2020  2022

Hardin County

Community Health Improvement Plan

Released on 12.12.19

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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.

Hardin County Community Assessment Advisory Committee has been conducting CHAs since 2014 to measure community health status. The most recent Hardin County CHA was cross-sectional in nature and included a written survey of adults and adolescents within Hardin 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 Hardin 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.

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

Public Health Accreditation Board (PHAB) Requirements

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

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

Mobilizing for Action through Planning & Partnerships (MAPP) Process Overview

This 2020-2022 CHIP was developed using the Mobilizing Action through Partnerships and Planning (MAPP) process, which is a nationally adopted framework developed by the National Association of County and City Health Officials (NACCHO) (see Figure 1.1). MAPP is a community-driven planning process for improving community health and is flexible in its implementation, meaning that the process does not need to be completed in a specific order. This process was facilitated by HCNO in collaboration with a broad range of local agencies representing a variety of sectors of the community. This process involved the following six phases:

1. Organizing for success and partnership development

During this first phase, community partners examined the structure of its planning process to build commitment and engage partners in the development of a plan that could be realistically implemented. With a steering committee already in place, members examined current membership to determine whether additional stakeholders and/or partners should be engaged, its meeting schedule (which occurs on a quarterly basis and more frequently as needed), and responsibilities of partnering organizations for driving change. The steering committee ensured that the process involved local public health, health care, faith-based communities, schools, local leadership, businesses, organizations serving minority populations, and other stakeholders in the community health improvement process.

Figure 1.1 The MAPP Framework

2. Visioning

Next, steering committee members re-examined its vision and mission. Vision and values statements provide focus, purpose, and direction to the CHA/CHIP so that participants collectively achieve a shared vision for the future. A shared community vision provides an overarching goal for the community—a statement of what the ideal future looks like. Values are the fundamental principles and beliefs that guide a community-driven planning process.

3. The four assessments

While each assessment yields valuable information, the value of the four MAPP assessments is multiplied considering results as a whole. The four assessments include: The Community Health Status Assessment (CHSA), the Local Public Health System Assessment (LPHSA), the Forces of Change (FOC) Assessment, and the Community Themes and Strengths Assessment (CTSA).

4. Identifying strategic issues

The process to formulate strategic issues occurs during the prioritization process of the CHA/CHIP. The committee considers the results of the assessments, including data collected from community members (primary data) and existing statistics (secondary data) to identify key health issues. Upon identifying the key health issues, an objective ranking process is used to prioritize health needs for the CHIP.

In order to identify strategic issues, the steering community considers findings from the visioning process and the MAPP assessments in order to understand why certain issues remain constant across the assessments. The steering committee uses a strategic approach to prioritize issues that would have the greatest overall impact to drive population health improvement and would be feasible, given the

resources available in the community and/or needed, to accomplish. The steering committee also arranged issues that were related to one another, for example, chronic disease related conditions, which could be addressed through increased or improved coordination of preventative services. Finally, the steering committee members considered the urgency of issues and the consequences of not addressing certain items.

5. Formulate goals and strategies

Following the prioritization process, a gap analysis is completed in which committee members identify gaps within each priority area, identify existing resources and assets, and potential strategies to address the priority health needs. Following this analysis, the committee to formulate various goals, objectives, and strategies to meet the prioritized health needs.

6. Action cycle

The steering committee begins implementation of strategies as part of the next community health improvement cycle. Both progress data to track actions taken as part of the CHIP's implementation and health outcome data (key population health statistics from the CHA) are continually tracked through ongoing meetings. As the end of the CHIP cycle, partners review progress to select new and/or updated strategic priorities based on progress and the latest health statistics.

Inclusion of Vulnerable Populations (Health Disparities)

Hardin County is a rural county. Approximately 16% of Hardin County residents were below the poverty line, according to the 2013-2017 American Community Survey 5-year estimates. For this reason, data is broken down by income (less than $25,000 and greater than $25,000) throughout the report to show disparities.

Alignment with National and State Standards

The 2020-2022 Hardin County CHIP priorities align with state and national priorities. Hardin County will be addressing the following priorities: mental health and addiction, and chronic disease, as well as focusing on access to health care and social determinants of health as cross-cutting factors.

Ohio State Health Improvement Plan (SHIP)

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

SHIP Overview

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

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

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

SHIP Priorities

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

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

Cross-cutting Factors

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

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

- **Health equity**: Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.
- **Social determinants of health**: Conditions in the social, economic and physical environments that affect health and quality of life.
- **Public health system, prevention and health behaviors**:
    - The public health system is comprised of government agencies at the federal, state, and local levels, as well as nongovernmental organizations, which are working to promote health and prevent disease and injury within entire communities or population groups.
    - Prevention addresses health problems before they occur, rather than after people have shown signs of disease, injury or disability.
    - Health behaviors are actions that people take to keep themselves healthy (such as eating nutritious food and being physically active) or actions people take that harm their health or the health of others (such as smoking). These behaviors are often influenced by family, community and the broader social, economic and physical environment.
- **Healthcare system and access**: Health care refers to the system that pays for and delivers clinical health care services to meet the needs of patients. Access to health care means having timely use of comprehensive, integrated and appropriate health services to achieve the best health outcomes.

CHIP Alignment with the 2017-2019 SHIP

The 2020-2022 Hardin County CHIP is required to select at least 2 priority topics, 1 priority outcome indicator, 1 cross cutting strategy and 1 cross-cutting outcome indicator to align with the 2017-2019 SHIP. The following Hardin County CHIP priority topics, outcomes and cross cutting factors very closely align with the 2017-2019 SHIP priorities:

Figure 1.2 2020-2022 Hardin CHIP Alignment with the 2017-2019 SHIP

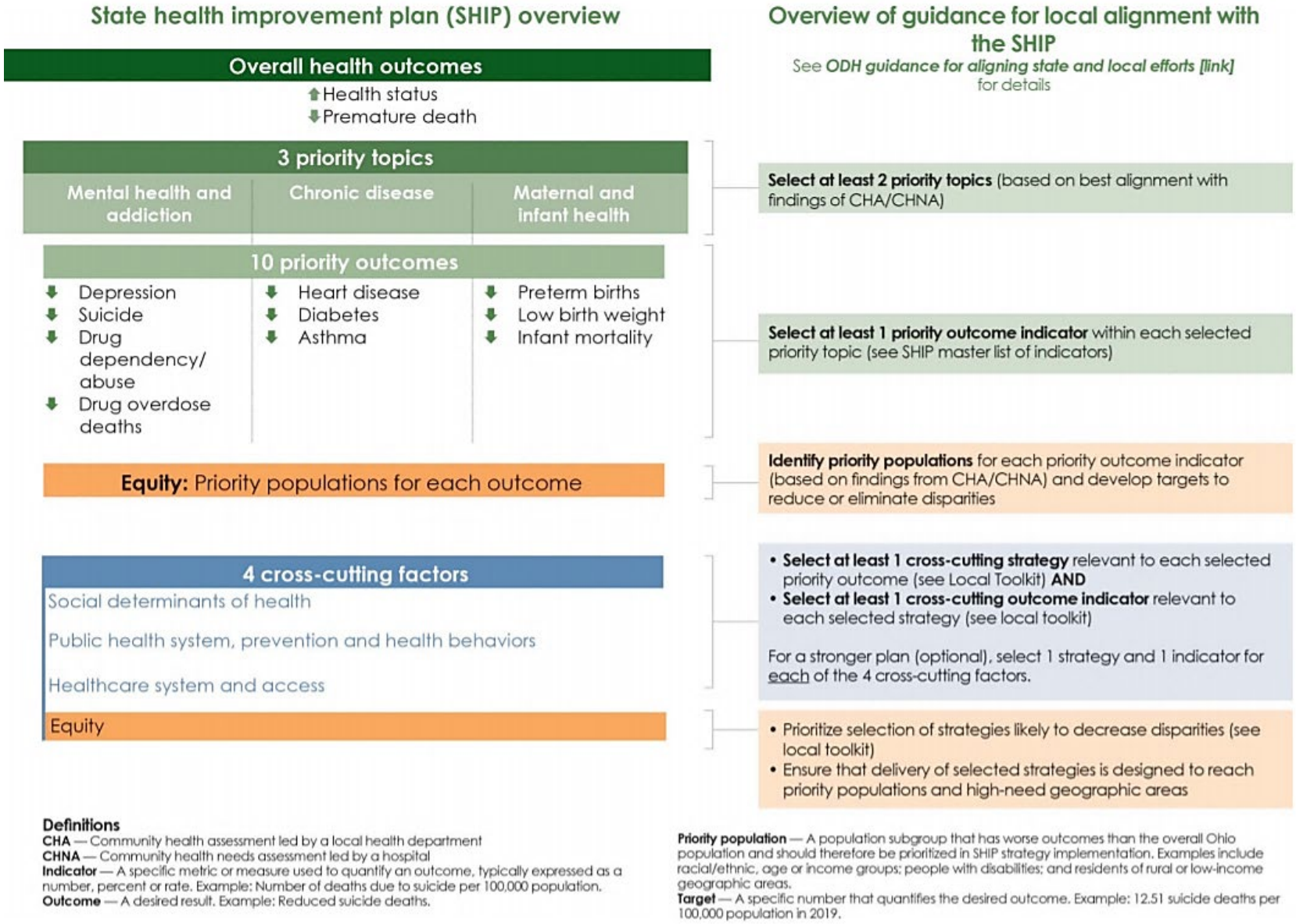
2020-2022 Hardin CHIP Alignment with the 2017-2019 SHIP				
Priority Topic	*Priority Outcome*	*Cross-cutting Factor*	*Cross-Cutting Strategy*	*Cross-Cutting Outcome*
Mental health and addiction	• Decrease suicide deaths • Decrease unintentional overdose deaths • Decrease youth depression	• Public Health System, Prevention and Health Behaviors	• Community-wide physical activity campaign	• Reduce physical inactivity • Reduce obesity
Chronic Disease	• Reduce diabetes			

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

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

Alignment with National and State Standards, continued

Figure 1.3 2017-2019 State Health Improvement Plan (SHIP) Overview



Strategies

To work toward **increasing mental health and decreasing addiction**, the following action steps are recommended:

1. Screening for Adverse Childhood Experiences (ACEs) using a standardized tool
2. Mental health first aid
3. Crisis Intervention Team (CIT)
4. Implement school-based social and emotional instruction
5. School-based alcohol/other drug prevention programs
6. Increase Naloxone access

To work toward **decreasing chronic disease,** the following actions steps are recommended:

1. Prediabetes screening and referral
2. Diabetes prevention program (DPP)
3. Nutrition prescriptions
4. Prescriptions for physical activity
5. Online community wellness calendar

To develop **cross-cutting strategies that address multiple priorities**, the following action steps are recommended:

Public Health System, Prevention and Health Behaviors

1. Advocate to state and local policy makers
2. Community-wide physical activity campaign

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 Hardin County:

Keeping Hardin County healthy by improving the lives of those we serve and strengthen our communities through collaborative partnerships.

The Mission of Hardin County:

To protect, maintain, and improve the health, environmental quality and safety of Hardin County residents.

Community Partners

The CHIP was planned by various agencies and service-providers within Hardin County. From September 2019 to November 2019, Hardin County Community Assessment Advisory reviewed many data sources concerning the health and social challenges that Hardin 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:

Hardin County Community Assessment Advisory

- Township Trustees
- American Red Cross
- Hardin County Commissioners
- Hardin County Job and Family Services
- HHWP Community Action Commission
- Kenton Hardin Health Department
- Board of Health
- Mental Health and Recovery Services of Allen, Auglaize and Hardin Counties
- Ohio Northern University
- Health Partners of Western Ohio
- United Way
- PASS
- OhioHealth Hardin Memorial Hospital
- Colemans

The community health improvement process was facilitated by Emily Golias, Community Health Improvement Coordinator, from Hospital Council of Northwest Ohio.

Community Health Improvement Process

Beginning in September 2019, the Hardin County Community Assessment Advisory 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 141-page report that includes primary data with over 100 indicators and hundreds of data points related health and well-being, including social determinants of health. Over 50 sources of secondary data are also included throughout the report. The CHA serves as the baseline data in determining key issues that lead to priority selection. The full report can be found at **www.hcno.org/community-services/community-health-assessments/**. Below is a summary of county primary data and the respective state and national benchmarks.

Hardin County Adult Trend Summary

Adult Variables	Hardin County 2014	Hardin County 2018	Ohio 2017	U.S. 2017
Health Status				
Rated general health as good, very good, or excellent	85%	81%	81%	83%
Rated general health as excellent or very good	43%	41%	49%	51%
Rated general health as fair or poor	15%	19%	19%	18%
Rated mental health as not good on four or more days (in the past 30 days)	27%	34%	24%*	23%*
Rated physical health as not good on four or more days (in the past 30 days)	20%	22%	22%*	22%*
Average number of days that physical health was not good (in the past 30 days)	3.1	4.3	4.0**	3.7**
Average number of days that mental health was not good (in the past 30 days)	4.2	4.7	4.3**	3.8**
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past 30 days)	24%	25%	22%*	22%*
Healthcare Coverage, Access, and Utilization				
Uninsured	13%	11%	9%	11%
Had one or more persons they thought of as their personal health care provider	58%	86%	81%	77%
Visited a doctor for a routine checkup (in the past 12 months)	52%	68%	72%	70%
Visited a doctor for a routine checkup (5 or more years ago)	11%	6%	7%	8%
Arthritis, Asthma, & Diabetes				
Ever been told by a doctor they have diabetes (not pregnancy-related)	13%	16%	11%	11%
Ever diagnosed with some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia	32%	41%	29%	25%
Had ever been told they have asthma	16%	14%	14%	14%
Cardiovascular Health				
Ever diagnosed with angina or coronary heart disease	4%	8%	5%	4%
Ever diagnosed with a heart attack, or myocardial infarction	5%	6%	6%	4%
Ever diagnosed with a stroke	1%	2%	4%	3%
Had been told they had high blood pressure	28%	44%	35%	32%
Had been told their blood cholesterol was high	28%	43%	33%	33%
Had their blood cholesterol checked within the last five years	72%	80%	85%	86%
Weight Status				
Overweight	35%	33%	34%	35%
Obese	35%	41%	34%	32%

N/A – Not Available

Indicates alignment with the Ohio State Health Assessment
**2016 BRFSS*
***2016 BRFSS as compiled by 2018 County Health Rankings*

Adult Variables	Hardin County 2014	Hardin County 2018	Ohio 2017	U.S. 2017
Alcohol Consumption				
Current drinker (had at least one drink of alcohol within the past 30 days)	43%	54%	54%	55%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	17%	23%	19%	17%
Tobacco Use				
Current smoker (smoked on some or all days)	18%	17%	21%	17%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	19%	29%	24%	25%
Current e-cigarette user (vaped on some or all days)	N/A	4%	5%	5%
Drug Use				
Adults who used marijuana in the past 6 months	6%	5%	N/A	N/A
Adults who misused prescription drugs in the past 6 months	9%	8%	N/A	N/A
Preventive Medicine				
Ever had a pneumonia vaccine (ages 65 and older)	44%	66%	76%	75%
Had a flu shot within the past year (ages 65 and older)	63%	70%	63%	60%
Had a clinical breast exam in the past two years (ages 40 and older)	66%	65%	N/A	N/A
Had a mammogram within the past two years (ages 40 and older)	61%	65%	74%*	72%*
Had a pap test in the past three years (ages 21-65)	69%	66%	82%*	80%*
Had a PSA test within the past two years (ages 40 and older)	45%	52%	39%*	40%*
Cancer				
Ever been told they had skin cancer	3%	5%	6%	6%
Ever been told they had other types of cancer (other than skin cancer)	8%	9%	7%	7%
Quality of Life				
Limited in some way because of physical, mental or emotional problem	23%	27%	21%*	21%*
Mental Health				
Felt sad or hopeless for two or more weeks in the past year	10%	11%	N/A	N/A
Seriously considered attempting suicide in the past year	6%	4%	N/A	N/A
Attempted suicide in the past year	<1%	1%	N/A	N/A
Sexual Behavior				
Had more than one sexual partner in past year	7%	7%	N/A	N/A
Oral Health				
Visited a dentist or a dental clinic (within the past year)	53%	57%	68%*	66%*
Visited a dentist or a dental clinic (5 or more years ago)	16%	18%	11%*	10%*
Had any permanent teeth extracted	44%	53%	45%*	43%*
Had all their natural teeth extracted (ages 65 and older)	21%	23%	17%*	14%*

N/A – Not Available
**2016 BRFSS*
***2015 BRFSS*

Hardin County Youth Trend Summary

Youth Comparisons*	Hardin County CHA 2014 (6th-12th)	Hardin County 2018 OHYES (7th-12th)	Hardin County 2018 OHYES (9th-12th)	U.S. 2017 YRBS (9th-12th)
Weight Control				
Obese	15%	23%	25%	15%
Overweight	16%	20%	21%	16%
Were trying to lose weight	43%	47%	49%	47%
Ate 5 or more servings of fruits and/or vegetables per day	11%	13%	12%	N/A
Ate 0 servings of fruits and/or vegetables per day	N/A	12%	12%	N/A
Physically active at least 60 minutes per day on every day in past week	29%	30%	28%	26%
Physically active at least 60 minutes per day on 5 or more days in past week	46%	54%	51%	46%
Did not participate in at least 60 minutes of physical activity on any day in past week	15%	13%	15%	15%
Watched 3 or more hours per day of television (on an average school day)	27%	19%	19%	21%
Unintentional Injuries and Violence				
Were in a physical fight (in the past 12 months)	24%	18%	15%	24%
Were in a physical fight on school property (in the past 12 months)	8%	9%	8%	9%
Threatened or injured with a weapon on school property (in the past 12 months)	7%	12%	13%	6%
Did not go to school because they felt unsafe (at school or on their way to or from school in the past 30 days)	5%	13%	13%	7%
Bullied on school property (in the past year)	29%	24%	22%	19%
Electronically bullied (bullied through e-mail, chat rooms, instant messaging, websites or texting in the past year)	8%	15%	14%	15%
Mental Health				
Felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities in the past 12 months)	21%	27%	30%	32%
Seriously considered attempting suicide (in the past 12 months)	12%	16%	15%	17%
Attempted suicide (in the past 12 months)	3%	8%	9%	7%
Alcohol Consumption				
Ever drank alcohol (at least one drink of alcohol on at least 1 day during their life)	39%	39%	47%	60%
Current Drinker (at least one drink of alcohol on at least 1 day during the past 30 days)	18%	14%	20%	30%
Binge drinker (drank 5 or more drinks within a couple of hours on at least 1 day during the past 30 days)	11%	7%	9%	14%
Drank for the first time before age 13 (of all youth)	13%	14%	14%	16%
Obtained the alcohol they drank by someone giving it to them (of current drinkers)	34%	43%	47%	44%
Drank and drove (of youth drivers)	11%	2%	3%	6%

N/A – Not Available
**Survey sampling methods differed for Hardin County from 2014 to 2018. Please compare with caution.*

Indicates alignment with Ohio SHA/SHIP

Youth Comparisons*	Hardin County CHA 2014 (6th-12th)	Hardin County 2018 OHYES (7th-12th)	Hardin County 2018 OHYES (9th-12th)	U.S. 2017 YRBS (9th-12th)
Tobacco Use				
Current smoker (smoked on at least 1 day during the past 30 days)	10%	8%	9%	9%
Smoked cigarettes frequently (of current smokers on 20 or more days during the past 30 days)	4%	4%	4%	3%
Current cigar smoker (cigars, cigarillos, or little cigars, on at least 1 day during the 30 days)	N/A	6%	6%	8%
Current electronic vapor product user (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on at least 1 day during the 30 days)	N/A	17%	21%	13%
Current smokeless tobacco user (chewing tobacco, snuff, dip, snus, or dissolvable tobacco products, such as Redman, Levi Garrett, Beechnut, Skoal, Skoal Bandits, Copenhagen, Camel Snus, Marlboro Snus, General Snus, Ariva, Stonewall, or Camel Orbs, not counting any electronic vapor products, on at least 1 day during the 30 days)	N/A	6%	8%	6%
Drug Use				
Ever used marijuana (one or more times during their life)	N/A	18%	23%	36%
Currently use marijuana (in the past 30 days)	12%	6%	9%	20%
Tried marijuana for the first time before age 13	N/A	6%	7%	7%
Ever took prescription drugs without a doctor's prescription (in their lifetime)	5%	8%***	9%***	14%
Were offered, sold, or given an illegal drug on school property (in the past 12 months)	7%	4%	4%	20%
Personal Health and Safety				
Visited a doctor or other healthcare professional (for a routine check-up in the past year)	67%	45%	44%	N/A
Visited a dentist within the past year (for a check-up, exam, teeth cleaning, or other dental work)	71%	63%	62%	74%**
Rode with a driver who had been drinking alcohol (in a car or other vehicle on 1 or more occasion during the past 30 days)	16%	12%	12%	17%

N/A – Not Available
**Survey sampling methods differed for Hardin County from 2014 to 2018. Please compare with caution.*
***Comparative YRBS data for U.S. is 2015*
**** OHYES questionnaire asked this question slightly different from the YRBSS. Please compare with caution.*

Key Issues

Hardin County Community Assessment Advisory reviewed the 2019 Hardin County Health Assessment. The detailed primary data for each identified key issue can be found in the section it corresponds to. Each member completed an "Identifying Key Issues and Concerns" worksheet. The following tables were the group results.

What are the most significant health issues or concerns identified in the 2018 assessment report? Example of how to interpret the information include: 34% of Hardin County adults rated mental health as not good on 4 or more days in the past month, increasing to 53% with income less than $25,000.

Key Issue or Concern	Percent of Population At risk	Age Group, Income Level, Race/Ethnicity, and/or Geography Most at Risk	Gender Most at Risk
Mental Health			
Adult felt sad or hopeless for two or more weeks in a row in the past year	11%	N/A	N/A
Adult seriously considered attempting suicide in the past 12 months (suicide ideation)	4%	N/A	N/A
Hardin County Age-Adjusted Suicide Deaths (2013-2017) *(Source: ODH, Ohio Public Health Data Warehouse, Mortality, Leading Causes of Death)*	13.7	N/A	N/A
Adult attempted suicide in the past 12 months	1%	N/A	N/A
Adult rated mental health as not good on 4 or more days in the past month	34%	Income <$25k (53%)	Female (43%)
Adult average number of days that mental health was not good (in the past 30 days)	4.7	N/A	N/A
Adult 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)	25%	N/A	N/A
Youth saw healthcare provider for a mental health problem in the past year	29%	N/A	Female (33%)
Youth who felt so sad or hopeless almost every day for 2 or more weeks in a row in the past year	27%	Age 14 to 16 (29%)	Female (36%)
Youth who seriously considered attempting suicide in the past year	16%	N/A	N/A
Youth attempted suicide (in the past 12 months)	8%	N/A	N/A
Addiction			
Adult current smoker (smoked on some or all days)	17%	Income <$25K (28%) Ages 30-64 (22%)	Female (17%)
Adult current e-cigarette user (vaped on some or all days)	4%	N/A	N/A
Adult current drinker (had at least one drink of alcohol within the past 30 days)	54%	Income $25K+ (62%)	Male (63%)

Key Issue or Concern	Percent of Population At risk	Age Group, Income Level, Race/Ethnicity, and/or Geography Most at Risk	Gender Most at Risk
Adult binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	23%	N/A	N/A
Hardin County Number of Prescription Opiate Related Overdose Deaths 2015-2017 *(Source: Ohio Department of Health, Unintentional Drug Overdose Data, 2015-2017)*	24	N/A	N/A
Hardin County Age-Adjusted Rate Fentanyl and Analogues Related Deaths 2015-2017 *(Source: Ohio Department of Health, Unintentional Drug Overdose Data, 2015-2017)*	14.3	N/A	N/A
Hardin County overdose deaths (age-adjusted) per 100,000 population, 2012-2017 *(Source: Ohio Department of Health, 2017 Ohio Drug Overdose Data: General Findings)*	36	N/A	N/A
Adult used marijuana (in the past 6 months)	5%	Under 30 (8%) Income $25k+ (5%)	Male (6%)
Adult 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)	8%	Income <$25k (16%) Ages 65+ (11%)	Female (11%)
Youth currently used an electronic vapor product	17%	N/A	N/A
Youth current drinker	14%	Ages 17 and older (25%)	Male (14%)
Youth binge drinker	7%	Ages 17 and older (10%)	Male (7%)
Youth current smoker	8%	Ages 17 and older (12%)	Male (9%)
Youth current marijuana user	6%	Age 17 and older (10%)	Male (7%)
Youth ever took prescription drugs without a doctor's prescription (in their lifetime)	8%	N/A	N/A
Youth were offered, sold, or given illegal drug on school property (in the past 12 months)	4%	N/A	N/A
Chronic Disease (including obesity-related indicators)			
Ever been told by a doctor they have diabetes (not pregnancy-related)	16%	Ages 65+ (26%) Income <$25K (24%)	Male and Female (16%)
Obesity	41%	Income <$25K (53%) Ages 65+ (48%)	Female (45%)
Hardin County 2015-2017 Age-adjusted mortality rates for Chronic Lower Respiratory Diseases (COPD) *(Source: ODH, Ohio Public Health Data Warehouse, Mortality, Leading Causes of Death)*	62	N/A	N/A
Overweight	33%	Income $25k+ (38%) Ages 30-64 (35%)	Male (45%)

Key Issue or Concern	Percent of Population At risk	Age Group, Income Level, Race/Ethnicity, and/or Geography Most at Risk	Gender Most at Risk
Diagnosed with high blood pressure	44%	Ages 65+ (70%) Income <$25K (57%)	Male (46%)
Coronary heart disease	8%	Ages 65+ (10%) Income <$25k (18%)	N/A
Youth obesity	23%	Ages 17 and older (26%)	Male (26%)
Youth overweight	20%	Ages 14 to 16 (21%)	Female (22%)
Youth did not participate in at least 60 minutes of physical activity on any day in the past week	13%	N/A	N/A
Youth ate zero servings of fruits and vegetables per day	12%	N/A	N/A
Ate 0 servings of fruits and/or vegetables per day	12%	N/A	N/A
Social determinants of health			
Hardin County residents were living in poverty *(Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-year Estimates)*	16.6%	N/A	N/A
Unemployment rate for Hardin County July 2019 *(Source: Ohio Department of Job and Family Services, July 2019)*	5.2	N/A	N/A
Owner-occupied housing unit rate for Hardin County *(Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year Estimates)*	72%	N/A	N/A
Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities *(Source: 2018 County Health Rankings)*	13%	N/A	N/A
Adults and their loved ones needed transportation assistance in the past year	3%	N/A	N/A
Experienced more than one food insecurity issue	9%	N/A	N/A
Food insecurity rate for Hardin County 2018 *(Source: Feeding America, Map the Meal Gap 2018)*	13.4%	N/A	N/A
Child insecurity rate for Hardin County 2016 *(Source: Feeding America, Map the Meal Gap 2016)*	20.6%	N/A	N/A
Adults experienced 4 or more ACEs	13%	N/A	N/A
Youth experienced 3 or more ACEs	25%	Ages 14 to 16 (27%)	Female (31%)
Access to healthcare			
Uninsured	11%	Ages <30 (11%) Ages 30-64 (11%) Income <$25k (16%)	Females (13%)
Had one or more persons they thought of as their personal healthcare	86%	N/A	N/A

Key Issue or Concern	Percent of Population At risk	Age Group, Income Level, Race/Ethnicity, and/or Geography Most at Risk	Gender Most at Risk
Visited a doctor for a routine checkup (in the past 12 months)	68%	Income $25k+ (68%) Ages <30 (56%)	Female (64%)
Visited a dentist or a dental clinic (within the past year)	57%	Ages 65+ (49%) Income <25K (29%)	Male (55%)
Youth visited a dentist within the past year	63%	N/A	N/A
Youth visited a doctor or other healthcare professional	45%	Ages 17 and older (37%)	Male (42%)

Priorities Chosen

Six key issues were identified by the committee based on the 2019 Hardin County Health Assessment. Each organization then completed a ranking exercise, giving a score for magnitude, seriousness of the consequence and feasibility of correcting, resulting in an average score for each issue identified. Afterwards, each organization was given 3 votes to place next to their 3 key issues that ranked the highest. The committee then voted and came to a consensus on the priority areas Hardin 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. Addiction	13
2. Obesity	12
3. Mental Health	10
4. Social determinants of health	10
5. Access to health care	6
6. Chronic diseases	5

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

1. Mental health and addiction
2. Chronic disease *(includes obesity)*

Hardin County will focus on the following cross-cutting factors over the next three years:

1. Public health system and behaviors

Community Themes and Strengths Assessment (CTSA)

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

Open-ended Questions to the Committee

1. What do you believe are the 2-3 most important characteristics of a healthy community?

    - Job availability
    - Community vitality
    - The community values health
    - Community engagement
    - Safe Infrastructure
    - Good education system
    - Availability of resources
    - Growth (population, employment, young people, etc.)
    - Environmental health
    - Pride

2. What makes you most proud of our community?

    - Abundance of resources
    - Community collaboration
    - Revitalization
    - Volunteerism
    - Growth
    - New businesses
    - Ohio Health's commitment to the community
    - School systems/building of new schools
    - Ohio Northern University

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

    - ONU Healthwise
    - Healthy Lifestyles
    - Hardin County Community Health Coalition
    - Substance abuse subcommittee
    - Rotary and other service organizations
    - School education programs
    - Area Council on Aging
    - YMCA
    - Religious organizations
    - FQHC
    - Chamber of commerce

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?

    - Chronic disease
    - Mental health and addiction
    - Social Determinants of Health
    - Access to health care
    - Obesity
    - Low activity levels
    - Health education/prevention initiatives
    - ACEs

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 funding
    - Lack of time
    - Lack of community buy-in
    - Recruiting and coordination volunteers
    - Lack of communication
    - Lack of marketing

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

    - Environmental clean up
    - Bike paths
    - Parks
    - Walking paths
    - Mid-level provider on ONU Healthwise bus

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

    - To know you can make a difference
    - Purpose
    - Success stories
    - Incentives
    - Tangible vision

Quality of Life Survey

Hardin County Community Assessment Advisory urged community members to fill out a short Quality of Life Survey via SurveyMonkey. There were 90 Hardin County community members who completed the survey. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1. For all responses of "Don't Know," or when a respondent left a response blank, the choice was a non-response and was assigned a value of 0 (zero). The non-response was not used in averaging response or calculating descriptive statistics.

Quality of Life Questions	2020-2022 Likert Scale Average Response
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]	3.63
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.03
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.78
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.)	3.36
5. Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)	2.86
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?)	3.73
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?	3.41
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.40
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	2.88
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.00
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.08
12. Is there an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments? (Are citizens working towards the betterment of their community to improve life for all citizens?)	3.13

Forces of Change Assessment

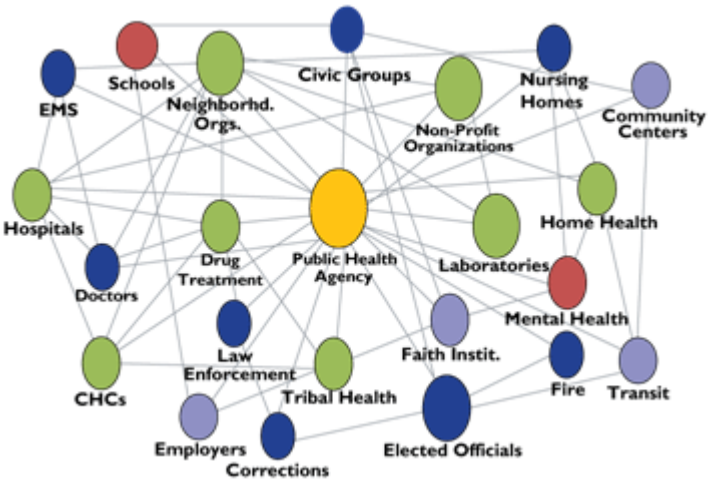
The Forces of Change Assessment focuses on identifying forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. This assessment answers the questions: "What is occurring or might occur that affects the health of our community or the local public health system?" and "What specific threats or opportunities are generated by these occurrences?" Hardin County Community Assessment Advisory was 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 Hardin County in the future. The table below summarizes the forces of change agent and its potential impacts:

Forces (Trend, Events, Factors)	Threats Posed	Opportunities Created
1. Lack of opportunities for growth	• Lack of available growth • Interest in growth, but can't get it done	• N/A
2. Climate	• Farmers planted crops late • "Half crop season" (low volume in crops) • Increase in food prices	• N/A
3. Retiring medical workforce	• Decrease in access to health care	• Change in healthcare delivery system • Recruit younger healthcare providers • Telemedicine
4. Decrease in general workforce	• Lack of population, especially young population	• Opportunities for recruitment
5. Changing of insurance coverage	• No signs of stabilizing • May affect access to quality healthcare	• Advocate for access to quality healthcare/improve communication • Prevention so people don't get sick
6. Prescription cost	• Lack of access to prescriptions • Opioid lawsuits could increase cost of other drugs to cover lawsuit	• N/A
7. Natural disasters	• Affects hospital supplies	• N/A
8. Lack of young people	• Lack of workforce due to low paying, not enough jobs	• Increase businesses/activities to attract young people
9. Increase in aging population	• Workforce retiring • Could affect industry in community • Lack of assisted living/nursing/hospice	• Mentoring • Volunteerism
10. Decrease in funding	• Can't pay for initiatives • Can't hire	• N/A
11. Lack of communication at state level	• No communication at ODE, OMHAS, ODH • No consistent funding • Conflicting strategies	• N/A
12. Downtown revitalization approved	• N/A	• Increase in young people • Increase in jobs/workforce
13. Wind energy	• N/A	• Money coming into the county
14. ONU	• N/A	• Community outreach • Resource to community • Pharmacy students going into school
15. Growth	N/A	• Strong partnerships and working relationships in and out of county

Local Public Health System Assessment

The Local Public Health System

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



The public health system includes:

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

The 10 Essential Public Health Services

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

Public health systems should:

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

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

The Local Public Health System Assessment (LPHSA)

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

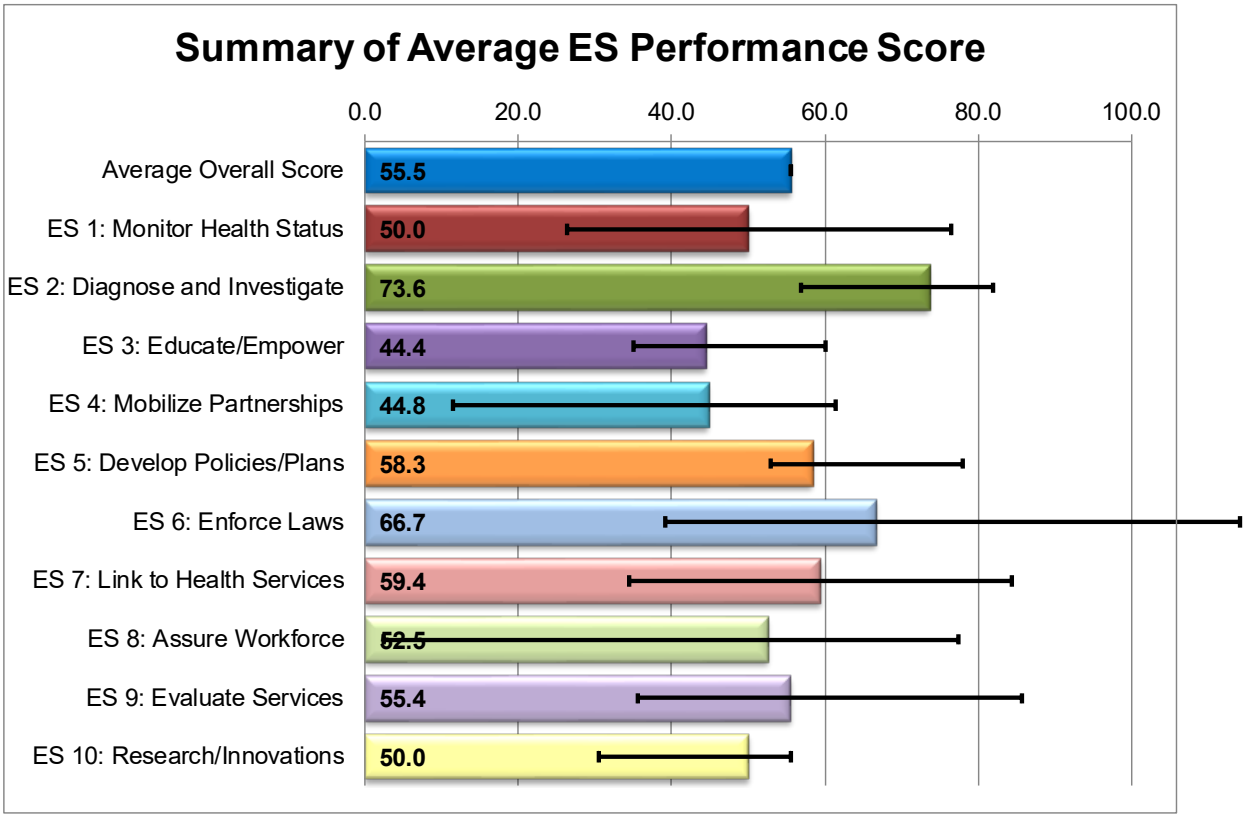
This assessment involves the use of a nationally recognized tool called the **National Public Health Performance Standards Local Instrument.**

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

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 Kenton-Hardin Health Department.

Hardin County Local Public Health System Assessment 2019 Summary



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

Gaps Analysis

A gap is an area where the community needs to expand its efforts to reduce a risk, enhance an effort, or address another target for change. A strategy is an action the community will take to fill the gap. Evidence is information that supports the linkages between a strategy, outcome, and targeted impact area. Hardin County Community Assessment Advisory was 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 Hardin County Community Assessment Advisory were asked to identify strategies for each priority area. Considering all previous assessments, including but not limited to the CHA, CTSA, quality of life survey and gap analysis, committee members determined strategies that best suited the needs of their community. Members referenced a list a of evidence-based strategies recommended by the Ohio SHIP, as well as brainstormed for other impactful strategies. Each resource inventory can be found with its corresponding priority area.

Evidence-Based Practices

As part of the gap analysis and strategy selection, the Hardin County Community Assessment Advisory 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.

Resource Inventory

Based on the chosen priorities, the Hardin County Community Assessment Advisory were asked to identify resources for each strategy. The resource inventory allowed the committee to identify existing community resources, such as programs, policies, services, and more. The committee was then asked to determine whether a policy, program or service was evidence-based, a best practice, or had no evidence indicated. Each resource inventory can be found with its corresponding strategy.

Priority #1: Mental Health and Addiction

Strategic Plan of Action

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

Priority #1: Mental Health and Addiction				
Strategy 1: Screening for Adverse Childhood Experiences (ACEs) using a standardized tool				
Goal: Improve behavioral health outcomes.				
Objective: Implement ACEs screenings in five different locations by May 23, 2023.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Responsible Person/ Agency
Year 1: Collect baseline data on the number of organizations, schools, primary care offices, programs such as home visiting programs, or other entities that are screening for Adverse Childhood Experiences (ACEs). Adopt a community-wide **screening tool** for ACEs and target the screening towards those who serve economically disadvantaged and/or minority populations. Pilot the tool with ONU Healthwise Mobile Clinic.	May 23, 2021	Adult and youth	TBD by Hardin County	Ohio Northern University Kenton-Hardin Health Department
Year 2: Continue efforts from year 1. Evaluate outcomes from year one and make necessary changes. Develop a resource and algorithm for referrals and document screens given and referrals made.	May 23, 2022			
Year 3: Continue efforts from years 1 and 2.	May 23, 2023			
Type of Strategy: ○ Social determinants of health ○ Public health system, prevention and health behaviors ○ Healthcare system and access ⊗ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: Mental Health and Recovery Services Board, PASS, Coleman, Ohio Northern University, Family Resource Center, SAFY, UMADAOP				

Priority #1: Mental Health and Addiction

Strategy 2: Mental health first aid

Goal: Improve behavioral health outcomes.

Objective: Conduct one mental health first aid training (per quarter) by May 23, 2023.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Responsible Person/ Agency
Year 1: Facilitate an assessment among healthcare providers, teachers, coaches, law enforcement, social service providers, and other community members on their ability to identify, understand and respond to signs of mental illnesses and substance use disorders. Continue to offer mental health first aid. Administer at least four **mental health first aid** trainings (one per quarter) to increase education and understanding of mental illnesses and substance use disorders. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations.	May 23, 2021	Adult and youth	1. Suicide deaths: Number of deaths due to suicide per 100,000 populations (age-adjusted) (baseline: 13.7, 2013-2017 ODH Data Warehouse) 2. Unintentional drug overdose deaths: Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted) (baseline: 24.2, 2013-2017 ODH Data Warehouse)	PASS
Year 2: Continue efforts from year 1. Administer at least four mental health first aid trainings (one per quarter) to increase education and understanding of mental illnesses and substance use disorders. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations.	May 23, 2022			
Year 3: Continue efforts from years 1 and 2. Administer at least four mental health first aid trainings (one per quarter) to increase education and understanding of mental illnesses and substance use disorders. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations.	May 23, 2023			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

- ○ Yes
- ○ No
- ⊗ Not SHIP Identified

Resources to address strategy: Mental Health and Recovery Services Board, PASS, Coleman, Ohio Northern University, Family Resource Center, SAFY, UMADAOP

Priority #1: Mental Health and Addiction

Strategy 3: Crisis Intervention Team (CIT)

Goal: Improve behavioral health outcomes.

Objective: By May 23, 2023, obtain a memorandum of understanding (MOU) for Hardin County law enforcement officers to attend mandatory CIT training.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Work with Hardin County law enforcement to collect baseline data on the number of law enforcement officers that have received CIT training. Discuss the importance of CIT training and obtain an MOU with Hardin County law enforcement for all newly hired law enforcement officers to receive mandatory CIT training.	May 23, 2021	Adult	1. Suicide deaths: Number of deaths due to suicide per 100,000 populations (age-adjusted) (baseline: 13.7, 2013-2017 ODH Data Warehouse) 2. Unintentional drug overdose deaths: Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted) (baseline: 24.2, 2013-2017 ODH Data Warehouse)	PASS
Year 2: Continue efforts from year 1. Arrange and implement a biannual CIT training for all newly hired law enforcement officers as well as officers that have not previously attended the training.	May 23, 2022			
Year 3: Continue efforts from years 1 and 2. Arrange and implement a biannual CIT training for all newly hired law enforcement officers as well as officers that have not previously attended the training.	May 23, 2023			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Mental Health and Recovery Services Board, PASS, Coleman, Ohio Northern University, Family Resource Center, SAFY, UMADAOP

Priority #1: Mental Health and Addiction

Strategy 4: Implement school-based social and emotional instruction

Goal: Improve social competence, behavior, and resiliency in youth.

Objective: By May 23, 2023, increase participation in PAX Good Behavior Game by 25% from baseline.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to offer **The PAX Good Behavior Game**, and/or another school-based social-emotional learning program to Hardin County school districts that primarily serve economically disadvantaged and/or minority populations. Collect baseline data on the number of students that have participated in PAX. Expand the program to additional schools and grade levels and increase participation by 5% from baseline.	May 23, 2021	Youth	1. Youth depression: Percent of youth who had a period of two or more weeks when they felt so sad or hopeless nearly every day that they stopped doing usual activities (baseline: 27%, 2018 CHA) 2. Youth suicide ideation: Percent of youth who report that they ever seriously considered attempting suicide within the past 12 months (baseline: 16%, 2018 CHA)	MHRB
Year 2: Continue efforts from year 1. Expand the program to additional schools and grade levels and increase participation by 15% from baseline.	May 23, 2022			
Year 3: Continue efforts from years 1 and 2. Expand the program to additional schools and grade levels and increase participation by 25% from baseline.	May 23, 2023			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Mental Health and Recovery Services Board, PASS, Coleman, Ohio Northern University, Family Resource Center, SAFY, UMADAOP

Priority #1: Mental Health and Addiction

Strategy 5: School-based alcohol/other drug prevention programs

Goal: Decrease substance use.

Objective: By May 23, 2023, increase participation in Refuse Remove Reasons (RRR) by 25% from baseline.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Continue to offer Refuse Remove Reasons (RRR) and/or another school-based alcohol/other drug prevention program (such as Too Good for Drugs, Class Action, **LifeSkills Training**, **Generation Rx**) to Hardin County school districts that primarily serve economically disadvantaged and/or minority populations. Collect baseline data on the number of students that have participated in RRR. Expand the program to additional grade levels and increase participation by 5% from baseline.	May 23, 2021	Youth	1. Youth alcohol use (past 30 days): Percent of youth who drank one or more drinks of an alcoholic beverage in the past 30 days (Baseline: 14%, 2018 CHA). 2. Youth marijuana use: Percent of youth who report using marijuana one or more time within the past 30 days (Baseline: 6%, 2018 CHA).	PASS MHRB
Year 2: Continue efforts from year 1. Expand the program to additional grade levels and increase participation by 15% from baseline.	May 23, 2022			
Year 3: Continue efforts from years 1 and 2. Expand the program to additional grade levels and increase participation by 25% from baseline.	May 23, 2023			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Mental Health and Recovery Services Board, PASS, Coleman, Ohio Northern University, Family Resource Center, SAFY, UMADAOP

Priority #1: Mental Health and Addiction

Strategy 6: Increase Naloxone access

Goal: Decrease drug overdose deaths

Objective: Increase the number of Naloxone mail orders 10% by May 23, 2023

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to implement Project DAWN and provide/distribute naloxone to law enforcement and increase awareness of free naloxone distribution for lay responders. Expand naloxone distribution to include mail order Naloxone kits.	May 23, 2021	Adult	Unintentional drug overdose deaths: Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted) (baseline: 24.2, 2013-2017 ODH Data Warehouse)	Health Department
Year 2: Continue efforts from year 1. Increase the number of Naloxone mail orders 5%.	May 23, 2022			
Year 3: Continue efforts from years 1 and 2. Increase the number of Naloxone mail orders 10%.	May 23, 2023			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Mental Health and Recovery Services Board, PASS, Coleman, Ohio Northern University, Family Resource Center, SAFY, UMADAOP

Priority #2: Chronic Disease

Strategic Plan of Action

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

Priority #2: Chronic Disease				
Strategy 1: Prediabetes screening and referral				
Goal: Prevent diabetes in adults.				
Objective: By May 23, 2023, increase prediabetes screening and referral by 25% from baseline.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Raise awareness of prediabetes screening, identification and referral through dissemination of the **Prediabetes Risk Assessment** (or a similar assessment) and/or the **Prevent Diabetes STAT Toolkit**. Increase the number of healthcare providers that currently screen and refer patients for prediabetes by 5% from baseline. Promote free/reduced cost screening events within the county, such as health fairs, hospital screening events, etc. Target screenings towards those who live in or serve economically disadvantaged and/or minority populations.	May 23, 2021	Adult	1. Diabetes: Percent of adults who have been told by a health professional that they have diabetes (Baseline: 16%, 2018 CHA) 2. Prediabetes screening: Percent of overweight or obese patients aged 40 to 70 years who had appropriate screening for abnormal blood glucose as part of cardiovascular risk assessment and were appropriately referred to intensive behavioral counseling interventions, such as DPP, to promote a healthful diet and physical activity (consistent with USPSTF recommendation) (Baseline: TBD by Hardin County)	ONU
Year 2: Continue efforts from year 1. Increase awareness of prediabetes screening, identification and referral. Increase the number of healthcare providers that currently screen and refer patients for prediabetes by 15% from baseline.	May 23, 2022			
Year 3: Continue efforts of years 1 and 2. Increase the number of healthcare providers that currently screen and refer patients for prediabetes by 25% from baseline.	May 23, 2023			
Type of Strategy: ○ Social determinants of health ○ Public health system, prevention and health behaviors ⊗ Healthcare system and access ○ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Ohio Northern University, OhioHealth Hardin Memorial Hospital, Area Agency on Aging, Healthy U, YMCA, Dining with Diabetes, Kenton Hardin Health Department, Healthy Lifestyles Coalition, Diabetes Self-Management Program, OSU Extension.				

Priority #2: Chronic Disease

Strategy 2: Diabetes prevention program (DPP)

Goal: Prevent diabetes in adults.

Objective: By May 23, 2023, increase enrollment in diabetes education programs by 25%

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Explore the **National Diabetes Prevention Program (DPP)** and determine the feasibility of implementing the program, or another program. Identify one healthcare agency or other organization to house the program. Recruit at-risk participants to join the DPP program. Collaborate with local hospitals and healthcare organizations for referrals and to assist in managed-care reimbursement training.	May 23, 2021		Diabetes: Percent of adults who have been told by a health professional that they have diabetes (Baseline: 16%, 2018 CHA)	ONU
Year 2: Implement the Diabetes Prevention Program. Evaluate participant data.	May 23, 2022			
Year 3: Increase program participation by 25%.	May 23, 2023			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Ohio Northern University, OhioHealth Hardin Memorial Hospital, Area Agency on Aging, Healthy U, YMCA, Dining with Diabetes, Kenton Hardin Health Department, Healthy Lifestyles Coalition, Diabetes Self-Management Program, OSU Extension.

Priority #2: Chronic Disease

Strategy 3: Nutrition prescriptions

Goal: Increase fruit and vegetable consumption.

Objective: Implement nutrition prescription programs into three Hardin County primary care offices by May 23, 2023.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Research **nutrition prescription programs** and determine the feasibility of implementing them in local health care organizations. Create a plan for integrating nutrition prescription programs into primary care venues, such as hospital clinics and FQHC's. Partner with local farmers markets and discuss the possibility of redeeming nutrition prescriptions at participating markets. Explore the feasibility of creating a food pharmacy program that accepts nutrition prescriptions.	May 23, 2021	Adult	1. Adult fruit consumption: Decrease the percentage of adults who report consuming 0 servings of fruit per day (Baseline: 15%, 2018 CHA) 2. Adult vegetable consumption: Decrease the percentage of adults who report consuming 0 servings of vegetables per day (Baseline: 4%, 2018 CHA) 3. Adult obesity: Percent of adults who were obese (Baseline: 41%, 2018 CHA)	OhioHealth
Year 2: Continue efforts from year 1. Implement a nutrition prescription program into one primary care office with accompanying referral options and evaluation measures. Target the program towards those who serve economically disadvantaged and/or minority populations.	May 23, 2022			
Year 3: Continue efforts from years 1 and 2. Implement a nutrition prescription program into two additional primary care offices with accompanying referral options and evaluation measures. Target the program towards those who serve economically disadvantaged and/or minority populations.	May 23, 2023			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Ohio Northern University, OhioHealth Hardin Memorial Hospital, Area Agency on Aging, Healthy U, YMCA, Kenton Hardin Health Department, Healthy Lifestyles Coalition, OSU Extension.

Priority #2: Chronic Disease

Strategy 4: Prescriptions for physical activity

Goal: Increase physical activity.

Objective: Implement physical activity prescription programs into three primary care offices by May 23, 2023.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research **exercise prescriptions.** Create a plan for integrating exercise prescriptions into primary care. Partner with local organizations such as the YMCA or the parks and recreation district to determine referral options and provide support for the exercise prescriptions.	May 23, 2021	Adult	1. Adult physical inactivity: Percentage of adults reporting no leisure time physical activity (Baseline: 26%, 2018 CHA) 2. Adult obesity: Percent of adults who were obese (Baseline: 41%, 2018 CHA)	OhioHealth
Year 2: Continue efforts from year 1. Pilot an exercise prescription program into one primary care office with accompanying referral options and evaluation measures. Target the program towards those who serve economically disadvantaged and/or minority populations.	May 23, 2022			
Year 3: Continue efforts from years 1 and 2. Implement an exercise prescription program into two additional primary care offices with accompanying referral options and evaluation measures. Target the program towards those who serve economically disadvantaged and/or minority populations.	May 23, 2023			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Ohio Northern University, OhioHealth Hardin Memorial Hospital, Area Agency on Aging, Healthy U, YMCA, Kenton Hardin Health Department, Healthy Lifestyles Coalition, OSU Extension.

Priority #2: Chronic Disease

Strategy 5: Online community wellness calendar

Goal: Increase physical activity and fruit and vegetable consumption.

Objective: Hardin County will create an online resource calendar and update it on a quarterly basis.

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collaborate with county organizations to create an online community wellness calendar. Include current information regarding nutrition, physical activity, diabetes and other chronic disease management opportunities in the county. Include information regarding community gardens, farmers markets, physical activity opportunities, and nutrition education, as well as senior programs. Highlight programs that are free or available at a reduced cost. Make sure the calendar is available on Facebook and other social network sites, as well as searchable online. Update key words on search engines for easy access. Print hard copies and make them available to senior centers, food pantries, and other relevant locations to reach populations that may not have internet access.	May 23, 2021	Adult	1. Adult physical inactivity: Percentage of adults reporting no leisure time physical activity (Baseline: 26%, 2018 CHA) 2. Adult obesity: Percent of adults who were obese (Baseline: 41%, 2018 CHA)	OhioHealth
Year 2: Continue efforts from year 1. Keep the online wellness calendar updated on a quarterly basis.	May 23, 2022			
Year 3: Continue efforts from year 2. Keep the online wellness calendar updated on a quarterly basis.	May 23, 2023			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy: Ohio Northern University, OhioHealth Hardin Memorial Hospital, Area Agency on Aging, Healthy U, YMCA, Kenton Hardin Health Department, Healthy Lifestyles Coalition, OSU Extension.

Cross-Cutting Strategies (Strategies that Address Multiple Priorities)

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

Cross-Cutting Factor: Public Health System, Prevention and Health Behaviors				
Strategy 1: Advocate to state and local policy makers				
Goal: Improve health outcomes.				
Objective: By May 23, 2023, create and implement a written advocacy plan.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Collaborate with local stakeholders to identify the biggest policy needs surrounding Mental Health and Addiction, and Chronic Disease. Include policy needs such as increasing funding for health education, increasing capacity for residential and recovery housing and making specific personal health information available for fatality review boards. Create a written advocacy plan detailing coordinated advocacy, specific activities and follow-up actions for each policy need.	May 23, 2021	Adult, and youth	1. Suicide deaths: Number of deaths due to suicide per 100,000 populations (age-adjusted) (baseline: 13.7, 2013-2017 ODH Data Warehouse) 2. Unintentional drug overdose deaths: Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted) (baseline: 24.2, 2013-2017 ODH Data Warehouse) 3. Diabetes: Percent of adults who have been told by a health professional that they have diabetes (Baseline: 16%, 2018 CHA) 4. Coronary heart disease: Decrease the percentage of adults ever diagnosed with coronary heart disease (Baseline: 8%, 2018 CHA)	Kenton-Hardon Health Department
Year 2: Continue efforts from year 1. Implement the advocacy plan.	May 23, 2022			
Year 3: Continue efforts from years 1 and 2. Implement the advocacy plan.	May 23, 2023			
Priority area(s) the strategy addresses: ○ Mental Health and Addiction ○ Chronic Disease ⊗ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: Ohio Northern University, OhioHealth Hardin Memorial Hospital, Area Agency on Aging, Healthy U, YMCA, Kenton Hardin Health Department, Healthy Lifestyles Coalition, OSU Extension.				

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

Strategy 2: Community-wide physical activity campaign

Goal: Increase physical activity.

Objective: Implement a community-wide physical activity campaign in collaboration with at least five Hardin County agencies by May 23, 2023

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Create a community-wide physical activity campaign. Recruit at least five agencies who are working to improve and promote Hardin County's physical activity opportunities. Determine the goals and objectives of the physical activity campaign. Engage community agencies to coordinate a unified message to increase awareness of Hardin County physical activity opportunities, such as **community fitness programs** and **activity programs for older adults**, and create a culture of health. Brand the campaign and explore the feasibility of creating a county physical activity resource that houses all physical activity opportunities.	May 23, 2021	Adult and youth	1. Adult physical inactivity: Percentage of adults reporting no leisure time physical activity (Baseline: 26%, 2018 CHA) 2. Adult obesity: Percent of adults who were obese (Baseline: 41%, 2018 CHA)	Healthy Lifestyles
Year 2: Continue efforts of year 1. Using the coordinated message, all participating agencies will increase awareness of physical activity opportunities and promote the use of them at least once a week. Provide non-participating community agencies with materials to support the campaign, such as social media messages, website information, infographics, maps of activities, booklets, flyers, etc.	May 23, 2022			
Year 3: Continue efforts of years 1 and 2.	May 23, 2023			

Priority area(s) the strategy addresses:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy: Ohio Northern University, OhioHealth Hardin Memorial Hospital, Area Agency on Aging, Healthy U, YMCA, Kenton Hardin Health Department, Healthy Lifestyles Coalition, OSU Extension.

Progress and Measuring Outcomes

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

Hardin 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 Hardin 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 WCHP meetings, keeping the committee on task and accountable. This progress report may also serve as meeting minutes.

Contact Us

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

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Appendix I: Gaps and Strategies

The following tables indicate gaps and potential strategies that were compiled by the Hardin County Community Assessment Advisory.

Mental Health and Addiction Gaps

Gaps	Potential Strategies
Lack of transportation in and out of the county	• ODOT Grants • Mobile Clinic (ONU) • Transportation Committee • Case management services • Telehealth and telemedicine • Community health workers
Lack of school-based prevention programming in schools	• School-based health centers • Strategic planning • Prevention programs
Lack of programs for the aging	• Activity programs for older adults (e.g. Silver Sneakers, treatment, WYSE)
Time it takes to manage people in a mental health crisis	• Care coordination (e.g. case management services, over staffing/under staffing, and Hotline/Hopeline) • Staffing for crisis
Lack of awareness around mental health service	• Suicide prevention • Parent education • Resource guide
Lack of knowledge on how to reach children/youth	• Grant MHTTC
Lack of self-esteem/coping	• School and emotional – school partnership • School Navigator – behaviors with target groups (e.g. DBT program) • Help Me Grow – with mothers and children
Lack of treatment	• Rehab and psychiatric beds, more providers
Uninsured/ Underinsured	• Navigator (sliding scale) • Partnering with other agencies
Lack of rehab facilities for pediatric abuse/mental health disorders	• None noted
Lack of beds for psychiatric patients	• None noted
Lack of detox beds	• Transportation to facilities
Peer pressure/social media	• School based programs (e.g. bulling/peer pressure)
Lack of familial support	• Help Me Grow • Support Groups • Mentoring • Job placing
Behavior is status quo	• Education
Lack of knowledge regarding hereditary connection to mental health	• Care provider • Let's Talk

Chronic Disease Gaps

Gaps	Potential Strategies
Lack of access to healthy food: a. Cost	• Increase referral services • Community Gardens
b. Food insecurity/food deserts	• Food availability • Pay what you can meals
c. Farmers markets	• Increase availability • Community Gardens • FFA Start your own garden
Lack of education about healthy diet/health education	• Lunch room education • Healthy concessions • School contact to see education • FFA
Lack of access to physical activity opportunities	• Resources • Programs • Shared use
Cost of fitness gyms/physical activity programs	• Sliding scale • Scholarships
Acceptance/status quo of chronic disease	• None noted
Lack of media/awareness regarding current programs	• None noted
Lack of community support programs (diabetes, weight, etc)	• Expand current programs
Lack of participation in screening (e.g. hypertension)	• Education
Lack of personal accountability	• None noted
Addiction to entertainment	• None noted
Lack of hereditary counseling	• None noted
Cost of prescriptions/medical supplies	• Healthcare enrollment and outreach
Lack of smoking cessation	• Education and awareness campaign