2023-2025

Hancock County Community Health Improvement Plan

BeHealthyNow™
Hancock County

Released on January 31st, 2023

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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 three 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 10% of Hancock County residents were below the poverty line, according to the 2019 American Community Survey 1-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 assessment, and the community health status assessment. These four assessments were used by the Be Healthy Now Hancock County members to prioritize specific health issues and population groups which are the foundation of this plan. Figure 1.1 illustrate how each of the four assessments contributes to the MAPP process.

Figure 1.1 The MAPP model

Alignment with National and State Standards

The 2023-2025 Hancock County Community Health Improvement Plan priorities align perfectly with regional, state and national priorities. Hancock County will be addressing the following priority health factors: *health behaviors and access to care*. Hancock County will be addressing the following priority health outcome: *mental health and addiction*.

Healthy People 2030

Hancock County's priorities also fit specific Healthy People 2030 goals. For example:

- Health Care Access and Quality (AHS) – 01: Increase the proportion of people with health insurance
- Mental Health and Mental Disorder (MHMD) – 02: Reduce suicide attempts by adolescents

Please visit **Healthy People 2030** for a complete list of goals and objectives.

Ohio State Health Improvement Plan (SHIP)

The 2020-2022 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 ensure all Ohioan's achieve their full health potential, the state will track the following health indicators: self-reported health status (reduce the percent of Ohio adults who report fair or poor health) and premature death (reduce the rate of deaths before age 75).

The SHIP also takes a comprehensive approach to improving Ohio's greatest health priorities by identifying 3 priority factors (community conditions, health behaviors, and access to care) that impact the 3 priority health outcomes (mental health and addiction, chronic disease, and maternal and infant health).

The three priority factors include the following:

1. **Community Conditions** (includes housing affordability and quality, poverty, K-12 student success, and adverse childhood experiences)
2. **Health Behaviors** (includes tobacco/nicotine use, nutrition, and physical activity)
3. **Access to Care** (includes health insurance coverage, local access to healthcare providers, and unmet needs for mental health care)

The three priority health outcomes include the following:

1. **Mental Health and Addiction** (includes depression, suicide, youth drug use, and drug overdose deaths)
2. **Chronic Disease** (includes conditions such as heart disease, diabetes and childhood conditions [asthma and lead])
3. **Maternal and Infant Health** (includes infant and maternal mortality and preterm births)

Hancock County Alignment with Ohio's State Health Improvement Plan (SHIP)

The Hancock County CHIP is required to select at least 1 priority factor, 1 priority health outcome, 1 indicator for each identified priority, and 1 strategy for each selected priority to align with the 2020-2022 SHIP. As outlined in figure 1.2, the following priority outcome, priority factors, priority indicators, and strategies very closely align with the 2020-2022 SHIP.

Figure 1.2 2023-2025 Hancock County CHIP Alignment with the 2020-2022 SHIP

Priority Factors	State Aligned Priority Indicators	Strategies to Impact State Priority Indicators	Additional Aligned Strategies*
Health Behaviors	• Adult smoking • Youth fruit consumption • Youth vegetable consumption • Adult physical activity	• Tobacco Cessation Therapy Affordability • Healthy Food Initiatives in Food Banks • Diabetes Prevention Program	• CATCH My Breath
Access to Care	• N/A	• N/A	• Deploy mobile clinic to connect patients with providers and other healthcare resources • Increase Use of Non-Emergency Medical Transportation for Medicaid/Medicare Patients
Priority Health Outcomes	**State Aligned Priority Indicators**	**Strategies to Impact State Priority Indicators**	**Additional Aligned Strategies***
Mental Health and Addiction	• Adult suicide deaths • Unintentional drug overdose deaths	• Suicide Death Review Teams • Medication-Assisted Treatment (MAT) Access Enhancement Initiatives • Naloxone Education and Distribution Programs • Syringe services Programs	• Implementation of Youth Thrive Framework • Health and Human Services Workforce Development Committee

N/A – Not Available

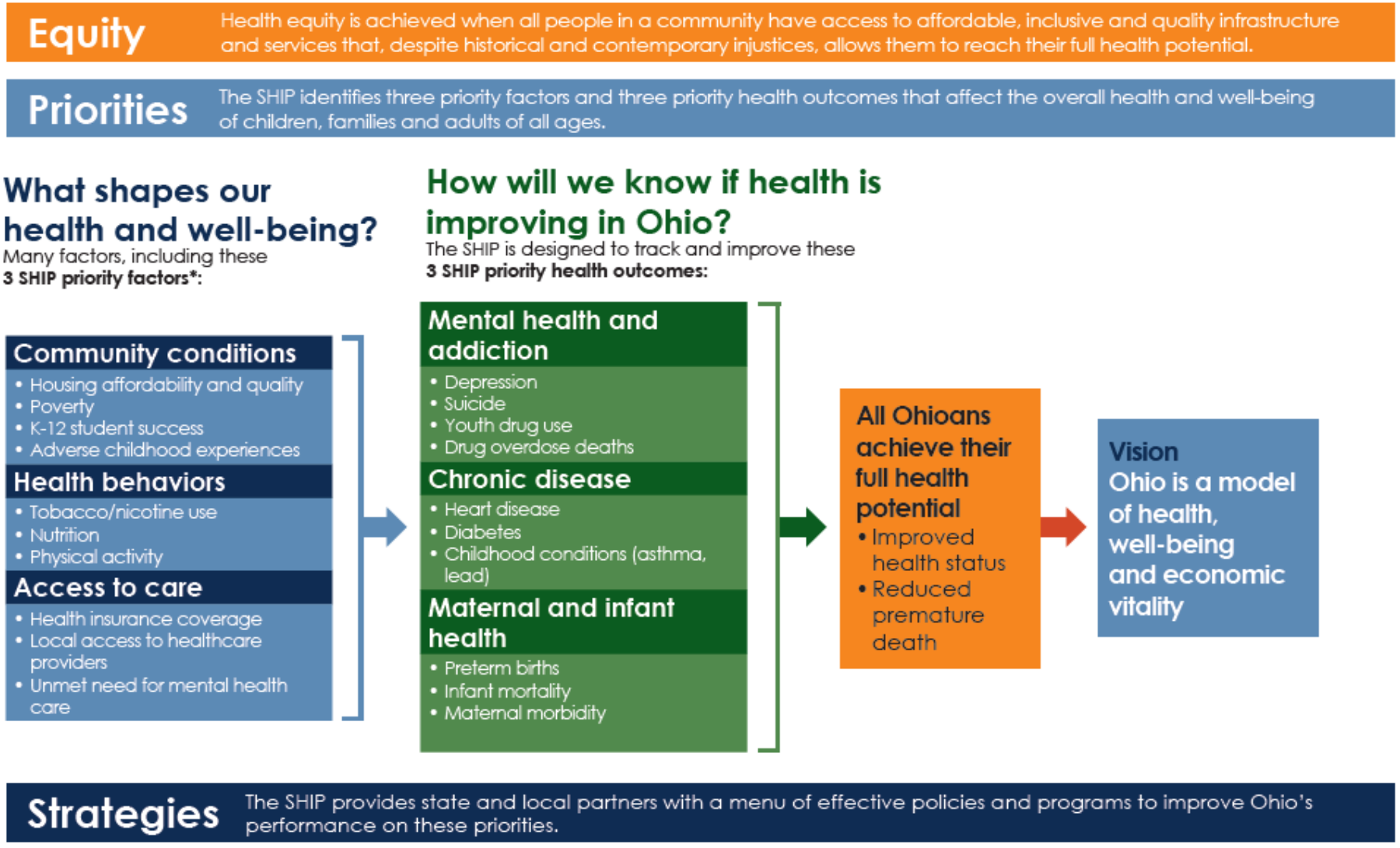
*Strategies are supported by the 2020-2022 SHIP, but Hancock County priority indicators do not directly align with sate identified indicators.

Note: This symbol will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2020-2022 SHIP.

Note: This symbol √ will be used throughout the report when a strategy has been rated by **What Works for Health** as "likely to decrease disparities" and/or recommended by the Community Guide as effective strategies for achieving health equity. These sources consider potential impact on disparities and inequities by racial/ethnic, socio-economic, geographic, or other characteristics.

Alignment with National and State Standards, continued

Figure 1.3 2020-2022 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 September 2022 to December 2022, Be Healthy Now Hancock County members 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 Members:

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 Gabrielle Mackinnon, Community Health Improvement Manager, from HCNO.

Community Health Improvement Process

Beginning in September 2022, the Be Healthy Now Hancock County members 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 100+ 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 http://Hancockcohealth.org/Hancock-county-public-health/. 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	Hancock County 2021	Ohio 2020	U.S. 2020
Health Status							
Rated general health as excellent or very good	58%	N/A	56%	51%	**55%**	55%	57%
Rated general health as fair or poor	12%	N/A	9%	11%	**15%**	16%	13%
Rated mental health as not good on four or more days (in the past 30 days)	20%	N/A	22%	32%	**40%**	29%†	26%†
Rated physical health as not good on four or more days (in the past 30 days)	13%	N/A	14%	22%	**16%**	24%†	23%†
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	**4.7**	4.8*	4.1*
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	**3.0**	4.1*	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%	**33%**	N/A	N/A
Health Care Coverage, Access, and Utilization							
Uninsured	8%	N/A	3%	5%	**8%**	9%	11%
Had one or more persons they thought of as their personal health care provider	N/A	N/A	90%	89%	**91%**	79%	77%
Visited a doctor for a routine checkup (in the past 12 months)	55%	N/A	65%	72%	**76%**	77%	76%
Diabetes, Asthma & Arthritis							
Ever been told by a doctor they have diabetes (not pregnancy-related)	6%	N/A	9%	12%	**13%**	12%	11%
Ever been diagnosed with pregnancy-related diabetes	2%	N/A	1%	1%	**1%**	1%	1%
Ever been diagnosed with pre-diabetes or borderline diabetes	N/A	N/A	7%	9%	**6%**	2%	2%
Had ever been told they have asthma	11%	N/A	11%	13%	**10%**	14%	14%
Ever diagnosed with some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia	N/A	N/A	N/A	32%	**28%**	31%†	25%†

N/A – Not Available
† 2019 BRFSS
†† 2019 BRFSS Data
** 2018 BRFSS as compiled by 2021 County Health Ranking*
Indicates alignment with the Ohio State Health Assessment

Adult Variables	Hancock County 2011	Hancock County 2013	Hancock County 2015	Hancock County 2018	Hancock County 2021	Ohio 2020	U.S. 2020
Cardiovascular Health							
Ever diagnosed with angina or coronary heart disease	N/A	N/A	4%	3%	**6%**	5%	4%
Ever diagnosed with a heart attack or myocardial infarction	4%	N/A	4%	3%	**5%**	5%	4%
Ever diagnosed with a stroke	3%	N/A	2%	4%	**2%**	4%	3%
Had been told they had high blood pressure	24%	N/A	29%	34%	**35%**	35%††	33%††
Had been told their blood cholesterol was high	36%	N/A	33%	39%	**38%**	33%††	33%††
Had their blood cholesterol checked within the past five years	74%	N/A	76%	81%	**92%**	85%††	87%††
Weight Status							
Normal weight (BMI of 18.5-24.9)	37%	33%	34%	27%	**30%**	29%	31%
Overweight (BMI of 25.0-29.9)	35%	34%	38%	28%	**36%**	34%	35%
Obese (includes severely and morbidly obese, BMI of 30.0 and above)	27%	32%	27%	44%	**34%**	36%	32%
Alcohol Consumption							
Current drinker (had at least one drink of alcohol within the past 30 days)	51%	N/A	60%	60%	**61%**	51%	53%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	15%	23%	19%	23%	**20%**	16%	16%
Tobacco Use							
Current smoker (currently smoke some or all days)	15%	N/A	13%	10%	**9%**	19%	16%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	20%	N/A	23%	24%	**29%**	24%	25%
Drug Use							
Adults who used marijuana (in the past 6 months)	4%	N/A	4%	3%	**11%**	N/A	N/A
Adults who misused prescription medication (in the past 6 months)	4%	N/A	9%	7%	**1%**	N/A	N/A
Sexual Behavior							
Had more than one sexual partner (in past 12 months)	8%	N/A	4%	4%	**1%**	N/A	N/A
Quality of Life							
Limited in some way because of physical, mental or emotional problem	20%	N/A	19%	21%	**25%**	N/A	N/A
Mental Health							
Considered attempting suicide (in the past 12 months)	3%	N/A	4%	5%	**2%**	N/A	N/A
Attempted suicide (in the past 12 months)	<1%	1%	1%	0%	**1%**	N/A	N/A
Oral Health							
Visited a dentist or dental clinic (within the past year)	71%	N/A	72%	73%	**80%**	65%	67%
Visited a dentist or dental clinic (5 or more years ago)	10%	N/A	8%	9%	**7%**	N/A	N/A

N/A - Not available
**Hancock 2011 and 2015 percentages are based on all women*
†† *2019 BRFSS Data*
*** 2017 BRFSS Data*
****Total population*
Indicates alignment with the Ohio State Health Assessment

Adult Variables	Hancock County 2011	Hancock County 2013	Hancock County 2015	Hancock County 2018	Hancock County 2021	Ohio 2020	U.S. 2020
Preventive Medicine							
Ever had a pneumonia vaccination (age 65 and older)	55%	N/A	N/A	68%	**62%**	72%	72%
Had a flu vaccine within the past year (age 65 and older)	62%	N/A	70%	79%	**79%**	65%	68%
Ever had a shingles or zoster vaccine	N/A	N/A	N/A	18%	**24%**	29%**	29%**
Had a clinical breast exam within the past two years (age 40 and older)	72%	N/A	70%	64%	**68%**	N/A	N/A
Had a mammogram within the past two years (age 40 and older)	59%	N/A	61%	64%	**73%**	71%	72%
Had a Pap smear within the past three years (ages 21-65)	70%*	N/A	71%*	71%	**66%**	77%	78%
Had a PSA test within the past two years (age 40 and older)	39%***	N/A	58%	56%	**50%**	32%	32%
Had a digital rectal exam within the past year	30%	N/A	18%	16%	**9%**	N/A	N/A

N/A - Not available
*** 2017 BRFSS Data*

Key Issues

The Be Healthy Now Hancock County members reviewed the 2021 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 2021 health needs assessment report? Examples of how to interpret the information include: 8% of adults were uninsured, increasing to 17% of those with lower incomes.

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Adult Mental Health (10 votes)			
Adults who seriously considered attempting suicide in the past 12 months	2%	N/A	N/A
Adults who reported attempting suicide in the past 12 months	1%	N/A	N/A
Adults who felt worried, tense or anxious in the past 12 months	70%	N/A	N/A
Adults who rated their mental health as not good on 4 or more days in the past month	40%	N/A	N/A
Adults reported their mental health as not good on average # of days in the past month	4.7 days	N/A	N/A
Suicide Demographics, from 2016-2021 – *Hancock County Overdose Fatality Review*	51 deaths	Age: 35-44 (11 deaths) Income: N/A	Males (41 deaths) Females (10 deaths)
Adult Weight Status (6 votes)			
Adults identified as obese (includes severely and morbidly obese, BMI of 30.0 and above)	34%	Age: 30-64 (41%) Income: $25K+ (35%)	Males (37%)
Adults identified as overweight (BMI of 25.0-29.9)	36%	Age: 65+ (46%) Income: <$25K (40%)	Males (43%)

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
Adult Drug Use (5 votes)			
Adults who used recreational marijuana in the past 6 months	11%	Age: 30-64 (14%) Income: <$25K (13%)	Females (18%)
Adult prescription medication misuse in the past 6 months	1%	Age: 30-64 & 65+(1%) Income: $25K+ (1%)	Females (1%)
Age-adjusted unintentional drug overdose rate per 100,000, from 2015-2020 – *Ohio Department of Health, 2020 Ohio Drug Overdose Report*	28.6	N/A	N/A
Total deaths - Fatal Overdose Trends, from 2015-2021 – *Hancock County Overdose Fatality Review*	139 deaths	Age: 25-34 (51 deaths) Income: N/A	Males (97 deaths) Females (42 deaths)
Fentanyl deaths - Fatal Overdose Trends, from 2015-2021 – *Hancock County Overdose Fatality Review*	86 deaths	N/A	N/A
Morphine deaths - Fatal Overdose Trends, from 2015-2021 – *Hancock County Overdose Fatality Review*	51 deaths	N/A	N/A
Cocaine deaths - Fatal Overdose Trends, from 2015-2021 – *Hancock County Overdose Fatality Review*	32 deaths	N/A	N/A
Methamphetamine deaths - Fatal Overdose Trends, from 2015-2021 – *Hancock County Overdose Fatality Review*	25 deaths	N/A	N/A
Quality of Life (4 votes)			
Adults limited in some way because of a physical, mental, or emotional problem	25%	Age: 65+ (40%) Income: <$25K (58%)	Females (34%)
Most limited health problems – *stress, depression, anxiety, or emotional problems*	46%	N/A	N/A
Adult Diabetes (4 votes)			
Adults who were diagnosed with diabetes	13%	Age: 65+ (26%) Income: <25K (25%)	Males (16%)

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
Women's Health (4 votes)			
Women ages 40 and older who had a mammogram in the past 2 years	73%	N/A	Females
Women ages 40 and older who had a clinical breast exams (CBEs) in the past 2 years	68%	N/A	Females
Women who had a Pap smear in the past 3 years	66%	N/A	Females
Adult Social Determinants of Health (3 votes)			
Adults who experienced 4 or more ACEs	14%	Age: N/A Income: <$25K (18%)	N/A
Adults who experienced 4 or more ACEs before their 18th birthday, from 2021 - *Hancock County Overdose Fatality Review*	5 people	N/A	N/A
Uninsured Adults (3 votes)			
Adults who were uninsured in 2021	8%	Age: 30-64 (8%) Income: <$25K (17%)	Females (11%)
Adult Cardiovascular Health (3 votes)			
Adults reported they had survived a heart attack	5%	Age: 65+ (12%) Income: N/A	N/A
Adults reported they had survived a stroke	2%	Age: 65+ (6%) Income: N/A	N/A
Adults reported they had angina or coronary heart disease	6%	Age: 65+ (14%) Income: N/A	N/A
Adults reported they had congestive heart failure	2%	Age: 30-64 (3%) Income: N/A	N/A
Adults diagnosed with high blood cholesterol	38%	Age: 65+ (52%) Income: <$25K (58%)	Males (46%)
Adults diagnosed with high blood pressure	35%	Age: 65+ (68%) Income: <25K (62%)	Males (40%)
Diversity and Inclusion (3 votes)			
Adults who felt comfortable being themselves in Findlay – *somewhat and strongly disagreed*	9%	N/A	N/A
Adults who attended a culturally diverse event in the past year – *never*	45%	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
Adult Alcohol Consumption (2 votes)			
Adult current drinkers (drank alcohol at least once in the past month)	61%	Age: 30-64 (67%) Income: N/A	N/A
Average number of drinks adults consumed per drinking occasion	2.6	Age: 30-64 (2.7) Income: $25K+ (2.5)	Males (2.8)
Adult binge drinkers (defined as consuming more than four [women] or five [men] alcoholic beverages on a single occasion in the past 30 days)	20%	N/A	N/A
Alcohol deaths - Fatal Overdose Trends, from 2015-2021 – *Hancock County Overdose Fatality Review*	33 deaths	N/A	N/A
Adult Environmental Health (2 votes)			
Adults and families who were negatively affected by the COVID-19 pandemic – *change in mental health*	18%	N/A	N/A
Men's Health (2 votes)			
Men who had a prostate-specific antigen (PSA) test in the past 12 months	19%	Age: 50+ (43%) Income: $25K+ (23%)	Males
Men who had a digital rectal exam in the past 12 months	9%	Age: 50+ (18%) Income: $25K+ (10%)	Males

N/A – Not Available

Priorities Chosen

Based on the 2021 Hancock County Health Needs Assessment, key issues were identified for adults and youth. Overall, there were 13 key issues identified by the Be Healthy Now Hancock County members. The Be Healthy Now Hancock County members 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
1. Adult Mental Health	10
2. Adult Weight Status	6
3. Adult Drug Use	5
4. Quality of Life	4
5. Adult Diabetes	4
6. Women's Health	4
7. Adult Social Determinants of Health	3
8. Uninsured Adults	3
9. Adult Cardiovascular Health	3
10. Diversity and Inclusion	3
11. Adult Alcohol Consumption	2
12. Adult Environmental Health	2
13. Men's Health	2

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

Priority Factor(s):

1) Health Behaviors
    a. Includes: **tobacco/nicotine use** (adult smoking and youth all-tobacco/nicotine use), **nutrition** (youth fruit consumption and youth vegetable consumption), and **physical activity** (child physical activity and adult physical inactivity)

2) Access to Care
    a. Includes: **local access to healthcare providers** (primary care health professional shortage and mental health professional shortage area) and **unmet need for mental health care** (youth depression treatment unmet need and adult mental health care unmet need)

Priority Health Outcome(s):

1) Mental Health and Addiction
    a. Includes: **depression** (youth depression and adult depression), **suicide** (youth suicide rates and adult suicide rates), and **drug overdose deaths** (unintentional drug overdose deaths)

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 committee 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?**
    - Financial security/stability (5)
    - Access to affordable healthcare (5)
    - High level of collaboration and an actionable shared vision by service agencies (5)
    - Access to healthy foods (3)
    - Access to physical activity i.e., gyms, parks, local trails (3)
    - Clean and safe environment and an environment that meets everyone's basic needs (3)
    - Sense of belonging (2)
    - Embracing diversity and true inclusion of those from all income categories, racial / ethnic groups, LGBTQIA+, people who with substance use and mental health issues, trauma, etc. (2)
    - Transportation
    - Strong workforce
    - Housing affordability
    - Respect for everyone
    - Access to prevention and treatment
    - Health Prevention education at our schools
    - Opportunities for personal and professional growth
    - Remove barriers due to mobility issues or disabilities
    - Systemic root-cause mitigation of health issues facing the community
    - Targeted approaches to disparate populations that seeks to increase universal health goals
    - A viable, long-term (25/50/100 year) community vision/plan that provides a lens for decision making and initiatives
    - Community infrastructure that supports citizens in pursuing physical, mental, social, emotional, and spiritual health
    - A healthy community helps make sure all residents have access to education, safe and affordable housing, employment in addition to quality health care

2. What makes you most proud of our community?

- Community partnerships/collaborations (9)
- Donors
- Volunteerism
- People trying to help others
- Robust social service network
- The family friendly atmosphere
- Access to prevention and treatment
- Leadership that is open to exploring progressive ideas to address disparities and inequality.
- Economic prosperity for most, but not all, creating a relatively attractive environment for new businesses and investments.
- Innovation of programming and ability to leverage Federal, State, and local resources to fund new programs and services.
- We have excellent schools and a number of generous companies and individuals willing to make Hancock County a great place to live.
- The fact that our county is big enough to have many services more populated communities do, while maintaining a small enough feel that we can have one-on-one conversations with key partners who can assist in completing our initiatives.
- I am proud of how genuine our community is with regard to collaboration. We are light years ahead of our peers in the region and state. We truly try to work together to co-address challenges and make this community a place a majority of people are proud to be a part of.

3. **What are some specific examples of people or groups working together to improve the health and quality of life in our community?**

- ADAMHS / Hancock County Opioid and Addictions Task Force (8)
- Partnership with University of Findlay (3)
- Raise the Bar - collaborating with Habitat's Financial Opportunity Center to ensure career coaches are informed of career opportunities and challenges, Millstream, Welcome to a New Life, and OMJ collaborating to provide a career assessment program to vulnerable adults to ensure they find a career that aligns with the skills and values (3)
- Habitat for Humanity (2)
- Hancock Public Health (2)
- Food Security Coalition (2)
- Faith-based community (2)
- Covid-entire community (2)
- Be Healthy Now coalition (2)
- The Community Foundation (2)
- Blanchard Valley Health System (2)
- Cultural Humility-Health Equity Delegation (2)
- Affordable Housing Alliance/Housing Steering Committee (2)
- Partnership with the City of Findlay building a strategic plan with input from local citizens and employers (2)
- YMCA
- FOCUS
- 50 North
- CHIP committee
- Backyard Mission Trip
- ROSC Leadership Team
- Transportation Coalition
- United Way Days of Caring
- Family and Children First Council
- Recovery programs between all agencies
- Partnership with school superintendents and school nurses
- Chamber of Commerce promotes businesses/economic growth
- Partnership with local libraries in the county to conduct vaccine clinics
- NAMI Walk brings together a lot of different people in support of mental health
- Partnerships with Marion Township to conduct vaccine clinics and COVID test distribution
- Partnership with police/sheriff/fire to discuss fatal and non-fatal overdoses and distribute naloxone
- Partnerships with local Fire Department to conduct CAMP 911 as well as multiple car seat check clinics

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?**

- Lack of affordable housing (6)
- Access to mental health treatment (4)
- Overall social determinants of health – poverty, incomes less than $25K, and populations with 4+ ACEs (4)
- Obesity/overweight (3)
- Investing in healthcare workforce development and retention (3)
- Access to Care (2)
- Income disparity (2)
- Behavioral health (2)
- Harmful substance use/addiction (2)
- Workforce training and opportunity (2)
- More acceptance of diversity in people and thinking (2)
- Diabetes
- Transportation
- Better coordination of services
- Expanding public and private partnerships
- More options to get residents physically active
- Providing people with the resources to monitor certain health conditions
- Jailing people who commit crimes in our community rather than letting them go
- Unhealthy living environments for children (both physical and emotional) and getting food resources to those to need it.
- Improve the safety and livability of neighborhoods throughout the county (neighborhood and built environment)

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

- Decreased trust in public health (2)
- Stigma, toward those living in poverty, those with addiction and mental illness, etc... (2)
- Need continued improvement with systems change efforts: coordination - collaboration – alignment (2)
- COVID-19
- Access to care
- Transportation
- Political division
- Lack of funding
- Affordable housing
- Politicizing public health/community health issues
- Social media trolls, and the systemic attack on science
- Fragmentation of plans - need for a common vision and priorities
- Making sure people are provided with practical things to do to be of help
- Influential community leaders trying to disprove and/or not acknowledge social challenges in Hancock County.
- Everyone running in different directions, not one unified theme that we all agree on and all working together on to attack the big issues, not enough workers.
- Having a true understanding of where the breakdowns are that are causing the issues. For example, why doesn't the community have more low-income housing.
- A fear of progress and clinging to the past which prevents the community from trying something different or outside the box to find solutions to its problems.
- Addressing human resource needs in the health and human services sector -- burnout of personnel and not enough personnel to provided needed services now, and especially in the future.
- Embracing a need to focus on population health. We often rush to immediate solutions without considering deeper root causes that need to be addressed through institutional change/policy.
- Too much competition for the same resources and financial stability among service agencies -- lack of community strategy for each agency to play a role in the plan rather than fill their own agency's mission.
- Our community is in a "dead zone" of philanthropic giving outside of our current donor base. If we were in a major metropolitan area, the resources from other businesses and donors would be much greater. However, being stuck between rural and metro, as well as being relatively healthy/good QOL already, keeps donors from putting their money in Hancock County because they perceive us as "not needing the support" like other regions of the state.
- We have a lot of trails, nice parks, good collaboration, etc. which is great. However, lack of jail space contributes to more crimes being committed/more stress on residents and reduced quality of life overall. Findlay/Hancock County is very nice but we are seeing more and more issues related to financial insecurity and there also seems to be a substantial amount of criminal activity - both reported as well as overlooked due to this crowding issue. Additional mental health support - including affordable options - for all ages and income levels is needed as well.

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

- Funding opportunities for affordable housing (4)
- Funding for mental illness access and facilities/treatment (4)
- Funding opportunities for transportation (3)
- Policies creating equity in access to resources (2)
- Change the goal of economic development at the state and federal level to incentivize job retention rather than job growth (2)
- Health in all policy
- Targeted universalism
- Anti-stigma education to the community
- More information on resilience in light of the trauma
- Creation of a long-term (25/50/100 year) community plan
- Funding for healthy food choices and more affordable healthy food choices
- Greater alignment and focus - with financial investments by more partners (private and public sectors)
- Anything that helps children who are neglected physically and/or emotionally. Supports to help fill the gaps
- I would support any of these that would aid in the decrease of negative health outcomes and improve the overall quality of life in the community
- An advocacy program that tells the story of what happens when you don't continue to invest in a productive community (i.e., what happens when just one major employer leaves town and the financial windfall that happens)
- I am supportive of most actions, policies or funding that helps Hancock County residents thrive and become or remain healthy. As an example, I really like the new Youth Initiative that the Findlay-Hancock Community Foundation is focused on currently. Perhaps future projects aimed at youth may be able to be funded by their work.

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

- A unified voice with a plan and the decision makers at the table all agreeing on the biggest priority and working together on it (3)
- Education efforts on public health issues (2)
- Time is my major issue
- Anti-stigma education efforts
- Opportunity to affect the lives of children
- Patient centered activities and engagement
- Creation of a long-term (25/50/100 year) community plan
- An initiative to reduce political division and politicization of social issues
- The chance to track and see changes in health outcomes based off our actions at the LHD.
- To become further involved, I'd like clear direction on what specific tasks can be done to move needle on improving the community.
- I am all-in already. I am just waiting to be asked to help complete a task/objective. My heart is with community health improvement already, I can't wait to support this more.
- Knowing that whatever task we accepted to address a priority, significant improvement (if not completion) of the identified area would be observed by the set deadline of the CHIP.
- To see real commitment that decisionmakers at the city and county level are committed to helping with the local affordable housing and transportation problem in Hancock County.

Community Themes and Strengths Assessment (CTSA) – Peer Board

Open-ended Questions to the Committee

1. **What do you believe are the 2-3 most important characteristics of a health community?**
   - Connection
   - Safety
   - More services to marginalized populations

2. **What makes you most proud of our community?**
   - We have great advocates who are working to make this a safe space for everyone.
   - We also have a wealth of resources that other communities do not have and the growth that has taken place in them over the last 10 year.

3. **What are some specific examples of people or groups working together to improve the health and quality of life in our community?**
   - Agencies being open to working with Hancock Public health and harm reduction efforts.
   - Peer Support Advisory working with the ADAMHS board.

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?**
   - Reducing the stigma on SUD/Mental Health.
   - Thinking about new solutions to old problems as the current are not working as effectively as they could.

5. **What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?**
   - People not wanting to share power and control on some things that need to be changed.
   - We also have people who shy away from discussing the hard topics and try to "sweep them under the rug".

6. **What actions, policy, or funding priorities would you support to build a healthier community?**
   - Inpatient substance use detox/treatment facility that accepts all insurance.
   - Low barrier shelter
   - Affordable housing

7. **What would excite you enough to become involved (or more involved) in improving our community?**
   - New programs
   - More effective events

Quality of Life Survey

The Be Healthy Now Hancock County members urged community members to fill out a short Quality of Life Survey via SurveyMonkey. There were **538** Hancock County community members who completed the survey. The table below incorporates responses from the previous Hancock County CHIP for comparison purposes. 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.

Quality of Life Questions	Likert Scale Average Response			
	2012 (n=99)	2015 (n=216)	2018 (n=198)	2022 (n=538)
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	3.73*
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	3.19*
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	3.75*
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	3.49*
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	3.58*
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	3.69*
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	3.66*
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	3.40*
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	3.16*
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	3.28*
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	3.27*
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	3.25*

**Results of this assessment were collected during the COVID-19 pandemic*

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?" The Be Health Now members 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. COVID-19 pandemic (4)	• Negative increase in priority areas-mental health, substance use, increase in obesity, and diabetes (3) • Strain on health care and public health systems (2) • Decreased trust in public health • Increase in political division	• Increased public awareness (2) • Increased partnerships/collaboration (2) • Additional funding from state, federal level, and local sources to address issues • Learning new ways to separate public health/health care issues from politics • Engage faith community to help with mentoring children
2. Lack of desire to work (4)	• Increased debt • Poor health • Families living with other families • Fluctuating income • Decreased access to quality services	• Workforce development programs • Financial literacy programming • Opportunity to explore non-traditional initiatives to attract, retain, and support workforce
3. Post COVID-19 polarization of society (4)	• Increase in infectious disease problems • Constituency deeply divided on proven prevention strategies. • Mistrust in prevention messaging, • Exhausted workforce, • the reemergence of preventable ailments. • Low employment rates	• Public education • Education on available jobs

Force of Change	Threats Posed	Opportunities Created
4. Increased cost of living (3)	• Not getting medical care as needed or prescriptions • Poor eating habits • Families living with other families • Lack of safe housing • Food insecurity • Neglect of children • Safety issues	• Budgeting classes • Programs to address issues to keep children safe
5. Increased obesity rates (3)	• Increase in chronic health conditions (2) • Increase in HTN and hyperlipidemia; • Increase cardiovascular risk • Decreased quality of life	• Discuss food insecurity and assistance • Increase engagement in school nutrition program • Promotion events at parks • Opportunity to set up community nutrition and wellness programs (Walk with a Doc, local farmer's markets, etc)
6. Increased substance abuse/overdoses in community (3)	• Increased deaths • Increased drug-related infections • Increased overdoses • Stigma towards people who use drugs • Tendency to "double-down" on old methods like "war on drugs" and "control the supply of drugs" through increased enforcement (which seem easier, but have proven ineffective)) rather than more evidence based methods such as harm reduction, prevention • Animosity from law enforcement toward people who use drugs and providers trying to prevent deaths through methods not involving increased penalties	• Increased use of Harm Reduction methods • Community education on overdoses • BIDPP program • Discussions around health education and awareness • Wellness programs • One Ohio settlement = increased resources • Grant funding • Support from Opioid and Addictions Task Force and ADAMHS for evidence-based solutions

Force of Change	Threats Posed	Opportunities Created
7. Mental health issues – depression, anxiety, suicidal thoughts (3)	• Increased suicides (2) • Overtaxing an already overwhelmed behavioral health and health care system • Decreased employment • Decreased quality of life • Increase in illicit drug use • Increase in overweight/obesity	• More education • Community events and awareness programs • We already have a well-structured network of community agencies and resources positioned to help and advocate for increased resources. This could provide an increased motivation for this group to work even more assertively in one unified direction
8. Changing leadership at community-leading organizations (3)	• Loss of historical perspective • Loss of knowledge, wisdom, experience, financial stability • Community "ownership"	• Creating mentoring opportunities to reinforce historical perspective, which may help in new/innovative decision making • new faces on boards and within community improvement discussions, • age of new participants will usher in new technology usage • bringing new and veteran leaders together to develop a shared vision
9. Lack of workforce (3)	• Businesses closing • Community collaborations • Lack of volunteers • Lack of future investment • Inability to meet needs	• Better economy • Community collaborations
10. Negative perception of public health and the healthcare system due to COVID pandemic (2)	• Decrease in childhood and other common vaccinations, along with fewer people seeking primary care	• Improve outreach strategies to enhance public's perception of the services offered.
11. Lack of affordable housing (2)	• Homelessness (2) • Blight • Cost burden • Families living with other families	• Include housing in the community strategic plan • Clean, affordable housing in health care issues

Force of Change	Threats Posed	Opportunities Created
12. Inflation (2)	• Increase the difficulty in workforce staffing • More public health issues it relates to housing, solid waste, sewage, and food particularly for infants and children. • Fewer dollars to invest in housing, solid waste removal, to repair/replace septic system, or to buy food.	• Other sectors of economy will be more affected • Housing Code • Community Trash Pickup • food banks focused on infants and children
13. Mental and behavioral health issues with addiction (2)	• Increased prevalence with decreased capacity for treatment • Due to workforce scarcity, it may become more difficult for people to access services	• Redesign prevention, diagnosis, and treatment workflows • Opportunity to increase the expansion of protective and promotive factors throughout all youth/young adult serving providers/activities
14. Increase in health disparities/inequity – low income (2)	• Increase in “heave vs have nots mentality” • Stressing existing resources to meet the growing needs and ill gaps • More people at-risk and not getting access to services	• Additional funding and collaboration to address conditions • Opportunity to gain more support from those who have resources of those without adequate resources. • Opportunity to do more "Bridges out of Poverty" type of training to the broader community to help them better understand why disparities exist and why the cycle of poverty persists.
15. Decrease in the number of mental health professionals	• Increase incidence of suicide and substance abuse	• Federal, state, and local funding to support the recruitment, training, and education of individuals interested in the field.
16. State and local politics towards public health and healthcare initiatives	• Legislative action to remove authorities of public health that are meant to keep the public safe.	• To inform these policy makers of public health's importance in mitigating vaccine-preventable diseases through various approaches.

Force of Change	Threats Posed	Opportunities Created
17. House Bill 463	• It would take away the ability of townships and villages to have a voice at the public health board.	• County Commissioners would be in charge of appointing the Health Board.
18. Antimicrobial resistance	• Increased risk of disease spread • Severe illness • Common medical procedures become more risky	• Promoting the appropriate and responsible use of antimicrobials • Development of new medical products
19. Unrest in the country	• Continued division "us vs them"	• Programs to promote ways to work together
20. Recruiting large employers to Hancock County which may dilute talent pool	• Lack of affordable housing • Lack of employees that puts strain on current workforce to keep up with demand • bringing in employees from other parts of the region who may have needs that strains Hancock County's services	• Business recruitment vs. retention plan that balances economic gains • Community development with more infrastructure and housing due to demand, • Improved tax base for schools and community use • New individuals to make Hancock County a diverse community
21. Lack of understanding on how prevention is more cost-affordable and better ROI than treatment	• Decrease (or plateau) in prevention funding • Demand for treatment • Burden on treatment practitioners, • Increase in need for social service support	• Advocacy program for prevention vs. treatment • Resource and agency leverage strategies
22. Increased insurance premiums and deductibles	• Increase in individuals not seeking care or medical compliance due to increased cost for medications co-pays etc.	• Redesign prevention, diagnosis, and treatment workflows • Education • Preventative measures • Offering free trials
23. Decreased trust in public health	• Decreased vaccination rates • Increase in communicable diseases	• Education opportunities • Vaccine campaigns
24. Decrease in individuals pursuing health and human service-related careers	• Lack of behavior and mental health counseling • Increase in substance misuse • Recidivism • Increase in chronic conditions	• Workforce strategic plan targeting health and human service sector • Employee recruitment and retention plan

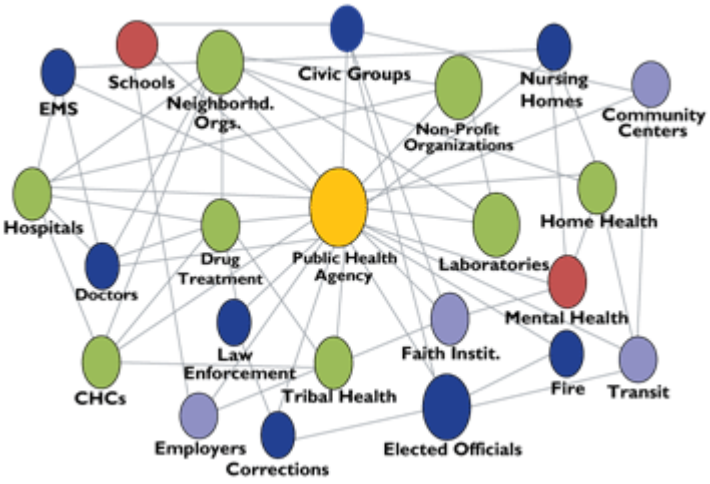
Force of Change	Threats Posed	Opportunities Created
25. Migration outside of county for healthcare needs/access to care	• Lack of preventive medicine visits	• Education campaigns on preventive medicine • Increased partnership with the hospital system
26. Increase in communicable diseases within the community	• Overall negative impact on community • Resistance to testing and treatments	• Test early on and often • Education on prevention and treatment
27. Increased rate of adults who are uninsured	• Increased chronic disease, • Untreated mental health disorders, • Increased evidence of late diagnosed cancer	• Provide the uninsured access to preventive medicine, • Improve overall quality of life
28. Post COVID-19 economy	• Health/mental health shortages and challenges	• N/A
29. Increased visibility of Health department	• Negative comments to the health department	• Better availability to education the community
30. Cooper Tire relocation	• General movement of white-collar jobs from area	• New leadership opportunities
31. Increased reliance on federal funding	• Funding may dry up putting continuation of services in jeopardy.	• Low risk time to pilot projects to see if they have impact
32. Limited public transportation	• Reduced access to medical appointment and service agencies	• Increase community agency participation to secure future funding and operation • Increased general health conditions of user populations
33. Lack of affordable childcare	• Cost burden • Prevents parents from going back to work • People choosing childcare over medical care	• Affordable childcare will permit back to work programs

N/A – Not Available

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.**

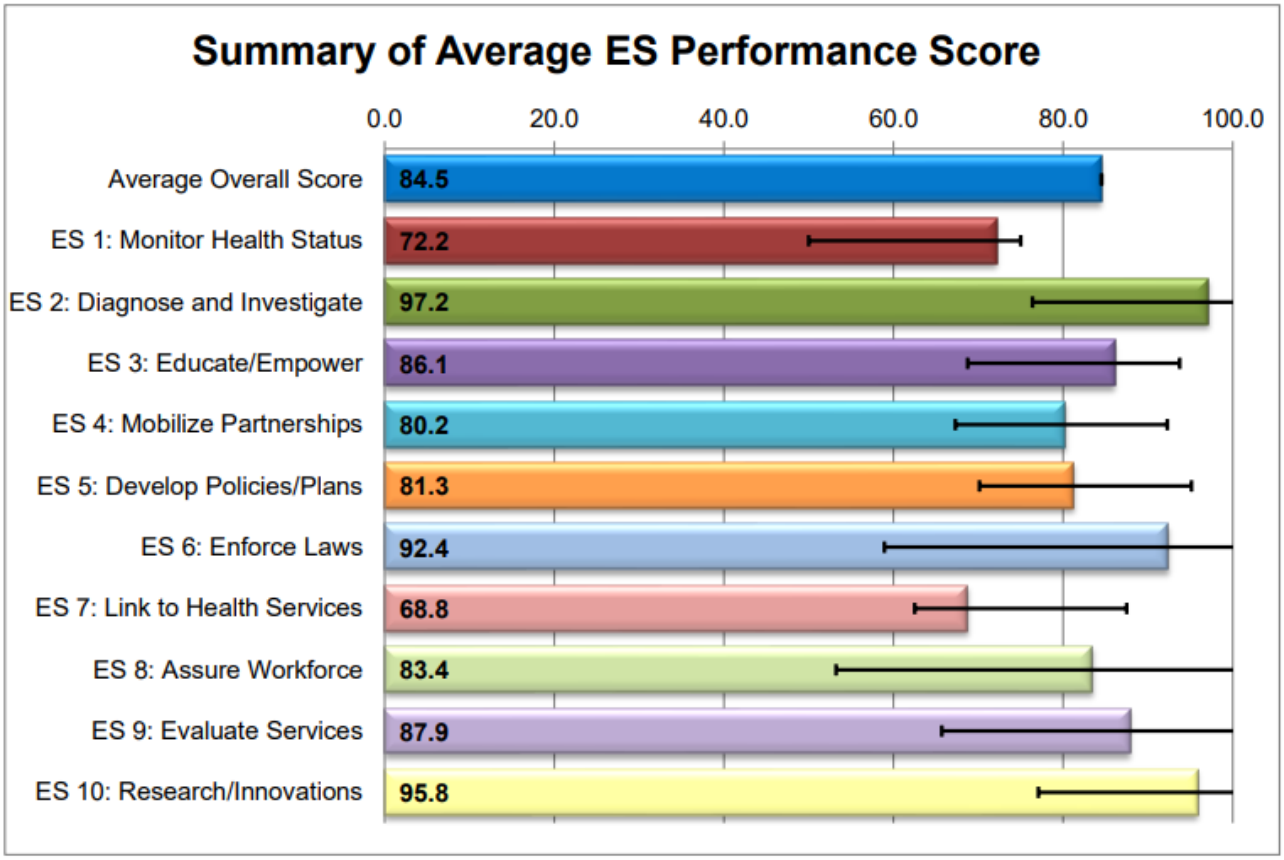
Members of Be Healthy Now Hancock County completed the performance measures instrument. The LPHSA results were then presented to the committee for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard was discussed, and 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.

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

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 2022 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. The Be Healthy Now Hancock County members 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, the Be Healthy Now Hancock County members 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 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, the Be Healthy Now Hancock County members 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, the Be Healthy Now Hancock County members 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. The Be Healthy Now Hancock County members was then asked to determine whether a policy, program or service was evidence-based, a best practice, or had no evidence indicated. Each resource inventory can be found with its corresponding strategy.

Priority #1: Health Behaviors

Strategic Plan of Action

To work toward improving health behaviors, the following strategies are recommended:

<table>
<tr><td colspan="5">Priority #1: Health Behaviors</td></tr>
<tr><td colspan="5">Strategy 1: CATCH My Breath</td></tr>
<tr><td>Action Step</td><td>Timeline</td><td>Priority Population</td><td>Indicator(s) to measure impact of strategy:</td><td>Lead Contact/Agency</td></tr>
<tr><td>Year 1: Gather baseline data on which all tobacco/nicotine prevention programs are currently being implemented within Hancock County school districts.
Explore the CATCH My Breathe evidence-based prevention program.
Determine the feasibility of piloting components of the CATCH My Breathe in Hancock County school districts.
Pilot the program in at least one school district.</td><td>June 12, 2023</td><td rowspan="3">Youth</td><td rowspan="3">Youth all-tobacco/nicotine use. Percent of high school students who have used cigarettes, smokeless tobacco (i.e. chewing tobacco, snuff or dip), cigars, pipe tobacco, hookah, bidis, e-cigarettes or other vaping products during the past 30 days (OYTS)</td><td rowspan="3">Hancock Public Health</td></tr>
<tr><td>Year 2: Continue efforts from year 1.
Pilot the program in at least one additional school district.</td><td>June 12, 2024</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2.</td><td>June 12, 2025</td></tr>
<tr><td colspan="5">Strategy identified as likely to decrease disparities?
○ Yes ○ No ⊗ Not SHIP Identified</td></tr>
<tr><td colspan="5">Resources to address strategy:
Findlay City Schools; Hancock County Schools and Educational Service Center (ESC)</td></tr>
<tr><td colspan="5">Outcome:
Increase the number of evidence-based all tobacco/nicotine use programs in Hancock County school districts.</td></tr>
</table>

Priority #1: Health Behaviors				
Strategy 2: Tobacco Cessation Therapy Affordability				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collect baseline data on the number of **evidence-based tobacco cessation treatments** available (including Nicotine Replacement Therapy - NRT), including individual, group and phone counseling (including Quitline) and cessation medications. Include information regarding cost, population (such as expectant mothers), insurance, transportation options and geography.	June 12, 2023	Adults (low-income)	Adult smoking. Percent of adults, ages 18 and older, that are current smokers (BRFSS)	Blanchard Valley Health System Hancock Public Health
Year 2: Continue efforts of year 1. Create a county-wide resource guide for evidence-based tobacco cessation treatments, highlighting cost, population, insurance, transportation options and geography. Disseminate the resource to healthcare providers. Encourage providers to share resources with patients who are current smokers, encourage them to quit, and refer them to treatment. Look for opportunities to reduce out-of-pocket costs for cessation therapies.	June 12, 2024			
Year 3: Continue efforts from years 1 and 2. Explore the feasibility of offering additional evidence-based tobacco cessation treatments to underserved areas in Hancock County.	June 12, 2025			
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: Blanchard Valley Health System, Findlay City Schools, Hancock County Schools				
Outcome: Increase the number of tobacco cessation treatments offered to Hancock County residents.				

Priority #1: Health Behaviors

Strategy 3: Healthy Food Initiatives in Food Banks

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Obtain baseline data regarding which cities, towns, school districts, churches, and organizations currently have **community gardens** and/or farmers markets. Obtain baseline data regarding which local **food pantries** have fresh produce available. Research grants and other funding opportunities to increase the number of community gardens and/or farmer's markets in Hancock County. Create and distribute a map of all available farmers markets, community gardens, and food pantries in Hancock County. Update the map on an annual basis.	June 12, 2023	Adults (low-income) and Youth	Youth fruit consumption. Percent of high school students who did not eat fruit or drink 100% fruit juices during past 7 days (YRBS) Youth vegetable consumption. Percent of high school students who did not eat vegetables (excluding french fries, fried potatoes or potato chips) during past 7 days (YRBS) Adult fruit and vegetable consumption.	Food Security Coalition
Year 2: Continue efforts from year 1. Assist churches, libraries, and other organizations in applying for grants to obtain funding for a community garden or farmer's market. 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 Encourage the use of **SNAP/EBT (Electronic Benefit Transfer) at farmers' markets**.	June 12, 2024			
Year 3: Continue efforts from years 1 and 2. Implement at least 2 items from the above bulleted list within local food pantries and/or farmers markets. Implement community gardens in various locations and increase the number of organizations with community gardens and/or farmer's markets by 5% from baseline. Increase the number of food pantries offering fresh produce by 5% from baseline. Implement the use of WIC and SNAP/EBT benefits in all farmer's markets.	June 12, 2025			

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy:

Hancock Public Health – Mobile Health Services, CHOPIN Hall, Farmer's Market Organizers

Outcome:

Increase the number of food initiatives offered in food banks to Hancock County residents.

Priority #1: Health Behaviors

Strategy 4: Diabetes Prevention Program

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. Engage population in Continuous Glucose Monitoring (CGM) and research its effects on day-to-day management of Type 2 diabetes.	June 12, 2023	Adults	Adult physical activity. Percent of adults, age 18 and older, reporting no leisure time physical activity (BRFSS) Reduction in A1C values for individuals enrolled in the study. Activity, Nutrition and weight management values	Hancock Public Health Blanchard Valley Health System
Year 2: Continue efforts from year 1. Promote and market individual success stories in relation to local diabetes prevention programming.	June 12, 2024			
Year 3: Continue efforts from years 1 and 2.	June 12, 2025			

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy:

The Ohio State University Extension Office, City of Findlay Recreation

Outcome:

Increase the number of diabetes prevention programs offered to Hancock County residents.

Priority #2: Access to Care

Strategic Plan of Action

To work toward improving access to care, the following strategies are recommended:

<table>
<tr><td colspan="5">Priority #2: Access to Care</td></tr>
<tr><td colspan="5">Strategy 1: Deploy mobile clinic to connect patients with providers and other healthcare resources</td></tr>
<tr><td>Action Step</td><td>Timeline</td><td>Priority Population</td><td>Indicator(s) to measure impact of strategy:</td><td>Lead Contact/Agency</td></tr>
<tr><td>Year 1: Utilize the 2022 Hancock County Health Equity Report 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.

Research costs associated with technology needs to determine funding streams.</td><td>June 12, 2023</td><td rowspan="3">Adults (low-income)</td><td rowspan="3">Primary care health professional shortage areas. Percent of Ohioans living in a primary care health professional shortage area* (HRSA, as compiled by KFF)

Mental health professional shortage areas. Percent of Ohioans living in a mental health professional shortage area* (HRSA, as compiled by KFF)</td><td rowspan="3">Hancock Public Health</td></tr>
<tr><td>Year 2: Continue efforts from year 1.

Identify strategies for telemedicine deployment (ex: what populations are going to be targeted for use, evaluation measures, etc.).</td><td>June 12, 2024</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2.</td><td>June 12, 2025</td></tr>
<tr><td colspan="5">Strategy identified as likely to decrease disparities?
○ Yes ○ No ⊗ Not SHIP Identified</td></tr>
<tr><td colspan="5">Resources to address strategy:
Blanchard Valley Health System's Director of Transitions of Care, ADAMHS Board, FRC</td></tr>
<tr><td colspan="5">Outcome:
Increase access to preventive care for Hancock County residents.</td></tr>
</table>

Priority #2: Access to Care

Strategy 2: Increase Use of Non-Emergency Medical Transportation for Medicaid/Medicare Patients

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collect baseline data on current use of NEMT in Hancock County through Hancock Job and Family Services. Identify what NEMT options are currently available in the county, and who oversees the programs (insurance company, JFS, etc.). Compile information into a handout to be provided at health care facilities within Hancock County. Share information on Hancock County agency and medical and mental health provider websites and social media.	June 12, 2023	Low Income Adults & Families	Number of trips by Medicaid recipients to medical providers.	Hancock County Transportation Coalition / Hancock County Mobility Manager
Year 2: Continue work from year 1 while implementing the following mass-reach communication initiatives: • Share messages and engage audiences on social networking sites like Facebook and Twitter. • Deliver messages through different websites and stakeholders communications. • Generate free press through public service announcements. • Pay to place ads on TV, radio, billboards, online platforms and/or print media. The strategies should focus on increasing use of non-emergency medical transportation for Medicaid patients, motivating them to contact Hancock County Job and Family Services as well as transportation providers to explore individual transportation options and raise awareness of all free medical transportation programs available. Promote and raise awareness of non-emergency medical transportation for Medicaid patients. Continue to promote the available transportation services and programs in the county.	June 12, 2024			
Year 3: Continue efforts from year 2.	June 12, 2025			

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy:

Cooperation between Hancock County transportation providers and local health and mental health providers and other agencies; funds for advertising and marketing built into JFS NEMT contracts.

Outcome:

Increase access to physical and mental health care for low-income Hancock County residents who face transportation-related issues.

Priority #3: Mental Health and Addiction

Strategic Plan of Action

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

Priority #3: Mental Health and Addiction				
Strategy 1: Suicide and Overdose Fatality Review Teams (SFR and OFR) (Suicide Death Review Teams)				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Engage a broad spectrum of community partners to actively participate in the formation of a hybrid **SFR/OFR** Committee (ORC 307.6410), begin review of cases on a bi-monthly basis.	June 12, 2023	Adults (low-income)	Adult suicide deaths. Number of deaths due to suicide for adults, ages 18 and older, per 100,000 population (ODH Vital Statistics) Unintentional drug overdose deaths. Number of deaths due to unintentional drug overdose, per 100,000 population (age adjusted) (ODH vital statistics)	Hancock Public Health
Year 2: (a) Continue efforts from year 1. (b) Enter data into local and state database to include trends and recommend system changes (c) Articulate and implement standardized model based on state and national best practices	June 12, 2024			
Year 3: (a) Continue efforts from years 1 and 2. (b) Create data dashboards and workplan to provide to community partners that highlight trends, recommendations for system changes, and outcomes	June 12, 2025			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Hancock County Opioid Addiction Task Force (HCOATF); ADAMHS; Hancock Suicide Prevention Committee				
Outcome: Decrease suicide and overdose fatalities by 20% year.				

Priority #3: Mental Health and Addiction

Strategy 2: Implementation of Youth Thrive Framework

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Develop and provide a formal trainings per year for parents, caregivers and grandparents on strategies to provide promotive/protective factors. Link youth who are placed out of home with peer support and other programs to build protective/promotive factors aligned to Youth Thrive. Ensure Camp FUN incorporates Youth Thrive promotive/protective factors.	June 12, 2023	Youth	Numbers attending trainings Number of programs/services incorporating at least one of the promotive/protective factors. Utilization of the Youth Thrive Self-Assessment	Family Resource Center ADAMHS Board
Year 2: Sustain efforts from year 1. Engage community members through training on Youth Thrive.	June 12, 2024			
Year 3: Sustain efforts from years 1 and 2.	June 12, 2025			

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy:

Family Resource Center; Youth Education and youth serving community agencies/organization; System of Care Grant; Opiates Taskforce

Outcome:

Increased youth engagement and success as an adult as a result of the presence of the 5 most impactful protective/promotive factors.

Priority #3: Mental Health and Addiction				
Strategy 3: Medication-Assisted Treatment (MAT) Access Enhancement Initiatives				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Implement local policies to enable induction of **medication-assisted treatment (MAT)** from BVHS with follow-up from local service providers. Work with local Justice Center to increase access to MAT for inmates and ensure continuity of availability upon discharge.	June 12, 2023	Adults (low-income)	Unintentional drug overdose deaths. Number of deaths due to unintentional drug overdose, per 100,000 population (age adjusted) (ODH Vital Statistics)	Blanchard Valley Health System ADAMHS Board
Year 2: Continue efforts from year 1. Continue community awareness campaign that will help those with substance use disorder, community members, and other stakeholders recognize signs of substance abuse and where to find treatment.	June 12, 2024			
Year 3: Continue efforts from years 1 and 2.	June 12, 2025			
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: Collaboration between BVHS, ADAMHS, Opiates Taskforce, local Justice Center, and local treatment providers.				
Outcome: Increase the number of drug-related treatment options for Hancock County residents.				

Priority #3: Mental Health and Addiction				
Strategy 4: Health and Human Services Workforce Development Committee				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Work with community partners to understand and develop implementation recommendations as provided by consultants and targeted efforts by Raise the Bar.	June 12, 2023	Adults and Youth	Reduced number of open positions in health and human service organizations	Family First Council
Year 2: Continue to implement recommendations.	June 12, 2024			
Year 3: Continue to implement recommendations.	June 12, 2025			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: Surgeon General's Report on Workforce; Participation of local health and human service employers; financial support to implement recommendations.				
Outcome: Hancock County becomes a destination for employment in health and human services.				

Priority #3: Mental Health and Addiction

Strategy 5: Harm Reduction Expansion
(Naloxone education and distribution programs and Syringe services programs - SSPs)

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: (a) Ensure the availability of **Naloxone and harm reduction education** to persons at high risk of overdose, including those experiencing health disparities and targeting sites serving them. (b) Ensure the availability of a comprehensive **syringe service program (SSPs)** [ORC 3707.52] that addresses overdose prevention, infectious disease prevention, reduction of health disparities, and connection to supportive services consistent with state and national best practices.	June 12, 2023	Adults and Families (including youth) experiencing health disparities and at risk of overdose identified by ODMAP, OFR, SSP, and other available data	Unintentional drug overdose deaths. Number of deaths due to unintentional drug overdose, per 100,000 population (age adjusted) (ODH Vital Statistics) Number of Naloxone kits distributed Number of reported overdose reversals Number of SSP participants / number of unique visits Overdose reversals reported by SSP participants	Hancock Public Health
Year 2: (a) Continue efforts from year 1. (b) Expand harm reduction education and secondary Naloxone distribution partnerships (along with Naloxbox placement) to treatment providers, law enforcement/first responders, health system, and businesses to ensure multiple points of contact are available 24 hours per day. (c) Expand access to SSPs via partnership with the mobile health clinic and street outreach.	June 12, 2024			
Year 3: (a) Continue efforts from years 1 and 2. (b) Expand harm reduction education using a "train-the-trainer" approach so that people at risk of overdose can receive harm reduction education at multiple points of contact (i.e., first responders, treatment providers, health system, and Peer Recovery Center). (c) Create and distribute community harm reduction education materials. (d) Expand SSP to community locations based on ODMAP data, OFR, SSP, and other available data.	June 12, 2025			

Strategy identified as likely to decrease disparities?
⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy:
Hancock County Opioid Addiction Task Force, ADAMHS

Outcome:
Increase reach of harm reduction services to adults and families (including youth) at highest risk of health disparities and overdose.

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 CHAs every three years to collect data and determine trends. Primary data will be collected for adults and secondary data will be analyzed for youth 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:

Karim Baroudi, MPH, RS, REHS
Health Commissioner
Hancock County Public Health
7748 County Road 140
Findlay, OH 45840
567-250-5142

Appendix I: Gaps and Strategies

The following tables indicate health behaviors, access to care, mental health and addiction, and potential strategies that were compiled by the Be Healthy Now Hancock County.

Priority Factors: Health Behaviors

Gaps	Potential Strategies
1. Tobacco/nicotine/vaping use (3)	• Tobacco cessation therapy affordability √ • Mass media campaigns against tobacco use • Ensure all youth tobacco prevention policies and programs include emphasis on e-cigarettes/nicotine addiction • Pushing 1-800-quit-now for quitting techniques
2. Physical activity (3)	• Community-wide physical activity campaigns (2) • Diabetes Prevention Program • Vouchers to purchase appropriate equipment/clothing
3. Adult weight status (3)	• Healthy food initiatives in food banks √ • Diabetes Prevention Program * • Continue work with Complete Streets • Bike and pedestrian master plans • Partner with Hancock County parks to increase number of paved trails and pathways
4. Access to healthy food (i.e., fruits and vegetables) (2)	• Fruit and vegetable incentive programs √ • Healthy food initiatives in food banks √ • Healthy cooking classes (i.e., preparation items, instructions, and vouchers) *

= Ohio SHIP supported strategy
√ = likely to decrease disparities
* Aligned with 2019-2022 CHIP

Priority Health Outcomes: Access to Care

Gaps	Potential Strategies
1. Local access to healthcare providers and services (2)	• Telemedicine √ • Health literacy interventions √ • Public transportation system √ • Financial incentives to recruit and retain health professionals in underserved areas √
2. Unmet need for mental health care (2)	• Telemental health services √ • Community health workers √ • Crisis lines • Mobile health clinic • Comparable insurance coverage for behavioral health
3. Transportation (2)	• Public transportation system √ • Continue to improve transportation in Findlay and County using volunteers
4. Healthcare worker shortage (2)	• Workforce strategy – committee working with Raise the Bar * • Utilizing existing medical support to see and route patients more efficiently to the correct healthcare provider
5. Wait time for medical appointments	• Telemedicine √
6. Barriers to access	• Public transportation system √ • Expansion of mobile health unit services
7. Afraid to miss work to attend appointments	• Extend hours for office visits and screenings
8. Non-English speaking persons access medical care	• Mobile translation technology for all healthcare providers and responders

= Ohio SHIP supported strategy
√ = likely to decrease disparities
* Aligned with 2019-2022 CHIP

Priority Health Outcomes: Mental Health and Addiction

Gaps	Potential Strategies
1. Not enough mental health providers for adults and youth (5)	• Local fund to help community mental health providers remain competitive for qualified employees • ACEs screenings • Workforce strategy – committee working with Raise the Bar * Review occupational incentive and salary to meet the needs of burnt-out staff
2. Wait times for psychiatry appointments	• Telemental health services √
3. Suicide deaths	Integration of behavioral health services into primary care √
4. Youth drug use	• Universal school-based alcohol prevention programs • Alcohol advertising restrictions
5. Youth depression	• School-based social and emotional instruction*
6. Drug overdose deaths	• Naloxone education and distribution programs • Support recovery communities and peer supports
7. Adult drug use	• Naloxone education and distribution programs • Increase OARRS integration with electronic records
8. Lack of available services to meet needs	• Mental health first aid • Online supports
9. Not enough youth mentors	• Community-wide campaign to encourage new mentors in additional settings (not just CMC)
10. Addiction	• Increased prevention and education
11. Establishing social support networks for youth outside of school	• Working with community partners for safe hang outs with different focuses
12. Counseling services based on cookie cutter approach	• Better screenings for types of specific counseling an individual requires

= Ohio SHIP supported strategy
√ = likely to decrease disparities
* Aligned with 2019-2022 CHIP

Priority: **Other**	
Gaps	**Potential Strategies**
1. Diabetes	• Mobile screening
2. Mobile clinic	• Availability to County with Caughman
3. Increase in STI among females in Hancock County	• Education and infection prevention supplies targeted population
4. Not prioritizing health screening	• Health screening events

Appendix II: Links to Websites

Title of Link	Website URL
CATCH My Breath	https://www.bevapefree.org/students/
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	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/community-gardens
Diabetes Prevention Programming	https://www.thecommunityguide.org/findings/diabetes-combined-diet-and-physical-activity-promotion-programs-prevent-type-2-diabetes.html
Food Pantries	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/healthy-food-initiatives-in-food-pantries
Medication-Assisted Treatment Access and Enhancement Initiatives	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/medication-assisted-treatment-access-enhancement-initiatives
Naloxone Education & Distribution Programs	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/naloxone-education-distribution-programs
SNAP/EBT (Electronic Benefit Transfer) at Farmers' Markets	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/electronic-benefit-transfer-payment-at-farmers-markets
Suicide Prevention Resources	https://www.cdc.gov/suicide/resources/prevention.html
Syringe Service Programs	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/syringe-services-programs
Tobacco Cessation Therapy Affordability	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/tobacco-cessation-therapy-affordability