2017  2020

Holmes County

Community Health Improvement Plan

Adopted on December 21, 2017

Table of Contents

Executive Summary

In 2016, the Partners for a Healthier Holmes County began conducting community health assessments (CHA) for the purpose of measuring and addressing health status. The most recent Holmes County Community Health Assessment was cross-sectional in nature and included a written survey of adults and adolescents within Holmes County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention for their national and state Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Surveillance System (YRBSS). This has allowed Holmes County to compare the data collected in their CHA to national, state and local health trends.

Holmes County CHA also fulfills national mandated requirements for the hospitals in our county. H.R. 3590 Patient Protection and Affordable Care Act states that in order to maintain tax-exempt status, not-for-profit hospitals are required to conduct a community health needs assessment at least once every three years, and adopt an implementation strategy to meet the needs identified through the assessment.

From the beginning phases of the CHA, community leaders were actively engaged in the planning process and helped define the content, scope, and sequence of the project. Active engagement of community members throughout the planning process is regarded as an important step in completing a valid needs assessment.

The Holmes County CHA has been utilized as a vital tool for creating the Holmes County Community Health Improvement Plan (CHIP). The Public Health Accreditation Board (PHAB) defines a CHIP as a long-term, systematic effort to address health problems on the basis of the results of assessment activities and the community health improvement process. This plan is used by health and other governmental, education, and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A CHIP is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community inclusively and should be done in a timely way.

The Holmes County Community Health Coalition hired the Hospital Council of Northwest Ohio (HCNO), a neutral regional non-profit hospital association, to facilitate the process. Partners for a Healthier Holmes County then invited key community leaders to participate in an organized process of strategic planning to improve the health of residents of the county. The National Association of City County Health Officer's (NACCHO) strategic planning tool, Mobilizing for Action through Planning and Partnerships (MAPP), was used throughout this process.

The MAPP Framework includes six phases which are listed below:

- Organizing for success and partnership development
- Visioning
- Conducting the MAPP assessments
- Identifying strategic issues
- Formulating goals and strategies
- Taking action: planning, implementing, and evaluation

The MAPP process includes four assessments: Community Themes & Strengths, Forces of Change, the Local Public Health System Assessment and the Community Health Status Assessment. These four assessments were used by Holmes County Community Health Coalition to prioritize specific health issues and population groups which are the foundation of this plan. The diagram below illustrates how each of the four assessments contributes to the MAPP process.

Figure 1.1 2017-2020 Holmes County CHIP Overview

Overall Health Outcomes	
↑ Increase Health Status	↓ Decrease Premature Death

Priority Topics		
Mental Health and Addiction	Chronic Disease	Access to Preventive Care

Priority Outcomes		
↓ Decrease adult and youth mental health ↓ Decrease youth violence ↓ Decrease youth suicide ↓ Decrease youth depression ↓ Decrease youth alcohol use	↓ Decrease adult and youth obesity ↓ Decrease adult cardiovascular disease ↓ Decrease adult diabetes ↑ Increase youth nutrition	↑ Increase adult access to medical care ↑ Increase health screenings ↑ Increase adult and youth access to dental care

Partners

The 2017-2020 Community Health Improvement Plan was drafted by agencies and service providers within Holmes County. During July-September 2017 the committee reviewed many sources of information concerning the health and social challenges Holmes County adults and youth may be facing. They determined priority issues which if addressed, could improve future outcomes, determined gaps in current programming and policies and examined best practices and solutions. The committee has recommended specific actions steps they hope many agencies and organizations will embrace to address the priority issues in the coming months and years. We would like to recognize these organizations and thank them for their devotion to this process and this body of work:

The Partners for a Healthier Holmes County

Anazao Community Partners
Center for Appalachia Research in Cancer Education (CARE) (Project Huffnung)
East Holmes School District
Holmes County Board of Developmental Disabilities
Holmes County Emergency Management Agency
Holmes County General Health District
OneEighty
Pomerene Hospital
United Way
Wayne-Holmes County Mental Health and Recovery Board
West Holmes School District

The community health improvement process was facilitated by Tessa Elliott, Community Health Improvement Coordinator, and Alyssa Miller, Graduate Assistant, from the Hospital Council of Northwest Ohio.

Vision

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 Holmes County

Through collaboration and partnership within the community, Holmes County will become the healthiest county in Ohio.

The Mission of Holmes County

Working together to improve the health and quality of life for residents of Holmes County.

Alignment with National and State Standards

The 2017-2020 Holmes County Health Improvement Plan priorities align perfectly with state and national priorities. Holmes County will be addressing the following priorities: mental health and addiction, chronic disease and access to preventive care.

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

The Holmes County Community Health Improvement Plan (CHIP) also aligns with four of the National Prevention Strategies for the U.S. population: healthy eating, active living, mental and emotional well-being and preventing drug abuse.

Healthy People 2020

Holmes County priorities also fit specific Healthy People 2020 goals. For example:

- ***Nutrition and Weight Status (NWS)-8:*** Increase the proportion of adults who are at a healthy weight. This plan also support goals *NWS 1-22*.
- ***Heart Disease and Stroke (HDS)*-5:** Reduce the proportion of persons in the population with hypertension**.** This plan also supports goals *HDS 1-8.*
- ***Mental Health and Mental Disorders (MHMD)-9:*** Increase the proportion of adults with mental health disorders who receive treatment. This plan also supports goals *MHMD 1-12*.
- ***Substance Abuse (SA)-2:*** Increase the proportion of adolescents never using substances. This plan also supports goals *SA 1-6, 8-11, 14, 16-17, & 20*.

Ohio State Health Improvement Plan (SHIP)

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 Ohio Department of Health contracted with the Health Policy Institute of Ohio (HPIO) to conduct the 2017-2018 Sate Health Improvement Plan. HPIO sub-contracted with the Hospital Council of Northwest Ohio to collect data, facilitate regional forums, and assist with the SHIP strategies.

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)

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)

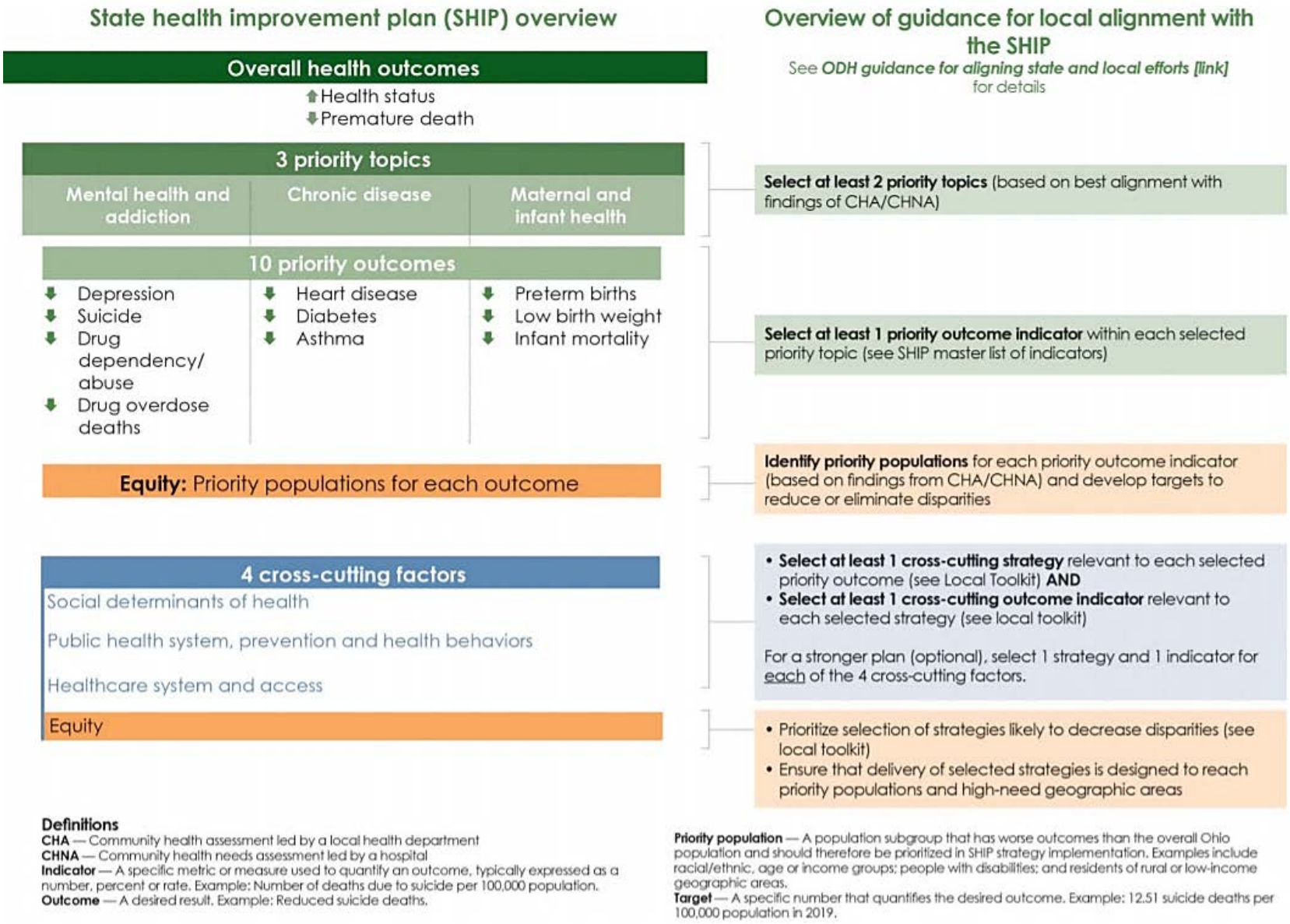
The SHIP also takes a comprehensive approach to improving Ohio's greatest health priorities by identifying cross-cutting factors that impact multiple outcomes: health equity, social determinants of health, public health system, prevention and health behaviors, and healthcare system and access.

The 2017-2020 Holmes County CHIP was 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 State Health Improvement Plan. The following Holmes County CHIP priority topics, outcomes and cross cutting factors very closely align with the 2017-2019 SHIP priorities:

2017-2020 Holmes CHIP Alignment with the 2017-2019 SHIP		
Priority Topics	*Priority Outcomes*	*Cross-Cutting Factors*
Mental and addiction	• Decrease depression • Decrease suicide • Decrease drug dependence/abuse	• Public health system, prevention and health behaviors • Healthcare system and access
Chronic Disease	• Decrease heart disease • Decrease diabetes	

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

Figure 1.2 2017-2019 State Health Improvement Plan (SHIP) Overview



Strategic Planning Model

Beginning in July 2017, The Partners for a Healthier Holmes County met four (4) times and completed the following planning steps:

1. **Initial Meeting:** Review of process and timeline, finalize committee members, create or review vision
2. **Choosing Priorities:** Use of quantitative and qualitative data to prioritize target impact areas
3. **Ranking Priorities:** Ranking the health problems based on magnitude, seriousness of consequences, and feasibility of correcting
4. **Resource Assessment:** Determine existing programs, services, and activities in the community that address the priority target impact areas and look at the number of programs that address each outcome, geographic area served, prevention programs, and interventions
5. **Forces of Change and Community Themes and Strengths:** Open-ended questions for committee on community themes and strengths
6. **Gap Analysis:** Determine existing discrepancies between community needs and viable community resources to address local priorities; identify strengths, weaknesses, and evaluation strategies; and strategic action identification
7. **Local Public Health Assessment:** Review the Local Public Health System Assessment with committee
8. **Quality of Life Survey:** Review results of the Quality of Life Survey with committee
9. **Best Practices:** Review of best practices and proven strategies, evidence continuum, and feasibility continuum
10. **Draft Plan:** Review of all steps taken; action step recommendations based on one or more the following: enhancing existing efforts, implementing new programs or services, building infrastructure, implementing evidence based practices, and feasibility of implementation

Action Steps

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

1. Community gardens
2. Community-based social support for physical activity
3. Implement nutrition policy in schools
4. School-based nutrition education programs
5. School-based physical activity programs and policies
6. Implement fruit and vegetable incentive programs

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

1. Screen for clinical depression for all patients using a standardized tool
2. Trauma informed care
3. Mental health first aid
4. School based violence prevention programs
5. School-based alcohol/other drug prevention programs
6. Expand the use of telemedicine
7. Implement a community-based comprehensive program to reduce alcohol abuse
8. Expand community collaboration to increase awareness and coordination of mental health services
9. Campaign to increase awareness of substance abuse and prevention
10. Provide trainings on mental health and substance abuse services to ER and primary care providers

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

1. Increase awareness of existing healthcare services or preventive care
2. Explore different chronic disease management practices
3. Increase access to dental care

To address all priority areas, the following cross-cutting strategies are recommended:

1. Shared use (joint use agreements)
2. Higher education financial incentives for health professionals serving in underserved areas

Needs Assessment

The Partners for a Healthier Holmes County reviewed the 2017 Holmes County Health Assessment. The detailed primary data for each individual priority area 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 <u>ADULT</u> health issues or concerns identified in the 2017 assessment report?

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk	Demographic most at risk
Access/Utilization of Preventive Care (10 votes)				
Had a mammogram in the past year (age 40 and older)	35%	Income: <$25K (30%)	N/A	N/A
Had a clinical breast exam in the past year (age 40 and older)	40%	Income: <$25K (32%)	N/A	N/A
Had a colonoscopy in the past five years (age 50 and older)	37%	N/A	N/A	N/A
Visited the dentist in the past year	57%	Age: 65+ (52%), Income: <$25K (27%)	Male (53%)	Amish (52%)
Visited a doctor for a routine checkup in the past year	33%	Age: <30 (10%), Income: $25K Plus (34%)	Male (28%)	Amish (16%)
Diagnosed with prostate cancer	26%	N/A	N/A	N/A
Weight Status (8 votes)				
Obese	30%	Age: 30-64 (35%), Income: <$25K (41%)	Female (31%)	Non-Amish (34%)
Overweight	35%	Age: 65+ (38%), Income: $25K Plus (37%)	Male (39%)	N/A
Chronic Disease (8 votes)				
Had angina or coronary heart disease	4%	Age: 65+ (16%)	N/A	N/A
Survived a heart-attack	3%	Age: 65+ (14%)	N/A	Non-Amish (6%)
Survived a stroke	2%	Age: 65+ (6%), Income: <25K (6%)	N/A	Non-Amish (4%)
Diagnosed with cancer	7%	N/A	N/A	N/A
Diagnosed with diabetes	5%	Age: 65+ (17%), Income: <25K (17%)	N/A	Non-Amish (8%)
Diagnosed with arthritis	21%	Age: 65+ (54%)	N/A	Non-Amish (31%)

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk	Demographic most at risk
Mental Health (6 Votes)				
Felt sad or hopeless every day for two or more weeks in a row	4%	Age: 30-64 (4%), Income: <$25K (12%)	Female (5%)	N/A
Seriously considered attempting suicide	1%	N/A	N/A	N/A
Diagnosed with anxiety or emotional problems	16%	N/A	N/A	N/A
Diagnosed with depression	15%	N/A	N/A	N/A
Average days that mental health not good in past month	2.4	N/A	N/A	N/A
Rated mental health as not good on four or more days	15%	N/A	N/A	N/A
Felt sad or hopeless every day for two or more weeks in a row	4%	Age: 30-64 (4%), Income: <$25K (12%)	Female (5%)	N/A
Drug/Alcohol Use (5 votes)				
Drank alcohol at least one in past month	40%	N/A	Males (47%)	Non-Amish (40%)
Binge drinker	8%	N/A	N/A	Non-Amish (26%)
Driving after drinking any alcoholic beverage	11%	Age: 30-64 (14%)	N/A	N/A
Failed to fulfill duties at work, home, or school because of drinking	1%	N/A	N/A	N/A
Used marijuana in the past 6 months	1%	Age: 30-64 (2%), Income: <$25K (2%)	N/A	N/A
Risk Factors for Chronic Disease (1 vote)				
Diagnosed with high blood pressure	20%	Age: 65+ (51%), Income: <$25K (47%)	Male (24%)	Non-Amish (31%)
Diagnosed with high blood cholesterol	19%	Age: 65+ (55%), Income: <$25K (39%)	Male (20%)	Non-Amish (30%)
Vaccinations (1 vote)				
Had a pneumonia vaccination (ages 65 and over)	60%	N/A	N/A	
Had a flu vaccine in the past year (ages 65 and over)	58%	N/A	N/A	
Children who received all recommended vaccinations	47%	N/A	N/A	N/A
Child had been vaccinated for HPV	10%	N/A	N/A	N/A
Adverse Childhood Experiences (ACE's) (1 vote)				
Had 4 or more ACE's in their lifetime	4%	Income: <$25K (10%)	N/A	N/A

What are the most significant YOUTH health issues or concerns identified in the 2017 assessment report?

Key Issue or Concern	Percent of Population At risk	Age Group (or Grade Level) Most at Risk	Gender Most at Risk
Mental Health (9 votes)			
Had seriously considered attempting suicide past year	12%	Age: 17+ (16%), Grade Level: 9-12 (15%)	Female (16%)
Had attempted suicide in the past year	5%	Grade Level: 6-12 (5%)	Female (7%)
Felt sad or hopeless almost every day for 2 or more weeks in a row	21%	Grade Level: 9-12 (24%)	N/A
Violence (7 votes)			
Bullied in the past year	43%	N/A	N/A
Bullied on school property in the past year	30%	N/A	N/A
Carried a weapon in the past 30 days	19%	Age: 17+ (28%), Grade Level: 6-12 (19%)	Male (30%)
Purposefully hurt themselves in the past year	15%	Age: 14-16 (17%)	Female (19%)
Alcohol Use (6 votes)			
Ever tried alcohol	38%	Age: 17+ (69%), Grade Level: 9-12 (56%)	Male
Current drinker	24%	Age: 17+ (50%), Grade Level: 9-12 (38%)	Female
Binge drinker (of all youth)	10%	Age: 17+ (28%), Grade Level: 9-12 (18%)	Male
Drank for the first time before age 13 (of all youth)	14%	N/A	N/A
Average age of onset for drinking	13.1	N/A	N/A
Got the alcohol they drank from their parents	26%	N/A	N/A
Weight Status (4 votes)			
Obese	16%	Age: 14-16 (19%), Grade Level: 9-12 (17%)	Male (17%)
Overweight	11%	Age: 14-16 (14%), Grade Level: 6-12 (11%)	Female (15%)
Had 5 or more servings of fruits and vegetables per day	5%	N/A	N/A
Access to Dental Care (3 votes)			
Visited a dentist for a check-up within the past year	71%	N/A	Male (69%)
Electronic Vapor Products (2 votes)			
Current electronic vapor product user	8%	Age: 14-16 (12%), Grade Level: 9-12 (11%)	Male (11%)

Priorities Chosen

Based on the 2017 Holmes County Health Assessment, key issues were identified for adults and youth. Committee members 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. Committee members' rankings were then combined to give an average score for the issue.

The rankings were as follows:

Health Issue	**Average Score**
Adult obesity and overweight	24.7
Adult access/utilization of preventive care	24.1
Youth mental health (suicide/depression)	23.8
Adult mental health	23.0
Adult chronic disease	22.8
Youth alcohol use	22.6
Youth obesity and nutrition	22.0
Youth violence	21.7
Youth access to dental care	19.8
Adult drug and alcohol use	19.7

Holmes County will focus on the following three priority area over the next 3 years:

1. **Chronic disease** *(includes adult and youth obesity, youth nutrition, adult diabetes, and adult heart disease)*
2. **Mental health and addiction** *(includes adult and youth mental health, youth violence, youth suicide, youth depression and youth alcohol use)*
3. **Access to preventive care** *(includes health screenings and medical and dental care)*

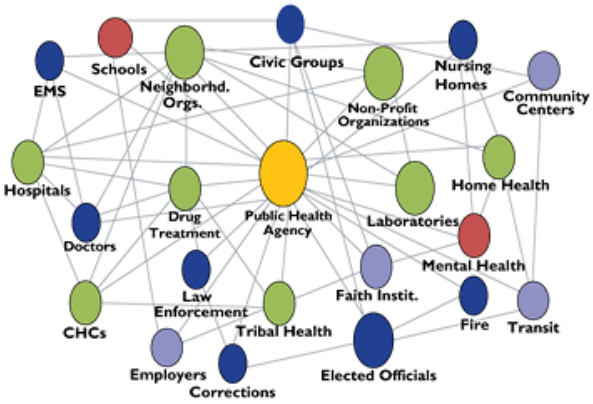
Forces of Change Assessment

The Partners for a Healthier Holmes County was asked to identify positive and negative forces which could impact community health improvement and overall health of this community over the next three to five years. This group discussion covered many local, state, and national issues and change agents which could be factors in Holmes County in the near future. The table below summarizes the forces of change agent and its potential impacts.

Force of Change	Potential Impact
1. Loss Medicaid/loss of block grants	• Anthem left the county, while Molina came in. This could potentially cause confusion and/or loss of healthcare for community members.
2. Cleveland Clinic ended contract with Care Source and picked up Molina	• Cleveland Clinic no longer contracts with Care Source, now contracts with Molina. Cleveland Clinic could potentially move in and provide additional health care services.
3. Mental Health and Recovery Board Services (MHRBS) Levy	• A MHRSB levy is coming up. Historically, this levy has never passed in Holmes County.
4. Opioid epidemic	• The Holmes County MHRSB has secured $75,000 to help combat the opioid epidemic.
5. Rehabilitation options	• Some judges are using alcohol prevention strategies and treatment options instead of sentencing jail time. • Rehabilitation services may reduce number of drug-related incidences as well as this could lower costs and overcrowding of the local jail
6. Cuts to funding at the national level	• The President is using executive orders to cut Centers for Disease Control and Prevention (CDC) and National Institute of Health (NIH) funding would could affect disaster preparedness and preventive medicine (i.e. vaccinations). • As a result of these cuts, disaster preparedness may become more difficult, and in the case of a disaster, more funding would be needed to restore the community.
7. Fear of an epidemic (West Nile, Lime disease, Zika) and an influx of infectious diseases	• Funding is being allocated to other projects, specifically state mandated programming which leaves the community vulnerable in case of an outbreak
8. Measles outbreak	• Another measles outbreak could affect the local tourism industry. The local economy would be impacted by any loss of tourism.
9. Road conditions	• The conditions of the roads in Holmes County is greatly impacted by the local tourism industry. Funding will be needed to improve the quality of the roadways.

Force of Change	Potential Impact
10. Regionalization	• The idea of regionalization could be a threat to local health departments, as it takes away local control. Health departments would be unable to control where funding goes based on what they see as a need.
11. Transportation	• The Hospital provides free transportation to surgical patients who live within a 30-mile radius. Better after-surgery care will be available to those who are unable to come in for follow-up appointments leading to better overall results as a result of having access to transportation.
12. Population growth	• The population in Holmes County has grown significantly (about 7% increase every year). This causes an increased need for more resources and may lead to a lack of available and accessible community resources.
13. Aging population	• There is a lack of resources for the aging population. Older adults may need to move out of the county or risk living in an unsafe environment. • Ambulances are being used much more frequently due to falls, causing an increase in ambulance prices.
14. Technology and social media use	• The use of technology and social media by teenagers has increased. This has led to an increase in cyber bullying, sexting and other risky behaviors.
15. Amish population	• The population is growing at a fast rate. Some Amish sectors are now accepting of cellphone use and other activities using technology. • The use of electricity, solar power/panels and generators is also increasing among the Amish. • The use of technology helps them with yardwork, etc.
16. Recreational marijuana use	• Recreational marijuana use is being pushed in Ohio without considering the economic and social issues it could cause. • Marijuana may lead to new growing facilities and a need for more regulation surrounding the dispensaries.
17. Grants focused on metropolitan areas	• Holmes county may continue to deal with a lack of funding due to funding going to more populated or metropolitan areas in the state.

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) 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.**

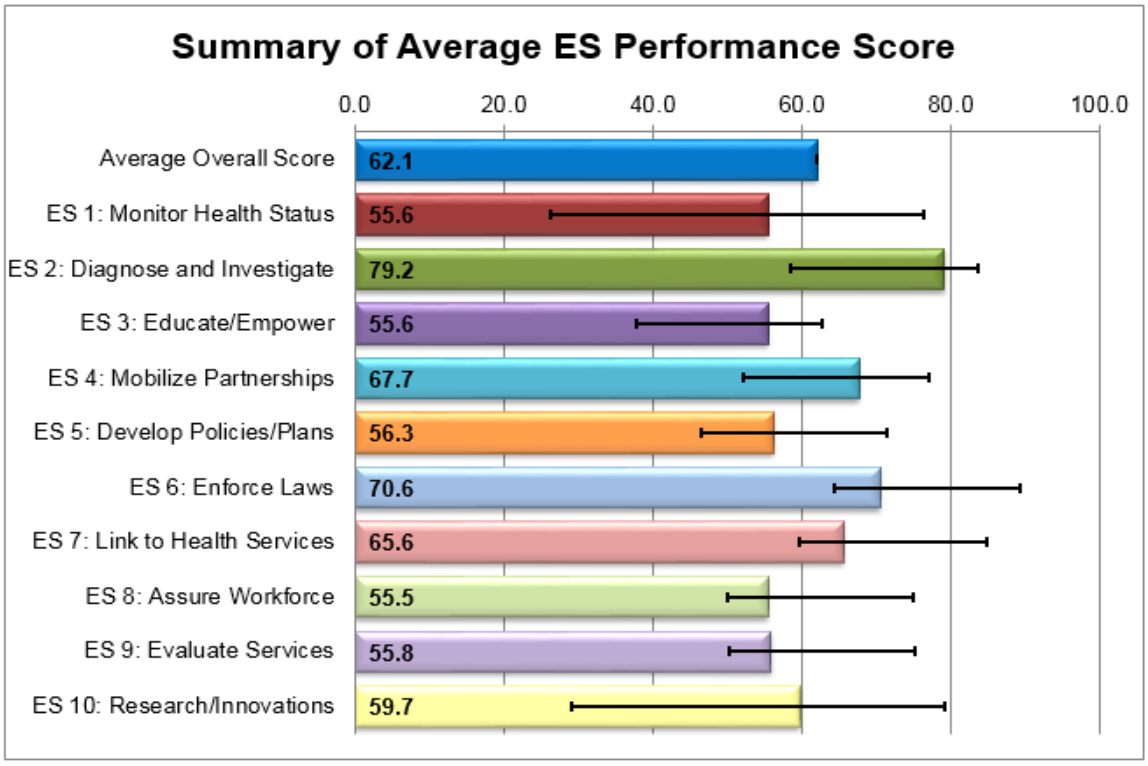
Members of the Holmes County General Health District completed the performance measures instrument. The LPHSA results were then presented to the full CHIP committee for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard 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.

The CHIP committee identified 10 indicators that had a status of "minimal" and 10 indicators that had a status of "no activity." The remaining indicators were all moderate, significant or optimal.

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

To view the full results of the LPHSA, please contact Jennifer McCoy from the Holmes County General Health District at **jmccoy@holmeshealth.org**

Holmes County Local Public Health System Assessment 2017 Summary



Community Themes and Strengths Assessment

The Partners for a Healthier Holmes County participated in an exercise to discuss community themes and strengths. The results were as follows:

Holmes County community members believed the most important characteristics of a healthy community were:

- Positive health outcomes
- Low infant mortality
- Lack of poverty
- High employment rates and employment opportunities
- Educational opportunities/high education levels
- An educated community
- Access to healthcare and healthcare providers
- Availability and access to a variety of community resources
- Access to healthful foods and physical activity
- Wellness and prevention programs in schools
- Residents staying and contributing to the community after high school
- As population increases, so do available resources

Community members were most proud of the following regarding their community:

- People help each other without needing to be asked
- Volunteers are always readily available
- Loyalty to local industry
- Hardworking/"do-it-yourself" mentality
- Residents are friendly and caring
- Generosity of community members
- Strong, small businesses who are dedicated to their community
- Residents are committed and have pride in their faith
- Community members are very welcoming and hospitable
- The local tourism industry is valued and profitable
- Everything is available for purchase within the county (self-sufficient)
- Employees are valued for their work/employers take care of their employees

The following were specific examples of people or groups who have worked together to improve the health and quality of life in the community:

- The faith-based community
- The Partners for a Healthier Holmes County - CHIP group
- Family and Children First Council (FCFC)
- Holmes County Association for Handicapped Citizens
- Local PTO's (Parent – Teacher Organization) raise money through different fundraising activities
- Sports and music booster clubs throughout the county
- Amish Safety Committee
- Strong Families, Safe Communities
- Spark Holmes County – a drug prevention program
- Rotary Club
- Lion's Club
- Share A Christmas
- Love center
- Love, Inc.
- Pomerene Hospital charity

The most important issues that Holmes County residents believed must be addressed to improve the health and quality of life in their community were:

- Recruit more health care and dental care providers into the county
- Recruit speech and language therapists
- People do not want to move into the county
- Access to WIC-accepting stores
- Forming trust and communication about cultural differences
- Cultural differences with medicine
- Educating Holmes County residents on basic health topics
- Providing education regarding tobacco use, chewing tobacco and cessation services
- Bringing in alternative care methods
- Care for the elderly (nursing homes, assisted care living)

The following were barriers that have kept the community from doing what needs to be done to improve health and quality of life:

- Thriftiness (people are not spending money on prevention)
- Cost of services
- Cannot find employment within the county
- People are not receptive to education, they feel they already know everything
- No time to exercise due to busy work lives
- Lack of a willingness to change
- Difficult to find funding for programs (much of the funding goes to metropolitan areas)
- Offices are not always accessible due to inconvenient hours
- Difficulty meeting health outcomes due to demographics of county
- Data looks "too positive"

Holmes County residents believed the following actions, policies, or funding priorities would support a healthier community:

- Health inequity/effects of policy changes
- Successful use of telemedicine in the county
- Organizations make working together effectively, thereby reducing the duplication of services
- Better housing opportunities (too many kids hopping from situation to situation, mortgage assistance, more apartments)
- School programs (preventive health, career education)
- The local community is a good place to live (start teaching it in schools)
- Funding for state mandates to prevent local money from being spent outside of the community

Holmes County residents were most excited to get involved or become more involved in improving the community through:

- Understandable and readable results
- Things getting done
- Seeing the community get excited

Quality of Life Survey

The Partners for a Healthier Holmes County urged community members to fill out a short Quality of Life Survey via Survey Monkey. There were 156 Holmes 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, was assigned a value of 0 (zero) and the response was not used in averaging response or calculating descriptive statistics.

Quality of Life Questions	Likert Scale Average Response
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]	4.06
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.37
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	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.)	3.74
5. Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)	3.37
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?)	4.13
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?	4.03
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.73
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.53
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.17
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.47
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?)	3.43

Resource Assessment

Based on the chosen priorities, The Partners for a Healthier Holmes County was asked to complete a resource inventory for each priority. The resource inventory allowed the committee to identify existing community resources, such as programs, exercise opportunities, free or reduced cost health screenings, and more. The committee was then asked to determine whether a program or service was evidence-based, a best practice, or had no evidence indicated based on the following parameters:

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. A **non-evidence based practice** has neither no documentation that it has ever been used (regardless of the principals it is based upon) nor has been implemented successfully with no evaluation.

Each resource assessment can be found at the following websites:

The Holmes County General Health District: **http://holmeshealth.org/**

Pomerene Hospital: **http://www.pomerenehospital.org/**

Priority 1: Chronic Disease

Chronic Disease Indicators

Adult Heart Disease

In 2017, 3% of Holmes County adults reported they had survived a heart attack or myocardial infarction, increasing to 14% of those over the age of 65.

Two percent (2%) of Holmes County adults reported they had survived a stroke, increasing to 6% of those over the age of 65 and those with incomes less than $25,000.

Four percent (4%) of adults reported they had angina or coronary heart disease, increasing to 16% of those over the age of 65.

Adult Diabetes

The 2017 health assessment has identified that 5% of Holmes County adults had been diagnosed with diabetes, increasing to 17% of those over the age of 65 and those with incomes less than $25,000. The 2015 BRFSS reports an Ohio prevalence of 11% and U.S. prevalence of 10%.

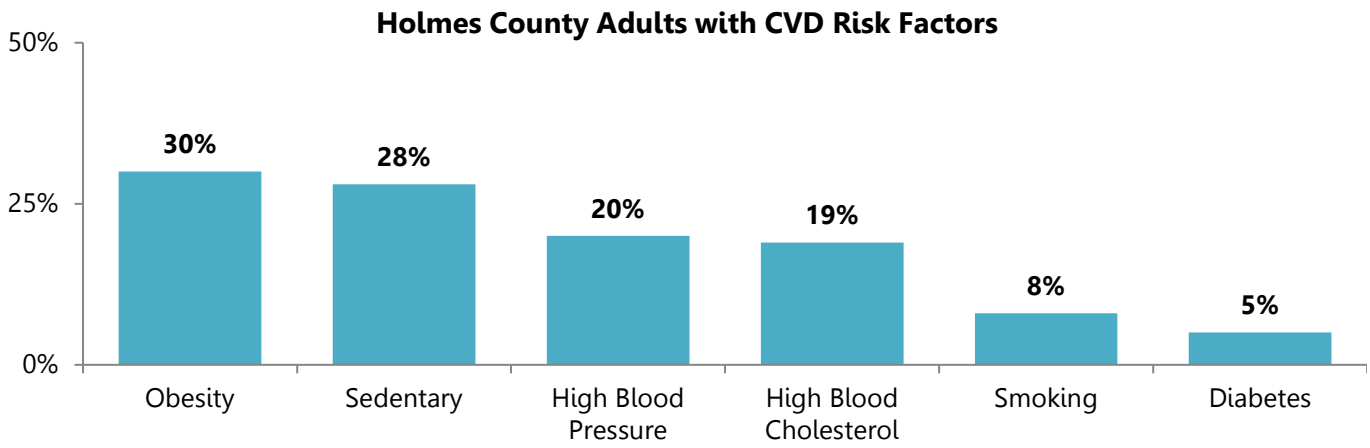
Adult Obesity

In 2017, the health assessment indicated that nearly two-thirds (65%) of Holmes County adults were either overweight (35%) or obese (30%) by Body Mass Index (BMI).

Youth Obesity

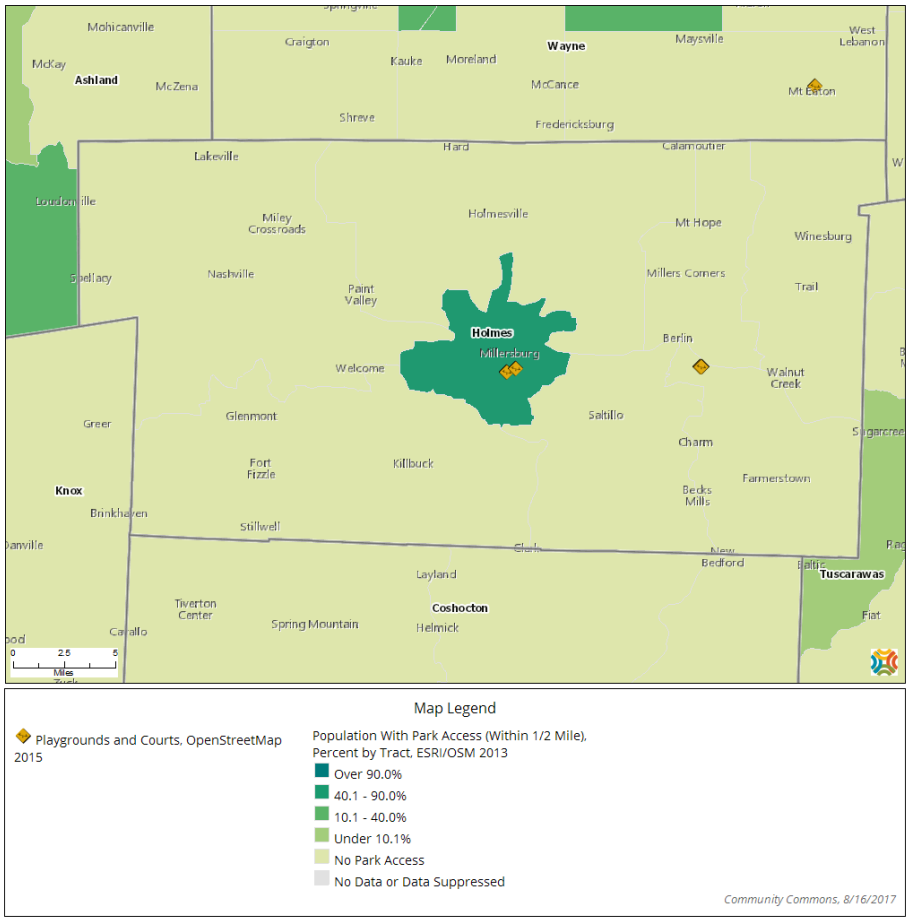
About one in six (16%) of Holmes County youth were classified as obese by Body Mass Index (BMI) calculations (2013 YRBS reported 13% for Ohio in 2013 and 14% for the U.S. in 2015). 11% of youth were classified as overweight (2013 YRBS reported 16% for Ohio and 2015 YRBS reported 16% for the U.S.).

5% of Holmes County youth ate 5 or more servings of fruits and vegetables per day. 28% ate 3 to 4 servings of fruits and vegetables per day, and 61% ate 1 to 2 servings per day. 6% reported not eating any fruits and vegetables.



Map: Population with Park Access

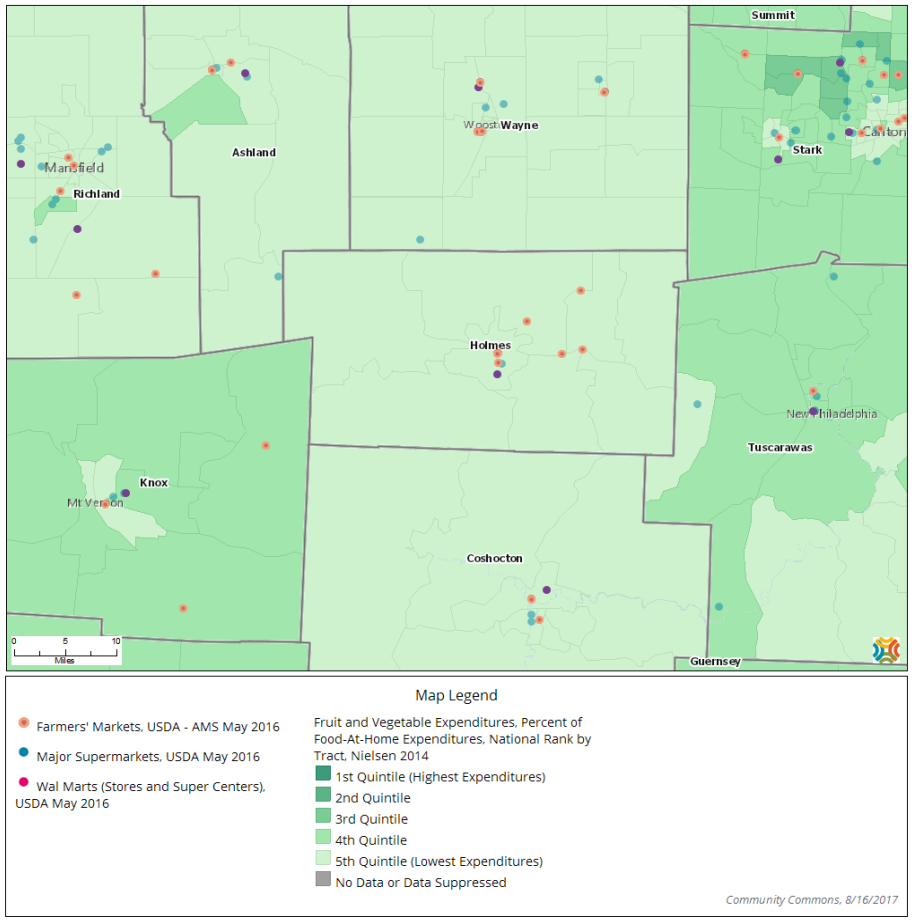
Population with Park Access (Within ½ Mile), Total by Tract, ESRI/OSM 2013



(Source: ESRI Map Gallery and OpenStreetMap: 2013. OpenStreetMap: 2013, as compiled by Community Commons)

Map: Fruit and Vegetable Expenditures

Fruit and Vegetable Expenditures, Percent of Food-At-Home Expenditures, National Rank by Tract, Nielsen 2014



(Source: Nielsen, Nielsen SiteReports: 2014, as compiled by Community Commons)

Gaps and Potential Strategies

Gaps	Potential Strategies
1. Lack of local healthcare providers	o Recruitment for primary care physicians (PCP's), specialists, etc.; specifically look at foreign physician recruitment. o Utilize community health workers (CHW's) to connect residents to services. o Consider recruiting and promoting individuals within an organization (i.e. workforce development). Convince younger people to stay and work in the county.
2. Fresh food availability with educational component	o Farmer's Markets with an educational component since sometimes the idea of what's healthy is unclear to the consumer. o Consider developing community gardens at different organizations and schools throughout the county. Possibly utilize the Future Farmers of America (FFA) traveling gardeners. o Research the healthy corner store initiative. Consider the feasibility of implementing that in Holmes County.
3. Lack of sports and exercise facilities for youth	o Consider developing and/or finding a space within the county that could accommodate classes (i.e. kinetics) and sports (i.e. basketball, karate) for youth and adults.
4. Youth nutrition in school	o Consider putting a community garden in the schools. o Expand the MyPlate curriculum to additional ages and grades.
5. Sharing of information	o Physicians are having a difficult time communicating to the public their successes in the areas of COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure), treatments, etc. o Expand the Million Hearts Initative
6. Lack of corner stores	o There is a lack of corner stores in Holmes County which can make it difficult to make any changes to the types of food they sell and/or how they market the food (i.e. marketing junk food instead of fresh fruit and vegetables.) o Focus on the few locally owned stores (i.e. IGA, Rohde's). Work with them on presenting healthier options and provide educational materials.

Best Practices

The following programs and policies have been reviewed and have proven strategies to **decrease chronic disease:**

1. Community Gardens: A community garden is any piece of land that is gardened or cultivated by a group of people, usually for home consumption. Community gardens are typically owned by local governments, not-for-profit groups, or faith-based organizations; gardens are also often initiated by groups of individuals who clean and cultivate vacant lots. Local governments, non-profits, and communities may support gardens through community land trusts, gardening education, distribution of seedlings and other materials, zoning regulation changes, or service provision such as water supply or waste disposal.

Expected Beneficial Outcomes

- Increased access to fruits and vegetables
- Increased fruit and vegetable consumption
- Increased physical activity

Other Potential Beneficial Outcomes

- Increased food security
- Increased healthy foods in food deserts
- Reduced obesity rates
- Improved mental health
- Improved sense of community
- Improved neighborhood safety

2. Community-based Social Support for Physical Activity: Community-based social support interventions for physical activity focus on changing physical activity behavior through building, strengthening, and maintaining social networks that provide supportive relationships for behavior change (e.g., setting up a buddy system or a walking group to provide friendship and support).

Expected Beneficial Outcomes

- Increased physical activity
- Improved physical fitness

3. School-based physical activity programs and policies: School-based programs to increase physical activity can include programs to expand school-based physical education (PE) and incorporate physical activity into regular classroom curricula. Physical education may be expanded by increasing the length of PE classes and increasing the number of fitness activities during PE classes. Physical activity also may be incorporated into academic classes through physically active lessons or classroom activity breaks. Programs may be combined with other school- and community-based interventions such as student health education about physical activity, activities that foster family involvement, and community partnerships to increase opportunities for physical activity. These programs can be implemented at the state or local school district level.

4. Serving Up MyPlate: A Yummy Curriculum (USDA Nutritional Guidelines): Serving Up MyPlate is a collection of classroom materials that helps elementary school teachers integrate nutrition education into Math, Science, English Language Arts, and Health. This "yummy curriculum" introduces the importance of eating from all five food groups using the MyPlate icon and a variety of hands–on activities. Students also learn the importance of physical activity to staying healthy. Serving Up MyPlate provides teacher lesson plans, activities, posters, parent education handouts, and additional games and resources.

5. Competitive pricing for healthy foods: Competitive pricing assigns higher costs to non-nutritious foods relative to nutritious foods. Competitive pricing can be implemented in various settings, including schools, worksites, grocery stores or other food retail outlets, cafeterias, and vending machines. Competitive pricing can take the form of incentives, subsidies, or price discounts for healthy foods and beverages and/or disincentives or price increases for unhealthy foods and beverages.

Expected Beneficial Outcomes

- Increased sales of healthy foods
- Increased healthy food consumption

Action Step Recommendations & Plan

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

1. Community gardens
2. Community-based social support for physical activity
3. Implement nutrition policy in schools
4. School-based nutrition education programs
5. School-based physical activity programs and policies
6. Implement fruit and vegetable incentive programs

Action Plan

<table>
<tr><th colspan="5">Priority Topic: Chronic Disease</th></tr>
<tr><th>Action Step</th><th>Priority Outcome & Indicator</th><th>Priority Population</th><th>Person/ Agency Responsible</th><th>Timeline</th></tr>
<tr><td colspan="5">Strategy 1: Community gardens</td></tr>
<tr><td>Year 1: Obtain baseline data regarding how many districts, churches, and organizations currently have community gardens and where they are located.

Research grants and funding opportunities to increase the number of community gardens.</td><td rowspan="3">Priority Outcome:
1. Reduce hypertension
2. Reduce diabetes

Priority Indicator:
1. Percent of adults ever diagnosed with hypertension (BRFSS and CHA)
2. Percent of adults who have been told by a health professional that they have diabetes (BRFSS and CHA)</td><td rowspan="3">Adults and youth</td><td rowspan="3">Jennifer McCoy
Holmes County General Health District

Tara Martin
Pomerene Hospital</td><td>December 2018</td></tr>
<tr><td>Year 2: Help school districts and other organizations apply for grants to obtain funding to start a garden.</td><td>December 2019</td></tr>
<tr><td>Year 3: Implement community gardens in all school districts and double the number of organizations with community gardens from baseline.</td><td>December 2020</td></tr>
</table>

<table>
<tr><th colspan="5">Priority Topic: Chronic Disease</th></tr>
<tr><td colspan="5">Strategy 2: Community–based social support for physical activity</td></tr>
<tr><th>Action Step</th><th>Priority Outcome & Indicator</th><th>Priority Population</th><th>Person/
Agency Responsible</th><th>Timeline</th></tr>
<tr><td>Year 1: Develop a community walking program. Recruit individuals to serve as walking leaders. Decide on the locations, walking routes and number of walking groups throughout Holmes County.

Link the walking groups with existing organizations to increase participation. Consider the following:
• Faith-based organizations
• Schools
• Community-based organizations
• Health care providers

Begin implementing the program.

Look for funding sources to incentivize participation in the walking program.</td><td rowspan="3">Priority Outcome:
1. Reduce adult obesity
2. Reduce youth obesity

Priority Indicator:
1. Percent of adults that report body mass index (BMI) greater than or equal to 30
2. Percent of youth who were obese (>95th percentile for BMI, based on sex- and age-specific reference data from the 2000 CDC growth charts)</td><td rowspan="3">Adult and youth</td><td rowspan="3">Tara Martin
Pomerene Hospital</td><td>December 2018</td></tr>
<tr><td>Year 2: Develop program goals and an evaluation process for tracking outcomes. Raise awareness and promote the walking programs.

Begin distributing incentives to participants. Evaluate program goals. Increase the number of walking groups by 25%.</td><td>December 2019</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2. Implement and promote the walking program county-wide. Increase the number of walking groups by 50%.</td><td>December 2020</td></tr>
</table>

Priority Topic: Chronic Disease				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy 3: Implement nutrition policy in schools				
Year 1: Choose at least one additional school district to implement a healthier choices campaign. Work with school wellness committees to introduce at least one priority area to focus on and implement: • Healthier snack "extra choices" offered during school lunches • Healthier fundraising foods • Healthier choices in vending machines • Healthier choices at sporting events and concession stands • Reducing unhealthy foods as rewards	**Priority Outcome:** Reduce youth obesity **Priority Indicator:** Percent of youth who were obese (>95th percentile for BMI, based on sex- and age-specific reference data from the 2000 CDC growth charts)	Youth	**Tara Martin** Pomerene Hospital	December 2018
Year 2: Continue efforts from year 1. Choose 1-2 additional school districts to implement a healthier choices campaign. Each of the selected school districts will choose at least 1-2 priority area to focus on and implement.				December 2019
Year 3: Continue efforts from years 1and 2. Each selected school district will implement at least 3 of the 5 priority areas.				December 2020

Priority Topic: Chronic Disease				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy 4: School-based nutrition education programs				
Year 1: Assess Holmes County schools to determine which schools are currently utilizing the **Serving Up MyPlate** framework. Work with at least one school to conduct a "healthy habit" parent survey (pre-test) to collect baseline data of nutrition and physical activity habits. By utilizing the *Serving Up MyPlate* framework, implement various educational activities and programming. "Healthy habit" post-tests will be given at the end of each year to measure knowledge gained. 50% of students will show increased knowledge of healthy habits.	**Priority Outcome:** Reduce youth obesity **Priority Indicator:** Percent of youth who were obese (>95th percentile for BMI, based on sex- and age-specific reference data from the 2000 CDC growth charts)	Youth	**Jennifer McCoy** Holmes County General Health District **Tara Martin** Pomerene Hospital	December 2018
Year 2: Continue efforts from Year 1 in 1 school district. Work with schools to offer "Try it Tuesday" fruit and vegetable taste testing for children *and/or* work with at least 1-2 schools to host a family education night. 75% of students will show increased knowledge of healthy habits.				December 2019
Year 3: Continue efforts from Years 1 and 2 in both school districts. 90% of students will show increased knowledge of healthy habits.				December 2020

Priority Topic: Chronic Disease				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy 5: School-based physical activity programs and policies				
Year 1: Research the **Fuel Up to Play 60 (FUTP60)** program and determine which school(s) should apply for a FUTP60 grant. Work with the selected school(s) to create organized programming and activities from the FUTP60 playbook that increases youth physical activity and healthy eating. Create a school-based awareness campaign using the FUTP60 program to educate students and families on the benefits of increasing physical activity and healthy eating habits. Disseminate educational information.	**Priority Outcome:** Reduce youth obesity **Priority Indicator:** Percent of youth who were obese (>95th percentile for BMI, based on sex- and age-specific reference data from the 2000 CDC growth charts)	Youth	**Tara Martin** Pomerene Hospital	December 2018
Year 2: Continue efforts from Year 1. Implement activities from the FUTP60 Playbook in at least 1 school district. Continue educating students and families on the importance of increasing physical activity and healthy eating habits.				December 2019
Year 3: Continue efforts from Years 1 and 2. Implement activities from the FUTP60 Playbook in both school districts. Continue educating students and families on the importance of increasing physical activity and healthy eating habits.				December 2020

Priority Topic: Chronic Disease				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy 6: Implement fruit and vegetable incentive programs				
Year 1: Recruit at least one local grocery store to commit to encouraging healthy food choices by doing any of the following: • Offer coupons for "healthy" food items such as fruits and vegetables. • Offer a convenience kiosk that includes ingredients for healthy meals, including recipe cards. • Offer free fruit/vegetables for children to eat while their parent/guardian shops. • Offer "Try it Tuesdays" for children (i.e. child tries a mango at the store and parent/guardian is given a mango coupon with recipe card that include mangos). • Properly label/identify healthy food options that are on sale in weekly ads. • Hold in-store healthy meal demonstrations, offering a recipe card and shopping list for each healthy meal. • Include recipes for quick and healthy meals in weekly ads.	**Priority Outcomes:** 1. Reduce hypertension 2. Reduce diabetes 3. Reduce adult obesity 4. Reduce youth obesity **Priority Indicators:** 1. Percent of adults ever diagnosed with hypertension (BRFSS and CHA) 2. Percent of adults who have been told by a health professional that they have diabetes (BRFSS and CHA) 3. Percent of adults that report body mass index (BMI) greater than or equal to 30 (per SHIP) 4. Percent of youth who were obese (>95th percentile for BMI, based on sex- and age-specific reference data from the 2000 CDC growth charts) (per SHIP)	Adults and youth	**Tara Martin** Pomerene Hospital	December 2018
Year 2: Enlist at least 2 local grocery stores who commit to encouraging healthy food choices by implementing at least one of the items above.				December 2019
Year 3: Continue to enlist new grocery stores and ask current participators to implement 2-3 items above.				December 2020

Priority 2: Mental Health and Addiction

Mental Health and Addiction Indicators

Adult Mental Health

4% of Holmes County adults felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities, increasing to 12% of those with incomes less than $25,000.

One percent (1%) of Holmes County adults considered attempting suicide in the past year.

In 2017, 15% of Holmes County adults rated their mental health as not good on four or more days in the previous month.

Holmes County adults reported their mental health as not good on an average of 2.4 days in the previous month. Ohio and U.S. adults reported their mental health as not good on an average of 4.3 days and 3.7 days, respectively, in the previous month.

Youth Mental Health

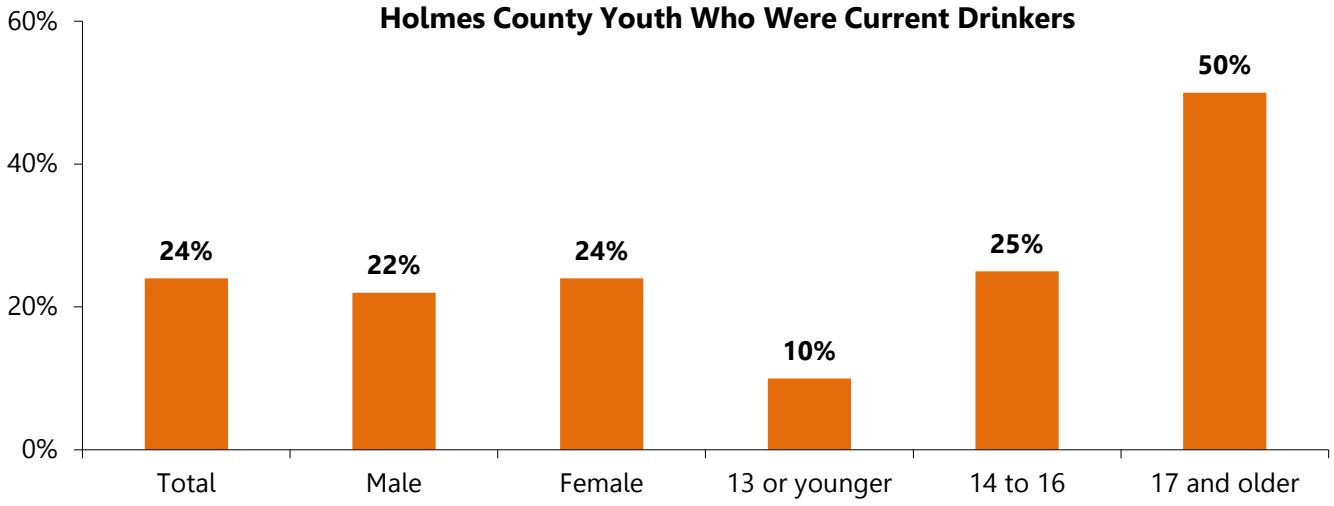
About one-fifth (21%) of youth reported they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities, increasing to 41% of females (YRBS reported 26% for Ohio in 2013 and 30% for the U.S. in 2015).

In the past year, 5% of youth had attempted suicide. One percent (1%) of youth had made more than one attempt. The 2015 YRBS reported a suicide attempt prevalence rate of 9% for U.S. youth and a 2013 YRBS rate of 6% for Ohio youth.

In the past year, 30% of youth had been bullied on school property (YRBS reported 21% for Ohio in 2013 and 20% for the U.S. in 2015).

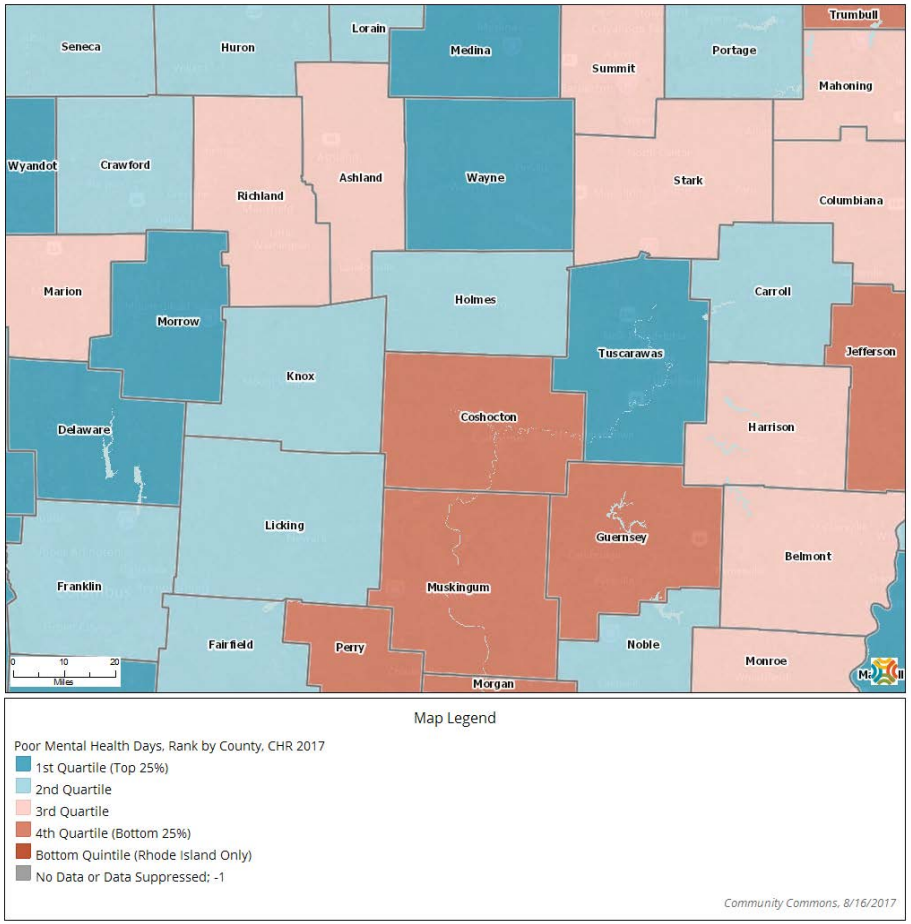
Youth Substance Abuse

Nearly two-fifths (38%) of youth had at least one drink of alcohol in their life, increasing to 69% of those ages 17 and older (2015 YRBS reports 63% for the U.S.).



Map: Poor Mental Health Days

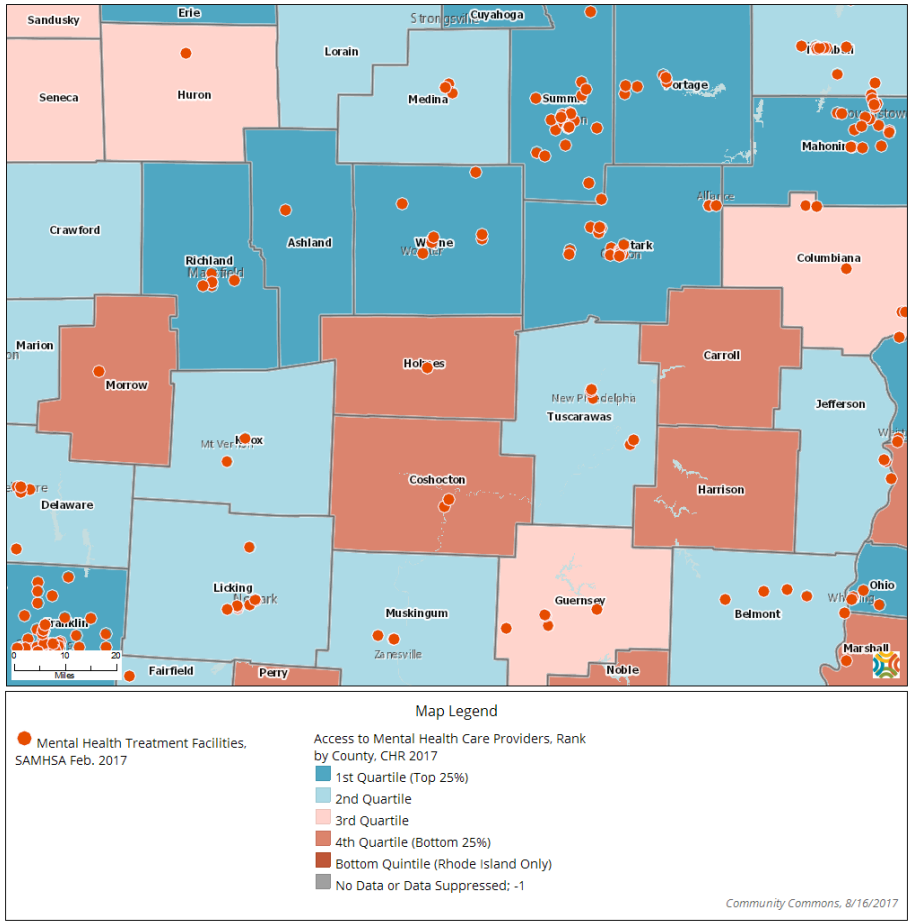
Poor Mental Health Days, Rank by County, CHR 2017



(Source: University of Wisconsin Population Health Institute, County Health Rankings: 2017, as compiled by Community Commons)

Map: Access to Mental Health Care Providers

Access to Mental Health Care Providers, Rank by County, CHR 2017



(Source: University of Wisconsin Population Health Institute, County Health Rankings: 2017, as compiled by Community Commons)

Gaps and Potential Strategies

Gaps	Potential Strategies
1. Stigma surrounding mental health and substance abuse	o There is significant stigma surrounding mental health and substance abuse, especially in the plain community. o Provide outreach to both the English and plain communities addressing the stigma. o Meet with the Bishops and persuade/educate them to speak to their respective congregations about breaking the stigma and promote reaching out for help. o Consider having local mental health/substance abuse organizations present at the Amish Health Conference. o Reach out to the faith based community. Get people to start talking about it. Consider developing an awareness campaign on the stigma.
2. Mental healthcare access	o Expand telemedicine (tele-psych) throughout the county. o Recruitment for mental health care providers (one counseling center has a wait list of 170 patients). o Consider recruiting and promoting individuals within an organization (i.e. workforce development). Host job fairs. Offer tuition reimbursement.
3. Bullying prevention	o Introduce bullying prevention programs into the schools and the parochial (Amish) schools. Consider afterschool programs.
4. Lack of coordinated coalition groups in Holmes County	o Work to develop a more coordinated approach between organizations.
5. Lack of 12-step (AA/NA) programs in the county	o No potential strategy identified

Best Practices

The following programs and policies have been reviewed and have proven strategies to **improve mental health and addiction:**

1. Trauma-informed care: Trauma informed care (TIC) is a framework that requires change to organizational practices, policies, and culture that reflect an understanding of the widespread impact of trauma and potential paths for recovery, and actively seek to prevent re-traumatization. In health care, TIC usually includes universal trauma precautions and practice changes for patients with a known trauma history. Universal trauma precautions emphasize patient-centered communication and care, often with careful screening for trauma, safe clinical environments (e.g., quiet waiting areas), and shared decision making for all patients. Under a trauma-informed clinical approach, providers collaborate across disciplines, use streamlined referral pathways, and remain aware of their own trauma histories and stress levels when they know patients have experienced trauma. TIC can also be implemented in oral health settings.

2. PHQ-9: The PHQ-9 is the nine-item depression scale of the Patient Health Questionnaire. The PHQ-9 is a powerful tool for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment. The primary care clinician and/or office staff should discuss with the patient the reasons for completing the questionnaire and how to fill it out. After the patient has completed the PHQ-9 questionnaire, it is scored by the primary care clinician or office staff.

There are two components of the PHQ-9:

- Assessing symptoms and functional impairment to make a tentative depression diagnosis
- Deriving a severity score to help select and monitor treatment

The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV).

3. Community Trials Intervention to Reduce High-Risk Drinking: Community Trials Intervention to Reduce High-Risk Drinking is a multicomponent, community-based program developed to alter the alcohol use patterns and related problems of people of all ages. The program incorporates a set of environmental interventions that assist communities in (1) using zoning and municipal regulations to restrict alcohol access through alcohol outlet density control; (2) enhancing responsible beverage service by training, testing, and assisting beverage servers and retailers in the development of policies and procedures to reduce intoxication and driving after drinking; (3) increasing law enforcement and sobriety checkpoints to raise actual and perceived risk of arrest for driving after drinking; (4) reducing youth access to alcohol by training alcohol retailers to avoid selling to minors and those who provide alcohol to minors; and (5) forming the coalitions needed to implement and support the interventions that address each of these prevention components.

4. LifeSkills Training (LST): LST is a school-based program that aims to prevent alcohol, tobacco, and marijuana use and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. LST is based on both the social influence and competence enhancement models of prevention. Consistent with this theoretical framework, LST addresses multiple risk and protective factors and teaches personal and social skills that build resilience and help youth navigate developmental tasks, including the skills necessary to understand and resist pro-drug influences. LST is designed to provide information relevant to the important life transitions that adolescents and young teens face, using culturally sensitive and developmentally and age-appropriate language and content. Facilitated discussion, structured small group activities, and role-playing scenarios are used to stimulate participation and promote the acquisition of skills. Separate LST programs are offered for elementary school (grades 3-6), middle school (grades 6-9), and high school (grades 9-12).

5. PAX Good Behavior Game: is a proven, research-based classroom management model designed for use in grades K–6. Based on a strategy developed by a classroom teacher 40 years ago, the PAX Game involves student teams "competing against" each other to earn rewards for refraining from disruptive, inattentive, or aggressive behavior. Approximately 20 published studies have shown that use of this model results in decreased classroom disruptions (by 50–90%), a greater number of students fully engaged in learning (by 20–50%), decreased referrals and suspensions (by 30–60%), and more time for teaching and learning (by 25%). Longitudinal studies have also shown that children who experienced the Good Behavior Game in elementary school were less likely to be involved in violent behaviors later in life and were less likely to use tobacco or other drugs later in life.

6. Telemedicine: Telemedicine, sometimes called telehealth, uses telecommunications technology to deliver consultative, diagnostic, and health care treatment services. Services can encompass primary and specialty care, referrals, and remote monitoring of vital signs, and may be provided via videoconference, email, smartphones, wireless tools, or other modalities. Telemedicine can supplement health care services for patients who would benefit from frequent monitoring or provide services to individuals in areas with limited access to care.

Expect Beneficial Outcomes:

- Increased access to care
- Improved mental health
- Reduced mortality
- Increased medication adherence

Action Step Recommendations & Plan

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

1. Screen for clinical depression for all patients using a standardized tool
2. Trauma informed care
3. Mental health first aid
4. School-based violence prevention programs
5. School-based alcohol/other drug prevention programs
6. Expand the use of telemedicine
7. Implement a community based comprehensive program to reduce alcohol abuse
8. Expand community collaboration to increase awareness and coordination of mental health services
9. Campaign to increase awareness of substance abuse and prevention
10. Provide trainings on mental health and substance abuse services to ER and primary care providers

Action Plan

<table>
<tr><th colspan="5">Priority Topic: Mental Health and Addiction</th></tr>
<tr><th>Action Step</th><th>Priority Outcome & Indicator</th><th>Priority Population</th><th>Person/ Agency Responsible</th><th>Timeline</th></tr>
<tr><td colspan="5">Strategy 1: Screen for clinical depression for all patients using a standardized tool</td></tr>
<tr><td>Year 1: Collect baseline data on the number of primary care providers that currently screen for depression during office visits.

Continue to educate providers regarding PHQ-2 and PHQ-9 or other similar screening tools. Increase the number of primary care providers using the PHQ-2 and PHQ-9 screening tools by 10% from baseline.</td><td rowspan="3">Priority Outcomes:
1. Reduce adult depression
2. Reduce adolescent depression

Priority Indicators:
1. Percentage of adults that felt sad or hopeless for two or more weeks in a row (alternate county indicator per SHIP)
2. Percentage of adolescents that felt sad or hopeless for two or more weeks in a row (alternate county indicator per SHIP)</td><td rowspan="3">Youth</td><td rowspan="3">Vicky Hartzler
Wayne-Holmes Mental Health and Recovery</td><td>December 2018</td></tr>
<tr><td>Year 2: Continue efforts from year 1. Increase the number of primary care providers using the PHQ-2 and PHQ-9 screening tools by 20% from baseline.</td><td>December 2019</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2. Increase the number of primary care providers using the PHQ-2 and PHQ-9 screening tools by 30% from baseline.</td><td>December 2020</td></tr>
</table>

Priority Topic: Mental Health and Addiction				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy 2: Trauma-informed health care				
Year 1: Facilitate an assessment among clinicians in Holmes County on their awareness and understanding of toxic stress and trauma informed care. Survey community members, social workers, pastors, etc. on their awareness and understanding of toxic stress and trauma. Facilitate a training to increase education and understanding of toxic stress and trauma.	**Priority Outcomes:** 1. Reduce suicide deaths in adults 2. Reduce suicide ideation in youth **Priority Indicator:** 1. Number of deaths due to suicide per 100,000 populations (age adjusted) (per SHIP) 2. Percent of youth who report that they ever seriously considered attempting suicide within the past 12 months (YRBS and CHA)	Adults and youth	**Vicky Hartzler** Wayne-Holmes Mental Health and Recovery	December 2018
Year 2: Facilitate trainings for Holmes County teachers on trauma and Adverse Childhood Experiences. Develop and implement a trauma screening tool for social service agencies who work with at risk youth.				December 2019
Year 3: Continue efforts of years 1 and 2 Increase the use of trauma screening tools by 25%.				December 2020
Strategy 3: Mental health first aid				
Year 1: Obtain baseline data on the number of trainings that have taken place. Market the training to Holmes County area churches, schools, Rotary Clubs, Law Enforcement, Chamber of Commerce, City Councils, college students majoring in social work/mental health, etc. Provide at least 2 trainings	**Priority Outcomes:** 1. Reduce suicide deaths in adults 2. Reduce suicide ideation in youth **Priority Indicator:** 1. Number of deaths due to suicide per 100,000 populations (age adjusted) (per SHIP) 2. Percent of youth who report that they ever seriously considered attempting suicide within the past 12 months (per SHIP)	Adults	**Vicky Hartzler** Wayne-Holmes Mental Health and Recovery	December 2018
Year 2: Provide 3 additional trainings and continue marketing efforts.				December 2019
Year 3: Continue efforts from year 2.				December 2020

Priority Topic: Mental Health and Addiction				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy 4: School-based violence prevention programs				
Year 1: Continue to implement the PAX Good Behavior Game in Holmes County schools (grades K-6). Introduce the program to one additional school district administration (superintendent, principals, and guidance counselors). Discuss program/service needs and gaps with school personnel at all schools within the county. Work with school administrators, guidance counselors and other school personnel to raise awareness of the program.	**Priority Outcome:** Reduce youth bullying at school **Priority Indicator:** Percent of youth who report being bullied on school property within the past 12 months (YRBS and CHA)	Youth	**J. Greg Morrison** Anazao Community Partners	December 2018
Year 2: Introduce and implement the PAX Good Behavior Game in both Holmes County school districts. Expand to additional grades.				December 2019
Year 3: Continue efforts from years 1 and 2.				December 2020
Strategy 5: School-based alcohol/other drug prevention programs				
Year 1: Continue to implement the Life Skills program to school district administrators. Introduce the program to one additional school district. Discuss program/service needs and gaps with school personnel at all schools within the county. Work with school administrators, guidance counselors and other school personnel to raise awareness of the program.	**Priority Outcome:** Reduce youth alcohol use **Priority Indicator:** Percent of youth who drank one or more drinks of an alcoholic beverage in the past 30 days (YRBS and CHA)	Youth	**J. Greg Morrison** Anazao Community Partners	December 2018
Year 2: Continue efforts from year 1. Expand the program to grades 9-12 in both school districts.				December 2019
Year 3: Continue efforts of years 1 and 2.				December 2020

Priority Topic: Mental Health and Addiction				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy 6: Expand the use of Telemedicine				
Year1: Collect baseline data on the number of organizations that currently utilize telemedicine and who in the county is offering it. Continue to introduce telemedicine to organizations within Holmes County. Focus efforts on the Amish and plain community.	**Priority Outcome:** Reduce adult depression **Priority Indicator:** Percentage of adults that felt sad or hopeless for two or more weeks in a row (alternate county indicator per SHIP)	Adult	**Vicky Hartzler** Wayne-Holmes Mental Health and Recovery	December 2018
Year 2: Continue efforts from year 1. Increase the number of organizations providing telemedicine 10% from baseline.				December 2019
Year 3: Continue efforts from years 1 and 2.				December 2020
Strategy 7: Implement a community-based comprehensive program to reduce alcohol abuse				
Year 1: Research Community Trials Intervention to Reduce High-Risk Drinking program. Work with all area law enforcement agencies to determine which components would be feasible to implement.	**Priority Outcome:** Reduce youth alcohol use **Priority Indicator:** Percent of youth who drank one or more drinks of an alcoholic beverage in the past 30 days (YRBS and CHA)	Youth	**J. Greg Morrison** Anazao Community Partners **Rhiannon Whalen** OneEighty	December 2018
Year 2: Implement at least 2 of the following strategies: • Sobriety checkpoints (working with law enforcement) • Compliance checks (working with the Ohio Investigative Unit) • Seller/server trainings (working with the Ohio Investigative Unit) • Parents Who Host Lose the Most campaign (educating parents on the laws for distributing alcohol to minors) • Use zoning and municipal regulations to control alcohol outlet density				December 2019
Year 3: Expand strategies to all areas of the county and implement remaining strategies. Publicize results of efforts.				December 2020

Priority Topic: Mental Health and Addiction				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy 8: Expand community collaboration to increase awareness and coordination of mental health services				
Year 1: Invite faith-based leaders, local businesses, community organizations and mental health service providers (both inside and outside the county) to have a round table discussion to gather baseline data on what programs and services are offered within or near Holmes County. Collaborate with local organizations to address gaps in services. Increase awareness and coordination of existing mental health services between all sectors involved. Measure progress based on number of clients served.	**Priority Outcomes:** 1. Reduce adult depression 2. Reduce adolescent depression **Priority Indicators:** 1. Percentage of adults that felt sad or hopeless for two or more weeks in a row (alternate county indicator per SHIP) 2. Percentage of adolescents that felt sad or hopeless for two or more weeks in a row (YRBS and CHA)	Adults and youth	**Vicky Hartzler** Wayne-Holmes Mental Health and Recovery **J. Greg Morrison** Anazao Community Partners **Linda Nisley** CARE (Project Hoffnung)	December 2018
Year 2: Continue efforts from year 1. Create an informational brochure/app/online guide that highlights all organizations in Holmes County that provide mental health programs and services. Include information on transportation options and which organizations offer free services, a sliding fee scale, and which insurance plans are accepted. Update on a quarterly basis. Create a presentation on available mental health services and present it to Holmes County area churches, law enforcement, chamber of commerce, city council, service clubs, and businesses. Include information on mental health stigma, and work to increase community awareness and education of stigma and how it is a barrier to treatment. Expand collaboration efforts to continue filling mental health service gaps. Continue to coordinate services between one another. Measure progress based on number of clients served.				December 2019
Year 3: Continue efforts of Years 1 and 2.				December 2020

Priority Topic: Mental Health and Addiction				
Strategy 9: Campaign to increase awareness of substance abuse and prevention				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Increase awareness of the *SPARK Holmes County* campaign. Provide community organizations (schools, businesses, hospital, health department) with ways to support the outreach campaign such as using social media (i.e. Facebook, Twitter, Instagram), websites, flyers, church bulletins, etc. Include information on alcohol use, opiates, e-cigarettes, prescription drug abuse, marijuana use, heroin use, other illegal drug use, risky behaviors and substance use trends. Additionally, include information on expanding and explaining youth protective factors. Determine best ways to educate community and parents (social media, newspaper, school websites or newsletters, television, church bulletins, etc.) Modify the campaign to better reach members of the Amish and plain community.	**Priority Outcome:** Reduce youth alcohol use **Priority Indicator:** Percent of youth who drank one or more drinks of an alcoholic beverage in the past 30 days (YRBS and CHA)	Adults and youth	**Vicky Hartzler** Wayne-Holmes Mental Health and Recovery **J. Greg Morrison** Anazao Community Partners **Linda Nisley** CARE (Project Hoffnung)	December 2018
Year 2: Increase the number of organizations participating in the SPARK Holmes County awareness campaign by 10% from baseline. Plan awareness programs/workshops focusing on different "hot topics" and risky behavior trends. Attain media coverage for all programs/workshops.				December 2019
Year 3: Continue efforts of Years 1 and 2.				December 2020

Priority Topic: Mental Health and Addiction				
Strategy 10: Provide trainings on mental health and substance abuse services to ER and primary care providers				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Develop a training on the mental health and substance abuse services available in the county. Market and offer the training to ER and primary care providers. Work with ER and primary care providers to assess what information and/or materials they may be lacking to provide better resources for patients with mental health and/or substance abuse issues.	**Priority Outcomes:** 1. Reduce adult depression 2. Reduce adolescent depression **Priority Indicators:** 1. Percentage of adults that felt sad or hopeless for two or more weeks in a row (alternate county indicator per SHIP) 2. Percentage of adolescents that felt sad or hopeless for two or more weeks in a row (YRBS and CHA)	Adults	**Nicole Kolacz** Pomerene Hospital **Tara Martin** Pomerene Hospital	December 2018
Year 2: Continue to provide the trainings. Increase the number of trainings by 5%.				December 2019
Year 3: Continue efforts from years 1 and 2. Increase the number of trainings by 10%.				December 2020

Priority 3: Access to Preventive Care

Access to Preventive Care Indicators

Access to Health Care

In 2017, 60% Holmes County adults had health care coverage, leaving 40% who were uninsured. The 2015 BRFSS reported that 8% of Ohioans and 11% of Americans are uninsured.

One-third (33%) of Holmes County adults visited a doctor for a routine checkup in the past year, increasing to 71% of those over the age of 65.

Less than half (46%) of adults reported they had one person they thought of as their personal doctor or healthcare provider. Thirty-eight percent (38%) of adults had more than one person they thought of as their personal healthcare provider, and 12% did not have one at all.

Adult Comparisons	Holmes County 2017	Ohio 2015	U.S. 2015
Had at least one person they thought of as their personal doctor or health care provider	46%	82%	79%
Visited a doctor for a routine checkup in the past year	33%	72%	70%

Health Screenings

More than one-third (35%) of women ages 40 and over had a mammogram in the past year, and 49% had one in the past two years. The 2014 BRFSS reported that 72% of women 40 and over in Ohio and 73% in the U.S. had a mammogram in the past two years.

More than two-thirds (68%) Holmes County women had a clinical breast exam at some time in their life, and 27% had one within the past year. More than half (55%) of women ages 40 and over had a clinical breast exam in the past two years.

More than one-third (37%) of adults ages 50 and over had a colonoscopy or sigmoidoscopy in the past five years.

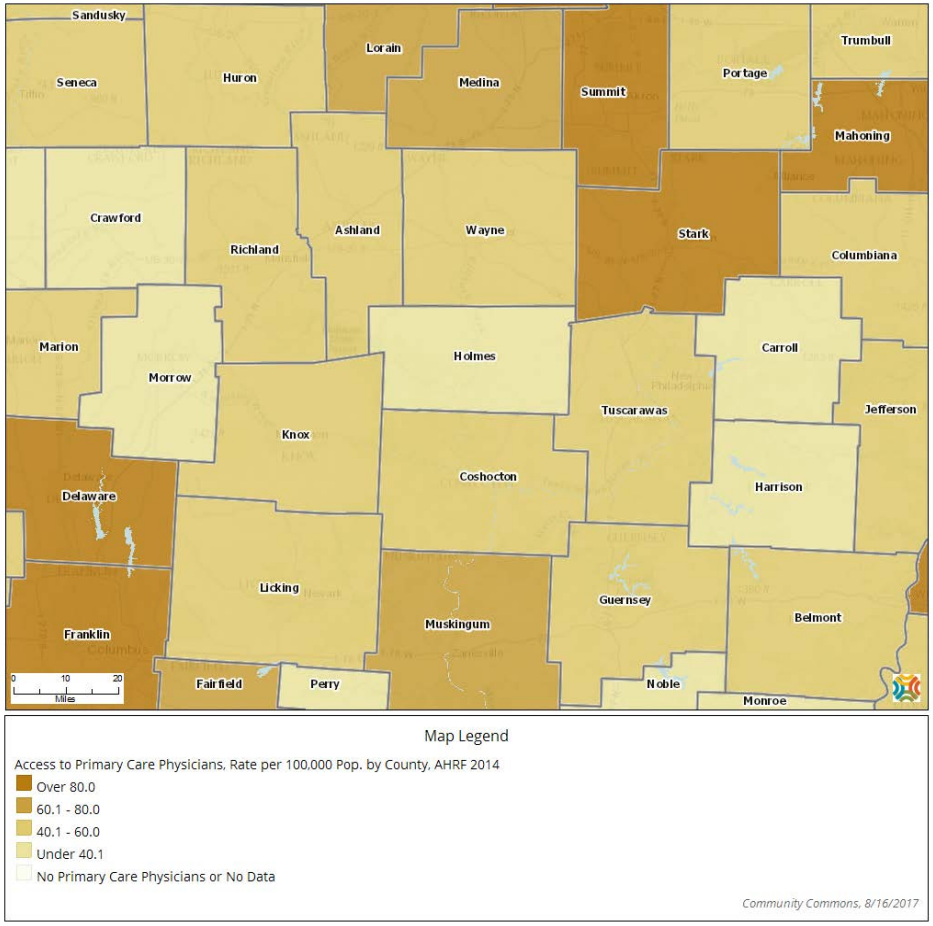
Oral Health

In the past year, 57% of Holmes County adults had visited a dentist or dental clinic, decreasing to 27% of those with incomes less than $25,000.

Holmes County youth last saw a dentist for a check-up, exam, teeth cleaning, or other dental work: less than a year ago (71%), (2013 YRBS reported 75% for Ohio and the 2015 YRBS reported 74% for the U.S.), 1 to 2 years ago (14%), more than 2 years ago (3%), never (3%), and do not know (9%).

Map: Access to Primary Care Physicians

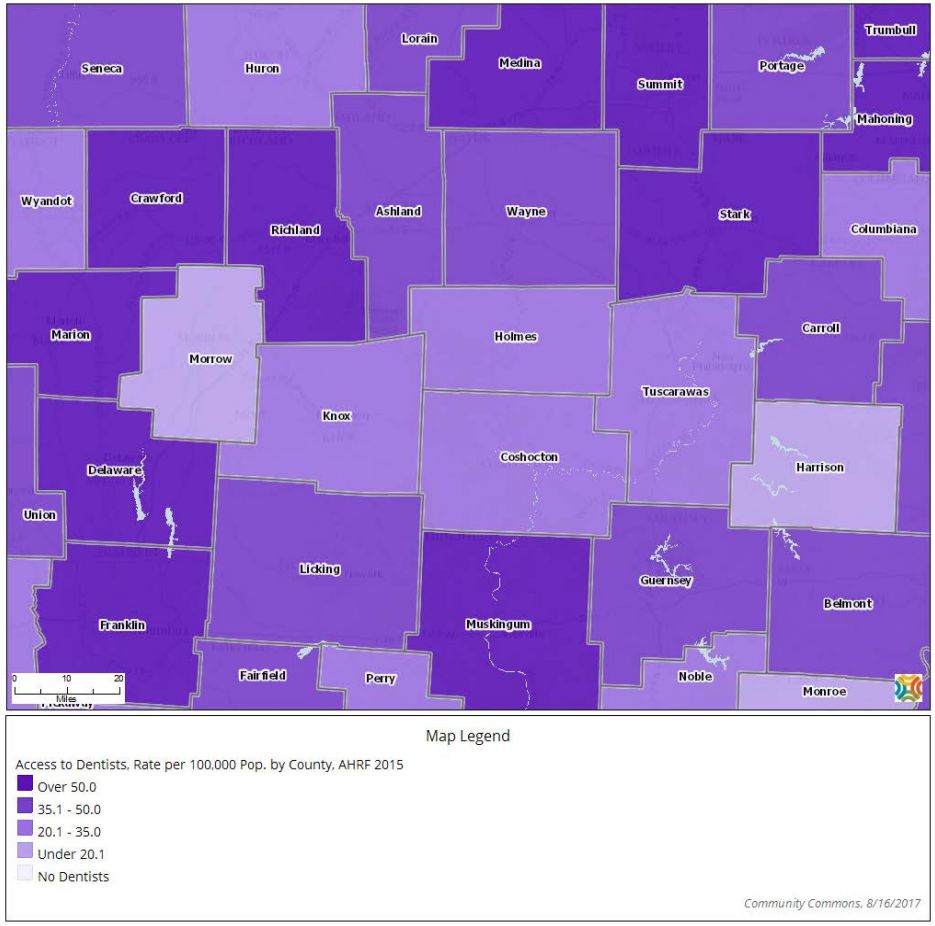
Access to Primary Care Physicians, Rate per 100,000 Population by County, AHRF 2014



(Source: U.S. Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File: 2014, as compiled by Community Commons)

Map: Access to Dentists

Access to Dentists, Rate per 100,000 Population by County, AHRF 2015



(Source: U.S. Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File: 2015, as compiled by Community Commons)

Gaps and Potential Strategies

Gaps	Potential Strategies
1. Transportation	o Consider introducing a main line bus to Holmes County.
2. Lack of dental providers in the county	o Recruit more dentists into the county. Consider tuition reimbursement. o Consider a mobile dental van that can go to schools and provide sealants to kids. o School-based program using a grant through the Ohio Department of Health – collaborate with the United Way. o Provide education on how dental issues can affect other health issues.
3. Safety net services	o There is a lack of safety net services in the county meaning places that offer services on a sliding scale or no pay options are very few, making reproductive health and wellness unavailable to many low-income community members.
4. Cost of healthcare & high uninsured rate	o Consider telemedicine. o Decrease utilization of hospital and emergency room (ER) by providing education on what constitutes an ER visit and what does not. o Consider utilizing community health workers (CHW's) to decrease the number of individuals being re-admitted to the hospital.
5. Low immunization rates	o No potential strategy identified

Best Practices

1. Community Health Workers: Community health workers (CHWs), sometimes called lay health workers, community health representatives, or community health advisors, serve a variety of functions including providing outreach, education, referral and follow-up, case management, advocacy, and home visiting services. CHWs may work autonomously in the community or as part of a multi-disciplinary team in primary or specialty care; training varies widely with intended role and location. CHW services are usually provided to underserved communities and to individuals at high risk of poor health outcomes. CHWs often work with individuals at risk for or suffering from chronic diseases such as diabetes or cardiovascular disease. They also work with women at high risk for poor birth outcomes, providing pregnant women and new mothers with emotional and practical support and education on topics such as family planning, pregnancy, childbirth, breastfeeding, and vaccination.

Expected Beneficial Outcomes:

- Increased patient knowledge
- Increased access to care
- Increased preventive care
- Improved healthy behaviors

Action Step Recommendations & Plan

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

1. Increase awareness of existing healthcare services on preventive care
2. Explore different chronic disease management practices
3. Increase access to dental care

Action Plan

<table>
<tr><th colspan="5">Priority Topic: Access to Preventive Care</th></tr>
<tr><th>Action Step</th><th>Priority Outcome & Indicator</th><th>Priority Population</th><th>Person/ Agency Responsible</th><th>Timeline</th></tr>
<tr><td colspan="5">Strategy 1: Increase awareness of existing healthcare services on preventive care</td></tr>
<tr><td>Year 1: Coordinate efforts between hospital, health department and other community organizations 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. Include information on what accounts for preventive care, what does insurance cover and different screening guidelines (mammograms, PSA's, etc.). Focus outreach efforts on the members of the Amish and plain community.

Update 2-1-1 to reflect all organizations providing free or reduced cost healthcare services. Increase awareness of 2-1-1 as a community resource.</td><td rowspan="3">Priority Outcome:
Decrease percentage of adults without usual source of care

Priority Indicator:
Percent of adults ages 18 and older who do not have one (or more) persons they think of as their personal healthcare provider (BRFSS and Holmes County CHA)</td><td rowspan="3">Adult</td><td rowspan="3">Nicole Kolacz
Pomerene Hospital

Tara Martin
Pomerene Hospital</td><td>December 2018</td></tr>
<tr><td>Year 2: Continue community outreach efforts.

Update 2-1-1 as needed.</td><td>December 2019</td></tr>
<tr><td>Year 3: Increase efforts from years 1 and 2.</td><td>December 2020</td></tr>
</table>

Priority Topic: Access to Preventive Care				
Strategy 2: Explore different chronic disease management practices				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Explore the **Pathways Community HUB** model via **Community Health Workers**, NEOMED, and other chronic disease management practices. Determine which practice or program will be implemented within the county.	**Priority Outcome:** Use of community health workers **Priority Indicator:** The number of certified CHW's in the county	Adult	**Nicole Kolacz** Pomerene Hospital **Tara Martin** Pomerene Hospital	December 2018
Year 2: Begin to implement the selected practice or program within the county.				December 2019
Year 3: Continue efforts from years 1 and 2.				December 2020
Strategy 3: Increase access to dental care				
Year 1: Collaborate with the Viola Startzman Clinic (located in Wayne County). Develop a plan to market dental services to Holmes County residents. Explore the feasibility of utilizing mobile dentistry at both school districts and locations that have low-income clients.	**Priority Outcome:** Ratio of population to dental health providers **Priority Indicator:** Provider availability	Youth	**Nicole Kolacz** Pomerene Hospital **Tara Martin** Pomerene Hospital	December 2018
Year 2: Continue to market dental services at the Startzman Clinic. Pilot use of mobile dentistry at one school building and one additional location in the county.				December 2019
Year 3: Continue efforts from year 2. Expand efforts to other schools as well as other areas of the county.				December 2020

Cross-cutting Strategies

Cross-cutting Outcomes

In addition to tracking progress on the CHIP priority outcome objectives, the county will evaluate the impact of strategies implemented by also measuring progress on a set of cross-cutting outcome objectives. Examples of cross-cutting outcomes are listed below. See the **master list of SHIP indicators** for the complete list of the SHIP cross-cutting outcome indicators and the community toolkits for a recommended set of aligned community indicators to track progress related to each CHIP strategy.

Social determinants of health: Examples of crosscutting outcomes that address all priorities

- Improve third grade reading proficiency
- Reduce chronic absenteeism in school
- Reduce high housing cost burden
- Reduce secondhand smoke exposure for children

Prevention, public health system and health behaviors: Examples of cross-cutting outcomes that address all priorities

- Increase adult vegetable consumption
- Reduce adult physical inactivity
- Reduce adult smoking
- Reduce youth all-tobacco use

Healthcare system and access: Examples of cross-cutting outcomes that address all priorities

- Reduce percent of adults who are uninsured
- Reduce percent of adults unable to see a doctor due to cost
- Reduce primary care health professional shortage areas

Specific, measurable objectives for selected cross-cutting outcomes will be included in the following action plans.

Best Practices

1. Higher Education Financial Incentives for Health Professionals Serving Underserved Areas: Financial incentives such as scholarships and loans with service requirements, educational loans with a service option, and loan repayment or forgiveness programs encourage health care providers to serve in rural or other underserved areas. Such incentives are available to various types of providers, including physicians, nurse practitioners, physician assistants, nurses, dentists, and mental health providers, but often focus most heavily on primary care and family medicine practitioners.

Expected Beneficial Outcomes

- Increased availability of health professionals in underserved areas
- Increased access to care

2. Shared Use Agreements: Shared use, joint use, open use, or community use agreements allow public access to existing facilities by defining terms and conditions for sharing the costs and risks associated with expanding a property's use. School districts, government entities, faith-based organizations, and private or nonprofit organizations may create shared use agreements to allow community access to their property before or after hours. Shared use agreements can be formal (i.e., based on a written, legal document) or informal (i.e., based on historical practice), and can be tailored to meet community needs.

Expected Beneficial Outcomes

- Increased access to places for physical activity

Other Potential Beneficial Outcomes

- Increased physical activity
- Increased access to public resources

Action Step Recommendations & Plan

1. Shared use (joint use agreements)
2. Higher education financial incentives for health professionals serving in underserved areas

Cross-Cutting Factor: Public Health System, Prevention and Health Behaviors				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy 1: Shared use (joint use agreements)				
Year 1: Assess how many Holmes County schools, churches, businesses and other organizations currently offer shared use of their facilities (gym, track, etc.). Create an inventory of known organizations that possess physical activity equipment, space, and other resources.	**Cross-cutting Outcome:** 1. Reduce adult obesity 2. Reduce youth obesity **Cross-cutting Indicator:** 1. Percent of adults that report body mass index (BMI) greater than or equal to 30 2. Percent of youth who were obese (>95th percentile for BMI, based on sex- and age-specific reference data from the 2000 CDC growth charts)	Adults and youth	**Jennifer McCoy** Holmes County General Health District **Tara Martin** Pomerene Hospital	December 2018
Year 2: Collaborate with local organizations to create a proposal for a shared-use agreement. Initiate contact with potential organizations from the inventory. Implement at least one shared-use agreement for community use. Publicize the agreement and its parameters.				December 2019
Year 3: Continue efforts from year 1. Implement 2-3 shared-use agreements for community use in Holmes County.				December 2020

Cross-cutting Factor: Healthcare System and Access				
Strategy 2: Higher education financial incentives for health professionals serving in underserved areas				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Collect baseline data on the current number of primary, mental, and dental health providers practicing in Holmes County and the need for more. Develop a marketing strategy focused on recruiting health providers. Work with local universities in and surrounding Holmes County to address the need for health providers and possible school loan reimbursement if students work in Holmes County after their education is complete. Increase the number of preceptors/placement sites for students in Holmes County 5% from baseline.	**Cross-cutting Outcome:** Ratio of population to primary, mental, and dental health providers **Cross-cutting Indicator:** Provider availability	Adult	**Rachel Green** Pomerene Hospital	December 2018
Year 2: Continue to work with local universities surrounding Holmes County. Begin implementing health provider recruitment strategies. Increase the number of preceptors/placement sites for students in Holmes County 10% from baseline.				December 2019
Year 3: Continue efforts from Years 1 and 2. Increase the number of preceptors/placement sites for students by 30% from baseline.				December 2020

Progress and Measuring Outcomes

The progress of meeting the local priorities will be monitored with measurable indicators identified for each strategy found within the action step and recommendation tables within each of the priority sections. Most indicators align directly with the SHIP. The individuals that are working on action steps will meet on an as needed basis. The CHIP sub-group committee will meet monthly to report out the progress. The entire Partner's for a Healthier Holmes County group will then meet quarterly. The committee will form a plan to disseminate the Community Health Improvement Plan to the community. Action steps, responsible agencies, and timelines will be reviewed at the end of each year by the committee. Edits and revisions will be made accordingly.

Holmes County will continue facilitating a Community Health Assessments every three years to collect and track data. Primary data will be collected for adults and youth using national sets of questions to not only compare trends in Holmes County, but also be able to compare to the state, the nation, and Healthy People 2020. This data will serve as measurable outcomes for each of the priority areas. 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 an ongoing basis to focus on how well action steps are being implemented. Areas of process evaluation that the CHIP committee will monitor will 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 action steps 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:

Jennifer McCoy, MPH
Policy Administrator/Accreditation Coordinator
Holmes County General Health District
Phone number: (330) 674-5035
Email: **jmccoy@holmeshealth.org**

Appendix I: Links to Websites

Title of Link	Website URL
Building the Fully Coordinated Transportation System	http://www.incog.org/transportation/coordinatedplan/UnitedWeRideFramework.pdf
Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services	http://www.cdc.gov/nphpsp/essentialservices.html
Community gardens	http://www.countyhealthrankings.org/policies/community-gardens
Community-based social support for physical activity	http://www.countyhealthrankings.org/policies/community-based-social-support-physical-activity
Community trials intervention to reduce high risk drinking	http://www.pire.org/communitytrials/index.htm
Competitive pricing for healthy foods	http://www.countyhealthrankings.org/policies/competitive-pricing-healthy-foods
Community Health Workers (CHW)	http://www.countyhealthrankings.org/policies/community-health-workers
Fuel Up to Play 60 (National Dairy Council & National Football League)	https://www.fueluptoplay60.com/
Healthy food in convenience stores	http://www.countyhealthrankings.org/policies/healthy-food-convenience-stores
Higher education financial incentives for health professionals serving underserved areas	http://www.countyhealthrankings.org/policies/higher-education-financial-incentives-health-professionals-serving-underserved-areas
LifeSkills training (LST)	http://www.lifeskillstraining.com/
Master list of SHIP indicators	http://www.odh.ohio.gov/sha-ship
Mental health first aid	https://www.mentalhealthfirstaid.org/
Nutrition prescriptions	http://www.countyhealthrankings.org/policies/nutrition-prescriptions
PAX good behavior game	http://www.hazelden.org/HAZ_MEDIA/gbg_insert.pdf
Pathways Community HUB Model	https://innovations.ahrq.gov/qualitytools/connecting-those-risk-care-quick-start-guide-developing-community-care-coordination
PHQ-9: The PHQ-9	http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression
ROX (ruling our experience)	http://www.rulingourexperiences.com/about_us
School-based alcohol/other drug prevention programs	http://www.countyhealthrankings.org/policies/universal-school-based-programs-alcohol-misuse-impaired-driving

Title of Link	Website URL
School-based nutrition education programs	http://www.countyhealthrankings.org/policies/school-based-nutrition-education-programs
School-based physical activity programs and policies	https://www.cdc.gov/policy/hst/hi5/physicalactivity/index.html
Screen for clinical depression for all patients 12 or older using a standardized tool	http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression
School dental programs	http://www.countyhealthrankings.org/policies/school-dental-programs
School-based violence prevention programs	https://www.cdc.gov/policy/hst/hi5/violenceprevention/index.html
Screening, brief intervention, and referral to treatment (SBIRT)	http://www.integration.samhsa.gov/clinical-practice/sbirt
Serving Up MyPlate: A Yummy Curriculum (USDA Nutritional Guidelines)	http://www.fns.usda.gov/tn/serving-myplate-yummy-curriculum
Shared use (joint use agreements)	http://www.countyhealthrankings.org/policies/joint-use-agreements
Telemedicine	http://www.countyhealthrankings.org/policies/telemedicine
Trauma-informed care	http://www.countyhealthrankings.org/policies/trauma-informed-health-care
Too good for drugs	http://www.toogoodprograms.org/
The Incredible Years®	http://www.incredibleyears.com/