2023-2025

WILLIAMS COUNTY

Community Health Improvement Plan

EXAMINING THE HEALTH OF THE COMMUNITY

Approved: March 1, 2023 Updated: January 30, 2024

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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.

The Williams County Health Partners has been conducting CHAs since 2006 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 an electronic survey of 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 the 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 Health Partners 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. This report serves as the implementation strategy for CHWC in Williams County and documents the hospital's efforts to address the community health needs identified in the CHA.

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 (78%) of CHWC—Bryan Hospital and 83% of CHWC—Montpelier Hospital's discharges in 2021 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 District 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 (Health Disparities)

Williams County is a rural county. Approximately 10.3% of Williams County residents were below the poverty line, according to the 2020 U.S. Censure Bureau Poverty and Median Income Estimates. For this reason, data is broken down by household 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 Williams County Health Partners 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 2023-2025 Williams County CHIP priorities align with state and national priorities. Williams County will be addressing the following priorities: access to care, health behaviors & built environment, and mental health and addiction.

Healthy People 2030

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

- Health Care Access and Quality (AHS) – 04: Reduce the proportion of people who can't get medical care when they need it
- Nutrition and Healthy Eating (NWS) – 03: Reduce the proportion of adults with obesity
- Mental Health and Mental Disorder (MHMD) – 01: Reduce the suicide rate

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

Ohio State Health Improvement Plan (SHIP)

The 2020-2022 SHIP serves as a strategic menu of priorities, objectives, and evidence-based strategies to be implemented by state agencies, local health departments, hospitals and other community partners and sectors beyond health including education, housing, employers, and regional planning.

The SHIP includes a strategic set of measurable outcomes that the state will monitor on an annual basis. Given that the overall goal of the SHIP is to ensure all Ohioan's achieve their full health potential, the state will track the following health indicators: self-reported health status (reduce the percent of Ohio adults who report fair or poor health) and premature death (reduce the rate of deaths before age 75).

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

The three priority factors include the following:

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

The three priority health outcomes include the following:

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

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

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

Priority Factors	State Aligned Priority Indicators	Strategies to Impact State Priority Indicators	Additional Aligned Strategies*
Access to Care	• Not available	• Not available	• Not available
Health Behaviors & Built Environment	• Adult physical activity	• Complete Streets • Green space and parks/bike and pedestrian master plans • Community fitness programs	• Community gardens • Healthy food initiatives and nutrition education
Priority Outcome	**State Aligned Priority Indicators**	**Strategies to Impact State Priority Indicators**	**Additional Aligned Strategies***
Mental Health & Addiction	• Youth alcohol use • Youth marijuana use • Adult suicide deaths	• School-based alcohol/other drug prevention programs • Mental Health First Aid	• School-based social and emotional instruction

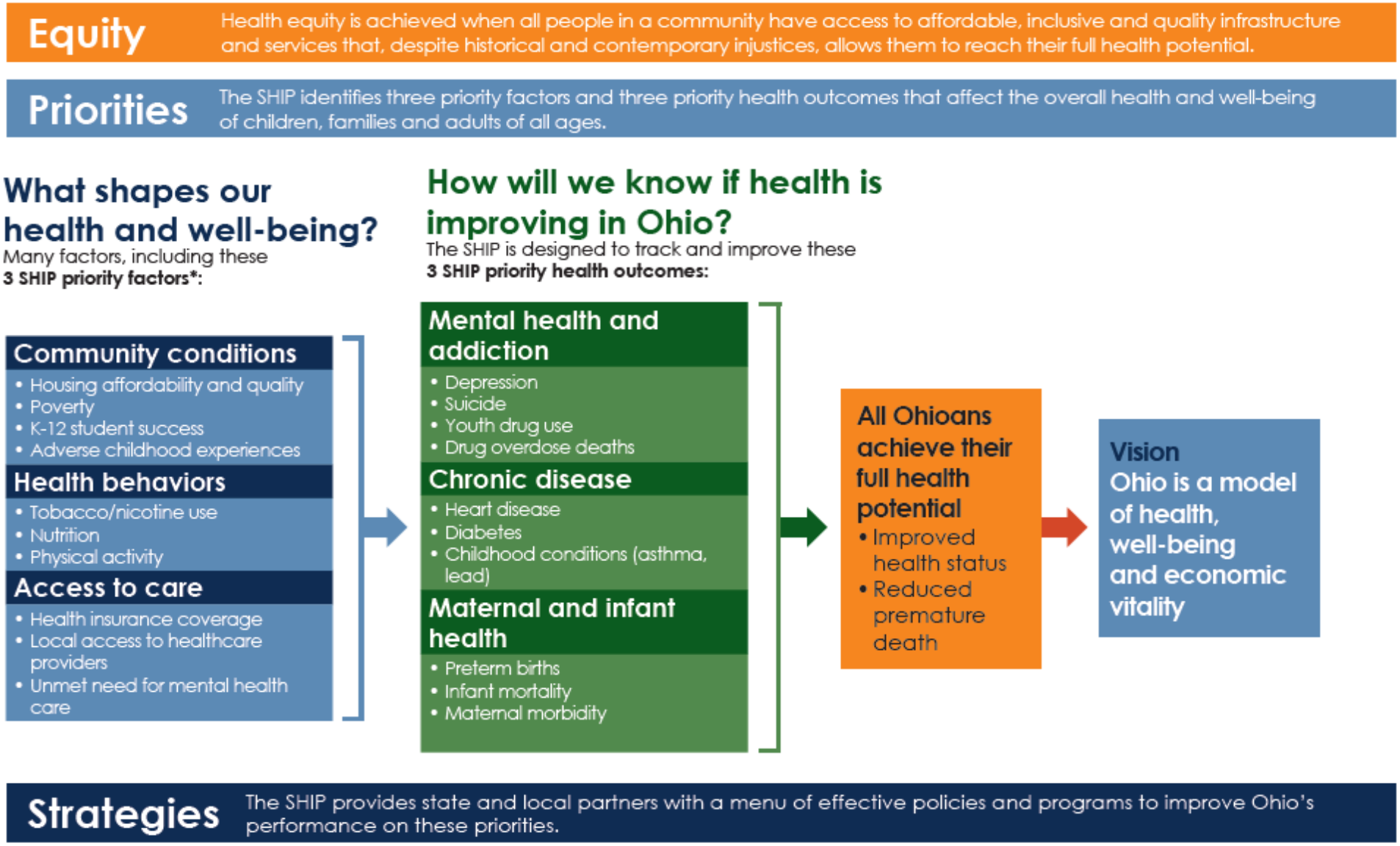
*Strategies are supported by the 2020-2022 SHIP, but Williams County priority indicators do not directly align with state identified indicators.

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

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

Alignment with National and State Standards, continued

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



Vision and Mission

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

The Vision of 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 2022 to January 2023, the Williams County Health Partners 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 Health Partners

Alicia Graham, Shalom Counseling & Mediation Center
Allyn Luce, Altenloh, Brinck & Co.
Amy Kirby, United Way of Williams County
Ashley Epling, Williams County Economic Development Corporation (WEDCO)
Becky Kimble, The Ability Center
Becky McGuire, Ohio State University Extension Office
Bethany Coutz, Educating Communities on Healthy Opportunities (ECHO) Coalition
Bethany Shirkey, Four County Alcohol, Drug Addiction and Mental Health Services (ADAMhs) Board
Bobbi Case, Community Hospitals and Wellness Centers (CHWC)
Chasity Yoder, United Way of Williams County
Chris Kannel, Village of Montpelier
Deanna Custar, Williams County Board of Health
Donna Sprow, Williams County Department of Aging
Gene McBride, Pioneer Area Ministerial Association
Jenni McKarns, Williams County Community Gardening Association (WCCGA)
Jim Watkins, Williams County Health Department (WCHD)
Jim Wyse, Millcreek-West Unity Local Schools
Karen VonDeylen, Maumee Valley Guidance Center
Katie Brown, WCHD
Keira Christman, WEDCO
Kermit Riehle, Edgerton Schools
Kim Lammers, Maumee Valley Planning Organization
Melissa Ewers, Village of Montpelier
Michelle Kannel, Montpelier Schools
Nathan Hoffer, WCHD
Rachel Aeschliman, WCHD
Rachel Blanton, Sarah's Friends
Ruth Peck, Recovery Services of Northwest Ohio
Sally Taylor, Parkview Physicians Group
Sarah Vashaw, Bryan City Schools
Sheana Behringer, NOCAC
Susan Sheets, Williams County Juvenile Courts
Tammy Riegsecker, WCHD
Todd Roth, Williams County Engineer's Office
Victoria Smith, WCHD

Hospital Council of Northwest Ohio (HCNO)

The community health improvement process was facilitated by Jodi Franks, MPH, CHES, Community Health Improvement Coordinator from HCNO.

Community Health Improvement Process

Beginning in October 2022, the Williams County Health Partners met four (4) times and completed the following planning steps:

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

Community Health Status Assessment

Phase 3 of the MAPP process, the Community Health Status Assessment, or CHA, is a 100+ page report that includes primary data with over 100 indicators and hundreds of data points related to 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	Williams County 2022	Ohio 2020	U.S. 2020
Health Status						
Rated general health as excellent or very good	56%	55%	47%	41%	55%	57%
Rated general health as fair or poor	10%	14%	13%	16%	16%	13%
Rated mental health as not good on four or more days (in the past 30 days)	15%	23%	30%	27%	29%*	26%*
Rated physical health as not good on four or more days (in the past 30 days)	18%	20%	20%	27%	24%*	23%*
Average number of days that physical health was not good (in the past 30 days)	2.6	3.5	3.5	4.8	4.8**	4.1**
Average number of days that mental health was not good (in the past 30 days)	2.3	4.5	4.4	4.6	4.1**	3.7**
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%	27%	N/A	N/A
Health Care Coverage, Access, and Utilization						
Uninsured	15%	5%	7%	7%	9%	9%
Visited a doctor for a routine checkup (in the past 12 months)	50%	59%	64%	67%	77%	76%
Visited a doctor for a routine checkup (5 or more years ago)	15%	8%	9%	6%	6%	6%
Had one or more persons they thought of as their personal health care provider	78%	76%	86%	80%	79%	77%
Arthritis, Asthma, & Diabetes						
Ever been told by a doctor they have diabetes (not pregnancy-related)	8%	7%	12%	14%	12%	11%
Had ever been told they have asthma	12%	18%	13%	16%	14%	14%
Cardiovascular Health						
Ever diagnosed with angina or coronary heart disease	6%	6%	7%	7%	5%	4%
Ever diagnosed with a heart attack, or myocardial infarction	5%	4%	6%	9%	5%	4%
Ever diagnosed with a stroke	3%	1%	4%	2%	4%	3%
Had been told they had high blood pressure	29%	35%	39%	41%	35%*	33%*
Had been told their blood cholesterol was high	35%	36%	37%	37%	33%*	33%*
Weight Status						
Overweight	38%	30%	31%	33%	34%	35%
Obese	30%	41%	42%	49%	36%	32%

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

Adult Variables	Williams County 2013	Williams County 2016	Williams County 2019	Williams County 2022	Ohio 2020	U.S. 2020
Alcohol Consumption						
Current drinker (had at least one drink of alcohol within the past 30 days)	45%	39%	62%	54%	51%	53%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion within the past 30 days)	18%	15%	17%	18%	16%	16%
Tobacco Use						
Current cigarette smoker (smoked on some or all days)	20%	22%	16%	14%	19%	16%
Former cigarette smoker (smoked 100 cigarettes in lifetime and now do not smoke)	24%	18%	25%	28%	24%	25%
Drug Use						
Adults who used marijuana in the past 6 months	3%	4%	3%	5%	N/A	N/A
Adults who misused prescription drugs in the past 6 months	6%	5%	5%	7%	N/A	N/A
Preventive Medicine						
Ever had a pneumonia vaccine (ages 65 and older)	56%	67%	77%	68%	72%	72%
Had a flu shot within the past year (ages 65 and over)	72%	72%	76%	72%	65%	68%
Had a clinical breast exam in the past two years (women ages 40 and older)	68%	66%	52%	51%	N/A	N/A
Had a mammogram within the past two years (women ages 40 and older)	69%	67%	65%	70%	71%	72%
Had a pap test in the past three years (women ages 21-65)	66%	54%	59%	58%	77%	78%
Quality of Life						
Limited in some way because of physical, mental or emotional problem	20%	15%	22%	28%	N/A	N/A
Mental Health						
Felt sad or hopeless for two or more weeks in the past year	8%	9%	13%	14%	N/A	N/A
Seriously considered attempting suicide in the past year	3%	2%	5%	5%	N/A	N/A
Attempted suicide in the past year	<1%	0%	1%	<1%	N/A	N/A
Sexual Behavior						
Had more than one sexual partner in past year	3%	4%	3%	4%	N/A	N/A
Oral Health						
Visited a dentist or a dental clinic (within the past year)	65%	53%	73%	58%	65%	67%
Visited a dentist or a dental clinic (5 or more years ago)	10%	15%	11%	16%	N/A	N/A

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

Youth Trend Summary

Youth Comparisons	Williams County 2009 (6th-12th)	Williams County 2013 (6th-12th)	Williams County 2016 (6th-12th)	Williams County 2019 (6th-12th)	Williams County 2022 (6th-12th)	Williams County 2022 (9th-12th)	Ohio 2019 (9th-12th)	U.S. 2019 (9th-12th)
Weight Control								
Obese	14%	13%	13%	14%	21%	20%	17%	16%
Overweight	16%	11%	16%	14%	15%	15%	12%	16%
Described themselves as slightly or very overweight	26%	31%	32%	N/A	33%	34%	N/A	32%
Were trying to lose weight	49%	50%	45%	46%	48%	47%	N/A	48%
Exercised to lose weight (in the past 30 days)	44%	51%	47%	51%	47%	46%	N/A	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%	42%	N/A	N/A
Went without eating for 24 hours or more (in the past 30 days)	4%	7%	2%	6%	9%	10%	N/A	N/A
Took diet pills, powders, or liquids without a doctor's advice (in the past 30 days)	1%	3%	2%	2%	2%	2%	N/A	N/A
Vomited or took laxatives (in the past 30 days)	2%	3%	1%	2%	4%	4%	N/A	N/A
Ate 0 servings of fruits and/or vegetables per day	N/A	N/A	N/A	4%	7%	5%	N/A	N/A
Ate 5 or more servings of fruit and/or vegetables per day	N/A	N/A	N/A	26%	21%	17%	N/A	N/A
Physically active at least 60 minutes per day on every day in past week	N/A	28%	33%	31%	28%	26%	24%	23%
Physically active at least 60 minutes per day on 5 or more days in past week	59%	49%	54%	59%	54%	56%	43%	44%
Did not participate in at least 60 minutes of physical activity on any day in past week	12%	11%	15%	10%	10%	10%	21%	17%
Watched television for 3 or more hours per day	33%	38%	24%	N/A	16%	17%	N/A	20%*
Unintentional Injuries and Violence								
Threatened or injured with a weapon on school property (in the past 12 months)	3%	7%	5%	11%	7%	8%	N/A	7%
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%	7%	9%	N/A	9%
Bullied (in past 12 months)	50%	47%	47%	43%	42%	41%	N/A	N/A
Electronically bullied (in past 12 months)	8%	13%	12%	9%	13%	12%	13%	16%
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%	30%	34%	33%	37%
Seriously considered attempting suicide (in the past 12 months)	7%	15%	10%	16%	14%	17%	16%	19%
Attempted suicide (in the past 12 months)	3%	8%	7%	8%	8%	9%	7%	9%
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%	3%	3%	3%

N/A – Not Available
**U.S. rate is for an average school day*
Indicates alignment with the Ohio State Health Assessment

Youth Comparisons	Williams County 2009 (6th-12th)	Williams County 2013 (6th-12th)	Williams County 2016 (6th-12th)	Williams County 2019 (6th-12th)	Williams County 2022 (6th-12th)	Williams County 2022 (9th-12th)	Ohio 2019 (9th-12th)	U.S. 2019 (9th-12th)
Alcohol Consumption								
Ever drank alcohol (at least one drink of alcohol on at least 1 day during their lifetime)	49%	50%	35%	42%	27%	39%	N/A	N/A
Current drinker (at least one drink of alcohol on at least 1 day during the past 30 days)	18%	18%	16%	11%	8%	13%	26%	29%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion within the past 30 days)	9%	10%	7%	6%	7%	12%	13%	14%
Drank for the first time before age 13 (of all youth)	20%	16%	11%	13%	10%	13%	16%	15%
Obtained the alcohol they drank by someone giving it to them (of current drinkers)	61%	57%	26%	32%	46%	51%	N/A	41%
Rode with a driver who had been drinking alcohol (in a car or other vehicle on one or more times during the past 30 days)	15%	12%	10%	13%	11%	12%	N/A	17%
Drove when they had been drinking alcohol (in a car or other vehicle on one or more times during the 30, among students who had driven a car or other vehicle during the past 30 days)	2%	N/A	1%	2%	2%	1%	N/A	5%
Tobacco Use								
Current cigarette smoker (smoked on at least one day during the past 30 days)	9%	10%	3%	5%	3%	4%	5%	6%
Smoked cigarettes frequently (smoked on 20 or more days during the past 30 days)	2%	5%	1%	0%	<1%	<1%	1%	1%
Smoked cigarettes daily (smoked on all 30 days during the past 30 days)	1%	4%	1%	1%	<1%	<1%	<1%	1%
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%	19%	26%	48%	50%
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 one day during the past 30 days)	N/A	N/A	N/A	17%	10%	15%	30%	33%
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%	5%	9%	8%	11%
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%	3%	6%	5%	7%
Usually got their own electronic vapor products by buying them in a store – among current e-cigarette users (such as a convenience store, supermarket, discount store, gas station, or vape store, including e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods, during the 30 past days)	N/A	N/A	N/A	N/A	9%	19%	13%	8%

N/A – Not Available

Indicates alignment with the Ohio State Health Assessment

Youth Comparisons	Williams County 2009 (6th-12th)	Williams County 2013 (6th-12th)	Williams County 2016 (6th-12th)	Williams County 2019 (6th-12th)	Williams County 2022 (6th-12th)	Williams County 2022 (9th-12th)	Ohio 2019 (9th-12th)	U.S. 2019 (9th-12th)
Drug Use								
Ever used marijuana (in their lifetime)	N/A	N/A	N/A	N/A	15%	23%	30%	37%
Currently used marijuana (in the past 30 days)	4%	9%	4%	6%	8%	12%	16%	22%
Tried marijuana for the first time before age 13 (of all youth)	N/A	N/A	2%	3%	3%	4%	N/A	6%
Currently used prescription drugs not prescribed to them (in the past 30 days)	N/A	N/A	N/A	2%	3%	4%	N/A	7%*
Ever used prescription medications not prescribed to them, or took more than prescribed to feel good or high (in their lifetime)	5%	8%	3%	N/A	3%	5%	12%*	14%*
Ever used methamphetamines (in their lifetime)	1%	2%	<1%	1%	1%	<1%	N/A	2%
Ever used cocaine (in their lifetime)	1%	2%	1%	1%	1%	2%	4%	4%
Ever used heroin (in their lifetime)	<1%	2%	0%	0%	1%	1%	2%	2%
Ever used inhalants (in their lifetime)	6%	9%	4%	3%	3%	4%	8%	6%
Ever used ecstasy (also called MDMA in their lifetime)	N/A	2%	2%	1%	1%	1%	N/A	4%
Ever took steroids without a doctor's prescription (in their lifetime)	1%	3%	1%	<1%	1%	2%	N/A	2%
Were offered, sold, or given an illegal drug on school property (in the past 12 months)	6%	5%	5%	4%	5%	7%	15%	22%

N/A – Not Available

**For Ohio and U.S. data, YRBS asks about prescription pain medicine used without a doctor's prescription or differently than how a doctor told them to use it*

Indicates alignment with the Ohio State Health Assessment

Key Issues

The Williams County Health Partners reviewed the 2022 Williams County Health Assessment. The detailed primary data for each individual priority area can be found in the section it corresponds to. Each organization completed an "Identifying Key Issues and Concerns" survey. The following tables were the group results.

What are the most significant health issues or concerns identified in the 2022 health assessment report? Examples of how to interpret the information include: 49% of adults, or 13,705 adults, in Williams County were considered obese, increasing to 50% of those ages 19-64 and 50% of females.

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Youth Mental Health (10 votes)			
Youth who 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 year)	30% (1,017 youth)	Age: 17-19 (37%) Grade: 9th – 12th (34%)	Females (38%)
Youth who had seriously considered attempting suicide (in the past year)	14% (474 youth)	Age: 14-16 (19%)	Females (19%)
Youth who attempted suicide (in the past year)	8% (271 youth)	Age: 14-16 (11%)	Females (10%)
Emergency department admissions with reported suicide ideation or attempt among youth *(CHWC, 2021)*	22 visits	N/A	N/A
Crisis Care & Counseling among adults and youth *(Four County ADAMhs Board, 2021)*	283 visits	N/A	N/A
Number of deaths due to suicide among youth, ages 0-19 *(ODH Vital Statistics, 2018-2020)*	1 death	N/A	N/A

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Adult Weight Status (7 votes)			
Adult obesity (includes severely and morbidly obese, BMI of 30.0 and above)	49% (13,705 adults)	Age: 19-64 (50%)	Females (50%)
Overweight adults (BMI of 25.0 – 29.9)	33% (9,230 adults)	Age: 65+ (38%) Household Income: <$25K (34%)	Males (35%)
Adults who did not participate in any physical activity in the past week	27% (7,552 adults)	N/A	N/A
Adults who reported no leisure-time physical activity in the past month *(BRFSS as compiled by CHR, 2019)*	30% (8,391 adults)	N/A	N/A
Adults who reported consuming 0 servings of fruits per day	17% (4,755 adults)	N/A	N/A
Adults who reported consuming 0 servings of fruits per day	8% (2,238 adults)	N/A	N/A
Youth Weight Status (6 votes)			
Youth obesity	21% (712 youth)	Age: 17+ (24%)	Males (26%)
Overweight youth	15% (508 youth)	Age: <13 (16%)	Females (21%)
Youth who did not participate in at least 60 minutes of physical activity on at least 1 day in the past week	10% (339 youth)	N/A	N/A
Youth who reported consuming 0 servings of fruits per day	11% (373 youth)	N/A	N/A
Youth who reported consuming 0 servings of fruits per day	16% (542 youth)	N/A	N/A

N/A- Not Available

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Adult Mental Health (6 votes)			
Adults who 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 year)	14% (3,916 adults)	Age: 19-64 (13%) Household Income: <$25K (15%)	Females (14%)
Adults who rated their mental health as not good (on 4 or more days in the past month)	27% (7,552 adults)	Age: 19-64 (30%) Household Income: <$25K (43%)	N/A
Adults who seriously considered attempting suicide (in the past year)	5% (1,399 adults)	Age: 19-64 (7%) Household Income: $25K+ (6%)	N/A
Adults who attempted suicide (in the past year)	<1% (<280 adults)	N/A	N/A
Crisis Care & Counseling among adults and youth *(Four County ADAMhs Board, 2021)*	283 visits	N/A	N/A
Number of deaths due to suicide among adults, ages 20 and older, *(ODH Vital Statistics, 2018-2020)*	20 deaths	N/A	N/A
Youth Vaping (5 votes)			
Youth current electronic vapor use (past month)	10% (339 youth)	Age: 17+ (20%)	Females (13%)
Youth Marijuana Use (4 votes)			
Youth current marijuana use (past month)	8% (271 youth)	Age: 17+ (12%) Age: 14-16 (10%)	Females (9%)
Adult ACEs (4 votes)			
Adults who experienced 4+ ACEs	16% (4,475 adults)	Age: 19-64 (16%) Household Income: <$25K (18%)	Females (19%)
Adults who experienced 3+ ACEs	23% (6,433 adults)	N/A	N/A
Youth Alcohol Consumption (3 votes)			
Youth current drinkers (had at least one drink in the past 30 days)	8% (271 youth)	Age: 17+ (17%) Age: 14-16 (9%)	N/A
Youth binge drinkers (defined as consuming more than four [females] or five [males] alcoholic beverages on a single occasion in the past month)	7% (237 youth)	Age: 14-16 (8%) Age: 17+ (16%)	N/A

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Adult Cancer and Cancer Screenings (3 votes)			
Ever diagnosed with cancer	18% (5,035 adults)	N/A	N/A
Cancer deaths per 100,000 (age-adjusted) *(ODH, 2017-2019)*	177 deaths	N/A	Males (22% of all total deaths)
Adults who received the HPV vaccine in their lifetime	12% (3,356 adults)	N/A	N/A
Adults who had a skin cancer screening in the past year	11% (3,077 adults)	N/A	N/A
Adults who had a colorectal cancer screening in the past 5 years	14% (3,916 adults)	N/A	N/A
Adults who had a lung cancer screening in the past 3 years	3% (839 adults)	N/A	N/A
Women ages 40 and older who had a mammogram within the past 2 years	70%	N/A	N/A
Youth ACEs (2 votes)			
Youth who experienced 3+ ACEs	30% (1,017 youth)	Age: 14-16 (36%) Age: 17+ (36%)	Females (37%)
Food Insecurity (2 votes)			
Adults who reported one or more barriers in consuming fruits and vegetables	33% (9,230 adults)	N/A	N/A
Adults who reported "too expensive" as a barrier to consuming fruits and vegetables	22% (6,153 adults)	N/A	N/A
Adults who reported "distance to access" as a barrier to consuming fruits and vegetables	2% (559 adults)	N/A	N/A
Adults who experienced more than one food insecurity issue in the past year	5% (1,399 adults)	N/A	N/A
Youth who went to bed hungry because their family did not have enough money for food on 1 or more days per week	7% (237 youth)	N/A	N/A

N/A- Not Available

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Adult Health Care Access and Utilization (2 votes)			
Adults who did not visit a doctor for a routine checkup (in the past year)	33% (9,230 adults)	Age: 19-64 (34%) Household Income: <$25K (36%)	Males (37%)
Adults who reported they did not receive medical care in the past 12 months due to not having transportation	3% (839 adults)	N/A	N/A
Ratio of population to mental health providers *(HRSA, as compiled by CHR, 2021)*	1,180:1	N/A	N/A
Ratio of population to primary care physicians *(HRSA, as compiled by CHR, 2019)*	2,160:1	N/A	N/A
Adults who usually utilized telemedicine when they were sick or needed advice about their health	<1% (<280 adults)	N/A	N/A
Housing (2 votes)			
Adults who reported 50% or more of their income goes toward housing	11% (3,077 adults)	N/A	N/A
Adults who reported 30-50% of their income goes toward housing	31% (8,671 adults)	N/A	N/A
Transportation (2 votes)			
Adults who reported one or more transportation issues	15% (4,196 adults)	N/A	N/A
No vehicle available *(US Census, 2020 5-yr ACS estimate)*	4.6% (708 adults)	N/A	N/A
Youth Bullying (2 votes)			
Youth who were bullied (in the past year)	42% (1,423 youth)	N/A	N/A
Youth verbally bullied (in the past year)	32% (1,084 youth)	Age: <13 (34%) Age: 14-16 (33%)	Females (39%)
Youth indirectly bullied (in the past year)	22% (746 youth)	Age: 14-16 (25%)	Females (29%)
Youth cyber bullied (in the past year)	13% (441 youth)	Age: 14-16 (14%)	Females (16%)
Youth physically bullied (in the past year)	6% (203 youth)	Age: 14-16 (7%)	N/A
Youth sexually bullied (in the past year)	4% (136 youth)	Age: 14-16 (5%)	Females (7%)

N/A- Not Available

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Adult Alcohol Consumption (2 votes)			
Adults who drank on 3 or more days in the past month	40% (11,188 adults)	Age: 19-64 (41%) Household Income: $25K+ (43%)	Males (46%)
Binge drinkers (defined as consuming more than four [females] or five [males] alcoholic beverages on a single occasion in the past month)	18% (5,035 adults)	N/A	N/A
Adult Health Perceptions (2 votes)			
Adults who rated general health as excellent or very good	41% (11,468 adults)	Age: 65+ (37%) Household Income: <$25K (23%)	Males (37%)
Adults who rated general health as fair or poor	16% (4,475 adults)	Household Income: <$25K (42%)	Males (20%)
Adults who reported that poor mental or physical health kept them from doing usual activities	27% (7,552 adults)	N/A	N/A
Adult Oral Health (2 votes)			
Adults who visited a dentist or dental clinic in the past year	59% (16,502 adults)	Household Income: <$25K (30%)	Males (54%)
Adults without dental insurance coverage (among adults with health care coverage)	30% (8,671 adults)*	N/A	N/A
Adult Prescription Drug Misuse (1 vote)			
Adults who had used drugs not prescribed for them or took more than prescribed to feel good, high, and/or more active or alert (in the past 6 months)	7% (1,958 adults)	Age: 65+ (9%) Household Income: <$25K (10%)	Females (9%)
Adult Vaping (1 vote)			
Adults who used e-cigarettes/vaping products in the past year	3% (839 adults)	N/A	N/A

N/A- Not Available

**Social math estimate includes those without any health care coverage, among the total population*

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Adult Mental Health Care Access (1 vote)			
Did not use a program or service for themselves or a loved one to help with depression, anxiety, or emotional problems due to cost	7% (1,958 adults)	N/A	N/A
Did not use a program or service for themselves or a loved one to help with depression, anxiety, or emotional problems due to co-pay/deductible too high	4% (1,119 adults)	N/A	N/A
Did not use a program or service for themselves or a loved one to help with depression, anxiety, or emotional problems because it took too long to see a doctor	2% (559 adults)	N/A	N/A
Adults without mental health insurance coverage (among those with health insurance)	6% (3,077 adults)*	N/A	N/A
Adults who did not know if they had mental health insurance coverage (among those with health insurance)	46%	N/A	N/A
Prenatal Care (1 vote)			
Had a prenatal appointment within the first 3 months of pregnancy (among those pregnant within the past 5 years)	40%	N/A	N/A
Adult Cardiovascular Health (1 vote)			
Adults who had been diagnosed with high blood pressure (in their lifetime)	41% (11,468 adults)	Age: 65+ (59%) Household Income: <$25K (49%)	Males (46%)
Adults who had been diagnosed with high blood cholesterol (in their lifetime)	37% (10,349 adults)	Age: 65+ (61%) Household Income: <$25K (38%)	N/A

N/A – Not Available
**Social math estimate includes those without any health care coverage, among the total population*

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Women's Health (1 vote)			
Women who had a pap smear in the past year	11%	Age: 40+ (7%) Household Income: $25K+ (10%)	N/A
Women who had a pap smear in the past three years (among women ages 21-65)	58%	N/A	N/A
Adult Quality of Life (1 vote)			
Adults limited in some way because of a physical, mental, or emotional problem	28% (7,832 adults)	Age: 65+ (29%) Household Income: <$25K (54%)	N/A
Adult Asthma (1 vote)			
Adults who had ever been diagnosed with asthma	16% (4,475 adults)	Age: 19-64 (17%) Household Income: <$25K (28%)	Females (19%)

N/A – Not Available

Additional feedback with no specific data/indicators reported:

1 vote:

- Isolationism
- Food banks offering fresh fruits and vegetables
- Chlamydia infection rate among those ages 15-24
- Gas station drugs (Delta 8, Kratom, etc.)
- Treatment program availability
- Bias

Priorities Chosen

Based on the 2022 Williams County Health Assessment, key issues were identified for adults and youth. Overall, there were 26 key issues identified by the Williams County Health Partners. To assist with priority selection, the Williams County Health Partners completed a ranking exercise for the top nine identified key issues via an online platform (SurveyMonkey). The ranking exercise required members of the Williams County Health Partners to give a score for magnitude, seriousness of the consequence, and feasibility of correcting- resulting in an average score for each issue identified. Committee members' rankings were then combined to give an average score for the issue.

The results were compiled and shared with the Williams County Health Partners. The committee then analyzed the results, discussed the options, and voted to come 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. Youth mental health	10
2. Adult weight status	7
3. Youth weight status	6
4. Adult mental health	6
5. Youth vaping	5
6. Youth marijuana use	4
7. Adult ACEs	4
8. Youth alcohol consumption	3
9. Adult cancer	3
10. Youth ACEs	2
11. Food insecurity	2
12. Adult health care access and utilization	2
13. Housing	2
14. Transportation	2
15. Youth bullying	2
16. Adult alcohol consumption	2
17. Adult health perceptions	2
18. Adult oral health	2
19. Adult prescription drug misuse	1
20. Adult vaping	1
21. Adult mental health care access	1
22. Prenatal care	1
23. Adult cardiovascular health	1
24. Women's health	1
25. Adult quality of life	1
26. Adult asthma	1

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

Priority Factor(s):

1) Access to Care
2) Health Behaviors

Priority Health Outcome(s):

1) Mental Health and Addiction

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. Votes are displayed in parentheses if more than one organization identified the same or similar response to the below questions. 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?**
    - Accessibility of services/resources (3)
    - Prevalent, stable mental health (2)
    - Prevalent, stable physical health (2)
    - Social cohesion & interaction/strong relationships (2)
    - Community support/involvement/spirit (2)
    - Parks
    - Healthy foods at grocery stores
    - Affordability of services
    - Housing
    - Collaboration
    - Comprehensive care
    - Emphasis on self-care
    - Prevalent, stable spiritual health
    - Community leadership considering, understanding, & working together to address the most critical needs of the community & then continuing to work together to plan & implement steps to meet those needs
    - Strategic plan that addresses the need for economic security and development
    - Community commitment to preserving the natural resources that sustain its members
    - Strong social safety nets
    - Community where all residents have long-lived lives
    - Community where all residents have the least amount of debilitating health conditions
    - Support programs (mental & physical)
    - Interest in helping each other
    - Prioritize needs over wants
    - Access to free or low cost health services
    - Promotion of health through built environment
    - Feeling safe, secure, & included
    - Opportunities to succeed
    - Nutrition
    - Economic development

2. **What makes you most proud of our community?**
   - Community support/community works well together/community generosity/dedication to each other (4)
   - Green spaces/parks in Bryan (3)
   - Community partnerships/desire to improve & willingness by individuals & groups to work toward improvement (2)
   - Cooperative efforts between different sectors (businesses, schools, churches, government) (2)
   - Rural county
   - Cleanliness
   - Williams County Drug Court – positive outcomes
   - Cultural opportunities – community concert series, community theater, community band
   - Demolishing blight/rehabbing buildings & housing new businesses
   - Resiliency of community
   - Strong history
   - Legacy of innovation
   - Variety of services offered

3. **What are some specific examples of people or groups working together to improve the health and quality of life in our community?**
   - Bryan Area Foundation (3)
   - Educating Communities on Health Opportunities coalition (2)
   - Williams County Drug Court - including community providers in regular meetings to help those struggling with addiction (2)
   - United Way/Hunger Summit (2)
   - Williams County courts working with community mental health providers to address issues
   - WIC program helping new mothers
   - Health Assessment/CHIP
   - Health District
   - Chamber of Commerce
   - Habitat for Humanity
   - Committee to Save our Water
   - Sarah's House
   - Large companies reinvesting in the community financially & promoting health care in their work force (e.g., Spangler's Candy Co & Altenloh Brink)
   - Hospital, Parkview Physicians Group, & health district working together on vaccinations
   - Montpelier Rotary collaboration with Friends of the Park
   - Montpelier's Village Council & Administration
   - Domestic Violence Task Force
   - Older Adults Task Force
   - Housing Committee
   - Transportation Committee
   - Williams County Social Services Network Group
   - Care Coordinators in schools
   - Protecting All Children Task Force (PACT)
   - Active transportation group
   - Suicide prevention coalition
   - Senior center meals
   - Community gardens
   - School lunch programs
   - Summer lunch programs
   - K-6 MyPlate
   - Williams County Department of Aging & Health District partnering for COVID/flu vaccines with transportation provided for older adults
   - Free church meals
   - Job and Family Services
   - English second language classes
   - NAMI
   - Law enforcement
   - Libraries

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?**
    - Improving access to affordable, stable, inclusive, & accessible housing (5)
    - Mental health services (3)
    - Transportation – especially for those disabled, those without cars or who can't drive (3)
    - Mental health support & promotion (3)
    - Insurance coverage – providing financial support to overcome high deductible health plans or limits on coverage (e.g., dental) (2)
    - Addiction/understanding the causes of substance abuse & appropriate treatment (2)
    - Re-establishing/reinforcing community connections
    - Reducing poverty/improving economic stability
    - Resumption/creation of social & recreational activities that encourage people to interact in person with each other
    - Unhealthy choices (nutrition, alcohol, narcotics) leading to unhappy people
    - Appropriate placement/housing of the mentally ill along with psychiatric personnel to diagnose & treat those with mental illness
    - ACEs
    - Access to health care
    - Need to build community around people & less around cars
    - Awareness of activities & affordability
    - Recreation resources
    - Family support (mental health/ACEs, trauma support & prevention)
    - Safer communities

5. **What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?**
    - Lack of resources (3)
    - Funding
    - Politics
    - Lack of support for new programs that may not produce immediate or drastic results
    - Budget to keep up with adequate cost of living based salaries/wages
    - Affordable health care/insurance
    - Lack of emphasis on self-care
    - Apathy/ignorance – most people don't care &/or don't know any better regarding their own health & quality of life
    - "Tunnel vision" – each organization working on its own agenda, unaware of what else is going on in community
    - Reliable/organized transportation
    - Stigma of seeking mental health care
    - Unaware of problems
    - Need for stronger community relationships
    - Not enough trust in health department & other agencies
    - Lack of exposure to other ideas
    - Willingness to look at options that are not common to the area
    - Beyond capacity in tackling mental health – mental health professionals overwhelmed & other organization feeling like they are unable/unqualified to help
    - Missed focus (project NEXT)
    - Lack of unified approach to address health concerns
    - Need for policy/decisions that benefit the whole community
    - Lack of volunteers

6. **What actions, policy, or funding priorities would you support to build a healthier Community**?
    - More opportunities like the Everside Health Clinic that multiple employers can purchase contracts with which would reduce the costs to employees choosing not to go due to high deductibles
    - Recreational venues
    - Social interaction programs (e.g., leagues, clubs, etc.)
    - Economic strategic plan that includes actionable steps to address the need for complete accessibility (i.e., address transportation, housing, etc.)
    - ACEs task force
    - Access to care resources & policies
    - Complete streets
    - Prioritizing planning & better research over actions taken
    - Increased mental health funding to hire additional therapists
    - Collaboration with existing providers to bring in-patient mental health resources to Williams County
    - Creation of low income apartments
    - Transportation solution
    - Contracts for mental health
    - More accurate assessment of community
    - Leadership understanding of health in all policies & health equity
    - Support/access to healthy options in areas with data showing limited opportunities/availability
    - Continued outreach to promote awareness
    - Need for Spanish translators

7. **What would excite you enough to become involved (or more involved) in improving our community?**
    - Seeing positive results both short-term & long-term in the community
    - Seeing that the community cares & participates on identifying local solutions to local problems
    - Explore grant opportunities
    - Grant writing courses for local agencies
    - Using churches as venues for community events
    - Energy/vision of the individual or organization
    - More action items for change
    - Greater consensus that mental health is the root of many of the issues in the county
    - Proper focus
    - Commitment
    - Progress/action in committees
    - Monthly meetings with individual workgroups, followed by quarterly committee meetings
    - Given tasks that creates feeling of responsibility & value
    - Utilization of resource guide & other services

Quality of Life Survey

The Williams County Health Partners urged community members to fill out a short quality of life survey via an online platform (SurveyMonkey) from September to November 2022. There were **384** Williams County community members who completed the survey. This tool will assist the Williams County Health Partners in understanding the overall quality of life in Williams County. The table below incorporates responses from the 2019 Williams County quality of life survey for comparison purposes. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1 was utilized. 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), and the response was not used in averaging response or calculating descriptive statistics.

Quality of Life Questions	Likert Scale Average Response	
	2019 n=528	2022 n=384
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]	3.78	3.61
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.23	3.09
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.92	3.70
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.)	3.49	3.28
5. Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)	3.25	3.09
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?)	3.86	3.75
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?	3.71	3.34
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.52	3.23
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.17	2.88
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.20	2.94
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.21	2.91
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?)	3.21	2.95

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 Williams County Health Partners 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. HCNO categorized the forces of change and their potential impacts based on common themes, which are displayed in the table below:

Force of Change	Threats Posed	Opportunities Created
Mental/Behavioral Health Forces		
1. Increased need for mental health services/shortage of mental health professionals	• Lack of insurance • High deductible health plans • Poor health • People going without help – threat to self, family, community	• Collaboration with local agencies to address common issues regarding mental health • Grant opportunities • Recruiting/retaining qualified mental health professionals
2. Declining mental health (youth)	• Increase in suicide • Increase in mental illnesses • Obesity • Drug use • Distracted kids • Increased ACEs • Declining test scores • Higher turnover in schools	• Mental health outreach/programs • Increase political will among elected officials to take corrective action
3. Increasing alcohol consumption/dependency	• Lack of awareness of habits being harmful • Difficulty with following through to make lasting changes	• Increase in providers being credentialed in chemical/alcohol dependency • Community outreach/education
4. Increasing incidence of amphetamine dependency	• Misuse of prescription medications • Increase of methamphetamine labs in the area	• Educational opportunities for community members • Prescription buybacks to reduce misuse of unused medications • Increased enforcement of reducing the opportunity to purchase items to create meth
5. Introduction of "gas station" drugs	• More youth & adults getting hooked on addictive substances	• Educational opportunities • Support for legislation to ban gas station drugs/substances
General Health Forces		
6. Increasing obesity rates	• Early death • Increase in chronic diseases • Increased hospital visits • Decline in mental health	• Affordable health foods/grocery stores • Health & wellness programs • Affordable gyms • More parks

Force of Change	Threats Posed	Opportunities Created
Development Forces		
7. Unaffordable housing	• Increased homelessness • Increase in mental stress (e.g., depression) • Increase in obesity • Increase in drug use • Unable to afford other necessities (e.g., food, health care) • Inability for people to relocate to Williams County for jobs/growth	• Affordable housing programs • Companies planning to build here
8. Development of Aqua Bounty in Pioneer	• None noted	• Save our Water Committee (bringing facts to the public)
9. Lack of public transportation	• Inability to meet needs for those without cars (i.e., unable to get to appointments, attend social events, buy groceries, etc.)	• Volunteer transportation service similar to Meal on Wheels • Grants to cover gasoline
Employment and Occupation Forces		
10. Inability to fill jobs in all sectors	• Businesses are closing early • Increase in mental health needs of the population but lower mental health workforce • Nursing homes consolidating (ties back into elderly population issues) • Local grocery stores now only located in Montpelier, Bryan, & Edgerton, Pioneer just opened a meat store • Loss of businesses or businesses forced to move	• Work on building social capital in community to attract employees to area (activities for after work, not just job improvement) • Jobs are available in the area to attract new residents • Grants available to attract mental health workers to area through financial assistance • Businesses could work to improve sponsorship process for immigrants • Improve work environment within jobs to help meet needs of employees to attract & retain employees • Educate youth about opportunities in the area & connect with a career path (ex. Montpelier E3 program)
11. Work type – factory & medical/health	• Hard on the body/long day • Stressful • Low pay • Lack of family/volunteer/community time	• Political • WEDCO to focus on other type of work • Higher pay

Force of Change	Threats Posed	Opportunities Created
Demographic Forces		
12. Aging/declining population	• Revenue would decrease for providers in community because of the pay differential between private insurance & Medicare • Increased demand on health care system • Loss of workforce • Not enough housing that might be affordable to the aging population • Transportation difficulty getting home from appointments, food, etc. • Increased population that may have difficulty navigating new technology	• Open positions to bring population this direction • Older people are more likely to stay within the county • Work on retaining current residents & attracting new residents • Opportunity for political awareness (reimbursement for insurance systems, etc.) • Increased population available for volunteering opportunities
Social and Cultural Forces		
13. Loss of pride in community/assets	• Increased vandalism • Reduced home maintenance • High rental turn-over	• Increasing enforcement of ordinances • Increased political will among elected officials to take corrective action
14. Emerging technology/addiction to screens/increase of misinformation	• Loss of communication & social skills • People can't get jobs because they lack social skills • Difficulty finding school programs that teach social emotional skills that all caregivers approve & that is not overwhelming for school staff • Society reinforces use of technology & tech skills are required to be successful & those who do not use technology are penalized • Increased isolation • Bullying, sexting, sex trafficking online & parents unaware • Opinions are shared as facts & spread quickly • Discord & distrust in the community from misinformation	• Improving critical thinking & technology skills for population lacking skillset • Ability to learn skills that allow you to compete • Increased awareness & access of resources without transportation barriers (ex. Mental health services, etc.) • Review policies in schools & local facilities to limit cell-phone use when needed • Campaigns to combat misinformation • Agencies (public & private sector) collaborate to share reliable information & offer support & resources for others to increase buy-in & understanding • Improve health department messaging based on best practices

Force of Change	Threats Posed	Opportunities Created
Social and Cultural Forces (continued)		
15. Breakdown of families	• Increased ACEs • Expectation of schools to take on greater responsibility & limited reinforcement at home • Lack of family connectiveness & support • Generational/cycle of trauma	• FAST programming • Promoting & increasing the Parent Cafes offered by Maumee Valley Guidance Center
16. Lack of religious affiliation/participation	• Limited programming for the whole family • Children not equipped or adapted to learning environment • Churches closing, resulting in loss of social services for community	• None noted
17. Organizational participation/cohesion	• Fewer participants volunteering or participating in organizational clubs/groups & lack of cohesion in the county	• Employers could offer modified work hours to allow employees time to be part of the community
18. Lack of awareness among leadership about benefits of being involved in groups	• Lack of participation of decision makers & reduced cohesion	• None noted
19. Repeat offenders	• Resources spent again & again • Community safety compromised • Spreads to others & family neighbors	• Reevaluate court programs & other programs • Education • New programs for the whole community
Health Care Access Forces		
20. Loss of dental/medical facilities	• Limited access to dental with Medicaid/Medicare • Reduced access for aging population • Increased barriers for accessing medical care in different areas of the county	• Political awareness/grants • Possible mobile dental/medical bus much like the blood mobile to travel needed areas for set number of days every quarter or so for treatments
Local Public Health System Forces		
21. Silo effect	• Agencies are not able to accomplish community change as single entities	• Resource guides available to show what is available in the county & how to get involved

Force of Change	Threats Posed	Opportunities Created
Political Forces		
22. Changes in politics/women's health care	• Some lower-income, ethnically diverse groups are at higher risk of dying for pregnancy -related reasons or infancy compared to middle & upper income, white groups • One study (Duke University) estimates total abortion ban in US would increase the # of pregnancy related deaths by 21% for ALL women & 33% among Black women. If Ohio court ban abortion, WMS county could face the possibility of increased single family home (death of the mother due to ectopic pregnancy or other untreated risk), increased mental health issues, increase in poverty, increase in children in the foster system, increase need for resources. • Infant mortality rate for some minority groups (Black & Native Hawaiian or Pacific Islander) is twice as high as White infants (10.8 & 9.4 per 1,000. Indigenous infants' mortality rate vs White infants is 8.2 vs 4.6 per 1,000) • Clinics providing abortions (Planned Parenthood) are located in lower income neighborhoods & are the main source for community members to have access to birth control, sex education, HIV Testing & counseling, STI testing & treatment as well as gynecological exams, emergency contraception, cervical cancer diagnosis & treatment, adoption referrals, pregnancy care, annual wellness exams, HPV Vaccination, UTI & vaginal infection diagnosis & treatment, menopause services, male health services, referrals for specialized care. • Access to care is at risk. Traveling more than 30 minutes for wellness exams, etc. is a burden on those without reliable transportation.	• Health care providers have the opportunity to provide all of those necessary services in the areas that have become 'health-care deserts' for millions of lower income citizens. • In this county, there is the opportunity to develop a more robust campaign for women's health & wellness.

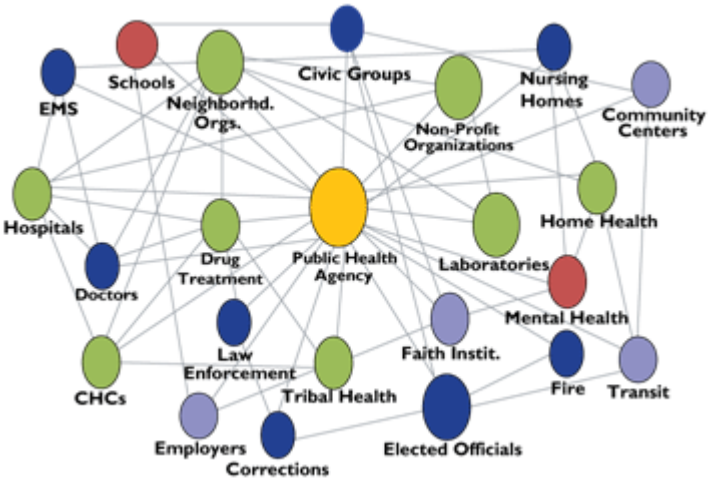
Local Public Health System Assessment

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 National Public Health Performance Standards (NPHPS) instruments.

Public health systems should:

1. Assess and monitor population health status, factors that influence health, and community needs and assets
2. Investigate, diagnose, and address health problems and hazards affecting the population
3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it
4. Strengthen, support, and mobilize communities and partnerships to improve health
5. Create, champion, and implement policies, plans, and laws that impact health
6. Utilize legal and regulatory actions designed to improve and protect the public's health
7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy
8. Build and support a diverse and skilled public health workforce
9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement
10. Build and maintain a strong organizational infrastructure for public health

(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 (ES) being provided to our community?"

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

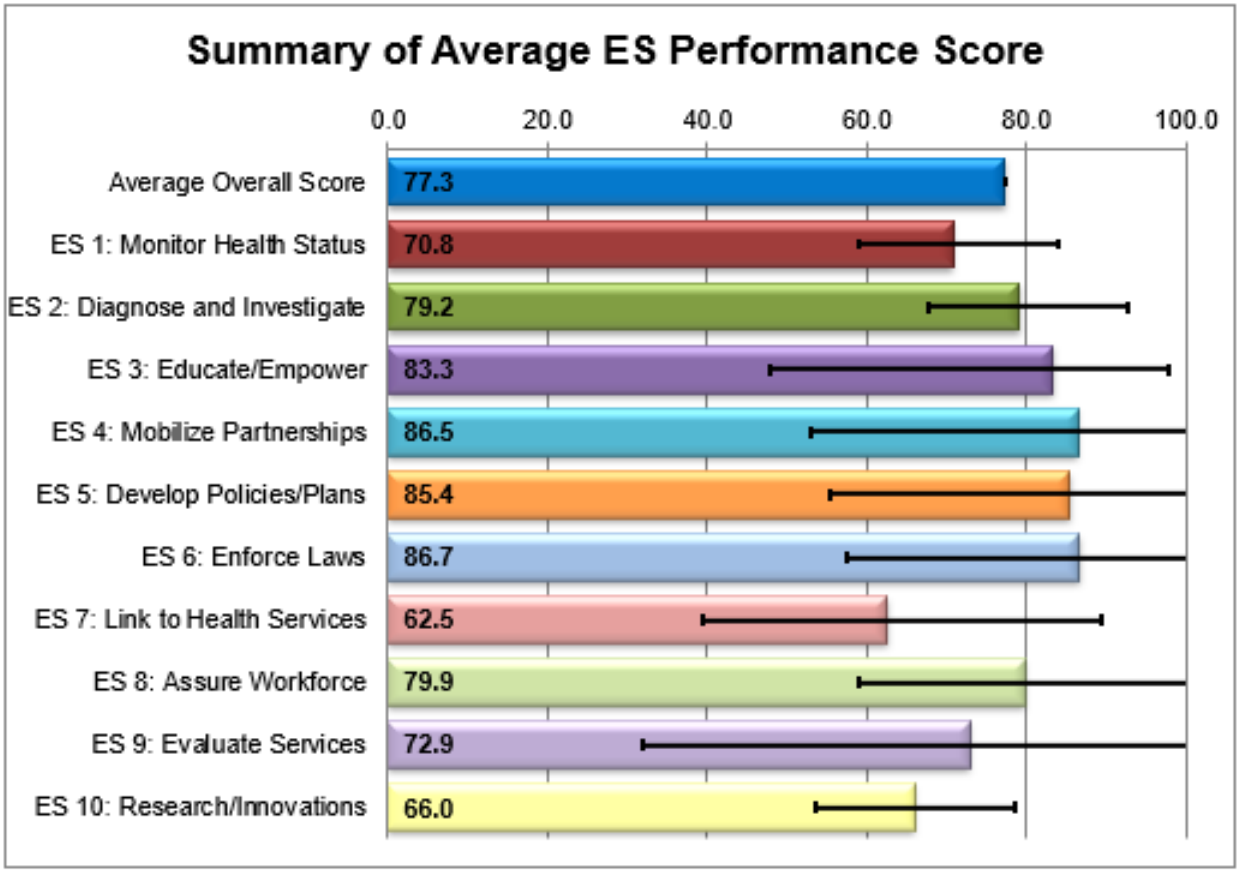
Members of the Williams County Health District completed the performance measures instrument. The LPHSA results were then presented to the Williams County Health Partners for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model 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 1 indicator that had a status of "minimal" and no indicators 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 2022 Summary



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

Gap Analysis, Built Environment, and Strategic Planning Terminology

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 Williams County Health Partners 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 Williams County Health Partners 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.

Evidence-Based Practices

As part of the gap analysis and strategy selection, the Williams County Health Partners 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.

Built Environment

Built environment includes the human-made design and layout of the communities in which people live, work and play. It includes but is not limited to the following: neighborhoods, homes, workplaces, schools, shops and services, sidewalks and bike paths, streets and transportation, green spaces and parks, food systems, and buildings and other infrastructure.

Healthy communities can help create environments that give everyone opportunities for all people to thrive and live their lives to the fullest. They have the potential to make the healthy choice the easier choice for residents. A healthy built environment can:

- Promote being active, eating healthy and other healthy habits;
- Encourage social connectedness;
- Prevent injuries and promote safety;
- Improve air, water and soil quality;
- Provide access to natural and green spaces;
- Ensure all members of the community have good opportunities to be healthy regardless of their age, physical ability, income level, gender, ethnic background, or any other social or economic reasons.

Recognizing that the physical world can lead to better or worse health outcomes, the Williams County Health Partners have emphasized built environment throughout their strategies where feasible.

Resource Inventory

Based on the chosen priorities, the Williams County Health Partners 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. Each resource inventory can be found with its corresponding strategy.

Further information about community resources in Williams County can be found by contacting United Way of Williams County by phone 419-636-8603 or visiting their **website**. Additional resources can be found by visiting Northwestern Ohio Community Action Commission's **website**.

Strategic Planning Terminology

Action Steps: specific steps that need to be taken to meet the objective(s)
Timeline: timeframe within activities will take place
Priority Population: population the strategy focuses on, with emphasis on specific populations at higher risk or impact (based on Key Issues)
Indicators: specific metric(s) used to measure long term progress and success of the strategy
Lead Contact/Agency: who will be responsible for ensuring the objective is met?
Strategy identified as likely to decrease disparities: Strategy has been rated by **What Works for Health** as "likely to decrease disparities" and/or recommended by the Community Guide as effective strategies for achieving health equity. These sources consider potential impact on disparities and inequities by racial/ethnic, socio-economic, geographic, or other characteristics.
Strategy identified as likely to impact built environment: Strategy has been rated by the Williams County Health Partners to impact built environment based on definition and criteria described on previous page. Strategies fitting this criteria are marked with a icon throughout the CHIP.
Evidence Rating: strategy has been rated by **What Works for Health** based on the amount, type, and quality of evidence available regarding strategy

Priority #1: Access to Care

Strategic Plan of Action

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

<table>
<tr><th colspan="5">Priority #1: Access to Care</th></tr>
<tr><th colspan="5">Strategy 1: Transit advocacy</th></tr>
<tr><th>Action Step</th><th>Timeline</th><th>Priority Population</th><th>Indicator(s) to measure impact of strategy:</th><th>Lead Contact/Agency</th></tr>
<tr><td>Year 1: Ensure representation from the Williams County Health Partners on Maumee Valley Planning Organization's transportation committee.

Advocate and assist in initiatives that improve access to care and other essential services in the county.

Assist Maumee Valley Planning Organization to improve and expand transportation services in Williams County by doing the following:
Raising public awareness of current transportation services available in the county
Researching and applying for grants
Garnering stakeholder support in the county
Assisting with implementation and expansion of transportation services in Williams County</td><td>December 31, 2023</td><td rowspan="3">Adults</td><td rowspan="3">Transportation issues:
Percent of adults reporting 1 or more transportation issues (CHA)</td><td rowspan="3">WEDCO</td></tr>
<tr><td>Year 2: Continue efforts from year 1.</td><td>December 31, 2024</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2.</td><td>December 31, 2025</td></tr>
<tr><td colspan="5">Strategy identified as likely to decrease disparities?
○ Yes ○ No ⊗ Not SHIP Identified</td></tr>
<tr><td colspan="5">Resources to address strategy:
Maumee Valley Planning Organization (MVPO)</td></tr>
</table>

Priority #1: Access to Care				
Strategy 2: Access to care initiatives				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collect baseline data from providers and community members to identify gaps and barriers for accessing mental health, behavioral, and healthcare services in Williams County. Host focus groups, listening sessions, and/or surveys to identify barriers to care. Develop a report that reviews the access to care barriers.	December 31, 2023	Adults and youth	Access & Utilization: Percent of Williams County adults who visited a doctor for a routine checkup in the past year (CHA) Mental Health: Percent of Williams County adults who had used a program or service for themselves or a loved one to help with depression, anxiety, or emotional problems (CHA)	Parkview Physicians Group Four County Alcohol, Drug, Addiction, and Mental Health Services Board
Year 2: Review the report and data collected in year 1. Prioritize the barriers to access mental health and healthcare services and determine which barriers are feasible to address as a coalition. Develop an action plan to address the barriers selected. Gather feedback from the public on the action plan and/or strategies selected to address the barriers.	December 31, 2024			
Year 3: Continue efforts from year 1 & 2. Implement at least one strategy. Evaluate the results.	December 31, 2025			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: Williams County Health Department, Everside Health Clinic, Four County Suicide Prevention Coalition, Maumee Valley Guidance Center, Bryan Community Health Center, Ohio Guidestone				

Priority #1: Access to Care				
Strategy 3: Cancer education outreach				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collect baseline data on cancer prevention education/screening efforts that are currently being offered in the county. Update community resource guide to reflect all organizations providing free or reduced cost health care services. Include information on what accounts for preventive care, what does insurance cover, and different screening guidelines. Work with local health systems to retrieve data from electronic health records and other data bases to identify gaps in cancer screenings, such as: • Type of cancer screening(s) with lower rates of patient adherence • Populations/demographics (e.g., sex, race, geographic location, age, etc.) with lower rates of cancer screenings • Types of cancer diagnoses identified more common at later stages • Etc.	December 31, 2023	Adults	Breast cancer screening: Percent of women ages 40 and older who had a mammogram within the past two years (CHA) Colorectal cancer screening: Percent of adults who had a colorectal cancer screening in the past 5 years (CHA) Lung cancer screening: Percent of adults who had a lung cancer screening in the past 3 years (CHA)	Community Hospitals and Wellness Centers Parkview Physicians Group Williams County Health Department
Year 2: Continue efforts from year 1. Conduct surveys in community to identify root causes for patient non-adherence to recommended cancer screenings. Locate participants at most risk, based on information obtained from electronic health records and geographical data from WCHD. Based on information gathered, identify barriers to receiving recommended cancer screenings (e.g., cost, access, age, education needed, etc.), and determine methods to overcome those barriers to increase cancer screening and early cancer diagnosis.	December 31, 2024			
Year 3: Continue efforts from years 1 and 2. Provide education to Williams County residents on cancer screening guidelines and services available within the community to increase early diagnosis. Identify and target populations most at risk (e.g., uninsured) to eliminate finance and access barriers to screening in order to reduce late-stage diagnoses and improve clinical outcomes.	December 31, 2025			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: Ohio Hospital Association, Cancer Committee, Electronic Health Records				

Priority #2: Health Behaviors & Built Environment

Strategic Plan of Action

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

Priority #2: Health Behaviors & Built Environment				
Strategy 1: Complete Streets *				
Action Step	Timeline	Priority Population	Indicator (s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Ensure representation from the Williams County Health Partners in Maumee Valley Planning Organization's active transportation plan initiatives.	December 31, 2023	Adults (specifically females, age 65+, household Income:<$25K) Youth (specifically males, age <16, grade 6-8)	Adult physical inactivity: Percent of adults reporting no physical activity in the past week (CHA) Adult physical activity: Percent of adults reporting no leisure-time physical activity in the past month (BRFSS as compiled by CHR) Youth physical inactivity: Percent of youth who did not participate in at least 60 minutes of physical activity on at least 1 day in the past week (CHA)	Village of Montpelier Williams County Health Department
Year 2: Continue efforts from year 1 and advocate for Complete Streets with local policymakers/leadership to build buy-in. Review potential grants and funding opportunities. Continue to raise awareness of Complete Streets policies and recommend that all local jurisdictions adopt comprehensive Complete Streets policies. Partner with Maumee Valley Planning Organization and the active transportation group for resources and support.	December 31, 2024			
Year 3: Continue efforts from years 1 and 2. Communicate and market Complete Streets policies 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, 2025			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Active Transportation Committee, Maumee Valley Planning Organization, Smart Growth America				

** Strategy is scientifically supported. Strategies with this rating are most likely to make a difference. These strategies have been tested in many robust studies with consistently positive results.*

- Strategy has been rated by the Williams County Health Partners to impact built environment

Priority #2: Health Behaviors & Built Environment				
Strategy 2: Green space and parks/bike and pedestrian master plans *				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Ensure representation from the Williams County Health Partners in Maumee Valley Planning Organization's active transportation plan initiatives. Advocate and assist in initiatives that improve access to **green spaces**, parks, and other active transportation opportunities. Assist Maumee Valley Planning Organization by doing the following: • Collaborating with local partners to advertise local parks, playgrounds, trails, walking paths, and other green spaces available in Williams County • Recruiting additional partners to assist with GIS mapping, website development, and other technology needs • Creating a publicly available guide that includes mapping of local trails to inform residents and visitors of trails in the county • Collaborating with local partners to create a bike and pedestrian master plan • Advocating for bike and pedestrian plans to local policy makers and/or jurisdictions	December 31, 2023	Adults (specifically females, age 65, household income <$25K) Youth (specifically males, age <16, grade 6-8)	Adult physical inactivity: Percent of adults reporting no physical activity in the past week (CHA) Adult physical activity: Percent of adults reporting no leisure-time physical activity in the past month (BRFSS as compiled by CHR) Youth physical inactivity: Percent of youth who did not participate in at least 60 minutes of physical activity on at least 1 day in the past week (CHA)	Williams County Engineer's Office
Year 2: Continue efforts from year 1. Create a county-wide strategy and build buy-in.	December 31, 2024			
Year 3: Continue efforts from years 1 and year 2.	December 31, 2025			
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: Maumee Valley Planning Organization, Active Transportation Committee, City & Village Administrators, Parks & Rec				

** Strategy is noted to have some evidence.* Strategies with this rating are likely to work, but further research is needed to confirm effects. These strategies have been tested more than once and results trend positive overall.

- Strategy has been rated by the Williams County Health Partners to impact built environment

Priority #2: Health Behaviors & Built Environment				
Strategy 3: Community fitness programs *				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Obtain baseline data on community fitness programs and activities currently being offered in the county. Include organized physical activities in the county as well as events (e.g., races), and if they offer a child or family component. Assess how many schools, churches, businesses and other organizations currently offer shared use of their facilities (gym, track, etc.). Create a publicly available guide that includes an inventory and calendar of programs to promote awareness. Ensure that guide is regularly updated. Research **community fitness programs**. When selecting programs, consider interests and activities for specific populations, such as seniors or families. Explore programming that includes group sports as well as individual fitness opportunities (e.g., weightlifting, running club, etc.). Assess the feasibility of integrating physical activity opportunities into planned events (e.g., festivals, farmer's markets, etc.).	December 31, 2023	Adults (specifically females, age 65+, household income <$25K) Youth (specifically males, age <16, grade 6-8)	Adult physical inactivity: Percent of adults reporting no physical activity in the past week (CHA) Adult physical activity: Percent of adults reporting no leisure-time physical activity in the past month (BRFSS as compiled by CHR) Youth physical inactivity: Percent of youth who did not participate in at least 60 minutes of physical activity on at least 1 day in the past week (CHA)	WEDCO
Year 2: Continue to update inventory and raise awareness of physical activity opportunities in the county. Partner with schools, churches, businesses, and other organizations to establish a shared use agreement for a new site that allows the public to use their facilities for indoor recreation.	December 31, 2024			
Year 3: Continue efforts from year 2. Identify potential community fitness programs to implement.	December 31, 2025			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Williams County Chambers of Commerce, Williams County Health District, Active Transportation Committee, libraries, schools, churches, local businesses, Parks & Rec				

** Strategy is scientifically supported. Strategies with this rating are most likely to make a difference. These strategies have been tested in many robust studies with consistently positive results.*

Priority #2: Health Behaviors & Built Environment				
Strategy 4: Community gardens *				
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. Determine need for additional community gardens and to secure volunteers and Master Gardeners.	December 31, 2023	Adults (specifically females, age 19-64, household income <$25K) Youth (specifically males, age 4-16, grade 6-8)	Adult fruit consumption: Percent of adults who report consuming 0 servings of fruits per day (CHA) Adult vegetable consumption: Percent of adults who report consuming 0 servings of vegetables per day (CHA) Youth fruit consumption: Percent of youth who report consuming 0 servings of fruits per day (CHA) Youth vegetable consumption: Percent of youth who report consuming 0 servings of fruits per day (CHA)	Williams County Community Gardening Association OSU Extension
Year 2: Identify specific demographic need for community gardens. Research grants and funding opportunities to increase the number of community gardens. Start 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.	December 31, 2024			
Year 3: Continue efforts from year 2. Market current and future community gardens within the county (i.e. location, offerings, etc.). Update the marketing information on an annual basis. Explore partnership opportunities to educate community members and families on gardening and healthy eating practices.	December 31, 2025			

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy:

United Way Hunger Summit, food pantries, schools, churches

** Strategy is noted to have some evidence.* Strategies with this rating are likely to work, but further research is needed to confirm effects. These strategies have been tested more than once and results trend positive overall.

- Strategy has been rated by the Williams County Health Partners to impact built environment

Priority #2: Health Behaviors & Built Environment				
Strategy 5: Healthy food initiatives and nutrition education				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to raise awareness of the available food pantries and farmers markets within the county (locations, offerings, etc.). Distribute information on where to obtain fresh fruit and vegetables. Encourage local **food pantries** to offer more fresh, healthy food (vs shelf stable foods). Partner with local agencies to promote and offer healthy cooking classes at food pantries. Continue to offer, and consider expanding, the following programs at food pantries and farmer's markets: • Cooking demonstrations/classes • Recipe tastings • Nutrition, diabetes and other health education classes	December 31, 2023	Adults Gender: Female Age: 19-64 Household Income: <$25K Youth Gender: Male Age: 14-16 Grade: 6-8	Adult fruit consumption: Percent of adults who report consuming 0 servings of fruits per day (CHA) Adult vegetable consumption: Percent of adults who report consuming 0 servings of fruits per day (CHA) Youth fruit consumption: Percent of youth who report consuming 0 servings of fruits per day (CHA) Youth vegetable consumption: Percent of youth who report consuming 0 servings of fruits per day (CHA)	OSU Extension
Year 2: Continue efforts from year 1. Assess nutrition education programming offered in schools, and consider implementing additional **school-based nutrition education programs**. Assess nutrition education programming offered at food pantries and consider expanding **healthy food initiatives in food banks**. Assess nutrition education programming offered at **farmers markets** and consider expanding.	December 31, 2024			
Year 3: Continue efforts from years 1 and 2.	December 31, 2025			
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: Williams County Health District, schools, farmers markets, food pantries				

Priority #2: Health Behaviors & Built Environment				
Strategy 6: Health in all policies **				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research how other counties/cities have implemented **health in all policies** initiatives. Educate local partners and community agencies on its importance. Recruit local partners and community agencies to form an interagency taskforce to advocate for health in all policies initiatives.	December 31, 2023	Adults and youth	General health status: Percent of adults who rated their health status as excellent or very good (CHA) Poor health: Percent of adults who reported that poor mental or physical health kept them from doing usual activities (CHA)	Williams County Health Department Village of Montpelier
Year 2: Continue efforts from year 1. Have the health in all policies task force advocate to local government officials for health in all policies resolution.	December 31, 2024			
Year 3: Continue efforts from years 1 and 2. Working with the health in all policies Task Force, develop a health in all policies resolution county-wide. Work to adopt a county-wide health in all policies resolution.	December 31, 2025			
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: National Association of County and City Health Officials, Public Health Institute				

Strategy is identified as a policy-related strategy aimed at addressing the causes of health inequities based on **CDC and other **supporting articles**

- *Strategy has been rated by the Williams County Health Partners to impact built environment*

Priority #3: Mental Health and Addiction

Strategic Plan of Action

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

<table>
<tr><td colspan="5">Priority #3: Mental Health and Addiction</td></tr>
<tr><td colspan="5">Strategy 1: School-based alcohol/other drug prevention programs</td></tr>
<tr><td>Action Step</td><td>Timeline</td><td>Priority Population</td><td>Indicator(s) to measure impact of strategy:</td><td>Lead Contact/Agency</td></tr>
<tr><td>Year 1: Continue to promote and implement the Too Good For Drugs and other programming (CATCH My Breath, etc.) program in Williams County schools.

If applicable, expand current programming to all school districts or grade levels. Identify other agencies that serve youth to expand programming. Incorporate aspects that involve parent/guardian engagement into programming.</td><td>December 31, 2023</td><td rowspan="3">Youth</td><td rowspan="3">Youth alcohol use: Percent of high school students who have used alcohol in the past month (CHA)

Youth marijuana use: Percent of high schools students who have used marijuana in the past month (CHA)

Youth electronic vapor use: Percent of youth who used electronic vapor products in the past month (CHA)</td><td rowspan="3">Recovery Services of Northwest Ohio</td></tr>
<tr><td>Year 2: Continue efforts from year 1.

Expand program service area where necessary.

Create and disseminate supporting educational materials for parents and families (ex. presentations for parents, packets, parent cafes, ECHO Coalition operation parents handbooks, truth initiative, etc.).</td><td>December 31, 2024</td></tr>
<tr><td>Year 3: Continue efforts of years 1 and 2.</td><td>December 31, 2025</td></tr>
<tr><td colspan="5">Strategy identified as likely to decrease disparities?
○ Yes ⊗ No ○ Not SHIP Identified</td></tr>
<tr><td colspan="5">Resources to address strategy:
Maumee Valley Guidance Center, ECHO Coalition, Four County ADAMhs Board</td></tr>
</table>

Priority #3: Mental Health and Addiction				
Strategy 2: School-based social and emotional instruction *				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Assess current social and emotional instruction being implemented in schools. Work with school social workers, care coordinators, and counselors to identify: • Types of programming currently being offered in different schools and grades • How often programming is incorporated • Admin/teacher satisfaction with current programming • Capacity and barriers to implementing social and emotional instruction Gather feedback from school administration and teachers regarding current programming and interest or need in additional/new social and emotional instruction programming. Collect information from schools regarding admin approval, selection of SEL program, teacher buy-in, capacity to train staff, etc. Explore evidence-based prevention programs such as the **PAX Good Behavior Game, ROX (Ruling Our Experience), Sources of Strength,** or **Steps to Respect**. Considering feedback from schools, decide which program(s) to implement or expand within schools.	December 31, 2023	Youth	Youth bullying: Percent of youth who had been bullied in the past year (CHA) Youth depression: Percent of youth who felt 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 (CHA)	Northwest Ohio Educational Service Center
Year 2: Determine the types of programming offered in schools and grades and teacher/administration satisfaction with programming. Introduce or reintroduce the evidence based program(s) to the school districts. Train staff to implement programming. Pilot any new programs in at least one district.	December 31, 2024			
Year 3: Expand programming to all districts in all grade levels.	December 31, 2025			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: School social workers, care coordinators, & counselors; school administration & teachers				

** Strategy is scientifically supported. Strategies with this rating are most likely to make a difference. These strategies have been tested in many robust studies with consistently positive results.*

Priority #3: Mental Health and Addiction				
Strategy 3: Mental Health First Aid *				
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 manufacturing entities, law enforcement, court, etc. 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.	December 31, 2023	Adults (specifically males) Youth (specifically females, age 14-16)	Adult and youth depression: Individuals who felt sad or hopeless almost every day for 2 or more week in a row in the past year that they stopped doing some usual activities in the past year (CHA) Adult suicide deaths: Number of deaths due to suicide among adults, ages 18 and older, per 100,000 population (ODH Vital Statistics) Youth mental health support: Percent of youth who were very likely to seek help if they were feeling depressed or suicidal (CHA)	Maumee Valley Guidance Center
Year 2: Continue efforts from year 1. Provide at least three additional trainings and continue marketing the training.	December 31, 2024			
Year 3: Continue efforts from years 1 and 2.	December 31, 2025			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Four County ADAMhs Board, NAMI, United Way, Four County Suicide Prevention Coalition				

** Strategy is noted to have some evidence.* Strategies with this rating are likely to work, but further research is needed to confirm effects. These strategies have been tested more than once and results trend positive overall.

Priority #3: Mental Health and Addiction				
Strategy 4: Suicide prevention initiatives				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Obtain baseline data on current mental health/suicide programming and resources available in the county. Identify gaps in populations that are at higher risk of suicide. Using the **CDC Suicide Prevention Guide**, identify approaches that focus on high risk populations. Identify one new approach to implement.	December 31, 2023	Adults Youth (specifically females, age 14-16)	Adult suicide deaths: Number of deaths due to suicide among adults, ages 18 and older, per 100,000 population (ODH Vital Statistics) Youth suicide contemplation: Percent of youth who considered attempting suicide in the past year (CHA)	Four County Suicide Prevention Coalition
Year 2: Continue efforts from year 1. Identify settings/populations to expand programming (ex. firearm community).	December 31, 2024			
Year 3: Continue efforts from years 1 and 2. Evaluate programming.	December 31, 2025			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: Four County ADAMhs Board, 4YourMentalHealth Campaign, Maumee Valley Guidance Center				

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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Health Commissioner
Williams County Combined Health District
419-485-3141 Ext.122
E-mail: **jim.watkins@williamscountyhealth.org**

Appendix I: Gaps and Strategies

The following tables indicate priority related gaps and potential strategies that were identified by the Williams County Health Partners. The Partners identified gaps and potential strategies via an online platform (SurveyMonkey). The results were compiled and presented to the committee. Additional gaps and potential strategies were identified and incorporated.

Note: parentheses indicate the number of organizations who reported the same or similar gaps/potential strategies

Priority Factor: Access to Care

Priority #1: Access to Care (focus: adult/youth access to mental & medical care, cancer screening)	
Gaps	**Potential Strategies**
1. Transportation (3)	• Rural transportation services: establish transportation services for areas with low population densities using publicly funded buses and vans on a set schedule, or Dial-a-ride transit (3) W √ • Carpool/rideshare programs: volunteer ridesharing (similar to ACS's Road to Recovery) (2) W • County-wide public transportation services W √ • Vouchers for local cab services for those ineligible for Medicaid
2. Access to mental health care (2)	• Telemental health services (2) W √ • Behavioral health primary care integration W √
3. Youth mental health care unmet need/lack of resources (2)	• Integration of behavioral health services into primary care W √ • Telemental health services W √ • School-Based Cognitive and Behavioral Therapy, including both targeted and universal approaches • Coordinated care for behavioral health conditions • Increase the number of quality school-based mental health providers
4. Uninsured population (2)	• Providing ongoing health insurance enrollment outreach and support to people without access to employer-sponsored insurance coverage (2) W √ • Insurance enrollment assistance for adults and children W √
5. Lack of providers/appointment unavailability (2)	• Health career recruitment for minority students W √ • Telemedicine W √ • Integration of behavioral health services into primary care W √ • Chronic disease management programs W • Regional cooperative efforts to refer patients to other providers more accessible within the region

= Ohio SHIP supported strategy
W = Strategy from County Health Ranking's What Works for Health Tool
√ = Strategy is likely to reduce disparities, according to Ohio SHIP or County Health Rankings

Priority #1: Access to Care (focus: adult/youth access to mental & medical care, cancer screening)	
Gaps	**Potential Strategies**
6. Cancer screenings (2)	• Patient financial incentives for preventive care W √ • Multicomponent cancer interventions C • Screening recommendations * • Health care bus • Education for cancer prevention and risk reduction (tobacco cessation, skin protection, lifestyle choices)
7. Shortage of mental health professionals	• Financial incentives to recruit and retain mental health professionals in underserved areas W √
8. Adults receiving a routine checkup in the past year	• Expand telehealth (2) W √ • Insurance enrollment assistance W √
9. Access to medical care	• School-based health centers W √ • Health literacy interventions W √ • Paid sick leave laws (within employment) W √ • Cultural competence training for health care professionals W √
10. High deductible health plans & health plans that do not include mental health coverage	• Increased grants to local providers to help pay for mental health services and offer broader range of sliding fee scales
11. Lack of regular dental visits	• Education on the importance of regular dental visits (how oral health affects physical health)

= Ohio SHIP supported strategy
C = Strategy from the CDC's Community Guide
W = Strategy from County Health Ranking's What Works for Health Tool
* = Aligned with previous Williams County CHIP
√ = Strategy is likely to reduce disparities, according to Ohio SHIP or County Health Rankings

Priority Factor: Health Behaviors

Priority #2: Health Behaviors & Built Environment (focus: adult/youth nutrition & food insecurity, physical activity)	
Gaps	**Potential Strategies**
1. Opportunities for physical activity/active living (7)	• Community fitness programs (4) W • Complete streets (3) W * • Social support for physical activity interventions in community settings (3) W • Community-wide physical activity campaigns (3) W • Green spaces and parks W √ * • Exercise prescriptions from health care providers W * • Worksite obesity prevention interventions W • Multi-component workplace supports for active commuting W • Individually-adapted physical activity programs W • Activity programs for older adults (e.g., Silver Sneakers) W • Places for physical activity W • Vouchers for fitness classes

= Ohio SHIP supported strategy
W = Strategy from County Health Ranking's What Works for Health Tool
* = Aligned with previous Williams County CHIP
√ = Strategy is likely to reduce disparities, according to Ohio SHIP or County Health Rankings

Priority #2: Health Behaviors & Built Environment (focus: adult/youth nutrition & food insecurity, physical activity)	
Gaps	**Potential Strategies**
2. Access to nutritious foods (6)	• Healthy food initiatives in food banks (3) W √ * • Utilization of gardens/community gardens (3) W * • Healthy food in convenience stores W √ • Fruit & vegetable incentive programs W √ • Farmers markets W • Fruit and vegetable taste testing W • Healthy food retailers * • Mobile produce markets: partnering with Toledo Food Bank to reinstate traveling food bank to Williams County, offering fresh produce and meats W √ • Good Food Here policies (Ohio Food & Beverage Guidelines Toolkit) adopted and implemented in community settings • Food insecurity screenings at medical appointments • Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) • Healthy foods at community/catered events W • Expansion of waiver programs for low/middle incomes
3. Nutrition education/expanding nutrition education across all demographics (2)	• Expand SNAP-Ed programming to qualifying participants (agency assistance) • Establish new nutrition education programs • Educational billboard/media blitz regarding how to use nutrition labeling to make better food choices, including sodium, sugar, & calories
4. Youth nutrition (2)	• School nutrition standards W √ • School breakfast programs W √ • School-based nutrition education programs (MyPlate) W * • School fruit and vegetable gardens W • Farm to institution programs, including farm-to-school programs W • School fruit and vegetable taste tests W • Healthy meals served at schools

= Ohio SHIP supported strategy
W = Strategy from County Health Ranking's What Works for Health Tool
* = Aligned with previous Williams County CHIP
√ = Strategy is likely to reduce disparities, according to Ohio SHIP or County Health Rankings

Priority #2: Health Behaviors & Built Environment (focus: adult/youth nutrition & food insecurity, physical activity)	
Gaps	**Potential Strategies**
5. Youth physical activity	• Active recess W • Physically active classrooms W • School-based physical education enhancements W • School-based programs to increase physical activity
6. Lack of interest in physical activity/increased screen time	• Earn to learn opportunities (fitness rewards for progress for community members)
7. Preparing healthy food at home vs fast/convenient food	• Explore grant-based programs for low cost healthy fast food restaurants/food trucks

= Ohio SHIP supported strategy
W = Strategy from County Health Ranking's What Works for Health Tool
√ = Strategy is likely to reduce disparities, according to Ohio SHIP or County Health Rankings

Priority Outcome: Mental Health and Addiction

Priority #3: Mental Health & Addiction (focus: adult/youth mental health; youth bullying; youth vaping, alcohol, & marijuana use; adult alcohol and drug use)	
Gaps	**Potential Strategies**
1. Social isolation/cohesion (4)	• Trauma-informed approaches to community building W √ • Intergenerational communities W • Socialization opportunities that exclude substance/alcohol use (sober coffee bar/club with separate designated times for minors and adults) • Extracurricular engagement activities for social engagement • Educational billboard/media blitz regarding the benefits of personal interactions
2. Adult mental health/depression (4)	• Mental Health First Aid courses for community members, first responders, and others (2) W √ * • Mental health benefits legislation, along with monitoring for implementation and compliance W √ • Integration of behavioral health services into primary care W √ • Chronic disease management programs W • Motivational interviewing training for those who may be trusted resources for people with mental health challenges, such as clinicians, providers, case managers, & community health workers • Comparable insurance coverage for behavioral health (parity) • Education to decrease stigma to encourage seeking treatment options
3. Youth mental health/depression (2)	• School-based social and emotional instruction (2) W • Sources of Strength (2) * • School-based violence & bullying prevention programs W • Parenting programs • Coordinated care for behavioral health • Continue evidence-based programs
4. Adult alcohol consumption (2)	• Alcohol screening and brief intervention with motivational interviewing techniques & training for providers (2) W • Media campaigns • Increase price
5. Adult drug use/drug overdose deaths (2)	• Naloxone education and distribution programs (2) W √ • Medication-assisted treatment (MAT) access W √

= Ohio SHIP supported strategy
W = Strategy from County Health Ranking's What Works for Health Tool
* = Aligned with previous Williams County CHIP
√ = Strategy is likely to reduce disparities, according to Ohio SHIP or County Health Rankings

Priority #3: Mental Health & Addiction (focus: adult/youth mental health; youth bullying; youth vaping, alcohol, & marijuana use; adult alcohol and drug use)	
Gaps	**Potential Strategies**
6. Youth alcohol & drug use (2)	• Alcohol brief interventions W * • Youth led prevention (ECHO coalition)
7. Destigmatizing of marijuana use	• Educational billboard/media blitz regarding the health risks associated with marijuana use
8. Unhealthy substance use	• Educational billboard/media blitz stating substance use is not a path toward happiness, rather it makes things worse
9. Trauma and addiction issues	• Grants to aid in funding for clinicians not yet trained in EDMR
10. Lack of an easy way to remember crisis hotline number	• Obtain funding to secure 211 phone number again for both resources and crisis needs W
11. Social skills	• Increase education on social skills in community schools to help students learn how to expand social circles with those that have health values as they prepare for life after high school

= Ohio SHIP supported strategy
W = Strategy from County Health Ranking's What Works for Health Tool
* = Aligned with previous Williams County CHIP
√ = Strategy is likely to reduce disparities, according to Ohio SHIP or County Health Rankings

Appendix II: Links to Websites

Title of Link	Website URL
America's Healthy Food Financing Initiative	https://www.investinginfood.com/
CDC Suicide Prevention Guide	https://www.cdc.gov/suicide/pdf/preventionresource.pdf
Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services	https://www.cdc.gov/publichealthgateway/nphps/index.html
Community fitness programs	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/community-fitness-programs
Community gardens	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/community-gardens
Farmers markets	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/farmers-markets
Good Food Here Guide	https://odh.ohio.gov/know-our-programs/creating-healthy-communities/Healthy-Eating/
Green space and parks	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/green-space-parks
Health in All Policies	www.apha.org/-/media/files/pdf/factsheets/health_inall_policies_guide_169pages.ashx?la=en&hash=641B94AF624D7440F836238F0551A5FF0DE4872A
Health in All Policies, Health Disparities, CDC	https://www.cdc.gov/policy/hiap/index.html
Health in All Policies, Health Disparities, Supporting Articles	https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1292
Healthy Food for Ohio	www.financefund.org/userfiles/files/Program%20Fact%20Sheets/HFFO%20Fact%20Sheet.pdf
Healthy food at meetings and catered events	https://odh.ohio.gov/know-our-programs/creating-healthy-communities/resources/meetings-and-catered-events-toolkit
Healthy food in cafes, cafeterias, snack carts, and micro-markets	https://odh.ohio.gov/know-our-programs/creating-healthy-communities/resources/cafes-snackcarts-toolkit
Healthy food in convenience stores	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/healthy-food-in-convenience-stores
Healthy food in food pantries/food banks	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/healthy-food-initiatives-in-food-pantries
Healthy food in vending machines	https://odh.ohio.gov/know-our-programs/creating-healthy-communities/resources/vending-machines-toolkit
Healthy People 2030	https://health.gov/healthypeople/objectives-and-data
Mental health first aid	https://www.mentalhealthfirstaid.org/
Northwestern Ohio Community Action Commission	https://nocac.org/nocac-resource-guide/
Northwest Ohio Food Council	http://ohiofpn.org/local-councils/
Ohio Food and Beverage Guidelines Toolkit	https://odh.ohio.gov/know-our-programs/creating-healthy-communities/Healthy-Eating/
Ohio State Health Improvement Plan	https://odh.ohio.gov/about-us/sha-ship/state-health-improvement-plan

Title of Link	Website URL
PAX Good Behavior Game	https://www.hazelden.org/HAZ_MEDIA/gbg_insert.pdf
ROX (Ruling Our Experience)	https://rulingourexperiences.com/#!about_us/csgz
School-based nutrition education programs	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/school-based-nutrition-education-programs
Serving Up MyPlate: A Yummy Curriculum	www.fns.usda.gov/tn/serving-myplate-yummy-curriculum
Sources of Strength	https://sourcesofstrength.org/
Steps to Respect	https://youth.gov/content/steps-respect%25C2%25AE
The Community Guide	https://www.thecommunityguide.org/
Too Good for Drugs	https://toogoodprograms.org/
United Way of Williams County	https://www.unitedwaywc.org/
What Works for Health	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies
Williams County Health Assessment - Community Hospitals and Wellness Centers	https://www.chwchospital.org/community-health-assessment/
Williams County Health Assessment - Williams County Health Department	http://www.williamscountyhealth.org/administration/community-health-assessment/

Appendix III: Secondary Data Sources – Strategies

Priority Indicator(s)	Secondary Data Source(s)	Secondary Data Source URL(s)	Applicable Strategy
Priority #2: Health Behaviors & Built Environment			
Percent of adults reporting no leisure-time physical activity in the past month	Behavioral Risk Factor Surveillance System, as compiled by Kaiser Family Foundation *Similar county level data (ratio of population to mental health providers) – County Health Rankings*	https://www.countyhealthrankings.org/explore-health-rankings/ohio/williams?year=2022	Strategy 1: Complete Streets (page 40) Strategy 2: Greene space and parks/bike and pedestrian master plans (page 41) Strategy 3: Community fitness programs (page 42)
Priority #3: Mental Health and Addiction			
Number of deaths due to suicide for adults, ages 18 and older; and youth, ages 8-17, per 100,0000 population	Ohio Department of Health Public Health Data Warehouse	https://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/Mortality	Strategy 3: Mental Health First Aid (page 50) Strategy 4: Suicide Prevention (page 51)

Appendix IV: Strategy Objectives

Strategy	Objective(s)	Indicator(s)
Priority #1: Access to Care		
Transit Advocacy	By December 2025, the percent of adults reporting one or more transportation issues in Williams County will be reduced from 15% to 12%.	Transportation issues: Percent of adults reporting 1 or more transportation issues (CHA)
Access to Care Initiatives	By December 2025, the percentage of Williams County adults who visited a doctor for a routine checkup in the past year will reduce from 67% to 60%. By December 2025, the percent of Williams County adults who had used a program or service for themselves or a loved one to help with depression, anxiety, or emotional problems will increase from 11% to 15%.	Access & Utilization: Percent of Williams County adults who visited a doctor for a routine checkup in the past year (CHA) Mental Health: Percent of Williams County adults who had used a program or service for themselves or a loved one to help with depression, anxiety, or emotional problems (CHA)
Cancer education outreach	By December 2025, the percent of women ages 40 and older who had a mammogram within the past 2 years will increase from 70% to 75%. By December 2025, the percentage of adults who had a colorectal cancer screening in the past 5 years will increase from 14% to 18%. By December 2025, the percent of adults who had a lung cancer screening in the past 3 years will increase from 3% to 5%.	Skin cancer screening: Percent of adults who had a skin cancer screening in the past year (CHA) Colorectal cancer screening: Percent of adults who had a colorectal cancer screening in the past 5 years (CHA) Lung cancer screening: Percent of adults who had a lung cancer screening in the past 3 years (CHA)
Priority #2: Health Behaviors & Built Environment		
Complete Streets	By December 2025, the percentage of adults reporting no physical activity in the past week will reduce from 27% to 24%. By December 2025, the percentage of adults reporting no leisure-time physical activity in the past month will reduce from 30% to 26%. By December 2025, the percent of youth who did not participate in at least 60 minutes of physical activity on at least one day in the past week will decrease from 10% to 8%.	Adult physical inactivity: Percent of adults reporting no physical activity in the past week (CHA) Adult physical activity: Percent of adults reporting no leisure-time physical activity in the past month (BRFSS as compiled by CHR) Youth physical inactivity: Percent of youth who did not participate in at least 60 minutes of physical activity on at least 1 day in the past week (CHA)
Green space and parks/bike and pedestrian master plans	By December 2025, the percentage of adults reporting no physical activity in the past week will reduce from 27% to 24%. By December 2025, the percentage of adults reporting no leisure-time physical activity in the past month will reduce from 30% to 26%. By December 2025, the percent of youth who did not participate in at least 60 minutes of physical activity on at least one day in the past week will decrease from 10% to 8%.	Adult physical inactivity: Percent of adults reporting no physical activity in the past week (CHA) Adult physical activity: Percent of adults reporting no leisure-time physical activity in the past month (BRFSS as compiled by CHR) Youth physical inactivity: Percent of youth who did not participate in at least 60 minutes of physical activity on at least 1 day in the past week (CHA)

Strategy	Objective(s)	Indicator(s)
Priority #2: Health Behaviors & Built Environment (continued)		
Community fitness programs	By December 2025, the percentage of adults reporting no physical activity in the past week will reduce from 27% to 24%. By December 2025, the percentage of adults reporting no leisure-time physical activity in the past month will reduce from 30% to 26%. By December 2025, the percent of youth who did not participate in at least 60 minutes of physical activity on at least one day in the past week will decrease from 10% to 8%.	Adult physical inactivity: Percent of adults reporting no physical activity in the past week (CHA) Adult physical activity: Percent of adults reporting no leisure-time physical activity in the past month (BRFSS as compiled by CHR) Youth physical inactivity: Percent of youth who did not participate in at least 60 minutes of physical activity on at least 1 day in the past week (CHA)
Community gardens	By December 2025, the percentage of Williams County adults who report consuming 0 servings of fruit per day will decrease from 17% to 13%. By December 2025, the percentage of Williams County adults who report consuming 0 vegetables per day will decrease from 8% to 6%. By December 2025, the percentage of youth who report consuming 0 servings of fruit per day will decrease from 11% to 8%. By December 2025, the percentage of youth who report consuming 0 servings of vegetables per day will decrease from 16% to 13%.	Adult fruit consumption: Percent of adults who report consuming 0 servings of fruits per day (CHA) Adult vegetable consumption: Percent of adults who report consuming 0 servings of fruits per day (CHA) Youth fruit consumption: Percent of youth who report consuming 0 servings of fruits per day (CHA) Youth vegetable consumption: Percent of youth who report consuming 0 servings of fruits per day (CHA)
Healthy food initiatives and nutrition education	By December 2025, the percentage of Williams County adults who report consuming 0 servings of fruit per day will decrease from 17% to 13%. By December 2025, the percentage of Williams County adults who report consuming 0 vegetables per day will decrease from 8% to 6%. By December 2025, the percentage of youth who report consuming 0 servings of fruit per day will decrease from 11% to 8%. By December 2025, the percentage of youth who report consuming 0 servings of vegetables per day will decrease from 16% to 13%.	Adult fruit consumption: Percent of adults who report consuming 0 servings of fruits per day (CHA) Adult vegetable consumption: Percent of adults who report consuming 0 servings of fruits per day (CHA) Youth fruit consumption: Percent of youth who report consuming 0 servings of fruits per day (CHA) Youth vegetable consumption: Percent of youth who report consuming 0 servings of fruits per day (CHA)
Health in all Policies	By December 2025, the percentage of adults who rated their health status as excellent or very good will increase from 41% to 45%. By December 2025, the percentage of adults who reported that poor mental or physical health kept them from doing usual activities will decrease from 27% to 23%.	General health status: Percent of adults who rated their health status as excellent or very good (CHA) Poor health: Percent of adults who reported that poor mental or physical health kept them from doing usual activities (CHA)

Strategy	Objective(s)	Indicator(s)
Priority #3: Mental Health and Addiction		
School-based alcohol/other drug prevention programs	By December 2025, the percentage of high school students who have used alcohol in the past month will decrease from 13% to 10%. By December 2025, the percentage of high school students who have used marijuana in the past month will decrease from 12% to 8%. By December 2025, percentage of youth who used electronic vapor products in the past month will decrease from 15% to 10%.	Youth alcohol use: Percent of high school students who have used alcohol in the past month (CHA) Youth marijuana use: Percent of high school students who have used marijuana in the past month (CHA) Youth electronic vapor use: Percent of youth who used electronic vapor products in the past month (CHA)
School-based social and emotional instruction	By December 2025, the percentage of youth who had been bullied in the past year will decrease from 42% to 39%. By December 2025, the percentage of youth who felt 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 will decrease from 30% to 27%.	Youth bullying: Percent of youth who had been bullied in the past year (CHA) Youth depression: Percent of youth who felt 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 (CHA)
Mental Health First Aid	By December 2025, the percentage of adults who felt sad or hopeless almost every day for 2 or more week in a row in the past year that they stopped doing some usual activities in the past year will decrease from 14% to 12%. By December 2025, the percentage of youth who felt sad or hopeless almost every day for 2 or more weeks in a row in the past year that they stopped doing some usual activities in the past year will decrease from 30% to 27%. By December 2025, the number of deaths due to suicide among adults, ages 18 and older, per 100,000 population will decrease from 87.3 in 2017-2021 to 68.2 in 2021-2025.	Adult depression: Percent of adults who felt sad or hopeless almost every day for 2 or more week in a row in the past year that they stopped doing some usual activities in the past year (CHA) Youth depression: Percent of youth who felt sad or hopeless almost every day for 2 or more weeks in a row in the past year that they stopped doing some usual activities in the past year (CHA) Adult suicide deaths: Number of deaths due to suicide among adults, ages 18 and older, per 100,000 population (ODH Vital Statistics)
Suicide prevention initiatives	By December 2025, the number of deaths due to suicide among adults, ages 18 and older, per 100,000 population will decrease from 87.3 in 2017-2021 to 68.2 in 2021-2025. By December 2025, the percentage of youth who considered attempting suicide in the past year will decrease from 14% to 11%.	Adult suicide deaths: Number of deaths due to suicide among adults, ages 18 and older, per 100,000 population (ODH Vital Statistics) Youth suicide contemplation: Percent of youth who considered attempting suicide in the past year (CHA)