



# 2017 2019

## Williams County

## Community Health Improvement Plan





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# EXECUTIVE SUMMARY

In 2006, Williams County Partners for Health (WCPH) began conducting community health assessments (CHA) for the purpose of measuring and addressing health status. The most recent Williams County Community Health Assessment was cross-sectional in nature and included a written survey of adults and adolescents within Williams County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention for their national and state *Behavioral Risk Factor Surveillance System* (BRFSS) and the *Youth Risk Behavior Surveillance System* (YRBSS). This has allowed Williams County to compare the data collected in their CHA to national, state and local health trends.

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

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

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

To facilitate the Community Health Improvement Process, the Williams County Health Department (WCHD) and Community Hospitals and Wellness Centers (CHWC) invited key community leaders to participate in an organized process of strategic planning to improve the health of residents of the county. The National Association of City County Health Officer's (NACCHO) strategic planning tool, Mobilizing for Action through Planning and Partnerships (MAPP), was used throughout this process.

The MAPP Framework includes six phases which are listed below:

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

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



**Strategies:**

Priority Health Issues for Williams County	
1.	Adult and Youth Obesity
2.	Adult Cardiovascular Disease
3.	Youth Mental Health
4.	Youth Substance Abuse
5.	Women’s Health Screenings

## **Action Steps:**

To work toward decreasing **adult and youth obesity**, the following action steps are recommended:

1. Increase education of healthy eating for adults
2. Implement food pharmacy program
3. Increase education of healthy eating for youth
4. Implement Complete Streets policies
5. Implement OHA Healthy Hospitals initiative

To work toward **improving adult cardiovascular health**, the following actions steps are recommended:

1. Implement Go Red for Women initiative
2. Increase nutrition/physical education materials being offered to patients by primary care offices

To work toward **improving youth mental health**, the following actions steps are recommended:

1. Increase awareness of trauma informed care
2. Increase the number primary care physicians screening for depression during office visits
3. Expand evidence-based programs targeting youth
4. Provide mental health first aid training
5. Implement evidence-based programs and counseling services targeting youth
6. Increase evidence-based services through providers

To work toward **decreasing youth substance abuse**, the following actions steps are recommended:

1. Expand evidence-based programs and counseling services targeting youth and families
2. Increase the number of schools screening for alcohol
3. Implement a community based comprehensive program to reduce alcohol abuse
4. Increase community awareness & education of substance abuse issues and trends
5. Implement parent project

To work toward **increasing women's health screenings**, the following actions steps are recommended:

1. Create consistent women's health screening recommendations
2. Increase education materials being offered to patients by primary care offices
3. Decrease barriers to treatment



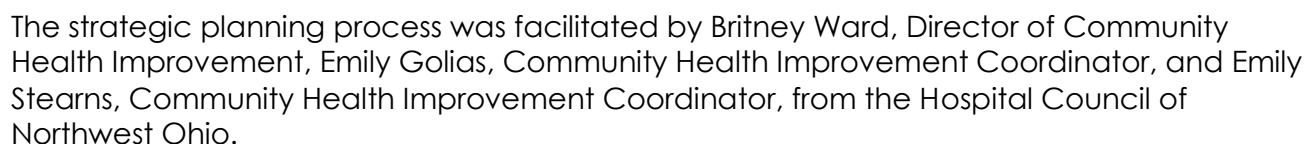
## PARTNERS

The 2017-2019 Community Health Improvement Plan was drafted by agencies and service providers within Williams County. During June-July, 2016, the committee reviewed many sources of information concerning the health and social challenges Williams County adults and youth may be facing. They determined priority issues which if addressed, could improve future outcomes, determined gaps in current programming and policies and examined best practices and solutions. The committee has recommended specific actions steps they hope many agencies and organizations will embrace to address the priority issues in the coming months and years. We would like to recognize these individuals and thank them for their devotion to this process and this body of work:

### ***Williams County Partners for Health***

Abby Calvin, Community Hospitals and Wellness Centers  
Amy Boehm, American Cancer Society  
Anna Meyers, Job & Family Services  
Bill Pepple, United Way of Williams County  
David Tilly, Montpelier Ministerial Association  
Diana Savage, Bryan City Schools  
Dottie Vollmar, Buckeye Community Hope Foundation  
Jamie Marshall, Parkview Physicians Group  
Jan David, Community Hospitals and Wellness Centers  
Jeanette Roberts, Community Hospitals and Wellness Centers  
Jerry Stollings, Juvenile Court Administration  
Jessica Reitzel, Community Hospitals and Wellness Centers  
Jill Ostrem, Parkview Physicians Group  
Jim Watkins, Williams County Health Department  
Kim Owen, Community Hospitals and Wellness Centers  
Kirsten Frissora, Williams County Health Department  
Larry Long, Millcreek-West Unity Schools  
Les McCaslin, Four County Alcohol, Drug and Mental Health Board  
Linda Trausch, Community Hospitals and Wellness Centers  
Lori Phillips, Parkview Physicians Group  
Maggie Fisher, Williams County Department of Aging  
Megan Riley, Williams County Health Department  
Michelle Price, Step Toward Health  
Nate Johnson, Stryker Local Schools  
Pam Pflum, Four County Alcohol, Drug and Mental Health Board  
Phil Ennen, Community Hospitals and Wellness Centers  
Rachel Aeschliman, Williams County Health Department  
Rob Imber, YMCA  
Ron Rittichier, Safe Schools/Healthy Students  
Ronda Muehlfeld, Bryan Community Health Center  
Sally Taylor, Parkview Physicians Group  
Steve Towns, Williams County Sheriff

## Williams County Circles of Involvement





## VISION

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

### **The Vision of Williams County:**

Working together to create a healthy Williams County

### **The Mission of Williams County:**

To foster and guide the implementation of recommendations resulting from the community health assessment with the collective purpose of improving the health of our community

## ALIGNMENT WITH NATIONAL AND STATE STANDARDS

The 2017-2019 Williams County Health Improvement Plan priorities align perfectly with state and national priorities. Williams County will be addressing the following priorities: obesity, cardiovascular disease, mental health, substance abuse and women's health screenings.

### **Ohio State Health Improvement Plan**

Williams County priorities very closely mirror the following 2015-2016 State Health Improvement Plan (SHIP) Addendum priorities:

*Priority 2:* Prevent and reduce the burden of chronic disease for all Ohioans

*Priority 5:* Implementing integrated mental and physical health care models to improve public health

To align with and support Priority 2 (Chronic Disease), Williams County will work to adopt Complete Streets policies to Williams County residents.

To align with and support Priority 5 (Integration of Physical and Behavioral Health), Williams County will expand evidence based programs and counseling services targeting youth. Furthermore, Williams County will increase awareness of available mental health services and implement screening tools.

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

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

## ALIGNMENT WITH NATIONAL AND STATE STANDARDS, *continued*

### Healthy People 2020

Williams County's priorities also fit specific Healthy People 2020 goals. For example:

- *Nutrition and Weight Status(NWS)*-8: Increase the proportion of adults who are at a healthy weight
- *Mental Health and Mental Disorders (MHMD)*-2: Reduce suicide attempts by adolescents
- *Substance Abuse (SA)*-2: Increase the proportion of adolescents never using substances
- *Heart Disease and Stroke (HDS)*-2: Reduce coronary heart disease deaths
- *Cancer (C)*-17: Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines

There are 22 other weight control objectives, 24 other heart disease and stroke objectives, 12 other mental health objectives, 13 other substance abuse objectives, and 9 other cancer objectives that support the work of the Williams County CHIP. These objectives can be found in each individual section.

## STRATEGIC PLANNING MODEL

Beginning in June 2016, Williams County Partners for Health met four (4) times and completed the following planning steps:

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

# NEEDS ASSESSMENT

Williams County Partners for Health reviewed the 2016 Williams County Health Assessment. The detailed primary data for each individual priority area can be found in the section it corresponds to. Each member completed an "Identifying Key Issues and Concerns" worksheet. The following tables were the group results.

**What are the most significant ADULT health issues or concerns identified in the 2016 assessment report?**

Key Issue or Concern	% of Population at risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
<b>1. Obesity (13 votes)</b> Obese Overweight No physical activity in past week Ate 5+ fruits and vegetables per day)	41% 30 % 28% 8%	Age: 30-64 Age: 65+; Income: >\$25K -- --	Female Male -- --
<b>2. Cardiovascular Disease (9 votes)</b> High blood cholesterol Diagnosed with high blood pressure Deaths from heart disease Had angina or coronary heart disease Survived a heart-attack	36% 35% 22% 6% 4%	Age: 65+; Income: <\$25K Age: 65+ -- Age: 65+ Age: 65+	Female -- Male -- --
<b>3. Tobacco Use (6 votes)</b> Current smoker	22%	Age: 30-64; Income: <\$25K	Male
<b>4. Oral Health (5 votes)</b> Dental visit in the last year	53%	Age: <30; Income: <\$25K	Female
<b>5. Women's Health Screenings (5 votes)</b> Had a Pap smear in the past year Had a mammogram in the past year	23% 29%	Age: 40+; Income: <\$25K Age: 40+; Income: <\$25K	Female Female
<b>6. Medication Misuse (4 votes)</b>	5%	Age: <30; Income: <\$25K	Males
<b>7. Maternal and Infant Health (2 votes)</b> Experienced domestic violence during pregnancy Smoked cigarettes during pregnancy Infants put to sleep on their back	13% 5% 70%	-- -- Age: 0-1	Female Female --
<b>8. Drug Abuse (2 votes)</b> Used marijuana in the past 6 months	4%	Age: <30; Income: <\$25K	Males
<b>9. Poor Mental Health (2 votes)</b> Felt sad or hopeless two or more weeks in a row	9%	Age: <30, <\$25K	Female
<b>10. Cancer Screenings (1 vote)</b> Had a colonoscopy or sigmoidoscopy in the past 5 years (50+)	52%	Age: 50+	--
<b>11. Asthma (1 vote)</b>	18%	Age: <30; Income: <\$25K	Female
<b>12. Distracted Driving (1 vote)</b> Texted while driving Ate while driving Talking on hand held cell phone	7% 42% 41%	-- -- --	-- -- --

# NEEDS ASSESSMENT, continued

What are the most significant YOUTH health issues or concerns identified in the 2016 assessment report?

Key Issue or Concern	% of Population at Risk	Age Group Most at Risk	Gender Most at Risk
<b>1. Obesity (14 votes)</b> Obese Overweight Ate 5+ fruits and vegetables per day Drank a sugary drink at least once per day during the past week No physical activity in past week	13% 16% 6% 23% 15%	Age: 14-16 Age: 14-16 -- -- --	Male Female -- -- --
<b>2. Poor Mental Health (8 votes)</b> Felt sad or hopeless two or more weeks in a row Contemplated suicide Attempted suicide Talked to parent when having feelings of depression or suicide	22% 10% 7% 32%	-- Age: 14-16 Age: 14-16 --	Female Female Female --
<b>3. Alcohol Use (7 votes)</b> Current drinker Binge drinker (of all youth) Binge drinker (of current drinkers) Obtained alcohol by a parent giving it to them	16% 7% 43% 35%	Age: 17+ Age: 17+ -- --	Male -- Female --
<b>4. Bullying (4 votes)</b> Bullied in past year	47%	--	--
<b>5. Drug Use (3 votes)</b> Tried inhalants in their lifetime Obtained an illegal drug by a parent giving it to them Obtained Rx medications (for misuse) by a parent giving it to them	4% 4% 16%	-- -- --	-- -- --
<b>6. Risky Sexual Activity (3 votes)</b> Ever had sexual intercourse Oral sex Anal sex Had multiple partners (or sexually active youth) Did not use protection or were unsure (of sexually active youth) Sexting Learned about pregnancy prevention, STDs, and HIV/AIDS from parents	16% 16% 4% 41% 14% 14% 54%	Age: 17+ Age: 17+ Age: 17+ -- -- Age: 17+ --	Male Male Male -- -- Male --
<b>7. Oral Health (2 votes)</b> Visited the dentist for a checkup within the past year	72%	--	--
<b>8. Injury Prevention (2 votes)</b> Did not wear seatbelt Unlocked firearm in or around the home Reported being hit, slapped or physically hurt on purpose from a parent	20% 14% 5%	-- -- --	-- -- --

# PRIORITIES CHOSEN

Based on the 2016 Williams County Health Assessment, key issues were identified for adults and youth at a prior meeting. Committee members then completed a ranking exercise, giving a score for magnitude, seriousness of the consequence, and feasibility of correcting, resulting in an average score for each issue identified. Committee members' rankings were then combined to give an average score for the issue.

The rankings were as follows:

Health Issue	Average Score
1. Adult Obesity	25.8
2. Youth Obesity	24.1
3. Adult Cardiovascular Disease	22.6
4. Youth Mental Health	20.9
5. Youth Substance Abuse (Alcohol)	18.6
6. Women's Health Screenings	18.4
7. Youth Bullying	16.9
8. Adult Tobacco	16.1
9. Adult Oral Health	16.1
10. Adult Medication Misuse	15.5

**Williams County will focus on the following five priorities over the next 3 years:**

1. Adult and Youth Obesity
2. Adult Cardiovascular Disease
3. Youth Mental Health
4. Youth Substance Abuse
5. Women's Health Screenings



# FORCES OF CHANGE

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

Force of Chance	Impact
1. Recession	<ul style="list-style-type: none"> <li>Property values have yet to recover</li> </ul>
2. Drug use	<ul style="list-style-type: none"> <li>Community members cannot pass drug tests</li> <li>Employers have difficulty finding employees</li> </ul>
3. Job availability outside the community	<ul style="list-style-type: none"> <li>Migration away from community</li> <li>Lack of workforce</li> </ul>
4. Parents moving to be with their children	<ul style="list-style-type: none"> <li>Migration away from the community</li> </ul>
5. Schools are not focusing on skilled trades/labor force	<ul style="list-style-type: none"> <li>Too much pressure to attend college</li> <li>Increased debt – not guaranteed to obtain a well-paying job out of college</li> </ul>
6. Increase in education for the skilled trades (Northwest State)	<ul style="list-style-type: none"> <li>Increase in quality and capability of workforce</li> </ul>
7. Expansion of physical and mental health awareness in community	<ul style="list-style-type: none"> <li>Increased physical activity and reduction of mental health stigma</li> </ul>
8. Closing of grocery stores in communities	<ul style="list-style-type: none"> <li>Lack of availability of healthy foods</li> <li>Community members go to Dollar General and similar stores for groceries</li> </ul>
9. Public Health Accreditation	<ul style="list-style-type: none"> <li>Increase in comprehensive public health services</li> </ul>
10. Family/community conflicts	<ul style="list-style-type: none"> <li>Migration from school districts</li> </ul>
11. Change happens slowly	<ul style="list-style-type: none"> <li>Lack of new community services/policies/programs</li> </ul>
12. Family unit has changed	<ul style="list-style-type: none"> <li>Tension between family members</li> <li>Tension in the community</li> <li>Lack of community pride—no attachment to community</li> <li>Grandparents taking on larger roles in families</li> </ul>
13. Social media	<ul style="list-style-type: none"> <li>People getting information from social media rather than credible sources</li> <li>Social media causes changes in community perception</li> </ul>
14. Technology	<ul style="list-style-type: none"> <li>May cause changes in family unit</li> <li>Parents may be less aware/vigilant of children</li> <li>Children use technology at a younger age—may have negative effects in terms of development/social skills</li> </ul>
15. Unknowns concerning health plans	<ul style="list-style-type: none"> <li>May not seek services because individuals do not understand health plans</li> </ul>
16. Increased technology in the workplace	<ul style="list-style-type: none"> <li>Employees may not be able to keep up with demands</li> </ul>
17. New urgent care in Bryan	<ul style="list-style-type: none"> <li>Increased access to health services</li> </ul>
18. Lack of specialists	<ul style="list-style-type: none"> <li>Specialists are retiring. Difficulty finding replacements.</li> <li>Difficult to attract specialists to the area</li> </ul>
19. Uninsured rate	<ul style="list-style-type: none"> <li>Uninsured rate declining</li> </ul>

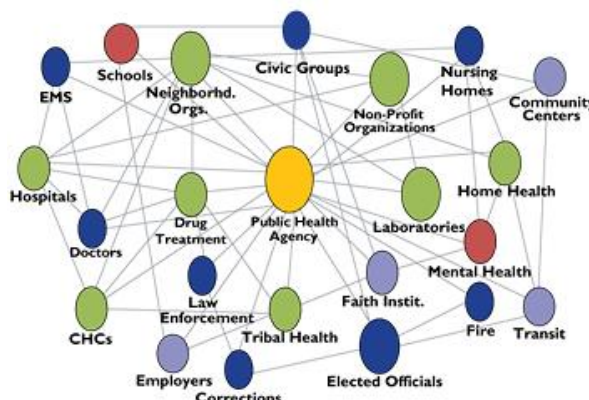
# LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

## 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; <http://www.cdc.gov/nphps/essentialservices.html>)

## LOCAL PUBLIC HEALTH SYSTEM, *continued*

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

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

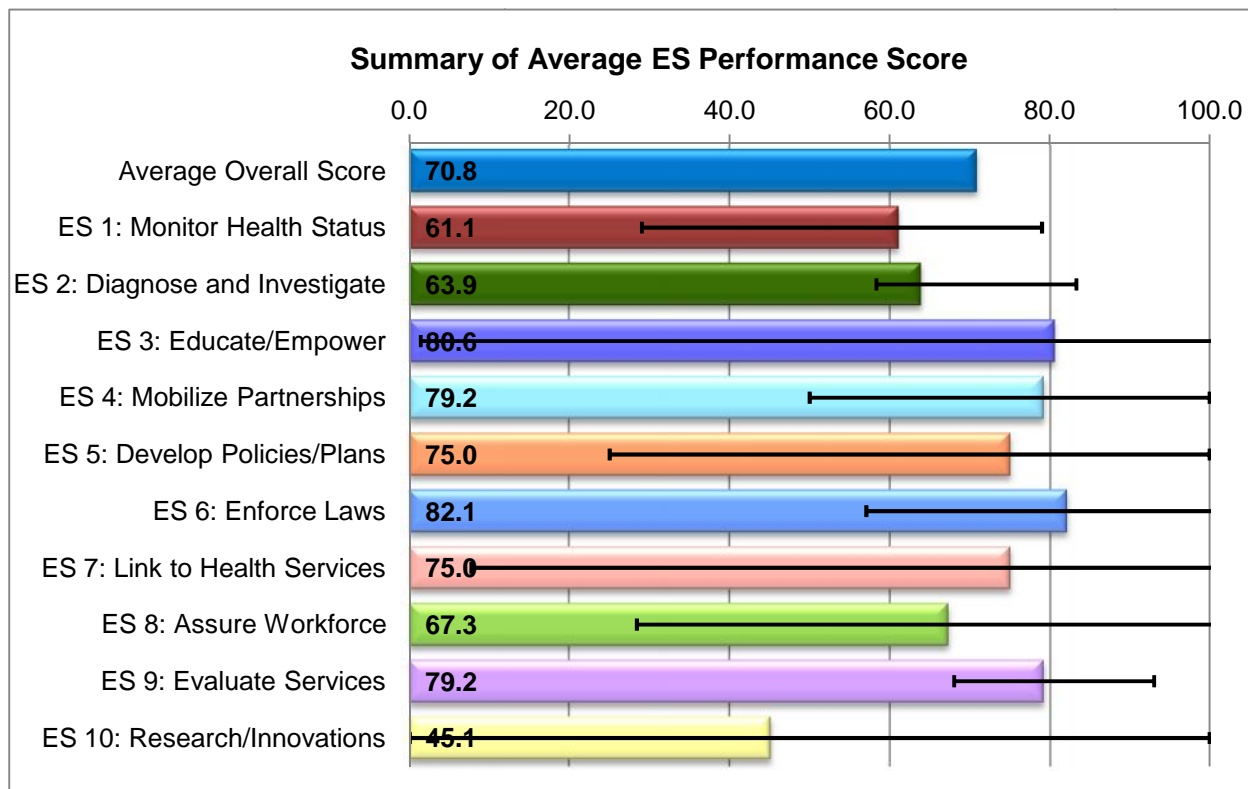
Members of the Williams County Health Department completed the performance measures instrument. The LPHSA results were then presented to the full CHIP committee for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard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

The CHIP committee identified 7 indicators that had a status of "minimal" and 5 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 Jim Watkins from the Williams County Health Department at [jim.watkins@williamscountyhealth.org](mailto:jim.watkins@williamscountyhealth.org).

### Williams County Local Public Health System Assessment 2016 Summary



# COMMUNITY THEMES AND STRENGTHS

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

## **Williams County community members believed the most important characteristics of a healthy community were:**

- o Safety
- o Community involvement
- o Availability of resources
- o Good jobs
- o Strong education system (all levels)
- o Availability of health care
- o Walkability
- o Participation
- o Strong family unit
- o Parks and recreation
- o Access to healthy food
- o Strong built environment/infrastructure
- o Variety of housing options
- o Faith/religion

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

- o Local education systems
- o Collaboration of organizations
- o Safety
- o Diversity of health care options
- o Strong fellowship/faith
- o Caring for one another
- o Availability of extracurricular activities

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

- o Williams County Partners for Health
- o Cancer Prevention and Early Detection Coalition
- o Safe Schools/Healthy Students Coalition
- o Court programs
- o United Way and food pantry hunger summits
- o Parkview/YMCA/Bryan Hospital MD and Me walk
- o Church walking groups
- o Schools collectively making efforts for more nutritious meals

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

- o Weak family unit
- o Income disparities
- o Obesity
- o Cardiovascular disease
- o Youth alcohol
- o Youth mental health
- o Women's health screenings

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

- o Funding
- o Challenges of living in a rural community
- o Less walkability
- o Lack of motivation for change
- o Lack of involvement from the community
- o Lack of policy/infrastructure
- o Cultural pressures
- o Community resistance to change
- o Stigma in community regarding mental health
- o Lack of utilization of available services
- o Lack of quality jobs
- o Weather

## COMMUNITY THEMES AND STRENGTHS, *continued*

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

- Tobacco-free policies
- Policies that promote healthier options (water vs. pop)
- Complete streets
- Worksite wellness
- Bike trails (Wabash Cannonball Trail)
- Nutritional policy for restaurants
- Program to decrease produce price on certain days
- Zoning for alcohol, liquor and tobacco
- Community activities along waterways
- Insurance incentives for worksite wellness
- Early detection programs in schools for mental health (increases available services)

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

- Increased collaboration and assembling around priorities
- Increased funding
- Increased positive outcomes
- Increased family activities



# QUALITY OF LIFE SURVEY

Williams County Partners for Health urged community members to fill out a short Quality of Life Survey via Survey Monkey. There were 241 Williams County community members who completed the survey. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1. For all responses of "Don't Know," or when a respondent left a response blank, the choice was a non-response, was assigned a value of 0 (zero) and the response was not used in averaging response or calculating descriptive statistics.

Quality of Life Questions	Likert Scale Average Response
1. Are you satisfied with the quality of life in our community? (Consider your sense of safety, well-being, participation in community life and associations, etc.) [IOM, 1997]	3.67
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	2.95
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.72
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.)	3.46
5. Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)	2.86
6. Is the community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?)	3.83
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?	3.52
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.36
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.07
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.03
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.10
12. Is there an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments? (Are citizens working towards the betterment of their community to improve life for all citizens?)	3.13

# RESOURCE ASSESSMENT

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

An **evidence-based** practice has compelling evidence of effectiveness. Participant success can be attributed to the program itself and have evidence that the approach will work for others in a different environment. A **best practice** is a program that has been implemented and evaluation has been conducted. While the data supporting the program is promising, its scientific rigor is insufficient. A **non-evidence based** practice has neither no documentation that it has ever been used (regardless of the principals it is based upon) nor has been implemented successfully with no evaluation.

Each resource assessment is provided with the corresponding priority section and can be found on the following pages:

- Adult and Youth Obesity, *pages 27-34*
- Adult Cardiovascular Disease, *pages 47-48*
- Youth Mental Health, *pages 57-61*
- Youth Substance Abuse, *pages 72-75*
- Women's Health Screenings, *pages 86-87*

# Priority #1 | Decrease Obesity

## Obesity Indicators

*The 2016 Health Assessment identified that 71% of Williams County adults were overweight or obese based on Body Mass Index (BMI). More than two-fifths (41%) of Williams County adults were obese. The 2016 Health Assessment identified that 13% of Williams County youth were obese, according to Body Mass Index (BMI) by age. 76% of youth were exercising for 60 minutes on 3 or more days per week.*

### **Adult Weight Status**

In 2016, the health assessment indicated that more than two-thirds (71%) of Williams County adults were either overweight (30%) or obese (41%) by Body Mass Index (BMI). This puts them at elevated risk for developing a variety of diseases.

More than two-fifths (45%) of adults were trying to lose weight, 32% were trying to maintain their current weight or keep from gaining weight, and 1% were trying to gain weight.

Williams County adults did the following to lose weight or keep from gaining weight: ate less food, fewer calories, or foods low in fat (55%), drank more water (54%), exercised (43%), ate a low-carb diet (7%), smoked cigarettes (3%), took diet pills, powders or liquids without a doctor's advice (3%), went without eating 24 or more hours (3%), used a weight loss program (2%), took prescribed medications (1%), took laxatives (1%), health coaching (1%), participated in a prescribed dietary or fitness program (<1%), and Bariatric surgery (<1%).

In Williams County, 50% of adults were engaging in some type of physical activity or exercise for at least 30 minutes 3 or more days per week. 19% of adults were exercising 5 or more days per week. More than one-fourth (28%) of adults were not participating in any physical activity in the past week, including 2% who were unable to exercise.

Williams County adults spent the most time doing the following physical activities in the past year: walking (47%), active video games (9%), running/jogging (8%), occupational exercise (6%), cycling (5%), exercise machines (2%), strength training (1%), group exercise class (1%), swimming (1%), exercise videos (<1%), and other activities (4%). 17% of adults did not exercise at all, including 1% who were unable to do so.

Reasons for not exercising included: time (38%), weather (23%), too tired (23%), laziness (17%), pain or discomfort (14%), could not afford a gym membership (10%), chose not to exercise (7%), did not know what activity to do (5%), no walking, biking trails, or parks (5%), doctor advised them not to exercise (3%), did not have child care (3%), no exercise partner (2%), no gym available (1%), transportation (1%), safety (1%), poorly maintained/no sidewalks (1%), no access to parks (<1%), and other reasons (1%).

Williams County adults had access to a wellness program through their employer or spouse's employer with the following features: lower insurance premiums for participation in wellness program (11%), health risk assessment (10%), free/discounted gym membership (8%), on-site health screenings (8%), gift cards or cash for participation in wellness program (5%), lower insurance premiums for positive changes in health status (4%), healthier food options in vending machines or cafeteria (4%), on-site fitness facility (3%), free/discounted weight loss program (3%), gift cards or cash for positive changes in health status (2%), free/discounted smoking cessation program (1%), on-site health education classes (1%), and other features (4%).

31% of Williams County adults did not have access to any wellness programs.

Williams County adults spent an average of 3.0 hours watching TV, 1.3 hours on their cell phone, 1.1 hours on the computer (outside of work), and 0.1 hours playing video games on an average day of the week.

# Priority #1 | Decrease Obesity

## Obesity Indicators, *continued*

### Adult Weight Status, continued

In 2016, 8% of adults were eating 5 or more servings of fruits and vegetables per day. 84% were eating between 1 and 4 servings per day. The American Cancer Society recommends that adults eat at least 2 ½ cups of fruits and vegetables per day to reduce the risk of cancer and to maintain good health. The 2009 BRFSS reported that only 21% of Ohio adults and 23% nationwide were eating the recommended number of servings of fruits and vegetables.

Williams County adults purchased their fruit and vegetables from the following places: grocery stores (97%), grow their own/garden (30%), Farmer's Market (29%), restaurants (6%), Dollar General/Store (3%), food pantry (2%), corner/convenience store (2%), community garden (1%), and other places (1%).

Adults reported the following barriers to consuming fruits and vegetables: too expensive (16%), no variety (6%), did not like the taste (2%), did not know how to prepare (1%), transportation (1%), no access (1%), did not take electronic benefit transfer (EBT) (1%), and other barriers (5%).

Williams County adults reported the following reasons they chose the types of food they ate: taste (58%), enjoyment (53%), cost (53%), healthiness of food (48%), ease of preparation (47%), time (35%), food they were used to (32%), availability (30%), nutritional content (28%), what their spouse prefers (23%), calorie content (22%), what their child prefers (13%), if it is organic (12%), if it is genetically modified (12%), gluten free (8%), lactose free (6%), health care provider's advice (5%), other food sensitivities (1%), and other reasons (1%).

Adults ate out in a restaurant or brought home take-out food an average of 2.1 times per week.

26% of adults drank soda pop, punch, Kool-Aid, sports drinks, energy drinks, or other fruit-flavored drinks at least once per day.

### Youth Weight Status

In 2016, 13% of youth were classified as obese by Body Mass Index (BMI) calculations (2013 YRBS reported 13% for Ohio and 14% for the U.S.). 16% of youth were classified as overweight (2013 YRBS reported 16% for Ohio and 17% for the U.S.). 69% were normal weight, and 2% were underweight.

32% of youth described themselves as being either slightly or very overweight (2013 YRBS reported 28% for Ohio and 31% for the U.S.).

Over-two-fifths (45%) of all youth were trying to lose weight, increasing to 55% of Williams County female youth (compared to 35% of males) (2013 YRBS reported 47% for Ohio and 48% for the U.S.).

6% of Williams County youth ate 5 or more servings of fruits and vegetables per day. 88% ate 1 to 4 servings of fruits and vegetables per day.

23% of youth drank soda pop (not diet), punch, Kool-Aid, sports drinks, energy drinks or other fruit flavored drinks at least once per day during the past week.

25% of youth reported they drank energy drinks for the following reasons: to stay awake (15%), to get pumped up (6%), to help them perform (3%), before games or practice (3%), to mix with alcohol (2%), and some other reason (8%).

Youth reported they ate most of their food at the following places: home (94%), school (3%), from a fast food place (1%), and a restaurant (<1%).

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## Obesity Indicators, *continued*

### Youth Weight Status, continued

7% of youth reported they went to bed hungry because their family did not have enough money for food at least one night per week. 2% of youth went to bed hungry every night of the week.

Over three-fourths (76%) of Williams County youth participated in at least 60 minutes of physical activity on 3 or more days in the past week. 54% did so on 5 or more days in the past week (2013 YRBS reports 48% for Ohio and 47% for the U.S.), and 33% did so every day in the past week (2013 YRBS reports 26% for Ohio and 27% for the U.S.). 15% of youth did not participate in at least 60 minutes of physical activity on any day in the past week (2013 YRBS reports 13% for Ohio and 15% for the U.S.).

Williams County youth spent an average of 3.0 hours on their cell phone, 1.9 hours on their computer/tablet, 1.8 hours watching TV and 1.2 hours playing video games on an average day of the week.

Nearly one-fourth (24%) of youth spent 3 or more hours watching TV on an average day (2013 YRBS reported 28% for Ohio and 33% for the U.S.).

90% of youth participated in extracurricular activities. They participated in the following: sports or intramural programs (56%), exercising (outside of school) (41%), school club or social organization (36%), church or religious organization (30%), church youth group (34%), part-time job (20%), caring for siblings after school (16%), babysitting for other kids (16%), volunteering in the community (13%), caring for parents or grandparents (3%) or some other organized activity (Scouts, 4H, etc.) (15%).



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## Obesity Indicators, *continued*

Adult Comparisons	Williams County 2013	Williams County 2016	Ohio 2014	U.S. 2014
Obese	30%	41%	33%	30%
Overweight	38%	30%	34%	35%

Youth Comparisons	Williams County 2006 (6 <sup>th</sup> -12 <sup>th</sup> )	Williams County 2009 (6 <sup>th</sup> -12 <sup>th</sup> )	Williams County 2013 (6 <sup>th</sup> -12 <sup>th</sup> )	Williams County 2016 (6 <sup>th</sup> -12 <sup>th</sup> )	Williams County 2016 (9 <sup>th</sup> -12 <sup>th</sup> )	Ohio 2013 (9 <sup>th</sup> -12 <sup>th</sup> )	U.S. 2013 (9 <sup>th</sup> -12 <sup>th</sup> )
Obese	N/A	14%	13%	13%	15%	13%	14%
Overweight	N/A	16%	11%	16%	16%	16%	16%
Described themselves as slightly or very overweight	29%	26%	31%	32%	35%	28%	32%
Trying to lose weight	44%	49%	50%	45%	47%	47%	46%
Exercised to lose weight	45%	44%	51%	47%	53%	61%‡	61%‡
Ate less food, fewer calories, or foods lower in fat to lose weight	21%	22%	38%	27%	30%	43%‡	39%‡
Went without eating for 24 hours or more	5%	4%	7%	2%	3%	10%	13%*
Took diet pills, powders, or liquids without a doctor's advice	3%	1%	3%	2%	3%	5%	5%*
Vomited or took laxatives	1%	2%	3%	1%	2%	5%	4%*
Ate 1 to 4 servings of fruits and vegetables per day	N/A	N/A	81%	88%	89%	85%‡	78%‡
Physically active at least 60 minutes per day on every day in past week	N/A	N/A	28%	33%	31%	26%	27%
Physically active at least 60 minutes per day on 5 or more days in past week	N/A	59%	49%	54%	53%	48%	49%
Did not participate in at least 60 minutes of physical activity on any day in past week	N/A	12%	11%	15%	13%	13%	14%
Watched TV 3 or more hours per day	N/A	33%	38%	24%	26%	28%	25%

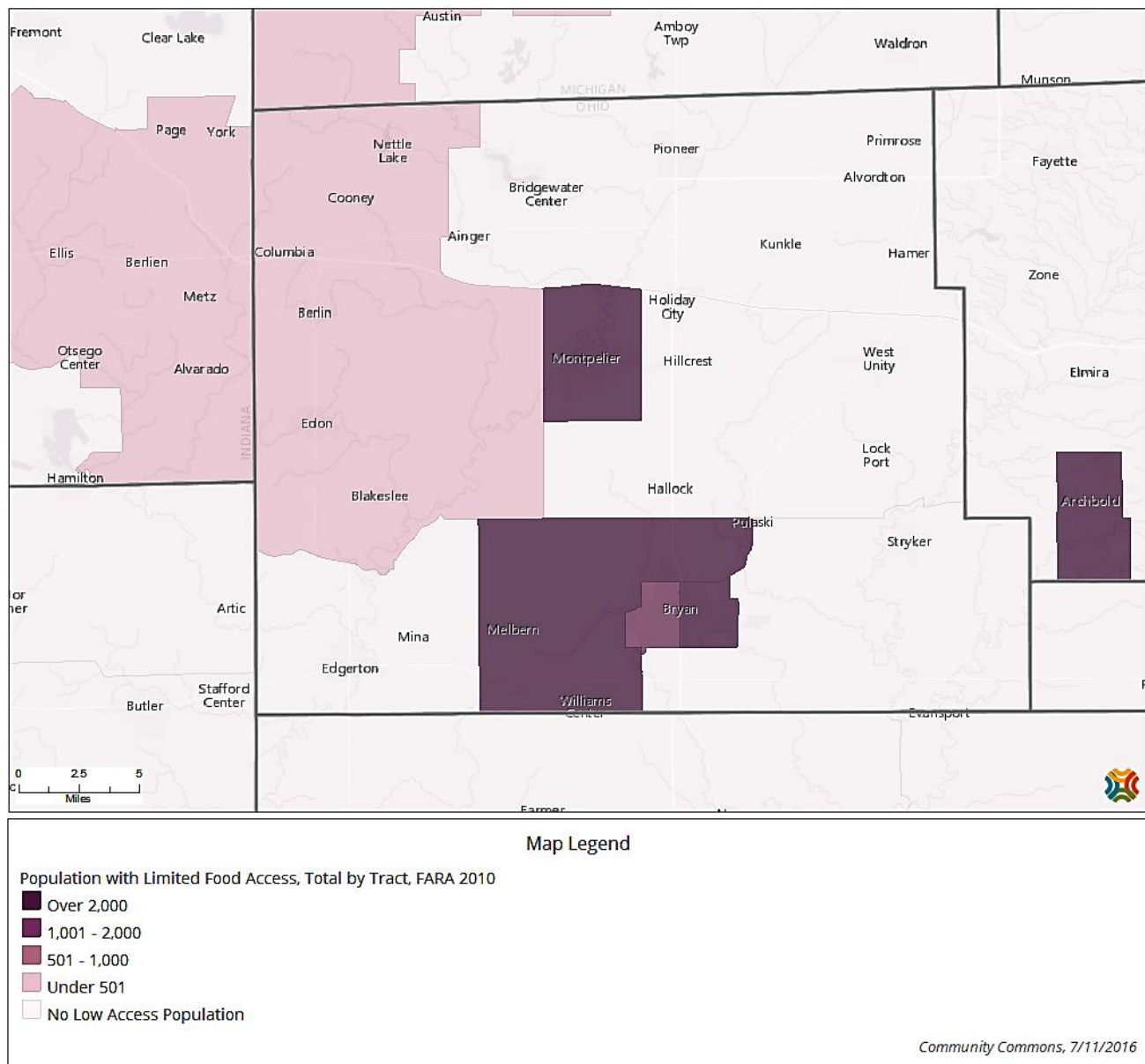
‡ Comparative YRBS data for Ohio is 2007 and U.S. is 2009

\*YRBS data is from 2013

N/A – Not available

# Priority #1 | Decrease Obesity

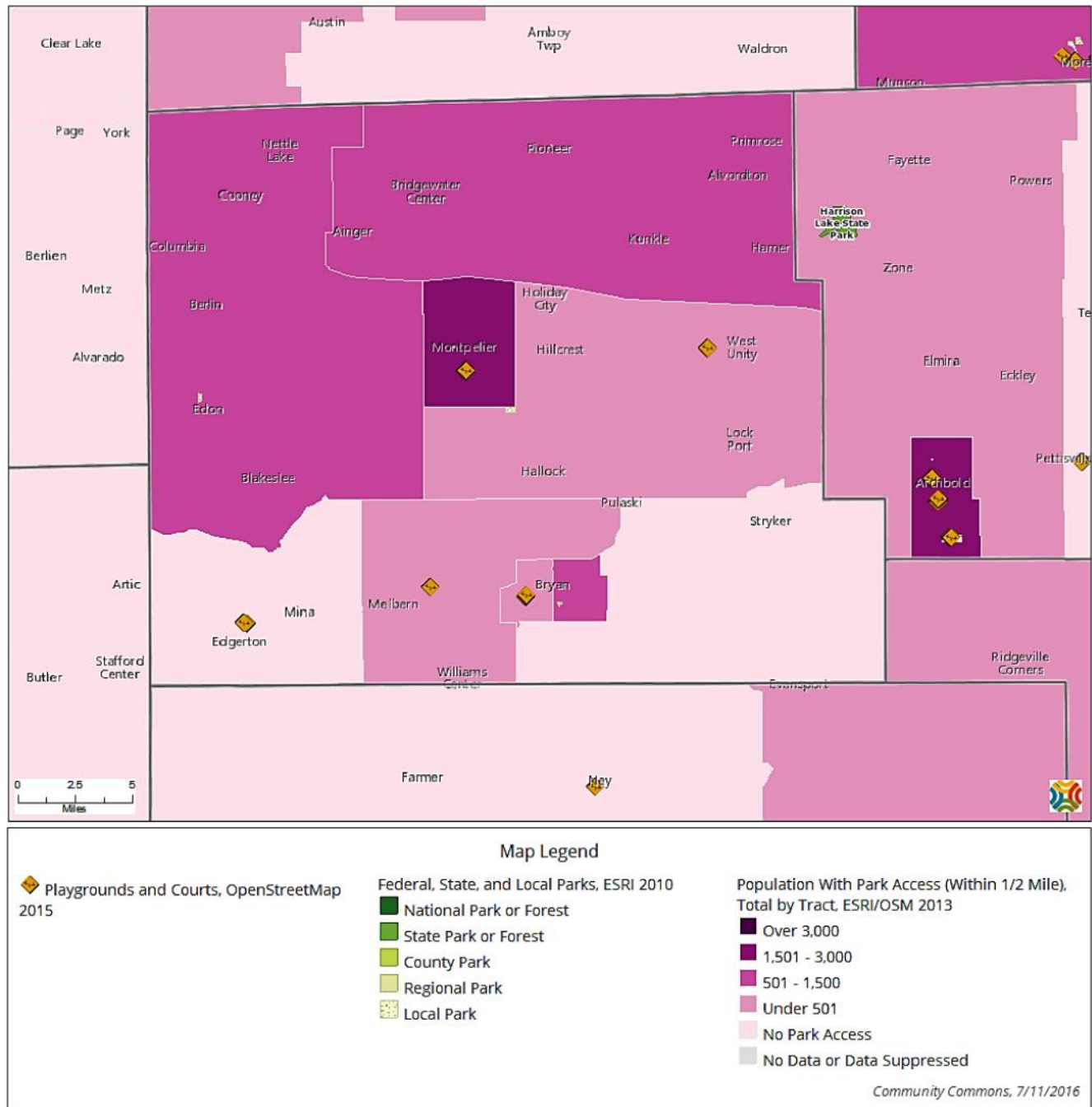
## Population with Limited Food Access, Low Income, Total by Tract, FARA 2010



(Source: Community Commons 7/10/16)

# Priority #1 | Decrease Obesity

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



(Source: Community Commons 7/11/16)

# Priority #1 | Decrease Obesity

## Resource Assessment

Program/Strategy/Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
<b>Evidence-based Practices</b>					
Weight Watchers	Weight Watchers	<ul style="list-style-type: none"> <li>Weightwatchers.com</li> <li>1-800-516-3535</li> <li>7773 Coldwater Road, Fort Wayne, IN 46825</li> </ul>	14 years and older	Prevention, early intervention, treatment	Evidence-based program
<b>Best Practices</b>					
Policy: Removal of sugar-sweetened beverages	Schools, churches, businesses	Bryan City Schools <ul style="list-style-type: none"> <li><a href="http://www.bryan.k12.oh.us">www.bryan.k12.oh.us</a></li> <li>(419)-636-6973</li> <li>1350 Fountain Grove Dr. Bryan, OH 43506</li> </ul> First Presbyterian Church <ul style="list-style-type: none"> <li>(419)-485-3339</li> <li>114 W. Washington St. Montpelier, OH 43543</li> </ul>	Bryan City Schools          First Presbyterian Church	Prevention, early intervention	Best practice
Various Aerobics	YMCA	<ul style="list-style-type: none"> <li><a href="http://www.wcymca.org">www.wcymca.org</a></li> <li>(419)-636-6185</li> <li>1 Faber Dr. Bryan, OH 43506</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Land-based & aquatic group exercise	YMCA	<ul style="list-style-type: none"> <li><a href="http://www.wcymca.org">www.wcymca.org</a></li> <li>(419)-636-6185</li> <li>1 Faber Dr. Bryan, OH 43506</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Zumba	Various sites	<ul style="list-style-type: none"> <li>CommitZFit Zumba (various locations)</li> <li>YMCA</li> <li>Bryan Moose Lodge               <ul style="list-style-type: none"> <li>701 N Main St. Bryan, OH 43506</li> </ul> </li> </ul>	Bryan, Edgerton, Stryker	Prevention, early intervention, treatment	Best practice
Silver Sneakers, Silver Splash, Golden Fit	YMCA	<ul style="list-style-type: none"> <li><a href="http://www.wcymca.org">www.wcymca.org</a></li> <li>(419)-636-6185</li> <li>1 Faber Dr. Bryan, OH 43506</li> </ul>	Seniors (65+)	Prevention, early intervention, treatment	Best practice
Personal training & fitness coaching	YMCA	<ul style="list-style-type: none"> <li><a href="http://www.wcymca.org">www.wcymca.org</a></li> <li>(419)-636-6185</li> <li>1 Faber Dr. Bryan, OH 43506</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Swimming (only year round pool in the county)	YMCA	<ul style="list-style-type: none"> <li><a href="http://www.wcymca.org">www.wcymca.org</a></li> <li>(419)-636-6185</li> <li>1 Faber Dr. Bryan, OH 43506</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Fitness Classes & gym	24/7 Fitness	<ul style="list-style-type: none"> <li><a href="https://www.facebook.com/247fitnessbryan/">https://www.facebook.com/247fitnessbryan/</a></li> <li>(419)-630-5698</li> <li>15591 County Road D50 Bryan, OH 43506</li> </ul>	Bryan	Prevention, early intervention, treatment	Best practice
City Pools	Parks and Rec	<ul style="list-style-type: none"> <li><a href="http://www.montpelierpark.net/activities.html">http://www.montpelierpark.net/activities.html</a></li> <li>(419)-485-5389</li> <li>1110 S. Platt St. Montpelier, OH</li> </ul>	Bryan, Montpelier	Prevention, early intervention, treatment	Best practice

# Priority #1 | Decrease Obesity

## Resource Assessment, continued

Program/Strategy/Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Adult & Youth Sports Programs	YMCA	<ul style="list-style-type: none"> <li><a href="http://www.wcymca.org">www.wcymca.org</a></li> <li>(419)-636-6185</li> <li>1 Faber Dr. Bryan, OH 43506</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Main Line Fitness Center	Main Line Fitness Center	<ul style="list-style-type: none"> <li><a href="http://mainlinefit.com/">http://mainlinefit.com/</a></li> <li>(419)-630-8755</li> <li>12909 OH-15, Montpelier, OH 43543</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Fitness Classes	Fulton County Health Center (FCHC)	<ul style="list-style-type: none"> <li><a href="https://www.fultoncountyhealthcenter.org/">https://www.fultoncountyhealthcenter.org/</a></li> <li>(419)-335-2015</li> <li>725 S Shoop Ave. Wauseon, OH</li> </ul>	Adults	Prevention, early intervention, treatment	Best practice
Active Life Program	American Cancer Society (ACS)	<ul style="list-style-type: none"> <li><a href="http://www.cancer.org/">http://www.cancer.org/</a></li> <li>1-800-227-2345</li> <li>740 Commerce Dr. Perrysburg, OH 43551</li> </ul>	Adults	Prevention, early intervention, treatment	Best practice
Employee Gym	Hospital (Community Hospitals and Wellness Centers)	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>(419)-636-1131</li> <li>433 W. High St. Bryan, OH 43506</li> </ul>	Employees	Prevention, early intervention, treatment	Best practice
Poker Walk for Employees	Hospital (Community Hospitals and Wellness Centers)	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>(419)-636-1131</li> <li>433 W. High St. Bryan,</li> </ul>	Employees	Prevention, early intervention, treatment	Best practice
Various Races (5k/biking)	Various	<ul style="list-style-type: none"> <li><a href="http://runningintheusa.com/Race/List.aspx?State=OH">http://runningintheusa.com/Race/List.aspx?State=OH</a></li> </ul>	All ages	Prevention, early intervention	Best practice
Adult & Youth Sports Programs	Parks and Rec	<p>Montpelier</p> <ul style="list-style-type: none"> <li><a href="http://www.montpelierpark.net/activities.html">http://www.montpelierpark.net/activities.html</a></li> <li>(419)-485-5389</li> <li>1110 S. Platt St. Montpelier</li> </ul> <p>Bryan</p> <ul style="list-style-type: none"> <li><a href="http://www.bryanparksandrec.com/">http://www.bryanparksandrec.com/</a></li> <li>(419)-633-6030</li> <li>1399 E. High St. Bryan</li> </ul>	3 years and older	Prevention, early intervention, treatment	Best practice
Health programs at Senior Centers	Williams County Department on Aging	<ul style="list-style-type: none"> <li><a href="http://www.co.williams.oh.us/wcsc/">http://www.co.williams.oh.us/wcsc/</a></li> </ul>	Seniors	Prevention, early intervention, treatment	Best Practice



# Priority #1 | Decrease Obesity

## Resource Assessment, continued

Program/Strategy/Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Dance Studios	Various	Julie's School of Dance <ul style="list-style-type: none"> <li><a href="http://www.julieschoolofdance.com/">http://www.julieschoolofdance.com/</a></li> <li>(419)-298-3600</li> <li>7309 Co Rd F Bryan, OH 43506</li> </ul> Bryan Community School of Dance <ul style="list-style-type: none"> <li><a href="http://www.bryandance.com/">http://www.bryandance.com/</a></li> <li>(419)-633-3003</li> <li>117 N Lynn St. Bryan, OH 43506</li> </ul>	Bryan, Edgerton	Prevention, early intervention, treatment	Best practice
School Lunches	Ohio Department of Education (ODE) Mandate	<ul style="list-style-type: none"> <li><a href="http://education.ohio.gov/Topics/Other-Resources/Food-and-Nutrition/National-School-Lunch-and-Breakfast">http://education.ohio.gov/Topics/Other-Resources/Food-and-Nutrition/National-School-Lunch-and-Breakfast</a></li> <li>1-877-644-6338</li> </ul>	All school districts	Prevention, early intervention, treatment	Best practice
Cheerleading	Class Act All-Star Cheerleading	<ul style="list-style-type: none"> <li><a href="http://www.classactallstar.com">www.classactallstar.com</a></li> <li>(419)-485-0704</li> <li>122 Empire St. Montpelier, OH 43543</li> </ul>	All county	Prevention, early intervention, treatment	Best practice
Worksite Wellness programs	American Cancer Society (ACS)	<ul style="list-style-type: none"> <li><a href="http://www.acsworkplacesolutions.com/">http://www.acsworkplacesolutions.com/</a></li> <li>1-800-227-2345</li> <li>740 Commerce Dr. Perrysburg, OH 43551</li> </ul>	Business	Prevention, early intervention, treatment	Best practice
Meeting Well (Healthy Meetings)	American Cancer Society (ACS)	<ul style="list-style-type: none"> <li><a href="http://www.acsworkplacesolutions.com/">http://www.acsworkplacesolutions.com/</a></li> <li>1-800-227-2345</li> <li>740 Commerce Dr. Perrysburg, OH 43551</li> </ul>	Business	Prevention, early intervention, treatment	Best practice
Nutrition Classes: Weight Control Heart Health	Hospital (Community Hospitals and Wellness Centers)	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>(419)-636-1131</li> <li>433 W. High St. Bryan, OH 43506</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Golf	Various golf facilities	Patriot Gold Course <ul style="list-style-type: none"> <li>(260)-319-6534</li> <li>15149 US 20 Alt. Montpelier, OH 43543</li> </ul> Suburban Golf Club <ul style="list-style-type: none"> <li>(419)-636-9988</li> <li>SR-15 Bryan, OH 43506</li> </ul> Riverside Greens Golf Course <ul style="list-style-type: none"> <li>(419)-682-2053</li> <li>20010 County Rd F Stryker, OH 43557</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice

# Priority #1 | Decrease Obesity

## Resource Assessment, continued

Program/Strategy/Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Diabetes Education Program	Hospital (Community Hospitals and Wellness Centers)	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>(419)-636-1131</li> <li>433 W. High St. Bryan, OH</li> </ul>	Adults	Treatment	Best practice
Medical Nutrition Therapy	Hospital (Community Hospitals and Wellness Centers)	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>(419)-636-1131</li> <li>433 W. High St. Bryan, OH 43506</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Coach in your Corner (nutrition program)	Hospital (Community Hospitals and Wellness Centers)	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>(419)-636-1131</li> <li>433 W. High St. Bryan, OH 43506</li> </ul>	Spangles Employees	Prevention, early intervention, treatment	Best practice
Employee Wellness Program	Hospital (Community Hospitals and Wellness Centers)	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>(419)-636-1131</li> <li>433 W. High St. Bryan, OH 43506</li> </ul>	Employees	Prevention, early intervention, treatment	Best practice
(Voluntary) Diabetes Support Group	Hospital (Community Hospitals and Wellness Centers)	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>(419)-636-1131</li> <li>433 W. High St. Bryan, OH 43506</li> </ul>	Those with diabetes	Treatment	Best practice
Cooking Classes	Helping Hands Food Pantry (Paula Pephley)	<ul style="list-style-type: none"> <li><a href="http://houseofprayermontpelier.org">http://houseofprayermontpelier.org</a></li> <li>(419)-485-5575</li> <li>309 W. Washington St. Montpelier, OH 43543</li> </ul>	Montpelier	Prevention	Best Practice
Farmer's Market	Various (OSU Extension, private, Pioneer, St. John's)	OSU Extension Office <ul style="list-style-type: none"> <li><a href="http://williams.osu.edu/">http://williams.osu.edu/</a></li> <li>(419)-636-5608</li> <li>1425 E. High St. Bryan, OH 43506</li> </ul> April's Greenhouse and Farmers Market <ul style="list-style-type: none"> <li>(419)-633-7545</li> <li>1025 US Highway 127 Bryan, OH 43506</li> </ul>	Various	Prevention, early intervention, treatment	Best practice
Public use of tracks and use of buildings	All schools	<ul style="list-style-type: none"> <li>Bryan Schools</li> <li>Edgerton Schools</li> <li>Edon Schools</li> <li>Hilltop Schools</li> <li>Montpelier Schools</li> <li>North Central Schools</li> <li>Stryker Schools</li> </ul>	All schools	Prevention	Best practice

# Priority #1 | Decrease Obesity

## Resource Assessment, continued

Program/Strategy/Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Walking Trails (Measured Distances)	Health Department s and Villages	<ul style="list-style-type: none"> <li><a href="http://www.williamscountyhealth.org/health-education/walking-directories/">http://www.williamscountyhealth.org/health-education/walking-directories/</a></li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Bike paths	Rails to Trails (City of Bryan)	<ul style="list-style-type: none"> <li><a href="http://www.trailink.com/city/bryan-oh-trails.aspx">http://www.trailink.com/city/bryan-oh-trails.aspx</a></li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Walking program (school is open in winter months for walking)	Bryan City Schools	<ul style="list-style-type: none"> <li><a href="http://www.bryan.k12.oh.us/">http://www.bryan.k12.oh.us/</a></li> <li>(419)-636-6973</li> <li>1350 Fountain Grove Dr. Bryan, OH 43543</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Fitness Classes	Bryan City Schools	<ul style="list-style-type: none"> <li><a href="http://www.bryan.k12.oh.us/">http://www.bryan.k12.oh.us/</a></li> <li>(419)-636-6973</li> <li>1350 Fountain Grove Dr. Bryan, OH 43543</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Volleyball/ basketball leagues	Parks and Rec at Bryan City Schools	Bryan City Schools <ul style="list-style-type: none"> <li><a href="http://www.bryan.k12.oh.us/">http://www.bryan.k12.oh.us/</a></li> <li>(419)-636-6973</li> <li>1350 Fountain Grove Dr. Bryan, OH 43543</li> </ul> Parks and Rec <ul style="list-style-type: none"> <li><a href="http://www.montpelierpark.net/activities.html">http://www.montpelierpark.net/activities.html</a></li> <li>(419)-485-5389</li> <li>1110 S. Platt St. Montpelier, OH 43543</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Yoga & nutrition coaching	Pure Yoga	<ul style="list-style-type: none"> <li><a href="http://purepotentiallife.com/">http://purepotentiallife.com/</a></li> <li>(419)-551-7944</li> <li>1109 W. High St. Bryan, OH 43506</li> </ul>	Adolescents & Adults	Prevention, early intervention, treatment	Best practice
Fitness classes	Fusion Health & Fitness Club	<ul style="list-style-type: none"> <li>Check Facebook page</li> <li>(419)-445-4000</li> <li>800 Stryker St. Archbold, OH 43512</li> </ul>	Adults	Prevention, early intervention, treatment	Best practice
Information about wellness related programs	Williams County Wellness	<ul style="list-style-type: none"> <li><a href="https://www.facebook.com/groups/williamscountywellness/">https://www.facebook.com/groups/williamscountywellness/</a></li> </ul>	All ages	Prevention, early intervention	Best practice
Fitness Classes /Nutrition Plan	Curves Gym	<ul style="list-style-type: none"> <li><a href="http://www.curves.com">http://www.curves.com</a></li> <li>(419)-633-3476</li> <li>1340 S Main St. Bryan, OH</li> </ul>	Women	Prevention, early intervention, treatment	Best practice
Indoor Mile (walking route inside church)	Wesley United Methodist Church --Open: M-F 8:30am-4pm	<ul style="list-style-type: none"> <li><a href="http://www.bryanwesleyumc.org/templates/System/details.asp?id=43837&amp;PID=1037457">http://www.bryanwesleyumc.org/templates/System/details.asp?id=43837&amp;PID=1037457</a></li> <li>(419)-636-6721</li> <li>903 Center Street, Bryan OH 43506</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice

# Priority #1 | Decrease Obesity

## Resource Assessment, continued

Program/Strategy/Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Outdoor Activities	Parks and Rec Department	Bryan <ul style="list-style-type: none"> <li><a href="http://www.bryanparksandrec.com/">http://www.bryanparksandrec.com/</a></li> <li>For activities scroll down to the calendar section</li> </ul> Montpelier <ul style="list-style-type: none"> <li><a href="http://www.montpelierpark.net/activities.html">http://www.montpelierpark.net/activities.html</a></li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Wabash Cannonball Trail (recreational path for walking, biking, etc.)	Northwestern Ohio Rails-to-Trails Association	<ul style="list-style-type: none"> <li><a href="https://www.wabashcannonballtrail.org/welcome">https://www.wabashcannonballtrail.org/welcome</a></li> <li>(419)-335-8376</li> <li>Check the maps section to find entry points near you</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Fitness Classes and gym	Anytime Fitness	<ul style="list-style-type: none"> <li><a href="http://www.anytimefitness.com">www.anytimefitness.com</a></li> <li>(419)-513-1029</li> <li>1120 S. Main St. Bryan, OH</li> </ul>	Adolescents and older	Prevention, early intervention, treatment	Best practice
Various fitness programs	Parks and Rec	<ul style="list-style-type: none"> <li>103 N Beech St, Bryan, OH 43506</li> <li>(419) 636-4232</li> <li><a href="http://www.bryanparksandrec.com/">http://www.bryanparksandrec.com/</a></li> </ul>	All ages	Prevention, early intervention, treatment	Best Practice
Various fitness classes	YMCA	<ul style="list-style-type: none"> <li>1 Faber Dr, Bryan, OH 43506</li> <li><a href="http://www.wcymca.org/">http://www.wcymca.org/</a></li> <li>(419) 636-6185</li> </ul>	All ages	Prevention, early intervention, treatment	Best Practice
MD and me	Parkview, CHWC, YMC A, Parks and Rec	<ul style="list-style-type: none"> <li>Garver park</li> <li>Central Drive located behind Bryan High School, at the Rotary Pavilion Bryan, Ohio 43506</li> <li><a href="mailto:mdandme@parkview.com">mdandme@parkview.com</a></li> <li><a href="http://www.parkview.com/en/community/events/Pages/default.aspx">http://www.parkview.com/en/community/events/Pages/default.aspx</a></li> </ul>	All ages	Prevention, early intervention, treatment	Best Practice
Live it!	CHWC—TV cooking demo	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/bryan-hospital/">https://www.chwchospital.org/bryan-hospital/</a></li> </ul>	All ages	Prevention, early intervention, treatment	Best Practice
Integrated care project	Primary care at Bryan Community Health Center	<ul style="list-style-type: none"> <li>228 S Main St, Bryan, OH 43506</li> <li>(567)-239-4562</li> </ul>	All ages	Prevention, early intervention, treatment	Best Practice
Diabetes Self-Management Training (DSMT)	Step Toward Health, LLC	<ul style="list-style-type: none"> <li><a href="http://www.step toward health.com">www.step toward health.com</a></li> <li>(419)-551-1684</li> <li>511 Wesley Avenue Bryan, OH</li> <li>Facebook page: Step Toward Health with Michelle Price RDN, CDE</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice

# Priority #1 | Decrease Obesity

## Resource Assessment, continued

Program/Strategy/Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Low-cost Community Wellness Programs -weight mgmt -heart health -pre-diabetes -diabetes -kidney health -nutrition for kids -sports nutrition	Step Toward Health, LLC	<ul style="list-style-type: none"> <li><a href="http://www.steptowardhealth.com">www.steptowardhealth.com</a></li> <li>(419)-551-1684</li> <li>511 Wesley Avenue Bryan, OH</li> <li>Facebook page: Step Toward Health with Michelle Price RDN, CDE</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Corporate Wellness Programs -weight mgmt -heart health -pre-diabetes -diabetes -kidney health	Step Toward Health, LLC	<ul style="list-style-type: none"> <li><a href="http://www.steptowardhealth.com">www.steptowardhealth.com</a></li> <li>(419)-551-1684</li> <li>511 Wesley Avenue Bryan, OH</li> <li>Facebook page: Step Toward Health with Michelle Price RDN, CDE</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Medical Nutrition Therapy (MNT)	Step Toward Health, LLC	<ul style="list-style-type: none"> <li><a href="http://www.steptowardhealth.com">www.steptowardhealth.com</a></li> <li>(419)-551-1684</li> <li>511 Wesley Avenue Bryan, OH</li> <li>Facebook page: Step Toward Health with Michelle Price RDN, CDE</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
<b>No Evidenced Indicated</b>					
Babysitting service (available to parents while exercising)	YMCA	<ul style="list-style-type: none"> <li><a href="http://www.wcymca.org">www.wcymca.org</a></li> <li>(419)-636-6185</li> <li>1 Faber Dr. Bryan, OH 43506</li> </ul>	Children	N/A	None
All Things Food (garden presentation, organic)	All Things Food	<ul style="list-style-type: none"> <li><a href="https://www.facebook.com/responsiblefoods/">https://www.facebook.com/responsiblefoods/</a></li> <li>(419)-636-0950</li> <li>1204 E High St, Bryan, OH 43506</li> </ul>	Bryan	Prevention, early intervention, treatment	None
Summer Food Programs	Private Northwestern Ohio Community Action Commission (NOCAC)	<ul style="list-style-type: none"> <li><a href="https://www.nocac.org/index.php/services/child-care-nutrition/summer-food-program">https://www.nocac.org/index.php/services/child-care-nutrition/summer-food-program</a></li> <li>(419)-542-9500</li> <li>237 W. Arthur St. Hicksville, OH 43526</li> </ul>	Montpelier, Bryan, Pioneer and Edgerton (preschool – high school)	Prevention, early intervention, treatment	None
Hypnosis for Weight Control	Hospital (CHWC)	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>(419)-636-1131</li> <li>433 W. High St. Bryan</li> </ul>	Employees and Community	Treatment	None
School Athletics	All schools	<ul style="list-style-type: none"> <li>Bryan Schools</li> <li>Edgerton Schools</li> <li>Edon Schools</li> <li>Hilltop Schools</li> <li>Montpelier Schools</li> <li>North Central Schools</li> <li>Stryker Schools</li> </ul>	All schools	Prevention	None
Church Sports Leagues	Area churches	<ul style="list-style-type: none"> <li>Various, contact churches near you for more information</li> </ul>	All youth	Prevention, early intervention	None
Babysitting service (available to parents while exercising)	YMCA	<ul style="list-style-type: none"> <li><a href="http://www.wcymca.org">www.wcymca.org</a></li> <li>(419)-636-6185</li> <li>1 Faber Dr. Bryan, OH 43506</li> </ul>	Children	N/A	None

## Priority #1 | Decrease Obesity

### Resource Assessment, continued

Program/Strategy/Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Upward Basketball	Nazarene Church	<ul style="list-style-type: none"> <li><a href="http://www.upward.org/find-a-place-to-play">http://www.upward.org/find-a-place-to-play</a></li> <li>Enter your zip code to find camps and leagues near you</li> </ul>	Community	Prevention, early intervention, treatment	None
Online/Apps for Nutrition or Physical Activity	Various	<ul style="list-style-type: none"> <li>Various</li> </ul>	All ages	Prevention, early intervention	None
Gymnastics classes	Head Over Heels Gymnastics	<ul style="list-style-type: none"> <li>500 W. Mulberry Bryan, OH 43506</li> <li>(419) 633-0735</li> <li><a href="https://www.facebook.com/Head-Over-Heels-Gymnastics-Academy-LLC-1096962377031763/">https://www.facebook.com/Head-Over-Heels-Gymnastics-Academy-LLC-1096962377031763/</a></li> </ul>	Adolescents and older	Prevention, early intervention, treatment	None
Grocery	Quality Health Foods	<ul style="list-style-type: none"> <li>1001 W High St, Bryan, OH 43506</li> <li>(419) 636-9055</li> </ul>	All ages	Prevention, early intervention, treatment	None
Local produce	Various farmers markets	<ul style="list-style-type: none"> <li><a href="http://www.co.williams.oh.us/Family%20First/2015%20Williams%20County%20Resource%20Guide%20Online%20Version.pdf">http://www.co.williams.oh.us/Family%20First/2015%20Williams%20County%20Resource%20Guide%20Online%20Version.pdf</a></li> </ul>	All ages	Prevention, early intervention, treatment	None

# Priority #1 | Decrease Obesity

## Gaps and Potential Strategies

Gaps	Potential Strategies
<b>1. Lack of Produce</b>	<ul style="list-style-type: none"> <li>○ Increase awareness of healthier foods already in the area (i.e. at convenience stores &amp; gas stations).</li> <li>○ See if these convenience stores and gas stations would be willing to sell some produce (start small, with produce that has a longer shelf life, i.e. apples).</li> <li>○ Farmer stands—try and bring some of the produce sold at farmer's markets to the smaller towns. To increase access to healthier foods and reduce the barrier of transportation.</li> </ul>
<b>2. Lack of knowledge</b>	<ul style="list-style-type: none"> <li>○ Youth: Continue the MyPlate program in the schools to increase knowledge of healthy eating and the need to exercise.</li> <li>○ Have menu labeling at fast food and sit-down restaurants, so consumers can have more information to use when making food decisions. Also increase awareness of portion sizes, what you need vs. what is served to you.</li> </ul>
<b>3. Built environment</b>	<ul style="list-style-type: none"> <li>○ Get policy makers involved in the coalition so the bigger changes to the built environment can have more input on the matter and possibly go further than simply discussion.</li> <li>○ Have it in the policy that any further development in the area will have complete streets and/or sidewalks included in the construction.</li> </ul>
<b>4. Cost of programs</b>	<ul style="list-style-type: none"> <li>○ United Way provides scholarships to youth and adults to cover their membership fees at the Bryan YMCA, increase awareness of these scholarships.</li> <li>○ See if these scholarships can be extended to other gyms, for those who do not live in Bryan and do not wish to travel to the YMCA to exercise.</li> </ul>
<b>5. Sedentary Culture</b>	<ul style="list-style-type: none"> <li>○ Youth: Try to implement Fuel Up to 60 in schools to increase knowledge on exercise and increase physical activity during the day.</li> <li>○ Adults: Promote worksite wellness               <ul style="list-style-type: none"> <li>a. Stretch breaks during meetings</li> <li>b. Business perks/incentives for health behaviors</li> <li>c. Standing desks/ getting up and moving every hour</li> </ul> </li> </ul>



# Priority #1 | Decrease Obesity

## Best Practices

The following programs and policies have been reviewed and have proven strategies to **reduce obesity**:

1. **School-Based Obesity Prevention Interventions:** School-based obesity prevention programs seek to increase physical activity and improve nutrition before, during, and after school.

Programs combine educational, behavioral, environmental, and other components such as health and nutrition education classes, enhanced physical education and activities, promotion of healthy food options, and family education and involvement. Specific components vary by program.

### Expected Beneficial Outcomes

- Increased physical activity
- Increased physical fitness
- Improved weight status
- Increased consumption of fruit & vegetables

For more information go to: <http://www.countyhealthrankings.org/policies/school-based-obesity-prevention-interventions>

2. **OHA Good4You Healthy Hospital Initiative:** Good4You is a statewide initiative of Ohio hospitals, sponsored by the Ohio Hospital Association. Good4You seeks to help hospitals lead Ohioans to better health through health eating, physical activity and other statewide population health initiatives.

As leaders in their communities and advocates of health and well-being, hospitals can model healthy eating to support the health of employees, visitors and the communities they serve.

Hospitals can participate in this voluntary initiative by adopting the Good4You Eat Healthy nutrition criteria in four specific areas within the hospital: vending machines, cafeterias and cafes, meetings and events; and outside vendors and franchises. Participation is easy, and tools and resources are available to help hospitals as they transition to an Eat Healthy environment.

For more information go to: [www.ohiohospitals.org/Good4You](http://www.ohiohospitals.org/Good4You)

3. **CATCH** (Coordinated Approach to Child Health): This program is designed for after-school youth groups and community recreation programs and has a large base of scientific evidence to support its effectiveness in teaching healthy activity to adolescents and younger kids. CATCH consists of classroom curricula for third through fifth grades, parental involvement programs, CATCH PE, the Eat Smart foodservice program and CATCH Kids Club (K-8th grade after-school participants). The emphasis in the curricula is on making healthy food choices through skills training.

For more information go to: <http://catchinfo.org>

# Priority #1 | Decrease Obesity

## Best Practices, continued

4. **Cooking Matters** (No Kid Hungry Center for Best Practices): Cooking Matters hands-on courses empower families with the skills to be self-sufficient in the kitchen. In communities across America, participants and volunteer instructors come together each week to share lessons and meals with each other.

Courses meet for two hours, once a week for six weeks and are team-taught by a volunteer chef and nutrition educator. Lessons cover meal preparation, grocery shopping, food budgeting and nutrition. Participants practice fundamental food skills, including proper knife techniques, reading ingredient labels, cutting up a whole chicken, and making a healthy meal for a family of four on a \$10 budget. Adults and teens take home a bag of groceries after each class so they can practice the recipes taught that day.

Community partners that serve low-income families offer six-week Cooking Matters courses to adults, kids and families. Share Our Strength provides seven specialized curricula that cover nutrition and healthy eating, food preparation, budgeting and shopping. Cooking Matters' culinary and nutrition volunteers teach these high-quality, cooking-based courses at a variety of community-based agencies—including Head Start centers, housing centers and after-school programs—with neighborhood locations that make it easy for families to attend.

For more information go to: <http://cookingmatters.org/courses>

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

For more information go to: <http://www.fns.usda.gov/tn/serving-myplate-yummy-curriculum>

# Priority #1 | Decrease Obesity

## Best Practices, *continued*

6. **Complete Streets:** Complete streets are designed and operated to enable safe access for all users, including pedestrians, bicyclists, motorists and transit riders of all ages and abilities. Complete Streets make it easy to cross the street, walk to shops, and bicycle to work.

Creating Complete Streets means transportation agencies must change their approach to community roads. By adopting a Complete Streets policy, communities direct their transportation planners and engineers to **routinely design and operate the entire right of way to enable safe access for all users**, regardless of age, ability, or mode of transportation. This means that every transportation project will make the street network better and safer for drivers, transit users, pedestrians, and bicyclists – making your town a better place to live.

Changing policy to routinely include the needs of people on foot, public transportation, and bicycles would make walking, riding bikes, riding buses and trains safer and easier. People of all ages and abilities would have more options when traveling to work, to school, to the grocery store, and to visit family.

For more information go to: <http://www.smartgrowthamerica.org/complete-streets/complete-streets-fundamentals/complete-streets-faq>

# Priority #1 | Decrease Obesity

## Alignment with National Standards

The Williams County CHIP helps support the following **Healthy People 2020 Goals**:

- **Nutrition and Weight Status (NWS)-1** Increase the number of States with nutrition standards for foods and beverages provided to preschool-aged children in child care
- **Nutrition and Weight Status (NWS)-2** Increase the proportion of schools that offer nutritious foods and beverages outside of school meals
- **Nutrition and Weight Status (NWS)-3** Increase the number of States that have State-level policies that incentivize food retail outlets to provide foods that are encouraged by the Dietary Guidelines for Americans
- **Nutrition and Weight Status (NWS)-4** (Developmental) Increase the proportion of Americans who have access to a food retail outlet that sells a variety of foods that are encouraged by the Dietary Guidelines for Americans
- **Nutrition and Weight Status (NWS)-5** Increase the proportion of primary care physicians who regularly measure the body mass index of their patients
- **Nutrition and Weight Status (NWS)-6** Increase the proportion of physician office visits that include counseling or education related to nutrition or weight
- **Nutrition and Weight Status (NWS)-7** (Developmental) Increase the proportion of worksites that offer nutrition or weight management classes or counseling
- **Nutrition and Weight Status (NWS)-8** Increase the proportion of adults who are at a healthy weight
- **Nutrition and Weight Status (NWS)-9** Reduce the proportion of adults who are obese
- **Nutrition and Weight Status (NWS)-10** Reduce the proportion of children and adolescents who are considered obese
- **Nutrition and Weight Status (NWS)-11** (Developmental) Prevent inappropriate weight gain in youth and adults
- **Nutrition and Weight Status (NWS)-12** Eliminate very low food security among children
- **Nutrition and Weight Status (NWS)-13** Reduce household food insecurity and in doing so reduce hunger
- **Nutrition and Weight Status (NWS)-14** Increase the contribution of fruits to the diets of the population aged 2 years and older
- **Nutrition and Weight Status (NWS)-15** Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older
- **Nutrition and Weight Status (NWS)-16** Increase the contribution of whole grains to the diets of the population aged 2 years and older
- **Nutrition and Weight Status (NWS)-17** Reduce consumption of calories from solid fats and added sugars in the population aged 2 years and older
- **Nutrition and Weight Status (NWS)-18** Reduce consumption of saturated fat in the population aged 2 years and older
- **Nutrition and Weight Status (NWS)-19** Reduce consumption of sodium in the population aged 2 years and older
- **Nutrition and Weight Status (NWS)-20** Increase consumption of calcium in the population aged 2 years and older
- **Nutrition and Weight Status (NWS)-21** Reduce iron deficiency among young children and females of childbearing age
- **Nutrition and Weight Status (NWS)-22** Reduce iron deficiency among pregnant females

# Priority #1 | Decrease Obesity

## Action Step Recommendations & Plan

To work toward decreasing **adult and youth obesity**, the following action steps are recommended:

1. Increase education of healthy eating for adults
2. Implement food pharmacy program
3. Increase education of healthy eating for youth
4. Implement Complete Streets policies
5. Implement OHA Healthy Hospitals initiative

## Action Plan

Decrease Obesity		
Action Step	Responsible Person/Agency	Timeline
<b>Increase Education of Healthy Eating for Adults</b>		
<p><b>Year 1:</b> Provide quarterly lunch and learn presentations on nutrition and fitness related topics at various locations in Williams County including senior centers, local businesses, YMCA and local groups/clubs.</p> <p>Utilizing the <i>Cooking Matters</i> framework, conduct monthly grocery store tours by a Registered Dietitian or Health Educator in grocery stores throughout Williams County. Invite seniors and disabled populations to attend along with the general public.</p> <p>Provide educational assistance at Williams County Farmers Markets to distribute healthy recipes and nutritional information and increase knowledge on healthy eating and cooking habits with fresh produce.</p> <p>Evaluations will be given at each lunch and learn, and grocery store tour to measure knowledge gained.</p>	<p><b>Phil Ennen</b> Community Hospitals and Wellness Centers</p> <p><b>Michelle Price</b> Step Toward Health</p>	December 31, 2017
<p><b>Year 2:</b> Increase awareness and participation in lunch and learns, grocery store tours and increase the number of individuals assisted at Williams County Farmers Markets.</p> <p>75% of clients will show increased knowledge of healthy eating habits and increased consumption of fresh produce consumed.</p>		December 31, 2018
<b>Year 3:</b> Continue efforts from Years 1 and 2.		December 31, 2019

# Priority #1 | Decrease Obesity

## Action Step Recommendations & Plan, continued

Decrease Obesity		
Action Step	Responsible Person/Agency	Timeline
<b>Implement Food Pharmacy Program</b>		
<p><b>Year 1:</b> Research the Alliance to End Hunger-ProMedica Food Pharmacy.</p> <p>Obtain baseline data to document need for a Food Pharmacy.</p> <p>Contact health care, food pantry, farmers market, and other potential partners. Schedule and attend meetings with potential partners – discussing the need and feasibility of a food pharmacy.</p> <p>Finalize location, program partners, vendors, and other details necessary for the implementation of a food pharmacy.</p> <p>Determine what additional program materials are needed. Develop program materials.</p>	<p><b>Phil Ennen</b> Community Hospitals and Wellness Centers</p>	December 31, 2017
<b>Year 2:</b> Continue efforts from Year 1. Implement the food pharmacy in one location with accompanying evaluation measures.		December 31, 2018
<b>Year 3:</b> Continue efforts from Years 1 and 2.		December 31, 2019
<b>Increase Education of Healthy Eating for Youth</b>		
<p><b>Year 1:</b> Continue to collect annual baseline “healthy habit” data for grades K through 6 in at least three school districts in Williams County. By utilizing the <i>Serving Up MyPlate</i> framework, continue to implement MyPlate educational activities in the same three school districts.</p> <p>Work with schools to offer “Try it Tuesday” fruit and vegetable taste testing for children.</p> <p>“Healthy habit” surveys will be given each year to measure knowledge gained. 50% of students will show increased knowledge of healthy habits.</p>	<p><b>Megan Riley</b> Williams County Health Department</p>	December 31, 2017
<p><b>Year 2:</b> Continue efforts from Year 1 in at least 4 school districts.</p> <p>Work with at least 1-2 schools to host a taste-testing event or family education night.</p> <p>75% of students will show increased knowledge of healthy habits.</p>		December 31, 2018
<p><b>Year 3:</b> Continue efforts from Years 1 and 2 in at least 4 school districts.</p> <p>90% of students will show increased knowledge of healthy habits.</p>		December 31, 2019

## Priority #1 | Decrease Obesity

### Action Step Recommendations & Plan, continued

Decrease Obesity		
Action Step	Responsible Person/Agency	Timeline
<b>Implement Complete Streets Policies</b>		
<b>Year 1:</b> Raise awareness of Complete Streets Policy and recommend that all local jurisdictions adopt comprehensive complete streets policies.  Gather baseline data on all of the Complete Streets Policy objectives.	<b>Jim Watkins</b> Williams County Health Department	December 31, 2017
<b>Year 2:</b> Begin to implement the following Complete Streets Objectives: <ul style="list-style-type: none"> <li>• Increase in total number of miles of on-street bicycle facilities, defined by streets and roads with clearly marked or signed bicycle accommodations.</li> <li>• Increase in member jurisdictions which adopt complete streets policies.</li> <li>• Increase in number of jurisdictions achieving or pursuing Bike-Friendly Community status from the League of American Bicyclists, or Walk-Friendly Community status from walkfriendly.org.</li> </ul>		December 31, 2018
<b>Year 3:</b> Continue efforts from years 1 and 2.		December 31, 2019
<b>Implement OHA Healthy Hospitals Initiative</b>		
<b>Year 1:</b> Hospitals should participate in Good4You educational webinars hosted by OHA.  Complete all Assessment Tools provided by OHA to gather baseline information on current food and beverages in the hospital cafeterias, vending, meetings, and gift shops.  Implement the Good 4 You Initiative in at least one of the following priority areas: <ul style="list-style-type: none"> <li>• Healthy Cafeterias/Cafes</li> <li>• Healthy Vending Machines</li> <li>• Healthy Meetings and Events</li> <li>• Healthy Outside Vendors and Franchises</li> </ul> Use marketing materials (posters, table tents, stickers, etc.) to better brand the program.	<b>Phil Ennen</b> Community Hospitals and Wellness Centers	December 31, 2017
<b>Year 2:</b> Implement the Good4You Initiative in all four priority areas within each hospital.		December 31, 2018
<b>Year 3:</b> Introduce the program into other areas of the community (businesses, schools, churches, etc.)		December 31, 2019



## Priority #2 | Improve Cardiovascular Health

### Cardiovascular Health Indicators

*Heart-related diseases accounted for 33% of all Williams County deaths in 2015 (Source: Williams County Health Department Annual Report, 2015). The 2016 Williams County Health Assessment found that 4% of adults had survived a heart attack and 1% had survived a stroke at some time in their life. Over two-fifths (41%) of Williams County adults were obese, 35% had been diagnosed with high blood pressure, 32% were sedentary, 36% had high blood cholesterol, and 22% were smokers, five known risk factors for heart disease and stroke.*

#### **Adult Cardiovascular Health**

In 2016, 4% of Williams County adults reported they had survived a heart attack (myocardial infarction), increasing to 11% of those over the age of 65. 5% of Ohio and 4% of U.S. adults reported they had a heart attack or myocardial infarction in 2014 (Source: 2014 BRFSS).

1% of Williams County adults reported they had survived a stroke, increasing to 4% of those over the age of 65. 4% of Ohio and 3% of U.S. adults reported having had a stroke in 2014 (Source: 2014 BRFSS).

6% of adults reported they had angina or coronary heart disease, increasing to 10% of those over the age of 65. 5% of Ohio and 4% of U.S. adults reported having had angina or coronary heart disease in 2014 (Source: 2014 BRFSS).

2% of adults reported they had congestive heart failure, increasing to 4% of those over the age of 65.

A doctor advised Williams County adults to do the following to lower their risk of developing heart disease or stroke: exercise more (31%), eat fewer high fat or high cholesterol foods (26%), and eat more fruits or vegetables (24%).

More than one-third (35%) of adults had been diagnosed with high blood pressure. The 2013 BRFSS reports hypertension prevalence rates of 34% for Ohio and 31% for the U.S.

82% of adults had their blood pressure checked within the past year.

Williams County adults diagnosed with high blood pressure were more likely to: have rated their overall health as fair or poor (71%), have been age 65 years or older (60%), have been classified as obese by Body Mass Index-BMI (44%).

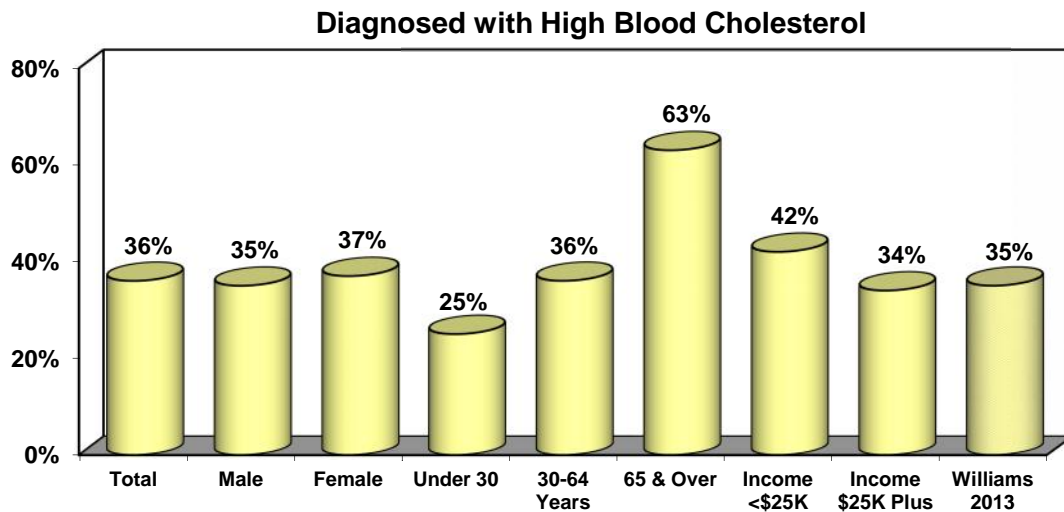
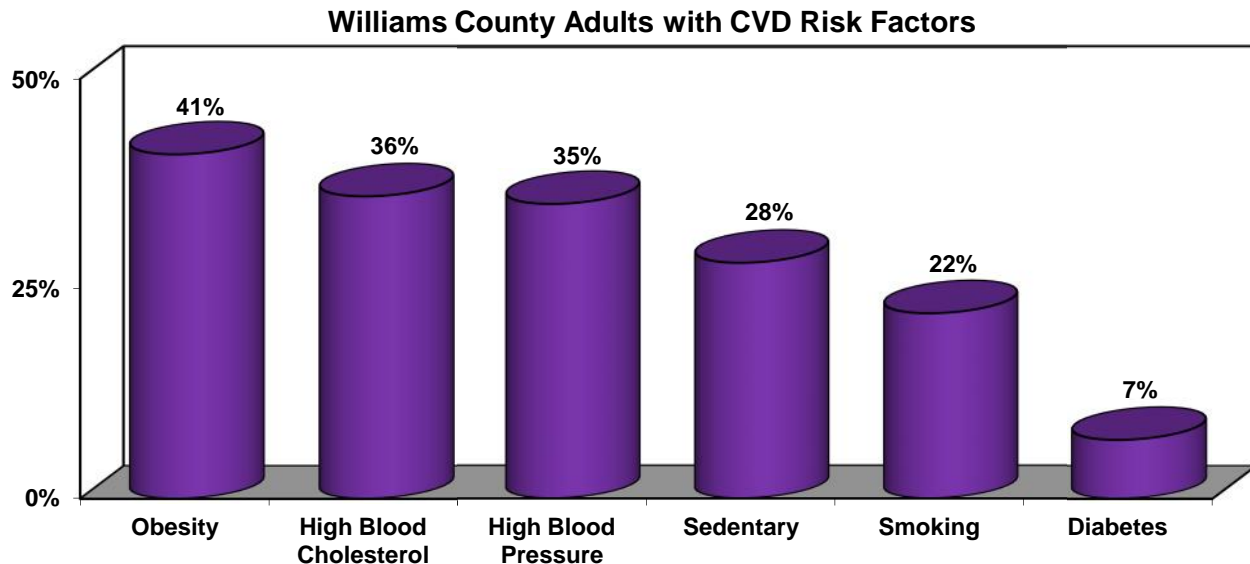
More than one-third (36%) of adults had been diagnosed with high blood cholesterol. The 2013 BRFSS reported that 38% of both Ohio and U.S. adults have been told they have high blood cholesterol.

More than three-fourths (79%) of adults had their blood cholesterol checked within the past 5 years. The 2013 BRFSS reported 78% of Ohio and 76% of U.S. adults had their blood cholesterol checked within the past 5 years.

Williams County adults with high blood cholesterol were more likely to: have been age 65 years or older (63%), have rated their overall health as fair or poor (62%), have been classified as obese by Body Mass Index-BMI (41%).

## Priority #2 | Improve Cardiovascular Health

### Cardiovascular Health Indictors, *continued*

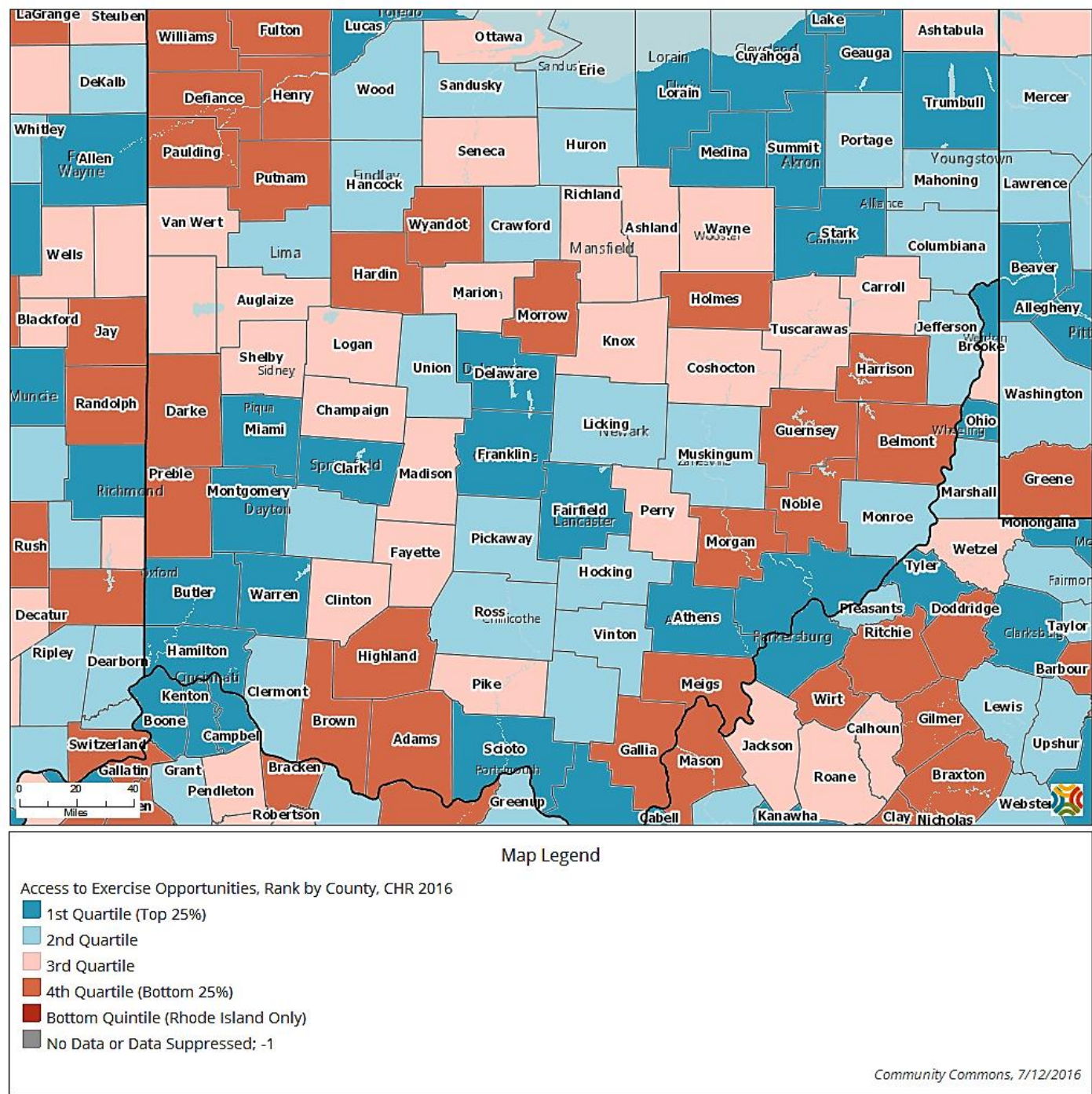


Adult Comparisons	Williams County 2013	Williams County 2016	Ohio 2014	U.S. 2014
Had angina	6%	6%	5%	4%
Had a heart attack	5%	4%	5%	4%
Had a stroke	3%	1%	4%	3%
Had high blood pressure	29%	35%	34%*	31%*
Had high blood cholesterol	35%	36%	38%*	38%*
Had blood cholesterol checked within past 5 years	70%	79%	78%*	76%*

\*2013 BRFSS Data

# Priority #2 | Improve Cardiovascular Health

Access to Exercise Opportunities, Rank by County, CHR 2016

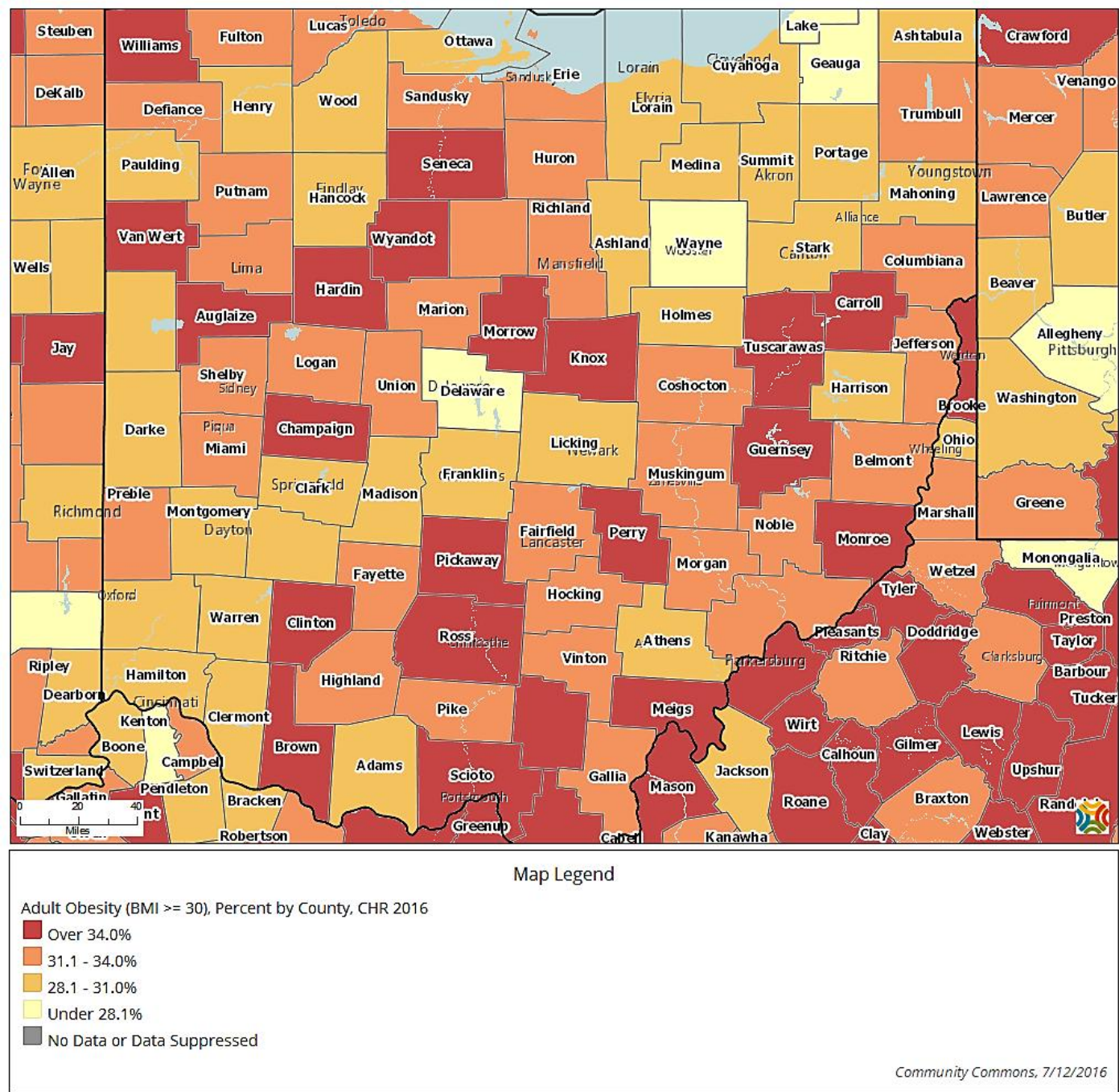


(Source: Community Commons 7/12/16)



# Priority #2 | Improve Cardiovascular Health

Adult Obesity (BMI >= 30), Percent by County, CHR 2016



(Source: Community Commons 7/12/16)

## Priority #2 | Improve Cardiovascular Health

### Resource Assessment

Program/Strategy /Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
<b>Evidence-based Practices</b>					
Cardiac Rehabilitation	Hospital (Community Hospitals and Wellness Centers)	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>(419)-636-1131</li> <li>433 W. High St, Bryan, OH 43506</li> </ul>	Individuals with coronary artery disease	Prevention, early intervention, treatment	Evidence based
<b>Best Practices</b>					
Heart Health Dietary Education Program	Hospital (Community Hospitals and Wellness Centers)	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>(419)-636-1131</li> <li>433 W. High St, Bryan, OH 43506</li> </ul>	All ages	Prevention	Best practice
Congestive Heart Failure Navigation Program	Hospital (Community Hospitals and Wellness Centers)	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>(419)-636-1131</li> <li>433 W. High St, Bryan, OH 43506</li> </ul>	Congestive heart failure patients	Prevention, early intervention, treatment	Best practice
Free Blood Pressure Checks	Hospital (Community Hospitals and Wellness Centers) Emergency Room	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>(419)-636-1131</li> <li>433 W. High St, Bryan, OH 43506</li> </ul>	All ages	Early intervention	Best practice
Community Lab Draw	Hospital (Community Hospitals and Wellness Centers)	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>419-636-1131</li> <li>433 W. High St, Bryan, OH 43506</li> </ul>	Community	Prevention	Best practice
Parkview Blood Pressure Clinic	Parkview	<ul style="list-style-type: none"> <li><a href="http://www.parkview.com/en/pg/FirstCare/Pages/default.aspx">http://www.parkview.com/en/pg/FirstCare/Pages/default.aspx</a></li> <li>419-636-4517</li> <li>442 W. High St, Bryan, OH 43506</li> </ul>	All ages	Early intervention	Best practice
Mychart Health Reminders	Parkview	<ul style="list-style-type: none"> <li><a href="mailto:mychart@parkview.com">mychart@parkview.com</a></li> <li>1-855-853-0001</li> </ul>	Parkview patients	Prevention	Best practice
Monthly Blood Pressure Checks	William's County Department of Aging	<ul style="list-style-type: none"> <li><a href="http://www.co.williams.oh.us/wcsc/">http://www.co.williams.oh.us/wcsc/</a></li> <li>(419)-633-4317</li> <li>1425 E High St Bryan, OH 43506</li> </ul>	Seniors	Prevention, early intervention, treatment	Best Practice

## Priority #2 | Improve Cardiovascular Health

### Resource Assessment, continued

Program/Strategy /Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
MD and Me Walk and Learn	Parkview, Hospital (Community Hospitals and Wellness Centers), YMCA	<ul style="list-style-type: none"> <li><a href="mailto:mdandme@parkview.com">mdandme@parkview.com</a></li> <li>1-855-637-0010</li> </ul>	All ages	Prevention, early intervention	Best practice
Free Blood Pressure Checks	Bryan Community Health Center	<ul style="list-style-type: none"> <li><a href="http://recovery.hpwohio.org/">http://recovery.hpwohio.org/</a></li> <li>(567) 239-4562</li> <li>228 South Main Street Bryan, Ohio 43506</li> </ul>	Bryan	Early intervention	Best practice
5 A's Intervention	Parkview, Hospital (Community Hospitals and Wellness Centers)	Parkview: <ul style="list-style-type: none"> <li>(877)-774-8649</li> <li>442 W High St, Bryan, OH 43506</li> </ul> CHWC: <ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>(419)-636-1131</li> <li>433 W. High St, Bryan, OH 43506</li> </ul>	Pregnant women	Prevention	Best practice
Low-cost Community Wellness Programs -weight mgmt -heart health -pre-diabetes -diabetes -kidney health -nutrition for kids -sports nutrition	Step Toward Health, LLC	<ul style="list-style-type: none"> <li><a href="http://www.step toward health.com">www.step toward health.com</a></li> <li>(419)-551-1684</li> <li>511 Wesley Avenue Bryan, OH</li> <li>Facebook page: Step Toward Health with Michelle Price RDN, CDE</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
Corporate Wellness Programs -weight mgmt -heart health -pre-diabetes -diabetes -kidney health	Step Toward Health, LLC	<ul style="list-style-type: none"> <li><a href="http://www.step toward health.com">www.step toward health.com</a></li> <li>(419)-551-1684</li> <li>511 Wesley Avenue Bryan, OH</li> <li>Facebook page: Step Toward Health with Michelle Price RDN, CDE</li> </ul>	All ages	Prevention, early intervention, treatment	Best practice
<b>No Evidenced Indicated</b>					
Prevention Fact Sheets	Parkview	<ul style="list-style-type: none"> <li>(877)-774-8649</li> <li>442 W High St, Bryan, OH 43506</li> </ul>	Community	Prevention	None
Company Health Fairs	Parkview	<ul style="list-style-type: none"> <li>(877)-774-8649</li> <li>442 W High St, Bryan, OH 43506</li> </ul>	Employees	Prevention, Early Intervention	None
Focus on health program at Bryan Eagles	Parkview	<ul style="list-style-type: none"> <li><a href="http://www.parkview.com">www.parkview.com</a></li> </ul>	Adults	Prevention, Early Intervention	None
Cardiopulmonary Care Committee	CHWC	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> </ul>	All ages	Prevention, Early Intervention	None
Pharmacist Education about Medications	Bryan Medical Center	<ul style="list-style-type: none"> <li>442 W High St, Bryan, OH 43506</li> <li>(419)-633-4029</li> </ul>	All ages	Prevention, Early Intervention	None

## Priority #2 | Improve Cardiovascular Health

### Gaps and Potential Strategies

Gaps	Potential Strategies
<b>1. Lack of motivation</b>	<ul style="list-style-type: none"> <li>○ Incentivize programs</li> <li>○ Implement programs that encourages family participation</li> <li>○ Focus groups to determine root causes</li> <li>○ Introduce health and wellness coaching</li> <li>○ Motivational interviewing</li> </ul>
<b>2. Tobacco addiction/increase in access</b>	<ul style="list-style-type: none"> <li>○ Work with all care providers to implement tobacco screening and intervention</li> <li>○ Educational campaign using billboards, etc.</li> <li>○ Tobacco free policy expansion</li> </ul>
<b>4. Lack of knowledge/education</b>	<ul style="list-style-type: none"> <li>○ Social campaign</li> <li>○ Work with physicians</li> <li>○ Work with business community</li> </ul>
<b>5. Sedentary culture</b>	<ul style="list-style-type: none"> <li>○ Use incentives to increase participation in wellness programs</li> <li>○ Promote active lifestyle with built environment</li> <li>○ Changes in work environment to promote more activity</li> </ul>
<b>6. Lack of compliance with prescriptions</b>	<ul style="list-style-type: none"> <li>○ Increase education</li> <li>○ Find new solutions for financial barriers</li> <li>○ Investigate root causes</li> </ul>
<b>7. Doctor/patient education</b>	<ul style="list-style-type: none"> <li>○ Work with physicians to assess what materials and/or education is needed</li> <li>○ Assess the patient's needs</li> <li>○ Provide materials to primary care physicians</li> </ul>



# Priority #2 | Improve Cardiovascular Health

## Best Practices

The following programs and policies have been reviewed and have proven strategies to improve cardiovascular health:

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

### Expected Beneficial Outcomes

- Increased physical activity
- Increased physical fitness

### Evidence of Effectiveness

There is strong evidence that community-based social support interventions increase physical activity and physical fitness among adults. Middle-aged women enrolled in a weight loss program, for example, have been shown to be more likely to lose weight if they experience social support from friends and family. Community-based social support interventions are considered cost effective.

### Impact on Disparities

No impact on disparities likely

For more information go to: <http://www.countyhealthrankings.org/policies/social-support-community-settings>

2. **Worksite Obesity Prevention Interventions:** Worksite nutrition and physical activity programs use educational, environmental, and behavioral strategies to improve health-related behaviors and health outcomes. These programs may include written materials, skill-building (e.g., cue control), individual or group counseling, improved access to healthy foods (e.g., changing cafeteria or vending machine options), and opportunities to be more active at work (e.g., on-site facilities for exercise or standing/walking workstations) (CG-Obesity).

### Expected Beneficial Outcomes

- Increased physical activity
- Increased weight loss
- Increased fruit & vegetable consumption

### Evidence of Effectiveness

There is strong evidence that worksite nutrition and physical activity programs increase physical activity, weight loss (Verweij 2011, CG-Obesity), and fruit and vegetable consumption among employees (Verweij 2011).

Worksite nutrition and physical activity programs that utilize multiple components appear to be more successful than programs that utilize only one component (CG-Obesity). Successful programs have been shown to enhance self-confidence for participants, and benefit employers through increased employee productivity and reduced medical care costs (CG-Obesity).

Worksite programs appear to be cost effective strategies to increase physical activity and improve weight status (CG-Obesity).

For more information go to: <http://www.countyhealthrankings.org/policies/worksite-obesity-prevention-interventions>

## Priority #2 | Improve Cardiovascular Health

### Alignment with National Standards

Through proven and promising best practices, effective programs will be better able to help achieve the Healthy People 2020 Heart Disease and Stroke Objectives to improve cardiovascular health through prevention and ensure access to appropriate, quality mental health services.

**Healthy People 2020 Goals** include:

- **Heart Disease and Stroke (HDS)-1** (Developmental) Increase overall cardiovascular health in the U.S. population
- **Heart Disease and Stroke (HDS)-2** Reduce coronary heart disease deaths
- **Heart Disease and Stroke (HDS)-3** Reduce stroke deaths
- **Heart Disease and Stroke (HDS)-4** Increase the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high
- **Heart Disease and Stroke (HDS)-5** Reduce the proportion of persons in the population with hypertension
- **Heart Disease and Stroke (HDS)-6** Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years
- **Heart Disease and Stroke (HDS)-7** Reduce the proportion of adults with high total blood cholesterol levels
- **Heart Disease and Stroke (HDS)-8** Reduce the mean total blood cholesterol levels among adults
- **Heart Disease and Stroke (HDS)-9** (Developmental) Increase the proportion of adults with prehypertension who meet the recommended guidelines
- **Heart Disease and Stroke (HDS)-10** (Developmental) Increase the proportion of adults with hypertension who meet the recommended guidelines
- **Heart Disease and Stroke (HDS)-11** Increase the proportion of adults with hypertension who are taking the prescribed medications to lower their blood pressure
- **Heart Disease and Stroke (HDS)-12** Increase the proportion of adults with hypertension whose blood pressure is under control
- **Heart Disease and Stroke (HDS)-13** (Developmental) Increase the proportion of adults with elevated LDL cholesterol who have been advised by a health care provider regarding cholesterol-lowering management, including lifestyle changes and, if indicated, medication
- **Heart Disease and Stroke (HDS)-14** (Developmental) Increase the proportion of adults with elevated LDL-cholesterol who adhere to the prescribed LDL-cholesterol lowering management lifestyle changes and, if indicated, medication
- **Heart Disease and Stroke (HDS)-15** (Developmental) Increase aspirin use as recommended among adults with no history of cardiovascular disease
- **Heart Disease and Stroke (HDS)-16** Increase the proportion of adults aged 20 years and older who are aware of the symptoms of and how to respond to a heart attack
- **Heart Disease and Stroke (HDS)-17** Increase the proportion of adults aged 20 years and older who are aware of the symptoms of and how to respond to a stroke
- **Heart Disease and Stroke (HDS)-18** (Developmental) Increase the proportion of out-of-hospital cardiac arrests in which appropriate bystander and emergency medical services (EMS) were administered
- **Heart Disease and Stroke (HDS)-19** Increase the proportion of eligible patients with heart attacks or strokes who receive timely artery-opening therapy as specified by current guidelines

## Priority #2 | Improve Cardiovascular Health

### Alignment with National Standards, *continued*

- **Heart Disease and Stroke (HDS)-20** (Developmental) Increase the proportion of adults with coronary heart disease or stroke who have their low-density lipoprotein (LDL) cholesterol level at or below recommended levels
- **Heart Disease and Stroke (HDS)-21** (Developmental) Increase the proportion of adults with a history of cardiovascular disease who are using aspirin or antiplatelet therapy to prevent recurrent cardiovascular events
- **Heart Disease and Stroke (HDS)-22** (Developmental) Increase the proportion of adult heart attack survivors who are referred to a cardiac rehabilitation program at discharge
- **Heart Disease and Stroke (HDS)-23** (Developmental) Increase the proportion of adult stroke survivors who are referred to a stroke rehabilitation program at discharge
- **Heart Disease and Stroke (HDS)-24** Reduce hospitalizations of older adults with heart failure as the principal diagnosis.
- **Heart Disease and Stroke (HDS)-25** (Developmental) Increase the proportion of patients with hypertension in clinical health systems whose blood pressure is under control

## Priority #2 | Improve Cardiovascular Health

### Action Step Recommendations & Plan

To work toward **improving adult cardiovascular health**, the following actions steps are recommended:

1. Implement Go Red for Women initiative
2. Increase nutrition/physical education materials being offered to patients by primary care offices

### Action Plan

Improve Cardiovascular Health		
Action Step	Responsible Person/Agency	Timeline
<b>Implement Go Red for Women Initiative</b>		
<p><b>Year 1:</b> Research the American Heart Association's "Go Red for Women" initiative.</p> <p>Engage Williams County organizations to design a unified women's heart health outreach campaign centered on Go Red for Women.</p> <p>Work to promote heart health by creating shared messages among Williams County organizations to distribute in Williams County. Include print and social media.</p> <p>Create a community calendar with the most up-to-date information regarding nutrition and exercise programs opportunities in Williams County. Put the calendar online and raise awareness about the calendar. Keep the community calendar updated on a quarterly basis.</p> <p>Work with city and county parks and recreation departments to create a list of free physical activity opportunities, such as walking paths, bike paths, parks, and free programs in Williams County.</p> <p>Use the Go Red for Women logo with a consistent message.</p> <p>Begin disseminating information in Williams County.</p>	<p><b>Phil Ennen</b> Community Hospitals and Wellness Centers</p>	December 31, 2017
<p><b>Year 2:</b> Increase awareness and dissemination of the wellness outreach campaign.</p> <p>Provide community organizations with ways to support the outreach campaign such as using social media, websites, flyers, etc.</p> <p>Continue to promote and update the community calendar.</p>		December 31, 2018
<p><b>Year 3:</b> Continue efforts from Year 2.</p>		December 31, 2019
<b>Increase Nutrition/Physical Education Materials Being Offered to Patients by Primary Care Offices</b>		
<p><b>Year 1:</b> Work with primary care physician offices to assess what information and/or materials they are lacking to provide better resources for patients with cardiovascular disease risk factors.</p>	<p><b>Sally Taylor</b> Parkview Physicians Group</p> <p><b>Jamie Marshall</b> Parkview Physicians Group</p>	December 31, 2017
<p><b>Year 2:</b> Offer trainings for PCP offices on nutrition and physical activity best practices, as well as referral sources. Enlist at least 3 primary care physician offices.</p>		December 31, 2018
<p><b>Year 3:</b> Offer additional trainings to reach at least 50% of the primary care physician offices in the county.</p>		December 31, 2019

## Priority #3 | Improve Youth Mental Health

### Mental Health Indicators

*In 2016, the Health Assessment results indicated that 10% of Williams County youth had seriously considered attempting suicide in the past year and 7% admitted to actually attempting suicide in the past year. 22% of youth reported they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities; increasing to 28% of females.*

#### Youth Mental Health

In 2016, 22% of youth reported they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities; increasing to 28% of females (2013 YRBS reported 26% for Ohio and 30% for the U.S.).

10% of youth reported they had seriously considered attempting suicide in the past 12 months, increasing to 14% of females. 10% of high school youth had seriously considered attempting suicide, compared to the 2013 YRBS rate of 17% for U.S. youth and 14% for Ohio youth.

In the past year, 7% of Williams County youth had attempted suicide, increasing to 11% of females. 4% of youth had made more than one attempt. The 2013 YRBS reported a suicide attempt prevalence rate of 8% for U.S. youth and a 6% rate for Ohio youth.

Of all youth, 2% made a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (2013 YRBS reported 1% for Ohio and 3% for the U.S.).

Of those who attempted suicide, 7% resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse.

13% of Williams County youth stated that they would be very likely to seek help if they were feeling depressed or suicidal. 13% reported that it would be very unlikely they would seek help.

55% of youth reported they would seek help if they were dealing with anxiety, stress, depression or thoughts of suicide. Of youth who reported they would not seek help the following reasons were reported: they can handle it themselves (56%), worried what others might think (40%), did not know where to go (28%), cost (15%), no time (14%), their family would not support them (12%) and transportation (3%). 7% of youth were currently seeking treatment.

Williams County youth reported the following causes of anxiety, stress and depression: academic success (29%), fighting with friends (29%), fighting at home (25%), sports (24%), peer pressure (22%), breakup (19%), being bullied (19%), death of close family member or friend (18%), self-image (18%), parent divorce/separation (15%), dating relationship (14%), caring for younger siblings (12%), poverty/no money (8%), ill parent (7%), parent/caregiver with a substance abuse problem (4%), not feeling safe at home (4%), parent lost their job (4%), parent with a mental illness (3%), alcohol or drug use at home (3%), family member in the military (3%), sexual orientation (3%), not feeling safe in the community (3%), not having enough to eat (3%), not having a place to live (1%) and other stress at home (18%).

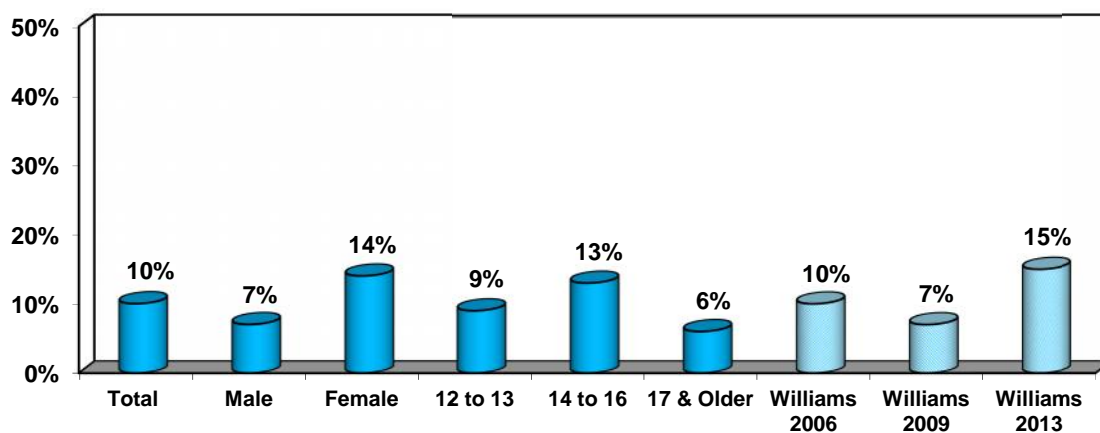
Williams County youth reported the following ways of dealing with anxiety, stress, or depression: sleeping (45%), hobbies (35%), playing video games (28%), talk to someone in their family (26%), praying (25%), texting someone (25%), exercising (25%), talking to a peer (23%), eating (17%), reading the Bible (14%), using social media (13%), writing in a journal (9%), shopping (9%), breaking something (7%), talk to a counselor or teacher (5%), self-harm (4%), using prescribed medication (4%), talking to a medical professional (3%), smoking/using tobacco (3%), drinking alcohol (3%), vandalism/violent behavior (2%), harm someone else (1%), using illegal drugs (1%), using un-prescribed medication (1%), and gambling (1%).

## Priority #3 | Improve Youth Mental Health

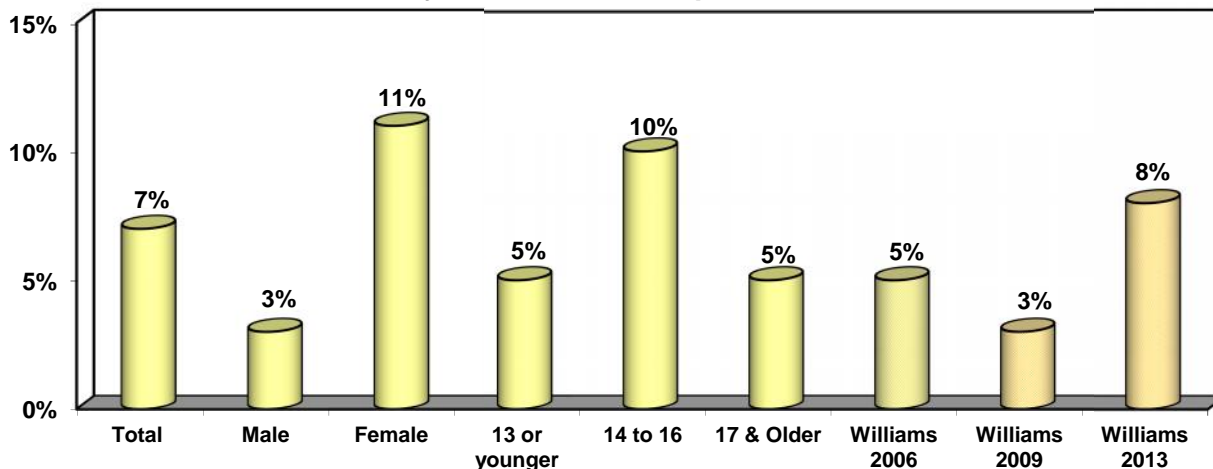
### Mental Health Indicators, *continued*

Youth Comparisons	Williams County 2006 (6 <sup>th</sup> -12 <sup>th</sup> )	Williams County 2009 (6 <sup>th</sup> -12 <sup>th</sup> )	Williams County 2013 (6 <sup>th</sup> -12 <sup>th</sup> )	Williams County 2016 (6 <sup>th</sup> -12 <sup>th</sup> )	Williams County 2016 (9 <sup>th</sup> -12 <sup>th</sup> )	Ohio 2013 (9 <sup>th</sup> -12 <sup>th</sup> )	U.S. 2013 (9 <sup>th</sup> -12 <sup>th</sup> )
Youth who had seriously considered attempting suicide in the past year	10%	7%	15%	10%	10%	14%	17%
Youth who had attempted suicide in the past year	5%	3%	8%	7%	8%	6%	8%
Suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (of all youth)	2%	1%	3%	2%	2%	1%	3%
Youth who felt sad or hopeless almost every day for 2 or more weeks in a row	16%	16%	22%	22%	26%	26%	30%

**Williams County Youth Who Had Seriously Considered Attempting Suicide in the Past 12 Months**

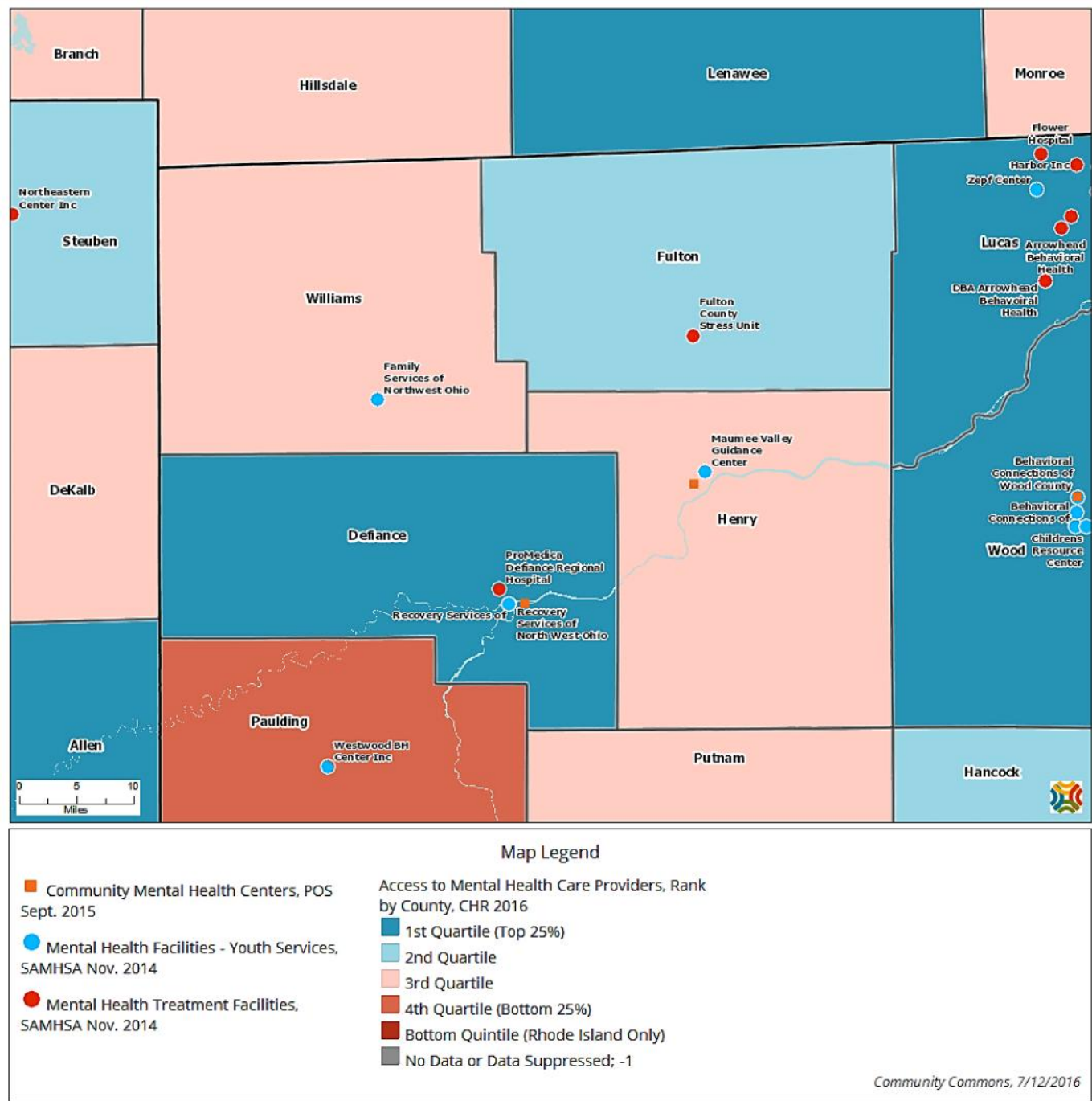


**Williams County Youth Who Attempted Suicide in Past 12 Months**



# Priority #3 | Improve Youth Mental Health

Access to Mental Health Care Providers, Rank by County, CHR 2016



(Source: Community Commons 7/12/16)



## Priority #3 | Improve Youth Mental Health

### Resource Assessment

Program/Strategy /Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
<b>Evidence-based Practices</b>					
Home-based Services (Referrals from JFS)	Center for Child & Family Advocacy	<ul style="list-style-type: none"> <li>(419)-592-0540</li> </ul>	Families	Treatment	Evidence based
Mental Health Counseling	Four County Family Center	<ul style="list-style-type: none"> <li><a href="http://www.fsno.org/fourcounty.aspx">http://www.fsno.org/fourcounty.aspx</a></li> <li>(419)-335-3732</li> <li>7320 Ohio 108, Wauseon, OH 43567</li> </ul>	Detained juveniles at JDC	Treatment	Evidence based
Signs of Suicide (SOS)	Four County Family Center, NWO Juvenile Detention, Training, and Rehabilitation Center (JDC)	<p>Four County Family Center:</p> <ul style="list-style-type: none"> <li><a href="http://www.fsno.org/fourcounty.aspx">http://www.fsno.org/fourcounty.aspx</a></li> <li>(419)-335-3732</li> <li>7320 Ohio 108, Wauseon, OH 43567</li> </ul> <p>JDC:</p> <ul style="list-style-type: none"> <li><a href="http://www.nwojdc.com/">http://www.nwojdc.com/</a></li> <li>(419)-428-2322</li> <li>03389 CR 24.25 Stryker, Ohio 43557</li> </ul>	Available to all school districts Hilltop, Montpelier, Stryker and North Central	Prevention	Evidence based
Home-based Therapy	Four County Family Center	<ul style="list-style-type: none"> <li><a href="http://www.fsno.org/fourcounty.aspx">http://www.fsno.org/fourcounty.aspx</a></li> <li>(419)-335-3732</li> <li>7320 Ohio 108, Wauseon, OH 43567</li> </ul>	5 – 18 Year Olds	Treatment	Evidence based
Mental Health First Aid	Four County	<ul style="list-style-type: none"> <li><a href="http://fourcountyadamhs.com/">http://fourcountyadamhs.com/</a></li> <li>(419)-267-3355</li> <li>T-761 SR 66, Archbold, Ohio 43502</li> </ul>	Adults and Youth	Prevention	Evidence based
L.O.S.S (Local Outreach to Survivors of Suicide)	ADAHMs Board	<ul style="list-style-type: none"> <li><a href="http://fourcountyadamhs.com/">http://fourcountyadamhs.com/</a></li> <li>(419)-267-3355</li> <li>T-761 SR 66, Archbold, Ohio 43502</li> </ul>	New Survivors of Suicide	Prevention/prevention	Evidence based
Post-partum depression screenings	William's County Health Department-WIC	<ul style="list-style-type: none"> <li>(419)-485-3141</li> <li>310 Lincoln Ave., P.O. Box 146 Montpelier, Ohio 43543</li> </ul>	Women	Prevention, early intervention	Best practice

## Priority #3 | Improve Youth Mental Health

### Resource Assessment, *continued*

Program/Strategy /Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
<b>Best Practices</b>					
Incredible Years (Pre-K-1 <sup>st</sup> grade child social skills training for conduct problems and drug abuse)	Four County Family Center	<ul style="list-style-type: none"> <li><a href="http://www.fsno.org/fourcounty.aspx">http://www.fsno.org/fourcounty.aspx</a></li> <li>(419)-335-3732</li> <li>7320 Ohio 108, Wauseon, OH 43567</li> </ul>	<p>Offered to all schools. In 2005-2016 school year:</p> <p>Bryan- Kindergarten and First and Third-Safe and Caring</p> <p>Edgerton-PreK, Kindergarten, and 3<sup>rd</sup> Safe and Caring</p> <p>Montpelier- Kindergarten and First and 4<sup>th</sup> -Safe and Caring</p> <p>North Central- Kindergarten and First and 3<sup>rd</sup> and 4<sup>th</sup> Safe and Caring</p> <p>Stryker- Kindergarten and 3<sup>rd</sup> and 4<sup>th</sup> Safe and Caring</p> <p>West Unity- PreK and Kindergarten</p>	Prevention	Best practice
Outpatient counseling services at hospital	Hospital (Community Hospitals and Wellness Centers)	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>(419)-636-1131</li> <li>433 W. High St, Bryan, OH 43506</li> </ul>	All ages	Treatment	Best practice
School Therapist	CHWC	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/">https://www.chwchospital.org/</a></li> <li>(419)-636-1131</li> <li>433 W. High St, Bryan, OH 43506</li> </ul>	Will start services to two schools in fall – Montpelier and Edon	Treatment	Best practice

## Priority #3 | Improve Youth Mental Health

### Resource Assessment, *continued*

Program/Strategy /Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Out-patient Therapy (Counseling Services)	Mental Health Agencies & Hospitals: Four County Family Center, Recovery Services of Northwest Ohio, Maumee Valley Guidance Center, A Renewed Mind	<p>Four County Family Center:</p> <ul style="list-style-type: none"> <li><a href="http://www.fsno.org/forcounty.aspx">http://www.fsno.org/forcounty.aspx</a></li> <li>(419)-335-3732</li> <li>7320 Ohio 108, Wauseon, OH 43567</li> </ul> <p>Recovery Services of NWO:</p> <ul style="list-style-type: none"> <li><a href="http://www.rsnwo.org/">http://www.rsnwo.org/</a></li> <li>(419) 782-9920</li> <li>511 Perry St, Defiance, OH 43512</li> </ul> <p>Maumee Valley Guidance Center:</p> <ul style="list-style-type: none"> <li><a href="http://www.maumeevalleyguidancecenter.org/">http://www.maumeevalleyguidancecenter.org/</a></li> <li>(419)-636-2932</li> <li>203 N Lynn St, Bryan, OH 43506</li> </ul> <p>A Renewed Mind:</p> <ul style="list-style-type: none"> <li><a href="http://www.arenewedmindservices.org/">http://www.arenewedmindservices.org/</a></li> <li>(419)-924-5371</li> <li>109 West Main Street, Alvordton, OH 43501</li> </ul>	Serves in 4 county area	Treatment	Best practice
Mental health/substance use screening when juveniles become court involved	NWO Juvenile Detention, Training, and Rehabilitation Center	<ul style="list-style-type: none"> <li><a href="http://www.nwojdc.com/">http://www.nwojdc.com/</a></li> <li>(419)-428-2322</li> <li>03389 CR 24.25 Stryker, Ohio 43557</li> </ul>	Court involved juveniles	Early intervention	Best practice
No Evidenced Indicated					
Four County Suicide Prevention Coalition	Four County Family Center	<ul style="list-style-type: none"> <li><a href="http://www.fsno.org/forcounty.aspx">http://www.fsno.org/forcounty.aspx</a></li> <li>(419)-335-3732</li> <li>7320 Ohio 108, Wauseon, OH 43567</li> </ul>	All ages; 4 county population	Prevention/early intervention	None
Suicide Prevention Awareness	Four County Family Center	<ul style="list-style-type: none"> <li><a href="http://www.fsno.org/forcounty.aspx">http://www.fsno.org/forcounty.aspx</a></li> <li>(419)-335-3732</li> <li>7320 Ohio 108, Wauseon, OH 43567</li> </ul>	Offered to all school districts.	Prevention	None

## Priority #3 | Improve Youth Mental Health

### Resource Assessment, *continued*

Program/Strategy /Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Act Out	Four County Suicide Prevention	<ul style="list-style-type: none"> <li><a href="http://4countysuicideprevention.org/">http://4countysuicideprevention.org/</a></li> </ul>	Available to all school districts 8 <sup>th</sup> grade students In 2015, were in Montpelier, Bryan, North Central, Edon, Edgerton, Hilltop, Stryker, St. Patrick	Prevention	None
Case Management	Four County Recovery, Maumee Valley Guidance Center, A Renewed Mind	<p>Four County Recovery:</p> <ul style="list-style-type: none"> <li><a href="http://fourcountyadams.com/">http://fourcountyadams.com/</a></li> <li>(419)-267-3355</li> <li>T-761 SR 66, Archbold, Ohio 43502</li> </ul> <p>Maumee Valley Guidance Center:</p> <ul style="list-style-type: none"> <li><a href="http://www.maumeevalleyguidancecenter.org/">http://www.maumeevalleyguidancecenter.org/</a></li> <li>(419)-636-2932</li> <li>203 N Lynn St, Bryan, OH 43506</li> </ul> <p>A Renewed Mind:</p> <ul style="list-style-type: none"> <li><a href="http://www.arenewedmindservices.org/">http://www.arenewedmindservices.org/</a></li> <li>(419)-924-5371</li> <li>109 West Main Street, Alvordton, OH 43501</li> </ul>	All ages	Treatment	None
Crisis Stabilization Unit	Comprehensive Crisis Care	<ul style="list-style-type: none"> <li><a href="http://www.fsno.org/comprehensivecrisiscare.aspx">http://www.fsno.org/comprehensivecrisiscare.aspx</a></li> </ul>	Ages 8-17	Prevention, early intervention, treatment	None
Integrated Care Project (Mental Health Services and Primary Care at the same place)	Bryan Community Health Center	<ul style="list-style-type: none"> <li><a href="http://recovery.hpwohi.org/">http://recovery.hpwohi.org/</a></li> <li>(567)-239-4562</li> <li>228 South Main Street Bryan, Ohio 43506</li> </ul>	Those living in the four county area	Prevention, early intervention, treatment	None
Survivors After Suicide Support Group	ADAMHs Board	<ul style="list-style-type: none"> <li><a href="http://fourcountyadams.com/">http://fourcountyadams.com/</a></li> <li>(419)-267-3355</li> <li>T-761 SR 66, Archbold, Ohio 43502</li> </ul>	Survivors of Suicide	Prevention/postvention	None

## Priority #3 | Improve Youth Mental Health

### Resource Assessment, *continued*

Program/Strategy /Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
211/Hotline	Comprehensive Crisis Care	<ul style="list-style-type: none"> <li><a href="http://www.fsno.org/comprehensivecrisiscare.aspx">http://www.fsno.org/comprehensivecrisiscare.aspx</a></li> </ul>	Anyone	Prevention	None
Mental Health Services	Four County Recovery Services for Juveniles, Recovery Services for Adults	<p>Four County Recovery Services:</p> <ul style="list-style-type: none"> <li><a href="http://fourcountyadamhs.com/">http://fourcountyadamhs.com/</a></li> <li>(419)-267-3355</li> <li>T-761 SR 66, Archbold, Ohio 43502</li> </ul> <p>Recovery Services of NWO:</p> <p>Recovery Services of NWO:</p> <ul style="list-style-type: none"> <li><a href="http://www.rsnwo.org/">http://www.rsnwo.org/</a></li> <li>(419)-782-9920</li> <li>511 Perry St, Defiance, OH 43512</li> </ul>	Incarcerated at CCNO	Treatment	None
School based mental health	Job & Family Services	<ul style="list-style-type: none"> <li>(419)-636-6725</li> <li>117 W. Butler Street Bryan OH 43506</li> </ul>	Montpelier	Treatment	None
PCP office education/awareness on patient navigation	ADAMHS Board	<ul style="list-style-type: none"> <li><a href="http://fourcountyadamhs.com/">http://fourcountyadamhs.com/</a></li> <li>(419)-267-3355</li> <li>T-761 SR 66, Archbold, Ohio 43502</li> </ul>	PCP offices	Prevention	None
Employee assistance programs – Children of Parkview employees may receive services	Parkview	<ul style="list-style-type: none"> <li>(877)-774-8649</li> <li>442 W High St, Bryan, OH 43506</li> </ul>	Employees	Treatment	None
Suicide Prevention Hotline (Teen Hotline/Texting)	Comprehensive Crisis Care	<ul style="list-style-type: none"> <li>1-877-419-SAFE (7233)</li> </ul>	Teens	Early Intervention	None
Mental Health Care Coordination	Safe Schools Healthy Students	<ul style="list-style-type: none"> <li><a href="http://www.samhsa.gov/safe-schools-healthy-students">http://www.samhsa.gov/safe-schools-healthy-students</a></li> </ul>	Students attending the following school districts: <ul style="list-style-type: none"> <li>Bryan</li> <li>Edon</li> <li>Montpelier</li> <li>North Central</li> <li>Stryker</li> <li>West Unity</li> </ul>	Prevention	None

## Priority #3 | Improve Youth Mental Health

### Gaps and Potential Strategies

Gaps	Potential Strategies
1. Lack of faith	<ul style="list-style-type: none"> <li>Explore opportunities for faith-based counseling programs</li> </ul>
2. Lack of parental involvement	<ul style="list-style-type: none"> <li>No strategies identified</li> </ul>
3. Lack of coordination	<ul style="list-style-type: none"> <li>Increase communication between professionals: Semi-annual in-service for mental health professionals</li> </ul>
4. Lack of communication skills	<ul style="list-style-type: none"> <li>No strategies identified</li> </ul>
6. Bullying	<ul style="list-style-type: none"> <li>Additional education/in-services for school faculty to better identify instances of bullying (physical/verbal/cyber) and to more readily ascertain those students who are victims</li> <li>Increased anti-bullying education to youth geared towards both instigators and victims</li> <li>Possible collaboration with Sheriff's Department and schools</li> </ul>
7. Generational gap/lack of understanding	<ul style="list-style-type: none"> <li>Encourage youth to communicate with parents/adults</li> <li>Focus groups with youth to increase understanding</li> </ul>
8. Lack of identifying mental health issues	<ul style="list-style-type: none"> <li>Integrate a mental health screening tool into Kindergarten registration</li> <li>Work with schools to determine their needs concerning screening and implement a screening tool</li> <li>Increase screenings by physicians and primary care providers</li> <li>Use college students for assessment and research</li> </ul>

## Priority #3 | Improve Youth Mental Health

### Best Practices

1. **SOS Signs of Suicide®:** The Signs of Suicide Prevention Program is an award-winning, nationally recognized program designed for middle and high school-age students. The program teaches students how to identify the symptoms of depression and suicidality in themselves or their friends, and encourages help-seeking through the use of the ACT® technique (Acknowledge, Care, Tell).

The SOS High School program is the only school-based suicide prevention program listed on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices that addresses suicide risk and depression, while reducing suicide attempts. In a randomized control study, the SOS program showed a reduction in self-reported suicide attempts by 40% (BMC Public Health, July 2007).

For more information go to:

<http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/>

2. **The Incredible Years®:** The Incredible Years programs for parents and teachers reduce challenging behaviors in children and increase their social and self-control skills. The Incredible Years programs have been evaluated by the developer and independent investigators. Evaluations have included randomized control group research studies with diverse groups of parents and teachers. The programs have been found to be effective in strengthening teacher and parent management skills, improving children's social competence and reducing behavior problems. Evidence shows that the program have turned around the behaviors of up to 80 percent of the children of participating parents and teachers. If left unchecked these behaviors would mean those children are at greater risk in adulthood of unemployment, mental health problems, substance abuse, early pregnancy/early fatherhood, criminal offending, multiple arrests and imprisonment, higher rates of domestic violence and shortened life expectancy. Incredible Years training programs give parents and teachers strategies to manage behaviors such as aggressiveness, ongoing tantrums, and acting out behavior such as swearing, whining, yelling, hitting and kicking, answering back, and refusing to follow rules. Through using a range of strategies, parents and teachers help children regulate their emotions and improve their social skills so that they can get along better with peers and adults, and do better academically. It can also mean a more enjoyable family life.

For more information go to: <http://www.incredibleyears.com>

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

There are two components of the PHQ-9:

- Assessing symptoms and functional impairment to make a tentative depression diagnosis, and
  - Deriving a severity score to help select and monitor treatment
- The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV).

For more information go to:

<http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/>



## Priority #3 | Improve Youth Mental Health

### Best Practice, *continued*

4. **Strengthening Families™:** Strengthening Families™ is a research-informed approach to increase family strengths, enhance child development and reduce the likelihood of child abuse and neglect. It is based on engaging families, programs and communities in building five protective factors:
- Parental resilience
  - Social connections
  - Knowledge of parenting and child development
  - Concrete support in times of need
  - Social and emotional competence of children

Strengthening Families implementation takes place at multiple levels – in programs, in larger agencies, in systems, in states and communities and at the national level. Learn more about what that implementation looks like and about the core functions of implementation that run across all of those levels.

At any level of implementation, attention must be paid to five core functions: building an infrastructure to advance and sustain the work; building parent partnerships; deepening knowledge and understanding of a protective factors approach; shifting practice, policy and systems to a protective factors approach; and ensuring accountability

For more Information go to: <http://www.cssp.org/reform/strengtheningfamilies/about>

5. **QPR:** QPR stands for Question, Persuade, and Refer — the 3 simple steps anyone can learn to help save a life from suicide. Just as people trained in CPR and the Heimlich maneuver help save thousands of lives each year, people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. QPR can be learned in the Gatekeeper course in as little as one hour. According to the Surgeon General's National Strategy for Suicide Prevention (2001), a gatekeeper is someone in a position to recognize a crisis and the warning signs that someone may be contemplating suicide. Gatekeepers can be anyone, but include parents, friends, neighbors, teachers, ministers, doctors, nurses, office supervisors, squad leaders, foremen, police officers, advisors, caseworkers, firefighters, and many others who are strategically positioned to recognize and refer someone at risk of suicide.

For more information go to: <https://www.qprinstitute.com/about-qpr>

## Priority #3 | Improve Youth Mental Health

### Alignment with National Standards

The Williams County CHIP will help support the following **Healthy People 2020** Goals:

- **Mental Health and Mental Disorders (MHMD)-1** Reduce the suicide rate
- **Mental Health and Mental Disorders (MHMD)-2** Reduce suicide attempts by adolescents
- **Mental Health and Mental Disorders (MHMD)-3** Reduce the proportion of adolescents who engage in disordered eating behaviors in an attempt to control their weight
- **Mental Health and Mental Disorders (MHMD)-4** Reduce the proportion of persons who experience major depressive episodes (MDEs)
- **Mental Health and Mental Disorders (MHMD)-5** Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral
- **Mental Health and Mental Disorders (MHMD)-6** Increase the proportion of children with mental health problems who receive treatment
- **Mental Health and Mental Disorders (MHMD)-7** Increase the proportion of juvenile residential facilities that screen admissions for mental health problems
- **Mental Health and Mental Disorders (MHMD)-8** Increase the proportion of persons with serious mental illness (SMI) who are employed
- **Mental Health and Mental Disorders (MHMD)-9** Increase the proportion of adults with mental health disorders who receive treatment
- **Mental Health and Mental Disorders (MHMD)-10** Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders
- **Mental Health and Mental Disorders (MHMD)-11** Increase depression screening by primary care providers
- **Mental Health and Mental Disorders (MHMD)-12** Increase the proportion of homeless adults with mental health problems who receive mental health services

## Priority #3 | Improve Youth Mental Health

### Action Step Recommendations & Action Plan

To work toward **improving youth mental health**, the following actions steps are recommended:

1. Increase awareness of trauma informed care
2. Increase the number primary care physicians screening for depression during office visits
3. Expand evidence-based programs targeting youth
4. Provide mental health first aid training
5. Implement evidence-based programs and counseling services targeting youth
6. Increase evidence-based services through providers

### Action Plan

Improve Youth Mental Health		
Action Step	Responsible Person/ Agency	Timeline
<b>Increase Awareness of Trauma Informed Care</b>		
<b>Year 1:</b> Facilitate an assessment among clinicians, teachers and community members in Williams County on their awareness and understanding of trauma informed care, including toxic stress and adverse childhood experiences.  Facilitate a training to increase education and understanding of trauma informed care.	<b>Ron Rittichier</b> Safe Schools/Healthy Students	December 31, 2017
<b>Year 2:</b> Continue efforts from Year 1. Develop and implement a trauma screening tool for social service agencies who work with at risk youth.		December 31, 2018
<b>Year 3:</b> Continue efforts of years 1 and 2  Increase the use of trauma screening tools by 25%.		December 31, 2019
<b>Increase the Number Primary Care Physicians Screening for Depression During Office Visits</b>		
<b>Year 1:</b> Collect baseline data on the number of primary care physicians that currently screen for depression during office visits.	<b>Les McCaslin</b> Four County Alcohol, Drug and Mental Health Board	December 31, 2017
<b>Year 2:</b> Introduce PQH2 and PQH9 to physicians' offices and hospital administration.  Pilot the protocol with one primary care physicians' office.		December 31, 2018
<b>Year 3:</b> Increase the number of primary care physicians using the PQH2 screening tool by 25% from baseline.		December 31, 2019
<b>Expand Evidence-based Programs Targeting Youth</b>		
<b>Year 1:</b> Continue implementing the SOS (Signs of Suicide) program. Implement the SOS program in at least one additional middle school.	<b>Les McCaslin</b> Four County Alcohol, Drug and Mental Health Board	December 31, 2017
<b>Year 2:</b> Implement the middle school SOS program in at least 1-2 additional school districts		December 31, 2018
<b>Year 3:</b> Implement the middle school SOS program in all school districts in Williams County.		December 31, 2019

## Priority #3 | Improve Youth Mental Health

### Action Step Recommendations & Action Plan, *continued*

Improve Youth Mental Health		
Action Step	Responsible Person/ Agency	Timeline
<b>Provide Mental Health First Aid Training</b>		
<b>Year 1:</b> Obtain baseline data on the number of trainings that have taken place.  Market the training to Williams County area churches, schools, Rotary Clubs, Law Enforcement, Chamber of Commerce, City Councils, college students majoring in social work/mental health, etc.  Provide at least 2 trainings.	<b>Ron Rittichier</b> Safe Schools/Healthy Students	December 31, 2017
<b>Year 2:</b> Provide 5 additional trainings and continue marketing efforts.		December 31, 2018
<b>Year 3:</b> Continue efforts from year 2. Provide 8 additional trainings and continue marketing efforts.		December 31, 2019
<b>Expand Evidence-based Programs and Counseling Services Targeting Youth</b>		
<b>Year 1:</b> Introduce at least one of the following programs or counseling services to schools: <ul style="list-style-type: none"> <li>• School-based mental health therapy</li> <li>• Second Step</li> <li>• PAX</li> <li>• Youth-led programming</li> <li>• Care coordination</li> <li>• Screening, Brief Intervention, and Referral to Treatment (SBIRT)</li> </ul> Discuss program/service needs and gaps with school personnel at all schools within the county.  Work with school administrators, guidance counselors, and other community organizations to raise awareness of the programs and/or services.  Implement the program or service in at least 1-2 schools.	<b>Ron Rittichier</b> Safe Schools/Healthy Students  <b>Phil Ennen</b> Community Hospitals and Wellness Centers	December 31, 2017
<b>Year 2:</b> Increase awareness and participation of the selected programs. Increase the number of programs/services offered in each school.  Double the number schools providing evidence based programming for youth and/or in school counseling services for youth.		December 31, 2018
<b>Year 3:</b> Continue efforts of years 1 and 2.		December 31, 2019

## Priority #3 | Improve Youth Mental Health

### Action Step Recommendations & Action Plan, *continued*

Improve Youth Mental Health		
Action Step	Responsible Person/ Agency	Timeline
<b>Increase Evidence-Based Services Through Providers</b>		
<b>Year 1:</b> Collect baseline data on all existing evidence-based services offered through mental health providers. Evaluate the services and determine gaps in delivery. Research additional evidence-based programs/models that demonstrate potential to fill gaps in services.	<b>Les McCaslin</b> Four County Alcohol, Drug and Mental Health Board  <b>Jerry Stollings</b> Juvenile Court Administration	December 31, 2017
<b>Year 2:</b> Based on current services being offered, work with at least 1-2 local mental health providers in determining the effectiveness of programs/services being offered and potential gaps in services. Create a plan to make services more evidence-based.		December 31, 2018
<b>Year 3:</b> Continue efforts from year 2.		December 31, 2019

## Priority #4 | Decrease Youth Substance Abuse

### Substance Abuse Indicators

*In 2016, the Health Assessment results indicated that 35% of Williams County youth had drank at least one drink of alcohol in their life, increasing to 51% of youth 17 and older. 34% of those who drank, took their first drink at 12 years or younger. 16% of all Williams County youth and 25% of those over the age of 17 had at least one drink in the past 30 days. 10% of all youth had ridden in a car driven by someone who had been drinking alcohol.*

#### Youth Alcohol Consumption

In 2016, the Health Assessment results indicated that over one-third (35%) of all Williams County youth (ages 12 to 18) had at least one drink of alcohol in their life, increasing to 51% of those ages 17 and older (2013 YRBS reports 66% for the U.S.).

16% of youth had at least one drink in the past 30 days, increasing to 25% of those ages 17 and older (2013 YRBS reports 30% for Ohio and 35% for the U.S.).

Based on all youth surveyed, 7% were defined as binge drinkers, increasing to 14% of those ages 17 and older (2013 YRBS reports 16% for Ohio and 21% for the U.S.).

Of those who drank, 43% had five or more alcoholic drinks on an occasion in the last month and would be considered binge drinkers by definition, increasing to 48% of females.

Over one-third (34%) of Williams County youth who reported drinking at some time in their life had their first drink at 12 years old or younger; 35% took their first drink between the ages of 13 and 14, and 31% started drinking between the ages of 15 and 18. The average age of onset was 12.8 years old.

Of all Williams County youth, 11% had drunk alcohol for the first time before the age of 13 (2013 YRBS reports 13% of Ohio youth drank alcohol for the first time before the age of 13 and 19% for the U.S.).

Youth drinkers reported they drank alcohol in the following places; at home (13%), at a friend's home (10%), at another person's home (5%), while riding in or driving a car or other vehicle (1%), at a public place such as a park, beach or parking lot (1%), at a public event (1%), at a restaurant, bar or club, at a public place (<1%), and on school property (<1%).

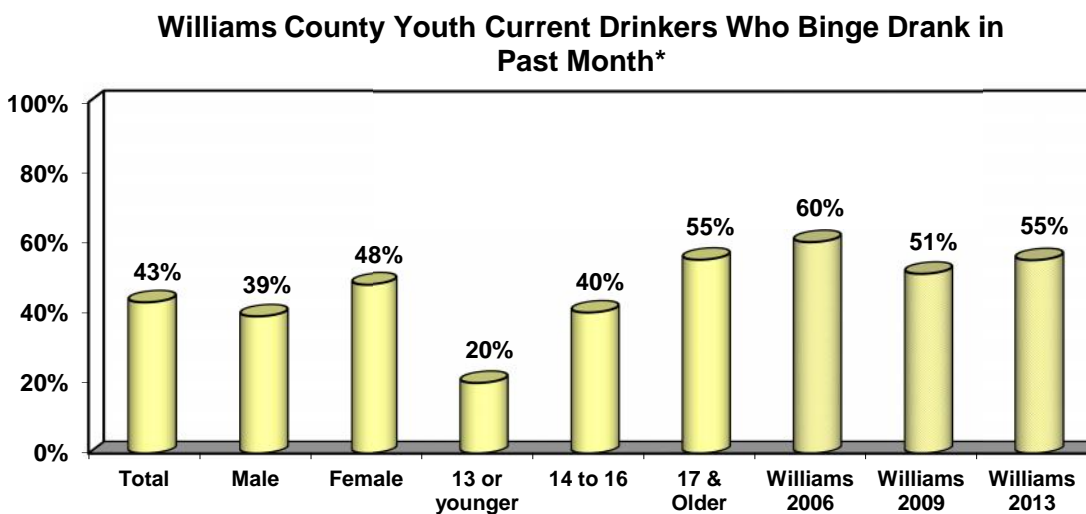
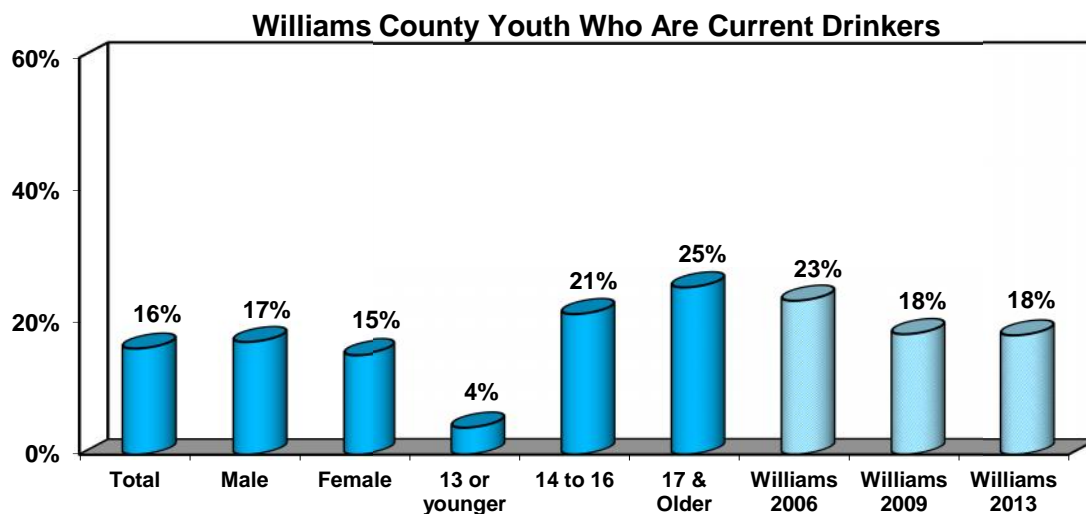
Williams County youth drinkers reported they got their alcohol from the following: a parent gave it to them (35%), someone gave it to them (26%) (2013 YRBS reports 38% for Ohio and 42% for the U.S.), an older friend or sibling bought it for them (23%), someone older bought it (20%), a friend's parent gave it to them (8%), gave someone else money to buy it for them (8%), took it from a store or family member (6%), bought it in a liquor store/ convenience store/gas station (2%), used a fake ID to buy alcohol (2%). No one reported buying alcohol at a restaurant, bar or club, or public event such as a concert or sporting event.

During the past month 10% of all Williams County youth had ridden in a car driven by someone who had been drinking alcohol (2013 YRBS reports 17% for Ohio and 22% for the U.S.).

## Priority #4 | Decrease Youth Substance Abuse

### Substance Abuse Indicators, *continued*

Youth Comparisons	Williams County 2006 (6 <sup>th</sup> -12 <sup>th</sup> )	Williams County 2009 (6 <sup>th</sup> -12 <sup>th</sup> )	Williams County 2013 (6 <sup>th</sup> -12 <sup>th</sup> )	Williams County 2016 (6 <sup>th</sup> -12 <sup>th</sup> )	Williams County 2016 (9 <sup>th</sup> -12 <sup>th</sup> )	Ohio 2013 (9 <sup>th</sup> -12 <sup>th</sup> )	U.S. 2013 (9 <sup>th</sup> -12 <sup>th</sup> )
Ever tried alcohol	54%	49%	50%	35%	48%	71%*	66%
Current drinker	23%	18%	18%	16%	25%	30%	35%
Binge drinker (of all youth)	14%	9%	10%	7%	12%	16%	21%
Drank for the first time before age 13 (of all youth)	23%	20%	16%	11%	11%	13%	19%
Rode with someone who was drinking	16%	15%	12%	10%	9%	17%	22%
Obtained the alcohol they drank by someone giving it to them	N/A	61%	57%	26%	28%	38%	42%

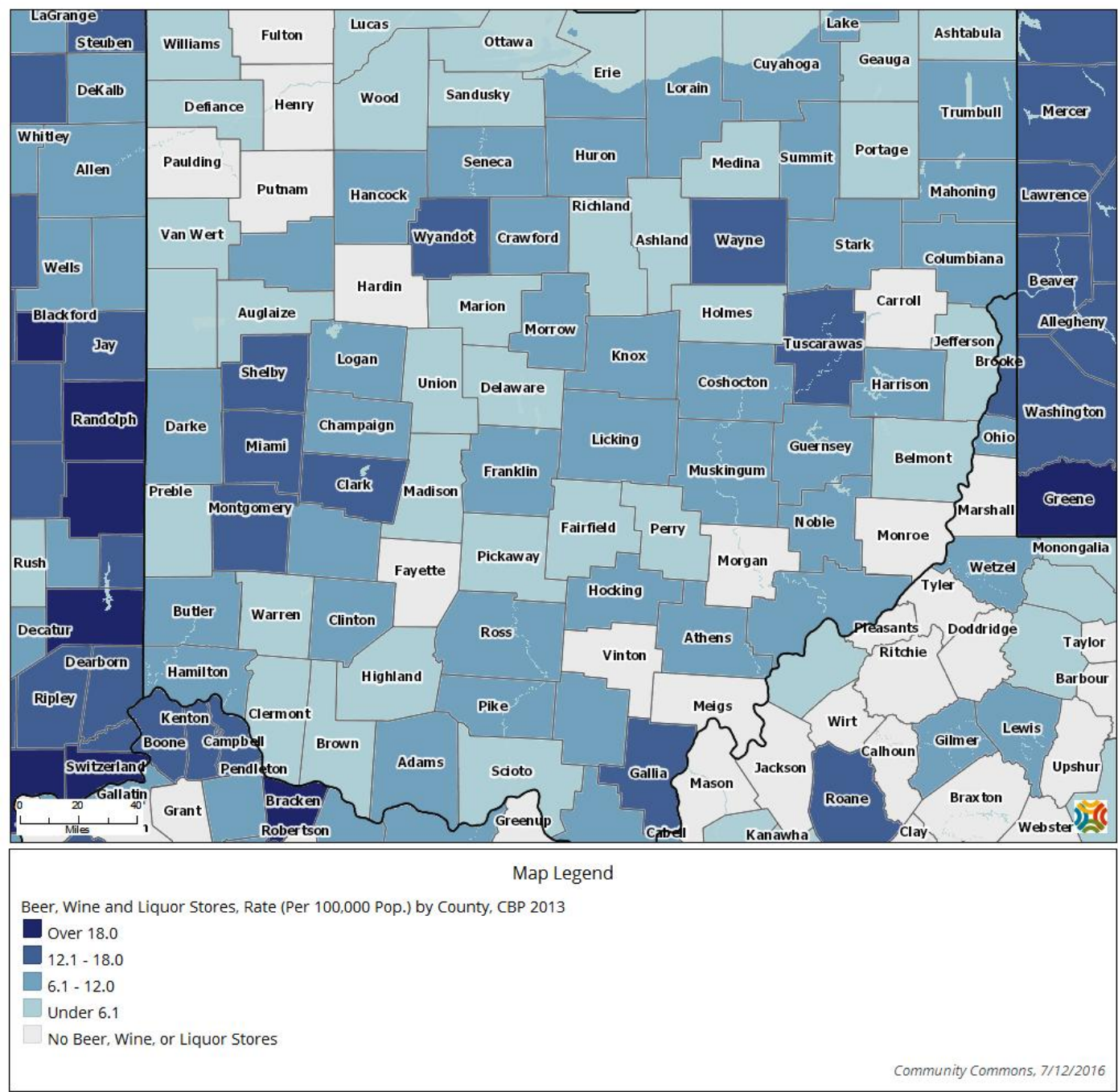


\*Based on all current drinkers. Binge drinking is defined as having five or more drinks on an occasion.



# Priority #4 | Decrease Youth Substance Abuse

Beer, Wine and Liquor Store, Rate (Per 100,000 Pop.) by County, CBP 2013



(Source: Community Commons 7/12/16)

## Priority #4 | Decrease Youth Substance Abuse

### Resource Assessment

Program/Strategy /Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
<b>Evidence-based Practices</b>					
FAST (Family & Schools Together)	Four County Family Center	<ul style="list-style-type: none"> <li><a href="http://www.fsno.org/fourcounty.aspx">http://www.fsno.org/fourcounty.aspx</a></li> <li>(419)-335-3732</li> <li>7320 Ohio 108, Wauseon, OH 43567</li> </ul>	Available to all school districts and Fairview Middle School	Prevention	Evidence based
Medication Assisted Treatment	Bryan Community Health Center	<ul style="list-style-type: none"> <li><a href="http://recovery.hpwohio.org/">http://recovery.hpwohio.org/</a></li> <li>(567)-239-4562</li> <li>228 South Main Street Bryan, Ohio 43506</li> </ul>	Primarily opiates; 18+	Treatment	Evidence based
Too Good for Drugs	Recovery Services of Northwest Ohio	<ul style="list-style-type: none"> <li><a href="http://www.rsnwo.org/">http://www.rsnwo.org/</a></li> <li>(419)-782-9920</li> <li>511 Perry St, Defiance, OH 43512</li> </ul>	Offered to all school districts  Currently in <ul style="list-style-type: none"> <li>Bryan: 4th, 7th, 8th</li> <li>Montpelier: 3rd, 4th, 5th, 6th, 7th, 8th</li> <li>North Central: K, 1st, 2nd, 7th, HS</li> </ul>	Prevention	Evidence based
Adolescent Education	Recovery Services of Northwest Ohio	<ul style="list-style-type: none"> <li><a href="http://www.rsnwo.org/">http://www.rsnwo.org/</a></li> <li>(419)-782-9920</li> <li>511 Perry St, Defiance, OH 43512</li> </ul>	8 hour program for adolescents who have been referred due to drugs/alcohol  Referrals from courts schools and counselors	Early intervention	Evidence based
Alcoholics Anonymous (12-Step)	Alcoholics Anonymous National Program	<ul style="list-style-type: none"> <li><a href="http://www.rsnwo.org/links/">http://www.rsnwo.org/links/</a></li> </ul>	All ages	Treatment	Evidence based

## Priority #4 | Decrease Youth Substance Abuse

### Resource Assessment, continued

Program/Strategy/Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Serenity Haven Services (Women's Resident Treatment Prevention)	Recovery Services of Northwest Ohio	<ul style="list-style-type: none"> <li><a href="http://www.rsnwo.org/">http://www.rsnwo.org/</a></li> <li>(419)-782-9920</li> <li>511 Perry St, Defiance, OH 43512</li> </ul>	Women with Substance Abuse Issues	Treatment	Evidence based
Fresh Start	A Renewed Mind	<ul style="list-style-type: none"> <li><a href="http://www.arenewedmindservices.org/">http://www.arenewedmindservices.org/</a></li> <li>(419)-924-5371</li> <li>109 West Main Street, Alvordton, OH 43501</li> </ul>	Men with Substance Abuse Issues	Treatment	Evidence based
Medication – Assisted Treatment Program	Recovery Services of Northwest Ohio, Bryan Community Health Center, A Renewed Mind	<p>Recovery Services of NWO:</p> <ul style="list-style-type: none"> <li><a href="http://www.rsnwo.org/">http://www.rsnwo.org/</a></li> <li>(419)-782-9920</li> <li>511 Perry St, Defiance, OH 43512</li> </ul> <p>Bryan Community Health Center:</p> <ul style="list-style-type: none"> <li><a href="http://recovery.hpwohi.org/">http://recovery.hpwohi.org/</a></li> <li>(567)-239-4562</li> <li>228 South Main Street Bryan, Ohio 43506</li> </ul> <p>A Renewed Mind:</p> <ul style="list-style-type: none"> <li><a href="http://www.arenewedmindservices.org/">http://www.arenewedmindservices.org/</a></li> <li>(419)-924-5371</li> <li>109 West Main Street, Alvordton, OH 43501</li> </ul>	Adult opiate users	Treatment	Evidence based
<b>Best Practices</b>					
Life Without Drugs (Alcohol/Drug Treatment & 90-Day Program) Individual, group and family counseling	Recovery Services of Northwest Ohio	<ul style="list-style-type: none"> <li><a href="http://www.rsnwo.org/">http://www.rsnwo.org/</a></li> <li>(419)-782-9920</li> <li>511 Perry St, Defiance, OH 43512</li> </ul>	12-18 years old Programming at Juvenile Detention Center	Treatment	Best practice
DARE (Drug Abuse Resistance Education)	Sheriff's Department	<ul style="list-style-type: none"> <li><a href="http://williamscosheriff.com/">http://williamscosheriff.com/</a></li> <li>(419)-636-3151</li> <li>1425 E. High St, Bryan, OH 43506</li> </ul>	Middle School Students	Prevention	Best practice

## Priority #4 | Decrease Youth Substance Abuse

### Resource Assessment, continued

Program/Strategy/ Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Out-patient Therapy (Counseling services)	Recovery Services of Northwest Ohio, Maumee Valley Guidance Center, A Renewed Mind	Recovery Services of NWO: <ul style="list-style-type: none"> <li>• <a href="http://www.rsnwo.org/">http://www.rsnwo.org/</a></li> <li>• (419)-782-9920</li> <li>• 511 Perry St, Defiance, OH 43512</li> </ul> Maumee Valley Guidance Center: <ul style="list-style-type: none"> <li>• <a href="http://www.maumeevalleyguidancecenter.org/">http://www.maumeevalleyguidancecenter.org/</a></li> <li>• (419)-636-2932</li> <li>• 203 N Lynn St, Bryan, OH 43506</li> </ul> A Renewed Mind: <ul style="list-style-type: none"> <li>• <a href="http://www.arenewedmindservices.org/">http://www.arenewedmindservices.org/</a></li> <li>• (419)-924-5371</li> <li>• 109 West Main Street, Alvordton, OH 43501</li> </ul>	Serves in 4 county area	Treatment	Best practice
Alcohol and Other Drug (AoD) Continuum of Care Program	Recovery Services of Northwest Ohio, A Renewed Mind	Recovery Services of NWO: <ul style="list-style-type: none"> <li>• <a href="http://www.rsnwo.org/">http://www.rsnwo.org/</a></li> <li>• (419)-782-9920</li> <li>• 511 Perry St, Defiance, OH 43512</li> </ul> A Renewed Mind: <ul style="list-style-type: none"> <li>• <a href="http://www.arenewedmindservices.org/">http://www.arenewedmindservices.org/</a></li> <li>• (419)-924-5371</li> <li>• 109 West Main Street, Alvordton, OH 43501</li> </ul>	Anyone with Addiction Issues	Treatment	Best practice
Drug and Alcohol Services	Recovery Services of Northwest Ohio	<ul style="list-style-type: none"> <li>• <a href="http://www.rsnwo.org/">http://www.rsnwo.org/</a></li> <li>• (419)-782-9920</li> <li>• 511 Perry St, Defiance, OH 43512</li> </ul>	Incarcerated at Corrections Centers of Northwest Ohio	Treatment	Best practice
Counseling for drug addiction	Maumee Valley Guidance Center	<ul style="list-style-type: none"> <li>• <a href="http://www.maumeevalleyguidancecenter.org/">http://www.maumeevalleyguidancecenter.org/</a></li> <li>• (419)-636-2932</li> <li>• 203 N Lynn St, Bryan, OH 43506</li> </ul>	All ages	Treatment	Best practice

## Priority #4 | Decrease Youth Substance Abuse

### Resource Assessment, *continued*

Program/Strategy/ Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
No Evidenced Indicated					
Support group for family members	Recovery Services of Northwest Ohio	<ul style="list-style-type: none"> <li><a href="http://www.rsnwo.org/">http://www.rsnwo.org/</a></li> <li>(419)-782-9920</li> <li>511 Perry St, Defiance, OH 43512</li> </ul>	All ages	None	None
Youth-led prevention at Bryan Middle School (sub abuse)	Bryan Middle School	<ul style="list-style-type: none"> <li><a href="http://www.bryan.k12.oh.us/2/Home">http://www.bryan.k12.oh.us/2/Home</a></li> </ul>	Youth	Prevention	None

## Priority #4 | Decrease Youth Substance Abuse

### Gaps and Potential Strategies

Gaps	Potential Strategies
1. Lack of parental knowledge of consequences	<ul style="list-style-type: none"><li>○ Educational campaign- involve law enforcement</li></ul>
2. Social norm/perceived risk	<ul style="list-style-type: none"><li>○ Youth led social media campaign-legal and health consequences of underage drinking</li><li>○ Involvement of youth in a coalition</li></ul>
3. Screening mechanisms	<ul style="list-style-type: none"><li>○ Increase clinical skills training among schools, healthcare professionals, etc. to help identify and refer substance abuse individuals</li></ul>
4. Legal system	<ul style="list-style-type: none"><li>○ Involve law enforcement with legal consequences</li><li>○ Increase enforcement and environmental scans</li></ul>
5. Lack of activities	<ul style="list-style-type: none"><li>○ Further promote current community activities that are targeted at youth</li><li>○ Involve youth when planning new activities</li></ul>

# Priority #4 | Decrease Youth Substance Abuse

## Best Practices

The following programs and policies have been reviewed and have proven strategies to **decrease youth substance abuse**:

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

For more information go to: <http://www.pire.org/communitytrials/index.htm>

2. **Project ASSERT**- Project ASSERT (Alcohol and Substance Abuse Services, Education, and Referral to Treatment) is a screening, brief intervention, and referral to treatment (SBIRT) model designed for use in health clinics or emergency departments (EDs). Project ASSERT targets three groups:
  - a. Out-of-treatment adults who are visiting a walk-in health clinic for routine medical care and have a positive screening result for cocaine and/or opiate use. Project ASSERT aims to reduce or eliminate their cocaine and/or opiate use through interaction with peer educators (substance abuse outreach workers who are in recovery themselves for cocaine and/or opiate use and/or are licensed alcohol and drug counselors).
  - b. Adolescents and young adults who are visiting a pediatric ED for acute care and have a positive screening result for marijuana use. Project ASSERT aims to reduce or eliminate their marijuana use through interaction with peer educators (adults who are under the age of 25 and, often, college educated).
  - c. Adults who are visiting an ED for acute care and have a positive screening result for high-risk and/or dependent alcohol use. Project ASSERT aims to motivate patients to reduce or eliminate their unhealthy use through collaboration with ED staff members (physicians, nurses, nurse practitioners, social workers, or emergency medical technicians).

On average, Project ASSERT is delivered in 15 minutes, although more time may be needed, depending on the severity of the patient's substance use problem and associated treatment referral needs. The face-to-face component of the intervention is completed during the course of medical care, while the patient is waiting for the doctor, laboratory results, or medications.

For more information go to: <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=222>



## Priority #4 | Decrease Youth Substance Abuse

### Best Practices, *continued*

3. **Parent Project** ®: The Parent Project is an evidence/science based parenting skills program specifically designed for parents with strong-willed or out-of-control children. Parents are provided with practical tools and no-nonsense solutions for even the most destructive of adolescent behaviors. The Parent Project is the largest court mandated juvenile diversion program in the country and for agencies, the least expensive intervention program available today.

There are two highly effective Parent Project® programs serving families:

- Loving Solutions is a 6 to 7 week program written for parents raising difficult or strong-willed children, 5 to 10 year of age. Designed for classroom instruction, this program has special application to ADD and ADHD issues, and was written for the parents of more difficult children.
- Changing Destructive Adolescent Behavior is a 10 to 16 week program designed for parents raising difficult or out-of-control adolescent children, ages 10 and up. Also designed for classroom use, it provides concrete, no-nonsense solutions to even the most destructive of adolescent behaviors.

For more information go to: <http://www.parentproject.com>

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

For more information go to: <http://www.lifeskillstraining.com>

## Priority #4 | Decrease Youth Substance Abuse

### Best Practices, *continued*

5. **Too Good For Drugs:** Too Good for Drugs (TGFD) is a school-based prevention program for kindergarten through 12th grade that builds on students' resiliency by teaching them how to be socially competent and autonomous problem solvers. The program is designed to benefit everyone in the school by providing needed education in social and emotional competencies and by reducing risk factors and building protective factors that affect students in these age groups. TGFD focuses on developing personal and interpersonal skills to resist peer pressures, goal setting, decision making, bonding with others, having respect for self and others, managing emotions, effective communication, and social interactions. The program also provides information about the negative consequences of drug use and the benefits of a nonviolent, drug-free lifestyle. TGFD has developmentally appropriate curricula for each grade level through 8th grade, with a separate high school curriculum for students in grades 9 through 12. The K-8 curricula each include 10 weekly, 30- to 60-minute lessons, and the high school curriculum includes 14 weekly, 1-hour lessons plus 12 optional, 1-hour "infusion" lessons designed to incorporate and reinforce skills taught in the core curriculum through academic infusion in subject areas such as English, social studies, and science/health. Ideally, implementation begins with all school personnel (e.g., teachers, secretaries, janitors) participating in a 10-hour staff development program, which can be implemented either as a series of 1-hour sessions or as a 1- or 2-day workshop.

Five studies conducted by an independent evaluator have examined TGFD's effectiveness in reducing adolescents' intention to use tobacco, alcohol, and marijuana; reducing fighting; and strengthening protective and resiliency factors. Each of the five studies showed positive effects on risk and protective factors relating to alcohol, tobacco, illegal drug use, and violence, including significant positive effects on the following:

- Attitudes toward drugs
- Attitudes toward violence
- Perceived peer norms
- Peer disapproval of use
- Emotional competence
- Social and resistance skills
- Goals and decision making
- Perceived harmful effects

For more information go to: <http://www.mendezfoundation.org/>

## Priority #4 | Decrease Youth Substance Abuse

### Alignment with National Standards

The Williams County CHIP will help support the following **Healthy People 2020** Goals:

- **Substance Abuse (SA)-1** Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol
- **Substance Abuse (SA)-2** Increase the proportion of adolescents never using substances
- **Substance Abuse (SA)-3** Increase the proportion of adolescents who disapprove of substance abuse
- **Substance Abuse (SA)-4** Increase the proportion of adolescents who perceive great risk associated with substance abuse
- **Substance Abuse (SA)-5** (Developmental) Increase the number of drug, driving while impaired (DWI), and other specialty courts in the United States
- **Substance Abuse (SA)-6** Increase the number of States with mandatory ignition interlock laws for first and repeat impaired driving offenders in the United States
- **Substance Abuse (SA)-8** Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year
- **Substance Abuse (SA)-9** (Developmental) Increase the proportion of persons who are referred for follow-up care for alcohol problems, drug problems after diagnosis, or treatment for one of these conditions in a hospital emergency department (ED)
- **Substance Abuse (SA)-10** Increase the number of Level I and Level II trauma centers and primary care settings that implement evidence-based alcohol Screening and Brief Intervention (SBI)
- **Substance Abuse (SA)-11** Reduce cirrhosis deaths
- **Substance Abuse (SA)-14** Reduce the proportion of persons engaging in binge drinking of alcoholic beverages
- **Substance Abuse (SA)-16** Reduce average annual alcohol consumption
- **Substance Abuse (SA)-17** Decrease the rate of alcohol-impaired driving (.08+ blood alcohol content [BAC]) fatalities
- **Substance Abuse (SA)-20** Reduce the number of deaths attributable to alcohol

## Priority #4 | Decrease Youth Substance Abuse

### Action Step Recommendations & Action Plan

To work toward decreasing **youth substance abuse**, the following actions steps are recommended:

1. Expand evidence-based programs and counseling services targeting youth and families
2. Increase the number of schools screening for alcohol
3. Implement a community based comprehensive program to reduce alcohol abuse
4. Increase community awareness & education of substance abuse issues and trends
5. Implement parent project

Decrease Youth Substance Abuse		
Action Step	Responsible Person/Agency	Timeline
<b>Expand Evidence-based Programs and Counseling Services Targeting Youth and Families</b>		
<b>Year 1:</b> Introduce the Too Good for Drugs/Second Step program(s) to schools, churches, parents and community members.  Discuss program/service needs and gaps with school personnel at all schools within the county.  Work with school administrators, guidance counselors and other community organizations to raise awareness of the program(s).  Implement the program(s) in at least one new location or school.	<b>Ron Rittichier</b> Safe Schools/Healthy Students	December 31, 2017
<b>Year 2:</b> Increase awareness and participation of the Too Good for Drugs/ Second Step program(s).  Double the number of locations and or schools providing evidence based programming for youth and/or in school counseling for youth and families.		December 31, 2018
<b>Year 3:</b> Continue efforts of years 1 and 2.		December 31, 2019
<b>Increase the Number of Schools Screening for Alcohol</b>		
<b>Year 1:</b> Introduce Project ASSERT.  Collect baseline data on the number of schools that currently screen for drug and alcohol abuse (and at what age they start screening).	<b>Ron Rittichier</b> Safe Schools/Healthy Students  <b>Jerry Stollings</b> Juvenile Court Administration	December 31, 2017
<b>Year 2:</b> Introduce a screening, brief intervention and referral to treatment model (SBIRT) to schools.  Work with schools to pilot the model during regular screenings with at least 1-2 schools.		December 31, 2018
<b>Year 3:</b> Increase the number of schools using the SBIRT model by 25% from baseline.		December 31, 2019

## Priority #4 | Decrease Youth Substance Abuse

### Action Step Recommendations & Action Plan, *continued*

Decrease Youth Substance Abuse		
Action Step	Responsible Person/Agency	Timeline
<b>Implement a Community Based Comprehensive Program to Reduce Alcohol Abuse</b>		
<b>Year 1:</b> Research Community Trials Intervention to Reduce High-Risk Drinking program.  Work with all area law enforcement agencies to determine which components would be feasible to implement.	<b>Les McCaslin</b> Four County Alcohol, Drug and Mental Health Board	December 31, 2017
<b>Year 2:</b> Implement at least 2 of the following strategies: <ul style="list-style-type: none"> <li>• Sobriety checkpoints (working with law enforcement)</li> <li>• Compliance checks (working with the Ohio Investigative Unit)</li> <li>• Seller/server trainings (working with the Ohio Investigative Unit)</li> <li>• Parents Who Host Lose the Most campaign (educating parents on the laws for distributing alcohol to minors)</li> <li>• Implement program that supports an underage party texting system.</li> <li>• Use zoning and municipal regulations to control alcohol outlet density</li> </ul>		December 31, 2018
<b>Year 3:</b> Expand strategies to all areas of the county and implement remaining strategies.  Publicize results of efforts.		December 31, 2019
<b>Increase Community Awareness &amp; Education of Substance Abuse Issues and Trends</b>		
<b>Year 1:</b> Plan a community awareness campaign to increase education and awareness of risky behaviors and alcohol use trends. Involve school-age youth in efforts by creating a youth-led coalition.  Determine best ways to educate community and parents (social media, newspaper, school websites or newsletters, television, church bulletins, etc.)	<b>Ron Rittichier</b> Safe Schools/Healthy Students	December 31, 2017
<b>Year 2:</b> Involve youth in planning awareness programs/workshops focusing on different "hot topics" and risky behavior trends.  Attain media coverage for all programs/workshops.		December 31, 2018
<b>Year 3:</b> Continue efforts of years 1 and 2.		December 31, 2019

## Priority #4 | Decrease Youth Substance Abuse

### Action Step Recommendations & Action Plan, *continued*

Decrease Youth Substance Abuse		
Action Step	Responsible Person/Agency	Timeline
<b>Implement Parent Project</b>		
<b>Year 1:</b> Determine who is currently offering Parent Project to parents of court-appointed youth.  Introduce the program to school guidance counselors and churches. Ask them to make referrals to those who offer the program.	<b>Jerry Stollings</b> Juvenile Court Administration	December 31, 2017
<b>Year 2:</b> Implement the program with at least 10 parents.  Seek funding to offer to others.		December 31, 2018
<b>Year 3:</b> Expand program to be offered in different areas of the county.  Implement the program with at least 20 parents.		December 31, 2019

## Priority #5 | Increase Women's Health Screenings

### Women's Health Indicators

In 2016, half (50%) of Williams County women over the age of 40 reported having a mammogram in the past year. 44% of Williams County women ages 19 and over had a clinical breast exam and 23% had a Pap smear to detect cancer of the cervix in the past year.

#### Women's Health Screenings

In 2016, 56% of women had a mammogram at some time and more than one-fourth (29%) had this screening in the past year.

Half (50%) of women ages 40 and over had a mammogram in the past year and 67% had one in the past two years. The 2014 BRFSS reported that 72% of women 40 and over in Ohio and 73% in the U.S., had a mammogram in the past two years.

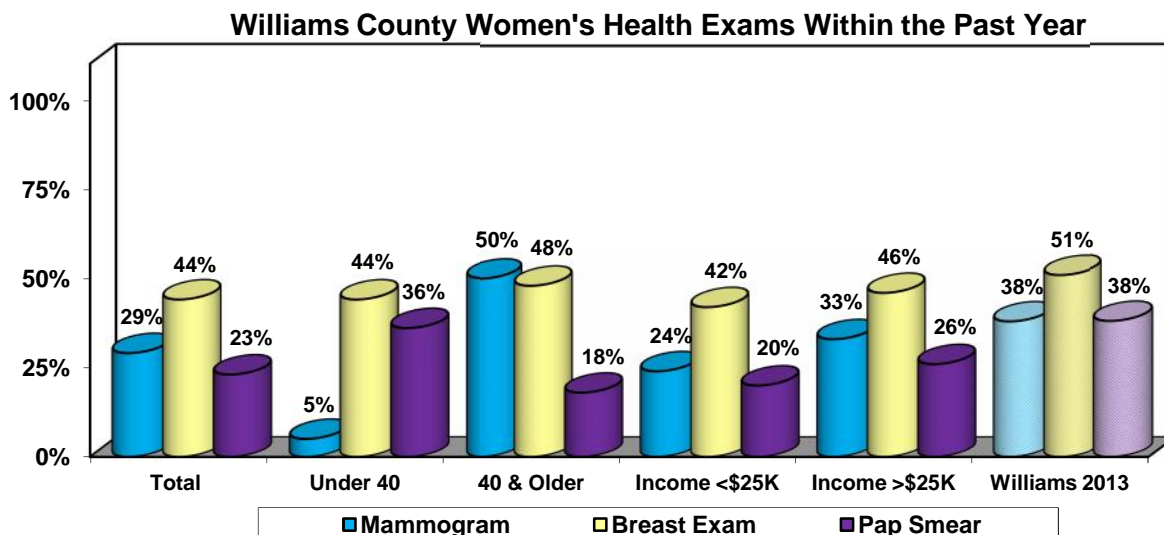
Most (88%) Williams County women have had a clinical breast exam at some time in their life and 44% had one within the past year. Nearly two-thirds (66%) of women ages 40 and over had a clinical breast exam in the past two years. The 2010 BRFSS reported that 75% of women 40 and over in Ohio and 77% in the U.S., had a clinical breast exam in the past two years.

42% of women have had a colonoscopy in their lifetime.

This assessment has identified that 87% of Williams County women have had a Pap smear and 23% reported having had the exam in the past year. 54% of women had a pap smear in the past three years. The 2014 BRFSS indicated that 74% of Ohio and 75% in the U.S. women had a pap smear in the past three years.

Adult Comparisons	Williams County 2013	Williams County 2016	Ohio 2014	U.S. 2014
Had a clinical breast exam in the past two years (age 40 & over)	68%	66%	75%**	77%**
Had a mammogram in the past two years (age 40 & over)	69%	67%	72%	73%
Had a pap smear in the past three years	66%	54%	74%	75%

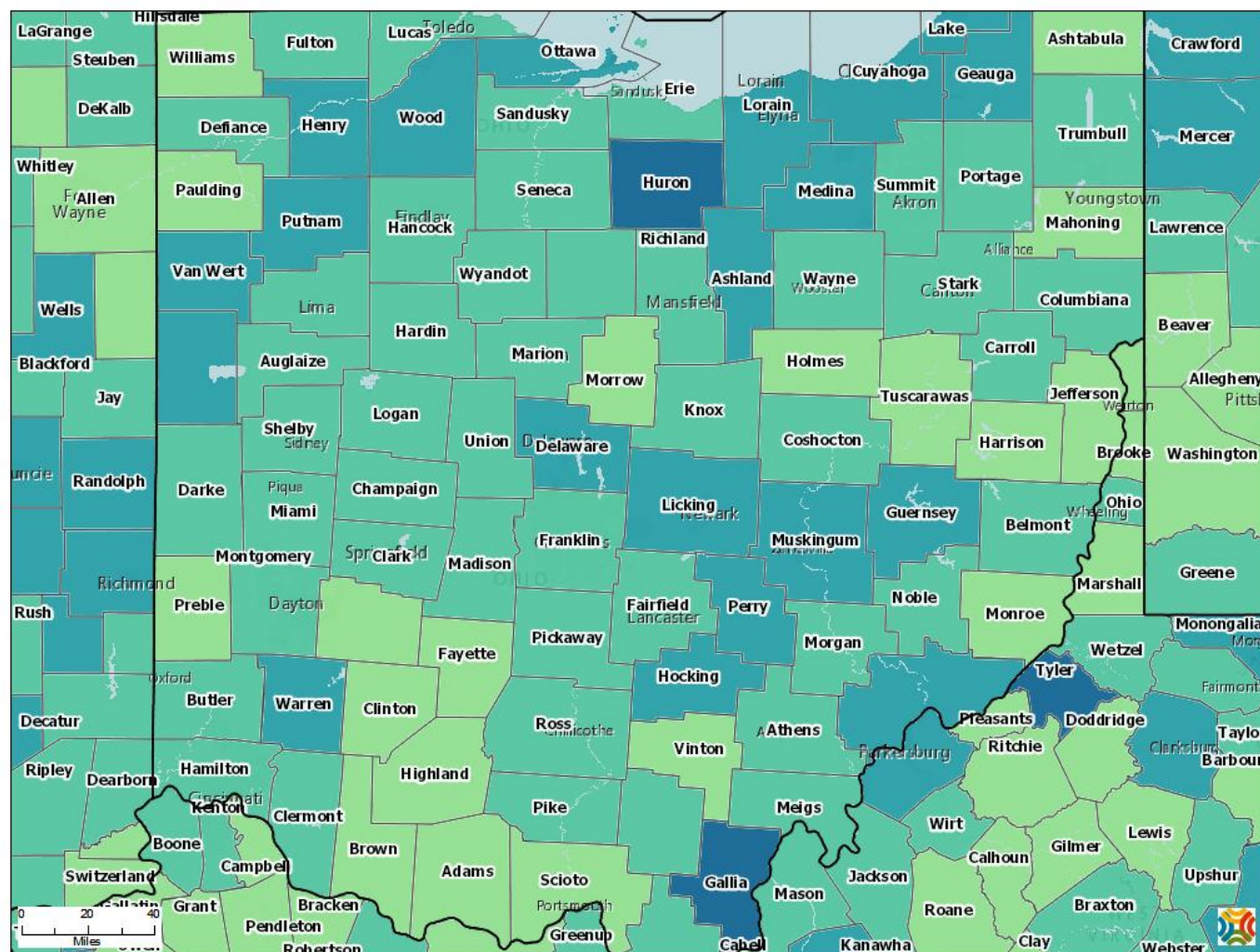
\*\*2012 BRFSS Data





## Priority #5 | Increase Women's Health Screenings

**Mammography Screening, Percent of Female Medicare Beneficiaries by County, CHR 2014**



Map Legend

Mammography Screening, Percent of Female Medicare Beneficiaries by County, CHR 2014

- Over 68.0%  
■ 62.1 - 68.0%  
■ 56.1 - 62.0%  
■ Under 56.1%  
■ No Data or Data Suppressed

Community Commons, 7/12/2016

(Source: Community Commons 7/12/16)

## Priority #5 | Increase Women's Health Screenings

### Resource Assessment

Program/Strategy /Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
<b>Evidence-based Practices</b>					
Breast and Cervical Cancer Project-"A Woman First"	Fulton County Health Department	<ul style="list-style-type: none"> <li><a href="http://www.fultoncountyhealthdept.com/#/nursing/bccp">http://www.fultoncountyhealthdept.com/#/nursing/bccp</a></li> <li>1-800-929-6626</li> <li>606 S. Shoop Ave., Wauseon, OH 43567</li> </ul>	Women, 40+, uninsured	Early Intervention	Evidence based
<b>Best Practices</b>					
Reproductive Health and Wellness Clinic	Fulton County Health Department	<ul style="list-style-type: none"> <li><a href="http://www.fultoncountyhealthdept.com/#/nursing/reproductive-health">http://www.fultoncountyhealthdept.com/#/nursing/reproductive-health</a></li> <li>(419)-337-0915</li> <li>606 S. Shoop Ave., Wauseon, OH 43567</li> </ul>	All ages	Prevention, Early Intervention, Treatment	Best practice
STD testing, PAP tests, and other screenings	Bryan Community Health Center, Parkview	Bryan Community Health Center: <ul style="list-style-type: none"> <li><a href="http://recovery.hpwohi.org/">http://recovery.hpwohi.org/</a></li> <li>(567)-239-4562</li> <li>228 South Main Street Bryan, Ohio 43506</li> </ul> Parkview: <ul style="list-style-type: none"> <li>(877)-774-8649</li> <li>442 W High St, Bryan, OH 43506</li> </ul>	All ages	Early Intervention	Best practice
Mobile mammography	Parkview	<ul style="list-style-type: none"> <li>(877)-774-8649</li> <li>442 W High St, Bryan, OH 43506</li> </ul>	Women, 40+, uninsured	Early Intervention	Best practice
Mychart health reminders for screenings	Parkview	<ul style="list-style-type: none"> <li><a href="mailto:mychart@parkview.com">mychart@parkview.com</a></li> <li>1-855-853-0001</li> </ul>	Parkview patients	Prevention	Best practice
Cancer Prevention and Early Detection Program	Hospital (Community Hospitals and Wellness Centers)	<ul style="list-style-type: none"> <li><a href="https://www.chwchospital.org/health-education/community-programs/classes/certifications/">https://www.chwchospital.org/health-education/community-programs/classes/certifications/</a></li> <li>(419)-636-1131</li> <li>433 W. High S, Bryan, OH 43506</li> </ul>	All ages	Prevention, early intervention	Best practice

## Priority #5 | Increase Women's Health Screenings

### Resource Assessment, *continued*

Program/Strategy /Service	Responsible Agency	Contact Information (Address, Website, etc.)	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Phytel phone reminders for screenings	Parkview	<ul style="list-style-type: none"> <li>(419)-636-4517</li> <li>442 W High St, Bryan, OH 43506</li> </ul>	All ages	Prevention, early intervention	Best practice
Cancer screening recommendation brochure	Hospital (Community Hospitals and Wellness Centers), Parkview, Williams County Health Department	CHWC: <ul style="list-style-type: none"> <li>(419)-636-1131</li> <li>433 W. High S, Bryan, OH 43506</li> </ul> Parkview: <ul style="list-style-type: none"> <li>(877)-774-8649</li> <li>442 W High St, Bryan, OH 43506</li> </ul> WCHD: <ul style="list-style-type: none"> <li>(419)-485-3141</li> <li>310 Lincoln Ave., P.O. Box 146 Montpelier, Ohio 43543</li> </ul>	Community	Prevention	Best practice
Galileo registry reminder for overdue health screenings	Parkview	<ul style="list-style-type: none"> <li>(419)-636-4517</li> <li>442 W High St, Bryan, OH 43506</li> </ul>	All ages	Prevention, early intervention	Best practice
<b>No Evidenced Indicated</b>					
Women's health day at the fair	Parkview	<ul style="list-style-type: none"> <li>(877)-774-8649</li> <li>442 W High St, Bryan, OH 43506</li> </ul>	Women	Prevention, early intervention	None

## Priority #5 | Increase Women's Health Screenings

### Gaps and Potential Strategies

Gaps	Potential Strategies
1. Change in recommendations/information noise	<ul style="list-style-type: none"><li>Keep brochures up-to-date</li><li>Utilize media to provide updates</li><li>Education with providers</li></ul>
2. Fear	<ul style="list-style-type: none"><li>Provide education on benefits of screenings and early detection</li></ul>
3. Lack of insurance/funding	<ul style="list-style-type: none"><li>Promote free/low cost services</li><li>Re-apply for grants- Komen</li><li>Utilize community center</li></ul>
4. Lack of time/prioritization	<ul style="list-style-type: none"><li>Partner with area providers and family practitioners to increase awareness of importance of early detection through marketing efforts</li><li>Implement the "Friends for Life" program</li></ul>
5. Transportation	<ul style="list-style-type: none"><li>Evaluate resources that are currently available</li><li>Share-a-ride to appointments (buddy system)</li><li>Implement the "Friends for Life" program</li></ul>

# Priority #5 | Increase Women's Health Screenings

## Best Practices

The following programs and policies have been reviewed and have proven strategies to **increase women's health screenings**:

1. **Systems Navigators and Integration (E.g., Patient Navigators):** Patient navigators provide culturally sensitive assistance and care-coordination, guiding patients through available medical insurance, and social support systems. These programs seek to reduce racial, ethnic, and economic disparities in access to care and disease outcomes.

### Expected Beneficial Outcomes

- Increased use of preventive services
- Increased cancer screenings
- Improved birth outcomes
- Improved maternal health

### Evidence of Effectiveness

- There is strong evidence that patient navigator programs improve cancer screenings, especially for breast cancer. Additional evidence is needed to confirm effects for programs focused on other health outcomes.

### Impact on Disparities

- Likely to decrease disparities

For more information go to: <http://www.countyhealthrankings.org/policies/systems-navigators-and-integration-eg-patient-navigators>

2. **Motivational Interviewing (MI):** MI is a goal-directed, client centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. MI has been applied to a wide range of problem behaviors related to alcohol and substance abuse as well as health promotion, medical treatment adherence, and mental health issues. The MI counseling style generally includes the following elements:

- Establishing rapport with the client and listening reflectively.
- Asking open-ended questions to explore the client's own motivations for change.
- Affirming the client's change-related statements and efforts.
- Eliciting recognition of the gap between current behavior and desired life goals.
- Asking permission before providing information or advice.
- Responding to resistance without direct confrontation. (Resistance is used as a feedback signal to the therapist to adjust the approach.)
- Encouraging the client's self-efficacy for change.
- Developing an action plan to which the client is willing to commit.

For more information go to: <http://www.motivationalinterview.org>

## Priority #5 | Increase Women's Health Screenings

### Best Practices, *continued*

3. **Financial incentives for patients undergoing preventive care:** Financial incentives such as payments, vouchers, and tickets for prize drawings can be used to encourage patients to undergo preventive care such as screenings, vaccinations, and other brief interventions. Personal incentive programs are usually offered through the public sector and typically offer incentives to low income individuals (Sutherland 2008).

#### **Expected Beneficial Outcomes**

- Increased vaccination
- Increased cancer screening
- Increased adherence to treatment
- Reduced health care costs

#### **Evidence of Effectiveness**

There is strong evidence that financial incentives increase preventive care among low income and high risk populations (Sutherland 2008). Effects appear strongest for brief, infrequent behaviors such as attending an appointment, and for rewards that are large or delivered soon after the patient completes a target behavior (Marteau 2009).

Financial incentives have been shown to improve patients' participation in vaccination programs, screening for various cancers, and adherence to treatments for tuberculosis and sexually transmitted infections (Sutherland 2008). Incentives can also reduce drug use in the short-term (Marteau 2009) and increase prenatal care for pregnant teenagers (Sutherland 2008).

For more information go to: <http://www.countyhealthrankings.org/policies/financial-incentives-patients-undergoing-preventive-care>

## Priority #5 | Increase Women's Health Screenings

### Alignment with National Standards

The Williams County CHIP helps support the following **Healthy People 2020 Goals**:

- **Cancer (C)-1** Reduce the overall cancer death rate
- **Cancer (C)-3** Reduce the female breast cancer death rate
- **Cancer (C)-4** Reduce the death rate from cancer of the uterine cervix
- **Cancer (C)-10** Reduce invasive uterine cervical cancer
- **Cancer (C)-11** Reduce late-stage female breast cancer
- **Cancer (C)-12** Increase the number of central, population-based registries from the 50 States and the District of Columbia that capture case information on at least 95 percent of the expected number of reportable cancers
- **Cancer (C)-13** Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis
- **Cancer (C)-15** Increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines
- **Cancer (C)-17** Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines
- **Cancer (C)-18** Increase the proportion of adults who were counseled about cancer screening consistent with current guidelines



## Priority #5 | Increase Women's Health Screenings

### Action Step Recommendations & Plan

To work toward increasing **women's health screenings**, the following action steps are recommended:

1. Create consistent women's health screening recommendations
2. Increase education materials being offered to patients by primary care offices
3. Decrease barriers to treatment

### Action Plan

Increase Women's Health Screenings		
Action Step	Responsible Person/Agency	Timeline
<b>Create Consistent Women's Health Screening Recommendations</b>		
<b>Year 1:</b> Complete a baseline survey with physician's offices to determine which screenings they are recommending.	<b>Amy Boehm</b> American Cancer Society  <b>Lori Phillips</b> Parkview Physicians Group	December 31, 2017
<b>Year 2:</b> Educate community on current screening recommendations.  Educate community on health care laws that pertain to 100% coverage for preventive health care.  Let community know when free screenings or health fairs will be taking place in the community. Offer incentives to participate.		December 31, 2018
<b>Year 3:</b> Continue efforts from Years 2.		December 31, 2019
<b>Increase Education Materials Being Offered to Patients by Primary Care Offices</b>		
<b>Year 1:</b> Work with primary care physician offices to assess what information and/or materials they are lacking to provide better resources for women in need of health screenings.	<b>Amy Boehm</b> American Cancer Society  <b>Lori Phillips</b> Parkview Physicians Group	December 31, 2017
<b>Year 2:</b> Offer trainings for PCP offices on health screening best practices, as well as referral sources.  Enlist at least 3 primary care physician offices.		December 31, 2018
<b>Year 3:</b> Offer additional trainings to reach at least 50% of the primary care physician offices in the county.		December 31, 2019

## Priority #5 | Increase Women's Health Screenings

### Action Step Recommendations & Plan, *continued*

Increase Women's Health Screenings		
Action Step	Responsible Person/Agency	Timeline
<b>Decrease Barriers to Treatment</b>		
<p><b>Year 1:</b> Create an informational brochure/guide that highlights all organizations in Williams County that provide women's health services. Include information on transportation options and which organizations offer free services; offer a sliding fee scale, and which insurance plans are accepted.</p> <p>Create a presentation on available women's health services and present to Williams County area churches, law enforcement, chamber of commerce, city council, service clubs, and businesses. Include information on benefits of screenings and early detection to increase community awareness.</p>	<p><b>Amy Boehm</b> American Cancer Society</p> <p><b>Lori Phillips</b> Parkview Physicians Group</p>	December 31, 2017
<p><b>Year 2:</b> Enlist organizations to update the brochure/guide on an annual basis and increase dissemination of the information.</p> <p>Continue and expand presentations on available women's health services to Williams County groups.</p>		December 31, 2018
<p><b>Year 3:</b> Continue efforts of years 1 and 2 and expand outreach.</p> <p>Determine on an annual basis, who will update and print the guides for the next 3 years.</p>		December 31, 2019

## PROGRESS AND MEASURING OUTCOMES

The progress of meeting the local priorities will be monitored with measurable indicators identified by Williams County Partners for Health. The individuals that are working on action steps will meet on an as needed basis. The full committee will meet quarterly to report out the progress. The committee will form a plan to disseminate the Community Health Improvement Plan to the community. Action steps, responsible person/agency, and timelines will be reviewed at the end of each year by the committee. Edits and revisions will be made accordingly.

Williams County will continue facilitating a Community Health Assessment every 3 years to collect and track data. Primary data will be collected for adults and youth using national sets of questions to not only compare trends in Williams County, but also be able to compare to the state, the nation, and Healthy People 2020.

This data will serve as measurable outcomes for each of the priority areas. Indicators have already been defined throughout this report:

- To evaluate decreasing obesity, the indicators found on pages 21-42 will be collected every 3 years.
- To evaluate improving cardiovascular health, the indicators found on pages 43-53 will be collected every 3 years.
- To evaluate improving youth mental health, the indicators found on pages 54-68 will be collected every 3 years.
- To evaluate decreasing youth substance abuse, the indicators found on pages 69-83 will be collected every 3 years.
- To evaluate increasing women's health screenings, the indicators found on pages 84-93 will be collected every 3 years.

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

Furthermore, all action steps have been incorporated into a Progress Report template that can be completed at all future Williams County Partners for Health meetings, keeping the committee on task and accountable. This progress report may also serving 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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