2024  2027

Hardin County

Community Health Improvement Plan

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Table of Contents

Table of Contents 3
Executive Summary 4
- Introduction 4
- Public Health Accreditation Board (PHAB) Requirements 4
- Mobilizing for Action through Planning and Partnerships (MAPP) 5
- Inclusion of Vulnerable Populations (Health Disparities) 6
- Alignment with National and State Standards 6
- Vision and Mission 10
- Community Partners 10
- Community Health Improvement Process 11

Community Health Status Assessment 12
Key Issues 16
Priorities Chosen 20
Community Themes and Strengths Assessment (CTSA) 21
- Open-ended Questions to the Committee 21
- Quality of Life Survey 24

Forces of Change Assessment 25
Local Public Health System Assessment 28
Gap Analysis and Strategic Planning Terminology 30
Priority #1: Health Behaviors 32
Priority #2: Chronic Disease 35
Priority #3: Mental Health and Addiction 36
Progress and Measuring Outcomes 42
Appendix I: Gaps and Strategies 43
Appendix II: Links to Websites 46
Appendix III: Secondary Data Sources - Strategies 47

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

Executive Summary

Introduction

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

The Hardin County Community Assessment Advisory Committee has been conducting CHAs since 2014 to measure community health status. The most recent Hardin County CHA was cross-sectional in nature and included a written survey of adults and electronic survey of adolescents within Hardin County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention (CDC) for their national and state Behavioral Risk Factor Surveillance System (BRFSS), and Youth Risk Behavior Surveillance System (YRBSS). This has allowed Hardin County to compare their CHA data to national, state, and local health trends. Community stakeholders were actively engaged in the early phases of CHA planning and helped define the content, scope, and sequence of the project.

The Hardin County Community Assessment Advisory Committee contracted with the Hospital Council of Northwest Ohio (HCNO), a neutral, regional, nonprofit hospital association, to facilitate the CHA and CHIP. The Hardin County Community Assessment Advisory then invited various community stakeholders to participate in the community health improvement process. Data from the most recent CHA were carefully considered and categorized into community priorities with accompanying strategies. This was done using the National Association of County and City Health Officials' (NACCHO) national framework, Mobilizing for Action through Planning and Partnerships (MAPP) 1.0. Over the next three years, these priorities and strategies will be implemented at the county-level with the hope to improve population health and create lasting, sustainable change. It is the hope of the Hardin County Community Assessment Advisory that each agency in the county will tie their internal strategic plan to at least one strategy in the CHIP.

Public Health Accreditation Board (PHAB) Requirements

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

PHAB standards also require that a community health improvement model is utilized when planning CHIPs. This CHIP was completed using NACCHO's MAPP 1.0 process. MAPP is a national, community-driven planning process for improving community health. This process was facilitated by HCNO in collaboration with various local agencies representing a variety of sectors.

Mobilizing for Action through Planning & Partnerships (MAPP)

NACCHO's strategic planning tool, MAPP 1.0, guided this community health improvement process. The MAPP 1.0 framework includes six phases which are listed below:

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

The MAPP 1.0 process includes four assessments: community themes and strengths, forces of change, local public health system assessment, and the community health status assessment. These four assessments were used by the Hardin County Community Assessment Advisory Committee to prioritize specific health issues and population groups which are the foundation of this plan. The figure below illustrates how each of the four assessments contributes to the MAPP 1.0 process.

The MAPP 1.0 Model

Inclusion of Vulnerable Populations (Health Disparities)

Hardin County is a rural county. Health disparities (including age, gender, and income-based disparities) were identified throughout the 2022 Hardin County Health Assessment. Approximately 18% of Hardin County residents were below the poverty line, according to the 2018-2022 American Community Survey 5-year estimates. For this reason, data is broken down by income (less than $25,000 and $25,000 or higher) throughout the report to show disparities.

Alignment with National and State Standards

The 2024-2027 Hardin County CHIP priorities align with state and national priorities. Hardin County will be addressing the following priorities: health behaviors, chronic disease, and mental health and addiction.

Healthy People 2030

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

- Nutrition and Healthy Eating (NWS) – 03: Reduce the proportion of adults with obesity
- Heart Disease and Stroke (HDS) – 04: Reduce the proportion of adults with high blood pressure
- Mental Health and Mental Disorder (MHMD) – 01: Reduce the suicide rate

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

Ohio State Health Improvement Plan (SHIP)

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

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

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

The three priority factors include the following:

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

The three priority health outcomes include the following:

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

The 2024-2027 Hardin County CHIP was required to select at least 1 priority factor, 1 priority health outcome, 1 indicator for each identified priority, and 1 strategy for each selected priority to align with the 2020-2022 SHIP. As outlined in the table below, the following priority factor, priority outcomes, priority indicators, and strategies very closely align with the 2020-2022 SHIP.

2024-2027 Hardin CHIP Alignment with the 2020-2022 SHIP

Priority Factor	State Aligned Priority Indicators	Strategies to Impact State Priority Indicators
Health Behaviors	• Adult physical inactivity	• Community-wide physical activity campaign
Priority Outcomes	**State Aligned Priority Indicators**	**Strategies to Impact State Priority Indicators**
Chronic Disease	• None	• None
Mental Health & Addiction	• Adult suicide deaths • Youth suicide deaths • Youth alcohol use • Youth marijuana use • Unintentional drug overdose deaths	• Launch and promote mobile health app for mental/behavioral health • Mental Health First Aid • Continue school-based social and emotional instruction • School-based alcohol/other drug prevention programs • Naloxone education and distribution programs

Note: This symbol will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2020-2022 SHIP.

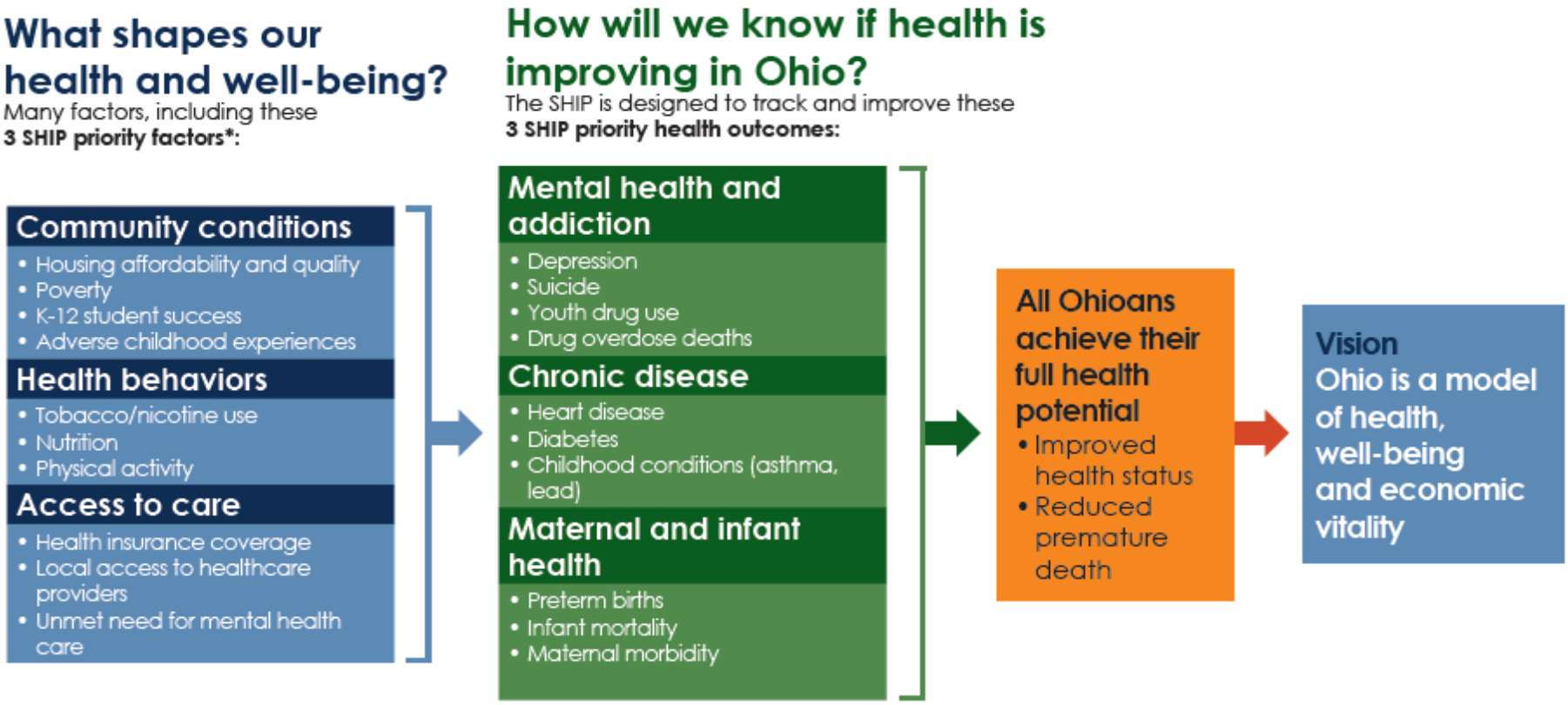
Note: This symbol √ will be used throughout the report when a strategy has been rated by **What Works for Health** as "likely to decrease disparities" and/or recommended by **The Community Guide** as effective strategies for achieving health equity. These sources consider potential impact on disparities and inequities by racial/ethnic, socio-economic, geographic, or other characteristics.

Alignment with National and State Standards, continued

2020-2022 State Health Improvement Plan (SHIP) Overview

Equity Health equity is achieved when all people in a community have access to affordable, inclusive and quality infrastructure and services that, despite historical and contemporary injustices, allows them to reach their full health potential.

Priorities The SHIP identifies three priority factors and three priority health outcomes that affect the overall health and well-being of children, families and adults of all ages.



Strategies The SHIP provides state and local partners with a menu of effective policies and programs to improve Ohio's performance on these priorities.

Vision and Mission

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

The Vision of Hardin County:

Keeping Hardin County healthy by improving the lives of those we serve and strengthen our communities through collaborative partnerships.

The Mission of Hardin County:

To protect, maintain, and improve the health, environmental quality and safety of Hardin County residents.

Community Partners

The CHIP was planned by various agencies and service-providers within Hardin County. From November 2023 to February 2024, the Hardin County Community Assessment Advisory reviewed many data sources concerning the health and social challenges that Hardin County residents are facing. They determined priority issues which, if addressed, could improve future outcomes; determined gaps in current programming and policies; examined best practices and solutions; and determined specific strategies to address identified priority issues. We would like to recognize these individuals and thank them for their dedication to this process:

Hardin County Community Health Improvement Plan Advisory Committee

- Ada Schools
- Area 3 Agency on Aging
- Bridge Home Health and Hospice
- Buckeye Ridge Habitat for Humanity of Marion, Morrow, Wyandot, and Hardin Communities
- Coleman Professional Services
- Community Health Professionals
- Family Resource Center
- Hardin Co. Ohio State University Extension Family and Consumer Sciences
- Hardin County Board of Developmental Disabilities
- Hardin County Chamber and Business Alliance
- Hardin County Commissioners
- Hardin County Council on Aging
- Hardin County Emergency Management Association
- Hardin County Family and Children First Council
- Hardin County GIS Coordinator
- Hardin County Office, North Central Ohio Chapter American Red Cross
- Hardin County YMCA
- Hardin Northern Schools
- Heartbeat of Hardin County
- Head Start and Women, Infants, and Children
- Kenton City Schools
- Kenton Hardin Health Department
- Lighthouse Behavioral Health Solutions
- Mental Health and Recovery Services of Allen, Auglaize, and Hardin Counties
- OhioHealth Hardin Memorial Hospital
- Prevention Awareness Support Services (formerly Partnership for Violence Free Families)
- Ridgemont Schools
- Township Trustees
- Universal Home Health and Hospice
- Upper Scioto Valley Schools

Hospital Council of Northwest Ohio (HCNO)

The community health improvement process was facilitated by Jodi Franks, MPH, Community Health Improvement Coordinator, from Hospital Council of Northwest Ohio.

Community Health Improvement Process

Beginning in November 2023, the Hardin County Community Assessment Advisory met four (4) times and completed the following planning steps:

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

Community Health Status Assessment

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

Hardin County Adult Trend Summary

Adult Variables	Hardin County 2014	Hardin County 2018	Hardin County 2022	Ohio 2021	U.S. 2021
Health Status					
Rated general health as good, very good, or excellent	85%	81%	85%	83%	85%
Rated general health as excellent or very good	43%	41%	50%	51%	53%
Rated general health as fair or poor	15%	19%	15%	17%	15%
Rated mental health as not good on four or more days (in the past 30 days)	27%	34%	40%	31%	29%
Rated physical health as not good on four or more days (in the past 30 days)	20%	22%	25%	21%	20%
Average number of days that physical health was not good (in the past 30 days)	3.1	4.3	4.3	4.2*	3.9*
Average number of days that mental health was not good (in the past 30 days)	4.2	4.7	6.2	5.2*	4.5*
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past 30 days)	24%	25%	29%	N/A	N/A
Health Care Coverage, Access, and Utilization					
Uninsured	13%	11%	12%	6%	7%
Had one or more persons they thought of as their personal health care provider	58%	86%	87%	86%	84%
Visited a doctor for a routine checkup (in the past 12 months)	52%	68%	75%	77%	76%
Visited a doctor for a routine checkup (5 or more years ago)	11%	6%	8%	5%	5%
Arthritis, Asthma, & Diabetes					
Ever been told by a doctor they have diabetes (not pregnancy-related)	13%	16%	11%	13%	11%
Ever diagnosed with some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia	32%	41%	35%	30%	25%
Had ever been told they have asthma	16%	14%	8%	15%	15%
Cardiovascular Health					
Ever diagnosed with angina or coronary heart disease	4%	8%	3%	5%	4%
Ever diagnosed with a heart attack, or myocardial infarction	5%	6%	6%	5%	4%
Ever diagnosed with a stroke	1%	2%	3%	4%	3%
Had been told they had high blood pressure	28%	44%	41%	36%	32%
Had been told their blood cholesterol was high	28%	43%	39%	36%	36%
Had their blood cholesterol checked within the last five years	72%	80%	80%	85%	85%

N/A – Not Available

Indicates alignment with the Ohio State Health Assessment
**2019 BRFSS Data compiled by 2022 County Health Rankings*
†2020 BRFSS Data

Adult Variables	Hardin County 2014	Hardin County 2018	Hardin County 2022	Ohio 2021	U.S. 2021
Weight Status					
Overweight	35%	33%	36%	33%	34%
Obese	35%	41%	45%	38%	34%
Did not participate in any type of physical activity or exercise in the past week (for at least 30 minutes)	26%	26%	24%	N/A	N/A
Alcohol Consumption					
Current drinker (had at least one drink of alcohol within the past 30 days)	43%	54%	52%	53%	53%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	17%	23%	16%	17%	15%
Drug Use					
Adults who used marijuana in the past 6 months	6%	5%	9%	N/A	N/A
Adults who misused prescription drugs in the past 6 months	9%	8%	6%	N/A	N/A
Tobacco Use					
Current smoker (smoked on some or all days)	18%	17%	14%	18%	14%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	19%	29%	30%	25%	25%
Current e-cigarette user (vaped on some or all days)	N/A	4%	10%	8%	7%
Preventive Medicine					
Ever had a pneumonia vaccine (ages 65 and older)	44%	66%	66%	71%	71%
Had a flu shot within the past year (ages 65 and older)	63%	70%	73%	66%	67%
Had a clinical breast exam in the past two years (ages 40 and older)	66%	65%	60%	N/A	N/A
Had a mammogram within the past two years (ages 40 and older)	61%	65%	64%	71%†	72%†
Had a Pap smear in the past three years (ages 21-65)	69%	66%	62%	77%†	78%†
Had a PSA test within the past year (of all males)	19%	28%	39%	N/A	N/A
Had a PSA test within the past two years (ages 40 and older)	45%	52%	60%	32%†	32%†
Cancer					
Ever been told they had skin cancer	3%	5%	6%	7%	7%
Ever been told they had other types of cancer (other than skin cancer)	8%	9%	12%	8%	8%
Quality of Life					
Limited in some way because of physical, mental or emotional problem	23%	27%	28%	N/A	N/A
Mental Health					
Seriously considered attempting suicide in the past year	6%	4%	6%	N/A	N/A
Attempted suicide in the past year	<1%	1%	1%	N/A	N/A
Sexual Behavior					
Had more than one sexual partner in past year	7%	7%	5%	N/A	N/A
Oral Health					
Visited a dentist or a dental clinic (within the past year)	53%	57%	53%	65%†	66%†
Visited a dentist or a dental clinic (5 or more years ago)	16%	18%	17%	N/A	N/A

N/A – Not Available

Indicates alignment with the Ohio State Health Assessment

**2019 BRFSS Data compiled by 2022 County Health Rankings*

†2020 BRFSS Data

Hardin County Youth Trend Summary

Youth Comparisons*	Hardin County CHA 2014* (6th-12th)	Hardin County 2018 OHYES (7th-12th)	Hardin County 2022 OHYES (7th-12th)	Hardin County 2022 OHYES (9th-12th)	Ohio 2021 YRBSS (9th-12th)	U.S. 2021 YRBSS (9th-12th)
Weight Control						
Obese	15%	23%	24%	22%	19%	16%
Overweight	16%	20%	19%	16%	13%	16%
Physically active at least 60 minutes per day on every day in past week	29%	30%	28%	25%	26%	24%
Physically active at least 60 minutes per day on 5 or more days in past week	46%	54%	50%	49%	49%	45%
Did not participate in at least 60 minutes of physical activity on any day in past week	15%	13%	10%	9%	16%	16%
Tobacco/Electronic Vapor Product Use						
Current smoker (smoked on at least 1 day during the past 30 days)	10%	8%	4%	4%	3%	4%
Current cigar smoker (cigars, cigarillos, or little cigars, on at least 1 day during the 30 days)	N/A	6%	2%	2%	3%	3%
Current electronic vapor product user (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on at least 1 day during the 30 days)	N/A	17%	10%	12%	20%	18%
Current smokeless tobacco user (chewing tobacco, snuff, dip, snus, or dissolvable tobacco products, such as Redman, Levi Garrett, Beechnut, Skoal, Skoal Bandits, Copenhagen, Camel Snus, Marlboro Snus, General Snus, Ariva, Stonewall, or Camel Orbs, not counting any electronic vapor products, on at least 1 day during the 30 days)	N/A	6%	2%	2%	2%	3%
Alcohol Consumption						
Ever drank alcohol (at least one drink of alcohol on at least 1 day during their life)	39%	39%	29%	34%	N/A	N/A
Current Drinker (at least one drink of alcohol on at least 1 day during the past 30 days)	18%	14%	8%	10%	23%	23%
Binge drinker (drank 5 or more drinks within a couple of hours on at least 1 day during the past 30 days)	11%	7%	3%	4%	13%	11%
Drank for the first time before age 13 (of all youth)	13%	14%	13%	12%	11%	15%
Drank and drove (of youth drivers)	11%	2%	1%	1%	N/A	N/A
Rode with a driver who had been drinking alcohol (in a car or other vehicle on 1 or more occasion during the past 30 days)	16%	12%	8%	7%	N/A	N/A
Drug Use						
Currently use marijuana (in the past 30 days)	12%	6%	5%	7%	13%	16%
Tried marijuana for the first time before age 13	N/A	6%	4%	4%	N/A	5%
Ever took prescription drugs without a doctor's prescription (in their lifetime)	5%	8%^	8%^	8%^	10%	12%
Ever used methamphetamines (in their lifetime)	N/A	N/A	<1%	<1%	2%	2%
Ever used cocaine (in their lifetime)	N/A	N/A	1%	<1%	2%	3%
Ever used heroin (in their lifetime)	N/A	N/A	<1%	<1%	N/A	1%
Ever used inhalants (in their lifetime)	N/A	N/A	1%	<1%	N/A	8%
Ever used ecstasy (also called MDMA in their lifetime)	N/A	N/A	1%	1%	N/A	3%
Ever took steroids without a doctor's prescription (in their lifetime)	N/A	N/A	0%	0%	N/A	N/A
Were offered, sold, or given an illegal drug on school property (in the past 12 months)	7%	4%	4%	4%	N/A	14%**

**Survey sampling methods differed for Hardin County in 2014. Please compare with caution.*

*** YRBSS is for youth who were ever offered, sold, or given an illegal drug on school property.*

^ OHYES questionnaire asked this question slightly different from the YRBSS. Please compare with caution.

Indicates alignment with Ohio SHA/SHIP

N/A – Not Available

Youth Comparisons*	Hardin County CHA 2014* (6th-12th)	Hardin County 2018 OHYES (7th-12th)	Hardin County 2022 OHYES (7th-12th)	Hardin County 2022 OHYES (9th-12th)	Ohio 2021 YRBSS (9th-12th)	U.S. 2021 YRBSS (9th-12th)
Mental Health						
Felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities in the past 12 months)	21%	27%	35%	36%	43%	42%
Seriously considered attempting suicide (in the past 12 months)	12%	16%	14%	13%	22%	22%
Attempted suicide (in the past 12 months)	3%	8%	7%	7%	10%	10%
Social Determinants of Health						
Visited a doctor or other health care professional (for a routine check-up in the past year)	67%	45%	50%	52%	N/A	N/A
Visited a dentist within the past year (for a check-up, exam, teeth cleaning, or other dental work)	71%	63%	60%	62%	N/A	N/A
Violence						
Were in a physical fight (in the past 12 months)	24%	18%	17%	13%	N/A	18%
Were in a physical fight on school property (in the past 12 months)	8%	9%	7%	4%	N/A	6%
Threatened or injured with a weapon on school property (in the past 12 months)	7%	12%	8%	6%	N/A	7%
Did not go to school because they felt unsafe (at school or on their way to or from school in the past 30 days)	5%	13%	11%	10%	9%	9%
Bullied on school property (in the past year)	29%	24%	25%	22%	20%	15%
Electronically bullied (bullied through e-mail, chat rooms, instant messaging, websites or texting in the past year)	8%	15%	15%	14%	19%	16%
Experienced physical dating violence (including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with in the past 12 months)	N/A	N/A	7%	7%	5%	9%

**Survey sampling methods differed for Hardin County in 2014. Please compare with caution.*
N/A – Not Available

Key Issues

The Hardin County Community Needs Assessment Advisory Committee reviewed the 2022 Hardin County Health Assessment. Each organization completed an "Identifying Key Issues and Concerns" exercise via an online survey. The following tables were the group results. The detailed primary data for each individual priority area can be found in the section it corresponds to.

What are the most significant health issues or concerns identified in the 2022 health assessment report? Examples of how to interpret the information include: 45% of Hardin County adults were obese, including 47% of males, 53% of adults ages 30-64, and 47% of adults with annual household incomes of $25,000 or greater.

Key Issue or Concern	Percent of Population At risk	Gender Most at Risk	Age Group Most at Risk	Income Level Most at Risk
Adult weight status (6 votes)				
Categorized as obese (including severely and morbidly obese) according to BMI	45%	Males (47%)	30-64 (53%)	$25K+ (47%)
Categorized as overweight according to BMI	36%	Males (45%)	<30 (47%)	<$25K (53%)
Sedentary lifestyle (did not participate in any physical activity in the past week)	24%	Females (27%)	30-64 (31%)	$25K+ (25%)
Adult mental health (5 votes)				
Felt sad, blue, or depressed almost every day for two or more weeks in a row in the past year	21%	Females (30%)	<30 (27%) 30-64 (27%)	N/A
Rated their mental health as not good on four or more days in the past month	40%	Females (49%)	N/A	$25K+ (41%)
Seriously considered attempting suicide in the past year	6%	Females (8%)	N/A	<$25K (8%)
Attempted suicide in the past year	1%	N/A	N/A	N/A
Suicide deaths *(ODH Warehouse, 2016-2020)*	26 deaths	Males (20 deaths)	N/A	N/A

N/A – Data not available

- aligned with 2020-2022 SHIP

- aligned with 2020-2022 Hardin County CHIP

- aligned with priorities identified from 2023 Hardin County young adult focus group

- aligned with priorities identified from 2023 Hardin County CHA community stakeholder perceptions feedback

Key Issue or Concern	Percent of Population At risk	Gender Most at Risk	Age Group Most at Risk	Income Level Most at Risk
Adult cardiovascular health (5 votes)				
Diagnosed with high blood pressure (in their lifetime)	41%	Males (59%)	65+ (67%)	<$25K (53%)
Diagnosed with high blood cholesterol (in their lifetime)	39%	Males (53%)	65+ (59%)	$25K+ (42%)
Survived a heart attack or myocardial infarction (in their lifetime)	6%	Males (11%)	65+ (10%)	<$25K (14%)
Youth mental health (4 votes)				
Felt sad or hopeless for two or more weeks in a row that they stopped doing some usual activities in the past year	35%	Females (43%)	14-16 (38%)	N/A
Seriously considered attempting suicide in the past year	14%	Females (15%)	14-16 (15%)	N/A
Attempted suicide in the past year	7%	Females (8%)	14-16 (8%)	N/A
Youth bullying/violence (4 votes)				
Bullied in the past year	38%	Females (46%)	<13 (47%)	N/A
Bullied on school property in the past year	25%	Females (29%)	<13 (31%)	N/A
Youth who did not go to school on one or more days in the past month because they felt unsafe	11%	Females (13%)	<13 (14%)	N/A
Adult diabetes (2 votes)				
Diagnosed with diabetes (not pregnancy-related) in their lifetime	11%	Males (16%)	65+ (26%)	<$25K (14%)
Youth weight status (2 votes)				
Categorized as obese according to BMI	24%	Females (25%)	<13 (29%)	N/A
Adult health care coverage (2 votes)				
Uninsured	12%	N/A	<30 (23%)	<$25K (13%)
Adult quality of life (2 votes)				
Limited in some way because of a physical, mental, or emotional problem	28%	Females (29%)	65+ (36%)	<$25K (47%)

N/A – Data not available

- aligned with 2020-2022 SHIP

- aligned with 2020-2022 Hardin County CHIP

- aligned with priorities identified from 2023 Hardin County young adult focus group

- aligned with priorities identified from 2023 Hardin County CHA community stakeholder perceptions feedback

Key Issue or Concern	Percent of Population At risk	Gender Most at Risk	Age Group Most at Risk	Income Level Most at Risk
Adult drug use (1 vote)				
Prescription drug misuse (used medication not prescribed or took more than prescribed to feel food or high and/or more active or alert in the past 6 months)	6%	Females (7%)	30-64 (8%)	<$25K (11%)
Youth drug use (1 vote)				
Current marijuana user (used marijuana at least once in the past month)	5%	Males (6%)	14 to 16 (6%) 17+ (6%)	N/A
Youth adverse childhood experiences (ACEs)/trauma (1 vote)				
Experienced 3 or more ACEs within their lifetime	28%	Females (30%)	14-16 (29%)	N/A
Youth reporting parents or adults in the home insulted or put them down in the past year	40%	Females (47%)	17+ (44%)	N/A
Adult adverse childhood experiences (ACEs)/trauma (1 vote)				
Experienced four or more ACEs	21%	Females (26%)	<30 (50%)	<$25K (22%)
Youth alcohol use (1 vote)				
Current drinker (consumed at least one alcoholic drink in the past month)	8%	N/A	17+ (11%)	N/A
Had their first drink of alcohol before the age of 13	13%	Females (14%)	<13 (16%)	N/A
Youth nicotine use (1 vote)				
Current electronic vapor product user (used electronic vapor products on at least one day in the past month)	10%	Females (11%)	14-16 (12%)	N/A
Used an electronic vapor product (in their lifetime)	20%	Females (22%)	17+ (25%)	N/A
Perceive every day electronic vapor product use as "no risk" or "slight risk" to themselves physically or in other ways	34%	Females (29%)	14-16 (31%)	N/A
Adult nicotine use (1 vote)				
Current e-cigarette user (vaped on some or all days)	10%	Females (13%)	<30 (33%)	N/A

N/A – Data not available

- aligned with 2020-2022 SHIP

- aligned with 2020-2022 Hardin County CHIP

- aligned with priorities identified from 2023 Hardin County young adult focus group

- aligned with priorities identified from 2023 Hardin County CHA community stakeholder perceptions feedback

Key Issue or Concern	Percent of Population At risk	Gender Most at Risk	Age Group Most at Risk	Income Level Most at Risk
Food insecurity (1 vote)				
Adults who experienced more than one food insecurity issue in the past year	11%	N/A	N/A	N/A
Adult health care costs (1 vote)				
Indicated "cost" as a potential barrier to seeing a doctor if they were sick, injured, or needed some type of health care	31%	N/A	N/A	N/A
Adult cancer (1 vote)				
Diagnosed with other types of cancer (other than skin cancer) in their lifetime	11%	Males (14%)	65+ (24%)	<$25K (26%)
Adult alcohol consumption (1 vote)				
Current drinker (consumed at least one alcoholic drink in the past month)	16%	Males (17%)	<30 (27%)	<$25K (18%)

N/A – Data not available

- aligned with 2020-2022 SHIP

- aligned with 2020-2022 Hardin County CHIP

- aligned with priorities identified from 2023 Hardin County young adult focus group

- aligned with priorities identified from 2023 Hardin County CHA community stakeholder perceptions feedback

Additional feedback with no specific data/indicators reported:

1 vote:

- Local specialists available for low income and elderly population
- High prescription costs for low income and elderly population

Priorities Chosen

Based on the 2022 Hardin County Health Assessment, key issues were identified for adults and youth. Overall, there were 20 key issues identified by the Hardin County Community Needs Assessment Advisory Committee. The committee then voted and came to a consensus on the priority areas Hardin County will focus on over the next three years. The key issues and their corresponding votes are described in the table below.

Key Issues	Votes
1. Adult weight status	6
2. Adult mental health	5
3. Adult cardiovascular health	5
4. Youth mental health	4
5. Youth bullying/violence	4
6. Adult diabetes	2
7. Youth weight status	2
8. Adult health care coverage	2
9. Adult quality of life	2
10. Adult drug use	1
11. Youth drug use	1
12. Youth adverse childhood experiences (ACEs)/trauma	1
13. Adult ACEs/trauma	1
14. Youth alcohol use	1
15. Youth nicotine use	1
16. Adult nicotine use	1
17. Food insecurity	1
18. Adult health care costs	1
19. Adult cancer	1
20. Adult alcohol consumption	1

Hardin County will focus on the following 3 priority areas over the next three years:

Priority Factor(s):

1) Health Behaviors (focus: adult/youth weight status, adult/youth vaping)

Priority Health Outcome(s):

1) Chronic disease (focus: cardiovascular health, diabetes)

2) Mental health and addiction (focus: adult/youth mental health & suicide, adult/youth drug use, youth alcohol use, youth bullying/violence, youth ACEs)

Community Themes and Strengths Assessment (CTSA)

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

Open-ended Questions to the Committee

1) **What do you believe are the 2-3 most important characteristics of a healthy community?**
    - Health
    - Safety
    - Sense of community
    - Taking care of our resources
    - Everyone having access to affordable health care when they need it
    - Residents having a trusted health professional to talk to and seek health advice/recommendations
    - Everyone having access to a safe home and neighborhood, clean water, healthy food, supportive family, etc.
    - Students feeling safe, valued, and encouraged at school
    - Students having healthy, positive relationships with fellow students and school staff
    - Residents being able to afford safe housing, healthy food, prescriptions, etc.
    - Residents having access to safe walking paths or parks for exercise

2) **What makes you most proud of our community?**
    - We have a lot of resources
    - People that care about helping others
    - Dedicated volunteers – “helping our own”
    - Community partners that are willing to be a part of the CHA/CHIP process to determine and implement ways to improve the health and safety of county residents
    - Collaboration for the betterment of the residents
    - Collaboration of organizations to reduce overlap/duplication in services

3) **What are some specific examples of people or groups working together to improve the health and quality of life in our community?**
    - Coalitions (e.g., Healthy Lifestyle) (2)
    - Hardin County Family and Children First Council
    - FAST
    - Mental health and substance use disorder treatment agencies
    - Courts working with agencies
    - Our health department nurses travel to locations around the county to offer blood pressure screenings, immunizations, education about lead prevention, etc.
    - Ohio Northern University Healthwise Mobile Clinic travels to various locations/events to provide health screenings
    - A group has been looking into finding a way to bring an additional grocery store to our county and possibly public transportation to our county in the future
    - Heartbeat of Hardin County offers pregnancy and parenting resources to expectant parents and families with children up through age 4. Heartbeat staff educate students about healthy relationships and abstinence.
    - Prevention Awareness Support Services teaches students about making healthy decisions, having healthy relationships, etc.
    - Multiple churches in Kenton hosted a Back to School Bash event this year and last year to provide school supplies for free to students in our county. There was also free food offered to attendees, and the opportunity to hear the gospel message.
    - Multiple churches in our county offered Vacation Bible School to students in the summer
    - Wings Recovery offers peer support to people going through mental health and substance use treatment, they also offer free lunch on weekdays, and free access to showering and doing laundry for people in need.

4) **What do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life in our community?**
    - Promoting substance use treatment (2)
    - Housing
    - Improve access to healthy, affordable food
    - Public transportation to and from work, medical appointments, etc.
    - Jobs that offer a higher wage and better benefits so that people can access the above and better access health care (including preventative care).
    - Offer free/low-cost resources to residents including physical activities
    - Poor physical health of residents
    - Poor mental health of residents

5) **What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?**
    - Politics
    - Limited funding and resources
    - Limited time to devote to this, other tasks are also competing for peoples' time and energy
    - Lack of education and/or drive from residents to make positive changes to improve their health

6) **What actions, policy, or funding priorities would you support to build a healthier community?**
    - Food drives
    - Personal care item drives to provide items to community organizations to give to clients/patients in need
    - Participating in a resource fair
    - Looking for and applying to grants if it will be feasible to meet the requirements of the grant and it will realistically help improve the lives of residents
    - Something around the obesity rates of residents
    - Sustainable solutions that address the root cause of issues

7) **What would excite you enough to become involved (or more involved) in improving our community?**
    - Being involved in change
    - More funding or resources available to use to work together
    - MHRSB is highly involved in the community and at the table to assist in addressing mental health/substance use disorder needs

Quality of Life Survey

The Hardin County Community Needs Assessment Advisory Committee urged community members to fill out a short quality of life survey via an online platform (SurveyMonkey) from November 2023 to January 2024. There were **246** Hardin County community members who completed the survey. This tool will assist the committee in understanding the overall quality of life in Hardin County. The table below incorporates responses from the previous Hardin County CHIP for comparison purposes. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1. When a respondent left a response blank, the response was not used in averaging responses or calculating descriptive statistics.

Quality of Life Questions	Likert Scale Average Response	
	2019 n=90	2023/2024 n=246
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]	3.63	3.31
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.03	2.85
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.78	3.37
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.)	3.36	3.02
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	2.35
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?)	3.73	3.67
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?	3.41	3.31
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.40	3.22
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	2.88	2.87
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.00	2.77
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.08	2.91
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	2.82

Forces of Change Assessment

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

Force of Change	Threats Posed	Opportunities Created
General Health Forces		
1. Pandemic	• Further increase in food costs • Limited availability of certain foods • Increase in utility costs • Increase in transportation costs • Increase in hospitalizations • Increased in emergency room and urgent care visits • Health care staff and members of the public may get sick • Non-essential businesses may be required to close • Increased stress/burnout/traumatic experiences among essential staff • Differing opinions on how to handle and resolve the pandemic • Further mistrust of public health and other health care organizations • Further misinformation being created and dispersed	• Community organizations and the public continue to work together to thrive and improve the conditions in the community • People are kinder to others and find ways to pay it forward to others • People continue to pray for others and (pray more often), and are more grateful for each other and things • Research is done that may help prevent future diseases/health conditions and to treat health conditions • Create more or expand wellness activities • Increase in food drives and community gardens • Increase the amount of people donating blood and registering to become organ donors
2. Increasing obesity rates	• Lack of healthy food options • Lack of transportation for food • Increase in chronic conditions	• Farmers markets • Physical fitness programs • Affordable physical activity opportunities (e.g., youth sports) • Healthy eating education • Affordable nutritious food options

Force of Change	Threats Posed	Opportunities Created
Economic Forces		
3. Inflation	• Housing costs • Affordability of food, especially nutritious options • Rising utility costs • Higher labor/repair costs	• Mobile food unit/farmers' market • Housing repair programs • Homeowner grants • Aging in place – supporting safe environments for seniors
Environmental Forces		
4. Train derailment/truck accident (causes hazardous chemical spill)	• Hazardous chemicals released into the air and water supply that causes illness to humans, animals, and plants • Road or railroad closures • Costs associated with caring for humans, animals, and plants affected • Costs associated with clean up and investigation	• Update laws/policies regarding rail or truck travel to encourage safer travel • Research done to improve air and water conditions for humans, animals, and plants • Training to prevent and help prepare for future hazardous spillage events.
5. Tornado	• Damages to the local hospital and/or doctors' offices • Hospitalized patients may need to be transferred to other hospitals in the region	• Increased mobile health clinics in the area (Ohio Northern University already has a mobile clinic) • American Red Cross and other organizations assist with clean up, supplies, and funding to rebuild damaged parts of the hospital and doctors' offices • The community continues to work together to try to improve the health and safety of county residents • Local schools and churches that were not damaged offer health care providers to utilize rooms at their buildings in which to exam and treat patients • Provide shelter to residents whose homes were damaged • Increase in the number of residents who are donating blood • Increase the number of residents who are registering to become organ donors • Creation of grants to help organizations and homeowners to repair their buildings or homes.
6. Lack of Housing – Victims of House Fires	• Temporary housing is of poor quality, causing people to move away	• None noted

Force of Change	Threats Posed	Opportunities Created
Social Forces		
7. Social media dispersing inaccurate health information	• People believe what information is posted online Distrust towards health care providers, health department, and other health organizations that serve the public	• Grant offered to health care organizations to pay for them to hire and retain community health workers to present accurate health information to the public • Healthy Lifestyles, The health department, local hospital, and other health organizations offer monthly free presentations to the public about various health topics and a monthly podcast • Continued communication of data-backed health information by health care organizations using social media • Health care providers speak to students and school staff about various health topics on a regular basis during the regular school day Weekly column in various local newspapers authored and driven by students in the area
Development Forces		
8. Housing	• Quality and affordability of housing in the county • Limited rental properties available • People deterred from residing in Hardin County	• None noted
9. Child care	• Limited options/openings in the county	• None noted
Mental Health Forces		
10. Increase demand for mental health treatment/support	• Lack of mental health staff • Suicide	• Creativity in how to offer mental health services (tele)
11. Increase in bullying	• Substance use • Mental health issues • Suicide	• Bullying programming in schools

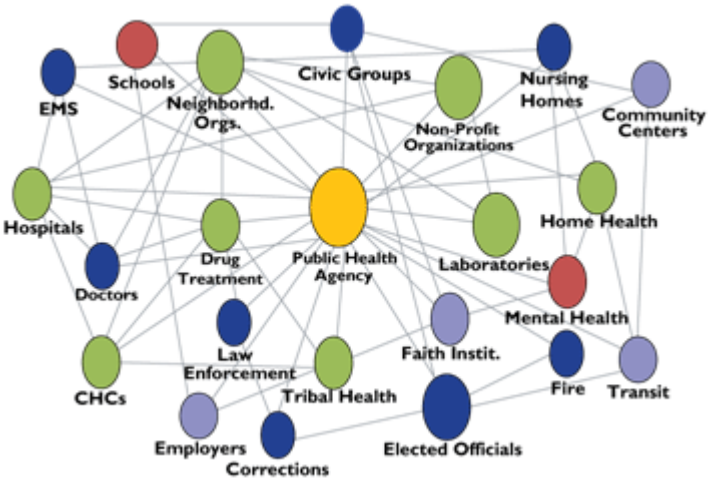
Local Public Health System Assessment

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
- Health care 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 Nation Public Health Performance Standards (NPHPS) instruments.

Public health systems should:

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

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

The Local Public Health System Assessment (LPHSA)

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

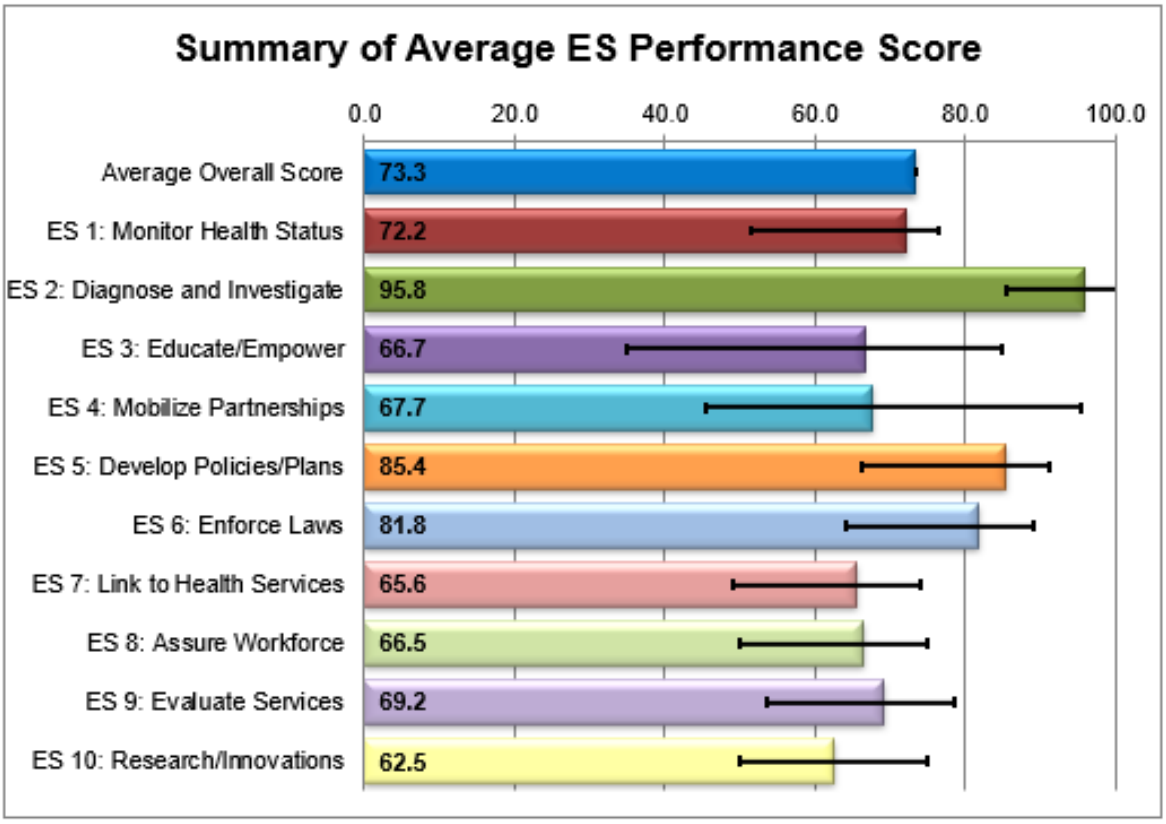
This assessment involves the use of a nationally recognized tool called the **National Public Health Performance Standards Local Instrument.**

Members of the Hardin County Community Assessment Advisory 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.

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 the Kenton-Hardin Health Department.

Hardin County Local Public Health System Assessment 2023 Summary



Gap Analysis and Strategic Planning Terminology

Gaps Analysis

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

Strategy Selection

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

Evidence-Based Practices

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

Resource Inventory

Based on the chosen priorities, the Hardin County Community Health Assessment Advisory Committee was asked to identify resources for each strategy. The resource inventory allowed the committee to identify existing community resources, such as programs, policies, services, and more. Each resource inventory can be found with its corresponding strategy.

Further information about community resources in Hardin County can by visiting **Hardin County United Way's website** for more information.

Strategic Planning Terminology

Action Steps: The specific steps that need to be taken to meet the objective(s).

Timeline: The timeframe in which activities will take place.

Priority Population: The population the strategy focuses on, with emphasis on specific populations at higher risk or impact (based on Key Issues).

Indicators: The specific metric(s) used to measure long term progress and success of the strategy.

Lead Contact/Agency: Who will be responsible for ensuring the objective is met?

Strategy identified as likely to decrease disparities: Strategy has been rated by **What Works for Health** as "likely to decrease disparities" and/or recommended by **The Community Guide** as effective strategies for achieving health equity. These sources consider potential impact on disparities and inequities by racial/ethnic, socio-economic, geographic, or other characteristics.

Policy development or enforcement strategies: Evidence-based health policies can help prevent disease and promote health. The Public Health Accreditation Board (PHAB) requires at least two strategies or activities to include a policy recommendation, one of which must be aimed at alleviating the causes of health inequities. Strategies fitting these criteria are marked with the  icon throughout the CHIP.

Priority #1: Health Behaviors

Strategic Plan of Action

To work toward improving health behaviors, the following strategies are recommended:

Priority #1: Health Behaviors				
Strategy 1: Healthy food initiatives and nutrition education				
Objective: Implement one policy initiative and at least one education initiative related to nutrition/food insecurity by March 31, 2027				
Action Step	Timeline	Priority Population	Indicator (s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Obtain baseline data on current nutrition programming offered in the county. Determine priority populations and topics to focus on by identifying gaps in current nutrition initiatives within the county and priority populations (e.g., adults with diabetes, WIC recipients, senior citizens, etc.). Explore partnership opportunities to educate the priority population on healthy eating practices. Identify nutrition initiative(s) to implement to the public (e.g., food pantries, farmer's markets, community gardens, senior center, etc.) such as: • Cooking classes or demonstrations (e.g., **Cooking Matters**) • Recipe cards • **Fruit and vegetable taste testing** • Home gardening support (e.g., **seed swaps**, **rain barrel workshops**) • **Fruit and vegetable incentive programs** • **MyPlate education** Identify one initiative from above to implement/expand.	April 30, 2025	Adult	Adult obesity: Percent of adults who were categorized as obese according to BMI *(2022 CHA)* Adult fruit and/or vegetable consumption: Percent of adults who consumed 0 servings of fruits and/or vegetables per day *(2022 CHA)*	OSU Snap Extension United Way of Hardin County
Year 2: Continue efforts of year 1. Implement/expand selected nutrition initiative(s) from year 1. Identify ways to advocate on behalf of policies related to nutrition, food insecurity, and physical activity (e.g., advocate for improved school nutrition and physical activity standards, expansion of WIC/SNAP benefits, etc.).	April 30, 2026			
Year 3: Continue efforts of years 1 and 2. Complete a yearly evaluation of current nutrition education programming to determine direction for further programming.	April 30, 2027			
Resources to address strategy: Area Agency on Aging, WIC, farmers' markets, food pantries, public housing, Council on Aging, Heartbeat of Hardin County				

- Ohio SHIP aligned priority/strategy/indicator

- Policy development, enforcement, or advocacy strategy

Priority #1: Health Behaviors

Strategy 2: Online community wellness calendar

Objective: Hardin County will create an online resource calendar/social media page and update it monthly

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collaborate with county organizations to create social media pages regarding local wellness opportunities and events. Include current information regarding nutrition, physical activity, diabetes, and other chronic disease management opportunities in the county. Include information regarding community gardens, farmers markets, physical activity opportunities, and nutrition education, as well as senior programs. Highlight programs that are free or available at a reduced cost. Ensure directions on how to access the social media pages are available for individuals not familiar with social media.	April 30, 2025	Adult	Adult physical inactivity: Percent of adults, age 18 and older, reporting no leisure time physical activity *(County Health Rankings)* Adult obesity: Percent of adults who were categorized as obese according to BMI *(2022 CHA)*	Healthy Lifestyles United Way of Hardin County
Year 2: Continue efforts from year 1. Keep the social media pages updated on a regular basis.	April 30, 2026			
Year 3: Continue efforts from year 2. Keep the social media pages updated on a regular basis.	April 30, 2027			
Resources to address strategy: Ohio Northern University, Area Agency on Aging, YMCA, Kenton Hardin Health Department, Healthy Lifestyles Coalition, OSU Extension, OhioHealth Hardin Memorial Hospital, United Way of Hardin County, Heartbeat of Hardin County, WIC				

- Ohio SHIP aligned priority/strategy/indicator

Priority #1: Health Behaviors

Strategy 3: Community-wide physical activity campaign

Objective: Implement a community-wide physical activity campaign in collaboration with at least five Hardin County agencies by March 31, 2027

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Create a community-wide physical activity campaign. Recruit at least five agencies who are working to improve and promote Hardin County's physical activity opportunities. Determine the goals and objectives of the physical activity campaign. Engage community agencies to coordinate a unified message to increase awareness of Hardin County physical activity opportunities, such as **community fitness programs**, Walk with a Doc, and **activity programs for older adults**, and create a culture of health. Brand the campaign and explore the feasibility of creating a county physical activity resource that houses all physical activity opportunities.	April 30, 2025	Adult and youth	Adult physical inactivity: Percent of adults, age 18 and older, reporting no leisure time physical activity *(County Health Rankings)* Adult obesity: Percent of adults who were categorized as obese according to BMI *(2022 CHA)* Youth physical inactivity: Percent of youth reporting they did not participate in at least 60 minutes of physical activity on 1 or more days in the past week *(2022 CHA)* Youth obesity: Percent of youth who were categorized as obese according to BMI *(2022 CHA)*	Healthy Lifestyles
Year 2: Continue efforts of year 1. Using the coordinated message, all participating agencies will increase awareness of physical activity opportunities and promote the use of them at least once a week. Provide non-participating community agencies with materials to support the campaign, such as social media messages, website information, infographics, maps of activities, booklets, flyers, etc.	April 30, 2026			
Year 3: Continue efforts of years 1 and 2.	April 30, 2027			

Resources to address strategy: Ohio Northern University, OhioHealth Hardin Memorial Hospital, Area Agency on Aging, YMCA, Kenton Hardin Health Department, Healthy Lifestyles Coalition, OSU Extension, United Way of Hardin County, Heartbeat of Hardin County, WIC

- Ohio SHIP aligned priority/strategy/indicator

Priority #2: Chronic Disease

Strategic Plan of Action

To work toward improving chronic disease outcomes, the following strategy is recommended:

Priority #2: Chronic Disease				
Strategy 1: Preventive health screening and referral				
Objective: Increase the number of patients screened and referred by ONU by 5% each year				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Ensure a referral guide for health care providers is available and up-to-date to connect at-risk patients to evidence-based preventive/self-management programs. Ensure the referral guide includes resources for a variety of conditions (e.g., prediabetes, hypertension, depression, cancer, tobacco use, etc.). Update the referral guide yearly to accurately reflect availability, eligibility criteria, and location of services. Promote free/reduced cost screening opportunities within the county, such as health fairs, hospital screening events, etc. Target screenings towards those who live in or serve economically disadvantaged and/or minority populations. Increase the number of patients screened and referred by 5% from baseline.	April 30, 2025	Adult	Hypertension screening: Percent of adults who had their blood pressure checked by a health professional within the past year *(2022 CHA)* Cholesterol screening: Percent of adults who had their blood cholesterol checked by a health professional within the past 5 years *(2022 CHA)* Prediabetes: Percent of adults who had ever been told by a health professional that they have prediabetes *(2022 CHA)*	Ohio Northern University
Year 2: Continue efforts from year 1. Increase the number of patients screened and referred by 5% from previous year.	April 30, 2026			
Year 3: Continue efforts of years 1 and 2. Increase the number of patients screened and referred by 5% from previous year.	April 30, 2027			
Resources to address strategy: OhioHealth Hardin Memorial Hospital, Area Agency on Aging, YMCA, Kenton Hardin Health Department, Healthy Lifestyles Coalition, Diabetes Self-Management Program, OSU Extension				

- Ohio SHIP aligned priority/strategy/indicator

Priority #3: Mental Health and Addiction

Strategic Plan of Action

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

Priority #3: Mental Health and Addiction				
Strategy 1: Launch and promote mobile health web based text alert system for mental/behavioral health				
Objective: By March 31, 2027, increase Ascend Notify system utilization by 5% from first year of launch				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Launch web based Ascend Notify text alert system. Utilize system to promote free/low-cost supportive services (e.g., Narcan distribution, behavioral health resources) for users to refer to. Explore partnerships to aid in implementing a marketing campaign.	April 30, 2025	Adult	Adult suicide deaths: Number of deaths due to suicide for adults, ages 18 and older, per 100,000 population (age-adjusted) *(ODH Data Warehouse)* Unintentional drug overdose deaths: Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted) *(ODH Data Warehouse)*	Mental Health and Recovery Services Board
Year 2: Continue efforts from year 1. Collect baseline data on first year launch of Ascend Notify system (e.g., number of viewers, popular topics, etc.). Evaluate Ascend Notify system usage yearly and determine direction for further programming.	April 30, 2026			
Year 3: Continue efforts from years 1 and 2. Increase Ascend Notify system utilization by 5% from previous year.	April 30, 2027			
Resources to address strategy: Family Resource Center, PASS				

- Ohio SHIP aligned priority/strategy/indicator

Priority #3: Mental Health and Addiction

Strategy 2: Mental Health First Aid

Objective: Conduct one mental health first aid training per quarter by March 31, 2027

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Responsible Person/ Agency
Year 1: Facilitate an assessment among health care providers, teachers, coaches, law enforcement, social service providers, and other community members on their ability to identify, understand, and respond to signs of mental illnesses and substance use disorders. Continue to offer mental health first aid. Administer at least three **mental health first aid** trainings to increase education and understanding of mental illnesses and substance use disorders. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations.	April 30, 2025	Adult and youth	Adult suicide deaths: Number of deaths due to suicide for adults, ages 18 and older, per 100,000 population (age-adjusted) *(ODH Data Warehouse)* Youth suicide deaths: Number of deaths due to suicide for youth, ages 8-17, per 100,000 population (age-adjusted) *(ODH Data Warehouse)*	Prevention Awareness Support Services (PASS)
Year 2: Continue efforts from year 1. Administer at least four mental health first aid trainings (one per quarter) to increase education and understanding of mental illnesses and substance use disorders. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations.	April 30, 2026			
Year 3: Continue efforts from years 1 and 2. Administer at least four mental health first aid trainings (one per quarter) to increase education and understanding of mental illnesses and substance use disorders. Target trainings towards those who live in or serve economically disadvantaged and/or minority populations.	April 30, 2027			
Resources to address strategy: Mental Health and Recovery Services Board, Coleman, Ohio Northern University, Family Resource Center, SAFY, UMADAOP, Kenton Hardin Health Department, OhioHealth Hardin Memorial Hospital				

- Ohio SHIP aligned priority/strategy/indicator

Priority #3: Mental Health and Addiction				
Strategy 3: Crisis Intervention Team (CIT)				
Objective: By March 31, 2027, implement a biannual CIT training to all newly hired law enforcement officers and officers that have not attended the training				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Work with Hardin County law enforcement to collect baseline data on the number of law enforcement officers that have received CIT training. Discuss the importance of CIT training with Hardin County law enforcement for all newly hired law enforcement officers to receive CIT training.	April 30, 2025	Adult	Adult suicide deaths: Number of deaths due to suicide for adults, ages 18 and older, per 100,000 population (age-adjusted) *(ODH Data Warehouse)* Youth suicide deaths: Number of deaths due to suicide for youth, ages 8-17, per 100,000 population (age-adjusted) *(ODH Data Warehouse)* Unintentional drug overdose deaths: Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted) *(ODH Data Warehouse)*	Prevention Awareness Support Services (PASS)
Year 2: Continue efforts from year 1. Arrange and implement a biannual CIT training for all newly hired law enforcement officers as well as officers that have not previously attended the training.	April 30, 2026			
Year 3: Continue efforts from years 1 and 2. Arrange and implement a biannual CIT training for all newly hired law enforcement officers as well as officers that have not previously attended the training.	April 30, 2027			
Resources to address strategy: Mental Health and Recovery Services Board, Coleman, Ohio Northern University, Family Resource Center, SAFY, UMADAOP				

- Ohio SHIP aligned priority/strategy/indicator

Priority #3: Mental Health and Addiction				
Strategy 4: Continue school-based social and emotional instruction				
Objective: Increase participation in school-based social and emotional instruction by 5% each year by March 31, 2027				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to offer **The PAX Good Behavior Game** and/or another school-based social-emotional learning program to Hardin County school districts that primarily serve economically disadvantaged and/or minority populations. Collect baseline data on the number of students that have participated in PAX and/or another school-based social-emotional learning program. Expand the program to additional schools and grade levels and increase participation by 5% from baseline.	April 30, 2025	Youth	Youth suicide deaths: Number of deaths due to suicide for youth, ages 8-17, per 100,000 population (age-adjusted) *(ODH Data Warehouse)* Youth suicide ideation: Percent of youth who report that they seriously considered attempting suicide within the year *(2022 CHA)* Youth depression: Percent of youth who had a period of two or more weeks when they felt so sad or hopeless nearly every day that they stopped doing usual activities in the past year *(2022 CHA)*	Mental Health and Recovery Services Board (MHRB)
Year 2: Continue efforts from year 1. Expand the program to additional schools and grade levels and increase participation by 5% from previous year.	April 30, 2026			
Year 3: Continue efforts from years 1 and 2. Expand the program to additional schools and grade levels and increase participation by 5% from previous year.	April 30, 2027			
Resources to address strategy: PASS, Coleman, Ohio Northern University, Family Resource Center, SAFY, UMADAOP				

- Ohio SHIP aligned priority/strategy/indicator

Priority #3: Mental Health and Addiction

Strategy 5: School-based alcohol/other drug prevention programs

Objective: Increase participation in school-based alcohol/other drug prevention programs by 5% each year by March 31, 2027

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/ Agency
Year 1: Continue to offer evidence-based programming, including tobacco/vaping prevention, to Hardin County school districts that primarily serve economically disadvantaged and/or minority populations. Collect baseline data on the number of students that have participated in specific evidence-based programs. Expand the program to additional grade levels and increase participation by 5% from baseline.	April 30, 2025	Youth	Youth alcohol use: Percent of high school students who have used alcohol within the past 30 days *(2022 CHA)* Youth marijuana use: Percent of high school students who have used marijuana within the past 30 days *(2022 CHA)*	Prevention Awareness Support Services (PASS) Mental Health and Recovery Services Board (MHRB)
Year 2: Continue efforts from year 1. Expand the program to additional grade levels and increase participation by 5% from previous year.	April 30, 2026			
Year 3: Continue efforts from years 1 and 2. Expand the program to additional grade levels and increase participation by 5% from previous year.	April 30, 2027			
Resources to address strategy: Ohio Northern University, Family Resource Center, SAFY, UMADAOP				

- Ohio SHIP aligned priority/strategy/indicator

Priority #3: Mental Health and Addiction				
Strategy 6: Naloxone education and distribution programs ✓				
Objective: Increase the number of Naloxone mail orders by 5% each year by March 31, 2027				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to implement Project DAWN and provide/distribute naloxone to law enforcement and increase awareness of free naloxone distribution for lay responders. Explore grant funding opportunities to expand naloxone access (e.g., naloxone vending machines/cabinets).	April 30, 2025	Adult	Unintentional drug overdose deaths: Number of deaths due to unintentional drug overdoses per 100,000 population (age adjusted) *(ODH Data Warehouse)*	Health Department
Year 2: Continue efforts from year 1. Increase the number of Naloxone mail orders by 5%. Identify ways to advocate on behalf of policies related to substance use (e.g., advocate for additional funding at the local, state, or national level to expand harm reduction services)	April 30, 2026			
Year 3: Continue efforts from years 1 and 2. Increase the number of Naloxone mail orders by 10%.	April 30, 2027			
Resources to address strategy: Mental Health and Recovery Services Board, PASS, Coleman, Ohio Northern University, Family Resource Center, SAFY, UMADAOP, Union County Health Department				

- Ohio SHIP aligned priority/strategy/indicator
✓ *Strategy is likely to reduce disparities based on review by What Works for Health or health equity strategy in The Community Guide*
- Policy development, enforcement, or advocacy strategy

Progress and Measuring Outcomes

Progress will be monitored with measurable indicators identified for each strategy. Many of the indicators align directly with the SHIP. The individuals or agencies that are working on strategies will meet on an as-needed basis. The full committee will meet biannually to report out progress. The committee will create a plan to disseminate the CHIP to the community. Strategies, responsible agencies, and timelines will be reviewed at each progress meeting by the committee. As this CHIP is a living document, edits and revisions will be made accordingly.

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

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

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

Contact Us

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

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Appendix I: Gaps and Strategies

The following tables indicate priority related gaps and potential strategies that were identified by the Hardin County Community Health Assessment Advisory Committee. The committee identified gaps and potential strategies via an online platform (SurveyMonkey). The results were compiled and presented to the committee.

Note: parentheses indicate the number of organizations who reported the same or similar gaps/potential strategies

Health Behavior Gaps

Priority Factor #1: Health Behaviors (focus: adult/youth weight status, adult/youth vaping)	
Gaps	**Potential Strategies**
1. Reducing nicotine use (tobacco/vaping) (4)	• School-based tobacco and prevention skill-building programs (e.g., Catch My Breath) (2) • Community education (e.g., secondhand smoke exposure) (2) • Promote smoke free policies (homes/multi-unit housing, schools) • Tobacco marketing restrictions • Text message-based and smartphone app health interventions to reduce tobacco use/increase tobacco cessation • Targeted interventions using staff with expertise in motivational interviewing and incentives to support participation
2. Lack of support/treatment for adults who are overweight/obese (2)	• Community-wide physical activity campaign * • Educate community on local exercise facilities/programs * • Encourage and promote healthy eating habits • Look for grants to help pay for our community to provide • Targeted interventions using staff with expertise in motivational interviewing and incentives to support participation
3. Youth obesity (2)	• Healthy meals served at schools √ • Healthy food in food banks √ • Community-wide physical activity campaign * • Farmer's markets • Look for grants to help pay for our community to provide
4. Lack of resources to support healthy food choices	• Incentive program to support healthy food choices (vouchers for healthy foods for intervention (appointments/class) participation

= Ohio SHIP supported strategy
√ = likely to reduce disparities
* Aligned with previous Hardin County CHIP
= policy development, enforcement, or advocacy strategy

Mental Health and Addiction Gaps

Priority Outcome #1: Mental Health & Addiction (focus: adult/youth mental health & suicide, adult/youth drug use, youth alcohol use, youth bullying/violence, youth ACEs)	
Gaps	**Potential Strategies**
1. Adult and youth substance abuse (3)	• Increase Naloxone distribution to community members and first responders (2) ✓ * • Too Good for Drugs course in school for students * • Increase the use of Mobile Health (text messaging & apps) to deliver health care services and support to individuals with substance abuse concerns • Education on Project DAWN • Increase access to care • Continue to offer Telehealth services
2. Adult/youth mental health & suicide (2)	• More education for community members (businesses, agencies, family members, patients, students, school staff) (e.g., Mental Health First Aid training) (2) * • Universal School Based Suicide Awareness/Prevention such as Lifelines • Increase the use of Mobile Health (text messaging & apps) to deliver health care services and support to individuals with mental health concerns • Continue to offer Telehealth services
3. Lack of mental health and addiction providers in the Hardin County area (2)	• Work with the local high schools, colleges, work for development, Chamber of Commerce, and other agencies to recruit new talent to this area ✓ • Increase access to outside services (Telehealth) • Consider alternative forms of management (support groups, peer counselors, wellness programming, etc.)
4. Stigma of mental health issues leading to patients not seeking help	• Offer mental health first aid classes and incentivize participation *
5. Alcohol abuse/misuse	• Increase education on risk factors associated with alcohol use * • Increase treatment options

= Ohio SHIP supported strategy
✓ = likely to reduce disparities
* Aligned with previous Hardin County CHIP

Chronic Disease Gaps

Priority Health Outcome #2: Chronic Disease (focus: cardiovascular health, diabetes)	
Gaps	**Potential Strategies**
1. Hypertension/cardiovascular disease (3)	• Offer blood pressure screenings and refer patients with elevated screenings to their physician for follow up care (3) • Increased education on disease management • Nutrition education • Exercise programs
2. Adult diabetes (2)	• Prediabetes screening for all adults, using American Diabetes Association (ADA) prediabetes risk assessment (2) * • Testing and referral to Diabetes Prevention Program (DPP) * • Blood glucose test for adults who score 5 or higher on the ADA prediabetes risk assessment • Testing and referral to a physician
3. Lack of preventative services	• Increase screening and education to lower incidence of disease
4. Poor outcomes for those diagnosed with conditions	• Increase access to evidence-based primary care services and incentivize patient participation/outcome achievement for providers
5. Prevention and risk reduction of chronic disease/pain	• Increased access to pain management

= Ohio SHIP supported strategy
√ = likely to reduce disparities
* Aligned with previous Hardin County CHIP

Appendix II: Links to Websites

Title of Link	Website URL
Activity programs for older adults	https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/activity-programs-for-older-adults
Community fitness programs	https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/community-fitness-programs
Cooking demonstrations	https://cookingmatters.org/community-resources/
Fruit and vegetable incentive programs	https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/fruit-vegetable-incentive-programs
Fruit and vegetable taste testing	https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/fruit-vegetable-taste-testing
Hardin County United Way	https://www.unitedwayhardincounty.org/2-1-1.html
Healthy People 2030	https://health.gov/healthypeople/objectives-and-data
Kenton-Hardin Health Department website	https://hardinhealth.org/
Mental health first aid	https://www.mentalhealthfirstaid.org/
MyPlate	https://www.myplate.gov/
Naloxbox	https://naloxbox.org/
Naloxone education and distribution programs	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/naloxone-education-distribution-programs
Ohio State Health Improvement Plan	https://odh.ohio.gov/about-us/sha-ship/state-health-improvement-plan
PAX Good Behavior Game	https://www.paxis.org/
Rain barrel workshops	https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/rain-barrels
Seed swaps	https://shop.seedsavers.org/site/pdf/csrp-seed-swap.pdf
Smoke-free indoor policies	https://codes.ohio.gov/ohio-revised-code/section-3794.02
Social and emotional instruction	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/school-based-social-and-emotional-instruction
The Community Guide	https://www.thecommunityguide.org/
What Works for Health	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies

Appendix III: Secondary Data Sources – Strategy Indicators

Priority Indicator(s)	Secondary Data Source(s)	Secondary Data Source URL(s)	Applicable Strategy
Priority #1: Health Behaviors			
Adult physical inactivity: Percent of adults reporting no leisure-time physical activity in the past month	Behavioral Risk Factor Surveillance System, as compiled by Kaiser Family Foundation	https://www.countyhealthrankings.org/	Strategy 2: Online community wellness calendar Strategy 3: Community-wide physical activity campaign
Priority #3: Mental Health and Addiction			
Adult suicide deaths: Number of deaths due to suicide for adults, ages 18 and older, per 100,0000 population	Ohio Department of Health Public Health Data Warehouse	https://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/Mortality	Strategy 1: Launch and promote mobile health app for mental/behavioral health Strategy 2: Mental Health First Aid Strategy 3: Crisis Intervention Team (CIT)
Youth suicide deaths: Number of deaths due to suicide for youth, ages 8-17, per 100,000 population	Ohio Department of Health Public Health Data Warehouse	https://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/Mortality	Strategy 2: Mental Health First Aid Strategy 3: Crisis Intervention Team (CIT) Strategy 4: Continue school-based social and emotional instruction
Unintentional drug overdose deaths: Number of deaths due to unintentional drug overdose, per 100,000 population (age adjusted)	Ohio Department of Health Public Health Data Warehouse	https://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/Mortality	Strategy 1: Launch and promote mobile health app for mental/behavioral health Strategy 3: Crisis Intervention Team (CIT) Strategy 6: Naloxone education and distribution programs