2020-2022

Ashland County

Community Health Improvement Plan

Released on October 24, 2019

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

Executive Summary

Introduction

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

The Ashland County Community Health Assessment Committee have been conducting CHAs since 2015 to measure community health status. The most recent Ashland County CHA was cross-sectional in nature and included a written survey of adults within Ashland County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention (CDC) for their national and state Behavioral Risk Factor Surveillance System (BRFSS). This has allowed Ashland County to compare their CHA data to national, state and local health trends. Community stakeholders were actively engaged in the early phases of CHA planning and helped define the content, scope, and sequence of the project.

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

Public Health Accreditation Board (PHAB) Requirements

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

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

Inclusion of Vulnerable Populations (Health Disparities)

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

Mobilizing for Action through Planning and Partnerships (MAPP)

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

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

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

Figure 1.1 The MAPP model

Alignment with National and State Standards

The 2020-2022 Ashland County CHIP priorities align with state and national priorities. Ashland County will be addressing the following priorities: mental health and addiction and chronic disease.

Ohio State Health Improvement Plan (SHIP)

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

SHIP Overview

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

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

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

SHIP Priorities

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

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

Cross-cutting Factors

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

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

- **Health equity**: Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

- **Social determinants of health**: Conditions in the social, economic and physical environments that affect health and quality of life.

- **Public health system, prevention and health behaviors**:
    - The public health system is comprised of government agencies at the federal, state, and local levels, as well as nongovernmental organizations, which are working to promote health and prevent disease and injury within entire communities or population groups.
    - Prevention addresses health problems before they occur, rather than after people have shown signs of disease, injury or disability.
    - Health behaviors are actions that people take to keep themselves healthy (such as eating nutritious food and being physically active) or actions people take that harm their health or the health of others (such as smoking). These behaviors are often influenced by family, community and the broader social, economic and physical environment.

- **Healthcare system and access**: Health care refers to the system that pays for and delivers clinical health care services to meet the needs of patients. Access to health care means having timely use of comprehensive, integrated and appropriate health services to achieve the best health outcomes.

CHIP Alignment with the 2017-2019 SHIP

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

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

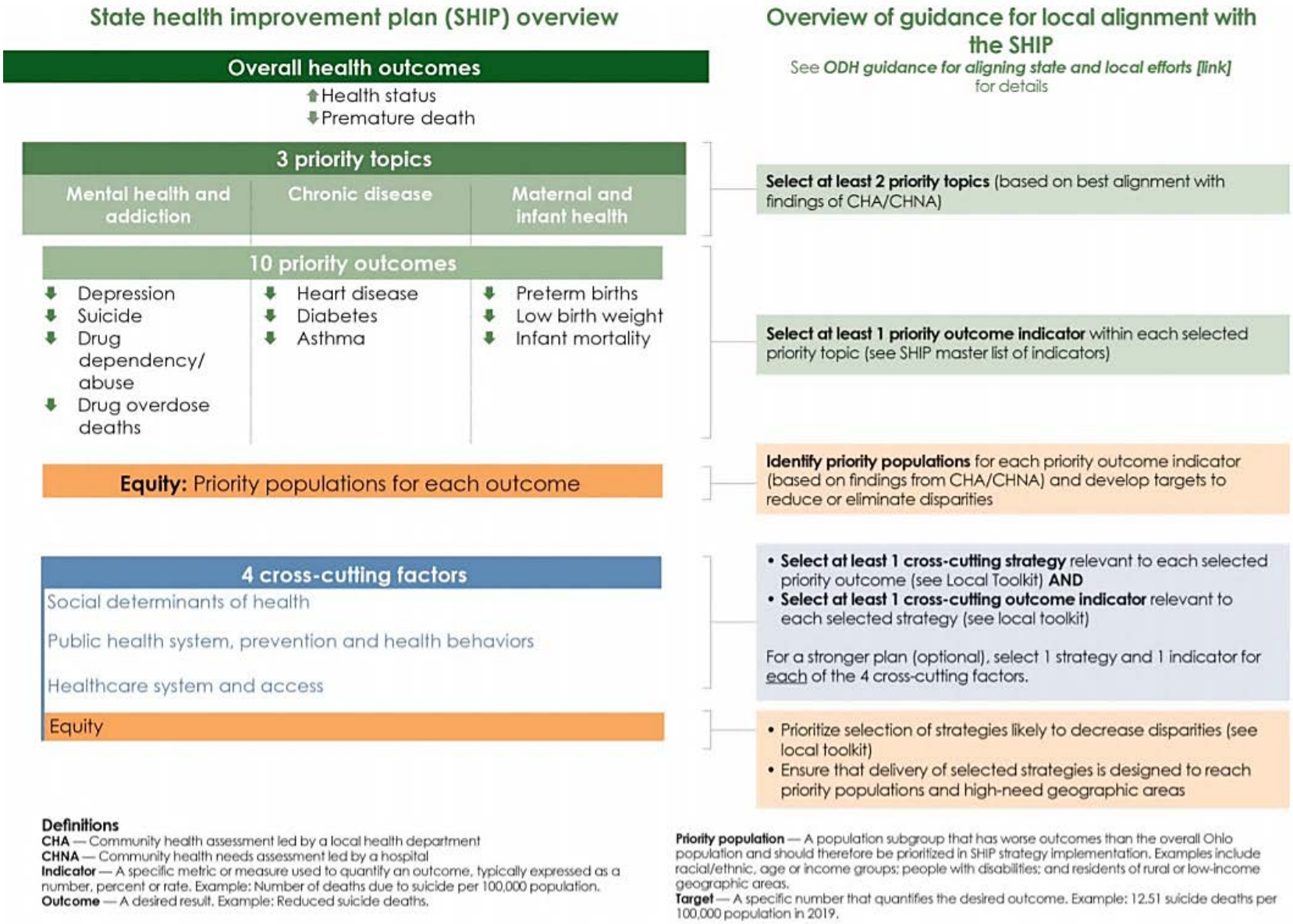
2020-2022 Ashland CHIP Alignment with the 2017-2019 SHIP			
Priority Topic	*Priority Outcome*	*Cross-Cutting Strategy*	*Cross-Cutting Outcome*
Mental health and addiction	• Reduce depression • Reduce suicide deaths	• Public Health System, Prevention, and Health Behaviors • Social Determinants of Health	• Decrease high housing costs • Decrease severe housing problems • Increase kindergarten readiness • Decrease child abuse and neglect • Decrease adult smoking
Chronic Disease	• Reduce diabetes • Reduce heart disease		

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

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

Alignment with National and State Standards, continued

Figure 1.4 2017-2019 State Health Improvement Plan (SHIP) Overview



Vision and Mission

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

The Vision of the Ashland County Community Health Assessment Committee

Healthy people, health environment, healthy community.

The Mission of the Ashland County Community Health Assessment Committee

We strive to promote optimal health for individuals and families of the Ashland community through public health education, prevention of disease and injury, and response to public health challenges.

Community Partners

The CHIP was planned by various agencies and service-providers within Ashland County. From April to May 2019, the Ashland County Community Health Assessment Committee reviewed many data sources concerning the health and social challenges that Ashland County residents are facing. They determined priority issues which, if addressed, could improve future outcomes; determined gaps in current programming and policies; examined best practices and solutions; and determined specific strategies to address identified priority issues. We would like to recognize these individuals and thank them for their dedication to this process:

Ashland County Community Health Assessment Committee

Mark Burgess, City of Ashland
Sarah Goodwill Humphrey, Ashland County Health Department
Steve Stone, Ashland County Mental Health & Recovery Board
Kathy Witmer, University Hospitals Samaritan Medical Center
Danielle Price, University Hospitals

With special thanks to our Community Health Partners, including:
Ashland City Schools
Mapleton Local Schools
Ashland County Community Academy
Ashland County Family & Children First Council
Ashland County Catholic Charities
Ashland County Council on Aging
Ashland County Board of Developmental Disabilities
Appleseed Community Mental Health Center
Ashland County Board of Health
Ashland YMCA
Ashland County Chamber of Commerce
Ashland Parenting Plus
Ashland County EMA
Ashland County Job & Family Services
Safe Haven of Ashland, Ohio

Hospital Council of Northwest Ohio (HCNO)

The community health improvement process was facilitated by Emily Stearns, MPH, Community Health Improvement Coordinator, from HCNO.

Community Health Improvement Process

Beginning in April 2019, the Ashland County Community Health Assessment Committee met four (4) times and completed the following planning steps:

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

Community Health Status Assessment

Phase 3 of the MAPP process, the Community Health Status Assessment, or CHA, is a 100+ page report that includes primary data with over 100 indicators and hundreds of data points related health and well-being, including social determinants of health. Over 50 sources of secondary data are also included throughout the report. The CHA serves as the baseline data in determining key issues that lead to priority selection. The full report can be found at **https://www.ashlandhealth.com/**. Below is a summary of county primary data and the respective state and national benchmarks.

Adult Trend Summary

Adult Variables	Ashland County 2018	Ohio 2017	U.S. 2017
Health Status			
Rated general health as good, very good, or excellent	88%	81%	83%
Rated general health as excellent or very good	52%	49%	51%
Rated general health as fair or poor	12%	19%	18%
Average number of days that physical health not good (in the past 30 days) (County Health Rankings)	3.2	4.0**	3.7**
Rated physical health as not good on four or more days (in the past 30 days)	18%	22%*	22%*
Average number of days that mental health not good (in the past 30 days) (County Health Rankings)	3.4	4.3**	3.8**
Rated mental health as not good on four or more days (in the past 30 days)	24%	24%*	23%*
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past 30 days)	25%	22%*	22%*
Healthcare Coverage, Access, and Utilization			
Uninsured	7%	9%	11%
Had one or more persons they thought of as their personal healthcare provider	82%	81%	77%
Visited a doctor for a routine checkup (in the past 12 months)	71%	72%	70%
Visited a doctor for a routine checkup (5 or more years ago)	10%	7%	8%
Arthritis, Asthma, & Diabetes			
Ever been told by a doctor they have diabetes (not pregnancy-related)	13%	11%	11%
Ever been diagnosed with pregnancy-related diabetes	3%	1%	1%
Ever been diagnosed with pre-diabetes or borderline diabetes	6%	2%	2%
Ever diagnosed with some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia	30%	29%	25%
Had ever been told they have asthma	13%	14%	14%
Cardiovascular Health			
Ever diagnosed with angina or coronary heart disease	4%	5%	4%
Ever diagnosed with a heart attack, or myocardial infarction	7%	6%	4%
Ever diagnosed with a stroke	3%	4%	3%
Had been told they had high blood pressure	29%	35%	32%
Had been told their blood cholesterol was high	30%	33%	33%
Had their blood cholesterol checked within the last five years	78%	85%	86%
Weight Status			
Normal weight (BMI of 18.5 – 24.9)	30%	30%	32%
Overweight (BMI of 25.0 – 29.9)	30%	34%	35%
Obese (includes severely and morbidly obese, BMI of 30.0 and above)	38%	34%	32%

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

Adult Variables	Ashland County 2018	Ohio 2017	U.S. 2017
Alcohol Consumption			
Current drinker (had at least one drink of alcohol within the past 30 days)	54%	54%	55%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	23%	19%	17%
Tobacco Use			
Current smoker (smoked on some or all days)	15%	21%	17%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	28%	24%	25%
Preventive Medicine			
Had a mammogram within the past two years (ages 40 and older)	75%	74%*	72%*
Had a Pap smear in the past three years (ages 21-65)	72%	82%*	80%*
Had a PSA test within the past two years (ages 40 and older)	58%	39%*	40%*
Quality of Life			
Limited in some way because of physical, mental or emotional problem	20%	21%**	21%**
Oral Health			
Visited a dentist or a dental clinic (within the past year)	64%	68%*	66%*
Visited a dentist or a dental clinic (5 or more years ago)	12%	11%	10%

Indicates alignment with the Ohio State Health Assessment
**2016 BRFSS*
***2015 BRFSS*

Key Issues

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

What are the most significant health issues or concerns identified in the 2019 assessment report? Examples of how to interpret the information include: 38% of Ashland County adults were obese, increasing to 42% of those ages 30-64.

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Mental Health (11 votes)			
Adults experienced feeling so sad or hopeless almost every day for two weeks or more in a row that stopped them from doing usual activities (in the past year)	8%	N/A	N/A
Adults considered attempting suicide in the past year	1%	N/A	N/A
Number of suicide deaths in 2017	8 deaths	N/A	N/A
Adults who looked for a program for depression, anxiety, or mental health but have not found a specific program	16%	N/A	N/A
Adults who have looked for a program for martial/family problems but have not found a specific program	89%	N/A	N/A
Obesity/Overweight (10 votes)			
Adults were overweight	30%	Age: 65+ (36%)	Males (41%)
Adults were obese	38%	Age: 30-64 (42%) Income: >$25K (40%)	Males (33%)
Adults trying to lose weight in the past year	44%	N/A	N/A
Poor Physical/Mental Health Days (9 votes)			
Adults rated their physical health as not good on four or more days in the previous month	18%	Age: 30-64 (42%) Income: <$25K (50%)	Males (35%)
Adults rated their mental health as not good on four or more days in the previous month	24%	Age: 30-64 (46%) Income: <$25K (49%)	N/A
Adults reported that poor mental or physical health kept them from doing usual activities such as self-care, work, or recreation (on at least one day during the past 30 days)	25%	N/A	N/A

N/A- Not Available

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Chronic Disease (9 votes)			
Adults diagnosed with high blood pressure	29%	Age: 65+ (63%) Income: <$25K (31%)	Females (31%)
Adults had been diagnosed with high blood cholesterol	30%	Age: 65+ (51%)	Males (33%)
Adults had been diagnosed with diabetes in their lifetime	13%	Age: 65+ (21%) Income: <$25K (22%)	N/A
Adverse Childhood Experiences (ACEs) (6 votes)			
Adults reported experiencing 4+ ACEs in their lifetime	14%	N/A	N/A
Addiction (6 votes)			
Adults average number of drinks consumed per drinking occasion	3.4 drinks	Age: Under 30 (7.0 drinks) Income: <$25K (5.4 drinks)	Males (4.5 drinks)
Adults reported they had been prescribed opioid based medications in their lifetime (1% had trouble stopping)	58%	N/A	N/A
Adults used medication not prescribed for them or they took more than prescribed to feel good or high and/or more active or alert during the past 6 months	6%	Income: <$25K (11%)	Females (7%)
Lack of Education and Health Literacy (3 votes)			
Adults reported that they or an immediate family member had literacy needs learning computer skills	11%	N/A	N/A
Adults reported that they or an immediate family member had literacy needs reading and understanding instructions	3%	N/A	N/A
Arthritis (1 vote)			
Adults were ever told by a health professional that they had some form of arthritis	30%	Age: 65+ (62%) Income: <$25K (44%)	Males (31%)
Adults limited in some way due to arthritis/rheumatism	44%	N/A	N/A
Sexual Behavior (0 votes)			
Annualized Chlamydia Cases, 2017 *(Source: ODH, STD Surveillance)*	138	N/A	N/A
Annualized Count for Gonorrhea, 2017 *(Source: ODH, STD Surveillance)*	30	N/A	N/A
Cancer (0 votes)			
Adults diagnosed with cancer at some point in their lives	13%	Age: 65+ (32%)	N/A

N/A- Not Available

Priorities Chosen

Based on the 2019 Ashland County Health Assessment, key issues were identified for adults. Key issues were combined by age group. Overall, there were 10 key issues identified by the committee. Each organization was given 5 votes. The committee then voted and came to a consensus on the priority areas Ashland County will focus on over the next three years. The key issues and their corresponding votes are described in the table below.

Key Issues	Votes
1. Mental Health	11
2. Obesity/Overweight	10
3. Poor Physical/Mental Health Days	9
4. Chronic Disease	9
5. Adverse Childhood Experiences	6
6. Addiction	6
7. Lack of Education and Health Literacy	3
8. Arthritis	1
9. Cancer	0
10. Sexual Behavior	0

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

1. **Mental health and addiction** (includes depression, suicide, and substance abuse)
2. **Chronic disease** (includes heart disease, diabetes, and arthritis)

Community Themes and Strengths Assessment (CTSA)

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

Open-ended Questions to the Committee

1. **What do you believe are the 2-3 most important characteristics of a healthy community?**
    - Low crime/safety (6)
    - Access to resources (4)
    - Fresh/clean water and sanitation (3)
    - Basic needs are met (housing, food, etc.) (2)
    - Interpersonal relationships (2)
    - Jobs
    - Sense of community/connectedness
    - Curbside appeal/places for families to gather
    - Diversity of activities
    - Access to healthy living activities
    - Affordable activities within the community
    - Good schools and education

2. **What makes you most proud of our community?**
    - Downtown activities (3)
    - Social services (2)
    - Caring community (2)
    - Educational opportunities (2)
    - Involved leadership (2)
    - Mayor
    - Residents feel safe
    - Parks
    - Small town feel
    - Opportunities for assistance
    - Availability of resources
    - Ashland University
    - Linkages across county
    - Community cooperation

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

- Family and Children First Council (3)
- United Way (3)
- University Hospitals Samaritan Medical Center (3)
- Health Department (3)
- Social service luncheons (3)
- Leadership Ashland (2)
- Ashland Community Foundation (2)
- Council on Aging (2)
- Ashland County Job and Family Services (2)
- Community response regarding opiate crisis
- Domestic Violence Task Force
- Community Health Assessment Committee
- CHIP Target Action Group's (TAG's)
- Appleseed
- Catholic Charities
- Downtown improvement and restoration

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

- County-wide transportation (6)
- Affordable housing (3)
- Communication (2)
- Specialists in health care (2)
- Affordable and flexible childcare (2)
- Economic stability
- Adverse Childhood Experiences (ACEs)
- Chronic disease management
- Mental health
- Protection of family life

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

- Funding (4)
- The need for quality employees and funds to pay appropriately (3)
- Lack of awareness (2)
- Time
- Apathy
- Lack of strategic and comprehensive plan of action
- Lack of resources (child abuse prevention)
- Sharing resources
- Generational poverty
- Aging population and technology gap

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

- Tobacco 21 (3)
- Pay scale equal to surrounding counties (3)
- Professional mentoring programs (2)
- Vaccination mandates
- Increase resources (child protective services)
- Policies that accommodate fiscal and health needs of our specific community
- Building social support networks

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

- Community interaction (2)
- More involvement (2)
- Ability to make a difference (2)
- Participation by others
- Collecting and using data to engage broad participation to improve quality of life
- Short term and long-term goals
- Well-developed ideas backed by statistics that creates a healthier community

Quality of Life Survey

The Ashland County Community Health Assessment Committee urged community members to fill out a short Quality of Life Survey via SurveyMonkey. There were 295 Ashland County community members who completed the survey. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1. For all responses of "Don't Know," or when a respondent left a response blank, the choice was a non-response and was assigned a value of 0 (zero). The non-response was not used in averaging response or calculating descriptive statistics.

Seventy-nine percent (79%) of respondents lived in Ashland County. Ninety-two percent (92%) of respondents worked in Ashland County.

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]	3.88
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.41
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.97
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.)	3.77
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.)	3.32
6. Is the community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?)	3.90
7. Are there networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, or organizations) during times of stress and need?	3.86
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.64
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.43
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.34
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.46
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?)	3.50

Forces of Change Assessment

The Forces of Change Assessment focuses on identifying forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. This assessment answers the questions: "What is occurring or might occur that affects the health of our community or the local public health system?" and "What specific threats or opportunities are generated by these occurrences?" The Ashland County Community Health Assessment Committee were asked to identify positive and negative forces which could impact community health improvement and overall health of this community over the next three years. This group discussion covered many local, state, and national issues and change agents which could be factors in Ashland County in the future. The table below summarizes the forces of change agent and its potential impacts:

Force of Change	Threats Posed	Opportunities Created
1. Aging population	• Additional resources needed • Grandparents raising children	• Ability to reach multi-generational families
2. Business growth within county	• Structural impact (i.e. roads) • Loss of affordable housing/buildable lots • Affordability of health care	• New businesses • Increase in workforce • More stability within homes • Health insurance opportunities
3. Funding	• Funding diminishes once impact is made surrounding specific issues	• None noted
4. Wages	• None noted	• None noted
5. Child care	• Hours not convenient	• None noted
6. Housing	• Not enough housing/lack of adorable options	• None noted
7. Gas tax	• Increase in gas prices	• None noted
8. Lack of mental health resources	• Hospital cannot provide for mental health patients (not enough staff, resources, space) • Patients stay in hospital for multiple days before placed elsewhere due to limited resources	• Increased advocacy efforts
9. Leadership changes within county	• Lack of consistency within leadership	• None noted
10. Reactive approach to life instead of proactiveness	• Citizens not approaching systems/assistance until problem is too large and people are in crisis mode • Lack of future planning • Dependency on local programs	• None noted

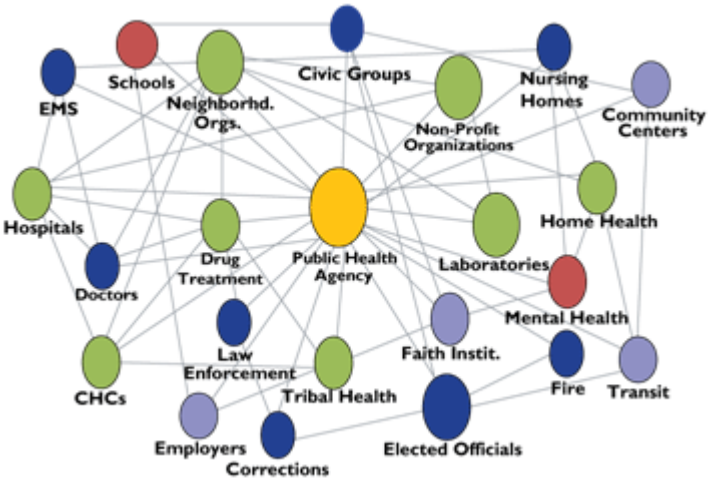
Force of Change	Threats Posed	Opportunities Created
11. Increase stress on schools and administrators	• Educators are burnt out • Difficult to engage students at places other than schools	• Schools are the last place to reach young people
12. Immigration system	• More communities may be impacted • Ability to address unique needs • English as a 2nd language	• Potential increase in diversity (culture, ideas, etc.) within community • Increase support and services
13. Farming industry	• Labor laws preventing young people to obtain work experience • Average age of farmers increasing	• Improved technology for farming
14. Fear of public places	• Less connections • People are more fearful (bombings or shooting scares)	• Food delivered to homes (convenience of not leaving home)
15. Increase in food banks	• None noted	• Nutritional value of foods • Farmers have an opportunity to donate to food banks • More access to food
16. Kroc Center	• Limited funding	• Multigenerational attendance • Increase in physical activity
17. Increase in medical services within county	• None noted	• Increase in urgent care, dentistry options, and wellness centers • Increase in jobs
18. Social media	• Increase prevalence of mental health issues (depression, suicide, bullying) • Decrease in physical activity	• Increased access to health care • Ability to educate many people at once
19. Delivery of fast food	• Increase in obesity • Increased access to fast food	• Increase in jobs • Opportunity for those that are disabled
20. Addiction/vaping	• Increase in lung disease and additional health issues • Breakdown of family structure	• Public education
21. Cell phone use	• Distracted driving • Students using cell phones while in school	• Organ donation

Force of Change	Threats Posed	Opportunities Created
22. Increase in Amish population	• Many unvaccinated • Undereducated • Midwives needed	• Health and safety days • Potential policy changes
23. Governor	• Programs/services may be cut • Loss of funding	• Increase in funding for family services, early childhood education and home visiting programs
24. Lack of self-sufficiency within organizations	• Dependent on state and federal support	• None noted
25. Sex-trafficking	• Long-term trauma • Sexually transmitted infections, AIDS/HIV	• Awareness and education
26. Reimbursement process/government regulations	• None noted	• None noted

Local Public Health System Assessment

The Local Public Health System

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



The public health system includes:

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

The 10 Essential Public Health Services

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

Public health systems should:

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

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

The Local Public Health System Assessment (LPHSA)

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

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

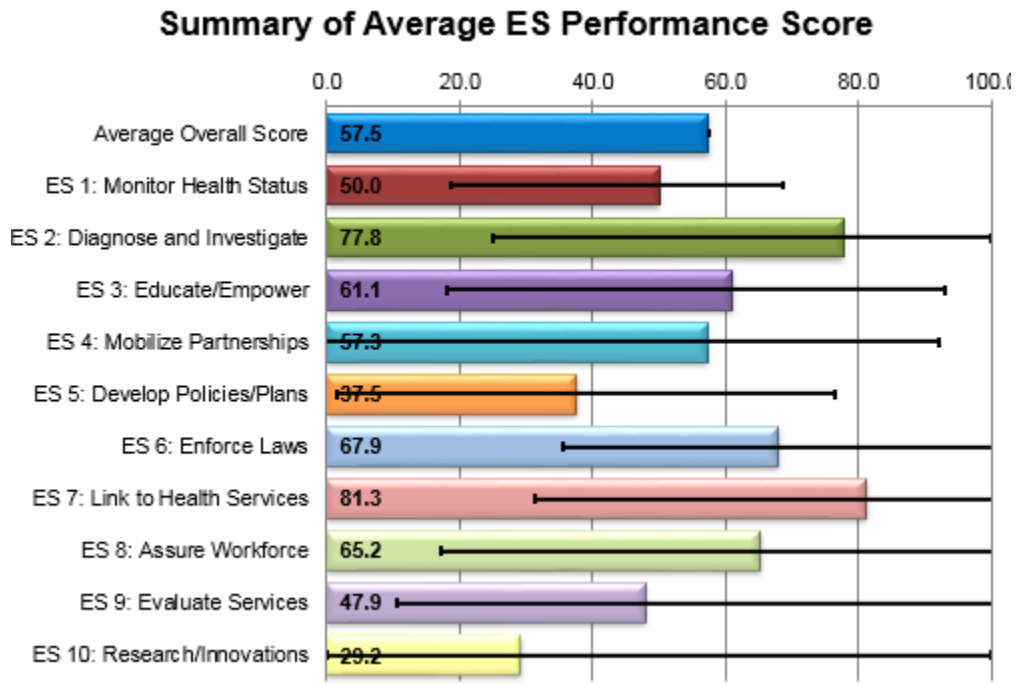
Members of the Ashland County Health Department completed the performance measures instrument. The LPHSA results were then presented to the Ashland County Community Health Assessment Committee for discussion. The 10 Essential Public Health Services and how they are being provided within the community 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 26 indicators that had a status of "minimal" and 12 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 Sarah Goodwill Humphrey from the Ashland County Health Department at (419) 282-4231.

Ashland County Local Public Health System Assessment 2019 Summary



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

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

Gaps Analysis

A gap is an area where the community needs to expand its efforts to reduce a risk, enhance an effort, or address another target for change. A strategy is an action the community will take to fill the gap. Evidence is information that supports the linkages between a strategy, outcome, and targeted impact area. The Ashland County Community Health Assessment Committee were asked to determine gaps in relation to each priority area, consider potential or existing resources, and brainstorm potential evidence-based strategies that could address those gaps. To view the completed gap analysis exercise, please view Appendix I.

Strategy Selection

Based on the chosen priorities, the Ashland County Community Health Assessment Committee were asked to identify strategies for each priority area. Considering all previous assessments, including but not limited to the CHA, CTSA, quality of life survey and gap analysis, committee members determined strategies that best suited the needs of their community. Members referenced a list of evidence-based strategies recommended by the Ohio SHIP, as well as brainstormed for other impactful strategies. Each resource inventory can be found with its corresponding priority area.

Evidence-Based Practices

As part of the gap analysis and strategy selection, the Ashland County Community Health Assessment Committee considered a wide range of evidence-based practices, including best practices. An evidence-based practice has compelling evidence of effectiveness. Participant success can be attributed to the program itself and have evidence that the approach will work for others in a different environment. A best practice is a program that has been implemented and evaluation has been conducted. While the data supporting the program is promising, its scientific rigor is insufficient. Each evidence-based practice can be found with its corresponding strategy.

Resource Inventory

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

Priority #1: Mental Health and Addiction

Strategic Plan of Action

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

Mental Health Strategies:

Priority #1: Mental Health and Addiction				
Strategy 1: Mental health first aid				
Goal: Reduce mental health stigma				
Objective: By May 28, 2022, Ashland County will increase mental health trainings by 20% from baseline				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Obtain baseline data on the number of mental health first aid trainings (or other community-based mental health trainings), that have taken place in the county. Identify gaps in existing programs and determine additional program needs. Determine effective marketing techniques among community organizations that will promote the identified trainings. Determine how to target priority populations (first responders, law enforcement, veterans, the workforce, etc.). Explore incentive options for participation.	May 28, 2020	Adult	Depression: Percentage of adults who reported feeling sad or hopeless almost everyday for 2 or more weeks in a row in the past year	**Trauma/Resiliency Target Action Group**
Year 2: Market the training to local churches, schools, law enforcement, chambers of commerce, college students, etc. Provide at least 3 trainings within the county.	May 28, 2021			
Year 3: Continue efforts of year 2. Increase trainings by 20% from baseline.	May 28, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy:

Trauma/Resiliency TAG, Mental Health and Recovery Board of Ashland County, University Hopsitals Samaritan Medical Center

Priority #1: Mental Health and Addiction

Strategy 2: Implement school-based social and emotional instruction

Goal: Increase social-emotional skills among youth

Objective: Implement programming to fidelity in participating school districts

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research the following programs and determine the feasibility of implementing at least one of the following social and emotional instruction programs to Ashland County school districts: • **The PAX Good Behavior Game** • **The Incredible Years** • **ROX (Ruling Our Experience)** • **Strengthening Families** Pilot the program(s) in at least one county school district. Promote early childhood mental health programs (ex: MHRB's Resiliency Project) in additional setting outside of the schools (ex: home-visits, Head Start, etc.).	May 28, 2020	Youth and child	Social-emotional skills: (not currently available via Ohio SHIP)	**Trauma/Resiliency Target Action Group**
Year 2: Continue efforts from year 1. Implement the program(s) in two additional county school districts. Continue to promote use of early childhood mental health programs throughout the county.	May 28, 2021			
Year 3: Continue efforts from years 1 and 2. Implement the program(s) in all county school districts.	May 28, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy:

Appleseed Community Mental Health Center, Catholic Charities, school relationships, Help Me Grow learning centers, Parenting Plus programming, Family and Children First Council, School-Community Liaison Program, Trauma/Resiliency TAG

Priority #1: Mental Health and Addiction

Strategy 3: Community-wide campaign to promote positive mental health and cell-phone based support programs

Goal: Increase awareness of suicide among adults and youth

Objective: Promote the Crisis Text Line in at least two new additional ways by May 28, 2022

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research mental health social marketing programs that specifically address stigma (ex: NAMI's **CureStigma**, OHMAS's **Be Present Campaign**). Secure funding for campaign.	May 28, 2020	Adult and youth	Suicide deaths: Number of deaths due to suicide per 100,000 populations (age adjusted)	**Suicide Prevention Coalition**
Year 2: Target campaign to specifically address demographics most at risk (ex: middle aged men, specific youth populations). Launch campaign. Promote and raise awareness of the Crisis Text Line (**Text 4hope**) throughout the county. Utilize youth-led prevention groups and the Ashland County Suicide Prevention Coalition to promote the use of the Crisis Text Line. Monitor the usage of the Crisis Text Line.	May 28, 2021			
Year 3: Continue efforts from years 1 and 2. Evaluate campaign effectiveness.	May 28, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy:

QPR tools, youth-led initiatives, Mental Health and Recovery Board of Ashland County, Suicide Prevention Coalition

Priority #1: Mental Health and Addiction

Strategy 4: Community collaboration to increase awareness and coordination of mental health and substance services

Goal: Increase awareness of mental health and substance abuse services within Ashland County

Objective: Present on the availability of mental health/substance abuse services within Ashland County to at least 4 community organizations by May 28, 2022

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Create a mental health/substance abuse combined coalition. Invite faith-based leaders, local businesses, community organizations, justice system liaisons, mental health/substance abuse service providers, health care providers, and other organizations to have a round-table discussion surrounding mental health and substance abuse in the county. Compile comprehensive baseline data on what programs and services (marital counseling services, Mental Health First Aid, prevention, detox, etc.) are offered within or near the county, and address gaps in care coordination.	May 28, 2020	Adult	Adults unable to find a mental health program: Adults who looked for a program for depression, anxiety, or mental health but have not found a specific program Suicide ideation: Percent of adults who seriously considered attempting suicide in the past 12 months	**Mental Health and Recovery Board of Ashland County** **Family and Children First Council**
Year 2: Continue efforts from year 1. Create an informational guide of all the county organizations that provide mental health/substance abuse 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/substance abuse services and present it to county area churches, law enforcement, city council, businesses, and other organizations. Include information on mental health stigma, and work to increase community awareness and education of stigma and how it is a barrier to treatment.	May 28, 2021			
Year 3: Continue efforts from years 1 and 2.	May 28, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy:

Family and Children First Council list serv, Mental Health and Recovery Board of Ashland County, Parenting Plus

Addiction Strategies:

Priority #1: Mental Health and Addiction

Strategy 5: Community awareness and education of risky behaviors and substance abuse issues and trends

Goal: Educate community members on substance abuse issues and trends

Objective: By May 28, 2022, develop at least 3 awareness programs and/or workshops focusing on "hot topics", risky behaviors, and substance abuse issues and trends

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue existing awareness campaigns to increase education and awareness of risky behaviors and substance abuse issues and trends. Include information on topics such as e-cigarettes, alcohol use, and prescription drug abuse. Work with youth-led prevention groups to determine best ways to educate community and parents (social media, newspaper, school websites or newsletters, television, church bulletins, etc.).	May 28, 2020	Adults	Prescription medication abuse: Percent of adults who misused prescription medication in the past 6 months Alcohol use: Number of drinks adults consumed per drinking occasion	**Opioid Target Action Team**
Year 2: Focus awareness programs and/or workshops on different "hot topics", risky behaviors, and substance abuse issues and trends. Consider implementing the **Hidden In Plain Sight** program. Attain media coverage for all programs and/or workshops.	May 28, 2021			
Year 3: Continue efforts of years 1 and 2.	May 28, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy:

Ashland County Health Department, Opioid TAG, Arcadia Local Schools, Appleseed Community Mental Health Center, University Hospitals Samaritan Medical Center, faith community

Priority #1: Mental Health and Addiction

Strategy 6: Community-based comprehensive program(s) to reduce alcohol abuse

Goal: Decrease alcohol abuse

Objective: By May 28, 2022, implement 2 strategies from the Community Trails Intervention to Reduce High-Risk Drinking Program

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research alcohol prevention programs or other like programs outside of law enforcement to address binge drinking. Focus on strategies that specifically target high use populations (ex: under 30, low income). Research the Community Trials Intervention to Reduce High-Risk Drinking program. Collect baseline data on current environmental interventions being administered by law enforcement including: Compliance checks, Responsible Beverage Service, and Parents Who Host Lose the Most campaign.	May 28, 2020	Adult	Binge drinking: Percent of adults who consumed 4 or more drinks on occasion (females) or 5 or more drinks on occasion (males) in the past 30 days	**Opioid Target Action Team**
Year 2: Work with area law enforcement agencies to determine feasibility of implementing/expanding at least 2 of the following strategies: • Sobriety checkpoints (working with law enforcement) • Compliance checks (working with the Ohio Investigative Unit) • Responsible Beverage Service (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	May 28, 2021			
Year 3: Expand strategies to all areas of the county and implement remaining strategies. Publicize the results.	May 28, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

- ○ Yes
- ○ No
- ⊗ Not SHIP Identified

Resources to address strategy:

Law enforcement, Opioid TAG

Priority #1: Mental Health and Addiction

Strategy 7: Increase safe disposal of prescription drugs

Goal: Decrease prescription medication abuse

Objective: By May 28, 2022, increase the number of prescription drug collection sites in Ashland County by 25% from baseline

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Increase awareness of prescription drug abuse and the location of existing prescription drug collection boxes. Work with local law enforcement to sponsor and host prescription drug take-back days. Promote the use of dissolvable prescription bags (i.e. Deterra) and provide education regarding safe disposal.	May 28, 2020	Adult	Prescription medication abuse: Percent of adults who misused prescription medication in the past 6 months	**Opioid Target Action Team**
Year 2: Host at least two additional prescription drug take-back days and increase participation. Expand the number of local practitioners and pharmacies providing information on prescription drug abuse and collection locations.	May 28, 2021			
Year 3: Continue to host drug take-back-days. Increase the number of local practitioners and pharmacies providing information on prescription drug abuse and collection locations by 25%.	May 28, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy:

Opioid TAG, drop box promotional videos, inventory of current disposal packets

Priority #1: Mental Health and Addiction

Strategy 8: Provider training on opioid prescribing guidelines and use of OARRS (Prescription Drug Monitoring Programs)

Goal: Decrease the number of opioid doses prescribed per capita

Objective: Train all new employees and provide one annual training regarding the use of OARRS by May 28, 2022

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collect baseline data on the number of primary care, urgent care, ambulatory care, and emergency department providers that utilize the **Ohio Automated Rx Reporting System (OARRS)** and at what frequency. Develop a training for all new employees on opioid prescribing guidelines and the use of OARRS, as well as an annual training for current health care providers.	May 28, 2020	Adults	Prescription medication abuse: Percent of adults who misused prescription medication in the past 6 months Sales of opioid pain relievers: Kilograms of opioid pain relivers sold per 100,000 population (OARRS)	**Opioid Target Action Team**
Year 2: Continue efforts from year 1. Train all new employees on the use of OARRS and provide an annual training for current health care providers.	May 28, 2021			
Year 3: Continue efforts from years 1 and 2. Train all new employees on the use of OARRS and provide an annual training for current health care providers.	May 28, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy:

University Hospitals Samaritan Medical Center, Opioid TAG

Priority #2: Chronic Disease

Strategic Plan of Action

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

Priority #2: Chronic Disease

Strategy 1: Online community wellness calendar

Goal: Increase physical activity

Objective: Ashland County will update the online community wellness calendar on a quarterly basis

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collaborate with county organizations to create an online community wellness calendar. Include current information regarding physical activity opportunities within the county (ex: Tai Chi, Walks in the Park, opportunities for young children, etc.). Highlight opportunities that are free or available at a reduced cost. Ensure that the calendar is available online (Ex: Facebook or other social network sites). Print hard copies and disseminate within the community (senior centers, food pantries, and other relevant locations) to reach populations that may not have Internet accessibility.	May 28, 2020	Adult	Physical inactivity: Percentage of adults reporting no leisure time physical activity	**Health and Wellness Target Action Group**
Year 2: Keep the online wellness calendar updated on a quarterly basis.	May 28, 2021			
Year 3: Continue efforts from years 1 and 2.	May 28, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy:

Health and Wellness TAG, Ashland County Health Department, Facebook page to create platform, current community-liaison list of free activities in Ashland County, Ashland Source current summer activities list, Wayne County community calendar (as a potential model), potential sponsorships

Priority #2: Chronic Disease

Strategy 2: Research chronic pain management best-practices

Goal: Reduce adults reporting they are limited in some way due to arthritis

Objective: Offer trainings and or materials regarding chronic disease best practices and resources by May 28, 2022

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research and/or monitor chronic pain management best practices (ex: **Department of Health and Human Services Pain Management Best Practices Inter-Agency Task Force**). Determine availability of local resources for chronic pain management. Complete a needs assessment focused on individual experiences with chronic pain and the process of navigating resources.	May 28, 2020	Adult	Limited due to arthritis: Percent of adults limited in some way due to arthritis/rheumatism	**Health and Wellness Target Action Group**
Year 2: Determine action steps based on needs assessment (completed in year 1). Promote local pain management resources. Work with primary care physician (PCP) offices to assess what information and/or materials they may be lacking to provide better resources for patients. Offer trainings and or materials regarding best practices and local referral sources and resources.	May 28, 2021			
Year 3: Continue efforts from years 1 and 2.	May 28, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy:

University Hospitals Samaritan Medical Center (pain management group), Health and Wellness TAG

Priority #2: Chronic Disease

Strategy 3: Activity programs for older adults

Goal: Implement activity programs for older adults

Objective: By May 28, 2022, Ashland County will increase referrals to activity programs for older adults

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to offer and promote activity programs for older adults within the county (ex: Tai Chi, Maintaining Better Balance, etc.). Work with physicians for referrals to programs. Partner with additional organizations to build referral avenues. Determine need to expand programs to additional areas of the county (ex: Loudonville, Sullivan, etc.).	May 28, 2020	Adult	Physical inactivity: Percentage of adults reporting no leisure time physical activity	**Health and Wellness Target Action Group**
Year 2: Continue efforts from year 1. Expand the activity programs to additional locations (determined in year 1) and times.	May 28, 2021			
Year 3: Continue efforts from years 1 and 2.	May 28, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy:

Health and Wellness TAG, Older Adults Behavioral Health Coalition, Mental Health and Recovery Board of Ashland County, Ashland YMCA

Priority #2: Chronic Disease

Strategy 4: Prediabetes screening and referral

Goal: Reduce diabetes in adults

Objective: By May 28, 2022, increase prediabetes referrals by 15%

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Determine the baseline number of organizations in the county that currently screen for prediabetes (ex: Diabetes Prevention Program (DPP)). Raise awareness of prediabetes screening, identification and referral through dissemination of the **Prediabetes Risk Assessment** (or similar assessment) and/or the **Prevent Diabetes STAT Toolkit**. Partner with local organizations to administer the screening or raise awareness of prediabetes. Promote and market free/reduced cost screening events within the county (ex: health fairs, hospital screening events, etc.).	May 28, 2020	Adult	Diabetes: Percent of adults who had been told by a doctor that they have diabetes Prediabetes: Percent of adults who had been told by a doctor that they have prediabetes	**Health and Wellness Target Action Group**
Year 2: Increase awareness of prediabetes screening, identification and referral. Increase the number of individuals within Ashland County that are screened for diabetes. If needed, increase the number of organizations that screen for prediabetes.	May 28, 2021			
Year 3: Continue efforts of years 1 and 2.	May 28, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy:

University Hospitals Samaritan Medical Center, Ashland Christian Health Center, Ashland County Health Department, Health and Wellness TAG

Priority #2: Chronic Disease

Strategy 5: Healthy food in convenience stores

Goal: Increase fruit and vegetable consumption

Objective: By May 28, 2022, increase participation in the Healthy Retail Initiative by 25% from baseline

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research the Healthy Food Retail Initiative. Collaborate with local organizations to implement the initiative in local convenience stores by working with stores to offer an assortment of affordable fresh fruits and vegetables as a means to eliminate food desert areas. Appoint a health educator to lead the Healthy Food Retail Initiative. Survey customers and community members to assess community need for healthy food items.	May 28, 2020	Adult	Fruit consumption: Percent of adults who report consuming fruits less than one time daily Vegetable consumption: Percent of adults who report consuming vegetables less than one time daily	**Health and Wellness Target Action Group**
Year 2: Initiate contact with local convenience stores. Recruit at least 1-2 corner stores to participate in the Healthy Food Retail Initiative. Design healthy recipe cards and nutrition education materials to accompany fresh produce being offered in convenience stores.	May 28, 2021			
Year 3: Continue efforts of years 1 and 2. Recruit an additional 3-5 corner stores to participate in the initiative.	May 28, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy:

Health and Wellness TAG, local convenience stores

Priority #2: Chronic Disease

Strategy 6: Healthy food initiatives

Goal: Increase fruit and vegetable consumption

Objective: By May 28, 2022, Ashland County will implement 2 healthy food initiatives in local food pantries or farmers markets

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Raise awareness of the available food pantries and farmers markets within the county (locations, offerings, etc.). Continue to distribute information on where to obtain fresh fruit and vegetables. Update information on a quarterly basis. Obtain baseline information of who currently accepts SNAP/EBT at local farmers markets. Determine feasibility of **SNAP/EBT at farmers markets** (meet with market managers to determine readiness). Educate vendors regarding food deserts and the benefits of accepting SNAP/EBT at farmers markets.	May 28, 2020	Adult	Fruit consumption: Percent of adults who report consuming fruits less than one time daily Vegetable consumption: Percent of adults who report consuming vegetables less than one time daily	**Health and Wellness Target Action Group**
Year 2: Continue efforts of year 1. Determine feasibility of implementing any of the following in local food pantries or farmers markets: • Cooking demonstrations and recipe tastings • Produce display stands • Nutrition and health education • Health care support services	May 28, 2021			
Year 3: Continue efforts of year 2. Implement at least 2 items above within local food pantries or farmers markets.	May 28, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy:

Health and Wellness TAG, Ashland County Job and Family Services, OSU Extension educators, A Whole Community, local farmers markets, local food pantries

Priority #2: Chronic Disease

Strategy 7: Community-wide physical activity campaigns

Goal: Increase physical activity

Objective: By May 28, 2022, Ashland County will implement a community-wide physical activity campaign in collaboration with at least four Ashland County organizations

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collaborate with local schools, businesses, healthcare providers, religious organizations, and other organizations in the county to create a **community-wide physical activity campaign.** Appoint at least one representative from each organization to serve on a steering committee for the community campaign. Establish a campaign and identify strategies to implement unified physical activity initiatives and policies within the county (ex: "Get Fit Ashland" program). Meet with decision-makers from various businesses, schools, and other organizations to provide education on physical activity initiatives and types of wellness policies. Work with at least one county organization to implement a physical activity initiative or policy.	May 28, 2020	Adults	Physical inactivity: Percentage of adults reporting no leisure time physical activity Heart disease: Percent of adults ever diagnosed with coronary heart disease	**Health and Wellness Target Action Group**
Year 2: Continue efforts from year 1. Review campaign goals, objectives, and strategies. Work with at least 2 additional county organizations to implement a physical activity initiative or policy.	May 28, 2021			
Year 3: Continue efforts from years 1 and 2. Review campaign goals, objectives, and strategies. Work with at least 3 additional county organizations to implement a physical activity initiative or policy.	May 28, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy:

Health and Wellness TAG, Get Fit Ashland, Ashland YMCA, connection with parks, Kroc Center, City parks and recreation

Priority #2: Chronic Disease

Strategy 8: Community gardens

Goal: Decrease obesity

Objective: By May 28, 2022, one additional community garden will be developed in Ashland County

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Obtain baseline data regarding how many school districts, churches, and other community organizations currently have **community gardens** and where they are located. Identify specific demographic need for community gardens. Determine need for additional community gardens and to secure volunteers and Master Gardeners (ex: potential partnership with OSU Extension).	May 28, 2020	Adults	Vegetable consumption: Percent of adults who report consuming vegetables less than one time daily	**Health and Wellness Target Action Group**
Year 2: Research grants and funding opportunities to increase the number of community gardens. Develop a sustainability plan to maintain existing and future community gardens year-round. Obtain baseline data regarding which local food pantries have fresh produce available. Work with food pantries to offer fresh produce and assist pantries in seeking donations from local grocers. Market current and future community gardens within the county (i.e. location, offerings, etc.). Update the marketing information on an annual basis.	May 28, 2021			
Year 3: Continue efforts from year 2. Explore partnership opportunities to educate community members and families on gardening and healthy eating practices.	May 28, 2022			

Type of Strategy:

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

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy:

Health and Wellness TAG, Ashland County school districts

Cross-Cutting Strategies

Cross-Cutting Factor: Healthcare System and Access

Cross-Cutting Factor: Healthcare System and Access				
Strategy 1: Trauma-informed health care*				
Goal: Reduce suicide deaths				
Objective: By May 28, 2022, Ashland County will increase the use of trauma screening tools by 15%				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Obtain baseline of the number of **trauma informed care** trainings which have been administered within the county. Facilitate an assessment among health care providers, teachers, social service providers, and other community members/agencies on their awareness and understanding of trauma informed care, including toxic stress and adverse childhood experiences (ACEs). Facilitate Trauma Informed Care trainings in the community to increase education and understanding of trauma within Ashland County.	May 28, 2020	Adult and youth	Suicide deaths: Number of deaths due to suicide per 100,000 populations (age adjusted)	**Trauma/Resiliency Target Action Group**
Year 2: Continue efforts of year 1. Develop and implement a trauma screening tool for social service organizations who work with at risk populations.	May 28, 2021			
Year 3: Continue efforts from years 1 and 2. Increase the use of trauma screening tools by 15%.	May 28, 2022			
Priority area(s) the strategy addresses: ⊗ Mental Health and Addiction ○ Chronic Disease ○ Not SHIP Identified				
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Mental Health and Recovery Board of Ashland County, Trauma/Resiliency TAG				

Note: Although "Trauma-informed care" falls within the mental health category of the SHIP aligned strategies, the Ashland County Community Health Assessment deemed this strategy as "cross-cutting."

Cross-Cutting Factor: Healthcare System and Access

Strategy 2: Access to transportation

Goal: Increase access to transportation opportunities

Objective: By May 28, 2022, Ashland County will research and market available transportation opportunities

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Conduct an environmental scan of all transportation opportunities, including public, regional, and private. Collect information regarding eligibility of services, cost, and other relevant information. Create an informational brochure or online guide detailing transportation options that are available to county residents. Once available, ensure the information is updated on 2-1-1.	May 28, 2020	Adult	Increase access to transportation opportunities: Number of trips provided through public and private transportation	**Homeless Target Action Group**
Year 2: Disseminate information regarding transportation opportunities in the county. Target businesses and agencies that serve at-risk populations, as well as seniors. Collaborate with neighboring counties to discuss the plausibility of shared transportation services. Continue to explore alternate transportation and opportunities to enhance coordination.	May 28, 2021			
Year 3: Continue efforts from years 1 and 2. Update the transportation guide on an annual basis.	May 28, 2022			

Priority area(s) the strategy addresses:

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

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy:

Homeless TAG, Appleseed Community Mental Health Center, City of Ashland

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

Cross-Cutting Factor: Public Health System, Prevention and Health Behaviors				
Strategy 3: Policies to decrease availability of tobacco products				
Goal: Reduce tobacco use				
Objective: By May 28, 2022, Ashland County will adopt smoke free policies in at least 2 new locations				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research the **Tobacco 21** Initiative. Raise awareness of Tobacco 21 and research the feasibility of local jurisdictions adopting this policy. Begin efforts to adopt smoke-free policies in county parks, fairgrounds, schools and other public locations. Ensure all forms of tobacco are included (i.e. e-cigarettes). Reach out to other communities who have implemented these policies to learn the best way to approach decision makers and to learn of potential barriers and challenges.	May 28, 2020	Adult	Adult smoking: Percent of adults that are current smokers	**Ashland County Health Department**
Year 2: Present information to City Councils on both the Tobacco 21 initiative and smoke-free outdoor public locations.	May 28, 2021			
Year 3: Continue efforts from years 1 and 2. Adopt at least 2 smoke-free policies in county parks, fairgrounds, schools, or other public locations.	May 28, 2022			
Priority area(s) the strategy addresses: ⊗ Mental Health and Addiction ⊗ Chronic Disease				
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: Ashland County Health Department, local hospital tobacco cessation programs				

Cross-Cutting Factor: Social Determinants of Health

Cross-Cutting Factor: Social Determinants of Health				
Strategy 4: Early childhood education (ECE) opportunities				
Goal: Expand awareness and education of early childhood education opportunities within Ashland County				
Objective: By May 28, 2022, Ashland County will increase the number of children enrolled in an early intervention program by 10% from baseline				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Conduct an environmental scan of all ECE opportunities that are available in the county, including school-based ECE, program-based ECE, universal preschool, Head Start, and others. Collect information regarding eligibility and cost. Gather baseline data on the number of children enrolled in a Head Start, Early Head Start or pre-kindergarten education program. Increase public awareness regarding access to early intervention programs.	May 28, 2020	Child	Kindergarten readiness: Percent of kindergarten students demonstrating readiness (entered kindergarten with sufficient skills, knowledge and abilities to engage with kindergarten-level instruction)	**Early Childhood Collaborative (FCFC)**
Year 2: Continue efforts from year 1. If there is a need for additional ECE opportunities in the county, apply for an **early childhood education grant** through the Ohio Department of Education (ODE). Increase the number of children enrolled in an early intervention program by 5% from baseline.	May 28, 2021			
Year 3: Continue efforts from years 1 and 2. Increase the number of children enrolled in an early intervention program by 10% from baseline.	May 28, 2022			
Priority area(s) the strategy addresses: ⊗ Mental Health and Addiction ⊗ Chronic Disease				
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: Early Childhood Collaborative, Family and Children First Council				

Cross-Cutting Factor: Social Determinants of Health

Strategy 5: Parenting programs and resources

Goal: Expand awareness and education of parenting programs and resources within Ashland County

Objective: By May 28, 2022, Ashland County will increase the number of parents enrolled in a parenting program by 10% from baseline

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Conduct an environmental scan and gather baseline data on the availability of parenting programs and resources in the county (ex: Parenting Plus parent education, Triple P, Healthy Kids Strong Families, etc.). Determine parenting resources specifically available for parents with children with behavioral health needs. Collect information regarding eligibility and cost. Increase public awareness regarding access to parenting programs within the county. Determine additional avenues for referrals.	May 28, 2020	Child	Kindergarten readiness: Percent of kindergarten students demonstrating readiness (entered kindergarten with sufficient skills, knowledge and abilities to engage with kindergarten-level instruction)	**Family and Children First Council**
Year 2: Continue efforts from year 1. If there is a need for additional parenting resources, increase the number of parenting programs available in Ashland County.	May 28, 2021			
Year 3: Continue efforts from years 1 and 2. Increase the number of parents enrolled in a parenting program by 10% from baseline.	May 28, 2022			

Priority area(s) the strategy addresses:

⊗ Mental Health and Addiction ⊗ Chronic Disease

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy:

Mental Health and Recovery Board of Ashland County, Family and Children First Council, Catholic Charities, Parenting Plus

Cross-Cutting Factor: Social Determinants of Health

Strategy 6: Early childhood home visiting program

Goal: Increase kindergarten readiness

Objective: Continue to promote and monitor the Help Me Grow program in Ashland County

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to offer the **Help Me Grow Home Visiting program** in Ashland County. Evaluate effectiveness of the program by using the following measures: • Improvement in maternal and newborn health; • Reduction in child injuries, abuse, and neglect; • Improved school readiness and achievement; • Reduction in crime or domestic violence; • Improved family economic self-sufficiency • Improved coordination and referral for other community resources and supports	May 28, 2020	Child	Kindergarten readiness: Percent of kindergarten students demonstrating readiness (entered kindergarten with sufficient skills, knowledge and abilities to engage with kindergarten-level instruction) Child abuse and neglect: Rate of child maltreatment victims per 1,000 children in population (DJFS)	**Family and Children First Council**
Year 2: Continue to promote and monitor the Help Me Grow Home Visiting program.	May 28, 2021			
Year 3: Continue efforts from years 1 and 2.	May 28, 2022			

Priority area(s) the strategy addresses:

⊗ Mental Health and Addiction ⊗ Chronic Disease

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy:

Cross-Cutting Factor: Social Determinants of Health

Strategy 7: Affordable, quality housing

Goal: Decrease severe housing problems

Objective: By May 28, 2022, Ashland County will research and identify at least one policy change in relation to housing issues in Ashland County

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Appoint a representative(s) from the committee to serve on the Ashland County Homeless Coalition or other local housing coalitions. Identify housing issues within the county that are impacting personal health. Identify what policy or legislative changes that the Ashland County Community Health Assessment Committee can assist in (ex: advocate to landlords/management companies regarding accepting those on housing assistance programs/complying with HUD safe housing regulations). Research low income housing tax credits, **home improvement grant opportunities**, and **service-enriched housing** to support efforts.	May 28, 2020	Adult, youth, child	High housing costs: Percent of households with monthly housing costs, including utilities, exceed 50% of monthly income (via U.S. HUD) Severe housing problems: Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities (via Community Health Rankings)	**Ashland County Housing Coalition**
Year 2: Continue efforts from year 1. Create a coordinated campaign of planned strategies and define interventions and resources.	May 28, 2021			
Year 3: Begin addressing strategies identified and implementing policy changes.	May 28, 2022			

Priority area(s) the strategy addresses:

⊗ Mental Health and Addiction ⊗ Chronic Disease

Strategy identified as likely to decrease disparities?

⊗ Yes ○ No ○ Not SHIP Identified

Resources to address strategy:

Appleseed Community Mental Health Center, Homeless TAG, Kroc Center, Ashland County Housing Coalition, ACCESS, City of Ashland

Progress and Measuring Outcomes

Progress will be monitored with measurable indicators identified for each strategy. Most indicators align directly with the SHIP. The individuals or agencies, identified as Target Action Groups (TAGs), will meet on an as-needed basis. TAGs will report out at Full Council Meetings of the Ashland County Family and Children First Council, which meets every other month. The CHA/CHIP Planning Committee will create a plan to disseminate the CHIP to the community. Strategies, responsible agencies, and timelines will be reviewed at the end of each year by the Planning Committee. As this CHIP is a living document, edits and revisions will be made accordingly.

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

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

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

Contact Us

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

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Health Commissioner
Ashland County Health Department
1763 State Route 60
Ashland, OH 44805
419-282-4231

Appendix I: Gaps and Strategies

The following tables indicate mental health and chronic disease gaps and potential strategies that were compiled by the Ashland County Community Health Assessment Committee.

Mental Health and Addiction Gaps

Gaps	Potential Strategies
1. Lack of education surrounding trauma and its impact on health	• Build ACEs literacy within community • Trauma-informed care
2. Increasing number of children with behavioral health problems	• Resources geared towards parents and family support
3. Lack of inpatient addiction options/treatment providers	• Opportunities for advocating/rolling up to decision makers
4. Lack of funding for placement of children with dual diagnoses'	• Opportunities for advocating/rolling up to decision makers
5. Breakdown of family/marriages (dynamic is changing with different attitudes regarding marriage)	• Make divorce more difficult obtain • Counseling services for marital issues – encourage churches to offer counseling/make it known that help is available
6. Incarcerated parents	• Education regarding how children are affected as the result of incarceration
7. Undiagnosed brain disease (diagnostic categories have grown, and many are labeled with a mental health diagnosis that should not)	• Awareness and education regarding diagnoses
8. Hospital does not have enough resources to address mental health patients (space, resources, referral sources, etc.)	• Existing partnership with Appleseed • Crisis lines • Funding for additional local services/more beds
9. OBGYN – not sure if there are screenings within County surrounding depression	• Depression screenings during office visits
10. Limited funding for mental health	• More services within schools due to receptiveness • School-Community Liaison Program • Drug and alcohol prevention within schools
11. Binge drinking above national/state levels	• Increase education (too much focus on opiates may be missing this component)

Chronic Disease Gaps

Gaps	Potential Strategies
1. Lack of health coping skills that could affect heart disease, obesity, etc.	• Crunch Out Obesity within schools (United Way Program) to increase access to fruit/vegetables, physical activity options • Early intervention opportunities within schools
2. Lack of transportation and access to services	• Bring services to community (for ex: closest Rheumatologist is in Wooster) • Telemedicine advances • Educate community regarding transportation options (Medicaid eligible population, seniors, etc.) • 2-1-1 system is coming back – opportunity for organizations to update information regarding transportation opportunities and services within community
3. Increase in diabetes and pre-diabetes within community – lack of healthy coping skills	• Approach to take ownership of health • Awareness of screening/free trainings within community • More diabetic education opportunities • Diabetic support groups (Ashland Christian Health Center- more people participating in programs)
4. Lack of programing geared towards chronic pain and arthritis	• Education regarding best practices to care for yourself • Pain education (lifestyle, diet, exercise) • YMCA arthritis programs • Increase provider availability (potentially offer services a few times a month in Ashland County) • Connect providers from other counties with resources that are available in Ashland County
5. Access to health coaching	• Offer free or lost cost health coaching opportunities (lower income, 65+)

Appendix II: Target Action Group Members

Current Target Action Group (TAG) participant agencies are listed below:

Trauma & Resiliency TAG:

Ashland University
Ashland County Council on Alcoholism and Drug Abuse
Safe Haven of Ashland, Ohio
Ashland County Job & Family Services
Redbird Resilient
Ashland Christian Health Center
Catholic Charities of Ashland County
Ashland Parenting Plus
Ashland County - Hospice of North Central Ohio

Health & Wellness TAG:

Ashland County Health Department
City of Ashland
Ashland University
Ashland YMCA
Ashland County Family & Children First Council
University Hospital – Samaritan Medical Center
A Whole Community
Ashland Church Community Emergency Shelter Services
Ashland Area Chamber of Commerce
Ashland County Cancer Association
Kingston of Ashland

Homeless Coalition/Bridges Out of Poverty TAG:

Ashland County Family & Children First Council
Ashland Parenting Plus
Ashland Church Community Emergency Shelter Services
Ashland Christian Health Center
Ashland County Mental Health & Recovery Board
Ashland County Council on Alcoholism and Drug Abuse
Kno-Ho-Co Ashland
Ashland Salvation Army Kroc Center
Ashland Grace
Ashland County Job & Family Services
Associated Charities of Ashland County
Ashland County Health Department
Fostering Families Ministries
Ashland County - Catholic Charities Diocese of Cleveland
Appleseed Community Mental Health Center
United Way of Ashland County
Transformation Network

Opiate TAG:

Ashland County Mental Health & Recovery Board
Appleseed Community Mental Health Center
Ashland Area Faith Based Organization
Ashland County Prosecutor's Office
University Hospital – Samaritan Medical Center
Ashland County Council on Alcoholism and Drug Abuse
Ashland County Health Department
Ashland County Job & Family Services

Appendix III: Links to Websites

Title of Link	Website URL
Text "4hope"	https://mha.ohio.gov/Portals/0/assets/Prevention/Suicide/CTL-fact-sheet.pdf
Ashlandheath.com	https://www.ashlandhealth.com/
Be Present Campaign	https://bepresentohio.org/
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-wide physical activity campaigns	https://www.thecommunityguide.org/findings/physical-activity-community-wide-campaigns
Complete streets	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/complete-streets-streetscape-design-initiatives
CureStigma	https://www.curestigma.org/
Department of Health and Human Services Pain Management Best Practices Inter-Agency Task Force	https://www.hhs.gov/ash/advisory-committees/pain/reports/2018-12-draft-report-on-updates-gaps-inconsistencies-recommendations/index.html
Early childhood education grant	http://education.ohio.gov/Topics/Early-Learning
Help Me Grow Home Visiting program	https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/help-me-grow/help-me-grow
Hidden In Plain Sight	http://powertotheparent.org/be-aware/hidden-in-plain-sight/
Home Improvement grant opportunities	https://www.cdc.gov/policy/hst/hi5/homeimprovement/index.html
Ohio Automated Rx Reporting System (OARRS)	https://www.ohiopmp.gov/
PAX Good Behavior Game	https://www.hazelden.org/HAZ_MEDIA/gbg_insert.pdf
Prevent Diabetes STAT Toolkit	https://preventdiabetesstat.org/index.html
Prediabetes Risk Assessment	http://www.diabetes.org/are-you-at-risk/diabetes-risk-test/
ROX (Ruling Our Experience)	https://rulingourexperiences.com/#!about_us/csgz
Service-enriched housing	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/service-enriched-housing

Title of Link	Website URL
SNAP/EBT at farmers markets	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/electronic-benefit-transfer-payment-at-farmers-markets
Strengthening Families	https://www.strengtheningfamiliesprogram.org/
Surgeongeneral.gov	surgeongeneral.gov
The Incredible Years	http://www.incredibleyears.com/
Tobacco 21	https://tobacco21.org/state-by-state/
Trauma informed care	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/trauma-informed-health-care