SALEM REGIONAL MEDICAL CENTER

2022-2025 IMPLEMENTATION PLAN

Addressing the 2022-2025 Columbiana County Health Needs Assessment

SALEM REGIONAL MEDICAL CENTER: 2022-2025 Implementation Plan

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I. INTRODUCTION

Salem Regional Medical Center (SRMC) collaborated with area health care providers to conduct the 2022-2025 Columbiana County Health Needs Assessment (CCHNA), which was developed as a multi-sector partnership that supports shared ownership of community health improvement activities; including assessment, planning, implementation and evaluation. The CCHNA was designed to assess the health status and needs of the residents of Columbiana County, Ohio; identify factors that affect population health; determine the availability of existing resources that can be mobilized to improve health status; and facilitate the development of evidence-based, population-wide interventions and measurable outcomes.

The CCHNA was conducted between the Fall of 2021 to May 2022, in a joint process led by the Columbiana County Health Partners' Workgroup, which included East Liverpool City Hospital; the Community Action Agency of Columbiana County; Salem Regional Medical Center; Akron Children's Hospital; the Columbiana County, East Liverpool City and Salem City Health Departments; the Columbiana County Mental Health and Recovery Services Board and other community providers. SRMC provided financial support and consultative assistance throughout the development of the CCHNA.

Collaboration among the partners was essential to align interests and coordinate resources with the goal of effectively promoting better health outcomes in Columbiana County by leveraging multiple perspectives, community relationships and areas of expertise. The Workgroup used both qualitative and quantitative data, including community survey data, key informant interviews, demographic data and other statistical secondary data; which was gathered to identify and prioritize health problems and risk factors for residents in the Columbiana County service area. The Workgroup made significant efforts to ensure that all geographic regions of the county and socio-demographic groups, such as underserved and/or vulnerable populations, were represented in the CCHNA; along with incorporating broad, community input. (Note that the full report of the CCHNA is posted on Salem Regional Medical Center's website at www.salemregional.com, and was approved by SRMC's Board of Directors in May 2022.)

In addition to collaborating with other organizations when conducting its 2022-2025 CCHNA, SRMC must fulfill the IRS requirement to adopt a written Implementation Plan with respect to its own hospital facility. This written plan is intended to satisfy the requirements set forth in Internal Revenue Code Section 501(r)(3), as established within the Patient Protection and Affordable Care Act (PPACA), requiring that non-profit hospitals develop written implementation strategies within a defined implementation plan to address the needs identified in their most recent community health needs assessment. The overall purpose of the implementation strategy process is to align the Medical Center's limited resources, programs, services and activities with the findings of the 2022-2025 CCHNA.

- Governance Approval Process: Findings from the 2022-2025 CCHNA were presented in May 2022 to SRMC's Board of Directors as part of SRMC's strategic planning process. Following approval of the 2022-2025 CCHNA by the SRMC Board of Directors on May 19, 2022, SRMC's implementation planning process was launched with input from the CCHNA Workgroup via the joint initiation of a community health improvement plan (CHIP), beginning in August 2022 and scheduled for tentative completion by the end of calendar 2022.

A CHIP is designed to set priorities, direct the use of resources, and develop and implement projects, programs, and policies; with input obtained from a broad set of community stakeholders and partners. The CCHNA Workgroup developed the CHIP as an extension of the CCHNA and invited various community stakeholders to participate in the community health improvement process, including Salem Regional Medical Center as an original and key member of the CCHNA Workgroup.

Selected priorities, strategies and indicators recommended in the Columbiana County 2022-2025 CHIP were incorporated into SRMC's 2022-2025 Implementation Plan, and presented to the SRMC Board of Directors for governing body approval in November 2022. (Note: SRMC's 2022-2025 Implementation Plan was created in collaboration with the initial development of the 2022-2025 CHIP, so that the county's

population health improvement activities and resources could be coordinated to address identified community needs. However, due to the IRS requirement that SRMC's Implementation Plan be adopted within six months of its CCHNA adoption, only about half of the CHIP had been completed by the Workgroup within that timeframe and was available for integration within SRMC's Implementation Planning process.)

II. MOBILIZING FOR ACTION: ASSESSMENTS & PRIORITIZATION PROCESS

Data from the most recent CCHNA was carefully considered and categorized into community priorities with accompanying strategies. This was accomplished using the National Association of County and City Health Officials' (NACCHO) national framework, *Mobilizing for Action through Planning and Partnerships* (MAPP). MAPP is a community-driven strategic planning process for improving community health that helps prioritize public health issues and identify resources to address them.

The MAPP framework includes 4 phases:
1. Organizing the planning process & developing the planning partnership
2. Visioning & values
3. Collecting & analyzing data (including analysis of the 4 MAPP assessments of Community Themes & Strengths, Local Public Health System Assessment, Community Health Status Assessment and Forces of Change Assessment)
4. Identifying and prioritizing issues

It should be noted that when feasible, the Workgroup incorporated MAPP's proposed, revised guiding values regarding Equity, Inclusion, Trusted Relationships, Community Power, Strategic Collaboration and Alignment, Data and Community Informed Action, Full Spectrum Actions, Flexible and Continuous Improvement into its process.

The four assessments required in MAPP's Phase 3 were completed by the Columbiana County Health Partners Workgroup for the purpose of identifying and prioritizing strategic health issues and vulnerable populations as the foundation for Columbiana County's 2022-2025 CHIP.

The prioritization findings were then categorized so that the 2022-2025 CHIP may serve as a catalyst going forward to develop community partnerships and implement evidence-based strategic interventions, which address priority health needs as identified by the county and state. With the goal of further aligning SRMC's Implementation Plan to address these top local, state and national health priorities; SRMC has integrated many of the 2022-2025 CHIP findings into its 2022-2025 Implementation Plan.

A. MAPP Assessment: Community Health Status Assessment (2022-2025 CCHNA)

The Columbiana County Health Partners contracted with the Lake County Health Department (LCHD) and two graduate students from the University of Alabama at Birmingham to collect and analyze primary and secondary data. In addition, the Partners independently conducted primary and secondary data collection and analysis to more fully capture the needs of vulnerable populations and the broad community, and help fill identified data gaps to support informed decision-making. The data assessment model used for the CCHNA followed best practices as outlined by the Association of Community Health Improvement and was also designed to ensure compliance with current Internal Revenue Service guidelines for charitable 501(c)(3) tax-exempt hospitals and National Public Health Department accreditation prerequisites.

1. Primary CCHNA Data

Primary qualitative data to reflect input from the broad community and vulnerable populations was collected through 599 written community surveys completed by individuals representing diverse constituent groups with this data gathered and analyzed by the LCHD and the Partners' Workgroup; and

32 stakeholder and focus group interviews, reflecting input from 106 participants with this data gathered and analyzed by the LCHD and the Partners' Workgroup.

- Community Survey: As a first step in the community survey design process, the Workgroup chose to derive the majority of the community survey items from the Behavioral Risk Factor Surveillance System (BRFSS), due to the ability to compare local data with state and national data and to the 2019 CCHNA. The Workgroup also identified questions critical to their own goals to be included in the community health survey.

The sampling frame for the community survey consisted of adults ages 19 and over living in Columbiana County, with the target sample size of 383 adults needed to ensure a 95% confidence level, with a corresponding margin of error of 5%. The confidence interval for the overall survey was met with 599 complete responses. The subpopulation of Salem also met the 95% confidence interval with a 10% margin of error with 128 complete responses. The subpopulation of East Liverpool fell short of the confidence interval with 91 complete responses, changing the margin of error from the goal of 10% to 10.24%. The subpopulation contained in Columbiana County outside of the two cities of Salem and East Liverpool also did not meet the confidence interval goal with 364 complete responses, changing the margin of error from 5% to 5.13%.

- Focus Groups and Stakeholder Interviews: Community leaders and key stakeholders were identified by the Partners as experts in a particular field related to their background experience or professional position; and/or those who understand the needs of a particular community/geographic region or under-represented group, including the medically underserved and vulnerable populations defined in the CCHNA.

Community participants represented in the focus group and stakeholder interviews included:

- School Districts and Youth Services
- Community Resource Centers
- Senior Services & Home Health Providers
- Hospital Case Managers
- Health and Human Service Providers
- Faith-Based Organizations Providing Assistance
- Juvenile Justice System
- Food Pantries
- Hispanic Community Members & Service Providers
- Local Government Officials/County Commissioners
- Mental Health and Recovery Service Providers
- Veteran's Service Commission

Findings from this source of primary data were obtained regarding factors impacting social determinants of health, top health care issues and priorities, community strengths and resources, opportunities to increase access to health care resources, and how to improve community support. In addition to collecting and analyzing data from focus groups and stakeholder interviews, primary data input and synthesis of conclusions were also performed by the community representatives, who served on the Columbiana County Health Partners' workgroup.

2. Secondary Data: The LCHD and Partners' Workgroup collected secondary data from multiple websites, including county-level data, whenever possible; along with the Behavioral Risk Factor

Surveillance System (BRFSS), numerous CDC sites, U.S. Census data ,and other national and local sources. The Partners collected additional epidemiological and population data to help establish benchmarks for health indicators and conditions at the county, state and national levels; representing a wide range of factors that impact community health, such as mortality rates, environmental factors and health care access issues. Data sources included the County Health Rankings, Association for Community Health Improvement's Community Health Assessment Toolkit, Truven Health Analytics' Community Need Index, etc.

In continuation of the vulnerability report for the community health assessment, the Columbiana County Health Partners analyzed secondary data through the lens of health equity; highlighting vulnerable,

underrepresented populations. These groups included children/youth, elderly, disabled, veterans, racial/ethnic minorities such as African Americans and Hispanics, the Amish population, and people who do not speak English. Most of these groups are accounted for within the dataset, however, there are some gaps such as lack of data for the Amish or specific groups, such as the Guatemalans.

3. CCHNA Data Gaps/Limitations: As with any assessment, it is important to consider the findings in light of possible limitations. The 2022-2025 CCHNA relied on multiple data sources and community input gathered between the fall of 2021 and May 2022. A number of data limitations should be recognized when interpreting results, such as some data only exists at a county-wide or state level, which does not allow for assessing needs at a more granular level. In addition, secondary data measures community health in prior years and may not reflect current conditions. The impacts of recent public policy developments, changes in the economy, the impact of Covid-19 and other community developments are not reflected in those data sets. In addition, there was a lack of local data available for the identified vulnerable populations of the Amish and the Hispanic population, including the Guatemalans.

4. Forces of Change: Findings from the primary data sources also indicated that there were "forces of change," defined as external trends, events and factors that positively or negatively are or will be impacting the health of Columbiana County residents. The following forces of change were considered in developing SRMC's implementation strategies, including:
a. Staff shortages at healthcare facilities, including local health districts and ODH; resulting in limited resources and support for providing healthcare and public health services.
b. Medical equipment supply-chain problems.
c. Community suspicion of healthcare workers, increase in misinformation, and combative and resistant patients resulting in safety risks to healthcare workers.
d. Resistance to all vaccines, potentially resulting in increased risk of disease occurrence.
e. Reduced patient loyalty to provider and increased expectation for "drive through" healthcare.
f. Loss of personalized/whole patient care and follow-up care resulting in an overall degradation of patient health.
g. Increased legislation to control and limit healthcare and public health.
h. Growing incidence of acute mental illness and increase of substance use and suicide resulting in increased demands on limited mental health resources.
i. Strong collaborative infrastructure of health providers and engaged community organizations is already established.

5. Findings from Other Needs Assessments: Findings from other health needs assessments that were conducted in the region and in the state of Ohio were also reviewed by the Partners to help inform the development of the CCHNA, including:
- The 2019-2022 CCHNA conducted by the Columbiana County Health Partners' workgroup.
- The 2019 Akron Children's Hospital CHNA and 2019 Mercy Health- Youngstown CHNA (conducted by Kent State University); and the 2019 Aultman Hospital CHNA conducted by the Center for Marketing & Opinion Research.
- Ohio's 2020-2022 State Health Improvement Plan (SHIP), as informed by the 2019 State Health Assessment (SHA).

The interconnectedness of Ohio's greatest health challenges, along with the overall consistency of health priorities identified in the assessment, indicate many opportunities for collaboration among a wide variety of partners at the state and local levels, including physical and behavioral health organizations and sectors beyond health.

III. SRMC'S IMPLEMENTATION PLAN'S DEFINITION OF SERVICE AREA

A. CCHNA's Definition of "Community" and Service Area Determination

In accordance with IRS and Public Health Accreditation Board (PHAB) guidelines, the Columbiana County Health Partners' workgroup defined the 2022-2025 CCHNA's "community" as Columbiana County, Ohio; by geographic location based on the shared primary service area of the workgroup. Columbiana County includes the zip codes listed below:

43920	E. Liverpool	44413	E. Palestine	44432	Lisbon	44460	Salem
43945	Salineville	44423	Hanoverton	44441	Negley	44490	Washingtonville
43968	Wellsville	44427	Kensington	44445	New Waterford	44625	East Rochester
44408	Columbiana	44431	Leetonia	44455	Rogers	44634	Homeworth

B. SRMC's Implementation Plan's Definition of "Community" and Service Area Determination

SRMC's 2022-2025 Implementation Plan defines "community" as SRMC's defined Service Area, which includes: Knox, Butler, Salem, Fairfield, Unity, West, Hanover, Center, Elkrun, Middleton, Franklin, Wayne, Madison, St. Clair and Washington townships in Columbiana County; and Smith, Goshen, Green, Beaver and Springfield townships in Mahoning County.

SRMC's 2019-2022 Implementation Plan does not include the zip codes of East Liverpool (43920) and Wellsville (43968), which were included in the 2019-2022 CCHNA; because these communities lie beyond the Medical Center's defined Service Area.

IV. SRMC'S IMPLEMENTATION STRATEGIES TO ADDRESS HEALTH CARE EQUITY AND REDUCE HEALTH DISPARITIES

As SRMC continues to play an increasingly vital role in reducing disparities in health outcomes caused by social drivers of health and improving health equity within the communities we serve, we have accelerated the enhancement of action steps as reflected in our 2022-2025 SRMC Implementation Plan.

ADDRESSING HEALTH EQUITY		
Ensuring that all people have full and equal access to opportunities that help them attain their highest level of health. (Source: American Hospital Association's Health Equity Roadmap- 2022)		
DEFINITION: SOCIAL DETERMINANTS/DRIVERS OF HEALTH (SDOH)	**DEFINITION: HEALTH-RELATED SOCIAL NEEDS (HRSN)**	**DEFINITION: HEALTH DISPARITIES**
Non-medical factors that affect health/ healthcare outcomes generally pertaining to populations and which are frequently identified as root causes of disparities. There are five SDOH domains: - Economic Stability - Education Access and Quality - Health Care Access and Quality - Neighborhood and Built Environment - Social and Community Context (Source: CMS Framework for Health Equity)	Pertain to an individual's unmet, adverse social and economic conditions that contribute to a person's ability to maintain their health and well-being. They include, but are not limited to the 5 domains of SDOHs. (Source: The Joint Commission -TJC & World Health Organization)	Differences in the incidence, prevalence, mortality and burden of disease and other adverse health conditions that exist among specific population groups in the U.S. (Source: NIH, TJC)

Beyond the requirements of the State Health Improvement Plan and as a priority in its 2022-2023 Strategic Planning update and annual Organizational Goals, Salem Regional Medical Center will continue to advance health care equity, SDOH/HRSN through the lens of our Mission: *"To Serve. To Care. To Heal."* SRMC is committed to advancing health care equity and eliminating health disparities; while supporting diversity, cultural competency and inclusion within our health care organization.

SRMC respects and values all members of its staff and communities served by embracing their diverse characteristics and talents, perspectives and experiences; and will continue to foster an inclusive culture that encourages equitable and inclusive organizational policies, systemic and shared accountability, community collaboration for solutions, representation in leadership and governance, and collection and use of data to drive action and provide culturally appropriate patient care. To that end, SRMC joined the AHA Institute for Diversity and Health Equity and utilizes the 2022 American Hospital Association's Health Equity Roadmap- 2022. SRMC's Chief Medical Officer is designated by the Governing Body to lead activities to reduce health care disparities for SRMC inpatients and select outpatients.

SRMC's "I CARE" Values Statement will provide the HRSN framework for carrying forward these efforts as follows: **I: INTEGRITY**- Do the right thing, even when no one is watching.

C: COMPASSION- Be empathetic to the needs of others.

A: ACCOUNTABILITY- Hold ourselves accountable as an organization and as individuals to act responsibly in everything we do and be excellent stewards of our resources.

R: RESPECT- Value others and respect their dignity, diversity and right to privacy.

E: EXCELLENCE- Put forth our personal and professional best.

A. Analysis of SRMC's Service Area Demographics

In order to develop a robust SDOH/HRSN program, SRMC is utilizing Columbiana County's demographic data gathered through the 2022-2025 CCHNA's data analysis process, to identify health disparities among the communities we serve.

According to the NIH, vulnerable populations include those who are racial or ethnic minorities, children, elderly, socioeconomically disadvantaged, underinsured or those with certain medical conditions. Members of vulnerable populations often have health conditions that are exacerbated by unnecessarily inadequate health care.

Based on the demographics of Columbiana County's population, the Partners' Workgroup has identified vulnerable populations as those living in poverty/socioeconomically disadvantaged (13.9% of "all ages in poverty," compared to 12.6% in Ohio and 11.9% in US-2020), the Appalachian culture, children/youth, the elderly and those facing ethnic and literacy barriers.

In addition, according to the most recent U.S. census data for Columbiana County, there are several minorities, ranging from African Americans who represent 2.5% of the county's population, to Hispanic or Latino, who represent 1.9% of the county. Considering that these percentages are quite small (and even smaller for other races such as Asians and American Indians), the disparities between races, especially African Americans and Hispanics or Latinos, is significant. Based on the analysis of this data in both the 2019-2022 and 2022-2025 CCHNAs, education on the importance of cultural competency has already become a priority to increase the understanding of factors that are important to patients and which play a key role in their care and decision-making.

Utilizing this data, SRMC's priority populations for reducing health disparities include, but are not limited to:

- Minority racial or ethnic groups
- Those living with a disability
- Being near or below the poverty level
- Populations impacted by social drivers of health, such as language proficiency, housing or food insecurity, difficulty with access to transportation or other factors unique to our hospital's patient community

- Other populations as indicated by other resources, which identify those underserved or marginalized by health care systems

Note: TJC has created a 2022 Leadership standard, “Reducing health care disparities for patients is a quality and safety priority.”

B. Analysis of Patient Care Demographics

According to the Centers for Medicare and Medicaid Services (CMS), strong commitment to the collection of race, ethnicity, and language (REaL) data is essential to identifying and addressing disparities in quality of care. For the purposes of analyzing SRMC patient demographics to identify health care disparities, the following sociodemographic patient characteristics will be collected for use in stratification analyses of selected health outcomes:

- REaL Data

- Age
- Gender
- Preferred language
- Race and ethnicity

To further understand and advance the organization’s commitment to achieving cultural change and accountability, SRMC will incorporate the planning and implementation process for CMS’ new 2023 structural health equity measures regarding inpatient screening for Social Drivers of Health (SDOH-1) and Screen Positive Rate for Social Drivers of Health (SDOH-2). An inpatient data collection framework will be developed using the five domains from the Hospital Commitment to Health Equity’s (HCHE) Measures: Domain 1: Equity is a Strategic Priority, Domain 2: Data Collection, Domain 3: Data Analysis, Domain 4: Quality Improvement and Domain 5: Leadership Engagement.

An inpatient screening process will be developed and implemented to screen for one or more of the following social risk factors and provide a rate for SRMC’s inpatient population who were identified as screening positive for one or more of these SDOH:

- **Food insecurity:** Limited or uncertain access to adequate quality and quantity of food at the household level.
- **Housing insecurity**: Multiple conditions ranging from the inability to pay rent or mortgage, frequent changes in residence including temporary stays with friends and relatives, living in crowded conditions, and actual lack of sheltered housing in which an individual does not have a personal residence.
- **Transportation needs:** Limitations that impede transportation to destinations required for all aspects of daily living.
- **Utility needs:** Inconsistent availability of electricity, water, oil and gas services is directly associated with housing instability and food insecurity.
- **Interpersonal safety:** Screening for exposure to intimate partner violence, child abuse, and elder abuse.

These health equity indicators will be used to evaluate outcomes achieved for the 2022-2025 SRMC Implementation Plan.

C. Analysis of SRMC’s Workforce Demographics

For the purposes of analyzing SRMC’s 2022 workforce demographics to identify racial disparities, the most common race/ethnicity is White/Caucasian (96%) amongst management, professionals and non-exempt staff; 1.4% for Black/African American and 2.6% for all other races combined. This compares to Columbiana County’s 2019 census data as being White/Caucasian (93.4%), Black/African American (2.1%) and all other combined (4.5%.) During the first year of the 2022-2025 SRMC Implementation Plan, SRMC will gather further data to help identify other workforce disparities, including evaluating data measurements for unconscious or implicit biases.

D. SRMC's Guiding Principles for Achieving Health Equity and Reducing Health Disparities

For the purposes of developing SRMC's HRSN Roadmap for Transformation (in alignment with AHA's Roadmap initiative) and in tandem with the 2022-2025 SRMC Implementation Plan, SRMC has created four guiding principles as its foundation for advancing health equity, eliminating health disparities and supporting diversity and inclusion.

SRMC's Guiding Principles
Culture & Community: Cultivate and institutionalize a culture of inclusion that encourages collaboration, flexibility, innovation and fairness to enable individuals within and outside of the organization to reach their full potential. Leverage community partnerships to strengthen SRMC's influence as an anchor organization for improving population health outcomes.
Systems & Shared Accountability: Develop structures and strategies to equip leaders with deeper insights into community needs and provide the ability to manage diversity, be accountable, measure results and refine approaches on the basis of objective data.
Recruitment and Retention: Assess, develop and engage internal talent and recruit from a diverse group of potential applicants to create a high-performance and sustainable organization to meet our strategic and operational plans and goals.
Culturally Appropriate Patient Care: Tailor health care delivery to meet patients' socioeconomic, cultural and linguistic needs and to identify and implement interventions to address gaps in patient care.

E. SRMC Resources Dedicated to Achieving Equity Goals

SRMC has determined that its Hospital Commitment to Health Equity (HCHE) will focus on addressing one or more health care disparity in 2023 as identified in its patient population. This will require the coordination of efforts across multiple departments and programs, such as Quality Improvement, Case Management and Nursing. Resources will be devoted to providing dedicated staff for screening patients and linking patients who screen positive with available resources, such as through the provision of resource pamphlets for coordination with community resources. (See CCHNA Appendix XIV: Columbiana County Community Resources). In addition, funding for technology related to EMR upgrades for screening and data management will be designated, along with additional staff training in the data collection process. These health equity indicators will be used to evaluate outcomes achieved for the 2022-2025 SRMC Implementation Plan.

F. Action Plan for Reducing Health Disparities and Annual Metrics for Success

SRMC's 2022-2025 Action Steps and Annual Metrics for Evaluation	
Employee Engagement & Belonging	**Annually assess organizational climate and culture** - All employees of SRMC can demonstrate knowledge of HRSN/SDOH definitions as measured by the annual Health & Safety online assessment.
HRSN Education & Training	**Increase HRSN knowledge, accountability and modeling among the governing body, senior leaders and management staff to enhance leadership roles and structures** - Board will be provided education annually as part of the reporting process. **Increase HRSN awareness of inclusive and equitable approaches for decision making, patient care and communications** - Training will be provided to all staff in cultural competency upon hire and annually. - Training will be provided upon hire to all RNs, Case Managers and Patient Registration staff on data collection in a patient centered manner.
Workforce Development & Retention	**Assess and improve HRSN results from measurements of equity within hiring, staff development, promotion and retention outcomes**

	- Complete anti-bias training by all managers. - Complete a "Top Leadership" Talent & HRSN Assessment as measured bi-annually. - Identify emerging leaders mentored in each year of the Implementation Plan. - Provide annual analytics of workforce demographics and succession planning, when feasible.
Data Analytics & Reporting	**Establish annual reporting processes to identify disparities, support action plans and strategic objectives** - Provide ongoing analytics of disparate health outcomes, workforce demographics and succession planning. - Continue the collection, stratification and use of "REaL" data and preference data. - Develop and implement an inpatient screening & reporting process for SDOH-1 and SDOH-2 populations in accordance with new CMS Health Equity measures for voluntary reporting by May 15, 2024 and required reporting by May 15, 2025. - Utilize the new Medisolv data collection module, identify and monitor the collection and use of patient HRSN data, and correlate to health outcomes, including: ○ Food insecurity ○ Housing insecurity ○ Transportation needs ○ Utility needs ○ Interpersonal safety Note: Only patients admitted to the hospital who are 18 years or older at the time of admission will be screened. - Increase transparency of HRSN data sharing with the governing body, and opportunities to use this data to drive strategic decisions. - Report metrics quarterly to Quality Management Committee, Quality Management Team and Quality Improvement Committee at their scheduled meetings; and the Medical Executive Committee annually. The Board will annually review performance indicators to assess progress toward achieving plan goals.
Community Collaboration	**Collaboratively advance and strengthen HRSN awareness and meaningful involvement in the broader community to address the societal factors that influence community health** - Provide multiple opportunities for external stakeholders to share input and participate in the HRSN planning and implementation process through the 2022-2025 Columbiana County Health Improvement Plan's implementation. - Track participation, feedback and shared progress with partnering organizations and utilize the 2022-2025 Columbiana County Improvement Plan as a vehicle for measuring county-wide outcomes.
Annual Priority Goal	Based upon analysis of REaL data, HRSN and safety data correlated to health outcomes; SRMC will focus on at least one health care disparity identified in the monitored patient population. - In 2023, the priority goal will be to evaluate the specific health-related social needs surrounding food insecurity in the inpatient population. - Action steps to improve this identified need will include: ○ Screening of inpatients by Nursing/Case Management Staff. ○ Dietary and disease management patient education. ○ Assistance with access to food sources through local social support systems as provided by Case Management. Action Plan Follow-up: SRMC will review outcomes quarterly and review/revise action steps to improve/sustain the goal to reducing health care disparities.

V. IDENTIFYING & PRIORITIZING ISSUES FROM THE CCHNA FOR THE CHIP (MAPP Phase 4)

The Workgroup used the 2019-2022 CCHNA data findings by key issue to identify, develop and prioritize a list of strategic health-related issues facing Columbiana County, for evaluation using a nominal objective voting process. A ranking exercise was then completed for each issue identified, based upon three prioritization criteria as identified below.

Criteria for Prioritization		
Magnitude of Problem	**Seriousness of Consequence**	**Feasibility of Correcting**
Incidence, burden, severity, urgency of the problem	Impact on the broad community and upon the most vulnerable populations	Capacity and resources: Internal and External, i.e. community, technical, economic, political, social-cultural, ethical, etc.

The top four CCHNA issues receiving the highest scores were prioritized as follows and carried forward into the "alignment" evaluation process, shown in IV. Alignment with State and County Priorities.

Prioritization of Key CCHNA Issues
1. Chronic disease (including cancer, diabetes, cardiac disease, asthma, etc.)
2. Mental health (including trauma, Adverse Childhood Experiences (ACEs), depression, suicide, etc.)
3. Substance use (including tobacco, alcohol and drug use, and youth perceptions)
4. Obesity (including nutrition and physical activity)

The Workgroup also found that underlying drivers of health must be addressed in order to improve health outcomes, including transportation, access to healthcare providers and financial resources, poverty/income, culturally-driven beliefs, stigmas, lack of health education/and awareness, barriers arising from unresolved health equity and health literacy issues.

VI. ALIGNMENT WITH STATE AND COUNTY PRIORITIES

Following a discussion of the top four 2022 CCHNA issues, the Workgroup again reviewed the priority topics identified in Ohio's 2020-2022 State Health Improvement Plan (SHIP), and noted that local community health improvement efforts must align with at least one of the three SHIP priority topics and at least one of their related health outcomes.

In addition, the SHIP framework is based on the premise that underlying drivers of inequity, such as poverty, racism, discrimination, trauma, violence and toxic stress; must be reduced for all people in a community to have access to affordable, inclusive and quality infrastructure and services that, despite historical and contemporary injustices, allow them to reach their full health potential.

Both the 2022-2025 CCHNA and 2020-2022 SHIP identify improving access to health care and reducing health disparities and equity issues as priorities. In addition, both highlight healthcare workforce needs as important to improving access to services.

A. Alignment of 2022 CCHNA Priorities with Ohio's 2020 State Health Improvement Plan

2020 Ohio's State Health Improvement Plan Priority Health Topics and Outcomes			
SHIP Priority Factors	**Alignment with 2022 CCHNA Priorities**	**SHIP Priority Health Outcomes**	**Alignment with 2022 CCHNA Priorities**
Community Conditions	**X**	**Mental Health and Addiction**	**X**
- Housing affordability and quality		- Depression	**X**
- Poverty		- Suicide	**X**
- K-12 Student success	**X**	- Youth drug use	**X**
- Adverse childhood experiences	**X**	- Drug overdose deaths	**X**
Health Behaviors	**X**	**Chronic Disease**	**X**
- Tobacco/nicotine use	**X**	- Heart disease	**X**
- Nutrition	**X**	- Diabetes	**X**
- Physical activity	**X**	- Childhood conditions (asthma, lead)	
Access to Care	**X**	**Maternal and Infant Health**	
- Health insurance coverage		- Preterm births	
- Local access to healthcare providers	**X**	- Infant mortality	
- Unmet need for mental health care	**X**	- Maternal morbidity	

B. Columbiana County's CHIP Strategic Planning Model as a Driver for SRMC's Health Implementation Plan

Beginning in June 2022 through November 2022, Salem Regional Medical Center and the other Columbiana County Workgroup Partners held a series of meetings to complete the 2022-2025 CHIP planning process. The steps for the CHIP completion were defined as follows:

1. Process review: Initial meeting to review process and timeline, finalize committee membership, create and/or review vision

2. Choosing Priorities:

a. Use of quantitative and qualitative data to prioritize target impact areas

b. Selection of at least one priority health factor and at least one priority health outcome

b. Selection of equity indicators

3. Resource Assessment: Review existing programs, services, and activities in Columbiana County and the surrounding region which address the priority target impact areas and analyze the number of programs that address each outcome, geographic area served, prevention programs and interventions

4. Gap Analysis: Determine existing discrepancies between community needs and viable community resources to address local priorities; identify strengths, weaknesses, and evaluation strategies; and strategic action identification

5. Best Practices: Review best practices, proven strategies and feasibility continuum

6. Plan Development: Review of all steps taken and make action step recommendations based on one or more of the following: enhancing existing efforts, implementing new programs or services, building infrastructure, implementing evidence-based practices and/or feasibility of implementation

In Step 2, when choosing priorities, the Columbiana County Health Partners determined gaps in relation to each priority area identified in the CHIP, considered potential or existing resources, and then referenced a list of evidence-based strategies recommended by the Ohio SHIP, which are defined as follows, to help identify strategic actions:
- Evidence-based practice has compelling evidence of effectiveness. Participant success can be attributed to the program itself and have evidence that the approach will work for others in a different environment.
- A best-practice is a program that has been implemented and evaluation has been conducted. While the data supporting the program is promising, its scientific rigor is insufficient.

As of early November 2022, the Workgroup had only completed Step 1 (Process review), Step 2.a. (Choosing priorities: Use of quantitative and qualitative data to prioritize target impact areas), and 2.b. (Choosing priorities: Selection of at least one priority health factor and at least one priority health outcome), with no Equity Indicators chosen. The remaining steps will be tentatively completed by the Workgroup by the end of calendar 2022. The Workgroup's Priority Factors, Outcomes, Strategies and Indicators as of November 3, 2022, are shown below.

Col. Cty. 2022-2025 Health Improvement Plan Priority Health Topics & Outcomes (Selected as of 11/3/22)			
Priority Factors Selected from SHIP	**Strategy Selected from SHIP**	**SHIP Indicator(s)**	**Evidence-Based Outcome(s)**
Community Conditions			
Priority CC-1: K-12 Student Success: Chronic Absenteeism	Attendance interventions for chronically absent students	CC4: % of students, grades K-12, who are chronically absent	Improved student attendance
Priority CC-2: Adverse Childhood Experiences	Supports for system-involved children & youth, including Multi-systemic therapy (MST) for juvenile offenders	CC7: Number of screened-in reports of child abuse and/or neglect per 1,000 children	- Reduced recidivism - Reduced incarceration
Health Behaviors			
Priority HB: Nutrition (Youth fruit/veggie consumption)	Healthy meals served at schools, including school-based nutrition education programs	- HB3: % of high school students who did not eat fruit or drink 100% fruit juices during past 7 days - HB4: % of high school students who did not eat vegetables (excluding french fries, fried potatoes or potato chips) during past 7 days	- Improved dietary habits - Increased fruit/vegetable consumption - Reduced sweetened beverage consumption - Improved weight status
Mental Health & Addiction			
Priority MH-1: Suicide Deaths	Suicide awareness, prevention and peer norm programs, including universal school-based suicide awareness and education programs	- MH3: Youth suicide deaths - MH4: Adult suicide deaths	- Reduced suicide -Increased knowledge of suicide -Improved coping skills
	Digital access to treatment services and crisis reports, including crisis lines	- MH3: Youth suicide deaths - MH4: Adult suicide deaths	- Improved mental health - Reduced suicide
	Mental health education, including mental health first aid	- MH3: Youth suicide deaths - MH4: Adult suicide deaths	- Increased knowledge of mental health - Reduced stigma

Priority MH-2: Drug Overdose Death	Naloxone education and distribution programs	MHA7: # of deaths due to unintentional drug overdose per 100,000	- Increased knowledge of appropriate drug overdose response - Reduced overdose deaths - Increased self-confidence
Chronic Disease			
Priority CD: Heart Disease	Hypertension screening and follow-up, including blood pressure screening for adults ≥18, including obtaining measurements outside of the clinical setting	CD2: Years of life lost before age 75 ~~due to heart disease~~ per 100,000* * Due to lack of available data, Workgroup modified the indicator as shown by strike-thru	Increase the number of hypertension screenings being offered

VII. SRMC IMPLEMENTATION PLAN'S SELECTED PRIORITIES, STRATEGIES & INDICATORS

Because SRMC is required to complete its Implementation Plan within six months of the CCHNA's Board approval date (May 19, 2022), the SRMC Implementation Plan incorporates the Workgroup's priorities and strategies selected as of early November 2022 as its foundational elements; however, SRMC has expanded and selected additional strategies to address the existing community needs within its Service Area.

SRMC will continue to collaborate with the Workgroup to develop and implement the CHIP's community-based strategies surrounding these Priority Factors and Outcomes; but will also add **Health Behaviors** (Physical activity), **Access to Care** (Local access to healthcare providers), expand **Chronic Disease** to include Heart disease and Diabetes), and address Overall Health & Health Equity (Health Status, Premature Death & Diversity, Equity and Inclusion.)

The 2022-2025 SRMC Implementation Plan's outline appears below. Rows that are color-coded in gray were added by SRMC to expand its impact beyond the initial CHIP strategies selected, and include implementation strategies to advance diversity, equity and inclusion in alignment with the *2022 American Hospital Association's (AHA) Health Equity Roadmap- 2022*.

SRMC's 2022-2025 Implementation Plan's Priority Health Topics and Outcomes			
Priority Factors Selected from SHIP	**Strategy Selected from SHIP**	**SHIP Indicator(s)**	**Evidence-Based Outcome(s)**
Community Conditions			
Priority CC: K-12 Student Success: Chronic Absenteeism	Attendance interventions for chronically absent students	CC4: % of students, grades K-12, who are chronically absent	Improved student attendance
Health Behaviors			
Priority HB-1: Nutrition (Youth fruit/veggie consumption)	Healthy meals served at schools, including school-based nutrition education programs	- HB3: % of high school students who did not eat fruit or drink 100% fruit juices during past 7 days - HB4: % of high school students who did not eat vegetables (excluding french fries, fried potatoes or potato chips) during past 7 days	- Improved dietary habits - Increased fruit/vegetable consumption - Reduced sweetened beverage consumption - Improved weight status
Added SRMC Priority HB-2: Physical Activity	Community fitness programs	HB6: % of adults, age ≥18 reporting no leisure time physical activity (BRFSS)	- Increased physical activity - Improved physical fitness

Added: Access to Care			
Added SRMC Priority AC 1- 5: Local access to healthcare providers	- Healthcare workforce professional development - Telemedicine - Comprehensive and coordinated primary care - Culturally competent workforce in underserved communities - Improved health literacy through discharge planning	AC43: % population living in a primary care health professional shortage area - New hire DEI education - Mammogram screening rates - Readmission rates	- Increased availability of health professionals in underserved areas - Increased availability of physicians in underserved areas - Increased access to care
Mental Health & Addiction			
Priority MH-1: Suicide Deaths	Suicide awareness, prevention and peer norm programs, including universal school-based suicide awareness and education programs	- MH3: Youth suicide deaths - MH4: Adult suicide deaths	- Reduced suicide - Increased knowledge of suicide - Improved coping skills
	Digital access to treatment services and crisis reports, including crisis lines	- MH3: Youth suicide deaths - MH4: Adult suicide deaths	- Improved mental health - Reduced suicide
	Mental health education, including mental health first aid	- MH3: Youth suicide deaths - MH4: Adult suicide deaths	- Increased knowledge of mental health - Reduced stigma
Priority MH-2: Drug Overdose Death	Naloxone education and distribution programs	MHA7: # of deaths due to unintentional drug overdose per 100,000	- Increased knowledge of appropriate drug overdose response - Reduced overdose deaths - Increased self-confidence
Chronic Disease			
Priority CD-1 Heart Disease	Hypertension screening and follow-up, including blood pressure screening for adults ≥18, including obtaining measurements outside of the clinical setting	CD2: Years of life lost before age 75 ~~due to heart disease~~ per 100,000* * Due to lack of available data, Workgroup modified the indicator as shown by strike-thru	Increase the number of hypertension screenings being offered
Added SRMC Priority CD-2: Diabetes	Prediabetes screening, testing and referral to Diabetes prevention Program (DPP), including combined diet & physical activity promotion programs to prevent Type-2 diabetes among people at increased risk	CD4: %adults, ≥18, ever diagnosed with diabetes (BRFSS)	Improve diabetes & cardiovascular disease risk factors
Added Overall Health & Equity			
Added SRMC Priority OH-1: Health Status	- Healthcare workforce professional development - Telehealth - Comprehensive & coordinated primary care - Community-based training to improve health literacy - Cultural competence training	OH1: % adults ≥18 with fair or poor health (BRFSS)	Area residents achieve their full health potential
Added SRMC Priority OH-2: Premature Death		OH2: Years of potential life lost before age 75/100,000 (ODH Vital Stats)	Area residents achieve their full health potential

A. Specific Strategies and Action Steps

Following are the specific strategies, action steps, indicators and lead agency(s) identified to achieve each priority listed above in the outline. This symbol will be used when a priority, indicator, or strategy

directly aligns with the 2019-2022 SHIP. In addition, strategies selected that are expected to improve equity according to the SHIP resources of *What Works For Health* and/or *ODH's Community Guide;* and/or those that align with the *2022 AHA Health Equity Roadmap* are indicated with this symbol (=).

1. Community Conditions focus on creating positive conditions so that all community members can thrive, such as equitable access to essential needs, social support and connection, racial and social justice, shared community responsibility for child and family well-being, etc.

- Chronic Absenteeism refers to students missing at least 10% of school days in a year. Students who are chronically absent risk falling behind peers academically, especially in the first few years of schooling. Chronic absenteeism can hinder academic success and is an early warning sign of dropout from high school. Lower educational attainment is linked to many negative health outcomes, including diabetes, depression and poor overall health status.

Community Conditions		
Priority CC: K-12 Student Success: Chronic Absenteeism		
Strategy: Attendance interventions for chronically absent students		
Priority Populations: Youth, K-12		
Action Steps & Timeline	**Indicator(s) to Measure Impact:**	**Lead Agency**
Year 1: SRMC will continue to work with the Coordinated Action for School Health (CASH) Coalition to fund the administration of Search Institute Youth Asset Surveys and prepare reports for participating Columbiana Cty. school districts to measure youth assets and deficits, and initiate school-based interventions	CC4: % of students, grades K-12, who are chronically absent	Col. Cty. Health Partners
Year 2: Continue efforts of year 1. SRMC will collaborate with the CASH Coalition and Col. Cty. Health Partners to execute school-specific improvement initiatives.	CC4: % of students, grades K-12, who are chronically absent	
Year 3: Continue efforts of year 2.	CC4: % of students, grades K-12, who are chronically absent	
Strategy identified as likely to decrease disparities: (=) Yes ❍ No ❍ Not SHIP Identified		
Resources to address strategy: Salem Regional Medical Center's community benefit initiatives, participation in the CASH Coalition as a principal member		
Outcome: Improved student attendance		

2. Health Behaviors: Nutrition & Physical Activity
Being overweight or obese contributes to numerous health conditions that limit the quality and length of life, including: hypertension, dyslipidemia (i.e. high total cholesterol or high levels of triglycerides), type 2 diabetes, coronary heart disease, stroke, gallbladder disease, depression, osteoarthritis, sleep apnea and respiratory problems, and is linked to some cancers (endometrial, breast and colon). Low physical activity and unhealthy eating are associated with a higher risk of these chronic diseases and result in overweight and obesity. The need for better nutrition and more exercise, and the lack of access to indoor walking facilities were identified as community needs related to physical activity and nutrition by survey respondents and interview participants.

SRMC's nutrition and physical activity goal is to work with existing and/or develop new community partnerships to broaden access to recreational opportunities and promote existing resources for improved physical activity and nutrition to positively impact the rates of physical activity and consumption of healthy foods for residents within SRMC's Service Area.

Health Behaviors		
Priority HB-1: Nutrition		
Strategy: Healthy meals served at schools, including school-based nutrition education programs & increase nutrition education about and access to healthy eating choices for adults and youth		
Priority Population: Adults, youth and vulnerable populations		
Action Steps & Timeline	**Indicator(s) to Measure Impact:**	**Lead Agency**

Year 1: Coordinate efforts between SRMC and other community providers to increase community outreach and education about healthy food choices. - Provide minimum of 1 community presentation that includes nutrition education; Distribute healthy recipes/nutrition information at major community events. Begin preparations to host a healthy meal preparation class for vulnerable populations in Year 2. - Enhance access to school-based programs promoting nutrition and physical activity in collaboration with the Coordinated Action for School Health (CASH) Coalition through annual community benefit grant funding.	1. Obesity: Percent of adults that report BMI ≥ 30 (BRFSS Baseline: 36%. 2022 CHNA) 2. Columbiana Cty. 3rd grade students classified as obese or overweight (baseline: 35.8%, 2016 Akron Children's Hospital Mahoning Valley CHNA)	Col. Cty. Health Partners
Year 2: Continue community education & outreach efforts as above.		
Year 3: Increase efforts from years 1 and 2.		
Type of Strategy: -Public health system, prevention and health behaviors - Healthcare system and access		
Strategy identified as likely to decrease disparities: Yes ❍ No ❍ Not SHIP Identified		
Resources to address strategy: SRMC has an annual community benefit budget to support prevention, education and school health initiatives through participation in the Coordinated Action for School Health CASH) Coalition.		

Health Behaviors		
Priority HB-2: Nutrition		
Strategy: Food insecurity and screening referral		
Priority Population: Adult inpatients and vulnerable populations		
Action Steps & Timeline	**Indicator(s) to Measure Impact:**	**Lead Agency**
Year 1: Continue to evaluate and develop a food insecurity inpatient screening tool and reporting process, in accordance with CMS Health Equity measures for voluntary reporting by May 15, 2024, and required reporting by May 15, 2025	1. Number of inpatients screened for food insecurity and voluntary compliance with CMS Health Equity measures 2. Referrals made to food banks/community resources	**SRMC**
Year 2: Continue efforts of year 1. Implement the inpatient screening tool and reporting process, with accompanying evaluation measures. Educate providers about food insecurity, its impact on health, and the importance of screening and referral.		
Year 3: Continue efforts of year 2. Expand awareness of food insecurity as part of inpatient assessment process. Consider expanding food insecurity screening and referral for older patients in primary care, using AARP resource guide		
Strategy identified as likely to decrease disparities: Yes ❍ No ❍ Not SHIP Identified		
Resources to address strategy: Salem Regional Medical Center, food pantries and community agencies, hospital referral systems		
Outcome: Reduce the percentage of food insecure households		

Health Behaviors		
Priority HB-3: Physical Activity		
Strategy: Community fitness programs		
Priority Population: Adults, children and vulnerable populations		
Action Steps & Timeline	**Indicator(s) to Measure Impact:**	**Lead Agency**
Year 1: Continue to promote organized physical activities carried over from the 2019-2022 CHIP, within SRMC's Service Area and in collaboration with community partners, i.e. "Walk With a Doc" programs - Encourage integration of child, family and senior components into current and future races and other organized physical activities within the county.	1. Obesity: Percent of adults that report BMI ≥ 30 (BRFSS Baseline: 36%. 2022 CHNA) 2. Adult physical activity: Percent of adults, age 18 and older, reporting no leisure time physical activity (30%, 2022 CHNA)	SRMC & Col. Cty. Health Partners
Year 2: Increase child, family and senior participation at organized physical activity events.		
Year 3: Increase child, family and senior participation at organized physical activity events beyond year 1 & 2.		
Type of Strategy: - Public health system, prevention and health behaviors		
Strategy identified as likely to decrease disparities: Yes ❍ No ● Not SHIP Identified		

Resources to address strategy: SRMC will continue to provide resources, staff and physician support for organized physical activities within the county and encourage the involvement of children, families and seniors.

3. Access to Medical Care

Columbiana County is identified as an underserved area with disparities related to being an Appalachian county, and has a high ratio of the population to primary care physicians, dentists and mental health providers; indicating the potential for greater access to care challenges. Barriers to health care access at the level of the individual and community were identified consistently across the CCHNA process and included deficits in income, education, lack of health insurance, lack of providers and lack of transportation. In addition, information technology (IT) was identified as a barrier to accessing and/or expanding telemedicine services.

Financial incentives such as scholarships, educational loans with a service option, and loan repayment or forgiveness programs encourage health care providers to serve in rural or other underserved areas. The expected beneficial outcome is increased availability of healthcare professionals in underserved areas, increased access to care and likeliness to decrease disparities.

In addition, the expanded use of telecommunications to remotely deliver consultative, diagnostic and health care treatment services can supplement health care services for patients who would benefit from frequent monitoring or provide services to individuals in areas with limited access to care.

Overall Health & Access to Care		
Priority AC-1: Healthcare Workforce Professional Development		
Strategy: Provide higher education financial incentives to recruit key health professionals within SRMC's rural/underserved Service Area		
Priority Population: Adults, vulnerable populations		
Action Steps & Timeline	**Indicator(s) to measure impact of strategy:**	**Lead Agency**
Year 1: Continue to recruit key healthcare professionals in accordance with community needs. Work with higher educational organizations to identify collaborative recruitment/placement opportunities	Ratio of PCPs to Population (baseline: 2250:1 for Columbiana County, 2019 RWJF County Health Rankings)	SRMC
Year 2: Continue efforts of year 1.		
Year 3: Continue efforts ofyears 1 and 2.		
Type of Strategy: - Healthcare system and access		
Strategy identified as likely to decrease disparities: Yes ❍ No ● Not SHIP Identified		
Resources to address strategy: SRMC will continue to provide funding and staffing resources to the recruitment of key healthcare professionals within its Service Area, based on identified community needs		

Overall Health & Access to Care		
Priority AC-2: Healthcare Workforce Professional Development		
Strategy: Develop sustainable workforce		
Priority Population: All DEI Targeted populations		
Action Steps & Timeline	**Indicator(s) to Measure Impact:**	**Lead Agency**
Year 1: Continue to identify local and regional employer challenges and best practices to identify disparities and maximize hiring and retention. - Increase opportunities for employee education and mentorship to enhance retention - Share career trainings and opportunities with high school and post-secondary students **-** Increase DEI awareness of inclusive and equitable approaches for decision making, patient care and communications	1. Provide annual analytics of workforce demographics, turnover rates and succession planning, when feasible 2. 80+% of new hires are provided with DEI education during general orientation as measured annually 3. 80% of total staff are provided with DEI education as measured annually via an annual online assessment	SRMC
Year 2: Continue efforts of year 1.		
Year 3: Continue efforts from years 1 and 2.		
Strategy identified as likely to decrease disparities: Yes ❍ No ● Not SHIP Identified		
Resources to address strategy: Salem Regional Medical Center and regional educational systems		
Outcome: Sustainable and enhanced workforce development, recruitment and retention		

Overall Health & Access to Care		
Priority AC-3: Telehealth		
Strategy: Develop feasibility of expanding telecommunications technology to remotely deliver consultative, diagnostic and health care treatment services		
Priority Population: Adults, vulnerable populations		
Action Steps & Timeline	**Indicator(s) to measure impact of strategy:**	**Lead Agency**
Year 1: Evaluate feasibility of and resources required for expanding telemedicine services	New or enhanced access to telemedicine-related technology	SRMC
Year 2: Continue efforts of years 1.		
Year 3: Continue efforts of years 1 and 2.		
Type of Strategy: - Healthcare system and access		
Strategy identified as likely to decrease disparities: Yes ❍ No ❍ Not SHIP Identified		
Resources to address strategy: SRMC will continue to provide staff support and IT resources to evaluate the feasibility of expanding telemedicine services within SRMC's Service Area, based on identified community needs and available resources		

Overall Health & Access to Care		
Priority AC-4: Comprehensive and coordinated primary care		
Strategy: Awareness of and access to existing health care services on preventive care		
Priority Population: Adults and vulnerable populations		
Action Steps & Timeline	**Indicator(s) to Measure Impact:**	**Lead Agency**
Year 1: Coordinate efforts between SRMC and other community providers to increase community outreach and education on available preventive health services (i.e., free or at a reduced cost). - Offer and promote cancer screenings at the hospital and other health care organizations (skin, colorectal, mammography, etc.). SRMC will offer a minimum of 2 free/reduced cost cancer screenings and 2 cancer prevention activities per year, in tandem with the Commission on Cancer (CoC) and National Accreditation Program for Breast Centers' requirements - Increase community education on the importance of preventive health care, awareness of health care services, cancer prevention and discontinuing tobacco use.	1. Colorectal cancer screening: Adults who had a colorectal cancer screening in the past 5 years (BRFSS Baseline: 33%, 2019 CHNA) 2. Breast cancer screening: Women who had a screening mammogram in past year BRFSS Baseline: 36%, 2022 CHNA)	SRMC & Col. County Health Partners
Year 2: Continue community education, screening and outreach efforts as above.		
Year 3: Increase efforts from years 1 and 2.		
Type of Strategy: - Public health system, prevention and health behaviors - Healthcare system and access		
Strategy identified as likely to decrease disparities: Yes ❍ No ● Not SHIP Identified		
Resources to address strategy: SRMC has an established annual budget and physicians/staff dedicated to Fulfill CoC- and NAPBC-related cancer screening and prevention activities.		

- Addressing Health Literacy through Patient and Family Engagement: SRMC continues to review its discharge process to reduce hospital readmissions and post-hospital ED visits, along with strengthening its medication education and communication process for patients, which is likely to decrease disparities among vulnerable populations. Interventions that combine various approaches, such as enhancing written materials and interpersonal interactions, appear to increase patients' comprehension and appropriate health care use, and promote improved communication between patients and providers. Evidence-based discharge planning tools used include the Agency for Healthcare Research and Quality's (AHRQ) *Guide to Patient and Family Engagement in Hospital Quality and Safety* and the *2022 AHA Roadmap for Health Equity.*

Overall Health & Access to Care		
Priority AC-5: Culturally competent workforce in underserved communities		
Strategy: Community-based training for health professionals to Improve health literacy		
Priority Population: Adults, vulnerable populations		
Action Steps & Timeline	**Indicator(s) to measure impact of strategy**	**Lead Agency**

Year 1: Continue to evaluate and implement evidence-based discharge planning literacy tools and support processes to decrease patient readmissions and post-hospital ED visits. **Year 2:** Continue efforts of year 1. **Year 3:** Continue efforts of years 1 and 2.	- Readmission rates	SRMC
Type of Strategy: - Healthcare system and access		
Strategy identified as likely to decrease disparities: Yes ❍ No ● Not SHIP Identified		
Resources to address strategy: SRMC will continue to provide staff and resource support to enhance discharge planning processes and house-wide communication and training efforts		

Overall Health & Access to Care		
Priority AC-6: Culturally competent workforce in underserved communities		
Strategy: Cultural competence training for healthcare professionals		
Priority Population: Adults, vulnerable populations		
Action Steps & Timeline	**Indicator(s) to Measure Impact:**	**Lead Agency**
Year 1: Assess county data related to demographics, determinants of health and health equity, measures of mortality, health behaviors, etc. - Research evidence-based cultural competency training opportunities with other community providers, such as Bridges Out of Poverty; AHRQ's Improving Cultural Competence to Reduce Health Disparities and AHA's Health Equity Roadmap **Year 2:** Educate health care providers and/or health care organizations on county demographics and the importance of becoming culturally competent (program focus may include: culture, language, health literacy and health equity). - Encourage organizations to adopt culturally competent principles, policies and/or practices within their organization. - Consider developing and providing cultural competency trainings. **Year 3:** Continue efforts from years 1 and 2.	Cultural understanding and skills: Not currently available via SHIP or CHIP	SRMC & The Columbiana County Health Partners
Priority area(s) the strategy addresses: Health Equity, Diversity and Inclusion		
Strategy identified as likely to decrease disparities: Yes ❍ No ● Not SHIP Identified		
Resources to address strategy: SRMC staff		

Other: Improve community-based coordination and delivery of services through implementation of Columbiana County's Health Improvement Plan (CCHIP)
- Year 1: Select appropriate strategies for intervention that fall within SRMC's mission and role as a healthcare leader and community partner to reduce chronic disease, prevent obesity, improve access to mental health care, reduce substance abuse, and improve access to care. Meet at least quarterly with CCHIP workgroup to assess progress and adjust work plan accordingly.
- Year 2: Continue work of year 1 and meet with CCHIP workgroup to evaluate outcomes at least semi-annually.
- Year 3: Continue work of year 1 and 2, and begin preparations for conducting next community health needs assessment.

4. Mental Health
The most frequently identified mental health need in the CCHNA included barriers to accessing mental health treatment services. The use of illegal drugs, especially related to opioid use was listed as a problem that is impacting the social determinants of community health. Participants indicated that more resources should be devoted to drug prevention activities and that medication abuse/misuse is a rising trend that needs to be closely monitored. According to stakeholders, the predominant and underlying factors of poverty and lack of education are major determinants of the mental health issues currently seen in Columbiana County; and several stakeholders stated that there is a need for additional mental health services in the County. It was also noted that these needs have increased since the emergence of COVID-19.

The stakeholders recommended that action needs to be taken to bring more awareness and prevention to this topic and that more psychiatrists and treatment alternatives are needed to provide mental health

care. SRMC will serve as a community partner in improving access to mental health and substance abuse treatment services by facilitating the coordination of and access to community-based, post-acute treatment resources.

Mental Health and Addiction		
Priority MH-1: Suicide- Youth		
Strategy: Universal school-based suicide awareness and education programs		
Priority Population: Youth		
Action Steps & Timeline	**Indicator(s) to measure impact of strategy:**	**Lead Agency**
Year 1: Continue to work with the CASH Coalition and Mental Health & Recovery Services Board to promote and implement suicide prevention programs in Columbiana County schools, i.e.: • Signs of Suicide (SOS) • QPR (Question, Persuade, Refer) • Red Flags If applicable, expand current programming to additional districts or grade levels. **Year 2:** Continue efforts of year 1. **Year 3:** Continue efforts of years 1 and 2.	1. Suicide deaths: Number of deaths due to suicide per 100,000 populations (age-adjusted) (baseline: 17.8 for Columbiana County, 2017 ODH Data Warehouse) 2. Youth who attempted suicide one or more times (baseline: 20%, 2018 Columbiana County Profiles of Student Life: Attitudes and Behavioral Survey) 3. Youth who felt depressed most or all of the time within the last month (baseline: 26%, 2018 Columbiana County Profiles of Student Life: Attitudes and Behavioral Survey)	Columbiana County Mental Health & Recovery Services Board Columbiana County Educational Service Center/CASH Coalition (SRMC is member of CASH Coalition)
Type of Strategy: Healthcare system and access		
Strategy identified as likely to decrease disparities: Yes ❍ No ❍ Not SHIP Identified		
Resources to address strategy: SRMC will increase community awareness and education regarding mental health and substance abuse issues and trends by serving as a community advocate for greater access to mental health and substance abuse resources through membership on the CASH Coalition; and facilitating the delivery of evidence-based programs to Columbiana County school districts. **Year 1**: Provide funding and staff support through a minimum of 1 local school's mini-grant and support of the asset development surveys and community data roll-out as a community awareness campaign to increase education and awareness of youth suicide and depression. **Year 2:** Continue work of Year 1 and support mini-grant funding for a minimum of one local school's mini-grant, involve youth in planning awareness programs/workshops on different "hot topics" and risky behavior trends. Solicit media coverage for all programs/workshops **Year 3:** Continue work of Year 1 and 2		

Mental Health and Addiction		
Priority MH-2: Coordinated care for behavioral health, including integration of behavioral health services into primary care		
Strategy: Integrate information about depression and suicide screening and treatment in primary care		
Priority Population: **Adults, youth, vulnerable populations**		
Action Steps &Timeline	**Indicator(s) to Measure Impact:**	**Lead Agency**
Year 1: Work with ER, primary care providers or office staff to assess what information and/or materials they are lacking to provide better care for patients with mental health issues. - Continue to provide post-discharge community support and follow-up to patients at high-risk for suicide ideation. - Limit access to prescription and non-prescription medications by continuing support of the DEA's medication take back events and drop-off lock-boxes. **Year 2:** Continue efforts of year 1 **Year 3:** Continue efforts of year 1 and 2	1. Suicide deaths: Number of deaths due to suicide per 100,000 populations (age-adjusted) (baseline: 17.8 for Columbiana County, 2017 ODH Data Warehouse) 2. Suicide ideation (adult): Percent of adults who report that they ever seriously considered attempting suicide within the past 12 months (baseline: 4%, 2019 CHNA) 3. Youth who attempted suicide one or more times (baseline: 20%, 2018 Columbiana County Profiles of Student Life: Attitudes and Behavioral Survey) 4. Youth who felt depressed most or all of the	Mental Health & Recovery Services Board Col. Cty. Health Partners Salem Regional Medical

	time within the last month (baseline: 26%, 2018 Columbiana County Profiles of Student Life: Attitudes and Behavioral Survey)	Center
Type of Strategy: - Public health system, prevention and health behaviors - Healthcare system and access		
Strategy identified as likely to decrease disparities: Yes ❍ No ● Not SHIP Identified		
Resources to address strategy: SRMC will continue to coordinate Case Management services in the ED and inpatient units and potential community-based interventional strategies targeting high-level resource users and coordination of care for patients at high-risk for suicide ideation. SRMC will continue to host and promote the semi-annual DEA drug take back event.		

- SRMC's Mental Health Initiatives Beyond the Scope of 2022-2025 CHIP:
Salem Regional Medical Center operates the Behavioral Medicine and Wellness Center as an intensive outpatient and partial hospitalization program designed to meet individual and group needs for mental health services in Columbiana and other surrounding counties. SRMC's professionally certified social workers will continue to support patient treatment and coordination of care through all of the appropriately identified treatment plans for inpatients and outpatients.

5. Chronic Disease: Coronary Disease and Diabetes
The heart disease mortality rate is the number of deaths due to heart disease per 100,000 population. Heart disease and stroke are particularly relevant for sub-populations, including low-income, underserved minorities, and older individuals within Columbiana County. Consistent with national trends, the coronary heart disease death rate was higher among men as compared to women, and increased with age. In parallel with mortality rates, the prevalence of those experiencing heart attacks or a stroke is much higher among specific sub-populations within Columbiana County, especially those with lower incomes and older individuals.

Heart disease was identified as a top community need by the focus group participants, and chronic disease management was identified by stakeholders and focus group members as a top health topic for the community.

Preventive medicine focuses on the health of individuals and communities and is the area of medicine that is primarily concerned with disease prevention. Its goal is to protect, promote, and maintain health and well-being and to prevent disease, disability, and death. Screenings are tests, physical examinations and/or other procedures to detect disease early in people who may not show symptoms. Healthy behaviors, such regular screenings and maintaining a healthy weight, can help reduce one's risk of adverse health conditions that can result in premature death, but these healthy behaviors are lower in some vulnerable populations, including low-income and minorities within Columbiana County.

Heart Disease & Diabetes		
Priority: Hypertension		
Strategy: Blood pressure screening for adults ≥18, including obtaining measurements outside of the clinical setting		
Priority Population: Adults and vulnerable populations		
Action Steps & Timeline	**Indicator(s) to Measure Impact:**	**Lead Agency**
Year 1: Continue to offer blood pressure screenings at community events, outside of the clinical setting - Raise awareness of the need for regular cardiovascular screening, identification and referral	1. CD-3: % of adults, ages ≥18, ever diagnosed with hypertension (BRFSS) 2. CD-2: Premature death: Years of potential life lost before age 75 per 100,000 population 3. Obesity: Percent of adults that report BMI greater than or equal to 30 (BRFSS Baseline: 36%. 2022 CHNA)	Col. County Health Partners Salem Regional Medical Center
Year 2: Continue efforts of year 1. - Increase awareness of and promote free/reduced cost screening events within SRMC's Service Area		
Year 3: Continue efforts of years 1 and 2. - If feasible, increase number of organizations that offer blood pressure screenings at community events.		
Type of Strategy: - Public health system, prevention and health behaviors - Healthcare system and access		

Strategy identified as likely to decrease disparities: ⊜ Yes ❍ No ❍ Not SHIP Identified	
Resources to address strategy: SRMC will provide dedicated resources and staff to support cardiovascular screening and awareness education at screening events within its Service Area.	

Heart Disease & Diabetes		
Priority: Diabetes		
Strategy: Diabetes Prevention Program (DPP) and prediabetes screening and referral		
Priority Population: Adults and vulnerable populations		
Action Steps & Timeline	**Indicator(s) to Measure Impact:**	**Lead Agency**
Year 1: Continue to implement diabetes education programs carried over from the 2019-2022 CHIP. - Create an inventory of current diabetes education programs in the county. Determine the baseline number of organizations in the county that currently screen for prediabetes. - Raise awareness of prediabetes screening, identification and referral through dissemination of the *Prediabetes Risk Assessment* (or a similar assessment) and/or the *Prevent Diabetes STAT Toolkit*.	1. Diabetes: Percent of adults who have been told by a health professional they have diabetes (BRFSS Baseline: 17%, 2022 CCHNA) 2. Prediabetes screening: Number of patients screened for prediabetes - Not currently available via SHIP 3. Obesity: Percent of adults that report BMI greater than or equal to 30 (BRFSS Baseline: 36%. 2022 CHNA)	Col. County Health Partners Salem Regional Medical Center
Year 2: Continue efforts of year 1. - Increase enrollment in diabetes education programs toward target of 2%. - Partner with local organizations to administer the screening and/or raise awareness of prediabetes. - Promote and market free/reduced cost screening events within the county (ex: health fairs, hospital screening events, etc.).		
Year 3: Continue efforts from years 1 and 2. - Increase awareness of prediabetes screening, identification and referral. - Increase the number of individuals within Columbiana County that are screened for diabetes toward target of 3%. - If feasible, increase number of organizations that screen for prediabetes.		
Type of Strategy: - Public health system, prevention and health behaviors - Healthcare system and access		
Strategy identified as likely to decrease disparities: ⊜ Yes ❍ No ❍ Not SHIP Identified		
Resources to address strategy: SRMC will provide dedicated resources and staff to support prediabetes/diabetes awareness education and screening events within its Service Area.		

VIII. RESOURCES TO ADDRESS NEEDS & IMPLEMENT PLAN

A. Community Resource Inventory

A strategic approach to community health improvement involves the collection and analysis of data regarding health status and factors contributing to poor health; combined with capacity building and collaborative efforts between diverse stakeholders to address both the symptoms and underlying causes of health needs. As such, hospitals are in a position to leverage their charitable resources and build greater capacity to address complex health concerns in a cost effective manner.

Acknowledging the many organizations and resources in place to address the health needs of our communities, SRMC will engage key community partners in implementing evidence-based[1] strategies across the Hospital's geographic Service Area. SRMC intends to implement these evidenced-based, preventive health activities to help reduce chronic disease rates, prevent the development of secondary conditions, address health disparities and the needs of vulnerable populations, and develop a stronger base of effective prevention programming.

As a not-for-profit hospital, SRMC will partner with local public health agencies to develop and implement a multi-pronged approach to impact these issues. Many of our community health improvement initiatives leverage substantial external resources and foster good working relationships with community stakeholders and other collaborative partners to achieve the strategic allocation of charitable resources, develop appropriate interventions, and establish metrics and systems to monitor community health improvement initiatives.

The CCHNA Workgroup identified existing health care facilities and resources within Columbiana County and the region, which are available to respond to the significant health needs of the community. This information was compiled from resource directories currently utilized by area case managers and social service organizations, and includes a listing of community and hospital-based services (referenced in the Appendix of this document: Columbiana County Community Resources.)

In addition, with the completion of Columbiana County's 2022-2025 CCHNA and CHIP, the Columbiana County Health Partners' workgroup will be in compliance with the state of Ohio's mandate (ORC3701.981) that all hospitals must collaborate with their local health departments on community health assessments and community health improvement plans, which includes the sharing of resources.

B. SRMC Resources

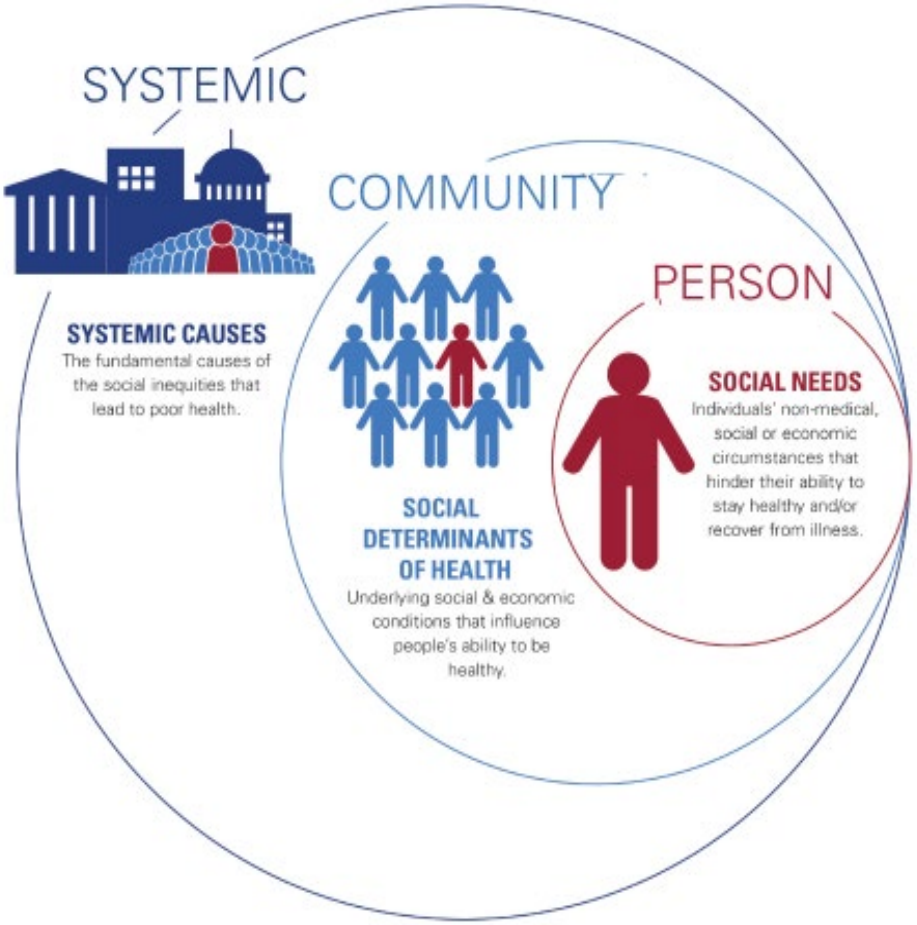
SRMC has developed an Implementation Plan that positions the Hospital in both a leadership and partnership role in coordinating county-wide collaboration and resources to analyze area healthcare utilization, explore barriers to access, identify partner needs and resources, plan/redesign services, measure outcomes against evidence-based benchmarks and share accountability in order to facilitate effective programming to improve the health of the residents within the Hospital's Service Area.

As a community leader in population health improvement, SRMC annually allocates budgeted funds and staff administrative hours through its Community Benefit funding and initiatives for implementing the activities described in the following sections of the 2022-2025 Implementation Plan. These resources combine SRMC's and local non-profit resources in unified efforts to improve health and health equity for our community members; especially low income, underserved and vulnerable populations.

C. Gap Analysis

As part of the CHIP planning process, the Columbiana County Health Partners Workgroup is to conduce a gap analysis to determine existing discrepancies between community needs and viable community resources to address local priorities; identify strengths, weaknesses, and evaluation strategies; and strategic action identification. This step in the CHIP's creation is to be completed after the strategies and indicators are selected. However, at the time of the SRMC Implementation Plan's approval in November 2022, the Gap Analysis has not been initiated. Note that the results of the Gap Analysis will be included as an Appendix to this Plan, when it is completed.

VIII. NEEDS NOT ADDRESSED IN IMPLEMENTATION PLAN



SRMC's 2022-2025 Implementation Plan advocates strategies to address many of Ohio's top health priorities and also integrates and coordinates SRMC's resources to help achieve the goals that are outlined in Columbiana County's 2022-2025 Health Improvement Plan.

However, the prevalence of clinical health issues is also frequently related to systemic causes of social inequities that lead to poor health, social determinants of health and individual social and/or economic issues and personal choices.

Figure 2- Source: *2020 Institute for Diversity and Health Equity's "Health Equity Snapshot: A Toolkit for Action* below.)

In addition, poor health may be related to residents' lack of access to health services and environmental and behavioral factors that impact health. Columbiana County has a high percentage of poverty among children, families and the general population as compared to other U.S. counties; along with a high unemployment rate, low health literacy and low proportion of adults with a college degree as compared to other U.S. counties.

The top environmental needs identified in the Community Survey portion of the CCHNA included poverty, lack of access to employment/better jobs, lack of access to health insurance, unsafe water/clean air, poor housing conditions, homelessness and personal safety. In addition, focus group participants identified the weather, chemical waste and unemployment as environmental determinants that impact community health.

Stakeholders interviewed cited multi-faceted and intertwined demographic and socio-economic issues related to income, the poor economy, drug abuse, lack of education, and unemployment as key environmental drivers of the unhealthy status of the community.

Each of the needs listed above could be addressed by various independent, county, state and/or federal organizations. However, due to their societal magnitude and SRMC's limited resources and capacity to meaningfully impact the environment and economic foundation of the county, SRMC has chosen to allocate significant resources to the priority health needs which yield the greatest opportunities to affect a positive change, as outlined in this 2022-2025 Implementation Plan.

A summary of the environmental and social determinants of health needs not addressed in SRMC's Implementation Plan includes:

Physical Environment (Natural environment that impacts health)	- Quality of air and water supply - Septic systems, lead poisoning and environmental hazards
Certain Social Determinants of Health	- Poverty/generational poverty and dependence on financial assistance - Poor economy/lack of job opportunities - Lack of transportation and infrastructure - Lack of adequate housing - Single-parent households - Lack of parenting skills - Growing number of non-traditional families - Low educational attainment - Lack of personal accountability/motivation

In addition, there are several health indicators in which Columbiana County residents have exceeded state and national population health benchmarks. Recognizing that Salem Regional Medical Center is not the only medical resource in the Hospital's Service Area, Hospital leadership felt that the most effective strategy to further decrease the prevalence of clinical health issues and improve population health is through a multi-faceted approach that:

1) Maintains current SRMC programs and services while evaluating their effectiveness
2) Evaluates new programs and services that are based in best practices and are proven effective at treating clinical health issues experienced by residents in the communities served by SRMC
3) Continues to explore partnership opportunities with external organizations to implement best practices that effectively and efficiently address regional health issues

X. PROGRESS AND MEASURING OUTCOMES

Progress in meeting the priorities identified in SRMC's 2022-2025 Implementation Plan will be monitored via measurable indicators that are evaluated on a minimum of an annual basis by SRMC's Senior Leadership team, including an annual status update provided to the SRMC Board of Directors.

In addition, SRMC will be collaborating on the implementation of the Columbiana County CHIP, so that population health improvement initiatives and resources can be coordinated and integrated throughout the county. The CHIP Steering Committee, of which SRMC is a key member, will meet at least semi-annually for the first year of the CHIP's implementation and depending on the progress, may meet annually after that to evaluate and report outcomes. Action steps, accountable person/organization, and timelines will be reviewed at the end of each year by the Steering Committee; with revisions made to the CHIP accordingly. Beyond outcome evaluation, process evaluation will also be used on an ongoing basis to focus on how well action steps are being implemented.

The Columbiana County Health Partners will also continue to facilitate a community health needs assessment every three years to collect data for determining community needs and trends. Primary data will be collected for adults using national sets of questions to not only compare trends in Columbiana County, but also be able to compare to the state and nation. This data will serve as measurable outcomes for each priority area. Indicators have already been defined throughout this report and are identified with the icon.

Because the Columbiana County Health Partners have selected community priorities that align with the SHIP indicators, we can obtain baseline data for select indicators within our defined geographic area to evaluate the outcomes of specific community health improvement efforts. As a result, there will be more widespread implementation of SHIP-aligned evidence-based strategies at the state and local level, resulting in improved data collection and more effective cross-sectional coordination of resources.

Appendix: Columbiana County Community Resources

Agency	Address	City	State	Zip	Phone Number
Assistance Programs					
A.I.D., Inc. (Action, Information, Direction)		Salem	OH	44460	330-332-1373
Catholic Charities Regional Agency Emergency Assistance	319 West Rayen Avenue	Youngstown	OH	44502	330-744-3320 800-670-6089
Columbiana County Department of Job & Family Services	7989 Dickey Drive Suite 2	Lisbon	OH	44432	330-424-1471
Columbiana County Veteran's Service Commission	7989 Dickey Drive Suite 1	Lisbon	OH	44432	330-424-7214
Columbiana Meals on Wheels	865 East Park	Columbiana	OH	44408	330-482-0366
Community Action Agency of Columbiana County	7880 Lincole Place	Lisbon	OH	44432	330-424-7221
Family & Community Services, Inc.	705 Oakwood Street Suite 221	Ravenna	OH	44266	330-297-7027
Mahoning-Youngstown Community Action Partnership (MYCAP)	1325 5th Avenue	Youngstown	OH	44504	330-747-7921
Making Kids Count	7178 West Boulevard Suite E	Youngstown	OH	44512	330-758-3434
United Way Services of Northern Columbiana County FamilyWize-Discount Drug Program	713 East State Street	Salem	OH	44460	330-337-0310
WIC (Women, Infants, Children) Columbiana County	7876 Lincole Place	Lisbon	OH	44432	330-424-7293
Assisted Living					
Copeland Oaks	800 South 15th Street	Sebring	OH	44672	330-938-1093
Crossroads at Beaver Creek	13280 Echo Dell Road	East Liverpool	OH	43920	330-385-2211
Grace Woods Senior Living, LLC	730 Youngstown Warren Road	Niles	OH	44446	330-652-4177
Grace Woods Senior Living of Salem, LLC	1166 Benton Road	Salem	OH	44460	330-332-1104
Senior Center of Mahoning County	1110 5th Avenue	Sebring	OH	44672	330-744-5071
Whispering Pines Village	937 East Park Avenue	Columbiana	OH	44408	844-305-8813
Children's Services					
Akron Children's Hospital Beeghly Campus	6505 Market Street	Boardman	OH	44512	330-746-8100
Akron Children's Hospital Pediatrics Lisbon	330 North Market Street	Lisbon	OH	44432	330-424-9866
Alta Behavioral Healthcare Early Childhood Mental Health	711 Belmont Avenue	Youngstown	OH	44502	330-793-2487
Alta Head Start	142 Javit Court	Austintown	OH	44515	330-736-0071
Belmont Pines Hospital Children's Behavioral Health Hospital and Residential Treatment Center	615 Churchill-Hubbard Road	Youngstown	OH	44505	330-759-2700 800-423-5666

Agency	Address	City	State	Zip	Phone Number
Boy Scouts of America Buckeye Council	2301 13th Street NW	Canton	OH	44708	330-580-4272 800-589-9812
Camp Fire Tayanoka		East Liverpool	OH	43920	330-385-0645
Columbiana County Department of Job & Family Services	7989 Dickey Drive Suite 2	Lisbon	OH	44432	330-424-1471
Columbiana County Educational Service Center	38720 Saltwell Road	Liston	OH	44432	330-424-9591
Columbiana County Help Me Grow- Columbiana County Board of Developmental Disabilities	34947 State Route 172	Lisbon	OH	44432	330-424-0288
Columbiana County Juvenile Court Charles A. Pike Center	260 West Lincoln Way	Lisbon	OH	44432	330-424-4071
Community Action Agency of Columbiana County	7880 Lincole Place	Lisbon	OH	44432	330-424-7221
Community Action Agency of Columbiana County Community Health Center-East Liverpool	16687 Saint Clair Avenue Suite 203	East Liverpool	OH	43920	330-386-7777
Community Action Agency of Columbiana County Community Health Center-Lisbon	7880 Lincole Place	Lisbon	OH	44432	330-424-5686
Community Action Agency of Columbiana County Salineville Community Health Center at Melhorn	103 West Main Street	Salineville	OH	43945	330-679-2640
Community Resource Center	940 Pennsylvania Avenue	East Liverpool	OH	43920	330-385-1301
Counseling Center of Columbiana County	40722 State Route 154	Lisbon	OH	44432	330-424-9573
Counseling Center of Columbiana County East Liverpool Branch Office	15613 Pineview Drive Suite A	East Liverpool	OH	43920	330-386-9004
Counseling Center of Columbiana County Salem Branch Office	166 Vine Ave	Salem	OH	44460	330-332-1514
Easter Seals of Mahoning, Trumbull, and Columbiana	299 Edwards Street	Youngstown	OH	44502	330-743-1168
Family & Children First of Columbiana County	38720 Saltwell Rd	Lisbon	OH	44432	330-424-9591
Girl Scouts of North East Ohio Youngstown	8580 South Avenue	Youngstown	OH	44514	330-652-5876 800-852-4474
Louis Tobin Attention Center	8363 County Home Road	Lisbon	OH	44432	330-424-9809
Making Kids Count	7178 West Boulevard Suite E	Youngstown	OH	44512	330-758-3434
Salem City Health District	230 North Lincoln Avenue #104	Salem	OH	44460	330-332-1618
Salem Comprehensive Pediatric Health Center	1076 East State Street	Salem	OH	44460	330-332-2710
Second Harvest Food Bank of Mahoning Valley BackPack food program		Youngstown	OH	44509	330-792-5522

Agency	Address	City	State	Zip	Phone Number
United Way Services of Northern Columbiana County	713 East State Street	Salem	OH	44460	330-337-0310
United Way Services of Northern Columbiana County FamilyWize-Discount Drug Program	713 East State Street	Salem	OH	44460	330-337-0310
Counseling and Mental Health Services					
Alta Behavioral Healthcare	711 Belmont Avenue	Youngstown	OH	44502	330-793-2487
Belmont Pines Hospital Children's Behavioral Health Hospital and Residential Treatment Center	615 Churchill-Hubbard Road	Youngstown	OH	44505	330-759-2700 800-423-5666
Community Action Agency Health & Behavioral Health Center at Lisbon	7880 Lincole Place	Lisbon	OH	44432	330-424-5686
Community Action Agency East Liverpool Campus Building #1	16480 St. Clair Ave.	East Liverpool	OH	44432	330-386-7777
Community Action Agency East Liverpool Campus Building #2	16494 St. Clair Ave	East Liverpool	OH	44432	330-386-7870
Catholic Charities Regional Agency	319 West Rayen Avenue	Youngstown	OH	44502	330-744-3320 800-670-6089
Catholic Charities Regional Agency Christina Center	115 East Washington Street	East Liverpool	OH	44432	330-420-0845
Catholic Charities Regional Agency Christina House (undisclosed domestic violence shelter)					24 hr Crisis Line: 330-420-0037
Cleveland Clinic Akron General Acute Care In-Patient Psychiatric Treatment	1 Akron General Avenue	Akron	OH	44307	330-344-6000
Columbiana County Mental Health and Recovery Services Board	27 Vista Drive	Lisbon	OH	44432	330-424-0195
Comprehensive Behavioral Health Association, Inc.- Austintown	104 Javit Ct.	Austintown	OH	44515	330-797-4050 866-900-5590
Comprehensive Behavioral Health Association, Inc.- East Liverpool	321 W. 5TH St.	E. Liverpool	OH	43920	330-385-8800 866-899-8318
Counseling Center of Columbiana County	40722 State Route 154	Lisbon	OH	44432	330-424-9573
Counseling Center of Columbiana County East Liverpool Branch Office	15613 Pineview Drive Suite A	East Liverpool	OH	43920	330-386-9004
Counseling Center of Columbiana County Salem Branch Office	188 North Lincoln Avenue	Salem	OH	44460	330-332-1514
East Liverpool City Hospital Behavioral Health Inpatient Center	425 West 5th Street	East Liverpool	OH	43920	330-386-3590
Family Recovery Center Administrative, Counseling & Criminal Justice Office	964 North Market Street	Lisbon	OH	44432	330-424-1468
Family Recovery Center Fleming House	1300 Rose Drive	Lisbon	OH	44432	330-420-3760

Agency	Address	City	State	Zip	Phone Number
Family Recovery Center Oxford House	320 Benton Road	Salem	OH	44460	330-337-7501
Family Recovery Center Prevention Office	966 North Market Street Lower Level	Lisbon	OH	44432	330-424-0531
Family Recovery Center Renaissance House	855 Newgarden Road	Salem	OH	44460	234-567-4746
HelpNetworkNEO		Youngstown	OH	44501	330-424-7767 800-427-3606
Insight Counseling & Wellness- Canfield	3685 Stutz Dr, Ste 103	Canfield	OH	44406	330-286-3558
Insight Counseling & Wellness- East Liverpool	45875 Bell School Rd, Ste B	E. Liverpool	OH	43920	234-254-5656
Insight Counseling & Wellness- East Palestine	678 E. Taggart St, Ste 105	E. Palestine	OH	44413	330-932-2095
Insight Counseling & Wellness- Salem	2400 Southeast Blvd. Ste B	Salem	OH	44460	234-567-4660
Insight Counseling & Wellness- Wintersville	115 Main St.	Wintersville	OH	43953	740-996-3376
Louis Stokes Cleveland VA Medical Center East Liverpool/Calcutta Multi-Specialty Outpatient Clinic	5655 State Route 170 Suite A	Calcutta	OH	43920	330-386-4303
Neil Kennedy Recovery Clinic	2151 Rush Boulevard	Youngstown	OH	44507	330-744-1181 800-228-8287
New Day Counseling & Psychiatric Services	Beldon Village Glass Tower- 4450 Beldon Village St NW, Ste 606	Canton	OH	44718	330-305-9696
On Demand Counseling- Austintown	5760 Patriot Dr.	Austintown	OH	44515	330-270-8610
On Demand Counseling- East Liverpool	658 Walnut St., Ste 3	E. Liverpool	OH	43920	330-932-0157
Behavioral Medicine and Wellness Center Intensive Outpatient Mental Health Services	Salem Regional Medical Center 2020 East State Street Suite J	Salem	OH	44460	330-337-4935
St. Elizabeth Youngstown Hospital Acute Care In-Patient Psychiatric Treatment	1044 Belmont Avenue	Youngstown	OH	44501	Main Number: 330-746-7211
Dr. Katherine Stutzman, Ph.D.	425 West Fifth Street	East Liverpool	OH	43920	330-386-2047
Summa St. Thomas Hospital Behavioral Health Services Acute Care In-Patient Psychiatric Treatment	444 North Main Street	Akron	OH	44310	330-379-9841
Drug and Alcohol Services					
Broadway Recovery Services	725 Boardman Canfield Rd, Ste C4	Youngstown	OH	44512	855-292-9778
Broadway Recovery House	1184 Third St.	Salem	OH	44460	

Agency	Address	City	State	Zip	Phone Number
Community Action Agency East Liverpool Campus Building #1	16480 St. Clair Ave.	East Liverpool	OH	44432	330-386-7777
Counseling Center of Columbiana County	40722 State Route 154	Lisbon	OH	44432	330-424-9573
Counseling Center of Columbiana County East Liverpool Branch Office	15613 Pineview Drive Suite A	East Liverpool	OH	43920	330-386-9004
Counseling Center of Columbiana County Salem Branch Office	188 North Lincoln Avenue	Salem	OH	44460	330-332-1514
Coleman Crisis Services	2421 13th Street NW	Canton	OH	44708	330-452-9812 800-956-6630
East Liverpool City Hospital Drug & Alcohol Medical Stabilization New Vision	425 West 5th Street	East Liverpool	OH	43920	330-386-3193 800-939-2273
Family Care Ministries	119 W. 6th Street	East Liverpool	OH	43920	330-368-0725
Family Recovery Center Administrative, Counseling & Criminal Justice Office	964 North Market Street	Lisbon	OH	44432	330-424-1468
Family Recovery Center Fleming House	7300 Rose Drive	Lisbon	OH	44432	330-420-3760
Family Recovery Center Oxford House	320 Benton Road	Salem	OH	44460	330-337-7501
Family Recovery Center Prevention Office	966 North Market Street Lower Level	Lisbon	OH	44432	330-424-0531
Family Recovery Center Renaissance House	855 Newgarden Road	Salem	OH	44460	234-567-4746
Louis Stokes Cleveland VA Medical Center East Liverpool/Calcutta Multi-Specialty Outpatient Clinic	5655 State Route 170 Suite A	Calcutta	OH	43920	330-386-4303
Neil Kennedy Recovery Clinic	2151 Rush Boulevard	Youngstown	OH	44507	330-744-1181 800-228-8287
New Start Treatment Center St. Joseph Warren Hospital	1296 Tod Avenue NW Suite 205	Warren	OH	44485	330-306-5010
Trinity Health System Behavioral Medical Center Drug and Alcohol Rehabilitation Center	380 Summit Avenue	Steubenville	OH	43952	740-283-7024
Emergency Assistance					
American Red Cross of Lake to River	3530 Belmont Avenue Suite 7	Youngstown	OH	44505	330-392-2551
Catholic Charities Regional Agency Emergency Assistance	319 West Rayen Avenue	Youngstown	OH	44502	330-744-3320 800-670-6089
Christians' Concern of Leetonia	764 Columbia Street	Leetonia	OH	44431	330-427-6827
Salvation Army East Liverpool Corps	413 East 4th Street	East Liverpool	OH	43920	330-385-2086

Agency	Address	City	State	Zip	Phone Number
Salvation Army Salem	1249 North Ellsworth Avenue	Salem	OH	44460	330-332-5624
Food Banks, Pantries, and Programs					
Community Action Agency of Columbiana County	7880 Lincole Place	Lisbon	OH	44432	330-424-7221
Farmers and Hunters Feeding the Hungry Northeast Ohio Chapter					330-424-7221
Making Kids Count	7178 West Boulevard Suite E	Youngstown	OH	44512	330-758-3434
Salem Community Pantry	794 East 3rd Street	Salem	OH	44460	330-332-5166
Second Harvest Food Bank Food Assistance Columbiana County					330-747-2696 330-424-7767
Second Harvest Food Bank of Mahoning Valley BackPack food program		Youngstown	OH	44509	330-792-5522
Second Harvest Food Bank of Mahoning Valley Mobile Pantry Program Fellowship of the Beloved	13696 Bethesda Road	Hanoverton	OH	44423	
Salvation Army East Liverpool Corps	413 East 4th Street	East Liverpool	OH	43920	330-385-2086
Salvation Army Salem	1249 North Ellsworth Avenue	Salem	OH	44460	330-332-5624
Waystation	125 W. 5th Street	East Liverpool	OH	43920	330-932-0353
Free or Low-Cost Clinics					
Columbiana County Health District	7360 State Route 45	Lisbon	OH	44432	330-424-0272
Community Action Agency East Liverpool Campus Building #1	16480 St. Clair Ave.	East Liverpool	OH	43920	330-386-7777
Community Action Agency East Liverpool Campus Building #2	16494 St. Clair Ave.	East Liverpool	OH	44432	330-386-7870
Community Action Agency Health & Behavioral Health Center at Lisbon	7880 Lincole Place	Lisbon	OH	44432	330-424-5686
Community Action Agency Dental Center at Lisbon	38722 Saltwell Road	Lisbon	OH	44432	330-424-4192
Community Action Agency Health and Dental Center at Melhorn, Salineville	103 West Main Street	Salineville	OH	43945	330-679-2640
The Dental Van East Liverpool Department of Health (at the Community Resource Center twice a month)	940 Pennsylvania Avenue	East Liverpool	OH	43920	Call for Appointment: 330-385-1301
Quota Club International of Salem, Inc. Salem Area Speech and Hearing Clinic		Salem	OH	44460	330-337-8136
Home Care					
Columbiana County Senior Services Levy Board	7989 Dickey Drive	Lisbon	OH	44432	330-420-6695

Agency	Address	City	State	Zip	Phone Number
Community Caregivers	888 Boardman-Canfield Road Suite D	Boardman	OH	44512	330-533-3427
OVHH- Katie Hughes, Director of Home Health Services	15549 State Route 170, Suite 7	East Liverpool	OH	43920	330-385-2333
Home Care Advantage, Inc.	718 East 3rd Street Suite C	Salem	OH	44460	330-337-HOME (4663)
mvi HomeCare & mvi Hospice Care (Salem)	2350 East State Street	Salem	OH	44460	330-332-1272
mvi HomeCare (Youngstown)	4891 Belmont Avenue	Youngstown	OH	44505	330-759-9487 800-449-4684
Salem Area Visiting Nurse Association	718 East 3rd Street Suite A	Salem	OH	44460	330-332-9986 800-879-6070
Hospice					
All Caring Hospice	6715 Tippecanoe Road Suite B-101	Canfield	OH	44406	330-286-3435 855-286-3435
Grace Hospice Ohio	7206 Market Street	Youngstown	OH	44512	330-729-2924
Hospice of the Valley Columbiana County	2388-B Southeast Boulevard	Salem	OH	44460	330-337-3182
Hospice of the Valley The Hospice House	9803 Sharrott Road	Poland	OH	44514	330-549-5850
mvi HomeCare & mvi Hospice Care (Salem)	2350 East State Street	Salem	OH	44460	330-332-1272
Hospitals					
Akron Children's Hospital in Boardman	6505 Market Street	Boardman	OH	44512	330-746-8040
Aultman Alliance Community Hospital	200 East State Street	Alliance	OH	44601	330-596-6000
East Liverpool City Hospital	425 W 5th Street	East Liverpool	OH	43920	330-385-7200
Mercy Health- Boardman	8401 Market Street	Boardman	OH	44512	330-729-2929
Mercy Health- Youngstown	1044 Belmont Avenue	Youngstown	OH	44501	330-746-7211
Salem Regional Medical Center	1995 East State Street	Salem	OH	44460	330-332-1551
The Surgical Hospital at Southwoods	7630 Southern Blvd.	Boardman	OH	44512	330-729-8000
Hotline & Resource Numbers					
AIDS National Hotline					800-342-2437
AIDS Treatment Information Services					800-448-0440
Alcoholics Anonymous Youngstown Area Intergroup	3373 Canfield Road	Youngstown	OH	44511	330-270-3000
Al-Anon Family Group Headquarters, Inc.					800-356-9996
Al-Anon/Alateen Hotline					800-344-2666
Alzheimer's Association					800-272-3900
American Cancer Society					800-227-2345
American Lung Association					800-548-8252
American Red Cross of Lake to River	3530 Belmont Avenue Suite 7	Youngstown	OH	44505	330-392-2551
Autism Society					800-328-8476
Gay & Lesbian National Hotline					888-843-4564

Agency	Address	City	State	Zip	Phone Number
Gay, Lesbian, Bisexual, and Transgender (GLBT) Youth Support Line					800-850-8078
HelpNetworkNEO					*211
National Adolescent Suicide Hotline					800-621-4000
National Alcoholism and Substance Abuse Information Center					800-784-6776
National Child Abuse Hotline					800-4-A-CHILD
National Cocaine Hotline					800-COCAINE
National Domestic Violence Hotline					800-799-7233 TTY: 800-787-3224
National Heroin Hotline					800-9-HEROIN
National Runaway Hotline					800-621-4000
National Suicide Prevention Lifeline					800-273-8255
National Teen Dating Abuse Hotline					866-331-9474
National Youth Crisis Hotline					800-HIT-HOME
Panic Disorder Information Hotline					800-64-PANIC
Poison Control					800-222-1222
Substance Abuse and Mental Health Services Administration National Helpline					800-784-6776
Suicide Hotline Community Resources Information					330-424-7767 1-800-427-3606 or *211
Vet2Vet Veteran's Crisis Line					877-838-2838
Veterans Crisis Line					800-273-8255 and Press 1
Warmline- Columbiana County					330-385-7000 hours M-F 8A-4P
Housing Assistance					
Catholic Charities Regional Agency Housing Counseling	319 West Rayen Avenue	Youngstown	OH	44502	330-744-3320 800-670-6089
Community Action Agency of Columbiana County	7880 Lincole Place	Lisbon	OH	44432	330-424-7221
Family & Community Services, Inc.	705 Oakwood Street Suite 221	Ravenna	OH	44266	330-297-7027
Habitat for Humanity of Northern Columbiana County	468 Prospect Street	Salem	OH	44460	330-337-1003
Medical and Dental Care Services					
Adult Endocrinology-Saira Mammen, M.D.	St. Clair Ave. Suite 2	East Liverpool	OH	43920	330-385-9670
Akron Children's Hospital Beeghly Campus	6505 Market Street	Boardman	OH	44512	330-746-8100
Akron Children's Hospital Pediatrics East Liverpool	15655 State Route 170	East Liverpool	OH	43920	330-385-1477

Agency	Address	City	State	Zip	Phone Number
Akron Children's Hospital Pediatrics Lisbon	330 North Market Street	Lisbon	OH	44432	330-424-9866
American Cancer Society Reach to Recovery	525 North Broad Street	Canfield	OH	44406	Regional Office: 888-227-6446 National Cancer Information Center: 800-227-2345
American Heart Association Great Rivers Affiliate: Youngstown Metro	840 Southwestern Run	Youngstown	OH	44514	330-965-9230
Arthritis Foundation, Great Lakes Region, Northeastern Ohio Chapter	4630 Richmond Road Suite 240,	Cleveland	OH	44128	800-245-2275 Ext. 114
Belmont Pines Hospital Children's Behavioral Health Hospital and Residential Treatment Center	615 Churchill-Hubbard Road	Youngstown	OH	44505	330-759-2700 800-423-5666
Community Action Agency East Liverpool Campus Building #1	16480 St. Clair Ave.	East Liverpool	OH	43920	330-386-7777
Community Action Agency East Liverpool Campus Building #2	16494 St. Clair Ave.	East Liverpool	OH	44432	330-386-7870
Community Action Agency Health & Behavioral Health Center at Lisbon	7880 Lincole Place	Lisbon	OH	44432	330-424-5686
Community Action Agency Dental Center at Lisbon	38722 Saltwell Road	Lisbon	OH	44432	330-424-4192
Community Action Agency Health and Dental Center, Melhorn, Salineville	103 West Main Street	Salineville	OH	43945	330-679-2640
Columbiana County General Health District	7360 State Route 45	Lisbon	OH	44432	330-424-0272
Columbiana County General Health District Cancer Detection Clinic	7360 State Route 45	Lisbon	OH	44432	330-424-0272
Columbiana Medical Center affiliated with Salem Regional Medical Center	750 East Park Avenue	Columbiana	OH	44408	330-482-3871
Easter Seals of Mahoning, Trumbull, and Columbiana - J. Ford Crandall Rehabilitation Center - Youngstown Hearing and Speech Center	299 Edwards Street	Youngstown	OH	44502	330-743-1168
East Liverpool City Health District	126 West 6th Street	East Liverpool	OH	43920	330-385-5123
East Liverpool City Hospital (See website for a full list of services: **http://www.elch.org)**	425 West 5th Street	East Liverpool	OH	43920	330-385-7200
Family Practice- Dr. Rikita Sharma, M.D.	TBA	East Liverpool	OH	43920	
Healthy Start & Healthy Families Columbiana Columbiana County Department of Jobs & Family Services	7989 Dickey Drive Suite 2	Lisbon	OH	44432	330-424-1471
Salem City Health District	230 North Lincoln Avenue #104	Salem	OH	44460	330-332-1618

Agency	Address	City	State	Zip	Phone Number
Salem Regional Medical Center (See website for a full list of services: **www.salemregional.com**)	1995 E. State Street	Salem	OH	44460	330-332-1551
Louis Stokes Cleveland VA Medical Center East Liverpool/Calcutta Multi-Specialty Outpatient Clinic	5655 State Route 170 Suite A	Calcutta	OH	43920	330-386-4303
Premier Health-Alliance	22792 Harrisburg Westville Rd	Alliance	OH	44601	330-823-4000
Premier Health-Sebring	116 South 15TH St	Sebring	OH	44672	330-938-9920
Salem Area Visiting Nurse Association	718 East 3rd Street Suite A	Salem	OH	44460	330-332-9986 800-879-6070
Sleep Clinic-Dr. Aziz	16218 St. Clair Ave.	East Liverpool	OH	43920	330-382-9355
SRMC at Firestone Farms	116 Carriage Drive Town Center at Firestone Farms	Columbiana	OH	44408	330-482-3871
SRMC Primary Care-Lisbon	38506 Saltwell Road	Lisbon	OH	44432	330-424-1404
SRMC Primary Care-Damascus	28885 US 62	Damascus	OH	44619	330-537-4661
Wound Healing Center	Salem Regional Medical Center 1995 East State Street	Salem	OH	44460	330-332-7415
Wound Care Clinic	425 West 5th Street	East Liverpool	OH	43920	330-386-5870
Nutrition					
Community Action Agency of Columbiana County Elderly Nutrition Program	7880 Lincole Place	Lisbon	OH	44432	330-424-7221
Community Resource Center	940 Pennsylvania Avenue	East Liverpool	OH	43920	330-385-1301
East Liverpool City Hospital Dietician-Debra Wick, RD	425 West Fifth Street	East Liverpool	OH	43920	330-386-2079
Recreation					
Beaver Creek State Park	12021 Echo Dell Rd.	East Liverpool	OH	43920	330-385-3091
Boy Scouts of America Buckeye Council	2301 13th Street NW	Canton	OH	44708	330-580-4272 800-589-9812
Camp Fire Tayanoka		East Liverpool	OH	43920	330-385-0645
The Firestone Pool	338 East Park Avenue	Columbiana	OH	44408	330-482-1026
Girl Scouts of North East Ohio Youngstown	8580 South Avenue	Youngstown	OH	44514	330-652-5876 800-852-4474
Salem Community Center	1098 North Ellsworth Avenue	Salem	OH	44460	330-332-5885
Salem Worlds War Memorial Building	785 East State Street	Salem	OH	44460	330-332-5512
Scenic Vista Park	11523 Township Hwy 764	Lisbon	OH	44460	330-424-9078
Thompson Park	2626 Park Way	East Liverpool	OH	44460	330-385-2255
Senior Services					

Agency	Address	City	State	Zip	Phone Number
Area Agency on Aging 11	5555 Youngstown Warren Road Suite 2685	Niles	OH	44446	800-686-7367
Catholic Charities Senior Center	600 East 4th Street	East Liverpool	OH	43920	330-385-4732
Ceramic City Senior Center	600 East 4th Street	East Liverpool	OH	43920	330-385-4732
Community Action Agency of Columbiana County Elderly Nutrition Program	7880 Lincole Place	Lisbon	OH	44432	330-424-7221
Columbiana County Senior Services Levy Board	7989 Dickey Drive	Lisbon	OH	44432	330-420-6695
Columbiana County Department of Job & Family Services	7989 Dickey Drive Suite 2	Lisbon	OH	44432	330-424-1471
Columbiana Meals on Wheels	865 East Park	Columbiana	OH	44408	330-482-0366
Columbiana Metropolitan Housing Authority	325 Moore Street	East Liverpool	OH	43920	330-386-5970
Community Caregivers	888 Boardman-Canfield Road Suite D	Boardman	OH	44512	330-533-3427
Community Resource Center	940 Pennsylvania Avenue	East Liverpool	OH	43920	330-385-1301
Counseling Center of Columbiana County	40722 State Route 154	Lisbon	OH	44432	330-424-9573
Counseling Center of Columbiana County- East Liverpool Branch Office	15613 Pineview Drive Suite A	East Liverpool	OH	43920	330-386-9004
Counseling Center of Columbiana County Salem Branch Office	188 North Lincoln Avenue	Salem	OH	44460	330-332-1514
Direction Home of Northeast Ohio	1030 N. Meridian Rd	Youngstown	OH	44509	330-505-2300 800-686-7367
Family & Community Services, Inc. Medication Assistance Program (MAP)	705 Oakwood Street Suite 221	Ravenna	OH	44266	330-297-7027
Family & Community Services, Inc. R.S.V.P. (Retired Senior Volunteer Program)		Lisbon	OH	44432	330-424-7877
Home Care Advantage, Inc.	718 East 3rd Street Suite C	Salem	OH	44460	330-337-HOME (4663)
Lifeline- East Liverpool City Hospital Women's Auxiliary	425 West Fifth Street	East Liverpool	OH	43920	330-386-2003
Mobile Meals of Salem, Inc.	1995 East State Street	Salem	OH	44460	330-332-2160
mvi HomeCare & mvi Hospice Care (Salem)	2350 East State Street	Salem	OH	44460	330-332-1272
mvi HomeCare (Youngstown)	4891 Belmont Avenue	Youngstown	OH	44505	330-759-9487 800-449-4684
Quota Club International of Salem, Inc. Salem Area Speech and Hearing Clinic		Salem	OH	44460	330-337-8136
Salem Area Adult Daycare Center Salem Area Visiting Nurse Association	718 East 3rd Street Suite B	Salem	OH	44460	330-332-9986 800-879-6070
Salem Area Visiting Nurse Association	718 East 3rd Street Suite A	Salem	OH	44460	330-332-9986 800-879-6070

Agency	Address	City	State	Zip	Phone Number
Salem Community Center Silver & Fit	1098 North Ellsworth Avenue	Salem	OH	44460	330-332-5885
Salem Worlds War Memorial Building	785 East State Street	Salem	OH	44460	330-332-5512
Senior Center of Mahoning County	1110 5th Avenue	Sebring	OH	44672	330-744-5071
Senior Link Adult Day Services	16351 State Route 267	East Liverpool	OH	43920	330-385-5111
Social Security Office East Liverpool	120 East 4th Street	East Liverpool	OH	43920	800-772-1213
Wellsville Area Resource Center	1335 Main Street	Wellsville	OH	43968	330-532-4507
Shelters					
Catholic Charities Regional Agency Christina House (undisclosed domestic violence shelter)					24 hr Crisis Line: 330-420-0037
Community Action Agency of Columbiana County Homeless Prevention Program	7880 Lincole Place	Lisbon	OH	44432	330-424-5686
Support Groups					
Autism Support Group East Liverpool City Hospital	425 West 5th Street	East Liverpool	OH	43920	330-386-2054
CAUSE (Connection, Autism, Understanding, Support, & Education) Salem Public Library-Quaker Meeting Room	821 East State Street	Salem	OH	44460	330-337-6193
Coping With Cancer SRMC Behavioral Medicine & Wellness Center	2020 East State Street Suite J	Salem	OH	44460	330-337-4935
Families Coping With Cancer SRMC Behavioral Medicine & Wellness Center	2020 East State Street Suite J	Salem	OH	44460	330-337-4935
Heroes & Halos	P.O. Box 392	Columbiana	OH	44408	
HIV Support Group Counseling Center of Columbiana County	260 West Lincoln Way	Lisbon	OH	44432	330-424-0604
Support Meeting- Salem Methodist Church	244 South Broadway Ave.	Salem	OH	44460	
Survivors of Suicide Support Group Meets at Columbiana County Counseling Center	40722 State Route 154	Lisbon	OH	44432	330-747-5111
Transportation					
Ambulance Service Inc. Ambulette Service	231 Webber Way	East Liverpool	OH	43920	330-385-4903
CARTS (Community Action Rural Transit System)	7880 Lincole Place	Lisbon	OH	44432	330-424-4015
Life Team EMS Ambulette Services	740 Dresdon Ave.	East Liverpool	OH	43920	330-396-5505
Women's Health					
The Center for Women	4139 Boardman-Canfield Road	Canfield	OH	44406	330-702-1281

Agency	Address	City	State	Zip	Phone Number
Columbiana County Health District- Cancer Detection Clinic (screenings)	7360 State Route 45	Lisbon	OH	44432	330-424-0272
Community Action Agency of Columbiana County Community Health Center-East Liverpool	16687 Saint Clair Avenue Suite 203	East Liverpool	OH	43920	330-386-7777
Community Action Agency of Columbiana County Community Health Center-Lisbon	7880 Lincole Place	Lisbon	OH	44432	330-424-5686
Community Action Agency of Columbiana County Salineville Community Health Center at Melhorn	103 West Main Street	Salineville	OH	43945	330-679-2640
East Liverpool City Hospital OB/GYN Heather Hissom, WHNP,OB/GYN	16761 St. Clair Avenue Suite #2	East Liverpool	OH	43920	330-385-9670
Gynecology- Constantine G. Economus, M.D.	2020 East State Street, Suite G	Salem	OH	44460	330-884-2400
Louis Stokes Cleveland VA Medical Center East Liverpool/Calcutta Multi-Specialty Outpatient Clinic	5655 State Route 170 Suite A	Calcutta	OH	43920	330-386-4303

Submitted for SRMC Board approval by:
Deborah Pietrzak, VP, Marketing/Planning
November 17, 2022

Revisions submitted for SRMC Board approval by:
Deborha Pietrzak, VP, Marketing/Planning
August 17, 2023