2020 - 2022

WILLIAMS COUNTY

COMMUNITY HEALTH IMPROVEMENT PLAN

EXAMINING THE HEALTH OF THE COMMUNITY

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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 II 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.

Williams County Partners for Health (WCPH) began conducting CHAs for the purpose of measuring community health status. The most recent Williams County CHA was cross-sectional in nature and included a written survey of adults and adolescents within Williams 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) and Youth Risk Behavior Surveillance System (YRBSS). This has allowed Williams 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.

The Williams County Combined Health District contracted with the Hospital Council of Northwest Ohio (HCNO), a neutral, regional, nonprofit hospital association, to facilitate the CHA and CHIP. The Williams County Combined Health District, along with Community Hospitals and Wellness Centers (CHWC), then invited various community stakeholders to participate in community health improvement process. Data from the most recent CHA were 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 the Williams County Partners for Health 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 Williams 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 collaboratively completed the CHA and CHIP, compliant with IRS requirements. This will result in increased collaboration, less duplication, and sharing of resources.

Hospital Mission Statement(s)

The mission of Community Hospitals and Wellness Centers: We will provide comprehensive, patient centered healthcare; We will respect the dignity and uniqueness of all; We will enhance the health, safety and well-being of our community.

Community Served by the Hospital

The community has been defined as Williams County. Most (80%) of CHWC—Bryan Hospital and 84% of CHWC—Montpelier Hospital's discharges were residents of Williams County. In addition, Community Hospitals and Wellness Centers collaborates with multiple stakeholders, most of which provide services at the county-level. For these two reasons, the county was defined as the community.

Public Health Accreditation Board (PHAB) Requirements

National Public Health Accreditation status through the Public Health Accreditation Board (PHAB) is the measurement of health department performance against a set of nationally recognized, practice-focused and evidenced-based standards. The goal of the national accreditation program is to improve and protect the health of the public by advancing the quality and performance of Tribal, state, local, and territorial public health departments. PHAB requires that CHIPs be completed at least every five years, however, Ohio state law (ORC 3701.981) requires that health departments and hospitals collaborate to create a CHIP every 3 years. Additionally, PHAB is a voluntary national accreditation program; however the State of Ohio requires that all local health departments become accredited by 2020, making it imperative that all PHAB requirements are met. The Williams County Health Department received accreditation through the Public Health Accreditation Board (PHAB) in August 2018.

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 at Risk for Health Disparities

Williams County is a rural county. Approximately 14% of Williams County residents were below the poverty line, according to the 2013-2017 American Community Survey 5-year estimates. For this reason, data is broken down by income (less than $25,000 and greater than $25,000) throughout the report to show disparities.

Mobilizing for Action through Planning and Partnerships (MAPP)

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

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

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

Figure 1.1 The MAPP model

Alignment with National and State Standards

The 2020-2022 Williams County CHIP priorities align with state and national priorities. Williams County will be addressing the following priorities (priority health outcomes and factors): mental health and addiction, chronic disease, obesity, cancer screenings and prevention, and health behaviors.

Ohio State Health Improvement Plan (SHIP)

SHIP Overview

The 2020-20122 State Health Improvement Plan (SHIP) serves as a strategic menu of priorities, objectives, and evidence-based strategies to be implemented by state agencies, local health departments, hospitals and other community partners and sectors beyond health including education, housing, employers, and regional planning.

The SHIP includes a strategic set of measurable outcomes that the state will monitor on an annual basis. Given that the overall goal of the SHIP is to ensure that all Ohioans 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)
- Premature death (reduce the rate of deaths before age 75)

The SHIP also addresses health equity by identifying priority populations (Ohioans with outcomes that are at least 10% worse than outcomes for Ohio overall), setting universal targets for outcomes, and selecting strategies that are likely to reduce disparities and inequities.

SHIP Health Outcome Priorities

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

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)

SHIP Priority Factors

The SHIP also takes a comprehensive approach to improving Ohio's greatest health priorities by identifying three priority factors that impact the three priority health outcomes: community conditions, health behaviors, and access to care. These modifiable factors that influence overall health are sometimes referred to as "social determinants or health" or the "social drivers of health." This approach is built upon the understanding that access to quality healthcare is necessary, but not sufficient, for good health. The SHIP is designed to prompt state and local stakeholders to implement strategies that address the social determinants of health and health behaviors, as well as approaches that strengthen connections between the clinical healthcare system, public health, community-based organizations and sectors beyond health.

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

Note: This symbol  will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2020-2022 SHIP. Whenever possible, the Williams County CHIP identifies strategies likely to reduce disparities and inequities. Throughout the report, hyperlinks will be highlighted in **bold, gold text**.

CHIP Alignment with the 2020-2022 SHIP

The Williams County CHIP was required to select at least 1 priority factor, 1 priority outcome, 1 indicator for each identified priority, & 1 strategy for each selected priority to align with the 2020-2022 SHIP.

The following Williams County priority factors, indicators, & strategies very closely align with the 2020-2022 SHIP:

Figure 1.2 2020-2022 Williams CHIP Alignment with the 2020-2022 SHIP

Priority Outcomes	Priority Indicators	Strategies to Impact Priority Indicators
Mental Health and Addiction	• Adult suicide deaths. Number of deaths due to suicide for adults, ages 18 and older, per 100,000 population. • Youth alcohol use. Percent of high school students who have used alcohol within the past 30 days. • Unintentional drug overdose deaths. Number of deaths due to unintentional drug overdose, per 100,000 population (age adjusted).	• Mental health first aid • Trauma-informed schools • Screening for clinical depression using a standardized tool and provider education to primary care and behavioral health providers regarding depression/suicide screening tools • Universal school-based suicide awareness and education programs and cell-phone based support programs • School-based alcohol/other drug prevention programs • Healthcare screening, brief intervention and referral to treatment (SBIRT)
Priority Factor	**Priority Indicators**	**Strategies to Impact Priority Indicators**
Health Behaviors	• Adult smoking. Percent of adults, ages 18 and older, that are current smokers. • Youth fruit consumption. Percent of high school students who did not eat fruit or drink 100% fruit juices during past 7 days. • 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. • Adult physical inactivity. Percent of adults, age 18 and older, reporting no leisure time physical activity.	• Complete streets • Community gardens • Prescriptions for physical activity • Green space and parks/bike and pedestrian master plans • Mass-reach communications

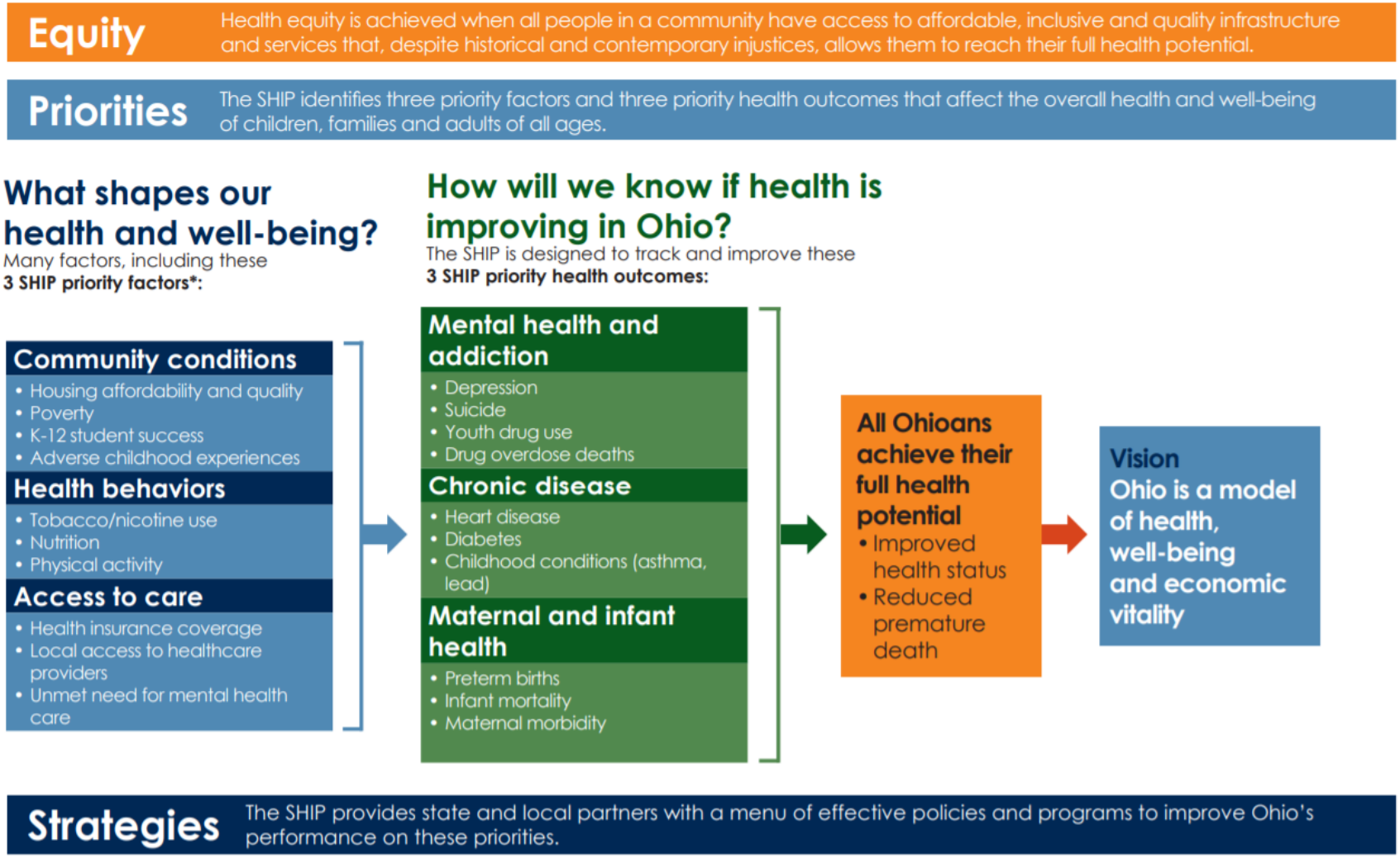
N/A – Not Available

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

The Williams County CHIP also aligns with five of the National Prevention Priorities for the U.S. population: tobacco free living, preventing drug abuse, healthy eating, active living, and mental and emotional well-being. For more information on the national prevention priorities, please go to **surgeongeneral.gov**.

Alignment with National and State Standards, continued

Figure 1.3 2020-2022 State Health Improvement Plan (SHIP) Overview



* These factors are sometimes referred to as the social determinants of health or the social drivers of health

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 Williams County

Working together to create a healthy Williams County

The Mission of Williams County

To foster and guide the implementation of recommendations resulting from the community health assessment with the collective purpose of improving the health of our community

Community Partners

The CHIP was planned by various agencies and service-providers within Williams County. From October to December 2019, the Williams County Partners for Health reviewed many data sources concerning the health and social challenges that Williams 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:

Williams County Partners for Health

Angelia Foster, Community Hospitals and Wellness Centers
Becky McGuire, OSU Extension, Williams County
Bethany Shirkey, Four County ADAMhs Board
Chad Tinkel, Community Hospitals and Wellness Centers
Dee Custar, Williams County Board of Health
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Jim Watkins, Williams County Health Department
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Megan Hausch, Williams County Economic Development Corporation
Megan Riley, Williams County Health Department
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Rob Imber, Williams County YMCA
Sara Bojorquez, A Renewed Mind
Shannon Keil, MD., Community Hospitals and Wellness Centers
Tessa Yoder, Williams County Health Department
Tiffany McBride, Northwest Ohio Community Action Commission
Victoria Smith, Williams County Health Department

Hospital Council of Northwest Ohio (HCNO)

The community health improvement process was facilitated by Tessa Elliott, MPH, Community Health Improvement Manager and Gabrielle MacKinnon, Community Health Improvement Coordinator, from HCNO.

Community Health Improvement Process

Beginning in October 2019, the Williams County Partners for Health 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 150-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 on the **Williams County Health Department** and **Community Hospitals and Wellness Centers** websites. Below is a summary of county primary data and the respective state and national benchmarks.

Adult Trend Summary

Adult Variables	Williams County 2013	Williams County 2016	Williams County 2019	Ohio 2017	U.S. 2017
Health Status					
Rated general health as excellent or very good	56%	55%	47%	49%	51%
Rated general health as fair or poor	10%	14%	13%	19%	18%
Rated mental health as not good on four or more days (in the past 30 days)	15%	23%	30%	26%	24%
Rated physical health as not good on four or more days (in the past 30 days)	18%	20%	20%	23%	22%
Average number of days that physical health was not good (in the past 30 days)	2.6	3.5	3.5	4.0*	3.7*
Average number of days that mental health was not good (in the past 30 days)	2.3	4.5	4.4	4.3*	3.8*
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past 30 days)	18%	17%	29%	24%	23%
Healthcare Coverage, Access, and Utilization					
Uninsured	15%	5%	7%	9%	11%
Had one or more persons they thought of as their personal healthcare provider	51%	51%	86%	81%	77%
Visited a doctor for a routine checkup (in the past 12 months)	50%	59%	64%	72%	70%
Cardiovascular Health					
Ever diagnosed with angina or coronary heart disease	6%	6%	7%	5%	4%
Ever diagnosed with a heart attack, or myocardial infarction	5%	4%	6%	6%	4%
Ever diagnosed with a stroke	3%	1%	4%	4%	3%
Had been told they had high blood pressure	29%	35%	39%	35%	32%
Had been told their blood cholesterol was high	35%	36%	37%	33%	33%
Had their blood cholesterol checked within the last five years	70%	79%	83%	85%	86%

Indicates alignment with the Ohio State Health Assessment

**2016 BRFSS* ***2016 BRFSS as compiled by 2018 County Health Rankings*

Adult Variables	Williams County 2013	Williams County 2016	Williams County 2019	Ohio 2017	U.S. 2017
Weight Status					
Overweight	38%	30%	31%	34%	35%
Obese	30%	41%	42%	34%	32%
Alcohol Consumption					
Current drinker (had at least one drink of alcohol within the past 30 days)	45%	39%	62%	54%	55%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	18%	15%	17%	19%	17%
Tobacco Use					
Current cigarette smoker (smoked on some or all days)	20%	22%	16%	21%	17%
Former cigarette smoker (smoked 100 cigarettes in lifetime and now do not smoke)	24%	18%	25%	24%	25%
Current e-cigarette user (vaped on some or all days)	N/A	N/A	5%	5%	5%
Drug Use					
Adults who used marijuana in the past 6 months	3%	4%	3%	N/A	N/A
Adults who misused prescription drugs in the past 6 months	6%	5%	5%	N/A	N/A
Preventive Medicine					
Ever had a pneumonia vaccine (ages 65 and older)	56%	67%	77%	76%	75%
Had a flu shot within the past year (ages 65 and over)	72%	72%	76%	63%	60%
Had a clinical breast exam in the past two years (women ages 40 and older)	68%	66%	52%	N/A	N/A
Had a mammogram within the past two years (women ages 40 and older)	69%	67%	65%	74%*	72%*
Had a pap test in the past three years (women ages 21-65)	66%	54%	59%	82%*	80%*
Asthma & Diabetes					
Ever been told by a doctor they have diabetes (not pregnancy-related)	8%	7%	12%	11%	11%
Had ever been told they have asthma	12%	18%	13%	14%	14%
Cancer					
Ever been told they had skin cancer	5%	6%	7%	6%	6%
Ever been told they had other types of cancer (other than skin cancer)	7%	9%	9%	7%	7%
Quality of Life					
Limited in some way because of physical, mental or emotional problem	20%	15%	22%	21%*	21%*

Indicates alignment with the Ohio State Health Assessment *N/A – Not Available* **2016 BRFSS*

Adult Variables	Williams County 2013	Williams County 2016	Williams County 2019	Ohio 2017	U.S. 2017
Mental Health					
Felt sad or hopeless for two or more weeks in the past year	8%	9%	13%	N/A	N/A
Seriously considered attempting suicide in the past year	3%	2%	5%	N/A	N/A
Attempted suicide in the past year	<1%	0%	1%	N/A	N/A
Sexual Behavior					
Had more than one sexual partner in past year	3%	4%	3%	N/A	N/A
Oral Health					
Visited a dentist or a dental clinic (within the past year)	65%	53%	73%	68%*	66%*
Visited a dentist or a dental clinic (5 or more years ago)	10%	15%	11%	11%*	10%*

Indicates alignment with the Ohio State Health Assessment *N/A – Not Available* **2016 BRFSS*

Youth Trend Summary

Youth Comparisons	Williams	Williams	Williams	Williams	Williams	U.S.

	County 2009 (6th-12th)	County 2013 (6th-12th)	County 2016 (6th-12th)	County 2019 (6h-12th)	County 2019 (9th-12th)	2017 (9th-12th)
Weight Control						
Obese	14%	13%	13%	14%	13%	15%
Overweight	16%	11%	16%	14%	14%	16%
Were trying to lose weight	49%	50%	45%	46%	48%	47%
Exercised to lose weight (in the past 30 days)	44%	51%	47%	51%	54%	N/A
Ate less food, fewer calories, or foods lower in fat to lose weight (in the past 30 days)	22%	38%	27%	35%	36%	N/A
Went without eating for 24 hours or more (in the past 30 days)	4%	7%	2%	6%	7%	13%**
Took diet pills, powders, or liquids without a doctor's advice (in the past 30 days)	1%	3%	2%	2%	2%	5%**
Vomited or took laxatives (in the past 30 days)	2%	3%	1%	2%	3%	4%**
Ate 0 servings of fruits and/or vegetables per day	N/A	N/A	N/A	4%	N/A	N/A
Ate 5 or more servings of fruit and/or vegetables per day	N/A	N/A	N/A	26%	N/A	N/A
Physically active at least 60 minutes per day on every day in past week	N/A	28%	33%	31%	30%	26%
Physically active at least 60 minutes per day on 5 or more days in past week	59%	49%	54%	59%	56%	46%
Did not participate in at least 60 minutes of physical activity on any day in past week	12%	11%	15%	10%	12%	15%
Unintentional Injuries and Violence						
Carried a weapon, other than hunting weapons, on school property (in the past 30 days)	2%	2%	1%	1%	1%	4%
Threatened or injured with a weapon on school property (in the past 12 months)	3%	7%	5%	11%	9%	6%
Did not go to school because they felt unsafe (at school or on their way to or from school in the past 30 days)	1%	5%	4%	4%	4%	7%
Bullied (in past year)	50%	47%	47%	43%	39%	N/A
Electronically bullied (in past year)	8%	13%	12%	9%	7%	15%
Were ever physically forced to have sexual intercourse (when they did not want to)	4%	4%	2%	2%	4%	7%
Experienced physical dating violence (including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with in the past 12 months)	3%	3%	1%	3%	4%	8%
Mental Health						
Felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities in the past 12 months)	16%	22%	22%	30%	32%	32%
Seriously considered attempting suicide (in the past 12 months)	7%	15%	10%	16%	16%	17%
Attempted suicide (in the past 12 months)	3%	8%	7%	8%	7%	7%
Suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (in the past 12 months)	1%	3%	2%	2%	2%	2%

Indicates alignment with the Ohio State Health Assessment; *N/A – Not Available* ***Comparative YRBS data for U.S. is 2013*

Youth Comparisons*	Williams County 2009 (6th-12th)	Williams County 2013 (6th-12th)	Williams County 2016 (6th-12th)	Williams County 2019 (6th-12th)	Williams County 2019 (9th-12th)	U.S. 2017 (9th-12th)
Alcohol Consumption						
Ever drank alcohol (at least one drink of alcohol on at least 1 day during their life)	49%	50%	35%	42%	52%	60%
Current drinker (at least one drink of alcohol on at least 1 day during the past 30 days)	18%	18%	16%	11%	16%	30%
Binge drinker (drank 5 or more drinks within a couple of hours on at least 1 day during the past 30 days)	9%	10%	7%	6%	9%	14%
Drank for the first time before age 13 (of all youth)	20%	16%	11%	13%	7%	16%
Obtained the alcohol they drank by someone giving it to them (of current drinkers)	61%	57%	26%	32%	31%	44%
Rode with a driver who had been drinking alcohol (in a car or other vehicle on 1 or more occasion during the past 30 days)	15%	12%	10%	13%	10%	17%
Tobacco Use						
Current cigarette smoker (smoked on at least 1 day during the past 30 days)	9%	10%	3%	5%	6%	9%
Smoked cigarettes frequently (smoked on 20 or more days during the past 30 days)	2%	5%	1%	0%	0%	3%
Smoked cigarettes daily (smoked all 30 days of the past 30 days)	1%	4%	1%	1%	1%	2%
Ever used an electronic vapor product (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens)	N/A	N/A	N/A	30%	39%	42%
Currently used an electronic vapor product (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on at least 1 day during the past 30 days)	N/A	N/A	N/A	17%	25%	13%
Used electronic vapor products frequently (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on 20 or more days during the past 30 days)	N/A	N/A	N/A	4%	7%	3%
Used electronic vapor products daily (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on all 30 days during the past 30 days)	N/A	N/A	N/A	2%	4%	2%
Sexual Behavior						
Ever had sexual intercourse	22%	25%	16%	29%	42%	40%
Had sexual intercourse before the age 13 (for the first time)	3%	3%	1%	4%	2%	3%
Used a condom (during last sexual intercourse)	76%	57%	56%	65%	69%	54%
Used birth control pills (during last sexual intercourse)	28%	36%	30%	42%	49%	21%
Used an IUD (during last sexual intercourse)	N/A	N/A	6%	9%	11%	4%
Used a shot, patch or birth control ring (during last sexual intercourse)	N/A	N/A	11%	9%	11%	5%
Did not use any method to prevent pregnancy (during last sexual intercourse)	3%	14%	7%	7%	6%	14%
Drug Use						
Currently used marijuana (in the past 30 days)	4%	9%	4%	6%	8%	20%
Tried marijuana for the first time before age 13 (of all youth)	N/A	N/A	2%	3%	3%	7%
Ever used methamphetamines (in their lifetime)	1%	2%	<1%	1%	1%	3%
Ever used cocaine (in their lifetime)	1%	2%	1%	1%	2%	5%
Ever used heroin (in their lifetime)	<1%	2%	0%	0%	0%	2%
Ever used inhalants (in their lifetime)	6%	9%	4%	3%	2%	6%
Ever used ecstasy (also called MDMA in their lifetime)	N/A	2%	2%	1%	2%	4%
Ever took steroids without a doctor's prescription (in their lifetime)	1%	3%	1%	<1%	<1%	3%
Were offered, sold, or given an illegal drug on school property (in the past 12 months)	6%	5%	5%	4%	5%	20%

Indicates alignment with the Ohio State Health Assessment *N/A – Not Available* ***Comparative YRBS data for U.S. is 2013*

Key Issues

The Williams County Partners for Health reviewed the 2019 Williams County Health Assessment. The detailed primary data for each identified key issue can be found in the section it corresponds to. Each member 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 2019 assessment report? Examples of how to interpret the information include: 31% of Williams County adults were overweight, increasing to 40% of males.

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Adult and Youth Obesity (6 votes)			
Adult overweight	31%	Age: 65 & older (41%) Income: $25K+ (35%)	Male (40%)
Adult obesity	42%	Age: 19-29 years (61%) Income: <$25K (50%)	Female (47%)
Youth overweight	14%	Age: 14 to 16 years (18%)	Males (59%)
Youth obesity	14%	Age: 14 to 16 years (16%)	Males (16%)
Adults who ate 0 or more servings of fruits per day	13%	N/A	N/A
Adults who ate 0 or more servings of vegetables per day	5%	N/A	N/A
Youth who ate 0 or more servings of fruits and/or vegetables per day	4%	N/A	N/A
Youth who ate 5 or more servings of fruits and/or vegetables per day	26%	N/A	N/A
Adults who did not participate in any physical activity in the past week	27%	Age: 65 & older (33%)	Female (28%)
Youth who did not participate in at least 60 minutes of physical activity on any day in past week	10%	Age: 17 & older (16%)	Female (12%)

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 and Youth Substance Use (6 votes)			
Adult current drinker (had at least one drink of alcohol within the past 30 days)	62%	Age: 30-64 years (68%)	N/A
Adult binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	17%	N/A	N/A
Youth ever drank alcohol (at least one drink of alcohol on at least 1 day during their life)	42%	Age: 17 & older (57%)	Female (43%)
Youth current drinker (at least one drink of alcohol on at least 1 day in the past 30 days)	11%	Age: 17 & older (20%)	Male & Female (11%)
Youth binge drinker (drank 5 or more drinks within a couple of hours on at least 1 day during the past 30 days)	6%	Age: 17 & older (14%)	Male (6%)
Youth who drank for the first time before age 13 (of all youth)	13%	Age: 13 & younger (19%)	Male (17%)
Youth obtained the alcohol they drank by someone giving it to them (of current drinkers)	32%	Age: 14 to 16 (38%)	Male (62%)
Youth who rode with a driver who had been drinking alcohol (in a car or other vehicle on 1 or more occasion during the past 30 days)	13%	Age: 13 & younger (14%)	Female (13%)
Youth who ever used and electronic vapor product (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens)	30%	Age: 17 & older (50%)	Male (34%)
Youth who currently used an electronic vapor product (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on at least 1 day during the past 30 days)	17%	Age: 17 & older (32%)	Male (20%)
Youth who used electronic vapor products frequently (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on 20 or more days during the past 30 days)	4%	Age: 17 & older (12%)	Male (6%)
Youth who used electronic vapor products daily (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on all 30 days during the past 30 days)	2%	Age: 17 & older (7%)	Male (4%)

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 Mental Health (5 votes)			
Adults who rated their mental health as not good on four or more days (in the past 30 days)	30%	Income: <$25K (43%)	Females (40%)
Average number of days that mental health was not good (in the past 30 days)	4.4	N/A	N/A
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past 30 days)	29%	Age: 19 to 29 (50%)	Female (35%)
Felt sad or hopeless for two or more weeks in the past year	13%	Age: 19 to 29 (46%)	Female (17%)
Williams County 2009-2018 suicide deaths *(Source: Williams County Health Department, 2009-2018)*	45 deaths from 2009-2018	N/A	N/A
Youth Mental Health (5 votes)			
Felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities in the past 12 months)	30%	Age: 14 to 16 (31%) Age: 17 & older (34%)	Female (40%)
Seriously considered attempting suicide (in the past 12 months)	16%	Age: 14 to 16 (16%) Age: 17 & older (16%)	Female (22%)
Attempted suicide (in the past 12 months)	8%	Age: 13 & younger (9%) Age: 14 to 16 (8%)	Female (9%)
Multiple suicide attempts (in the past 12 months)	4%	Age: 13 & younger (6%)	Female (5%)
Bullied (in the past 12 months)	43%	Age: 13 & younger (46%)	Female (54%)
Verbally bullied (in the past 12 months)	34%	Age: 13 & younger (37%) Age: 14 to 16 (37%)	Female (40%)
Cyber bullied (in the past 12 months)	9%	N/A	Female (14%)
Adverse Childhood Effects (ACEs) (5 votes)			
Adults who experienced 4 or more adverse childhood experiences in their lifetime (ACEs)	16%	Age: 19 to 29 (23%)	Female (23%)
Youth who experienced 3 or more adverse childhood experiences in their lifetime (ACEs)	30%	Age: 14 to 16 (31%)	Female (35%)

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
Cancer Prevention and Screenings (4 votes)			
Had a clinical breast exam in the past two years (women ages 40 and older)	52%	N/A	N/A
Had a mammogram within the past two years (women ages 40 and older)	65%	N/A	N/A
Had a pap test in the past three years (women ages 21-65)	59%	N/A	N/A
Adults who had a lung cancer screening in the past 3 years	4%	N/A	N/A
Adults who had a sigmoidoscopy in the past 5 years	3%	N/A	N/A
Adults who had a colonoscopy in the past 10 years	13%	Age: 50 & older (64%)	N/A
Chronic Disease (4 votes)			
Had been told they had high blood pressure	39%	Age: 65 & older (71%) Income: <$25K (60%)	Male (45%)
Had been told their blood cholesterol was high	37%	Age: 65 & older (66%) Income: <$25K (50%)	Male (45%)
Rated physical health as not good on four or more days (in the past 30 days)	20%	Age: 65 & older (24%) Income: <$25K (41%)	Female (24%)
Quality of Life (0 votes)			
Limited in some way because of physical, mental, or emotional problem	22%	Age: 65 & older (40%) Income: <$25K (53%)	Female (25%)

N/A- Not Available

Priorities Chosen

Based on the 2019 Williams County Health Assessment, key issues were identified for adults and youth. Key issues were combined by age group. Overall, there were 8 key issues identified by the committee. Each organization was given 5 votes. The committee then voted and came to a consensus on the priority areas Williams 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/Youth Obesity	6
2. Adult/Youth Substance Use	6
3. Adverse Childhood Experiences (ACEs)	5
4. Adult Mental Health	5
5. Youth Mental Health	5
6. Cancer Preventions and Screenings	4
7. Chronic Disease	4
8. Quality of Life	0

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

1. Mental health and addiction *(includes depression, suicide, substance abuse, ACEs, and bullying*)
2. Chronic disease *(includes high blood pressure, high blood cholesterol, and poor physical health)*
3. Obesity *(includes physical activity and fruit/vegetable consumption)*
4. Cancer prevention and screenings

Williams County will focus on the following priority factor over the next three years:

1. Health behaviors

Priorities Chosen by Williams County Students

A representative population of Williams County students (median age: 16 years) were included in the prioritization process to determine CHIP priorities at a youth input event hosted by Williams County Health District. Williams County students ranked their perception of the top ten most severe health concerns to address among youth in Williams County. Their rankings are reflected in the chosen youth priorities of mental health and addiction and obesity and are also shown below.

Student Perception of Health Concern Severity Ranked
1. Mental Health
2. Using E-Cigarettes and Vapor Products
3. Sadness/Hopelessness
4. Bullying
5. Suicide
6. ACEs
7. Drinking Alcohol
8. Fruit & Vegetable Consumption
9. Using Marijuana
10. Smoking Cigarettes

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?**

    - Safety
    - Interconnectivity
    - Ways for people to be heard
    - Equal opportunities
    - Family friendly events
    - Community involvement
    - Economic growth & stability
    - Diversity
    - Mental Wellness

2. **What makes you most proud of our community?**

    - School system
    - Strong collaborations
    - People care about each other

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

    - CHIP Committee
    - Mental Health Board & Health Department Collaboration
    - Social Service Networking Groups
    - Summit Breakfast
    - United Way
    - YMCA
    - Educating Communities on Healthy Opportunities (ECHO)
    - Collaboration with Churches and Food Pantries
    - Community Advocates
    - Bryan Foundation
    - School System
    - Health Equity Steering Committee
    - Cancer Symposium
    - Service Clubs

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?**

    - Opioid epidemic
    - Mental wellness
    - Housing
    - Social & economic conditions
    - Social connectedness
    - 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?**

    - Stigma/financial services
    - Awareness of services
    - Societal & cultural norms (family structure, technology, & social media)
    - Measuring program outcomes

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

    - Built environment
    - Health policies
    - Stronger strategic alignment
    - Community connectivity

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

    - Strategic alignment
    - Measuring outcomes

Quality of Life Survey

The WCPH urged community members to fill out a short Quality of Life Survey via SurveyMonkey. There were 528 Williams County community members who completed the survey. The chart below shows the Likert scale average response for Williams County compared to the Likert scale average response of demographically similar counties in Ohio who also participated in the Quality of Life survey. 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	
	2016 n=241	2019 n=528
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]	3.67	3.78
2. Are you satisfied with the healthcare system in the community? (Consider access, cost, availability, quality, options in healthcare, etc.)	2.95	3.23
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.72	3.92
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.)	3.46	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.)	2.86	3.25
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?)	3.83	3.86
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?	3.52	3.71
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.36	3.52
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.07	3.17
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.03	3.20
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.10	3.21
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?)	3.13	3.21

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 WCPH 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 Williams 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. 2020 election	• Health reform	• None noted
2. Federally Qualified Health Center (FQHC)	• None noted	• Dental services available in the county
3. Williams County population	• Younger people are leaving the county (causing a decrease in the overall population) • Decrease in population could cause industry in the county to leave • The aging population are going to require more resources	• Downtown development/revitalization • County is becoming more ethnically diverse
4. Opioid epidemic	• Opioid epidemic has overshadowed the increase in suicide related deaths	• None noted
5. Active transportation	• None noted	• Bike trails • Parks • More collaboration among organizations for funding
6. Lack of safe, affordable housing	• Effects on physical and mental health • Transient families	• None noted
7. Low wage jobs	• Financial instability among workers and families	• None noted
8. Businesses/companies hiring mental health counselors and	• None noted	• Availability of mental health counseling/services • Healthier workforce

providing mental health services		
9. Employers unable to hire because potential candidates cannot pass a drug screen	• Under-staffed businesses • Job insecurity	• None noted
Force of Change	**Threats Posed**	**Opportunities Created**
10. Youth mental health	• Trauma and adverse childhood experiences (ACEs) • Loss of school therapists	• Increase school-based mental health programs
11. Physician/other skilled professions recruitment	• Lack of entertainment, etc.	• None noted
12. Social mobility	• The gap between income levels is increasing (technology vs. manufacturing)	• None noted
13. Community Hospitals Wellness Centers (Bryan and Montpelier)	• None noted	• Increase in mental health services • Variety of resources • Hiring surgeons & OBGYNs
14. Transient families within and out of the county	• Creates instability in education for students • Reduced social cohesion	• None noted
15. Second highest manufacturing county in the state	• Need highly skilled employees to maintain competitiveness of manufacturing business • Economically, can be a vulnerability if there is a downturn in the economy for manufacturing	• Engage large employers to improve health
16. Trends of diversity	• None noted	• Engage members that may not have been represented in the past

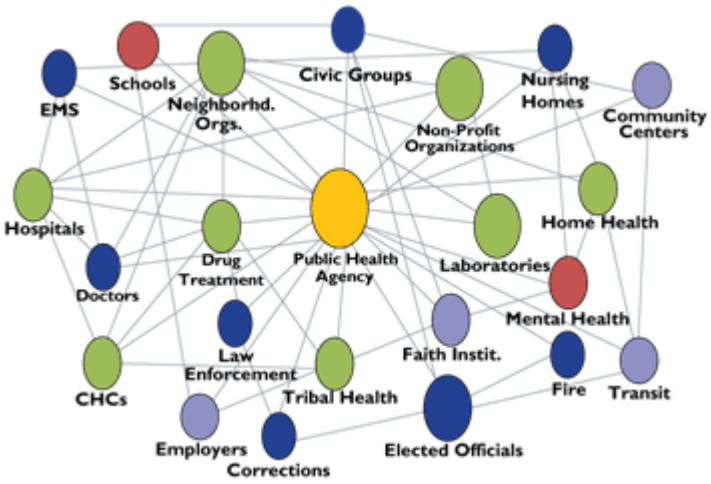
Local Public Health System Assessment

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 healthcare when otherwise unavailable.
8. Assure competent public and personal healthcare 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.**

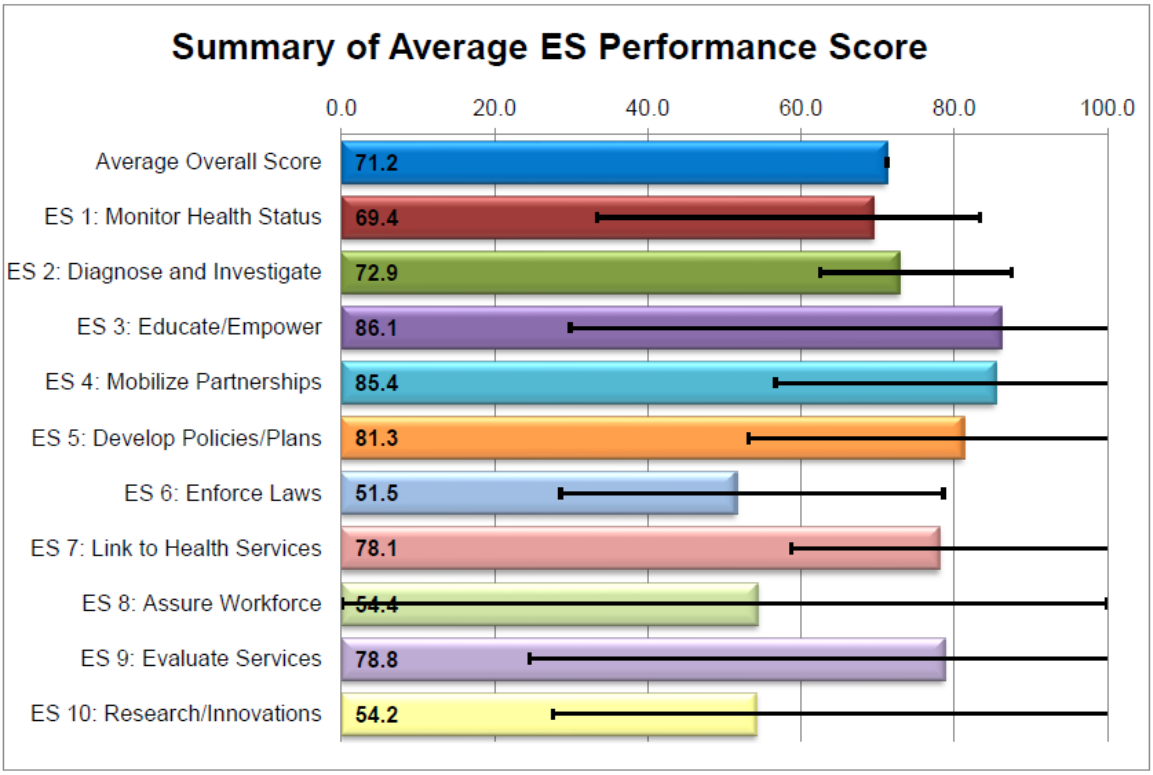
Members of the Williams County Health Department completed the performance measures instrument. The LPHSA results were then presented to the WCPH for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard was discussed, 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 CHIP committee identified 11 indicators that had a status of "minimal" and 3 indicators that had a status of "no activity." The remaining indicators were all moderate, significant or optimal.

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

To view the full results of the LPHSA, please contact the Williams County Combined Health District at (419) 485-3141.

Williams County Local Public Health System Assessment 2019 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 WCPH 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 WCPH 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 WCPH 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 WCPH 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 committee 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.

For a comprehensive list of Williams County resources view the 2019 Williams County Community Resource Guide at the following link: **https://sites.google.com/montpelier-k12.org/williams-county-resource-guide/home**

Priority #1: Mental Health and Addiction

Strategic Planning Terminology

Goal: broad, major initiatives that need to be undertaken
Objectives: interim steps that address the goal; should be SMART
Action Steps: specific steps that need to be taken to meet the objective(s)
Indicators: specific metric(s) used to measure long term progress and success of the strategy
Timeline: timeframe within activities will take place
Lead Contact/Agency: who will be responsible for ensuring the objective is met?

Strategic Plan of Action

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

Priority #1: Mental Health and Addiction				
Strategy 1: Mental health first aid (MHFA)				
Goal: Reduce mental health stigma.				
Objective: By December 31, 2022, Williams County will provide at least three MHFA trainings annually.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Expand **mental health first aid** (MHFA) trainings to area factories and other manufacturing entities. Determine effective marketing techniques among community organizations that will promote the identified trainings. Determine how to target priority populations. Continue to promote and administer youth MHFA trainings. Explore incentive options for participation.	December 31, 2020	Adult Ages: 19-29 Youth Ages: 13 & younger Gender: Female	Depression (adults): Percent of adults who reported feeling sad or hopeless almost everyday for 2 or more weeks in a row in the past year (Baseline, 13%, 2019 CHA) Depression (youth): Percent of youth who reported feeling sad or hopeless almost every day for 2 or more weeks in a row in the past year (Baseline, 30%, 2019 CHA)	Four County Board of Alcohol, Drug Addiction and Mental Health Services (ADAMhs) Maumee Valley Guidance Center (MVGC)
Year 2: Continue efforts from year 1. Provide at least three additional trainings and continue marketing the training.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2.	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Williams County Economic Development Cooperation (WEDCO), YMCA, Department of Aging, Williams County schools				

Priority #1: Mental Health and Addiction				
Strategy 2: Trauma-informed schools				
Goal: Increase trauma awareness.				
Objective: By December 31, 2022, a trauma screening tool will be implemented in Williams County.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to administer trainings to increase education, understanding and awareness of the following: • Trauma informed care • Toxic stress • ACEs and what the ACE scores mean Assess interest in the showing of the **Resilience Film** in schools, faith-based organizations, and other local organizations.	December 31, 2020	Adult/youth	Suicide deaths: Number of deaths due to suicide per 100,000 populations (age adjusted) (Baseline, 16.3 for Williams County, 2016-2018 ODH Data Warehouse)	Williams County Health District
Year 2: Continue efforts from year 1. Research existing trauma screening tools. Determine the feasibility of implementing a trauma screening tool for agencies and organizations who work with at-risk adults and youth (e.g., healthcare providers, social service agencies). Market and educate organizations on the importance of the trauma screening tool. Determine interest and potential organizations to implement the trauma screening tool. Provide technical assistance where necessary.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Implement the trauma screening tool.	December 31, 2022			
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: Northwestern Ohio Community Action Commission (NOCAC), Community Hospitals and Wellness Centers, Jobs and Family Services (JFS), ADAMhs, ECHO, veteran groups, Williams County schools, Parkview Physicians Group (PPG)				

Priority #1: Mental Health and Addiction				
Strategy 3: Community-wide campaign to promote positive mental health and cell-phone based support programs				
Goal: Increase awareness of mental wellness and suicide.				
Objective: The 4 Your Mental Health Campaign will utilize two new marketing strategies to increase awareness of the campaign by December 31, 2022.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to promote the 4 Your Mental Health mental wellness and suicide awareness campaign county-wide. Target campaign to specifically address demographics most at risk (ex: middle aged men, specific youth populations). Increase awareness of the campaign using TV, billboards, social media, newspapers, etc. Secure funding for campaign.	December 31, 2020	Adult Ages: 19-29 Youth Ages: 14-16, Gender: Female	Suicide deaths: Number of deaths due to suicide per 100,000 populations (age adjusted) (baseline: 16.3 for Williams County, 2016-2018 ODH Data Warehouse)	Williams County Health District
Year 2: Continue efforts from year 1. Evaluate marketing strategies being used to promote the 4 Your Mental Health campaign.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Evaluate campaign effectiveness.	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: ADAMhs, WEDCO, Four County Suicide Prevention Coalition				

Priority #1: Mental Health and Addiction				
Strategy 4: Screening for clinical depression using a standardized tool and provider education to primary care and behavioral health providers regarding depression/suicide screening tools				
Goal: Increase provider knowledge regarding mental health issues.				
Objective 1: By December 31, 2022, at least 50% of Williams County providers will have attended a training on how to provide better care for their patients with mental health issues.				
Objective 2: Implement a depression screening tool into 3 new settings by December 31, 2022.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to screen for depression using PHQ-2, or **another screening tool**. Identify another setting, such as a medical specialty office (pediatrician, OBGYN) or schools, to implement the screening tool. Work with healthcare provides to assess what resources, information and/or materials they are lacking to provide better care for patients with mental health issues.	December 31, 2020	Adult Gender: Female Youth Gender: Female	Number of positive and negative screenings completed by health care providers	Parkview Physicians Group Four County Board of Alcohol, Drug Addiction and Mental Health Services (ADAMhs)
Year 2: Continue efforts from year 1. Implement the depression screening in one new setting. Begin offering depression and suicide specific trainings and/or education to providers to provide better care for patients and/or clients with mental health issues. Enlist at least 5 healthcare providers to be trained.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Implement the depression screening in one new setting. Offer additional trainings to reach at least 50% of providers in Williams County.	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: ADAMhs, Activate, Health Partners, Community Hospitals and Wellness Centers				

Priority #1: Mental Health and Addiction				
Strategy 5: Universal school-based suicide awareness and education programs and cell-phone based support programs				
Goal: Increase suicide awareness among youth.				
Objective: By December 31, 2022, all school districts will have at least one school-based suicide awareness and education program.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to promote and implement the **Signs of Suicide (SOS)** program in Williams County schools. If applicable, expand current programming to additional districts or grade levels. Determine the feasibility of expanding SOS in the high school setting. Promote and raise awareness of the Crisis Text Line (**Text 4hope**). Utilize youth-led prevention groups to promote the use of the Crisis Text Line. Monitor the usage of the Crisis Text Line with accompanying evaluation measures.	December 31, 2020	Youth Age: 14-16 Gender: Female	Suicide ideation (youth): Percent of youth who report that they ever seriously considered attempting suicide within the past 12 months (Baseline: 16%, 2019 CHA)	Four County Board of Alcohol, Drug Addiction and Mental Health Services (ADAMhs)
Year 2: Continue efforts from years 1.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Expand program service area where necessary.	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Maumee Valley Guidance Center (MVGC), school-based mental health therapy, care coordination				

Priority #1: Mental Health and Addiction				
Strategy 6: School-based alcohol/other drug prevention programs				
Goal: Decrease drug dependence or abuse.				
Objective: All participating schools will implement the Too Good for Drugs programming in selected grades by December 31, 2022.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to promote and implement the **Too Good For Drugs** program in Williams County schools: If applicable, expand current programming to additional districts or grade levels. Continue screening for drug and alcohol abuse using the QBIRT model.	December 31, 2020	Youth Age: 17 & older Gender: Male	Youth alcohol use: Percent of high school students who have used alcohol within the past 30 days (Baseline: 16%, 2019 CHA) Electronic vapor product (youth): Percent of youth who currently use an electronic vaping product (Baseline: 17%, 2019 CHA)	Four County Board of Alcohol, Drug Addiction and Mental Health Services (ADAMhs)
Year 2: Continue efforts from year 1. Expand program service area where necessary. Create and disseminate supporting educational materials for parents and families.	December 31, 2021			
Year 3: Continue efforts of years 1 and 2.	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Recovery Services, school-based mental health therapy, care coordination				

Priority #1: Mental Health and Addiction				
Strategy 7: Healthcare screening, brief intervention and referral to treatment (SBIRT)				
Goal: Decrease drug abuse and alcohol use.				
Objective: At least five providers will be trained in the SBIRT model or another screening tool by December 31, 2022.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collect baseline data on the number of healthcare providers screening for substance use using the **SBIRT model** (screening, brief intervention, and referral to treatment) or another screening tool.	December 31, 2020	Adult Age: 30-64	Unintentional drug overdose deaths: Number of deaths due to unintentional drug overdoses per 100,000 population (age-adjusted) (baseline: 22.7 for Williams County, 2016-2018 ODH Data Warehouse)	Parkview Physicians Group
Year 2: Evaluate and continue efforts from year 1. Introduce the SBIRT model or a similar screening tool to hospital emergency departments, urgent care centers, and primary care providers (including pediatricians) or other healthcare providers. Educate healthcare providers on the SBIRT model. Work with both public and private providers to ensure that clinicians have up to date community resources for referrals.	December 31, 2021			
Year 3: Evaluate and continue efforts from years 1 and 2. Enlist at least 5 providers to be trained in the SBIRT model (or another screening tool).	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Community Hospitals and Wellness Centers				

Priority #1: Mental Health and Addiction				
Strategy 8: School questionnaire, brief intervention and referral to treatment (QBIRT)				
Goal: Decrease depression and alcohol use.				
Objective: By December 31, 2022, all Williams County school districts will implement the QBIRT model.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to implement the QBIRT (Questionnaire, Brief Intervention, and Referral to Treatment) model in Williams County schools.	December 31, 2020	Youth Age: 17 & older Gender: Male & Female (youth alcohol use); Female (lifetime drinker)	Depression (youth): Percent of youth who felt so sad or hopeless almost every day for two or more weeks in a row that they stopped doing some usual activities in the past year (Baseline: 30%, 2019 CHA) Youth alcohol use: Percent of high school students who have used alcohol within the past 30 days (Baseline: 16%, 2019 CHA)	Juvenile Court Administration
Year 2: Evaluate and continue efforts from year 1. Educate school personnel on the QBIRT model. Work with school personnel to ensure that the schools have up to date community resources for referrals.	December 31, 2021			
Year 3: Evaluate and continue efforts from years 1 and 2.	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Williams County schools, ADAMHs Board				

Priority #2: Chronic Disease

Strategic Plan of Action

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

Priority #2: Chronic Disease				
Strategy 1: Complete Streets				
Goal: Increase physical activity.				
Objective: Williams County will increase awareness of existing Complete Street policies by December 31, 2022.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to raise awareness of Complete Streets policies and recommend that all local jurisdictions adopt comprehensive Complete Streets policies.	December 31, 2020	Adult Age: 65 & Older Gender: Female Youth Age: 17 & Older Gender: Female	Physical inactivity: (adult) Percent of adults reporting no physical activity in the past week (Baseline: 27%, 2019 CHA) Physical inactivity (youth): Percent of youth who did not participate in at least 60 minutes of physical activity on at least 1 days in the past seven days (Baseline: 10%, 2019 CHA)	Williams County Health District
Year 2: Communicate and market existing and new Complete Streets policies throughout the community.	December 31, 2021			
Year 3: Continue to communicate and market Complete Streets policy throughout the community. Identify a champion from Williams County to assist in technical assistance and the creation of a county-wide policy. Evaluate policy utilization.	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Maumee Valley Planning Organization (MVPO), Elected officials				

**Strategy is considered a priority factor (health behaviors) strategy per the 2020-2022 Ohio State Health Improvement Plan (SHIP)*
Note: Implementation of strategy will likely affect the outcome of the cancer prevention and screening strategies.

Priority #2: Chronic Disease				
Strategy 2: Community gardens				
Goal: Increase fruit and vegetable consumption.				
Objective: By December 31, 2022, one additional community garden will be developed in Williams County.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Obtain baseline data regarding how many school districts, churches, and other community organizations currently have **community gardens** and where they are located. Identify specific demographic need for community gardens. Determine need for additional community gardens and to secure volunteers and Master Gardeners (ex: potential partnership with OSU Extension).	December 31, 2020	Adult Age: 19-29, 65 & Older Gender: Male Youth Age: 14-16, 19-29 Gender: Male	Fruit consumption: Percent of adults and youth who report consuming 0 servings of fruits and 100% fruit juices per day (Baseline: 13% (adults), 7% (youth), 2019 CHA) Vegetable consumption: Percent of adults and youth who report consuming 0 servings of vegetables per day (Baseline: 5% (adults), 14% (youth), 2019 CHA)	The Williams County Community Gardens Association (WCCGA)
Year 2: Research grants and funding opportunities to increase the number of community gardens. Develop a sustainability plan to maintain existing and future community gardens year-round. Obtain baseline data regarding which local food pantries have fresh produce available. Work with food pantries to offer fresh produce and assist pantries in seeking donations from local grocers. Market current and future community gardens within the county (i.e. location, offerings, etc.). Update the marketing information on an annual basis.	December 31, 2021			
Year 3: Continue efforts from year 2. Explore partnership opportunities to educate community members and families on gardening and healthy eating practices.	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: None noted				

**Strategy is considered a priority factor (health behaviors) strategy per the 2020-2022 SHIP*

Note: Implementation of strategy will likely affect the outcome of the cancer prevention and screening strategies.

Priority #3: Obesity

Strategic Plan of Action

To work toward decreasing obesity rates, the following strategies are recommended:

Priority #3: Obesity				
Strategy 1: Healthy food initiatives				
Goal: Increase fruit and vegetable consumption in Medicaid-eligible adult and youth.				
Objective: By December 31, 2022, Williams County will implement 2 healthy food initiatives in local food pantries or farmers markets.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Raise awareness of the available food pantries and farmers markets within the county (locations, offerings, etc.). Continue to distribute information on where to obtain fresh fruit and vegetables. Encourage local **food pantries** to offer more fresh, healthy food (vs shelf stable foods). Determine feasibility of **SNAP/EBT at farmers markets** (meet with market managers to determine readiness). Educate vendors regarding food deserts and the benefits of accepting SNAP/EBT at farmers markets.	December 31, 2020	Adult Gender: Male Youth Age: 14-16, 19-29 Gender: Male	Fruit consumption: Percent of adults and youth who report consuming 0 servings of fruits and 100% fruit juices per day (Baseline: 13% (adults), 7% (youth), 2019 CHA) Vegetable consumption: Percent of adults and youth who report consuming 0 servings of vegetables per day (Baseline: 5% (adults), 14% (youth), 2019 CHA)	OSU Extension
Year 2: Continue efforts of year 1. Determine feasibility of implementing any of the following in local food pantries or farmers markets: • Cooking demonstrations/classes • Recipe tastings • Produce display stands • Nutrition, diabetes and other health education classes • Healthcare support services	December 31, 2021			
Year 3: Continue efforts of year 2. Implement at least 2 items above within local food pantries or farmers markets.	December 31, 2022			
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: Food pantries, farmers markets, United Way Hunger Summit, WIC, JFS				

Note: Implementation of strategy will likely affect the outcome of the cancer prevention and screening strategies.

Priority #3: Obesity				
Strategy 2: Nutrition education programs for adults/school-based education programs				
Goal: Decrease obesity.				
Objective 1: Implement the Serving Up MyPlate framework to fidelity in participating school districts.				
Objective 2: By December 31, 2022, increase participation in the SNAP-Ed program 5% from baseline.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1 Objective 1: Assess what nutrition education programs and/or nutrition interventions are available in Williams County for youth. Determine which schools are currently utilizing the **Serving Up MyPlate** framework. Measure knowledge gained through pre- and post-test evaluations, Healthy Habit Surveys, produce voucher redemptions, and taste test evaluations. Expand current programming to additional districts.	December 31, 2020	Adult/ youth/ child Income: Less than $25,000	Fruit consumption: Percent who report consuming 0 servings of fruits per day (Baseline: 13% (adult), 7% (youth), 2019 CHA) Vegetable consumption: Percent who report consuming 0 servings of vegetables per day (Baseline: 5% (adult), 14% (youth), 2019 CHA)	**Objective 1** Williams County Health District **Objective 2** OSU Extension
Year 1 Objective 1: Continue efforts from year 1.	December 31, 2021			
Year 3 Objective 1: Continue efforts from years 1 and 2. Expand program(s) service area where necessary.	December 31, 2022			
Year 1 Objective 2: Continue to implement the **Supplemental Nutrition Assistance Program Education (SNAP-Ed)** to low income/Medicaid eligible adults, youth and children through the Ohio State University Extension. Evaluate effectiveness of the program annually.	December 31, 2020			
Year 2; Objective 2: Increase participation in the SNAP-Ed program 5% from year 1. Measure knowledge gained through evaluations.	December 31, 2021			
Year 3 Objective 2: Continue efforts from years 1 and 2. Expand program(s) service area where necessary.	December 31, 2022			
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				

Resources to address strategy: ADAMhs, Community Hospitals and Wellness Centers, United Way, Williams County schools, HeadStart/afterschool

Note: Implementation of strategy will likely affect the outcome of the cancer prevention and screening strategies.

Priority #3: Obesity				
Strategy 3: Grocery development and improvement in underserved areas				
Goal: Reduce food insecurity.				
Objective: By December 31, 2022, collaborate with at least one local grocery store to improve access to fresh food.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Assess county data related to food deserts and food insecurity. Research and review requirements of the **Healthy Food for Ohio Program**, which aims to encourage the development and/or improvement of grocery stores and other retail outlets selling fresh food in underserved areas.	December 31, 2020	Adult/youth	Food insecurity: Percent of households that are food insecure (Baseline: 12%, Feeding America Map the Meal Gap, 2017)	OSU Extension
Year 2: Continue efforts of year 1. Determine feasibility of providing technical assistance to local grocery stores or future grocery stores to develop/improve fresh food access in underserved areas.	December 31, 2021			
Year 3: Continue efforts of year 2.	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: None noted				

Note: Implementation of strategy will likely affect the outcome of the cancer prevention and screening strategies.

Priority #4: Cancer Prevention and Screenings

Strategic Plan of Action

To work toward improving cancer prevention and screenings, the following strategies are recommended:

Priority #4: Cancer Prevention and Screenings				
Strategy 1: Cancer screenings and treatment barriers				
Goal: Decrease barriers to cancer screenings.				
Objective: A community resource guide will be updated quarterly to reflect organizations providing free or reduced cost healthcare services by December 31, 2022.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Determine barriers to cancer screenings and other preventive care. Develop a survey tool and disseminate survey to Williams County residents. Facilitate focus groups or listening sessions county-wide to determine barriers to screenings and other preventive care.	December 31, 2020	Adult	Colorectal cancer screening: Adults who had a colorectal cancer screening in the past 10 years (Baseline: 40%, 2019 CHA) Lung cancer screening: Adults who had a lung cancer screening in the past 3 years (Baseline: 4%. 2019 CHA)	Community Hospitals and Wellness Centers/ Cancer Committee
Year 2: Compile and review results from the focus groups/listening sessions and survey. Disseminate results to the hospitals, health department and other community organizations. Develop a plan to reduce barriers to cancer screenings and treatment. Coordinate efforts between the hospitals, health department and other community organizations to increase community outreach and education on available preventive health services. Promote cancer screenings at the hospital. Create or update a community resource guide to reflect all organizations providing free or reduced cost healthcare services. Include information on what accounts for preventive care, what does insurance cover and different screening guidelines.	December 31, 2021			

Year 3: Increase efforts from years 1 and 2. Continue community outreach efforts.	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: CHWC, PPG, FQHC, Activate, WCHD, BARD Cancer Symposium				

Priority #4: Cancer Prevention and Screenings				
Strategy 2: Consistent cancer screening recommendations				
Goal: Increase awareness of cancer screening recommendations.				
Objective: By December 31, 2022 develop a unified message to be used across healthcare agencies.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Complete a baseline assessment with physician's offices to determine which cancer screening guidelines and recommendations are currently being utilized. Seek input from target audience about the barriers to screening. Explore the feasibility of unified messaging across health agencies.	December 31, 2020	Adult	Colorectal cancer screening: Adults who had a colorectal cancer screening in the past 10 years (Baseline: 40%, 2019 CHA) Lung cancer screening: Adults who had a lung cancer screening in the past 3 years (Baseline: 4%. 2019 CHA)	Community Hospitals and Wellness Centers/ Cancer Committee
Year 2: Develop uniform messaging to utilize across healthcare agencies. Distribute guidelines and educate community on current screening recommendations. Educate community on healthcare laws that pertain to 100% coverage for preventive healthcare.	December 31, 2021			
Year 3: Continue efforts from year 2. Market free screening opportunities that will be taking place in the community. Offer incentives to participate.	December 31, 2022			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: CHWC, PPG, FQHC, Activate, WCHD, BARD Cancer Symposium				

Priority Factor: Health Behaviors
(Factors address priority health outcomes)

To work toward improving mental health & addiction, chronic disease, obesity, and cancer prevention & screenings, the following strategies are recommended:

Strategy 1: Green space and parks/bike and pedestrian master plans

Goal: Increase physical activity.

Objective: By December 31, 2022, create a written plan to create additional green space in Williams County.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collaborate with local partners to advertise local parks, playgrounds, trails, walking paths and other **green space** available in Williams County.	December 31, 2020	Adult Age: 65 & Older Gender: Female Youth Age: 17 & Older Gender: Female	Physical inactivity: (adult) Percent of adults reporting no physical activity in the past week (Baseline: 27%, 2019 CHA) Physical inactivity (youth): Percent of youth who did not participate in at least 60 minutes of physical activity on at least 1 days in the past seven days (Baseline: 10%, 2019 CHA)	Williams County Engineer
Year 2: Continue efforts from year 1. Target spaces that are in economically distressed areas. Present the bike and pedestrian master plan proposal to local policy makers and/or jurisdictions. Collaborate with local partners to create a bike and pedestrian master plan.	December 31, 2021			
Year 3: Continue efforts from year 1 and year 2. Create a written plan to create the additional green space. Evaluate policy utilization.	December 31, 2022			

SHIP Priority area(s) the strategy addresses:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy: None noted

Strategy 2: Mass-reach communications				
Goal: Reduce tobacco use and vaping.				
Objective: By December 31, 2022, at least two mass-reach communication campaigns will be implemented.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research vaping and tobacco specific **Mass-reach communication** strategies. Consider implementing the following strategies: • 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 adds on TV, radio, billboards, online platforms and/or print media. The **strategies** should focus on motivating tobacco users to quit, protecting people from the harm of secondhand smoke exposure, and preventing tobacco use and vaping initiation.	December 31, 2020	Adult Age: 19-29 Gender: Female Youth Age: 17 & older Gender: Male	Adult smoking: Percentage of adults who are current smokers (Baseline: 16%, 2019 CHA) Electronic vapor product (youth): Percent of youth who currently use an electronic vaping product (Baseline: 17%, 2019 CHA)	Williams County Health District
Year 2: At least two mass-reach communications will be implemented county-wide.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2.	December 31, 2022			
SHIP Priority area(s) the strategy addresses: ⊗ Mental Health and Addiction ⊗ Chronic Disease ○ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: None noted				

Strategy 3: Prescriptions for physical activity				
Goal: Reduce obesity.				
Objective: Implement an exercise prescription program into two additional primary care offices by October 1, 2022.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Determine the baseline number of healthcare providers and primary care physicians that currently provide prescriptions for physical activity and exercise (**exercise prescriptions**) to their patients. Partner with local organizations such as the YMCA, the parks and recreation district or the municipal and county parks to determine referral options and provide support for the exercise prescriptions.	December 31, 2020	Adult Age: 19-29 Gender: Female	Obesity: Percent of adults that report BMI greater than or equal to 30 (Baseline: 42%, 2019 CHA) Adult physical inactivity: Percent of adults, age 18 and older, reporting no leisure time physical activity (Baseline: 27%, 2019 CHA)	Parkview Physicians Group
Year 2: Continue efforts from year 1. Meet with and educate local physicians about exercise prescriptions.	December 31, 2021			
Year 3: Continue efforts from years 1 and 2. Pilot an exercise prescription program into one additional primary care office with accompanying referral options and evaluation measures. Identify another setting, such as a medical specialty office (psychiatry), schools, or local businesses to provide physical activity and exercise prescriptions.	December 31, 2022			
SHIP Priority area(s) the strategy addresses: ⊗ Mental Health and Addiction ⊗ Chronic Disease ○ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: YMCA, other local gyms, school facilities, parks and recreation				

Note: Implementation of strategy will likely affect the outcome of the cancer prevention and screening strategies.

Strategy 4 Health in all policies				
Goal: Develop a health in all policies resolution.				
Objective: By December 31, 2021, Williams County will adopt a health in all policies resolution.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research **health in all policies** and educate local partners and community agencies on its importance. Reach out to interested organizations and local government officials to develop a health in all policies resolution county-wide.	December 31, 2020	Adult/youth	Indicator to measure impact of strategy not identified	Williams County Health District
Year 2: Continue efforts of year 1.	December 31, 2021			
Year 3: Continue efforts of years 1 and 2. Work to adopt a county-wide health in all policies resolution.	December 31, 2022			
Priority area(s) the strategy addresses: ○ Mental Health and Addiction ○ Chronic Disease ⊗ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: Elected officials, non-government organization policymakers				

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 or as needed 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.

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

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

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

Contact Us

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

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Williams County Combined Health District
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Appendix I: Gaps and Strategies

The following tables indicate mental health and addiction, chronic disease, obesity and cancer prevention and screenings gaps and potential strategies that were compiled by the WCPH.

Mental Health and Addiction Gaps

Gaps	Potential Strategies
1. Stigma	• Continue offering mental health first aid (MHFA) trainings. Work with economic development, human resource professionals, local factories and other businesses to offer the training to employees and/or management. • Continue to offer the Signs of Suicide (SOS) program in the schools. • Continue efforts of the LOSS team in Williams County.
2. Mental health professionals	• Continue to offer and expand Telemedicine services. • Research and implement recruitment strategies (focusing on mental health counselors and social workers).
3. Transportation	• Invite additional stakeholders to the table (county commissioners).
4. Cost	• None noted.
5. No inpatient mental health services available in county	• Educate physicians and other healthcare providers on the mental health and substance use resources available in Williams County. • Consider implementing a suicide screening tool.
6. Education on vaping	• Provide vaping education and supporting data to parents and students. Address miseducation surrounding vaping.
7. Bullying	• Continue evidence-based programming in the school.

Chronic Disease Gaps

Gaps	Potential Strategies
1. Walkability/safety	• Continue Complete Street efforts.
2. Fast food convenience	• Expand community gardens. • Research health food in convenience stores.
3. Inactive lifestyle	• None noted.
4. Health screenings	• Increase A1C, blood pressure and blood cholesterol screenings.
5. Lack of quick, affordable food options	• Advocate to the Downtown Association for healthier food options.

Obesity Gaps

Gaps	Potential Strategies
1. Lack of knowledge surrounding physical activity and nutrition	• Provide education about overeating and nutritional consumption. • Offer education on why physical activity is important. • Continue to offer the MyPlate program in the schools.
2. Weather (challenge to be physically active in the winter)	• Consider implementing shared use agreements.
3. Transportation	• Invite additional stakeholders to the table (county commissioners).
4. Cooking and food preparation	• Promote OSU Extension activities (SNAP Ed).
5. Built environment	• Improve walkability

Cancer Prevention and Screening Gaps

Gaps	Potential Strategies
1. Inconsistent cancer screening recommendations	• None noted.
2. Lack of knowledge surrounding what is/is not included in their healthcare coverage	• Encourage providers and employers to educate patients/employees on available benefits.
3. Health screenings	• Continue to partner with manufacturing companies to provide health screenings.
4. Communication	• Implement effective communication strategies targeted at specific populations.
5. Information overload	• Implement a coordinated messaging campaign. • Continue to attend the Williams County Social Service Networking meetings.

Appendix II: Links to Websites

Title of Link	Website URL
Screening, brief intervention and referral to treatment (SBIRT)	www.integration.samhsa.gov/clinical-practice/sbirt
The Incredible Years	www.incredibleyears.com/programs/
PAX Good Behavior Game	www.hazelden.org/HAZ_MEDIA/gbg_insert.pdf
Second Step	www.secondstep.org/what-is-second-step
Too Good For Drugs	https://toogoodprograms.org/
Hidden in Plain Sight	http://powertotheparent.org/be-aware/hidden-in-plain-sight/
Signs of Suicide (SOS)	www.sprc.org/resources-programs/sos-signs-suicide
SAFE-T	www.integration.samhsa.gov/images/res/SAFE_T.pdf
C-SSRS	www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf
Depression screening tools	www.integration.samhsa.gov/clinical-practice/screening-tools#depression
Crisis Text Line	www.crisistextline.org/
Resilience Film	https://kpjrfilms.co/resilience/about-the-film/
Mental health first aid (MHFA)	www.mentalhealthfirstaid.org/
Health in All Policies	www.apha.org/-/media/files/pdf/factsheets/health_inall_policies_guide_169pages.ashx?la=en&hash=641B94AF624D7440F836238F0551A5FF0DE4872A
Physical activity community wide campaigns	www.thecommunityguide.org/findings/physical-activity-community-wide-campaigns
Healthy Food for Ohio	www.financefund.org/userfiles/files/Program%20Fact%20Sheets/HFFO%20Fact%20Sheet.pdf
Safe Routes to School	www.saferoutespartnership.org/
Go Noodle	www.gonoodle.com/
Power Up for 30	https://healthmpowers.org/programs/power-up-for-30/
Instant recess	www.toniyancey.com/IR_NEWS_SHO_112213.html
Take 10	https://take10.net/
Physically active classrooms	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/physically-active-classrooms
Serving Up MyPlate: A Yummy Curriculum	www.fns.usda.gov/tn/serving-myplate-yummy-curriculum
Electronic Benefit Transfer payment at farmers markets	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/electronic-benefit-transfer-payment-at-farmers-markets
Healthy food initiatives in food banks	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/healthy-food-initiatives-in-food-banks
Exercise prescriptions	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/exercise-prescriptions
Community gardens	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/community-gardens