2021-2023

Morrow County Community Health Improvement Plan

Released on January 18, 2022

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

Executive Summary

Introduction

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

The Morrow County Community Partners (MCCP) have been conducting CHAs since 2016 to measure community health status. The most recent Morrow County CHA was cross-sectional in nature and included a written survey of adults and youth within Morrow 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 Morrow 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 Morrow County Health Department contracted with the Hospital Council of Northwest Ohio (HCNO), a neutral, regional, nonprofit hospital association, to facilitate the CHIP. The health district invited various community stakeholders to participate in the community health improvement process. Data from the most recent CHA was carefully considered and categorized into community priorities with accompanying strategies. This was done using the National Association of County and City Health Officials' (NACCHO) national framework, Mobilizing for Action through Planning and Partnerships (MAPP). Over the next three years, these priorities and strategies will be implemented at the county-level with the hope to improve population health and create lasting, sustainable change. It is the hope of the Morrow County Health Partners 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 three years. Additionally, PHAB is a voluntary national accreditation program, however the State of Ohio requires that all local health departments become accredited by 2020, making it imperative that all PHAB requirements are met.

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

Inclusion of Vulnerable Populations (Health Disparities)

Approximately 11% of Morrow County residents were below the poverty line, according to the 2012-2016 American Community Survey 5 year estimates. For this reason, data is broken down by income (less than $25,000 and greater than $25,000) throughout the report to show disparities.

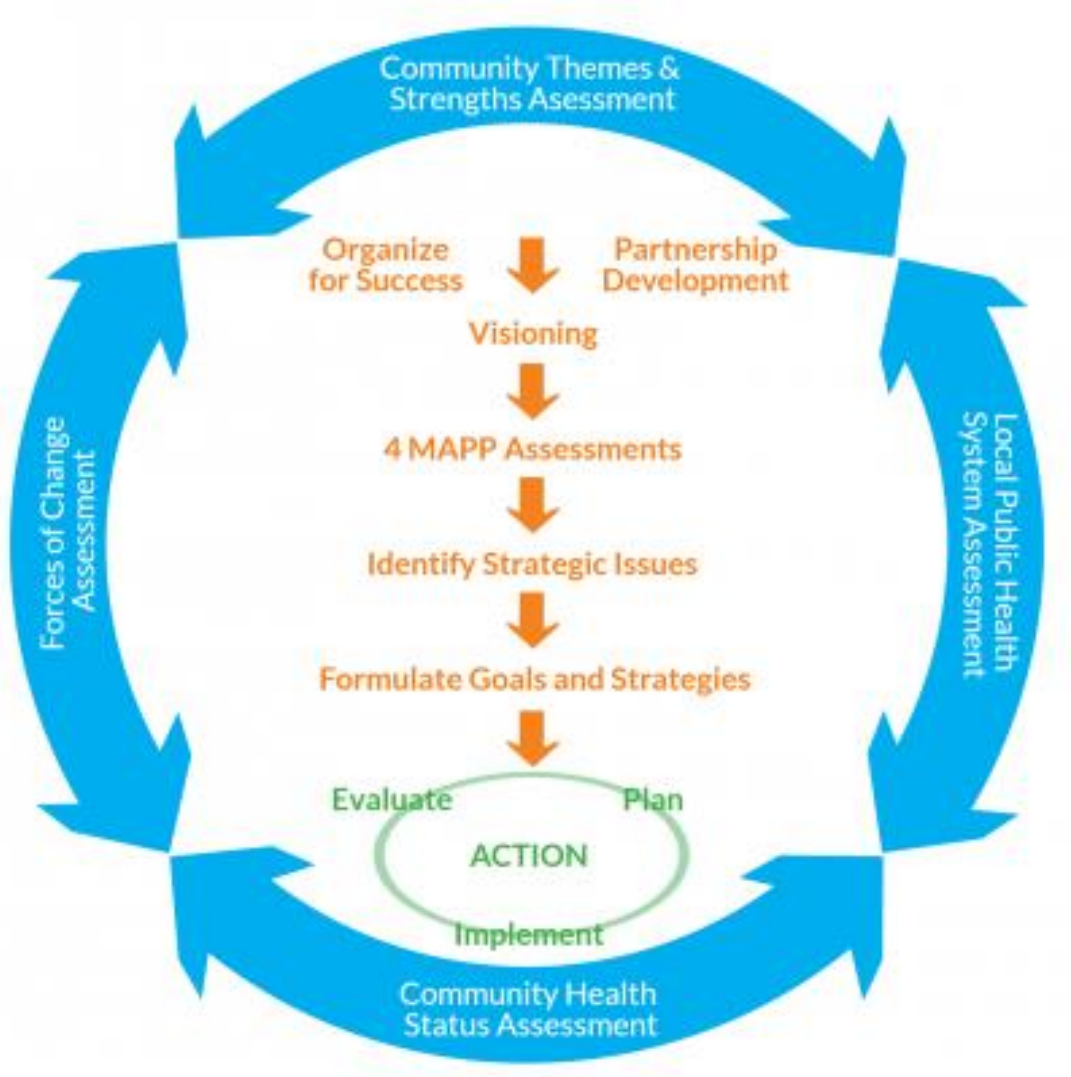
Mobilizing for Action through Planning and Partnerships (MAPP)

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

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

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

Figure 1.1 The MAPP model



Alignment with National and State Standards

The 2021-2023 Morrow County Community Health Improvement Plan priorities align perfectly with regional, state and national priorities. Morrow County will be addressing the following priority health factors: community conditions and access to care. Additionally, Morrow County will be addressing the following priority health outcomes: mental health and addiction.

Healthy People 2030

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

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

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

Ohio State Health Improvement Plan (SHIP)

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

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

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

The three priority factors include the following:

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

The three priority health outcomes include the following:

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

The Morrow 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.

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

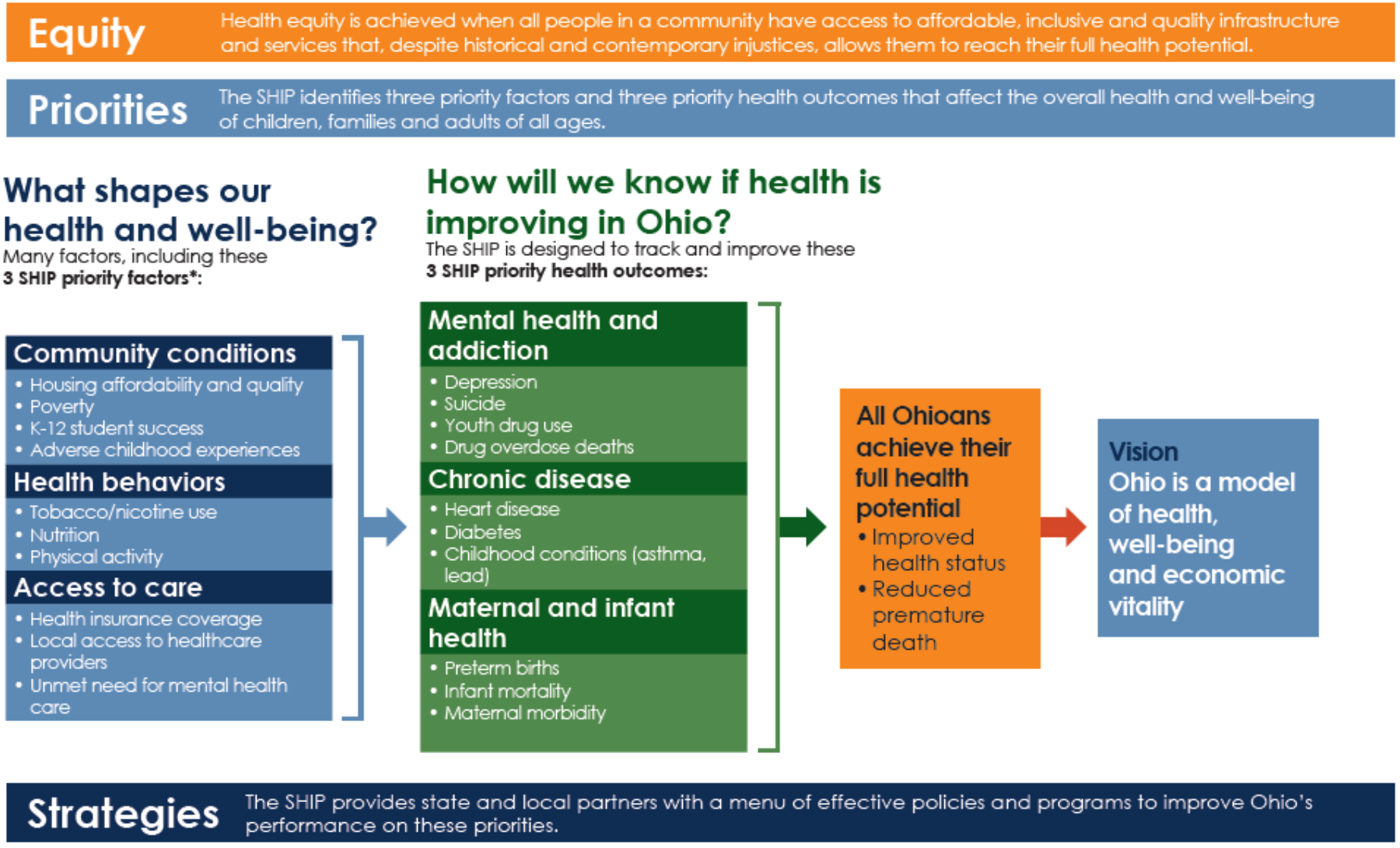
The following Morrow County priority factors, priority indicators, and strategies very closely align with the 2020-2022 SHIP:

Figure 1.2 2021-2023 Morrow CHIP Alignment with the 2020-2022 SHIP

Priority Factors	Priority Indicators	Strategies to Impact Priority Indicators	Additional Aligned Strategies
Community Conditions	• Adverse childhood experiences (ACEs) • Child abuse and neglect	• School-based violence and bullying prevention programs	• N/A
Access to Care	• Primary care health professional shortage areas. • Mental health professional shortage areas.	• Telemedicine	• Awareness of Healthcare Services and Education on Preventive Care • Education materials being offered to patients by primary care offices
Priority Health Outcomes	**Priority Indicators**	**Strategies to Impact Priority Indicators**	**Additional Aligned Strategies**
Mental Health and Addiction	• Youth depression (major depressive episode) • Adult depression (major depressive episode)	• Crisis lines	• Trauma informed care • Re-establish suicide prevention coalition • Increase treatment options for those with substance use disorders and mental health issues • Expand Hidden in Plain Sight programs to reduce alcohol and drug use among youth

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 the Morrow County Community Partners

Improve the health and wellbeing in Morrow County through partnerships that engage individuals and organizations.

The Mission of the Morrow County Community Partners

Promoting a healthy Morrow County through Partnerships.

Community Partners

The CHIP was planned by various agencies and service-providers within Morrow County. From June 2021 to August 2021, the Morrow County Community Partners reviewed many data sources concerning the health and social challenges that Morrow 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:

Morrow County Community Partners

Bragg, Stephanie – Morrow County Health District
Brant, Deanna – Delaware-Morrow Mental Health & Recovery Services
Briski, Amy – Northmor School District
Dewey, Sharon – Syntero
Garver, Jessica – Morrow County Health District
Harris, Le-Ann – Morrow County Hospital
Hayes, Jodi – United Way
Hinton, John – Morrow County Sheriff's Office
Kocher, Morgan – Morrow County Health District
Maceyko, Tim – Mobility Manager: Crawford, Marion, & Morrow Counties
Mattix, Rhianna – Delaware-Morrow Mental Health & Recovery Services
Miller, CJ – Morrow County Hospital
Richardson, Tiffany – Morrow County Health District
Rockas, Megan – Morrow County DAAP
Sayre, Tiffany – Morrow County Hospital
Steele, Rich – Morrow County Help Line
Warren, Kristan – Delaware-Morrow Mental Health & Recovery Services
Worstell, Kelly – Morrow County Health District
Zmuda, Stephanie – Morrow County Health District

Hospital Council of Northwest Ohio (HCNO)

The community health improvement process was facilitated by Gabrielle Mackinnon, Community Health Improvement Manager, from HCNO.

Community Health Improvement Process

Beginning in June 2021, the Morrow County Community 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 health and well-being, including social determinants of health. Over 50 sources of secondary data are also included throughout the report. The CHA serves as the baseline data in determining key issues that lead to priority selection. The full report can be found at **http://www.morrowcountyhealth.org/**. Below is a summary of county primary data and the respective state and national benchmarks.

Adult Trend Summary

Adult Variables	Morrow County 2016	Morrow County 2019	Ohio 2017	U.S. 2017
Health Status				
Rated general health as good, very good, or excellent	91%	86%	81%	83%
Rated general health as excellent or very good	51%	48%	49%	51%
Rated general health as fair or poor	9%	14%	19%	18%
Rated mental health as not good on four or more days (in the past month)	16%	26%	26%	24%
Rated physical health as not good on four or more days (in the past month)	20%	22%	23%	22%
Average number of days that physical health was not good (in the past month) (County Health Rankings)	3.5	3.5	4.0¥	3.7¥
Average number of days that mental health was not good (in the past month) (County Health Rankings)	2.9	3.9	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 month)	20%	26%	24%	23%
Health Care Coverage, Access, and Utilization				
Uninsured	10%	14%	8%	11%
Had at least one person they thought of as their personal doctor or health care provider	88%	84%	81%	77%
Visited a doctor for a routine checkup (in the past year)	66%	67%	72%	70%
Visited a doctor for a routine checkup (five or more years ago)	N/A	6%	7%	8%
Arthritis, Asthma, & Diabetes				
Ever been told by a doctor they have diabetes (not pregnancy related)	13%	16%	11%	11%
Ever been diagnosed with pregnancy-related diabetes	N/A	2%	1%	1%
Ever been diagnosed with pre-diabetes or borderline diabetes	N/A	3%	2%	2%
Diagnosed with arthritis by a doctor, nurse or other health professional	39%	39%	N/A	N/A
Had ever been told they have asthma	12%	12%	14%	14%
Cardiovascular Health				
Ever diagnosed with angina or coronary heart disease	5%	5%	5%	4%
Ever diagnosed with a heart attack, or myocardial infarction	4%	7%	6%	4%
Ever diagnosed with a stroke	2%	3%	4%	3%
Had been told they had high blood pressure	35%	40%	35%	32%
Had been told their blood cholesterol was high	39%	33%	33%	33%
Had their blood cholesterol checked within the last five years	87%	81%	85%	86%

¥2016 BRFSS Data as compiled by 2019 County Health Rankings
**2016 BRFSS Data*
N/A – Not Available
Indicates alignment with the Ohio State Health Assessment

Adult Variables	Morrow County 2016	Morrow County 2019	Ohio 2017	U.S. 2017
Weight Status				
Normal weight (BMI of 18.5 – 24.9)	24%	25%	30%	32%
Overweight (BMI of 25.0 – 29.9)	41%	38%	34%	35%
Obese (includes severely and morbidly obese, BMI of 30.0 and above)	35%	36%	34%	32%
Alcohol Consumption				
Current drinker (had at least one drink of alcohol within the past month)	50%	55%	54%	55%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	11%	16%	19%	17%
Drinking and driving (had driven after drinking too much)	7%	12%	4%*	4%*
Tobacco Use				
Current smoker (smoked on some or all days)	11%	13%	21%	17%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	26%	30%	24%	25%
Drug Use				
Adults who used recreational marijuana in the past six months	3%	3%	N/A	N/A
Adults who misused prescription drugs in the past six months	9%	7%	N/A	N/A
Preventive Medicine				
Ever had a pneumonia vaccine in lifetime (ages 65 and older)	77%	64%	76%	75%
Ever had shingles or zoster vaccine	14%	16%	29%	29%
Had a flu shot within the past year (ages 65 and over)	77%	68%	63%	60%
Had a clinical breast exam in the past two years (ages 40 and older)	66%	67%	N/A	N/A
Had a mammogram within the past two years (ages 40 and older)	70%	65%	74%*	72%*
Had a Pap smear in the past three years (ages 21-65)	65%ǂ	76%	82%*	80%*
Had a PSA test within the past two years (ages 40 and older)	45%	52%	39%*	40%*
Had a digital rectal exam within the past year	17%	13%	N/A	N/A
Had a colonoscopy/sigmoidoscopy within the past five years (ages 50 and over)	53%	49%	N/A	N/A
Quality of Life				
Limited in some way because of physical, mental or emotional problem	19%	21%	21%**	21%**
Mental Health				
Considered attempting suicide in the past year	2%	6%	N/A	N/A
Felt sad or hopeless for two or more weeks in a row	7%	14%	N/A	N/A
Sexual Behavior				
Had more than one sexual partner in past year	4%	6%	N/A	N/A
Oral Health				
Visited a dentist or a dental clinic (within the past year)	65%	65%	68%*	66%*
Visited a dentist or a dental clinic (five or more years ago)	11%	13%	11%*	10%*
Had any permanent teeth extracted	42%	47%	45%*	43%*
Had all their natural teeth extracted (ages 65 and older)	19%	19%	17%*	14%*

N/A – Not Available
**2016 BRFSS Data*
***2015 BRFSS Data*
ǂPap smear was reported for women ages 19 and over
Indicates alignment with the Ohio State Health Assessment

Youth Trend Summary

Youth Variables	Morrow County 2016 (6th-12th)	Morrow County 2019 (6th-12th)	Morrow County 2019 (9th-12th)	U.S. 2017 (9th-12th)
Weight Control				
Obese	18%	29%	29%	15%
Overweight	15%	13%	14%	16%
Described themselves as slightly or very overweight	30%	39%	41%	32%
Were trying to lose weight	46%	54%	52%	47%
Exercised to lose weight (in the past month)	51%	57%	59%	N/A
Ate less food, fewer calories, or foods lower in fat to lose weight (in the past month)	31%	33%	32%	N/A
Went without eating for 24 hours or more (in the past month)	5%	5%	5%	N/A
Took diet pills, powders, or liquids without a doctor's advice (in the past month)	2%	2%	3%	N/A
Vomited or took laxatives (in the past month)	1%	2%	3%	N/A
Physically active at least 60 minutes per day on every day in past week	36%	29%	28%	26%
Physically active at least 60 minutes per day on five or more days in past week	58%	53%	51%	46%
Did not participate in at least 60 minutes of physical activity on any day in the past week	8%	12%	12%	15%
Watched three or more hours per day of television (on an average school day)	N/A	19%	20%	21%
Unintentional Injuries and Violence				
Were in a physical fight (in the past year)	18%	23%	21%	24%
Carried a weapon (in the past month)	10%	16%	14%	16%
Threatened or injured with a weapon on school property (in the past year)	7%	7%	7%	6%
Did not go to school because they felt unsafe (at school or on their way to or from school in the past month)	3%	10%	9%	7%
Electronically bullied (in past year)	13%	14%	13%	15%
Bullied (in past year)	44%	40%	37%	N/A
Were bullied on school property (during the past year)	34%	29%	25%	19%
Experienced physical dating violence (including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with in the past year)	4%	7%	9%	8%
Alcohol Consumption				
Ever drank alcohol (at least one drink of alcohol on at least one day during their life)	47%	43%	50%	60%
Current Drinker (at least one drink of alcohol on at least one day during the past month)	19%	18%	20%	30%
Binge drinker (drank five or more drinks within a couple of hours on at least one day during the past month)	14%	9%	12%	14%
Drank for the first time before age 13 (of all youth)	12%	14%	12%	16%
Obtained the alcohol they drank by someone giving it to them (of youth drinkers)	28%	38%	43%	44%
Rode with a driver who had been drinking alcohol (in a car or other vehicle on one or more occasion during the past month)	14%	12%	11%	17%
Drove when they had been drinking alcohol (in a car or vehicle, one or more times during the past month, among youth who had driven a car or other vehicle)	3%	2%	2%	6%
Mental Health				
Seriously considered attempting suicide (in the past year)	14%	18%	20%	17%
Attempted suicide (in the past year)	6%	8%	8%	7%
Felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities in the past year)	27%	29%	28%	32%

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

Youth Variables	Morrow County 2016 (6th -12th)	Morrow County 2019 (6th -12th)	Morrow County 2019 (9th-12th)	U.S. 2017 (9th-12th)
Tobacco Use				
Ever tried cigarette smoking (even one or two puffs)	25%	23%	30%	29%
Currently smoked cigarettes (on at least one day during the past month)	9%	9%	11%	9%
Currently frequently smoked cigarettes (on 20 or more days during the past month)	2%	1%	1%	3%
First tried cigarette smoking before age 13 years (even one or two puffs)	5%	10%	11%	10%
Tried to quit using all tobacco products (during the past year)	44%	57%	59%	41%
Sexual Behavior				
Ever had sexual intercourse	25%	27%	38%	40%
Had sexual intercourse with four or more persons (of all youth during their life)	5%	9%	12%	10%
Had sexual intercourse before the age 13 (for the first time of all youth)	3%	3%	3%	3%
Used a condom (during last sexual intercourse)	37%	35%	37%	54%
Used birth control pills (during last sexual intercourse)	38%	27%	31%	21%
Used an IUD (during last sexual intercourse)	3%	3%	3%	4%
Used a shot, patch or birth control ring (during last sexual intercourse)	1%	4%	4%	5%
Did not use any method to prevent pregnancy (during last sexual intercourse)	4%	9%	7%	14%
Drug Use				
Used marijuana in the past month	8%	11%	13%	20%
Misused medications that were not prescribed to them or took more to feel good or high (in their lifetime)	3%	7%	8%	N/A
Ever used methamphetamines (in their lifetime)	2%	1%	1%	3%
Ever used cocaine (in their lifetime)	2%	2%	2%	5%
Ever used heroin (in their lifetime)	2%	1%	1%	2%
Ever took steroids without a doctor's prescription (in their lifetime)	2%	2%	2%	3%
Ever used inhalants (in their lifetime)	6%	6%	5%	6%
Ever used ecstasy (also called MDMA/Molly in their lifetime)	2%	2%	2%	4%
Ever used hallucinogenic drugs (such as LSD, acid, PCP, angel dust, mescaline, or mushrooms in their lifetime)	N/A	3%	4%	7%
Ever been offered, sold, or given an illegal drug by someone on school property (in the past year)	4%	12%	14%	20%
Oral Health				
Visited a dentist within the past year (for a check-up, exam, teeth cleaning, or other dental work)	75%	73%	74%	74%*

N/A – Not Available
**Comparative YRBS data for U.S. in 2015*

Key Issues

The Morrow County Community Partners reviewed the 2019 Morrow County Health Assessment. The detailed primary data for each individual priority area can be found in the section it corresponds to. Each organization completed an "Identifying Key Issues and Concerns" worksheet. The following tables were the group results.

What are the most significant health issues or concerns identified in the 2019 health assessment report? Examples of how to interpret the information include: 36% of adults were obese, increasing to 42% of those ages 30-64.

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Adult Mental Health (9 votes)			
Adults feeling so sad or hopeless almost every day for two weeks or more in a row that stopped them from doing usual activities (in the past year)	14%	Age: 30-64 (11%) Income: <$25K (43%)	Females (15%)
Adult who considered attempting suicide (in the past year)	6%	N/A	N/A
Adult Weight Status (6 votes)			
Adult obesity (includes severely and morbidly obese, BMI of 30.0 and above)	36%	Age: 30-64 (42%) Income: <$25K (40%)	Males (42%)
Overweight adults	38%	Age: 65+ (40%) Income: $25k Plus (36%)	Males (48%)
Youth Alcohol Consumption (6 votes)			
Youth current drinkers (had at least one drink in the past month)	18%	Age: 17 & older (27%) 14-16 (27%)	Females (18%)
Youth binge drinkers (had 5 or more alcoholic drinks on an occasion in the last month)	9%	Age: 17 & older (14%) 14-16 (10%)	Males (10%)
Youth who had one drink (in their lifetime)	43%	Age: 17 & older (51%) 14-16 (48%)	Males (45%)
Youth Weight Status (6 votes)			
Youth obesity (includes severely and morbidly obese, BMI of 30.0 and above)	29%	Age: 14-16 (28%) 13 & Younger (27%)	Males (32%)

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
Youth Mental Health (6 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)	29%	Age: 14-16 (31%) 13 or younger (30%)	Females (41%)
Youth who had seriously considered attempting suicide (in the past year)	18%	Age: 17 & older (26%) 14-16 (16%)	Females (25%)
Youth who experienced three or more ACEs (in their lifetime)	29%	Age: 17 & older (32%) 14-16 (31%)	Females (36%)
Youth Sexual Behavior (6 votes)			
Youth who had sexual intercourse (in their lifetime)	27%	Age: 17 & older (54%) 14-16 (23%)	Males & Females (27%)
Adult Health Care Access (3 votes)			
Adults who were uninsured (in the past year)	14%	Age: 30-64 (15%) Income: $25K Plus (14%)	Males (20%)
Adult who visited a doctor for a routine checkup (in the past year)	67%	Age: 30-64 (72%) Income: <$25K (73%)	Males (62%)
Adult Cardiovascular Health (3 votes)			
Adults who had been diagnosed with high blood pressure (in their lifetime)	40%	Age: 65+ (64%) Income: <$25K (51%)	Males (48%)
Adults who had been diagnosed with high blood cholesterol (in their lifetime)	33%	Age: 65+ (53%) Income: <25K (41%)	Males (41%)
Youth Tobacco Use (3 votes)			
Youth current smokers (smoked at some time in the past month)	9%	Age: 17 & older (17%) 14-16 (7%)	Males (11%)
Youth who used e-cigarettes (in the past year)	20%	N/A	N/A
Adult Sexual Behavior (2 votes)			
Adults who were forced or coerced to have sexual activity when they did not want to (in their lifetime)	7%	Age: N/A Income: <$25K (16%)	Females (12%)
Adult Alcohol Consumption (2 votes)			
Adult current drinker (drank alcohol at least once in the past month)	55%	Age: N/A Income: $25K Plus (59%)	Males (59%)
Adult binge drinker (defined as consuming more than four [women] or five [men] alcoholic beverages on a single occasion in the past month)	16%	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 Drug Use (2 votes)			
Adult prescription medication misuse (in the past 6 months)	7%	Age: 30-64 (7%) Income: $25K Plus (9%)	Females (10%)
Youth Violence (2 votes)			
Youth who were bullied (in the past year)	40%	Age: 14-16 (44%)	Females (49%)
Youth Drug Use (2 votes)			
Youth marijuana use (in the past month)	11%	Age: 17 & older (14%) 14-16 (12%)	Males (13%)
Adult Diabetes (1 vote)			
Adult who had been diagnosed with diabetes (in their lifetime)	16%	Age: 30-64 (17%) Income: <$25K (31%)	Males (16%)
Quality of Life (1 vote)			
Adults who were limited in some way because of physical, mental, or emotional problems	21%	Age: 30-64 (23%) Income: <$25K (58%)	Females (22%)
Youth Food Insecurity (1 vote)			
Youth reported they went to bed hungry (at least one day per week because their family did not have enough money for food at least one night per week)	11%	N/A	N/A

N/A- Not Available

Priorities Chosen

Based on the 2019 Morrow County Health Assessment, key issues were identified for adults and youth. Overall, there were 17 key issues identified by the Morrow County Community Partners. The Morrow County Community Partners then voted and came to a consensus on the priority areas Morrow County will focus on over the next three years. The key issues and their corresponding votes are described in the table below.

Key Issues	Votes
1. Adult mental health	9
2. Adult weight status	6
3. Youth alcohol consumption	6
4. Youth weight status	6
5. Youth mental health	6
6. Youth sexual behavior	6
7. Adult health care access	3
8. Adult cardiovascular health	3
9. Youth tobacco use	3
10. Adult sexual behavior	2
11. Adult alcohol consumption	2
12. Adult drug use	2
13. Youth violence	2
14. Youth drug use	2
15. Adult diabetes	1
16. Quality of life	1
17. Youth food insecurity	1

Morrow County will focus on the following three priority factors and priority health outcomes over the next three years:

Priority Factor(s):

1) Community Conditions
2) Access to Care

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. 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?**
    - Access to health care (4)
    - Access to healthy food (4)
    - Access to recreation (i.e., gym, exercise classes, walking/bike paths) (4)
    - Low crime rates
    - Law enforcement presence
    - Engagement from community leaders
    - Thriving community wellness center(s)
    - Decreased mortality
    - Transportation
    - Safe homes
    - Engagement
    - Inclusion
    - Involvement

2. **What makes you most proud of our community?**
    - Community collaboration (6)
    - Partnerships between agencies (2)
    - School spirit
    - School activities
    - Local pride (i.e., Cardington Community)
    - Multiple physicians
    - Hospital
    - Options for health care services
    - Small businesses
    - Resiliency

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

    - CHIP (2)
    - Vaccinations in the community
    - Drug take back day
    - Friends of Cardington
    - Fishburn and Bonecutter development
    - Community collaboration during COVID-19 pandemic
    - Coordinated Transportation Plan
    - Safe Routes to School program
    - Health district
    - Hospital
    - Healthy snacks to share with team members
    - Support for those eating healthy/exercising
    - Referrals between agencies
    - School support for students and families
    - Drug and Alcohol Awareness Prevention Coalition – DAAP
    - United Way events
    - Family and Children First Council
    - Delaware-Morrow Mental Health and Recovery Services Board

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

    - Mental health (5)
    - Obesity (2)
    - Physical activity (2)
    - Healthy eating/nutrition education (2)
    - Preventative health services and education (2)
    - Accessibility to more medical, mental health, and drug programs (2)
    - Law enforcement presence
    - Affordable recreational opportunities
    - Implementation/completion of Active Transportation Plan
    - Smoking
    - Generational resistance to higher education
    - Jobs
    - Internet access

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

    - Funding (4)
    - Leadership voids
    - Apathy
    - Education
    - Community desire
    - Resources
    - Access to transportation
    - Different cultures (i.e., Amish)
    - Resistance to change

- Stigma
- Need for financial resources

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

    - Mental health services and resources (3)
    - Community gardens/farmers markets (2)
    - Levies
    - Grants
    - Infrastructure (i.e., transportation, roads, broadband, indoor/outdoor recreation)
    - Preventative care services
    - Recreational wellness
    - Housing opportunities
    - Domestic violence programs
    - Expansion of broadband access
    - Affordable childcare
    - School staff addressing behavioral health issues through a holistic model

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

    - Funding
    - Value of being added to the conversation
    - Community gardens
    - Recreational facilities
    - Walking paths
    - Concepts to reduce stigma on a community level
    - Wider net for short term volunteer opportunities

*Quality of Life Survey

The Morrow County Community Partners urged community members to fill out a short Quality of Life Survey via SurveyMonkey. There were 256 Morrow County community members who completed the survey. The table below incorporate responses from the previous Morrow County CHIP for comparison purposes. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1. For all responses of "Don't Know," or when a respondent left a response blank, the choice was a non-response and was assigned a value of 0 (zero). The non-response was not used in averaging response or calculating descriptive statistics. *74% of survey participants live in Morrow County.*

Quality of Life Questions	Likert Scale Average Response	
	2016 (n=111)	2021 (n=256)
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]	3.41	3.95
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.01	3.53
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.72	4.07
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.)	3.51	3.84
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.)	2.12	3.12
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?)	3.63	4.08
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?	3.36	3.84
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.27	3.81
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.08	3.55
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	2.80	3.18
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.38	3.41
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?)	3.25	3.29

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

Forces of Change Assessment

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

Force of Change	Threats Posed	Opportunities Created
1. Mental health – adult & youth (6)	• Lack of access to care/resources (3) • Increased suicide rates (3) • Shortage of professionals • Missed school	• Educational/wellness programs (5) • Telemental health services (2) • Increased in-school programs • Inpatient facilities • Decrease in suicide • Increased counseling services
2. Overdoses/drug use (6)	• Increased deaths (3) • Increased crime (2) • Increased depression (2) • Increased ER visits • Public safety concerns • Employer costs for absenteeism • Higher criminal justice costs	• Educational programs (3) • Recovery and addict therapy groups (2) • Diversion to treatment from CJ
3. COVID-19 (4)	• Lack of funding • Delayed care • Increased mental illness • Healthcare provider shortages • Public distrust of government • Frustration with containment/prevention measures • Decrease in public health support • Job loss • Safety	• More jobs when restrictions are lifted • Telemedicine • Public health awareness • Increase in prevention measures • Community support • Wellness program opportunities

Force of Change	Threats Posed	Opportunities Created
4. Access to care (4)	• Less access to medications • Increased use of ERs • Decrease in routine healthcare screenings • Waiting lists • Limited programming by workforce gaps • Treatment costs • Affordability of care	• Incentives for provider recruitment (3) • Identify programs to help with costs • Insurance navigators • Telehealth • Peer programming • On site screenings • Community health fairs/expos
5. Housing market increase (2)	• Less affordable housing	• Growth • Inclusion and diversity
6. State legislative change (2)	• Decrease in authority • Decrease in vaccination uptake • Decreased ability for public health to mitigate health threats	• Opportunities for public education about disease transmission and vaccine safety
7. Health risks (i.e., heart disease, cancer) (2)	• Increased risk factors • Increased mortality	• Preventive health programs • Health screenings • Walking path • Fitness programs
8. Obesity – adult & youth (2)	• Too many fast-food restaurants • Lack of money to spent on healthy food	• Organize wellness/workout goods • Healthy eating habits
9. Population increase (2)	• Lack of housing • Food insecurities • Transportation	• Safe paths to school • Parks • Housing • Food • Inclusion and diversity
10. Rural community (2)	• Older homes • Septic issues	• N/A
11. Youth sexual activity	• Teen pregnancy • STDs	• Sexual health programs • Free contraceptives
12. Youth alcohol use	• Increased depression • Ability to get alcohol	• Community group to monitor underage alcohol purchasing
13. Lack of reproductive health providers	• No OB doctors in county	• Advertising for reproductive health clinic

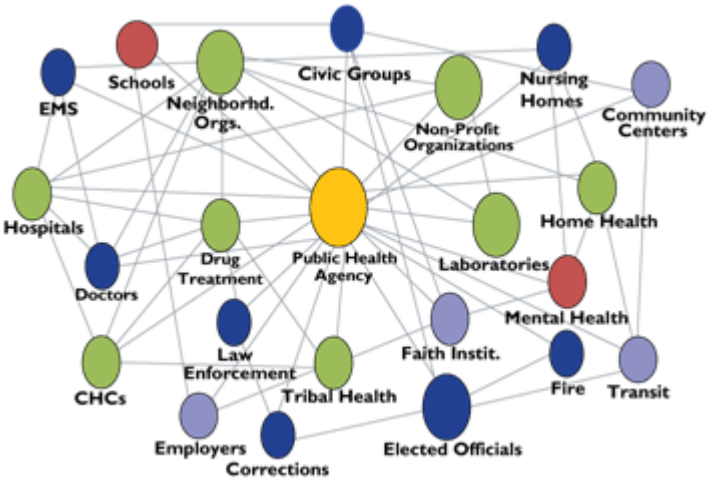
Force of Change	Threats Posed	Opportunities Created
14. Low employment rates	• Increased poverty rates	• N/A
15. Changes in diversity	• Concerns regarding policing and regulations • Changes in community dynamics	• Diversity programming • Community resources
16. Lack of funding for non-profits	• Less opportunity to give back to the community	• Events to raise money
17. Political climate	• Leadership void from local through national government	• Opportunity for individuals to become better educated
18. Social media	• Speed of information • Miss information exchange	• Leverage messaging to impact health behaviors quickly and consistently
19. Increased stress in workers and public	• Stress-related illness • Decrease in workforces	• Anger and stress management classes/trainings
20. Food insecurity	• Lack of local employment • Need to travel for employment	• Community gardens • Increased resources through food pantry

N/A – Not available

Local Public Health System Assessment

The Local Public Health System

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



The public health system includes:

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

The 10 Essential Public Health Services

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

Public health systems should:

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

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

The Local Public Health System Assessment (LPHSA)

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

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

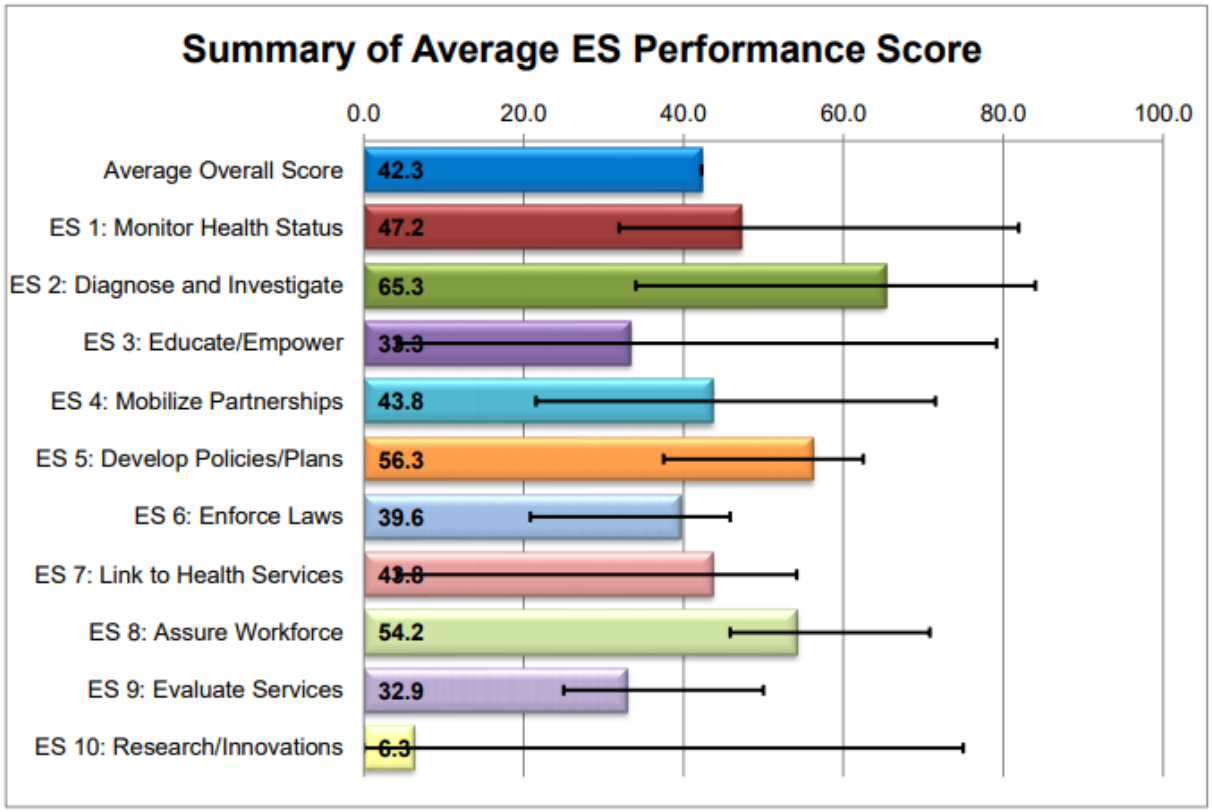
Members of the Morrow County Community completed the performance measures instrument. The LPHSA results were then presented to the Morrow County Community Partners for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard 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 Morrow County Community Partners identified 0 indicators that had a status of "no activity" and 1 indicator that had a status of "minimal". The remaining indicators were all moderate or significant.

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

To view the full results of the LPHSA, please contact Stephanie Bragg from Morrow County Health District at (419) 947-1545.

Morrow County Local Public Health System Assessment 2021 Summary



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

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

Gaps Analysis

A gap is an area where the community needs to expand its efforts to reduce a risk, enhance an effort, or address another target for change. A strategy is an action the community will take to fill the gap. Evidence is information that supports the linkages between a strategy, outcome, and targeted impact area. The Morrow County Community 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, Morrow County Community 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. Each resource inventory can be found with its corresponding priority area.

Evidence-Based Practices

As part of the gap analysis and strategy selection, the Morrow County Community 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.

Resource Inventory

Based on the chosen priorities, the Morrow County Community 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. The Morrow County Community Partners 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: Community Conditions

Strategic Plan of Action

To work toward improving community conditions, the following strategies are recommended:

Priority #1: Community Conditions

Strategy 2: School-based violence and bullying prevention programs

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1 and Year 2: Gather baseline data on which suicide prevention/violence prevention/bullying/and social inclusion programs are currently being implemented within Morrow County school districts. Explore evidence-based prevention programs such as: **The PAX Good Behavior Game**, **Steps to Respect**, **Olweus Bullying Prevention Program**, **LifeSkills Training**, **The Incredible Years**, and **ROX (Ruling Our Experience)**. Determine which program(s) will be offered and are sustainable. Determine feasibility of piloting components within the Leader in Me Program. Pilot the program(s) in at least one school district.	December 31, 2022	Youth	Adverse childhood experiences (ACEs): Percent of children, ages 0-17, who have experienced two or more adverse experiences (NSCH) Child abuse and neglect: Number of screened-in reports of child abuse and/or neglect, per 1,000 children in the population** (SACWIS, via ODJFS)	DMMHRSB Syntero
Year 1 and Year 2: Introduce or re-introduce the evidence-based program(s) to the school districts. Pilot any new programs in at least one district. Determine the baseline number of mentoring and early-literacy opportunities within the county. Determine interest and need for additional programming and/or mentoring opportunities.	December 31, 2022			
Year 3: Continue efforts from years 1 and 2. Expand any current programming to additional districts or grade levels. Research and determine feasibility of community initiatives/mentoring programs to engage families/at-risk students.	December 31, 2023			

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy:

DMMHRSB and Syntero

Outcome:

Increase the number of bullying prevention programs implemented in schools

Priority #2: Access to Care

Strategic Plan of Action

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

<table>
<tr><td colspan="5">Priority #2: Access to Care</td></tr>
<tr><td colspan="5">Strategy 1: Telemedicine</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 and Year 2: Collect baseline on the number of organizations that currently utilize telemedicine and who in Morrow County is offering it.

Continue to introduce telemedicine to organizations within Morrow County.</td><td>December 31, 2022</td><td rowspan="3">Adult and Youth</td><td rowspan="3">Primary care health professional shortage areas. Percent of Ohioans living in a primary care health professional shortage area* (HRSA, as compiled by KFF)

Mental health professional shortage areas. Percent of Ohioans living in a mental health professional shortage area* (HRSA, as compiled by KFF)</td><td rowspan="3">OhioHealth

DMMHRSB</td></tr>
<tr><td>Year 1 and Year 2: Continue efforts from year 1. Increase the number of organizations providing telemedicine 10% from baseline.</td><td>December 31, 2022</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2.</td><td>December 31, 2023</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:
OhioHealth and DMMHRSB</td></tr>
<tr><td colspan="5">Outcome:
Increase the use of telemedicine throughout the county</td></tr>
</table>

Priority #2: Access to Care				
Strategy 2: Awareness of Healthcare Services and Education on Preventive Care				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1 and Year 2: Coordinate efforts between agencies to increase community outreach and education on available health services (many of which are free or at a reduced cost). Increase community education on the importance of preventive health care. Update 2-1-1 to reflect all organizations providing free or reduced cost healthcare services. Increase awareness and education on using 2-1-1 as a community resource.	December 31, 2022	Adult, Youth, Children	Adults who were uninsured (in the past year) Adults who visited a doctor for a routine checkup (in the past year)	Morrow County Hospital Helpline
Year 1 and Year 2: Continue community outreach efforts. Update 2-1-1 as needed.	December 31, 2022			
Year 3: Increase efforts from years 1 & 2.	December 31, 2023			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: Morrow County Hospital and Helpline				
Outcome: Increase community health education efforts				

Priority #2: Access to Care				
Strategy 3: Education materials being offered to patients by primary care offices				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1 and Year 2: Work with primary care physician offices to assess what information and/or materials they are lacking to provide better resources for any of the following: • Women's health screenings • Men's health screenings • Weight management • Tobacco use and cessation • Cancer prevention practices	December 31, 2022	Adult	Adult obesity (includes severely and morbidly obese, BMI of 30.0 and above) Adults who had been diagnosed with high blood pressure (in their lifetime) Adults who had been diagnosed with high blood cholesterol (in their lifetime) Adults who had been diagnosed with diabetes (in their lifetime) Adult current drinker (drank alcohol at least once in the past month)	OhioHealth
Year 1 and Year 2: Offer trainings for PCP offices on health screening best practices, as well as referral sources. Enlist at least 3 primary care physician offices.	December 31, 2022			
Year 3: Offer additional trainings to reach at least 30% of the primary care physician offices in the county.	December 31, 2023			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: OhioHealth				
Outcome: Increase community health education efforts				

Priority #3: Mental Health and Addiction

Strategic Plan of Action

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

Mental Health Strategies

Priority #3: Mental Health and Addiction				
Strategy 1: Trauma Informed Care				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1 and Year 2: Facilitate an assessment among clinicians, teachers and community members in Morrow County on their awareness and understanding of trauma informed care (TIC), including toxic stress and adverse childhood experiences. Facilitate focus groups to discuss TIC initiatives and supports needed at districts.	December 31, 2022	Youth	Youth who felt so 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) Youth who experienced three or more ACEs (in their lifetime)	DMMHRSB Syntero
Year 1 and Year 2: Continue efforts from year 1. Implement the CANS assessment for social service agencies who work with At Risk or Multi System Youth.	December 31, 2022			
Year 3: Continue efforts from years 1 and 2. Increase the use of trauma screening tools by 10%.	December 31, 2023			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: CANS training for Social Service agencies and Treatment agencies				
Outcome: Increase youth trauma screenings				

Priority #3: Mental Health and Addiction

Strategy 2: Re-establish suicide prevention coalition

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Implement the SOS program in all four districts serving 7th and 9th graders.	December 31, 2022	Youth	Youth who felt so 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) Youth who has seriously considered attempting suicide (in the past year) Youth who experienced three or more ACEs (in their lifetime)	DMMHSRB Helpline
Year 2: Begin planning and recruitment to restart the Suicide Prevention Coalition. Enlist any missing sectors to be part of the coalition. Increase community awareness and participation in the coalition.	December 31, 2022			
Year 3: Continue efforts from years 1 and 2. Restart Suicide Prevention Coalition.	December 31, 2023			

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy:

DMMHSRB and Helpline

Outcome:

Decrease depression rates and suicide attempts

Priority #3: Mental Health and Addiction

Strategy 3: Crisis lines

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Promote and raise awareness of the Crisis Text Line (Text **4hope** to 741741) throughout Morrow County.	December 31, 2022	Adult and Youth	Youth depression (major depressive episode): Percent of youth, ages 12-17, who experienced a major depressive episode within the past year (NSDUH) Adult depression (major depressive episode): Percent of adults, ages 18 and older, who experienced a major depressive episode within the past year (NSDUH)	Helpline
Year 2: Continue to promote and monitor the use of the Crisis Text Line. Initial roll out of 988 Crisis line. (Scheduled for release in July 2022) Work with school administrators, guidance counselors, churches, and other community organizations to promote the Crisis Text Line and 988.	December 31, 2022			
Year 3: Continue efforts from year 2.	December 31, 2023			

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy:

Helpline

Outcome:

Decrease depression rates and suicide attempts

Addiction Strategies

Priority #3: Mental Health and Addiction				
Strategy 4: Increase treatment options for those with substance use disorders and mental health issues				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1 and Year 2: Establish procedure for referral system for treatment.	December 31, 2022	Adult	Adult current drinker (drank alcohol at least once in the past month) Adult binge drinker (defined as consuming more than four [women] or five [men] alcoholic beverages on a single occasion in the past month) Adult prescription medication misuse (in the past 6 months)	OhioHealth BH Provider DAAP
Year 1 and Year 2: Plan a community awareness campaign that will help others recognize signs of substance abuse and where to find treatment.	December 31, 2022			
Year 3: Explore options for a community awareness campaign that will help community members recognize the signs of Substance Abuse and where to find treatment.	December 31, 2023			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: OhioHealth BH Provider and DAAP				
Outcome: Increase treatment option availability				

Priority #3: Mental Health and Addiction				
Strategy 5: Expand Hidden in Plain Sight programs to reduce alcohol and drug use among youth				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Coordinate with local school districts to designate a location in 1-2 schools to set up a display for Hidden in Plain Sight and parents who host events. Enlist local law enforcement to assist with providing materials for the program.	December 31, 2022	Youth	Youth current drinkers (had at least one drink in the past month) Youth binge drinker (had 5 or more alcoholic drinks on an occasion in the last month) Youth marijuana use (in the past month)	Sheriff's office DAAP
Year 2: Introduce the program to 2-3 more schools.	December 31, 2022			
Year 3: Continue efforts of years 1 and 2 with the goal to introduce the program in all Morrow County school districts.	December 31, 2023			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: Sheriff's office and DAAP				
Outcome: Decrease youth drinking and marijuana rates				

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 Morrow County Community Partners will meet quarterly to report our progress. The Morrow County Community Partners 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.

Morrow County will continue facilitating CHAs every three years to collect data and determine trends. Primary data will be collected for adults and secondary data will be analyzed for youth using national sets of questions to not only compare trends in Morrow 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:

Stephanie Bragg, RN, BSN, MHA
Health Commissioner
Morrow County Health District
619 West Marion Road
Mt. Gilead, OH 43338
419-947-1545

Appendix I: Gaps and Strategies

The following tables indicate community conditions, access to care, and mental health and addiction gaps and potential strategies that were compiled by the Morrow County Community Partners.

Priority Factors: Community Conditions

Gaps	Potential Strategies
1. Youth adverse childhood experiences (4)	• School-based violence and bullying prevention programs *  • Leader in Me program * • Big Brother Big Sisters (BBBS) √  (2) • School-based social emotional instruction  • Extracurricular activities for physical activity  • Counseling services
2. Affordable housing	• METRO/TANF cash
3. Chronic absenteeism	• Trauma-informed schools √  (2) • Career academics √  • School-based social emotional instruction 

 = Ohio SHIP supported strategy
√ = likely to decrease disparities
* Aligned with previous Morrow County CHIP

Priority Health Outcomes: Access to Care

Gaps	Potential Strategies
1. Uninsured adults (4)	• Health insurance enrollment outreach and support *√  (4) • Paid sick leave laws √  • Medicaid applications (2)
2. Medically underserved area/access (3)	• Financial incentives to recruit and retain health professionals in underserved areas √  (3) • Telemedicine √  (2) • Health literacy interventions √  • Mental health benefits legislation, along with monitoring for implementation and compliance √  • HelpLine Crisis Engagement Services
3. Transportation	• Public transportation systems * √  • JFS gas vouchers • MCAT
4. Adults who were limited in some way because of physical, mental, or emotional problems	• Integration of behavioral health services into primary care √  (2) • Rural training in medical education √  • Chronic disease management programs  (2)

 = Ohio SHIP supported strategy
√ = likely to decrease disparities
* Aligned with previous Morrow County CHIP

Priority Health Outcomes: Mental Health and Addiction

Gaps	Potential Strategies
1. Adult and youth depression, suicide, bullying (5)	• Mental health first aid * √ (2) • Primary care physicians screening for depression in office visits * √ • Suicide prevention coalition * • Telemental health services √ (2) • Crisis lines (3) • Peer support specialists (2) • Universal school-based suicide awareness and education programs (2) • Youth peer mentoring (2) • School-based social and emotional instruction (2) • Activity programs for older adults • Community-based social support for physical activity • Motivational interviewing training • Depression screening • Counseling services (2) • Expand question, persuade, refer (QPR) training
2. Adult and youth drug use	• Syringe services programs (SSPs) √ • Peer support specialists • Counseling services (2)
3. Adult and youth alcohol use	• Big Brothers Big Sisters (BBBS) √ (3) • Universal school-based alcohol prevention programs • Youth-led prevention • SBIRT – alcohol brief interventions • Counseling services (2)

= Ohio SHIP supported strategy
√ = likely to decrease disparities
* Aligned with previous Morrow County CHIP

Appendix II: Links to Websites

Title of Link	Website URL
Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services	http://www.cdc.gov/nphpsp/essentialservices.html
Crisis Text Line	https://www.crisistextline.org/
Healthy People 2030	https://health.gov/healthypeople/objectives-and-data
LifeSkills Training	https://www.lifeskillstraining.com/
Olweus Bullying Prevention Program	https://www.violencepreventionworks.org/public/index.page
PAX Good Behavior Game	https://www.hazelden.org/HAZ_MEDIA/gbg_insert.pdf
ROX (Ruling Our Experience)	https://rulingourexperiences.com/#!about_us/csgz
Steps to Respect	https://www.blueprintsprograms.org/programs/224999999/steps-to-respect/print/
The Incredible Years	http://www.incredibleyears.com/
Trauma informed care	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/trauma-informed-health-care