lethal means 2. Behavioral health integration in primary care 3. Telehealth	1. Increased number of depression/suicide screenings performed by community agencies, schools, community members 2. Increased patient access to mental health services through behavioral health integration in primary care organizations 3. Increased community member access to mental health services through telehealth	● **Reduced number of deaths due to suicide for adults ages 18 years old and older.**

Inputs	Activities	Outputs	Outcomes
Funding via: ● Mental Health Drug and Alcohol Services Board for Logan and Champaign Counties ● In-kind support from local community organizations	4. Zero Suicide training 5. Mental Health First Aid training 6. Question Persuade Refer training 7. Motivational Interviewing training	4. Increased number of community members/agencies trained in Zero Suicide practices. 5. Increased number of community members/agencies trained in Mental Health First Aid 6. Increased number of community members/agencies trained in Question Persuade Refer 7. Increased number of community members/agencies trained in Motivational Interviewing	
Progress/Action taken in 2021:			
Progress/Action taken in 2022:			
Progress/Action taken in 2023:			

Coalition for Ongoing Recovery Efforts: Logic Model

GOAL: Reduce substance use to protect the health, safety, and quality of life for all, especially children.

GUIDING PRINCIPLES:

- Priority populations to be targeted include high school-aged children, low-income and minority individuals, and families, as well as census tracts with health disparities/inequities or vulnerable populations.
- Social determinants considered include quality education access, social and community support, uninsured and under-insured, household income.
- Policy change strategies to be implemented include reducing evictions and increasing use of lead disclosures for rentals.

Inputs	Activities	Outputs	Outcomes
Partnership Staffing: ● Mental Health Drug and Alcohol Services Board (Logan and Champaign Counties) ● Logan County Health District (LCHD) ● TCN ● Community Health and Wellness Partners (CHWP) ● Mary Rutan Hospital (MRH) ● Logan County Family Courts ● Logan County School Districts ● Coleman Behavioral Health ● Logan County Children Services ● Other community members **Funding via:** ● Strategic Prevention Framework Rx Grant	1. Targeted prevention activities 2. Creative Prevention and Education activities across the lifespan 3. Address stigmatizing media messaging/advertising	1. Increased number of students who receive K-12 drug prevention education through Universal school-based alcohol prevention programs. 2. Increased number of students who receive SBIRT (Alcohol Screening) in healthcare settings, schools, etc. 3. Decreased stigmatizing media messaging and advertising through alcohol policy changes/advertising restrictions	● **Reduced number of high school students who have used alcohol.**

Inputs	Activities	Outputs	Outcomes
• SOR 2.0 Grant • MHDAS Board • Ohio Association of Community Behavioral Health Association Grant • In-kind support from local partner agencies			
Partnership Staffing: • Mental Health Drug and Alcohol Services Board (Logan and Champaign Counties) • Logan County Health District (LCHD) • TCN • Community Health and Wellness Partners (CHWP) • Mary Rutan Hospital (MRH) • Logan County Family Courts • Logan County School Districts • Coleman Behavioral Health • Logan County Children Services • Other community members **Funding via:** • Strategic Prevention Framework Rx Grant • SOR 2.0 Grant • MHDAS Board • Ohio Association of Community Behavioral Health Association Grant	1. Targeted prevention activities 2. Creative Prevention and Education activities across the lifespan 3. Address stigmatizing media messaging/advertising	1. Increased number of students who receive K-12 drug prevention education including but not limited to Universal school-based substance use prevention programs; K-12 Social Emotional Learning and positive behavior initiatives. 2. Increased number of students who receive SBIRT (Drug Screening) in healthcare settings, schools, etc.; Parental engagement/Group-based parenting programs. 3. Decreased stigmatizing media messaging and advertising through drug policy changes/advertising restrictions	• **Reduce the number of high school students who have used marijuana.**

Inputs	Activities	Outputs	Outcomes
• In-kind support from local partner agencies			
Partnership Staffing: • Mental Health Drug and Alcohol Services Board (Logan and Champaign Counties) • Logan County Health District (LCHD) • TCN • Community Health and Wellness Partners (CHWP) • Recovery Zone • Mary Rutan Hospital (MRH) • Steve Marshall • Dr. Grant Varian and Cheryl Varian • Pastor Larry, First Lutheran Church - Bellefontaine • Logan County Jail/Sherriff's Department • Russells Point Police Department • Bellefontaine Police Department • West Central Correctional • Logan County Common Pleas and Family Courts • Bellefontaine Municipal Court • Coleman Behavioral Health • Logan County Children Services	1. Naloxone education and distribution programs 2. Syringe Service Programs (SSP) 3. Medication Assisted Treatment (MAT) Access 4. Recovery communities and peer supports. 5. Address Mental Health and Substance Use Disorders within the criminal justice system	1. Increased Naloxone access in the community, increase messaging and the use of the Logan County Opiate Response team 2. More community members will access medical and behavioral health care screenings and referral to treatment, education on harm reduction/healthy living practices, and unused syringes through the implementation of the SSP. Increase law enforcement and community support for SSP. 3. More community members will access medication-assisted treatment by increasing the number of MAT providers in Logan County; Improve access to Mental Health and Substance Use Crisis Beds for Logan County residents. 4. Increased access to sober events for the recovery community. (i.e., increase sober DORA options, increase childcare options for residents attending peer support meetings). 5. Increased resident access to Medication Assisted Treatment through the Logan County Jail; Specialty Docket Courts; further	• **Reduced number of deaths due to unintentional drug overdoses.**

Inputs	Activities	Outputs	Outcomes
● Shelley Stevens Ministries ● Other community members **Funding via:** ● SOR grant – specifically for vivitrol ● Other grants to be determined. ● MHDAS board funding ● In-kind support by local community agencies.		outputs to be determined by CORE Legal and Advocacy.	
Progress/Action taken in 2021:			
Progress/Action taken in 2022:			
Progress/Action taken in 2023:			

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Housing & Homelessness Coalition
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Coalition Advisory Board (CAB)
Comprised of senior leadership team from:

Mary Rutan Hospital
Mary Rutan Foundation
Logan County Health District
MHDAS Board
Indian Lake School District
Chamber of Commerce
Job & Family Services
United Way of Logan County
Community Health & Wellness Partners
Logan County Commissioners
Logan County Family Court
Bellefontaine Mayor
Work Force Development Committee
Continuum of Care/Homeless Coalition
Kiwanis/Civic Organizations Housing & Business /Community Leaders
Family & Children First Council

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DATA SOURCES:

1. 2020 Logan County Community Health Assessment
2. Community Health and Wellness Partners
3. Logan County public schools
4. Mary Rutan Hospital
5. Ohio Department of Health

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For additional information or to request a copy of the CHIP, please contact the following:

Logan County Health District
(937) 651-6217
https://loganhealth.org/data-and-reports/

Mary Rutan Community Relations Dept.
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www.maryrutan.org/needs-assessment