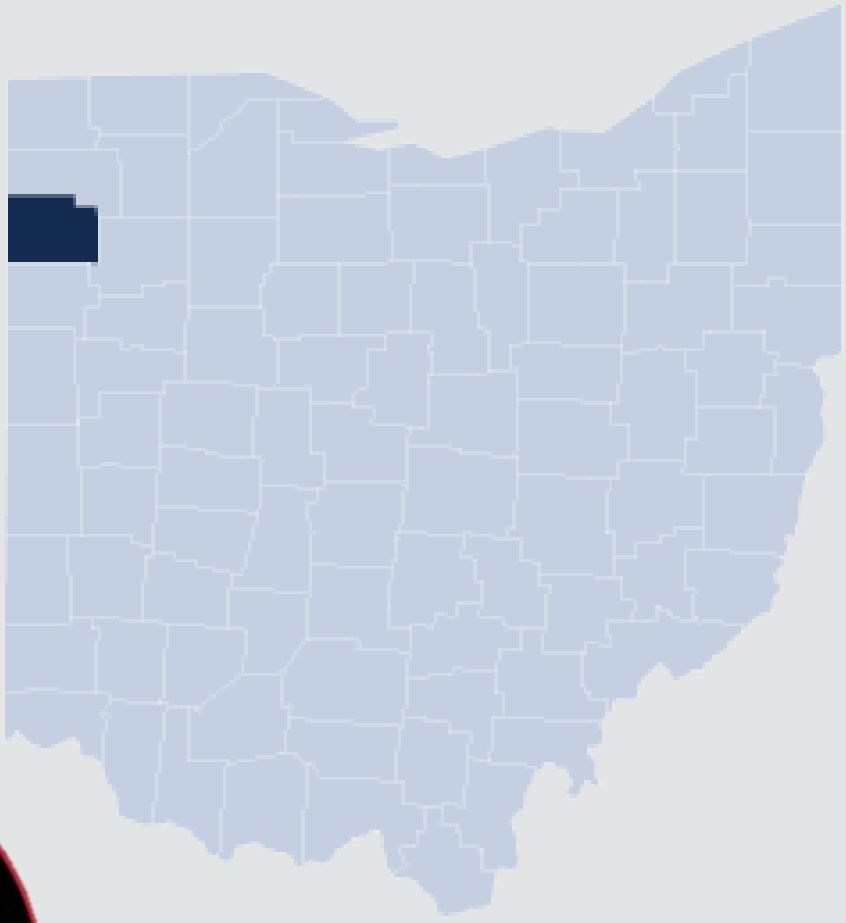

2024-2026 COMMUNITY HEALTH IMPROVEMENT PLAN

PAULDING COUNTY, OHIO

DELIVERED BY: Moxley PUBLIC HEALTH

PCHD Paulding County Health Department

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A NOTE FROM **PAULDING COUNTY HEALTH DEPARTMENT**

Paulding County Health Department strives to bring people and organizations together to improve community wellness. The community health assessment and improvement plan process is one way we can live out our mission. To fulfill this mission, we must be intentional about understanding the health issues that impact residents and work together to create a healthy community.

A primary component of creating a healthy community is assessing and prioritizing needs for impact, and then addressing those needs. In 2023, Paulding County conducted a comprehensive Community Health Assessment (CHA) to identify priority health issues and evaluate the overall current health status of the health department's service area. These findings were then used to develop an Improvement Plan (CHIP) to describe the response to the needs identified in the CHA report.

The 2024-2026 CHIP report is the second of these reports released, all following a CHA. We want to provide the best possible care for our residents, and we can use this report to guide us in our strategic planning concerning future programs, clinics, and health resources.

The Paulding County CHIP would not have been possible without the help of numerous organizations. It is vital that assessments such as this continue so that we can know where to direct our resources and use them in the most advantageous ways.

More importantly, the possibility of this report relies solely on the participation of individuals in our community who committed to participating in interviews and completing health need prioritization surveys. We are grateful for those individuals who are committed to the health of the community, as we are, and take the time to share their health concerns, needs, praises, and behaviors.

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

Sincerely,

Brandi Schrader MEd REHS

Brandi Schrader
Director of Environmental Health & Deputy Health Commissioner
Paulding County Health Department

ACKNOWLEDGEMENTS

This Improvement Plan (CHIP) was made possible thanks to the collaborative efforts of Paulding County Health Department, community partners, local stakeholders, non-profit partners and community residents (listed below). Their contributions, expertise, time and resources played a critical part in the completion of this strategic plan.

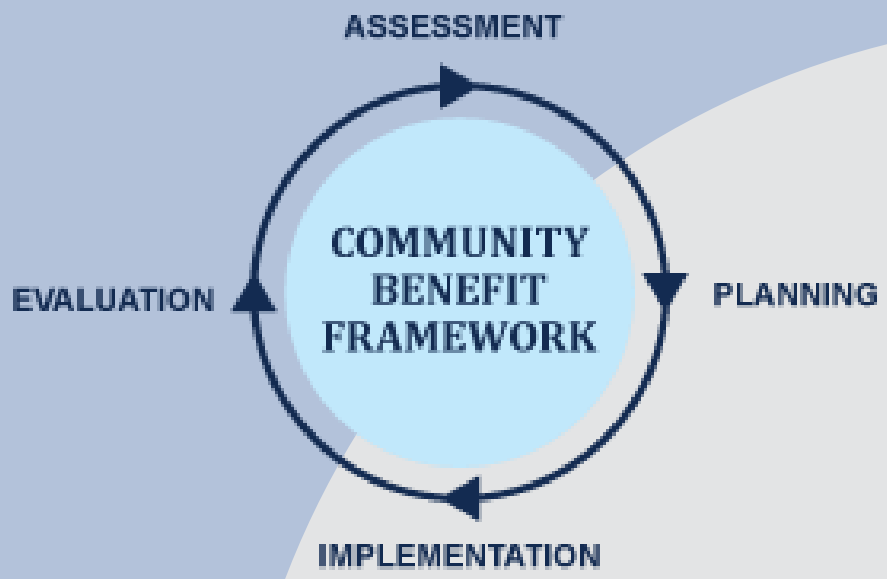
PAULDING COUNTY HEALTH DEPARTMENT WOULD LIKE TO RECOGNIZE THE FOLLOWING INDIVIDUALS AND ORGANIZATIONS FOR THEIR CONTRIBUTIONS TO THIS REPORT:

Antwerp Local Schools
CHP Homecare and Hospice
Cooper Farms
Foundations Behavior Health
Hands of Hope Pregnancy Services
Little Sprouts Early Learning Center
Ohio Farm Bureau
Ohio State University Extension Office
Paulding County Board of Developmental Disabilities
Paulding County Court of Common Pleas
Paulding County Emergency Management Agency
Paulding County Hospital
Paulding County Senior Center
Paulding County Opportunity Center
Paulding County Probate and Juvenile Courts
Paulding County Sheriff's Office
Paulding County Veterans Affairs
Paulding Exempted Village Schools
PC Workshop, Inc.
Tri County Alcohol, Drug Addiction and Mental Health Services Board
United Way of Paulding County, Ohio
Vancrest Health Care Centers
Vantage Career Center
Wayne Trace Local School District
West Ohio Food Bank
Western Buckeye Educational Service Center

The 2024-2026 Improvement Plan (CHIP) report was prepared by Moxley Public Health, LLC, (www.moxleypublichealth.com) an independent consulting firm that works with hospitals, health departments, and other community-based nonprofit organizations both domestically and internationally to conduct Community Health Assessments (CHAs)/Community Health Needs Assessments/CHNAs and Improvement Plans (CHIPs)/Implementation Strategies.

INTRODUCTION

WHAT IS AN IMPROVEMENT PLAN (CHIP)?



An **Improvement Plan (CHIP)** is part of a framework that is used to guide community benefit activities - policy, advocacy, and program-planning efforts. For health departments, the Improvement Plan (CHIP) fulfills the mandates of the Public Health Accreditation Board (PHAB).

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Paulding County Health Department

OVERVIEW
OF THE PROCESS

In order to develop an Improvement Plan (CHIP), Paulding County Health Department followed a process that included the following steps:

STEP 1: Plan and prepare for the CHIP.

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

STEP 3: Consider approaches/strategies to address prioritized needs, health disparities, and social determinants of health.

STEP 4: Select approaches with community partners.

STEP 5: Integrate CHIP with community partners and health department plans.

STEP 6: Develop a written CHIP.

STEP 7: Adopt the CHIP.

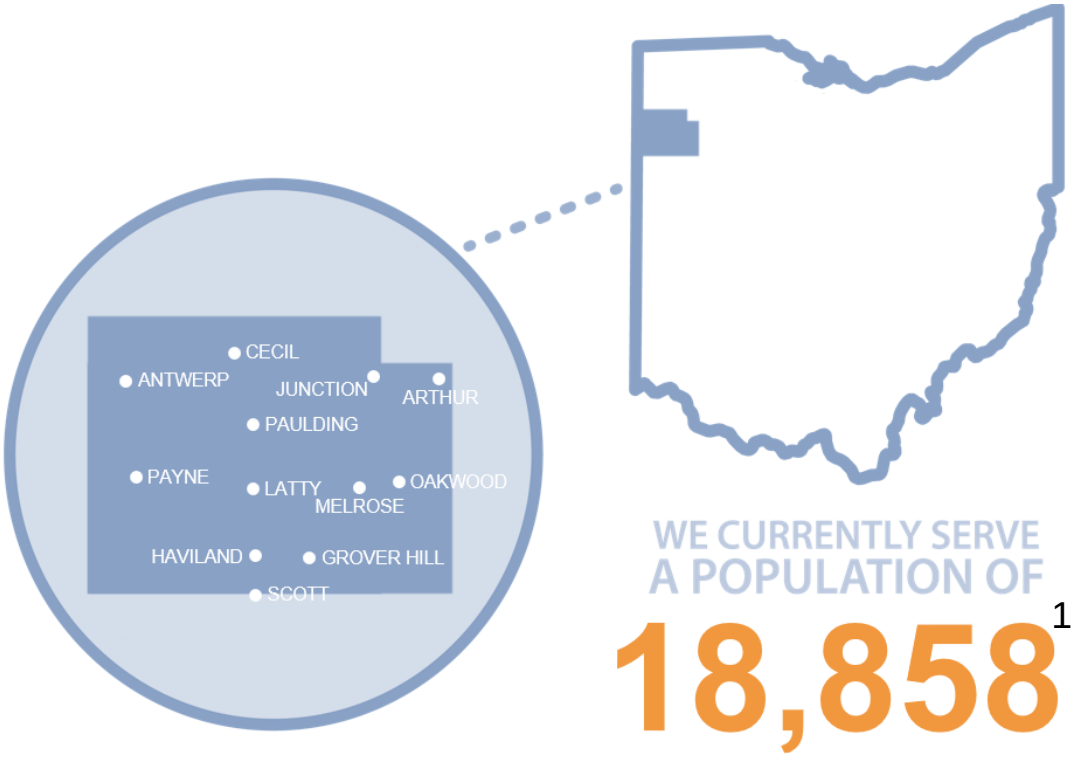
STEP 8: Update and sustain the CHIP.

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

THE 2024-2026 PAULDING COUNTY CHIP MEETS ALL OHIO DEPARTMENT OF HEALTH AND PUBLIC HEALTH ACCREDITATION BOARD (PHAB) REGULATIONS.

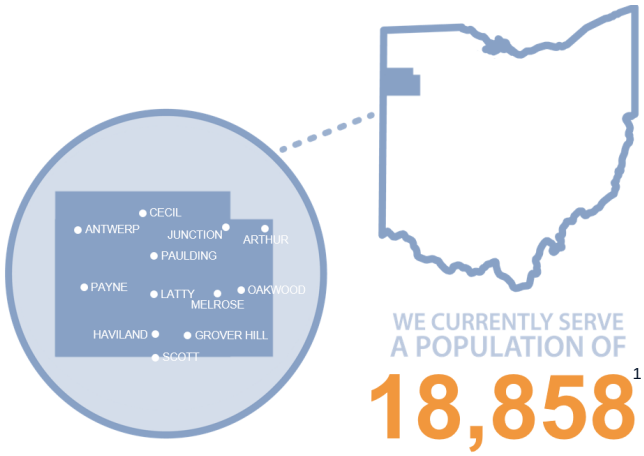
DEFINING THE PAULDING COUNTY **SERVICE AREA**

For the purposes of this report, Paulding County Health Department defines their primary service area as being made up of Paulding County, Ohio. The CHA and this resulting Improvement Plan (CHIP) identify and address significant community health needs and help guide community benefit activities. This CHIP plans to address the selected priority health needs identified by the CHA.



PAULDING COUNTY SERVICE AREA			
GEOGRAPHIC AREA	**ZIP CODE**	**GEOGRAPHIC AREA**	**ZIP CODE**
Antwerp	45813	Latty	45827
Cecil	45821	Melrose	45861
Cloverdale	45827	Oakwood	45873
Defiance	43512	Paulding	45879
Grover Hill	45849	Payne	45880
Haviland	45851		

PAULDING COUNTY
AT-A-GLANCE



WE CURRENTLY SERVE A POPULATION OF

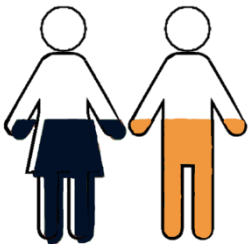
18,858[1]

THE POPULATION OF OHIO IS INCREASING, WHILE THE PAULDING COUNTY POPULATION HAS SLIGHTLY DECREASED IN THE PAST 10 YEARS

-1% PAULDING COUNTY

+2% OHIO

THE % OF MALES AND FEMALES IS APPROXIMATELY EQUAL[3]

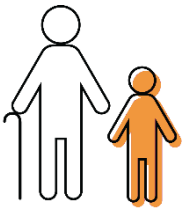


50% **50%**

8%

OF PAULDING COUNTY RESIDENTS ARE VETERANS, SLIGHTLY HIGHER THAN THE STATE RATE[4]

OVER HALF OF VETERANS IN THE SERVICE AREA ARE AGED 65+[4]



YOUTH AGES 0-19 AND SENIORS 65+ MAKE UP

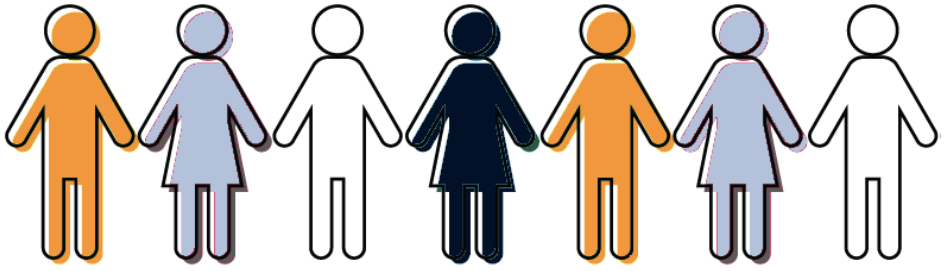
45% OF THE POPULATION

IN THE PAULDING COUNTY SERVICE AREA[5]

NEARLY 1 IN 5 PAULDING COUNTY RESIDENTS ARE AGE 65+[6]

98% OF THE POPULATION IN THE PAULDING COUNTY SERVICE AREA SPEAKS ONLY ENGLISH AND ONLY 3% ARE FOREIGN-BORN[7]

THE MAJORITY (92%) OF THE POPULATION IN PAULDING COUNTY IDENTIFIES AS WHITE AS THEIR ONLY RACE[1]



92% WHITE	5% HISPANIC OR LATINO	1% BLACK/ AFRICAN AMERICAN	0.5% AMERICAN INDIAN/ AK NATIVE	0.4% ASIAN	0.0% NATIVE HI/PACIFIC ISLANDER	2% MULTI RACIAL/ OTHER

THE AGE-ADJUSTED MORTALITY RATE IN PAULDING COUNTY OF 852 PER 100,000 POPULATION IS SLIGHTLY HIGHER THAN THE STATE OF OHIO[8]

1 IN 256 PAULDING COUNTY RESIDENTS WILL DIE PREMATURELY, WHICH IS LOWER THAN THE OHIO STATE RATE[9]

PAULDING COUNTY IS RANKED IN THE TOP 25% OF HEALTHIEST COUNTIES IN OHIO BASED ON HEALTH FACTORS THAT WE CAN MODIFY[9]

STEP 1

PLAN AND PREPARE FOR THE IMPROVEMENT PLAN (CHIP)

IN THIS STEP, PAULDING COUNTY:

- DETERMINED WHO WOULD PARTICIPATE IN THE DEVELOPMENT OF THE CHIP
- ENGAGED BOARD AND EXECUTIVE LEADERSHIP
- REVIEWED COMMUNITY HEALTH ASSESSMENT

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PLAN AND PREPARE FOR THE 2024-2026 PAULDING COUNTY IMPROVEMENT PLAN (CHIP)

Secondary and primary data were collected to complete the 2023 Paulding County Community Health Assessment (CHA) report. (Available at https://www.pauldingcountyhealth.com/). Secondary data were collected from a variety of local, county and state sources to present community demographics, social determinants of health, health care access, birth characteristics, leading causes of death, chronic disease, health behaviors, mental health, substance use, and preventive practices. The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection.

Primary data was collected through key informant interviews with **25** experts from various organizations serving the Paulding County service area and included leaders and representatives of medically underserved, low-income, and minority populations, or local health or other departments or agencies. A *Community-Wide Survey* was distributed via a QR code and link with **354** responses. The survey responses (from community members) were used to prioritize the health needs, answer in-depth questions about the health needs in the county, and to identify health disparities present in the community. Finally, there were **8** focus groups held across the county, representing a total of 72 community members. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets potentially available to address needs, and prioritize health needs. More detail on methodology can be found in the 2023 Paulding County CHA Report.

> **The improvement plan (CHIP) deals with the "how and when" of addressing needs. While the community health assessment considers the "who, what, where and why" of community health needs, the CHIP takes care of the how and when components.**

STEP 2

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

IN THIS STEP, PAULDING COUNTY:

- DEVELOPED GOALS FOR THE IMPROVEMENT PLAN (CHIP) BASED ON THE FINDINGS FROM THE CHA
- SELECTED INDICATORS TO ACHIEVE GOALS

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Paulding County Health Department

PRIORITY HEALTH NEEDS
GOALS, OBJECTIVES, AND INDICATORS

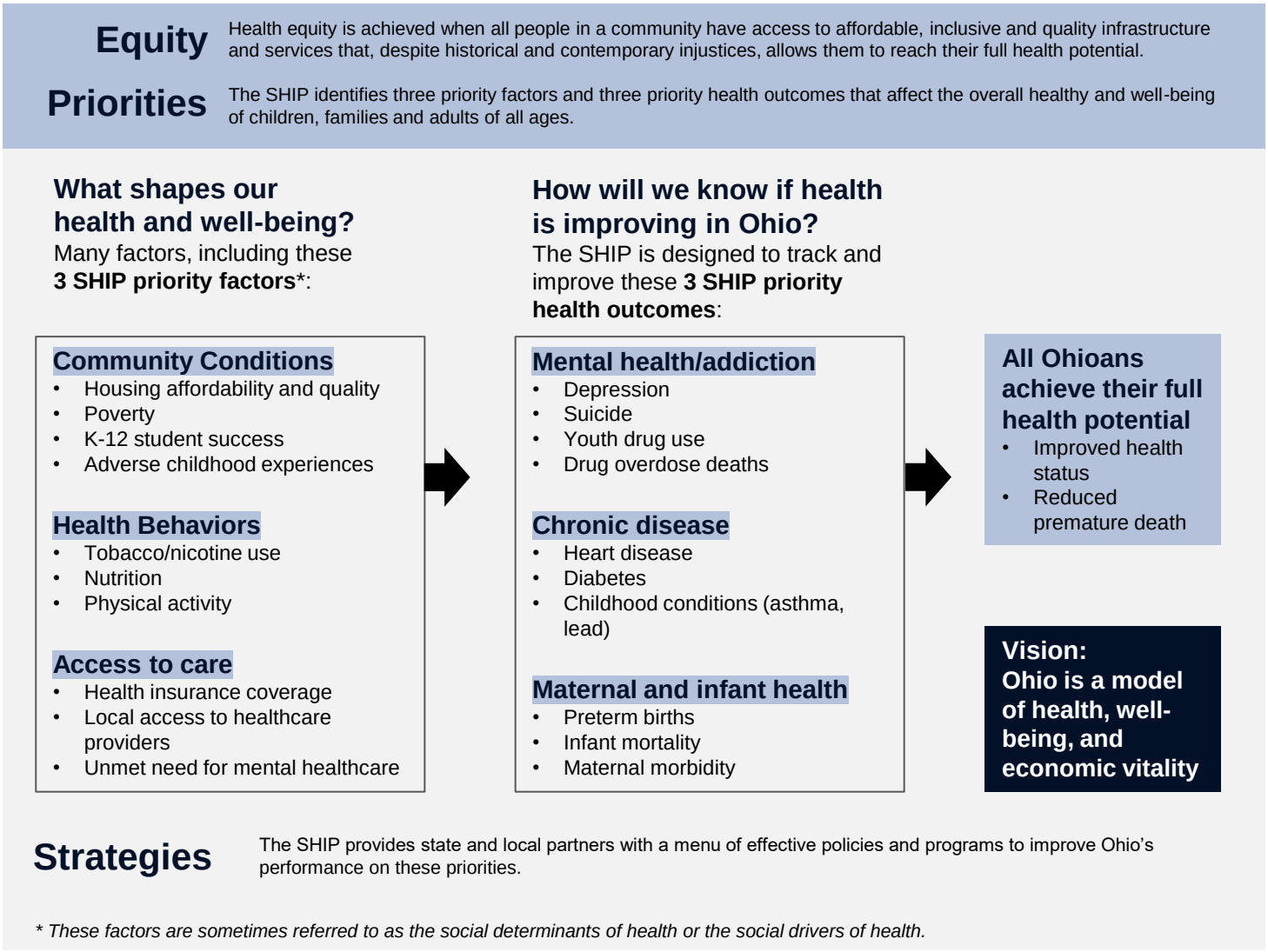
Ohio Department of Health (ODH) Requirements

The following image shows the framework from ODH that this report followed while also adhering to federal requirements and the community's needs.

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

First, Paulding County Health Department used the same language as the state of Ohio when assessing the factors and health outcomes of their community in the 2023 Paulding County Community Health Assessment.

Figure 1: Ohio State Health Improvement Plan (SHIP) Framework



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

ALIGNMENT WITH PRIORITIES AND INDICATORS

Figure 3. **Alignment with priorities and indicators**

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

PRIORITY FACTORS	PRIORITY HEALTH OUTCOMES
☑ Community Conditions (strongly recommended)	☑ Mental Health and Addiction
☑ Health Behaviors	☑ Chronic Disease
☑ Access to Care	☑ Maternal and Infant Health

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

PRIORITY FACTORS	
COMMUNITY CONDITIONS	
TOPIC	**INDICATOR NAME***
Housing affordability and quality	☐ CC1. Affordable and Available Housing Units
Poverty	☐ CC2. Child Poverty
	☐ CC3. Adult Poverty
K-12 student success	☐ CC4. Chronic Absenteeism (K-12 students)
	☐ CC5. Kindergarten Readiness
Adverse childhood experiences	☑ CC6. Adverse Childhood Experiences (ACEs)
	☑ CC7. Child Abuse and Neglect
HEALTH BEHAVIORS	
TOPIC	**INDICATOR NAME***
Tobacco/nicotine use	☑ HB1. Adult Smoking
	☑ HB2. Youth All-Tobacco/Nicotine Use
Nutrition	☑ HB3. Youth Fruit Consumption
	☑ HB4. Youth Vegetable Consumption
Physical Activity	☑ HB5. Child Physical Activity
	☑ HB6. Adult Physical Activity
ACCESS TO CARE	
TOPIC	**INDICATOR NAME***
Health Insurance Coverage	☑ AC1. Uninsured Adults
	☑ AC2. Uninsured Children
Local Access to Healthcare Services	☑ AC3. Primary Care Health Professional Shortage Areas
	☑ AC4. Mental Health Professional Shortage Areas
Unmet Need for Mental Health Care	☑ AC5. Youth Depression Treatment Unmet Need
	☑ AC6. Adult Mental Health Care Unmet Need

ALIGNMENT WITH PRIORITIES AND INDICATORS (CONTINUED)

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

PRIORITY HEALTH OUTCOMES	
MENTAL HEALTH AND ADDICTION	
TOPIC	**INDICATOR NAME***
Depression	☑ MHA1. Youth Depression
	☑ MHA2. Adult Depression
Suicide Deaths	☑ MHA3. Youth Suicide Deaths
	☑ MHA4. Adult Suicide Deaths
Youth Drug Use	☑ MHA5. Youth Alcohol Use
	☑ MHA6. Youth Marijuana Use
Drug Overdose Deaths	☑ MHA7. Unintentional drug overdose deaths
CHRONIC DISEASE	
TOPIC	**INDICATOR NAME***
Heart Disease	☑ CD1. Coronary Heart Disease
	☑ CD2. Premature Death - Heart Disease
	☑ CD3. Hypertension
Diabetes	☑ CD4. Diabetes
Harmful Childhood Conditions	☑ CD5. Child Asthma Morbidity
	☑ CD6. Child Lead Poisoning
MATERNAL AND INFANT HEALTH	
TOPIC	**INDICATOR NAME***
Preterm Births	☐ MIH1. Uninsured Adults
Infant Mortality	☐ MIH2. Infant Mortality
Maternal Morbidity/Mortality	☐ MIH3. Severe Maternal Morbidity

ADDRESSING THE **HEALTH NEEDS**

The 2023 Community Health Assessment (CHA) identified the following significant health needs from an extensive review of the primary and secondary data. The significant health needs were ranked:

HEALTH NEEDS RANKED IN THE COMMUNITY MEMBER SURVEY:
#1 Substance use
#2 Mental health and access to mental healthcare
#3 Income/poverty and employment
#4 Food insecurity (e.g. not being able to access and/or afford healthy food)
#5 Access to healthcare (e.g. doctors, hospitals, specialists, medical appointments, etc.)
#6 Access to childcare
#7 Adverse childhood experiences (e.g. child abuse, mental health, family issues, trauma)
#8 Transportation (e.g. public transit, cars, cycling, walking)
#9 Chronic diseases (e.g. heart disease, diabetes, cancer, asthma)
#10 Nutrition and physical health/exercise
#11 Housing and homelessness
#12 Education (e.g. early childhood education, elementary school, post-secondary education)
#13 Crime and violence
#14 Environmental conditions (e.g. air and water quality)
#15 Internet/Wi-Fi access
#16 Tobacco and nicotine use/smoking
#17 Preventive care and practices (e.g. mammograms, vaccinations)
#18 Maternal, infant and child health (e.g. pre-term births, infant mortality, maternal mortality)
#19 HIV/AIDS and Sexually Transmitted Infections (STIs)

ADDRESSING THE **HEALTH NEEDS**

From the significant health needs, Paulding County Health Department chose health needs that considered the health department's capacity to address community needs, the strength of community partnerships, and those needs that correspond with the health department's priorities.

THE 3 PRIORITY HEALTH NEEDS THAT WILL BE ADDRESSED IN THE 2024-2026 IMPROVEMENT PLAN (CHIP) ARE:

Priority Area 1: Mental Health & Substance Misuse

Priority Area 2: Chronic Disease

Priority Area 3: Access to Healthcare

STEPS 3 & 4

CONSIDER AND SELECT APPROACHES/STRATEGIES TO ADDRESS PRIORITIZED NEEDS, HEALTH DISPARITIES, AND SOCIAL DETERMINANTS OF HEALTH WITH COMMUNITY PARTNERS

IN THESE STEPS, PAULDING COUNTY HEALTH DEPARTMENT:

- SELECTED APPROACHES/ STRATEGIES TO ADDRESS PAULDING COUNTY SERVICE AREA PRIORITIZED HEALTH NEEDS, HEALTH DISPARITIES, AND SOCIAL DETERMINANTS OF HEALTH
- DEVELOPED A WRITTEN IMPROVEMENT PLAN (CHIP) REPORT

PCHD
Paulding County Health Department

#1 PRIORITY AREA MENTAL HEALTH & SUBSTANCE MISUSE

Includes adverse childhood experiences and tobacco & nicotine use

IN OUR COMMUNITY

54% OF YOUTH in Ohio with major depressive episodes in the past year **did not receive mental health services**[10]

39% OF YOUTH in Ohio with major depressive episodes in the past year received some **consistent mental health services** (7+ visits)[10]

29% OF ADULTS in BRFSS* Region 1 have been diagnosed with **depression and suicidal ideation** by a mental health professional, compared to 29% for Ohio[11]

17% OF ADULTS in Paulding County experienced **frequent mental distress** (2+ weeks/ month in the past year), compared to 16% for Ohio[11]

Paulding County's suicide rate has **increased over time**, from 9.8 per 100,000 in 2011-2013 to 11.1 per 100,000 in 2018-2020[12]

In 2022, **29 of every 10,000** emergency department visits in the county could be **attributed to suspected overdose**, compared to 44 per 10,000 for Ohio[12]

STRATEGIES

ALL POPULATIONS			YOUTH
Develop Paulding County Mental Health and Substance Misuse Coalition.	Increase awareness of Mental Health & Substance Misuse Resources.	Share Community Health Assessment (CHA) findings on mental health and substance misuse to the public via social media and other channels.	Provide education, support and/or services for Mental Health and Addiction.

PARTNERS

Tri County Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board, Paulding County Health Department (PCHD), Paulding County Schools, Mental Health and substance misuse agencies (Foundations Behavioral Health, Westwood Behavioral Health Center (WBHC)), Parkview Education Forum and Annual Meeting (EFAM), Family Children First Council (FCFC), Paulding County Hospital, Western Buckeye Educational Service Center (WBESC)	PCHD, Tri County ADAMHS Board, WBESC, United Way of Paulding County, Northwestern Ohio Community Action Commission, Inc. (NOCAC)	PCHD	PCHD, Paulding County Schools, Paulding County Sheriff's Office, Paulding County Courts, WBESC

POPULATIONS

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

Children and youth, adults, older adults, low-income residents, Black/African American, Black, Hispanic, and Non-Hispanic White residents, LGBTQ+ residents, men, people experiencing homelessness

Youth in the service area will **significantly benefit**, as they are less likely to report being able to access help for mental health and substance use issues and may be greatly impacted by adverse childhood experiences early in life.

OUTCOMES

DESIRED OUTCOMES OF STRATEGIES

- ↑ Education and awareness on mental health
- ↓ Mental health stigma
- ↑ Access to mental health and substance abuse care and support

OVERALL IMPACT OF STRATEGIES

- ↑ Mental health
- ↑ Quality of life
- ↓ Substance abuse
- ↓ Mental health and substance abuse emergency department visits and hospitalizations
- ↓ Overdose deaths
- ↓ Suicides
- ↓ Psychological distress and depression

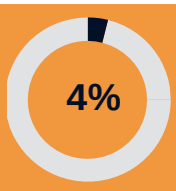
ALL PAULDING COUNTY RESIDENTS ACHIEVE THEIR FULL HEALTH POTENTIAL

*Behavioral Risk Factor Surveillance System; BRFSS Region 1 contains Paulding County.

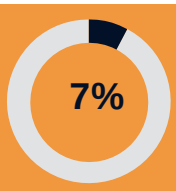
#2 PRIORITY AREA
CHRONIC DISEASE

Includes nutrition and physical health, overweight and obesity, food security, preventive care and practices

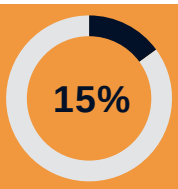
IN OUR COMMUNITY



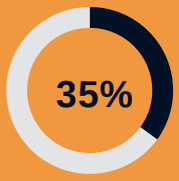
of both Paulding County and Ohio adults reported they have had a **stroke**[14]



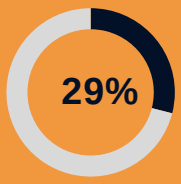
of Paulding County adults reported having had a **heart attack, angina, or coronary heart disease**, compared to 8% for Ohio[14]



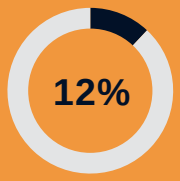
of Paulding County adults have **diabetes,** compared to 12% for the state[14]



of both Paulding County and Ohio adults have **hypertension**[14]



of Paulding County adults have **high cholesterol**, compared to 31% of Ohio adults[14]



of BRFSS* Region 1 has **asthma, compared to 11% for Ohio**[14]

CANCER IS THE **LEADING CAUSE OF DEATH** IN PAULDING COUNTY, WHILE THE OVERALL INCIDENCE PER 100,000 IS **SLIGHTLY LOWER** THAN OHIO[15]

454	461
PAULDING	OHIO

STRATEGIES

ALL POPULATIONS		YOUTH, LOWER INCOME HOUSEHOLDS, INDIVIDUALS/HOUSEHOLDS WITH MEDICAL NEEDS	ELDERLY
Share Community Health Assessment (CHA) findings on chronic disease to the public via social media and other channels.	Create a policy at PCHD that will require that at all events hosted by PCHD (where food is provided), healthy food options will be made available (fruits and vegetables).	Expand nutrition education.	Decrease falls in elderly.

PARTNERS

Paulding County Health Department (PCHD)	PCHD	Ohio State University (OSU) Extension Office, PCHD, Women, Infants, and Children (WIC), Paulding County Hospital, Antwerp School District, Paulding School District, Wayne Trace School District, Northwestern Ohio Community Action Commission, Inc. (NOCAC), Paulding County Senior Center	PCHD, Paulding County Hospital, Paulding County Senior Center, Home Health Care businesses

POPULATIONS

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

Children and youth, adults, older adults, low-income residents, Black/African American, Multiracial, Latino/a, Asian, American Indian and Alaska Native, and Native Hawaiian and Pacific Islander residents, LGBTQ+ residents

Older adult residents in the service area will **significantly benefit**, as they are at a higher risk of developing many chronic conditions.

OUTCOMES

DESIRED OUTCOMES OF STRATEGIES

- ↑ Education on chronic diseases & risk factors
- ↑ Chronic disease prevention, screening & management
- ↓ Sedentary youth & adults
- ↑ Opportunities for physical activity
- ↓ Food insecurity
- ↑ Nutrition, including fruit and vegetable consumption

OVERALL IMPACT OF STRATEGIES

- ↑ Mental and physical health
- ↑ Quality of life
- ↑ Health status
- ↓ Overweight & obesity
- ↓ Chronic disease
- ↓ Premature mortality

ALL PAULDING COUNTY RESIDENTS ACHIEVE THEIR FULL HEALTH POTENTIAL

*Behavioral Risk Factor Surveillance System; BRFSS Region 1 contains Paulding County.

#3 PRIORITY AREA
ACCESS TO HEALTHCARE

IN OUR COMMUNITY

PAULDING COUNTY HAS LESS ACCESS TO PRIMARY CARE PROVIDERS THAN OHIO OVERALL, WHILE MORE ACCESS TO VISION CARE PROVIDERS[16]

PAULDING COUNTY	OHIO
4,660:1	1,291:1
1,291:1	1,566:1

1 IN 10
COMMUNITY SURVEY RESPONDENTS DO NOT HAVE A USUAL PRIMARY CARE PHYSICIAN[17]

1 IN 5
COMMUNITY SURVEY RESPONDENTS HAVE NOT BEEN TO THE DENTIST IN THE LAST 5 YEARS[17]

MORE THAN
1 IN 5 (22%)
BRFSS* REGION 1 RESIDENTS (PAULDING COUNTY AREA) DID NOT HAVE A ROUTINE CHECKUP IN THE PRIOR YEAR[18]

29% of community survey respondents delayed or did not get medical care in the past year[17]

STRATEGIES

ALL POPULATIONS		HISPANIC RESIDENTS	NON-ENGLISH SPEAKING POPULATION, PEOPLE WITH HEARING & VISUAL DISABILITIES
Develop a Health Living Coalition.	Share Community Health Assessment (CHA) findings on access to healthcare to the public via social media and other channels.	Increase insurance benefit awareness and education.	Add translation services to the Paulding County Health Department (includes policy development at PCHD).

PARTNERS

Paulding County Health Department (PCHD), Hospitals, Dentists, Optometrists, Schools, Tri County Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board	PCHD	Paulding County Hospital, Employers, Employees, PCHD, United Way, Economic Development, Ohio State University (OSU) Extension Office, Hands of Hope	PCHD

POPULATIONS

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

Children and youth, adults, older adults, low-income residents, Black/African American, Multiracial, Latino/a, Asian, American Indian and Alaska Native, and Native Hawaiian and Pacific Islander residents, LGBTQ+ residents, rural residents

Rural residents in the service area will **significantly benefit**, as they may have to travel farther to access healthcare services. They may particularly benefit from mobile and telehealth services.

OUTCOMES

DESIRED OUTCOMES OF STRATEGIES

- ↑ Increase access and utilization of non-emergency healthcare services and existing healthcare resources
- ↑ Access to primary care, screening, and routine checkups
- ↑ Access to culturally and linguistically appropriate care
- ↓ Delayed care

OVERALL IMPACT OF STRATEGIES

- ↑ Health status
- ↑ Quality of life
- ↑ Prevention and management of chronic diseases
- ↓ Emergency department visits and hospitalizations
- ↓ Unmet care needs
- ↓ Premature mortality and morbidity

ALL PAULDING COUNTY RESIDENTS ACHIEVE THEIR FULL HEALTH POTENTIAL

CURRENT RESOURCES
ADDRESSING PRIORITY HEALTH NEEDS

Information was gathered on assets and resources that currently exist in the community. This was done using feedback from the community and an overall assessment of the service area. While this list strives to be comprehensive, it may not be complete.

Crime and Violence
Paulding County Court of Common Pleas
Paulding County Probate and Juvenile Courts
Paulding County Sheriff's Office

Education
Antwerp Local Schools
Ohio State University Extension Office
Paulding Exempted Village Schools
Wayne Trace Local School District
Western Buckeye Educational Service Center

Emergency & General Needs
Auglaize Chapel Church of God
Caring and Sharing Food Pantry
Furniture Bank- Defiance, Paulding and Southern Henry County
Grover Hill Food Pantry
Paulding County Emergency Management Agency
Paulding County Ministerial
Paulding County Senior Center
Rainbow Ministries
St. Paul United Methodist Church - Payne

Employment/Job Training
Defiance-Paulding Consolidated Job & Family Services
Department of Job and Family Services – Paulding
Ohio Farm Bureau
Ohio Means Jobs – Paulding
Paulding County Opportunity Center
Vantage Career Center

Food Security
Caring and Sharing Food Pantry
Northwestern Ohio Community Action Commission (NOCAC) – Partnership Assistance to the Homeless (PATH) Center
Paulding County Health Department – Women, Infants, and Children (WIC)
Paulding Family Worship Center
Pioneer Christian
St. Paul Lutheran Church
The Gathering Place Church
West Ohio Food Bank

Healthcare
Allcaring Home Health Services
Approved Home Health
CHP Homecare and Hospice
David Deal Ph.D. & Associates
Defiance Family Physicians
Defiance Orthopedic Center
Dental Smile Express
InfantSEE
Ohio Early Intervention
Paulding County Hospital
Professional Vision Services
Paulding County Health Department - Help Me Grow
Vancrest Health Care Centers

Housing and Homelessness
Habitat for Humanity-Paulding
House of Ruth - Center for Child & Family Advocacy
Maumee Valley Planning Organization
Northwestern Ohio Community Action Commission (NOCAC) – Partnership Assistance to the Homeless (PATH) Center
Regional Coordinated Entry Point of Access

Legal Assistance
Advocates for Basic Legal Equality (ABLE)
Birth Injury Justice Center
Crime Victims
Habitat for Humanity-Paulding
Legal Aid of Western Ohio

Mental Health and Substance Use
988
Coping Center
Crisis Text Line
Foundations Behavioral Health
Hope Alive Counseling Services
HopeLine
Ohio Guide Stone
Paulding County Health Department - Help Me Grow
Recovery Services of Northwest Ohio
Tri County Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board
Westwood Behavioral Health Center

Social Services
Alzheimer Association NW Ohio Chapter
American Red Cross of West Central Ohio
Approved Home Health
Area Office on Aging
Defiance-Paulding Consolidated Job & Family Services
Department of Job and Family Services – Paulding
Family of Addicts (FOA)
Fellowship Club
Goodwill Industries – Defiance
Hands of Hope Pregnancy Services
House of Ruth - Center for Child & Family Advocacy
Northwestern Ohio Community Action Commission (NOCAC) – Paulding
Paulding County Board of Developmental Disabilities
Paulding County Health Department
Paulding County Veterans Affairs
PC Workshop, Inc.
Power2Change
Salvation Army – Defiance
United Way of Paulding County, Ohio

Preschool/Childcare
Ann's Bright Beginnings Preschool, LTD.
Antwerp Local Elementary School
Divine Mercy School
Emmaus Christian Preschool
Grover Hill School
Head Start/Northwestern Ohio Community Action Commission (NOCAC)
Little Sprouts Early Learning Center
Oakwood Elementary
Ohio Early Intervention
Paulding County Health Department - Help Me Grow
Paulding Elementary School
Payne School
Teresa Stahl

STEPS 5-8

INTEGRATE, DEVELOP, ADOPT, AND SUSTAIN IMPROVEMENT PLAN (CHIP)

IN THIS STEP, PAULDING COUNTY WILL:

- INTEGRATE CHIP WITH COMMUNITY PARTNERS AND HEALTH DEPARTMENT PLANS
- ADOPT THE CHIP
- UPDATE AND SUSTAIN THE CHIP

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PAULDING COUNTY
NEXT STEPS

The Community Health Assessment (CHA) and this resulting Improvement Plan (CHIP) identify and address significant community health needs and help guide community benefit activities. This CHIP explains how Paulding County Health Department plans to address the selected priority health needs identified by the CHA.

This CHIP report was adopted by Paulding County Health Department leadership in 2024.

This report is widely available to the public on the health department website:
Paulding County Health Department: https://www.pauldingcountyhealth.com/

Written comments on this report can be made by contacting the Paulding County Health Department: brandis@pcohhd.com.

EVALUATION OF IMPACT

Paulding County Health Department will monitor and evaluate the programs and actions outlined above. We anticipate the actions taken to address significant health needs will improve health knowledge, behaviors, and status, increase access to care, and overall help support good health. Paulding County is committed to monitoring key indicators to assess impact. Our reporting process includes the collection and documentation of tracking measures, such as the number of people reached/served and collaborative efforts to address health needs. A review of the impact of Paulding County's actions to address these significant health needs will be reported in the next scheduled CHA.

ADDITIONAL HEALTH NEEDS NOT DIRECTLY ADDRESSED

Since Paulding County Health Department cannot directly address all the health needs present in the community, we will concentrate our resources on those health needs where we can effectively impact our region given our areas of focus and expertise. Taking existing organization and community resources into consideration, Paulding County will not directly address the remaining health needs identified in the CHA, including but not limited to crime and violence, environmental conditions, internet access, access to childcare, education, maternal and child health, HIV/AIDS and STIs, economic stability, and COVID-19. We will continue to look for opportunities to address community needs where we can make a meaningful contribution. Community partnerships may support other initiatives that the health department cannot independently lead in order to address the other health needs identified in the 2023 CHA.

APPENDIX A

PUBLIC HEALTH ACCREDITATION BOARD (PHAB) CHECKLIST: IMPROVEMENT PLAN (CHIP)

MEETING THE PHAB REQUIREMENTS FOR THE CHIP

The Public Health Accreditation Board (PHAB) Standards & Measures serve as the official guidance for PHAB national public health department accreditation, and includes requirements for the completion of Community Health Assessments (CHAs) and CHIPs for local health departments. The following page demonstrates how this CHIP meets the PHAB requirements.

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APPENDIX B:

PHAB COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) REQUIREMENTS CHECKLIST

PUBLIC HEALTH ACCREDITATION BOARD (PHAB) REQUIREMENTS FOR CHIPs			
YES	**PAGE #**	**PHAB REQUIREMENTS CHECKLIST**	**NOTES/ RECOMMENDATIONS**
✓		**MEASURE 5.2.1 A: Engage partners and members of the community in a community health improvement process.** 1. A collaborative process for developing the community health improvement plan (CHIP), which includes:	
	4	a. A list of participating partners involved in the CHIP process. Participation must include: i. At least 2 organizations representing sectors other than public health. ii. At least 2 community members or organizations that represent populations that are disproportionately affected by conditions that contribute to health risks or poorer health outcomes.	
✓	7-8, 12-16, 18-21	b. Review of information from the community health assessment.	
✓	18-20	c. Review of the causes of disproportionate health risks or health outcomes of specific populations.	
✓	12-16	d. Process used by participants to select priorities.	
		The CHIP process must address the jurisdiction as described in the description of Standard 5.2.	
		MEASURE 5.2.2 A: Adopt a community health improvement plan.	
		1. A community health improvement plan (CHIP), which includes all of the following:	
✓	18-20	a. At least two health priorities.	
✓	18-20	b. Measurable objective(s) for each priority.	
✓	18-20	c. Improvement strategy(ies) or activity(ies) for each priority. i. Each activity or strategy must include a timeframe and a designation of organizations or individuals that have accepted responsibility for implementing it. ii. At least two of the strategies or activities must include a policy recommendation, one of which must be aimed at alleviating causes of health inequities.	A detailed work plan (living document) has been developed that included strategies, SMART objectives, annual activities, indicators, partners, and priority populations.
✓	21	d. Identification of the assets or resources that will be used to address at least one of the specific priority areas.	
✓	24	e. Description of the process used to track the status of the effort or results of the actions taken to implement CHIP strategies or activities.	
		The CHIP must address the jurisdiction as described in the description of Standard 5.2.	

APPENDIX B:

PHAB COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) REQUIREMENTS CHECKLIST (CONT.)

PUBLIC HEALTH ACCREDITATION BOARD (PHAB) REQUIREMENTS FOR CHIPs			
YES	**PAGE #**	**PHAB REQUIREMENTS CHECKLIST**	**NOTES/ RECOMMENDATIONS**
✓ ✓ ✓	N/A	**MEASURE 5.2.3 A: Implement, monitor, and revise as needed, the strategies in the community health improvement plan in collaboration with partners.** 1. Community health improvement plan (CHIP) activity or strategy implemented. 2. Annual review of progress made in implementing all strategies and activities in the community health improvement plan (CHIP). 3. Revisions to the community health improvement plan (CHIP) based on the review in Required Documentation 2 (above).	A description of how the previous CHIP was implemented is provided in the 2023 Paulding County Community Health Assessment (CHA). The 2024-2026 CHIP will be evaluated and examples of implementation will be provided to PHAB. Any revisions will be noted.
✓ ✓	18-20	**MEASURE 5.2.4 A: Address factors that contribute to specific populations' higher health risks and poorer health outcomes.** 1. A policy or procedure that demonstrates how health equity is incorporated as a goal into the development of programs that serve the community. 2. Implementation of one strategy, in collaboration with stakeholders, partners, or the community, to address factors that contribute to specific populations' higher health risks and poorer health outcomes, or inequities. The documentation must define the health department's role in the strategy as well as the roles of stakeholders, partners, or the community.	All CHIP strategies are specifically tied to health equity and indicate which priority population(s) the strategy will focus on and the social determinants of health and barriers that will be addressed.

APPENDIX B

REFERENCES

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APPENDIX H:
REFERENCES

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