Glenbeigh

2022
Community Health Needs Assessment

Glenbeigh
ACMC Healthcare System

An affiliate of
Cleveland Clinic

Board Approved: October 26, 2022

Glenbeigh 2022 Community Health Needs Assessment

Table of Contents

Executive Summary

Introduction/Background

Glenbeigh is part of the Ashtabula County Medical Center (ACMC) Healthcare System. It consists of a single inpatient hospital with 188 total beds, 4 freestanding extended treatment and 7 sober living residences along with 5 outpatient centers serving northeast Ohio and western Pennsylvania. In 2022, to better serve the Toledo, Lucas County, Ohio, community, Glenbeigh transitioned from in-person outpatient care to exclusive telehealth services. Glenbeigh provides treatment to adults with substance use disorders; providing assessments, detoxification, rehabilitation, extended treatment and much more. More information about Glenbeigh's services can be found at https://www.glenbeigh.com/ while more information about ACMC Healthcare System can be found at https://www.acmchealth.org/.

During the formation of this 2022 Community Health Needs Assessment (CHNA), COVID-19, an infectious disease caused by the SARS-CoV-2 virus, continues to impact community health as well as access to services. While collecting data for the 2022 CHNA, COVID-19 protocols and precautions, initiated to limit the spread of the virus, remained in place resulting in more reliance on phone interviews, surveys and other non-contact means of collecting primary data. Data was also gleaned from work completed by Shilling Consulting Services, Inc., of Rockford, Michigan. Glenbeigh undertook a strategic plan initiative with Shilling Consulting concurrently to the CHNA. The strategic plan provided data on Glenbeigh's defined service community as well as primary data collected from community leaders and people working with individuals impacted by alcohol and drug addiction. At the time of this publication, the COVID-19 pandemic continues to affect community health resulting in shifting health priorities and access to services.

In January 2022, Glenbeigh commenced work on a comprehensive Community Health Needs Assessment (CHNA) to identify significant health needs related to substance use disorders as well as addiction treatment and recovery support. The CHNA assessment was completed in a timeline consistent with the requirements set forth in the Affordable Care Act[1], per Ohio's State Health Improvement Plan[2] and by the Internal Revenue Service[3]. The ultimate goal of this CHNA is to further Glenbeigh's commitment to community health and population health management. The findings from this assessment will be utilized by Glenbeigh to guide community benefit initiatives and to engage collaborative partners in order to address the identified health needs related to substance use disorders.

The following Community Health Needs Assessment includes both primary and secondary data that was collected and analyzed as a means of formulating key findings. In total, 57 individuals representing public and private organizations, social service agencies, health and human service entities, vulnerable populations as well as individuals and families directly affected by addiction participated in the primary data interviews and surveys.

Secondary data was compiled from local, state and federal figures to provide insight on the impact of substance use disorders on the defined service community. Collected data included economic information, educational information, population changes, general demographics, drug use and overdose information, alcohol usage and other available statistics.

Glenbeigh is dedicated to the communities where it has inpatient and outpatient facilities as well as those communities identified by the CHNA as significant service areas. Through the process of identifying key findings and creating a strategic implementation plan, Glenbeigh strives to be a strong partner in the community and an organization committed to elevating the health of individuals touched by addiction. Through a collaborative network, Glenbeigh is committed to improving health, sustaining recovery and achieving obtainable, measurable goals.

Glenbeigh's 2022 CHNA was created with input and guidance from both the Ashtabula County Medical Center (ACMC) Healthcare System and Cleveland Clinic. The final CHNA was reviewed by the board and approved on October 26, 2022.

1. https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3#:~:text=Section%20501(r)(3)(A)%20requires%20a%20hospital,needs%20identified%20through%20the%20CHNA.
2. https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship
3. https://www.irs.gov/charities-non-profits/section-501r-reporting

Defined Service Area/Community Definition

While the COVID-19 pandemic reduced Glenbeigh admissions, it did not significantly shift Glenbeigh's service community. From 2019 through 2022, Glenbeigh provided treatment predominantly to individuals from throughout Ohio, Pennsylvania, and surrounding states. During the peak of the pandemic, Glenbeigh remained open. However, patients were admitted from a restricted area to limit the introduction and spread of virus variants. For a significant period, patient admissions were exclusive to Ohio residents. Eventually, admissions expanded to include individuals from western Pennsylvania, then to individuals from adjacent states. For purposes of this report, Glenbeigh's primary service area is defined as eleven counties with the highest volume of admissions tallied from zip codes and comprising 80% of the total inpatient population.

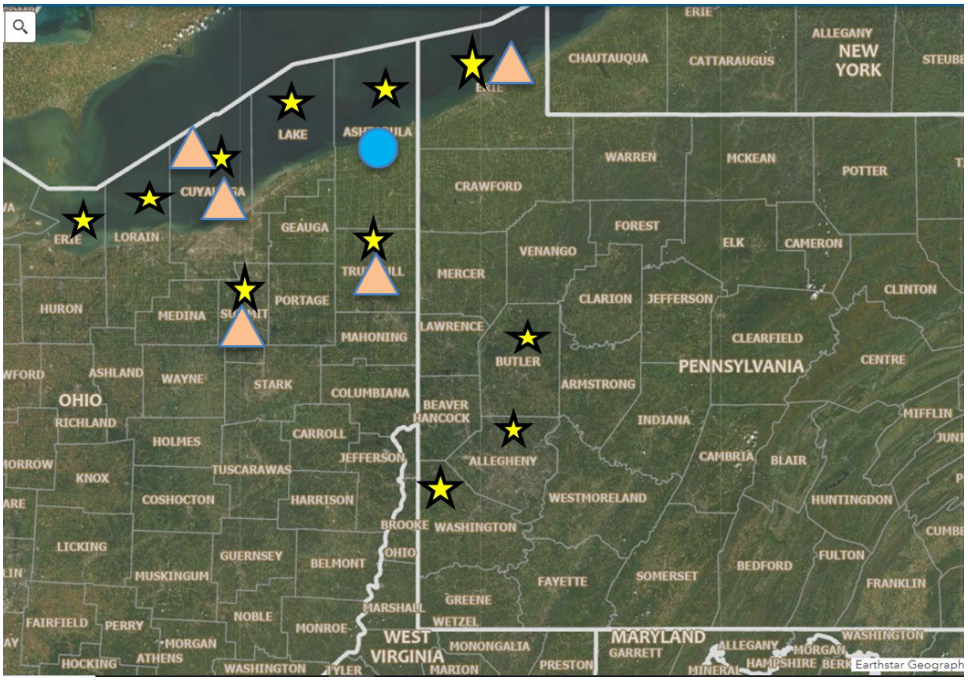
Ohio service area counties include Ashtabula, Cuyahoga, Erie, Lake, Lorain, Summit and Trumbull. Service area counties in Pennsylvania include: Allegheny, Butler, Erie and Washington. The total population of Glenbeigh's defined service community from the U.S. Census Bureau resident population estimate reported for 2021 is approximately 4,619,000.

Ashtabula County, Ohio	Cuyahoga County, Ohio
Erie County, Ohio	Lake County, Ohio
Lorain County, Ohio	Summit County, Ohio
Trumbull County, Ohio	Allegheny County, Pennsylvania
Butler County, Pennsylvania	Erie County, Pennsylvania
Washington County, Pennsylvania	

Glenbeigh's inpatient hospital is located in Rock Creek, Ashtabula County, Ohio. Outpatient Centers are located in Beachwood and Rocky River in Cuyahoga County, Canton in Stark County and Niles in Trumbull County, Ohio. Glenbeigh has an outpatient center located in Erie, Pennsylvania to serve the western Pennsylvania community. Glenbeigh's Toledo, Lucas County, location was closed in 2022, transitioning services to telehealth options. The total population of counties (from the U.S. Census Bureau resident population estimate reported for 2021) with Glenbeigh services available is just under 2,191,000.

Beachwood, Ohio	Canton, Ohio
Niles, Ohio	Rock Creek, Ohio
Rocky River, Ohio	Erie, Pennsylvania

The following map highlights (with a star) the communities served by Glenbeigh in Ohio and Pennsylvania.



Glenbeigh Outpatient Centers **Glenbeigh Inpatient Hospital**

Detailed information on Glenbeigh's service area is available in the secondary data section starting on page 14.

Hospital Profile

Glenbeigh, located in Rock Creek, Ashtabula County, Ohio is a regional provider of inpatient and outpatient services for individuals with alcohol and/or drug addiction, also referred to as substance use disorders. Providing treatment services since 1981, Glenbeigh is a non-profit hospital that is a member of the ACMC Healthcare System and a Cleveland Clinic affiliate. Glenbeigh also has outpatient treatment centers located in Beachwood, Cuyahoga County; Canton, Stark County; Niles, Trumbull County; and Rocky River, Cuyahoga County, in Ohio as well as Erie, Erie County, Pennsylvania.

Mission Statement:

To provide the highest quality healthcare to those in need of alcohol and drug addiction treatment and to support ongoing recovery efforts.

Mission. Glenbeigh's mission is to provide the highest quality healthcare to those in need of alcohol and drug addiction treatment and to support ongoing recovery efforts. Glenbeigh's mission is carried out without regard of race, ethnicity, marital status, color, religion, sex, national origin, disability, sexual orientation, gender identity or socioeconomic status. Glenbeigh is staffed and equipped to provide treatment services to adults, 18 years and older. Individuals seeking treatment for minors under the age of 18 are referred to appropriate facilities.

Vision. Glenbeigh promotes a culture of safety and quality in all that we do; to always have the patient at the center of everything we do; to provide state of the art clinical services in the most cost-effective setting; to attract, develop, and retain quality employees in every area of our operation; to go the extra step to build positive referent relationships; to be financially sound; and to be the premier substance use disorder treatment provider within the country.

Values. At Glenbeigh, we care for individuals and families impacted by alcohol and drugs. We are committed to a philosophy of mutual respect and compassionate caring to guide patients on the path to sustained recovery. We practice empathy and active listening in all our interactions. We are dedicated to leading by example and promoting Glenbeigh values.

Patient Care Services at Glenbeigh includes inpatient and outpatient evaluation and treatment. The inpatient hospital collaborates with outpatient centers to provide the best care possible for the individual, to improve outcomes, to engage family members in the treatment process, and to ensure services are consistent with our mission, vision, values and goals. Patient care services are provided to all patients by a collaborative team of professional and ancillary staff members.

Addiction is an illness that, if left untreated, results in the progressive physical, mental, emotional, social and spiritual deterioration of individuals and their families. With treatment, individuals with substance use disorders have the capacity to lead meaningful and productive lives. Successful treatment for addiction is a combination of medical and clinical practices, taking every aspect of each individual into careful consideration to develop a unique treatment plan. Patient care is provided in an atmosphere of privacy, dignity and respect and includes:

Inpatient Services

Glenbeigh's Rock Creek facility has 188 licensed chemical dependency beds for the provision of treatment services twenty-four hours a day, seven days a week. The inpatient regimen is individually prescribed and supervised by physicians and monitored by nursing, counseling and clinical staff. Inpatient services include: comprehensive evaluations, detoxification, group therapy, individual therapy, Eye Movement Desensitization and Reprocessing (EMDR) therapy, Cognitive Behavioral Therapy (CBT), specialized groups, patient-centered care, educational lectures, family programming, fitness regiments and pain management.

Intensive Outpatient Treatment/Aftercare

Intensive Outpatient Treatment (IOP) is a concentrated, structured, inter-disciplinary clinical service designed to treat clients in a program where the goal is to achieve ongoing abstinence. It addresses the treatment needs of clients who have completed inpatient treatment or whose clinical conditions do not require inpatient or residential care yet would benefit from a structured treatment program. Ongoing Aftercare sessions are available at each of Glenbeigh's six locations for clients who have completed Intensive Outpatient Treatment. Family participation is welcomed in both IOP and Aftercare sessions on a weekly basis. Engaging and educating family is vital to successful long-term recovery.

Extended Residential Treatment and Transitional Living

Extended Residential Treatment and Transitional Living in recovery housing are part of the continuum of care provided at Glenbeigh. Extended residential treatment is designed to help rehabilitate those who appear unable to maintain sobriety following primary care. Candidates often have met with repeated failure in the past or, because of early onset of substance use disorders, have not developed the skills necessary to sustain abstinence or be successful in recovery. These patients require additional time in a highly structured program with continued access to medical and clinical staff. Extended residential treatment assists patients in establishing a solid foundation in recovery and making personal changes to achieve lasting recovery. The purpose of transitional housing is to provide people leaving inpatient treatment with a safe living environment, free from alcohol and other drugs. The benefits of living in this type of community in early recovery are:

- Residents can work a program of recovery based on the principles learned in treatment.
- Residents can learn communication skills essential for healthy relationships with other people.
- Transitional living helps develop coping skills and builds self-esteem.
- It is an environment where residents can develop beliefs, values and attributes that are consistent with the recovery themes of acceptance, humility, service to others and gratitude.

Family Programs

Glenbeigh offers a single day family program expressly for loved ones, age 12 and older, touched by the disease of addiction and who have family in inpatient treatment. The family program includes educational presentations, group sessions and family conferences. Glenbeigh is committed to strengthening families and believes they are an integral component of the treatment process therefore the family program is provided at no additional charge. The family program is an opportunity for family members to work with addiction counselors and to begin the healing process.

Due to COVID-19 protocols, in-person family programming transitioned to a telehealth platform to reduce the risks associated with transmission of the virus. At the time of this publication, in-person family programming has resumed on the outpatient level while inpatient programming remains as a telehealth option. Glenbeigh's top priority remains access to care while ensuring the health of patients and staff. Virus transmissions levels continue to be monitored and family programs have the flexibility to easily transition back to telehealth platforms as needed.

Research Components

Glenbeigh utilized an in-depth, comprehensive approach to identifying the needs within its defined service area and in areas where Glenbeigh has outpatient facilities. For the purposes of this report, Glenbeigh formulated key findings within the collective service areas using primary and secondary data. A variety of quantitative and qualitative research factors were used to formulate the 2022 CHNA. Note: COVID-19 restrictions eliminated the collection of data from focus group formats. Instead, in-person surveys were distributed to individuals attending programs at the Niles outpatient center. The components used to collect primary data include:

- Key Stakeholder Informant Interviews (Phone)
- Online Surveys
- In-person Surveys

Each element provided Glenbeigh with a unique perspective on the community's needs related to substance use disorders. Selected demographics varied and included individuals who have completed treatment for alcohol or drug use from any treatment center, family members, treatment providers, physicians and ancillary agency representatives. Summaries of each component are included in this report. Detailed accounts of the findings can be viewed in the individual module.

ACMC Healthcare System and Glenbeigh leadership were engaged in the planning process and provided guidance during the formulation of the assessment. Past assessments were referenced to ensure questions obtained relative metrics. Furthermore, community members were engaged throughout the process to ensure the assessment captured data relevant to individuals affected by addiction.

To obtain primary data, this community health assessment utilized written surveys of adults, age 18 and over, from various regions of Glenbeigh's overall service community. Several survey instruments were utilized to capture data and the perspective of a diverse group of individuals. An online survey was created to solicit input from professionals working with individuals in active addiction or recovery. In August, electronic surveys were sent and kept open for 30 days. A total of 30 individuals representing organizations, businesses and criminal justice participated in the online survey. The survey had a 27.25% submission rate for participation. A second survey was designed to capture basic demographic information from what would have been focus group participants. This survey was distributed to individuals attending family program days at the Glenbeigh Outpatient Center of Niles. Several questions were added to gauge local input regarding overall healthcare, mental health issues, employment and stigma. Two open-ended questions were utilized to gather information on barriers to treatment and an understanding of what community services participants feel improve quality of life.

In order to delineate key findings, Glenbeigh utilized secondary and primary data. Prevalence of issues defined in secondary data helped establish the scope and burden of need throughout the region. Primary data provided the details to ensure this assessment addresses the needs of the community that Glenbeigh serves. The approach Glenbeigh utilized to prioritize health issues is detailed in Appendix I.

Key Findings/Significant Community Health Needs

A number of community needs were identified as a result of conducting the 2022 CHNA. Significant Community Health Needs, or Key Findings, were based on the assessment of secondary data, which included a broad range of statistics, health indicators and resources, and of primary data, which was amassed from various stakeholders. The following needs emerged across the various research components and were identified as significant health needs within Glenbeigh's service area.

Socioeconomic Needs:

1. Drug and alcohol abuse continues to affect people of all races and ages. Poverty, income and insurance coverage restrict access to treatment and successful recovery. Employment and income, along with other social and economic determinants, correspond to alcohol and drug use. Transportation remains a significant barrier.
2. Drug abuse has transitioned to synthetic opioids such as fentanyl. There was also an increase in the use of cocaine and methamphetamines. The use of poly-substances is common. While alcohol involved accidents decreased during the pandemic, alcohol use reportedly increased. Drugs remain easily available and inexpensive.
3. Many drugs, such as cocaine, are laced with fentanyl resulting in overdoses. Alcohol use remains a top drug of choice. Prescription abuse continues to be prevalent yet transitioned from opioids to stimulants and other types of drugs.
4. People dealing with active addiction continue to encounter roadblocks when seeking information on addiction, treatment and recovery. There continues to be a lack of understanding, education and information regarding addiction, treatment and recovery support.
5. In many areas there continues to be a lack of recovery support options. Recovery support includes recovery housing and recovery oriented events.

Health Needs:

1) Barriers exist that affect access to treatment either limiting or excluding certain demographics from obtaining treatment services. Telehealth is contingent on access to internet services.
2) Individuals with a substance use disorder more often than not feel they do not need treatment. Yet self-help groups remain an important resource within the community.
3) Stigma continues. Employers lack education to help employees secure confidential treatment and return to work. Stigma around drug abuse remains while alcohol use is tolerated.
4) Among healthcare providers, there is a lack of qualified, educated, licensed individuals to work in the field of addiction treatment: from entry-level positions to physicians and nurses.
5) Established healthcare professionals lack education on addiction, treatment and recovery.
6) There is a need for combined mental health and addiction services within the community.

OBJECTIVES AND METHODOLOGY

Regulatory Requirements

Federal law requires that non-profit, tax-exempt hospitals conduct a Community Health Needs Assessment (CHNA) every three years and adopt an Implementation Strategy that addresses the significant community health needs identified in the CHNA. In addition, the State of Ohio requires the CHNA align with priority topics as outlined in the State Health Improvement Plan (SHIP). As a result, Glenbeigh conducted an assessment that identifies the significant health needs within its defined service community. A secondary goal is to pinpoint potential collaborative partners working toward the same goals.

The regulations require that Glenbeigh:

- Take into account input from persons representing the broad interests of the community served, including those with expertise in public health issues.
- Make the CHNA widely available to the public.

The CHNA report must consist of certain information including, but not limited to:

- A description of the defined service area and how it was determined.
- An assessment of the health needs of that community.
- A description of how input was secured from persons representing a broad demographic range within the service community as well as those with special knowledge of, or expertise in, addiction, treatment and recovery.
- A description of the methodology used to ascertain the health needs of the community.
- A listing of organizations that contributed to the data collection or development of the CHNA.
- A prioritized, descriptive, list of the community's health needs identified through the CHNA.

Non-profit healthcare providers are also required to report information about the CHNA process and about community benefits they provide on IRS Form 990, Schedule H. As described in the Schedule H instructions, community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. Furthermore, the State of Ohio requires annual reporting to the Ohio Department of Health be submitted consisting of the complete Schedule H and any corresponding attachments.

Community benefit activities and programs seek to achieve specific goals, which include:

- Improving access to health services.
- Enhancing public health.
- Advancing increased general knowledge.
- Relief of a government burden to improve health.

In order to be reported, community need for the activity or program must be established, which can be done so through the community health assessment. CHNAs identify significant health needs for particular geographic areas and populations by focusing on the following questions:

- Who in the community is most vulnerable in terms of health status or access to care?
- What are the unique health status and/or access needs for these populations?
- Where do these people live in the community?
- Why are these problems present?

How the significant community health needs will be addressed will be detailed in a separate Implementation Strategy available at www.glenbeigh.com.

Methodology

Federal regulations that govern the community health needs assessment process provide hospitals with the autonomy to define the community based on relevant facts and circumstances including the geographic locations served by the hospital. In defining its service community, Glenbeigh considered its primary service area, secondary service area and, as a provider of treatment for alcohol and drug addiction, focused on this specific subset within the defined service community. The CHNA examines both health issues and risk factors for the population covered by the assessment. Also taken into account are social, economic and environmental conditions known to influence alcohol and drug use.

Secondary Data Profile

Secondary Data was obtained from a variety of institutions and government agencies and collected in the Secondary Data Profile section. Social determinants of health, particularly those that correlate with drug and alcohol use, were reported at county levels when available. Glenbeigh utilized information from multiple websites such as the Ohio Department of Health, Appalachian Regional Commission, Pennsylvania Office of Drug Surveillance and Misuse Prevention, Substance Abuse and Mental Health Services Administration (SAMHSA), National Center for Health Statistics, Rural Health Information Hub, Centers for Disease Control and Prevention, Drug Enforcement Administration (DEA) and the U.S. Census Bureau among others. All data include a source citation and URLs for reference. Examples of collected data include poverty and unemployment rates, education levels and poverty statistics. Drug and alcohol use, abuse, and death rates were reported and compared to both state and national statistics. Finally, trends in drug and alcohol use were researched as Glenbeigh strives to stay abreast of developing factors in an effort to best anticipate future care needs for the service population.

Secondary data, or data that are already existing and collected by other agencies or organizations, are a key component of the CHNA. The tables included in the CHNA secondary data section represent the counties Glenbeigh has identified as service populations based on admissions. Indicators that influence drug and alcohol use and abuse were included to better understand the social determinants of health in the population. Data on drug and alcohol use and abuse, including overdose deaths, were included and compared to state and national data to provide information about prevalence. Additionally, Glenbeigh

utilized the findings reported in the Ashtabula County 2022 Community Needs Assessment. Considering a wide array of information is vital when assessing community health needs to ensure the assessment captures relevant facts and perspectives thus improving accuracy and objectivity.

Primary Data Profile

Input from the community was obtained by the use of phone interviews and surveys. Participants represented the broad interests of the service community and included individuals with special knowledge of, or expertise in, working with clients and families impacted by substance use disorders. Detailed interviews were conducted with nine key informants, which consisted of professionals from throughout Ohio and western Pennsylvania. Key informant raw data is available in Appendix A. An electronic survey was utilized to engage 30 additional professionals and strategic contacts representing the geographic areas of Ashtabula, Chagrin Falls, Cleveland, Dover, Elyria, Euclid, Lakewood, Maumee, Niles, and Warren, in Ohio as well as Beaver, Butler, Coraopolis, Erie, Irwin, Pittsburgh and Washington in Pennsylvania. The survey was tallied with results detailed in Appendix C. Stakeholders from the survey group included; counselors, social workers, therapists, family service organizations, court case managers, interventionists, EAP's (employee assistance program specialists), human resource professionals, recovery housing owners, mental health providers, peer support specialists, education professionals and other specialists in the field of addiction. The content of the survey focused on perceptions of the availability of and access to treatment services.

Due to COVID-19 restrictions, no focus groups were conducted for the 2022 CHNA. Instead, surveys were distributed in-person to individuals participating in three separate outpatient service groups. Participants include individuals in recovery as well as family members and other individuals attending sessions. A total of 19 adults participated by completing the survey. The purpose of the survey was to gather qualitative feedback from individuals with first-hand experience navigating the healthcare system for addiction services and living in recovery. The in-person surveys provided Glenbeigh with a multi-faceted perspective of individuals experience with addiction, treatment and recovery. Topics covered included access to services, workplace stigma and recovery support. Results, along with the survey tool, are presented in Appendix B

Collaborating Organizations

Glenbeigh is a member of the ACMC Healthcare System, which is affiliated with the Cleveland Clinic health system. As such, in conducting this CHNA, Glenbeigh collaborated with Cleveland Clinic Main Campus and with Ashtabula County Medical Center. Furthermore, Ashtabula County Medical Center was involved in the development of the Ashtabula County 2022 Community Health Needs Assessment, working with the Ashtabula County Health Department as well as other healthcare providers and county agencies.

Limitations/Information Gaps

It should be noted that data limitations exist when interpreting results. The findings of this CHNA may vary from those of other organizations conducted in the community. Differences may be caused by

variances in data sources, the defined service area, and community developments that may not be reflected in data sets. Moreover, it is important to note that while the same questions were asked using the same wording, data collection methods varied therefore caution should be used when interpreting interview results as there may be a margin of error.

During the course of the conducting the CHNA, Glenbeigh compiled the most recent data available at the time information was being researched. The research period began in January 2022 and ended in mid-September 2022. Secondary data, upon which this assessment relies, often measure community health in prior years. The impact of more recent public policy changes and developments may not be reflected in the secondary data.

SECONDARY DATA

A key component of the CHNA is the accumulation of "secondary data". The following information details multiple indicators of social determinants of health related to alcohol and drug use across the defined service area. Social determinants such as income and education are known to significantly influence alcohol and drug use. Research has shown that indicators such as poverty, lower education levels and in some instances, race or ethnicity, can be associated with greater risk factors and poorer health outcomes.

Ashtabula County, Ohio

Glenbeigh's main hospital facility is located in Ashtabula County, Morgan Township, with a Rock Creek Zip Code in Ohio of 44084. Ashtabula County is a 2021 designated Health Resources and Services Administration (HRSA) Health Professional Shortage Area (HPSA) for primary care, dental health and mental health. The county also has regions eligible as Medically Underserved Areas for program year 2022 as designated by the Ohio Department of Health. According to U.S. Census Bureau Quick Facts, the population density of Ashtabula County is 97,337.

Age and Sex	Ashtabula County	Ohio
Persons under 5 years, percent	5.6%	5.7%
Persons under 18 years, percent	22.0%	22.1%
Persons 65 years and over, percent	20.0%	17.8%
Female persons, percent	49.2%	50.7%

Source: U.S. Census Bureau Quick Facts
https://www.census.gov/quickfacts/fact/table/ashtabulacountyohio,OH/PST045221

Income & Poverty	Ashtabula County	Ohio
Median household income (in 2020 dollars), 2016-2020	$47,925	$58,116
Per capita income in past 12 months (in 2020 dollars), 2016-2020	$25,556	$32,465
Persons in poverty, percent	16.5%	12.6%

Source: U.S. Census Bureau Quick Facts
https://www.census.gov/quickfacts/fact/table/ashtabulacountyohio,OH/PST045221

Race and Origin	Ashtabula County	Ohio
White alone, percent	92.7%	81.2%
Black or African American alone, percent(a)	3.9%	13.2%
American Indian and Alaska Native alone, percent	0.4%	0.3%
Asian alone, percent(a)	0.5%	2.7%
Native Hawaiian and Other Pacific Islander alone, percent	0.1%	0.1%
Two or More Races, percent	2.5%	2.6%
Hispanic or Latino, percent	4.8%	4.3%

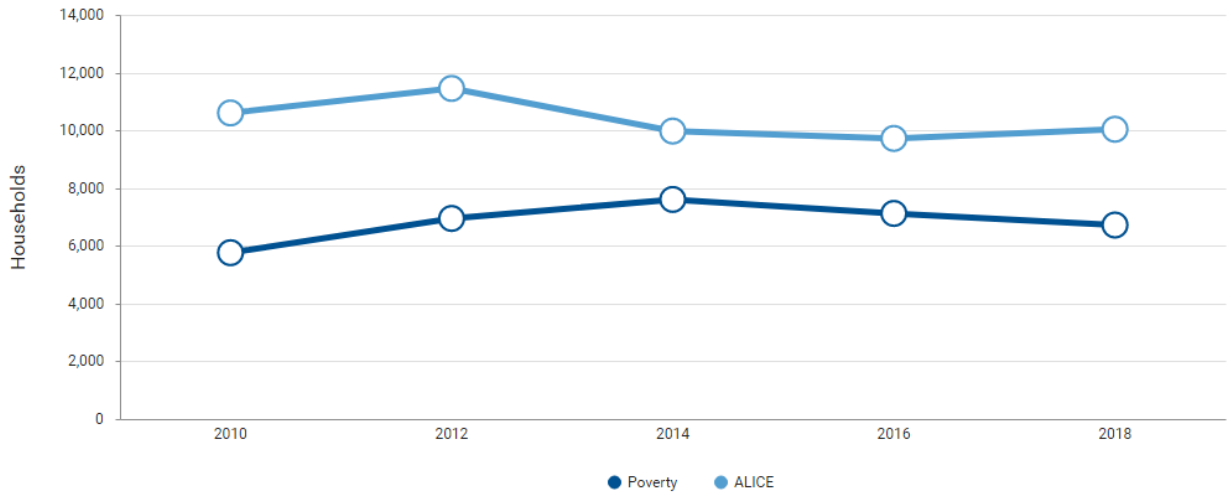
Source: U.S. Census Bureau Quick Facts
https://www.census.gov/quickfacts/fact/table/ashtabulacountyohio,OH/PST045221

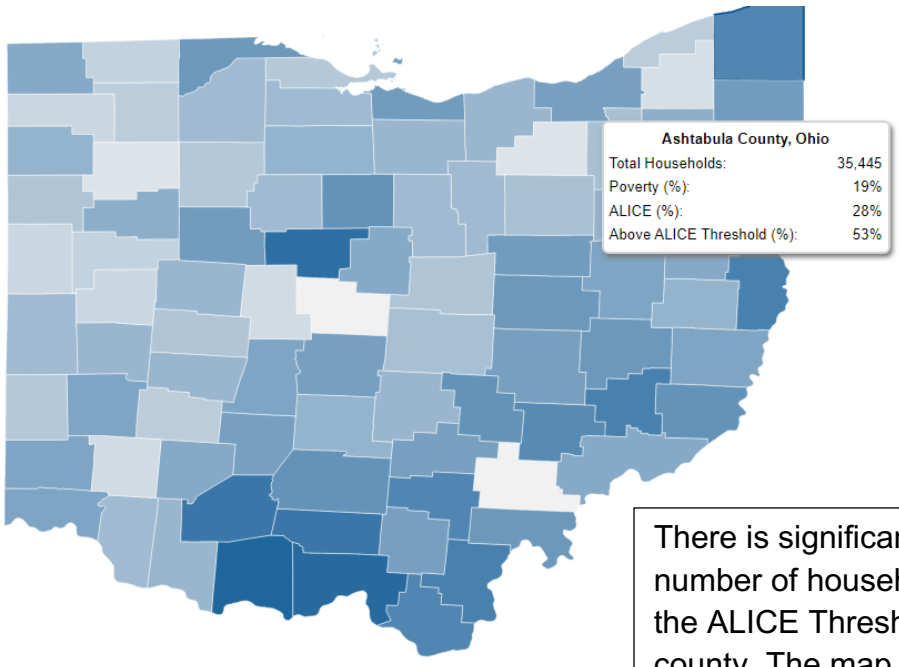
The United Way 2018 ALICE (Asset Limited, Income Constrained, Employed) report (https://www.unitedforalice.org/county-profiles-mobile/ohio) along with U.S. Census Bureau data (https://www.census.gov/quickfacts/fact/table/ashtabulacountyohio,OH/PST045221) delved deeper into community statistics. Ashtabula County decreased from 38,728 households in 2016 to 35,445 in 2018 with a total population of 97,493 in 2018. Census Bureau statistics for 2021 showed households increased from 38,381 to 38,614 while the population dropped to 97,337. ALICE reported the number of Ashtabula County households in poverty at 19%, while the state average was 14%. By 2021, the U.S. Census Bureau reported the number of Ashtabula County residents living in poverty at 16.5%. The unemployment rate in the county endured at above the state average.

S

How Has the Number of ALICE Households Changed Over Time?

ALICE – **A**sset **L**imited, **I**ncome **C**onstrained, **E**mployed – households that earn more than the Federal Poverty Level, but less than the basic cost of living for the county (the ALICE Threshold). While conditions have improved for some households, many continue to struggle, especially as wages fail to keep pace with the cost of household essentials (housing, child care, food, transportation, health care, and a basic smartphone plan).





There is significant variation in the number of households that live below the ALICE Threshold within each county. The map is shaded to show the percentage of households that are below the ALICE Threshold (poverty level and ALICE households combined). The darker the blue, the higher the percentage.

Source: United for ALICE, United Way 2018
https://www.unitedforalice.org/county-profiles-mobile/ohio

ASHTABULA COUNTY

County Subdivision by ZIP Code	Total Households	% Below ALICE
44003	1,695	51
44004	13,151	56
44010	595	48
44030	5,904	47
44032	501	63
44041	6,011	52
44047	3,424	34
44048	853	45
44076	1,655	40
44082	578	41
44084	1,231	27
44085	1,166	38
44093	418	24
44099	740	41

Source: United for ALICE, United Way 2018
https://www.unitedforalice.org/county-profiles-mobile/ohio

Ashtabula County 2022 Community Health Needs Assessment Data

Through a collaborative effort coordinated by *Healthy Ashtabula County*, Ashtabula County completed and published a 2022 Community Health Needs Assessment. Participating agencies included the Ashtabula County Health Department, Ashtabula City Health Department, ACMC Healthcare System, Conneaut City Health Department, University Hospitals Conneaut Medical Center, University Hospitals Geneva Medical Center and many other partners (see Ashtabula County 2022 Community Health Needs Assessment at https://www.healthyneo.org/content/sites/cuyahoga/Resources/2022_Ashtabula_CHNA_Report.pdf). The process followed by the *Ashtabula County 2022 Community Health Needs Assessment* reflected an adapted version of the Robert Wood Johnson's County Health Ranking and Roadmaps: Assess Needs and Resources process. *Healthy Ashtabula County* contracted with Illuminology, a central Ohio based research firm to ensure federal and state compliance when completing the CHNA.

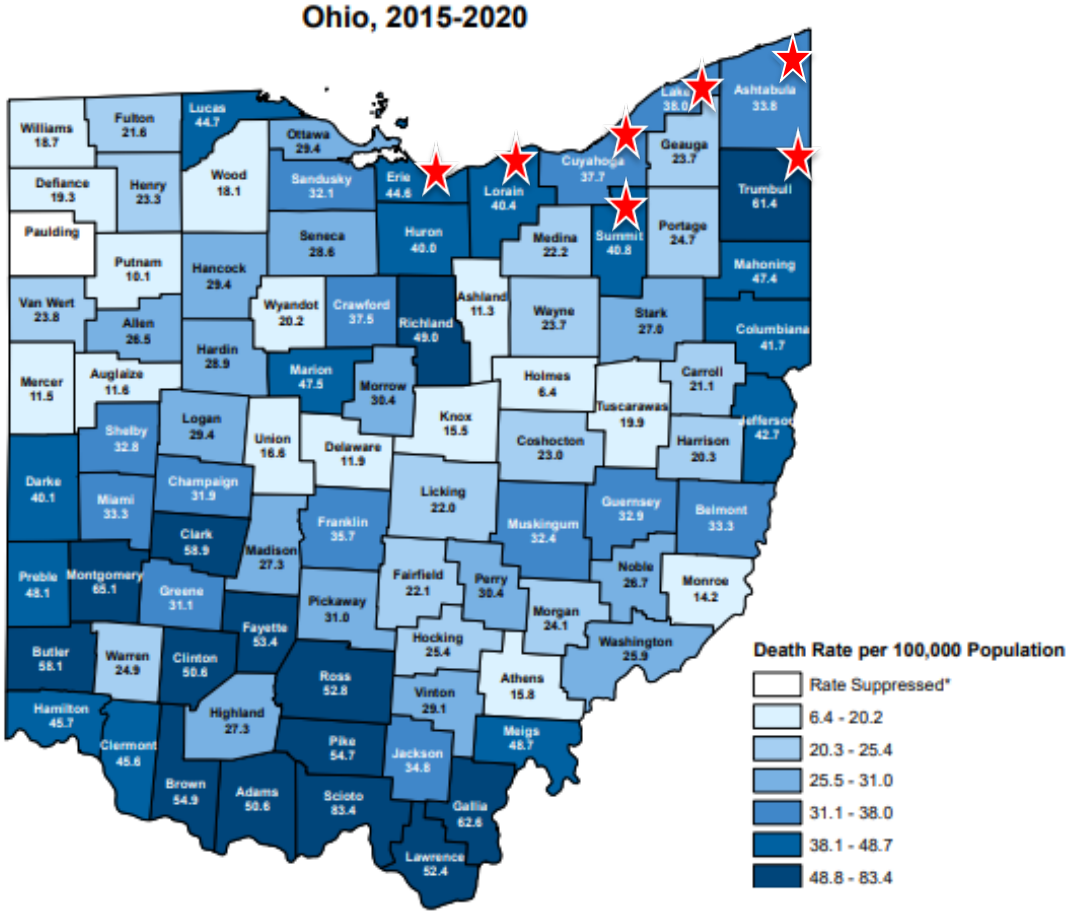
The Ashtabula County 2022 CHNA reported that over one-third (42%) of respondents know someone in their community who has a substance use problem involving alcohol, illegal drugs and/or prescription pain medications. In addition, over one-third of Ashtabula County adults (39%) reported binge drinking (i.e. five or more drinks on one occasion for men, four or more drinks on one occasion for women) at least once in the past month. The average number of days reported for binge drinking was 7.1. Also in Ashtabula County, the percentage of respondents age 19 and older reporting binge drinking in the past month increased from 23% in 2019 to 39% in 2022. Resident perception of the most important health issues in the county were COVID-19 (42.4%) followed by drug or alcohol addiction or abuse (23%), lack of medical care access (10%) and mental health issues (7.9%).

Source: Ashtabula County 2022 Community Health Needs Assessment, Released, July 2022

Other Ohio Service Areas

The Ohio Department of Health published *Preliminary Data Summary: Ohio Unintentional Drug Overdose Deaths* reporting data through November 2021. The report was updated on June 7, 2022 offering finalized mortality data from 2011 to 2020. Combined with the *2020 Ohio Drug Overdose* report, the following information provided unintentional drug overdose death rates and insight on drug use within the state.

Figure 8. Average Age-Adjusted Rate of Unintentional Drug Overdose Deaths by County, Ohio, 2015-2020



A red star indicates counties that fall in Glenbeigh's Ohio Defined Service Area per the 2022 CHNA community definition.

- Scioto County had the highest unintentional drug overdose death rate at 83.4 deaths per 100,000 population, followed by Montgomery County and Gallia County (65.1 and 62.6 deaths per 100,000 population, respectively).

Source: Ohio Department of Health
https://odh.ohio.gov/wps/wcm/connect/gov/2d25c2cb-7d69-4fb3-9079-4ab6bfa5940e/OHIOMO~2.PDF?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-2d25c2cb-7d69-4fb3-9079-4ab6bfa5940e-o836MxD

Per Ohio Department of Health data, in 2020, 5,017 Ohioans died from unintentional drug overdoses, a 25% increase over 2019 deaths. Additionally, from 2019 to 2020, the overdose death rate also increased by 25% to a rate of 45.6 deaths per year.

Of Glenbeigh's seven defined Ohio service counties, one, Trumbull County, had a death rate of 61.4 per 100,000 population ranking the county as the fourth highest in the state for unintentional drug overdose deaths. Of Ohio's 88 total counties, Scioto at 83.4, Montgomery at 65.1, Gallia at 62.2 and Trumbull at 61.4 rank as the top four counties with the highest number of unintentional drug overdose deaths per 100,000 population.

Ohio County	Total Population * (Census Data)	Death Rate per 100,000 Population +
Ashtabula	97,337	33.8
Cuyahoga	1,249,387	37.7
Erie	74,852	44.6
Lake	232,023	38.0
Lorain	315,595	40.4
Summit	537,633	40.8
Trumbull	201,335	61.4

*Source: U.S. Census Bureau Quick Facts
https://www.census.gov/quickfacts/fact/table/trumbullcountyohio,OH/PST045221
+ Source: Preliminary Data Summary: Ohio Unintentional Drug Overdose Deaths
https://odh.ohio.gov/wps/wcm/connect/gov/2d25c2cb-7d69-4fb3-9079-4ab6bfa5940e/OHIOMO~2.PDF?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-2d25c2cb-7d69-4fb3-9079-4ab6bfa5940e-o836MxD

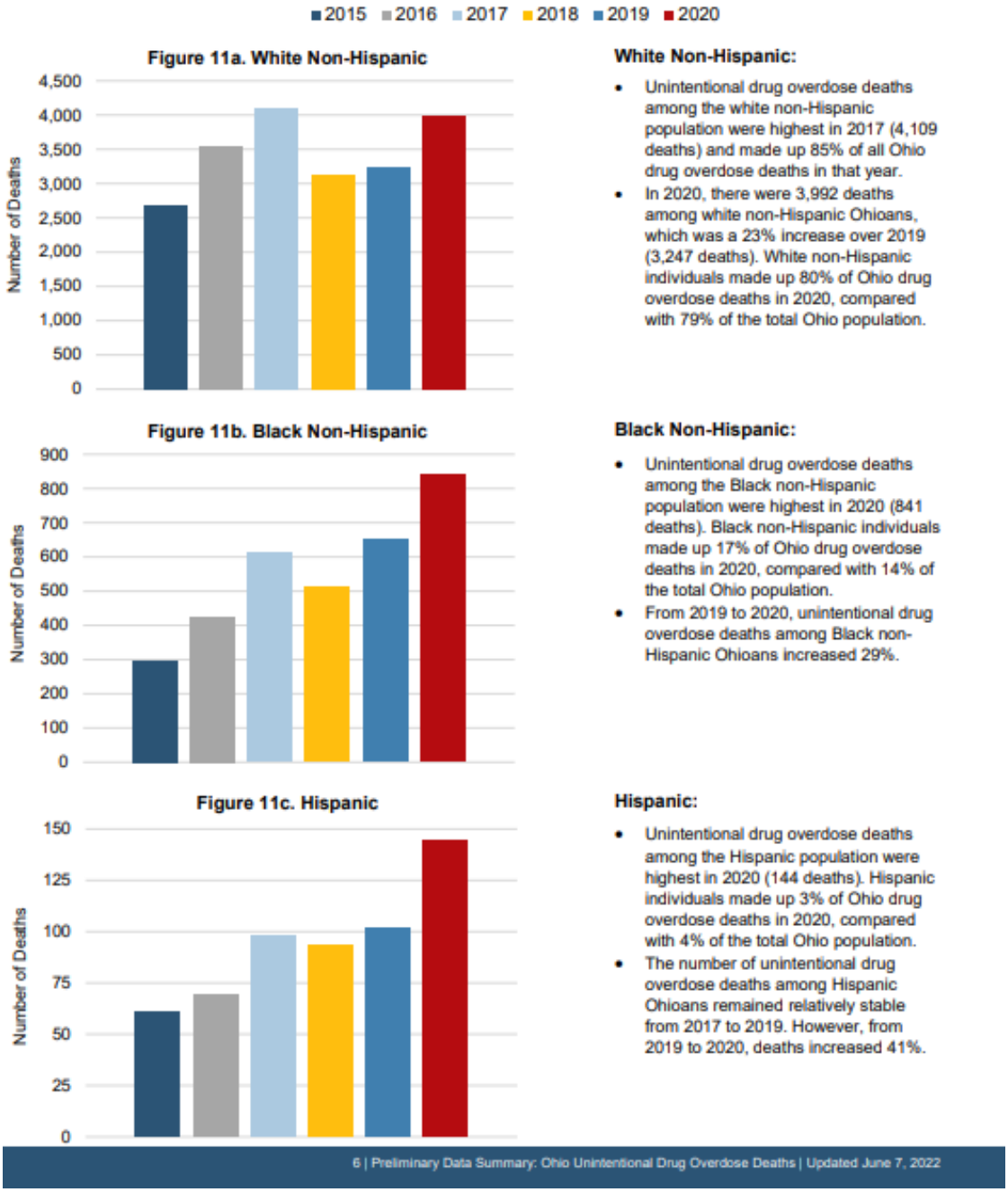
Glenbeigh's Ohio service community includes counties within the three highest tiers for unintentional drug overdose deaths. Three counties, Erie, Lorain and Summit rank among the second highest with death rate ranges between 40 and 49 per 100,000. Ashtabula, Cuyahoga and Lake Counties, while still with high rankings, had death rate ranges below the state rate of 45.6. These three counties ranged between 30 and 39.

Ohio's overdose deaths continued to be driven by fentanyl, predominantly in combination with other drugs. Cocaine and psychostimulant use grew between 2019 and 2021 resulting in significant increases in drug overdose deaths. During the same period, heroin use tapered off while the use of benzodiazepines and natural or semi-synthetic opioids stayed relatively unchanged.

Unintentional drug overdose deaths continued to be high among the White, non-Hispanic population. From 2019 through 2021, the death rate for this population remained steady at 250-300 deaths per month. May 2020 saw a surge with over 450 deaths. Among Black and Hispanic populations, overdose deaths increased steadily. Both populations were affected by the May 2020 surge with over 90 deaths in the Black community and roughly 18 deaths in the Hispanic community. Contrary with the White community, both the Black and Hispanic populations have consistently increasing rates of overdose

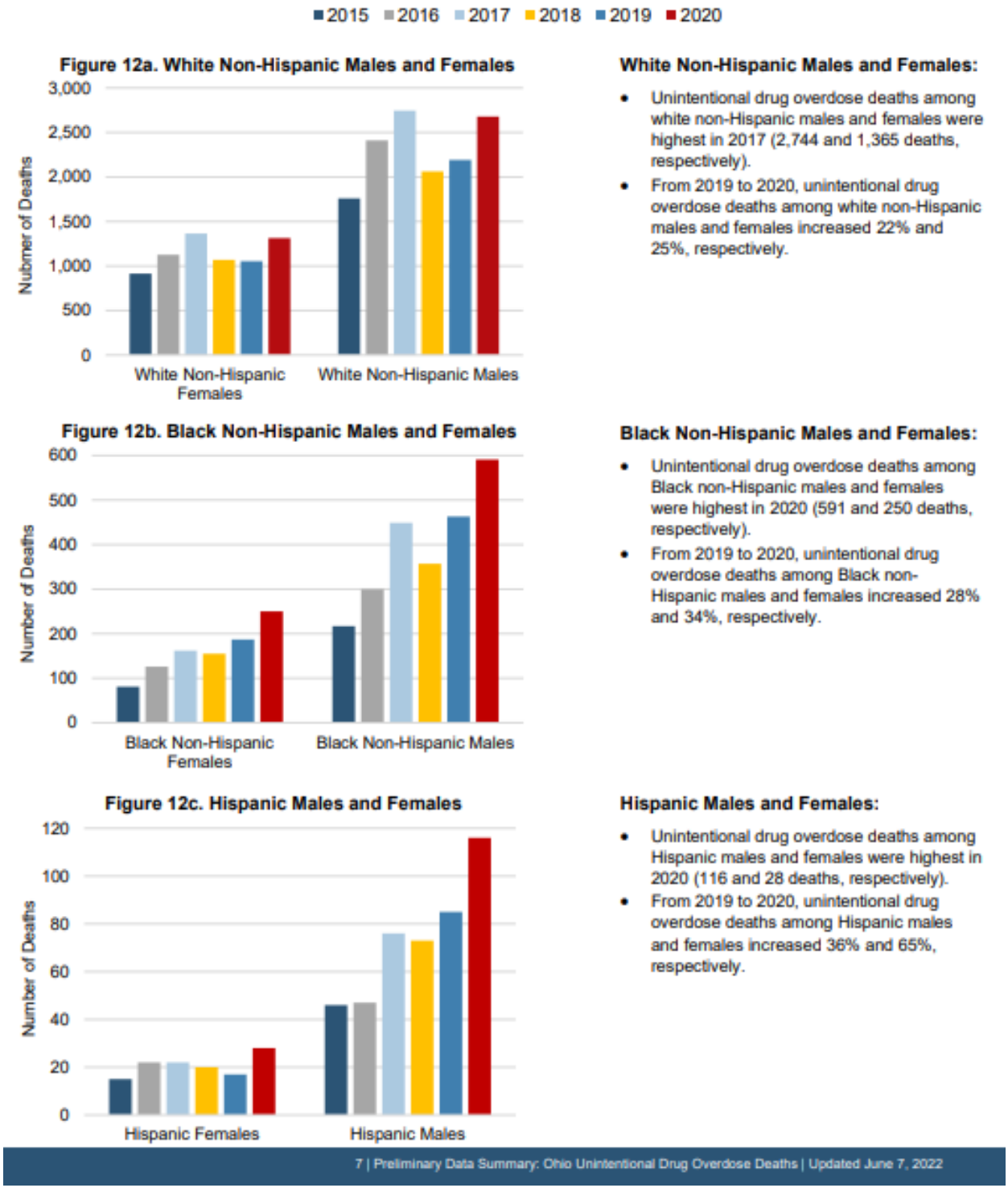
deaths through the end of 2021. In the White population, May 2020 was an anomaly, with overdose rates returning to pre-May rates through the end of 2021. Overall, May 2020 had the highest number of deaths per month ever recorded in Ohio at 574 deaths.

Figure 11. Number of Unintentional Drug Overdose Deaths by Race/Ethnicity, Ohio, 2015-2020



Source: Preliminary Data Summary: Ohio Unintentional Drug Overdose Deaths
https://odh.ohio.gov/wps/wcm/connect/gov/2d25c2cb-7d69-4fb3-9079-4ab6bfa5940e/OHIOMO~2.PDF?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-2d25c2cb-7d69-4fb3-9079-4ab6bfa5940e-o836MxD

Figure 12. Number of Unintentional Drug Overdose Deaths by Sex and Race/Ethnicity, Ohio, 2015-2020



Source: Preliminary Data Summary: Ohio Unintentional Drug Overdose Deaths
https://odh.ohio.gov/wps/wcm/connect/gov/2d25c2cb-7d69-4fb3-9079-4ab6bfa5940e/OHIOMO~2.PDF?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-2d25c2cb-7d69-4fb3-9079-4ab6bfa5940e-o836MxD

Treatment Episode Data Set

Data Source: TEDS | State: Ohio | Year: 2021 | Type: Admissions | View By: View All | Update

Ohio TEDS admissions aged 12 years and older, by primary substance use and gender, age at admission, race, and ethnicity: Percent, 2021

State: OH	All Substances	Alcohol Only	Alcohol with secondary drug	Heroin	Other opiates	Cocaine (smoked)	Cocaine (other route)	Marijuana	Amphetamines	Other stimulants
Total (Number)	19,453	2,253	2,612	4,127	2,045	764	478	3,824	2,810	60
Total	100.0	11.6	13.4	21.2	10.5	3.9	2.5	19.7	14.4	0.3
Gender	**All Substances**	**Alcohol Only**	**Alcohol with secondary drug**	**Heroin**	**Other opiates**	**Cocaine (smoked)**	**Cocaine (other route)**	**Marijuana**	**Amphetamines**	**Other stimulants**
Male	60.9	68.0	67.5	58.4	53.5	52.9	60.7	63.3	57.8	55.0
Female	38.9	31.6	32.4	41.4	46.3	47.1	39.1	36.6	41.7	45.0
Unknown	0.2	0.4	0.2	0.1	0.2	0.0	0.2	0.2	0.5	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Race	All Substances	Alcohol Only	Alcohol with secondary drug	Heroin	Other opiates	Cocaine (smoked)	Cocaine (other route)	Marijuana	Amphetamines	Other stimulants
White	73.2	71.4	62.6	89.9	85.4	47.1	51.0	51.8	92.6	86.7
Black or African-American	21.9	24.7	32.0	5.9	9.9	47.6	38.9	42.3	3.9	6.7
American Indian or Alaska Native	0.3	0.2	0.5	0.1	0.1	0.7	0.8	0.2	0.2	0.0
Asian or Native Hawaiian or Other Pacific Islander	0.2	0.6	0.0	0.3	0.1	0.0	1.3	0.2	0.1	0.0
Other	1.3	1.2	1.8	1.2	1.6	1.0	2.5	1.4	0.4	1.7
Unknown	3.1	2.0	3.1	2.5	2.8	3.5	5.4	4.1	2.7	5.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Ethnicity	**All Substances**	**Alcohol Only**	**Alcohol with secondary drug**	**Heroin**	**Other opiates**	**Cocaine (smoked)**	**Cocaine (other route)**	**Marijuana**	**Amphetamines**	**Other stimulants**
Hispanic or Latino	3.2	3.3	2.9	3.6	3.0	3.4	4.8	3.5	2.0	3.3
Not Hispanic or Latino	90.6	91.3	90.9	92.4	86.3	90.6	86.4	91.6	90.4	93.3
Unknown	6.2	5.4	6.2	4.0	10.8	6.0	8.8	4.9	7.6	3.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Substance Abuse and Mental Health Services Administration (SAMHSA)
https://www.samhsa.gov/data/quick-statistics-results?qs_type=teds&state=Ohio&year=2021&type=Admissions&view=full

United States TEDS Admissions Report

Data from the TEDS admissions report for 2021 show that typically more men seek treatment for substance use disorders than women. The percentages of men seeking treatment exceed women seeking treatment by 30 percentage points or more for alcohol and alcohol with a secondary drug. Almost equal amounts of men as women sought treatment for other opiates and cocaine (smoked). In Glenbeigh's 2019 CHNA, TED data showed just over 52 percent of women sought treatment for sedatives, the only category where more women than men sought treatment. TEDS Data for 2021 does not include a sedative category.

TEDS data also shows a disparity in the drug of choice between Caucasian/White users and African American/Black users. The percentage of White users of alcohol only and alcohol with a secondary drug is at 71.4% and 62.6%, while Black users are at 24.7% and 32.0%, all increases from 2017. Heroin and other opioid use remained disproportionally high among White users. Cocaine (smoked) decreased from 51.4% to 47.6% among Black users but remained the top drug of choice.

Appalachian Region: Eastern Ohio and Western Pennsylvania

In July 2021, The Appalachian Regional Commission (ARC) published the Appalachian Regional Commission Strategic Plan: Synthesis Report. As part of the process, input was gathered from a diverse group of stakeholders to identify strengths, challenges, and opportunities facing the Appalachian Region, along with ideas for strategies and solutions. While the context of the report was to advance economic prosperity, it identified social determinants of health affecting counties falling within the Appalachian Region. These counties include Allegheny, Butler, Erie and Washington, which are part of Glenbeigh's 2022 CHNA defined service community in Pennsylvania, as well as Ashtabula and Trumbull counties in Ohio.

Appalachian Region within United States

Source: Appalachian Regional Commission Strategic Plan: Synthesis Report July 2021
https://www.arc.gov/wp-content/uploads/2022/01/ARC-Stakeholder-Synthesis-Report-Final-July-2021.pdf

Several areas explored in the ARC report are relevant to Glenbeigh's CHNA. The report gave insight on how the Region was affected by, and people reacted to, economic, health and social impacts of the COVID-19 pandemic. Relevant takeaways include:

- Appalachia is a multifaceted, varied Region where place matters. This requires locally tailored solutions to meet the needs of local communities.
- The pandemic both highlighted and exacerbated the depth and breadth of all of the challenges in the Region.
- Access to reliable, affordable broadband is a crosscutting theme as well as an equity issue viewed as essential to improving the lives of Appalachians.
- A singular focus on job creation does not fix or address underlying challenges (generational poverty, lack of internet access, etc.) faced by some areas of Appalachia.

The ARC report compiled data collected from 1,250 survey respondents; 473 individuals who attended 6 community conversations and 158 individuals who participated in 16 focus groups. Respondents were predominantly white (83%), non-Hispanic (77%), over 45 years old (82%) and held a bachelor's degree or higher (82%). Over 50% were female and nearly 50% reported a household income over $75,000 per year.

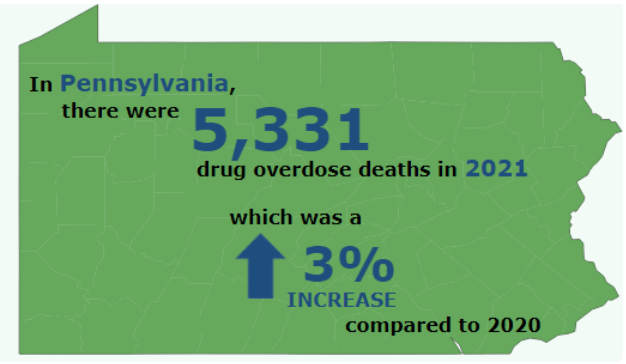
Pertinent issues affecting the Appalachian Region noted in the ARC report include:

- Devastating poverty, lack of affordable housing, lack of easily accessible grocery stores and healthcare.
- Lack of a driver's license, insurance and a reliable car remains a barrier. The Region is car dependent and for many people, the cost is beyond their means.
- Rural communities and small towns lack services resulting in long drives for medical care or to secure basic necessities.
- Long hours, commutes and low wages for workers reduce their ability to be involved in the community. Low wages and lack of quality employment remain a challenge. It is difficult for youth to enter the workforce or obtain work experience.
- Generational poverty was compounded by the pandemic. Substance abuse, child abuse and domestic violence interconnect with poverty.
- Challenges and barriers remain throughout the Region due to limited broadband infrastructure and availability. This limits the ability to utilize telehealth.
- There is a need for high quality and readily available educational opportunities to advance residents' careers and support the workforce.
- Physical and mental health challenges as well as substance abuse prevents many from working. Peer-support specialists are needed as well as workforce reintegration programs and recovery support services.
- Explore the benefits of Employer Resource Networks (ERNs), where companies have an on-site success coach to help employees with support and addressing barriers.
- Substance abuse remains a major challenge throughout Appalachia where declining economic conditions exacerbate mental health and addiction issues. While substance abuse is rampant, treatment is limited. Survey respondents connected substance abuse and mental health treatment and believe they should be treated collectively.
- Limited availability to treatment is one barrier. The cost of treatment, even for individuals with health insurance, is also challenging due to high co-pays and deductibles.
- Treatment, prevention and intervention should work together to provide comprehensive services. This promotes collaboration among service agencies and other systems within the community that serve individuals with substance use disorders.
- There remains continued need for education and training to build a qualified workforce to treat substance abuse and mental health issues.
- Recovery support services are lacking in the Region. There is need for services to support family members raising children as well as individuals in treatment. There is a need for ongoing community education and participation in community-based coalitions and other collaborative partners.

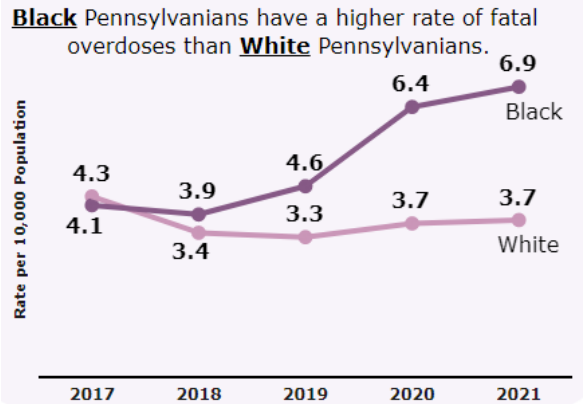
Source: Appalachian Regional Commission Strategic Plan: Synthesis Report July 2021
https://www.arc.gov/wp-content/uploads/2022/01/ARC-Stakeholder-Synthesis-Report-Final-July-2021.pdf

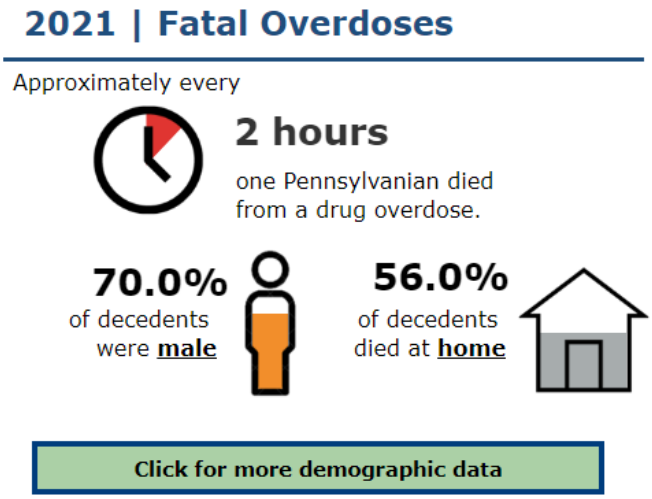
Western Pennsylvania

Glenbeigh's defined service area continues to include areas of western Pennsylvania. Two counties, Erie and Washington, boarder Ohio. Allegheny County includes the city of Pittsburgh and its suburbs. Butler County is north of Allegheny County. Pennsylvania communities continue to be significantly impacted by the use of drugs and alcohol.

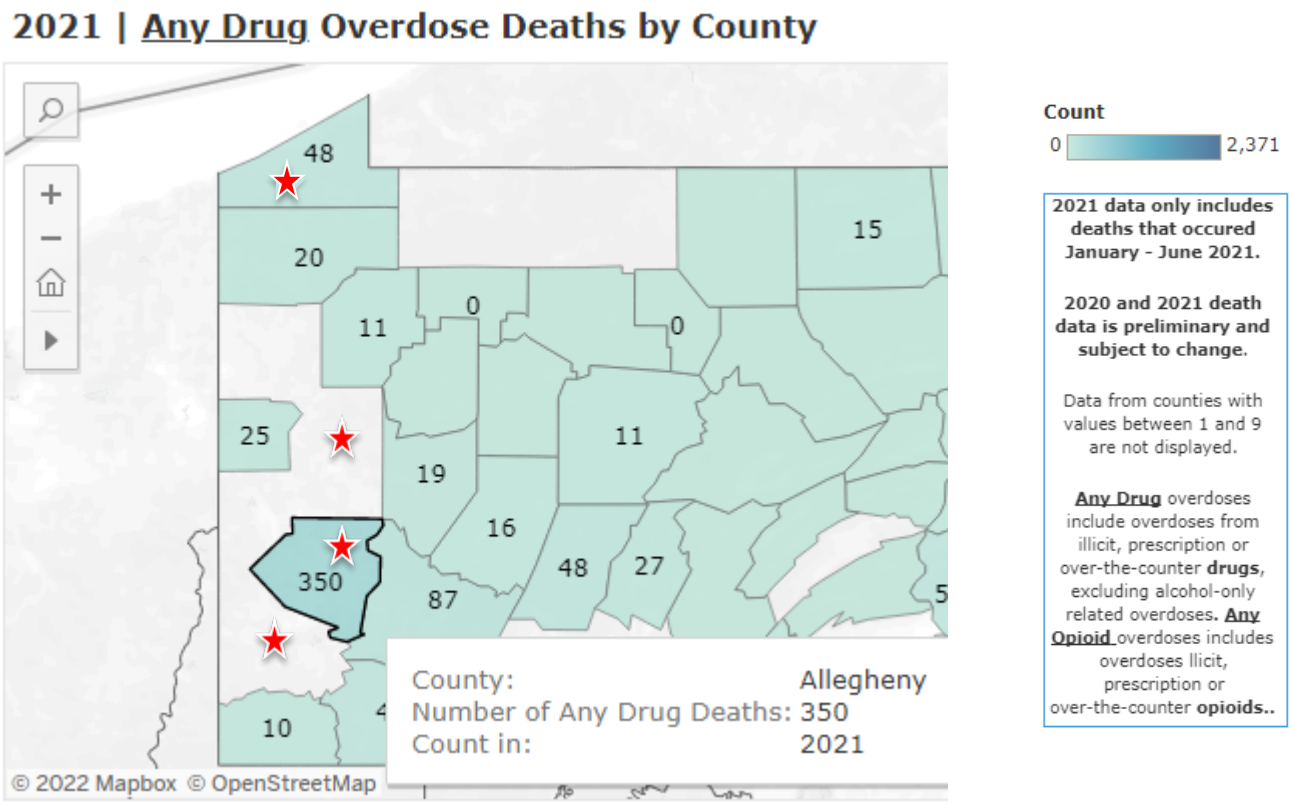


According to data from the Pennsylvania Office of Drug Surveillance and Misuse Prevention (ODSMP), there were 5,331 drug overdose deaths in Pennsylvania during 2021, which was a 3% increase compared to 2020. This equates to approximately one person dying from a drug overdose every two hours. Opioids were involved in 84.5%, while fentanyl was involved in 78.0%, of overdose deaths. In addition, most drug overdose-related emergency room visits occurred among 25 to 34 and 35 to 44 year olds. Consistent with Ohio findings, the number of Black Pennsylvanians experiencing a fatal overdose increased in 2020 and continued to increase since. Fatal overdoses among White Pennsylvanians remained relatively steady between 2017 and 2021.





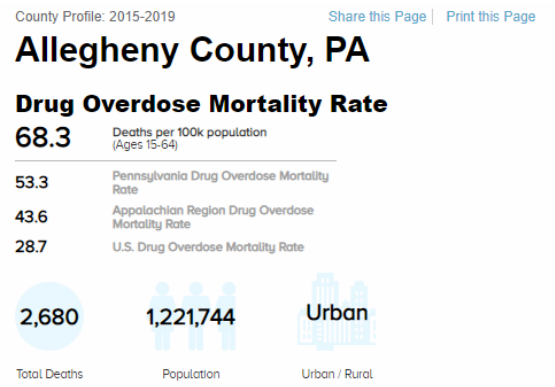
Source: Pennsylvania Office of Drug Surveillance and Misuse Prevention
https://public.tableau.com/app/profile/pennsylvania.pdmp/viz/PennsylvaniaODSMPDrugOverdoseSurveillanceInteractiveDataReport/Contents



Source: Pennsylvania Office of Drug Surveillance and Misuse Prevention
https://public.tableau.com/app/profile/pennsylvania.pdmp/viz/PennsylvaniaODSMPDrugOverdoseSurveillanceInteractiveDataReport/Contents

	2019	2020	2021*
Allegheny County Drug Overdose Deaths:	517	683	350
Butler County Drug Overdose Deaths:	N/A	N/A	N/A
Erie County Drug Overdose Deaths:	69	81	48
Washington County Drug Overdose Deaths:	N/A	N/A	N/A
Total PA Drug Overdose Deaths:	4,076	4,559	5,331

N/A indicates counties that did not participate by reporting data or data was unavailable.
* 2021 statistics only include data from January to June 2021 and do not reflect an entire year.



County Profile: 2015-2019 Share this Page | Print this Page

Allegheny County, PA

Drug Overdose Mortality Rate

68.3 Deaths per 100k population (Ages 15-64)

53.3 Pennsylvania Drug Overdose Mortality Rate

43.6 Appalachian Region Drug Overdose Mortality Rate

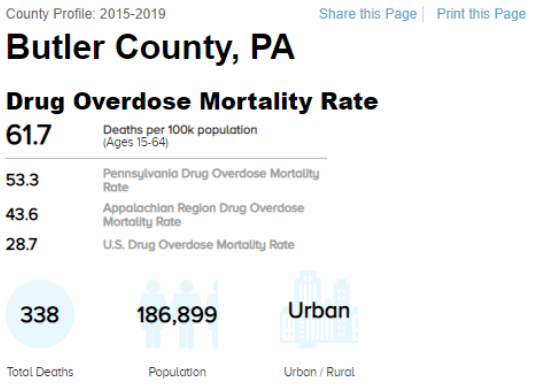
28.7 U.S. Drug Overdose Mortality Rate

2,680 Total Deaths | 1,221,744 Population | Urban Urban / Rural

Choose County Profile Data Time Period

- 2010-2014
- 2015-2019
- Change from 2010-2014 to 2015-2019

SOCIO DEMOGRAPHIC	Allegheny County	Pennsylvania	Appalachian Region	United States
Race /Ethnicity				
White (non-Hispanic)	78.5%	76.4%	81.3%	60.7%
African American (non-Hispanic)	12.7%	10.7%	9.6%	12.3%
Hispanic or Latino	2.1%	7.3%	5.1%	18.0%
Other (non-Hispanic)	6.7%	5.6%	4.0%	9.0%
Age				
Under 15	15.6%	17.1%	17.5%	18.7%
15-64	65.9%	65.0%	64.6%	65.6%
65+	18.5%	17.8%	18.0%	15.6%
Educational Attainment				
At least High School Diploma (25+)	94.6%	90.5%	87.2%	88.0%
Bachelor's Degree or more (25+)	41.6%	31.4%	24.7%	32.1%
Disability Status				
% Residents with a disability (18-64)	10.3%	11.3%	13.8%	10.3%
ECONOMIC				
Median Household Income	$61,043	$61,744	$46,074	$62,843
Poverty Rate	11.6%	12.4%	15.2%	13.4%
Unemployment Rate	4.8%	5.3%	5.4%	5.3%
Accident-prone Employment				
Construction	4.3%	4.3%	4.1%	4.8%
Mining	0.3%	0.9%	1.1%	1.3%
Manufacturing	5.2%	9.8%	13.1%	8.7%
Trade, Transportation, & Utilities	15.9%	19.2%	19.7%	18.9%



County Profile: 2015-2019 Share this Page | Print this Page

Butler County, PA

Drug Overdose Mortality Rate

61.7 Deaths per 100k population (Ages 15-64)

53.3 Pennsylvania Drug Overdose Mortality Rate

43.6 Appalachian Region Drug Overdose Mortality Rate

28.7 U.S. Drug Overdose Mortality Rate

338 Total Deaths | 186,899 Population | Urban Urban / Rural

Choose County Profile Data Time Period

- 2010-2014
- 2015-2019
- Change from 2010-2014 to 2015-2019

SOCIO DEMOGRAPHIC	Butler County	Pennsylvania	Appalachian Region	United States
Race /Ethnicity				
White (non-Hispanic)	94.7%	76.4%	81.3%	60.7%
African American (non-Hispanic)	0.9%	10.7%	9.6%	12.3%
Hispanic or Latino	1.5%	7.3%	5.1%	18.0%
Other (non-Hispanic)	2.9%	5.6%	4.0%	9.0%
Age				
Under 15	16.4%	17.1%	17.5%	18.7%
15-64	65.4%	65.0%	64.6%	65.6%
65+	18.2%	17.8%	18.0%	15.6%
Educational Attainment				
At least High School Diploma (25+)	94.9%	90.5%	87.2%	88.0%
Bachelor's Degree or more (25+)	36.0%	31.4%	24.7%	32.1%
Disability Status				
% Residents with a disability (18-64)	9.5%	11.3%	13.8%	10.3%
ECONOMIC				
Median Household Income	$70,668	$61,744	$46,074	$62,843
Poverty Rate	8.2%	12.4%	15.2%	13.4%
Unemployment Rate	3.9%	5.3%	5.4%	5.3%
Accident-prone Employment				
Construction	5.0%	4.3%	4.1%	4.8%
Mining	1.1%	0.9%	1.1%	1.3%
Manufacturing	14.0%	9.8%	13.1%	8.7%
Trade, Transportation, & Utilities	21.2%	19.2%	19.7%	18.9%

Source: Appalachian Regional Commission and NORC at the University of Chicago
https://overdosemappingtool.norc.org/

County Profile: 2015-2019 Share this Page | Print this Page

Erie County, PA

Drug Overdose Mortality Rate

46.3 Deaths per 100k population (Ages 15-64)

53.3 Pennsylvania Drug Overdose Mortality Rate

43.6 Appalachian Region Drug Overdose Mortality Rate

28.7 U.S. Drug Overdose Mortality Rate

386	273,835	Urban
Total Deaths	Population	Urban / Rural

Choose County Profile Data Time Period

- ○ 2010-2014
- ◉ 2015-2019
- ○ Change from 2010-2014 to 2015-2019

SOCIO DEMOGRAPHIC	Erie County	Pennsylvania	Appalachian Region	United States
Race /Ethnicity				
White (non-Hispanic)	84.2%	76.4%	81.3%	60.7%
African American (non-Hispanic)	6.8%	10.7%	9.6%	12.3%
Hispanic or Latino	4.2%	7.3%	5.1%	18.0%
Other (non-Hispanic)	4.7%	5.6%	4.0%	9.0%
Age				
Under 15	17.7%	17.1%	17.5%	18.7%
15-64	65.0%	65.0%	64.6%	65.6%
65+	17.4%	17.8%	18.0%	15.6%
Educational Attainment				
At least High School Diploma (25+)	91.3%	90.5%	87.2%	88.0%
Bachelor's Degree or more (25+)	27.9%	31.4%	24.7%	32.1%
Disability Status				
% Residents with a disability (18-64)	12.5%	11.3%	13.8%	10.3%
ECONOMIC				
Median Household Income	$51,529	$61,744	$46,074	$62,843
Poverty Rate	16.0%	12.4%	15.2%	13.4%
Unemployment Rate	5.4%	5.3%	5.4%	5.3%
Accident-prone Employment				
Construction	3.2%	4.3%	4.1%	4.8%
Mining	0.4%	0.9%	1.1%	1.3%
Manufacturing	16.5%	9.8%	13.1%	8.7%
Trade, Transportation, & Utilities	17.1%	19.2%	19.7%	18.9%

County Profile: 2015-2019 Share this Page | Print this Page

Washington County, PA

Drug Overdose Mortality Rate

74.7 Deaths per 100k population (Ages 15-64)

53.3 Pennsylvania Drug Overdose Mortality Rate

43.6 Appalachian Region Drug Overdose Mortality Rate

28.7 U.S. Drug Overdose Mortality Rate

442	207,212	Urban
Total Deaths	Population	Urban / Rural

Choose County Profile Data Time Period

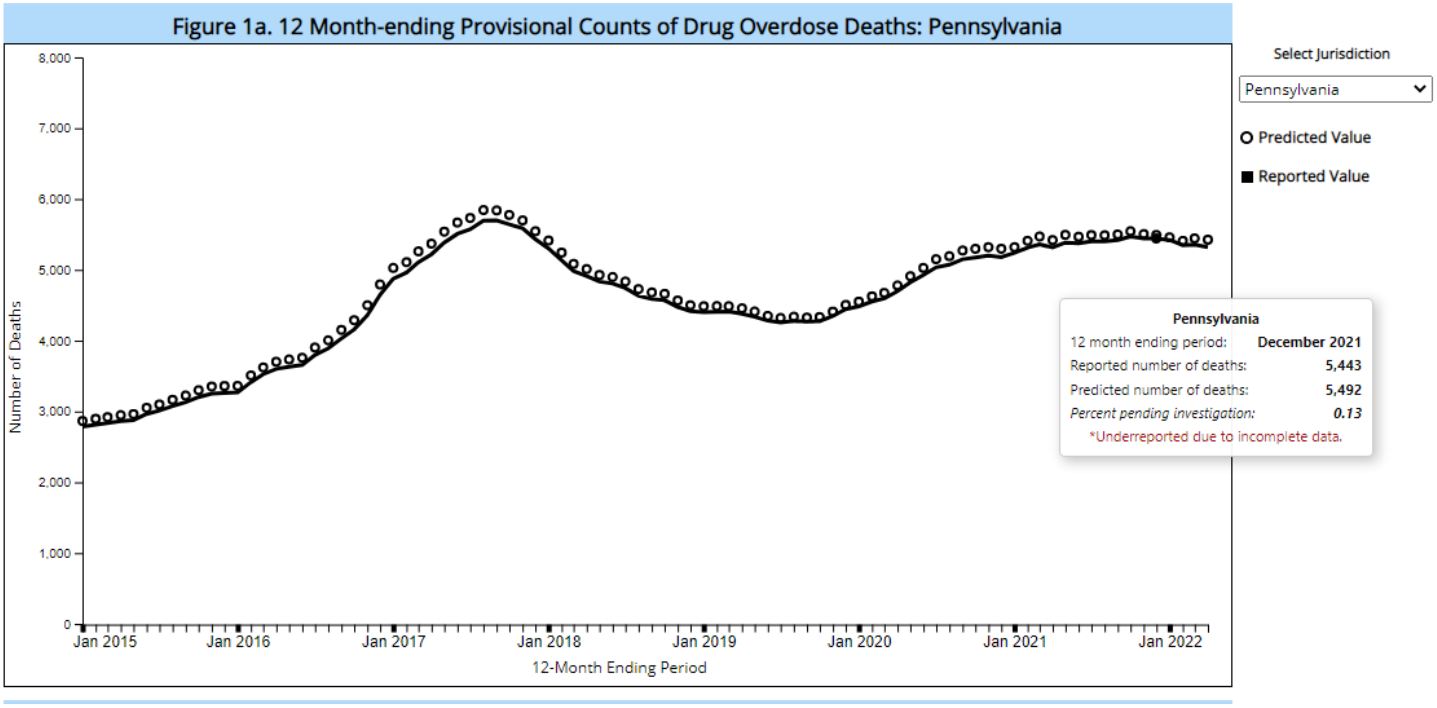
- ○ 2010-2014
- ◉ 2015-2019
- ○ Change from 2010-2014 to 2015-2019

SOCIO DEMOGRAPHIC	Washington County	Pennsylvania	Appalachian Region	United States
Race /Ethnicity				
White (non-Hispanic)	92.2%	76.4%	81.3%	60.7%
African American (non-Hispanic)	3.0%	10.7%	9.6%	12.3%
Hispanic or Latino	1.7%	7.3%	5.1%	18.0%
Other (non-Hispanic)	3.1%	5.6%	4.0%	9.0%
Age				
Under 15	16.1%	17.1%	17.5%	18.7%
15-64	63.8%	65.0%	64.6%	65.6%
65+	20.1%	17.8%	18.0%	15.6%
Educational Attainment				
At least High School Diploma (25+)	93.1%	90.5%	87.2%	88.0%
Bachelor's Degree or more (25+)	30.0%	31.4%	24.7%	32.1%
Disability Status				
% Residents with a disability (18-64)	11.9%	11.3%	13.8%	10.3%
ECONOMIC				
Median Household Income	$63,543	$61,744	$46,074	$62,843
Poverty Rate	9.2%	12.4%	15.2%	13.4%
Unemployment Rate	5.0%	5.3%	5.4%	5.3%
Accident-prone Employment				
Construction	8.0%	4.3%	4.1%	4.8%
Mining	4.9%	0.9%	1.1%	1.3%
Manufacturing	10.1%	9.8%	13.1%	8.7%
Trade, Transportation, & Utilities	18.7%	19.2%	19.7%	18.9%

Source: Appalachian Regional Commission and NORC at the University of Chicago
https://overdosemappingtool.norc.org/

12 Month-ending Provisional Number and Percent Change of Drug Overdose Deaths

Based on data available for analysis on: September 04, 2022



Source: National Center for Health Statistics
https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

Treatment Episode Data Set

Data Source: TEDS State: Pennsylvania Year: 2021 Type: Admissions View By: View All Update

Pennsylvania TEDS admissions aged 12 years and older, by primary substance use and gender, age at admission, race, and ethnicity: Percent, 2021

State: PA	All Substances	Alcohol Only	Alcohol with secondary drug	Heroin	Other opiates	Cocaine (smoked)	Cocaine (other route)	Marijuana	Amphetamines	Other stimulants
Total (Number)	18,371	3,837	2,344	4,731	1,460	638	393	2,289	2,230	43
Total	100.0	20.9	12.8	25.8	7.9	3.5	2.1	12.5	12.1	0.2
Gender	**All Substances**	**Alcohol Only**	**Alcohol with secondary drug**	**Heroin**	**Other opiates**	**Cocaine (smoked)**	**Cocaine (other route)**	**Marijuana**	**Amphetamines**	**Other stimulants**
Male	73.5	75.9	79.3	70.2	71.5	69.1	76.8	76.7	69.9	74.4
Female	26.5	24.1	20.7	29.8	28.4	30.9	23.2	23.3	30.1	25.6
Unknown	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Race	**All Substances**	**Alcohol Only**	**Alcohol with secondary drug**	**Heroin**	**Other opiates**	**Cocaine (smoked)**	**Cocaine (other route)**	**Marijuana**	**Amphetamines**	**Other stimulants**
White	75.4	78.9	69.0	79.0	75.8	45.8	57.0	63.7	93.1	76.7
Black or African-American	13.6	9.1	20.1	9.5	14.3	43.6	25.4	21.7	2.4	11.6
American Indian or Alaska Native	0.2	0.2	0.0	0.1	0.1	0.6	0.3	0.3	0.3	0.0
Asian or Native Hawaiian or Other Pacific Islander	0.5	0.8	0.3	0.5	0.5	0.3	0.0	0.5	0.3	0.0
Other	6.2	7.2	7.3	6.4	5.1	6.1	10.9	7.8	1.5	11.6
Unknown	4.2	3.8	3.3	4.6	4.3	3.6	6.4	6.0	2.5	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Ethnicity	**All Substances**	**Alcohol Only**	**Alcohol with secondary drug**	**Heroin**	**Other opiates**	**Cocaine (smoked)**	**Cocaine (other route)**	**Marijuana**	**Amphetamines**	**Other stimulants**
Hispanic or Latino	10.3	10.7	10.3	11.4	9.7	9.9	17.8	13.9	2.8	4.7
Not Hispanic or Latino	84.7	84.3	84.3	84.1	84.4	87.0	75.3	79.7	93.7	81.4
Unknown	5.0	5.0	5.4	4.4	6.0	3.1	6.9	6.4	3.5	14.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Substance Abuse and Mental Health Services Administration (SAMHSA)
https://www.samhsa.gov/data/quick-statistics-results?qs_type=teds&state=Pennsylvania&year=2021&type=Admissions&view=full

TEDS data for Pennsylvania show that White males outpace every other demographic in both alcohol and other substance use. Cocaine (smoked) is the only drug of choice where a second demographic, Black males (43.6), have numbers close to White males (45.8).

Population Change Comparison

Population fluctuations can transform communities. Population decline often goes hand-in-hand with reduced employment opportunities, limited pay or career growth opportunities, increased taxation and a loss of healthcare as well as other services. Significant population growth can overtax systems. It can cause a lack of beds in healthcare settings or reduced access to assistance at social service or other agencies. Six of the eleven counties in Glenbeigh's service area experienced a population decline from 2010 to 2020, despite state and national population growth. Ashtabula and Trumbull counties in Ohio as well as Erie County in Pennsylvania were the most heavily impacted by population decline. Butler County, Pennsylvania experienced the highest level of growth at 5.4% over the ten-year period between 2010 and 2020.

Population Change

	2010 Population	2020 Population	% Population Change 2010-2020
United States	**308,745,538**	**331,893,745**	**7.5%**
Ohio	**11,536,504**	**11,799,448**	**2.3%**
Ashtabula County	101,497	97,574	**-3.9%**
Cuyahoga County	1,280,122	1,264,817	**-1.2%**
Erie County	77,079	75,622	**-1.9%**
Lake County	230,041	232,603	**1.1%**
Lorain County	301,356	312,964	**3.9%**
Summit County	541,781	540,428	**-0.3%**
Trumbull County	210,312	201,997	**-3.9%**
Pennsylvania	**12,702,379**	**13,002,700**	**2.4%**
Allegheny County	1,223,348	1,250,578	**2.2%**
Butler County	183,862	193,763	**5.4%**
Erie County	280,566	270,876	**-3.5%**
Washington County	207,820	209,349	**0.7%**

Source: U.S. Census Bureau, Population, percent change – April 1, 2010 to July 1, 2018, (V2018)
https://www.census.gov/quickfacts/fact/table/US/PST045218

The population change table above shows Glenbeigh's CHNA defined service communities. Red indicates communities with a population decrease. In Ohio, five out of seven counties, roughly 71.4% had a decrease in population. In Pennsylvania, 25%, or one out of 4 counties had a reduced population. The remaining three counties, 75%, experienced a population increase.

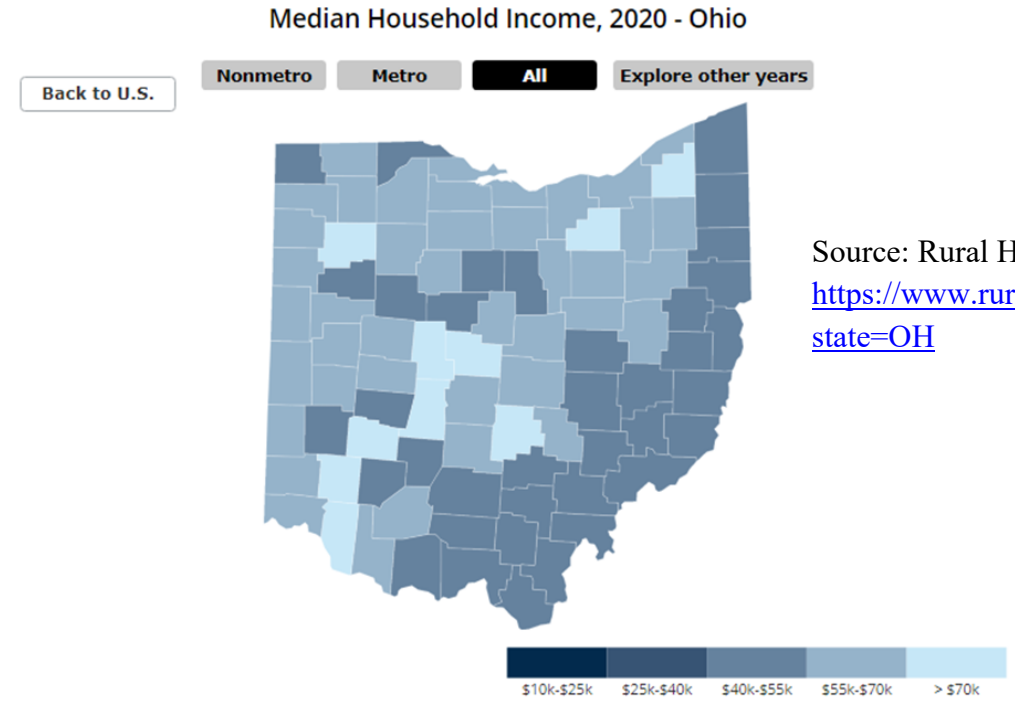
Economic Indicators

Drug and alcohol use rates tend to be higher in areas with higher levels of persons living in poverty, higher unemployment rates, and lower median household income. With the exception of Lake (Ohio) and Washington (Pennsylvania) counties, the number of people living in poverty were at or above national percentages. While unemployment rates were generally at or below the national rate in the 2019 CHNA, 2021/22 rates in nine service counties remained in the 5.5% to 6.4%, now well above the United States. Additionally, the median household income in all of Glenbeigh's service communities is below the national rate.

Economic Indicators

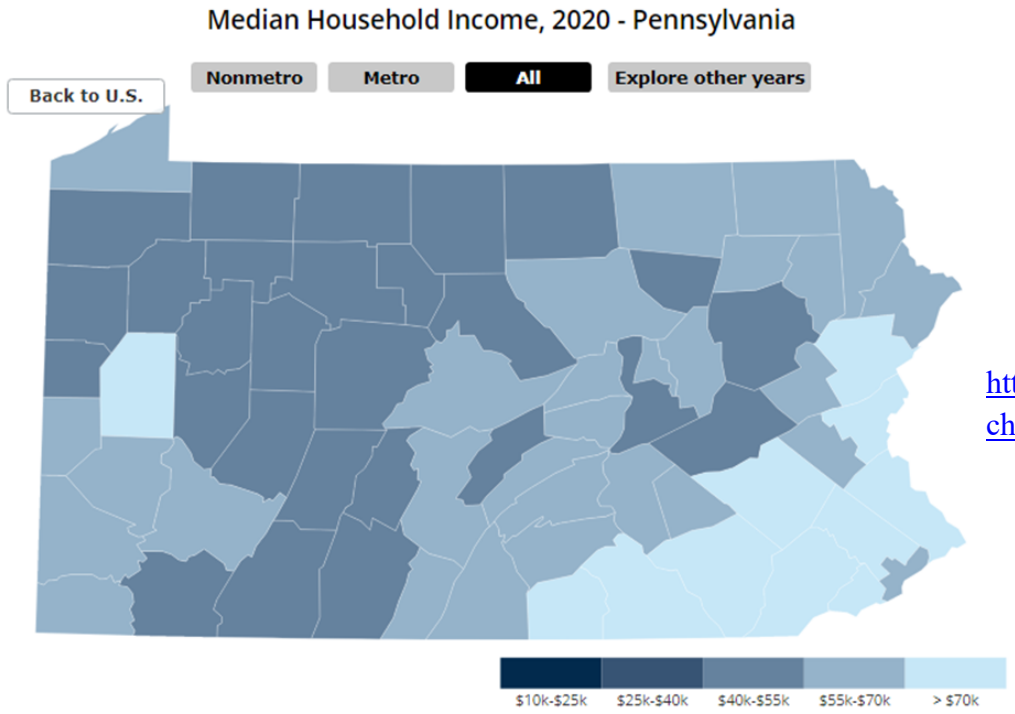
	Median Household Income 2020 *	Percent Living in Poverty 2022 *	Unemployment Rate Aug 2021-July 2022 +
United States	**$64,994**	**11.6%**	**4.0%**
Ohio	**$58,116**	**13.4%**	**4.5%**
Ashtabula County	$47,925	16.5%	6.0%
Cuyahoga County	$51,741	15.3%	5.4%
Erie County	$58,408	10.9%	N/A
Lake County	$65,814	7.9%	4.8%
Lorain County	$58,789	11.9%	5.9%
Summit County	$59,253	12.1%	5.0%
Trumbull County	$47,799	15.8%	6.7%
Pennsylvania	**$63,627**	**12.1%**	**5.5%**
Allegheny County	$62,320	10.5%	5.2%
Butler County	$72,642	7.4%	4.0%
Erie County	$52,863	13.4%	6.6%
Washington County	$65,478	8.6%	6.2%

Source: U.S. Census Bureau * and Bureau of Labor Statistics +



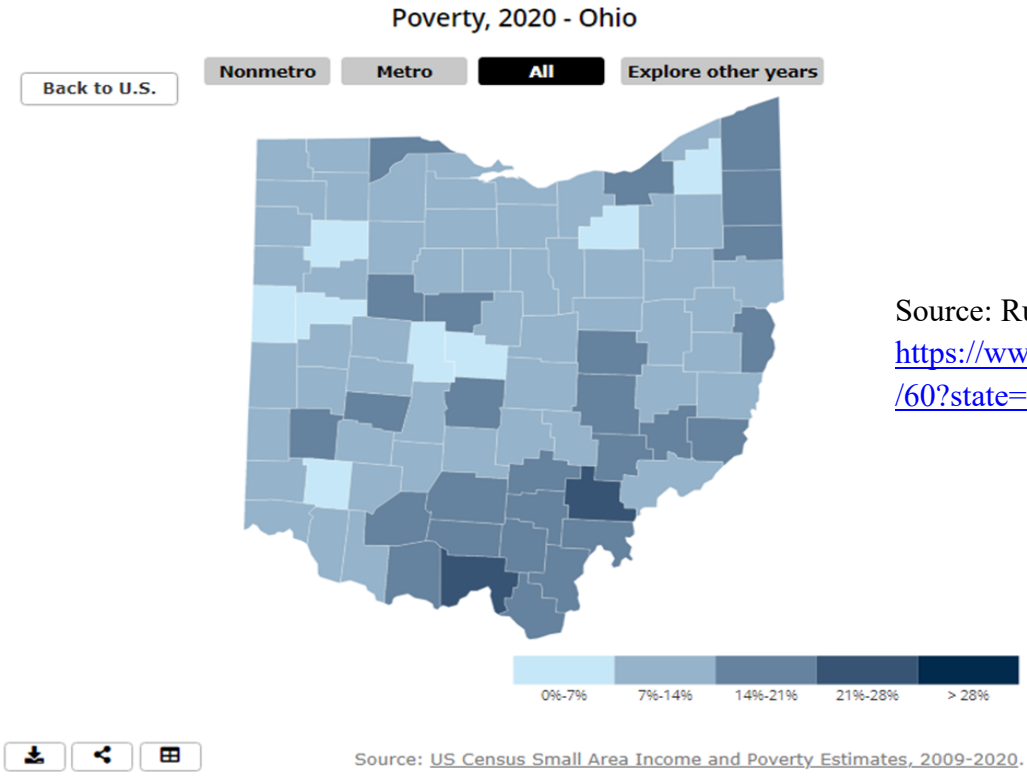
Source: Rural Health Information Hub
https://www.ruralhealthinfo.org/charts/58?state=OH

Note: Metro and nonmetro averages are calculated by weighting county median household income by ACS 5-year estimates of total households.
Source: US Census Small Area Income and Poverty Estimates, 2009-2020.

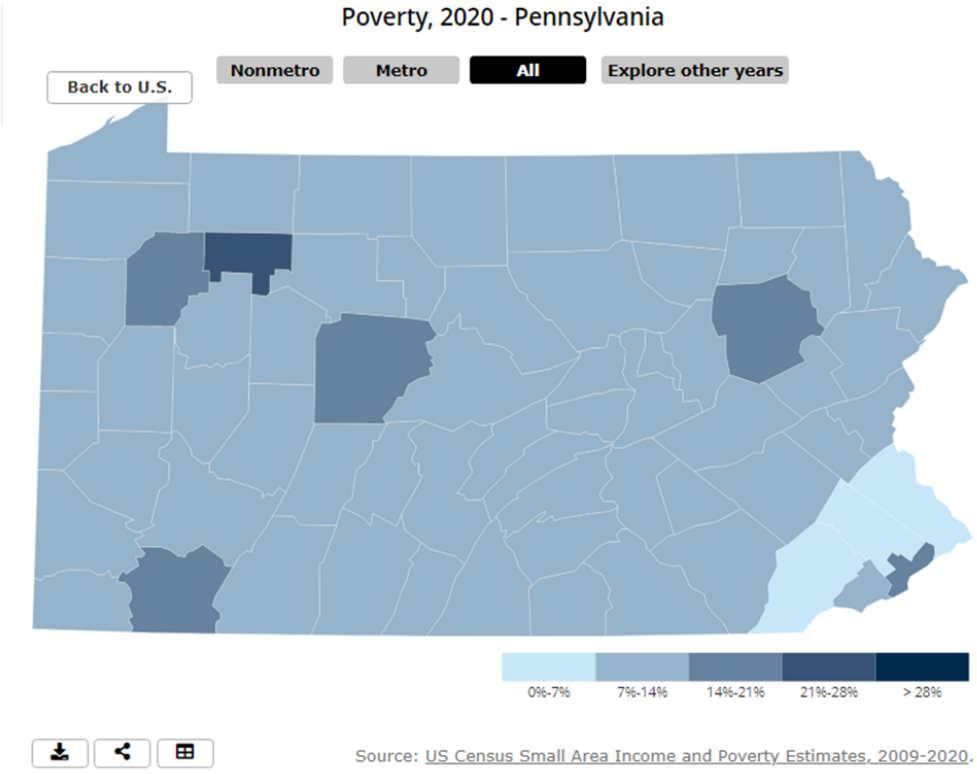


https://www.ruralhealthinfo.org/charts/58?state=PA

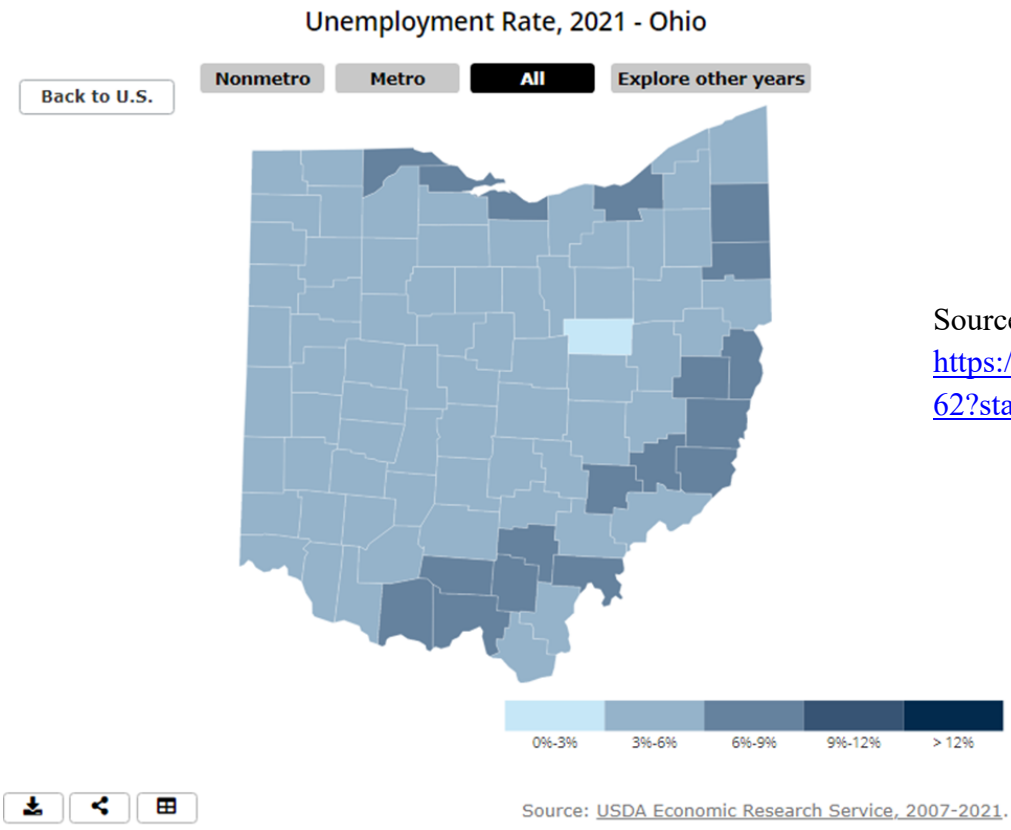
Note: Metro and nonmetro averages are calculated by weighting county median household income by ACS 5-year estimates of total households.
Source: US Census Small Area Income and Poverty Estimates, 2009-2020.



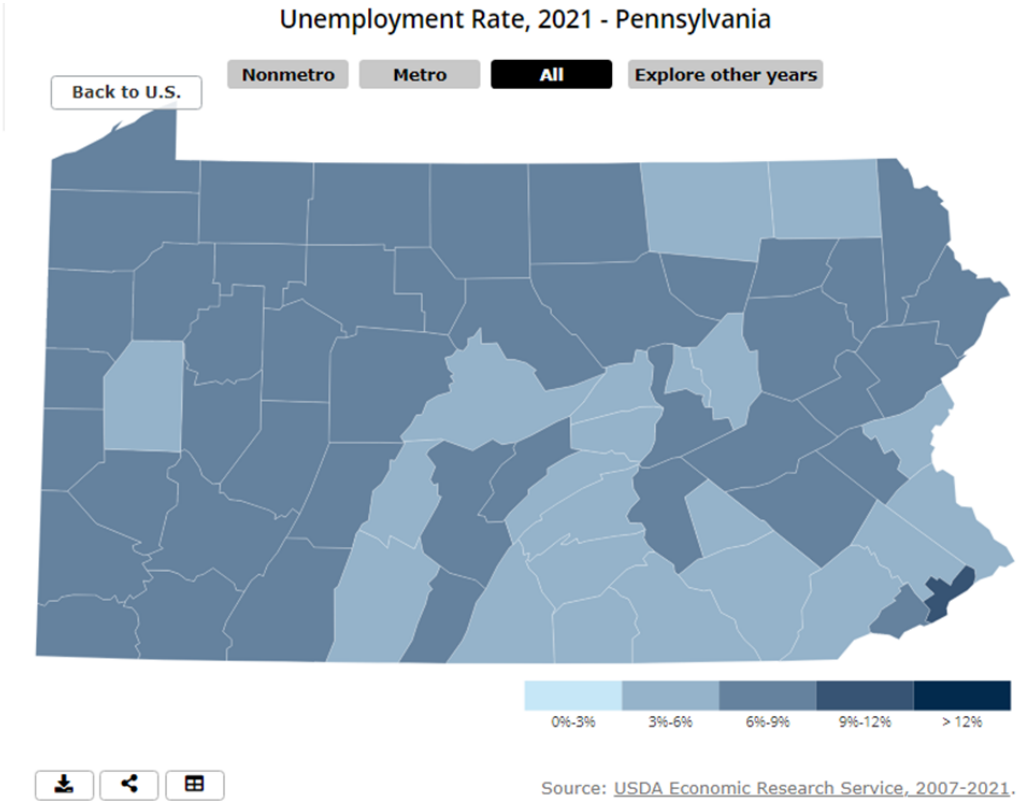
Source: Rural Health Information Hub
https://www.ruralhealthinfo.org/charts/60?state=OH



https://www.ruralhealthinfo.org/charts/60?state=PA



Source: Rural Health Information Hub
https://www.ruralhealthinfo.org/charts/62?state=OH



https://www.ruralhealthinfo.org/charts/62?state=PA

The Centers for Disease Control and Prevention attributes specific economic costs to excessive alcohol use. These include: an overall national cost of $249 billion, which equates to roughly $2.05 per drink or $807 per person; losses in workplace productivity accounted for 72% of the total cost, health care expenses at 11% and other costs were due to a combination of criminal justice expenses, motor vehicle crash costs and property damage. Excessive alcohol consumption cost Ohio $8.5 billion in 2010, the latest published data available from the CDC.

Source: CDC, Alcohol and Public Health – Excessive Drinking 2010, uploaded 9/15/2022.
https://www.cdc.gov/alcohol/features/excessive-drinking.html

The Ashtabula County 2022 Community Health Assessment explored health disparities between populations or areas in the community and reported the following economic findings related to alcohol and drug use as well as mental health issues:

- Those with an annual household income of $75,000 or more were more likely than those with a household income of less than $75,000 to have binge drank at least once in the past month: 62.2% v. 29.3%
- Those with an annual household income of less than $75,000 are more likely to report a depressive disorder diagnosis than those with an annual household income of $75,000 or more: 23.7% v. 11.7%.
- Days of poor mental health in the past 30 days, on average, differed by annual household income: 5.1 for those with less than $50,000, 2.5 for those with $50,000 to less than $100,000 and 5.5 for those with $100,000 or more.
- The likelihood of receiving mental health care differed by annual household income: 5.4% of those with less than $50,000, 22.9% of those with $50,000 to less than $100,000 and 12.2% of those with $100,000 or more.
- Percent who had at least one poor mental health day differed by education: 27.4% for those with a high school degree or less education, 59.0% for those with some college education and 36.4% for those with a Bachelor's degree or more education.

Source: Ashtabula County 2022 Community Health Needs Assessment, Released, July 2022
https://www.healthyneo.org/content/sites/cuyahoga/Resources/2022_Ashtabula_CHNA_Report.pdf

Access to Healthcare

Access to Healthcare by County

	% Without Health Insurance (2019)	Mental Health Providers* (2021)
United States	**N/A**	**250:1**
Ohio	**9%**	**350:1**
Ashtabula	11.0%	510:1
Cuyahoga	8.0%	230:1
Erie	9.0%	370:1
Lake	8.0%	400:1
Lorain	9.0%	520:1
Summit	9.0%	310:1
Trumbull	10.0%	540:1
Pennsylvania	**8.0%**	**420:1**
Allegheny	6.0%	260:1
Butler	5.0%	550:1
Erie	8.0%	440:1
Washington	7.0%	800:1

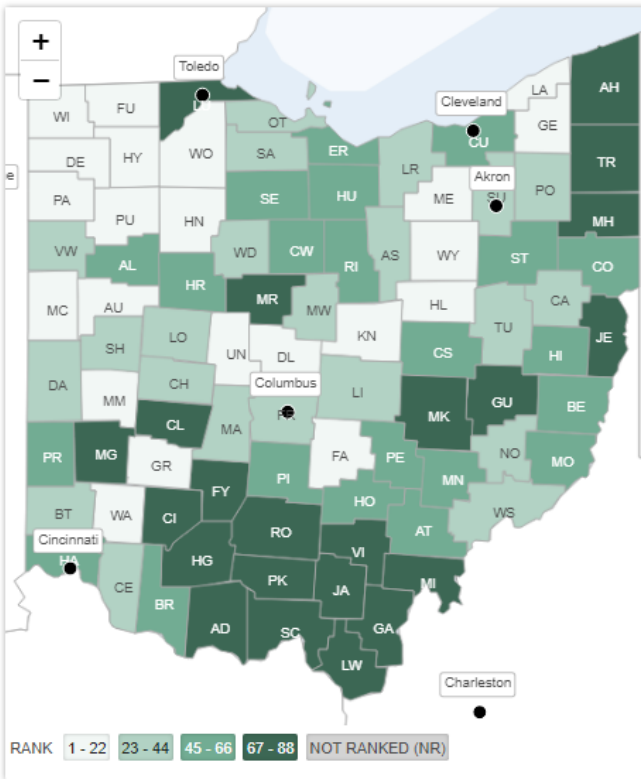
Comparing data from Glenbeigh's 2019 CHNA, the percentage of adults without health insurance increased by an average of 2% for adults living in the defined service community. Erie (Ohio) and Butler (Pennsylvania) counties were excluded as they were not part of the 2019 CHNA defined service community. Ashtabula and Trumbull counties have higher percentages of uninsured adults than the state average.

While inequities continue to exist for access to mental health providers, which is evidenced by the ratio of providers to the general population in each county, the number of mental health providers has increased since the 2019 CHNA, lowering the ratio.

Measure Methods: Uninsured Adults is the percentage of the population ages 18 to 64 that have no health insurance coverage in a given county. Uninsured Adults was created using complex statistical modeling. Modeling generates more stable estimates for places with small numbers of residents or survey responses. There are also drawbacks to using modeled data. The smaller the population or sample size of a county, the more the estimates are derived from the model itself and the less they are based on survey responses. Models make statistical assumptions about relationships that may not hold in all cases. Finally, there is no perfect model and each model generally has limitations specific to their methods.

Source: County Health Rankings. * Ratio shows population: mental health providers.
https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/clinical-care/access-to-care/mental-health-providers

Overall Rankings in Health Outcomes

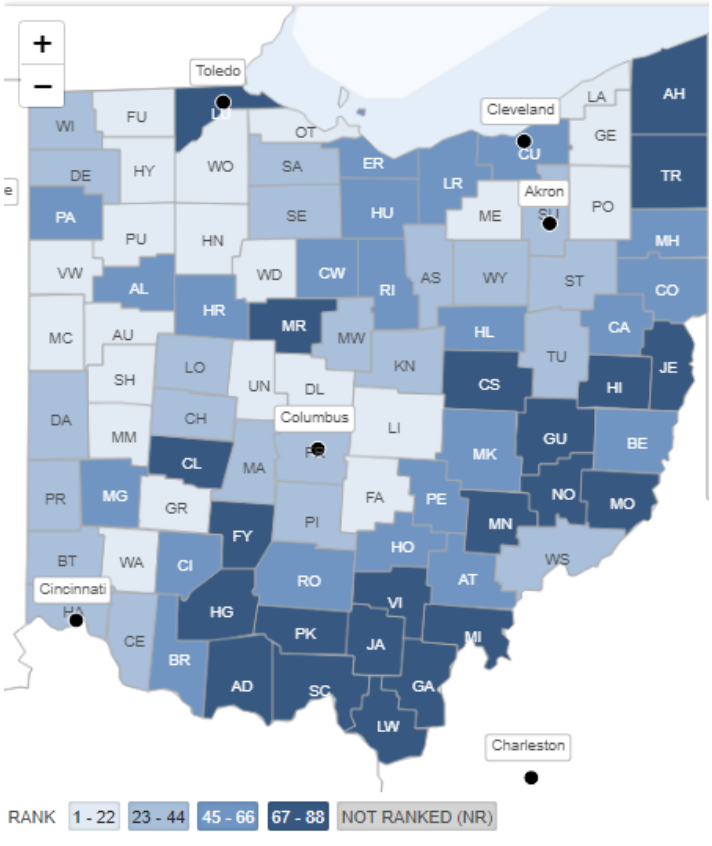


The overall rankings in health outcomes represent how healthy counties are within the state. The healthiest county in the state is ranked #1. Ranks are based on two types of measures: how long people live and how healthy people feel while alive.

Ashtabula, ranked #71, and Trumbull, ranked #72, are at the low end of the positive health outcomes rating. Cuyahoga ranked #65, Erie #49, Summit #43, Lorain #35 and Lake #12. The majority of Glenbeigh's seven Ohio service areas fall within the top two categories indicating low life longevity and people not feeling healthy while alive.

Note: Ohio has a total of 88 counties.

Overall Rankings in Health Factors

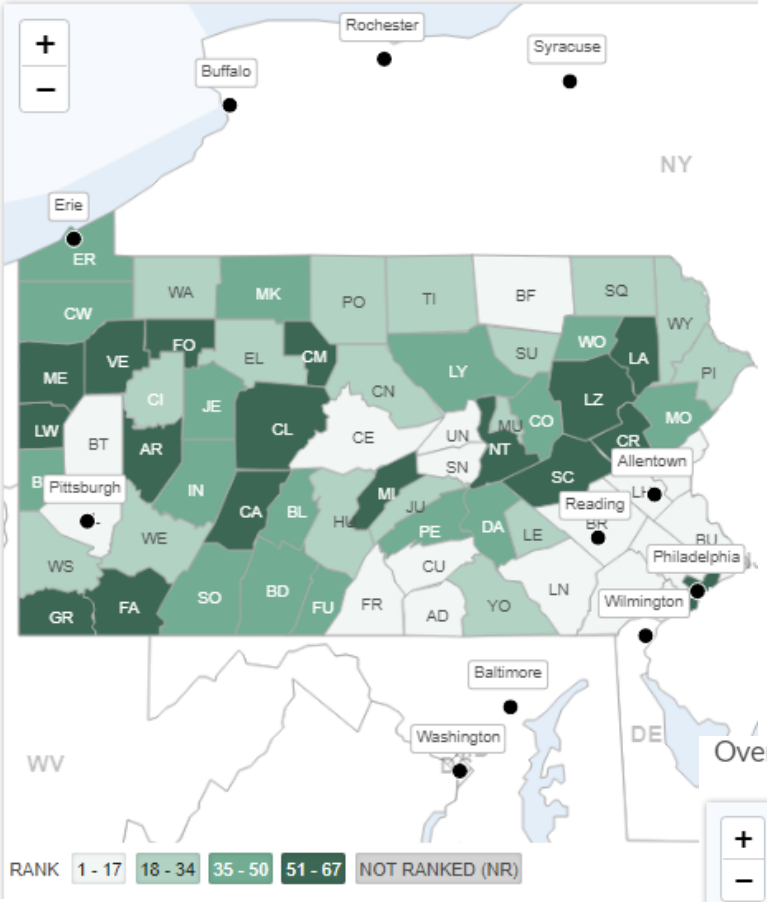


The overall rankings in health factors represent what influences the health of a county. They are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors.

In regards to health factors, Ashtabula ranked #84, Trumbull #80, Cuyahoga #61, Lorain #50, Erie #48, Summit #25 and Lake #15.

Source: County Health Rankings: 2022
https://www.countyhealthrankings.org/app/ohio/2022/overview

Overall Rankings in Health Outcomes

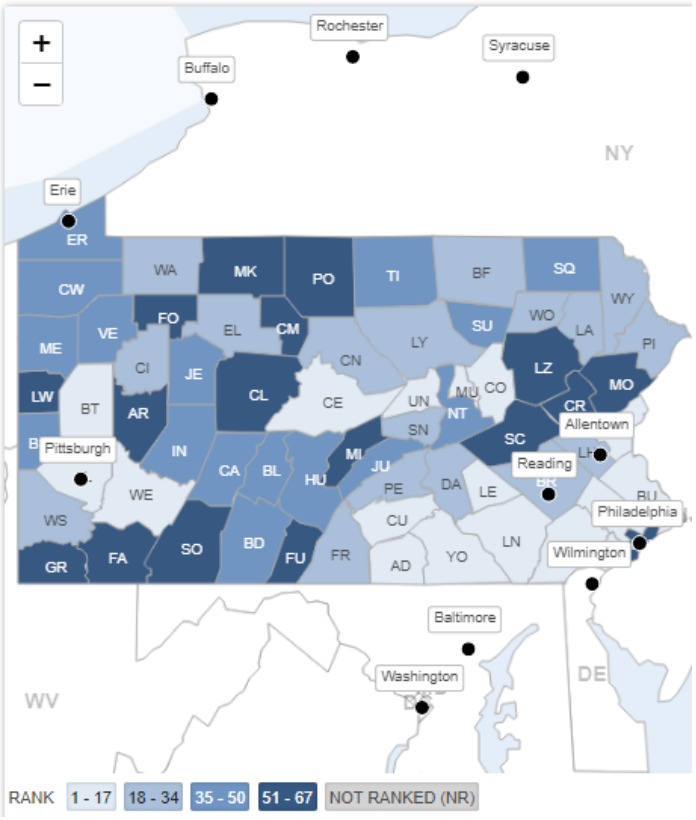


The overall rankings in health outcomes represent how healthy counties are within the state. The healthiest county in the state is ranked #1. The ranks are based on two types of measures: how long people live and how healthy people feel while alive.

Erie ranked #42, Washington #32, Allegheny #16 and Butler #6 in health outcomes ratings.

Note: Pennsylvania has a total of 67 counties.

Overall Rankings in Health Factors



The overall rankings in health factors represent what influences the health of a county. They are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors.

Erie ranked #41, Washington #19, Allegheny #5 and Butler #5 in overall health factors. Both Allegheny and Butler rank among the top counties with excellent health factors.

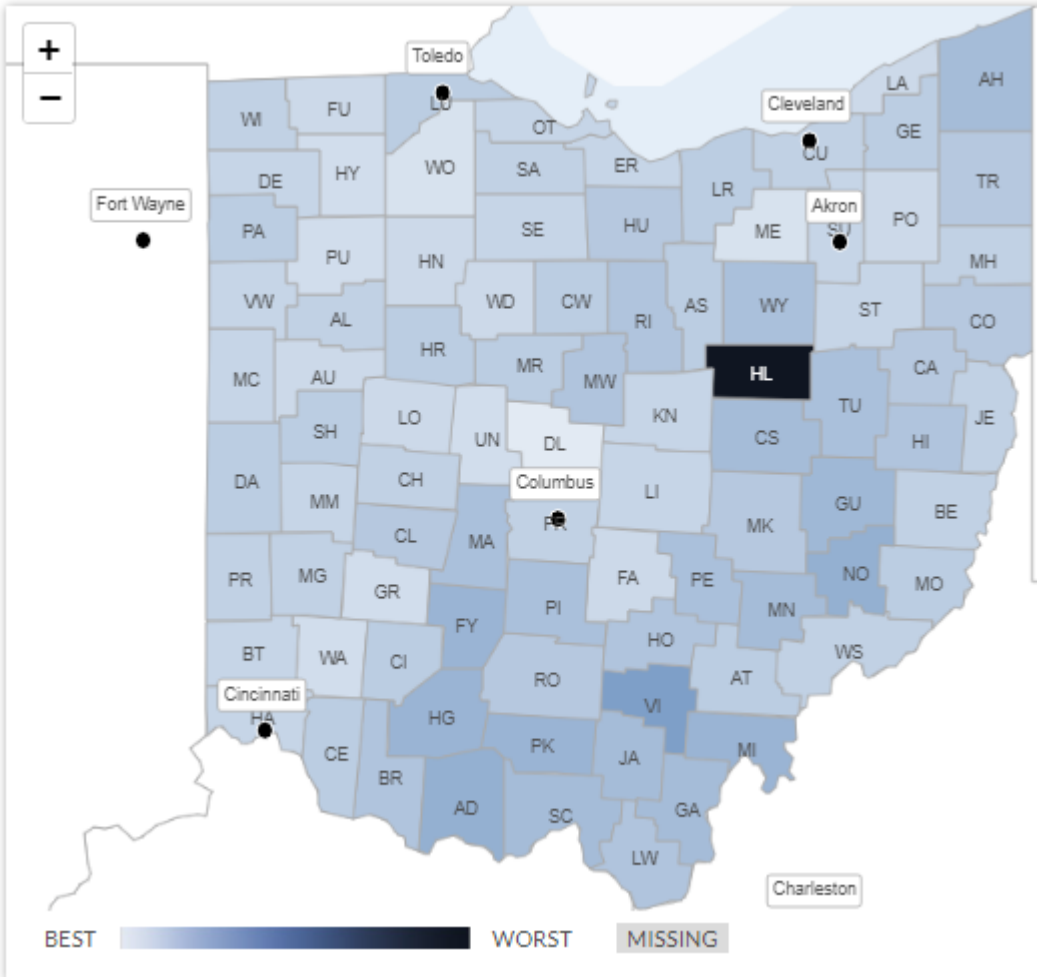
Source: County Health Rankings: 2022
https://www.countyhealthrankings.org/app/pennsylvania/2022/overview

Education

High School Completion Rates for Ohio Service Areas

Percentage of adults ages 25 and over with a high school diploma or equivalent.
The 2022 County Health Rankings used data from 2016-2020 for this measure.

Each county within Glenbeigh's Ohio defined service area performs as well as or better than the national average with students obtaining a high school diploma. The National Average for high school graduation is at 86%. In Ohio, the graduation range is from 56% to 97% with and overall graduation rate of 91%. Ashtabula County has the lowest high school graduation rate of 86% and only a 48% rate of residents having some college education within Glenbeigh's service area.



Percent of Population that have graduated from high school by county.

Ashtabula	86%
Cuyahoga	91%
Erie	92%
Lake	93%
Lorain	90%
Summit	92%
Trumbull	89%
Ohio	91%

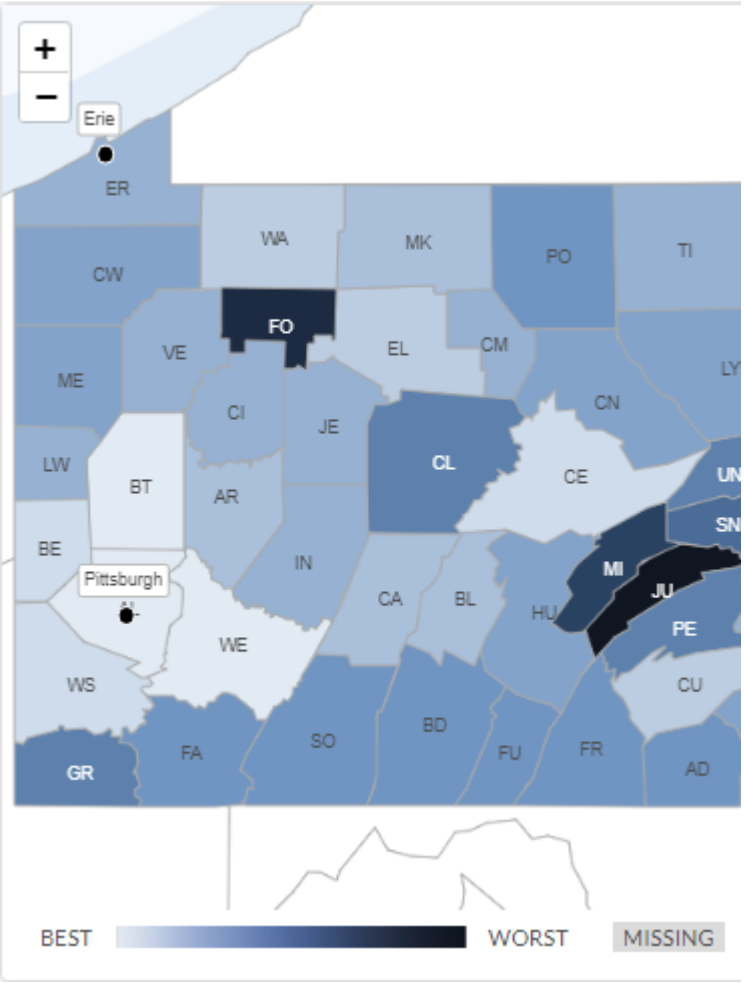
Percent with some college.

Ashtabula	48%
Cuyahoga	70%
Erie	65%
Lake	70%
Lorain	66%
Summit	69%
Trumbull	53%
Ohio	66%

Source: County Health Rankings
https://www.countyhealthrankings.org/app/ohio/2022/measure/factors/168/map

High School Completion Rates for Pennsylvania Service Areas
Percentage of adults ages 25 and over with a high school diploma or equivalent.
The 2022 County Health Rankings used data from 2016-2020 for this measure.

In Pennsylvania, both Allegheny and Butler Counties have overall high school graduation rates exceeding the state rate of 91%. All four Pennsylvania counties that fall within Glenbeigh's defined service area have high school graduation rates equal to or exceeding the state rate as well as the national rate of 86%. The rate of people with some college (adults, age 25-44) for Pennsylvania is 67% with a range of 28% to 81%.



Percent of Population that have graduated from high school by county.

Allegheny	95%
Butler	95%
Erie	91%
Washington	94%
Pennsylvania	91%

Percent with some college.

Allegheny	81%
Butler	76%
Erie	63%
Washington	71%
Pennsylvania	67%

Educational Attainment for Metro and Nonmetro Counties, 2020 - Ohio

Chart view | Table view

	Metropolitan	Nonmetropolitan
Less than HS	8.7%	11.4%
HS diploma	30.4%	42.4%
Some college	20.6%	19.1%
Associate's degree	8.6%	9.3%
College degree	19.6%	11.2%
Graduate degree	12.0%	6.6%

Source: U.S. Census ACS, 2010, 2015, and 2020 5-year estimates.

Source: Rural Health Information Hub
https://www.ruralhealthinfo.org/charts/64?state=OH

Educational Attainment for Metro and Nonmetro Counties, 2020 - Pennsylvania

Chart view | Table view

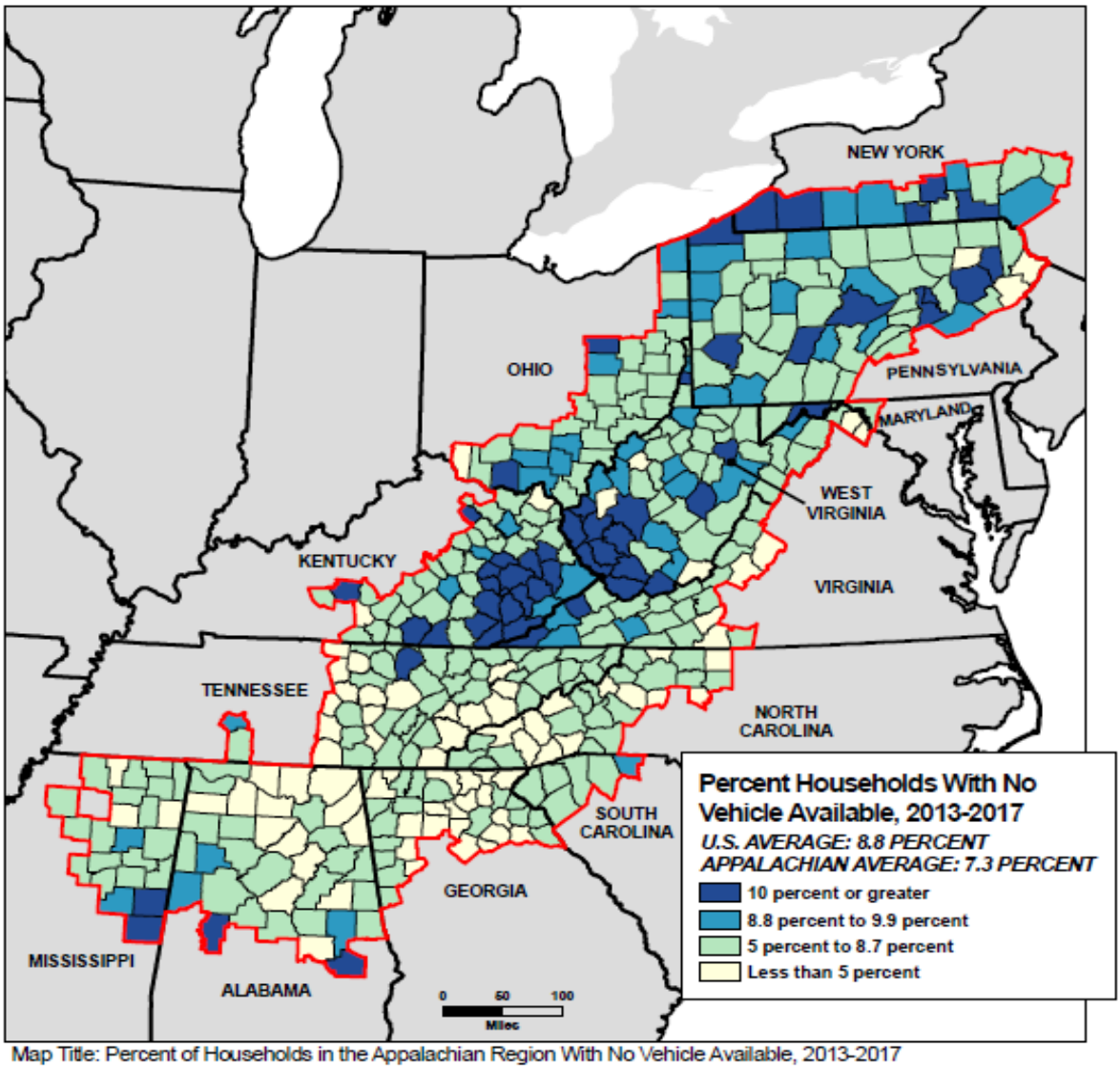
	Metropolitan	Nonmetropolitan
Less than HS	8.8%	10.5%
HS diploma	32.5%	46.6%
Some college	16.0%	14.8%
Associate's degree	8.6%	9.2%
College degree	20.5%	12.1%
Graduate degree	13.6%	6.8%

Source: U.S. Census ACS, 2010, 2015, and 2020 5-year estimates.

Source: Rural Health Information Hub
https://www.ruralhealthinfo.org/charts/64?state=PA

Transportation

Figure 7.3: Percent of Households in the Appalachian Region With No Vehicle Available, 2013-2017



Map Title: Percent of Households in the Appalachian Region With No Vehicle Available, 2013-2017
Data Source: U.S. Census Bureau, 2013-2017 American Community Survey.

The Appalachian Region: A Data Overview from the 2013-2017 American Community Survey reported, "Having a reliable mode of transportation is an important part of many household members' ability to gain and keep employment. Yet in Appalachia, just over 7 percent of households have no vehicle available to get to current and/or potential employment. While this is lower than the national average of almost 9 percent that is not the case in much of the Region. In fact, there were 54 Appalachian counties where at least one in 10 households had no vehicle available; 44 of these counties were in four states—New York, Pennsylvania, West Virginia, and Kentucky."

Source: https://www.arc.gov/report/the-appalachian-region-a-data-overview-from-the-2013-2017-american-community-survey/

The Ashtabula County 2022 Community Health Needs Assessment examined the demographic and household characteristics of the population in Ashtabula County. The county covers 703 square miles and is predominately rural. Glenbeigh's inpatient treatment center is located near the center of the county in Rock Creek, Ohio. Transportation remains a significant barrier to accessing services, healthcare and necessities such as groceries and sundries. According to the Ashtabula County 2022 CHNA, the number of households in the county without a vehicle is 9.0%. For the entire state of Ohio, the average is 7.7%.

According to the American Public Transportation Association, 45% of Americans have no access to public transportation. Within Glenbeigh's defined service community, public transportation is available in urban areas. Rural populations rely on private transportation.

During the COVID-19 pandemic, supply chain issues caused the prices of private transportation, new and used cars and trucks, to spike well above the means of people, those living at or below the poverty level up through the middle class. As pandemic restrictions eased, the price of gasoline spiked in 2022, once again affecting vulnerable populations.

Trends in Alcohol and Drug Use

The following table reveals health behaviors associated with problematic alcohol use. Excessive drinking is defined as: a woman averaging more than one alcoholic beverage per day or more than three alcoholic beverages on a single occasion or a male averaging more than two beverages per day or four in a single occasion in the last 30 days. This is reported as the percentage of the population who engage in this behavior. Alcohol impairment significantly contributes to driving deaths in both Ohio and Pennsylvania.

Alcohol Use

County	Excessive Drinking (Percentage of Adults) 2019	Alcohol-Impaired Driving Deaths (Percentage of total driving deaths 2016-2020)
Ohio	21%	33%
Ashtabula	18%	33%
Cuyahoga	18%	41%
Erie	19%	28%
Lake	19%	58% *
Lorain	19%	41%
Summit	18%	40%
Trumbull	17%	33%
Pennsylvania	20%	25%
Allegheny	23%	23%
Butler	22%	29%
Erie	19%	28%
Washington	21%	28%

Source: County Health Rankings
https://www.countyhealthrankings.org/app/ohio/2022/measure/factors/134/map
https://www.countyhealthrankings.org/app/pennsylvania/2022/measure/factors/134/map

* See more data on Lake County statistics on page 48.

Alcohol use within Glenbeigh's service area varies. In Ohio, Erie County had less alcohol-impaired driving deaths than the state average, while Ashtabula and Trumbull were at the state rate. The four remaining counties tracked well above the state rate. In Pennsylvania, only Allegheny was below the state percentage while the remaining counties were above. Overall, Pennsylvania counties have a lower percentage of total driving deaths involving alcohol than Ohio, yet higher percentages of reported excessive drinking.

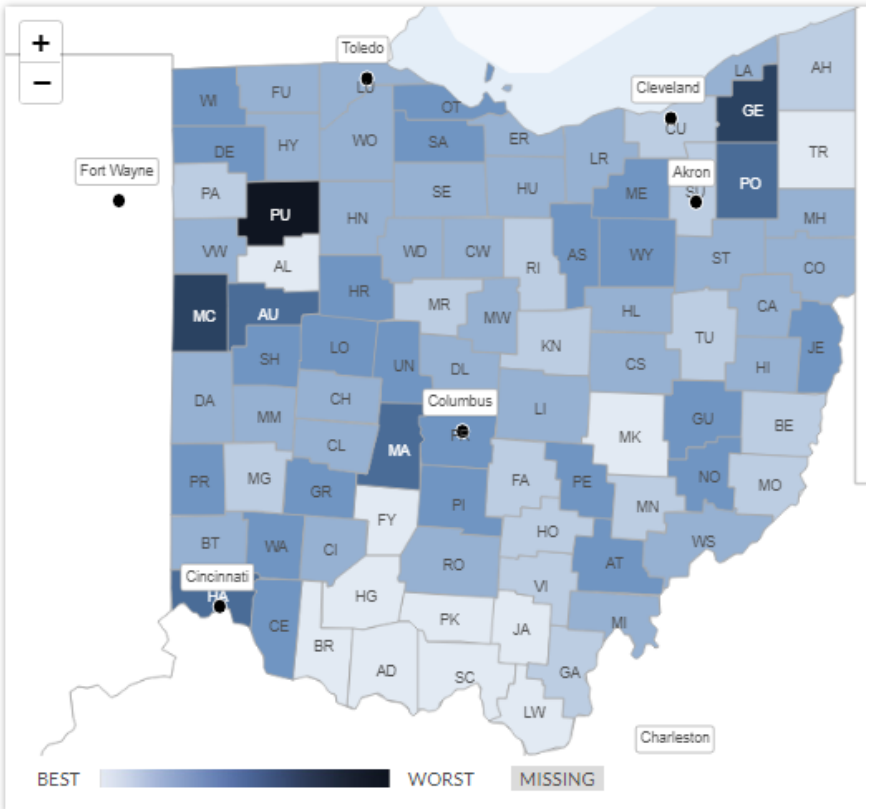
Source: National Institute of Health at https://www.rethinkingdrinking.niaaa.nih.gov/

Excessive Drinking

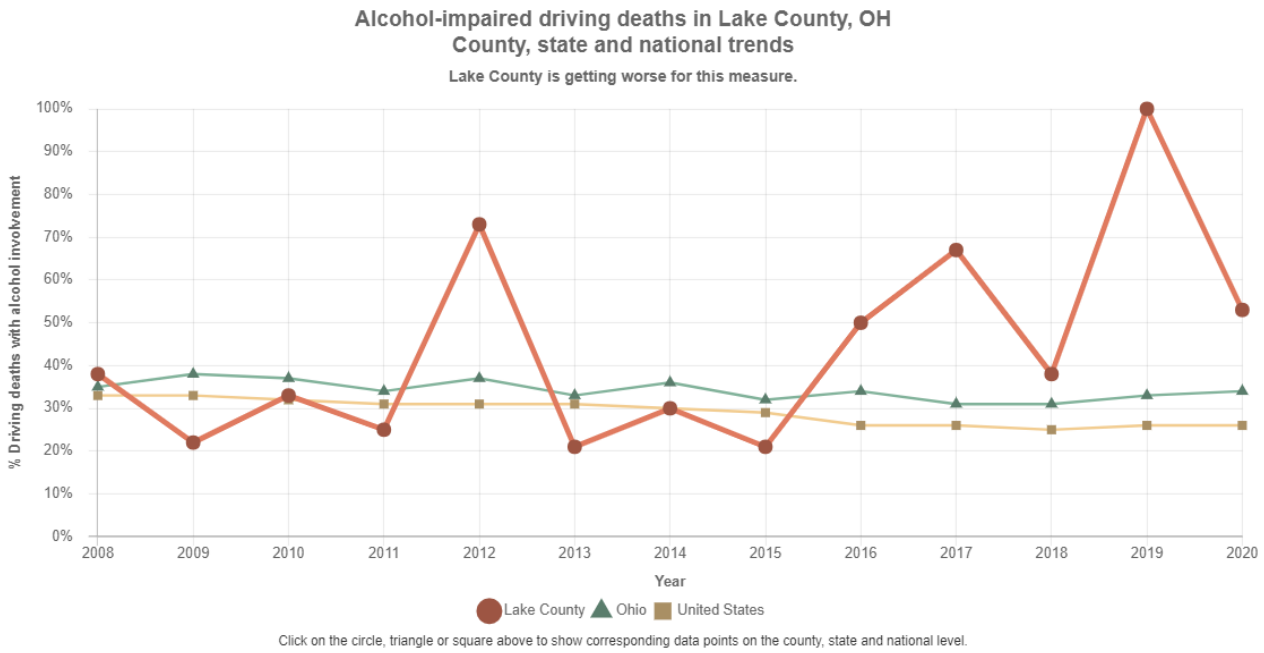
Percentage of adults reporting binge or heavy drinking (age-adjusted).

The 2022 County Health Rankings used data from 2019 for this measure.

Map | Data | Description | Data Source | Strategies



Source: County Health Rankings: 2022
https://www.countyhealthrankings.org/app/ohio/2022/measure/factors/49/map



Source: https://www.countyhealthrankings.org/app/ohio/2022/measure/factors/134/data

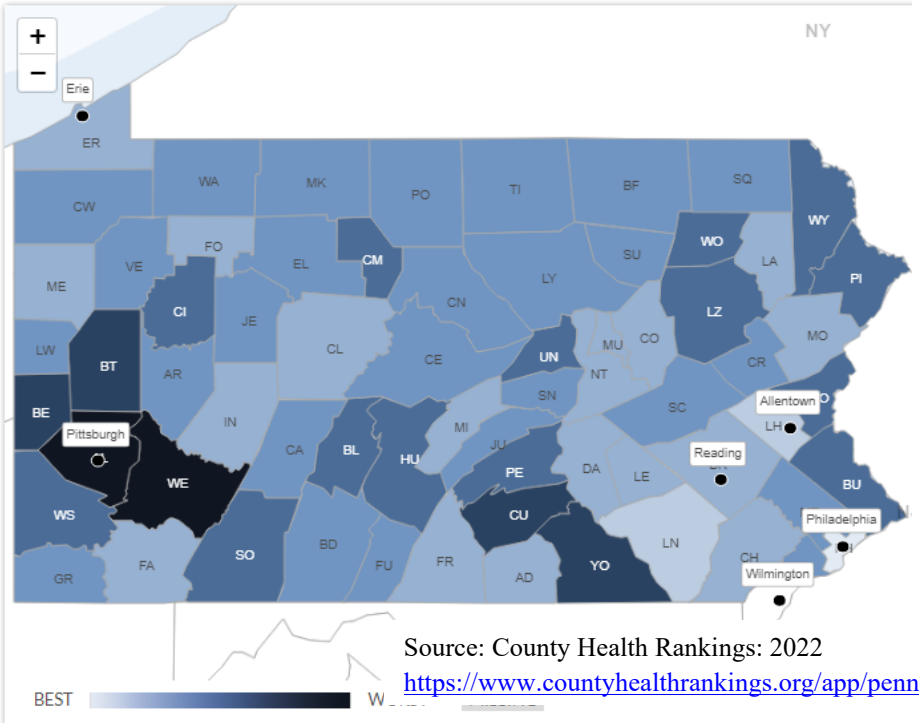
---

Excessive Drinking

Percentage of adults reporting binge or heavy drinking (age-adjusted).

The 2022 County Health Rankings used data from 2019 for this measure.

Map | Data | Description | Data Source | Strategies



Source: County Health Rankings: 2022
https://www.countyhealthrankings.org/app/pennsylvania/2022/measure/factors/49/map

Ohio State Highway Patrol Driving Data

Traffic Enforcement

Traffic Enforcement	2017	2018	2019	2020	2021	Total	Average
Total Contacts	1,471,748	1,448,239	1,362,583	1,074,802	1,133,476	6,490,848	1,298,169.6
Enforcement	634,841	618,349	556,697	364,681	440,639	2,615,207	523,041.4
Non-Enforcement	836,907	829,890	805,886	710,121	692,837	3,875,641	775,128.2
OVI Arrests	27,375	26,615	22,524	16,531	18,597	111,642	22,328.4
Speed Violations	380,548	366,192	345,833	236,355	291,039	1,619,967	323,993.4
Safety Belt Violations	139,315	137,044	104,149	57,003	73,150	510,661	102,132.2
Driver License Violations	39,982	39,167	32,549	25,880	28,136	165,714	33,142.8
Traffic Warnings	467,009	459,038	404,890	261,336	295,920	1,888,193	377,638.6
Motorist Assists	216,149	218,756	208,374	175,855	161,620	980,754	196,150.8

Crime Enforcement

Crime Enforcement	2017	2018	2019	2020	2021	Total	Average
Cases	12,745	21,890	21,589	20,194	21,995	98,413	19,682.6
Drug Arrests	16,669	16,974	13,569	12,008	12,527	71,747	14,349.4
Illegal Weapon Violations	971	1,094	941	1,229	1,581	5,816	1,163.2
Resisting Arrests	1,106	1,174	980	1,147	1,299	5,706	1,141.2

*Source: OSHP Computer-Aided Dispatch (CAD) System, Ohio Trooper Information System (OTIS), and DPS Electronic Crash Record System. Updated on 04/27/22.

Source: Ohio State Highway Patrol
https://statepatrol.ohio.gov/dashboards-statistics/statistics/activity-summaries-and-complaints

It is important to note that COVID-19 had a significant impact on criminal activity, drunk driving and law enforcement. Due to mandated travel restrictions, only essential workers were reporting to work while non-essential workers worked from home or were displaced. It should also be noted that during this same time period, alcohol sales increased significantly.

Traffic Stop Data

This data is compiled from all traffic stops in which a citation, inspection, warning, or vehicle defect notice was issued by Ohio State Highway Patrol Troopers in 2021.

Race	Asian	Black	Hispanic	Native American	Native Hawaiian	White	Unknown	Total
Traffic Stop Contacts:	9,172	116,829	25,289	333	227	511,259	1,690	664,799

Source: Ohio State Highway Patrol
https://statepatrol.ohio.gov/dashboards-statistics/statistics/activity-summaries-and-complaints

---

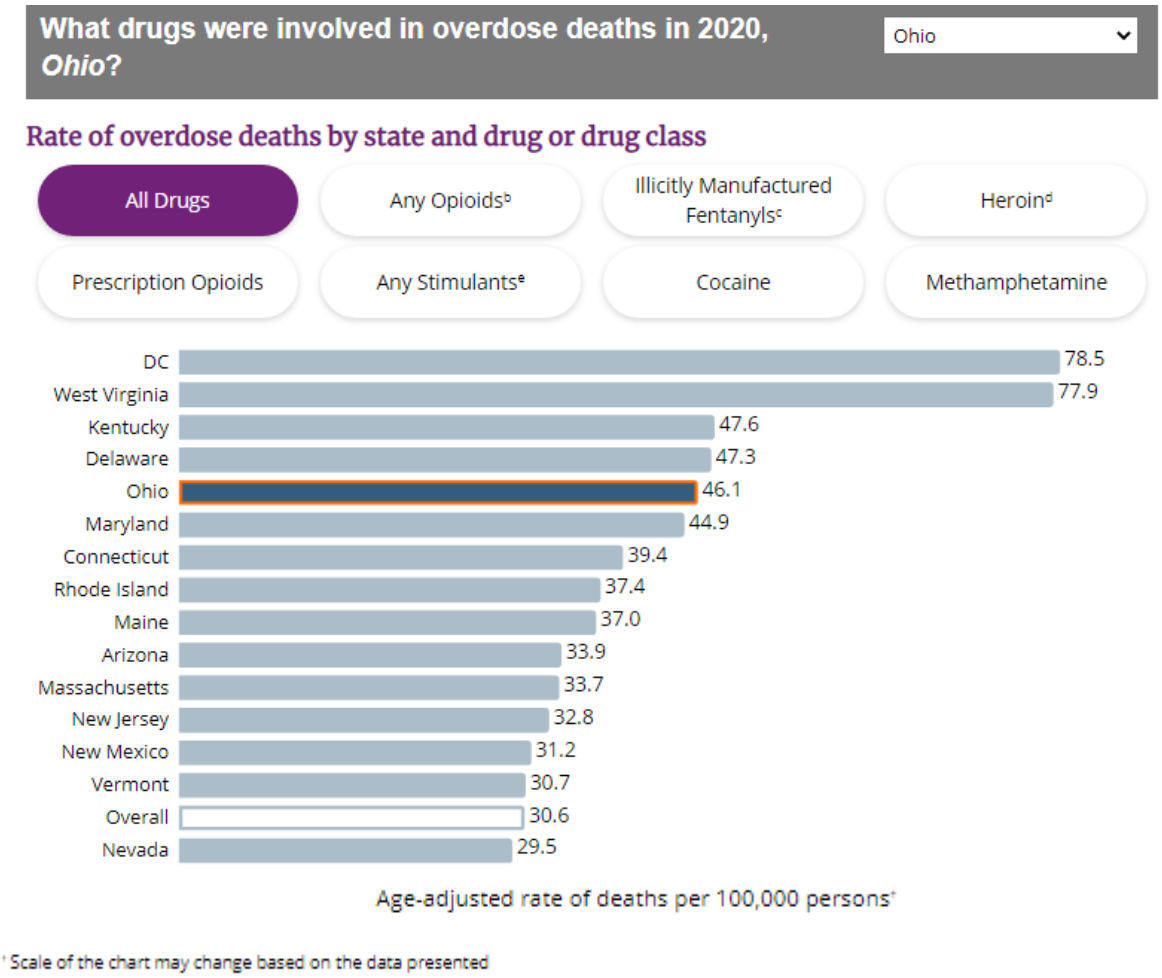
The states of Ohio and Pennsylvania have consistently led the nation in drug overdoses throughout the opioid epidemic. Deaths caused by an unintentional drug overdose began to decrease slightly prior to COVID-19. However, during the pandemic, death rates in both states began to increase again. Both Ohio and Pennsylvania rank among the top five states in the nation with the highest number of drug related deaths during 2020. Ohio lost over 5,200 residents while Pennsylvania lost just over 5,100 residents.

Drug Overdose Mortality by State 2020

Data Table

Location	Death Rate (Click for…	Deaths
California	21.8	8,908
Florida	35	7,231
Ohio	47.2	5,204
Pennsylvania	42.4	5,168
New York	25.4	4,965
Texas	14.1	4,172
Illinois	28.1	3,549
North Carolina	30.9	3,146
Tennessee	45.6	3,034
New Jersey	32.1	2,840

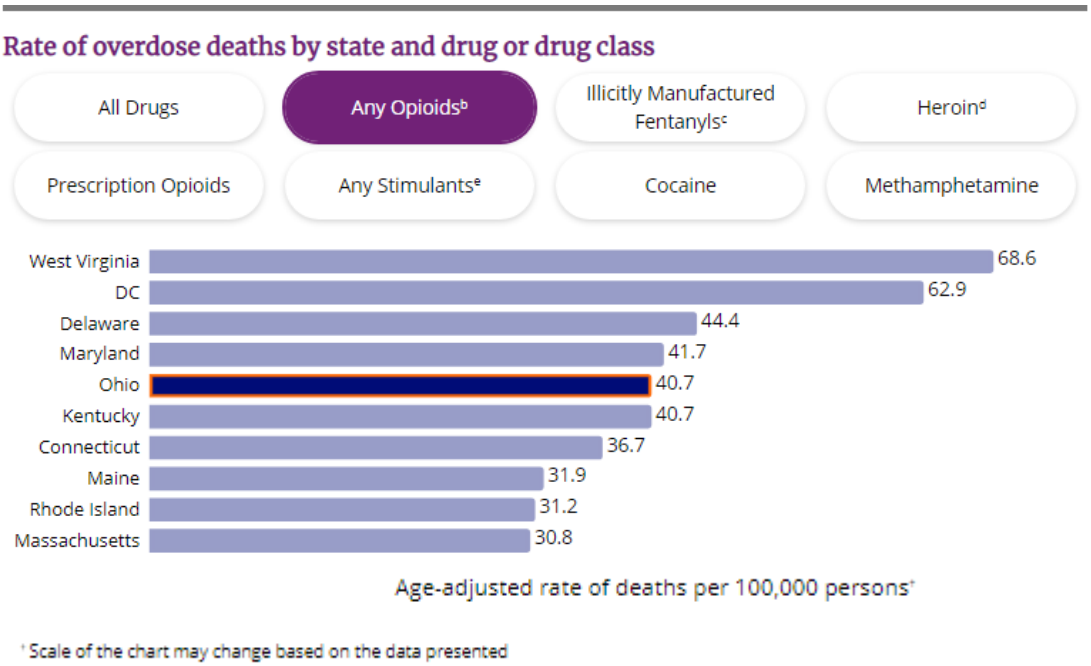
Source: Centers for Disease Control and Prevention
https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm



Source: Centers for Disease Control and Prevention
https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html

Data from the Centers for Disease Control and Prevention report that in 2020, Ohio ranked as the state with the fourth highest rate of overdose deaths for all drugs. Washington DC ranked as number one based on the rate of overdose deaths.

Ohio was also the state with the fourth highest rate of overdose deaths attributed to the use of any type of opioid. West Virginia ranked as the state with the highest rate of overdose deaths, followed by Washington DC, Delaware and then Maryland.



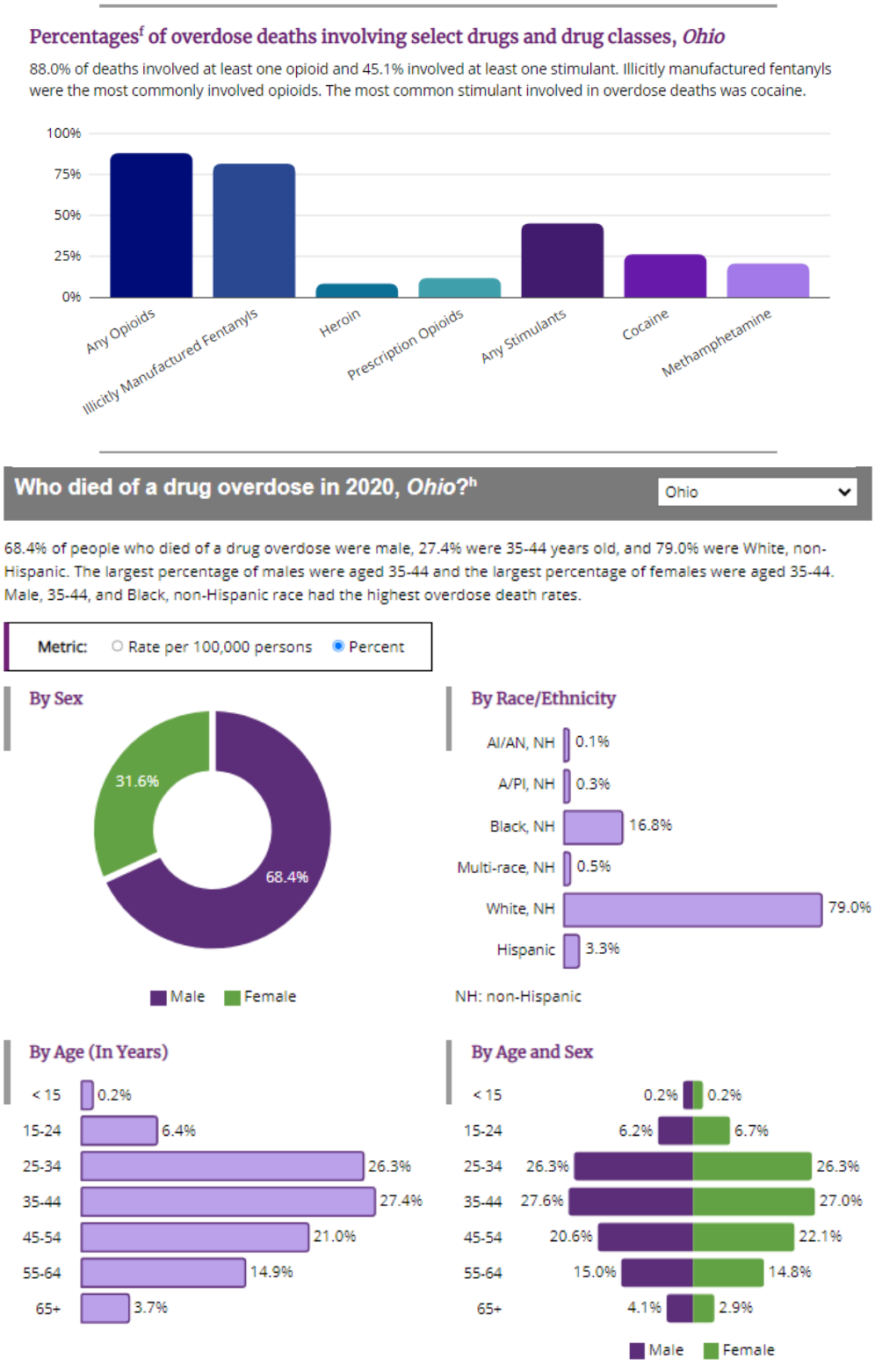
"Any Opioids" includes deaths that had at least one opioid listed as a cause of death. The "Any Opioids" category includes illicitly manufactured fentanyl, heroin, prescription opioids, and any other opioids involved in overdose deaths.

Source: Centers for Disease Control and Prevention
https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html

It is not uncommon for residents living in poverty to face multiple challenges resulting from lower levels of education, low wages, limited access to job opportunities and limited access to health care as well as high crime rates. Socioeconomic factors such as a poor living environment affect quality of life and may lead to alcohol and drug usage resulting a shorter lifespan and health disparities. In September 2022, the CDC published data reporting Ohio's life expectancy decreased by 1.6 years from 2019, making Ohio's life expectancy the 13th lowest in the U.S. for 2020. The decline reflects societal issues that include high numbers of overdose and COVID-19 deaths.

Primary data collected from Trumbull county residents show that the ratio of non-working people to working people is roughly 42:52 percent. The U.S. Census Bureau reports 15.4% of Trumbull residents live in poverty (2022). Of the total number of respondents, 47.4% feel stigma remains in the workplace when it comes to addiction, treatment and recovery. This confirms that individuals with substance use disorders should remain a vulnerable population.

When it comes to alcohol use in Ashtabula County, data collected for the 2022 county CHNA contradicts the idea that poverty correlates to increased alcohol use. In the Ashtabula report, households with an annual income of $75,000 or more were more likely to binge drink than those making less than $75,000. A ratio of 62.2% v. 29.3%. It is important to note Ashtabula has 19.3% of its population living in poverty (2022), the highest in Glenbeigh's defined service area.



Opioids, often combined with other drugs, continue to contribute to a significant number of overdose deaths.

In Ohio, White males between the ages of 25 and 54 continue to be the largest population succumbing to drug overdoses.

In addition, the Black male population, between the ages of 35 and 44, were devastated by drug overdose deaths. According to data from the Office of Drug Surveillance, in Pennsylvania, this demographic has emerged as having the highest risk for fatal overdoses. This trend began in 2019 and continued through 2021, the latest data available.

Source: Centers for Disease Control and Prevention
https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html

Source: Centers for Disease Control and Prevention
https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html

The Ashtabula County Community 2022 Health Needs Assessment surveyed area residents to learn their perspective on various health issues including the impact of substance use in the community. Survey respondents ranked COVID-19 as the most important health issue with drug and alcohol addiction or abuse second at 23.0% across the county. Among the key findings, main barriers were the lack of health care resources, insufficient health insurance, poverty, lack of education and attitudes toward improving health issues. Residents reported more direct interaction within the community rather than relying on social media or other media sources. This may correspond to the lack of access to broadband internet services within the community.

Survey participants also noted an interest in receiving more information on mental health issues including depression and anxiety. More so for residents within the City of Ashtabula. While the report noted alcohol and drug problems among the top issues affecting county residents, there was little interest by the same participants in receiving help or information about drug abuse or alcohol abuse. A key finding in the report states:

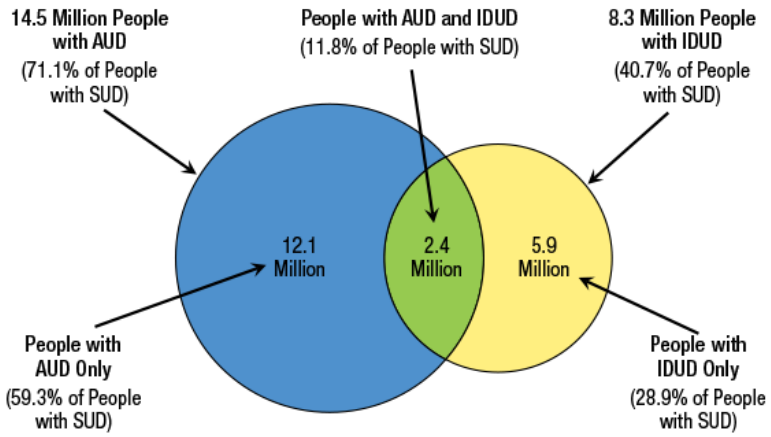
> *"While low percentages of respondents reported abusing prescription drugs, nearly 40% reported binge drinking at least once in the past month, and over a third reported knowing someone with and alcohol problem in the community."*

In the 2019 CHNA, 7% of Ashtabula County adults reported using marijuana in the past 6 months. This number increased to 8% in 2022 for the number reporting the use of marijuana in the past month. Medical marijuana use was approved mid-2016 for Ohio residents. In 2022, 46% reported the use of marijuana for medical conditions while only 19% reported use solely for recreational purposes. Additionally, 35% reported using for both medical and non-medical purposes.

Substance Abuse and Mental Health Services Administration Data on Alcohol and Drug Use, Treatment and Recovery. National Survey on Drug Use and Health (NSDUH) Report

SAMHSA reported that among the 20.4 million people aged 12 or older with a past year substance use disorder (SUD) in 2019, 71.1 percent (or 14.5 million people) had a past year alcohol use disorder, 40.7 percent (or 8.3 million people) had a past year illicit drug use disorder. Among the 14.5 million people with a past year alcohol use disorder, 12.1 million had an alcohol use disorder but not an illicit drug use disorder. Among the 8.3 million people with a past year illicit drug use disorder, 5.9 million had an illicit drug use disorder but not an alcohol use disorder. Among people with a past year SUD, 11.8 percent (or 2.4 million people) had both an alcohol use disorder and an illicit drug use disorder in the past year.

Figure 47. Alcohol Use Disorder (AUD) and Illicit Drug Use Disorder (IDUD) in the Past Year among People Aged 12 or Older with a Past Year Substance Use Disorder (SUD): 2019

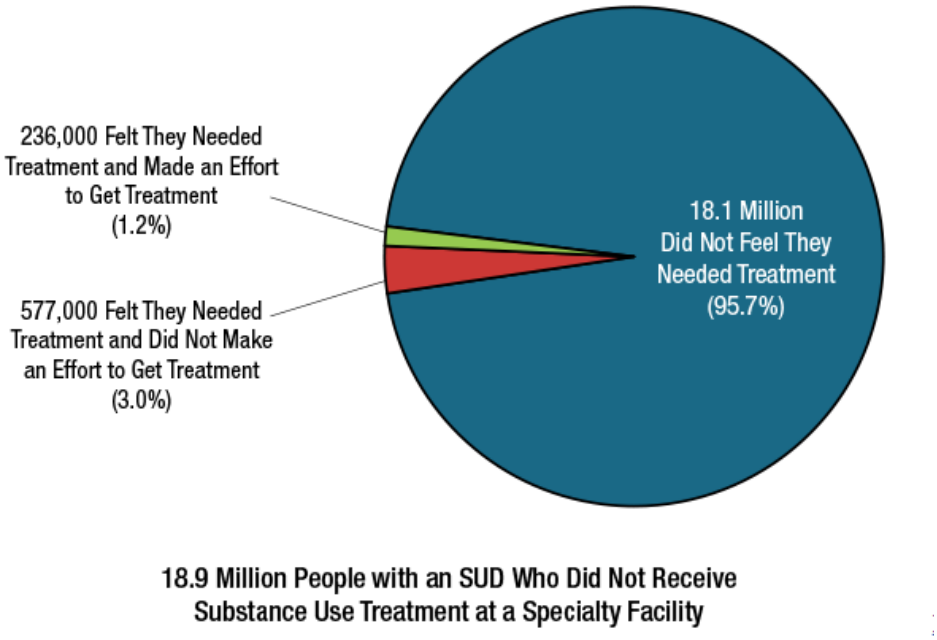


Source: SAMHSA National Survey on Drug Use and Health (NSDUH)
https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm#mhisud

The 2019 National Survey on Drug Use and Health (NSDUH) report offered insight into the perceived need for substance use treatment. The 2019 national report published by SAMHSA estimated that the perceived need for substance use treatment among the approximate 18.9 million people aged 12 or older who had an existing SUD in the past year and who did not receive treatment at a specialty facility, 95.7 percent, or 18.1 million people, did not feel they needed treatment. Additionally, 3.0 percent, or 557,000 people, perceived a need for treatment but did not seek or secure treatment and 1.2 percent, or 236,000 people, sought treatment.

NSDUH respondents were classified as having a perceived need for substance use treatment (i.e., treatment for problems related to their use of alcohol or illicit drugs) if they indicated that they felt they needed substance use treatment in the past year. Respondents may have a perceived need for substance use treatment, regardless of whether they had an SUD in the past year. In this report, estimates for the perceived need for substance use treatment are discussed only for people aged 12 or older who were classified as having an SUD in the past year but did not receive substance use treatment at a specialty facility.

Among 2019 survey participants with a past year SUD who did not receive substance use treatment at a specialty facility, 4.3 percent perceived that they needed treatment. The 2019 percentage was similar to the percentages in most years from 2015 to 2018.



Note: People who had an SUD were classified as needing substance use treatment.
Note: The percentages do not add to 100 percent due to rounding.

NSDUH Graphic: Perceived Need for Substance Use Treatment among People Aged 12 or Older with a Past Year Substance Use Disorder (SUD) Who Needed but Did Not Receive Substance Use Treatment at a Specialty Facility in the Past Year: 2019

Source: SAMHSA National Survey on Drug Use and Health (NSDUH)
https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm#mhisud

Breakdown by Age

The following details are directly from the 2019 NSDUH report:

> ***Aged 18 to 25***
>
> Among the 4.5 million young adults aged 18 to 25 in 2019 with an SUD in the past year who did not receive substance use treatment at a specialty facility, 96.5 percent (or 4.3 million people) did not feel they needed treatment. Additionally, 2.6 percent (or 119,000 people) felt they needed treatment but did not make an effort to get treatment, and 0.9 percent (or 40,000 people) felt they needed treatment and made an effort to get treatment. Among young adults in 2019 with a past year SUD who did not receive substance use treatment at a specialty facility, 3.5 percent perceived that they needed treatment. This percentage in 2019 was similar to the percentages in 2015 to 2018.
>
> ***Aged 26 or Older***
>
> Among the 13.4 million adults aged 26 or older in 2019 with an SUD in the past year who did not receive substance use treatment at a specialty facility, 95.2 percent (or 12.7 million people) did not feel they needed treatment. Furthermore, 3.4 percent (or 448,000 people) felt they needed treatment but did not make an effort to get treatment, while 1.4 percent (or 190,000 people) felt they needed treatment and made an effort to get treatment. Among adults aged 26 or older in 2019 with a past year SUD who did not receive substance use treatment at a specialty facility, 4.8 percent perceived they needed treatment. This percentage in 2019 was similar to the percentages in most years from 2015 to 2018.

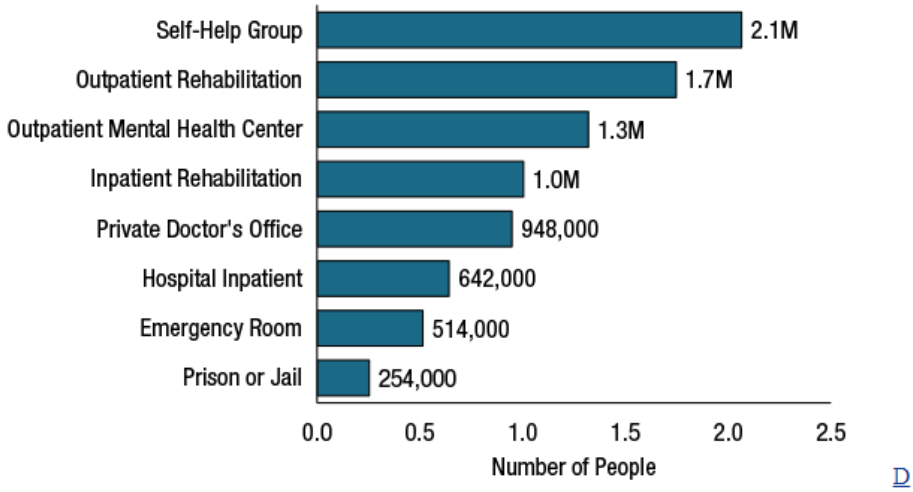
Reasons for Not Seeking Treatment

The NSDUH report for 2019 further explored reasons for not receiving specialty substance use treatment. "NSDUH respondents who did not receive substance use treatment in the past 12 months but felt they needed treatment were asked to report the reasons for not receiving treatment.

Common reasons expressed for not receiving specialty substance use treatment despite the individual perceiving a need for treatment were:

- Not being ready to stop using (39.9 percent) - remained stable between 2015 and 2019
- Did not know where to go to get treatment (23.8 percent) - higher than the percentages in 2015 (12.5 percent) and 2017 (10.9 percent), but similar to the percentages in 2016 and 2018
- Having no health care coverage and not being able to afford the cost of treatment (20.9 percent) - lower than the 2018 percentage (32.5 percent), but similar to the percentages in 2015 to 2017

Figure 66. Locations Where Substance Use Treatment in the Past Year Was Received among People Aged 12 or Older: 2019



D

Note: Locations where people received substance use treatment are not mutually exclusive because respondents could report that they received treatment in more than one location in the past year.

Source: SAMHSA National Survey on Drug Use and Health (NSDUH)
https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm#mhisud

Self-help groups remain the top location individuals report as receiving substance use treatment. The National Institute of Health 2006 study exploring the success of self-help groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) concluded that the number of patients remaining abstinent after two years ranked as high. A self-reported drug-free state of 39–59% over the past six months, two years after start-up, was categorized as a good result." (Source: Vederhus JK, Kristensen Ø. High effectiveness of self-help programs after drug addiction therapy. BMC Psychiatry. 2006 Aug 23;6:35. doi: 10.1186/1471-244X-6-35. PMID: 16928266; PMCID: PMC1574294. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1574294/).

Perceived Recovery as Defined by SAMHSA National Survey on Drug Use and Health

Respondents reporting ever having a problem with alcohol or drug use were asked if they considered themselves (at the time of the interview) in recovery or to have recovered from a substance use problem.

Among adults, aged 18 or older in 2019, 11.4 percent (or 28.2 million people) admitted having a problem with alcohol or drugs at some time. This is a similar percentage as reported in 2018 (11.0 percent). Moreover, among the 28.2 million adults in 2019 who believed they ever had a substance use problem, 75.5 percent (or 21.2 million people) considered themselves to be in recovery or to have recovered from their alcohol or drug use problem, which was similar to the percentage in 2018 (74.5 percent).

Medication-Assisted Treatment for Alcohol Use or Opioid Misuse

Questions were added to the 2019 NSDUH interview to assess the receipt of medication-assisted treatment (MAT) for problems with alcohol use or opioid misuse. NSDUH respondents aged 12 or older who reported receiving any treatment in the past year for problems related to their use of alcohol were asked to report whether a doctor or other health professional prescribed them medication in the past year to help reduce or stop their use of alcohol. Questions on MAT for opioid misuse were asked if respondents aged 12 or older reported ever using heroin or ever misusing prescription pain relievers *and* reported receiving any treatment in the past year for illicit drug use problems. These respondents were asked whether a doctor or other health professional prescribed them medication in the past year to help reduce or stop their use of heroin, misuse of prescription pain relievers, or both. Respondents also were informed that MAT for opioid misuse was different from medications given to stop a drug overdose.

Medication-Assisted Treatment for Alcohol Use

Among the 14.5 million people aged 12 or older in 2019 with a past year alcohol use disorder, 7.6 percent (or 1.1 million people) received treatment for alcohol use at any location in the past year, and 1.6 percent (or 228,000 people) received MAT in the past year for alcohol use. Among the 2.5 million people aged 12 or older in 2019 who received alcohol use treatment at any location in the past year (regardless of whether they had a past year alcohol use disorder, 11.3 percent (or 286,000 people) received MAT in the past year for alcohol use. In contrast, among the 1.1 million people aged 12 or older in 2019 who had a past year alcohol use disorder and received alcohol use treatment at any location in the past year, 20.7 percent (or 228,000 people) received MAT in the past year for alcohol use.

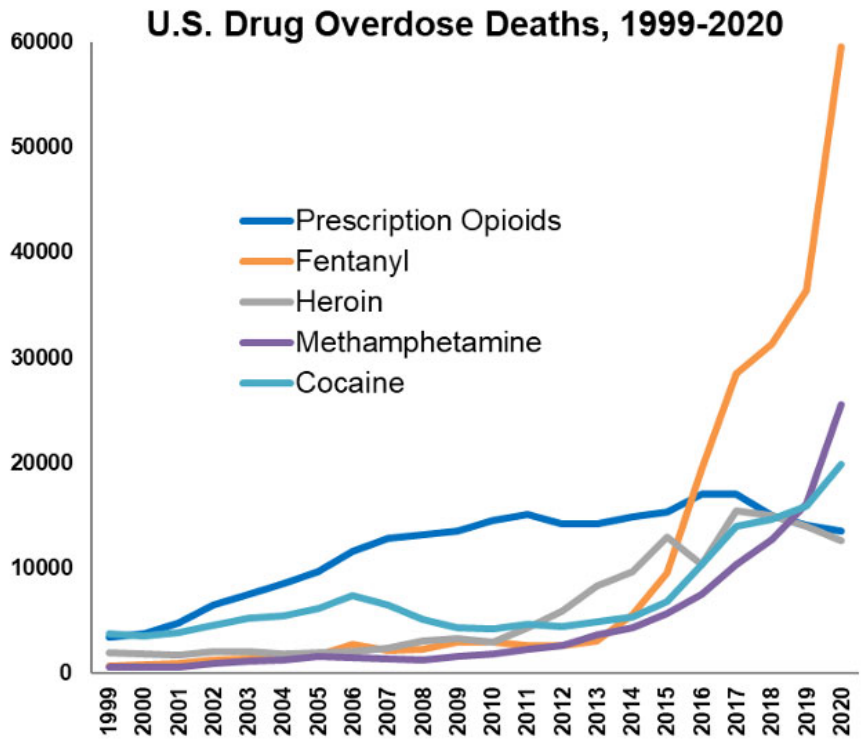
Medication-Assisted Treatment for Opioid Misuse

Among the 2.3 million people aged 12 or older in 2019 who received illicit drug use treatment (i.e., not necessarily for opioid misuse) in the past year, 28.7 percent (or 664,000 people) received MAT in the past year for opioid misuse. Among the 1.6 million people aged 12 or older with a past year opioid use disorder, 18.1 percent (or 294,000 people) received MAT in the past year for opioid misuse.

Source: SAMHSA National Survey on Drug Use and Health (NSDUH)
https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm#mhisud

Drug Trends

National Institute on Drug Abuse (NIDA) Data



Source: National Institute on Drug Abuse FY 2022-2026 NIDA Strategic Plan
https://nida.nih.gov/download/48192/fy-2022-2026-nida-strategic-plan.pdf?v=e6225ddacc47b5fa5ddde6c937b50bc0

The National Institute on Drug Abuse (NIDA) is the lead federal agency tasked with investigating and publishing information on drug use and addiction. After decades of research, substance use disorder (SUD) is understood as a chronic but treatable brain disorder that emerges from the complex interplay of biological, social, and developmental factors.

NIDA's strategic plan, covering 2022 to 2026, noted that drug overdoses in the United States have been increasing exponentially for at least 40 years. While substances of choice have transitioned over the years, opioids have been involved in most overdoses over the past two decades. The opioid crisis began with the misuse of prescription opioids. When prescription availability was limited, heroin use increased. Since 2016, synthetic opioids, including fentanyl and fentanyl compounds, are involved in a significant number of overdose deaths.

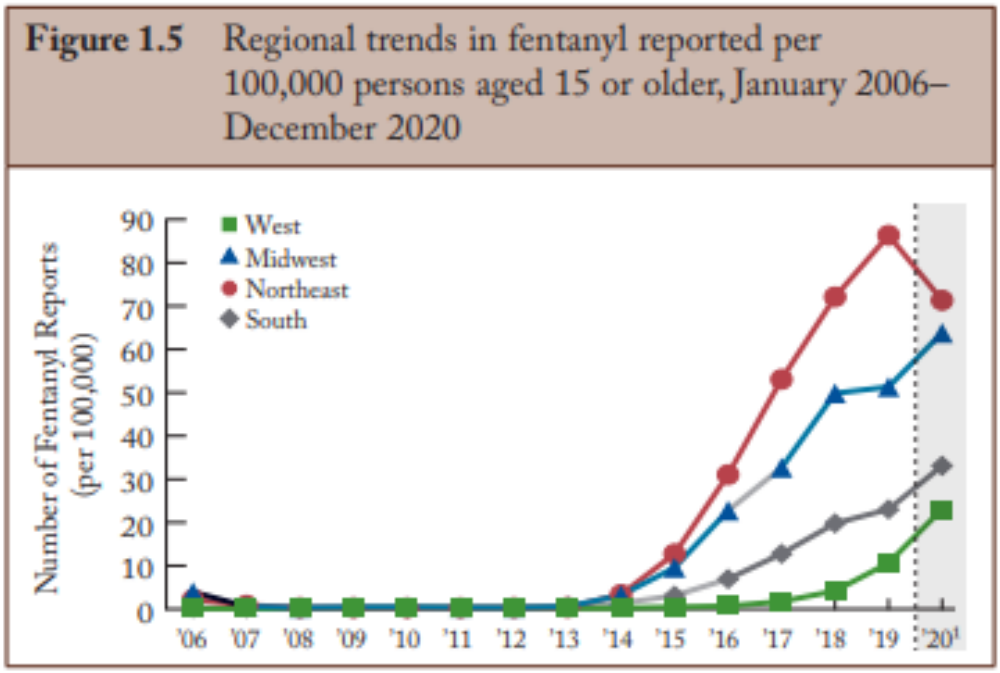
NIDA's plan states, "Provisional data from the Centers for Disease Control and Prevention show a record high of close to 109,000 overdose deaths in 2021, with more than 75 percent involving opioids. Stimulants also have reemerged as an overdose threat. From 2012 through 2021, the number of deaths involving methamphetamine increased nearly 13-fold (from ~2,600 to nearly 33,500); the number

involving cocaine increased nearly six-fold (from ~4,400 to nearly 25,000). The alarming increase in stimulant-involved overdose deaths is a stark illustration that we face an evolving addiction and overdose crisis characterized by shifting use of different substances and use of multiple drugs and drug classes together.

The collision of the overdose crisis with the coronavirus disease 2019 (COVID-19) pandemic puts people with SUDs at particular risk. Drug use and overdose markedly increased after the pandemic began; the 34 percent increase in overdose deaths between 2019 and 2020 was the largest one-year increase ever recorded. Individuals with SUDs are at higher risk for COVID-19 and its adverse outcomes. Social isolation and stress—factors long known to drive substance use and relapse—are likely contributing factors."

Source: National Institute on Drug Abuse FY 2022-2026 NIDA Strategic Plan
https://nida.nih.gov/download/48192/fy-2022-2026-nida-strategic-plan.pdf?v=e6225ddacc47b5fa5ddde6c937b50bc0

Drug Enforcement Agency (DEA) Data



Note: *There is a noticeable decrease in the number of cases submitted and analyzed during 2020, which is likely due, in part, to the impacts of the COVID-19 pandemic. Use caution when comparing the shaded estimates with previous years' estimates.*

Source: U.S. Drug Enforcement Administration, Diversion Control Division. (2021). National Forensic Laboratory Information System: NFLIS Drug 2020 Annual Report. Springfield, VA: U.S. Drug Enforcement Administration.
https://www.nflis.deadiversion.usdoj.gov/publicationsRedesign.xhtml?jfwid=p_EZ3hAUJTTaQsL19l1s15NUo_elUdkd2oZJfnrP:0

National Forensic Laboratory Information System Data

The National Forensic Laboratory Information System (NFLIS) Drug 2020 Annual Report was used to compile data on tracked drug trends. The NFLIS report notes that COVID-19 may have influenced numbers due to closures and other pandemic restrictions.

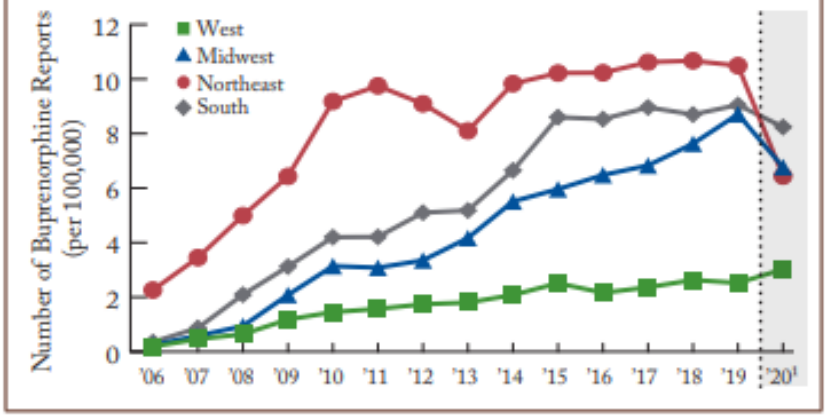
"For fentanyl, the Northeast showed a gradual increase from 2006 to 2014, followed by considerable increases from 2015 through 2019 and a recent decrease in 2020. Reports were steady from 2006 through 2013 for the Midwest, West, and South until substantial increases began in 2014.

More recently, from 2019 to 2020, reports of fentanyl increased significantly throughout the Midwest, West, and South and decreased significantly in the Northeast. Reports of Tramadol increased significantly in all regions except the West. Alprazolam, buprenorphine, oxycodone, and amphetamine reports decreased significantly in all regions except the West. Heroin use continues to decrease after peaking in 2015/2016.

Methamphetamine was the most frequently identified drug (377,787 reports) in 2020, followed by cannabis/THC (188,735 reports), cocaine (153,372 reports), fentanyl (117,045 reports), and heroin (98,077 reports). These five most frequently identified drugs accounted for 73% of all drug reports.

Buprenorphine reports increased from 2006 through 2010 for the Midwest, South, and Northeast, while the increase continued into 2011 for the West. The increase in reports slowed for all regions from 2011 to 2013. Reports then continued to increase through 2020 in the West while decreasing from 2019 to 2020 in the Midwest, South, and Northeast."

Figure 1.7 Regional trends in buprenorphine reported per 100,000 persons aged 15 or older, January 2006–December 2020



Note: U.S. Census 2020 population data by age were not available for this publication. Population data for 2020 were imputed.

[1] *There is a noticeable decrease in the number of cases submitted and analyzed during 2020, which is likely due, in part, to the impacts of the COVID-19 pandemic. Use caution when comparing the shaded estimates with previous years' estimates.*

Source: U.S. Drug Enforcement Administration, Diversion Control Division. (2021). National Forensic Laboratory Information System: NFLIS Drug 2020 Annual Report. Springfield, VA: U.S. Drug Enforcement Administration. https://www.nflis.deadiversion.usdoj.gov/publicationsRedesign.xhtml?jfwid=p_EZ3hAUJTTaQsL19l1s15NUo_elUdkd2oZJfnrP:0

Centers for Disease Control and Prevention Data

Concurrently, the Centers for Disease Control and Prevention reported that the Number and Age-adjusted Rate of Drug Overdose Deaths increased 23.2% in Ohio and 19.1% in Pennsylvania from 2019 to 2020.

Top Ten States with Drug Overdose Deaths, 2020

Location	Range Category	2020 Age-adjusted R...	2020 Number of Dea...
California	13.6 to 16.0	21.8	8908
Florida	21.1 to 57.0	35.0	7231
Ohio	21.1 to 57.0	47.2	5204
Pennsylvania	21.1 to 57.0	42.4	5168
New York	16.1 to 18.5	25.4	4965
Texas	6.9 to 11.0	14.1	4172
Illinois	21.1 to 57.0	28.1	3549
North Carolina	21.1 to 57.0	30.9	3146
Tennessee	21.1 to 57.0	45.6	3034
New Jersey	21.1 to 57.0	32.1	2840

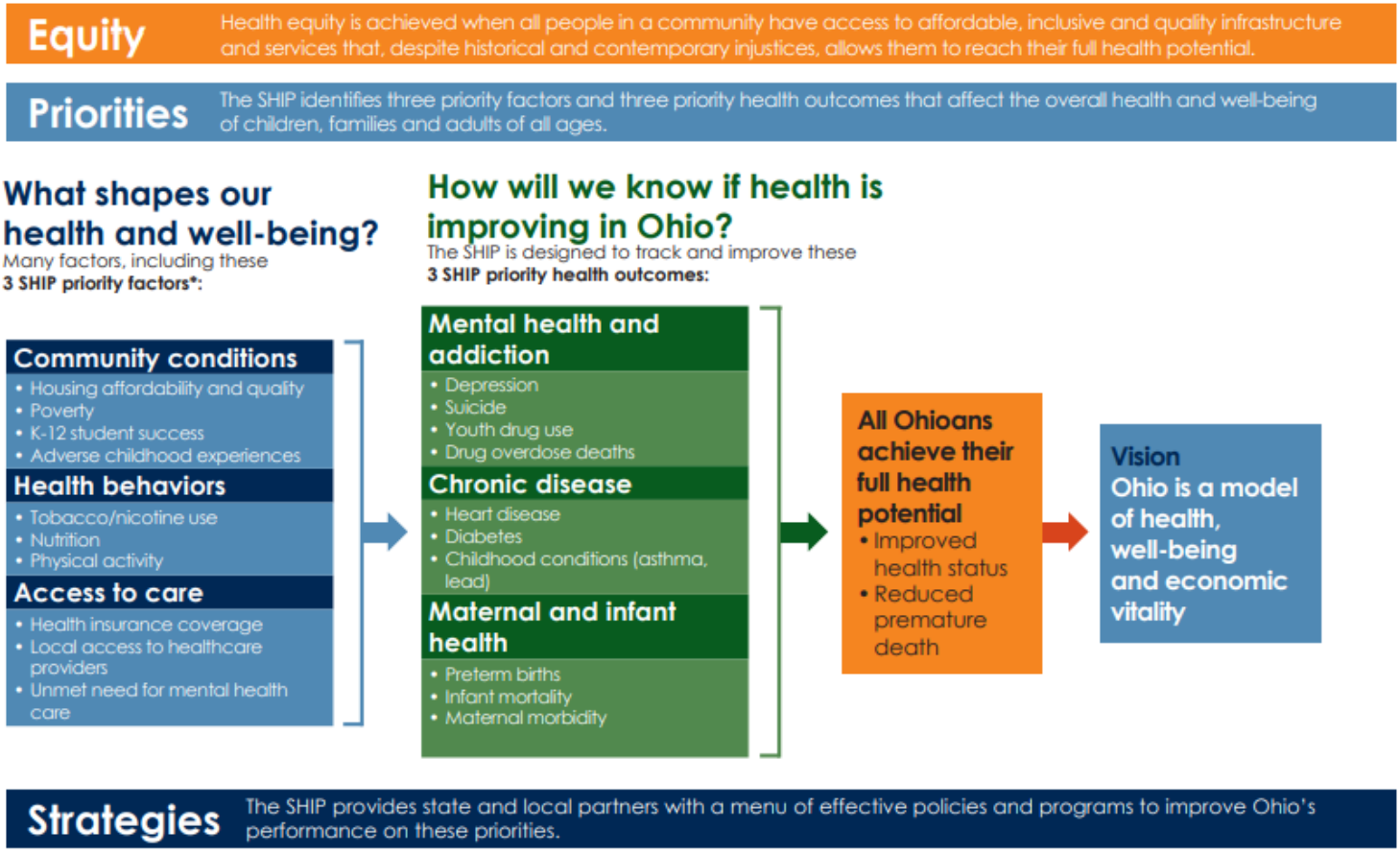
Source: Centers for Disease Control and Prevention
https://www.cdc.gov/drugoverdose/deaths/2020.html

Previous CHNA data (Glenbeigh, 2016) showed an increase in heroin and prescription opioid related mortality rates in Ohio as reported by the State Epidemiological Outcomes Workgroup (SEOW). Since 2016, changes in Ohio laws have effectively decreased the availability of prescription opioids and subsequently, overdose deaths decreased related to their abuse. At that time, SEOW reported that unadulterated heroin was increasingly difficult for individuals to obtain as fentanyl and fentanyl-analogs entered the supply. Data for the 2022 CHNA continue to support this trend with data showing fentanyl remaining as a top threat and being involved in a significant number of overdose deaths.

Provisional data was released in mid-2022 by the CDC estimating that more than 107,000 people died as a result of a drug overdose in the United Stated during 2021. This number was adjusted to 109,000 in NIDA's strategic plan document with revisions dated September 2022. In both releases of information, the number of deaths that involved an opioid remained at 75%.

Recommendations for Addressing Substance Use Issues

Ohio State Health Improvement Plan (SHIP) 2020-2022



Source: State Health Improvement Plan, Ohio 2020-2022, April 2020
https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

Ohio's SHIP identified priorities based on information acquired from primary and secondary data analysis. In relation to addiction, the goal remains to reduce drug overdose deaths specifically for adults, ages 25-54. Target areas include the Appalachian region as well as urban counties. The report also noted that males continue to be most susceptible to drug overdose deaths.

As a means of increasing access to healthcare services, the Ohio SHIP recommends strategies that include workforce development initiatives targeting underrepresented and minority communities as well as expansion of telehealth services and improving/supporting transportation availability.

Mirroring information collected in the Ashtabula County 2022 CHNA as well as primary data collected by Glenbeigh, there is an increased need for mental health services in Ohio communities. The SHIP noted a baseline from 2013 to 2015 of approximately 20.2% of adults, age 18 and over, with an existing mental health condition who felt they needed care, but did not receive care.

Ohio set the goal of reducing that number to 18.6% between 2023 and 2025. Strategies listed include: expanding telehealth services; offering training and workforce development options, especially in rural areas and integrating more mental health services into other services such as primary health care.

Drug overdose death

How will we know if health is improving in Ohio?

Fewer Ohioans will die from drug overdoses, disparities in the drug overdose death rate will be eliminated and more Ohioans will be on the path to recovery from addiction.

Objectives

Ohio will use the following objectives to monitor progress toward reducing drug overdose death. Local communities can select this indicator to evaluate their own community health improvement activities. Priority populations refer to groups with outcomes worse than Ohio overall.

Indicator (source)	**Baseline** (2018)	**Short-term target** (2022)	**Intermediate target** (2025)	**Long-term target** (2028)
MHA7. Unintentional drug overdose deaths. Number of deaths due to unintentional drug overdose, per 100,000 population (age adjusted) (ODH Vital Statistics)	34.1	28.7	24.6	20.5
Priority populations				
Adults, ages 25-34	68.8	49.5	35	20.5
Adults, ages 35-44	75.8	53.7	37.1	20.5
Adults, ages 45-54	47.3	36.6	28.5	20.5
Residents of Appalachian counties*	39.4	31.8	26.2	20.5
Residents of urban counties*	37.7	30.8	25.7	20.5
Male	45.8	35.7	28.1	20.5

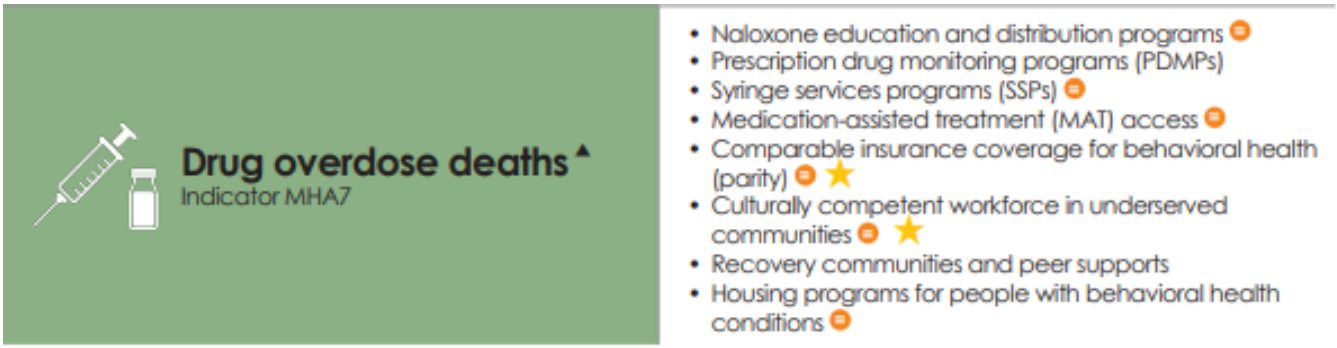
*County typology from the Ohio Medicaid Assessment Survey. See Appendix C for map of county types.

Note: The unintentional drug overdose death rate for non-Hispanic white Ohioans (36.5 deaths per 100,000 population) and non-Hispanic black Ohioans (33.5 deaths per 100,000 population) were both within 10% of the overall rate in 2018.

Target source: ODH and OMHAS

Source: State Health Improvement Plan, Ohio 2020-2022, April 2020
https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

The top strategies for reducing drug overdose deaths remains education on and distribution of naloxone to the public and to first responders, workforce development to improve access to care and offering recovery support services.



Source: State Health Improvement Plan, Ohio 2020-2022, April 2020
https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

National Institute on Drug Abuse (NIDA)

The National Institute on Drug Abuse published recommendations to address the addiction crisis. The NIDA strategic plan identified areas to improve outcomes. These areas include:

- **Reduce Stigma**. According to the NIDA plan, people with substance use disorders (SUDs) are often marginalized by work, families, friends and health care providers. People in active addiction or even those in recovery are often viewed negatively in society. Stigma may prevent people from openly discussing their struggles with substances, which is a barrier to seeking or obtaining treatment or other care services. Additionally, the NIDA report notes that if care is sought, providers may not deliver adequate care. Consequently, NIDA is prioritizing research to identify and combat stigma and develop approaches to improve engagement in treatment.
- **Reduce Health Disparities**. Social, economic and environmental disadvantages affect people with and without substance use issues. NIDA's proposed solutions include identifying and developing approaches that address inequities for people living in rural areas where there are few treatment options, limited child-care resources and barriers to transportation. Solutions should also concentrate on racial barriers and the provision of equitable care. Intervention, treatment and recovery support should identify needs and be culturally responsive.
- **Comprehensive Care**. Individuals with substance use disorders often require comprehensive physical and mental health care. For many, other health conditions such as HIV, Hepatitis, Tuberculosis and chronic pain need to be treated concurrently with addiction services. NIDA recommends continued research to develop strategies for delivering comprehensive care.

Source: NIDA. 2022, September 20. Director's Message. Retrieved from https://nida.nih.gov/about-nida/2022-2026-strategic-plan/directors-message on 2022, September 22
https://nida.nih.gov/about-nida/2022-2026-strategic-plan/directors-message

The NIDA strategic plan also redefines recovery. It suggests that recovery from substance use disorders be broadened to beyond complete abstinence from mood altering substances to a general improvement of an individual's health and well-being. This would redefine recovery to include abstinence as well as the lessening of substance use. Recovery would still include the development of effective coping strategies and the improvement of physical and mental health.

NIDA proposes continued research to explore recovery strategies, such as family-based support networks for youth, peer recovery support models, virtual reality-based mindfulness, and other digital health approaches as well as strategies tailored to specific populations and settings.

NIDA recognizes the importance of recovery support both during and after treatment. The strategic plan suggests further work to promote peer recovery support as well as effective recovery strategies that address stigma, racial inequities, housing instability, legal system barriers and other barriers that keep people from sustaining long-term recovery.

Key Focus Areas from the NIDA Strategic Plan:

- Understand the mechanisms by which recovery support groups exert their effects.
- Support research on different pathways by which people recover from SUDs.
- Incorporate a broader range of clinical outcomes in recovery research beyond abstinence and reduced drug use, such as improved quality of life and health or reduction in risk behaviors and medical consequences.
- Develop and refine research methods for evaluating recovery support services and support research on the efficacy of these services.
- Develop novel interventions for sustained recovery that target factors that increase vulnerability for relapse.
- Investigate the impact of stigma and other social determinants of health on recovery.

Source: NIDA. 2022, September 20. Director's Message. Retrieved from https://nida.nih.gov/about-nida/2022-2026-strategic-plan/directors-message on 2022, September 22
https://nida.nih.gov/about-nida/2022-2026-strategic-plan/directors-message

Centers for Disease Control and Prevention

The CDC recommends the following actions as appropriate based on community needs, changes resulting from the COVID-19 pandemic, significant increases in overdose deaths and the perceived need to expand response activities. This is a portion of CDC recommendations that relate to treatment providers and strategies identified by Glenbeigh as those that can be addressed in the defined service community.

- Expand the provision and use of naloxone and continue to provide overdose prevention education. Distribute naloxone to people who have a history of using drugs when leaving treatment prematurely or post-incarceration. These individuals are at high risk of overdose if relapse occurs after a period of abstinence.
- Provide strategic messaging to community groups (particularly those providing services to high-risk populations), community leaders, school officials, faith based leaders, parents, students and others about addiction, treatment and recovery. Include education on the risks of drug use, including unintentional overdose caused by exposure to drugs such as illicitly manufactured fentanyl or counterfeit drugs designed to look like legal prescription medications.
- Reduce stigma in healthcare settings by educating healthcare providers on how to speak to and help individuals seeking treatment or information on addiction, treatment and recovery. Include education on responsible prescribing and how to accommodate patients with a history of substance use disorders. Work with clinicians to encourage the distribution of naloxone along with information on overdose and treatment options.
- Expand access to treatment for substance use disorders. Treatment with FDA-approved medications (methadone, buprenorphine, or naltrexone) are lifesaving for individuals with opioid use disorders. Ensure treatment access to at risk populations, which include those in the criminal justice system, residential treatment or hospital setting.
- Continue to offer telehealth treatment options.
- Continue to collaborate with other agencies to provide SUD patients with the appropriate level of care and access to FDA-approved treatments.
- Expand treatment services for Stimulant Use Disorder. As there are no FDA-approved treatments for stimulant use disorders, the most effective treatments include psychosocial therapies such as motivational interviewing, contingency management, contingency management combined with community reinforcement approach, and contingency management combined with cognitive-behavioral therapy.
- Offer referral services to secure treatment options for individuals at high risk for overdose.
- Provide recovery support services that promote long-term recovery.
- Collaborate with public health, emergency departments, treatment providers, community-based service organizations, and healthcare providers to implement post-overdose response protocols that promote overdose education, treatment, linkage to care and MOUD, and naloxone distribution.

Source: Centers for Disease Control and Prevention
https://emergency.cdc.gov/han/2020/han00438.asp

Secondary Data Analysis (Summary)

Demographics/Household Indicators

- Ashtabula County has a lower median household income and per capita income than Ohio
- Ashtabula County has a significant percentage of persons living in poverty
- The majority of Glenbeigh's defined service area includes Appalachian Region counties
- The majority of Glenbeigh's defined service area has been impacted by population decline
- Both Lorain County (OH) and Butler County (PA) had a population increase exceeding 3% between 2010 and 2020
- Ashtabula and Trumbull (OH) along with Erie (PA) counties had a population decrease exceeding 3% between 2010 and 2020
- Six out of 7 Ohio counties and 2 out of 4 Pennsylvania counties have over 10% living in poverty
- Unemployment rates are the lowest in Lake County (4.8%) and Butler County (4.0%)
- Butler County had the highest median income ($72,642) of Pennsylvania service communities
- In Ohio, Lake County had the highest median household income at $65,814
- The median household income for the U.S. was $64,994, Ohio $58,116 and Pennsylvania $63,627
- The lowest median household income in the Ohio service area was Trumbull County at $47,799
- The lowest median household income in the Pennsylvania service area was Erie County at $52,863

Access to Health Care

- Ashtabula County remains a HRSA designated health professionals shortage area for primary care, dental health and mental health
- Ashtabula County remains a HRSA designated medically underserved area
- Ashtabula and Trumbull counties have higher percentages of uninsured adults than the state average
- Access to reliable, affordable broadband remains a challenge in many Appalachian communities. Lack of internet limits access to telehealth services
- Substance abuse is defined as rampant throughout Appalachia yet treatment remains limited
- More people believe substance use and mental health issues should be treated collectively
- Collaboration among agencies is needed to provide prevention, intervention and treatment services
- The cost of treatment remains a barrier for seeking treatment for substance use disorders
- Healthcare providers would benefit from education and training on addiction, treatment and recovery
- Butler County has experienced a significant population increase of 5.4% yet is located within the Appalachian Region known as a healthcare shortage area
- While the number of mental health care providers has increased across the entire defined service community, there remains a high proportion of clients to providers
- Inequities continue to exist for access to mental health providers
- Self-help remains an important resource for people with substance use disorders

Education

- Compounding factors limit access to educational opportunities especially in the Appalachian Region
- Limited access to reliable, affordable broadband is a challenge to education and workforce development
- There remains a need for readily available educational opportunities to advance careers
- Education and development opportunities are needed to build a qualified workforce to treat substance abuse and mental health issues
- In Ohio, 4 of 7 counties exceed or equal the overall state high school graduation rate of 91%
- In Pennsylvania, 4 of 4 counties exceed or equal the state high school graduation rate of 91%
- Lake County has the highest Ohio high school graduation rate at 93%
- Allegheny and Butler counties tie at 95% with the highest Pennsylvania high school graduation rates
- There remains a need for more providers with the appropriate education and certification to work in the field of addiction treatment and social services

Health Behaviors

- Over 1/3 of Ashtabula County 2022 CHNA participants reported knowing someone with an alcohol or drug addiction problem yet express little interest in learning about treatment or recovery
- Roughly 39% of the respondents reported binge drinking activity
- Lake County, within the defined service area, has a high percentage of alcohol-impaired driving deaths despite low poverty levels and positive health rankings
- Butler County has a drug overdose death rate of 61.7 yet has high education and employment rates
- The overall defined service area continues to experience significant increases in the number of overdose deaths
- A high percentage of adults in Ashtabula County reported no interest in help for alcohol or drug use
- Nationally, a high percentage of people classified as needing treatment did not think they needed treatment for their substance use
- In Appalachia, physical/mental health issues as well as substance use prevents many from working
- Drug of choice varies by race. White populations use more opioids and alcohol while Black populations use more Marijuana. Both demographics have a high rate of Cocaine use
- More people are reporting poor or declining mental health and believe there is a correlation with substance use
- Glenbeigh's Ohio service area includes counties with poor rankings for health outcomes and factors
- While opioids contribute to significant numbers of overdose deaths, stimulant use has been increasing
- There is more awareness of MAT use for opioid use disorders than for alcohol use disorders
- Naloxone distribution remains critical to prevent overdose deaths caused by opioids and related compounds

Other

- The defined service area includes several Appalachian Region areas where the percentage of households with no vehicle exceed the national average
- Appalachia is territorial therefore solutions should be locally tailored to meet local needs
- The COVID-19 pandemic intensified challenges within the Appalachian Region
- Generational poverty within Appalachia complicates efforts to create jobs
- Substance abuse, child abuse and domestic violence interconnect with poverty
- The Appalachian Region continues to be impacted by a lack of affordable housing, healthcare and access to general services
- Transportation remains a challenge in rural communities
- There is a need for more recovery support services for individuals as well as family members, including children

Alcohol/Drug Trends

- Between 2019 and 2020, the Ohio overdose rate increased 25% to a rate of 45.6 deaths per year
- Trumbull ranked among the top four Ohio counties with the highest number of drug overdose deaths per 100,000 population with a death rate of 61.4 per 100,000
- Glenbeigh's service community includes counties within the three highest tiers for drug deaths
- Drug overdose deaths continue to be driven by Fentanyl, often combined with other drugs
- Cocaine and psychostimulant use grew between 2019 and 2021
- Heroin use tapered off between 2019 and 2021
- There has been a leveling-off/decrease in prescription opioid demand
- There has been a documented increase in cocaine and methamphetamine demand
- The marketing of Fentanyl as counterfeit prescription pills remains an issue
- Ohio remains among the top 5 based on rate of drug overdose deaths
- During May 2020, there was a significant surge of drug overdose deaths resulting in the highest number of deaths per month ever recorded in Ohio through the end of 2021
- From 2019 to 2020, drug overdose deaths among White males and females increased 22% and 25% respectively in Ohio
- From 2019 to 2020, drug overdose deaths among Black males and females increased 28% and 34% respectively in Ohio
- From 2019 to 2020, drug overdose deaths among Hispanic males and females increased 36% and 65% respectively in Ohio
- In 2021, 5,331 Pennsylvanians died because of a drug overdose. A 3% increase compared to 2020
- Opioids were involved in 84.5% of Pennsylvania overdose deaths
- Excessive drinking is noted in Allegheny, Butler and Washington counties in Pennsylvania
- COVID-19 reduced the number of OVI and Drug Arrests in Ohio from 2019 through 2021

Socioeconomic factors directly affect the health needs of residents within the defined service community. Glenbeigh's service community stretches across northeast Ohio and includes areas of western Pennsylvania. The majority of the area is part of the Appalachian Region, which provides limited educational opportunities, employment options, income advancement and access to housing and health care. These limitations cause residents to focus on obtaining basic living needs such as food, shelter and clothing, for themselves and their families as the priority. Socioeconomic factors intertwine with substance use. Secondary data shows that there are significant disparities between northeast Ohio and the rest of the state as well as western Pennsylvania versus the remainder of the commonwealth.

Economically disadvantaged families face life challenges that affect their ability to access or secure resources and improve their health, education and overall living conditions. Limited employment opportunities often lead to the inability to secure a sustainable living wage resulting in a higher likelihood to engage in unhealthy behaviors. Typically, this includes excessive or binge alcohol consumption. Data compiled in the Ashtabula County 2022 CHNA contradict the correlation between poverty and alcohol consumption. When examining disparities by household income, the county CHNA noted binge drinking was more prevalent in homes with an annual household income of $75,000 or more. Similarly, Lake County, Ohio, with positive socioeconomic factors, has the highest incidence of alcohol related traffic fatalities. In Pennsylvania, Allegheny County, with an educated population, has a significantly high rate of excessive drinking.

Glenbeigh's defined service area has many factors contributing to the abuse of alcohol and the use of illicit substances. The COVID-19 pandemic exacerbated conditions leading to increased substance use and relapse. In general, the community recognizes the dangers of opioid use, especially fentanyl use, but do not recognize the dangers associated with fentanyl disguised as, or mixed with, other drugs. Results from the primary data surveys revealed that respondents working in addiction treatment and ancillary fields reported that stigma continues to play a role in people delaying treatment for substance use disorders. Much of the public still believes that drugs prescribed by a physician are not addictive. Alcohol is more widely accepted, which was evident during the pandemic lock downs when alcohol inspired games proliferated on social media. Alcohol use continues unabated and affects all demographics.

Communities within Glenbeigh's service area have made progress addressing substance use disorders. However, more work remains to overcome the roadblocks resulting from the pandemic's extended isolation and continued stigma within healthcare and the workplace. The general idea that treatment is not necessary for substance use issues, which has not changed since 2015, needs further exploration.

Drug and Alcohol Treatment Centers in the Service Communities *

Facility	County
OHIO	
Community Counseling Center	Ashtabula
Glenbeigh Hospital	Ashtabula
Lake Area Recovery Center	Ashtabula
Signature Health	Ashtabula
Addiction Recovery Services	Cuyahoga
Applewood Centers Inc.	Cuyahoga
Bellefaire Jewish Children's Bureau	Cuyahoga
Catholic Charities Diocese Cleveland	Cuyahoga
Charak Center for Health and Wellness	Cuyahoga
Circle Health Services (formerly the	Cuyahoga
Cleveland Christian Home Inc.	Cuyahoga
Cleveland Clinic	Cuyahoga
Cleveland Department of Health	Cuyahoga
Cleveland Treatment Center Inc.	Cuyahoga
Community Action Against Addiction	Cuyahoga
Community Assessment and	Cuyahoga
Glenbeigh Outpatient Center of Beachwood	Cuyahoga
Glenbeigh Outpatient Center of Rocky River	Cuyahoga
Harbor Light	Cuyahoga
Highland Springs Hospital	Cuyahoga
Hitchcock Center for Women Inc.	Cuyahoga
Key Decisions/Positive Choices Inc.	Cuyahoga
McIntyre Center Inc.	Cuyahoga
MetroHealth System	Cuyahoga
Moore Counseling and Mediation Service	Cuyahoga
MPTS Casa ALMA/Casa MARIA	Cuyahoga
New Directions Inc.	Cuyahoga
New Visions Unlimited Inc.	Cuyahoga
Northeast Ohio VA Healthcare System	Cuyahoga
OldSchool LLC	Cuyahoga
Psych Services Inc.	Cuyahoga
Recovery Resources	Cuyahoga
Rosary Hall	Cuyahoga
Salvation Army	Cuyahoga
Signature Health Inc.	Cuyahoga

Southwest General Health Center/Oakview	Cuyahoga
Stella Maris	Cuyahoga
Women's Recovery Center	Cuyahoga
Y Haven	Cuyahoga
Beacon Health	Lake
Charak Center for Health and Wellness	Lake
Crossroads Lake County	Lake
Lake Geauga Recovery Centers Inc.	Lake
Louis Stokes VA Medical Center	Lake
Signature Health	Lake
Windsor Laurelwood Center	Lake
Charak Center for Health and Wellness	Lorain
Firelands Counseling/Recovery Services	Lorain
LCADA Way	Lorain
Louis Stokes VA Medical Center	Lorain
Nord Center	Lorain
Psych and Psych Services	Lorain
Akron Urban Minority Alcohol/DA	Summit
CHC Addiction Services	Summit
Child Guidance and Family Solutions	Summit
Cleveland Clinic Akron General	Summit
Community Health Center	Summit
Greenleaf Family Center	Summit
Interval Brotherhood Homes Inc.	Summit
Northeast Ohio Applied Health	Summit
Northeast Ohio VA Medical Center	Summit
OhioGuidestone	Summit
Oriana House	Summit
Pinnacle Treatment Center/Akron	Summit
Summa Health Saint Thomas Campus	Summit
Summit County Health District	Summit
Summit Psychological Associates Inc.	Summit
Urban Ounce of	Summit
Vantage Aging	Summit
COMPASS Family and Community Services	Trumbull
Glenbeigh Outpatient Center of Niles	Trumbull
Louis Stokes VA Medical Center	Trumbull
Meridian Healthcare	Trumbull

Neil Kennedy Recovery Centers	Trumbull
PENNSYLVANIA	
Adaptive Behavioral Services Inc.	Allegheny
Alliance Medical Services Inc.	Allegheny
Alpha House Inc.	Allegheny
Cove Forge Behavioral Health System	Allegheny
Discovery House	Allegheny
Familylinks	Allegheny
Freedom Healthcare Services	Allegheny
Gateway Rehab	Allegheny
Gaudenzia Inc.	Allegheny
Greenbriar Treatment Center	Allegheny
Holy Family Institute/Shores Program	Allegheny
Jade Wellness Center	Allegheny
LaurelCare Treatment Services	Allegheny
Persad Center Inc.	Allegheny
Pittsburgh Mercy	Allegheny
POWER House	Allegheny
Program for Offenders	Allegheny
Progressive Medical Specialists Inc.	Allegheny
Pyramid Healthcare Inc.	Allegheny
Salvation Army	Allegheny
Sojourner House	Allegheny
Summit Medical Services	Allegheny
Tadiso Inc.	Allegheny
TCV Alternatives Program	Allegheny
UPMC Western Psychiatric Hospital	Allegheny
UPMC/Mercy Hospital	Allegheny
VA Pittsburgh Healthcare System	Allegheny
Western PA Adult/Teen Challenge	Allegheny
Clear Choices LLC	Beaver
Drug and Alcohol Services of Beaver County	Beaver
Gateway Rehab	Beaver
Pinnacle Treatment Services of Aliquippa	Beaver
Catholic Charities	Erie
Cove Forge Behavioral Health System	Erie
Esper Treatment Center	Erie
Gage House	Erie
Gateway Erie	Erie
Gaudenzia Erie Inc.	Erie

Glenbeigh Outpatient Center of Erie	Erie
House of Healing	Erie
New Directions Healthcare	Erie
Pyramid Healthcare Inc.	Erie
Safe Harbor Behavior Health of UPMC	Erie
Stairways Drug and Alcohol Outpatient	Erie
Veterans Affairs Medical Center	Erie
Abstinent Living at the Turning Point	Washington
Care Center Inc.	Washington
Echo Treatment Center	Washington
Greenbriar Treatment Center	Washington
Outside in School	Washington
Progressive Medical Specialists Inc.	Washington
Turning Point II	Washington
Wesley Family Services	Washington

Source: Substance Abuse and Mental Health Services Administration
https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/National_Directory_SA_facilities_2019.pdf

* Note: Most current listing is the 2019 National Directory.

Other Community Resources

There are myriad agencies, coalitions and organization serving Glenbeigh's defined service areas. The 988 Suicide & Crisis Lifeline, United Way Helpline 211 and Help Network of Northeast Ohio, maintain a considerable referral network available at no charge to individuals in need of health and human services assistance. The United Way 211 offers assistance in the following areas:

- Basic Needs – includes food, housing/shelters, transportation and assistance with utilities and other services
- Mental Health and Substance Abuse – includes counseling, mental health care facilities as well as evaluations, treatment programs and support services. Substance abuse services include suicide and crisis intervention/prevention, peer-to-peer support services and housing assistance for specific counties.
- Veterans Outreach – offering resources for veterans who are homeless or need assistance and other services
- Food – information on local food pantries and free meal sites
- Dispute Resolution – offering services to advocate on behalf of individuals in need and mediating disputes between two or more parties
- Victim's Assistance – connecting people to the victims assistance program and the victims of crime support group
- Health – providing resource information on available health services throughout the community as well as information on assistance for individuals with developmental disabilities or special needs. Provides a connection to resources for seniors

A full listing of services and referral networks is available at https://www.helpnetworkneo.org/, https://www.samhsa.gov/find-help/988, or at https://www.211.org/ on the internet. Immediate assistance is available by calling 988 or 211.

Primary Data Summary

Community input (primary data) was gathered through key informant interviews and through in-person and online surveys. During the formation of the 2022 Community Health Needs Assessment (CHNA), COVID-19, an infectious disease caused by the SARS-CoV-2 virus, continues to impact community health as well as access to services. While collecting data for the 2022 CHNA, COVID-19 protocols and precautions, initiated to limit the spread of the virus, remained in place resulting in more reliance on phone interviews, surveys and other non-contact means of collecting primary data. Primary data was gleaned from work completed by Shilling Consulting Services, Inc., of Rockford, Michigan. Glenbeigh undertook a strategic plan initiative with Shilling Consulting concurrently to the CHNA. The strategic plan provided data on Glenbeigh's defined service community as well as primary data collected from community leaders and people working with individuals impacted by alcohol and drug addiction.

Interviews were conducted by Shilling representatives during the spring of 2022. Interview participants represented a) leaders and professionals working in the field of addiction treatment or services and persons with public health and social service knowledge. Survey participants included a mix of individuals in recovery as well as family members or loved ones of individuals with addiction. All participants were at least 18 years of age. Eight individuals were interviewed as key informants. An additional 19 individuals participated in an in-person survey conducted at the Glenbeigh Outpatient Center of Niles. Another 30 individuals completed an online survey that was sent to individuals across Glenbeigh's defined service area. A total of 57 individuals provided information on the social determinants of health affecting individuals and families as related to addiction, treatment and recovery. The following appendixes catalogue input collected from these methodologies and include supplemental information used to formulate the 2022 Community Health Needs Assessment.

Appendix A: Key Informant Interviews

Key Informant Interviews

February 25, 2022 - March 14, 2022

Conducted by Shilling Consulting Services, LLC
Rockford, Michigan

Key Informant Interview List

Tim Shaffner Executive Director, Trumbull County Children's Services	Mark Fuller, M.D., FACP Executive Director, Care for Recovery Medicine, Allegheny Health Network	Miriam Walton Executive Director, Ashtabula County Mental Health & Recovery Services
David Streem, M.D., FASAM Gregory Collins Endowed Chair in Alcohol and Drug Recovery, Cleveland Clinic	**Interviews conducted February/ March 2022**	Kevin Smith, Ph.D. Clinical Psychologist Chief, Veterans Addiction Recovery Center, Cleveland VA
April Caraway Executive Director, Trumbull Mental Health and Recovery Board	Nelson Heise, PCC-S Clinical Director, Ohio Physicians Health Programs Columbus, Ohio	Joann Megon, RN, BSN Executive Director, PA Nursing & Pharmacy Recovery Programs

Stakeholder Interviews Question Template

Glenbeigh Hospital and Outpatient Centers would highly value your perspectives and insights as they prepare to develop a new Strategic Plan. As part of that preparation, they are conducting a series of structured interviews with community stakeholders, industry and treatment experts, and thought leaders. The information gained in these 30-minute interviews will add to their understanding of addiction treatment and recovery industry trends, issues and best practices that will help shape their Vision and Goals for the future.

The interviews will be conducted by a consultant, Jeff Schilling. Should you have any questions or follow-up comments, [contact information was provided].

Thank you for participating in these interviews. Your thoughts and observations will contribute tremendously to Glenbeigh's Strategic Plan development.

Interview Questions (Draft)

1. Can you briefly describe the behavioral health services that your organization provides?
2. From your own perspective, what are some of the greatest strengths of Glenbeigh? What are some of the greatest weaknesses [2-3]?
3. Thinking about the landscape of drug & alcohol treatment specifically, and behavioral health in general, what strengths or new capabilities should Glenbeigh cultivate in the next few years that could better serve our communities?
4. What innovation or improvement in services or service delivery would you most like to see Glenbeigh achieve in order to improve the effectiveness of, or access to, drug and alcohol treatment? Is there a different care model (e.g. virtual visit-based vs. find a physical space to meet with patients) that you would be interested in exploring?
5. Do you think there may be new partnership opportunities, or opportunities to strengthen existing collaboration, between your organization and Glenbeigh in any of the following or other areas? (If so, please describe)

   ☐ Drug & Alcohol Treatment: New care strategies, innovative approaches

   ☐ Eating Disorders ☐ Increasing community awareness

   ☐ Complex Patient Care (Co-occurring Disorders / Comorbidity (Physical Issues))

   ☐ Advocacy (better insurance coverage, One Bite legislation, other?)

   ☐ Professional Staff Education ☐ Other?

   In any of these partnership or collaboration efforts, should Glenbeigh's role be that of a leader, convener, supporter, or an advocate (or any combination).
6. **CLOSING QUESTION (Time Permitting):** Any other comments you would like to make that you think might be helpful to Glenbeigh as it engages in strategic planning?

Responses – Stakeholder Interview 1

Note: Replies have been edited to reflect only material relevant to the CHNA

Interview conducted March 11, 2022, 9:00 AM EST

Interview Questions

1. Can you briefly describe the behavioral health services that your organization provides?
   [The interviewee organization] conducts assessments, collects data, and arranges for services to meet the mental health and recovery needs of county residents. They prepare a Community Plan and then contract with providers for needed services.

2. From your own perspective, what are some of the greatest strengths of Glenbeigh? What are some of the greatest weaknesses [2-3]?
   Strengths:
   a) *We have had a long relationship with Glenbeigh (GB). We had to back off for a while – couldn't afford residential treatment. We are [now] expanding our relationship more.*
   b) *We have started to work with them on our training academy; they have provided trainers at times.*
   c) *The Residential Detox Program.*
   d) *Working together on the CRAFT Program (Community Reinforcement and Family Training, is an approach for families who have a loved one struggling with substances, but who is not really interested in making changes or getting help).*
   e) *Willing to look at new opportunities – open to working with us.*
   f) *They have been working on improving their communication – it has been improving, discussing what the Board needs.*

   Weaknesses:
   a) *Evidence based practice – indicates the effectiveness of more than what GB does currently (e.g. Vivitrol). This will be a shift in philosophy, but we really need it.*
   b) *Continue improving communication. This is really important as new opportunities, funding surfaces from the State – [this organization would] then better able to make connections to what GB could do related to these opportunities.*
   c) *GB does not accept [Ohio] Medicaid for residential treatment. Keep looking at this. While reimbursement may be low, Ashtabula County has a high Medicaid population. This would be really beneficial (Detox and Residential).*

3. Thinking about the landscape of drug & alcohol treatment specifically, and behavioral health in general, what strengths or new capabilities should Glenbeigh cultivate in the next few years that could better serve our communities?
   a) *Methamphetamine treatment – it is different – look at evidence-based practice.*
   b) *Increase the number of staff who are trained in recognizing signs of suicide.*
   c) *The number of providers that can handle co-occurring mental health disorders is increasing, and needs to. We have more patients like this. This would include better screening, better psychiatric coverage. Dually certified licensed staff.*

d) Ability to provide continued drug therapy for patients where that was initiated in the ER or at the hospital. Have the staff that can oversee this.

4. What innovation or improvement in services or service delivery would you most like to see Glenbeigh achieve in order to improve the effectiveness of, or access to, drug and alcohol treatment?
   [Refer to answers to other questions].

5. Do you think there may be new partnership opportunities, or opportunities to strengthen existing collaboration, between your organization and Glenbeigh in any of the following or other areas? (If so, please describe)
   ☐ Drug & Alcohol Treatment: New care strategies, innovative approaches
   ☐ Eating Disorders ☐ Increasing community awareness
   ☐ Complex Patient Care (Co-occurring Disorders / Comorbidity (Physical Issues))
   ☐ Advocacy (better insurance coverage, One Bite legislation, other?)
   ☐ Professional Staff Education ☐ Other?

   In any of these partnership or collaboration efforts, should Glenbeigh's role be that of a leader, convener, supporter, or an advocate (or any combination).
   - *Outreach. The CRAFT is a good example of an outreach program. Community education. More things like this would be helpful. Expand outreach.*
   - ***Keep educating us about your capabilities...new services, expertise, pilot programs, etc. Keep us up to speed on what they are doing.*** *[Especially important in this next GB Strategic Plan period if there are efforts to expand the services portfolio.]*
   - *With the SOAR (SSI/SSDI Outreach, Access, and Recovery), the Ohio Opioid Response funding, is GB providing or capable of providing needed services that are within the parameters of this funding?*
   - *More parent education for those who struggled with SA; important considerations regarding their children.*

6. **CLOSING QUESTION:** Any other comments you would like to make that you think might be helpful to Glenbeigh as it engages in strategic planning?
   - *We would like to see the Behavioral Health inpatient unit at ACMC and GB working more together – coordinate on the care needs of patients.*
   - *Expand to mental health and dual diagnosis.*
   - *Are they looking at some point stepping into prevention? Adult prevention is an area of need and increasing focus for us.*
   - *Leverage their data and discuss findings with us, especially those specific to Ashtabula County. For example, we hear that a lot of counties are seeing an spike in alcohol abuse, especially with the COVID pandemic. Our own data may not be picking that up, but is GB seeing this? That would be very helpful information because there may be funding to help. Another example is what do we know about Seniors and their needs? Are they increasing? Is there a prevention strategy (e.g. perhaps one initial step is to connect with our Senior Centers in an education and outreach effort. There may be funding to support this.)*

Responses – Stakeholder Interview 2

Note: Replies have been edited to reflect only material relevant to the CHNA

Interview conducted February 28, 2022, 3:00 PM EST

Interview Questions

1. Can you briefly describe the behavioral health services that your organization provides?

   Interviewee works at an *Alcohol and Drug Recovery Center and Detox Unit. This includes treatment, PHP and 3 Intensive OP programs. Interviewee is also involved with other treatment providers and understands compliance and privacy issues. Stakeholder has extensive experience with behavioral health and substance abuse treatment.*

2. From your own perspective, what are some of the greatest strengths of Glenbeigh? What are some of the greatest weaknesses [2-3]?

   Strengths: *Individual's organization works more closely with Glenbeigh than any other SA treatment center. Genbeigh's strengths include:*

   a) *Geographic distribution of their facilities gives them the ability to draw from a large area. This benefits both Glenbeigh and ACMC. Their location(s) is a strength.*
   b) *Their efforts in contracting.*
   c) *Good facility design; feels more comfortable than what might be expected in such a large facility.*
   d) *Individual counseling.*
   e) *Family Program.*

   Opportunities for Improvement:

   a) *Lack of support for med-assisted treatment. This may be grounded in their focus on residential treatment. This presents a very real operational issue, though, in that it makes the follow-up that goes with med-assisted treatment challenging if not impossible. They should not provide med-assisted treatment if they can't provide the follow-up, but med-assisted treatment is becoming more common.*
   b) *Eating Disorder Patients: There are few programs that can provide capable care for dual diagnosis of eating disorder and substance abuse. Few centers do this well – many centers that do not have the expertise to address both eating disorders and substance abuse (usually because they lack the eating disorder expertise), will accept these dual diagnosis patients anyway. Glenbeigh is an exception in that they refer these patients elsewhere. However, if they could develop the eating disorder expertise, they could accept some of these patients.*
   c) *Physician (psychiatrist) involvement with IOP. Glenbeigh Psychiatrist coverage probably not enough to provide good coverage of the IOP patients that may benefit from it.*

3. Thinking about the landscape of drug & alcohol treatment specifically, and behavioral health in general, what strengths or new capabilities should Glenbeigh cultivate in the next few years that could better serve our communities?
    a) *Psychiatric consultation availability – need more Psychiatrist coverage, including for IOP.*
    b) *Use measurable questionnaires to measure things like social anxiety, trauma, etc. There needs to be opportunities for patients to fill out these as they progress through treatment, at specific stages.*
    c) *Long acting injectable medications such as Vivitrol® and Sublocade®.*

4. What innovation or improvement in services or service delivery would you most like to see Glenbeigh achieve in order to improve the effectiveness of, or access to, drug and alcohol treatment?
    Don't fall for the "Fluff". Focus on evidence-based treatment. There have been some programs that have focused more on amenities and creature comforts and were lacking on effective treatment. They don't usually last.

5. Do you think there may be new partnership opportunities, or opportunities to strengthen existing collaboration, between your organization and Glenbeigh in any of the following or other areas? (If so, please describe)

    ☐ Drug & Alcohol Treatment: New care strategies, innovative approaches

    ☐ Eating Disorders ☐ Increasing community awareness

    ☐ Complex Patient Care (Co-occurring Disorders / Comorbidity (Physical Issues))

    ☐ Advocacy (better insurance coverage, One Bite legislation, other?)

    ☐ Professional Staff Education ☐ Other?

    In any of these partnership or collaboration efforts, should Glenbeigh's role be that of a leader, convener, supporter, or an advocate (or any combination).
    Having ACMC as an affiliation of Cleveland Clinic may provide opportunities for more collaboration.

6. **CLOSING QUESTION (Time Permitting):** Any other comments you would like to make that you think might be helpful to Glenbeigh as it engages in strategic planning?
    a) *They have an opportunity, if they want, to pursue hosting more professional education – put on a conference.*
    b) *When asked about Glenbeigh's Nurses Program, the interviewee complimented this kind of thinking, and agreed there are probably more opportunities with other licensed professions.*
    c) *Transportation of Patients. Stakeholder was very complimentary of how Glenbeigh provided transportation of patients to their facility (pre-Pandemic). He felt this was a very positive move and set them apart from other options. He recalled that they would go anywhere in northern Ohio. This can be a real plus, especially if drivers have some kind of relevant background / experience with substance abuse. It offers an opportunity to begin relating to the patient immediately and form a very positive first impression.*

Responses – Stakeholder Interview 3

Note: Replies have been edited to reflect only material relevant to the CHNA

Interview conducted February 2, 2022, 9:30 AM EST

Interview Questions

1. Can you briefly describe the behavioral health services that your organization provides?

   The Interviewee's responsibilities include oversight of an addiction program, which includes a psychiatric unit and observation. Stakeholder has comprehensive experience with Treatment Teams in the Addiction Program including 2 OP Men's, OP Gambling, Women OP Services, Residential Gambling for men and women, a Large Opioid Treatment Program (w Methadone and other drugs), and Detox services. Program is well equipped to address comorbid conditions (medical and Psych/Addiction).

2. From your own perspective, what are some of the greatest strengths of Glenbeigh? What are some of the greatest weaknesses [2-3]?

   Strengths:

   a) *Huge advantage in that they have staff therapists who have recovery experience.*
   b) *Emphasis on 12 step recovery.*
   c) *Glenbeigh [does a good job] conducting residential treatment – don't allow patients to just sleep in the rooms – have to participate. Take the cell phones, provide family passes. Restrictions are valuable.*

   Weaknesses:

   a) *Consider more CBT focus in treatment interventions.*
   b) *More "smart" recovery.*
   c) *Not much integration with mental health – more "trauma", PTSD.*

3. Thinking about the landscape of drug & alcohol treatment specifically, and behavioral health in general, what strengths or new capabilities should Glenbeigh cultivate in the next few years that could better serve our communities?

   Expanding Medical Assisted Treatment beyond Suboxone, in conjunction with psycho-social treatment. Expand beyond abstinence in some cases to a "harm reduction" approach – an alternative. Meet the patient where they are at.

4. What innovation or improvement in services or service delivery would you most like to see Glenbeigh achieve in order to improve the effectiveness of, or access to, drug and alcohol treatment?

   a) *Recent article – Brain intervention – Deep brain stimulation? May have impact on SA.*
   b) *Explore smart recovery.*
   c) *Fentanyl Test Strips – Is GB using them? Stakeholder agency uses them with Meth or Cocaine patients. Should not use with Heroin addiction.*

d) *Syringe service program (needle exchange)...if it would be compatible with mission. [a harm reduction program] Need to have ability to refer to infectious disease specialist. Gun locks, condoms are other examples of harm reduction strategies.*

5. Do you think there may be new partnership opportunities, or opportunities to strengthen existing collaboration, between your organization and Glenbeigh in any of the following or other areas? (If so, please describe)

   ☐ Drug & Alcohol Treatment: New care strategies, innovative approaches

   ☐ Eating Disorders ☐ Increasing community awareness

   ☐ Complex Patient Care (Co-occurring Disorders / Comorbidity (Physical Issues))

   ☐ Advocacy (better insurance coverage, One Bite legislation, other?)

   ☐ Professional Staff Education ☐ Other?

   In any of these partnership or collaboration efforts, should Glenbeigh's role be that of a leader, convener, supporter, or an advocate (or any combination).

   a) *Stakeholder's organization cannot refer clients directly to Glenbeigh. [Need to] refer patients to a 3rd party, OPTUM, a qualified Community Care Consulting Program. Organization did not have Evening IOP, so referred some of those patients to OPTUM. Also some other conditions - borderline personality disorder. For addiction, most referrals to OPTUM involve daily methadone dosing. Glenbeigh should have a strong relationship with OPTUM.*
   b) *If GB sees a veteran that does not have insurance, refer to the VA.*
   c) *Interviewee's organization would be very willing to come out and do a presentation on their addiction services.*

6. **CLOSING QUESTION (Time Permitting):** Any other comments you would like to make that you think might be helpful to Glenbeigh as it engages in strategic planning?

   The stakeholder's organization has a high opinion of Glenbeigh – the patients and staff that worked there all have favorable comments. Nothing negative. Reach out to us any time if we can offer or provide information or just listen.

Responses – Stakeholder Interview 4

Note: Replies have been edited to reflect only material relevant to the CHNA

Interview conducted March 14, 2022, 10:30 AM EST

Interview Questions

1. Can you briefly describe the behavioral health services that your organization provides?
   Social service agency covering Trumbull County.

2. From your own perspective, what are some of the greatest strengths of Glenbeigh? What are some of the greatest weaknesses [2-3]?

   Strengths:

   a) *Good staff.*
   b) *Care is great. Effective care model and methods - Therapeutic Alliance between staff and patients.*
   c) *Great reputation among patients – always positive feedback.*
   d) *Cleveland Clinic alliance.*
   e) *Access is good. Good front door. Will take assessment after hours. Will even suggest another provider if they can't take someone.*
   f) *They are good at getting more days (approved by insurance plan).*

   Weaknesses:

   a) *They don't market their services...not in traditional or modern sense. Very low awareness. Perhaps relying too much on their history?*
   b) *Don't take Medicaid – 99% of our clients are Medicaid.*
   c) *Maybe some lack of knowledge of other organizations and services that could be a referral source. Just went to visit them. They did not know what we do.*
   d) *They have a very conservative philosophy regarding treatment...no MAT. And "Harm Reduction" won't work for us – we are focused on getting families reunited.*

3. Thinking about the landscape of drug & alcohol treatment specifically, and behavioral health in general, what strengths or new capabilities should Glenbeigh cultivate in the next few years that could better serve our communities?

   [Refer to next question].

4. What innovation or improvement in services or service delivery would you most like to see Glenbeigh achieve in order to improve the effectiveness of, or access to, drug and alcohol treatment?

   e) *Carnegie Mellon Study is very interesting – smart devices on people. Able to predict when a person is ready to leave the program. Research like this will be very helpful to GB...can help change their image from one that is getting left behind regarding treatment approach to one that is on the cutting edge.*
   f) *Ohio is doing some stigma-busting campaigns. Hard to understand – all strange. Efforts to reduce / overcome stigma around of mental health / SA are needed, but need to be effective and done well.*

g) *Explore using Peer Counselors in some treatment plans. However, only Medicaid pays for it.*

5. Do you think there may be new partnership opportunities, or opportunities to strengthen existing collaboration, between your organization and Glenbeigh in any of the following or other areas? (If so, please describe)

   ☐ Drug & Alcohol Treatment: New care strategies, innovative approaches

   ☐ Eating Disorders ☐ Increasing community awareness

   ☐ Complex Patient Care (Co-occurring Disorders / Comorbidity (Physical Issues))

   ☐ Advocacy (better insurance coverage, One Bite legislation, other?)

   ☐ Professional Staff Education ☐ Other?

   In any of these partnership or collaboration efforts, should Glenbeigh's role be that of a leader, convener, supporter, or an advocate (or any combination).

   - *Meridian has been a long-term provider and resource for us, but they accept Medicaid. They are always at the table with us and responsive to our needs. Would Glenbeigh be able to start a Non-Profit subsidiary, and accept Medicaid there?*

6. **CLOSING QUESTION:** Any other comments you would like to make that you think might be helpful to Glenbeigh as it engages in strategic planning?

   Treatment programs for various licensed professionals would contribute positively to their reputation and maybe help build awareness a little. But would it translate into significant volume of patients?

Responses – Stakeholder Interview 5

Note: Replies have been edited to reflect only material relevant to the CHNA

Interview conducted March 9, 2022, 11:00 AM EST

Interview Questions

1. Can you briefly describe the behavioral health services that your organization provides?

   Interviewee works with a Peer Assistance Program for licensed professionals. The program arranges for evaluations with a Case Manager, and if appropriate, arranges for treatment and required monitoring after completion of treatment. It is not a punitive program – they focus on advocacy and help, with a goal of getting licenses reinstated if the treatment is successful. The stakeholder's organization uses Glenbeigh for Inpatient treatment. Interview input reflects the interviewee's opinion plus input from the organization's Case Manager group.

2. From your own perspective, what are some of the greatest strengths of Glenbeigh? What are some of the greatest weaknesses [2-3]?

   Strengths:

   g) *Great communication between Glenbeigh's intake and other personnel and our Case Managers. Communication has been great from the Erie location.*

   a) *Access for our clients is great.*

   b) *They run a health care professionals group for us weekly. It is well attended and well run, very successful.*

   c) *It is a plus that they can accept funding through Medicaid (Erie); many of our other providers don't.*

   Weaknesses:

   a) *If someone is just getting an initial evaluation, sometimes the evaluations are not that detailed. Glenbeigh agrees to add information at times if asked. The State expects evaluations to be pretty detailed.*

   b) *Abstinence only approach.*

3. Thinking about the landscape of drug & alcohol treatment specifically, and behavioral health in general, what strengths or new capabilities should Glenbeigh cultivate in the next few years that could better serve our communities?

   The Mental Health (MH) component at most Substance Abuse (SA) providers is a weakness. Many of our clients have an underlying MH issue as well – often exacerbated by lack of access to MH. This is a growing need since COVID-19. If Glenbeigh could be more Dual Dx oriented, it would be a big help. Another center that we work with has added weekly psychiatrist coverage.

4. What innovation or improvement in services or service delivery would you most like to see Glenbeigh achieve in order to improve the effectiveness of, or access to, drug and alcohol treatment?

We utilize the Erie location. It would be great if we had another location in PA, something more south...Meadville, Greenville. There are very few options in much of the Western side of the state.

5. Do you think there may be new partnership opportunities, or opportunities to strengthen existing collaboration, between your organization and Glenbeigh in any of the following or other areas? (If so, please describe)

   ☐ Drug & Alcohol Treatment: New care strategies, innovative approaches

   ☐ Eating Disorders ☐ Increasing community awareness

   ☐ Complex Patient Care (Co-occurring Disorders / Comorbidity (Physical Issues))

   ☐ Advocacy (better insurance coverage, One Bite legislation, other?)

   ☐ Professional Staff Education ☐ Other?

   In any of these partnership or collaboration efforts, should Glenbeigh's role be that of a leader, convener, supporter, or an advocate (or any combination).

   - *There are very few providers that treat both substance abuse with an eating disorder – but our numbers are small.*
   - *We are seeing more and more clients with Dual Dx (SA and Psych).*

6. **CLOSING QUESTION:** Any other comments you would like to make that you think might be helpful to Glenbeigh as it engages in strategic planning?
   - *Take a hard look at growing and building. There is a growing need, so we will need more capacity that is also accepted by insurance. We are somewhat selective given the role of our clients. ...very confident in GB.*
   - *When asked about it, interviewee thought expansion to other licensed professionals (pilots, teachers) makes a lot of sense. She believes there is a great need among teachers.*
   - *Stakeholder gets e-mails about specialty meetings (and speakers) from Glenbeigh which she thinks are amazing opportunities. She now forwards some of these to clients so they can connect and participate. Having them specific to certain professions (Health care, teachers) are great.*

Responses – Stakeholder Interview 6

Note: Replies have been edited to reflect only material relevant to the CHNA

Interview conducted March 10, 2022, 11:00 AM EST

Interview Questions

1. Can you briefly describe the behavioral health services that your organization provides?

   Two individuals from this organization participated in the interview. They represent an organization that provides assistance for licensed professionals.

2. From your own perspective, what are some of the greatest strengths of Glenbeigh? What are some of the greatest weaknesses [2-3]?

   Strengths:

   a) *Very competent regarding regulations and requirements. They know the ropes; we don't have to teach them anything.*
   b) *Very successful program – good quality of care.*
   c) *Accessibility and willingness to problem solve and trouble shoot*
   d) *Excellent communication – the best among all organizations we work with.*
   e) *When we have an urgent need, they expedite things very well.*
   f) *They are highly accountable. They "own" things that don't go right and do all they can to fix and prevent a repeat.*

   Improvement Opportunities:

   a) *Glenbeigh (GB) has indicated they have a program for health care professionals. Go to the "next level" with that program and that group. Focus more on their unique needs and wants in treatment design and scope. One way we have noticed that some providers do this is by creating "tracks" within their residential treatment component (the Chronic Pain track or the Trauma track). So a client with a residential treatment component might experience the basic Substance abuse program there, but also be enrolled in the Pain Management track where he / she would have some additional, concurrent treatment targeted toward their Pain Management.*
   b) *Some patients require longer treatment, but both stakeholders sometimes sense a pressure to strictly limit services or the length of treatment. "Feel" the pressure to limit it [and wonder if this is due to insurance limitations or other factors].*
   c) *GB seems to have limited resources. Look for ways to expand and build on their reputation with health care professionals as a means of generating more capacity for supporting other kinds of expansion and growth.*

3. Thinking about the landscape of drug & alcohol treatment specifically, and behavioral health in general, what strengths or new capabilities should Glenbeigh cultivate in the next few years that could better serve our communities? **Is there a different care model (e.g. virtual visit-based vs. find a physical space to meet with patients) that you would be interested in exploring?**

   The Telehealth component is realistic for the after-care phase of treatment and even for some other applications during the full spectrum of care. But for the kinds

of patients we deal with, we don't believe it can be the entire care delivery mode. Most of our patients would still need Acute Care or Intensive Outpatient Care on-site / in person.

4. What innovation or improvement in services or service delivery would you most like to see Glenbeigh achieve in order to improve the effectiveness of, or access to, drug and alcohol treatment?
    a) *We are working a lot with many professionals, and we think the need there will continue to grow. As a result, we need to grow and evolve. We have relied a great deal on our partnership with GB and would like to continue working with them on ways to bring more local access to our clients, even if it isn't residential. We would love find ways to grow together!*
    b) *We need an entity that can handle the more complex intake (toxicology, comprehensive 3-day eval, meet with psychiatrist, obtaining collateral / family info, etc.).*

5. Do you think there may be new partnership opportunities, or opportunities to strengthen existing collaboration, between your organization and Glenbeigh in any of the following or other areas? (If so, please describe)

    ☐ Drug & Alcohol Treatment: New care strategies, innovative approaches

    ☐ Eating Disorders ☐ Increasing community awareness

    ☐ Complex Patient Care (Co-occurring Disorders / Comorbidity (Physical Issues))

    ☐ Advocacy (better insurance coverage, One Bite legislation, other?)

    ☐ Professional Staff Education ☐ Other?

    In any of these partnership or collaboration efforts, should Glenbeigh's role be that of a leader, convener, supporter, or an advocate (or any combination).

    a) *We need more services in more locations. We cover the whole state, but there are areas where we don't have any providers to refer to. Our highest need is in Columbus. We get the highest number of referrals from the Columbus area, but we must send everyone out of the area for treatment. Cincinnati is another challenge. We had a facility there that we referred to but they closed a few years ago, so it really created a hole for us. We tried working with someone else, but it went poorly. There was a huge learning curve with this "new" provider. GB knows the requirements and needed protocols.*
    b) *Complex Patients: Yes, this is a significant growing need. They find almost all their patients are multiple diagnosis. Professional-focused programs need to have co-occurring groups and resources for each of the issues. IOP is probably not always the best place for some of these patients. A benefit of residential treatment is the ability to bring all the components together for the patient.*
    c) *Advocacy efforts? We should explore this more – can always use allies.*

6. **CLOSING QUESTION:** Any other comments you would like to make that you think might be helpful to Glenbeigh as it engages in strategic planning?

- *Growing GB! Expanding is the big thing. Get outside the box a bit. Build on the foundation.*
- *Consider MAT. For some populations and some patients...probably need to consider this.*
- *We have worked very well with GB. Our own organization leadership believes we are in the midst of a cultural shift in the US, one that may result in increased demand for services. We have always counted on GB as a partner. Continue to be committed to the partnership, especially in bringing services to some high need areas (e.g. Columbus).*
- *Let us know what we can do. If you want to launch a new professionals program or pilot "tracks" within an existing program, we would like to help.*

Responses – Stakeholder Interview 7

Note: Replies have been edited to reflect only material relevant to the CHNA

Interview conducted March 4, 2022, 2:30 PM EST

Interview Questions

1. Can you briefly describe the behavioral health services that your organization provides?

   Stakeholder is part of a hospital-based SA treatment program – part of an Integrated Delivery Network providing services to people receiving medical-surgical services. Our programs are embedded in the health care system to provide services and align with other providers. Examples of some of the services we provide or arrange for are: Consultation, an OP Clinic, some outreach services with the County Jail and mobile vans.

2. From your own perspective, what are some of the greatest strengths of Glenbeigh? What are some of the greatest weaknesses [2-3]?

   Strengths:

   a) *Never had a dissatisfied customer! Always feel comfortable referring patients there.*
   b) *Intake group is very easy to work with and responds rapidly. Not always true of other organizations.*
   c) *Good that they accept some Medicare Plans*

   Weaknesses:

   a) *Abstinence-based program needs to be augmented by MAT.*
   b) *Community Care Behavioral Health Organization* (CCBHO), a payer – Glenbeigh is not in their network. We see a lot of their patients.*
   c) *Some Medicare Plans are not accepted by Glenbeigh.*

   * Part of the UPMC Insurance Services Division, which also includes UPMC Health Plan, WorkPartners, and UPMC for You (Medical Assistance).

3. Thinking about the landscape of drug & alcohol treatment specifically, and behavioral health in general, what strengths or new capabilities should Glenbeigh cultivate in the next few years that could better serve our communities?

   a) *Telehealth, particularly in <u>follow-up care</u>.*
   b) *Mental Health and Substance Abuse – Dual Dx. Not many good sources. Challenging population. A real need. Need psychiatrist coverage and involvement.*

4. What innovation or improvement in services or service delivery would you most like to see Glenbeigh achieve in order to improve the effectiveness of, or access to, drug and alcohol treatment?

   a) *Transportation – we are a good distance from Glenbeigh.*
   b) *Treatment for Adolescents. Not a lot of competition.*
   c) *A Women's track. (Include Trauma-Informed care.)*

5. Do you think there may be new partnership opportunities, or opportunities to strengthen existing collaboration, between your organization and Glenbeigh in any of the following or other areas? (If so, please describe)

   ☐ Drug & Alcohol Treatment: New care strategies, innovative approaches

   ☐ Eating Disorders ☐ Increasing community awareness

   ☐ Complex Patient Care (Co-occurring Disorders / Comorbidity (Physical Issues))

   ☐ Advocacy (better insurance coverage, One Bite legislation, other?)

   ☐ Professional Staff Education ☐ Other?

   In any of these partnership or collaboration efforts, should Glenbeigh's role be that of a leader, convener, supporter, or an advocate (or any combination).

   Nothing comes to mind.

6. **CLOSING QUESTION:** Any other comments you would like to make that you think might be helpful to Glenbeigh as it engages in strategic planning?

   There is a continued rise in stimulant use, more pronounced on the coasts, but slowly working its way toward the Midwest. This presents challenges in treatment. May not be an immediate problem for Glenbeigh in this area, but might want to begin planning ahead.

Responses – Stakeholder Interview 8

Note: Replies have been edited to reflect only material relevant to the CHNA

Interview conducted March 2, 2022, 1:30 PM EST

Interview Questions

1. Can you briefly describe the behavioral health services that your organization provides?

   The interviewee represents an organization that audits and funds treatment agencies such as Glenbeigh. The organization is a resource for the community by offering education and networking for individuals touched by addiction and mental health problems.

2. From your own perspective, what are some of the greatest strengths of Glenbeigh? What are some of the greatest weaknesses [2-3]?

   Strengths

   a) *Rock Creek for Detox and IP care.*
   b) *Glenbeigh does a very good job with Alcohol Use Disorders – the best.*

   Improvement Opportunities

   a) *Glenbeigh does not bill Medicaid, so we pay based on a different rate structure - that's an issue.*
   b) *Increase treatment and outreach for families and children – sober houses – keeping kids with parent.*
   c) *Proximity: The facilities in Rock Creek are very good, but a little bit of a journey for our clients. Glenbeigh has a presence in Niles. That's closer for our clients, but it is very small. Would it be possible to increase capacity and services there? Or provide transportation to the Rock Creek facility?*

3. Thinking about the landscape of drug & alcohol treatment specifically, and behavioral health in general, what strengths or new capabilities should Glenbeigh cultivate in the next few years that could better serve our communities?

   a) *Include safe family units.*
   b) *Grow Niles operations.*
   c) *We are trying to find an agency that treats juveniles. Also, looking for help in overcoming barriers to treatment for this population. There is a stigma among some parents regarding substance abuse among children, contributing to them sometimes being in denial that it may be an issue in their family. How could Glenbeigh help us with community outreach, marketing, and prevention efforts to reduce the stigma and reach the parents of children that have a SA issue, and then be able to provide services for those kids that need it.*

4. What innovation or improvement in services or service delivery would you most like to see Glenbeigh achieve in order to improve the effectiveness of, or access to, drug and alcohol treatment?

   a) *Medically Assisted Treatment (MAT) – Not providing these services limits the clients we can refer to them. There is too much research that supports MAT.*

Outside of Alcohol Abuse, the recidivism rates of 12 step approaches among other substance abuse is very high.

b) *Behavioral Health – Psychiatric coverage. Our most common conditions in this county are depression and anxiety, and some of these cases also have a substance abuse issue. We find some resources for dual diagnosis, but they don't do it well. Would like to see Glenbeigh develop their behavioral health capabilities and psychiatric coverage to the point where they can effectively treat dual diagnosis patients.*

c) *Embrace a holistic, broad spectrum mental and behavioral health model as part of an even broader medical / mental health model.*

d) *The Drug and Alcohol Treatment field is increasingly staffed with people who are themselves in recovery. However, many of them lack the academic background of therapists who used to be more common in the field from licensed social workers on up. They lack the formal mental / behavioral health education that would equip them to more effectively deal with more complex cased and conditions.*

5. Do you think there may be new partnership opportunities, or opportunities to strengthen existing collaboration, between your organization and Glenbeigh in any of the following or other areas? (If so, please describe)

☐ Drug & Alcohol Treatment: New care strategies, innovative approaches

☐ Eating Disorders ☐ Increasing community awareness

☐ Complex Patient Care (Co-occurring Disorders / Comorbidity (Physical Issues))

☐ Advocacy (better insurance coverage, One Bite legislation, other?)

☐ Professional Staff Education ☐ Other?

In any of these partnership or collaboration efforts, should Glenbeigh's role be that of a leader, convener, supporter, or an advocate (or any combination).

The stakeholder's organization always encourages our agencies to talk to and work with each other. It is difficult for some of our clients to get all the care they need unless multiple organizations work together. We have regularly scheduled Core Provider Meetings (Director level) where Glenbeigh participates. Thinking about Glenbeigh, it would ideal to see them continue to build collaboration with the primary metal health agencies in our service area (Compass, Coleman and Valley).

6. **CLOSING QUESTION:** Any other comments you would like to make that you think might be helpful to Glenbeigh as it engages in strategic planning?

Trumbull County has a bigger contract with Glenbeigh than does the Ashtabula County Mental Health and Recovery Board, which is where Glenbeigh is located. This seems counter intuitive. Any rationale behind this?

Appendix B: In-Person Surveys

In-Person Survey Results

Conducted between August 1 and August 12, 2022

Location: Glenbeigh Outpatient Center of Niles

Due to continued COVID-19 spread, focus groups were replaced with surveys distributed in-person to people attending Intensive Outpatient Treatment and Continuing Care services at Glenbeigh facilities. The following data was secured from individuals, age 18 and older, at Glenbeigh's Niles Outpatient Center. Participants include patients receiving outpatient services, family members or other loved ones, friends and members of the general recovery community.

The survey was distributed prior to the start of several sessions. By limiting the survey distribution to a two-week period, no duplication occurred. Surveys were completed by individuals with a direct connection to Glenbeigh therefore providing insights from people directly affected by substance use and addiction.

The following pages provide an overview of information gathered from the surveys.

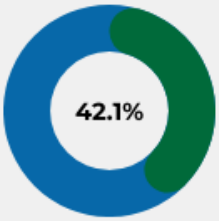
Glenbeigh Community Health Needs Assessment Survey Results

DEMOGRAPHICS

Primary data collection. Data was collected from surveys distributed to individuals participating in Intensive Outpatient Treatment and Continuing Care services. Participants include current patients, people in recovery, family members and others directly impacted by substance use. Data was collected at the Glenbeigh Outpatient Center of Niles between August 1 and August 12, 2022.

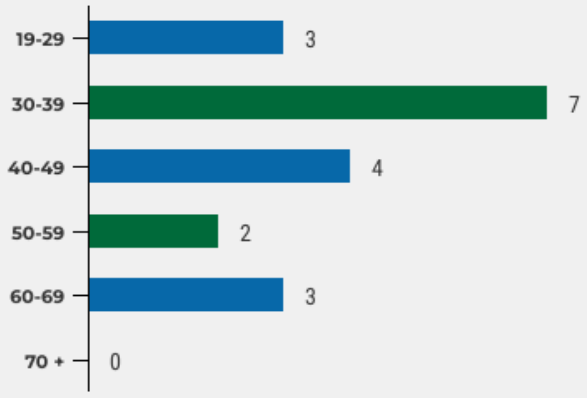
19 Participants

Participant Gender		Participant Race	
Male	16	White	17
Female	3	Black/African-American	2



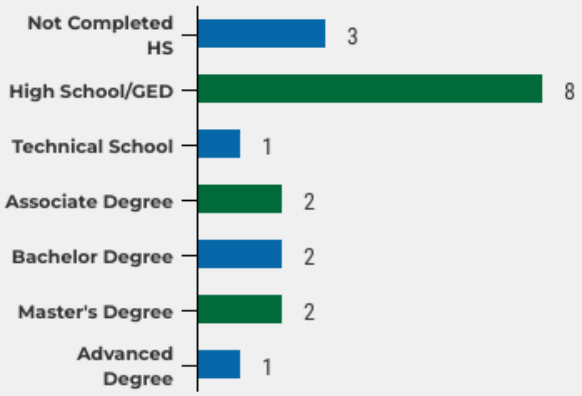
of participants have, or are currently, living in a sober house or sober community.

AGE OF PARTICIPANTS



EDUCATION LEVEL OF PARTICIPANTS

Question: What is the highest level of education you have completed?



42.1% 8/19 participants are not working.

52.6% 10/19 participants are working full time.

5.3% 1/19 participant did not answer.

Glenbeigh Community Health Needs Assessment Survey Results

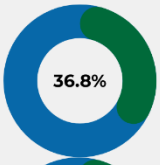
RECOVERY AND WELLNESS

Primary data collection continued. Data was collected from surveys distributed to individuals participating in Intensive Outpatient Treatment and Continuing Care services. Participants include current patients, people in recovery, family members and others directly impacted by substance use. Data was collected at the Glenbeigh Outpatient Center of Niles between August 1 and August 12, 2022.

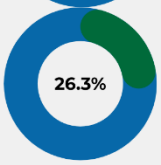
---

17 Participants believe there are enough recovery support options in the area.

13 Participants believe healthcare providers understand the needs of people impacted by substance use.



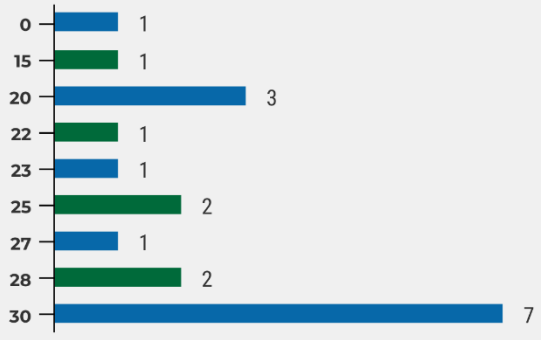
of participants did not experience a barrier when seeking treatment



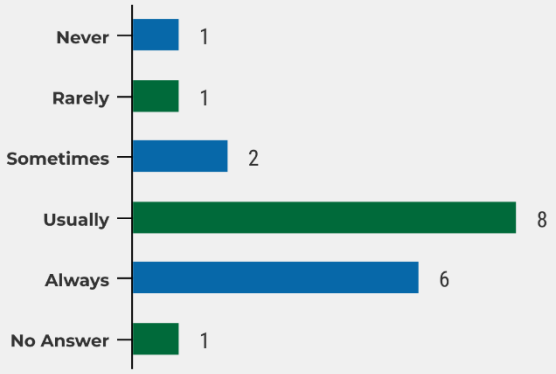
of participants reported cost as a barrier when seeking treatment

Reported barriers include: being open about use, poor decisions, COVID - hospital setting, race, distance to treatment and lack of physician understanding.

Mental Health. Question: Thinking about your mental health...for about how many days during the past 30 days was your mental health good?



Mental Health. Question: During the past 6 months, how often did you get the social and emotional support you need?



47.4% **9/19 feel stigma remains in the workplace.**

31.6% **6/19 feel stigma is not in the workplace.**

21% **4/19 were not sure or did not respond.**

2022 Glenbeigh Health Needs Survey

Your responses to this optional survey are anonymous and will be used by Glenbeigh to report on the people touched by addiction and help us improve health in our service areas. Thank you!

Instructions: You must be 18 years or older to complete this survey.
Please answer all questions and return the survey as indicated.

1. What best describes your gender? _____
2. What is your age (years)? (WRITE A NUMBER) _____
3. What race do you consider yourself to be? _____
4. What is your zip code? (Please write your 5-digit ZIP code) _____
5. What is the highest level of education you have completed? _____
6. Are you currently employed? No ☐ Yes, Part Time ☐ Yes, Full Time

7. Are you currently in recovery? ☐ Yes ☐ No
8. Are you a family member or other loved one of someone in recovery? ☐ Yes ☐ No

9. Do you believe there are enough recovery support options in the area? ☐ Yes ☐ No

10. Have you ever, or are you currently living in a sober house or sober community? _____

11. During the past 6 months, how often did you get the social and emotional support you need? (CIRCLE ONE ANSWER) ALWAYS USUALLY SOMETIMES RARELY NEVER

12. Thinking about your mental health, which includes stress, depression and problems with emotions, for about how many days during the past 30 days was your mental health good? (WRITE A NUMBER) _____

13. Do you believe healthcare providers understand the needs of family members seeking help for a loved one and/or the needs of people living in recovery? Yes ☐ No ☐

14. What is the most significant barrier you personally experienced when seeking access to health care? _____

15. In the workplace, do you feel stigma continues or that employers help employees secure treatment confidentially and support their return to work? _____
_____

16. In your opinion, what is being done ***well*** in the community in terms of addressing drug and alcohol addiction and improving quality of life?
_____
_____

17. We welcome any other feedback you would like to share.
_____
_____

Survey Comments

Question 14: What is the most significant barrier you personally experienced when seeking access to health care?

- I really didn't experience any barriers.
- Cost
- None
- None
- My own decisions.
- Race
- Many physicians don't understand addiction.
- Distance. Inpatient facility approximately 1 hour away.
- Cost, not knowing where to start.
- Being up front about costs.
- Lack of Health Care.
- None
- Being open with everything.
- Don't like hospitals (germ infested)
- None
- Healthcare cost.

Questions 15: In the workplace, do you feel stigma continues or that employers help employees secure treatment confidentially and support their return to work?

- Yes, there is stigma in the workplace.
- A little of both.
- No
- Yes
- Yes, mostly.
- There is a stigma.
- I think some stigma remains, but it's getting better.
- Yes
- Both
- No
- Self-employed
- Yes
- I feel a sense of confidentiality.
- They help.
- No

Question 16: In your opinion, what is being done well in the community in terms of addressing drug and alcohol addiction and improving quality of life?

- Choice of AA meetings: outpatient treatment.
- Treatment in lieu of conviction.
- Educating the public.
- I believe there is an abundance of help if you need – go get it.
- Lots of recovery programs.
- Just moved to the area – seems good so far.
- Able to pay my bills.
- More public awareness on media seems to be helping.
- Attention
- Glenbeigh in Niles & plenty of meetings.
- The help is there as long as you want it.
- Not sure.
- Everything.
- Cracking down on sales during the day.
- Treatment in lieu of conviction.
- Most things. Sober living needs more space, storage and places to keep food.
- Lots of meetings in area.

Question 17: Any other feedback.

- Great job.
- I'm happy with my treatment.

Appendix C: Online Survey

Online Survey Results

Conducted between August 22 and September 2, 2022

Individuals Working Directly with Those Affected by Addiction

The following survey questions were distributed electronically to individuals working with people with substance use disorders along with family and others affected by alcohol and drug use. Of the online surveys submitted, 109 began the process with 30 completing and submitting survey results. The survey had a 27.25% submission rate.

1. What is the zip code where you work?
15108
15009
15642
44107
15212
44484
15317
44124
63123
44134
44130
15241
15301
44130
16001
44004
44113
44023
16502
44132
44446
43537
48302
16510
44113
44622
44484
44484
44035
16501

2. What is your job title?
Psychotherapist/ Counselor
Social Worker
Certified Peer Support Specialist, Certified Family Recovery Specialist, Recovery Coach
Finance
Practice Manager
Director
Interventionist
Clinical Counselor
National Case Manager - EAP - OH
CDCA / Residential Assistant
Process Engineer
President
Case Management Specialist
E.A.P.
Recovery House Owner
Court Based Case Manager
TASC Case Manager
Owner
D&A Counselor
Social Worker
Lead Therapist
Mother/Wife/Homemaker/Teacher
Clinical Care Manager
Human Resource Manager
Public Defender
Clinical Counselor
Executive Director
Director
Maintenance Technician
Program Specialist

3. What is the highest level of education you have completed?	4. How would you describe yourself?
Graduate or professional degree	In recovery
Graduate or professional degree	Not in recovery
Some college (no degree)	In recovery
Associate's degree	A loved one of someone in recovery
Graduate or professional degree	Not in recovery
Graduate or professional degree	Not in recovery
Some college (no degree)	In recovery
Graduate or professional degree	Not in recovery
Graduate or professional degree	A loved one of someone in recovery
Some college (no degree)	In recovery
Graduate or professional degree	A loved one of someone in recovery
Graduate or professional degree	In recovery
Bachelor's degree	In recovery
Some college (no degree)	In recovery
Bachelor's degree	In recovery
Bachelor's degree	A loved one of someone in recovery
Graduate or professional degree	Not in recovery
Graduate or professional degree	In recovery
Graduate or professional degree	Not in recovery
Graduate or professional degree	Not in recovery
Graduate or professional degree	A loved one of someone in recovery
Bachelor's degree	In recovery
Graduate or professional degree	Not in recovery
Bachelor's degree	Not in recovery
Graduate or professional degree	Not in recovery
Graduate or professional degree	Not in recovery
Graduate or professional degree	A loved one of someone in recovery
Graduate or professional degree	Not in recovery
High School/GED	A loved one of someone in recovery
Bachelor's degree	In recovery

5. Is there a sufficient number of resources for those in need of addiction services in the area?	6. In general, do people in the area know where to go for addiction treatment?
No	No
Yes	Yes
Other: I do my best. LGBTQ community is still a hard fit.	Other: I work with the LGBTQ population, as you know resources are lacking.
No	No
No	No
No	No
Yes	Other: They're never certain
No	No
No	No
Yes	Yes
Yes	Yes
No	No
No	No
Yes	No
Yes	Yes
No	Yes
No	Yes
No	Yes
Yes	Yes
No	No
Yes	Yes
Other: I really don’t know. I found treatment at Rock Creek but attend meetings in my area that assist in my recovery.	Other: I would say no.
No	Yes
Yes	No
No	Yes
No	No
Other: There are too many agencies competing for clients with Medicaid. More extended care, MAT, peer support and housing/employment services are needed.	Yes
No	No
Yes	Yes
Other: There are a lot of resources but still more is needed. Especially when it comes to detox and adolescent inpatient services.	Yes

7. What is the most significant barrier you feel people encounter when seeking treatment for addiction problems? (This can be lack of transportation, insurance or local services.)
Insurance will not cover the cost.
Transportation. Lack of true dual diagnosed programs
Time it takes to get into treatment with transportation, behavioral health, ID.
Insurance companies limiting the amount of help they will give you based on an arbitrary timeline, rooted in judgement of this disease. Lack of resources and options for those in need. Covid-19 has made these barriers even more deadly.
So many barriers. Lack of knowledge, lack of easy access, lack of bed availability for inpatient treatment or provider availability for outpatient treatment, lack of insurance coverage or acceptance of certain products (e.g., Medicare), etc.
Need for immediate availability of treatment
Insurance
Stigma
Lack of insurance and lack of available treatment resources
Willingness
Family support and long-term commitment
Lack of understanding on how treatment services function and the admission process to get help.
Transportation, secular options for mutual support. 12 step is the default and helps some but can be a waste of time or even damaging to some, 13th step for example
Still a stigma about getting help
It’s critical that I have availability of a bed immediately. 24/7 There’s a limited amount of time that a person in active addiction has the willingness to go to treatment. Once that window of opportunity closes we lose them.
Transportation and affordable sober living, lack of mental health treatment/medication management.
Lack of motivation along with new disease and illnesses.
Money and local services
Don't know
Insurance and lack of locations
Too long of a waiting list for access to services; too many hoops to jump through with insurance company requirements.
The main barrier I see is the individual themselves. Aside from that, knowing where to go can be tricky.
Mbrs express not being able to get into treatment when they are ready for treatment due to not enough beds/ waiting list. Also Mbrs reports their treatment is not long enough which in their opinion cause them to relapse.
Insurance and Local Services
Child care and transportation
Stigma
Lack of transportation and private insurance doesn't provide the same coverage as Medicaid
Need for immediate availability of treatment
I don't think there is 1 significant barrier. The examples you list are the barriers. I would want more local services.
Lack of transportation, lack of immediate bed availability, lack of detox beds.

MULTIPLE CHOICE

Is there a sufficient number of resources for those in need of addiction services in the area?

Answer Choice	0% 100%	Number of Responses	Response Ratio
Yes		10	33%
No		16	53%
Other		4	13%
	Total Responses	30	100%

MULTIPLE CHOICE

In general, do people in the area know where to go for addiction treatment?

Answer Choice	0% 100%	Number of Responses	Response Ratio
Yes		14	46%
No		13	43%
Other		3	10%
	Total Responses	30	100%

MULTIPLE CHOICE

Do you believe there are enough recovery support options in the area? These include sober housing, recovery events, AA/NA meetings, etc.

Answer Choice	0% 100%	Number of Responses	Response Ratio
Yes		11	36%
No		18	60%
Other		1	3%
	Total Responses	30	100%

CHECKBOXES

Have you participated in any of the activities offered by Glenbeigh over the last 12 months?

Answer Choice	0% 100%	Number of Responses	Response Ratio
Listened to Glenbeigh Podcasts		13	43%
Viewed or Interacted with Glenbeigh Social Media (Facebook/LinkedIn/Instagram/TicTok/Twitter)		12	40%
Visited the Glenbeigh Website for Treatment or Event Information		14	46%
Attended an Online Rise & Shine Educational Presentation		10	33%
Referred Someone to Glenbeigh for Treatment		26	86%
	Total Responses	30	100%

OPEN QUESTION

In general, is there a need for more professional education on addiction and recovery in your community? Do you prefer in-person or virtual presentations?

Virtual
Yes always - both
In person
30 Response(s)

CHECKBOXES

How satisfied are you with the ease of accessing treatment services at Glenbeigh?

Answer Choice	0% 100%	Number of Responses	Response Ratio
Very Satisfied		14	46%
Satisfied		12	40%
Neither Satisfied nor Dissatisfied		2	6%
Dissatisfied		2	6%
Very Dissatisfied		0	0%
Other		2	6%
	Total Responses	30	100%

10. In general, is there a need for more professional education on addiction and recovery in your community? Do you prefer in-person or virtual presentations?
Yes. Addiction and Medical issues. Prefer in person.
n/a
Education is powerful, always open to learn more.
There is a strong need for educating communities on addiction as a disease. There is so much shame and judgement put on those suffering, and the people supporting them. We need real data and science to be shared on the debilitating disease addiction is and how it affects families and communities. Clarify the misinformation and misconceptions. I would like to see this disease get the attention is desperately needs rather than the judgement it gets. Education saves.
Education is always needed, and updates on best practices is most needed. Though in-person is preferable, getting away from work is difficult. So, I find that virtual is easier to access but maybe not as fulfilling in terms of personal connection, networking, etc.
Yes there is a need. I prefer in-person but virtual is necessary
In person
In person
Yes always - both
I believe were very fortunate living in NE Ohio. Plenty of resources for recovery. In person is my preference, but virtual was needed during the height of the pandemic. The sooner a person can get into the rooms, the better.
Yes. In-person.
Additional information about addiction and recovery. Would prefer in-person but both work well for me.
Yes, we need more training and I prefer in person but virtual should be available as well
Always a need - and in person presentations
Yes. In person
In person is my preference as many don't get the full benefit when not face to face with others.
I prefer in-person presentations but understand the need to stay safe from disease.
In person
No. I like the Rise and Shine presentations. I'm not sure if I am still on the notification list.
Virtual
Virtual preferred
Yes! I think both are extremely important to have. Both keep me sober!
I live in Michigan and there is always a need for more addiction and recovery service. The clientele I represent prefer face-to face.
Yes. In person
Virtual
Yes. Virtual and in-person
Yes; virtual
Yes there is a need. I prefer in-person but virtual is necessary
Definitely a need of more my personal experience is face to face
Yes, and both virtual and in person.

11. In your opinion, what is being done well in the community in terms of addressing drug and alcohol addiction and improving quality of life? What more can Glenbeigh do for referents?
Glenbeigh does a great job.
Information on how to access. Signs on telephone poles, Billboard signs; informational packets in business, etc.
I work in Allegheny County for some reason you are not contracted with our County. I wish you were. I have an enormous caseload. I have heard great things about your facility. A lot of my clients have asked for you, and I can't place them with you.
I'm glad that AA/NA have been able to adapt to the virtual world, but it does not replace in-person therapy (group or otherwise). I think the risk of death from active addiction/relapse is much more threatening than covid-19 and I would like to see in-person at-your-own-risk groups to re-enter the community. People NEED this to stay in recovery, and I think taking that risk to be in-person should be an individual decision and still offered by professionals. It is essential.
Community-based services are working extremely hard to educate the public and offer avenues for connecting interested individuals to treatment and support services
Addiction education, prevention in schools, Narcan distribution, ASAP rallies and other events, recovery housing
Local communities are doing the best they can...and so is Glenbeigh
12 step support groups.
Since I don't actually live in the community, I can't say but Glenbeigh can continue to be a resource for their clients and guide them to appropriate services
One of the biggest things being done is on Harm Reduction. Not everyone is going to stop, but we can make it safer for them while there still trying to decide. This can save the taxpayers loads of money, and maybe they can educate themselves further and reduce the stigma that addiction carries. Glenbeigh can start going back to all in person IOP and Aftercare groups like prior to Covid.
In my opinion, not much is being done well. Very difficult for Glenbeigh to do anything additional as alcohol is a legal drug. Additionally, there is a social stigma for those who don't drink.
Provide more community education especially for parents.
In this community there is some good support structures in place. Glenbeigh needs to have more coordination in aftercare for clients
Some education meetings but need to reach young people to be educated about addictions and more clean and sober role models to show it gets better
Nothing. An intake person 24/7. Drug use is not limited to normal work hours. The majority of my men have a 10p curfew. Therefore, I may not confirm drug use until after curfew. It's imperative beds are available to address their need for inpatient treatment
Aftercare when someone graduates or is released from rehab.
The community is doing well by getting clients into treatment the best way they can. The community and Glenbeigh need to offer clients with treatment alternatives on Saturdays, as well.
Upgrade the mental health track
More advertising?
There needs to be more awareness for treatment on other substances and activities other than Opiates, addiction is more than just a drug activity. There are other forms of addiction that are treatable.
I know that there are some strong home groups in the area. Besides that, I don't think this area offers strong support. There are places but the reputations are not good. Even professionals, do not often recommend.
Glenbeigh is awesome and is proving all necessary options for treatment.
Cleve muni drug court

Community education
We need more groups.
Glenbeigh has changed my significant other life. I give thanks every day for what the people of Glenbeigh did for my girlfriend

MULTIPLE CHOICE

Do you have enough information about the programs offered by Glenbeigh to share with the people you serve? (Including Glenbeigh's specialty professional, nursing, first responder and teacher tracks.)

Answer Choice	0% 100%	Number of Responses	Response Ratio
Yes		18	62%
No		11	37%
	Total Responses	29	100%

CHECKBOXES

Other than a substance use disorder, what would you say is the most pressing need of the people you serve? Please check your top two areas of need.

Answer Choice	0% 100%	Number of Responses	Response Ratio
Mental Health Issues		27	93%
Specialized Services for Professionals		4	13%
Medication Assisted Treatment		4	13%
Housing Issues		12	41%
Employment/Occupational Issues		6	20%
Education/Literacy Issues		2	6%
Hunger/Access to Healthy Foods		0	0%
Community Engagement		3	10%
Health Coverage/Access to Quality Care		7	24%
Other		1	3%
	Total Responses	29	100%

16. What more can Glenbeigh do for the people you serve?
Info on specific treatment tracks and aftercare programs.
Assist with transportation to your inpatient facility
Contract with Allegheny County
If someone needs treatment more than once a year, they shouldn't be punished with outrageous fees as a barrier to entry. If addiction is being viewed as a disease, we would understand that relapse is not entirely a person's "choice" and shouldn't be treated as such. This just signals that someone is suffering greatly and needs access to support and treatment. We would never turn away a cardiac patient because they "should have done more" but this is norm in addiction recovery.
Get DDAP to contract Glenbeigh with CCBH!!!!! :)
Keep up the good work
N/A
Nothing
Should do regular patient follow-up from hospital residential program. Should assist employers during back to work issues.
Continue its excellent work.
Any new material to display in information boards on floor and also in office.
Provide an overnight intake person with a designated cell number.
Offer more of a variety of drug treatment via phone/telehealth.
Do a better job with mental health which is becoming as big an issue as addiction
Nothing, I appreciate everything you do for all of us!
Offering more psychoeducation on topics that are relevant to recovery
Nothing, Glenbeigh has the state of the arts in all of its services.
Keep up the good work

Appendix D: State of Ohio Health Assessment 2019

State of Ohio Health Assessment

2019

In mid-September 2019, the state of Ohio published the 2019 State Health Assessment online at https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship/. The 2020-2022 State Health Improvement Plan was developed from that document and used as part of Glenbeigh's CHNA report. The executive summary, prepared by the Health Policy Institute of Ohio, identifies the key findings along with next steps the state of Ohio plans to implement between 2020 and 2022. Glenbeigh's CHNA complements the state improvement plan areas that are in line with the mission of Glenbeigh – with a focus on addiction and recovery from substance use disorders.

Executive Summary of the 2019 Ohio Health Assessment (SHA)

- Key Findings
    - Overall wellbeing for Ohioans has declined. Unintentional injuries (including drug overdose), cancer and heart disease were the leading causes of premature death in 2017.
    - Many Ohioans lack opportunities to reach their full health potential. Demographics that experience much worse outcomes than the state overall include African/American/black, people with lower incomes, those with disabilities or those who live in Appalachian counties.
    - Underlying drivers of health must be addressed. Crosscutting factors the state will address include: physical activity, tobacco use, access to dental and mental health care, income and unemployment, adverse childhood experiences, transportation, lead poisoning risk and racism.
    - Mental health and addiction, chronic disease, and maternal and infant health continue to be significant challenges in Ohio. These areas have worsened or remained unchanged in recent years.
    - New concerns emerge in the wake of Ohio's addiction crisis. Drug use has contributed to increases in hepatitis C and children in foster care.

Other information from the 2019 Ohio Health Assessment

- Life expectancy among Ohioans has dropped over the last seven years.
- Impact of racism and discrimination persists – particularly among African American/black population.
- Underlying drivers of inequity include: poverty, racism, discrimination, trauma, violence and toxic stress.
- In order to improve, the SHA recommends sharing priorities across rural, urban and Appalachian regions of the state.
- Build cross-sector partnerships to address the factors that shape health.

How to access the SHA

Summary report
prepared by HPIO
www.hpio.net/
2019-state-health-assessment-summary-report

Online, interactive data website
prepared by ODH
https://odh.ohio.gov/wps/portal/gov/odh/explore-data-and-stats/interactive-applications/2019-Online-State-Health-Assessment

The road to improvement

SHA findings emphasize that improvement must build upon:

- A comprehensive framework with clear priorities and measurable objectives
- Shared priorities across rural, urban and Appalachian regions of the state
- Cross-sector partnerships to address the many factors that shape our health
- State and local efforts to achieve health equity

Next steps

A collaborative of stakeholders from across Ohio are developing the 2020-2022 State Health Improvement Plan (SHIP), to be released later in 2019. This plan will provide a roadmap to address the challenges highlighted in the SHA.

The 2020-2022 SHIP will include a strategic menu of priorities, outcome objectives and evidence-based strategies to be implemented by state agencies, local health departments, hospitals and other community partners, including sectors beyond health.

How was the SHA developed?

Led by ODH, the SHA was developed with input from hundreds of Ohioans through:

- Five regional forums held in October 2018 with 521 participants
- Online survey completed by 308 stakeholders
- Advisory Committee with 101 participants (as of April 2019)
- Steering Committee made up of representatives from 13 state agencies, including sectors beyond health

The Online SHA includes data on a wide range of topics, including:

- Health outcomes and behaviors
- Healthcare spending, access and quality
- Public health and prevention
- Social, economic and physical environment factors, such as education, employment, poverty, housing, violence and transportation
- Disparities, trends and comparisons between Ohio and the U.S. overall

Regional forum insights

While each community is unique, results from SHA regional forums and an online survey found that there were many shared strengths, challenges and priorities across the state. Top priorities overall included:

Health outcomes

- Mental health and addiction
- Chronic disease
- Maternal and infant health

Cross-cutting factors

- Poverty
- Transportation
- Physical activity and nutrition
- Access to care

Funded by ODH, the SHA and SHIP provide information and guidance for many state agencies. The 2020-2022 SHIP will align state agency priorities toward a shared vision of improved health and economic vitality.

Source: https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship/

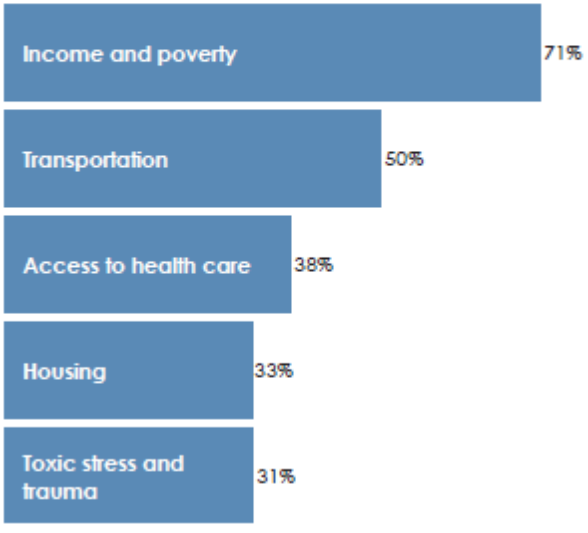
Throughout the course of obtaining qualitative data for the Glenbeigh CHNA, informants reported barriers to treatment for substance use disorders. Comparing this information to the top-five barriers reported in the 2019 SHA, similarities exist.

Transportation remains a significant barrier for individuals. Quantitative and qualitative data both confirm that many individuals within Glenbeigh's defined service area do not have access to transportation in order to obtain or sustain treatment. It would also be safe to assume that transportation would be a key barrier to participation in recovery support programing and family education programming.

Limited access to health care remains a significant barrier to treatment for substance use disorders. Community input highlights insurance limitations as well as a lack of insurance. The acceptance of individuals insured under various Medicaid programs was also noted.

More treatment facilities continue to open specializing in opioid addiction however the need for facilities that treat alcohol and other drug addictions remains high. A secondary factor limiting access to health care in the Glenbeigh region remains a shortage of licensed, eductated professionals to treat substance use disorders. Areas of Northeast Ohio and Western Pennsylvania are predominantly rural and fall within the Appalachian Region, which has specific challenges.

Figure 3.5. **Top-five barriers to equity**
"Which of the following barriers do you think are most important to address in order to improve [health outcomes for priority populations in your county(ies)]?" (n=302)

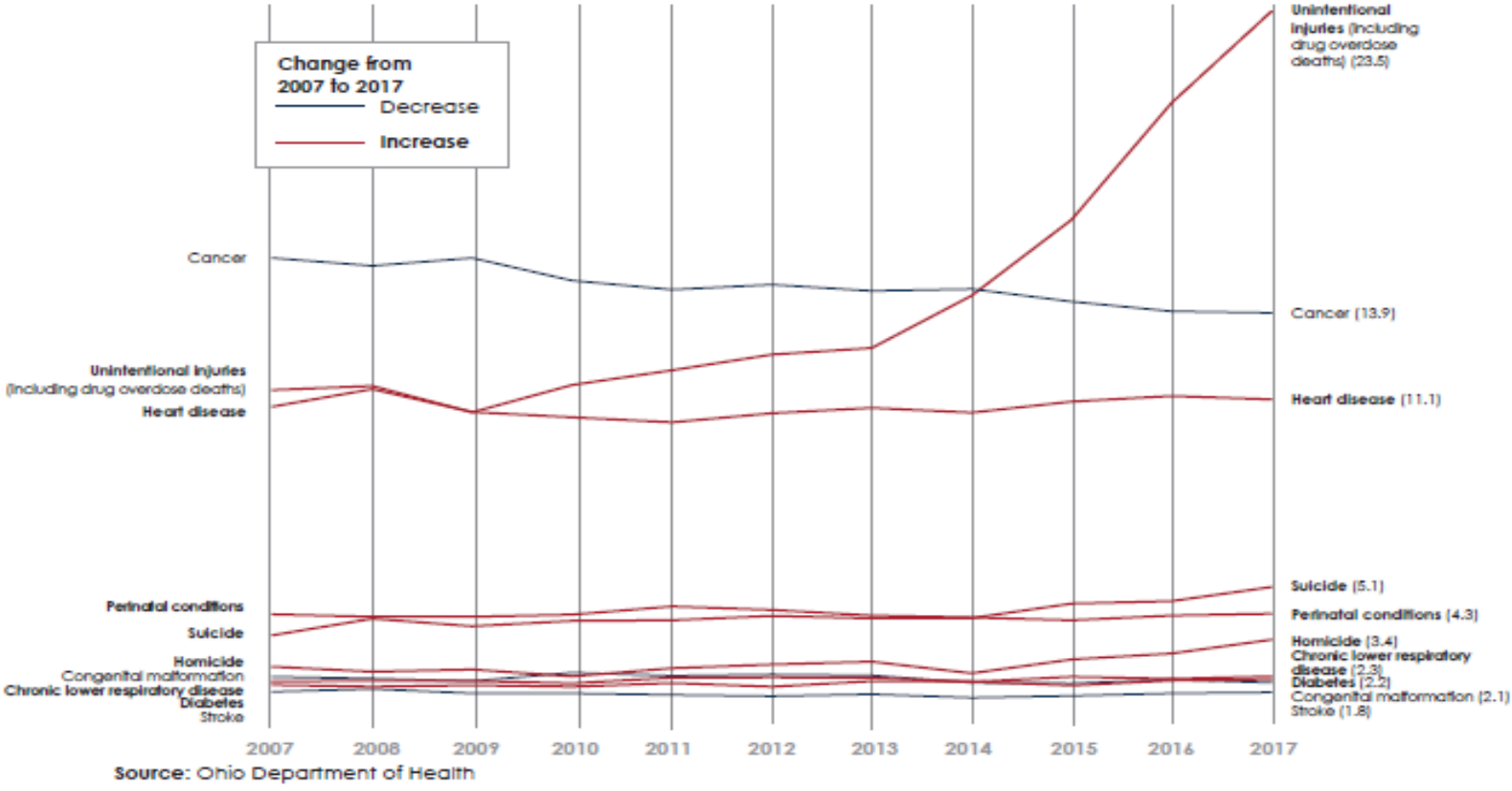


Source: 2018 SHA regional forum online survey

According to the 2019 Ohio SHA, priority topics identified in the 2017-2019 State Health Improvement Plan (SHIP) remain relevant as both mental health and addiction continue to be among the significant challenges in the state. Moreover, Ohio's performance, as reported in the 2019 SHA, did not improve for the mental health and addiction priority outcomes detailed in the 2017-2019 SHIP. Drug overdose deaths increased from 27.7 deaths per 100,000 population in 2015 to 44.1 deaths per 100,000 in 2017.

Figure 5.2. **Years of potential life lost before age 75**

Ten leading causes of premature death, Ohio 2007-2017 per 1,000 population (age-adjusted rates)



Source: Ohio Department of Health

The Ohio SHA reports that drug overdose deaths, adolescent depression, and suicide deaths along with heart disease, diabetes and infant mortality are major threats to the health of Ohioans. Depression, suicide, heart disease, diabetes and infant mortality are often interlinked to, and compounded by, alcohol and drug abuse or addiction.

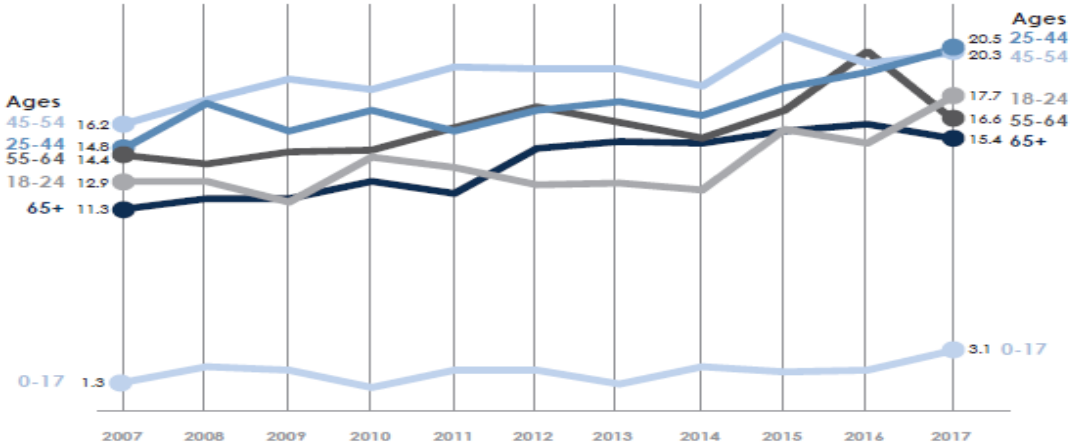
Heart Disease: According to the American Heart Association, illegal drugs can adversely affect the cardiovascular system and heart function. Cocaine, heroin and some amphetamines can affect the central nervous system and may cause changes in heart rates, blood pressure and heart tissue. Both recreational and habitual cocaine use increases the risk for heart attack. Amphetamines increase heart rates and blood pressure.

Diabetes: The Mayo Clinic affirms that individuals who consume greater amounts of alcohol may experience chronic inflammation of the pancreas that can potentially lead to diabetes.

Infant Mortality: The National Center for Biotechnology Information (https://www.ncbi.nlm.nih.gov/pubmed/23439895) reports that there is a high risk of sudden infant death syndrome (SIDS) in infants of mothers with an alcohol diagnosis recorded during pregnancy or within one-year post pregnancy. According to a 2013 study, maternal alcohol-use disorder is a significant risk factor for SIDS and infant mortality excluding SIDS.

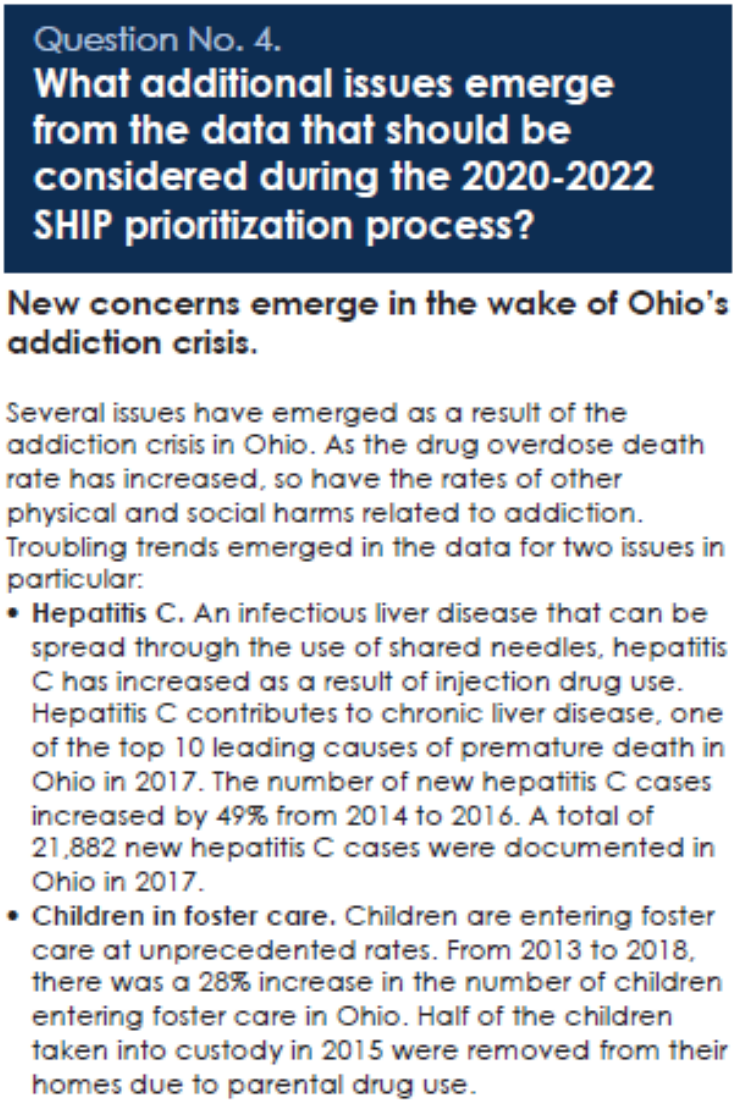
Depression and Suicide: In 2010, the National Center for Biotechnology Information reported (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2872355/) that suicide was an escalating public health issue and that alcohol use often led to suicidal behaviors. Depression and substance abuse are often associated with cases of suicide. The report predicted increased suicide rates worldwide through 2020 based on a rate of increase of 60% in suicides from 1965 to 2010. According to the report, suicide links to socioeconomic factors. The 2019 SHA noted that Ohio suicide deaths increased gradually between 2007 and 2017. Suicide rates increased during the pandemic.

Figure 5.3. **Suicide deaths per 100,000 population, by age group, Ohio, 2007-2017**



Source: Ohio Department of Health, Ohio Public Health Data Warehouse. Accessed by HPIO on April 9, 2019.

Also mentioned in the 2019 Ohio SHA were concerns directly connected to the opioid epidemic and subsequent drug addiction crises. Stakeholders interviewed for the 2019 Glenbeigh CHNA substantiated an increase in Hepatitis C and concern of an increase in HIV infection. Stakeholders also expressed concern for the ramifications of alcohol use/abuse, which can result in both short and long-term health issues.



Question No. 4.

What additional issues emerge from the data that should be considered during the 2020-2022 SHIP prioritization process?

New concerns emerge in the wake of Ohio's addiction crisis.

Several issues have emerged as a result of the addiction crisis in Ohio. As the drug overdose death rate has increased, so have the rates of other physical and social harms related to addiction. Troubling trends emerged in the data for two issues in particular:

- **Hepatitis C.** An infectious liver disease that can be spread through the use of shared needles, hepatitis C has increased as a result of injection drug use. Hepatitis C contributes to chronic liver disease, one of the top 10 leading causes of premature death in Ohio in 2017. The number of new hepatitis C cases increased by 49% from 2014 to 2016. A total of 21,882 new hepatitis C cases were documented in Ohio in 2017.
- **Children in foster care.** Children are entering foster care at unprecedented rates. From 2013 to 2018, there was a 28% increase in the number of children entering foster care in Ohio. Half of the children taken into custody in 2015 were removed from their homes due to parental drug use.

Source: Ohio 2019 State Health Assessement at https://odh.ohio.gov/wps/wcm/connect/gov/64b4e06c-b1ec-45fa-921c-de2be8f84943/2019SHA_SummaryReport_Final.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-64b4e06c-b1ec-45fa-921c-de2be8f84943-mQx5M1O

Appendix E: State Health Improvement Plan (SHIP) Ohio 2020-2022

State Health Improvement Plan

OHIO 2020-2022

The following material is from the Ohio State Health Improvement Plan, which is a high-level compilation of SHIP strategies presented as a quick guide at https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

How will the SHIP be implemented?

The SHIP is designed to be implemented by a wide range of public and private partners. The menu of objectives and strategies in the SHIP provides flexible options for rural, Appalachian, suburban and urban communities, as well as approaches to improve outcomes for Ohioans of all ages.

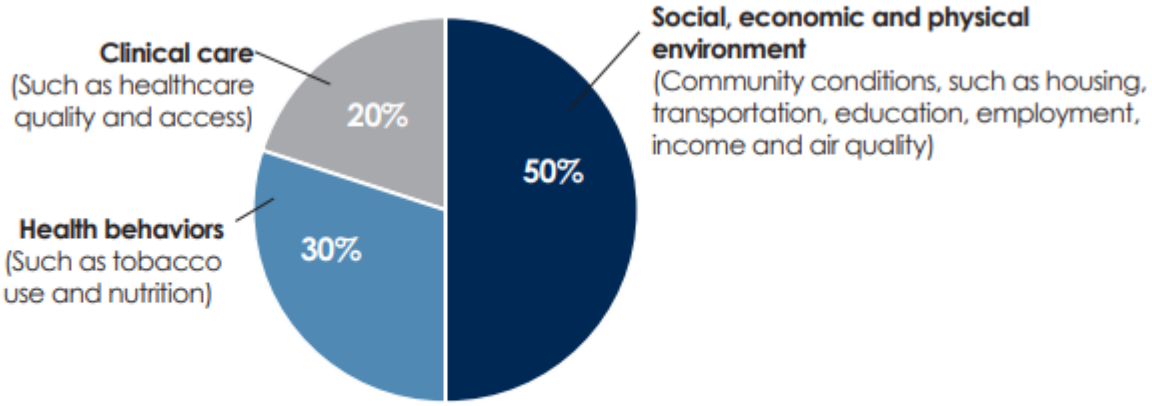
State and local partners

There are many partners at the state and local levels that contribute to achieving the vision of the SHIP, such as:

- State agencies and other statewide organizations
- Hospitals
- Local health departments
- Alcohol, Drug and Mental Health (ADAMH) boards
- Area Agencies on Aging
- Boards of developmental disabilities
- Community behavioral health providers
- Employers and workforce development organizations
- Housing organizations
- Medicaid managed care plans
- Philanthropy
- Schools
- Other local agencies and organizations

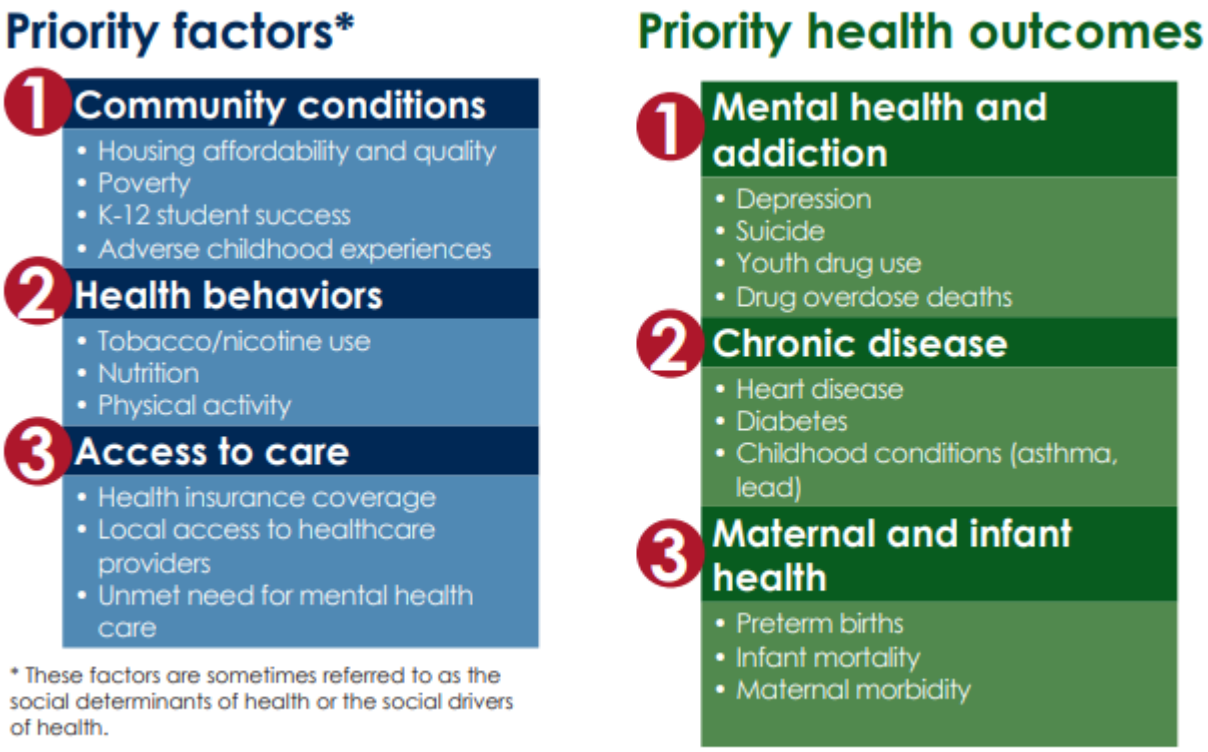
Public and private partners must row in the same direction to achieve the **SHIP vision: Ohio is a model of health, well-being and economic vitality**

Figure 1.1. **Factors that influence health***



Underlying drivers of inequity such as poverty, racism, discrimination, trauma, violence and toxic stress

* These factors are sometimes referred to as the "social determinants of health" or the "social drivers of health."
Source: Booske, Bridget C. et. al. *County Health Rankings Working Paper: Different Perspectives for Assigning Weights to Determinants of Health*. University of Wisconsin Public Health Institute, 2010.



Source: State Health Improvement Plan Ohio 2020-2022
https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

Local access to healthcare providers

What shapes our health and well-being?

Ensuring local access to healthcare providers makes it easier for residents to get to primary and specialty healthcare services. Increasing access to local healthcare providers in underserved areas can reduce disparities in access to care and improve health outcomes.

Strategies

If well-implemented, the following evidence-informed strategies are likely to achieve the SHIP objectives for increasing local access to healthcare providers in Ohio.

Featured strategies	Includes
Comprehensive and coordinated primary care	• Medical homes, such as Ohio Comprehensive Primary Care practices • Healthcare safety net providers, including federally qualified health centers (FQHCs) and school-based health centers (SBHCs)
Culturally competent workforce in underserved communities	• Community health workers • Community-based training for health professions students in rural and other underserved areas • Financial incentives to recruit and retain health professionals in underserved areas
Telehealth	Telemedicine

Additional strategies	Includes
Healthcare workforce professional development	• Health career recruitment for minority students and other underrepresented or disadvantaged students (for example, Career Academies)
Telehealth for mental health	Telemental health services
Public transportation	Develop, improve and maintain public transportation systems
Other access supports	• Paid sick leave laws • Health literacy interventions

= Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

Relevant resources

- Community Health Worker Statewide Assessment, Ohio Department of Health
- Community Paramedicine Compendium, Ohio Department of Public Safety
- RecoveryOhio Advisory Council's Initial Report
- Rural Health Care Access, Ohio University
- Community Commons Initiative
- CARES Engagement Network, University of Missouri

Source: https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

Source: State Health Improvement Plan Ohio 2020-2022
https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

Drug Overdose Death

Strategies

If well-implemented and targeted to meet the needs of priority populations, the following evidence-informed strategies are likely to achieve the SHIP objectives for reducing drug overdose deaths in Ohio. To effectively reduce drug overdose deaths, SHIP partners should also implement community conditions, health behaviors and access to care strategies (see parts 3-5).

Strategies▲	Includes
Overdose prevention and reversal programs	
Naloxone education and distribution programs	Naloxone education and distribution programs ⊖ Ohio-specific activities: • Increase the number of Project DAWN and other community sites that can distribute naloxone • Integrate naloxone distribution models within addiction treatment settings, reentry from prison and jail and syringe services programs • Increase utilization of the Community Innovation Fund, which provides local health departments with funding to purchase naloxone for first responders
Prescription drug monitoring programs (PDMPs)	Prescription drug monitoring programs (PDMPs) (known as OARRS in Ohio) Ohio-specific activities: • Increase OARRS integration with electronic health records • Continually enforce OARRS tracking requirements • Provide education and technical assistance to prescribers to operationalize opioid prescribing limits and guidelines • Utilize the OARRS Peer Review Module
Syringe services programs (SSPs)	Syringe services programs (SSPs) (also known as needle exchange programs) ⊖ Ohio-specific activities: • Provide technical assistance to SSPs so that they can obtain Terminal Distributor of Dangerous Drugs (TDDD) licenses and distribute naloxone • Increase the number of SSPs in Ohio, particularly in counties with the highest rates of hepatitis C and HIV • Establish a statewide coordination hub for SSPs that can assist local programs with information sharing, technical assistance, evaluation and quality improvement • Increase referrals and links from SSPs to substance use treatment and social support services
Addiction treatment access	
Medication-assisted treatment (MAT) access	• MAT access enhancement initiatives, including access to buprenorphine, methadone and naltrexone ⊖ • Increase the number of physicians, physician assistants and advance practice nurses who have obtained a waiver to prescribe buprenorphine (DATA 2000 waiver) • Provide technical assistance and support to providers who have a waiver to prescribe MAT
Comparable insurance coverage for behavioral health (parity)	Mental health benefits legislation, along with monitoring for implementation and compliance ⊖

▲ None of the strategies for this topic area met the criteria for featured strategies. These criteria are listed in Part 1 and Appendix C.
⊖ = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

Strategies▲ (cont.)	Includes
Addiction treatment access (cont.)	
Culturally competent workforce in underserved communities	• Certified community health workers ⊖ • Support and expand the role of peer support specialists • Health career recruitment for minority students ⊖ and other underserved communities (for example, Career Academies ⊖) • Rural training in medical education ⊖ and other underserved communities • Higher education financial incentives for health professionals serving underserved areas ⊖
Recovery supports	
Recovery communities and peer supports	Support recovery-friendly communities and workplaces, including: • Peer recovery organizations • Recovery community organizations • Recovery-oriented high schools • Collegiate recovery communities • Alternative peer groups
Housing programs for people with behavioral health conditions	• Certified recovery housing • Housing First ⊖

▲ None of the strategies for this topic area met the criteria for featured strategies. These criteria are listed in Part 1 and Appendix C.
⊖ = Likely to reduce disparities, based on review by WWFH, or health equity strategy in CG

Relevant resources

- RecoveryOhio Advisory Council Initial Report
- Addiction Evidence Project, Health Policy Institute of Ohio
- Parity at 10 initiative, Legal Action Center

Source: State Health Improvement Plan Ohio 2020-2022
https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

Ohio's response to improve mental health and addiction

Student Wellness
Kids today are facing unprecedented challenges at home that come with them into the classroom, creating challenges for both students and teachers. The operating budget included a brand-new funding stream called Student Wellness and Success. This $675 million fund can be used to support student health, mental wellbeing, and academic success by providing schools with the financial resources to embed mental health counseling, physical health services, mentoring, after-school programs, and much more into their school buildings. As a result, schools will have more support and students will be better equipped for a brighter future.

Mental Health Care When and Where It is Needed
Immediate access to treatment and support to help people who are struggling with mental health or substance use disorders is critical. That is why Governor DeWine directed more than $22 million to local Alcohol, Drug and Mental Health Boards so communities can provide crisis response efforts to families when they need it the most.

Suicide
The Ohio Department of Health (ODH)'s Violence and Injury Prevention Section (VIPS) supports suicide prevention by collecting and analyzing data and supporting a statewide coalition specifically for sharing best practices on youth suicide prevention.

VIPS houses the Ohio Violent Death Reporting System (OH-VDRS), which collects information from multiple sources in an attempt to better understand the circumstances surrounding suicides and other violent deaths. To create a comprehensive record of each death, OH-VDRS links information from: the ODH Bureau of Vital Statistics (including death certificates); coroners and medical examiners; state and local law enforcement agencies; and the Ohio Automated Rx Reporting System.

Additionally, VIPS is implementing a project to monitor state and local emergency department (ED) visits to identify nonfatal suicide-related outcomes. This project will disseminate collected data to local health departments and the public using dashboards. This will allow for the studying of trends, the identification of risk factors, and the development of data-to-action intervention and prevention strategies.

Further, VIPS, through the Ohio Injury Prevention Partnership's Child Injury Action Group, facilitates a youth suicide subcommittee to identify and share best practices from local projects.

VIPS also has provided funding to three local sub-grant programs to facilitate community engagement, strategic planning and implementation of prevention strategies including:

- Partnering with emergency departments to establish policies requiring Counseling on Access to Lethal Means (CALM) trainings.
- Providing technical assistance to EDs to establish patient safety planning and crisis support plans for parents.

Drug Overdose Death
The Ohio Department of Health (ODH) Violence and Injury Prevention Section (VIPS) collects timely, high-quality surveillance data on fatal and nonfatal unintentional drug overdoses to identify, focus, and implement appropriate and timely prevention strategies at the state and local levels. Specific prevention strategies and programs include:

- ***Community naloxone distribution,*** with an emphasis on reaching high-risk people through community agencies, jails, recovery housing, emergency departments, homeless outreach, mail, drug courts, syringe access programs, and Federally Qualified Health Centers.
- ***Local supports and linkages,*** through funding local projects in high-burden areas to facilitate local coalitions, strategic plan implementation, overdose fatality reviews, community response plans, community/clinical links, and implementation of comprehensive care systems.
- ***Health care systems support,*** through emergency department projects to support comprehensive care and resources for primary care providers to implement Ohio prescribing rules and guidelines.
- ***Public/prescriber engagement,*** through social media campaigns aimed at informing the public; reducing stigma on use of Medication-Assisted Treatment among health care providers; and educating people who use drugs on the dangers of fentanyl in Ohio's drug supply.

Source: State Health Improvement Plan Ohio 2020-2022
https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

Mental health and addiction

Desired outcome	Indicator	Source	Lead state agency	Local data availability
Reduce depression	**MHA1. Youth depression (major depressive episode).** Percent of youth, ages 12-17, who experienced a major depressive episode within the past year	NSDUH	OMHAS	No
	MHA2. Adult depression (major depressive episode). Percent of adults, ages 18 and older, who experienced a major depressive episode within the past year	NSDUH	OMHAS	Yes, similar: County-level data for a similar indicator is available from County Health Rankings & Roadmaps. See also, online SHA.
Reduce suicide deaths	**MHA3. Youth suicide deaths.** Number of deaths due to suicide for youth, ages 8-17, per 100,000 population	ODH Vital Statistics	ODH and OMHAS	Yes: County-level data is available from the Ohio Department of Health's Public Health Data Warehouse. See also, online SHA.
	Priority populations: White, non-Hispanic; Residents of Appalachian counties*; Male			
	MHA4. Adult suicide deaths. Number of deaths due to suicide for adults, ages 18 and older, per 100,000 population	ODH Vital Statistics	ODH and OMHAS	Yes: County-level data is available from the Ohio Department of Health's Public Health Data Warehouse. See also, online SHA.
	Priority populations: Adults, ages 35-44; Adults, ages 55-64; Residents of Appalachian counties*; Male			
Reduce youth drug use	**MHA5. Youth alcohol use.** Percent of high school students who have used alcohol within the past 30 days	YRBS	ODH and OMHAS	No
	Priority population(s): Female students			
	MHA6. Youth marijuana use. Percent of high school students who have used marijuana within the past 30 days	YRBS	ODH and OMHAS	No
	Priority population(s): Black students; Hispanic students; Gay, lesbian or bisexual students			
Reduce drug overdose deaths	**MHA7. Unintentional drug overdose deaths.** Number of deaths due to unintentional drug overdose, per 100,000 population (age adjusted)	ODH Vital Statistics	ODH and OMHAS	Yes: County-level data is available from the Ohio Department of Health's Public Health Data Warehouse. See also, online SHA.
	Priority populations: Adults, ages 25-34; Adults, ages 35-44; Adults, ages 45-54; Residents of Appalachian counties*; Residents of urban counties*; Male			

*County typology from the Ohio Medicaid Assessment Survey. See Appendix C for map of county types.

SHIP topic area	Featured strategies
Access to care	
Health insurance coverage Indicators AC1 and AC2	• Outreach and advocacy to maintain Ohio Medicaid eligibility level and enrollment assistance • Insurance enrollment assistance for adults and children
Local access to healthcare providers Indicators AC3 and AC4	• Comprehensive and coordinated primary care • Culturally competent workforce in underserved communities ★ • Telehealth
Unmet need for mental health care Indicators AC5 and AC6	• Comparable insurance coverage for behavioral health (parity) ★ • Telehealth for mental health
Mental health and addiction	
Depression Indicators MHA1 and MHA2	• Social and emotional instruction • Coordinated care for behavioral health • Digital access to treatment services and crisis response ★ • Physical activity programs • Parenting programs
Suicide Indicators MHA3 and MHA4	• Suicide awareness, prevention and peer norm programs • Limits on access to lethal means
Youth drug use Indicators MHA5 and MHA6	• K-12 drug prevention education • Alcohol policy changes • Alcohol and other drug use screening (SBIRT)
Drug overdose deaths▲ Indicator MHA7	• Naloxone education and distribution programs • Prescription drug monitoring programs (PDMPs) • Syringe services programs (SSPs) • Medication-assisted treatment (MAT) access • Comparable insurance coverage for behavioral health (parity) ★ • Culturally competent workforce in underserved communities ★ • Recovery communities and peer supports • Housing programs for people with behavioral health conditions

Source: State Health Improvement Plan Ohio 2020-2022
https://odh.ohio.gov/static/SHIP/2020-2022/2020-2022-SHIP.pdf

Defined Service Community by County and Zip Code

Ashtabula County, Ohio

ZIP	CITY AND STATE	COUNTY
44099	Windsor, OH	Ashtabula
44093	Williamsfield, OH	Ashtabula
44088	Unionville, OH	Ashtabula
44030	Conneaut, OH	Ashtabula
44032	Dorset, OH	Ashtabula
44041	Geneva, OH	Ashtabula
44010	Austinburg, OH	Ashtabula
44003	Andover, OH	Ashtabula
44004	Ashtabula, OH	Ashtabula
44005	Ashtabula, OH	Ashtabula
44082	Pierpont, OH	Ashtabula
44084	Rock Creek, OH	Ashtabula
44085	Rome, OH	Ashtabula
44076	Orwell, OH	Ashtabula
44047	Jefferson, OH	Ashtabula
44048	Kingsville, OH	Ashtabula
44068	North Kingsville, OH	Ashtabula

Erie County, Ohio

ZIP	CITY AND STATE	COUNTY
43438	Kelleys Island, OH	Erie
44089	Vermilion, OH	Erie
44814	Berlin Heights, OH	Erie
44816	Birmingham, OH	Erie
44824	Castalia, OH	Erie
44839	Huron, OH	Erie
44846	Milan, OH	Erie
44870	Sandusky, OH	Erie
44871	Sandusky, OH	Erie

Lake County, Ohio

ZIP	CITY AND STATE	COUNTY
44045	Grand River, OH	Lake
44081	Perry, OH	Lake
44077	Painesville, OH	Lake
44097	Eastlake, OH	Lake
44096	Willoughby, OH	Lake
44095	Eastlake, OH	Lake
44094	Willoughby, OH	Lake

	44061	Mentor, OH	Lake
	44060	Mentor, OH	Lake
	44057	Madison, OH	Lake
	44092	Wickliffe, OH	Lake
Summit County, Ohio	**ZIP**	**CITY AND STATE**	**COUNTY**
	44203	Barberton, OH	Summit
	44210	Bath, OH	Summit
	44087	Twinsburg, OH	Summit
	44056	Macedonia, OH	Summit
	44067	Northfield, OH	Summit
	44314	Akron, OH	Summit
	44315	Akron, OH	Summit
	44317	Akron, OH	Summit
	44313	Akron, OH	Summit
	44311	Akron, OH	Summit
	44312	Akron, OH	Summit
	44316	Akron, OH	Summit
	44398	Akron, OH	Summit
	44325	Akron, OH	Summit
	44326	Akron, OH	Summit
	44303	Akron, OH	Summit
	44302	Akron, OH	Summit
	44301	Akron, OH	Summit
	44334	Fairlawn, OH	Summit
	44334	Akron, OH	Summit
	44328	Akron, OH	Summit
	44333	Akron, OH	Summit
	44304	Akron, OH	Summit
	44320	Akron, OH	Summit
	44309	Akron, OH	Summit
	44319	Akron, OH	Summit
	44310	Akron, OH	Summit
	44308	Akron, OH	Summit
	44305	Akron, OH	Summit
	44321	Akron, OH	Summit
	44307	Akron, OH	Summit

	44306	Akron, OH	Summit
	44286	Richfield, OH	Summit
	44237	Hudson, OH	Summit
	44250	Lakemore, OH	Summit
	44223	Cuyahoga Falls, OH	Summit
	44216	Clinton, OH	Summit
	44232	Green, OH	Summit
	44224	Stow, OH	Summit
	44236	Hudson, OH	Summit
	44222	Cuyahoga Falls, OH	Summit
	44372	Akron, OH	Summit
	44278	Tallmadge, OH	Summit
	44396	Akron, OH	Summit
	44221	Cuyahoga Falls, OH	Summit
	44262	Munroe Falls, OH	Summit
	44264	Peninsula, OH	Summit
Cuyahoga County, Ohio	**ZIP**	**CITY AND STATE**	**COUNTY**
	44111	Cleveland, OH	Cuyahoga
	44130	Parma, OH	Cuyahoga
	44130	Parma Heights, OH	Cuyahoga
	44112	Cleveland, OH	Cuyahoga
	44110	Cleveland, OH	Cuyahoga
	44130	Middleburg Heights, OH	Cuyahoga
	44130	Cleveland, OH	Cuyahoga
	44108	Cleveland, OH	Cuyahoga
	44109	Cleveland, OH	Cuyahoga
	44129	Parma, OH	Cuyahoga
	44143	Cleveland, OH	Cuyahoga
	44117	Euclid, OH	Cuyahoga
	44144	Cleveland, OH	Cuyahoga
	44149	Strongsville, OH	Cuyahoga
	44124	Mayfield Heights, OH	Cuyahoga
	44116	Rocky River, OH	Cuyahoga
	44126	Cleveland, OH	Cuyahoga
	44142	Brookpark, OH	Cuyahoga
	44125	Cleveland, OH	Cuyahoga

	44124	Pepper Pike, OH	Cuyahoga
	44142	Cleveland, OH	Cuyahoga
	44145	Westlake, OH	Cuyahoga
	44119	Cleveland, OH	Cuyahoga
	44120	Cleveland, OH	Cuyahoga
	44122	Beachwood, OH	Cuyahoga
	44121	Cleveland, OH	Cuyahoga
	44146	Bedford, OH	Cuyahoga
	44147	Broadview Heights, OH	Cuyahoga
	44124	Lyndhurst, OH	Cuyahoga
	44124	Cleveland, OH	Cuyahoga
	44118	Cleveland, OH	Cuyahoga
	44123	Euclid, OH	Cuyahoga
	44017	Berea, OH	Cuyahoga
	44114	Cleveland, OH	Cuyahoga
	44198	Cleveland, OH	Cuyahoga
	44195	Cleveland, OH	Cuyahoga
	44197	Cleveland, OH	Cuyahoga
	44113	Cleveland, OH	Cuyahoga
	44199	Cleveland, OH	Cuyahoga
	44139	Solon, OH	Cuyahoga
	44129	Cleveland, OH	Cuyahoga
	44022	Chagrin Falls, OH	Cuyahoga
	44140	Bay Village, OH	Cuyahoga
	44188	Cleveland, OH	Cuyahoga
	44190	Cleveland, OH	Cuyahoga
	44115	Cleveland, OH	Cuyahoga
	44181	Cleveland, OH	Cuyahoga
	44127	Cleveland, OH	Cuyahoga
	44128	Cleveland, OH	Cuyahoga
	44193	Cleveland, OH	Cuyahoga
	44194	Cleveland, OH	Cuyahoga
	44192	Cleveland, OH	Cuyahoga
	44141	Brecksville, OH	Cuyahoga
	44191	Cleveland, OH	Cuyahoga
	44104	Cleveland, OH	Cuyahoga

	44131	Independence, OH	Cuyahoga
	44137	Maple Heights, OH	Cuyahoga
	44131	Seven Hills, OH	Cuyahoga
	44131	Parma, OH	Cuyahoga
	44105	Cleveland, OH	Cuyahoga
	44101	Cleveland, OH	Cuyahoga
	44103	Cleveland, OH	Cuyahoga
	44131	Cleveland, OH	Cuyahoga
	44040	Gates Mills, OH	Cuyahoga
	44131	Brooklyn Heights, OH	Cuyahoga
	44136	Strongsville, OH	Cuyahoga
	44133	North Royalton, OH	Cuyahoga
	44135	Cleveland, OH	Cuyahoga
	44134	Cleveland, OH	Cuyahoga
	44107	Lakewood, OH	Cuyahoga
	44102	Cleveland, OH	Cuyahoga
	44138	Olmsted Falls, OH	Cuyahoga
	44106	Cleveland, OH	Cuyahoga
	44070	North Olmsted, OH	Cuyahoga
	44132	Euclid, OH	Cuyahoga
Lorain County, Ohio	**ZIP**	**CITY AND STATE**	**COUNTY**
	44049	Kipton, OH	Lorain
	44052	Lorain, OH	Lorain
	44050	Lagrange, OH	Lorain
	44044	Grafton, OH	Lorain
	44053	Lorain, OH	Lorain
	44054	Sheffield Lake, OH	Lorain
	44035	Elyria, OH	Lorain
	44036	Elyria, OH	Lorain
	44039	North Ridgeville, OH	Lorain
	44028	Columbia Station, OH	Lorain
	44001	Amherst, OH	Lorain
	44011	Avon, OH	Lorain
	44012	Avon Lake, OH	Lorain
	44055	Lorain, OH	Lorain
	44090	Wellington, OH	Lorain

	44074	Oberlin, OH	Lorain
Trumbull County, Ohio	**ZIP**	**CITY AND STATE**	**COUNTY**
	44446	Niles, OH	Trumbull
	44444	Newton Falls, OH	Trumbull
	44453	Orangeville, OH	Trumbull
	44450	North Bloomfield, OH	Trumbull
	44440	Mineral Ridge, OH	Trumbull
	44437	Mc Donald, OH	Trumbull
	44430	Leavittsburg, OH	Trumbull
	44439	Mesopotamia, OH	Trumbull
	44438	Masury, OH	Trumbull
	44485	Warren, OH	Trumbull
	44484	Warren, OH	Trumbull
	44491	West Farmington, OH	Trumbull
	44486	Warren, OH	Trumbull
	44483	Warren, OH	Trumbull
	44473	Vienna, OH	Trumbull
	44470	Southington, OH	Trumbull
	44482	Warren, OH	Trumbull
	44481	Warren, OH	Trumbull
	44410	Cortland, OH	Trumbull
	44417	Farmdale, OH	Trumbull
	44404	Burghill, OH	Trumbull
	44402	Bristolville, OH	Trumbull
	44403	Brookfield, OH	Trumbull
	44424	Hartford, OH	Trumbull
	44420	Girard, OH	Trumbull
	44418	Fowler, OH	Trumbull
	44425	Hubbard, OH	Trumbull
	44428	Kinsman, OH	Trumbull
Allegheny County, Pennsylvania	**ZIP**	**CITY AND STATE**	**COUNTY**
	15102	Bethel Park, PA	Allegheny
	15101	Allison Park, PA	Allegheny
	15108	Coraopolis, PA	Allegheny
	15106	Carnegie, PA	Allegheny
	15104	Braddock, PA	Allegheny

	15116	Glenshaw, PA	Allegheny
	15120	Homestead, PA	Allegheny
	15095	Warrendale, PA	Allegheny
	15096	Warrendale, PA	Allegheny
	15110	Duquesne, PA	Allegheny
	15112	East Pittsburgh, PA	Allegheny
	15031	Cuddy, PA	Allegheny
	15032	Curtisville, PA	Allegheny
	15028	Coulters, PA	Allegheny
	15030	Creighton, PA	Allegheny
	15037	Elizabeth, PA	Allegheny
	15044	Gibsonia, PA	Allegheny
	15034	Dravosburg, PA	Allegheny
	15035	East McKeesport, PA	Allegheny
	15025	Clairton, PA	Allegheny
	15014	Brackenridge, PA	Allegheny
	15015	Bradfordwoods, PA	Allegheny
	15006	Bairdford, PA	Allegheny
	15007	Bakerstown, PA	Allegheny
	15020	Bunola, PA	Allegheny
	15024	Cheswick, PA	Allegheny
	15017	Bridgeville, PA	Allegheny
	15018	Buena Vista, PA	Allegheny
	15082	Sturgeon, PA	Allegheny
	15084	Tarentum, PA	Allegheny
	15075	Rural Ridge, PA	Allegheny
	15076	Russellton, PA	Allegheny
	15090	Wexford, PA	Allegheny
	15091	Wildwood, PA	Allegheny
	15086	Warrendale, PA	Allegheny
	15088	West Elizabeth, PA	Allegheny
	15071	Oakdale, PA	Allegheny
	15047	Greenock, PA	Allegheny
	15049	Harwick, PA	Allegheny
	15045	Glassport, PA	Allegheny
	15046	Crescent, PA	Allegheny

15064	Morgan, PA	Allegheny
15065	Natrona Heights, PA	Allegheny
15051	Indianola, PA	Allegheny
15056	Leetsdale, PA	Allegheny
15239	Pittsburgh, PA	Allegheny
15240	Pittsburgh, PA	Allegheny
15241	Pittsburgh, PA	Allegheny
15295	Pittsburgh, PA	Allegheny
15290	Pittsburgh, PA	Allegheny
15238	Pittsburgh, PA	Allegheny
15283	Pittsburgh, PA	Allegheny
15282	Pittsburgh, PA	Allegheny
15243	Pittsburgh, PA	Allegheny
15242	Pittsburgh, PA	Allegheny
15289	Pittsburgh, PA	Allegheny
15286	Pittsburgh, PA	Allegheny
15237	Pittsburgh, PA	Allegheny
15228	Pittsburgh, PA	Allegheny
15229	Pittsburgh, PA	Allegheny
15230	Pittsburgh, PA	Allegheny
15225	Pittsburgh, PA	Allegheny
15226	Pittsburgh, PA	Allegheny
15227	Pittsburgh, PA	Allegheny
15234	Pittsburgh, PA	Allegheny
15235	Pittsburgh, PA	Allegheny
15236	Pittsburgh, PA	Allegheny
15231	Pittsburgh, PA	Allegheny
15232	Pittsburgh, PA	Allegheny
15233	Pittsburgh, PA	Allegheny
15281	Pittsburgh, PA	Allegheny
15272	Pittsburgh, PA	Allegheny
15260	Pittsburgh, PA	Allegheny
15270	Pittsburgh, PA	Allegheny
15257	Pittsburgh, PA	Allegheny
15258	Pittsburgh, PA	Allegheny
15259	Pittsburgh, PA	Allegheny

	15262	Pittsburgh, PA	Allegheny
	15265	Pittsburgh, PA	Allegheny
	15264	Pittsburgh, PA	Allegheny
	15268	Pittsburgh, PA	Allegheny
	15261	Pittsburgh, PA	Allegheny
	15267	Pittsburgh, PA	Allegheny
	15255	Pittsburgh, PA	Allegheny
	15251	Pittsburgh, PA	Allegheny
	15278	Pittsburgh, PA	Allegheny
	15277	Pittsburgh, PA	Allegheny
	15244	Pittsburgh, PA	Allegheny
	15250	Pittsburgh, PA	Allegheny
	15279	Pittsburgh, PA	Allegheny
	15252	Pittsburgh, PA	Allegheny
	15253	Pittsburgh, PA	Allegheny
	15254	Pittsburgh, PA	Allegheny
	15276	Pittsburgh, PA	Allegheny
	15275	Pittsburgh, PA	Allegheny
	15274	Pittsburgh, PA	Allegheny
	15147	Verona, PA	Allegheny
	15148	Wilmerding, PA	Allegheny
	15201	Pittsburgh, PA	Allegheny
	15146	Monroeville, PA	Allegheny
	15143	Sewickley, PA	Allegheny
	15144	Springdale, PA	Allegheny
	15145	Turtle Creek, PA	Allegheny
	15202	Pittsburgh, PA	Allegheny
	15207	Pittsburgh, PA	Allegheny
	15208	Pittsburgh, PA	Allegheny
	15209	Pittsburgh, PA	Allegheny
	15206	Pittsburgh, PA	Allegheny
	15203	Pittsburgh, PA	Allegheny
	15204	Pittsburgh, PA	Allegheny
	15205	Pittsburgh, PA	Allegheny
	15129	South Park, PA	Allegheny
	15131	Mckeesport, PA	Allegheny

	15132	Mckeesport, PA	Allegheny
	15127	Ingomar, PA	Allegheny
	15122	West Mifflin, PA	Allegheny
	15123	West Mifflin, PA	Allegheny
	15126	Imperial, PA	Allegheny
	15133	Mckeesport, PA	Allegheny
	15139	Oakmont, PA	Allegheny
	15140	Pitcairn, PA	Allegheny
	15142	Presto, PA	Allegheny
	15137	North Versailles, PA	Allegheny
	15134	Mckeesport, PA	Allegheny
	15135	Mckeesport, PA	Allegheny
	15136	McKees Rocks, PA	Allegheny
	15210	Pittsburgh, PA	Allegheny
	15221	Pittsburgh, PA	Allegheny
	15216	Pittsburgh, PA	Allegheny
	15222	Pittsburgh, PA	Allegheny
	15217	Pittsburgh, PA	Allegheny
	15218	Pittsburgh, PA	Allegheny
	15219	Pittsburgh, PA	Allegheny
	15220	Pittsburgh, PA	Allegheny
	15224	Pittsburgh, PA	Allegheny
	15212	Pittsburgh, PA	Allegheny
	15211	Pittsburgh, PA	Allegheny
	15213	Pittsburgh, PA	Allegheny
	15215	Pittsburgh, PA	Allegheny
	15214	Pittsburgh, PA	Allegheny
	15223	Pittsburgh, PA	Allegheny
Erie County, Pennsylvania	**ZIP**	**CITY AND STATE**	**COUNTY**
	16413	Elgin, PA	Erie
	16415	Fairview, PA	Erie
	16412	Edinboro, PA	Erie
	16438	Union City, PA	Erie
	16411	East Springfield, PA	Erie
	16430	North Springfield, PA	Erie
	16423	Lake City, PA	Erie

	16428	North East, PA	Erie
	16426	McKean, PA	Erie
	16427	Mill Village, PA	Erie
	16417	Girard, PA	Erie
	16410	Cranesville, PA	Erie
	16421	Harborcreek, PA	Erie
	16401	Albion, PA	Erie
	16407	Corry, PA	Erie
	16502	Erie, PA	Erie
	16522	Erie, PA	Erie
	16504	Erie, PA	Erie
	16503	Erie, PA	Erie
	16501	Erie, PA	Erie
	16534	Erie, PA	Erie
	16538	Erie, PA	Erie
	16530	Erie, PA	Erie
	16531	Erie, PA	Erie
	16515	Erie, PA	Erie
	16510	Erie, PA	Erie
	16507	Erie, PA	Erie
	16509	Erie, PA	Erie
	16508	Erie, PA	Erie
	16506	Erie, PA	Erie
	16505	Erie, PA	Erie
	16514	Erie, PA	Erie
	16511	Erie, PA	Erie
	16512	Erie, PA	Erie
	16443	West Springfield, PA	Erie
	16442	Wattsburg, PA	Erie
	16550	Erie, PA	Erie
	16553	Erie, PA	Erie
	16444	Edinboro, PA	Erie
	16565	Erie, PA	Erie
	16563	Erie, PA	Erie
	16441	Waterford, PA	Erie
	16541	Erie, PA	Erie

	16475	Albion, PA	Erie
	16546	Erie, PA	Erie
	16544	Erie, PA	Erie
Butler County, Pennsylvania	**ZIP**	**CITY AND STATE**	**COUNTY**
	16020	Boyers	Butler
	16022	Bruin	Butler
	16001	Butler	Butler
	16002	Butler	Butler
	16023	Cabot	Butler
	16024	Callery	Butler
	16025	Chicora	Butler
	16027	Connoquenessing	Butler
	16066	Cranberry Township	Butler
	16029	East Butler	Butler
	16030	Eau Claire	Butler
	16373	Emlenton	Butler
	16033	Evans City	Butler
	16034	Fenelton	Butler
	16035	Forestville	Butler
	16229	Freeport	Butler
	15044	Gibsonia	Butler
	16127	Grove City	Butler
	16037	Harmony	Butler
	16038	Harrisville	Butler
	16040	Hilliards	Butler
	16041	Karns City	Butler
	16045	Lyndora	Butler
	16046	Mars	Butler
	16048	North Washington	Butler
	16049	Parker	Butler
	16050	Petrolia	Butler
	16051	Portersville	Butler
	16052	Prospect	Butler
	16053	Renfrew	Butler
	16055	Sarver	Butler
	16056	Saxonburg	Butler

	16057	Slippery Rock	Butler
	16059	Valencia	Butler
	15086	Warrendale	Butler
	16061	West Sunbury	Butler
	16063	Zelienople	Butler
Washington County, Pennsylvania	**ZIP**	**CITY AND STATE**	**COUNTY**
	15055	Lawrence, PA	Washington
	15366	Van Voorhis, PA	Washington
	15057	Mc Donald, PA	Washington
	15378	Westland, PA	Washington
	15060	Midway, PA	Washington
	15377	West Finley, PA	Washington
	15365	Taylorstown, PA	Washington
	15033	Donora, PA	Washington
	15361	Southview, PA	Washington
	15363	Strabane, PA	Washington
	15368	Vestaburg, PA	Washington
	15053	Joffre, PA	Washington
	15054	Langeloth, PA	Washington
	15038	Elrama, PA	Washington
	15376	West Alexander, PA	Washington
	15379	West Middletown, PA	Washington
	15483	Stockdale, PA	Washington
	15067	New Eagle, PA	Washington
	15367	Venetia, PA	Washington
	15434	Elco, PA	Washington
	15477	Roscoe, PA	Washington
	15313	Beallsville, PA	Washington
	15078	Slovan, PA	Washington
	15312	Avella, PA	Washington
	15301	Washington, PA	Washington
	15311	Amity, PA	Washington
	15432	Dunlevy, PA	Washington
	15021	Burgettstown, PA	Washington
	15019	Bulger, PA	Washington
	15419	California, PA	Washington

	15412	Allenport, PA	Washington
	15022	Charleroi, PA	Washington
	15427	Daisytown, PA	Washington
	15429	Denbo, PA	Washington
	15063	Monongahela, PA	Washington
	15423	Coal Center, PA	Washington
	15004	Atlasburg, PA	Washington
	15360	Scenery Hill, PA	Washington
	15339	Hendersonville, PA	Washington
	15336	Gastonville, PA	Washington
	15340	Hickory, PA	Washington
	15323	Claysville, PA	Washington
	15314	Bentleyville, PA	Washington
	15333	Fredericktown, PA	Washington
	15332	Finleyville, PA	Washington
	15317	Canonsburg, PA	Washington
	15321	Cecil, PA	Washington
	15342	Houston, PA	Washington
	15331	Ellsworth, PA	Washington
	15358	Richeyville, PA	Washington
	15330	Eighty Four, PA	Washington
	15329	Prosperity, PA	Washington
	15324	Cokeburg, PA	Washington
	15347	Meadow Lands, PA	Washington
	15345	Marianna, PA	Washington
	15350	Muse, PA	Washington
	15348	Millsboro, PA	Washington

Appendix G: Patient Demographics

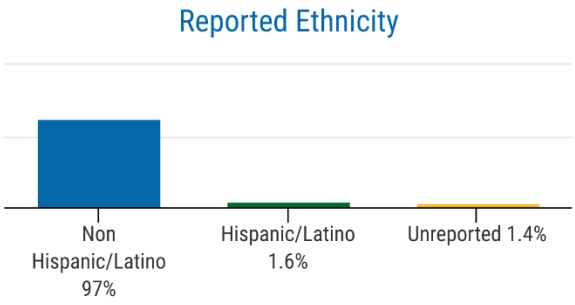
Patient Demographics

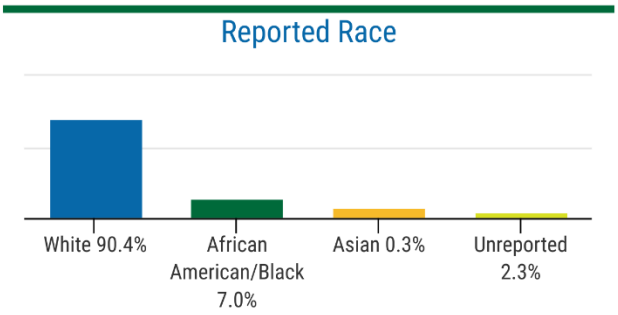
January 1, 2021 - December 31, 2021

Glenbeigh Reported Numbers
(Data Integrity Report -Ohio Hospital Association)

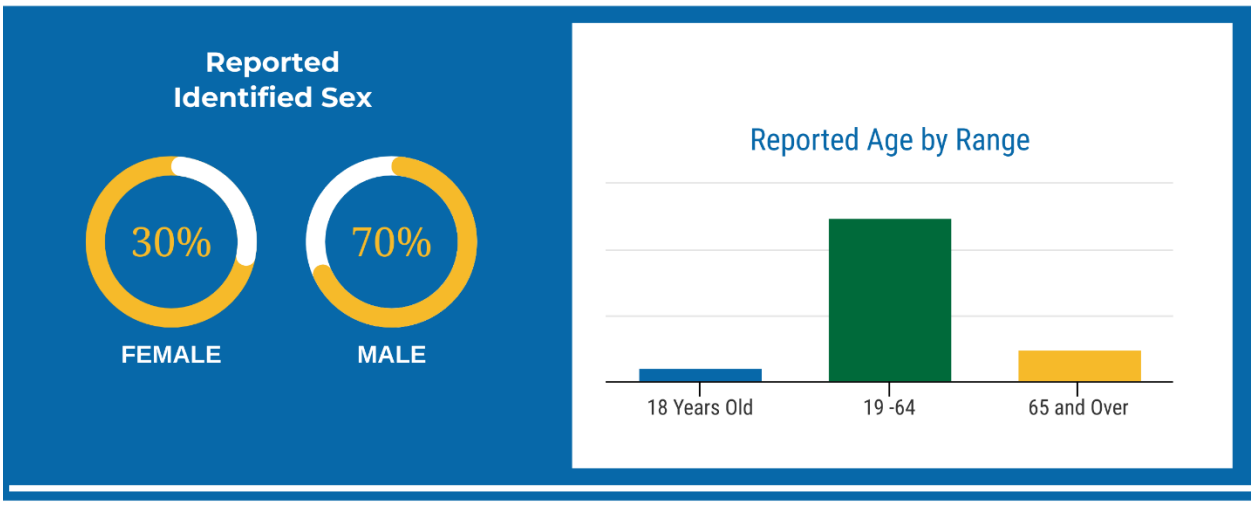
Glenbeigh 2021 Patient Demographics

Inpatient Statistics for Ethnicity and Race





Source: Data Integrity Report - Ohio Hospital Association Glenbeigh



Appendix H: Glenbeigh Impact Matrix 2019 – August 2022

Glenbeigh Impact Matrix

Community Benefit Initiatives
2019 through August 2022

Guided by 2019 CHNA Identified Needs and
2019 Implementation Strategy

Glenbeigh Impact Matrix

2019 to August 2022

Socioeconomic

Drug and alcohol abuse continues to impact people of all races and ages. Poverty, income and insurance coverage significantly impact access to treatment and successful recovery. Employment and income, along with other social and economic determinants, correspond to alcohol and drug use.

- Collaborate with other agencies as part of a referral network. Established with UniteUs referral network to assist physicians and other healthcare professionals with connecting clients to addiction treatment providers. Member of Cleveland State University network providing hospitals with daily bed availability information for people with substance use disorders.
- Provide financial assistance and discounts to maximize access to treatment. Collaborate with other agencies to provide underserved communities with improved access to health services.
- Continue to maintain a referral network to assist individuals in need of support services. Refer to and accept from other agencies.
- Opened a sober living residence that can house up to 8 women. Home is peer run and residents have access to clinical and other support services.
- Glenbeigh continues to work with other sober living providers creating a referral network for individuals seeking sober housing.
- Support efforts of people in recovery to establish structured sober living.
- Collaborate with other agencies offering GED and continued education. These organizations provide job training and other programs to help those in recovery reenter the workforce.
- Expanded the provision of outpatient level Telehealth services due to COVID-19 restrictions. Telehealth services allowed individuals to establish and continue treatment while lock-down measures were in place.
- Glenbeigh recognized that Telehealth services were limited to individuals with internet access therefore established in-person outpatient services as soon as restrictions were lifted. Telehealth services remain an option for individuals with transportation barriers.
- Leadership is engaged with community organizations providing a continuum of care to people in need.
- Offer assistance to social service agencies and reestablish connections with drug courts once services began after ease of COVID-19 restrictions.
- Glenbeigh remained open throughout the pandemic offering treatment services at a reduced capacity in order to meet social distance and other COVID-19 requirements.
- Continue to provide information to the public and to patients on screening for infections diseases that often accompany addiction such as Hepatitis C and HIV. Provide follow-up resources and prevention information.

Glenbeigh Impact Matrix

2019 to August 2022

Socioeconomic

People dealing with active addiction do not understand how to get assistance or help a loved one/client sustain recovery. There is a lack of education and information available regarding addiction, treatment and recovery support.

- Distribute *Streetdrug* reference books and other reference materials to professionals working in the addiction treatment or support fields, law enforcement and schools.
- Continue to sponsor non-clinical programs to increase awareness of addiction, treatment and recovery. Includes sponsorship of Trumbull Mental Health and Recovery Board programs as well as the Scrappers family section and support of the Scrappers Healthy Community Program.
- Provide and participate in educational and social events for the recovery community or other agencies. Sponsored events include:
- **2019:** Rock & Resilience Community Day, Rock & Recovery Stage at the Gate Lodge, Niles summer picnics, Alumni & Recovery Community Picnic, Bridges to Recovery Pittsburgh, PA, Rocky River, OH, Canton, OH, Annual ARCHway Institute Collaborative Golf Outing, Niles Community Holiday Banquet, Recovery Halloween at Elsworth Acres, Feed the Hope project and Christmas for Children's Services.
- **2020/2021:** Many events were cancelled due to COVID-19 throughout 2020, 2021 and part of 2022. Understanding the need for continued connection and support for people in recovery, Glenbeigh transitioned to virtual platforms when possible. Limited in-person events were offered as COVID restrictions eased and requirements could be met. The following services were provided:
- Bridges to Recovery - transitioned to a virtual platform and expanded to providing multiple topic options each week. Pod Casts posted that featured personal stories of addiction, treatment and recovery. Free virtual discussions were also hosted. Live Bridges events began in 2022.
- Created the "Steps for Sobriety" challenge that was open to alumni and friends in the recovery community.
- ARCHway Institute Annual Golf Outing - continued to host the event throughout the pandemic. Attendance restrictions were implemented as were social distancing practices.
- Education: Glenbeigh transitioned the Rise and Shine educational program to a virtual format. Courses were designed to keep professionals abreast of current trends and treatment modalities. Free Continuing Education credits were offered. Glenbeigh also collaborated with the Ashtabula Mental Health & Recovery Services Board to offer professional educational opportunities. Glenbeigh also collaborated with this agency to offer free CRAFT programming for families dealing with active addiction. These programs were hosted throughout Ashtabula County and were open to anyone in the community interested in addiction, treatment options and sustaining recovery.
- Explored successful programs and adopted new means of caring for people with SUDs.
- Continue to distribute naloxone to the public as well as to other agencies working with the public.

Glenbeigh Impact Matrix

2019 to August 2022

Socioeconomic

In many areas there continues to be a lack of recovery support options. Recovery support includes recovery housing and recovery oriented events.

- Continue to assess the need for transitional sober living housing and recovery living options.
- During the COVID-19 pandemic, Glenbeigh continued to operate sober housing providing a home for up to 32 men. Glenbeigh provided rent assistance to individuals who could no longer work. Collaborating with other agencies, food and other services were provided to residents in need.
- In April 2020, Glenbeigh opened its first sober living home for women. The 2,000 square foot facility can house up to 8 women.
- Continue to work with other recovery residences and providers building a recovery support network that benefits the entire community.
- Explore new ways to engage people in recovery in order to prevent isolation and potential relapse.
- Utilize social media and publicize virtual events as well as other resources.
- Continue to provide meeting space to local support groups that met pandemic standards.

Health Needs

Barriers exist that affect access to treatment either limiting or excluding certain demographics from obtaining treatment services.

- Transportation services were suspended during the pandemic. Due to restrictions, for a time only individuals from Ohio were admitted to Glenbeigh. As restrictions eased, admissions were open to individuals from out of state. Transportation services resumed in early 2022 with limited contact restrictions in place.
- Continue to work with individuals having limited resources to secure detoxification and treatment.
- Provide charitable care to individuals who meet clinical and financial eligibility when possible.
- Maintain a referral network to assist individuals in need of support services. Collaborate with other agencies to find and secure the best level of care.
- Provide education and information on testing services within the community. Distribute information on where and how to seek further care for HIV and Hepatitis.

Glenbeigh Impact Matrix

2019 to August 2022

Health Needs

Among providers there is a lack of qualified, educated, licensed individuals to work in the field of addiction treatment: from entry level positions to physicians and nurses.

- Undertake partnerships and collaborative efforts to address workforce development. Provide educational opportunities for individuals to advance their education and secure sustainable wages. Work with colleges, universities and local agencies offering workforce development opportunities.
- Develop educational workshops for professionals offering free continuing education credits in order to sustain licensure.
- Offer internship opportunities for nursing, social work and counseling students and other healthcare professionals to provide education on caring for individuals with substance use disorders.
- Provide support to individuals in recovery who wish to enter the addiction treatment field. Offer entry level positions and support education.
- Develop specialty workshops to provide educational experience for the community.
- Provide speakers and resource materials on the topics of addiction, treatment and recovery.
- Provide reference materials to healthcare providers, clergy and others to help guide individuals seeking information on addiction and treatment.
- Work with community agencies to provide helpful information to the public.
- Create and distribute information about trends affecting addiction, treatment and recovery.

Other

Social media and other online platforms offer a means of connecting with people affected by addiction as well as those living in recovery. During the COVID-19 pandemic, Glenbeigh expanded the use of online formats to promote recovery support and reduce the risk of relapse caused by isolation.

- Continue to deliver information through social media platforms. Glenbeigh websites, Facebook, Twitter, LinkedIn and Instagram. Use podcasts to deliver positive stories and messaging.
- Added TikTok to distribute recovery messaging to individuals age 18 and over.
- Launched Glenbeigh 365 app for alumni, family and the recovery community. Provides recovery-oriented messaging and motivational material for daily use.

Appendix I: Approach to Prioritizing Health Issues

The 2022 CHNA utilized a cross-sectional study as the tool to prioritize health issues. Multiple approaches were used to collect data and prioritize qualitative data. Secondary (quantitative) data was used in a supporting role to confirm information gleaned from stakeholders.

Community perspective (qualitative data) was a key component to construct a complete community resource inventory. Over 55 community stakeholders were engaged across a diverse cross-section of northeast Ohio and western Pennsylvania encompassing health and non-health disciplines. Using a semi-structured data collection methodology, Glenbeigh conducted phone interviews and utilized in-person and electronic surveys. Due to COVID-19 risks, focus groups were not held. Survey questions remained focused on community needs, seeking clarity on issues elevating health equity throughout the region.

Quantitative data was obtained from the U.S. Census Bureau, the Ashtabula County Health Assessment, state health analysis, Appalachian Regional Commission reports, the Ohio Department of Health, the Centers for Disease Control and Prevention, Ohio State Highway Patrol and an assortment of federal agency reports. Data was collected to ascertain population characteristics, including socioeconomic factors, along with substance use trends.

The congregate data provide important context to guide how and where Glenbeigh may provide resources for the greatest impact. As the nature of substance use continually changes, the 2022 assessment was broken into two areas that emerged as priority areas based on the evidence gathered. Key findings concentrate on socioeconomic and health needs as it did in the 2019 CHNA. As many of the social determinants of health, the conditions that influence differences in health status, have not changed in the service area, many of the related issues are interrelated with the 2016 and 2019 key findings.

Glenbeigh will undertake a system-based approach to address the key needs of the defined service area. Glenbeigh may also undertake community benefit initiatives within other communities served by Glenbeigh that did not qualify as part of the CHNA defined service area.

In order to provide transparent information on Glenbeigh Community Benefit activities, the 2022 CHNA, along with the Implementation Strategy, will be posted on Glenbeigh's main website at www.glenbeigh.com. Community members are welcome to submit input or comments by contacting Glenbeigh at https://www.glenbeigh.com/community-benefit-feedback.

Overview of 2022 Community Health Needs Assessment

The Glenbeigh 2022 Community Health Needs Assessment fulfills requirements as defined by the State of Ohio and the federal government under the Patient Protection and Affordable Care Act. Glenbeigh is an owned subsidiary of ACMC Healthcare System. ACMC Healthcare System reports community benefit initiatives to the Ohio Department of Health and the Internal Revenue Service on behalf of Glenbeigh.

Glenbeigh will submit the 2022 Community Health Needs Assessment to ACMC Healthcare System management for review prior to Board presentation. The finalized CHNA will be presented to the Board for adoption with the final vote occurring on October 26, 2022.

Per federal requirements, Glenbeigh will publish the approved 2022 CHNA no later than December 31, 2022. Afterwards, using key findings along with supporting data, Glenbeigh will formulate and publish an accompanying Implementation Strategy within the established timeline.

The following is an overview of the 2022 CHNA process:

Process Management: Glenbeigh, working with oversight provided by ACMH Healthcare System and Cleveland Clinic, was the lead agency in undertaking the formation of the 2022 CHNA. Prior to starting the process, the 2019 CHNA and community benefit data were reviewed. Survey questions were reviewed for relevance and updated as needed.

Defined Service Area: In early 2022, Glenbeigh contracted with Shilling Consulting Services, Inc., of Rockford, Michigan, to formulate a strategic plan for the organization. During that process, Shilling Consulting Services researched and defined Glenbeigh's service area, which was used for the CHNA. The defined service area was determined based on the geography from which the majority of Glenbeigh patients came from. Due to the impact of COVID-19 on admissions, data that is more extensive was used to define the service community. The file contained data for 2016, 2017, 2018, 2019, 2020 and 2021 through Quarter 3. A combination of volume from 2020 and 2021 through Quarter 3 (total of 7 months) was also examined. Taken into consideration was how the service area differed from the service area in 2016. Patient-origin maps were created using multiple state-specific, Zip Code level patient volume data and Medical Record data. From that data, seven Ohio counties and four Pennsylvania counties were identified as Glenbeigh's defined service area.

Primary Data Collection and Analysis:
Input from Vulnerable Populations: Due to the nature of Glenbeigh's services, many of our clients represent vulnerable populations. Despite that, Glenbeigh took measures to ensure the

inclusion of myriad vulnerable populations in the primary data collection process. In-person surveys were conducted at the Niles outpatient center to include input from an area impacted by poverty, high unemployment, low pay, lack of insurance, lack of transportation, limited healthcare resources, and high rates of deaths due to unintentional drug overdoses. Trumbull County is partially rural, partially urban and has areas with limited access to broadband service. The aggregate feedback from data collected from this demographic provided information on issues directly affecting individuals living with substance use disorders.

Inclusion of Community Leaders and Individuals Working in the Field: Interviews and electronic surveys were utilized to collect information from professionals working in the field of addiction treatment as well as individuals providing services to people affected by substance use. This provided a comprehensive overview of the issues affecting those who provide services within the defined area. Respondents include individuals in recovery, with a loved-one in recovery or an individual working in the field. These interviews provided insight from community members and leaders and offer input on direct addiction services as well as ancillary services.

Secondary Data Collection and Analysis:

Research: First, Glenbeigh revisited data collected in 2019. During the formulation of the 2022 CHNA, much of the data was updated with current information. However, some data sets were no longer available or not updated. Within the 2022 CHNA, data inconsistencies are noted. Research was expanded to define ever-changing material relevant to addiction, treatment and recovery. It is important to note that drug and alcohol statistics take several years to compile and may change after original publication. Local, state and federal reports and statistics were researched. All sources are documented throughout the 2022 CHNA and include URL's active at the time of publication.

Formulating the 2022 CHNA:

Assessment: After completing the research phase, data was reviewed, analyzed and tabulated. Issues that appeared in multiple forums were counted and factors mentioned multiple times in responses were prioritized as community needs. Primary data was used similarly, noting issues that were repeatedly mentioned as affecting the service area.

Defining Key Findings: Through quantitative and qualitative data analysis, Glenbeigh prioritized the needs of the defined service community. Due to the extensive nature of addiction on multiple communities, key findings were categorized into two groups: socioeconomic needs and health needs. This methodology provides a strategic means of assessing the significant health needs within Glenbeigh's defined service area and provides an overview of areas to address in the Implementation Strategy.

Community Assets and Resources: Glenbeigh's defined service area extends throughout Northeast Ohio and Western Pennsylvania, a territory that includes 11 non-contiguous counties. Throughout each county, non-profit healthcare systems complete community health needs assessments that list community assets and resources. Glenbeigh's CHNA includes a truncated list of resources in place of a full list encompassing all 11 counties. For detailed information on community assets and resources, it is recommended that readers contact their local hospital or health system, health department or social/mental health board for a comprehensive list of local resources. Publication of community resources should be included in the county issued needs assessments.

Glenbeigh
ACMC Healthcare System
An affiliate of Cleveland Clinic

Glenbeigh | Rock Creek | Ohio
www.glenbeigh.com
Published October 2022