1. **Activate self management/empowerment in populations at risk and/or experiencing chronic disease in Cuyahoga County (Public Health & Community Goal) (26 votes; commonality with Clinical/PH Group)**
   a. Encourage Health Literacy standards and education of vulnerable communities
   b. Engage community programs such as intergenerational programs and programs that promote/engender social cohesion (V. Impt)
   c. Create incentives for engagement (benefit re-design)
   d. Expand use of community health workers and engage 211 referral line
   e. Address homeliness - provide shelter based treatment services and increase resources
   f. Telemedicine/mobile technology
   g. Strategies for behavioral health
   h. Understand & reduce barriers to self management ownership including expanding and increasing facilitators to work with community
   i. Increase awareness of self management, self monitoring and volunteering opportunities
   j. Aging population – assisted living, housing, community services, health system

2. **Expand place based public health prevention programs (especially those in key risk zip codes) (Public Health & Community Goal) (25 votes, commonality with racism, Clin/PH group, nutrition/PA group)**
   a. Increase funding for implementation for partners
   b. Target youth early childhood (providers, K – 18 years)
   c. Identify chronic disease issues/conditions by zip code and then appropriately target programs
   d. Prevention programs, policies, systems, environmental changes focused on obesity and tobacco
   e. Social and emotional health development
   f. Target behavioral health

3. **Increase meaningful, ongoing cross sector engagement to facilitate and support chronic disease management and prevention. (Public Health & Community Goal) (15 votes, commonality with Clinical/PH Group and Nutrition/PA Group)**
   a. Increase patient engagement in chronic disease prevention and management
   b. Target behavioral health
   c. Build the case to make transparent the systemic costs of chronic disease
   d. Increase outreach and involvement with policy makers and politicians and faith based communities
   e. Explore integration of funding sources and strategies across sectors
f. Involve community organizations involved in economic development, environmental, livability, walkability, safety – neighborhood work

g. Increase purchasers and payers engagement

h. Increase sustainability and public health connection

i. Involve chronic disease experts

j. Involve criminal justice especially when talking about behavioral health

k. Expand use of HIAs across sectors

l. Engage employers and integrate workplace wellness

m. Build and share the holistic case to increase awareness of the systemic cost of chronic disease so that sectors understand role in prevention and treatment

4. Conduct research to better understand the barriers and facilitators to access self management and wellbeing to find out what is working (Public Health & Community Goal) (10 votes, commonality with Clin/PH group)

   a. Find what works-best practices to build on those for behavioral health

   b. Engage community based groups as partners in innovative research collection

   c. Conduct surveys, focus groups, and alternative community based participatory strategies to understand barriers and needs centered on prevention as place matters

   d. Explore/learn from national and international practices for success

5. Encourage health professions training schools to increase the focus on primary care, prevention, and wellness. (Public Health Goal) (5 votes, commonality with Clin/PH group)

   a. Address behavioral health

   b. Focus payment system change to incentivize primary care

   c. Create incentives for students to go into primary care

   d. Build a career pipeline to increase representation of vulnerable populations in the healthcare workforce

   e. Improve curriculum to include preventive care and medicine

6. Increase appropriate use of chronic disease related health services (e.g. Community health workers, 211 community resources phone referral service, health care delivery systems, public health, patient centered medical home) (Public Health & Community Goal) (2 votes, commonality with ClinPH Group)

   a. Understand and reduce barriers and expand facilitators

   b. Provide information for families dealing with family members mental health and how and when to find help

   c. Technology connectivity to reduce duplication of clinical tests

   d. Include community based solutions in to care for chronic mental and behavioral health concerns

   e. Increase # of patients who identify a primary care provider and receive care from a patient centered medical home (primary, patient centered care) – increase the use

   f. Expand use of community health workers and 211
g. Payment system changes
h. Target behavioral health
i. Attract, retain mental health providers to help reduce wait times and increase prescription adherence
j. Telemedicine/mobile technology
k. Integrate mental health, behavioral health, and primary care services