CCHP CRAWFORD COUNTY HEALTH PARTNERS

DELIVERED BY:
Moxley
PUBLIC HEALTH

2023-2025
IMPLEMENTATION STRATEGY

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A LETTER FROM **CRAWFORD COUNTY HEALTH PARTNERS**

Crawford County Health Partners strive to bring together people and organizations to improve community wellness in Crawford County. The community health needs assessment and implementation strategy process is one way we can live out our mission. In order to fulfill this mission, we must be intentional about understanding the health issues that impact residents and work together to create a healthier community.

A primary component of creating a healthy community is assessing the needs and prioritizing those needs for impact. In 2022, Crawford County Health Partners conducted a comprehensive community health needs assessment to identify primary health issues and other current health needs in the area. In Fall 2022, the findings were then used to develop an implementation strategy to describe the response to the needs identified in the CHNA report.

The 2023-2025 Crawford County Implementation Strategy report is the fourth improvement/implementation plan undergone by Avita Health System and the community agencies who are active members of Crawford County Health Partners. We want to provide the best possible care for our residents, and we have used this report to guide us in our strategic planning and decision-making concerning future programs, clinics, and health resources.

The Crawford County Health Partners Implementation Strategy would not have been possible without the help of numerous Crawford County organizations, acknowledged on the following page. It is vital that assessments and strategies such as this continue so that we know where to direct our resources and use them in the most advantageous ways.

More importantly, the possibility of this report relies solely on the participation of individuals in our community who committed to responding honestly to the survey and interviews that were conducted to assess the health of our community.

The work of public health is a community job that involves individual facets, including our community members, working together to be a thriving community of health and well-being at home, work, and play.

Sincerely,

Cinda M. Kropka, MHA
Corporate Compliance & Privacy Officer
Avita Health System

Kate Siefert, RS, MPH
Health Commissioner
Crawford County Public Health

Jason McBride, MPH
Health Commissioner
Galion City Health Department

Crawford County Health Partners

Avita Health System*
Crawford County Public Health*
Galion City Health Department*
Marion-Crawford ADAMH Board*
Crawford County Board of Developmental Disabilities*
Together We Hurt, Together We Heal*
Community Counseling Wellness Centers
Community Foundation for Crawford County
Crawford County Council on Aging
Crawford County Partnership for Education & Economic Development
Crawford County School Districts
Family and Children First Council
Family Life Counseling
Jobs & Family Services
Marion Crawford Prevention Programs
Maryhaven
Pathways
Project Noelle
Rally for Hope
Turning Point
United Way of Crawford County
Voice of Hope
Wesley Chapel/Restore Ministries
YMCA

***Funding Partner**

ACKNOWLEDGEMENTS

This Implementation Strategy was made possible thanks to the collaborative efforts of many members of the Crawford County Health Partners staff, local stakeholders, partners, and community residents. Their contributions, expertise, time and resources played a critical part in the completion of this assessment. The board would like to thank and acknowledge everyone for their contribution in striving to bring together people and organizations to improve community wellness in Crawford County.

The 2023-2025 Implementation Strategy report was prepared by Moxley Public Health, LLC, (www.moxleypublichealth.com) a consulting firm that works with hospitals, health departments and other community-based nonprofit organizations both domestically and internationally. Stephanie Moxley served as the lead, joined by Dr. Melissa Biel, Alexandra Piatkowski, Elissa Morgan, and Denise Flanagan. Moxley Public Health, LLC seeks to improve healthcare throughout the world one community at a time and believes that quality healthcare is a universal human right.

CRAWFORD COUNTY HEALTH PARTNERS AND MOXLEY PUBLIC HEALTH WOULD LIKE TO RECOGNIZE THE FOLLOWING INDIVIDUALS AND ORGANIZATIONS FOR THEIR CONTRIBUTIONS TO THIS REPORT:

Avita Health System*
Crawford County Public Health*
Galion City Health Department*
Marion-Crawford ADAMH Board*
Crawford County Board of Developmental Disabilities*
Together We Hurt, Together We Heal*
Community Counseling Wellness Centers
Community Foundation for Crawford County
Crawford County Council on Aging
Crawford County Partnership for Education & Economic Development
Crawford County School Districts
Family and Children First Council
Family Life Counseling
Jobs & Family Services
Marion Crawford Prevention Programs
Maryhaven
Pathways
Project Noelle
Rally for Hope
Turning Point
United Way of Crawford County
Voice of Hope
Wesley Chapel/Restore Ministries
YMCA

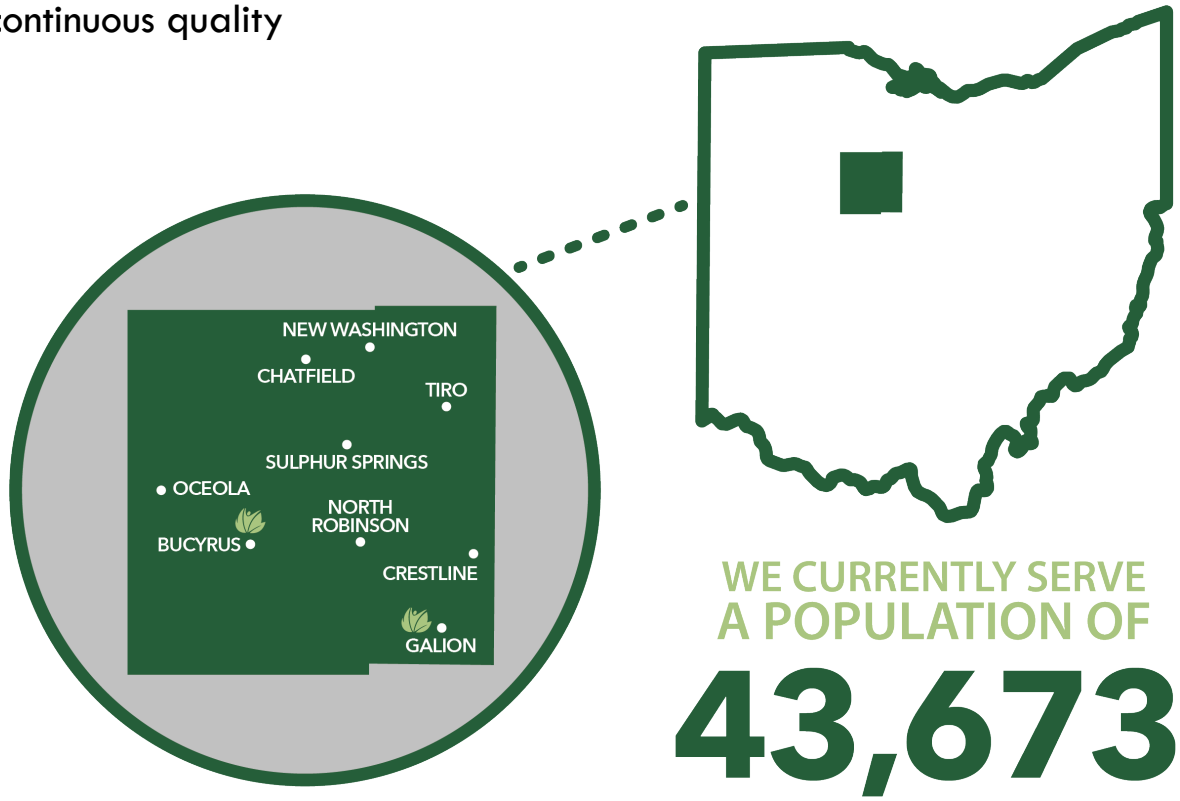
*Funding Partner

DEFINING THE AVITA HEALTH SYSTEM

SERVICE AREA

Avita Health System has two hospitals in Crawford County: Bucyrus Hospital is located at 629 N. Sandusky Avenue, Bucyrus, Ohio, 44820, and Galion Hospital is located at 269 Portland Way South, Galion, Ohio, 44833. Avita Health System is a locally governed, patient-centered, integrated health care system that is committed to providing superior medical services to North Central Ohio. Avita Health System is the health care system and employer of choice, strategically using its resources to maximize the mission, and strive for continuous quality improvements.

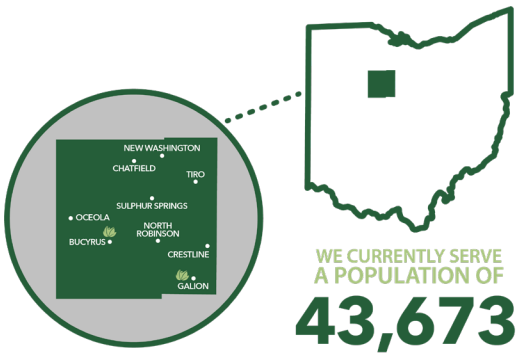
The CHNA and the resulting Implementation Strategy identify and address significant community health needs and help guide Avita Health System's community benefit activities. This Implementation Strategy report explains how Crawford County Health Partners plans to address the selected priority health needs identified by the CHNA.



WE CURRENTLY SERVE A POPULATION OF

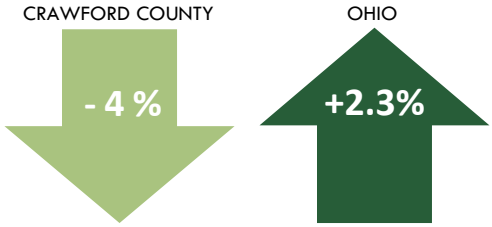
43,673

AVITA HEALTH SYSTEM
AT-A-GLANCE

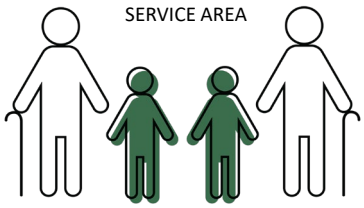


WE CURRENTLY SERVE A POPULATION OF
43,673

CRAWFORD COUNTY'S POPULATION HAS DECREASED, WHILE OHIO'S POPULATION IS INCREASING:



YOUTH AGES 0-17 AND SENIORS 65+ MAKE UP 42.3% OF THE POPULATION
IN THE AVITA HEALTH SERVICE AREA

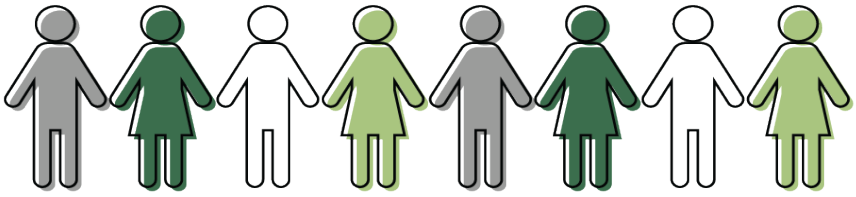


THE % OF MALES AND FEMALES IS NEARLY EQUAL

AVITA HEALTH SYSTEM SERVES 4,073 VETERANS
OR 9% OF THE POPULATION

CRAWFORD COUNTY RANKS 53rd IN SOCIAL AND ECONOMIC FACTORS
OUT OF 88 COUNTIES, WITH 1 BEING THE BEST

THE MAJORITY OF THE POPULATION IS WHITE, WITH A SMALL REPRESENTATION OF OTHER RACIAL IDENTITIES



95.3% WHITE	1.7% HISPANIC OR LATINO	1.0% BLACK/ AFRICAN AMERICAN	1.4% MULTI-RACIAL	0.5% ASIAN	0.04% OTHER	0.1% AMERICAN INDIAN/ AK NATIVE	0.04% NATIVE HI/PACIFIC ISLANDER

THE COUNTY HAS LESS ACCESS TO CERTAIN HEALTH CARE PROVIDERS THAN OHIO OVERALL:

	CRAWFORD COUNTY	OHIO
POPULATION TO PRIMARY CARE PHYSICANS	2,770:1	1,300:1
POPULATION TO DENTISTS	1,730:1	1,560:1
POPULATION TO MENTAL HEALTH PROVIDERS	720:1	380:1

PRIORITY HEALTH NEEDS IN CRAWFORD COUNTY

1 ADVERSE CHILDHOOD EXPERIENCES (ACES)

NEARLY ONE-QUARTER (24.7%)
OF CRAWFORD COUNTY TEENS REPORT 3+ ACEs, VS. 20.9% FOR OHIO

2 PHYSICAL ACTIVITY

38% OF TEENS IN CRAWFORD COUNTY
ARE EITHER OVERWEIGHT OR OBESE VS. 30% FOR OHIO

3 UNMET NEEDS FOR MENTAL HEALTHCARE

ONLY 27% OF CRAWFORD COUNTY CHILDREN WITH A MENTAL HEALTH PROBLEM RECEIVED TREATMENT IN THE PAST YEAR, VS. 29% FOR OHIO

4 DEPRESSION & SUICIDE

CRAWFORD COUNTY ADULTS REPORT
5.2 MENTALLY UNHEALTHY DAYS PER MONTH
VS. 4.8 FOR OHIO

CRAWFORD COUNTY HAS A HIGHER SUICIDE MORTALITY RATE OF
16.6 PER 100,000
VS. 14.6 PER 100,000 FOR OHIO

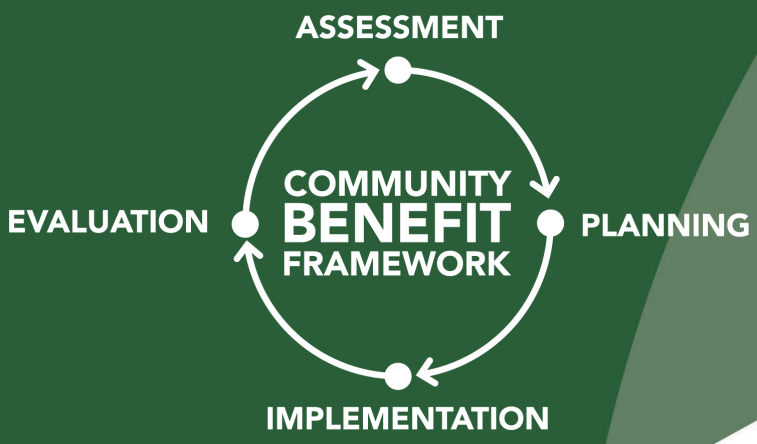
5 HEART DISEASE, HYPERTENSION & DIABETES

HEART DISEASE IS THE
LEADING CAUSE OF DEATH
(206.4 DEATHS PER 100,000)
IN CRAWFORD COUNTY

CRAWFORD COUNTY HAS A HIGHER DIABETES MORTALITY RATE OF
36.8 PER 100,000
VS. 25.2 PER 100,000 FOR OHIO

INTRODUCTION

WHAT IS AN IMPLEMENTATION STRATEGY?



An Implementation Strategy is part of a framework that is used to guide community benefit activities - policy, advocacy, and program-planning efforts. For hospitals, the Implementation Strategy describes their plan to respond to the needs identified through the previous CHNA process. The Implementation Strategy also fulfills a requirement mandated by the IRS in Section 1.501(r)(3).

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OVERVIEW
OF THE PROCESS

In order to develop an Implementation Strategy, Crawford County Health Partners followed a process that included the following steps:

STEP 1: Plan and prepare for the implementation strategy.

STEP 2: Develop goals/objectives and identify indicators to address health needs.

STEP 3: Consider approaches to address prioritized needs.

STEP 4: Select strategies and approaches to address prioritized health needs.

STEP 5: Integrate implementation strategy with community and hospital plans.

STEP 6: Develop a written implementation strategy.

STEP 7: Adopt the implementation strategy.

STEP 6: Update and sustain the implementation strategy.

Within each step of this process, the guidelines and requirements of both the state and federal governments are followed precisely and systematically.

Affordable Care Act (Federal) Requirements
Enacted on March 23, 2010, the Affordable Care Act (ACA) provided guidance at a national level for CHNAs and Implementation Strategies for the first time. Federal requirements included in the ACA stipulate that hospital organizations under 501(c)(3) status must adhere to new 501(r) regulations, one of which is developing an implementation strategy/improvement plan every three years to address the needs identified in the previous CHNA. Moxley Public Health utilized a checklist to ensure that all federal requirements were met in this report.

Ohio Department of Health Requirements
The Ohio Department of Health (ODH) is required by state law to provide guidance to hospitals and local health departments on community health needs assessments and implementation strategies/plans. On July 2016, HB 390 (ORC 3701.981) was enacted by Ohio in order to improve population health planning in the state by identifying health needs and priorities by conducting a CHNA and subsequently developing an implementation strategy/improvement plan to address those needs in the community.

THE 2023-2025 CRAWFORD COUNTY HEALTH PARTNERS IMPLEMENTATION STRATEGY MEETS ALL OHIO DEPARTMENT OF HEALTH AND FEDERAL (IRS) REGULATIONS.

STEP 1

PLAN AND PREPARE FOR THE IMPLEMENTATION STRATEGY

IN THIS STEP, CRAWFORD COUNTY HEALTH PARTNERS:

- ✓ DETERMINED WHO WOULD PARTICIPATE IN THE DEVELOPMENT OF THE IMPLEMENTATION STRATEGY
- ✓ ENGAGED AVITA HEALTH SYSTEM BOARD AND EXECUTIVE LEADERSHIP
- ✓ REVIEWED COMMUNITY HEALTH NEEDS ASSESSMENT

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PLAN AND PREPARE FOR THE 2023-2025 CRAWFORD COUNTY HEALTH PARTNERS IMPLEMENTATION STRATEGY

Secondary data were collected from a variety of local, county, and state sources to present community demographics, social determinants of health, health care access, birth characteristics, leading causes of death, chronic disease, health behaviors, mental health, substance use and misuse, and preventative practices. Primary data was collected through key informant interviews with 18 experts from various organizations serving the Crawford County area and included leaders and representatives of medically underserved, low-income, and minority populations, or local health or other departments or agencies. Additionally, 159 responses were received for the *Crawford County Prioritization Survey*. The collection and analysis of the secondary and primary data resulted in the 2022 Crawford County Health Partners Community Health Needs Assessment (CHNA) report. (Available at **https://www.communitymedical.org/about-us/community-benefit**).

The 2022 CHNA findings were used to select the priority health needs that will be addressed during the fiscal years 2023-2025. To be selected as a priority health need, the data that was collected in the CHNA process was used to identify poor health outcomes, health disparities, health trends, and community priorities. Additionally, Crawford County Health Partners compared the data against Healthy People 2030 (HP2030) benchmarks, and statewide averages and rates. The list of 2023-2025 priority health needs were finalized by reviewing the focus areas from the previous Implementation Strategy and Avita Health System's and the county's capacity to address each health need.

> **The implementation strategy deals with the "how and when" of addressing needs. While the community health needs assessment considers the "who, what, where and why" of community health needs, the implementation strategy takes care of the how and when components.**

STEP 2

DEVELOP GOALS/ OBJECTIVES AND IDENTIFY INDICATORS FOR ADDRESSING COMMUNITY HEALTH NEEDS

IN THIS STEP, CRAWFORD COUNTY HEALTH PARTNERS:

- ✓ DEVELOPED GOALS FOR IMPLEMENTATION STRATEGY BASED ON THE FINDINGS FROM THE CHNA
- ✓ SELECTED INDICATORS TO MEASURE GOALS

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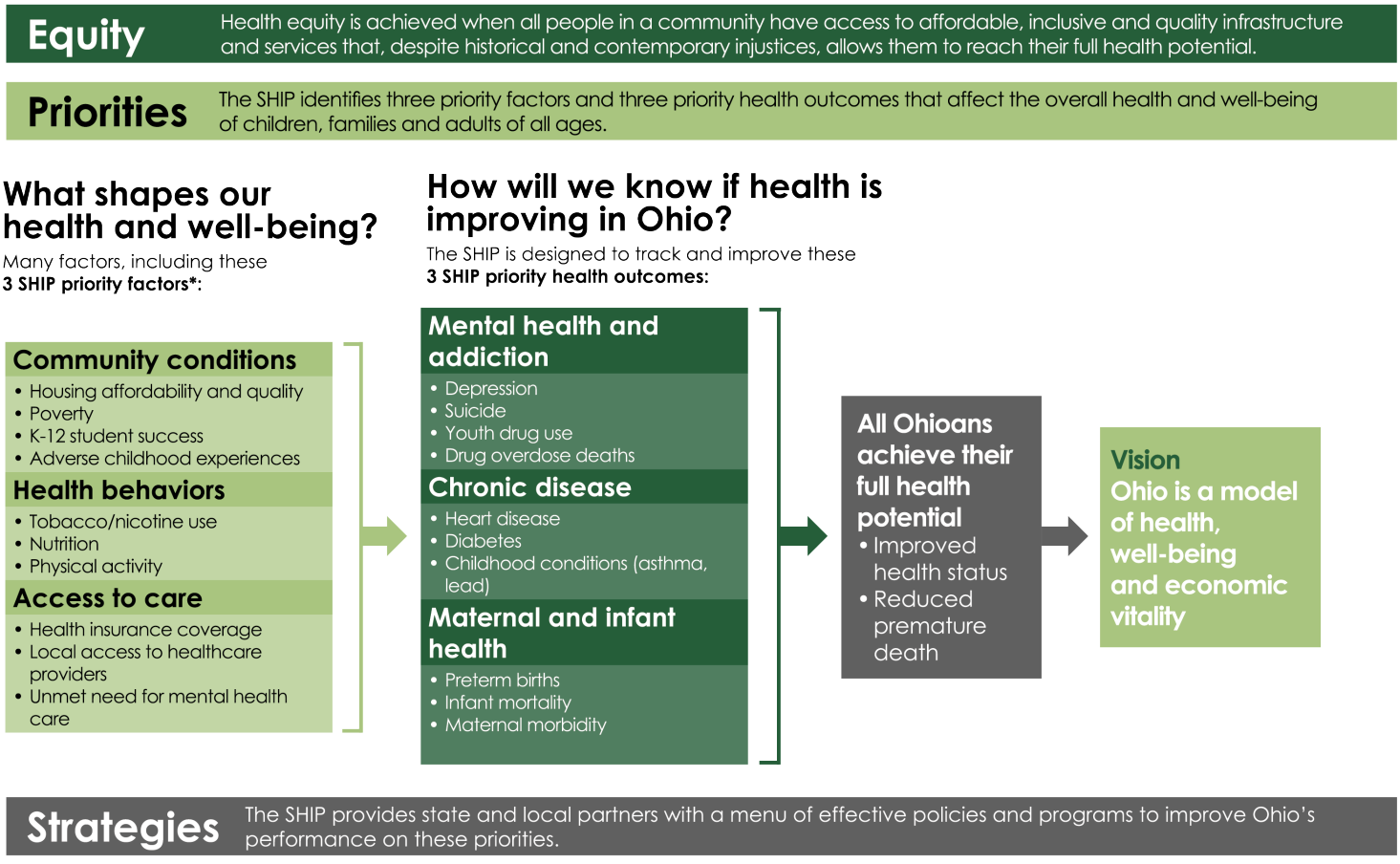
PRIORITY HEALTH NEEDS

GOALS, OBJECTIVES, AND INDICATORS

Crawford County Health Partners desired to align with the priorities and indicators of the Ohio Department of Health (ODH). In order to do this, Crawford County Health Partners used the following guidelines when prioritizing the health needs of their community.

First, they used the same language as the state of Ohio when assessing the factors and health outcomes of their community in the 2022 Crawford County Health Partners Community Health Needs Assessment.

Figure 1: SHIP Framework



* These factors are sometimes referred to as the social determinants of health or the social drivers of health

Next, with the data findings from the community health needs assessment process, Crawford County Health Partners used the following worksheet to choose priority factors and priority health outcomes. Using the guidance from ODH's State Health Improvement Plan (SHIP) strengthened the ability to align with the state in order to strengthen the efforts to improve the health, well-being, and economic vitality of both Crawford County Health Partners' service area and the state of Ohio (worksheet/guidelines continued to next page).

Figure 2: Alignment with priorities and indicators

STEP 1 Identify at least one priority factor and at least one priority health outcome

Priority factors	Priority health outcomes
☑ Community conditions (strongly recommended)	☑ Mental health and addiction
☑ Health behaviors	☑ Chronic disease
☑ Access to care	☐ Maternal and infant health

STEP 2 Select at least 1 indicator for each identified priority factor

Priority factors	
Community conditions	
Topic	**Indicator name***
Housing affordability and quality	☐ CC1. Affordable and available housing units
Poverty	☐ CC2. Child poverty
	☐ CC3. Adult poverty
K-12 student success	☐ CC4. Chronic absenteeism (K-12 students)
	☐ CC5. Kindergarten readiness
Adverse childhood experiences	☑ CC6. Adverse childhood experiences (ACEs)
	☑ CC7. Child abuse and neglect
Health behaviors	
Topic	**Indicator name***
Tobacco/nicotine use	☐ HB1. Adult smoking
	☐ HB2. Youth all-tobacco/nicotine use
Nutrition	☐ HB3. Youth fruit consumption
	☐ HB4. Youth vegetable consumption
Physical activity	☑ HB5. Child physical activity
	☑ HB6. Adult physical inactivity
Access to care	
Topic	**Indicator name***
Health insurance coverage	☐ AC1. Uninsured adults
	☐ AC2. Uninsured children
Local access to healthcare services	☐ AC3. Primary care health professional shortage areas
	☑ AC4. Mental health professional shortage areas
Unmet need for mental health care	☑ AC5. Youth depression treatment unmet need
	☑ AC6. Adult mental health care unmet need

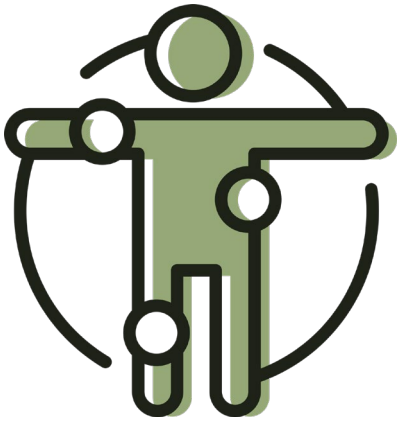
* See Appendix A of the SHIP for the specific indicator description, suggested data source and local data availability.

STEP 2 (cont.) Select at least 1 indicator for each identified priority health outcome

Priority health outcomes	
Mental health and addiction	
Topic	**Indicator name***
Depression	☑ MHA 1. Youth depression
	☑ MHA 2. Adult depression
Suicide deaths	☑ MHA3. Youth suicide deaths
	☑ MHA4. Adult suicide deaths
Youth drug use	☐ MHA5. Youth alcohol use
	☐ MHA6. Youth marijuana use
Drug overdose deaths	☐ MHA7. Unintentional drug overdose deaths
Chronic disease	
Topic	**Indicator name***
Heart disease	☑ CD1. Coronary heart disease
	☑ CD2. Premature death - heart disease
	☑ CD3. Hypertension
Diabetes	☑ CD4. Diabetes
Harmful childhood conditions	☐ CD5. Child asthma morbidity
	☐ CD6. Child lead poisoning
Maternal and infant health	
Topic	**Indicator name***
Preterm births	☐ MIH1. Total preterm births
Infant mortality	☐ MIH2. Infant mortality
Maternal morbidity/mortality	☐ MIH3. Severe maternal morbidity

* See Appendix A of the SHIP for the specific indicator description, suggested data source and local data availability.

ADDRESSING THE HEALTH NEEDS



The 2022 CHNA identified the following significant health needs from an extensive review of the primary and secondary data. The significant health needs were ranked:

PRIORITY FACTORS THAT AFFECT HEALTH RANKED BY REGION (ASSESSED IN SURVEY AND INCLUDE COMMUNITY CONDITIONS, HEALTH BEHAVIORS, AND ACCESS TO CARE)
Local access to healthcare (access to care)
Nutrition and access to healthy foods (health behavior and community condition)
Poverty/economic security (social determinant of health/community condition)
Adverse childhood experiences (social determinant of health/community condition)
Unmet need for mental health care (access to care)
Physical activity (health behavior)
Health insurance coverage (access to care)
Housing affordability/quality (social determinant of health/community condition)
Access to childcare (social determinant of health/community condition)
Transportation (social determinant of health/community condition)
Crime/Violence (social determinant of health/community condition)
Tobacco and nicotine use (health behavior)
K-12 student success (social determinant of health/community condition)

PRIORITY HEALTH OUTCOMES RANKED BY REGION (ASSESSED IN SURVEY)
Depression (mental health and addiction)
Drug overdose deaths (mental health and addiction)
Youth drug use (mental health and addiction)
Suicide (mental health and addiction)
Heart disease (chronic disease)
Diabetes (chronic disease)
Childhood conditions-asthma and lead (chronic diseases)
Infant mortality/maternal morbidity/preterm births (maternal and infant health)

From the significant health needs, Crawford County Health Partners chose health needs that considered their capacity to address community needs, the strength of community partnerships, and those needs that correspond with Avita Health System's organizational priorities.

THE FIVE PRIORITY HEALTH NEEDS THAT WILL BE ADDRESSED IN THE 2023-2025 IMPLEMENTATION STRATEGY ARE:

Priority Area 1: Adverse Childhood Experiences (Community Conditions)
Priority Area 2: Physical Activity (Health Behaviors)
Priority Area 3: Unmet Needs for Mental Healthcare (Access to Care)
Priority Area 4: Depression & Suicide (Mental Health & Addiction)
Priority Area 5: Heart Disease, Hypertension & Diabetes (Chronic Disease)

STEPS 3 & 4

CONSIDER AND SELECT APPROACHES AND STRATEGIES TO ADDRESS PRIORITIZED HEALTH NEEDS

IN THIS STEP, CRAWFORD COUNTY HEALTH PARTNERS:

- ✓ SELECTED APPROACHES AND STRATEGIES TO ADDRESS CRAWFORD COUNTY HEALTH PARTNERS SERVICE AREA PRIORITIZED HEALTH NEEDS

AVITA HEALTH SYSTEM

#1 REDUCE ADVERSE CHILDHOOD EXPERIENCES (ACEs)

COMMUNITY CONDITIONS

EXPERIENCES OF YOUTH IN YOUR COMMUNITY

N/A	7.9%	9.4%	24.7%
Sexual abuse or coercion	Physical abuse by parents or adults in home	Physical abuse between parents or adults in home	Cumulative ACEs score of 3 or more

STRATEGIES

- **Post educational material with contact information, phone numbers, and resources on youth intimate partner violence (IPV)/domestic violence in each Middle School and High School restroom in the Crawford County School District**
- **Train Crawford County School Districts on ACE Scores and their meaning**
- **Implement 2 interventions in the Crawford County School District:**
  1. PAX Good Behavior Game
  2. "Handle with Care" (HWC) Program
- **Promote the 211 county-wide resource list for all to access so appropriate referrals can be made**
- **Implement or enhance healthcare screening and follow up for intimate partner violence**

PARTNERS

- Crawford County School Districts
- CCPH
- ADAMH
- Marion/ Crawford Prevention
- Crawford County School District
- ADAMH
- MCPP
- CCPH
- Schools
- Law Enforcement
- All Crawford County Health Partners
- Avita Health System

POPULATIONS

THESE STRATEGIES WILL POSITIVELY IMPACT ALL RESIDENTS, BUT DATA SHOWS THESE POPULATIONS ARE IN THE MOST NEED:

Black (non-Hispanic), Hispanic, Low-income (<15k annual income), Children with special healthcare needs

Though Crawford County's prevalence of ACEs is **similar to the Ohio average,** it should be recognized that this **data is difficult to collect,** and many ACEs likely go **unreported and/or untreated.**

OUTCOMES

DESIRED OUTCOMES OF STRATEGIES

- ↓ Adverse Childhood Events
- ↓ Cumulative ACE scores

OVERALL IMPACT OF STRATEGIES**

- ↓ Youth Risk Behaviours (smoking & heavy drinking)
- ↑ Youth Education & Employment Potential
- ↓ Chronic Disease

ALL RESIDENTS OF CRAWFORD COUNTY ACHIEVE THEIR FULL HEALTH POTENTIAL

Source: Ohio Healthy Youth Environments Survey, 2015-2016, 2016-2017, 2017-2018 & 2018-2019 combined. https://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/MHYouthSurvey N/A=insufficient responses for statistical reporting, this question may not have been asked in this Board.

**Source: https://www.cdc.gov/vitalsigns/aces/index.html#:~:text=ACEs%20can%20include%20violence%2C%20abuse,and%20substance%20misuse%20in%20adulthood.

#2 IMPROVE YOUTH & ADULT PHYSICAL ACTIVITY

HEALTH BEHAVIORS

YOUTH IN YOUR COMMUNITY

12.7%

7th – 12th graders with no days of 60+ min. of physical activity in past week

ADULTS IN YOUR COMMUNITY

31%

Adults with no leisure-time physical activity in past 30 days

STRATEGIES

- Create and share master document of opportunities for people to participate in physical activities
- Create a Healthy Eating and Activity Living Coalition in Crawford County
- Add bike racks to downtown Buycyrus area near retail locations to encourage use of bikes to shop and run errands
- Develop Worksite Wellness Programs and provide template policies for businesses to adopt
- Healthcare providers give exercise prescriptions to patients

PARTNERS

- Crawford County Healthy Living Coalition
- Chamber of Commerce
- Community Members
- Elected Officials
- Mayors
- County Commissioners
- Health Departments
- Avita Health System
- Health Departments
- Avita Health System

POPULATIONS

THESE STRATEGIES WILL POSITIVELY IMPACT ALL RESIDENTS, BUT DATA SHOWS THESE POPULATIONS ARE MOST IN NEED:

Black (non-Hispanic), Hispanic, Adults, 65+, Low-income (<15k annual income), People with a disability

Adults 18+ in Crawford County will **significantly benefit,** as they surpass the Ohio average, with **31% reporting no leisure time physical activity.**

OUTCOMES

DESIRED OUTCOMES OF STRATEGIES

- ↓ Adult physical inactivity
- ↓ Youth physical inactivity

OVERALL IMPACT OF STRATEGIES**

- ↑ Heart Health
- ↑ Brain Health
- ↓ Risk of Weight Gain

ALL RESIDENTS OF CRAWFORD COUNTY ACHIEVE THEIR FULL HEALTH POTENTIAL

*Source: *For All Adults, accessed via County Health Rankings, 2021.* http://www.countyhealthrankings.org

**Source: https://www.cdc.gov/physicalactivity/basics/adults/health-benefits-of-physical-activity-for-adults.html

#3 REDUCE UNMET NEEDS FOR MENTAL HEALTHCARE

ACCESS TO CARE

YOUTH IN YOUR COMMUNITY

22.1%

Youth with Major Depressive Episodes who did not receive mental health services in past year

27%

Saw health care provider for mental health problem in past year

It is recognized that it can be difficult and sensitive to collect data on minors. More data should be collected on this in the next CHNA

ADULTS IN YOUR COMMUNITY

52.2%

Adults who were not able to receive treatment for mental illness in past year

More data should be collected on this in the next CHNA

STRATEGIES

Implement Sequential Intercept Mapping (SIM) through 'Stepping Up' initiative to develop jail diversion process for patients in Criminal Justice system	Work with employers to train supervisors on how to identify mental health needs	Expand training opportunities for individuals to become certified peer support specialists	Promote Crisis Lines using community awareness campaigns	Provide telemental health services, implement behavioral health/primary care integration, enrich chronic disease management program, & launch mHealth mobile app for mental health

PARTNERS

❖ ADAMH ❖ Sheriff ❖ Judges ❖ Probation Officers ❖ Mental Health Care Providers ❖ NAMI	❖ Crawford County Public Health ❖ Marion/Crawford Prevention ❖ ADAMH ❖ Community Counselling & Wellness Centers	❖ ADAMH ❖ NAMI	❖ Avita Health System ❖ Health Departments ❖ ADAMH	❖ Avita Health System

POPULATIONS

THESE STRATEGIES WILL POSITIVELY IMPACT ALL RESIDENTS, BUT DATA SHOWS THESE POPULATIONS ARE IN THE MOST NEED:

Those who have experienced the loss of a loved one, those often seen in triage notes for suicide ideation, depression, & grief

The ratio of Crawford County **residents to mental health providers is 720:1**, while the **state ratio is 380:1**. **Improving access** to mental health providers is **essential** in our community.

OUTCOMES

DESIRED OUTCOMES OF STRATEGIES

↑ Youth & Adult Mental Health Care Visits

↓ Untreated Youth & Adult Mental Health Conditions

OVERALL IMPACT OF STRATEGIES**

↓ Mental Health Conditions

↓ Risk for Chronic Disease (Diabetes, Heart Disease, & Stroke)

ALL RESIDENTS OF CRAWFORD COUNTY ACHIEVE THEIR FULL HEALTH POTENTIAL

*Source: *Ohio Healthy Youth Environments Survey, 2015-2016, 2016-2017, 2017-2018 & 2018-2019, combined.* https://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/MHYouthSurvey

**Source: https://www.cdc.gov/mentalhealth/learn/index.htm

#4 REDUCE DEPRESSION

MENTAL HEALTH & ADDICTION

YOUTH IN YOUR COMMUNITY

14.3% Moderate or severe psychological distress (PHQ)

20.9% In past year felt sad or hopeless almost every day for 2+ weeks

17.8% Anxious (PHQ)

38.9% Got 8 or more hours of sleep on average school night)

27% Saw health care provider for mental health problem in past year

14% Depressed (PHQ)

ADULTS IN YOUR COMMUNITY

20.7% Adults diagnosed with depression in past year*

STRATEGIES

- **Implement Grief Counselling**
- **Promote and share master list of mental health providers (MHPs) in the area for ease of referral**
- **Implement referral process from Primary Care Providers (PCPs) to MHPs for clients who trip Patient Health Questionnaire-9 (PHQ-9)**
- **Promote Crisis Lines using community awareness campaigns**

PARTNERS

- LOSS Team
- LEAP Program
- ADAMH
- Mental Health Providers
- Funeral Homes

- Pathways of Central Ohio
- ADAMH

- Avita Health System
- ADAMH
- CCWC
- MHPs

- Avita Health System
- Health Departments
- ADAMH

POPULATIONS

THESE STRATEGIES WILL POSITIVELY IMPACT ALL RESIDENTS, BUT DATA SHOWS THESE POPULATIONS ARE MOST IN NEED:

Those who have experienced the loss of a loved one, those often seen in triage notes for suicide ideation, depression, & grief → This population will **significantly benefit** as this experience is often associated with **depression and suicidal ideation**, based on hospital triage notes

OUTCOMES

DESIRED OUTCOMES OF STRATEGIES ↓ Youth & Adult Depression

OVERALL IMPACT OF STRATEGIES ↑ Youth & Adult Mental Health ↓ Suicide Deaths

ALL RESIDENTS OF CRAWFORD COUNTY ACHIEVE THEIR FULL HEALTH POTENTIAL

**Source: Ohio Healthy Youth Environments Survey, 2015-2016, 2016-2017, 2017-2018 & 2018-2019, combined. https://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/MHYouthSurvey*

***Source: BRFSS Region 3 – Ohio Behavioral Risk Factor Surveillance System Region 3 comprises the following counties: Crawford, Erie, Huron, Ottowa, Richland, Sandusky, Seneca, and Wyandot*

****Source: 2017 BRFSS Annual Report. https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/chronic-disease/data-publications/ohio-2017-brfss-annual-report*

#4 REDUCE SUICIDE DEATHS

MENTAL HEALTH & ADDICTION

YOUTH IN YOUR COMMUNITY

1

WHITE MALE

# of youth suicide deaths (5 yr avg)

ADULTS IN YOUR COMMUNITY

38 # of adult suicide deaths (5 yr avg)

16.6 Adult suicide death rate per 100,000*

4.7% Adults who seriously considered suicide in past year**

STRATEGIES

- **Create a suicide death review team**
- **Implement Grief Counselling**
- **Endorse and enlighten the community about 988**
- **Offer training in QPR to the entire community**
- **Offer 'Signs of Suicide (SOS)' program training**
- **Offer 'Working Minds Training' for businesses**
- **Continue CIT with law enforcement**

PARTNERS

- CCPH
- ADAMH

- LOSS Team
- LEAP Program
- ADAMH
- MHPs
- Funeral Homes

- Suicide Prevention Coalition
- ADAMH
- CCPH
- Pathways of Central Ohio

- CCPH
- Marion-Crawford County Prevention

- Community Counselling & Wellness Programs

- ADAMH
- MCPP

- NAMI
- ADAMH

POPULATIONS

THESE STRATEGIES WILL POSITIVELY IMPACT ALL RESIDENTS, BUT DATA SHOWS THESE POPULATIONS ARE MOST IN NEED:

YOUTH

White, male, resident of Appalachian counties

ADULTS

Ages 35-44, 55-64, **65+,** male, resident of Appalachian counties

In your community, **32%** of suicide deaths were in **adults 65+.** This population will **significantly benefit!**

OUTCOMES

DESIRED OUTCOMES OF STRATEGIES

Youth & Adult Suicide Deaths

OVERALL IMPACT OF STRATEGIES

Youth & Adult Mental Health

ALL RESIDENTS OF CRAWFORD COUNTY ACHIEVE THEIR FULL HEALTH POTENTIAL

**Source: U.S. Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Mortality public-use data 2015-2019, on CDC WONDER. https://wonder.cdc.gov/Deaths-by-Underlying-Cause.html*

***Source: Ohio Department of Health, Ohio 2019 BRFSS Annual Report. https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/chronic-disease/data-publications/ohio-2019-brfss-annual-report and 2017 BRFSS Annual Report. https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/chronic-disease/data-publications/ohio-2017-brfss-annual-report*

#5 REDUCE HEART DISEASE, HYPERTENSION & DIABETES

CHRONIC DISEASE

HEART DISEASE IN YOUR COMMUNITY

8.4% Adults diagnosed with CHD*

137.4 Heart disease death rate per 100,000**

37.5% Adults diagnosed with Hypertension***

DIABETES IN YOUR COMMUNITY

12% Adults diagnosed with Diabetes****

STRATEGIES

Implement a diabetes-specific screening intervention

- Provide free A1C screenings

Implement 4 interventions that target heart disease, hypertension & diabetes

- Create a Healthy Eating and Activity Living Coalition in Crawford County
- Launch mobile Core 4 Screener A1C, Cholesterol, BMI, BP
- Create and Implement SMS-based health intervention programs
- Create and share master document of opportunities to participate in physical activities including walking maps

Implement a heart disease-specific screening intervention

- Promote available walk-in free blood pressure screenings

PARTNERS

- Avita Health System
- Health Departments
- Chamber of Commerce
- Community Members
- Elected Officials
- Matrix Mobile Units
- Avita Health System
- Crawford County Healthy Living Coalition
- CCPH
- Bucyrus City
- Avita Health System
- Health Departments

POPULATIONS

THESE STRATEGIES WILL POSITIVELY IMPACT ALL RESIDENTS, BUT DATA SHOWS THESE POPULATIONS ARE MOST IN NEED:

HEART DISEASE
Ages 55-64, ages 65+, low-income (<$15,000 annual household income), people with a disability, male

PREMATURE HEART DISEASE DEATH
Black, Residents of Appalachian counties, Male

HYPERTENSION
Black, ages 55-64, ages 65+, low-income (<$15,000 annual household income), people with a disability

DIABETES
Black, ages 55-64, ages 65+, low-income (<$15,000 annual household income), people with a disability

Hypertension & diabetes **disproportionately affect the same communities,** listed above. Implementing strategies that target **both diabetes and hypertension** simultaneously allows **for significant benefit for these communities.**

OUTCOMES

DESIRED OUTCOMES OF STRATEGIES

- ↑ Awareness of Diabetes
- ↑ Treatment of Diabetes & Heart Disease
- ↑ Physical Activity & Health Eating
- ↑ Awareness of High Blood Pressure & Heart Disease

OVERALL IMPACT OF STRATEGIES***

- ↓ Diabetes
- ↓ Coronary Heart Disease
- ↓ Heart Disease
- ↓ Hypertension

ALL RESIDENTS OF CRAWFORD COUNTY ACHIEVE THEIR FULL HEALTH POTENTIAL

*Source: Ohio Department of Health, Ohio 2019 BRFSS Annual Report. https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/chronic-disease/data-publications/ohio-2019-brfss-annual-report

**Source: U.S. Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Mortality public-use data 2015-2019, on CDC WONDER. https://wonder.cdc.gov/Deaths-by-Underlying-Cause.html

***Source: Ohio Department of Health, Ohio 2019 BRFSS Annual Report. https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/chronic-disease/data-publications/ohio-2019-brfss-annual-report

****Source: U.S. Centers for Disease Control (CDC), Behavioral Risk Factor Surveillance System (BRFSS), via County Health Rankings for 2016 & 2021, using 2012 & 2017 data. http://www.countyhealthrankings.org

*****Source: https://www.cdc.gov/diabetes/library/features/diabetes-and-heart.html

STEPS 5-8

INTEGRATE, DEVELOP, ADOPT, AND SUSTAIN IMPLEMENTATION STRATEGY

IN THIS STEP, CRAWFORD COUNTY HEALTH PARTNERS WILL:

- ✓ INTEGRATE IMPLEMENTION STRATEGY WITH COMMUNITY AND HOSPITAL PLANS
- ✓ DEVELOP A WRITTEN IMPLEMENTATION STRATEGY
- ✓ ADOPT THE IMPLEMENTATION STRATEGY
- ✓ UPDATE AND SUSTAIN THE IMPLEMENTATION STRATEGY

CCHP CRAWFORD COUNTY HEALTH PARTNERS

NEXT STEPS

DOCUMENT, ADOPT, AND COMMUNICATE RESULTS

In compliance with the IRS regulations 501(r) for charitable hospitals, a hospital Community Health Needs Assessment (CHNA) and Implementation Strategy are to be made widely available to the public and public comment is to be solicited. These reports are posted on the following websites:

Avita Health System: www.avitahealth.org/about-us/#community-wellness
Crawford County Public Health: www.crawfordhealth.org
Galion City Public Health: https://galionhealth.org/community-health-assessment/

Written comments on these reports can be submitted to: ckropka@avitahs.org

The Implementation Strategy was adopted by Crawford County Heath Partners & Avita Health System leadership by November 15, 2022.

EVALUATION OF IMPACT

Crawford County Health Partners will monitor and evaluate the program and actions outlined above. They anticipate the actions taken to address significant health needs will improve health knowledge, behaviors, and status, increase access to care, and overall help support good health. Crawford County Health Partners is committed to monitoring key initiatives to assess impact. Our reporting process includes the collection and documentation of tracking measures and the collaborative efforts to address health needs. A review of the impact of the actions chosen to address these significant health needs will be reported in the next scheduled CHNA.

NEEDS CRAWFORD COUNTY HEALTH PARTNERS WILL NOT ADDRESS

Taking existing organizational and community-based resources into consideration, Crawford County Health Partners is choosing not to address all the health needs identified in the CHNA as significant in the community. Crawford County Health Partners cannot address all the health needs in the community and must focus on areas where we have the greatest potential for impact and that also align with our mission and prevent duplication of effort. Community partnerships may support other initiatives that the hospital cannot independently lead in order to address the other health needs identified as having significance in the 2022 CHNA.

CCHP CRAWFORD COUNTY HEALTH PARTNERS

Moxley PUBLIC HEALTH

www.moxleypublichealth.com
stephanie@moxleypublichealth.com