2019 2021

Hancock County Community Health Improvement Plan

BeHealthyNow™
Hancock County

Released on October 9, 2019

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Note: Throughout the report, hyperlinks will be highlighted in bold, gold text. If using a hard copy of this report, please see Appendix I for links to websites.

Executive Summary

Introduction

A community health improvement plan (CHIP) is a community-driven, long-term, systematic plan to address issues identified in a community health assessment (CHA). The purpose of the CHIP is to describe how hospitals, health departments, and other community stakeholders will work to improve the health of the county. A CHIP is designed to set priorities, direct the use of resources, and develop and implement projects, programs, and policies. The CHIP is more comprehensive than the roles and responsibilities of health organizations alone, and the plan's development must include participation of a broad set of community stakeholders and partners. This CHIP reflects the results of a collaborative planning process that includes significant involvement by a variety of community sectors.

Be Healthy Now Hancock County has been conducting CHAs since 2003 to measure community health status. The most recent Hancock County CHA was cross-sectional in nature and included a written survey of adults, adolescents and parents within Hancock County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention (CDC) for their national and state Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS) and the National Survey of Children's Health (NSCH). This has allowed Hancock County to compare their CHA data to national, state and local health trends. Community stakeholders were actively engaged in the early phases of CHA planning and helped define the content, scope, and sequence of the project.

Hancock County Public Health contracted with the Hospital Council of Northwest Ohio (HCNO), a neutral, regional, nonprofit hospital association, to facilitate the CHA and CHIP. The health department then invited various community stakeholders to participate in community health improvement process. Data from the most recent CHA was carefully considered and categorized into community priorities with accompanying strategies. This was done using the National Association of County and City Health Officials' (NACCHO) national framework, Mobilizing for Action through Planning and Partnerships (MAPP). Over the next three years, these priorities and strategies will be implemented at the county-level with the hope to improve population health and create lasting, sustainable change. It is the hope of Be Healthy Now Hancock County that each agency in the county will tie their internal strategic plan to at least one strategy in the CHIP.

Hospital Requirements

Internal Revenue Services (IRS)

The Hancock County CHA and CHIP fulfills national mandated requirements for hospitals in the county. The H.R. 3590 Patient Protection and Affordable Care Act (ACA), enacted in March 2010, added new requirements in Part V, Section B, on 501 (c)(3) organizations that operate one or more hospital facilities. Each 501 (c)(3) hospital organization must conduct a CHNA and adopt an implementation strategy at least once every three years in order to maintain tax-exempt status. To meet these requirements, the hospital shifted their definition of "community" to encompass the entire county, and collaboratively completed the CHA and CHIP, compliant with IRS requirements. This will result in increased collaboration, less duplication, and sharing of resources. This report serves as the implementation strategy for Blanchard Valley Health System and documents the hospital's efforts to address the community health needs identified in CHA.

Blanchard Valley Health System Mission Statement

Caring for a lifetime.

Community Served by Blanchard Valley Health System

City of Findlay, Hancock County and the Contiguous Counties.

Public Health Accreditation Board (PHAB) Requirements

National Public Health Accreditation status through the Public Health Accreditation Board (PHAB) is the measurement of health department performance against a set of nationally recognized, practice-focused and evidenced-based standards. The goal of the national accreditation program is to improve and protect the health of the public by advancing the quality and performance of Tribal, state, local, and territorial public health departments. PHAB requires that CHIPs be completed at least every five years, however, Ohio state law (ORC 3701.981) requires that health departments and hospitals collaborate to create a CHIP every 3 years. Additionally, PHAB is a voluntary national accreditation program, however the State of Ohio requires that all local health departments become accredited by 2020, making it imperative that all PHAB requirements are met.

PHAB standards also require that a community health improvement model is utilized when planning CHIPs. This CHIP was completed using NACCHO's MAPP process. MAPP is a national, community-driven planning process for improving community health. This process was facilitated by HCNO in collaboration with various local agencies representing a variety of sectors.

Inclusion of Vulnerable Populations (Health Disparities)

Approximately 12% of Hancock County residents were below the poverty line, according to the 2013-2017 American Community Survey 5 year estimates. For this reason, data is broken down by income (less than $25,000 and greater than $25,000) throughout the report to show disparities.

Mobilizing for Action through Planning and Partnerships (MAPP)

NACCHO's strategic planning tool, MAPP, guided this community health improvement process. The MAPP framework includes six phases which are listed below:

1. Organizing for success and partnership development
2. Visioning
3. The four assessments
4. Identifying strategic issues
5. Formulate goals and strategies
6. Action cycle

The MAPP process includes four assessments: community themes and strengths, forces of change, local public health system, and the community health status assessment. These four assessments were used by OCHP to prioritize specific health issues and population groups which are the foundation of this plan. Figure 1.1 illustrates how each of the four assessments contributes to the MAPP process.

Figure 1.1 The MAPP model

Alignment with National and State Standards

The 2019-2021 Hancock County CHIP priorities align with state and national priorities. Hancock County will be addressing the following priorities: mental health and addiction, chronic disease, and violence.

Ohio State Health Improvement Plan (SHIP)

Note: This symbol will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2017-2019 SHIP.

SHIP Overview

The 2017-2019 State Health Improvement Plan (SHIP) serves as a strategic menu of priorities, objectives, and evidence-based strategies to be implemented by state agencies, local health departments, hospitals and other community partners and sectors beyond health including education, housing, employers, and regional planning.

The SHIP includes a strategic set of measurable outcomes that the state will monitor on an annual basis. Given that the overall goal of the SHIP is to improve health and wellbeing, the state will track the following health indicators:

- Self-reported health status (reduce the percent of Ohio adults who report fair or poor health)
- Premature death (reduce the rate of deaths before age 75)

SHIP Priorities

In addition to tracking progress on overall health outcomes, the SHIP will focus on three priority topics:

1. Mental health and addiction (includes emotional wellbeing, mental illness conditions and substance abuse disorders)
2. Chronic Disease (includes conditions such as heart disease, diabetes and asthma, and related clinical risk factors-obesity, hypertension and high cholesterol, as well as behaviors closely associated with these conditions and risk factors- nutrition, physical activity and tobacco use)
3. Maternal and Infant Health (includes infant and maternal mortality, birth outcomes and related risk and protective factors impacting preconception, pregnancy and infancy, including family and community contexts)

Cross-cutting Factors

The SHIP also takes a comprehensive approach to improving Ohio's greatest health priorities by identifying cross-cutting factors that impact multiple outcomes. Rather than focus only on disease-specific programs, the SHIP highlights powerful underlying drivers of wellbeing, such as student success, housing affordability and tobacco prevention. This approach is built upon the understanding that access to quality health care is necessary, but not sufficient, for good health. The SHIP is designed to prompt state and local stakeholders to implement strategies that address the Social Determinants of health and health behaviors, as well as approaches that strengthen connections between the clinical healthcare system, public health, community-based organizations and sectors beyond health.

SHIP planners drew upon this framework to ensure that the SHIP includes outcomes and strategies that address the following cross-cutting factors:

- **Health equity**: Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

- **Social Determinants of health**: Conditions in the social, economic and physical environments that affect health and quality of life.

- **Public health system, prevention and health behaviors**:
    - The public health system is comprised of government agencies at the federal, state, and local levels, as well as nongovernmental organizations, which are working to promote health and prevent disease and injury within entire communities or population groups.
    - Prevention addresses health problems before they occur, rather than after people have shown signs of disease, injury or disability.
    - Health behaviors are actions that people take to keep themselves healthy (such as eating nutritious food and being physically active) or actions people take that harm their health or the health of others (such as smoking). These behaviors are often influenced by family, community and the broader social, economic and physical environment.

- **Healthcare system and access**: Health care refers to the system that pays for and delivers clinical health care services to meet the needs of patients. Access to health care means having timely use of comprehensive, integrated and appropriate health services to achieve the best health outcomes.

CHIP Alignment with the 2017-2019 SHIP

The 2019-2021 Hancock County CHIP is required to select at least 2 priority topics, 1 priority outcome indicator, 1 cross cutting strategy and 1 cross-cutting outcome indicator to align with the 2017-2019 SHIP. The following Hancock County CHIP priority topics, outcomes and cross cutting factors very closely align with the 2017-2019 SHIP priorities:

Figure 1.2 2019-2021 Hancock CHIP Alignment with the 2017-2019 SHIP

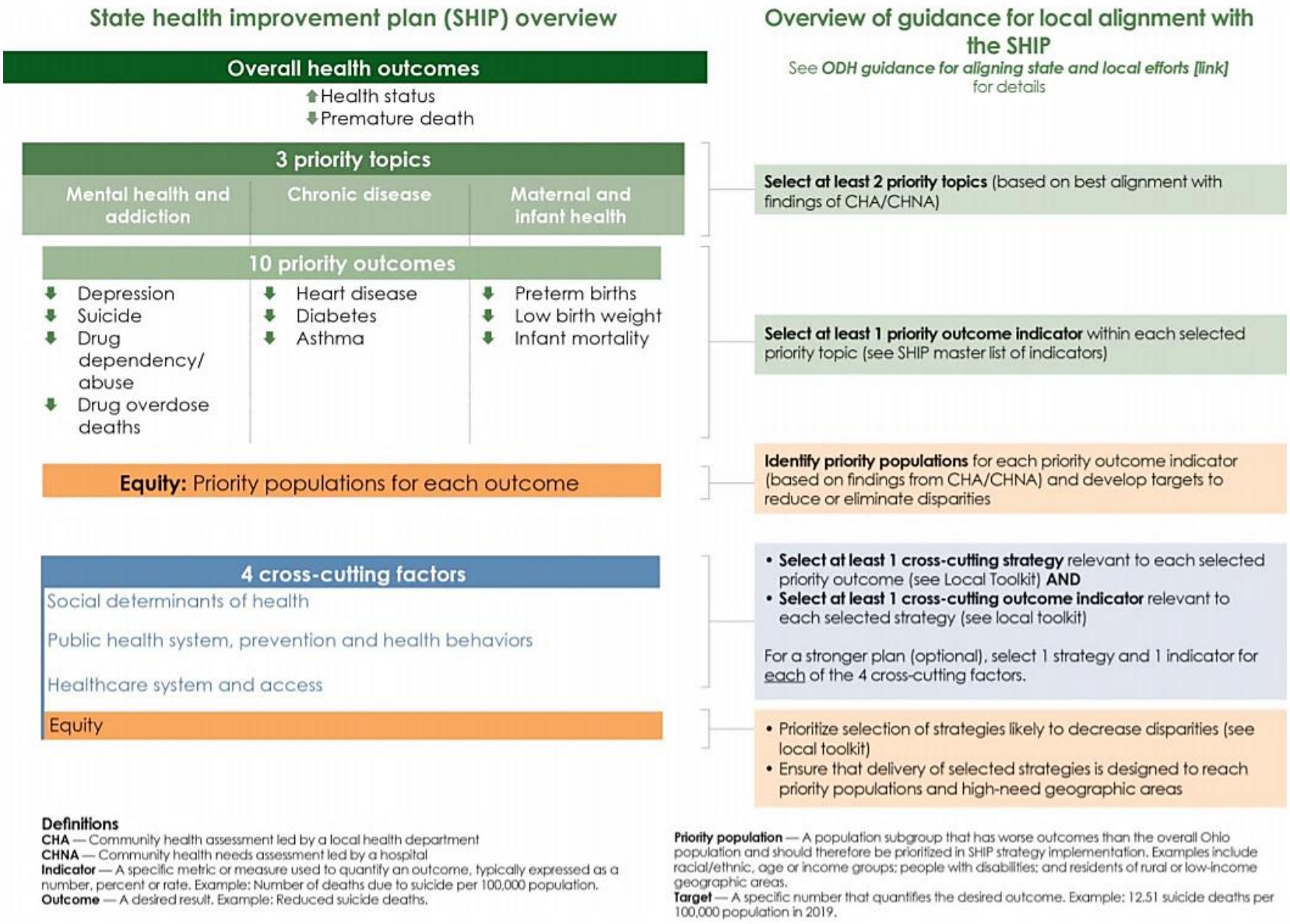
2019-2021 Hancock CHIP Alignment with the 2017-2019 SHIP			
Priority Topics	***Priority Outcomes***	***Cross-Cutting Factors***	***Cross-Cutting Outcomes***
Mental health and addiction	• Decrease depression • Decrease suicide deaths	• Social determinants of health • Public health system, prevention and health behaviors	• Decrease high housing costs • Decrease severe housing problems • Decrease adult smoking
Chronic Disease	• Decrease heart disease • Decrease diabetes		

U.S. Department of Health and Human Services National Prevention Strategies

The Hancock County Community Health Improvement Plan also aligns with six of the **National Prevention Strategies** for the U.S. population: tobacco free living, preventing drug abuse and excessive alcohol use, healthy eating, active living, injury and violence free living, and mental and emotional well-being.

Alignment with National and State Standards, continued

Figure 1.4 2017-2019 State Health Improvement Plan (SHIP) Overview



Vision and Mission

Vision statements define a mental picture of what a community wants to achieve over time while the mission statement identifies why an organization/coalition exists and outlines what it does, who it does it for, and how it does what it does.

The Vision of Be Healthy Now Hancock County

To be the healthiest county in Ohio.

The Mission of Be Healthy Now Hancock County

Creating a culture of wellness in Hancock County.

Community Partners

The CHIP was planned by various agencies and service-providers within Hancock County. From April 2019 to June 2019, Be Healthy Now Hancock County reviewed many data sources concerning the health and social challenges that Hancock County residents are facing. They determined priority issues which, if addressed, could improve future outcomes; determined gaps in current programming and policies; examined best practices and solutions; and determined specific strategies to address identified priority issues. We would like to recognize these individuals and thank them for their dedication to this process:

Be Healthy Now Hancock County

Black Heritage Library and Multicultural Center
Blanchard Valley Health System
City of Findlay Parks & Recreation
Cultural Connections
Findlay City Schools
Findlay-Hancock County Community Foundation
Findlay YMCA
Hancock County ADAMHS Board/Community Partnership
Hancock County Family and Children First Council
Hancock County Schools and Educational Service Center
Hancock Public Health
HHWP Community Action Commission
LGBTQ+ Spectrum of Findlay
The Ohio State University Extension Office
United Way of Hancock County
50 North

Hospital Council of Northwest Ohio (HCNO)

The community health improvement process was facilitated by Emily Stearns, MPH, Community Health Improvement Coordinator, and Layla Abraham, MPH, Community Health Improvement Coordinator, from the Hospital Council of Northwest Ohio.

Community Health Improvement Process

Beginning in April 2019, Be Healthy Now Hancock County met four (4) times and completed the following planning steps:

1. Initial Meeting
    - Review the process and timeline
    - Finalize committee members
    - Create or review vision
2. Choose Priorities
    - Use of quantitative and qualitative data to prioritize target impact areas
3. Rank Priorities
    - Rank health problems based on magnitude, seriousness of consequences, and feasibility of correcting
4. Community Themes and Strengths Assessment
    - Open-ended questions for committee on community themes and strengths
5. Forces of Change Assessment
    - Open-ended questions for committee on forces of change
6. Local Public Health Assessment
    - Review the Local Public Health System Assessment with committee
7. Gap Analysis
    - Determine discrepancies between community needs and viable community resources to address local priorities
    - Identify strengths, weaknesses, and evaluation strategies
8. Quality of Life Survey
    - Review results of the Quality of Life Survey with committee
9. Strategic Action Identification:
    - Identification of evidence-based strategies to address health priorities
10. Best Practices
    - Review of best practices, proven strategies, evidence continuum, and feasibility continuum
11. Resource Assessment
    - Determine existing programs, services, and activities in the community that address specific strategies
12. Draft Plan:
    - Review of all steps taken
    - Action step recommendations based on one or more of the following: enhancing existing efforts, implementing new programs or services, building infrastructure, implementing evidence-based practices, and feasibility of implementation

Community Health Status Assessment

Phase 3 of the MAPP process, the Community Health Status Assessment, or CHA, is a 167-page report that includes primary data with over 100 indicators and hundreds of data points related health and well-being, including Social Determinants of health. Over 50 sources of secondary data are also included throughout the report. The CHA serves as the baseline data in determining key issues that lead to priority selection. The full report can be found at **https://www.co.hancock.oh.us/government-services/board-of-health/about-our-agency/annual-reports**. Below is a summary of county primary data and the respective state and national benchmarks.

Adult Trend Summary

Adult Variables	Hancock County 2011	Hancock County 2013	Hancock County 2015	Hancock County 2018	Ohio 2017	U.S. 2017
Health Status						
Rated general health as excellent or very good	58%	N/A	56%	51%	49%	51%
Rated general health as fair or poor	12%	N/A	9%	11%	19%	18%
Rated mental health as not good on four or more days (in the past 30 days)	20%	N/A	22%	32%	24%*	23%*
Rated physical health as not good on four or more days (in the past 30 days)	13%	N/A	14%	22%	22%*	22%*
Average number of days that mental health not good (in the past 30 days) (County Health Rankings)	N/A	N/A	3.2	4.3	4.3**	3.8**
Average number of days that physical health not good (in the past 30 days) (County Health Rankings)	N/A	N/A	2.4	4.4	4.0**	3.7**
Poor mental or physical health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past 30 days)	21%	N/A	21%	27%	22%*	22%*
Health Care Coverage, Access, and Utilization						
Uninsured	8%	N/A	3%	5%	9%	11%
Had one or more persons they thought of as their personal health care provider	N/A	N/A	90%	89%	81%	77%
Visited a doctor for a routine checkup (in the past 12 months)	55%	N/A	65%	72%	72%	70%
Diabetes, Asthma & Arthritis						
Ever been told by a doctor they have diabetes (not pregnancy-related)	6%	N/A	9%	12%	11%	11%
Ever been diagnosed with pregnancy-related diabetes	2%	N/A	1%	1%	1%	1%
Ever been diagnosed with pre-diabetes or borderline diabetes	N/A	N/A	7%	9%	2%	2%
Had ever been told they have asthma	11%	N/A	11%	13%	14%	14%
Ever diagnosed with some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia	N/A	N/A	N/A	32%	29%	25%

N/A- Not available
**2016 BRFSS Data*
***2016 BRFSS as compiled by 2018 County Health Rankings*
Indicates alignment with the Ohio State Health Assessment

Adult Variables	Hancock County 2011	Hancock County 2013	Hancock County 2015	Hancock County 2018	Ohio 2017	U.S. 2017
Cardiovascular Health						
Ever diagnosed with angina or coronary heart disease	N/A	N/A	4%	3%	5%	4%
Ever diagnosed with a heart attack or myocardial infarction	4%	N/A	4%	3%	6%	4%
Ever diagnosed with a stroke	3%	N/A	2%	4%	4%	3%
Had been told they had high blood pressure	24%	N/A	29%	34%	35%	32%
Had been told their blood cholesterol was high	36%	N/A	33%	39%	33%	33%
Had their blood cholesterol checked within the past five years	74%	N/A	76%	81%	85%	86%
Weight Status						
Normal Weight	37%	33%	34%	27%	30%	32%
Overweight	35%	34%	38%	28%	34%	35%
Obese	27%	32%	27%	44%	34%	32%
Alcohol Consumption						
Current drinker (had at least one drink of alcohol within the past 30 days)	51%	N/A	60%	60%	54%	55%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	15%	23%	19%	23%	19%	17%
Tobacco Use						
Current smoker (currently smoke some or all days)	15%	N/A	13%	10%	21%	17%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	20%	N/A	23%	24%	24%	25%
Drug Use						
Adults who used marijuana (in the past 6 months)	4%	N/A	4%	3%	N/A	N/A
Adults who misused prescription medication (in the past 6 months)	4%	N/A	9%	7%	N/A	N/A
Sexual Behavior						
Had more than one sexual partner (in past 12 months)	8%	N/A	4%	4%	N/A	N/A
Preventive Medicine						
Ever had a pneumonia vaccination (age 65 and older)	55%	N/A	N/A	68%	76%	75%
Had a flu shot within the past year (age 65 and older)	62%	N/A	70%	79%	63%	60%
Ever had a shingles or zoster vaccine	N/A	N/A	N/A	18%	29%	29%
Had a sigmoidoscopy or colonoscopy within the past 5 years (age 50 and over)	44%	N/A	57%	55%	N/A	N/A
Had a clinical breast exam within the past two years (age 40 and older)	72%	N/A	70%	64%	N/A	N/A
Had a mammogram within the past two years (age 40 and older)	59%	N/A	61%	64%	74%*	72%*
Had a Pap test within the past three years (ages 21-65)	70%¥	N/A	71%¥	71%	82%*	80%*
Had a PSA test within the past two years	39%	N/A	36%	30%	39%*	40%*
Had a digital rectal exam within the past year	30%	N/A	18%	16%	N/A	N/A

N/A - Not available
**2016 BRFSS Data*
***2015 BRFSS Data*
¥Hancock 2011 and 2015 percentages are based on all women
Indicates alignment with the Ohio State Health Assessment

Adult Variables	Hancock County 2011	Hancock County 2013	Hancock County 2015	Hancock County 2018	Ohio 2017	U.S. 2017
Quality of Life						
Limited in some way because of physical, mental or emotional problem	20%	N/A	19%	21%	21%**	21%**
Mental Health						
Considered attempting suicide (in the past 12 months)	3%	N/A	4%	5%	N/A	N/A
Attempted suicide (in the past 12 months)	<1%	1%	1%	0%	N/A	N/A
Oral Health						
Visited a dentist or dental clinic (within the past year)	71%	N/A	72%	73%	68%*	66%*
Visited a dentist or dental clinic (5 or more years ago)	10%	N/A	8%	9%	11%*	10%*

N/A - Not available
**2016 BRFSS Data*
***2015 BRFSS Data*

Youth Trend Summary

Youth Variables	Hancock County 2011 (6th-12th)	Hancock County 2015 (6th-12th)	Hancock County 2018 (6th-12th)	Hancock County 2018 (9th-12th)	U.S. 2017 (9th-12th)
Weight Control					
Obese	15%	15%	13%	9%	15%
Overweight	13%	12%	12%	11%	16%
Tried to lose weight	42%	41%	46%	46%	47%
Exercised to lose weight (in the past 30 days)	29%	39%	49%	48%	N/A
Ate less food, fewer calories, or foods lower in fat to lose weight (in the past 30 days)	20%	26%	27%	30%	N/A
Went without eating for 24 hours or more (in the past 30 days)	2%	4%	3%	4%	N/A
Took diet pills, powders, or liquids without a doctor's advice (in the past 30 days)	<1%	2%	1%	1%	N/A
Vomited or took laxatives (in the past 30 days)	<1%	2%	1%	2%	N/A
Physically active at least 60 minutes per day on every day in past week	31%	39%	25%	27%	26%
Physically active at least 60 minutes per day on 5 or more days in past week	55%	57%	51%	55%	47%
Did not participate in at least 60 minutes of physical activity on any day in past week	11%	14%	13%	14%	15%
Tobacco Use					
Ever tried cigarette smoking (even one or two puffs)	22%	22%	10%	14%	29%
Current smoker (smoked on at least 1 day during the past 30 days)	8%	7%	4%	5%	9%
Currently frequently smoked cigarettes (on 20 or more days during the past 30 days)	3%	2%	<1%	1%	3%
First tried cigarette smoking before the age of 13 (even one or two puffs)	N/A	7%	4%	3%	10%
Alcohol Consumption					
Ever drank alcohol (at least one drink of alcohol on at least 1 day during their life)	40%	37%	34%	46%	60%
Current Drinker (at least one drink of alcohol on at least 1 day during the past 30 days)	17%	12%	12%	17%	30%
Binge drinker (drank 5 or more drinks within a couple of hours on at least 1 day during the past 30 days)	9%	7%	5%	10%	14%
Had their first drink of alcohol before age 13 years (other than a few sips)	N/A	14%	13%	10%	16%
Rode with a driver who had been drinking alcohol (in a car or other vehicle on 1 or more occasion during the past 30 days)	15%	16%	13%	10%	17%
Drove when they had been drinking alcohol (in a car or other vehicle on 1 or more occasion during the past 30 days, among students who had driven a car or other vehicle during the past 30 days)	3%	3%	3%	3%	6%
Obtained the alcohol they drank by someone giving it to them (of youth drinkers)	33%	27%	27%	29%	44%

N/A – Not Available

Indicates alignment with the Ohio State Health Assessment

Youth Variables	Hancock County 2011 (6th-12th)	Hancock County 2015 (6th-12th)	Hancock County 2018 (6th-12th)	Hancock County 2018 (9th-12th)	U.S. 2017 (9th-12th)
Drug Use					
Used marijuana (in the past month)	7%	7%	3%	6%	20%
Ever used methamphetamines (in their lifetime)	2%	1%	1%	1%	3%
Ever used cocaine (in their lifetime)	3%	3%	1%	3%	5%
Ever used heroin (in their lifetime)	1%	1%	1%	2%	2%
Ever took steroids without a doctor's prescription (in their lifetime)	4%	2%	2%	1%	3%
Ever used inhalants (in their lifetime)	7%	6%	5%	3%	6%
Prescription medication abuse (in their lifetime)	7%	5%	2%	3%	N/A
Were offered, sold, or given an illegal drug on school property (in the past 12 months)	13%	6%	5%	5%	20%
Sexual Behavior					
Ever had sexual intercourse	15%	15%	9%	18%	40%
Drank alcohol or used drugs before last sexual intercourse	5%	9%	4%	6%	19%
Used a condom (during last sexual intercourse)	55%	54%	29%	30%	54%
Used birth control pills (during last sexual intercourse)	28%	31%	16%	20%	21%
Did not use any method to prevent pregnancy during last sexual intercourse	2%	12%	4%	5%	14%
Had sexual intercourse with four or more persons (of all youth during their life)	4%	3%	3%	6%	10%
Had sexual intercourse before age 13 (of all youth)	N/A	2%	2%	1%	3%
Mental Health					
Seriously considered attempting suicide (in the past 12 months)	12%	13%	12%	13%	17%
Attempted suicide (in the past 12 months)	9%	7%	6%	5%	7%
Felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities in the past 12 months)	16%	19%	25%	27%	32%
Social Determinants of Health					
Visited a dentist within the past year (for a check-up, exam, teeth cleaning, or other dental work)	80%	72%	75%	75%	N/A
Violence					
Were in a physical fight (in the past 12 months)	5%	3%	4%	3%	N/A
Carried a weapon (in the past 30 days)	13%	8%	11%	11%	16%
Did not go to school because they felt unsafe (at school or on their way to or from school in the past 30 days)	4%	5%	5%	5%	7%
Electronically bullied (in the past year)	7%	13%	11%	9%	15%
Bullied (in the past year)	41%	51%	43%	41%	N/A
Threatened or injured with a weapon on school property (in the past 12 months)	5%	5%	9%	13%	6%
Experienced physical dating violence (including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with in the past 12 months)	6%	4%	6%	10%	8%

N/A – Not Available

Indicates alignment with the Ohio State Health Assessment

Child Trend Summary

Child Comparisons	Hancock County 2015 Ages 0-5	Hancock County 2018 Ages 0-5	Ohio 2016 Ages 0-5	U.S. 2016 Ages 0-5	Hancock County 2015 Ages 6-11	Hancock County 2018 Ages 6-11	Ohio 2016 Ages 6-11	U.S. 2016 Ages 6-11
Health and Functional Status								
Rated health as excellent or very good	97%	96%	94%	93%	93%	97%	91%	89%
Dental care visit in the past year	65%	45%	54%¥	59%¥	92%	93%	95%	91%
Diagnosed with asthma	4%	4%	9%	6%	12%	9%	16%	15%
Diagnosed with diabetes	0%	0%	N/A	N/A	1%	0%	N/A	<1%
Diagnosed with ADHD/ADD	0%	0%	2%**	3%**	6%	6%	13%	9%
Diagnosed with behavioral or conduct problems	1%	0%	3%**	5%**	5%	3%	13%	11%
Diagnosed with epilepsy	0%	2%	N/A	1%	0%	1%	N/A	1%
Diagnosed with a head injury, brain injury, or concussion	2%	0%	N/A	1%	1%	2%	N/A	2%
Diagnosed with depression	0%	0%	N/A	<1%**	1%	2%	N/A	2%
Diagnosed with cerebral palsy	2%	2%	N/A	<1%**	0%	0%	N/A	<1%
Diagnosed with anxiety problems	1%	1%	1%**	2%**	7%	6%	9%	8%
Diagnosed with developmental delay	2%	5%	4%**	7%**	5%	3%	7%	6%
Diagnosed with intellectual disability/mental retardation	N/A	1%	N/A	1%**	N/A	<1%	N/A	1%
Diagnosed with learning disability	1%	1%	3%**	3%**	4%	2%	9%	7%
Diagnosed with speech or language delay	7%	6%	5%**	10%**	7%	9%	8%	9%
Child had one or more health conditions	N/A	4%	22%	22%	N/A	8%	46%	42%
Health Care Access								
Had public insurance	15%	14%	28%	37%	17%	13%	33%	38%
Been to doctor for preventive care in past year	91%	97%	91%	89%	76%	81%	83%	79%
Received all the medical care they needed	87%	94%	N/A	N/A	86%	94%	N/A	N/A
Had a personal doctor or nurse	86%	88%	75%	74%	86%	88%	77%	72%
Child received treatment or counseling from a mental health professional in the past year	2%	3%	1%*	3%	9%	7%	10%	10%
2 or more visits to the ER in the past year	9%	2%	9%	6%	2%	4%	5%	4%
Early Childhood (Ages 0-5)								
Never breastfed their child	17%	19%	30%	21%	N/A	N/A	N/A	N/A
Parent or family member read to child every day (in the past week)	N/A	39%	39%	38%	N/A	N/A	N/A	N/A

¥Ages 3-5
***Ages 1-5*
N/A – Not Available
Indicates alignment with the Ohio State Health Assessment

Child Comparisons	Hancock County 2015 Ages 0-5	Hancock County 2018 Ages 0-5	Ohio 2016 Ages 0-5	U.S. 2016 Ages 0-5	Hancock County 2015 Ages 6-11	Hancock County 2018 Ages 6-11	Ohio 2016 Ages 6-11	U.S. 2016 Ages 6-11
Middle Childhood (Ages 6-11)								
Child participated in one or more activities	N/A	N/A	N/A	N/A	N/A	93%	82%	76%
Child did not miss any days of school because of illness or injury	N/A	N/A	N/A	N/A	18%	22%	26%	29%
Did not engage in any physical activity during the past week	N/A	N/A	N/A	N/A	N/A	2%	3%	5%
Parent definitely agreed that their child was safe at school	N/A	N/A	N/A	N/A	N/A	96%	77%	79%
Family and Community Characteristics								
Family ate a meal together every day of the week	40%	33%	51%	53%	35%	30%	43%	45%
Child never attends religious services	36%	34%	N/A	N/A	22%	35%	N/A	N/A
Parent definitely agreed that their child lives in a safe neighborhood	N/A	70%	64%	63%	N/A	69%	66%	62%
Someone living in the household uses cigarettes, cigars, or pipe tobacco	17%	15%	19%	15%	22%	13%	28%	17%
Parent Health								
Mother's mental or emotional health is fair/poor	5%	11%	5%	5%	5%	5%	9%	6%
Father's mental or emotional health is fair/poor	0%	0%	5%	3%	0%	3%	6%	3%

N/A – Not Available

Key Issues

Be Healthy Now Hancock County reviewed the 2018 Hancock County Health Assessment. The detailed primary data for each individual priority area can be found in the section it corresponds to. Each organization completed an "Identifying Key Issues and Concerns" worksheet. The following tables were the group results.

What are the most significant health issues or concerns identified in the 2018 assessment report? Examples of how to interpret the information include: 25% of youth who felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities in the past 12 months), increasing to 31% of females.

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Mental Health (8 votes)			
Rated mental health as not good on four or more days (in the past 30 days)	32%	N/A	N/A
Average number of days that mental health not good (in the past 30 days)	4.3	N/A	N/A
Youth who experienced 3+ adverse childhood experiences (ACEs) in their lifetime	21%	N/A	N/A
Youth who felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities in the past 12 months)	25%	Age: 17+ (28%)	Females (31%)
Addiction (8 votes)			
Youth average age of onset for smoking	12.6	N/A	N/A
Youth average age of onset for drinking alcohol	12.6	N/A	N/A
Youth who used e-cigarettes in the past year	11%	N/A	N/A
Youth who reported e-cigarettes/vapes were easily available to them	22%	N/A	N/A
Adults who did not know if e-cigarette vapor was harmful to themselves or others	40%	N/A	N/A
Youth who had smoked for the first time did so at 10 years old or younger	21%	N/A	N/A
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	23%	N/A	N/A

N/A- Not Available

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Obesity/Overweight (7 votes)			
Youth obese	13%	N/A	Males (17%)
Youth overweight	12%	N/A	Females (15%)
Obese (includes severely and morbidly obese, BMI of 30.0 and above)	44%	Income: <$25K (49%) Age: 30-64 (45%)	Females (46%)
Overweight (BMI of 25.0 – 29.9)	28%	Income: <$25K (36%) Age: 65+ (39%)	Males (38%)
Sexual Activity (5 votes)			
Youth obese	13%	N/A	Males (17%)
Youth overweight	12%	N/A	Females (15%)
Diabetes (4 votes)			
Adults ever been told by a doctor they have diabetes (not pregnancy-related)	12%	Age: 56+ (23%) Income: <25K (23%)	Males (13%)
Ever been diagnosed with pre-diabetes or borderline diabetes	9%	N/A	N/A
Violence (4 votes)			
Youth who carried a weapon (in the past 30 days)	11%	N/A	N/A
Youth who were bullied (in the past year)	43%	Age: 14 to 16 (50%)	Females (54%)
Parents of 6-11-year old's who reported their child was bullied in the past year	45%	N/A	N/A
Suicide (4 votes)			
Adults who considered attempting suicide in the past 12 months	5%	N/A	N/A
Number of suicide deaths in 2018 *(Source: ODH, Ohio Public Health Data Warehouse)*	10 deaths	N/A	N/A
Seriously considered attempting suicide (in the past 12 months)	12%	Age: 14 to 16 (15%)	Females (15%)
Attempted suicide (in the past 12 months)	6%	N/A	Females (7%)
Adults kept a firearm in or around their home	46%	Age: Under 30 (50%) Income: >25K (52%)	Males (55%)
Sexual Activity (1 vote)			
Youth who used a condom during last sexual intercourse	57%	N/A	N/A
Sexually active youth who had multiple sexual partners	56%	N/A	N/A
Adult chlamydia rates (per 100,000 population - 2017)	411.4	N/A	N/A
Dental Care (0 votes)			
Parents who read to their child every day (0-5 years)	35%	N/A	N/A

N/A- Not Available

Priorities Chosen

Based on the 2018 Hancock County Health Assessment, key issues were identified for adults. Overall, there were 9 key issues identified by the committee. Each organization was given 5 votes. The committee then voted and came to a consensus on the priority areas Hancock County will focus on over the next three years. The key issues and their corresponding votes are described in the table below.

Key Issues	Votes
Mental health	8
Addiction	8
Obesity/overweight	7
Sexual activity	5
Diabetes	4
Violence	4
Suicide	4
Lack of physical activity	0
Dental care	0

Hancock County will focus on the following three priority areas over the next three years:

1. **Mental health and addiction** (includes suicide, depression, and substance abuse)
2. **Chronic disease** (includes diabetes and obesity)
3. **Violence**

Community Themes and Strengths Assessment (CTSA)

The Community Themes and Strengths Assessment (CTSA) provides a deep understanding of the issues that residents felt were important by answering the questions: "What is important to our community?" "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?" The CTSA consisted of two parts: open-ended questions to the community and the Quality of Life Survey. Below are the results:

Open-ended Questions to the Committee

1. **What do you believe are the 2-3 most important characteristics of a healthy community?**
    - Inclusion
    - Peaceful co-existence
    - Body, spirit, and mind
    - Engagement
    - Informed community
    - Collaboration
    - Education system

2. **What makes you most proud of our community?**
    - Collaboration
    - Opportunities
    - Resources
    - Service orientation
    - School systems
    - Passion
    - Public health

3. **What are some specific examples of people or groups working together to improve the health and quality of life in our community?**
    - Healthy Kids Day (Blanchard Valley, WIC, University of Findlay)
    - WIC
    - Center for Civic Engagement
    - Coalitions focusing on various health issues
    - Family Center
    - Opiate Task Force
    - Family and Children First Council
    - Be Healthy Now Hancock County
    - HATS (Hancock Area Transportation Services)
    - Diabetes Prevention Program (YMCA, Blanchard Valley, Public Health, etc.)
    - 50 North

4. **What do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life in our community?**

   - Mental health
   - Addiction
   - Family functioning/structure
   - Job security
   - Poverty
   - Housing
   - Work force issues
   - More equitable economy
   - Health disparities
   - Transportation
   - Moving conversations from "us" and "them" to "we"

5. **What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?**

   - Human resources
   - Need to be more intentional about alignment with each other's work and organizations
   - Aligned from the top so we stop making assumptions
   - Not having a common vision and mission
   - Complexity of changing perceptions in the community
   - Recognition of problems
   - Changes are slow and changing behaviors takes time

6. **What actions, policy, or funding priorities would you support to build a healthier community?**

   - Focus on prevention
   - Science is available to identify those at high risk populations for mental health and addiction that needs to be used
   - Social and emotional learning
   - Targeted messaging instead of universal approaches
   - Alignment to help tie issues together at community level
   - Built environment (parks, bike paths, walking baths, etc.)

7. **What would excite you enough to become involved (or more involved) in improving our community?**

   - Seeing results
   - Being a part of something bigger
   - Leveraging resources
   - Small wins and progress
   - Keeping people engaged
   - Making a difference within the community
   - Culture changes
   - Seeing impact within youth
   - Letting individuals who were impacted with issues lead the way

Quality of Life Survey

Be Healthy Now Hancock County urged community members to fill out a short Quality of Life Survey via Survey Monkey. There were 198 Hancock County community members who completed the survey. The chart below shows the Likert scale average response for Hancock County compared to the 2012 and 2015 Hancock County CHIP quality of life results. 80% of respondents were female (20% male). 77% were a college graduate, 18% had some college or technical schooling, and 5% reported high school as being the highest year of school they had completed. 84% of respondents lived in Hancock County and 89% worked in Hancock County.

The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1. For all responses of "Don't Know," or when a respondent left a response blank, the choice was a non-response and was assigned a value of 0 (zero). The non-response was not used in averaging response or calculating descriptive statistics. The average scores indicate comparisons between the current 2018 CHIP quality of life responses and previous 2011 and 2015 CHIP quality of life responses. Additionally, a comparison was added to indicate an average score of surrounding Northwest Ohio (NWO) counties who also participated in the Quality of Life survey.

Quality of Life Questions	Likert Scale Average Response			
	2012 (n=99)	2015 (n=216)	2018 (n=198)	2018-19 average NWO
1. Are you satisfied with the quality of life in our community? (Consider your sense of safety, well-being, participation in community life and associations, etc.) [IOM, 1997]	3.97	3.90	3.94	3.69
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.33	3.28	3.35	3.40
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	4.04	3.86	3.94	3.81
4. Is this community a good place to grow old? (Consider elder-friendly housing, transportation to medical services, churches, shopping; elder day care, social support for the elderly living alone, meals on wheels, etc.)	3.87	3.61	3.63	3.54
5. Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)	3.49	3.67	3.80	3.05
6. Is the community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?)	3.89	3.82	3.73	3.72

Quality of Life Survey, continued

Quality of Life Questions	Likert Scale Average Response			
	2012 (n=99)	2015 (n=216)	2018 (n=198)	2018-19 average NWO
7. Are there networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, or organizations) during times of stress and need?	3.81	3.85	3.79	3.61
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.39	3.34	3.37	3.50
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.08	3.08	3.14	3.13
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.22	3.35	3.40	3.12
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.19	3.25	3.37	3.25
12. Is there an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments? (Are citizens working towards the betterment of their community to improve life for all citizens?)	3.35	3.39	3.38	3.19

Quality of Life Survey, continued

Be Healthy Now Hancock County added two open ended questions at the end of the Quality of Life survey. Below are some common themes.

When asked what the <u>best aspect</u> of living in Hancock County, the following was reported:

"The number of churches and organizations offering assistance to individuals"

"The consistent growth of the town is encouraging yet it still has a small-town feel. Most people are kind and caring and welcoming to new members of the community."

"I feel that Findlay's schools, parks system, and thriving business environment make this a great small city, and you can get to 5 metropolitan areas within 2-5 hours, making this a wonderful place to be."

"Watching it evolve in a positive manner. I think downtown has a lot of untapped potential, but in the last year it has started to blossom."

" Strong economy and consistently low unemployment rate."

"It's easy to access things in Hancock County provided you have a car as the roads are well maintained and there's easy access to what amenities we have."

"Programs such as Hancock Literacy's Dolly Patron Imagination Library and the Leader in Me program are helping to level the playing field for our youngest citizens."

"Opportunities: Findlay is not that big so most things that you would want to do is available within a mile radius (employment, medical, shopping, recreation, parks, school, etc.) Perfect for children gaining their independence. Also, I like the diversity the University of Findlay brings in."

When asked what <u>worried</u> people the most about living in Hancock County, the following was reported:

"The high rate of drug use and drug related deaths in our community."

"The county needs stronger green initiatives. We should be promoting walking and biking, not expanding roadways and parking for more cars. Encourage hybrid or electric vehicles with public charging stations and tax credits for businesses who offer them."

"That some people like to pretend there are no problems or that the problems of others shouldn't concern them so they act like the problems don't exist (especially drug abuse). Somewhat a "head in the sand" mentality. Also the divide between the upper and working class."

"Housing (rentals) are extremely overpriced and the employment that's available doesn't pay enough to allow people the money they need to live is said housing."

"There is not sufficient "public" transportation available for those that live in Hancock County outside of the City of Findlay limits."

"I worry most about the disconnect and increasing lack of community involvement. It seems to me this could unravel a strong fabric of community/family/work ethic."

"Lack of diversity (not just measured in skin color)."

Forces of Change Assessment

The Forces of Change Assessment focuses on identifying forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. This assessment answers the questions: "What is occurring or might occur that affects the health of our community or the local public health system?" and "What specific threats or opportunities are generated by these occurrences?" Be Healthy Now Hancock County were asked to identify positive and negative forces which could impact community health improvement and overall health of this community over the next three years. This group discussion covered many local, state, and national issues and change agents which could be factors in Hancock County in the future. The table below summarizes the forces of change agent and its potential impacts:

Force of Change	Threats Posed	Opportunities Created
1. New political parties (governor, mayor, etc.)	• Unknown financial threats	• Unknown financial opportunities • Potential support for health departments • New outlook and ideas
2. Hancock Public Health accreditation	• Potential loss of funding	• Potential increase in funding opportunities • Uniform standards across all health departments
3. Organizational struggles within health care	• Unknown sustainability of programs	• None noted
4. Loss of understanding of basic skills and behaviors	• Children grow up with lack of knowledge of basic skills	• Soft skills education
5. Potential new health department location	• Budgeting/future funding	• Expansion of services • Improved accessibility
6. Urban development/rural communities growing	• Lack of renting available in city • Resources could be lacking to address a larger population	• Increase in businesses/economic development • More diversity within county
7. Lack of transportation	• Barriers to obtaining services • Limitation with parking in city limits	• Increase in infrastructure for transportation
8. Personal beliefs changing	• Larger anti-vaccination population • Sexual health challenges – lower condom usage	• None noted
9. Lack of community gardens	• None noted	• Need to sustain and improve current community gardens • Potential to donate produce to local food banks
10. Lack of healthy eating/nutrition for at risk populations	• None noted	• Donate healthy foods to food banks • Education opportunities (cooking/preparing healthy food)

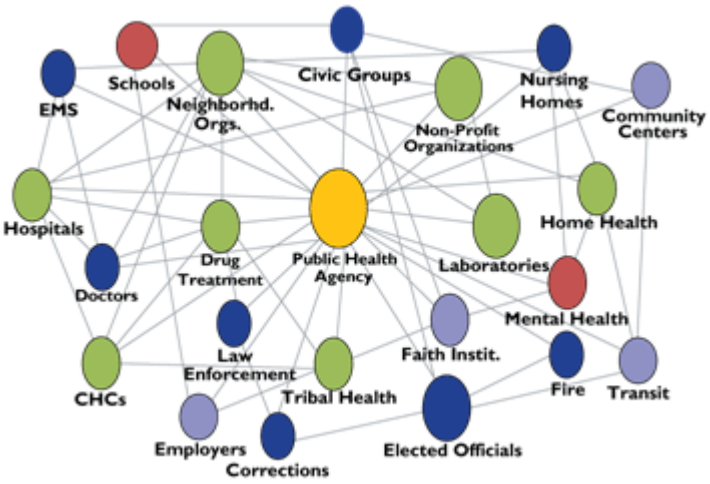
Force of Change	Threats Posed	Opportunities Created
11. Increase in advertisements on social media (JUUL)	• Increase in youth e-cigarette use	• None noted
12. Climate change	• Flooding, droughts • Increase in diseases • Potential food shortages • City costs for repairs • Increase in school closings • Farmers cannot utilize land	• Opportunities to make a difference in environment before it worsens
13. Increase in vaping/medical marijuana	• Negative health impacts	• Education/awareness opportunities
14. Workforce development	• Lack of livable wages • Shortage in areas/quality of workforce	• None noted
15. Family stability	• Grandparents raising children	• None noted
16. Lack of services for veterans	• Increase in suicide	• None noted
17. Social media usage	• Increase in bullying and predators • Difficult to build social skills	• Soft skills education • Leader in Me program
18. Infrastructure updates (parks, trails, bike paths, etc.)	• None noted	• Elevating opportunities to make healthy choices • Increase in physical activity
19. Aging population	• Lack of housing • Food insecurity • Lack of resources to address needs • Increase in chronic conditions • Older population caring for younger generation • Increase in elder abuse	• Additional respite care services and opportunities • Wellness program opportunities • Community collaboration with other wellness programs
20. Lack of livable wages	• Lack of financial stability	• None noted
21. Health disparities	• Many health impacts (especially with low income population)	• None noted
22. Addiction trends	• Lack of focus on areas of addiction other than opiates	• Increase resources surrounding other areas of addiction
23. Increase in wellness programs	• None noted	• Grow wellness programs within smaller businesses • Increase wellness opportunities
24. Immigration/undocumented citizens	• Local resources not being used due to fear of deportation	• None noted
25. Children experiencing mental health issues at a younger age	• Caregivers lacking support for mental health issues	• Social emotional learning for adults and children and community as a whole

Force of Change	Threats Posed	Opportunities Created
26. Lack of mental health pediatric care	• Emergency Room usage increasing for mental health care	• None noted
27. Increase in technology scams	• Financial vulnerability (specifically among older adults)	• Education/awareness opportunities
28. Increase in reported elder abuse	• Decline in health • Older adults taken advantage of	• None noted
29. Flooding	• Negative impacts on housing quality • Unhealthy conditions • Stress	• FEMA money • Awareness
30. Hunger	• Food insecurity	• Increase access to healthy food
31. Increase in opiate use/addiction	• Threat to family stability	• None noted
32. Lack of safe and affordable housing	• Reduction in housing support	• None noted
33. Many local resources are accessed by out of county residents	• Limited resources for those living in the county	• None noted

Local Public Health System Assessment

The Local Public Health System

Public health systems are commonly defined as "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction." This concept ensures that all entities' contributions to the health and well-being of the community or state are recognized in assessing the provision of public health services.



The public health system includes:

- Public health agencies at state and local levels
- Healthcare providers
- Public safety agencies
- Human service and charity organizations
- Education and youth development organizations
- Recreation and arts-related organizations
- Economic and philanthropic organizations
- Environmental agencies and organizations

The 10 Essential Public Health Services

The 10 Essential Public Health Services describe the public health activities that all communities should undertake and serve as the framework for the NPHPS instruments.

Public health systems should:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

(Source: **Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services**)

The Local Public Health System Assessment (LPHSA)

The LPHSA answers the questions, "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services being provided to our community?"

This assessment involves the use of a nationally recognized tool called the **National Public Health Performance Standards Local Instrument.**

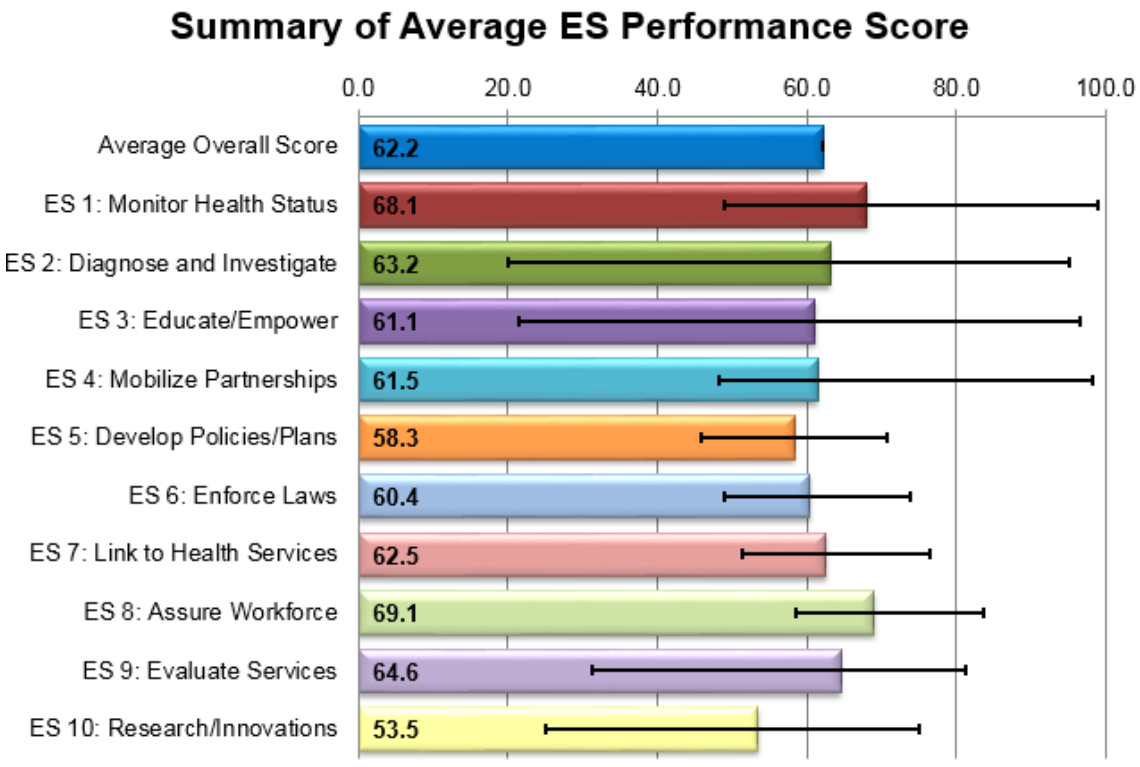
Members of Hancock Public Health completed the performance measures instrument. The LPHSA results were then presented to Be Healthy Now Hancock County for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard was discussed, and the group came to a consensus on responses for all questions. The challenges and opportunities that were discussed were used in the action planning process.

Be Healthy Now Hancock County identified 20 indicators that had a status of "minimal" and 0 indicators that had a status of "no activity." The remaining indicators were all moderate, significant or optimal.

As part of minimum standards, local health departments are required to complete this assessment at least once every five years.

To view the full results of the LPHSA, please contact Karim Baroudi, from Hancock Public Health at 567-250-5142.

Hancock County Local Public Health System Assessment 2018 Summary



Note: The black bars identify the range of reported performance score responses within each Essential Service

Gap Analysis, Strategy Selection, Evidence-Based Practices, and Resources

Gaps Analysis

A gap is an area where the community needs to expand its efforts to reduce a risk, enhance an effort, or address another target for change. A strategy is an action the community will take to fill the gap. Evidence is information that supports the linkages between a strategy, outcome, and targeted impact area. Be Healthy Now Hancock County were asked to determine gaps in relation to each priority area, consider potential or existing resources, and brainstorm potential evidence-based strategies that could address those gaps. To view the completed gap analysis exercise, please view Appendix I.

Strategy Selection

Based on the chosen priorities, Be Healthy Now Hancock County were asked to identify strategies for each priority area. Considering all previous assessments, including but not limited to the CHA, CTSA, quality of life survey and gap analysis, committee members determined strategies that best suited the needs of their community. Members referenced a list a of evidence-based strategies recommended by the Ohio SHIP, as well as brainstormed for other impactful strategies. Each resource inventory can be found with its corresponding priority area.

Evidence-Based Practices

As part of the gap analysis and strategy selection, Be Healthy Now Hancock County considered a wide range of evidence-based practices, including best practices. An evidence-based practice has compelling evidence of effectiveness. Participant success can be attributed to the program itself and have evidence that the approach will work for others in a different environment. A best practice is a program that has been implemented and evaluation has been conducted. While the data supporting the program is promising, its scientific rigor is insufficient. Each evidence-based practice can be found with its corresponding strategy.

Resource Inventory

Based on the chosen priorities, Be Healthy Now Hancock County were asked to identify resources for each strategy. The resource inventory allowed the committee to identify existing community resources, such as programs, policies, services, and more. Resources are identified within each strategy table.

Priority #1: Mental Health and Addiction

Strategic Plan of Action

To work toward improving mental health and addiction outcomes, the following strategies are recommended:

Mental Health Strategies:

Priority #1: Mental Health and Addiction				
Strategy 1: Trauma-informed health care				
Goal: Reduce suicide ideation				
Objective: By June 12, 2022, Hancock County will increase the use of trauma screening tools by 15%				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to work toward a trauma informed community through ongoing education to health care providers, teachers, social service providers, and other community members/agencies. Determine focus areas, for example, a special emphasis on vicarious trauma education; advance trauma informed training among service providers; and inclusion of evidence-based practices to address trauma once it has been identified.	June 12, 2020	Adult and youth	Suicide ideation: Percent of adult and youth with suicidal thoughts within the past year	**Hancock County ADAMHS Board**
Year 2: Continue efforts of year 1. Continue trauma informed care trainings in the community to increase education and understanding of trauma within Hancock County. Determine feasibility of implementing a formal trauma screening tool for social service organizations who work with at risk populations.	June 12, 2021			
Year 3: Continue efforts from years 1 and 2. Increase the use of trauma screening tools by 15%.	June 12, 2022			

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ⊗ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Hancock County ADAMHS Board

Priority #1: Mental Health and Addiction

Strategy 2: Mobile response and stabilization services

Goal: Reduce suicide deaths

Objective: By June 12, 2021, Hancock County will determine the feasibility of the development of comprehensive mobile response and stabilization services

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research comprehensive mobile response and stabilization services and the need for the development of a crisis continuum in Hancock County.	June 12, 2020	Adult and youth	Suicide deaths: Number of deaths due to suicide per 100,000 populations (age adjusted)	**Hancock County ADAMHS Board**
Year 2: Determine feasibility of the development of comprehensive mobile response and stabilization services in Hancock County. Determine funding opportunities and strategies for the development of the crisis continuum.	June 12, 2021			
Year 3: Continue efforts of years 1 and 2.	June 12, 2022			

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ⊗ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Hancock County ADAMHS Board

Priority #1: Mental Health and Addiction

Strategy 3: Implement school-based social and emotional instruction

Goal: Increase social-emotional skills among youth

Objective: Implement programming to fidelity in participating school districts

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue implementation of the Leader in Me program throughout Hancock County/Findlay City school districts. Meet with Hancock County principals (ex: Krista Miller) to determine feasibility of connecting the Leader in Me program to age-appropriate **social and emotional learning** components. Ensure fidelity of programming within school districts. If feasible, simplify/link messaging within Leader in Me programming.	June 12, 2020	Youth	Social-emotional skills: (not currently available per Ohio SHIP) Depression: Percent of youth who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities	**Raise the Bar Hancock County** **Findlay City Schools** **Hancock County Schools** **Family Resource Center** **Hancock County ADAMHS Board**
Year 2: Continue efforts of year 1. Gain community support by promoting the Leader in Me program successes throughout the county. Identify opportunities in which the program can be implemented within additional settings (ex: Scouts).	June 12, 2021			
Year 3: Continue efforts of years 1 and 2.	June 12, 2022			

Type of Strategy:

- ○ Social determinants of health
- ⊗ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Hancock County ADAMHS Board, Findlay City Schools, Raise the Bar Hancock County, Leader in Me programming

Addiction Strategies:

Priority #1: Mental Health and Addiction

Strategy 4: Community awareness and education of risky behaviors and substance abuse issues and trends

Goal: Educate community members on substance abuse issues and trends

Objective: By June 12, 2022, develop at least 3 awareness programs and/or workshops focusing on "hot topics", risky behaviors, and substance abuse issues and trends

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue existing awareness campaigns to increase education and awareness of risky behaviors and substance abuse issues and trends. Include information on topics such as e-cigarettes, alcohol use, and prescription drug abuse. Work with youth-led prevention groups to determine best ways to educate/implement programming (ex: social media, newsletters, etc.). Ensure messaging incorporates "delay the onset" and family education components (ex: research Putnam County's "Let's Talk" campaign).	June 12, 2020	Adult and youth	Prescription medication abuse: Percent of youth who misused prescription medication in their lifetime Prescription medication abuse: Percent of adults who misused prescription medications in the past 6 months E-cigarette use: Percent of youth who reported using e-cigarettes in the past year	**Findlay City Schools** **Hancock County Community Partnership**
Year 2: Focus awareness programs and/or workshops on different "hot topics", risky behaviors, and substance abuse issues and trends. Continue implementation of the **Hidden In Plain Sight** program and adjust topics to align with identified key issues. Attain media coverage for all programs and/or workshops.	June 12, 2021			
Year 3: Continue efforts of years 1 and 2.	June 12, 2022			

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ⊗ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Hancock County ADAMHS Board, Findlay City Schools, Hancock Public Health, subcommittee for e-cigarettes and marijuana abuse, Hancock County Community Partnership

Priority #1: Mental Health and Addiction

Strategy 5: Community-based comprehensive program(s) to reduce alcohol abuse

Goal: Decrease alcohol abuse

Objective: By June 12, 2022, implement 2 strategies from the Community Trails Intervention to Reduce High-Risk Drinking Program

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research alcohol prevention programs or other like programs outside of law enforcement to address binge drinking. Focus on strategies that specifically target high use populations (ex: under 30, low income). Research the Community Trials Intervention to Reduce High-Risk Drinking program. Collect baseline data on current environmental interventions being administered by law enforcement including: Compliance checks, Responsible Beverage Service, and Parents Who Host Lose the Most campaign.	June 12, 2020	Adult and youth	Binge drinking: Percent of adults who consumed 4 or more drinks on occasion (females) or 5 or more drinks on occasion (males) in the past 30 days Binge drinking: Percent of youth who consumed 4 or more drinks on occasion (females) or 5 or more drinks on occasion (males) in the past 30 days	**Hancock Public Health** **Hancock County Community Partnership**
Year 2: Work with area law enforcement agencies to determine feasibility of implementing/expanding at least 2 of the following strategies: • Sobriety checkpoints (working with law enforcement) • Compliance checks (working with the Ohio Investigative Unit) • Responsible Beverage Service (working with the Ohio Investigative Unit) • Parents Who Host Lose the Most campaign (educating parents on the laws for distributing alcohol to minors) • Use zoning and municipal regulations to control alcohol outlet density	June 12, 2021			
Year 3: Expand strategies to all areas of the county and implement remaining strategies. Publicize the results.	June 12, 2022			

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ⊗ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Hancock Public Health, law enforcement, Safe Communities grant, Ohio Department of Transportation, state highway patrol, sheriff's office, Hancock County Community Partnership

Priority #2: Chronic Disease

Strategic Plan of Action

To work toward improving chronic disease, the following strategies are recommended:

Priority #2: Chronic Disease

Strategy 1: Healthy food initiatives

Goal: Increase fruit and vegetable consumption

Objective: By June 12, 2022, Hancock County will implement 2 healthy food initiatives in local food pantries or farmers markets

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Raise awareness of the available food pantries and farmers markets within the county (locations, offerings, etc.). Update information on a quarterly basis. Obtain baseline information of who currently accepts SNAP/EBT at local farmers markets. Determine feasibility of **SNAP/EBT at farmers markets** (meet with job and family services). Educate vendors regarding food deserts and the benefits of accepting SNAP/EBT at farmers markets.	June 12, 2020	Adult and youth	Fruit consumption: Percent of adults/youth who report consuming fruits less than one time daily Vegetable consumption: Percent of adults/youth who report consuming vegetables less than one time daily	**Food Security Coalition**
Year 2: Continue efforts of year 1. Determine feasibility of implementing any of the following in local food pantries or farmers markets: • Cooking demonstrations and recipe tastings • Produce display stands • Nutrition and health education • Health care support services	June 12, 2021			
Year 3: Continue efforts of year 2. Implement at least 2 items above within local food pantries or farmers markets.	June 12, 2022			

Type of Strategy:

- ○ Social determinants of health
- ⊗ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy: Food Security Coalition, Hancock Public Health, fresh produce at food banks, local farmers markers, Hancock Public Health educational materials, Western Ohio Food Bank, Chamber at Lima, JFS, Community Action Commission

Priority #2: Chronic Disease

Strategy 2: Increase healthy-eating practices through fostering self-efficacy

Goal: Decrease obesity

Objective: By June 12, 2022, 3 organizations will implement a healthier choices campaign

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to recruit additional grocery stores to commit to encouraging healthy food choices by doing any of the following: offering coupons for healthy food items, offer "Try it Tuesdays", hold in-store healthy meal demonstrations, etc. Work with current participants to determine how often the above items are implemented. Provide technical assistance to increase participation in the initiatives. Determine interest within county/city schools, daycare centers, or other organizations regarding implementation of a healthier choices campaign. Work with organizations to introduce at least one priority area to focus on and implement: 1. **Family style** mealtime approaches 2. Healthier snack options offered during school lunches 3. Healthier fundraising foods 4. Healthier options in vending machines 5. Healthier options at sporting events and concession stands 6. Reducing unhealthy food as rewards	June 12, 2020	Adult	Fruit consumption: Percent of adults who report consuming fruits less than one time daily Vegetable consumption: Percent of adults who report consuming vegetables less than one time daily	**Hancock Public Health**
Year 2: Continue efforts of year 1. Explore additional recruitment strategies to obtain participation from addiction grocery stores. Choose 2-3 organizations to implement a healthier choices campaign. Each will choose at least 1-2 priority area to focus on and implement. Provide technical assistance	June 12, 2021			
Year 3: Continue efforts from years 1 and 2.	June 12, 2022			

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ⊗ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Hancock Public Health, local grocery stores

Priority #2: Chronic Disease

Strategy 3: Community gardens

Goal: Decrease obesity

Objective: By June 12, 2022, one additional community garden will be developed in Hancock County

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Obtain baseline data regarding how many school districts, churches, and other community organizations currently have **community gardens** and where they are located. Identify specific demographic need for community gardens. Determine need for additional community gardens and to secure volunteers and Master Gardeners (ex: potential partnership with OSU Extension).	June 12, 2020	Adult, youth, and child	Vegetable consumption: Percent of adults, youth and children who report consuming vegetables less than one time daily	**Food Security Coalition** **United Way**
Year 2: Research grants and funding opportunities to increase the number of community gardens. Develop a sustainability plan to maintain existing and future community gardens year-round. Obtain baseline data regarding which local food pantries have fresh produce available. Work with food pantries to offer fresh produce and assist pantries in seeking donations from local grocers. Market current and future community gardens within the county (i.e. location, offerings, etc.). Update the marketing information on an annual basis.	June 12, 2021			
Year 3: Continue efforts from year 2. Explore partnership opportunities to educate community members and families on gardening and healthy eating practices.	June 12, 2022			

Type of Strategy:

- ○ Social determinants of health
- ⊗ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Food Security Coalition, United Way, school district interest, current gardens at schools used for food services

Priority #2: Chronic Disease

Strategy 4: Increase businesses/organizations providing wellness programs and insurance incentive programs to their employees

Goal: Decrease obesity

Objective: By June 12, 2021, enlist 2 small and 2 large businesses/organizations to initiate wellness and/or insurance incentive programs

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Begin to collect baseline data or disseminate results of baseline data on businesses and organizations offering wellness and insurance incentive programs to employees. Determine specific CHIP priority areas to potentially tie into outreach efforts (ex: healthy food initiatives, physical activity campaigns, prediabetes screenings, etc.). Target large businesses such as city/county level employees. Encourage businesses and organizations to offer free or subsidized evidence-based programs to their employees and their spouses. Educate county businesses about the benefits of implementing these programs. Potentially partner with local organizations to showcase benefits/results of successful programming (ex: City of Findlay, YMCA).	June 12, 2020	Adult	Fruit consumption: Percent of adults, youth and children who report consuming fruits less than one time daily Vegetable consumption: Percent of adults, youth and children who report consuming vegetables less than one time daily	**Health Coalition**
Year 2: Continue efforts of year 1. Enlist 2 small and 2 large businesses/organizations to initiate wellness and/or insurance incentive programs. Partner with hospitals when appropriate.	June 12, 2021			
Year 3: Double the number of businesses/organizations providing wellness and insurance incentive programs from baseline.	June 12, 2022			

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ⊗ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Health Coalition (YMCA, Blanchard Valley Health System, Hancock Public Health)

Priority #2: Chronic Disease

Strategy 5: Nutrition Prescriptions

Goal: Reduce obesity

Objective: Implement nutrition prescription programs into three primary care offices by June 12, 2022

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research **nutrition prescription programs.** Create a plan for integrating nutrition prescription programs into primary care. Partner with local farmers markets (produce prescription or fruit and vegetable prescription (FVRx) programs) and discuss the possibility of redeeming nutrition prescriptions at participating markets.	June 12, 2020	Adult, youth, child	Fruit consumption: Percent of adults/youth/children who report consuming fruits less than one time daily Vegetable consumption: Percent of adults/youth/children who report consuming vegetables less than one time daily Heart disease: Percent of adults ever diagnosed with coronary heart disease	**Food Security Coalition**
Year 2: Continue efforts from year 1. Pilot a nutrition prescription program into one primary care office with accompanying referral options and evaluation measures.	June 12, 2021			
Year 3: Continue efforts from years 1 and 2. Implement a nutrition prescription program into two additional primary care offices with accompanying referral options and evaluation measures.	June 12, 2022			

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ⊗ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Health Coalition (YMCA, Blanchard Valley Health System, Hancock Public Health), Food Security Coalition

Priority #2: Chronic Disease

Strategy 6: Implement Diabetes Prevention Programs

Goal: Reduce diabetes in adults

Objective: By June 12, 2020, partner with local health care organizations to promote/market current programming and determine additional referral avenues

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Determine gaps in local diabetes prevention programming and the need to train additional staff/coaches (ex: PreventT2 campaign, disarming diabetes program, etc.). Partner with local health care organizations to promote/market current programming and determine additional referral avenues. Determine the feasibility of partnering with local health care organizations/dieticians for coaching opportunities.	June 12, 2020	Adult	Diabetes: Percent of adults who had been told by a doctor that they have diabetes Prediabetes: Percent of adults who had been told by a doctor that they have prediabetes	**Health Coalition**
Year 2: Continue efforts of year 1. Promote and market individual success stories in relation to local diabetes prevention programming.	June 12, 2021			
Year 3: Continue efforts of years 1 and 2.	June 12, 2022			

Type of Strategy:

- ○ Social determinants of health
- ⊗ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Health Coalition (YMCA, Blanchard Valley Health System, Hancock Public Health)

Priority #2: Chronic Disease

Strategy 7: Prediabetes screening and referral

Goal: Reduce diabetes in adults

Objective: By June 12, 2022, increase prediabetes referrals by 15%

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Determine the baseline number of organizations in the county that currently screen for prediabetes (ex: Diabetes Prevention Program (DPP)). Raise awareness of prediabetes screening, identification and referral through dissemination of the **Prediabetes Risk Assessment** (or similar assessment) and/or the **Prevent Diabetes STAT Toolkit**. Partner with local organizations to administer the screening or raise awareness of prediabetes. Promote free/reduced cost screening events within the county (ex: PreventT2 campaign, health fairs, hospital screening events, etc.). Connect organizations and providers with community resources available (ex: diabetes support groups, outpatient clinic education, YMCA programming, mobile meals diabetic choices, food security coalition offerings, etc.).	June 12, 2020	Adult	Diabetes: Percent of adults who had been told by a doctor that they have diabetes Prediabetes: Percent of adults who had been told by a doctor that they have prediabetes	**Health Coalition**
Year 2: Increase awareness of prediabetes screening, identification and referral. Increase the number of individuals within Hancock County that are screened for diabetes. If needed, increase the number of organizations that screen for prediabetes. Continue to update organizations on current resources available.	June 12, 2021			
Year 3: Continue efforts of years 1 and 2.	June 12, 2022			

Type of Strategy:

- ○ Social determinants of health
- ⊗ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Health Coalition (YMCA, Blanchard Valley Health System, Hancock Public Health)

Priority #2: Chronic Disease

Strategy 8: Advance care directives

Goal: Improve quality of care at the end of life

Objective: Increase the percentage of Hancock County residents who reported they have a living will and/or durable power of attorney

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Review CHA data and determine gaps regarding Hancock County advance care planning. Work with partners to research and determine strategies to increase the percentage of residents that have advance care directives (living will and/or durable power of attorney).	June 12, 2020	Adult	Living will: Percent of adults who reported they have a living will Durable power of attorney: Percent of adults who reported they have a durable power of attorney	**Blanchard Valley Health System**
Year 2: Implement strategies determined in year 1. Continue efforts of year 1.	June 12, 2021			
Year 3: Continue efforts of years 1 and 2.	June 12, 2022			

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ⊗ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Blanchard Valley Health System

Priority #3: Violence

Priority #3: Violence

Strategy 1: School-based violence prevention programs

Goal: Decrease violence among youth

Objective: By June 12, 2020, pilot at least one evidence-based violence prevention program in Hancock County/Findlay City schools

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Gather baseline data on which violence/bullying prevention programs are currently being implemented within school districts. Explore evidence-based prevention programs such as: **The PAX Good Behavior Game, Steps to Respect, Olweus Bullying Prevention Program, LifeSkills Training, The Incredible Years,** and **ROX (Ruling Our Experience).** Determine which program(s) will be offered and are sustainable. Determine feasibility of piloting components within the Leader in Me Program. Pilot the program(s) in at least one school district.	June 12, 2020	Youth	Bulling at school: Percent of youth who report being bullied on school property within past 12 months Weapon carrying: Percent of youth who carried a weapon within the past 30 days	**Family Resource Center**
Year 2: Introduce or re-introduce the evidence-based program(s) to the school districts. Pilot any new programs in at least one district. Determine the baseline number of mentoring and early-literacy opportunities within the county. Determine interest and need for additional programming and/or mentoring opportunities.	June 12, 2021			
Year 3: Continue efforts from years 1 and 2. Expand any current programming to additional districts or grade levels. Research and determine feasibility of community initiatives/mentoring programs to engage families/at-risk students. For example: Ashland County's **Multi-Generational Mentoring (MGM) program** or Defiance County's **WATCH D.O.G.S. program**.	June 12, 2022			

Type of Strategy:

- ○ Social determinants of health
- ⊗ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ○ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Findlay City Schools

Cross-Cutting Strategies

Cross-Cutting Factor: Healthcare system and Access

Cross-Cutting Factor: Healthcare system and access				
Strategy 1: Health disparities research				
Goal: Increase understanding of health disparities and the impact on chosen priorities				
Objective: By June 12, 2021, determine strategies to improve practicing patterns and to better target priority populations				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Convene a work group to assess county data related to chosen priority topics and health disparities. Research the impact of health disparities on chosen strategies to determine how to improve practicing patterns and to better target priority populations.	June 12, 2020	Adult	TBD	**Center for Civic Engagement**
Year 2: Educate/inform local partners of results of year 1. Determine next steps to impact priority areas.	June 12, 2021			
Year 3: Continue efforts from years 1 and 2.	June 12, 2022			
Priority area(s) the Priority area(s) the strategy addresses: ○ Mental Health and Addiction ○ Chronic Disease ⊗ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: Center for Civic Engagement, partnership with medical professionals, Hancock Public Health				

Cross-Cutting Factor: Healthcare system and access

Strategy 2: Workforce issues and shortages

Goal: Increase access to care

Objective: Hancock County will research and determine feasibility of implementing future health care cohorts within Raise the Bar by June 12, 2021

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Survey existing coalitions/partnerships to determine health care agencies that are impacted by workforce issues and shortages. Research and determine areas or organizations with greatest needs in relation to their workforce. Develop a partnership with Raise the Bar to discuss strategies related to health care workforce issues that are impacting Hancock County.	June 12, 2020	Adult	Provider availability mental health professionals: ratio of population to mental health providers (CHR) Provider availability primary care providers: ratio of population to other primary care providers (CHR)	**Raise the Bar Hancock County**
Year 2: Continue efforts of year 1. Determine feasibility of implementing future health care cohorts within Raise the Bar. Facilitate an assessment to determine gaps in service coordination and the potential need for patient navigators across service providers. Explore partnerships to determine the feasibility of hiring **community health workers** (CHW).	June 12, 2021			
Year 3: Continue efforts of years 1 and 2.	June 12, 2022			

Priority area(s) the Priority area(s) the strategy addresses:

○ Mental Health and Addiction ○ Chronic Disease ⊗ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Raise the Bar Hancock County, Hancock Public Health, ADAMHS Board, current model in place for potential replication (Raise the Bar)

Cross-Cutting Factor: Healthcare system and access

Strategy 3: Ensure alignment between the mobile health clinic and CHIP strategies

Goal: Increase access to care

Objective: Hancock County will identify and implement linkages between the mobile health clinic and CHIP by June 12, 2021

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Utilize the Community Health Improvement Plan to develop/determine services and initiatives within the mobile health clinic (ex: access to primary care, diabetes prevention and screening, depression screening, healthy food initiatives, etc.). Identify strategies that would be feasible to implement within the mobile health clinic.	June 12, 2020	Adult	Mobile health clinic services: number of services/initiatives that align with Hancock County CHIP strategies	**Hancock Public Health** **Hancock County ADAMHS Board**
Year 2: Continue efforts of year 1. Implement at least two strategies that align with current CHIP strategies.	June 12, 2021			
Year 3: Continue efforts of years 1 and 2.	June 12, 2022			

Priority area(s) the Priority area(s) the strategy addresses:

○ Mental Health and Addiction ○ Chronic Disease ⊗ Not SHIP Identified

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Hancock Public Health, Hancock County ADAMHS Board

Cross-Cutting Factor: Public Health System, Prevention and Health Behaviors

Cross-Cutting Factor: Public Health System, Prevention and Health Behaviors				
Strategy 4: Policies to decrease availability of tobacco products				
Goal: Reduce tobacco use				
Objective: By June 12, 2022, Hancock County will adopt smoke free policies in at least 2 new locations				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Raise awareness of the recently passed **Tobacco 21** initiative. Begin efforts to adopt smoke-free policies in county parks, fairgrounds, schools and other public locations. Ensure all forms of tobacco are included (i.e. e-cigarettes). Reach out to other communities who have implemented these policies to learn the best way to approach decision makers and to learn of potential barriers and challenges.	June 12, 2020	Adult and youth	Current smokers: Percent of adults who smoked at least 100 cigarettes in their lifetime and currently smoke some or all days Current smokers: Percent of youth who smoked cigarettes in the past 30 days	**Health Coalition**
Year 2: Present information to City Councils on smoke free outdoor public locations.	June 12, 2021			
Year 3: Continue efforts from years 1 and 2. Adopt at least 2 smoke-free policies in county parks, fairgrounds, schools, or other public locations.	June 12, 2022			
Priority area(s) the strategy addresses: ⊗ Mental Health and Addiction ⊗ Chronic Disease				
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: Health Coalition (YMCA, Blanchard Valley Health System, Hancock Public Health)				

Cross-Cutting Factor: Social Determinants of Health

Cross-Cutting Factor: Social Determinants of Health				
Strategy 5: Affordable, quality housing				
Goal: Decrease severe housing problems				
Objective: By June 12, 2022, Hancock County will research and identify at least one policy change in relation to housing issues in Hancock County				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Appoint a representative(s) from Be Healthy Now Hancock County to serve on a local housing coalition. Identify housing issues within the county that are impacting personal health. Identify what policy or legislative changes that Be Healthy Now Hancock County can assist in (ex: advocate to landlords/management companies regarding accepting those on housing assistance programs/complying with HUD safe housing regulations). Research low income housing tax credits, **home improvement grant opportunities**, and **service-enriched housing** to support efforts.	June 12, 2020	Adult, youth, child	High housing costs: Percent of households with monthly housing costs, including utilities, exceed 50% of monthly income (via U.S. HUD) Severe housing problems: Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities (via Community Health Rankings)	**Housing Coalition**
Year 2: Continue efforts from year 1. Create a coordinated campaign of planned strategies and define interventions and resources.	June 12, 2021			
Year 3: Begin addressing strategies identified and implementing policy changes.	June 12, 2022			
Priority area(s) the strategy addresses: ⊗ Mental Health and Addiction ⊗ Chronic Disease				
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: Housing Coalition				

Progress and Measuring Outcomes

Progress will be monitored with measurable indicators identified for each strategy. Most indicators align directly with the SHIP. The individuals or agencies that are working on strategies will meet on an as-needed basis. The full committee will meet quarterly to report out progress. The committee will create a plan to disseminate the CHIP to the community. Strategies, responsible agencies, and timelines will be reviewed at the end of each year by the committee. As this CHIP is a living document, edits and revisions will be made accordingly.

Hancock County will continue facilitating the CHA every three years to collect data and determine trends. Primary data will be collected using national sets of questions to not only compare trends in Hancock County, but also be able to compare to the state and nation. This data will serve as measurable outcomes for each priority area. Indicators have already been defined throughout this report and are identified with the icon.

In addition to outcome evaluation, process evaluation will also be used on a continuous basis to focus on the success of the strategies. Areas of process evaluation that the CHIP committee will monitor include the following: number of participants, location(s) where services are provided, number of policies implemented, economic status and racial/ethnic background of those receiving services (when applicable), and intervention delivery (quantity and fidelity).

Furthermore, all strategies have been incorporated into a "Progress Report" template that can be completed at all future meetings, keeping the committee on task and accountable. This progress report may also serve as meeting minutes.

Contact Us

For more information about any of the agencies, programs, and services described in this report, please contact:

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Appendix I: Gaps and Strategies

The following tables indicate mental health and chronic disease gaps and potential strategies that were compiled by Be Healthy Now Hancock County.

Mental Health and Addiction Gaps

Gaps	Potential Strategies
Mental health *(including suicide, depression, poor mental health days)*	
1. Lack of support for family needs	• Opiate task force providing services for families • PAX tools modified for caregivers for social and emotional support/regulation (possible state funding coming) • Increase skills and tools for seniors and young adults (soft skills education) • Provide support for families that are giving support to those who have addiction problems
2. Increase in youth depression	• Mental health first aid for youth and those that work with youth population
3. Lack of resources for those dealing with suicide	• Education regarding warning signs and why people commit suicide • Support for suicide loss team
4. Increase in isolation	• Give opportunities for those that are dealing with isolation/loss (ex: transportation, learning new skills, etc.)
5. Increase in mental health cognitive issues	• Slow down progression
6. Increase in depression among caregivers	• Increase support for caregivers
7. Lack of education regarding mental health and depression	• Education regarding positive coping skills to deal with stress (ex: physical activity, ROX program, etc.)
8. Lack of support for those dealing with grief/loss	• Mental health first aid • Grief/loss training and education (potential church-based programs)
9. Loss of housing/unsafe housing conditions	• Skill building to sustain employment - ability to access jobs and employment • Increase availability of affordable, accessible, and safe housing
10. Economic impact of co-habitation	• Financial preparedness for those taking on parenting roles (ex: grandparents)
11. Difficult to have hard conversations with youth	• Putnam County "Let's Talk" videos
12. Increase in trauma among children	• Support for families and children • Trauma informed care • "Handle with Care" program (partnership between schools and law enforcement). Increase community support for this program
13. Mental health stigma	• Support and awareness of screenings • Elevate awareness of the interconnectedness of physical and mental health

Gaps	Potential Strategies
Addiction *(substance abuse including tobacco use, alcohol use, and vaping)*	
1. Lack of enforcement and regulation for vaping (not FDA regulated)	• Findlay City Schools and Findlay College of Pharmacy partnership (Challenge program referral if there is a tobacco/e-cigarette violation) • Include e-cigarettes in compliance checks • Add vaping to Hidden in Plain Sight program • Strengthen laws
2. Lack of prevention regarding vaping	• Parent education • Peer education • Education within schools at every grade level (incorporate within existing curriculums and programming) • Education via social media to targeted audiences
3. Lack of data surrounding impact of e-cigarette use	• Grass roots/school programming - implement programming twice a year in each grade to educate using current data
4. Uncertainty among youth regarding positive/negative effects of marijuana (data is old)	• Education in every grade level before marijuana becomes recreational • Review current research regarding THC levels
5. Average age of onset for substance abuse is lowering	• Education among youth regarding effect on brain development • Target youth with trauma (identify priority populations)
6. Alcohol more easily accessible/available due to city development	• Education regarding how much is too much • Adjust messaging to kids to delay onset (most messaging is "no" instead of "not now")

Chronic Disease Gaps

Gaps	Potential Strategies
Chronic Disease (including obesity and diabetes)	
1. Disarming Diabetes program - need to build capacity/get more people trained	• Showcase individual success stories • Support mentoring coaches • Sustainable and intentional support for program • Potential diabetes registry within hospital system
2. Community impression that eating healthy is expensive and too difficult	• Coaching opportunities with dietitians within diabetes prevention program
3. Duplication within schools	• Embed/incorporate education into programs that are already in schools (ex: programs that already have buy-in such as Leader in Me
4. Lack of commitment from community leaders/organization to make bold moves and policy changes	• Take out unhealthy foods within businesses (ex: hospital took out fryers in cafeterias) • Incentivize health behaviors within businesses • Provide technical support for businesses (ex: template wellness policies) • County-wide policy changes among businesses (ex: get together in one room to work on county wide changes)
5. Schools lack time in school day to provide services/support	• Support for schools • Schools as champions for success stories (Leader in Me program) • Reach out to schools to discuss opportunities to incorporate or supplement information within current curriculums
6. Family structure does not match school environment	• Family Days in schools • Enforce/elevate Leader in Me program within other community settings (ex: Scouts)
7. Biking/walking opportunities and initiatives not widely promoted/marketed	• Complete Streets (work being done/grants available) • Market physical activity programs within community (especially indoor activities) • Expand Keep Active Keep Fit program within community • Master plan for bike paths available

Violence Gaps

Gaps	Potential Strategies
Violence (including youth bullying and youth carrying weapons)	
1. Kids cannot get a break from bullying (follows kids home due to prevalence of social media use)	• None noted
2. Violence being linked to mental health issues within the home environment	• Encourage bonds and building relationships (potentially include those that are dealing with isolation and link relationships) • Education regarding what healthy relationships look like
3. Exposure to violence (ex: video games, media, etc.)	• Limit exposure
4. Difficult to get mentors within early literacy programs at schools	• Powerful relationships needed within schools • Creativeness when building linkages and connections
5. Resiliency skills needed in schools and within community	• Leader in Me program • Education regarding personal responsibility of one's mindset • Ensuring that messaging is intentional • Trauma informed care as a language within community. Community action needed (ex: "Year of Kindness" and "Year of Compassion")

Appendix II: Continuation of Previous Strategies

Although the following strategies do not fall under the current 2019-2021 CHIP, Be Healthy Now Hancock County supports the continuation of the following strategies. Note: the categories below indicate previous 2016 CHIP priority areas.

Mental health:

Expand the Zero Suicide Initiative

Increase the number of primary cate physicians screening for depression during office visits

Increase recruitment for mental health professionals

Promote mental health first aid trainings

Promote the Hancock County texting hotline program

Re-introduce evidence-based programs and counseling services targeting youth (ex: Signs of Suicide, Incredible Years, Strengthening Families)

Use technology as treatment extenders (ex: MoodKit, WorryWatch, T2 Mood Tracker)

Substance abuse:

Expand drug-free workplace policies

Expand youth-led programming (ex: Youth Led Prevention Summit)

Implement the Life Skills Training Curriculum

Increase coordination of services, with Blanchard Valley Health System (BVHS), for pregnant women with substance use disorders (ex: MOMs Project)

Increase the number of primary care offices screening for alcohol and drug abuse

Increase the number of schools screening for substance abuse

Continue withdrawal management services in Hancock County at BVHS

Continue expansion of Community Diabetic Clinic at BVHS

Continue refinement of acute care for diabetic at Blanchard Valley Hospital Emergency Department.

Obesity/diabetes:

Implement complete streets policies

Implement Safe Routes to School

Increase education of healthy eating for youth (ex: Balance My Day framework)

Increase education of healthy eating for adults (ex: Cooking Matters classes)

Initiate formalized breastfeeding policies for employers

Partner with local grocery stores to encourage low-cost healthy food choices

Public Health will continue its Type II diabetes prevention efforts through the Prevent T2 CDC Program

Partner with local restaurants to offer "Healthy Choices" on their menus

Bullying:

Girls on the Run Program

Increase awareness and education of social media issues and trends

Family functioning:

Incorporate families and children into community physical activities

Increase efforts to engage the community (ex: community conversations)

Introduce the Positive Parenting Program (Triple P)

Appendix III: Links to Websites

Title of Link	Website URL
Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services	http://www.cdc.gov/nphpsp/essentialservices.html
Community gardens	http://www.countyhealthrankings.org/policies/community-gardens
Community health workers	http://www.countyhealthrankings.org/policies/community-health-workers
Culture, language, and health literacy	https://www.hrsa.gov/cultural-competence/index.html
Earned income tax credits (EITC)	https://www.cdc.gov/policy/hst/hi5/taxcredits/index.html
Family style	https://occrra.org/wp-content/occrra/spec/spec-fsd.pdf
Hidden In Plain Sight	http://powertotheparent.org/be-aware/hidden-in-plain-sight/
Home improvement grant	https://www.cdc.gov/policy/hst/hi5/homeimprovement/index.html
https://www.co.hancock.oh.us/government-services/board-of-health/about-our-agency/annual-reports	https://www.co.hancock.oh.us/government-services/board-of-health/about-our-agency/annual-reports
LifeSkills Training	https://www.lifeskillstraining.com/
Multi-Generational Mentoring (MGM) program	https://ccdocle.org/program/multi-generational-mentoring-mgm
National Prevention Strategies	https://www.surgeongeneral.gov/priorities/prevention/strategy/index.html
Nutrition prescription programs	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/nutrition-prescriptions
Olweus Bullying Prevention Program	http://www.violencepreventionworks.org/public/index.page
Prediabetes Risk Assessment	http://www.diabetes.org/are-you-at-risk/diabetes-risk-test/
Prevent Diabetes STAT Toolkit	https://preventdiabetesstat.org/index.html
Rox (Ruling Our Experience)	http://www.rulingourexperiences.com/#!about_us/csgz
Service-enriched housing	http://www.countyhealthrankings.org/policies/service-enriched-housing
SNAP/EBT at farmers markets	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/electronic-benefit-transfer-payment-at-farmers-markets
Social and emotional learning	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/school-based-social-and-emotional-instruction
Steps to Respect	http://www.blueprintsprograms.com/factsheet/steps-to-respect

Title of Link	Website URL
The Incredible Years	http://www.incredibleyears.com/programs/
The PAX Good Behavior Game	http://www.hazelden.org/HAZ_MEDIA/gbg_insert.pdf
Tobacco 21	https://tobacco21.org/state-by-state/
Trauma-informed Care	http://www.countyhealthrankings.org/policies/trauma-informed-health-care
WATCH D.O.G.S. program	http://www.defiancecityschools.org/protected/ArticleView.aspx?iid=63I0AU0&dasi=3YU2