Glenbeigh

2019

Community Health Needs Assessment

Glenbeigh
ACMC Healthcare System

An affiliate of
Cleveland Clinic

Glenbeigh 2019 Community Health Needs Assessment

Table of Contents

Executive Summary

Introduction/Background

In November 2018, Glenbeigh commenced work on a comprehensive Community Health Needs Assessment (CHNA) to identify significant health needs related to alcohol and drug use as well as addiction treatment and recovery support. The CHNA assessment was completed in a timeline consistent with the requirements set forth in the Affordable Care Act[1], per Ohio's State Health Improvement Plan[2] and by the Internal Revenue Service[3]. The ultimate goal of the CHNA is to further Glenbeigh's commitment to community health and population health management. The findings from this assessment will be utilized by Glenbeigh to guide its community benefit initiatives and to engage collaborative partners to address the identified health needs related to substance use disorders.

The following Community Health Needs Assessment includes both primary and secondary data that was collected and analyzed as a means of formulating key findings. In total, 51 individuals representing public and private organizations, social service agencies, law enforcement, health and human service entities, vulnerable populations and individuals and families directly affected by addiction participated in the interviews, focus groups and surveys to collect primary data. Secondary data was compiled from local, state and federal figures to provide insight on the impact of substance use disorders on the defined service community. Collected data included economic information, educational information, population changes, general demographics, drug use and overdose information, alcohol usage, crime statistics, accident statistics, etc.

The development of 2019 CHNA and the Implementation Strategy was led by Glenbeigh's Chief Executive Officer. Input and oversight was provided by both the Ashtabula County Medical Center and the Cleveland Clinic.

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

1 https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-_organizations-section-501r3
2 https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship
3 https://www.irs.gov/charities-non-profits/section-501r-reporting

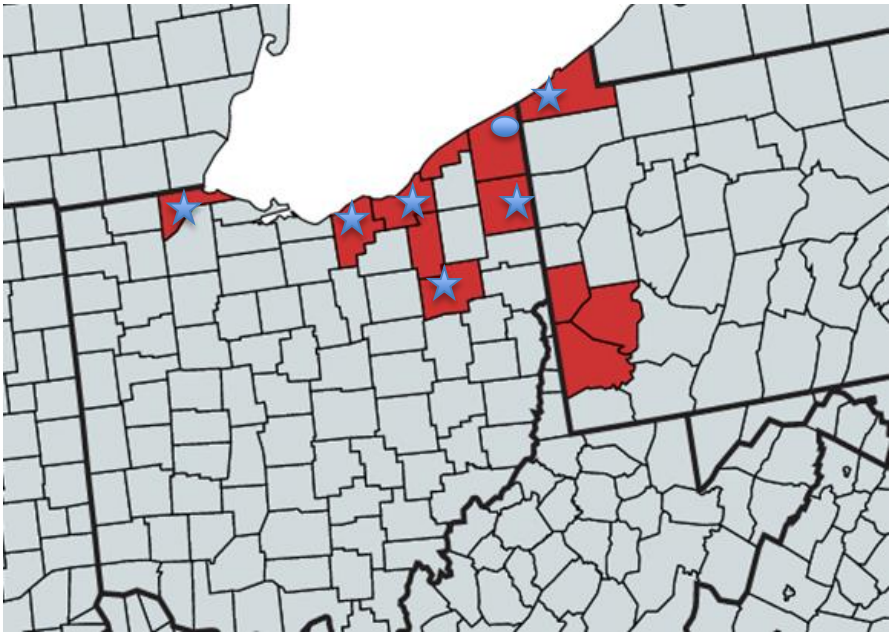
Defined Service Area/Community Definition

Glenbeigh provides treatment predominantly to individuals from throughout Ohio, Pennsylvania, and during 2018 from 16 other states. Inpatient admissions to Glenbeigh primarily came from 57 Ohio counties and 22 counties in Pennsylvania. For purposes of this report, Glenbeigh's primary service area is defined as the 10 counties from which there were 95 or more inpatient admissions during 2018.

Ohio service area counties include: Ashtabula, Cuyahoga, Lake, Lorain, Summit and Trumbull. Service area counties in Pennsylvania include: Allegheny, Beaver, Erie and Washington. Statistically, patients from the six Ohio counties represent 66% of the total number of individuals admitted for inpatient treatment from Ohio while patients from the four Pennsylvania counties constitute 63% of the total number of patients admitted from that state. The total population of Glenbeigh's defined service community in 2018 was approximately 4,485,000.

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

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



Glenbeigh Outpatient Centers **Glenbeigh Inpatient Hospital**

Detailed information on Glenbeigh's service area is available in the secondary data section starting on page 12.

Hospital Profile

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

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

Mission Statement:

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

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

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

Addiction is an illness that, if left untreated, results in the progressive physical, emotional, social and spiritual deterioration of individuals and their families. With treatment, individuals with substance use disorders have the capacity to lead meaningful and productive lives. Successful treatment of addiction is a combination of medical and clinical practices focusing on a holistic approach. Patient care is provided in an atmosphere of privacy, dignity and respect and includes:

Inpatient Services

Glenbeigh's Rock Creek facility is licensed for 180 chemical dependency beds for the provision of treatment services twenty-four hours a day, seven days a week. The inpatient regimen is individually prescribed and supervised by physicians and monitored by nursing and counseling staff. Inpatient services include: comprehensive evaluations, detoxification, group therapy, individual therapy, specialized groups, gender-specific care, educational lectures, family programming, fitness regiments and pain management.

Intensive Outpatient Treatment/Aftercare

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

Extended Residential Treatment and Transitional Living

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

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

Family Programs

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

Research Components

Glenbeigh utilized an in-depth, comprehensive approach to identifying the needs within its defined service area and in areas where Glenbeigh has outpatient facilities. For the purposes of this report, Glenbeigh will report key findings associated with the defined service areas. A variety of quantitative and qualitative research factors were used to formulate the CHNA. These components include:

- Secondary Data Collection
- Key Informant Surveys and Interviews
- Focus Group Surveys and Interviews

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

Development Advisory Board members and Glenbeigh leadership were engaged in the planning process and helped guide the assessment. Past assessments were referenced to ensure questions obtained relative metrics. Furthermore, community members were engaged throughout the process to ensure the assessment captured data relevant to individuals affected by addiction.

To obtain primary data, this community health assessment utilized verbal and written surveys of adults, age 18 and over, from various regions of Glenbeigh's overall service community. Two survey instruments were utilized to capture data and the perspective of a diverse group of individuals impacted by substance use disorders. An online survey was created to solicit input from professionals working with individuals in active addiction or recovery. In June, 1364 electronic surveys were sent and kept open for 30 days. A total of 23 individuals representing organizations, businesses and criminal justice participated in the online survey. A second survey was designed to capture basic demographic information from focus group participants. Three yes/no questions were added to gauge local input regarding healthcare and workforce development. Two open ended questions were utilized to gather information on barriers to treatment and an understanding of what activities participants feel improve quality of life.

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

Key Findings/Significant Community Health Needs

A number of community needs were identified as a result of conducting the 2019 CHNA. Significant Community Health Needs, or Key Findings, were based on the assessment of secondary data, which included a broad range of statistics, health indicators and resources, and of primary data, which was amassed from key stakeholder interviews, focus groups and an electronic survey. The following needs emerged across the various research components and were identified as significant health needs within Glenbeigh's service area.

Socioeconomic Needs:

1. Drug and alcohol abuse continues to impact people of all races and ages. Poverty, income and insurance coverage significantly impact access to treatment and successful recovery. Employment and income, along with other social and economic determinants, correspond to alcohol and drug use.
2. Drug abuse has transitioned from the use of heroin to fentanyl, cocaine and methamphetamines. Alcohol involved accidents continue to occur. Drugs are easily available and inexpensive.
3. Synthetic drug use is becoming more prevalent. Many drugs, such as cocaine, are laced with fentanyl resulting in overdoses. Alcohol use remains a top drug of choice. Prescription abuse continues to be prevalent.
4. People dealing with active addiction do not understand how to get assistance or help a loved one/client sustain recovery. There is a lack of education and information available regarding addiction, treatment and recovery support.
5. In many areas there continues to be a lack of recovery support options. Recovery support includes recovery housing and recovery oriented events.

Health Needs:

1) Barriers exist that affect access to treatment either limiting or excluding certain demographics from obtaining treatment services.
2) Stigma continues. Employers lack education to help employees secure treatment confidentially and return to work. Stigma around drug abuse remains while alcohol use is tolerated.
3) Among providers there is a lack of qualified, educated, licensed individuals to work in the field of addiction treatment: from entry level positions to physicians and nurses.
4) Established healthcare professionals lack education on addiction, treatment and recovery.

OBJECTIVES AND METHODOLOGY

Regulatory Requirements

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

The regulations require that Glenbeigh:

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

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

- A description of the defined service area and how it was determined.
- A description of the methodology used to ascertain the health needs of the community.
- A prioritized list of the community's health needs.

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

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

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

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

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

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

Methodology

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

Secondary Data Profile

Secondary Data was obtained from a variety of institutions and government agencies and collated into a Secondary Data Profile. Social determinants of health, particularly those that correlate with drug and alcohol use, were reported at county levels when available. Glenbeigh utilized information from multiple websites such as the Ohio Department of Health, Pennsylvania Department of Health, Substance Abuse and Mental Health Services Administration (SAMHSA), Drug Enforcement Administration (DEA) and the U.S. Census Bureau. All data include a source citation and URLs were included for reference. Examples of collected data include poverty and unemployment rates, education levels and health insurance status. Drug and alcohol use, abuse, and death rates were reported and compared to state and national statistics. Finally, trends in drug and alcohol use were researched as Glenbeigh strives to stay abreast of developing factors in an effort to best anticipate care needs for the service population.

Secondary data, or data that are already existing and collected by other agencies or organizations, are a key component of the CHNA. The tables included in the CHNA secondary data section represent the counties Glenbeigh has identified as service populations based on admission records. Indicators that impact drug and alcohol use and abuse were included to better understand the social determinants of health in the population. Data on drug and alcohol use and abuse, including overdose deaths, were included and compared to state and national data to provide information about prevalence. Additionally, Glenbeigh utilized the findings reported in various community health assessments. Considering a wide array of information is vital when assessing community health needs to ensure the assessment captures various facts and perspectives thus improving accuracy and objectivity.

Primary Data Profile

Input from the community was obtained through key informant interviews, surveys and focus groups. Participants represented the broad interests of the service community and included individuals with special knowledge of, or expertise in, working with clients and families impacted by substance use disorder. Key informant interviews were conducted with 28 professionals and strategic contacts from throughout northeast Ohio and western Pennsylvania. Moreover, a survey was utilized to engage 23 additional professionals representing the geographic areas of Akron, Canton, Cleveland, Niles and Toledo, Ohio as well as Beaver, Erie and Pittsburgh, Pennsylvania. The survey was distributed and tallied electronically and results are detailed in Appendix F and Appendix G. The key informants from

the survey group included healthcare providers, counselors, social workers, family service organizations, law enforcement, criminal behaviorists, interventionists, government representatives, and other specialists in the field of addiction. The content of the survey focused on perceptions of the availability of and access to treatment services. Key Informant findings are detailed in Appendix E.

Three focus groups were facilitated by Glenbeigh from July to September 2019. Focus groups were conducted with individuals who are in recovery or who have a loved one with a substance addiction. A total of 20 adults participated in the groups. Three locations were selected to ensure representation across Glenbeigh's regional service area. Five individuals participated in the group held in Beachwood, Ohio, representing Cuyahoga County, while eight individuals were in the group conducted in Niles, Ohio, representing Trumbull County. Seven individuals participated in Erie, Pennsylvania, representing northwestern Erie County. The groups were facilitated by a moderator from Glenbeigh. The groups lasted from 65 to 90 minutes. In exchange for participation, each individual received a $25 Giant Eagle gift card. The purpose of the focus groups was to gather qualitative feedback from individuals with first-hand experience navigating the healthcare system for addiction services and living in recovery from multiple perspectives. Focus groups allowed Glenbeigh to gain the perspective of individuals experienced with addiction treatment and the criminal justice system. Topics covered included access to services, community perceptions and recovery support and are detailed in Appendix C. The Survey Tool can be referenced in Appendix D.

Collaborating Organizations

Glenbeigh is a member of the ACMC Healthcare System, which is affiliated with the Cleveland Clinic health system. As such, in conducting this CHNA, Glenbeigh collaborated with Cleveland Clinic Main Campus and with Ashtabula County Medical Center. Furthermore, Ashtabula County Medical Center was involved in the 2019 Ashtabula County Health Needs Assessment, working with the Ashtabula County Health Department as well as other county agencies. Glenbeigh collaborated with Kent State University providing an internship opportunity to a Master's level student in the Public Health program. The intern researched and compiled a portion of the secondary data presented in this report.

Limitations/Information Gaps

It should be noted that data limitations exist when interpreting results. The findings of this CHNA may vary from those of other organizations conducted in the community. Differences may be caused by variances in data sources, the defined service area, and community developments that may not be reflected in data sets. Moreover, it is important to note that while the same questions were asked using the same wording, data collection methods varied therefore caution should be used when interpreting interview results as there may be a margin of error.

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

SECONDARY DATA

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

Ashtabula County, Ohio

Glenbeigh's main hospital facility is located in Ashtabula County, Ohio, Morgan Township, with a Rock Creek Zip Code of 44084. Ashtabula County is a designated Health Resources and Services Administration (HRSA) Health Professional Shortage Area (HPSA) for primary care, dental health and mental health. The county also has regions eligible as Medically Underserved Areas for program year 2019 as designated by the Ohio Department of Health. According to U.S. Census Bureau Quick Facts, the population density of Ashtabula County is 97,493.

Age and Sex	Ashtabula County	Ohio
Persons under 5 years, percent	5.7%	5.9%
Persons under 18 years, percent	22.1%	22.2%
Persons 65 years and over, percent	19.1%	17.1%
Female persons, percent	49.6%	51.0%

Source: U.S. Census Bureau Quick Facts
https://www.census.gov/quickfacts/fact/table/ashtabulacountyohio,OH/PST045218

Income & Poverty	Ashtabula County	Ohio
Median household income (in 2017 dollars), 2013-2017	$43,017	$52,407
Per capita income in past 12 months (in 2017 dollars), 2013-2017	$21,936	$29,011
Persons in poverty, percent	19.3%	14.0%

Source: U.S. Census Bureau Quick Facts
https://www.census.gov/quickfacts/fact/table/ashtabulacountyohio,OH/PST045218

Race and Origin	Ashtabula County	Ohio
White alone, percent	93.0%	81.9%
Black or African American alone, percent(a)	3.9%	13.0%
American Indian and Alaska Native alone, percent	0.3%	0.3%
Asian alone, percent(a)	0.5%	2.5%
Native Hawaiian and Other Pacific Islander alone, percent	Z	0.1%
Two or More Races, percent	2.3%	2.3%
Hispanic or Latino, percent	4.3%	3.9%

Source: U.S. Census Bureau Quick Facts
https://www.census.gov/quickfacts/fact/table/ashtabulacountyohio,OH/PST045218

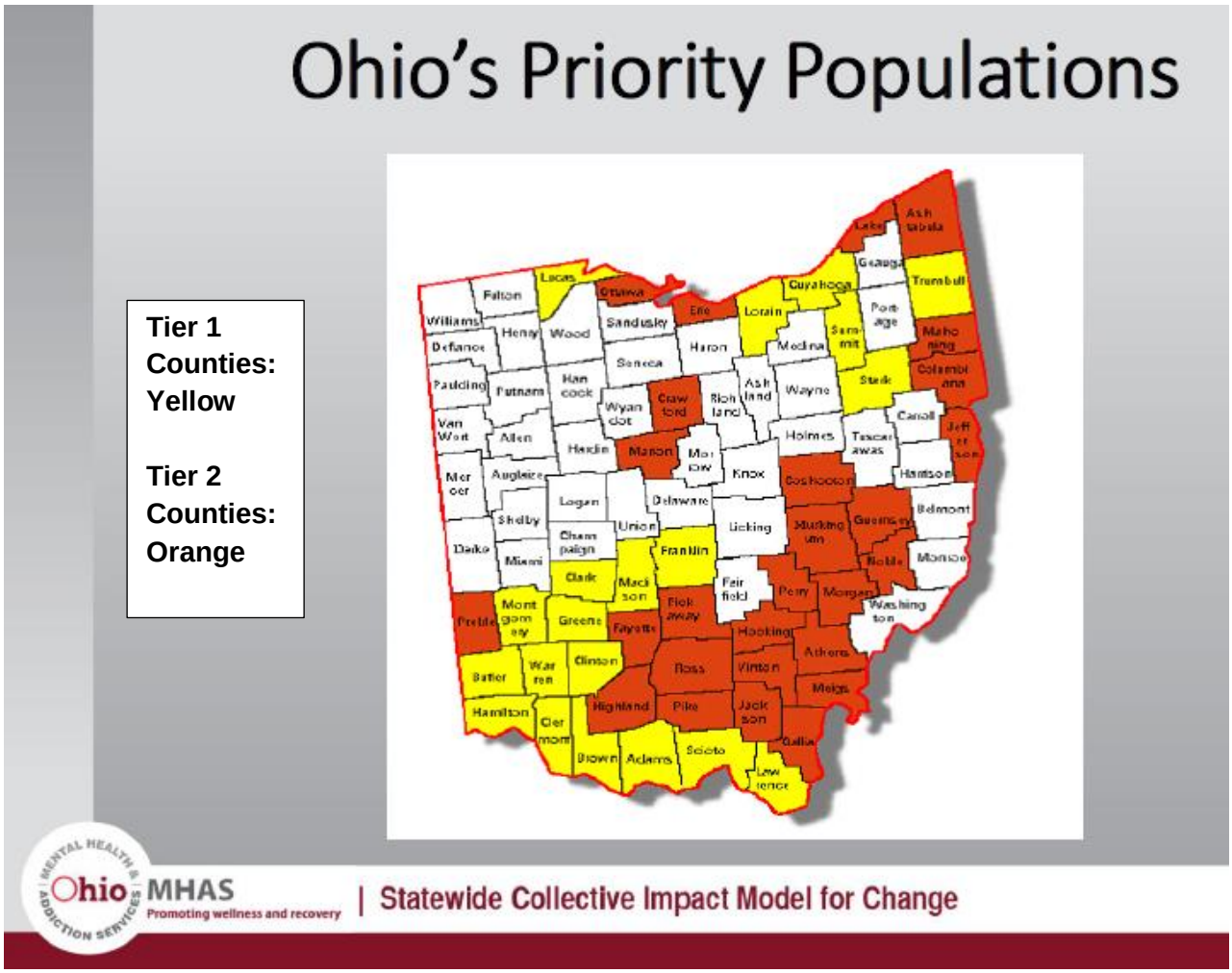
The United Way 2016 ALICE (Asset Limited, Income Constrained, Employed) report (https://www.unitedforalice.org/ohio) along with U.S. Census Bureau data (https://www.census.gov/quickfacts/fact/dashboard/ashtabulacountyohio/PST045218) delved deeper into community statistics. Ashtabula County consisted of 38,728 households with a total population of 98,231 in 2016. Census Bureau statistics for 2018 showed households decreased to 38,381 and the population dropped to 97,493. ALICE reported the number of Ashtabula County households in poverty at 18%, while the state average was 14%. By 2018, the U.S. Census Bureau reported the number of Ashtabula County residents living in poverty at 19.3%.The unemployment rate in the county sustained at above the state average.

Ashtabula County engaged The Hospital Council of Northwest Ohio (HCNO), a 501(c) 3 non-profit regional hospital association located in Toledo, Ohio, to conduct a county wide community health needs assessment in 2019. The Ashtabula County CHNA reported that ten percent (10%) of Ashtabula County adults, a total of 7,611, were without health care coverage in 2019. Reasons cited included: unable to afford to pay insurance premiums (72%); individual lost/changed jobs or employers (33%) and employer does not/stopped offering coverage (21%). The Trend Summary showed that in 2019, 74% of Ashtabula County residents (56,319) self-identified as current drinkers (drank alcohol at least once in the past month), 23% identified as binge drinkers (consuming defined amounts on a single occasion in the past 30 days) and 6% drove after having perhaps too much alcohol to drink. Ohio 2017 self-reported rates were 54%, 19% and 4% respectively.[4]

[4] Source: 2019 Examining the Health of Ashtabula County Ashtabula County Community Health Assessment http://ashtabulacountyhealth.com/wp-_content/uploads/2019/06/Ashtabula-County-2019-DRAFT-CHA-5-31-19.pdf

Other Ohio Service Areas

The Ohio Department of Mental Health and Addiction Services completed and published the *Statewide Collective Impact Model for Change.*[5] In that report, Cuyahoga, Lorain, Summit and Trumbull counties were listed as Tier 1 counties with the highest overdose death counts (2010-2015), rates (2010-2015), and fentanyl deaths (2015). The total number of residents in the 20 Tier 1 counties was 7,030,825, representing 61% of the state population. Additionally, 27 Ohio counties represent Tier 2 communities of which Lake and Ashtabula were included. Tier 2 counties had the next highest overdose death rates (2010-2015), and need for treatment (NSDUH 2012-2014).



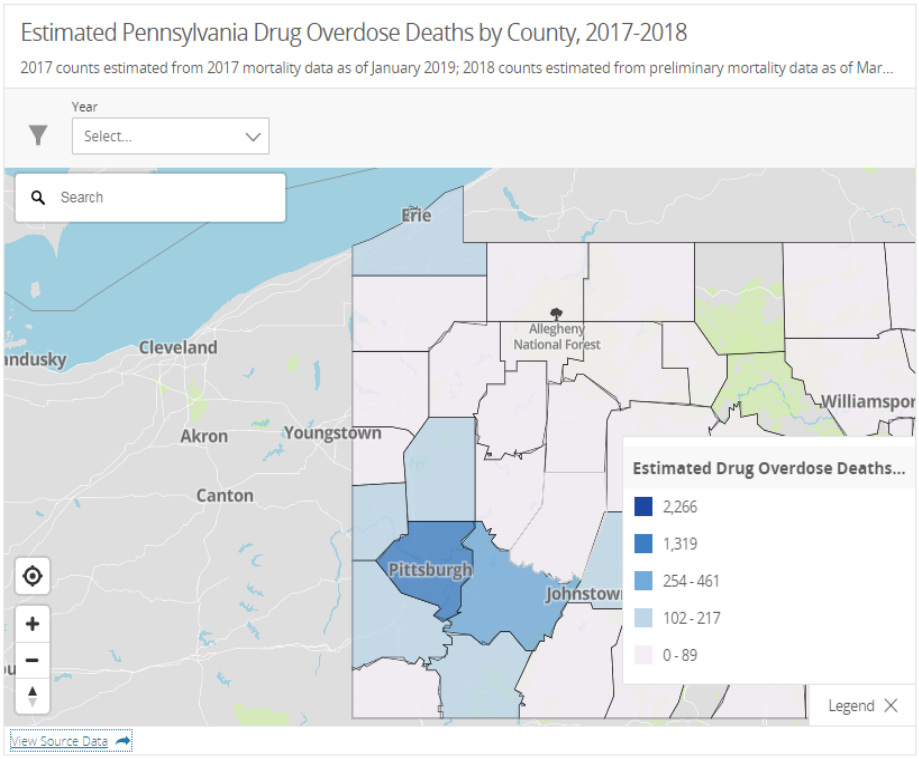
Tier 2 counties represent 14% of the state population or 1,678,383 individuals. Combined, Tier 1 and Tier 2 counties contained 75% of the state's population, or 8,709,208 Ohioans. Ohio's Priority Populations map (above) highlights key areas throughout the state affected by significant overdose deaths and includes Glenbeigh's 6 Ohio service communities.

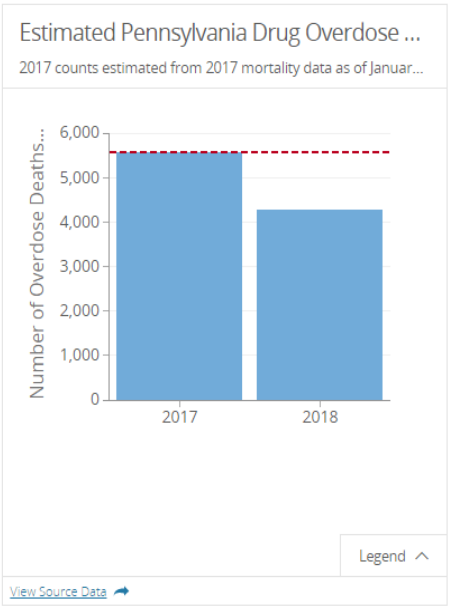
[5] Ohio Collective Impact Summit, "Collective Impact as a Framework to Address Opioid Addiction" March 20, 2019.

Western Pennsylvania

Glenbeigh's defined service area has transitioned to a more compressed region that shifted eastward into western Pennsylvania. This transition coincides with Pennsylvania communities impacted significantly by the opioid epidemic. According to data from the National Opinion Research Center (NORC) at the University of Chicago, Pennsylvania's Drug Overdose Mortality Rate from 2013 to 2017 was 44.3 deaths per 100,000 population for individuals between 15 and 64 years old. The Drug Overdose Mortality Rate in Allegheny County was 57.6 (2,297 deaths), Beaver County was 64.1 (317 deaths), Erie County was 43.3 (367 deaths) and Washington County was at 62.0 (375 deaths). Glenbeigh's defined service area in Pennsylvania consists of 4Appalachian region counties as defined by the Appalachian Regional Commission.

Source: https://www.arc.gov/appalachian_region/CountiesinAppalachia.asp





Source: Pennsylvania Department of Health at https://data.pa.gov/stories/s/9q45-nckt/

Allegheny County Drug Overdose Deaths:	1,319
Beaver County Drug Overdose Deaths:	129
Erie County Drug Overdose Deaths:	196
Washington County Drug Overdose Deaths:	170
Total PA Drug Overdose Deaths 2017:	5,559
Total PA Drug Overdose Deaths 2018:	4,267

Population Changes Comparison

Population decline can negatively impact communities as resources leave the area and the local economy suffers. Six of the ten counties in Glenbeigh's service area experienced population decline from 2010 to 2018, despite state and national level population growth. Ashtabula, Cuyahoga and Trumbull counties in Ohio as well as Beaver and Erie counties in Pennsylvania were most heavily impacted by population decline.

Population Change

	2010 Population	2018 Population	% Population Change 2010-2018
United States	**308,758,105**	**327,167,434**	**6.0%**
Ohio	**11,536,757**	**11,689,422**	**1.3%**
Ashtabula County	101,490	97,493	**-3.9%**
Cuyahoga County	1,280,115	1,243,857	**-2.8%**
Lake County	230,050	230,514	**0.2%**
Lorain County	301,371	309,461	**2.7%**
Summit County	541,778	541,918	**N/A**
Trumbull County	210,325	198,627	**-5.6%**
Pennsylvania	**12,702,873**	**12,807,060**	**0.8%**
Allegheny County	1,223,323	1,218,452	**0.4%**
Beaver County	170,549	164,742	**-3.4%**
Erie County	280,584	272,061	**-3.0%**
Washington County	207,841	207,346	**-0.2%**

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

The table above shows Glenbeigh's defined service communities. Red indicates CHNA defined service communities with a population decrease. Blue indicates CHNA defined service communities with a population increase.

Economic Indicators

Drug and alcohol use rates tend to be higher in areas with higher levels of persons living in poverty, higher unemployment rates, and lower median household income. While unemployment rates are generally at or below the national rate, some service areas show lower median income and a higher percentage of individuals living in poverty. Ashtabula, Cuyahoga, and Erie counties are most affected by economic indicators.

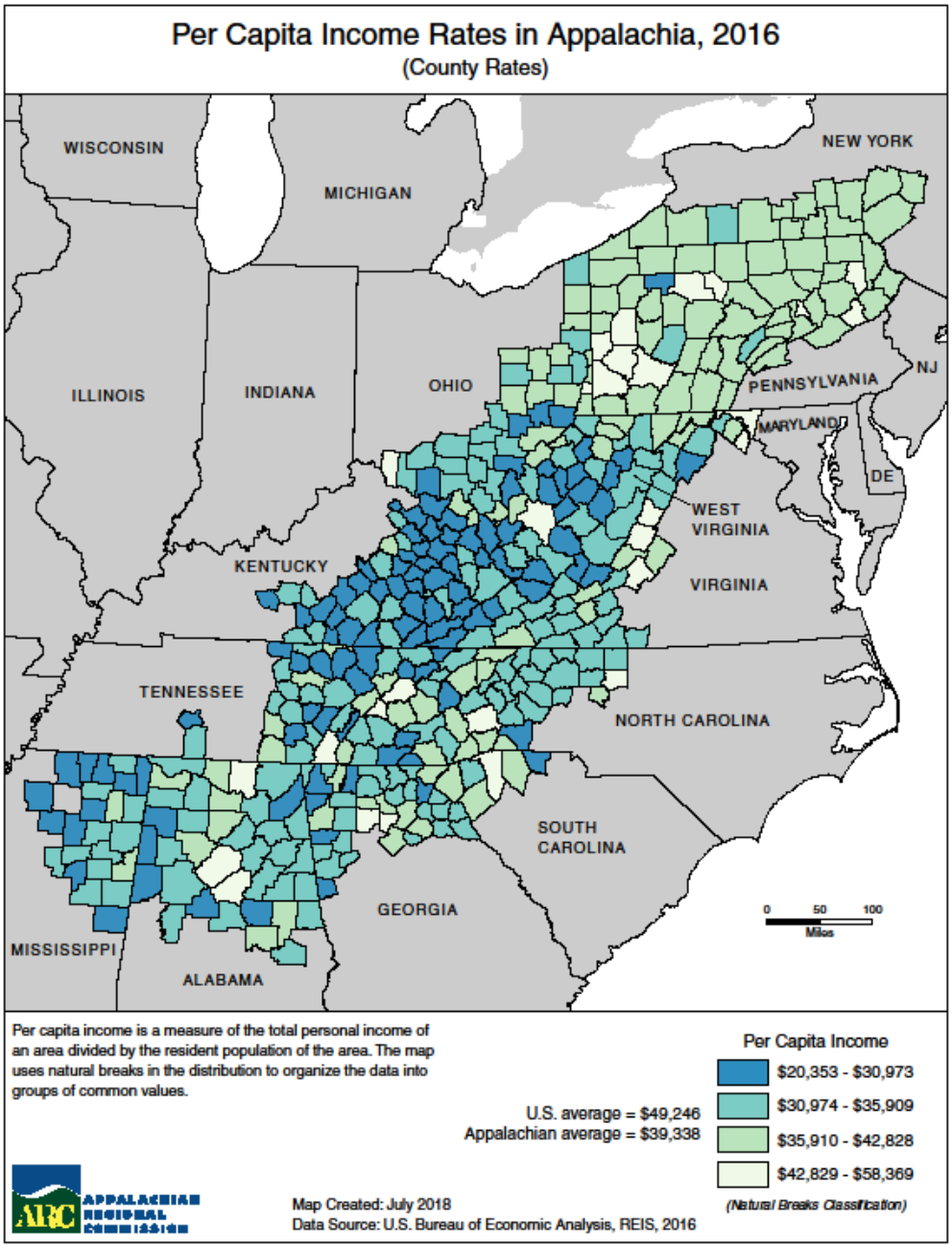
Economic Indicators

	Median Household Income	Percent Living in Poverty	Unemployment Rate
United States	**$57,617**	**14.6%**	**6.6%**
Ohio	**$52,407**	**14%**	**4.9%**
Ashtabula County	$43,017	19.3%	6%
Cuyahoga County	$46,720	18.1%	5.4%
Lake County	$61,137	8.7%	4.8%
Lorain County	$54,987	13.5%	5.9%
Summit County	$53,291	12.9%	5%
Trumbull County	$45,380	15.4%	6.7%
Pennsylvania	**$56,951**	**12.5%**	**5.4%**
Allegheny County	$56,333	11.2%	5.2%
Beaver County	$53,981	11.1%	4.0%
Erie County	$48,192	15.7%	6.6%
Washington County	$59,309	9.4%	6.2%

Source: U.S. Census Bureau, 2017; Unemployment rate source County Health Rankings
Source: https://www.bls.gov/lau/ Bureau of Labor Statistics

The Ashtabula County Community Health Assessment listed several economic costs attributed to excessive alcohol use. These include: an overall national cost of $249 billion in 2010 which equates to roughly $2.05 per drink or $807 per person; losses in workplace productivity accounted for 72% of the total cost, health care expenses 11% , and other costs were due to a combination of criminal justice expenses, motor vehicle crash costs and property damage. Excessive alcohol consumption cost Ohio $8.5 billion in 2010.

Source: CDC, Alcohol and Public Health – Excessive Drinking, updated June 13, 2018



Source: https://www.arc.gov/assets/research_reports/DataOverviewfrom2013to2017ACS.pdf

The map above from the Appalachian Regional Commission shows Glenbeigh designated service areas in Ashtabula and Trumbull counties in Ohio as well as Allegheny, Beaver, Erie and Washington counties in Pennsylvania are part of the Appalachian region. Ashtabula, Trumbull and Erie counties have a per capita income below the national average. The remaining Pennsylvania service communities are equal to or above the national per capita income average.

Access to Healthcare

Ohio and Pennsylvania both participate in the Medicaid expansion, which is reflected in a same or lower than national percentage of uninsured individuals in each county in the service area. Inequities exist in access to mental health providers, which is evidenced by the ratio of providers to the general population in each county. Ashtabula, Lorain, Beaver and Washington counties are particularly affected.

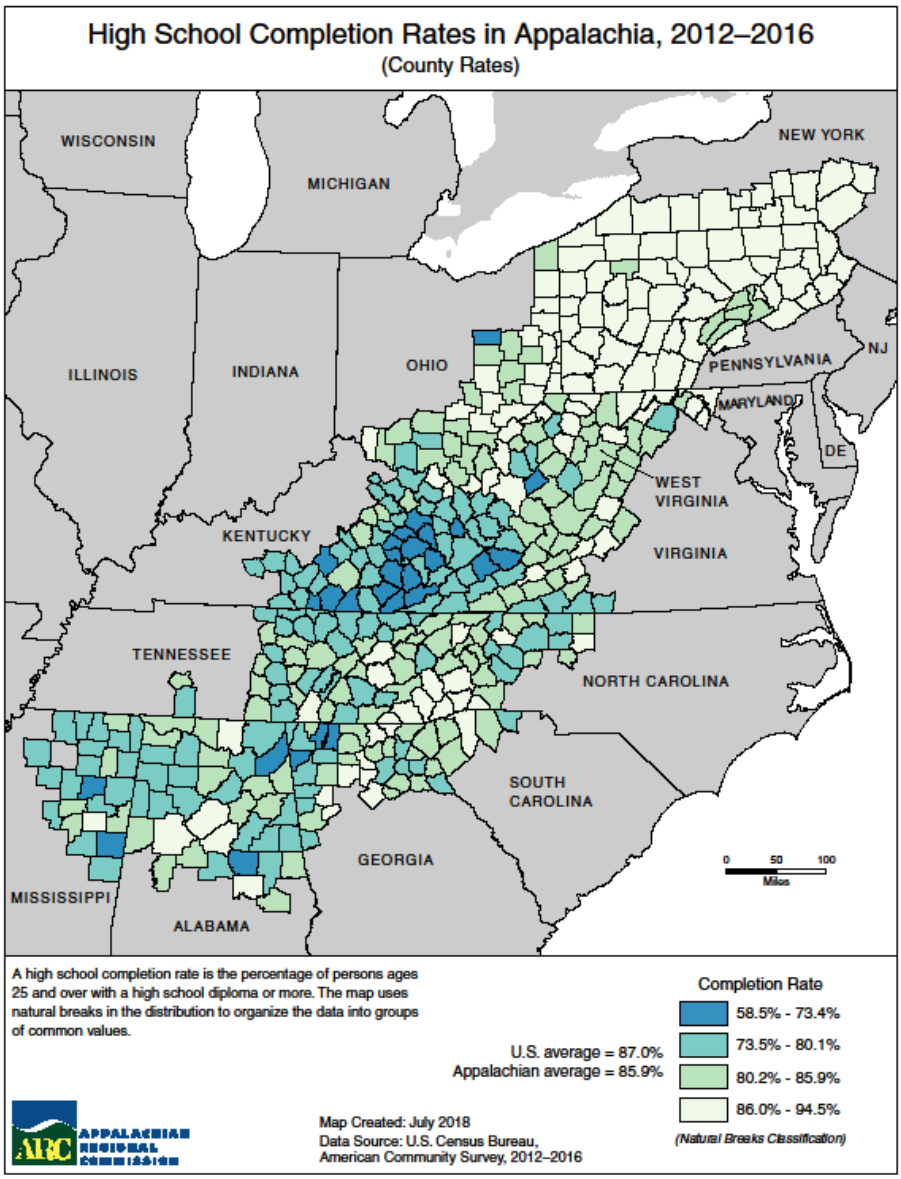
Access to Healthcare by County

	% Without Health Insurance	Mental Health Providers*
United States	**8.6%**	**n/a**
Ohio	**7%**	**560:1**
Ashtabula	8.6%	1,140:1
Cuyahoga	6.3%	360:1
Lake	5.6%	680:1
Lorain	6.4%	770:1
Summit	6.8%	470:1
Trumbull	6.7%	820:1
Pennsylvania	**6.6%**	**560:1**
Allegheny	4.9%	360:1
Beaver	6.0%	1,190:1
Erie	6.2%	570:1
Washington	5.2%	1,070:1

Source: County Health Rankings at https://www.countyhealthrankings.org/explore-health-rankings
*Ratio shows population: mental health providers

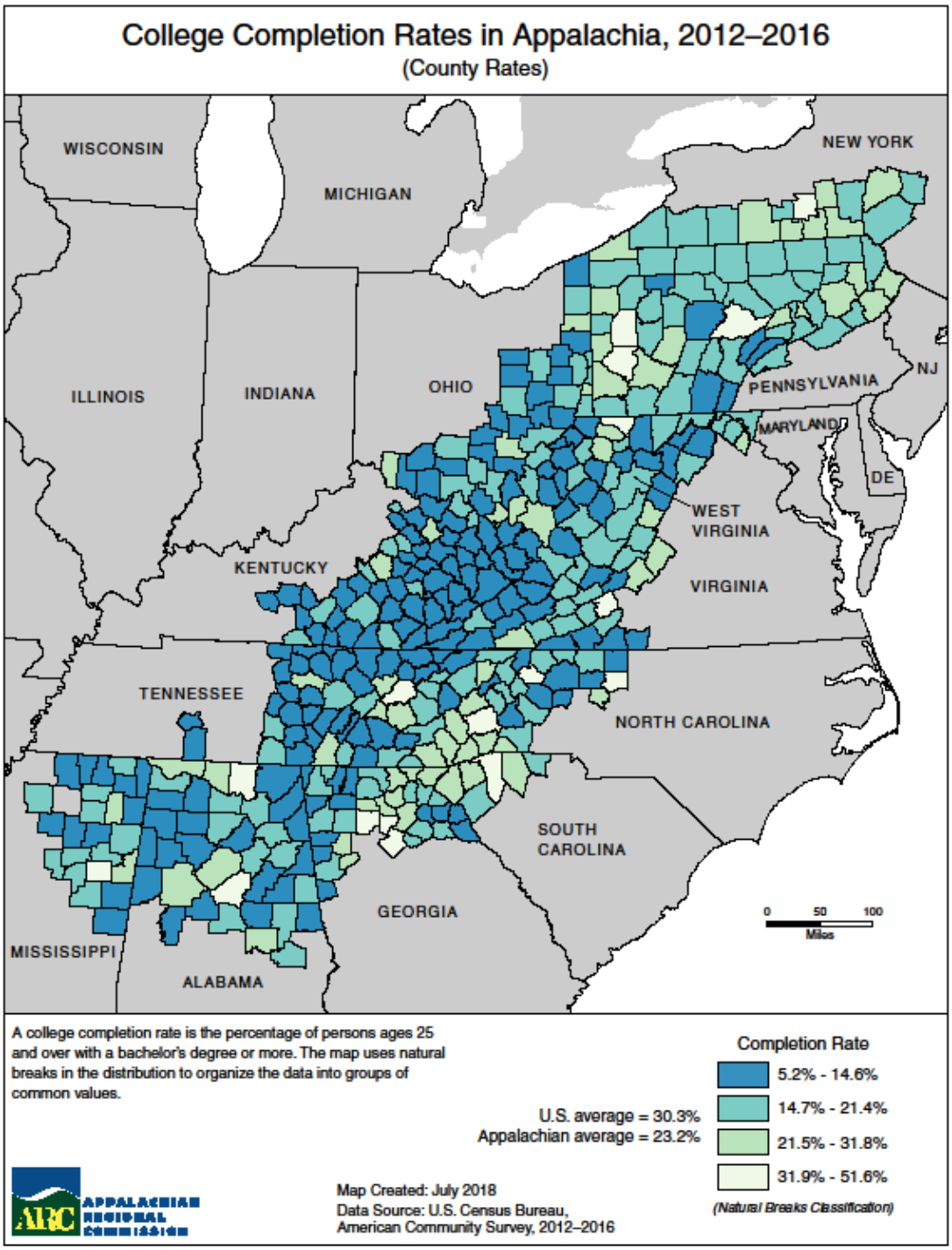
Education

With the exception of Ashtabula, each county in Glenbeigh's service area performs as well as or better than the national average with students obtaining a high school diploma. However, when further broken down by zip code, graduation rates vary widely and correlate with other socioeconomic indicators that influence alcohol and drug use.



Source: https://www.arc.gov/assets/research_reports/DataOverviewfrom2013to2017ACS.pdf

The Appalachian Region: A Data Overview from the 2013-2017 American Community Survey reported, "During the 2013-2017 period, 54 percent of adults ages 25 and over in the Appalachian Region had a high school diploma, but no postsecondary degree (including an associate's degree). And the share was at least 60 percent in 150 of the Region's 420 counties—122 of which were in four states: Ohio, Pennsylvania, Tennessee, and West Virginia. Many of these adults had attended college but did not graduate, while others acquired vocational training. Conversely, 32 percent of adults in Appalachia did earn an associate's or bachelor's degree, while 14 percent never finished high school."[6]

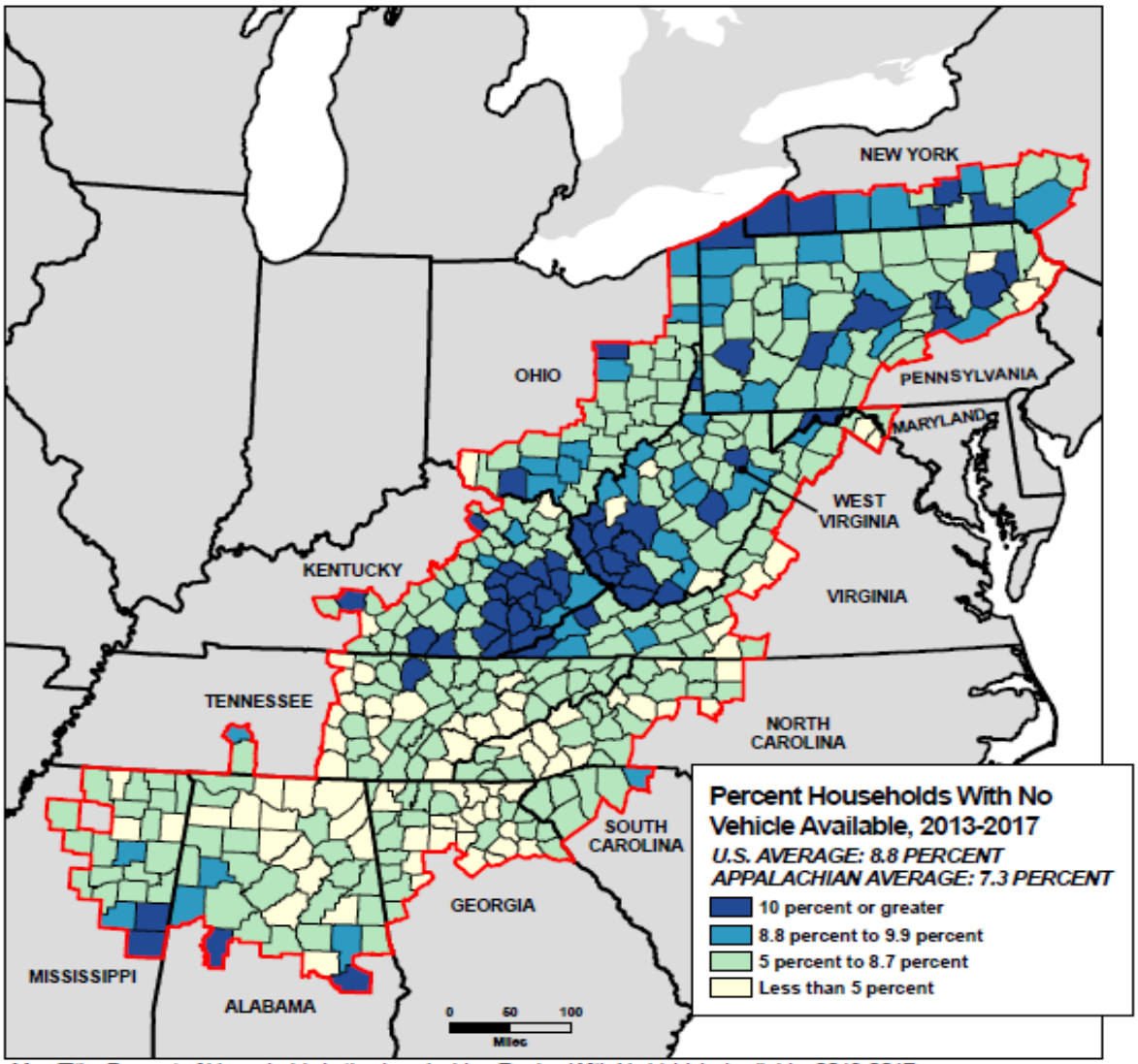


Source: https://www.arc.gov/assets/research_reports/DataOverviewfrom2013to2017ACS.pdf

[6] https://www.arc.gov/assets/research_reports/DataOverviewfrom2013to2017ACS.pdf

Transportation

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



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

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

[7] Source: https://www.arc.gov/assets/research_reports/DataOverviewfrom2013to2017ACS.pdf

Trends in Alcohol and Drug Use

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

Alcohol Use

County	Excessive Drinking (Percentage of Adults)	Alcohol-Impaired Driving Deaths (Percentage of total driving deaths)
Ashtabula	17%	43%
Cuyahoga	17%	44%
Lake	18%	38%
Lorain	17%	46%
Summit	18%	50%
Trumbull	17%	38%
Allegheny	24%	27%
Beaver	20%	18%
Erie	19%	30%
Washington	21%	34%

Sources: County Health Rankings 2012-2016 https://www.countyhealthrankings.org/

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

Ohio State Highway Patrol Driving Data

Traffic Enforcement	2014	2015	2016	2017	2018	5 Year Total
Total Contacts	1,583,786	1,505,336	1,445,429	1,465,002	1,434,537	7,434,090
Enforcement	615,150	616,581	585,707	634,590	617,901	3,069,929
Non-Enforcement	968,636	888,755	859,722	830,412	816,636	4,364,161
OVI Arrests	24,704	24,676	25,276	27,372	26,614	128,642
Speed Citations	385,453	379,061	357,062	380,543	366,184	1,868,303
Safety Belt Citations	110,492	118,731	118,060	139,315	137,079	623,677
Driver License Citations	33,404	35,494	36,041	39,981	39,160	184,080
Traffic Warnings	433,280	440,828	448,443	467,006	458,915	2,248,472
Motorist Assists	289,963	248,951	229,988	216,587	219,609	1,205,098

Crime Enforcement	2014	2015	2016	2017	2018	5 Year Total
Cases	21,888	12,746	11,009	10,294	10,060	65,997
Drug Arrests	11,156	12,392	13,341	16,666	16,971	70,526
Illegal Weapon Arrests	494	556	727	972	1,095	3,844
Resisting Arrests	642	756	878	1,106	1,174	4,556

Traffic Stop Data

Data is compiled from all traffic stops in which a citation, inspection, warning, or vehicle defect notice was issued by the Ohio State Highway Patrol in 2018.

	Asian	**Black**	**Hispanic**	**Native American**	**White**	**Unknown**	**Total**
Traffic Stop Contacts:	13,594	159,877	29,733	676	765,042	2,675	971,597

Source: OSHP Computer-Aided Dispatch (CAD) System, Ohio Trooper Information System (OTIS), and DPS Electronic Crash Record System. Updated on 07/19/19.

The states of Ohio and Pennsylvania have led the nation in drug overdoses in recent years. In 2017, overdose death rates in both states were more than double that of the national rate. These rates have also increased over prior years in every county in Glenbeigh's designated service community.

Drug-Induced Mortality Rates by County

	2010 Age-Adjusted Overdose Death Rate	2017 Age-Adjusted Overdose Death Rate	% Rate Increase
United States	**12.9**	**22.8**	**↑77%**
Ohio	**16.7**	**47.9**	**↑186%**
Ashtabula County	20.1	51	↑154%
Cuyahoga County	14.3	50.2	↑251%
Lake County	18.8	48	↑155%
Lorain County	12.6	48.6	↑286%
Summit County	18.3	50.3	↑175%
Trumbull County	24.1	79.2	↑229%
Pennsylvania	**15.8**	**45**	**↑185%**
Allegheny County	19.3	63.3	↑228%
Erie County	9.4	45.4	↑383%
Washington County	22.2	60.2	↑171%

Source: Centers for Disease Control and Prevention, CDC Wonder. Retrieved from: https://wonder.cdc.gov/ Beaver County, Pennsylvania data was not secured.

Ohio and Pennsylvania have experienced significant community health risks related to opioid addiction. Ohio had the second-highest number of opioid-involved overdose deaths per capita…behind only West Virginia, according to a report from the U.S. Centers for Disease Control and Prevention. Furthermore, the 2017 death rate for opioid overdoses in Appalachia's 420 counties nationwide was 72% higher than non-Appalachian counties. It is not uncommon for residents living in poverty areas to face multiple challenges resulting from lower levels of education, low wages, limited access to job opportunities, and limited access to health care and high crime rates. Socioeconomic factors such as a poor living environment impact quality of life and may lead to alcohol and drug usage resulting a shorter lifespan and health disparities.

The Ashtabula County Community Health Needs Assessment preliminary results, found online at http://ashtabulacountyhealth.com/wp-content/uploads/2019/06/Ashtabula-County-2019-DRAFT-CHA-5-31-19.pdf, reported the following information regarding drug and alcohol use:

Only 7% of Ashtabula County adults reported using recreational marijuana or hashish in the past 6 months. Furthermore, only 3% reported using other drugs such as cocaine, synthetic marijuana, heroin, LSD, inhalants, etc.

The Ashtabula County Community Health Assessment documented adults experiencing the following:

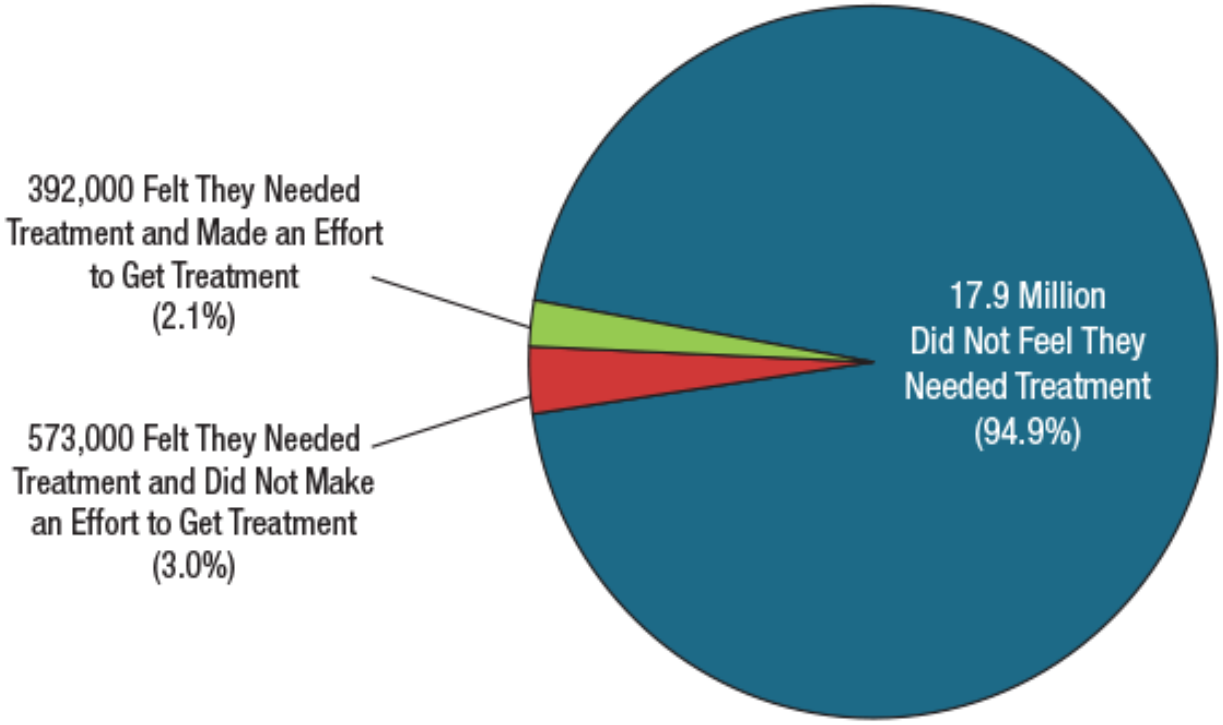
- Drove after having any alcoholic beverage (11%)
- Used prescription drugs while drinking (6%)
- Drank more than they expected (5%)
- Spent a lot of time drinking (3%)
- Drank more to get the same effect (2%)
- Tried to quit or cut down but could not (2%)
- Failed to fulfill duties at work, home or school (2%)
- Gave up other activities to drink (1%)
- Continued to drink despite problems caused by drinking (1%)
- Drank to ease withdrawal symptoms (1%)
- Had legal problems (1%)
- Placed themselves or their family in harm (<1%)

Only one percent of adults reported using a program or service to help with an alcohol or drug problem and cited various reasons for not using such a program. Top reasons included: stigma of seeking drug services (3%), transportation (2%), cost (2%), and no insurance coverage (2%). Ninety-two percent (92%) of adults indicated such a program was not needed.

Contrary to the self-reported instances of drug use detailed above, the Ohio Department of Health published demographic data showing that in 2017, the number of overdose deaths involving fentanyl related drugs, natural and semi-synthetic opioids and cocaine are increasing across all groups regardless of sex or race. Additionally, illicit fentanyl and related drugs were involved in 71% of 2017 overdose deaths, often in combination with other drugs.

The 2018 National Survey on Drug Use and Health (NSDUH) report offered insight into the perceived need for substance use treatment. The national report, published by SAMHSA, found at (https://www.samhsa.gov/data/report/2018-nsduh-annual-national-report), estimates for the perceived need for substance use treatment among the approximate 18.9 million people aged 12 or older who needed substance use treatment but did not receive specialty treatment in the past year, about 964,000 perceived a need for treatment for their use of alcohol and illicit drugs. These individuals who perceived a need for substance use treatment include 392,000 who made an effort to get treatment and 573,000 who did not make an effort to get treatment.

NSDUH Graphic: Perceived Need for Substance Use Treatment among People Aged 12 or Older Who Needed but Did Not Receive Specialty Substance Use Treatment in the Past Year: 2018



The report stated, "The estimated 964,000 people who perceived a need for substance use treatment correspond to about 5.1 percent of people aged 12 or older who needed treatment but did not receive specialty substance use treatment in the past year. Thus, the large majority (94.9 percent) of people aged 12 or older who needed substance use treatment but did not receive specialty treatment did not think they needed treatment in the past 12 months for their substance use. Among people aged 12 or older who needed treatment but did not receive specialty substance use treatment, the percentage in 2018 who perceived they needed treatment was similar to the percentages in 2015 to 2017."

The NSDUH report for 2018 further explored reasons for not receiving specialty substance use treatment. "NSDUH respondents who did not receive substance use treatment in the past 12 months but felt they needed treatment were asked to report the reasons for not receiving treatment. As noted in the previous section, 94.9 percent of people aged 12 or older in 2018 who were classified as needing substance use treatment (i.e., either had an SUD or received specialty substance use treatment) but who did not receive specialty substance use treatment did not think they needed treatment."

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

- Not being ready to stop using (38.4 percent)
- Having no health care coverage and not being able to afford the cost of treatment (32.5 percent)
- Did not know where to go to get treatment (21.1 percent)
- Felt that getting treatment would have a negative effect on their job (16.0 percent). Roughly 14.9 percent of these people also felt getting treatment would cause neighbors or community to have a negative opinion of them *

The report expanded on these numbers as:

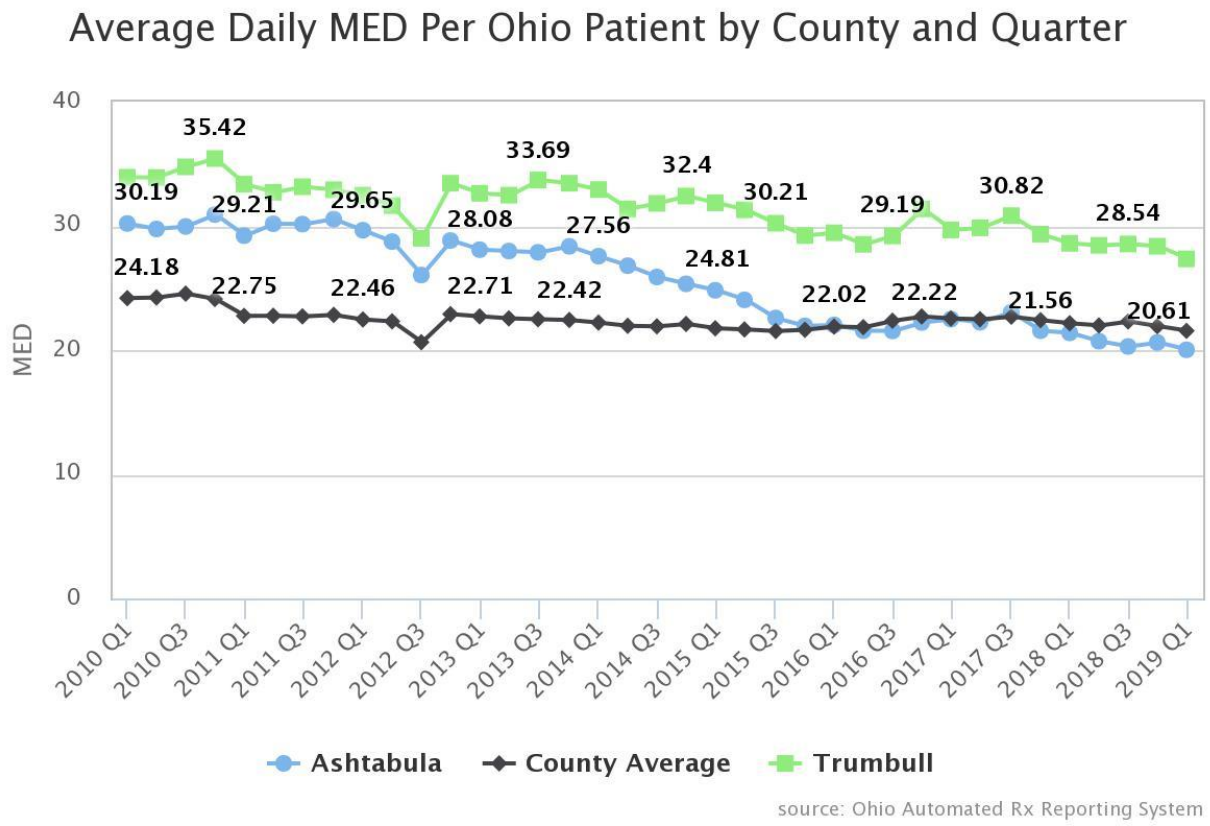
- Roughly 2 in 5 people who needed and perceived a need for treatment but did not receive substance use treatment at a specialty facility were not ready to stop using
- About 1 in 3 had no health care coverage and were not able to afford the cost
- About 1 in 5 people did not know where to go for treatment

Also noted in the report was the percentages did not significantly change between 2015 and 2018.

The information presented in the 2018 NSDUH report is important for identifying and addressing barriers to treatment. It verified comments made during the focus groups and key informant interviews conducted by Glenbeigh. The NSDUH report provides insight into the information presented in the 2019 Ashtabula County CHNA as well as other county CHNA reports related to reasons for not receiving specialty substance use treatment.

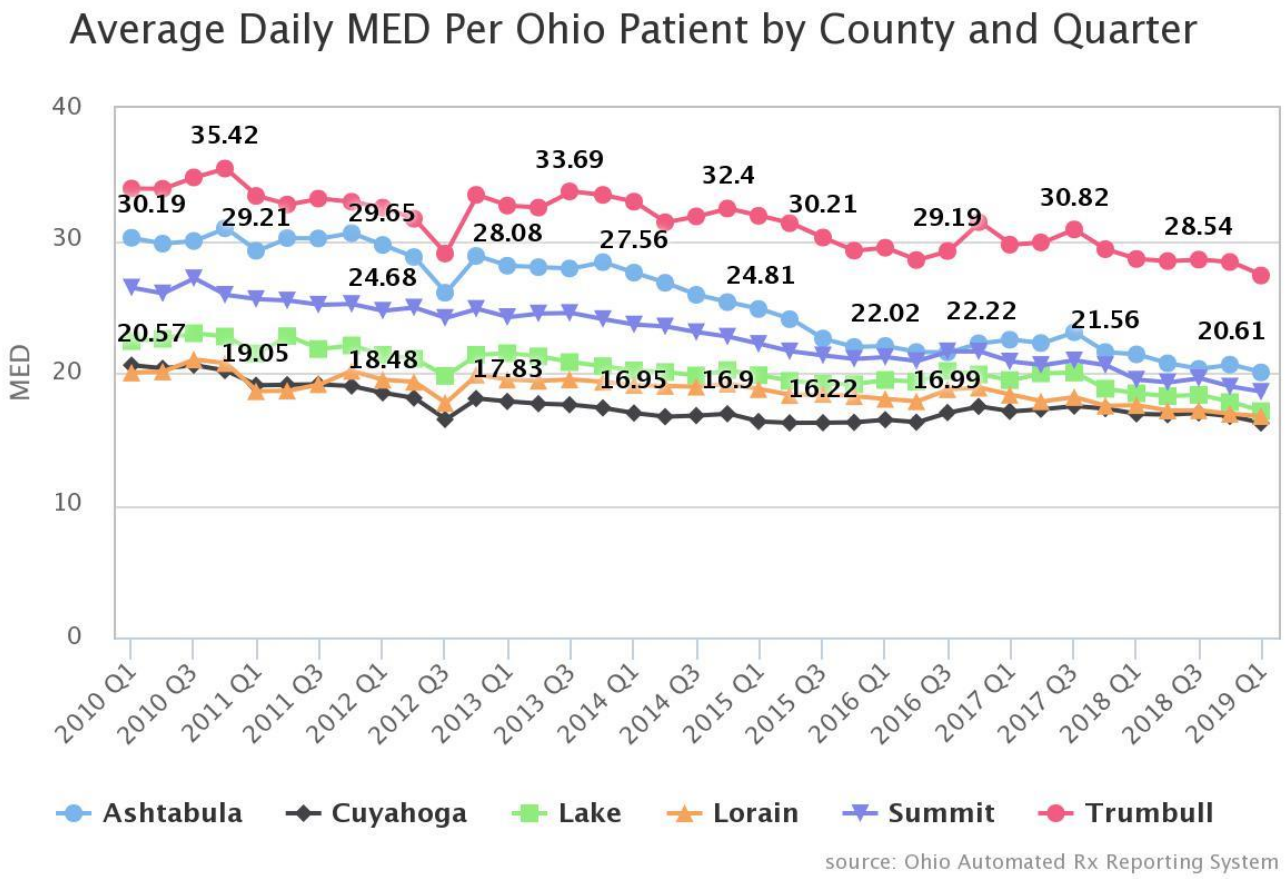
* Total percentage exceeds 100%.

Regional Drug Use



Ohio's Automated Rx Reporting System shows significant amounts of Morphine Equivalent Doses, including Suboxone®, for Trumbull County (green). Ashtabula County (blue) totals dipped below the county average during the 4th quarter of 2017 and have slowly decreased since. As of the end of Quarter 1, 2019, the Average Daily MED for Ashtabula County was at 20.02.

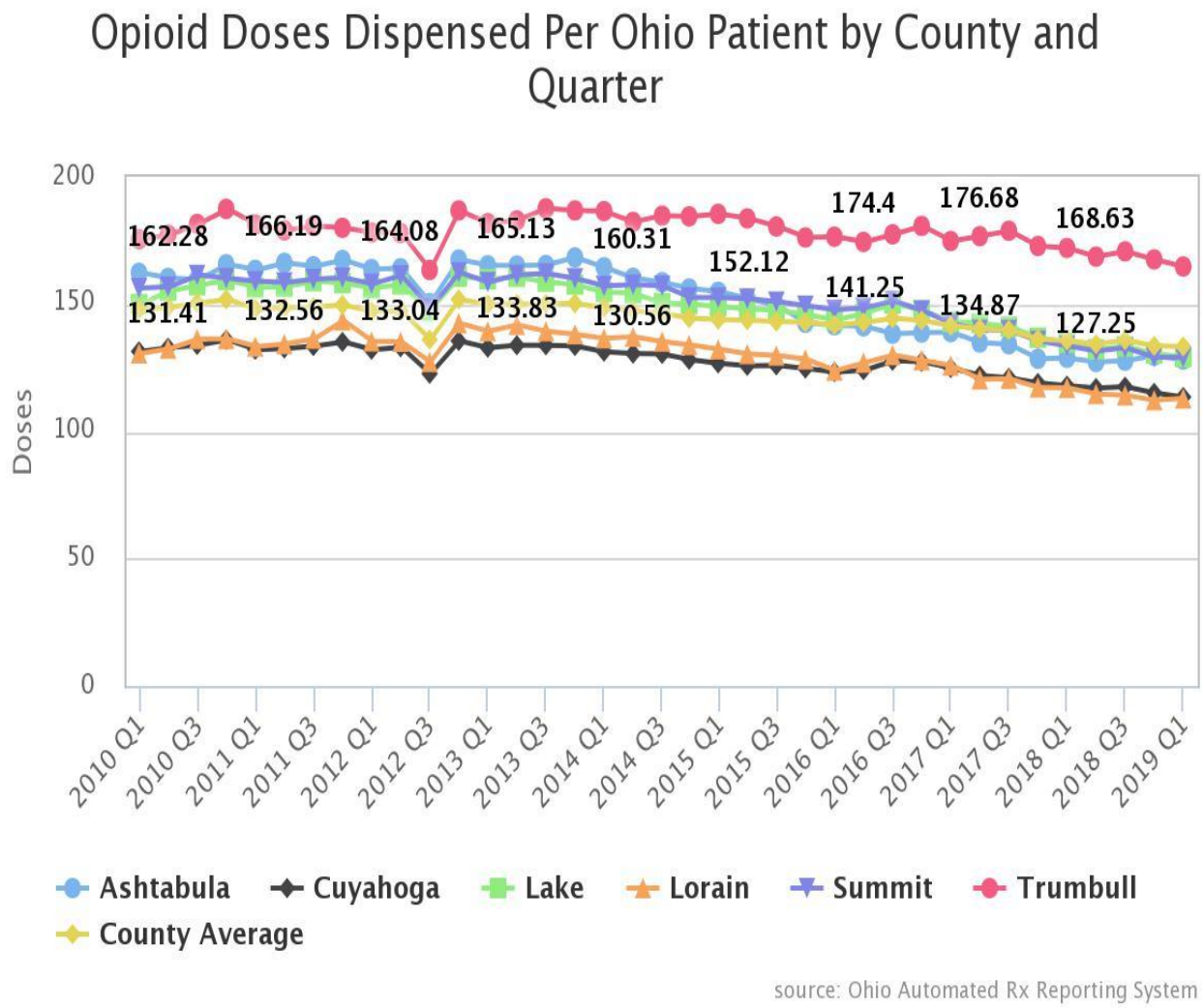
Source: Ohio Automated Rx Reporting System at https://www.ohiopmp.gov/County.aspx



Data from the Ohio Automated Prescription Reporting System (OARRS) shows the average daily morphine equivalent dose (MED), including Suboxone® as an opioid, for Glenbeigh's Ohio designated counties. Trumbull, Ashtabula and Summit counties continue to show significant amounts of usage above the other counties in Glenbeigh's designated service area.

Source: Ohio Automated Rx Reporting System at https://www.ohiopmp.gov/County.aspx

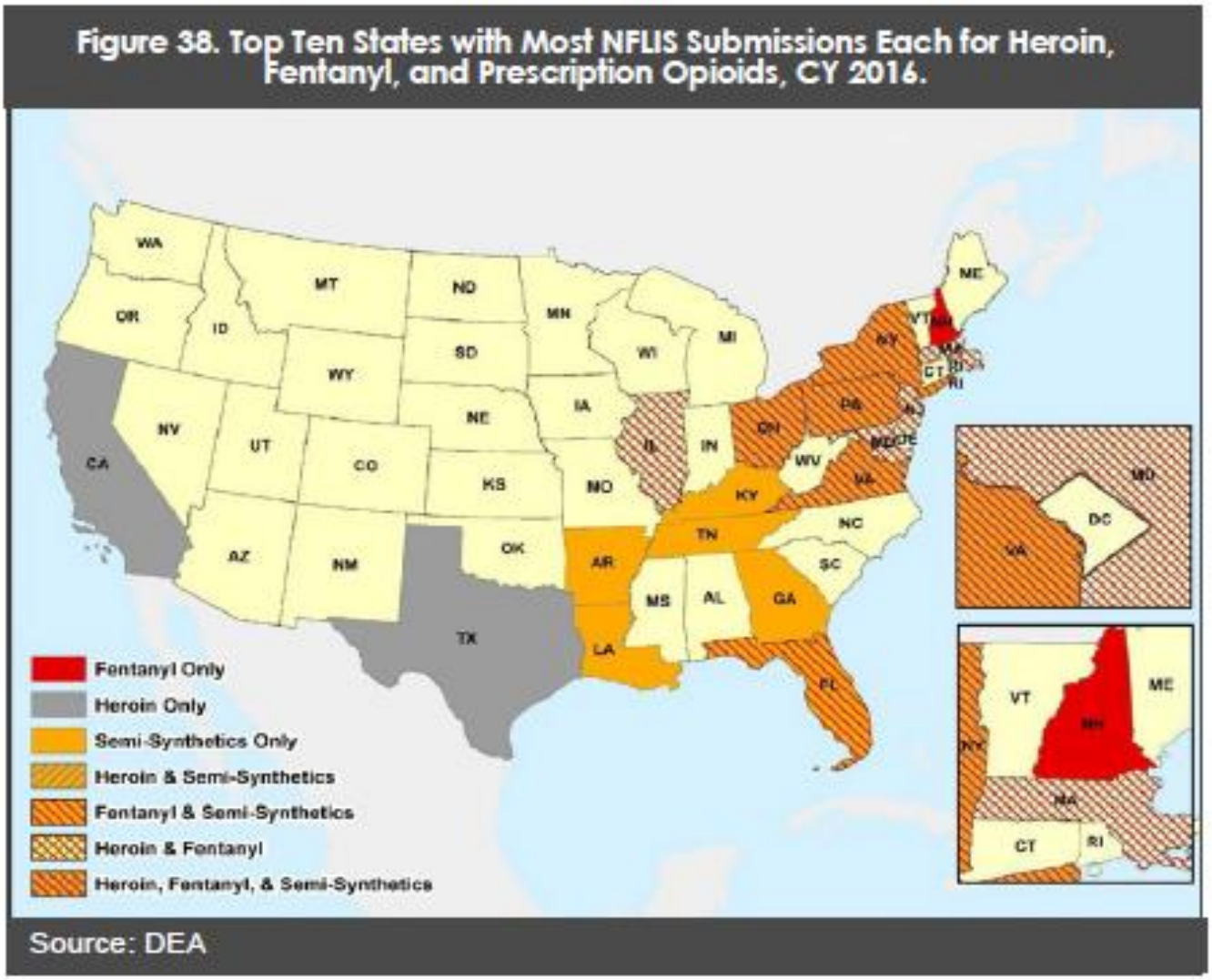
OARRS also shows the average amount of opioid doses dispensed in Ashtabula, Lake, Trumbull and Summit counties typically exceeded the county average. Trumbull County continues to exceed the county average well into 2019.



- Overall county average dosages reported during the first quarter of 2019 were at 133.34, down from a peak of 151.87 during the fourth quarter of 2012.
- Ashtabula County dosages peaked at 168.32 during the fourth quarter of 2013 dropping to 128.1 for the first quarter of 2019.
- Trumbull County dosages peaked at 185.41 during the first quarter of 2015 dropping to 164.75 for the first quarter of 2019.

Source: Ohio Automated Rx Reporting System at https://www.ohiopmp.gov/County.aspx

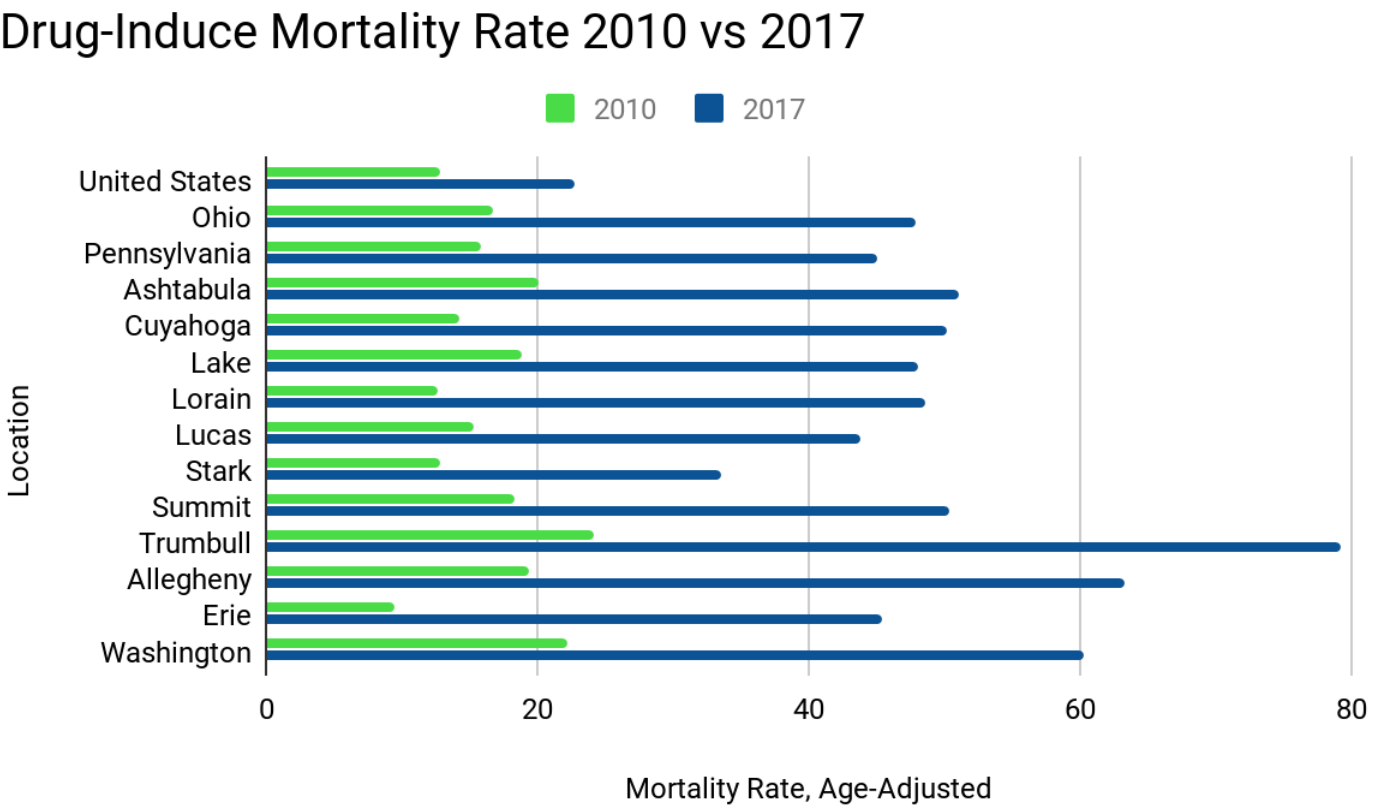
Fentanyl Top Ten Overdose by State

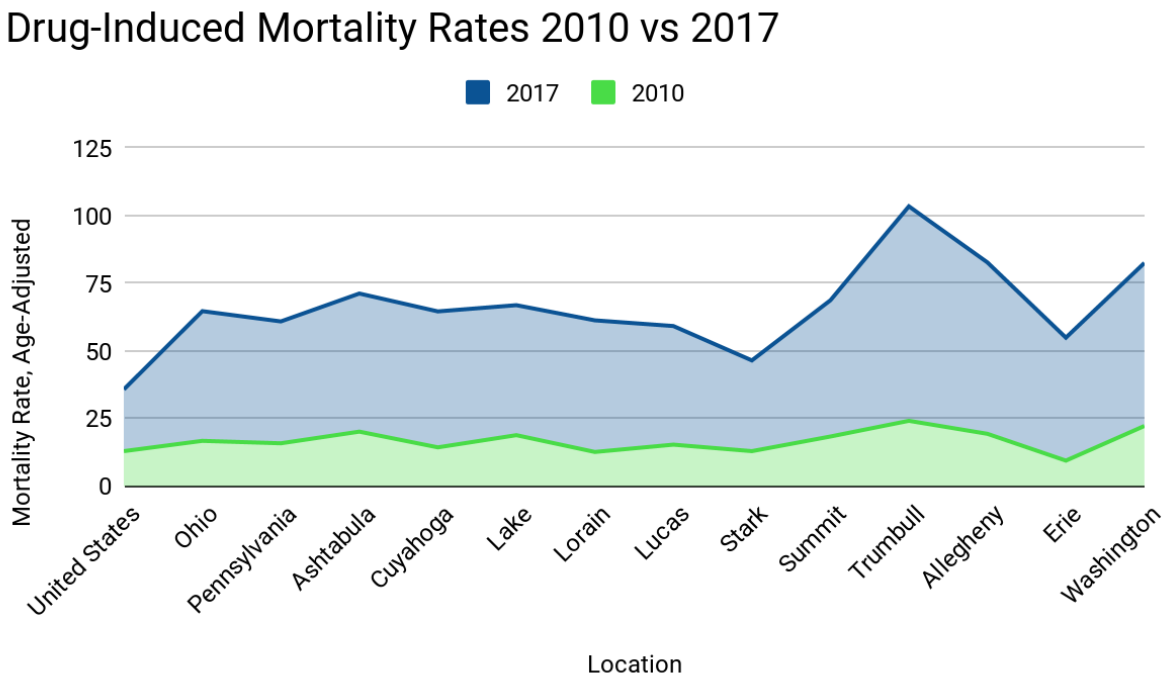


National Forensic Laboratory Information System (NFLIS) data shows fentanyl's top ten list for overdoses shares three states—Ohio, Connecticut, and Massachusetts— in common with heroin's top ten list for overdoses. The top ten lists reports among all three drugs (fentanyl, heroin, prescription opioids) shared three states: Ohio, Pennsylvania, and New York.

Source: 2018 National Drug Threat Assessment https://pfs.ohio.gov/Portals/0/assets/Webinars/2018-DEA-NDTA.pdf

Drug Use/Misuse for Designated Service Areas





Previous CHNA data demonstrated an increase in heroin and prescription opioid related mortality rates in Ohio as reported by the State Epidemiological Outcomes Workgroup (SEOW). Since the last CHNA was conducted in 2016, changes in Ohio laws have effectively decreased the availability of prescription opioids and subsequently, overdose deaths related to their abuse. SEOW reports that unadulterated heroin is increasingly difficult for individuals to obtain as fentanyl and fentanyl-analogs have entered the supply. This is supported by the data showing the rapidly emerging threat of fentanyl related deaths. According to SAMHSA (https://www.cdc.gov/drugoverdose/pdf/pubs/2018-cdc-drug-surveillance-report.pdf), in 2016, a total of 42,249 individuals died in the United States from drug overdoses involving opioids. The following tables and graphs show trends and changes in overdose deaths.

Unintentional Drug Overdose Deaths (Count)

County	2012	2013	2014	2015	2016
Ohio	1,914	2,110	2,531	3,050	4,050
Ashtabula	26	15	27	21	39
Cuyahoga	230	255	255	275	547
Lake	48	43	53	50	94
Lorain	70	69	71	63	146
Lucas	88	72	115	118	157
Stark	35	42	59	59	97
Summit	91	76	118	173	298
Trumbull	34	37	54	89	111

Source:
http://state.oh.networkofcare.org/indicator_maps/ohio/seow.aspx?domain=Other%20Drugs&indicator=Prescription%20Opioids-related%20Overdose%20Deaths%20(Rate%20per%20100K)

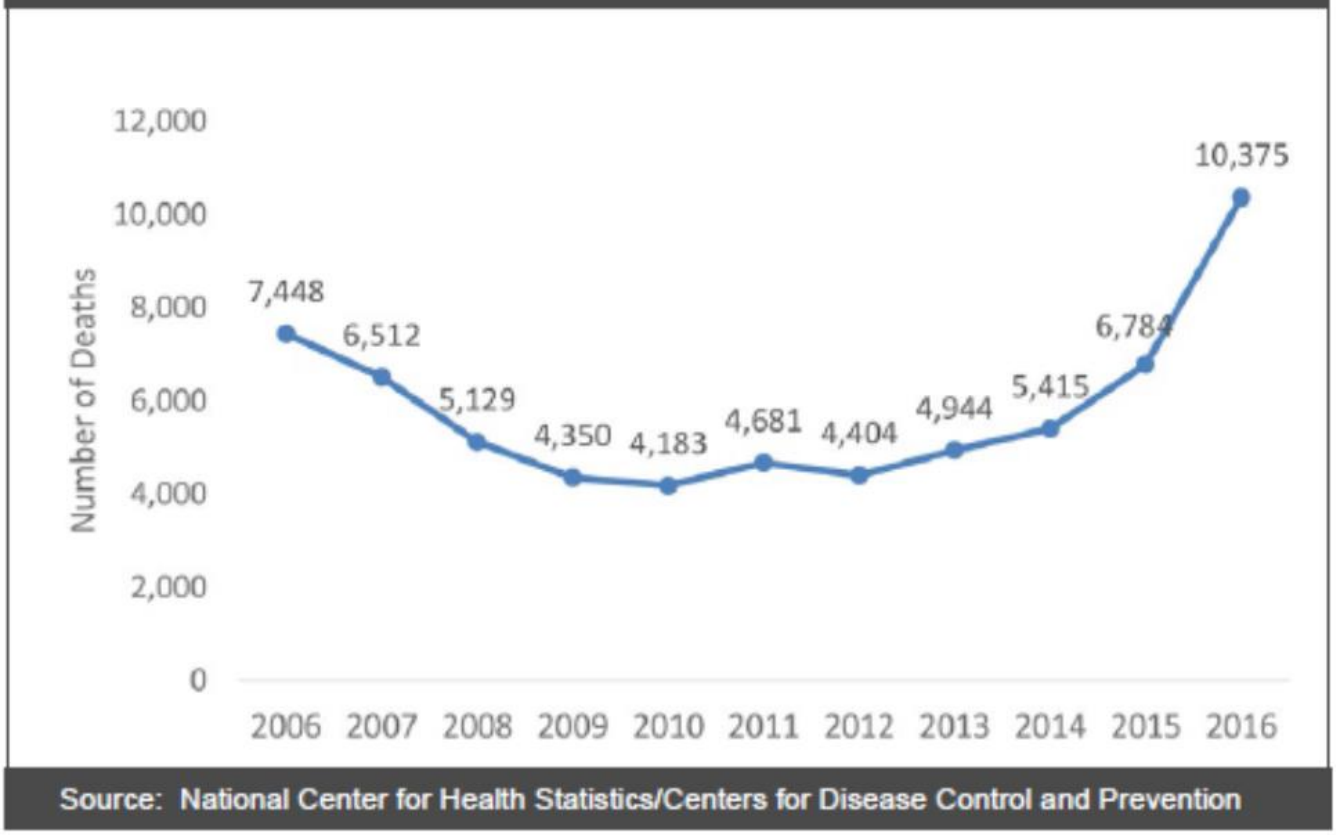
In the 2018 National Drug Threat Assessment published by the Drug Enforcement Agency (https://pfs.ohio.gov/Portals/0/assets/Webinars/2018-DEA-NDTA.pdf) Controlled Prescription Drugs (CPDs) are listed as being responsible for the most drug-involved overdose deaths and as the second most commonly abused substance in the United States. Furthermore, as CPD abuse increased, traffickers began disguising other opioids as CPDs in attempts to gain access to new users. Most individuals reporting misuse of prescription pain relievers cite physical pain as the most common reason for abuse and pain relievers are most frequently obtained from a friend or relative.

Figure A1. Top Ten States Impacted by Drug Overdose Deaths, 2016.			
Rank	State	Age-Adjusted Death Rate Per 100,000 Population	Number of Deaths
1	West Virginia	52	884
2	Ohio	39.1	4329
3	New Hampshire	39	481
4	Washington D.C.	38.8	269
5	Pennsylvania	37.9	4627
6	Kentucky	33.5	1,419
7	Maryland	33.2	2,044
8	Massachusetts	33	2227
9	Delaware	30.8	282
10	Rhode Island	22.2	326
Source: National Center for Health Statistics/Centers for Disease Control and Prevention			

Source: 2018 National Drug Threat Assessment at https://pfs.ohio.gov/Portals/0/assets/Webinars/2018-DEA-NDTA.pdf

Ohio and Pennsylvania remained in the top states with significant numbers of deaths resulting from drug overdoses. The Centers for Disease Control data for 2017 list West Virginia with the top national death rate at 57.8 followed by Ohio at 46.3 and Pennsylvania at 44.3.

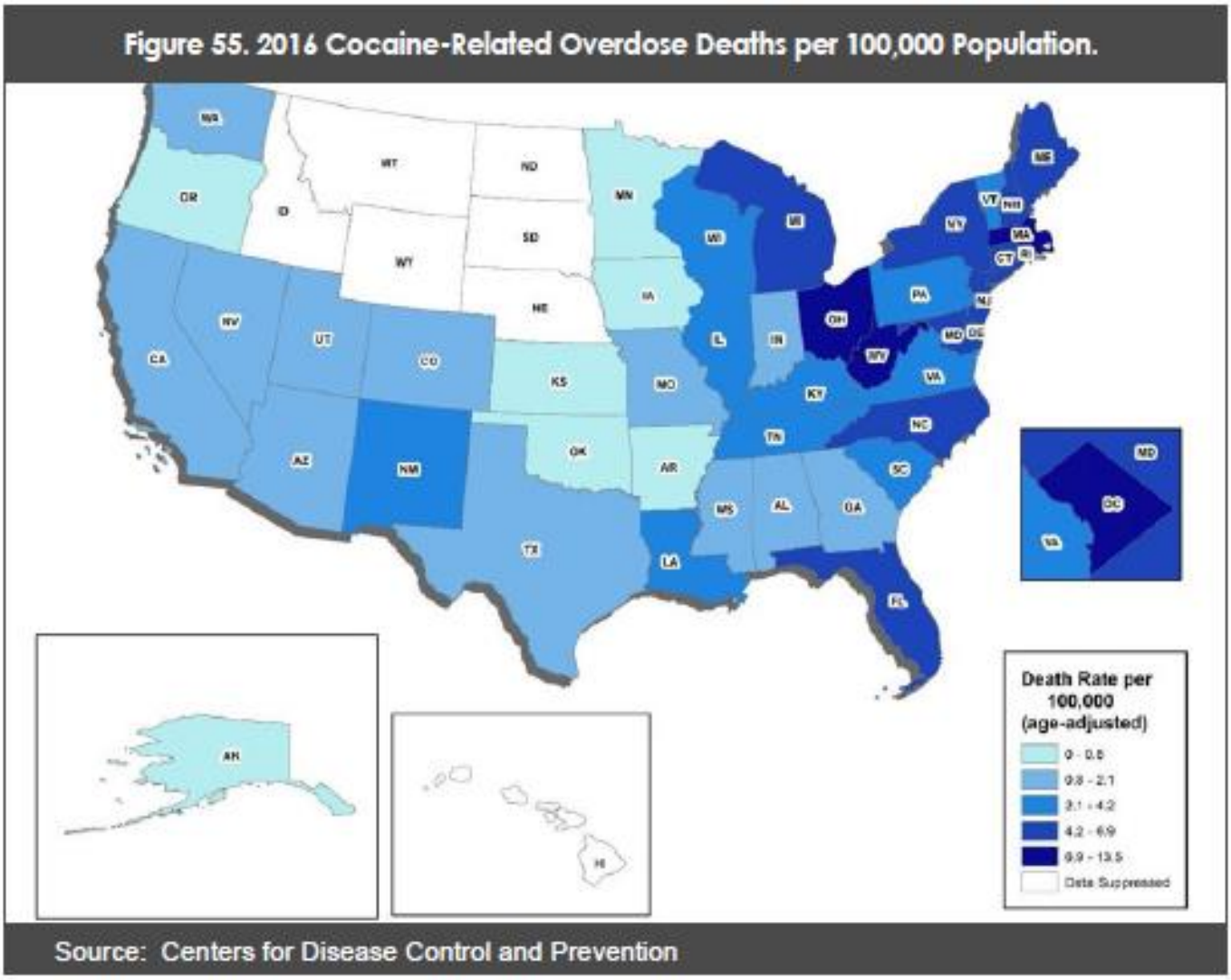
Figure 54. Drug Poisoning Deaths Involving Cocaine, 2006 – 2016.



Source: National Center for Health Statistics/Centers for Disease Control and Prevention

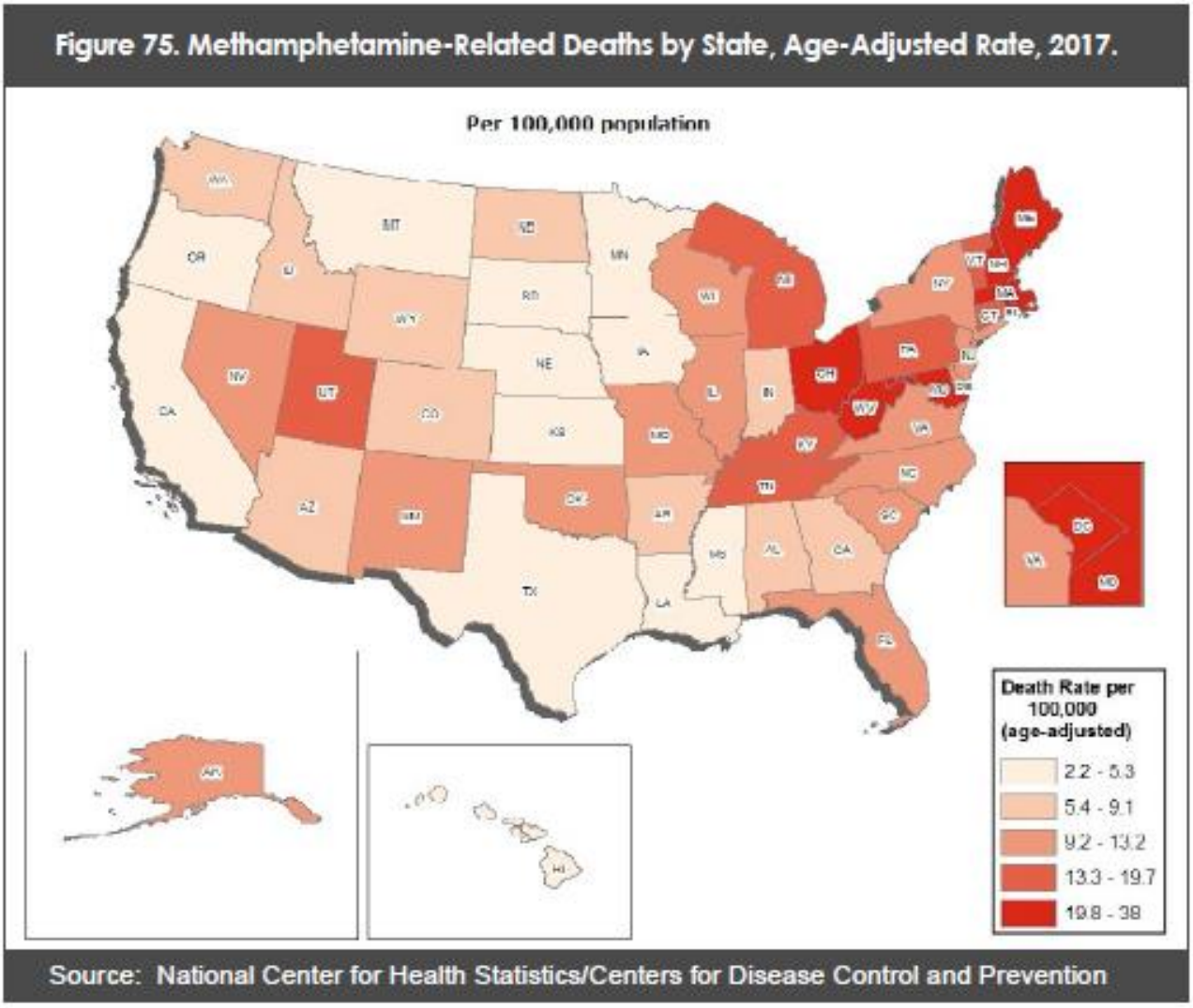
The DEA Threat Assessment indicated, "The CDC reported cocaine-involved drug poisoning deaths increased for the fourth straight year, with more cocaine deaths recorded in 2016 than any other year since at least 1999. Cocaine contributes to a significant number of drug poisoning deaths in the United States, with some regions of the United States seeing significant increases in cocaine-related deaths and other areas continuing to report low fatalities concurrent with lower levels of cocaine availability and use compared with other drugs. According to the CDC, there were 10,375 cocaine-involved deaths in the United States in 2016 (see Figure 54). This represents a 52.9 percent increase in cocaine-related overdose deaths from 2015 to 2016. Analysis of state-level 2016 drug overdose data reveals the greatest age adjusted drug overdose rates for cocaine deaths were in Washington DC, Rhode Island, Ohio, Massachusetts, and West Virginia."[8] See Figure 55 on next page.

[8] Source: 2018 National Drug Threat Assessment https://pfs.ohio.gov/Portals/0/assets/Webinars/2018-DEA-NDTA.pdf



Source: 2018 National Drug Threat Assessment https://pfs.ohio.gov/Portals/0/assets/Webinars/2018-DEA-NDTA.pdf

The Ohio Department of Health, Bureau of Vital Statistics, published a Rate of Unintentional Drug Overdose Deaths by Age, Ohio, 2012-2017, which indicated that the highest rates of unintentional overdose deaths were observed among 35-44 year olds followed by 25-34 year olds. The report also indicated that rates among all age groups had increased however males had consistently higher overdose death rates than females. The rate for males increased 169% compared to 138% among females between 2012 and 2017.



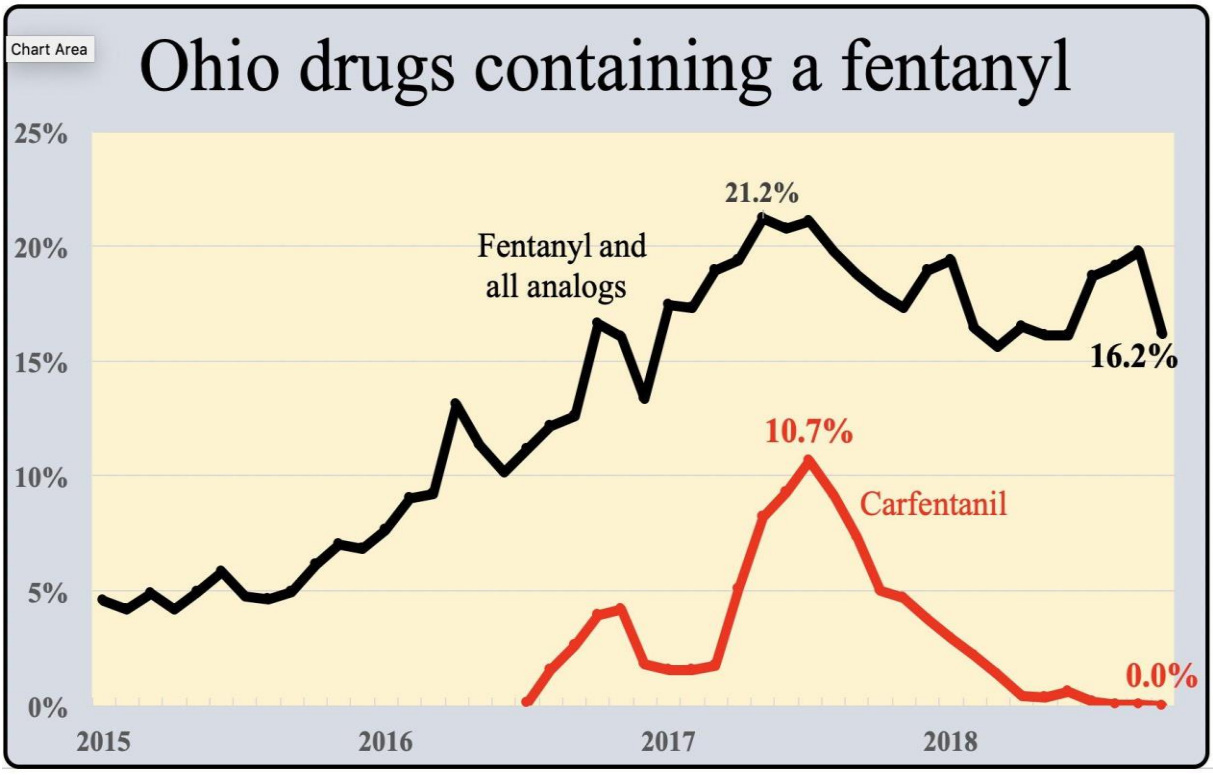
Source: 2018 National Drug Threat Assessment https://pfs.ohio.gov/Portals/0/assets/Webinars/2018-DEA-NDTA.pdf

The DEA Threat Assessment states, "The price of methamphetamine has continued to decline possibly due to an oversupply of methamphetamine in the U.S. market; however, as Mexican TCOs continue to explore new markets in an attempt to increase the methamphetamine customer base, the price may begin to rebound."[9]

[9] Source: 2018 National Drug Threat Assessment https://pfs.ohio.gov/Portals/0/assets/Webinars/2018-DEA-NDTA.pdf

Harm Reduction Ohio reports on the composition of drugs that are seized by law enforcement and sent to the crime lab. From this data, it can be concluded that a major contributing factor to the increased death rate was the presence of fentanyl analogs, particularly carfentanil, in the Ohio drug supply. Carfentanil and other fentanyl analogs have been found in heroin, cocaine, and methamphetamine, causing a surge in unintentional overdose deaths even when usage rates stayed level. The presence of fentanyl in other non-opioids such as cocaine and methamphetamine as confirmed by crime labs prompted the Ohio Department of Health to update recommendations for the use of Naloxone for all drug overdoses, even those suspected to be the result of non-opioid substances.

The National Institute on Drug Abuse states that in 2017, synthetic opioids, including fentanyl, became the most common drugs involved in drug overdose deaths in the United States. In 2017, 59.8 percent of opioid-related deaths involved fentanyl compared to 14.3 percent in 2010. Drug dealers began mixing fentanyl with other drugs, such as heroin, cocaine, methamphetamine, and MDMA to produce a high with very little fentanyl, making it a cheaper option.



Source: Harm Reduction Ohio

Note: News sources began reporting a resurgence of Carfentanil in Ohio in February, 2019.

Law Enforcement

Drug arrest rates can provide insight into the supply of substances available and their composition. Drug arrests rates have increased in all Ohio counties in Glenbeigh's defined service area.

Ohio Drug Arrest Rates 2017-2018

	Drug Arrests per 100,000 2017	Drug Arrests per 100,000 2018	% Change 2017-2018
Ashtabula	165.9	302.6	↑45.2%
Cuyahoga	61.4	85.1	↑27.9%
Lake	94.9	112.1	↑15.3%
Lorain	176.9	187.1	↑5.4%
Summit	70.3	144.3	↑51.3%
Trumbull	174.4	212.6	↑18%

Source: Ohio State Highway Patrol Drug Arrests 2018. Retrieved from: https://www.statepatrol.ohio.gov/statistics/default.asp*Comparable data not available for Pennsylvania

Drug arrests also provide valuable information as seized substances are tested at a forensic crime lab. One such example is the release of a public health warning by the medical examiner of Cuyahoga County after crime lab testing revealed a re-emergence of deadly Carfentanil in a seized supply coupled with a sharp and unexpected increase of overdose deaths in the month of January 2019 (Harris, 2019).[10]

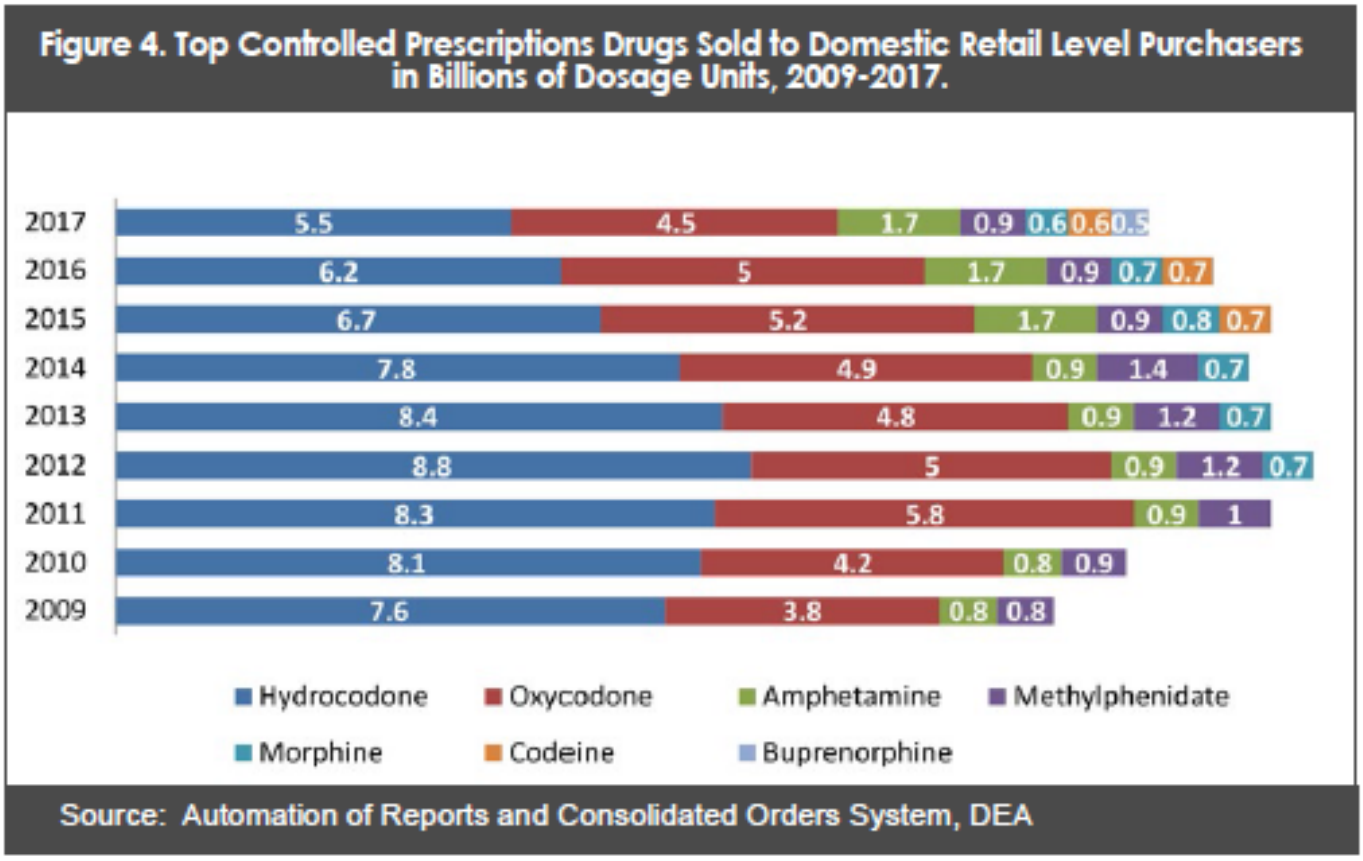
The most recent trends reported by the State Epidemiological Outcomes Workgroup (SEOW) for the time period of June 2017-January 2018 revealed a leveling off or decrease in opioid demand with an increase in cocaine and methamphetamine demand. Focus group participants reported that individuals who use opiates have a heightened awareness of the potential for overdose death and are therefore switching to other substances to provide similar effects, coupling opiates with stimulants in an effort to counter the sedative effect of opiates, or using substances such as kratom, Suboxone®, and prescription gabapentin in an effort to wean off opiates and avoid symptoms of withdrawal. Forensic labs in Ohio report fentanyl analogs detected in seized samples of cocaine and methamphetamine. Regardless of the substance, overdose deaths remain a threat.

[10] Harris, Christopher. (Jan 2019). Medical Examiner Issues Public Health Warning: Increase in Carfentanil Seized in January. Retrieved from: http://executive.cuyahogacounty.us/en-US/ME-IssuesPubicHealthWarning.aspx

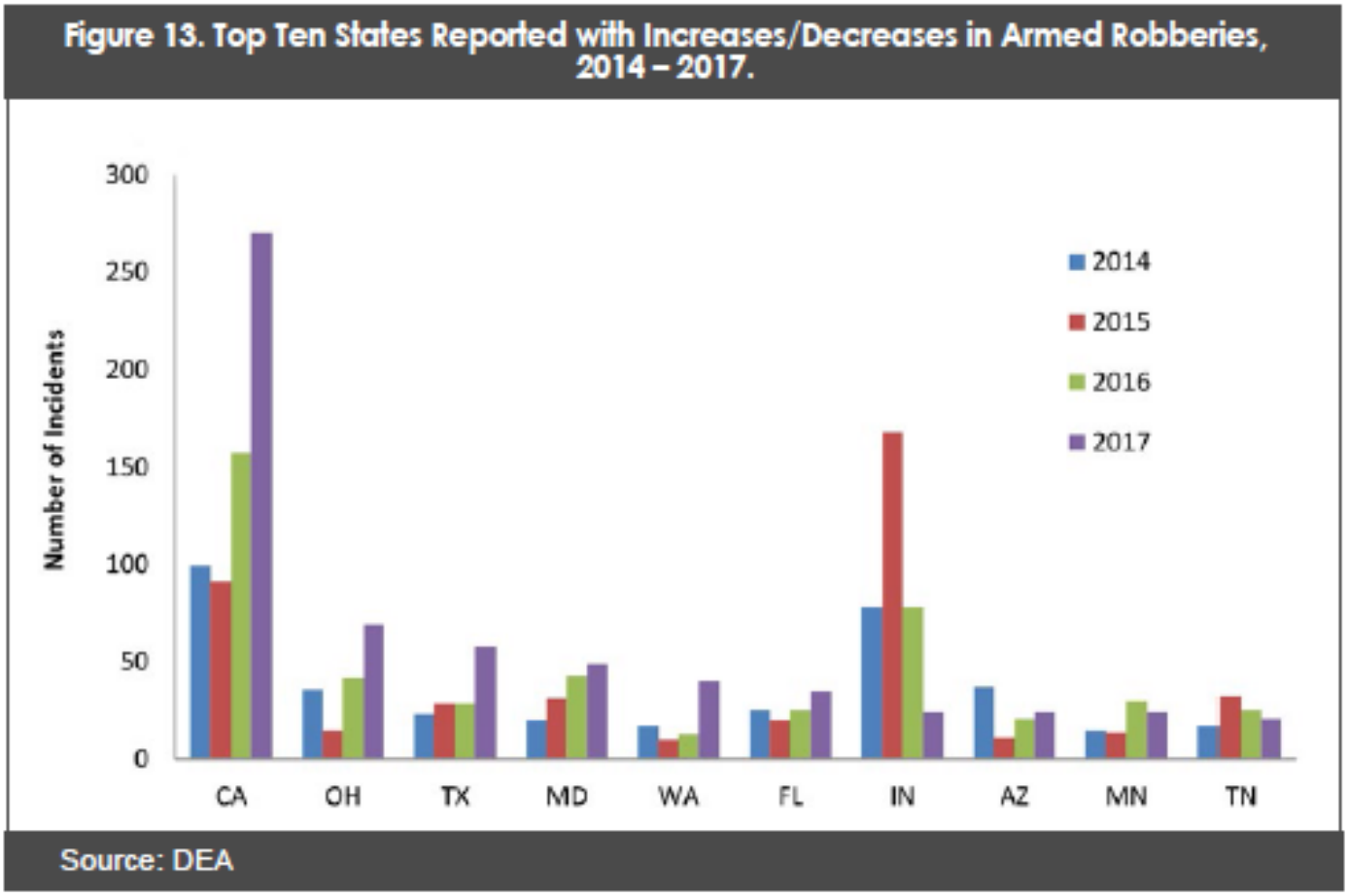
The Drug Enforcement Agency reports illicit fentanyl and other synthetic opioids — primarily sourced from China and Mexico—are now the most lethal category of opioids used in the United States. Traffickers are increasingly selling unadulterated fentanyl in the form of counterfeit prescription pills. The expectation is that fentanyl suppliers will continue to experiment with new fentanyl-related substances and adjust supplies in attempts to circumvent new regulations imposed by the United States, China, and Mexico. Source: https://pfs.ohio.gov/Portals/0/assets/Webinars/2018-DEA-NDTA.pdf

Additional threats identified in the 2018 DEA report include cocaine, whose use and availability in the United States has rebounded, and methamphetamine, which remains prevalent and widely available. Cocaine-involved overdose deaths have exceeded 2007 benchmark levels. Simultaneously, the increasing presence of fentanyl in the cocaine supply has been exacerbating the re-merging cocaine threat.

The number of new psychoactive substances NPS continues to increase worldwide, but remains a limited threat in the United States compared to other widely available illicit drugs. The availability and popularity of synthetic drugs change every year, as traffickers experiment with new and unregulated substances.



Source: 2018 National Drug Threat Assessment https://pfs.ohio.gov/Portals/0/assets/Webinars/2018-DEA-NDTA.pdf



Source: 2018 National Drug Threat Assessment https://pfs.ohio.gov/Portals/0/assets/Webinars/2018-DEA-NDTA.pdf

Historically, there has been a close relationship between drug abuse/addiction and crime. Drug abusers commit crimes to pay for drugs and activities relative to illicit drug use are illegal. The DEA report shows a consistent increase in armed robberies occurring in Ohio during the timeframe that corresponds to the rise of the opioid epidemic in the state.

Pennsylvania's Prescription Drug Monitoring Program (PA PDMP online at https://www.health.pa.gov/topics/programs/PDMP/Pages/PDMP.aspx) reiterates the connection between opioid use and an individual's involvement in the criminal justice system. The increase in opioid use impacts the entire criminal justice system from courts to incarceration to probation to recidivism rates.

The Ohio State Highway Patrol made 16,956 total drug arrests in 2018 – a 2% increase from 2017 and a 20% rise over the previous 3-year average (2015-2017). Total drug arrests in 2018 were 76% higher than in 2013.

Figure 35. Top Ten States by Age-Adjusted Rate of Drug-Involved Overdose Deaths Each for Heroin, Fentanyl, and Semi-Synthetic Prescription Pain Medications, CY 2016.					
Heroin		Fentanyl		Semi-Synthetic Prescription Pain Medication	
States	Death Rate	States	Death Rate	States	Death Rate
District of Columbia	17.3	New Hampshire	30.3	West Virginia	18.5
West Virginia	14.9	West Virginia	26.3	Utah	11.5
Ohio	13.5	Massachusetts	23.5	Maine	10.8
Connecticut	13.1	Ohio	21.1	Maryland	10.7
Maryland	10.7	District of Columbia	19.2	Tennessee	10.2
New Jersey	9.7	Maryland	17.8	Kentucky	9.3
Massachusetts	9.5	Rhode Island	17.8	Rhode Island	8.1
Vermont	8.7	Maine	17.3	Nevada	7.6
Illinois	8.2	Connecticut	14.8	New Mexico	7.5
New Mexico	8.2	Kentucky	11.5	District of Columbia	7.4
Source: DEA and Centers for Disease Control and Prevention					

The DEA report stated, "Fentanyl will continue to be a serious threat to the United States while the current illicit production continues and fentanyl availability remains prevalent. Fentanyl's lethality will continue to pose challenges and risks to law enforcement and first responders as well as contribute to increasing numbers of overdose deaths. Moreover, new regulations imposed by the United States, China, and Mexico may decrease fentanyl availability and trafficking in the short term but are unlikely to affect long term change, as traffickers will continue to experiment with new FRS and adjust supplies accordingly. Drug traffickers will continue to be drawn to fentanyl because of the high profits associated with its distribution. Additionally, the use of both the open and dark web to obscure transactions and to distribute fentanyl directly to both users and independent drug trafficking organizations presents challenges for law enforcement and policy makers working to restrict the flow of fentanyl to the United States."

Source: 2018 National Drug Threat Assessment https://pfs.ohio.gov/Portals/0/assets/Webinars/2018-DEA-NDTA.pdf

Demographics - Availability of Substances by Region

The Ohio Substance Abuse Monitoring Network (OSAM) collects data from participants on the availability of substances in various regions of Ohio and their own personal substance use. This information is valuable for tracking trends and is displayed below.

	Akron-Canton		Cleveland		Youngstown	
Substance	**Current Availability**	**Availability Change**	**Current Availability**	**Availability Change**	**Current Availability**	**Availability Change**
Powdered Cocaine	High	No Change	Moderate to High	No Change	High	Increase
Crack Cocaine	High	No Change	High	No Change	High	No Change
Heroin	High	No Change	High	Decrease	High	No Change
Fentanyl*	High	Increase	High	Increase	High	Increase
Prescription Opioids	Moderate	Decrease	Moderate	Decrease	Moderate	No Consensus
Suboxone	High	No Consensus	High	No Consensus	Moderate to High	No Consensus
Sedative-Hypnotics	High	No Consensus	High	No Change	Moderate	No Change
Marijuana	High	Increase	High	No Change	High	Increase
Methamphetamine	High	Increase	High	Increase	High	Increase
Prescription Stimulants	Moderate to High	No Consensus	Moderate to High	No Change	Low to Moderate	No Change
Ecstasy/Molly	Moderate	No Consensus	Moderate to High	No Change	No Consensus	No Consensus

Source: Ohio Substance Abuse Monitoring Network. (Jan 2018). Surveillance of Drug Abuse Trends in the State of Ohio: June 2017-January 2018. Retrieved from: https://mha.ohio.gov/Portals/0/assets/Research/OSAM-TRI/Jan2018/Executive_Summary_January_%202018_FINAL.pdf

Demographics – OSAM Participants

Indicator	Akron-Canton Region		Cleveland Region		Youngstown Region	
	Total	OSAM Drug Consumers	Total	OSAM Drug Consumers	Total	OSAM Drug Consumers
Total Population	1,195,922	45	2,269,670	41	700,453	43
Gender (% Female)	51.3%	55.6%	51.6%	27.5%	50.7%	53.5%
White	85.4%	93%	76.8%	68.3%	88%	81.4%
African American	9.9%	4.7%	18.7%	26.8%	9.1%	4.7%
Hispanic or Latino	2.0%	6.7%	5.2%	0%	3.3%	4.7%
High School Grad Rate	90.4%	86.3%	88.7%	84.6%	88.7%	86%
Median Household Income	$49,767	$12,000-$15,999	$56,960	$20,000-$24,999	$42,911	$16,000-$19,999
Persons Below Poverty Level	13.4%	65.9%	14.5%	42.1%	17.9%	55%

Source: Ohio Substance Abuse Monitoring Network. (Jan 2018). Surveillance of Drug Abuse Trends in the State of Ohio: June 2017-January 2018. Retrieved from: https://mha.ohio.gov/Portals/0/assets/Research/OSAM-TRI/Jan2018/Executive_Summary_January_%202018_FINAL.pdf

Demographics – OSAM Participants

OSAM Drug Consumer Characteristics	Akron-Canton (N=45)	Cleveland (N=41)	Youngstown (N=43)
Gender			
Male	44.4%	70.8%	46.5%
Female	55.6%	26.8%	53.5%
Age			
<20	2.2%	0	0
20s	37.8%	24.4%	41.9%
30s	22.2%	24.4%	32.6%
40s	24.4%	17.1%	16.3%
50s	13.3%	22.0%	9.8%
60s	0	7.3%	0
Education			
Less than High School Graduate	13.3%	14.6%	14.6%
High School Graduate	53.3%	51.2%	53.5%
Some College or Associate's	26.7%	22.0%	20.9%
Degree	2.2%	7.3%	12.2%
Bachelor's Degree or Higher			
Household Income			
<$12,000	44.4%	31.7%	27.9%
$12,000 - $19,999	15.6%	12.2%	23.3%
$20,000 - $28,999	6.7%	17.1%	20.9%
$29,000 - $36,999	1.1%	4.9%	4.7%
>$37,000	15.6%	29.2%	18.6%
Drugs Used			
Alcohol	48.9%	58.5%	39.5%
Cocaine, Crack	35.6%	46.3%	48.8%
Cocaine, Powdered	28.9%	17.1%	30.2%
Ecstasy/Molly	2.2%	2.4%	7.0%
Heroin/Fentanyl	37.8%	22.0%	37.2%
Marijuana	46.7%	41.5%	41.9%
Methamphetamine	51.1%	12.2%	18.6%
Prescription Opioids	33.3%	12.2%	34.9%
Prescription Stimulants	17.8%	7.3%	16.3%
Sedative-Hypnotics	37.8%	14.6%	25.6%
Suboxone/Subutex	26.7%	0	37.2%
Other Drugs	6.7%	12.2%	4.7%

Source: https://mha.ohio.gov/Portals/0/assets/Research/OSAM-TRI/Jan2018/Executive_Summary_January_%202018_FINAL.pdf

Demographics - Regional Characteristics - Pennsylvania

According to the Pennsylvania Department of Health, the prescription opioid and heroin overdose epidemic is the worst public health crisis to affect the state.

Opioid drug addiction impacted the economic standing and health of residents in urban, suburban and rural areas. The Pennsylvania Department of Health reported, "The economic cost of the opioid crisis stretches far beyond the person suffering from this disease. Business owners and industries are impacted through loss of life, time away from work to get healthy and lack of workforce because of a criminal history related to an opioid use disorder. As thousands die each year because of this disease, the economic impacts will continue to be far reaching."[11]

Furthermore, the state recognized the long-term crises that will arise from future opioid-related diseases. "This includes future costs for long-term care of infants with neonatal abstinence syndrome; impacts of hepatitis C and HIV treatment on Medicaid; funding for long-term recovery supports of those living in recovery; and access to treatment for those with a co-occurring mental health disorder."[11]

Pennsylvania's Department of Health believes the opioid epidemic will have significant lifelong impacts and consequences on children and families.

In an effort to decrease the availability of opioids, Pennsylvania's Prescription Drug Monitoring Program (PA PDMP) was created to collect information, similar to Ohio's OARRS, on all prescriptions for controlled substances. The information is available to health care professionals as a means of reducing overprescribing.

Also, in collaboration with the Department of Drug and Alcohol Programs and the University of Pittsburgh's Program Evaluation and Research Unit (PERU), PA PDMP developed continuing educational curriculum for prescribers that provides training on best practices for using the PDMP system and on how to address substance use disorder with patients.

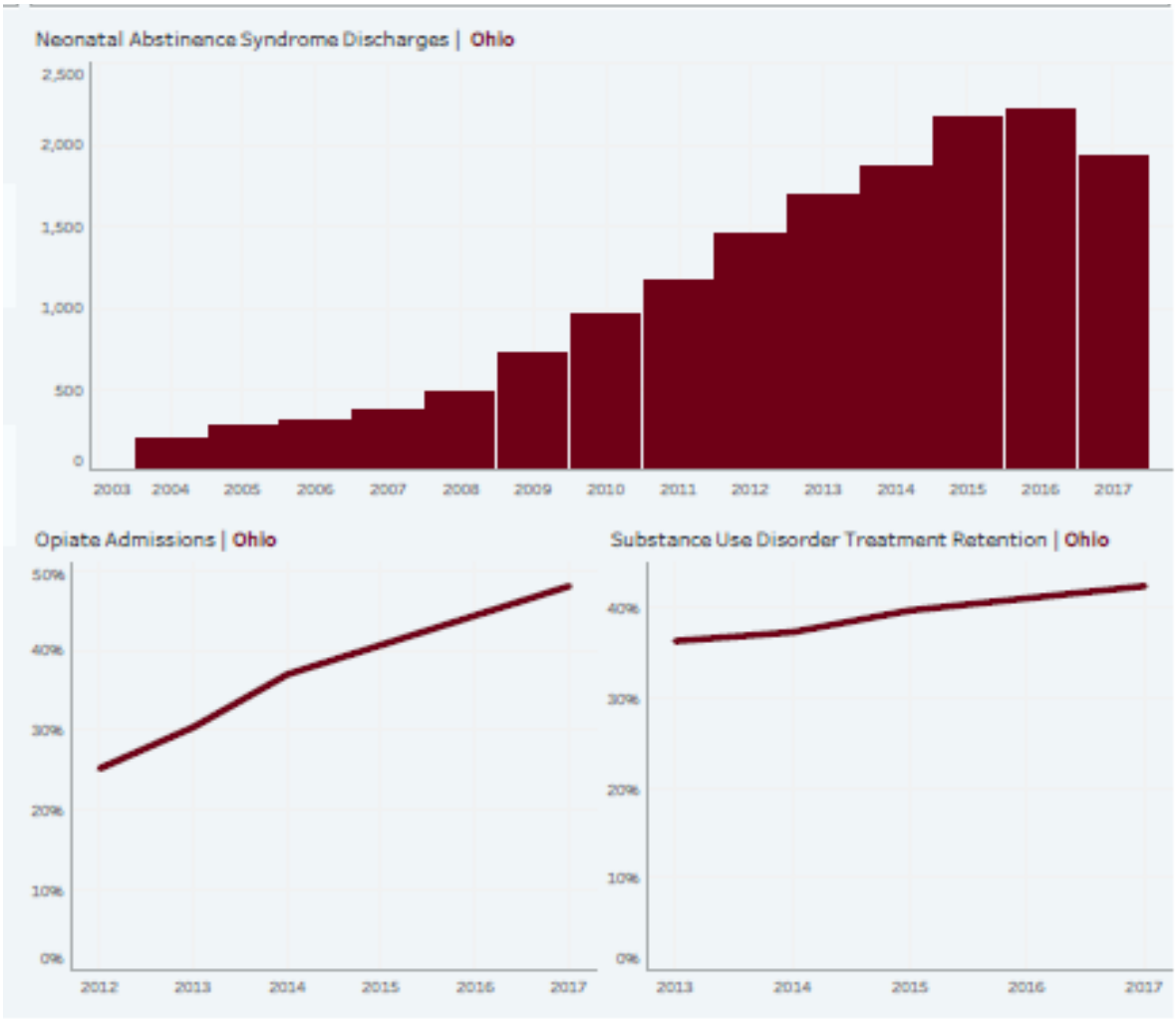
The Pennsylvania Medical Society, the Hospital and Health System Association, the Pharmacists Association and the other specialty societies concurrently developed an easily accessed online continuing education series.[12]

[11] Source: Pennsylvania Department of Health at https://www.health.pa.gov/topics/disease/Opioids/Pages/Opioids.aspx

[12] Source: Pennsylvania Department of Health https://data.pa.gov/

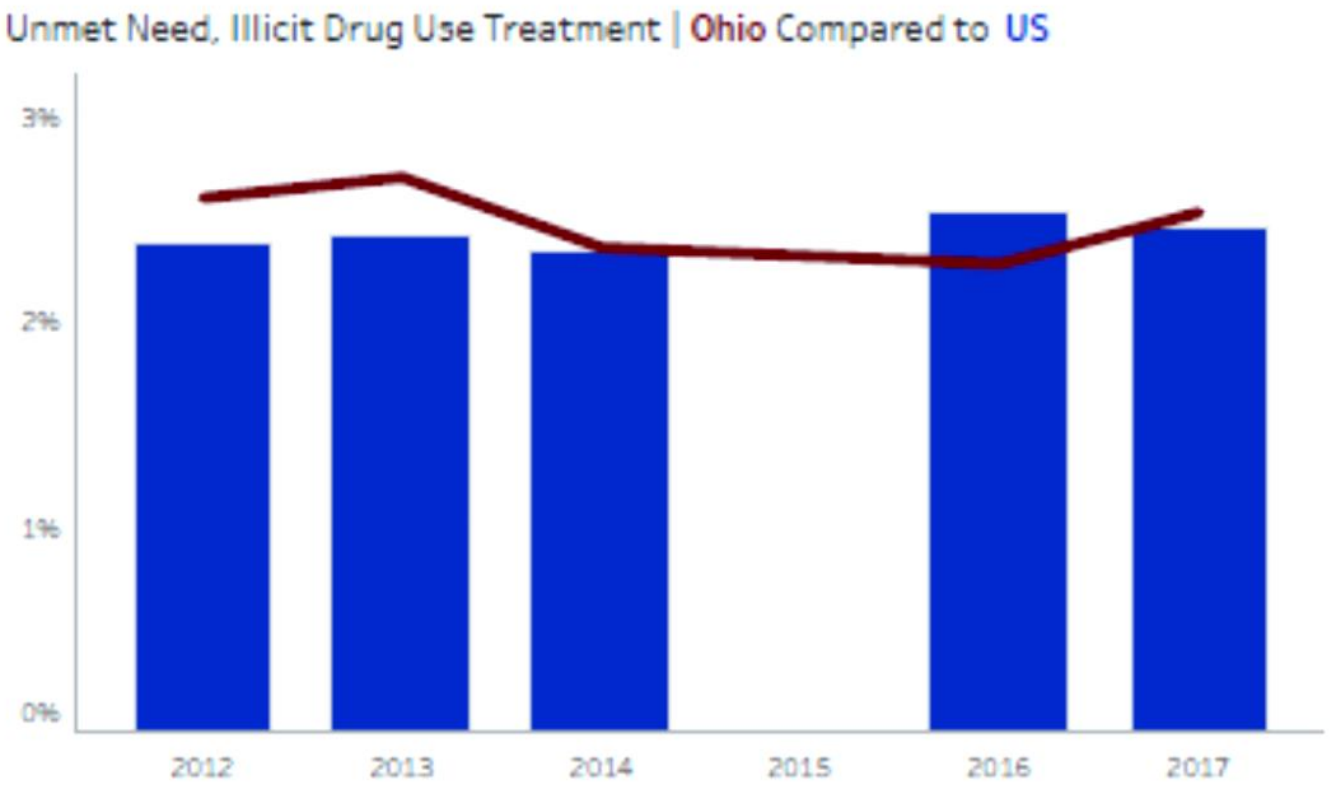
Treatment

2017 data reports an Opiate Admission Rate of 48.1%. This reflects the percentage of clients in treatment with a primary diagnosis of opiate abuse or dependence (heroin/prescription opioid) in Ohio.

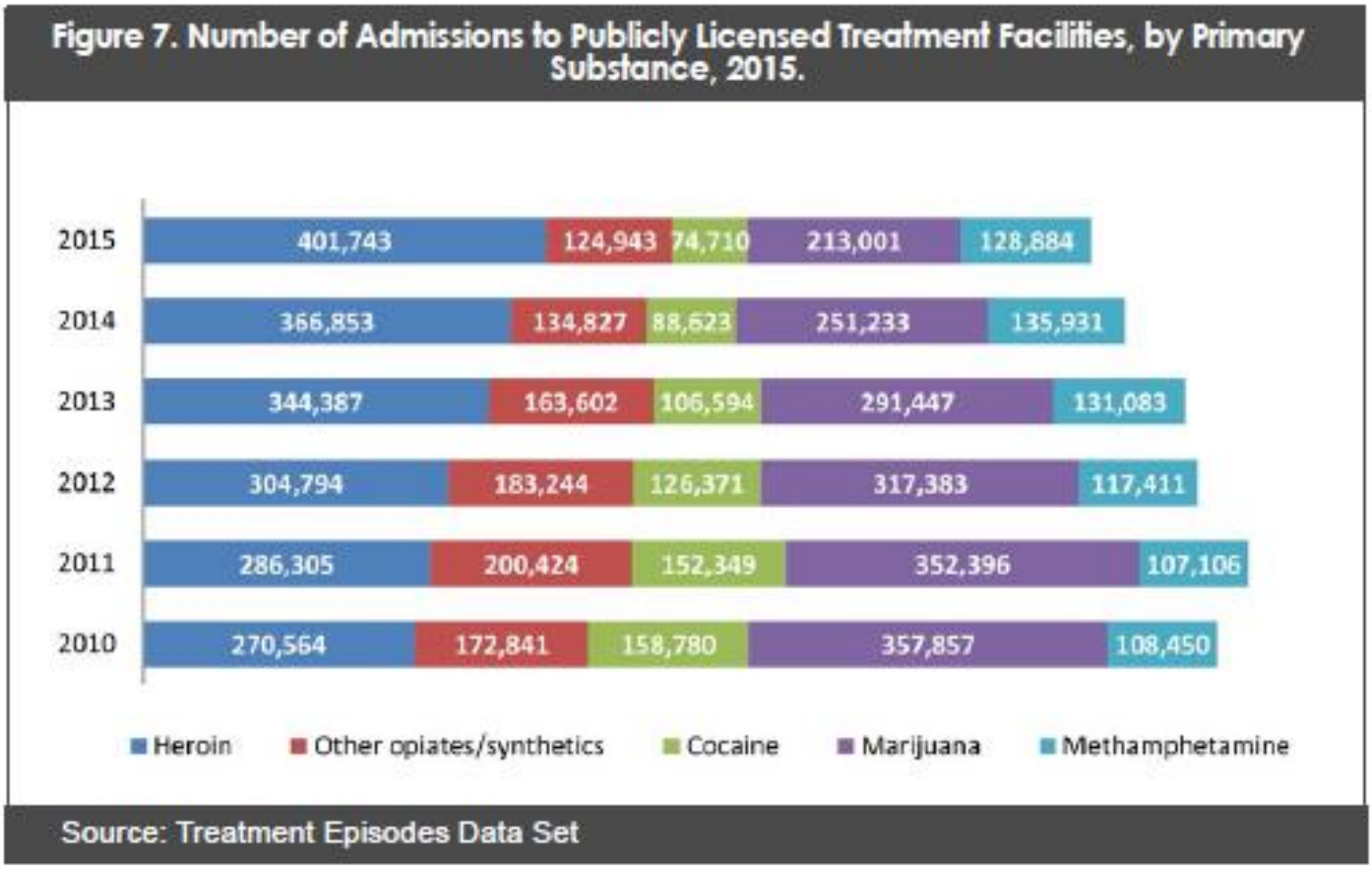


The Substance Use Disorder Treatment Retention rate of 42.5% reflects the percent of individuals age 12 and older with an intake assessment who received one outpatient index service within a week and two additional outpatient index services within 30 days of intake.

Source: Ohio Department of Health 2017
https://analytics.das.ohio.gov/t/ODHPIPUB/views/SHA_DRAFT_Domain_HlthCareSystem/18_HCsystem?:linktarget=_self&:isGuestRedirectFromVizportal=y&:embed=y



Ohio Department of Health graph shows overall United States Unmet Need, Illicit Drug Use Treatment at 2.45% and Ohio at 2.53%. This is the percent, ages 12 and older, needing but not receiving treatment for illicit drug use in the period, 2016-2017.



Source: National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration

According to the DEA report, "124,943 treatment admissions to publicly funded facilities for non-heroin opiates/ synthetic abuse, in 2015, the latest year for which data is available (see Figure 7). The number of non-heroin opiate treatment admissions peaked in 2011 and has decreased steadily since then. This decline can in part be attributed to some controlled prescription drug (CPD) abusers switching to heroin or other illicit opioids. A relatively small percentage of CPD abusers, when unable to obtain or afford CPDs, begin using heroin as a cheaper alternative offering similar opioid like effects. As the CPD abuser population is approximately seven times larger than the heroin user population, CPD abusers transitioning to heroin or other synthetic opioids represent a significant portion of the people who initiate use of these substances. Other reasons for the decline in admissions could include the success of PDMPs, pill abusers seeking treatment at private facilities, increased efforts from law enforcement and public health entities, and corresponding increases in overdose deaths of non-heroin opioid abusers."

The DEA report mentioned that products prescribed for the treatment of attention deficit hyperactivity disorder (ADHD) among other conditions, which are schedule II drugs, are being used on campuses as study-aids to improve concentration. This was mentioned in the Glenbeigh focus groups as well.

Source: 2018 National Drug Threat Assessment at https://pfs.ohio.gov/Portals/0/assets/Webinars/2018-DEA-NDTA.pdf

Figure A4. Number of Admissions to Publicly-Licensed Treatment Facilities, By Primary Substance, 2011 – 2015.					
	2011	2012	2013	2014	2015
Cocaine	152,349	126,371	106,594	88,623	74,710
Heroin	286,305	304,794	344,387	366,853	401,743
Marijuana	352,396	317,383	291,447	251,233	213,001
Methamphetamine	107,242	117,594	131,270	135,264	135,264
Non-Heroin Opiates/ Synthetics*	200,424	183,244	163,602	134,827	124,943

Source: Treatment Episode Data Set

*These drugs include codeine, hydrocodone, hydromorphone, meperidine, morphine, opium, oxycodone, pentazocine, propoxyphene, tramadol, and any other drug with morphine-like effects. Non-prescription use of methadone is not included.

Source: 2018 National Drug Threat Assessment https://pfs.ohio.gov/Portals/0/assets/Webinars/2018-DEA-NDTA.pdf

United States TEDS Admissions Report

Data from the TEDS admissions report for 2017 show that typically more men seek treatment for substance use disorders than women. The percentages of men seeking treatment exceed women seeking treatment by 30 percentage points or more for alcohol and alcohol with a secondary drug. Almost equal amounts of men as women sought treatment for other opiates and cocaine (smoked). Just over 52 percent of women sought treatment for sedatives, the only category where more women than men sought treatment.

TEDS data also shows a disparity in the drug of choice between Caucasian/White users and African American/Black users. The percentage of white users of alcohol only and alcohol with a secondary drug is at 68.6% and 61.1%, while black users are at 14.5% and 22.7%. Heroin and other opioid use are disproportionally high among white users. PCP at 65.0% and cocaine (smoked) at 51.4% use is disproportionally high among black users.

United States TEDS admissions aged 12 years and older, by primary substance use and gender, age at admission, race, and ethnicity: Percent, 2017

UNITED STATES	All substances	Alcohol only	Alcohol with secondary drug	Heroin	Other opiates	Cocaine (smoked)	Cocaine (other route)	Marijuana	Amphetamines	Other stimulants	Tranquilizers	Sedatives	Hallucinogens	PCP	Inhalants	Other/Unknown
Total (Number)	1,879,223	319,228	245,408	501,771	143,514	58,728	39,887	234,085	194,089	1,918	19,397	3,142	2,143	5,133	881	109,899
Total	100.0	17.0	13.1	26.7	7.6	3.1	2.1	12.5	10.3	0.1	1.0	0.2	0.1	0.3	0.0	5.8

GENDER	All substances	Alcohol only	Alcohol with secondary drug	Heroin	Other opiates	Cocaine (smoked)	Cocaine (other route)	Marijuana	Amphetamines	Other stimulants	Tranquilizers	Sedatives	Hallucinogens	PCP	Inhalants	Other/Unknown
Male	64.6	70.6	71.5	63.5	52.8	59.0	67.5	70.5	55.6	59.1	57.7	47.1	73.1	62.8	60.2	59.0
Female	35.3	29.3	28.4	36.4	47.2	41.0	32.5	29.5	44.3	40.9	42.3	52.9	26.8	37.1	39.8	40.5
Unknown	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.1	0.0	0.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

AGE	All substances	Alcohol only	Alcohol with secondary drug	Heroin	Other opiates	Cocaine (smoked)	Cocaine (other route)	Marijuana	Amphetamines	Other stimulants	Tranquilizers	Sedatives	Hallucinogens	PCP	Inhalants	Other/Unknown
12-17 years	3.6	0.7	1.6	0.1	0.4	0.2	1.3	20.3	1.3	3.8	4.8	5.2	8.4	0.1	7.2	6.9
18-20 years	3.5	1.4	2.4	2.0	1.8	1.0	3.7	11.5	3.7	3.5	9.2	5.9	10.0	0.8	5.0	4.5
21-25 years	12.5	6.5	9.9	14.1	12.4	4.3	12.0	20.1	14.6	12.6	15.5	10.9	19.4	6.6	14.0	12.9
26-30 years	18.4	11.0	14.8	23.6	24.0	8.8	17.5	17.4	21.5	19.9	20.0	13.7	20.9	21.6	15.8	17.8
31-35 years	16.1	12.5	14.7	18.3	21.4	10.6	16.8	11.8	20.5	20.8	16.7	11.6	15.1	29.1	18.2	15.6
36-40 years	12.3	12.2	13.2	12.1	14.8	11.1	14.0	7.8	15.6	15.1	11.6	8.5	11.2	22.0	13.6	11.5
41-45 years	8.6	11.2	10.3	7.7	8.2	12.1	9.8	4.2	9.2	9.2	6.0	6.0	5.9	10.1	11.1	7.9
46-50 years	8.9	13.4	11.9	8.0	6.4	18.8	10.0	2.9	6.8	6.4	5.7	4.7	4.1	4.9	7.0	7.6
51-55 years	8.0	14.0	11.4	6.8	5.1	17.9	8.4	2.1	4.2	5.3	4.8	5.1	3.0	3.3	3.7	7.1
56-60 years	5.2	10.2	6.8	4.4	3.4	10.7	4.5	1.2	2.0	2.5	3.3	4.3	1.6	1.2	2.8	4.7
61-65 years	2.2	4.5	2.4	2.1	1.5	3.5	1.5	0.4	0.5	0.9	1.7	3.2	0.2	0.3	1.2	2.2
66 years and over	0.9	2.4	0.7	0.8	0.6	1.0	0.5	0.1	0.1	0.1	0.8	20.9	0.2	0.0	0.3	1.1
Unknown	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

RACE	All substances	Alcohol only	Alcohol with secondary drug	Heroin	Other opiates	Cocaine (smoked)	Cocaine (other route)	Marijuana	Amphetamines	Other stimulants	Tranquilizers	Sedatives	Hallucinogens	PCP	Inhalants	Other/Unknown
White	66.0	68.6	61.1	70.8	81.2	38.3	53.5	50.0	75.6	73.5	80.9	81.3	58.5	19.0	76.3	63.5
Black or African-American	18.2	14.5	22.7	15.3	8.3	51.4	31.7	32.5	5.2	15.1	7.2	6.6	29.0	65.0	7.3	15.1
American Indian or Alaska Native	2.4	3.9	3.3	1.1	1.6	1.0	1.1	1.9	3.4	2.0	0.7	1.6	2.1	0.7	3.4	3.8
Asian or Native Hawaiian or Other Pacific Islander	1.1	1.1	0.8	0.7	0.6	0.6	0.9	1.3	2.4	1.6	0.9	1.2	1.1	0.7	1.7	1.8
Other	7.7	7.1	7.5	8.1	3.3	4.5	9.0	9.7	9.0	4.3	7.3	5.5	5.1	10.7	6.9	7.6
Unknown	4.7	4.8	4.5	4.1	5.0	4.3	3.7	4.7	4.4	3.4	2.9	3.8	4.2	3.9	4.4	8.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

ETHNICITY	All substances	Alcohol only	Alcohol with secondary drug	Heroin	Other opiates	Cocaine (smoked)	Cocaine (other route)	Marijuana	Amphetamines	Other stimulants	Tranquilizers	Sedatives	Hallucinogens	PCP	Inhalants	Other/Unknown
Hispanic or Latino	14.0	14.0	13.7	13.1	7.0	8.5	17.5	19.2	18.7	7.2	11.5	11.6	11.1	20.3	12.7	10.2
Not Hispanic or Latino	83.3	83.5	84.2	84.8	88.6	89.6	80.4	78.6	79.8	90.9	86.6	86.4	87.0	78.1	84.3	79.6
Unknown	2.8	2.5	2.1	2.1	4.4	1.9	2.1	2.1	1.5	1.8	1.8	1.9	2.0	1.6	3.0	10.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Based on administrative data reported by states to TEDS through July 1, 2019.

Secondary Data Analysis (Summary)

Demographics/Household Indicators

- Ashtabula County has a higher percentage of persons age 65+ than the state of Ohio
- Ashtabula County has a lower median household per capita income than Ohio
- Ashtabula County has a higher percentage of persons living in poverty
- The majority of Glenbeigh's defined service area includes Appalachian region counties
- The majority of Glenbeigh's defined service area has been impacted by population decline
- In the Ohio service community half of the population have a lower median household income and the majority of the community population has a higher percentage of persons living in poverty
- In the Ohio service community there is a higher percentage of unemployment
- In the Pennsylvania service community over half of the population has a lower median household income than the state value. Three out of four counties have a lower percentage living in poverty while half have a higher than state average unemployment rate
- A high percentage of drug consumers are persons living below the poverty level
- The percentage of female drug consumers remains high yet varies considerably by region
- A high percentage of drug consumers are Caucasian/White regionally while the Cleveland area has a high percentage of African American/Black drug consumers
- Hispanic/Latino drug consumers remains low
- The highest rates of unintentional overdose deaths were among 35-44 year olds followed by 25-34 year olds in Ohio
- Males have high rates of overdose deaths

Access to Health Care

- Ashtabula and Trumbull Counties have HRSA designated health professionals shortage areas for primary care, dental health and mental health
- Ashtabula County is a HRSA designated medically underserved area
- All counties within the defined service area have the same, or lower, than national percentage of uninsured individuals
- Low numbers of mental health providers are available in the defined service area
- Drug induced mortality rates within Appalachian counties is significantly higher than non-Appalachian counties
- Increasing percentages of clients are in treatment with a primary diagnosis of opiate abuse/dependence

Education

- With the exception of Ashtabula County, Ohio and Beaver County, Pennsylvania, residents in the defined service area exceed the national average for students obtaining a high school diploma
- Over 50% of adults age 25 and over in the Appalachian region have a high school diploma but no secondary degree
- A low percentage of the defined service area population have completed college with a bachelor's degree or more
- There is a need for more providers with the appropriate education and certification to work in the field of addiction treatment and social services

Health Behaviors

- A high percentage of Ashtabula County residents self-identify as current drinkers
- A high percentage of drug consumers use alcohol
- The defined service area has a high percentage of alcohol-impaired driving deaths
- The defined service area has experienced significant increases in the number of overdose deaths
- A high percent of adults in Ashtabula County indicated no need for help for alcohol or drug problems
- Nationally, a high percent of people classified as needing treatment did not think they needed treatment for their substance use
- While amounts have decreased, the average daily morphine equivalent dose continues to be dispensed above the Ohio county average in several Ohio communities in the defined service area
- The drug-induced mortality rate remains significantly higher than the national average for the entire defined service area
- Nationally, drug poisoning deaths involving cocaine surpassed 2006 rates in 2016

Other

- The defined service area includes several Appalachian region areas where the percent of households with no vehicle exceed the national average
- A significant number of overdose deaths involve illicit fentanyl alone or combined with other drugs in Ashtabula County
- Ohio remains on the top 10 list for overdoses from fentanyl, heroin and prescription opioids
- The availability of cocaine, heroin and fentanyl, among other drugs, remains high in the northeast Ohio corridor
- Nationally, meth-related deaths have increased. Ohio and Pennsylvania have high age-adjusted death rates per 100,000 population

Safety/Law Enforcement

- The re-emergence of Carfentanil has been documented in drug seizures
- There has been a leveling-off/decrease in opioid demand
- There is a documented increase in cocaine and methamphetamine demand
- Fentanyl analogs have been detected in seized samples of cocaine and meth
- Cocaine-involved deaths are increasing
- Fentanyl is being marketed in counterfeit prescription pills
- The number of armed robbery incidences have increased in Ohio corresponding to the increase in opioid use
- The number of OVI (Operating a vehicle while under the influence of alcohol or drugs) arrests in Ohio has consistently increased between 2014 and 2017
- The number of drug arrests in Ohio increased between 2014 and 2018
- Summit County, Ohio, had the highest percent of total driving deaths (50%) due to alcohol-impaired driving in Glenbeigh's Ohio defined service community
- The Pennsylvania statewide death toll resulting from drunk driving in 2018 was 1,190, a 4.7% increase over 2017

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

Economically disadvantaged families face life challenges that impact their ability to access or secure resources and improve their health, education and overall living conditions. Limited employment opportunities often lead to the inability to secure a sustainable living wage resulting in a higher likelihood to engage in unhealthy behaviors. This includes excessive or binge alcohol consumption and drug use. This behavior results in increased interaction with law enforcement, arrests and incarceration.

Glenbeigh's defined service area has many factors occurring that contribute to the abuse of alcohol, misuse of prescription medications and the use of illicit substances. In general, the community recognizes the dangers of opioid addiction but do not recognize the dangers associated with prescription misuse. Results from the primary data surveys revealed that respondents working in addiction treatment and law enforcement reported that the public believes that drugs prescribed by a physician are not addictive. They also report that alcohol use is unabated while the focus remains on reducing opioid death rates.

Drug and Alcohol Treatment Centers in the Service Communities

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

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

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

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

Other Community Resources

There are myriad agencies, coalitions and organization serving Glenbeigh's defined service areas. Ohio 211, Help Network of Northeast Ohio, maintains a considerable referral network available at no charge to individuals in need of health and human services assistance. 211 offers assistance in the following areas:

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

A full listing of services and referral networks is available at https://www.helpnetworkneo.org/

Primary Data Summary

Community input (primary data) was gathered through key informant interviews, focus groups and through an online survey. Interviews were conducted by Glenbeigh representatives from May 2019 through September 2019. Interview and focus group participants represented a) leaders and professionals working in the field of addiction treatment or services, b) populations of need, c) persons with public health and social service knowledge and d) law enforcement. Participants also included a mix of individuals in recovery as well as family members or loved ones of individuals with addiction. All participants were at least 18 years of age. 28 individuals were interviewed one-on-one and through focus group participation. An additional 23 responded to the written survey totaling 51 participants. This section summarizes the input that was obtained from these methodologies.

Niles Focus Group: Stark County – Mahoning County – Trumbull County, Ohio
Erie Focus Group: Erie County, Pennsylvania – Ashtabula County, Ohio
Beachwood Focus Group: Cuyahoga County – Lake County, Ohio

Key Informant Interviews/Focus Group Interviews

Issues identified by participants and areas of opportunity are presented by topic in the general order of how the questions were asked. The following was collected directly from participants.

Significant issues with regard to addiction/substance use.

- People reaching out for professional help. 1 in 10 people have the disease, 1 in 3 families dealing with it yet only 20% ask for professional help. If you can't get people to ask for help because of the stigma attached, or whatever reason, then there is a problem.
- Families will disclose privately an alcohol/drug issue within the family. People relate to caregivers – people who've been through it. Successful speaker: walking in my footsteps resonates with community. Definition of family – can be extended out to cousins/other relatives. May take a few years for extended family to speak about/acknowledge issues. Relief to hear others going through same thing.
- When dealing with other diseases, open discussion with family and friends leads to suggestions on how to proceed. With addiction, doctors don't know, clergy can't help. Stigma causes families to keep issue a secret resulting in no support system to find help. When not selling a product – people are more open.
- Stigma surrounds drug use. Alcohol is more acceptable in society.
- Addiction starts at a young age in the home. Prevention for all children. More needed for children growing up in a home where there is active addiction.

- Create a way for people who have relapsed to regroup and get back into recovery. Specialized housing for people who had a single relapse rather than dismissal from programs.
- There is a need for sustained abstinence based programs.
- County referrals make sure new centers are OMHAS Certified or either Joint Commission or CARF accredited – onsite review prior to referring.
- Poverty and generational poverty is great in area. Infant mortality rate in area is higher than in third-world countries. Poverty is a significant driver for alcohol and drug use.
- Ohio lacks a cohesive central call line to explain the process for getting treatment. Pennsylvania has a system in place that the community is aware of and is well publicized. Offer assistance to people seeking treatment.
- OARRS system has been a great help to reduce access to prescription opioids.
- Treatment for individuals with Medicaid at centers with 16 or more beds is confusing. Is it permitted in Ohio or not?
- Availability of drugs – easy access is an issue. Not limited to one type of drug. Meth use is number one – very inexpensive. Cocaine is coming back and is cheaper, breaking down financial barriers. Drugs that are in strip form are big in prison populations.
- PA service area: Driven by insurance coverage that limits treatment – follow-up care is restricted if you are not in the legal system. Long term care is driven by insurance companies.

Usage Trends

- Adderall is readily available – get it to sell. People who no longer have access to Adderall are switching to meth. Heroin users are transitioning to meth to avoid withdrawal.
- Some schools deny there are students experimenting with drugs. Did not see heroin epidemic coming because it did not impact the schools directly.
- There are specific jobs where alcohol and drug use is rampant. Employers feel use in the parking lot is not an issue as long as individual comes in and does their job. If OD on the job, fired and replaced by another body. Construction/landscaping/restaurant workers across all demographics. Outdated education in small business. Small employers don't have time to attend training. Partner with something all small business owners will see – partner with Ohio Bureau of Workers Compensation. Paired together they will see it. Just "are you aware of what services are available?" Once in a job – majority of jobs don't care if there is drug/alcohol use. Triggers folks in recovery due to access to drugs.
- Culture promotes alcohol consumption.
- Prisons are not conducive to recovery. Some prisons have recovery pods. Not in local jails or Ohio state jails. Heart program in Albany NY. Live in separate pods. Would work in Ohio state prisons – not local.

- Increased marijuana use. Marijuana creeped into top 10 diagnosis list in 2019. Few people seek treatment for marijuana use disorder.
- Synthetic drugs are not going to go away – will always be available.
- More people in treatment in 20's – treatment population is getting younger.
- 9 out of 10 callers seeking treatment are a family member. Rarely is it the addict who is calling.
- PA area: Majority of people don't know that alcohol is the most dangerous drug to detox from. Binge drinkers don't think they have an issue because they can stop at any time.
- Binge drinkers are the hardest to diagnose.
- Drug free workplace training isn't addressing alcohol because drug usage is focus.
- Parents aren't worried that children are drinking or smoking pot – at least they aren't shooting heroin. Epidemic has skewed perspective.
- 90% of treatment groups consist of alcoholics – fewer drug addicts.
- People switching from heroin because of fear of it containing Carfentanil or fentanyl. Addicts rationalize marijuana is safe because it is legal medication.
- Belief that meth is safe. Meth users also suffer from sleep deprivation – causing issues.
- University prevention programs struggling with use of medical marijuana.
- No area support for people with history of trauma connected to drug/alcohol use.

Use of Illicit and Prescription Drugs

- Older people still believe doctor prescriptions are not something that can be abused or addictive. People are aware of opioids – challenging doctors when getting scripts for oxy. People are not aware of issues with other prescription drugs that can be abused as they aren't educated. Public is seeing pharmaceutical companies are under pressure to answer for opioids. Doctors need education – don't have time to deal with issues.
- PA: Family program explains how prescription drug abuse leads to addiction. People still don't understand connection. Generational. People only read/grab headlines: Overdose/Heroin – don't get connection with other drug use. Effective treatment is not 30 days then back to original situation. Treatment mode needs to catch up to sober living – long-term recovery.
- The general mindset is that if a doctor prescribed a drug, it is okay to use – safe even if overusing. Majority of people don't question their doctor regarding what medication is prescribed. Even fewer read the medication warnings. Pharmaceutical use remains high.
- OARRS in Ohio has helped reduce the number of opioids prescribed. While focus is on opioids, other drugs are being prescribed that can become abused or are addictive.

Healthcare Professionals

- Medical forms do not ask if addiction runs in the family. People are often dismissed by healthcare workers when questioning use/prescribing of opioids. It is good that doctor's ability to write scripts for high doses of opioids is limited.
- Doctors are more knowledgeable of opioid addiction due to the business impact. Question if doctors have received adequate training in addiction medicine, pain management or working with patients in recovery. Doctors need trained before they leave medical school. Once out, it is difficult to train physicians. They are open to training presented by a doctor and will not attend training featuring people who do not have their level of education. Doctors do not know who to refer to when approached by patients seeking addiction treatment.
- Business models drive MAT for many physicians due to lobbying. Harm reduction is good if working on the co-occurring issues and work on changes. Harm reduction alone does not change behaviors. MAT should be followed by an IOP/Aftercare program.
- Difference on success rate based on form of MAT. Need to stay on MAT of choice for adequate amount of time – not fall off when feeling better.
- Doctors know how to prescribe medication but they do not truly understand addiction. People will fall through the cracks.
- More education is needed in medical schools. Ohio still lacks addiction education in medical schools. All physicians should be prepared to work with a patient in active addiction or in recovery.
- Several local hospitals are implementing SBIRT. Finding that nursing and other healthcare professionals are stigmatizing patients in active addiction or in recovery. Internal resistance from healthcare professionals as SBIRT is being implemented.
- To do physician training – must be peer to peer training and after standard hours.
- PA area: Psychiatrists are prescribing medical marijuana-not educated on how to work with people in recovery. Challenge people in recovery – not a doctor – cannot tell me what you can/cannot take.
- Erie has a medical school. Hospice and drug abuse are not welcome in physicians world. Consider getting involved with medical school and provide training on addiction and recovery. May be open to this. Professional nursing board in PA has an excellent program in place with high long-term recovery rate. Promote recovery – assist nurses needing help.

Stigma Against Seeking Treatment

- People affected want to know about addiction/recovery. People affected by addiction are gathering information by word of mouth and networking until they are ready to take action.
- Getting people to treatment is an issue. If they don't want it for themselves, they are not successful. When they are ready for treatment – it needs to be available. They need to understand how to go about getting help and have support.
- Consider working with college branches to offer education for nurses – expanded to other areas including general caregivers, social workers and counselors. Offer both during and after work to accommodate all groups. "What's happening in your neighborhood?"
- There are more recovery options for heroin addiction due to features on opioid epidemic. Treatment options for other drugs such as cocaine are still limited either by availability or insurance coverage.
- Access restrictions. Addicts do not really know how to go about getting help. Long process is detrimental to getting treatment especially when person is hopeless. May not have insurance.
- Clergy are turned to for help and there is a need for more education.
- Many healthcare professionals have no empathy for those with addiction or families seeking help for someone with addiction.
- Stigma against saving heroin addicts with Narcan came up during the opioid epidemic.
- "It's an individuals' choice to get clean" is a preconceived idea of how people should get clean. Important to have as many outlets and avenues available for treatment as one type of treatment does not work for all. Give people the best chance for success.

Underage Drinking

- Alcohol is not viewed in same realm as drug addiction. Not viewed as a drug.
- Huge stigma for family with drug abuse – viewed as 2 separate problems. Drug addicts are worse than alcoholics. People don't see alcohol as issue.
- Focus on opiates has shifted perspective. Alcohol abuse has shifted back into shadows.

Availability of Services

- Not enough facilities. Treatment side is understaffed when putting real problem in perspective – number of people in need.
- Quality of treatment centers is hard to determine. Family is in panic mode – family member can die tonight. If a center tells you they can help "now" family will take it right now to save them today. Marketing/business model – very confusing. Not like going to the ER – hearing you have cancer – and sent to a specialist.

- Treatment is available but the individual needs to take the first step. Many people are referred to treatment then go online and check out the treatment center. Some people seek treatment as a last resort – losing home or other significant event.
- Insurance coverage often dictates where people can get treatment.

Barriers to Treatment

- Continue education of clergy – alcohol is an issue.
- Most folks reaching out for help are caregivers seeking help for someone in 20's-30's. Young adults have less to lose. Older people are worried about loss of income, career, etc. Older people have so much to lose and people are tied to the 40-50 year olds. Someone needs to make house payment – car payment – etc. The price tag for treatment is more than just the treatment.
- There are few resources for people needing financial aid for recovery housing.
- Limited funding/insurance to get full treatment to sustain long-term recovery. Those with limited insurance can go to detox but then back on the street. No chance for long-term recovery.
- Lack of programs for/acceptance of people with gender/sexual identity. LGBTQ community has a high rate of alcohol and drug use – community is not cohesive.
- Stigma in Ohio – don't think outside the box – limited help for Hepatitis or HIV. Harm reduction – no local needle exchange programs.
- Availability of transportation is vital to getting treatment.
- Medicaid not accepted at all treatment centers.
- Not all addicts have access to a phone or computer. They don't know how to seek treatment nor expect help from anyone. Have no idea if there are treatment centers.
- Privately insured – working poor – have high deductibles. Lack of healthcare. "Why bother looking because I won't be able to get into a place." Finite funds available for people who have lost insurance and seeking treatment.
- Promote release from jail to treatment programs with county agencies. Treatment and recovery supports. Not all want or need recovery housing.
- PA area: No detox centers in PA. 4-A requires 24 hour medical monitoring – opioid addicts are turned away. Alcohol and benzo users accepted. Only six beds to serve county – has not changed in Erie County for over 15 years. Don't have level of care for detox. Addicts in Erie know to get drunk if they want to be admitted for care.

Need for Programs

- Education: Physicians need to participate. Create medical training programs. Addiction medicine – takes time to build knowledge – always changing.
- Direct source to people impacted. Support harm reduction programs – reduce exposure to other diseases. Have resources available. Offer Hepatitis/HIV testing.
- RAM Van in rural areas. Offer onsite Hepatitis/HIV testing to underserved demographics. Offer at outpatient centers.
- Larger cities in Ohio have harm reduction locations where people can get clean needles to reduce transmission of other diseases.
- People in active addiction want to get high safely. Do not want to get Hepatitis/HIV
- Word of mouth in the community still works if organization is offering something worthwhile.
- More programs/education on addiction and the consequences.
- Continued education needed in the school systems.
- Lack services for youth age 18 and under with SUD.
- Education that resonates with locals. Do not present statewide statistics or data – hone in on local numbers. Use zip codes to pull in what is happening in local neighborhoods. Prevents people from saying the problem does not exist in the area. Look at OD rates and comparing rates across zip codes and communities. Shows a different picture of drug use.
- There will never be enough treatment centers. Law enforcement working with treatment has been beneficial and has helped people get treatment. Have come a long way collaborating to help people – still work to do. Competition exists among some agencies.

Drug Courts/Law Enforcement

- Good programs. The Justice system/law enforcement has been a big supporter of recovery - more than the medical community. Police/Sheriff/Courts participate in events and are guest speakers. Doctors/medical community do not come/do not support. They should support or participate as it looks like medical community is part of the problem along with pharmaceuticals. No doctor's sign up for education until someone well known nationally, or who is on their level, is the speaker.
- Inner city area drug courts send more folks to prison.
- Need clear distinction between court and treatment. Individual is responsible for getting clean, not the drug court.
- Drug Courts are a good idea to help people avoid entering the criminal justice system. However sentencing an individual to treatment is not absolute. Recovery comes when the individual is ready.
- Sentencing someone to IOP is not always productive. There is a need for understanding individual need.

- A good introduction to assessment and what is available. Catches people at the bottom. Given options to choose treatment facility. Court intervention can bring people to treatment.
- Provide more education/information to attorneys/judges and the criminal justice system. Interest in perspective of criminal justice on addiction/recovery to hear their side of story.
- Some judges tell addicts to rehabilitate in prison. There are more drugs available in prison than on streets. Life in addiction continues in prison. Recovery in prison works against person. AA/NA available through visiting ministry.
- People of color feel they get prison sentence rather than rehabilitation. Once sentenced to prison, public defender disengages. Racism is prevalent is some communities.
- Gender bias for getting into drug court is noted in certain communities.
- Attorney typically recommends drug court – judge agrees. Can be a socioeconomic block to being referred into drug court. Depends on offense as well. Public defenders involved in system work better. Race appears to be a determining factor for drug court recommendation.
- Education and representation at local drug courts is needed.
- Suggestion of collaborating with prison ministers. Transport people being released from prison to treatment. There are fliers in the prisons on getting treatment.
- Law enforcement using "inducing panic" charge on OD calls where Narcan is used. Going around "Good Samaritan" law. Varies by community.
- Law enforcement needs to think further out. When focusing on one drug, something new will take its place. Need to have options in place to help people during a transition.

Harm Reduction

- Narcan – people educated on Narcan are the designated person for the night. First responders trained and using Narcan is good. All people deserve to live. Need more availability in the community. Cost can be prohibitive to people with financial limitations. Still pay through pharmacy – in high poverty communities the cost is prohibitive.
- Recovery houses have Narcan – all house managers should be trained.
- Churches/all businesses with AED's should have Narcan available.
- Majority of participants have not been trained on the use of Narcan in the Niles focus group. Cost to purchase limits availability.
- Promote Narcan training at Glenbeigh for recovery houses and house managers. After hours training is a vital need in the county. Need to distribute the Narcan as part of the program. 6:00 PM or later. No prescription needed. Order kits through central pharmacy.
- The majority of law enforcement personnel support the use of Narcan. Always believe your loved one can be saved – keep Narcan in the community.

- PA area: Narcan is readily available. Free clinics give away Narcan. Still stigma involved with Narcan distribution. Fragmented approach – Narcan is good – not pushing treatment to work on addiction issues. No reeducation offered – promote take a pill to fix issue.

Recovery Support

- Felons have a hard time finding employment. Some employers will work with people in recovery and give them a chance. Need to be more flexible.
- Limited functions that don't feature alcohol. Recovery houses feature events for holidays. Paintball, bowling, baseball games.
- Drug Courts have programs that assist people to sustain recovery and find employment.
- Sober events are beneficial to people in recovery. Opportunity to network with people who met in treatment.
- More opportunities needed to get involved and meet people - to do stuff clean.
- Sober houses in the community were once connected. As more opened, became less connected. Fragmented due to size of recovery community.
- Picnics and banquets are still needed. Other centers are competing with events. Must have a clear distinction between treatment and fellowship events.
- Not enough recovery support in community. There is poor/bad recovery housing in existence. Need more for children. There are only 2 Al-A-Teen groups in area. There is a group for younger children – not in Trumbull County. Need a younger person to facilitate group. Adults cannot run Al-A-Teen groups.
- Support groups not available at CSB – stay isolated from recovery programs. They offer mental health assistance/individual counseling. Considered treatment rather than recovery support.
- There are programs for grief support and families. Family members are struggling with addiction related issues – may not have time or ability to attend.
- Continue to promote recovery support programs in the community and work with other organizations that foster recovery.
- PA area: Only one known recovery house to serve county – this lags behind other areas where sober living is an option. Women and children have some services through Catholic Charities. No private options. PA is basing success rate on incarceration rates and using MAT to show success. Only addressing opiates – not other drug use. Number of overdose (OD) deaths reduced – calling it a success. Funding is only available to entities that allow all MAT – Medical Marijuana is approved for the treatment of opioid use disorder in PA. No treatment services are permitted in sober housing in PA. Zoning issues limit rehabs and sober living housing. Stigma is prevalent in area – bad experience with MAT centers. Interferes with other businesses and neighborhoods. MAT clinics –

only treating opioids – can test positive for other mood altering drugs and still get MAT and be considered in recovery.

- Female ¾ house opening in NW Pennsylvania.

Other

- People need more information on intervention – how does it work? What can parents, spouse, etc. do to prepare for an intervention? Families need support to get on the same page to get a loved one help. When does someone need help and how do you get your loved one to agree to get help? A professional won't go to just an off the street AA meeting they do not know. Family doesn't know enough to help loved one – know there is a problem. How do you make them want to get help? How does family get someone in for help? Education on what the possibilities are for getting treatment? Make it part of another event to draw folks in. Consider getting an interventionist to talk about the process?
- People do not have the option of leaving a job and coming back after treatment. Stigma at employers. Stress and genetics enhance addiction. Addicts think they are alone – they think about how they can solve the addiction alone – do not see/acknowledge how family is affected by addiction.
- OARRS is good for comparing community risk factors – why a specific community is hit harder than another. Local versus state data. Use Ohio Department of Health OD data and local coroner data. High rate of elderly and high rate of on the job injuries skews prescription data.
- Law enforcement perspective is that families want their loved one to get help and get into a treatment program. They do not always know how to go about getting help. Rapid Response teams have helped.
- PA area: Family support. Families are buying drugs – think their loved one will die without drugs. Families are strong-armed. There are family education programs available in the county but they do not participate/attend. Family feels addiction is not their problem – will not change behavior. Family program attendance is down across the area. Treatment programs need to promote importance of family participation. Some referral sources really promote family participation. Offered a community family program 4 years ago in Erie – packed with hurting people – shared stories. Had series of 3 offered at the local library. Barrier to family education is patient does not want them to participate. If under the age of 26, living in family home, parent should have to come for family programs. Need to offer at off-site location.
- How do people hear about treatment options? Erie is saturated with marketers for addiction treatment centers. Attend community events – sponsor events. Advertising has gone down in Erie – doing ER visits with donuts – Florida centers are predatory. Erie has

a good coalition of local treatment centers. Promote treatment for people needing treatment. No animosity – friends – collaboration among all Erie centers. Community connections promoted by county manager.

- Erie once published a service catalog that detailed all services/providers. All social service professionals had the guide. More than enough business for everyone.
- Top needs in Erie County: Sober living/1/2 way housing (extensive wait lists to get in) – Long-term treatment (City Mission is only one offering long-term treatment).

Appendix A: Key Informant Participants

Name	Relationship	Location
Jan Stuckey	Caregiver	Ashtabula/National
Dan Stuckey	Advocate	Ashtabula/National
Laruen Thorp	Director of Recovery & Youth Programs	Trumbull County, OH
Lisa Horton	Counselor	Erie County, PA
Anonymous	Educator/Case Manager	Western Pennsylvania
Amanda Millerin	Community Referral	Erie County, PA
Brad Curry	Recovery Specialist	Erie County, PA
Anonymous	Law Enforcement	Ohio

Appendix B: Defined Service Community by County and Zip Code

Ashtabula County, Ohio

ZIP	CITY AND STATE	COUNTY
44099	Windsor, OH	Ashtabula
44093	Williamsfield, OH	Ashtabula
44088	Unionville, OH	Ashtabula
44030	Conneaut, OH	Ashtabula
44032	Dorset, OH	Ashtabula
44041	Geneva, OH	Ashtabula
44010	Austinburg, OH	Ashtabula
44003	Andover, OH	Ashtabula
44004	Ashtabula, OH	Ashtabula
44005	Ashtabula, OH	Ashtabula
44082	Pierpont, OH	Ashtabula
44084	Rock Creek, OH	Ashtabula

	44085	Rome, OH	Ashtabula
	44076	Orwell, OH	Ashtabula
	44047	Jefferson, OH	Ashtabula
	44048	Kingsville, OH	Ashtabula
	44068	North Kingsville, OH	Ashtabula
Lake County, Ohio	44045	Grand River, OH	Lake
	44081	Perry, OH	Lake
	44077	Painesville, OH	Lake
	44097	Eastlake, OH	Lake
	44096	Willoughby, OH	Lake
	44095	Eastlake, OH	Lake
	44094	Willoughby, OH	Lake
	44061	Mentor, OH	Lake
	44060	Mentor, OH	Lake
	44057	Madison, OH	Lake
	44092	Wickliffe, OH	Lake
Summit County, Ohio	**ZIP**	**CITY AND STATE**	**COUNTY**
	44203	Barberton, OH	Summit
	44210	Bath, OH	Summit
	44087	Twinsburg, OH	Summit
	44056	Macedonia, OH	Summit
	44067	Northfield, OH	Summit
	44314	Akron, OH	Summit
	44315	Akron, OH	Summit
	44317	Akron, OH	Summit
	44313	Akron, OH	Summit
	44311	Akron, OH	Summit
	44312	Akron, OH	Summit
	44316	Akron, OH	Summit
	44398	Akron, OH	Summit
	44325	Akron, OH	Summit
	44326	Akron, OH	Summit
	44303	Akron, OH	Summit
	44302	Akron, OH	Summit
	44301	Akron, OH	Summit
	44334	Fairlawn, OH	Summit

	44334	Akron, OH	Summit
	44328	Akron, OH	Summit
	44333	Akron, OH	Summit
	44304	Akron, OH	Summit
	44320	Akron, OH	Summit
	44309	Akron, OH	Summit
	44319	Akron, OH	Summit
	44310	Akron, OH	Summit
	44308	Akron, OH	Summit
	44305	Akron, OH	Summit
	44321	Akron, OH	Summit
	44307	Akron, OH	Summit
	44306	Akron, OH	Summit
	44286	Richfield, OH	Summit
	44237	Hudson, OH	Summit
	44250	Lakemore, OH	Summit
	44223	Cuyahoga Falls, OH	Summit
	44216	Clinton, OH	Summit
	44232	Green, OH	Summit
	44224	Stow, OH	Summit
	44236	Hudson, OH	Summit
	44222	Cuyahoga Falls, OH	Summit
	44372	Akron, OH	Summit
	44278	Tallmadge, OH	Summit
	44396	Akron, OH	Summit
	44221	Cuyahoga Falls, OH	Summit
	44262	Munroe Falls, OH	Summit
	44264	Peninsula, OH	Summit
Cuyahoga County, Ohio	**ZIP**	**CITY AND STATE**	**COUNTY**
	44111	Cleveland, OH	Cuyahoga
	44130	Parma, OH	Cuyahoga
	44130	Parma Heights, OH	Cuyahoga
	44112	Cleveland, OH	Cuyahoga
	44110	Cleveland, OH	Cuyahoga
	44130	Middleburg Heights, OH	Cuyahoga
	44130	Cleveland, OH	Cuyahoga

44108	Cleveland, OH	Cuyahoga
44109	Cleveland, OH	Cuyahoga
44129	Parma, OH	Cuyahoga
44143	Cleveland, OH	Cuyahoga
44117	Euclid, OH	Cuyahoga
44144	Cleveland, OH	Cuyahoga
44149	Strongsville, OH	Cuyahoga
44124	Mayfield Heights, OH	Cuyahoga
44116	Rocky River, OH	Cuyahoga
44126	Cleveland, OH	Cuyahoga
44142	Brookpark, OH	Cuyahoga
44125	Cleveland, OH	Cuyahoga
44124	Pepper Pike, OH	Cuyahoga
44142	Cleveland, OH	Cuyahoga
44145	Westlake, OH	Cuyahoga
44119	Cleveland, OH	Cuyahoga
44120	Cleveland, OH	Cuyahoga
44122	Beachwood, OH	Cuyahoga
44121	Cleveland, OH	Cuyahoga
44146	Bedford, OH	Cuyahoga
44147	Broadview Heights, OH	Cuyahoga
44124	Lyndhurst, OH	Cuyahoga
44124	Cleveland, OH	Cuyahoga
44118	Cleveland, OH	Cuyahoga
44123	Euclid, OH	Cuyahoga
44017	Berea, OH	Cuyahoga
44114	Cleveland, OH	Cuyahoga
44198	Cleveland, OH	Cuyahoga
44195	Cleveland, OH	Cuyahoga
44197	Cleveland, OH	Cuyahoga
44113	Cleveland, OH	Cuyahoga
44199	Cleveland, OH	Cuyahoga
44139	Solon, OH	Cuyahoga
44129	Cleveland, OH	Cuyahoga
44022	Chagrin Falls, OH	Cuyahoga
44140	Bay Village, OH	Cuyahoga

	44188	Cleveland, OH	Cuyahoga
	44190	Cleveland, OH	Cuyahoga
	44115	Cleveland, OH	Cuyahoga
	44181	Cleveland, OH	Cuyahoga
	44127	Cleveland, OH	Cuyahoga
	44128	Cleveland, OH	Cuyahoga
	44193	Cleveland, OH	Cuyahoga
	44194	Cleveland, OH	Cuyahoga
	44192	Cleveland, OH	Cuyahoga
	44141	Brecksville, OH	Cuyahoga
	44191	Cleveland, OH	Cuyahoga
	44104	Cleveland, OH	Cuyahoga
	44131	Independence, OH	Cuyahoga
	44137	Maple Heights, OH	Cuyahoga
	44131	Seven Hills, OH	Cuyahoga
	44131	Parma, OH	Cuyahoga
	44105	Cleveland, OH	Cuyahoga
	44101	Cleveland, OH	Cuyahoga
	44103	Cleveland, OH	Cuyahoga
	44131	Cleveland, OH	Cuyahoga
	44040	Gates Mills, OH	Cuyahoga
	44131	Brooklyn Heights, OH	Cuyahoga
	44136	Strongsville, OH	Cuyahoga
	44133	North Royalton, OH	Cuyahoga
	44135	Cleveland, OH	Cuyahoga
	44134	Cleveland, OH	Cuyahoga
	44107	Lakewood, OH	Cuyahoga
	44102	Cleveland, OH	Cuyahoga
	44138	Olmsted Falls, OH	Cuyahoga
	44106	Cleveland, OH	Cuyahoga
	44070	North Olmsted, OH	Cuyahoga
	44132	Euclid, OH	Cuyahoga
Lorain County, Ohio	**ZIP**	**CITY AND STATE**	**COUNTY**
	44049	Kipton, OH	Lorain
	44052	Lorain, OH	Lorain
	44050	Lagrange, OH	Lorain

	44044	Grafton, OH	Lorain
	44053	Lorain, OH	Lorain
	44054	Sheffield Lake, OH	Lorain
	44035	Elyria, OH	Lorain
	44036	Elyria, OH	Lorain
	44039	North Ridgeville, OH	Lorain
	44028	Columbia Station, OH	Lorain
	44001	Amherst, OH	Lorain
	44011	Avon, OH	Lorain
	44012	Avon Lake, OH	Lorain
	44055	Lorain, OH	Lorain
	44090	Wellington, OH	Lorain
	44074	Oberlin, OH	Lorain
Trumbull County, Ohio	**ZIP**	**CITY AND STATE**	**COUNTY**
	44446	Niles, OH	Trumbull
	44444	Newton Falls, OH	Trumbull
	44453	Orangeville, OH	Trumbull
	44450	North Bloomfield, OH	Trumbull
	44440	Mineral Ridge, OH	Trumbull
	44437	Mc Donald, OH	Trumbull
	44430	Leavittsburg, OH	Trumbull
	44439	Mesopotamia, OH	Trumbull
	44438	Masury, OH	Trumbull
	44485	Warren, OH	Trumbull
	44484	Warren, OH	Trumbull
	44491	West Farmington, OH	Trumbull
	44486	Warren, OH	Trumbull
	44483	Warren, OH	Trumbull
	44473	Vienna, OH	Trumbull
	44470	Southington, OH	Trumbull
	44482	Warren, OH	Trumbull
	44481	Warren, OH	Trumbull
	44410	Cortland, OH	Trumbull
	44417	Farmdale, OH	Trumbull
	44404	Burghill, OH	Trumbull
	44402	Bristolville, OH	Trumbull

	44403	Brookfield, OH	Trumbull
	44424	Hartford, OH	Trumbull
	44420	Girard, OH	Trumbull
	44418	Fowler, OH	Trumbull
	44425	Hubbard, OH	Trumbull
	44428	Kinsman, OH	Trumbull
Allegheny County, Pennsylvania	**ZIP**	**CITY AND STATE**	**COUNTY**
	15102	Bethel Park, PA	Allegheny
	15101	Allison Park, PA	Allegheny
	15108	Coraopolis, PA	Allegheny
	15106	Carnegie, PA	Allegheny
	15104	Braddock, PA	Allegheny
	15116	Glenshaw, PA	Allegheny
	15120	Homestead, PA	Allegheny
	15095	Warrendale, PA	Allegheny
	15096	Warrendale, PA	Allegheny
	15110	Duquesne, PA	Allegheny
	15112	East Pittsburgh, PA	Allegheny
	15031	Cuddy, PA	Allegheny
	15032	Curtisville, PA	Allegheny
	15028	Coulters, PA	Allegheny
	15030	Creighton, PA	Allegheny
	15037	Elizabeth, PA	Allegheny
	15044	Gibsonia, PA	Allegheny
	15034	Dravosburg, PA	Allegheny
	15035	East McKeesport, PA	Allegheny
	15025	Clairton, PA	Allegheny
	15014	Brackenridge, PA	Allegheny
	15015	Bradfordwoods, PA	Allegheny
	15006	Bairdford, PA	Allegheny
	15007	Bakerstown, PA	Allegheny
	15020	Bunola, PA	Allegheny
	15024	Cheswick, PA	Allegheny
	15017	Bridgeville, PA	Allegheny
	15018	Buena Vista, PA	Allegheny
	15082	Sturgeon, PA	Allegheny

15084	Tarentum, PA	Allegheny
15075	Rural Ridge, PA	Allegheny
15076	Russellton, PA	Allegheny
15090	Wexford, PA	Allegheny
15091	Wildwood, PA	Allegheny
15086	Warrendale, PA	Allegheny
15088	West Elizabeth, PA	Allegheny
15071	Oakdale, PA	Allegheny
15047	Greenock, PA	Allegheny
15049	Harwick, PA	Allegheny
15045	Glassport, PA	Allegheny
15046	Crescent, PA	Allegheny
15064	Morgan, PA	Allegheny
15065	Natrona Heights, PA	Allegheny
15051	Indianola, PA	Allegheny
15056	Leetsdale, PA	Allegheny
15239	Pittsburgh, PA	Allegheny
15240	Pittsburgh, PA	Allegheny
15241	Pittsburgh, PA	Allegheny
15295	Pittsburgh, PA	Allegheny
15290	Pittsburgh, PA	Allegheny
15238	Pittsburgh, PA	Allegheny
15283	Pittsburgh, PA	Allegheny
15282	Pittsburgh, PA	Allegheny
15243	Pittsburgh, PA	Allegheny
15242	Pittsburgh, PA	Allegheny
15289	Pittsburgh, PA	Allegheny
15286	Pittsburgh, PA	Allegheny
15237	Pittsburgh, PA	Allegheny
15228	Pittsburgh, PA	Allegheny
15229	Pittsburgh, PA	Allegheny
15230	Pittsburgh, PA	Allegheny
15225	Pittsburgh, PA	Allegheny
15226	Pittsburgh, PA	Allegheny
15227	Pittsburgh, PA	Allegheny
15234	Pittsburgh, PA	Allegheny

15235	Pittsburgh, PA	Allegheny
15236	Pittsburgh, PA	Allegheny
15231	Pittsburgh, PA	Allegheny
15232	Pittsburgh, PA	Allegheny
15233	Pittsburgh, PA	Allegheny
15281	Pittsburgh, PA	Allegheny
15272	Pittsburgh, PA	Allegheny
15260	Pittsburgh, PA	Allegheny
15270	Pittsburgh, PA	Allegheny
15257	Pittsburgh, PA	Allegheny
15258	Pittsburgh, PA	Allegheny
15259	Pittsburgh, PA	Allegheny
15262	Pittsburgh, PA	Allegheny
15265	Pittsburgh, PA	Allegheny
15264	Pittsburgh, PA	Allegheny
15268	Pittsburgh, PA	Allegheny
15261	Pittsburgh, PA	Allegheny
15267	Pittsburgh, PA	Allegheny
15255	Pittsburgh, PA	Allegheny
15251	Pittsburgh, PA	Allegheny
15278	Pittsburgh, PA	Allegheny
15277	Pittsburgh, PA	Allegheny
15244	Pittsburgh, PA	Allegheny
15250	Pittsburgh, PA	Allegheny
15279	Pittsburgh, PA	Allegheny
15252	Pittsburgh, PA	Allegheny
15253	Pittsburgh, PA	Allegheny
15254	Pittsburgh, PA	Allegheny
15276	Pittsburgh, PA	Allegheny
15275	Pittsburgh, PA	Allegheny
15274	Pittsburgh, PA	Allegheny
15147	Verona, PA	Allegheny
15148	Wilmerding, PA	Allegheny
15201	Pittsburgh, PA	Allegheny
15146	Monroeville, PA	Allegheny
15143	Sewickley, PA	Allegheny

15144	Springdale, PA	Allegheny
15145	Turtle Creek, PA	Allegheny
15202	Pittsburgh, PA	Allegheny
15207	Pittsburgh, PA	Allegheny
15208	Pittsburgh, PA	Allegheny
15209	Pittsburgh, PA	Allegheny
15206	Pittsburgh, PA	Allegheny
15203	Pittsburgh, PA	Allegheny
15204	Pittsburgh, PA	Allegheny
15205	Pittsburgh, PA	Allegheny
15129	South Park, PA	Allegheny
15131	Mckeesport, PA	Allegheny
15132	Mckeesport, PA	Allegheny
15127	Ingomar, PA	Allegheny
15122	West Mifflin, PA	Allegheny
15123	West Mifflin, PA	Allegheny
15126	Imperial, PA	Allegheny
15133	Mckeesport, PA	Allegheny
15139	Oakmont, PA	Allegheny
15140	Pitcairn, PA	Allegheny
15142	Presto, PA	Allegheny
15137	North Versailles, PA	Allegheny
15134	Mckeesport, PA	Allegheny
15135	Mckeesport, PA	Allegheny
15136	McKees Rocks, PA	Allegheny
15210	Pittsburgh, PA	Allegheny
15221	Pittsburgh, PA	Allegheny
15216	Pittsburgh, PA	Allegheny
15222	Pittsburgh, PA	Allegheny
15217	Pittsburgh, PA	Allegheny
15218	Pittsburgh, PA	Allegheny
15219	Pittsburgh, PA	Allegheny
15220	Pittsburgh, PA	Allegheny
15224	Pittsburgh, PA	Allegheny
15212	Pittsburgh, PA	Allegheny
15211	Pittsburgh, PA	Allegheny

	15213	Pittsburgh, PA	Allegheny
	15215	Pittsburgh, PA	Allegheny
	15214	Pittsburgh, PA	Allegheny
	15223	Pittsburgh, PA	Allegheny
Erie County, Pennsylvania	**ZIP**	**CITY AND STATE**	**COUNTY**
	16413	Elgin, PA	Erie
	16415	Fairview, PA	Erie
	16412	Edinboro, PA	Erie
	16438	Union City, PA	Erie
	16411	East Springfield, PA	Erie
	16430	North Springfield, PA	Erie
	16423	Lake City, PA	Erie
	16428	North East, PA	Erie
	16426	McKean, PA	Erie
	16427	Mill Village, PA	Erie
	16417	Girard, PA	Erie
	16410	Cranesville, PA	Erie
	16421	Harborcreek, PA	Erie
	16401	Albion, PA	Erie
	16407	Corry, PA	Erie
	16502	Erie, PA	Erie
	16522	Erie, PA	Erie
	16504	Erie, PA	Erie
	16503	Erie, PA	Erie
	16501	Erie, PA	Erie
	16534	Erie, PA	Erie
	16538	Erie, PA	Erie
	16530	Erie, PA	Erie
	16531	Erie, PA	Erie
	16515	Erie, PA	Erie
	16510	Erie, PA	Erie
	16507	Erie, PA	Erie
	16509	Erie, PA	Erie
	16508	Erie, PA	Erie
	16506	Erie, PA	Erie
	16505	Erie, PA	Erie

	16514	Erie, PA	Erie
	16511	Erie, PA	Erie
	16512	Erie, PA	Erie
	16443	West Springfield, PA	Erie
	16442	Wattsburg, PA	Erie
	16550	Erie, PA	Erie
	16553	Erie, PA	Erie
	16444	Edinboro, PA	Erie
	16565	Erie, PA	Erie
	16563	Erie, PA	Erie
	16441	Waterford, PA	Erie
	16541	Erie, PA	Erie
	16475	Albion, PA	Erie
	16546	Erie, PA	Erie
	16544	Erie, PA	Erie
Beaver County, Pennsylvania	**ZIP**	**CITY AND STATE**	**COUNTY**
	15003	Ambridge, PA	Beaver
	15010	Beaver Falls, PA	Beaver
	15009	Beaver, PA	Beaver
	15074	Rochester, PA	Beaver
	15005	Baden, PA	Beaver
	15050	Hookstown, PA	Beaver
	16123	Fombell, PA	Beaver
	16136	Koppel, PA	Beaver
	16141	New Galilee, PA	Beaver
	16115	Darlington, PA	Beaver
	15027	Conway, PA	Beaver
	15043	Georgetown, PA	Beaver
	15026	Clinton, PA	Beaver
	15077	Shippingport, PA	Beaver
	15052	Industry, PA	Beaver
	15081	South Heights, PA	Beaver
	15042	Freedom, PA	Beaver
	15066	New Brighton, PA	Beaver
	15001	Aliquippa, PA	Beaver
	15059	Midland, PA	Beaver

	15061	Monaca, PA	Beaver
Washington County, Pennsylvania	**ZIP**	**CITY AND STATE**	**COUNTY**
	15055	Lawrence, PA	Washington
	15366	Van Voorhis, PA	Washington
	15057	Mc Donald, PA	Washington
	15378	Westland, PA	Washington
	15060	Midway, PA	Washington
	15377	West Finley, PA	Washington
	15365	Taylorstown, PA	Washington
	15033	Donora, PA	Washington
	15361	Southview, PA	Washington
	15363	Strabane, PA	Washington
	15368	Vestaburg, PA	Washington
	15053	Joffre, PA	Washington
	15054	Langeloth, PA	Washington
	15038	Elrama, PA	Washington
	15376	West Alexander, PA	Washington
	15379	West Middletown, PA	Washington
	15483	Stockdale, PA	Washington
	15067	New Eagle, PA	Washington
	15367	Venetia, PA	Washington
	15434	Elco, PA	Washington
	15477	Roscoe, PA	Washington
	15313	Beallsville, PA	Washington
	15078	Slovan, PA	Washington
	15312	Avella, PA	Washington
	15301	Washington, PA	Washington
	15311	Amity, PA	Washington
	15432	Dunlevy, PA	Washington
	15021	Burgettstown, PA	Washington
	15019	Bulger, PA	Washington
	15419	California, PA	Washington
	15412	Allenport, PA	Washington
	15022	Charleroi, PA	Washington
	15427	Daisytown, PA	Washington
	15429	Denbo, PA	Washington

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

Appendix C: Focus Groups

Various methods were used to invite people to participate in the focus groups that were conducted in Erie, Pennsylvania, Niles, Ohio, and Beachwood, Ohio. Individuals from a wide variety of organizations and communities participated in the focus group process.

In the Cleveland area, a flier was distributed through the community advertising the focus group. The goal was to engage participants from throughout the community rather than being limited to individuals with a direct connection to Glenbeigh. The flier was successful and individuals representing many aspects of the community attended and participated.

The following section provides an overview of key findings from the focus groups. The findings are representative of the defined service area of Glenbeigh.

Primary data collection. Input from survey distributed to community members participating in focus group conducted at the Glenbeigh Outpatient Center of Beachwood. Participants represent people in recovery, family of people in recovery and individuals working in the addiction treatment field.

OVERVIEW

5 PARTICIPANTS

AVERAGE TIME OF INTERVIEW: **90** MINUTES

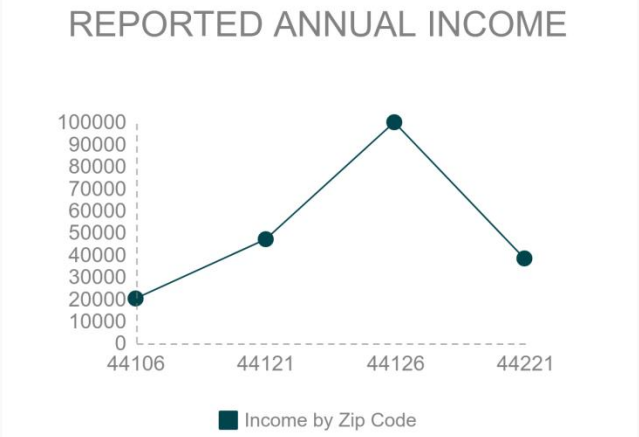
PARTICIPANTS GENDER

MALE	3
FEMALE	2

PARTICIPANTS RACE

BLACK/AFRICAN AMERICAN	0
WHITE/CAUCASIAN	5
NO RESPONSE	0

PARTICIPANT INCOME SELF-REPORTED (1 NO RESPONSE)



ZIP CODE

44106	1
44121	1
44126	1
44140	1
44221	1

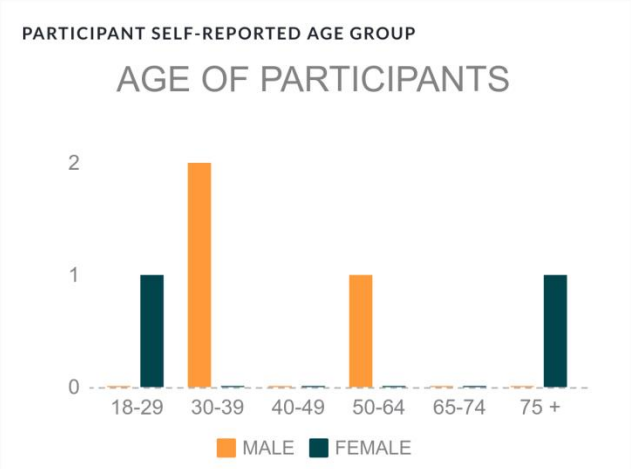
IN RECOVERY

YES	4
NO	1

QUESTIONS	YES	NO
Participants with a family member in recovery.	4	1
In recovery who have found sustainable employment.	3	*
Participants interested in field of addiction treatment if scholarships paid education.	3	*
Participants who believe there are enough recovery support options in area.	3	1*

* Indicates left blank or N/A

PARTICIPANT SELF-REPORTED AGE GROUP



Do healthcare providers understand the needs of family members seeking help and/or the needs of people living in recovery?
Yes - 3 No - 2

What is the most significant barrier you experienced when seeking access to addiction treatment?

- Insurance/Payment
- Ignorance of intake people
- Insurance/care provider bias
- Detoxification for indigent

What is being done well in the community in terms of addressing addiction and improving quality of life?

- Disease model is more accepted
- Sending people to AA - NA meetings
- Newspaper/press coverage
- Court systems
- Treatment - length of care
- Legislature attention/media attention
- Self-help - awareness and understanding
- Half-way house community
- Increase funding

Primary data collection. Input from survey distributed to community members participating in focus group conducted at the Glenbeigh Outpatient Center of Niles. Participants represent people in recovery, family of people in recovery and individuals working in the addiction treatment field.

OVERVIEW

8 PARTICIPANTS

AVERAGE TIME OF INTERVIEW: **90** MINUTES

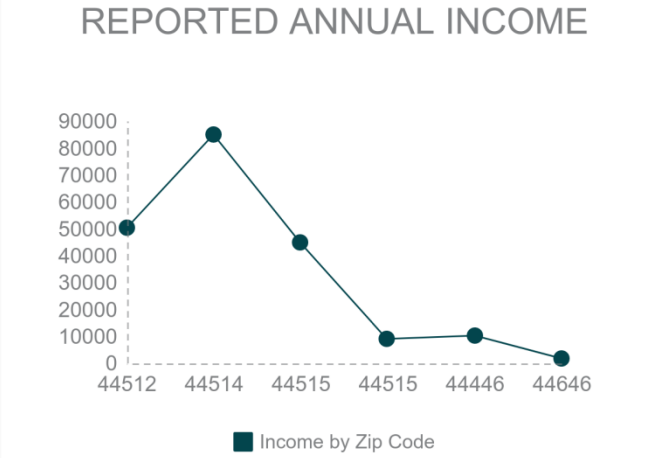
PARTICIPANTS GENDER

MALE	5
FEMALE	3

PARTICIPANTS RACE

BLACK/AFRICAN AMERICAN	2
WHITE/CAUCASIAN	5
NO RESPONSE	1

PARTICIPANT INCOME SELF-REPORTED (2 NO RESPONSE)



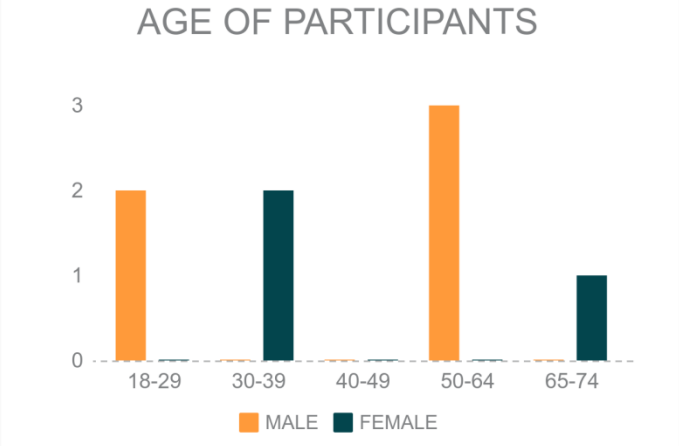
ZIP CODE	
44512	1
44514	1
44515	2
44446	3
44646	1

IN RECOVERY	
YES	7
NO	1

QUESTIONS

	YES	NO
Participants with a family member in recovery.	3	5
In recovery who have found sustainable employment.	5	3
Participants interested in field of addiction treatment if scholarships paid education.	3	5
Participants who believe there are enough recovery support options in area.	5	3

PARTICIPANT SELF-REPORTED AGE GROUP



Do healthcare providers understand the needs of family members seeking help and/or the needs of people living in recovery?

Yes - 2 No - 6

What is the most significant barrier you experienced when seeking access to addiction treatment?

- Lack of education of patient and physician
- Cost
- Lack of insurance
- Knowledge of recovery
- Cost and shortage of providers
- Marginalized groups - LGBTQ

What is being done well in the community in terms of addressing addiction and improving quality of life?

- Empathy and care from within community
- Collaboration to bring Vivitrol to community
- Strong recovery in fellowships - AA/NA
- Judicial system support for addiction
- Group meetings
- Community Outreach

Primary data collection. Input from survey distributed to community members participating in focus group conducted at the Raymond Blasko MD Memorial Library, Erie, PA. Participants represent people in recovery and individuals working in the addiction treatment field. Note: One individual did not return the survey which is reflected in overview numbers and accounts for only 6 responses.

OVERVIEW

7 PARTICIPANTS

AVERAGE TIME OF INTERVIEW
65 MINUTES

PARTICIPANTS GENDER

MALE	3
FEMALE	4

PARTICIPANTS RACE

BLACK/AFRICAN AMERICAN	0
WHITE/CAUCASIAN	7
NO RESPONSE	0

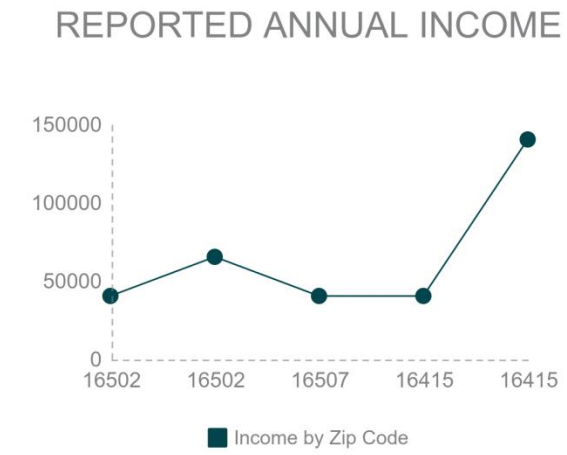
ZIP CODE

16502	2
16507	1
16510	1
16415	2
N/A	1

IN RECOVERY

YES	3
NO	3
N/A	1

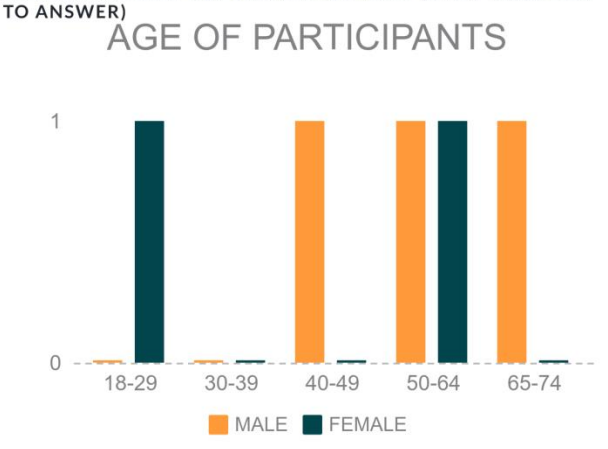
PARTICIPANT INCOME SELF-REPORTED (2 NO RESPONSE)



QUESTIONS

	YES	NO
Participants with a family member in recovery.	2	4
In recovery who have found sustainable employment.	2	N/A
Participants interested in field of addiction treatment if scholarships paid education.	1	N/A
Participants who believe there are enough recovery support options in area.	3	3

PARTICIPANT SELF-REPORTED AGE GROUP (ONE PREFER NOT TO ANSWER)



Do healthcare providers understand the needs of family members seeking help and/or the needs of people living in recovery?
Yes - 1 No - 4 Not Sure - 1

What is the most significant barrier you experienced when seeking access to addiction treatment?
- Affordability/Cost
- Access
- Awareness
- No sober living
- The process of getting signed up
- Lack of extended care options for under/uninsured

What is being done well in the community in terms of addressing addiction and improving quality of life?
- Options for varying levels of treatment
- Options for those without insurance
- Educating community-especially teens
- Expansion beyond 12-Step programs
- Good initial access
- Erie County availability of services is amazing

Appendix D: Focus Group Survey

The following survey was distributed to, and collected from, all focus group participants.

2019 Glenbeigh Health Needs Survey

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

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

1. What is your zip code? (Please write your 5-digit ZIP code) _____

2. What is your sex? (Please check one)
   - ☐ Male
   - ☐ Female
   - ☐ Transgender
   - ☐ Other _____

3. What is your age group (years)?
   - ☐ 18-29
   - ☐ 30-39
   - ☐ 40-49
   - ☐ 50-64
   - ☐ 65-74
   - ☐ 75+
   - ☐ Don't know
   - ☐ Prefer not to answer

4. What race do you identify as? _____

5. Are you currently in recovery? ☐ Yes ☐ No

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

7. What is your annual income? _____

8. If you are in recovery, have you found sustainable employment? ☐ Yes ☐ No
   If no, what is the greatest barrier to finding a well-paying job? _____
   Would you be interested in entering the field of addiction treatment if scholarships were available to cover your education? ☐ Yes ☐ No

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

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

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

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

Appendix E: Key Informant Interview Summary

4 Phone Interviews:
30 Minutes Each

Service Area Perspective:
Erie County - Western Pennsylvania

Glenbeigh
ACMC Healthcare System
An affiliate of
Cleveland Clinic

YES - YES - YES - NO

In your opinion, are there enough services and treatment programs in your community?

NO - NO - YES - NO

Do you believe there are enough recovery support options in the area?

NO - NO - NO - NO

Do you believe healthcare providers understand the needs of family members seeking help for a loved one and/or the needs of people living in recovery?

Do you feel in general that people are aware of existing resources and service available to them? What steps would you recommend someone take to get help?

Zip Code 16505. People who have been in treatment know the resources. Those new to treatment don't know how to navigate the system. PA has a central exchange that helps folks with private insurance. Uninsured don't get direction. Impersonal service. Treatment centers in Florida are enticing people there with money and false hope.

Zip Code 16506. Erie County has may services available and treatment providers are active and visible in the community. Easy to work with and many provide transportation. Focusing on helping addicted pregnant women.

Zip Code 16505. Older/disabled/Medicare population is under served. Not accepted by many providers.

Zip Code 16506. In Erie, a good portion of public know hospitals have detox. There are billboards with 800 number to get help locally. Collaboration among agencies and networking helps people get treatment options.

What suggestions do you have to enhance recovery support?

Zip Code 16505. The area has a strong AA/NA offering recovery oriented events. People need to ***want*** to do them. The are no sober businesses - places run by people in recovery, and few places willing to hire people in recovery.

Zip Code 16506. More agency presence in the community to make addiction a recognized disorder.

Zip Code 16505. Need for more sober living housing. NA/AA is very strong and offers plenty of events.

Zip Code 16506. There are still some meetings that are for alcoholics only that don't welcome drug addicts. Alcohol is a drug of choice so no one should be excluded. Still stigma around drug use even in alcoholic community. Erie county lacks sober housing. Don't know of any.

Do you believe healthcare providers understand the needs of family members seeking help for a loved one and/or the needs of people living in recovery?

Zip Code 16505. Doctors don't have a clue and remain uneducated. They aren't well rounded in the field of addiction treatment. Should be added to medical books.

Zip Code 16506. Some doctors still refuse to recognize addiction. Some are starting to work with agencies. There are 2-3 doctors in Erie County that are actively involved in Drug & Alcohol programs. A physician has a therapist that meets with clients in the office. Nurses are trained to administer Vivitrol. Private.

Zip Code 16505. Majority of doctors don't understand addiction or recovery. Can't get to them to train them. Once doctors are in practice it's almost impossible to speak with them. Many are not interested in hearing/learning about addiction.

Zip Code 16506. Considering the amount of time spent in medical school, very little instruction time is spent on addiction and recovery. Some doctors admit they don't know much. Some are willing to listen and learn from patients in recovery. Doctors need to learn to not enable people.

What is the most significant barrier when seeking access to health care (for addiction)?

Zip Code 16505. The #1 fear is leaving your current situation - not knowing if your family or job will be there when you return. The unknown. The stigma at work - will people look at me funny. Does treatment jeopardize employment and reputation? Middle-class addicts want to do outpatient treatment fearing job loss.

Zip Code 16506. Medicare doesn't carry over to other states for inpatient treatment. Insurance limitations (including large deductibles). Several treatment providers/agencies are offering transportation which is helping. Transportation needed for IOP services. Taxi company is closed and bus passes are being distributed by the county. Slow process. Rural areas are not served - city bus available once a week. Medicare limits to 12 rides per year.

Zip Code 16505. Determining the appropriate level of care. Need medically managed detox as alcohol and drug withdrawal are too acute for medically monitored.

Zip Code 16506. Lack of insurance. Enabling by family members. People are convinced they don't have a problem. Pride/occupation - afraid of being seen. Want anonymity. Professionals groups are good.

What type of education would help professionals/public regarding addiction and recovery?

Zip Code 16505. We are seeing a drop off of family participation. Families are burned out and no longer willing to do anything until confronted. Similar to death - you know it's coming but you don't think about it until it happens, then you deal with it. Clients/patients need to be advocating and wanting family there. Issue is they don't want family to know about disease because they can't manipulate them if they understand the behaviors. Consider a presentation on "What your loved one doesn't want you to know about addiction"

Zip Code 16506. Any education that offers free CEU's for professionals. Topics in need: LGBTQ 101 - understanding the needs of this population and how to effectively work with LGBTQ clients. Family education. The whole family is sick. Open community events including grief groups. Teach family to understand disease - don't understand why loved one can't stop. If family isn't interested, user get annoyed and disengages. Can't for anyone to participate. Find the key.

Zip Code 16505. Outreach/programs for family members. Few Nar-Anon meetings in area. Families are there - need to engage.

Zip Code 16506. Continue to offer educational programs offering CEU's for professionals. Need to publicize better to reach all - have missed some events.

Are there any new trends or emerging issues you feel need to be "on the radar" of providers?

Zip Code 16505. Meth and cocaine use - people have transitioned to these drugs because they are afraid to die. Alcohol use is still number one and has been consistent through the heroin crisis.

Zip Code 16506. Meth and cocaine with fentanyl is taking over. Heroin was everywhere. Alcohol in not being watched - focus is on drugs.

Zip Code 16505. Alcohol is still number one. Meth use with acute psychosis - more dual diagnosis clients. Need to educate clients about MAT. Seeing large numbers of clients starting on MAT, feel good after 2-3 months, stop taking shots, stop IOP/Aftercare, end result is relapse. Need to understand how MAT works and the need to continue treatment despite feeling good.

Zip Code 16506. Early education is key. Educate law enforcement.

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

Zip Code 16505. The Warm Hand Off program works well. MAT program is partially successful. MAT does save lives so from that perspective it is successful. It helps people who will never get clean not die. OD deaths are down. Conversely, there is too much reliance on MAT - behaviors are not changing. MAT changes that addicts are not going to die - it doesn't help them become productive in society. MAT doesn't help set goals. No elevation beyond addiction.

Zip Code 16506. High visibility of agencies in community - show they care about issues by supporting related issues such as suicide prevention.Collaboration among agencies. Contact information is shared among agencies. No competition.

Zip Code 16505. Agencies offer different options - clients have a choice. Good collaboration between agencies. Group texting - meet every 3 months to talk about emerging issues.

Zip Code 16506. Outside AA/NA there are meetings offering unity. Mix of ages is good. Drug folks are feeling more comfortable. The City Mission has a positive program for younger people. Discussion group where they can just say they are doing well. Grateful to have a new life. No pressure.

Other Comments:

One participant has over 20 years in recovery and is a professional in the field of addiction treatment. That participant stated that key to a successful recovery is the desire to get clean. Attend meetings - engage a sponsor - work the steps. 12-Step program should not be dismissed and replaced with MAT. 12-Step is proven effective and with counseling, addictive behaviors can be changed. Families need more education. Fathers tend to think their addicted child should have the self-will to overcome. Mothers tend to enable the addict. Need to address this behavior for positive outcomes.

One participant mentioned that securing entry level employment in the addiction treatment field is difficult, even for individuals in recovery. Some credentialing services aren't recognized as billable therefore agencies are not hiring.

Another participant mentioned that a single entity is becoming a major provider in the area and does not participate in the established inter-agency collaboration. Is limiting access to physicians and other addiction treatment providers.

All participants mentioned inter-agency collaboration in Erie County as a significant strength. Also mentioned was the fact that information on where/how to get help is available and visible throughout the community. Individuals seeking help for addiction can call the county authority or any agency and receive a phone screening. Can also receive assistance with placement for treatment. Heavily marketed on TV, Radio, billboards, in jails, in hospitals - anywhere the information is accepted. PA Get Help Now offers resources including funding for treatment.

The majority of those interviewed feel Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) offer a sufficient number of events throughout the area in addition to meetings. Both organizations are highly regarded as doing good work within the community and offering fellowship opportunities for those in recovery.

	A	B	C	D	E	F
1	**Constant Contact Survey**					
2						
3	**Survey Name:** Glenbeigh Community Health Needs Assessment Survey					
4	**Response Status:** Partial & Completed					
5	**Filter:** None					
6	Jul 22, 2019 10:27:16 AM					
7						
8	**1. Please rate your level of agreement with the following statements.**					
9	selecting the option. Bottom % is percent of the total respondents selecting the option.	**Strongly disagree**	**Disagree**	**Neither agree or disagree**	**Agree**	**Strongly agree**
10	There is a sufficient number of resources	2	9	1	7	3
11	for those in need of addiction services in	9%	41%	5%	32%	14%
12	Area addiction and mental health	1	7	5	9	0
13	providers effectively collaborate to	5%	32%	23%	41%	0%
14	In general, residents in your area know	1	9	5	5	2
15	where to go to get help for substance	5%	41%	23%	23%	9%
16	As a result of the opioid epidemic,	0	3	6	10	3
17	physicians and other healthcare	0%	14%	27%	45%	14%
18	There are sufficient recovery support	5	10	2	4	1
19	services such as sober housing and	23%	45%	9%	18%	5%
20	3 Comment(s)					
21						
22						
23	**2. What do you feel are the most significant barriers in your area for people who need access to treatment services for substance abuse and addiction problems?**					
24	21 Response(s)					

	A	B	C	D	E	F
25						
26						
27	**3. What groups, if any, do you feel are most in need of substance abuse and addiction services in your community?**					
28	21 Response(s)					
29						
30						
31	**4. In general, is there a need for more professional education programs on addiction and recovery in your community? Are there any topics not currently covered that you feel should be?**					
32	20 Response(s)					
33						
34						
35	**5. What county do you represent? Select all that apply.**					
36			**Number of Response(s)**	**Response Ratio**		
37	Ashtabula		0	0.0%		
38	Cuyahoga		6	28.5%		
39	Lake		2	9.5%		
40	Portage		2	9.5%		
41	Stark		2	9.5%		
42	Summit		2	9.5%		
43	Trumbull		5	23.8%		
44	Other		11	52.3%		
45	Total		21	100%		
46						
47						

	A	B	C	D	E	F
48	6. What is your gender?					
49			Number of Response(s)	Response Ratio		
50	Male		7	31.8%		
51	Female		15	68.1%		
52	Prefer not to answer		0	0.0%		
53	No Responses		0	0.0%		
54	Total		22	100%		
55						
56						
57	7. Are you in recovery from alcohol or drug addiction?					
58			Number of Response(s)	Response Ratio		
59	Yes		8	36.3%		
60	No		14	63.6%		
61	No Responses		0	0.0%		
62	Total		22	100%		
63						
64						
65	8. Please feel free to add any additional comments.					
66	5 Response(s)					

- Too many PCPs prescribe Benzos ignoring psychiatrists' recommendations. Many inpatient D&A treatment centers refuse to take a psychiatric patient even if they are a 3.5 facility. Glenbeigh is one of the few who will accept the dually diagnosed.
- There are limited positive things for recovering people to do other than attend meetings - they need fun things to do.
- In my opinion treatment for opioid addiction is sorely lacking. Financial restrictions aside, long term, residential treatment is the only option.

What do you feel are the most significant barriers in your area for people who need access to treatment services for substance abuse and addiction problems?

- Knowing what is available; being able to discern quality treatment providers from predatory treatment providers; no money for recovery supports (i.e. recovery housing, peer support, etc.)
- Cost, barriers to obtain medical insurance, transportation
- Stigma attached to addiction, multiple relapses, etc.
- Ready availability of opiates, meth, and other substances
- Psychiatric history
- Lack of information in the community
- Available beds and financial resources
- A high percentage of people who need treatment are uninsured or underinsured and facilities won't accept these people
- Transportation
- Lack of motivation for treatment
- Timely service for people who do not have insurance
- In Medina County, housing and transportation are the largest barriers
- Transportation and demands from parole and probation
- The ability to access services when they are ready without having to jump through all the hoops. Either you don’t have insurance or the facility doesn't take your insurance
- Lack of insurance coverage or insurance coverage with very high deductibles and coinsurance percentages
- Lack of resources - especially healthcare
- Lack of motivation on the part of the user
- Not knowing where to go for help
- The belief that all I have to do is stop
- Switching drugs so I won't get addicted: from alcohol to opiates, to heroin, to cocaine, to meth, etc.

- Fear of stygmatization and criminalization of a public health crisis and lack of harm-reduction resources in the community, particularly access to MAT's while remaining compliant with the rigors of mandatory criminal justice interventions and community control sanctions
- Immediate access
- Expense
- Money, housing, emotional support
- The cost of the treatment facility
- The stereo-type of a drug user
- Transportation
- Quality programs

What groups, if any, do you feel are most in need of substance abuse and addiction services in your community?

- All, including those who are addicted, family members and children living with an addicted parent
- I believe there is a gap for older individuals, most groups focus on younger persons
- Young, old, and middle-aged
- The unemployed and alienated
- Co-occurring consumers
- The homeless
- Ones with no insurance or underinsured
- I suppose there are some groups that are less educated about services but I don't believe substance abuse or addiction discriminates so all people need to be considered
- Teens with addiction. Support groups for partners and family
- All
- Co-occurring with assignments to review in individual or group support settings
- Middle income bracket due to insurance issues
- No specific employment groups. If you consider "relapsers" a group then I'd say them
- Opioid users for sure. But there is a general lack of education, knowledge and support on the part of the medical community
- High school kids and folks in early 20's
- The homeless population, dual-diagnosed, co-morbid mental health/substance use disorder clients and ex-offenders re-entering the community following lengthy periods of incarceration
- Adults
- Employers
- The uninsured

- Blue-collar workers
- Young adults in their 20's
- Teenage thru 50 year olds
- Access to more recovery groups for skilled workers and professionals (healthcare, law, and other professionals)

In general, is there a need for more professional education programs on addiction and recovery in your community? Are there any topics not currently covered that you feel should be?

- Info on meth addiction
- Yes - there is a need for continuing education in the area of addiction for professionals
- Prevention / education
- In a perfect world, no one would ever start using an addictive substance without first knowing the risks
- More community knowledge of relapse and recovery needed
- More job opportunities and job training for those with addictions. They come out of rehabs with no jobs. Idle time causes them to relapse.
- Dual dx, a better collaboration between mental health and addiction
- In my capacity I am satisfied with what is being offered.
- Not known
- Unsure - more is always better
- The topics, knowledge and training are all there. The issue is the people/employers/legal system/medical communities that really need the education never seem to show up for trainings even when they are free
- Of course. Both for the medical community and the general public
- Still addiction as a disease rather than as personal weakness
- Suicide lethality awareness and mandatory intervention, reporting and response training
- Yes because no matter how much you think so people who do not suffer from addiction truly do not understand the disease
- Childhood trauma caused by addicted family members
- Need for more education programs
- There is always a need for more education on the topic of alcohol and substance abuse. It is about education, education, education

Appendix H: State of Ohio Health Assessment 2019

In mid-September 2019, the state of Ohio published the 2019 State Health Assessment online at https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship/. The 2020-2022 State Health Improvement Plan is still in development and is not available at the time of this CHNA report.

The executive summary, prepared by the Health Policy Institute of Ohio, identifies the key findings along with next steps the state of Ohio plans to implement over the next three years. Glenbeigh's CHNA will complement the state improvement plan areas that are in line with the mission of Glenbeigh – with a focus on addiction and recovery from substance use disorders.

Executive Summary of the 2019 Ohio Health Assessment (SHA)

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

Other information from the 2019 Ohio Health Assessment

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

SHA State Health Assessment Ohio 2019

Released Sept. 9, 2019

Executive summary

What is the State Health Assessment (SHA)?

The 2019 SHA is a comprehensive and actionable picture of health and wellbeing in Ohio. The SHA has two main components:

- Summary report prepared by the Health Policy Institute of Ohio (HPIO)
- Online, interactive data website prepared by the Ohio Department of Health (ODH)

Key findings

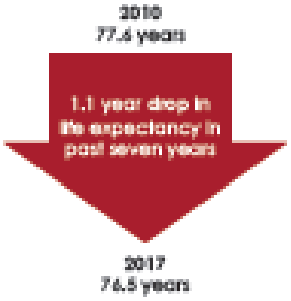
Overall wellbeing for Ohioans has declined. Trends in premature death, life expectancy and overall health status indicate that the health of Ohioans has worsened. Unintentional injuries (including drug overdose), cancer and heart disease were the leading causes of premature death in 2017.

Many Ohioans lack opportunities to reach their full health potential. SHA data identifies several groups that experience much worse outcomes than the state overall, including Ohioans who are black/African American, have lower incomes, have disabilities or live in Appalachian counties.

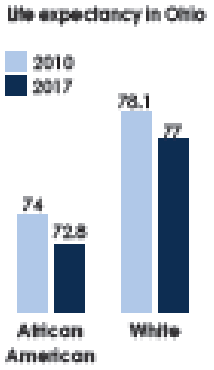
Underlying drivers of health must be addressed. Data and regional forum findings support the need to address the following cross-cutting factors: physical activity, tobacco use, access to dental and mental health care, income and unemployment, adverse childhood experiences, transportation, lead poisoning risk and racism.

Mental health and addiction, chronic disease, and maternal and infant health continue to be significant challenges in Ohio. Ohio's performance on these priorities has worsened or remained unchanged in recent years.

New concerns emerge in the wake of Ohio's addiction crisis. Drug use has contributed to troubling increases in hepatitis C and children in foster care.

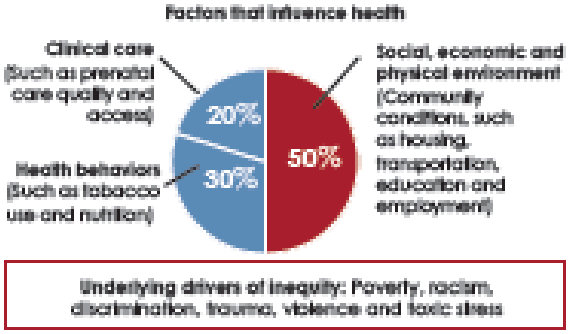


Life expectancy drop serves as call to action
After decades of improvement, Ohioans' life expectancy at birth declined from 2010 to 2017 by about one year.



Impact of racism and discrimination persists
Historical and contemporary injustices compound over a lifetime, leading to higher rates of infant deaths, blood pressure, late-stage cancer diagnoses and shorter lives for some groups, particularly black/African-American Ohioans.

Multi-sector collaboration to improve health is critical
An estimated 80 percent of the modifiable factors that impact overall health are attributed to community conditions and the opportunity to make healthy choices.



How to access the SHA

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

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

The road to improvement

SHA findings emphasize that improvement must build upon:

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

Next steps

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

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

How was the SHA developed?

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

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

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

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

Regional forum insights

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

Health outcomes

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

Cross-cutting factors

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

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

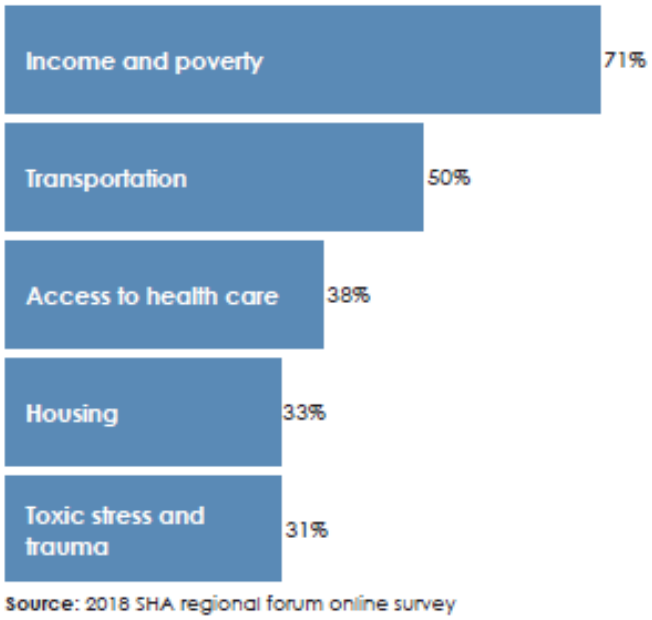
Source: https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship/

Throughout the course of obtaining qualitative data for the Glenbeigh CHNA, informants reported barriers to treatment for substance use disorders. Comparing this information to the top-five barriers reported in the 2019 SHA, similarities exist. Income and poverty are the most significant barrier reported in the SHA. Glenbeigh stakeholders reported a fear of unemployment, or not being able to go without a paycheck, as a significant barrier.

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

Limited access to health care remains a significant barrier to treatment for substance use disorders. More treatment facilities have opened specializing in opioid (heroin) addiction however the need for facilities that treat alcohol and other drug addictions remains high. A seocndary factor limiting access to health care in the Glenbeigh region is the shortage of licensed, eductated professionals to treat substance use disorders. Northeast Ohio and areas of Western Pennsylvania are predominantly rural and are within the Appalachian region.

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

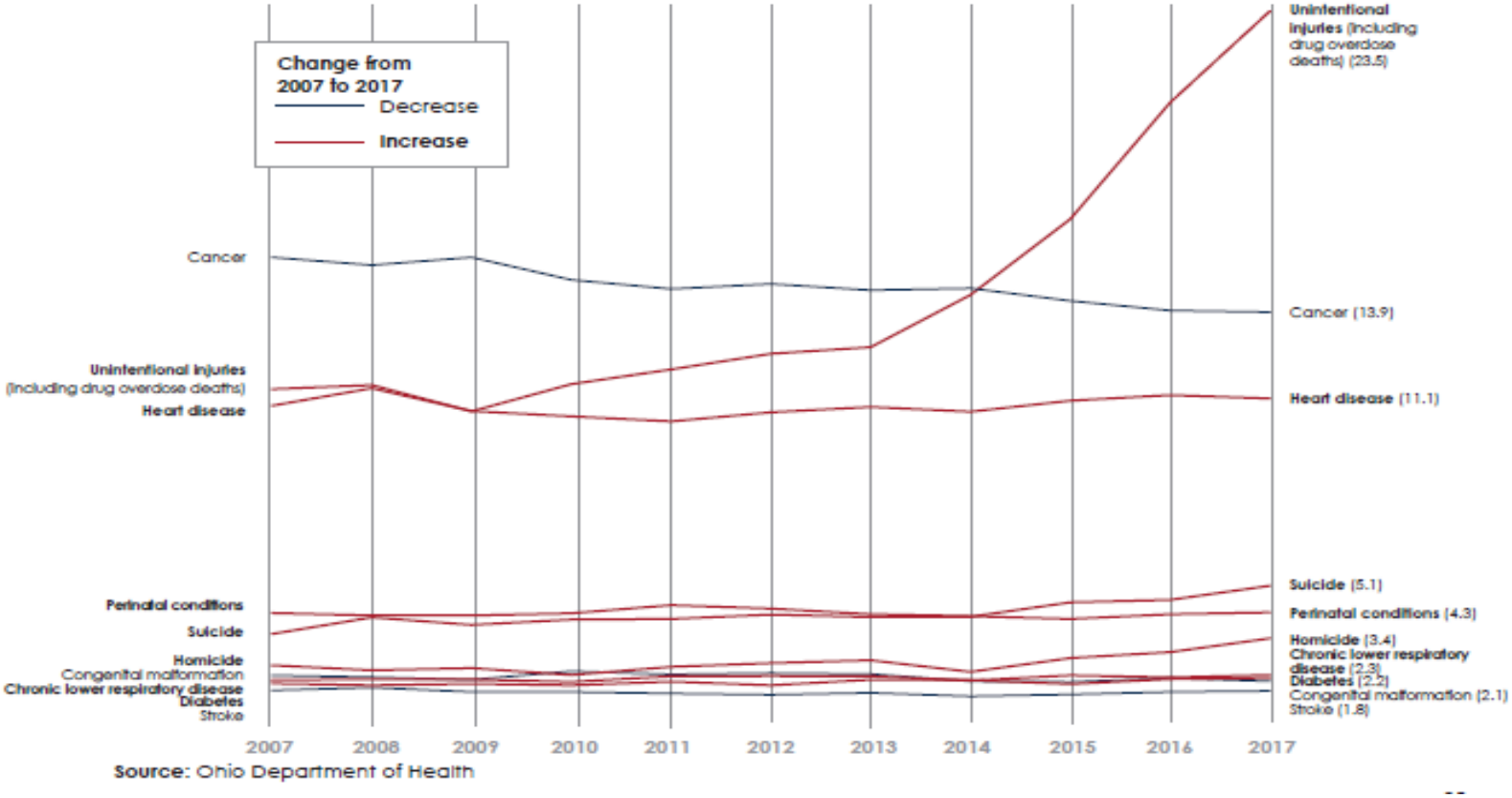


Source: 2018 SHA regional forum online survey

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

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

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



Source: Ohio Department of Health

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

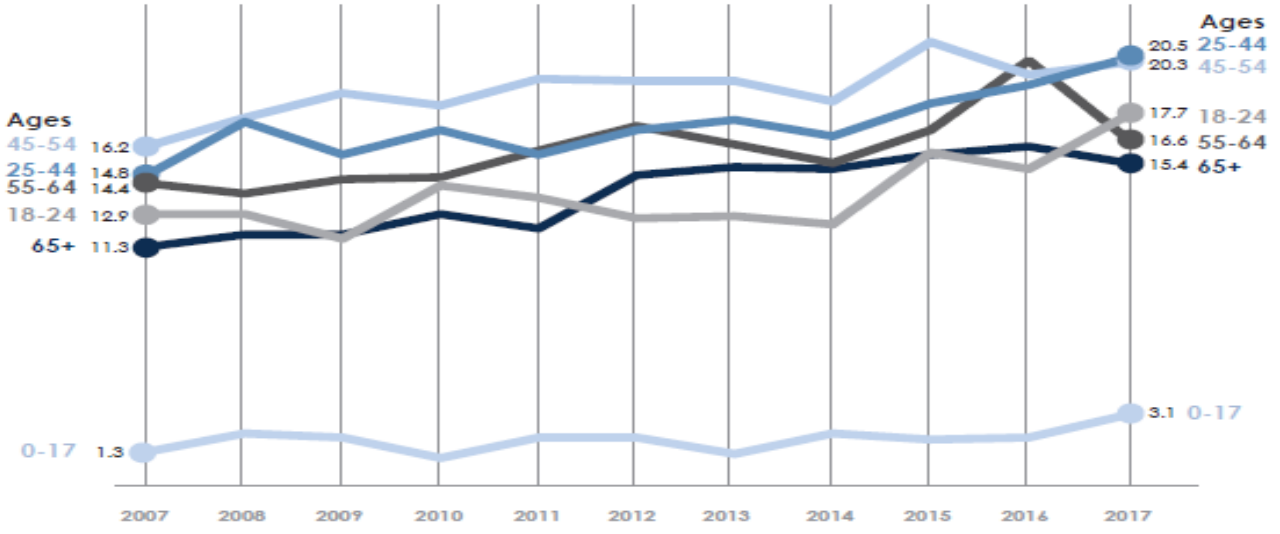
Heart Disease: According to the American Heart Association (https://www.heart.org/HEARTORG/Conditions/More/MyHeartandStrokeNews/Cocaine-Marijuana-and-Other-Drugs-and-Heart-Disease_UCM_428537_Article.jsp), illegal drugs can adversely affect the cardiovascular system and heart function. Cocaine, heroin and some amphetamines can affect the central nervous system and may cause changes in heart rates, blood pressure and heart tissue. Both recreational and habitual cocaine use increases the risk for heart attack. Amphetamines increase heart rates and blood pressure.

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

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

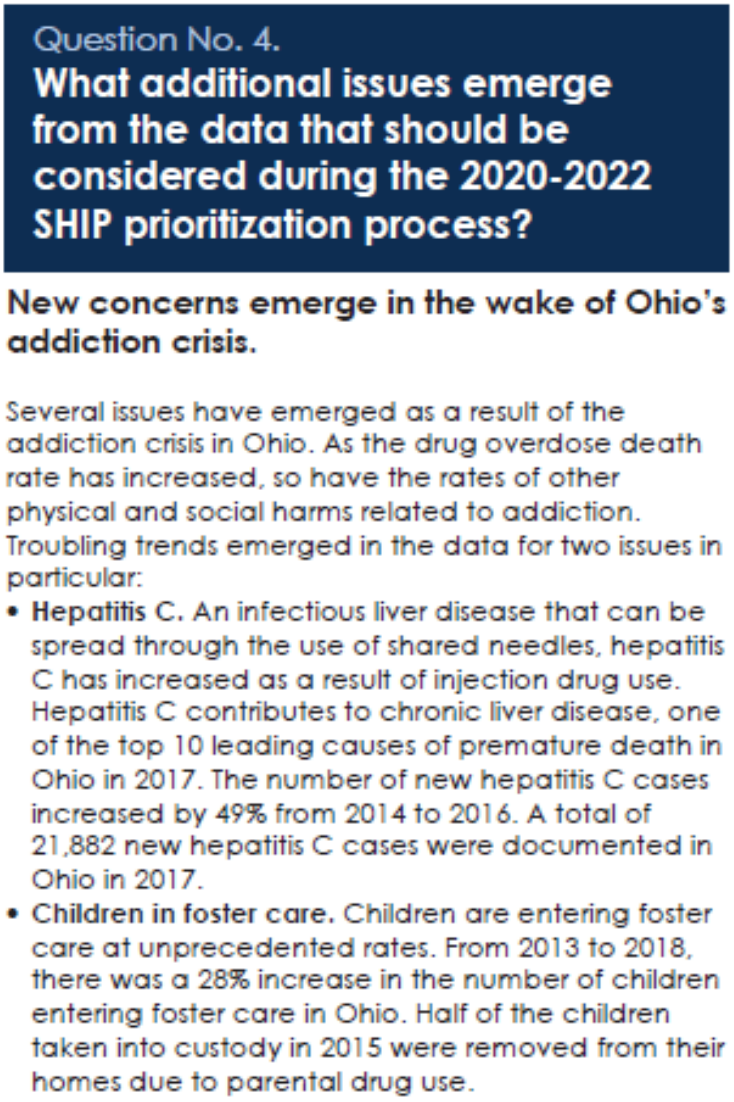
Depression and Suicide: In 2010, the National Center for Biotechnology Information reported (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2872355/) that suicide was an escalating public health issue and that alcohol use often led to suicidal behaviors. Depression and substance abuse are often associated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

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



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

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



Question No. 4.

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

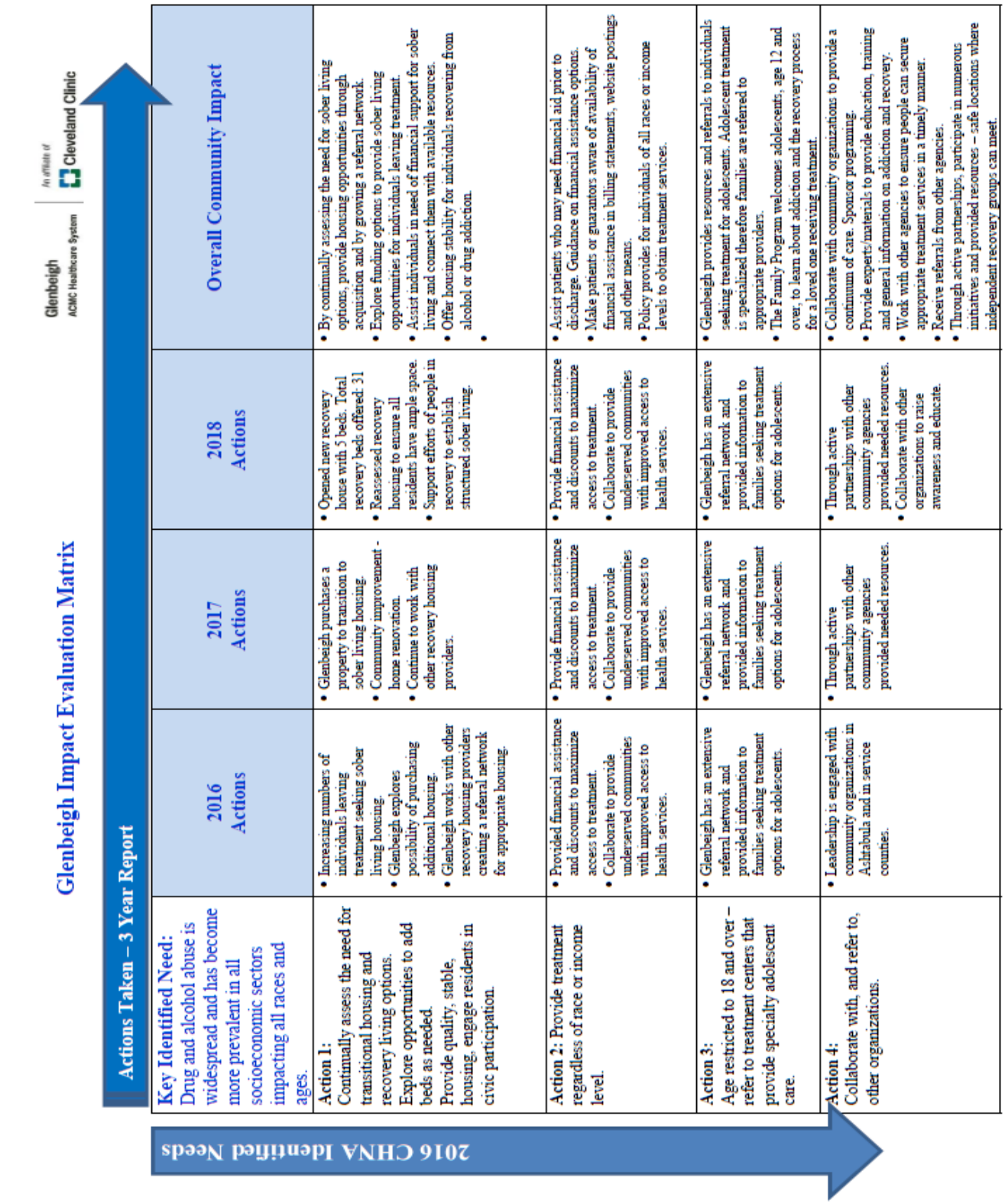
New concerns emerge in the wake of Ohio's addiction crisis.

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

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

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

Appendix I: Glenbeigh Impact Matrix 2016 to 2018



Key Identified Need: Drug and alcohol abuse is widespread and has become more prevalent in all socioeconomic sectors impacting all races and ages.	2016 Actions	2017 Actions	2018 Actions	Overall Community Impact
Action 1: Continually assess the need for transitional housing and recovery living options. Explore opportunities to add beds as needed. Provide quality, stable, housing, engage residents in civic participation.	• Increasing numbers of individuals leaving treatment seeking sober living housing. • Glenbeigh explores possibility of purchasing additional housing. • Glenbeigh works with other recovery housing providers creating a referral network for appropriate housing.	• Glenbeigh purchases a property to transition to sober living housing. • Community improvement - home renovation. • Continue to work with other recovery housing providers.	• Opened new recovery house with 5 beds. Total recovery beds offered: 31 • Reassessed recovery housing to ensure all residents have ample space. • Support efforts of people in recovery to establish structured sober living.	• By continually assessing the need for sober living options, provide housing opportunities through acquisition and by growing a referral network. • Explore funding options to provide sober living opportunities for individuals leaving treatment. • Assist individuals in need of financial support for sober living and connect them with available resources. • Offer housing stability for individuals recovering from alcohol or drug addiction. •
Action 2: Provide treatment regardless of race or income level.	• Provided financial assistance and discounts to maximize access to treatment. • Collaborate to provide underserved communities with improved access to health services.	• Provide financial assistance and discounts to maximize access to treatment. • Collaborate to provide underserved communities with improved access to health services.	• Provide financial assistance and discounts to maximize access to treatment. • Collaborate to provide underserved communities with improved access to health services.	• Assist patients who may need financial aid prior to discharge. Guidance on financial assistance options. • Make patients or guarantors aware of availability of financial assistance in billing statements, website postings and other means. • Policy provides for individuals of all races or income levels to obtain treatment services.
Action 3: Age restricted to 18 and over – refer to treatment centers that provide specialty adolescent care.	• Glenbeigh has an extensive referral network and provided information to families seeking treatment options for adolescents.	• Glenbeigh has an extensive referral network and provided information to families seeking treatment options for adolescents.	• Glenbeigh has an extensive referral network and provided information to families seeking treatment options for adolescents.	• Glenbeigh provides resources and referrals to individuals seeking treatment for adolescents. Adolescent treatment is specialized therefore families are referred to appropriate providers. • The Family Program welcomes adolescents, age 12 and over, to learn about addiction and the recovery process for a loved one receiving treatment.
Action 4: Collaborate with, and refer to, other organizations.	• Leadership is engaged with community organizations in Ashtabula and in service counties.	• Through active partnerships with other community agencies provided needed resources.	• Through active partnerships with other community agencies provided needed resources. • Collaborate with other organizations to raise awareness and educate.	• Collaborate with community organizations to provide a continuum of care. Sponsor programing. • Provide experts/materials to provide education, training and general information on addiction and recovery. • Work with other agencies to ensure people can secure appropriate treatment services in a timely manner. • Receive referrals from other agencies. • Through active partnerships, participate in numerous initiatives and provided resources – safe locations where independent recovery groups can meet.

Glenbeigh Impact Evaluation Matrix

Glenbeigh ACMC Healthcare System | An affiliate of Cleveland Clinic

2016 CHNA Identified Needs

Actions Taken – 3 Year Report

Key Identified Need: Social and economic factors are correlated with drug and alcohol abuse.	**2016 Actions**	**2017 Actions**	**2018 Actions**	**Overall Community Impact**
Action 1: Continue to provide detoxification services to counties that lack resources.	• Provide detoxification services to counties without resources.	• Provide detoxification services to counties without resources.	• Provide detoxification services to counties without resources.	• Work with counties throughout Ohio and provide detoxification services to those that have no or limited service providers in their communities. • Outreach programs with community agencies helps individuals in need of detox and treatment receive appropriate services.
Action 2: Provide charitable care options for uninsured/underinsured who meet clinical and financial eligibility and who are in need of treatment.	• Provided financial assistance and discounts to maximize access to treatment. • Financial assistance is based upon a combination of factors. • $4.97 million in charitable care was provided.	• Provided financial assistance and discounts to maximize access to treatment. • Financial assistance is based upon a combination of factors. • $4.13 million in charitable care was provided.	• Provided financial assistance and discounts to maximize access to treatment. • Financial assistance is based upon a combination of factors. • $4.60 million in charitable care was provided. • Financial policy is available to the public.	• Financial assistance is available based upon a sliding fee scale. Allows individuals with low income, minimal net assets and without health insurance to access health care. • Patients are informed of the estimated amounts that are their responsibility prior to discharge. • Individuals are provided with guidance on how to apply for financial assistance. • Over $13.70 million in charitable care was provided to assist uninsured and underinsured individuals who met financial eligibility criteria for inpatient and outpatient treatment.
Action 3: Collaborate and refer to, or accept referrals from, other agencies to assist individuals seeking treatment.	• Glenbeigh has an extensive referral network and provided information to individuals seeking treatment.	• Glenbeigh continued to expand its referral network and provided options for individuals seeking treatment for drug or alcohol addiction.	• Glenbeigh continued to expand and refine a referral network. Reached out to drug courts and other social service agencies offering assistance/education.	• Admission specialists speak with callers to determine the best course of action based on reported use of alcohol or drugs. • Glenbeigh's referral network is a two-way street with referrals made between agencies.
Action 4: Provide transportation to individuals who have no access to a vehicle.	• Glenbeigh provided transport to individuals seeking treatment and to those with a standing off-site appointment such as doctor, dentist or court. • Glenbeigh provided transport for IOP/Aftercare.	• Glenbeigh provided transport to individuals seeking treatment and to patients with off-site appointments such as doctor, dentist or court. • Glenbeigh provided transport for IOP/Aftercare	• Glenbeigh provided transport to individuals seeking treatment and to patients with off-site appointments such as doctor, dentist or court. • Glenbeigh provides transport for IOP/Aftercare	• Glenbeigh provides transportation services to individuals seeking treatment who have no means of transport. • Glenbeigh has several transport vehicles available and uses local taxi or other services. • Lack of transportation is a barrier to securing treatment for drug and alcohol addiction. Providing transport breaks down this barrier and allows Glenbeigh to serve all patients regardless of ability to pay.
Action 5: Address economic stability.	• Volunteer at food bank and other social service agencies.	• Volunteer at food bank and other social service agencies.	• Established community garden. • Volunteer at food bank.	• Collaborate within community to enhance food security. • Offer engagement in community garden. • Locate recovery housing near employment and other resources.

Glenbeigh Impact Evaluation Matrix

Glenbeigh ACMC Healthcare System | An affiliate of Cleveland Clinic

2016 CHNA Identified Needs

Actions Taken – 3 Year Report

Key Identified Need: Drug overdose death rates have increased significantly throughout the community, as have the accessibility and affordability of heroin.	2016 Actions	2017 Actions	2018 Actions	Overall Community Impact
Action 1: Promote the use of, and provide training for, Naloxone. Support efforts of other organizations to provide Naloxone.	• Offered Naloxone training to individuals leaving treatment prematurely and at high risk of overdose. • Provided training for business representatives in various communities.	• Collaborated with other agencies and local law enforcement to distribute Naloxone to public. Provided Naloxone for distribution. • Provided training and kits to recovery house managers and residents.	• Provided training and kits to recovery house managers and residents. • Collaborated with other agencies to offer education on overdose risks and the use of Naloxone.	• Work with other organizations to compliment Naloxone training. • Provide Naloxone for distribution through area agencies. • Provide education on the risks of overdose associated with relapse after abstinence. • Continue to collaborate with county health agencies to ensure Naloxone is distributed to individuals in need.
Action 2: Provide education on short-term medically assisted treatment options.	• Develop education curricula on medically assisted treatment options. • Work with other treatment providers to establish a referral network for individuals seeking alternative treatment options.	• Educate on use and effectiveness of MAT options with continued therapeutic care. • Interact with treatment providers to refer individuals seeking specialized treatment. • Explore need for providing community access to Vivitrol®.	• Educate on use and effectiveness of MAT options with continued therapeutic care. • Interact with treatment providers to refer individuals seeking specialized treatment. • Work to establish program to offer community access to Vivitrol®.	• Provide education on medically assisted treatment (MAT) options for opioid addiction. • Protocol in place to counsel and educate on use of MAT options. • Protocol in place for those wishing to begin MAT treatment options. • Interagency referral network assists patients seeking alternative treatment options. • Provide education on the importance of continued treatment in conjunction with MAT.
Action 3: Provide resource materials and education to address drug use and how to successfully achieve long-term recovery after treatment.	• Offered a series of Alcohol and Other Drug Education & Support Group meetings at no cost. • Provide education and support groups for family and friends of addicted adults. • Promote long-term recovery.	• Offered Alcohol and Other Drug Education & Support Group meetings at no cost. • Canton offers a Support Group for Family Members of Addicted Adults	• Canton offers support for Family Members of Addicted Adults.	• Develop and offer education and support groups that provide the latest information on addiction and recovery. • Collaborate with community organizations to provide a continuum of care that supports economically and medically underserved areas. • Through education on addiction and recovery all parties involved with the addicted individual benefit thus reducing the risk of relapse.
Action 4: Offer family support groups in service areas.	• Family members may participate in free family education and family programming.	• Family members may participate in free family education and family programming.	• Family members may participate in free family education and family programming.	• Provide family education and other family programs. Involving family members in the recovery journey facilitates healthy behaviors for when the patient returns home.

Glenbeigh Impact Evaluation Matrix

Glenbeigh ACMC Healthcare System | An affiliate of Cleveland Clinic

2016 CHNA Identified Needs

Actions Taken – 3 Year Report

Key Identified Need: Opioid pain medication is being over-prescribed throughout the region.	**2016 Actions**	**2017 Actions**	**2018 Actions**	**Overall Community Impact**
Action 1: Distribute relevant addiction and recovery information to caregivers and the community.	• Offered professional and general education opportunities with focus on opioids. • Offered programs where participants can learn the latest about addiction and recovery.	• Developed new video for website. • Launched Glenbeigh speaks series that promotes positive messaging and information on addiction and recovery. • New Music & Message series launched.	• Offer professionals and general educational opportunities with focus on alcohol and drug use. • Host Music & Message series in various communities.	• Provide professional education workshops free of charge providing an opportunity to learn about addiction and recovery. Provide CEUs for professionals. • Offer free seminars that educate, motivate and empower. • Have available positive messaging about addiction and recovery.
Action 2: Make resources available through mobile communications and social media sources.	• Maintain active Facebook/ Linked-in/Twitter accounts. • Distribute information using electronic and print platforms.	• Updated website platform to ensure access via mobile devices. • Create original content for Facebook postings. • Distribute information using electronic and print platforms.	• Resources are available through the website on drug and alcohol use. • Distribute information using electronic and print platforms. • E-newsletter distributed with event information.	• Social media networks are used to reach young adults to connect them with a supportive recovery community. • The website is a resource for information on educational programming and events. • The website provides information of various drugs and alcohol.
Action 3: Support efforts to educate and spread positive recovery messaging. Offer social events for the recovery community.	• Sponsor Rock & Recovery Radio – CLEAR -alcohol free zone at Scrappers field. • Created Bridges to Recovery to engage people tied to recovery.	• Sponsor Radio-CLEAR-county events-alcohol free zone at Scrappers field. • Expanded Bridges to Recovery to more communities – introduce new format.	• Sponsor Radio- county events-CLEAR-alcohol free zone at Scrappers field. • Provide free events including picnics, pumpkin parties, etc.	• Sponsor the efforts of organizations that promote recovery. • Support efforts of spreading positive messaging. • Create new formats/social events for the recovery community. • Provide opportunities for people in recovery to enjoy inclusive social events.
Action 4: Offer support and education to family and friends of addicted adults.	• Provide free education to family members. • Refer families and help find resources. • Support and educate family and patient.	• Revised family education program. • Refer families and help find resources. • Support and educate family and patient. • Host community forums that offer education/ support.	• Provide free education to family members. • Refer families and help find resources. • Support and educate family and patient.	• Provide materials and education to support families affected by addiction. • Offer support and encouragement to family/ friends of addicted adults. • Collaborate with other agencies to provide support and education to family and friends. • Work with professionals to offer assistance to families.

Glenbeigh Impact Evaluation Matrix

Glenbeigh ACMC Healthcare System | An affiliate of Cleveland Clinic

2016 CHNA Identified Needs

Actions Taken – 3 Year Report

Key Identified Need: There is a lack of resources available in the community to treat alcohol and drug addiction.	**2016 Actions**	**2017 Actions**	**2018 Actions**	**Overall Community Impact**
Action 1: Continually assess the need for additional beds for all levels of care. Explore need for expansion.	• Continually assess need for additional treatment beds and recovery housing beds.	• Continually assess need for additional treatment beds and recovery housing beds. • Added 32 bed extended care unit.	• Continually assess need for additional treatment beds and recovery housing beds. • Added 5 sober living (3/4) beds.	• Continually assess need for additional treatment beds and recovery housing beds. • Added/removed recovery housing beds to provide optimal conditions for sustained recovery. • Provide housing stability for people in recovery.
Action 2: Create guidelines for living successfully in a recovery community.	• Distribute information to individuals in outpatient treatment and to those living in the recovery community. • Offer programs that promote long-term recovery. • Volunteer at other agencies to promote positive image of recovery.	• Updated information on successfully achieving long-term recovery to address issues related to opioid epidemic. • Offer programs that promote long-term recovery.	• Offer programs that promote long-term recovery. • Volunteer at other agencies to promote positive image of recovery.	• Update information as needed to address usage trends and demographic changes of clients. • Offer relevant programs that promote recovery. • Provide recovery support in all service areas that lack opportunity. • Promote community inclusion and support efforts of other agencies that address social determinants of health.
Action 3: Refer to other agencies to effectively meet the needs of people seeking help for alcohol and drug addiction.	• Explored ways to meet the needs of people with history of drug use. • Maintain an up-to-date referral list and network with other treatment providers and agencies.	• Collaborated with other agency to offer free HIV/Hepatitis testing.	• Continue and explore new ways to collaborate with other agencies to provide access to health care.	• Collaborate with other agencies to provide access to health care. • Maintain a referral network and ties with other treatment providers and acute care facilities to meet the needs of people with pervasive health issues. • Provide relevant information to ensure appropriate access to healthcare.
Action 4: Explore opportunities to provide scholarship funding for students pursuing education in addiction treatment field.	• Provided education and internship opportunities. • Offer continuing education for professionals. • Assist people in recovery interested in entering the field of addiction treatment.	• Provided education and internship opportunities. • Offer continuing education for professionals. • Assist people in recovery interested in entering the field of addiction treatment.	• Provided education and internship opportunities. • Offer continuing education for professionals. • Assist people in recovery interested in entering the field of addiction treatment. • Support workforce development initiatives.	• Offer opportunities to individuals in recovery to obtain education/training to enter addiction treatment workforce. • Support workforce development opportunities offered through local agencies. • Provide oversight and clinical experience to advance career in addiction treatment. • Support goals for obtaining credentialing or advanced degrees in addiction treatment. • Offer programs that educate, empower, motivate and improve addiction treatment.

Glenbeigh Impact Evaluation Matrix

Glenbeigh ACMC Healthcare System | An affiliate of Cleveland Clinic

2016 CHNA Identified Needs

Actions Taken – 3 Year Report

Key Identified Need: The community lacks education and information regarding the services and programs available.	**2016 Actions**	**2017 Actions**	**2018 Actions**	**Overall Community Impact**
Action 1: Distribute information to schools and other organizations that serve the community.	• Distributed 50 Streetdrugs books and reference materials to schools as part of Scrappers Healthy Community Program. • Participated in community events that provide education on addiction and recovery. • Sponsor/participate in events that reduce stigma.	• Distributed 50 Streetdrugs books and reference materials to schools as part of Scrappers Healthy Community Program. • Participated in various community events. • Collaborated with other agencies to educate and reduce stigma.	• Distributed 50 Streetdrugs books and reference materials to schools as part of Scrappers Healthy Community Program. • Collaborate with other agencies to educate and reduce stigma.	• Help school employees recognize illicit drugs and be aware of associated behaviors. • Share information and resources to enhance prevention efforts. • Support prevention efforts. • Distribute materials to law enforcement and caregivers. • Distribute resources to the general community and to service providers. • Sponsor Opiate Summits in various counties. • Invest in education. Offer drug/alcohol presentations and professional workshops at health fairs. Specialize for groups such as future pharmacists, EAP's and business entities. • Presence at community events.
Action 2: Provide educational and social events for the recovering community.	• Social events offered included: Niles Community Banquets, Memorial, Labor Day and 4th of July Picnics, and Rock Creek Recovery Community Picnic.	• Social events offered included: Niles Community Banquets, Memorial, Labor Day and 4th of July Picnics, Rock Creek Recovery Community Picnic, Bridges to Recovery, Yoga	• Alumni Coordinator offers social events for the recovering community. • Explore and test new ideas.	• Glenbeigh has consistently offered sober events for members of the recovery community. The Alumni Coordinator is responsible for the number of sober events offered in each service community. There has been a consistent increase in the number of people attending sober events.
Action 3: Offer educational workshops to professionals in the addiction field.	• Provide free educational workshops for professionals offering CEUs. Update topics to reflect trends. • Attend health fairs and distribute information.	• Provide free educational workshops for professionals offering CEUs. Update topics to reflect trends.	• Provide free educational workshops for professionals offering CEUs. Update topics to reflect trends.	• Provide free educational workshops for professionals offering CEUs. Update topics to reflect trends. • Provide guest speakers at no cost to organizations that promote addiction treatment and recovery efforts.
Action 4: Create educational forum targeting physicians and ministers.	• Developed programing to educate clergy on how to assist people seeking help for addiction. • Distribute resource materials to the public to use as a resource when prescribed medications.	• Offered special training to clergy and others who assist families seeking assistance for addiction. • Update resource materials for physicians/healthcare professionals working with people in recovery.	• Update specialized curriculum to address new trends. • Distribute resource materials to the public to use as a resource when prescribed medications.	• Provide free education to clergy and other professionals working with the public. • Create specialized educational programming. • Expand addiction/recovery literacy among professionals. • Provide resource materials to the public to enhance long-term recovery.

Appendix J: Approach to Prioritizing Health Issues

The 2019 CHNA utilized a cross-sectional study as the tool to prioritize health issues. Multiple approaches were used to collect data and prioritize qualitative data. Secondary (quantitative) data was used in a supporting role to confirm information gleaned from stakeholders.

Community perspective (qualitative data) was a key component to construct a complete community resource inventory. Over 50 community stakeholders were engaged across a diverse cross-section of northeast Ohio and western Pennsylvania encompassing health and non-health disciplines. Using a semi-structured data collection methodology, Glenbeigh conducted interviews, focus groups, and surveys with questions focusing on community needs with a particular focus on elevating health equity throughout the region.

Quantitative data was obtained from the U.S. Census Bureau, county health assessments, state health analysis, Appalachian Regional Commission reports, the Ohio Department of Health, the Centers for Disease Control and Prevention, Ohio State Highway Patrol, Ohio's Automated Rx Reporting System, State Epidemiological Outcomes Workgroup, Harm Reduction Ohio, Ohio Substance Abuse Monitoring Network, the Pennsylvania Department of Health, and the National Drug Threat Assessment to ascertain population characteristics, including socioeconomic factors.

The collective data provide important context to guide how and where Glenbeigh may provide resources for the greatest impact. As the nature of substance use continually changes, the 2019 assessment was broken into two areas that emerged as priority areas based on the evidence gathered. Key findings concentrate on socioeconomic and health needs. As many of the social determinants of health, the conditions that influence differences in health status, have not changed in the service area, many of the related issues are interrelated with the 2016 key findings. A major change from the 2016 CHNA is that Glenbeigh's defined service area shifted to eastern Ohio and western Pennsylvania with a majority of counties in the Appalachian region.

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

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