Health Council of Northwest Ohio

hcno

Community Health Improvement Plan

Auglaize County

2025-2028

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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 Auglaize County Community Health Engagement Committee (CHEC) has been conducting CHAs since 2008 to measure community health status. The most recent Auglaize County CHA was cross-sectional in nature and included a written survey of adults within Auglaize County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention (CDC) for their national and state Behavioral Risk Factor Surveillance System (BRFSS). This has allowed Auglaize 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 Auglaize County Health Department contracted with the Health Council of Northwest Ohio (HCNO), a neutral, regional, nonprofit association, to facilitate the CHA and CHIP. The health department then invited various community stakeholders to participate in the community health improvement process. Data from the most recent CHA was carefully considered and categorized into community priorities with accompanying strategies. This was done using the National Association of County and City Health Officials' (NACCHO) national framework, Mobilizing for Action through Planning and Partnerships (MAPP). Over the next three years, these priorities and strategies will be implemented at the county-level with the hope to improve population health and create lasting, sustainable change. It is the hope of The Auglaize County Community Health Engagement Committee that each agency in the county will tie their internal strategic plan to at least one strategy in the CHIP.

Executive Summary

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 three years. Additionally, PHAB is a voluntary national accreditation program, however the State of Ohio requires that all local health departments become accredited by 2020, making it imperative that all PHAB requirements are met.

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

Inclusion of Vulnerable Populations (Health Disparities)

Approximately 9% of Auglaize County residents were below the poverty line, according to the 2023 Poverty and Median Household Income Estimates provided by the U.S. Census Bureau. For this reason, data is broken down by income (less than $25,000 and greater than $25,000) throughout the report to show disparities.

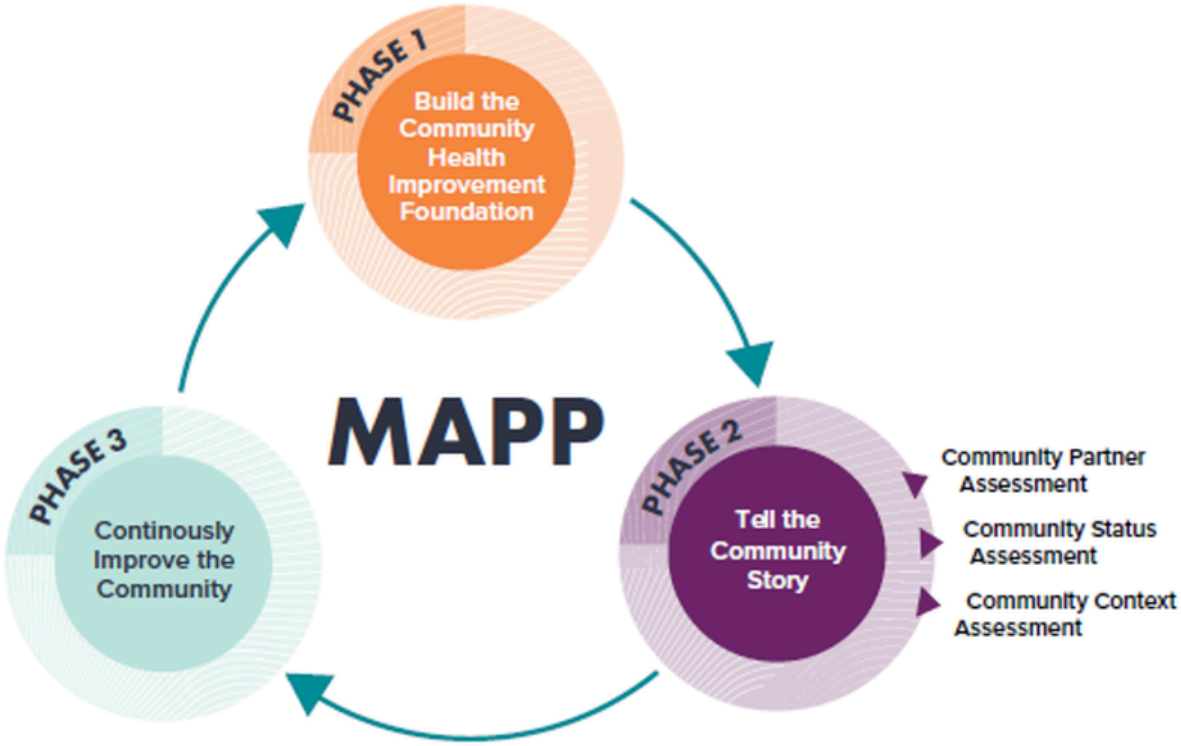
Mobilizing for Action through Planning and Partnerships (MAPP)

NACCHO's strategic planning tool, MAPP, guided this community health improvement process. The MAPP 2.0 framework includes three phases which are listed below:

1. Build the Community Health Improvement Foundation
2. Tell the Community Story
3. Continuously Improve the Community

The MAPP 2.0 process includes three assessments: community partner assessment, community status assessment, and community context assessment. These three assessments were used by the Auglaize County Community Health Engagement Committee to prioritize specific health issues and population groups which are the foundation of this plan. Figure 1.1 illustrates how each of the three assessments contribute to the MAPP 2.0 process.

Figure 1.1 The MAPP 2.0 Model



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Alignment with National and State Standards

The 2026-2028 Auglaize County Community Health Improvement Plan priorities align perfectly with regional, state, and national priorities. Auglaize County will be addressing the following priority factors: access to care and community conditions. Auglaize County will be addressing the following priority health outcomes: mental health and addiction as well as chronic disease.

Healthy People 2030

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

- Healthcare Access and Quality – AHS 01: Increase the proportion of people with health insurance
- Housing and Homes – SDOH 04: Reduce the proportion of families that spend more than 30 percent of income on housing
- Heart Disease and Stroke – HDS 01: Improve cardiovascular health in adults
- Mental Health and Mental Disorder – MHMD 01: Reduce the suicide rate
- Substance Use – SU 05: Reduce the proportion of adolescents who used drugs in the past month
- Environmental Health – EH 04: Reduce blood lead levels in children ages 1 to 5 years

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).

Executive Summary

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 healthcare 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 Auglaize 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.

Note: This symbol will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2020-2022 SHIP. Whenever possible, the Auglaize County CHIP identifies strategies likely to reduce disparities and inequities. This symbol ^ will be used throughout the report when a strategy includes a policy recommendation, as required by PHAB. Throughout the report, hyperlinks will be highlighted in **bold, teal text.**

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The following Auglaize County priority factors, priority indicators, and strategies very closely align with the 2020-2022 SHIP:

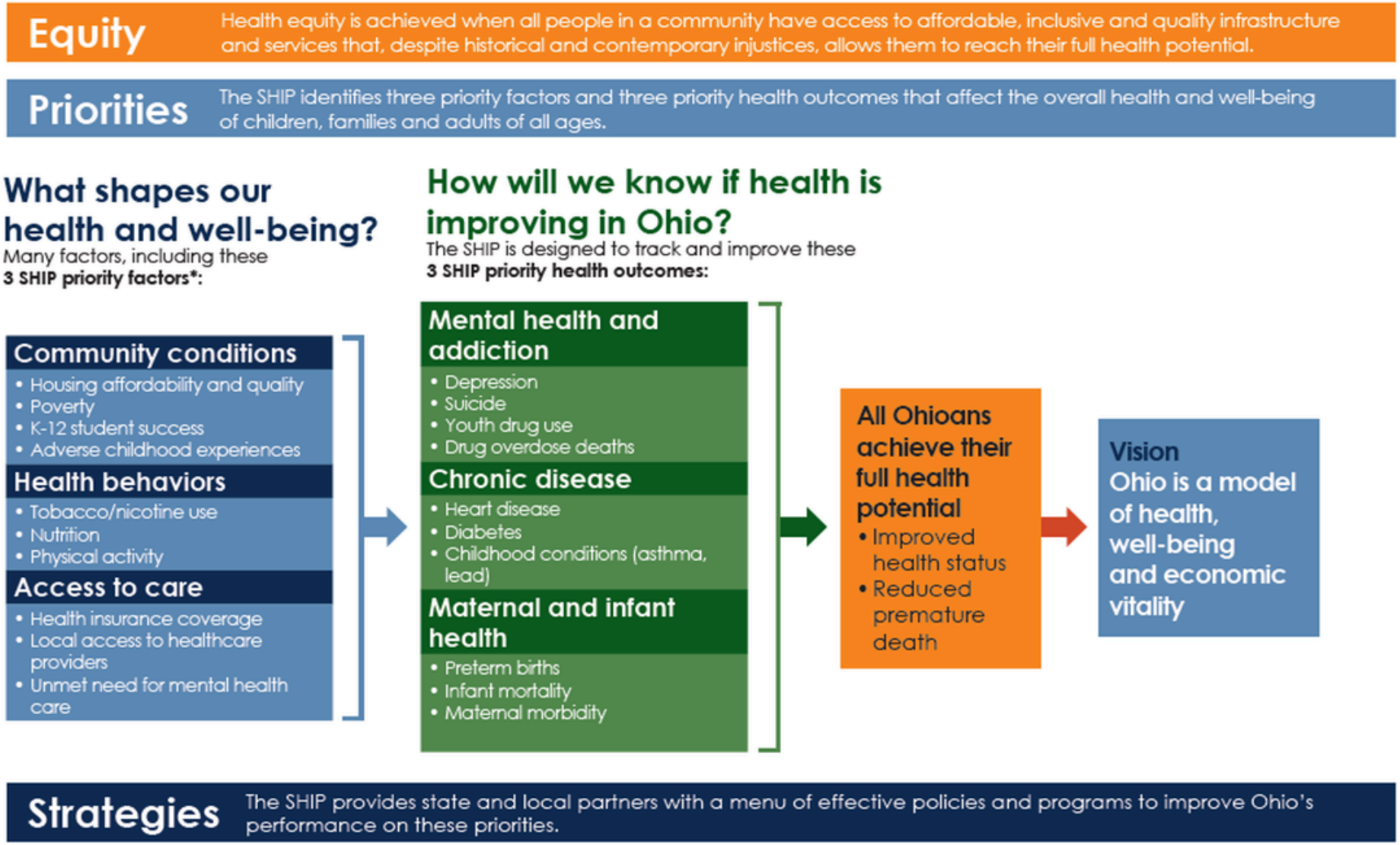
Figure 1.2 2025-2028 Auglaize CHIP Alignment with the 2020-2022 SHIP

Priority Factors	Priority Indicators	Strategies to Impact Priority Indicators
Access to Care	• Uninsured adults: Percent of adults, ages 19-64, who are uninsured (ACS estimates) • Uninsured children: Percent of children, ages 0-18, who are uninsured (ACS estimates)	• Insurance literacy and enrollment assistance
Community Conditions	• N/A	• N/A

Priority Health Outcomes	Priority Indicators	Strategies to Impact Priority Indicators
Mental Health and Addiction	• Adult suicide deaths: Number of deaths due to suicide for adults, ages 18 and older, per 100,000 population (ODH Vital Statistics) • Youth suicide deaths: Number of deaths due to suicide for youth, ages 8-17, per 100,000 population (ODH Vital Statistics) • Youth alcohol use: Percent of high school students who have used alcohol within the past 30 days (YRBS)	• Mental Health First Aid • Universal school-based alcohol prevention programs • Question Persuade Refer training
Chronic Disease	• Child lead poisoning: Percent of children, ages 0-5, with elevates blood lead levels (ODH)	• Blood lead level screening

Alignment with National and State Standards, continued

Figure 1.3 2020-2022 State Health Improvement Plan (SHIP) Overview



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Vision and Mission

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

The Vision of The Auglaize County Community Health Engagement Committee

By working together, guide Auglaize County towards a healthier future.

The Mission of The Auglaize County Community Health Engagement Committee

Bring people and organizations together to empower residents of Auglaize County and promote overall wellness.

Community Partners

The CHIP was planned by various agencies and service-providers within Auglaize County. From September 2025 to December 2025, The Auglaize County Community Health Engagement Committee reviewed many data sources concerning the health and social challenges that Auglaize 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:

Auglaize County Community Health Engagement Committee (CHEC)

Auglaize County Board of Developmental Disabilities
Auglaize County Commissioners
Auglaize County Council on Aging
Auglaize County Family and Children First Council
Auglaize County Head Start
Auglaize County Health Department
Auglaize County Job and Family Services
Auglaize County Juvenile Court
Auglaize County OSU Extension Office
Council on Rural Services - Head Start
Family Resource Center of Auglaize County
Grand Lake Health System
Mental Health and Recovery Services Board of Allen, Auglaize, and Hardin Counties
Mercy Health - St. Rita's Medical Center
Minster Local School District
New Bremen Schools
New Knoxville Local Schools
Prevention Awareness Support Services
St. Mary's City Schools
Wapakoneta City Schools
Waynesfield Goshen Local Schools
West Ohio Community Action Partnership
United Way of Auglaize County

Health Council of Northwest Ohio (HCNO)

The community health improvement process was facilitated by Jodi Franks, Community Health Improvement Coordinator, from HCNO.

Executive Summary

Community Health Improvement Process

Beginning in September 2025, the Auglaize County Community Health Engagement Committee met four (4) times and completed the following planning steps:

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

Community Health Status Assessment

Included in phase 3 of the MAPP 2.0 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. Over 50 sources of secondary data are also included throughout the report. The CHA serves as the baseline data in determining key issues that lead to priority selection. The full report can be found on **Auglaize County's Health Department website**. Below is a summary of county primary data and the respective state and national benchmarks.

Adult Trend Summary

Adult Variables	Auglaize County 2008	Auglaize County 2012	Auglaize County 2017	Auglaize County 2023	Ohio 2022	U.S. 2022
Health Care Coverage, Access, and Utilization						
Uninsured	6%	12%	9%	11%	6%	7%
Had at least one person they thought of as their personal doctor or health care provider	77%	77%	92%	92%	86%	84%
Visited a doctor for a routine checkup in the past year	45%	52%	59%	78%	79%	77%
Preventive Medicine						
Had a flu vaccine in the past year (ages 65 and older)	N/A	65%	67%	73%	65%	68%
Ever had a pneumonia vaccine in lifetime (ages 65 and older)	65%	58%	61%	64%	71%	71%
Had a sigmoidoscopy/colonoscopy in the past 5 years (ages 50 and over)	N/A	58%	52%	58%	N/A	N/A
Men's Health						
PSA test within the past 2 years (age 40 & over)	N/A	N/A	N/A	52%	32%*	32%*
Had a digital rectal exam within the past year	24%	24%	12%	9%	N/A	N/A

N/A - Not Available
**2020 BRFSS Data*
Indicates alignment with the Ohio State Health Assessment

Adult Trend Summary Continued

Adult Variables	Auglaize County 2008	Auglaize County 2012	Auglaize County 2017	Auglaize County 2023	Ohio 2022	U.S. 2022
Women's Health						
Had a clinical breast exam in the past 2 years (age 40 and over)	71%	77%	66%	65%	N/A	N/A
Had a mammogram in the past 2 years (age 40 and over)	64%	71%	64%	75%	68%	70%
Had a pap smear in the past 3 years (ages 21-65)	70%	65%	64%	57%	77%*	78%*
Quality of Life						
Limited in some way because physical, mental, or emotional problems	16%	22%	27%	23%	N/A	N/A
Oral Health						
Adults who visited the dentist in the past year	63%	65%	69%	74%	64%	65%
Alcohol Consumption						
Current drinker (drank alcohol at lease once in the past month)	57%	51%	61%	64%	53%	53%
Binge drinker (defined as consuming more than five [men] of four [women] alcoholic beverages on a single occasion in the past 30 days)	20%	20%	28%	30%	18%	17%
Drove after having perhaps too much alcohol to drink (in the past month)	N/A	N/A	6%	8%	3%*	2%*

N/A - Not Available
**2020 BRFSS Data*
Indicates alignment with the Ohio State Health Assessment

Adult Trend Summary Continued

Adult Variables	Auglaize County 2008	Auglaize County 2012	Auglaize County 2017	Auglaize County 2023	Ohio 2022	U.S. 2022
Tobacco Use						
Current smoker (currently smoke all or some days)	18%	19%	17%	11%	17%	14%
Former smoker (smoked 100 cigarettes in their lifetime & now do not smoke)	22%	23%	27%	30%	26%	25%
Diabetes						
Had been diagnosed with diabetes	8%	11%	11%	12%	13%	12%
Ever been diagnosed with pre-diabetes or borderline diabetes	11%	12%	7%	8%	2%	2%
Cardiovascular Health						
Had angina or coronary heart disease	8%	7%	5%	5%	6%	4%
Had a heart attack or myocardial infection	6%	7%	6%	4%	5%	5%
Had a stroke	4%	2%	4%	3%	4%	3%
Had high blood pressure	35%	41%	37%	42%	36%**	32%**
Had high blood cholesterol	30%	37%	34%	41%	36%**	36%**

N/A - Not Available
*** 2021 BRFSS Data*
Indicates alignment with the Ohio State Health Assessment

Adult Trend Summary Continued

Adult Variables	Auglaize County 2008	Auglaize County 2012	Auglaize County 2017	Auglaize County 2023	Ohio 2022	U.S. 2022
Weight Status						
Obese, including severely and morbidly obese (BMI of 30 and above)	33%	38%	39%	36%	38%	34%
Overweight (BMI of 25.0 - 29.9)	39%	33%	39%	39%	33%	34%
Normal weight (BMI of 18.5-24.9)	26%	27%	21%	23%	27%	30%
Health Status						
Rated health as excellent or very good	54%	53%	50%	49%	49%	50%
Rated general health as fair or poor	11%	11%	11%	14%	19%	17%
Rated mental health as not good on four or more days (in the past month)	19%	20%	27%	30%	31%**	29%**
Average days that mental health was not good (in the past month) (County Health Rankings)	N/A	2.9	4.1	4.2	5.0*	4.4*
Rated physical health as not good on four or more days (in the past month)	21%	20%	22%	19%	21%**	20%**
Average days that physical health was not good (in the past month) (County Health Rankings)	N/A	2.8	4.3	3.1	3.2*	3.0*
Average days that poor physical or mental health kept them from doing their usual activities in the past month	N/A	2.0	2.8	2.3	N/A	N/A

N/A - Not Available
**2020 BRFSS Data as compiled by County Health Rankings*
*** 2021 BRFSS Data*
Indicates alignment with the Ohio State Health Assessment

Key Issues

The Auglaize County Community Health Engagement Committee reviewed the 2024 Auglaize 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 2024 health assessment report? Examples of how to interpret the information include: 42% of Auglaize County adults had ever been diagnosed with high blood pressure, including 45% of males, 58% of adults with annual household incomes less than $25,000, and 62% of adults ages 65+.

Key Issue or Concern	Percent of Population At Risk	Gender Most at Risk	Age Group Most at Risk	Income Level Most at Risk
Weight status (3 votes)				
Adults categorized as obese (including severely and morbidly obese) according to BMI	36%	Males (37%)	30-64 (41%)	<$25K (46%)
Adults categorized as overweight according to BMI	24%	Females (31%)	<30 (36%)	$25K+ (25%)
Cardiovascular health (3 votes)				
Adults diagnosed with high blood pressure in their lifetime	42%	Males (45%)	65+ (62%)	<$25K (58%)
Adults diagnosed with high cholesterol in their lifetime	41%	Males (44%)	65+ (59%)	<$25K (49%)
Mental health (2 votes)				
Adults who indicated they felt sad, blue, or depressed almost every day for two or more weeks in a row in the past year	19%	Females (24%)	30-64 (21%)	<$25K (26%)
Adults who rated mental health as not good on 4 or more days in the past month	30%	Females (37%)	<30 (40%)	<$25K (33%)
Adults who rated mental health as not good on 8 or more days in the past month	18%	Females (22%)	30-64 (20%)	<$25K (26%)
Deaths due to suicide in Auglaize County *(Data Ohio Warehouse, 2019-2023)*	19 deaths	N/A	N/A	N/A

N/A – Data not available

- aligned with 2020-2022 SHIP

- aligned with 2020-2024 Auglaize County CHIP

Key Issues

Key Issue or Concern	Percent of Population At Risk	Gender Most at Risk	Age Group Most at Risk	Income Level Most at Risk
Health care access (2 votes)				
Adults who were uninsured in the past year	11%	Females (13%)	30-64 (18%)	<$25K (23%)
Adults who did not recieve medical care due to no transportation in the past year	1%	N/A	N/A	N/A
Alcohol consumption (2 votes)				
Adults who consumed an alcoholic beverage in the past month	64%	Males (71%)	<30 (79%)	$25K+ (66%)
Adults who engaged in binge drinking in the past month (had five or more alcoholic drinks (for males) or 4 or more drinks (for females) on an occasion)	30%	Males (38%)	N/A	N/A
Substance use (1 vote)				
Adults who used medication not prescribed for them or took more than prescribed to feel good or high and/or more active or alert during the past 6 months	7%	Males (8%)	<30 (8%)	<$25K (20%)
Adults who used recreational marijuana in the past 6 months	4%	N/A	N/A	N/A
Cancer (1 vote)				
Cancer mortality rate - higher than Ohio and U.S. rates *(ODH Warehouse, CDC Wonder, 2018-2020)*	168 deaths per 100,000 population	N/A	N/A	N/A
Environmental conditions (1 vote)				
Adults who indicated air quality threatened their health or their family's health in the past year	8%	N/A	N/A	N/A
Adults who indicated chemicals found in household products threatened their health or their family's health in the past year	2%	N/A	N/A	N/A

N/A – Data not available

- aligned with 2020-2022 SHIP

- aligned with 2022-2024 Auglaize County CHIP

Key Issues

Key Issue or Concern	Percent of Population At Risk	Gender Most at Risk	Age Group Most at Risk	Income Level Most at Risk
Housing (1 vote)				
Percent of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities *(American Community Survey, 2017-2021)*	8%	N/A	N/A	N/A
Child lead exposure (1 vote)				
Percent of tests among Auglaize children ages 0-5 with elevated blood lead levels (BLL>ug/dl) *(Data Ohio, 2020-2024)*	76% (16 out of 21 tests)	N/A	N/A	N/A
Non-compliant hazardous lead properties in Auglaize County that have been issued orders to vacate the property due to lead hazards being declared unsafe for human occupation *(Data Ohio, 2025)*	1 property	N/A	N/A	N/A
Diabetes (1 vote)				
Adults diagnosed with diabetes in their lifetime	12%	Females (13%)	65+ (23%)	<$25K (21%)
Nicotine use (1 vote)				
Adults categorized as a current smoker (smoked at least 100 cigarettes in their lifetime and currently smoked cigarettes on some or all days)	11%	Males (14%)	<30 (20%)	<$25K (20%)

Additional key issues provided without data:

- Neonatal Abstinence Syndrome (NAS) or Neonatal Opioid Withdrawal Syndrome (NOWS)

N/A – Data not available

- aligned with 2020-2022 SHIP

- aligned with 2022-2024 Auglaize County CHIP

Priorities Chosen

Based on the 2024 Auglaize County Health Assessment, key issues were identified for adults and youth. Overall, there were 12 key issues identified by the Auglaize County Community Health Engagement Committee (CHEC). The CHEC then voted and came to a consensus on the priority areas Auglaize County will focus on over the next three years. The key issues and their corresponding votes are described in the table below.

Key Issues	
1. Weight status	3
2. Cardiovascular health	3
3. Mental health	2
4. Health care access	2
5. Alcohol consumption	2
6. Substance use	1
7. Cancer	1
8. Housing	1
9. Environmental conditions	1
10. Childhood lead exposure	1
11. Diabetes	1
12. Nicotine use	1

Auglaize County will focus on the following four priority areas over the next three years:

Priority Factor(s):

1. Access to Care
2. Community Conditions

Priority Health Outcome(s):

1. Mental Health and Addiction
2. Chronic Disease

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:

Total survey respondents = 12

Open-ended Questions to the Committee

1.What do you believe are the 2-3 most important characteristics of a healthy community?

- Access to quality, affordable healthcare (e.g., health providers, health insurance, wellness resources, preventive programs) (5)
- Strong, diverse, innovative economy with thriving local businesses and job opportunities, low poverty rates, and opportunities for growth (5)
- Engaged citizens/community pride/community networks (5)
- Strong community partnerships that ensure easy local access to quality, affordable social services (5)
- Safe, welcoming neighborhoods/community (3)
- Strong families (2)
- Strong schools (e.g., high graduation rates) (2)
- Safe, affordable housing (2)
- Education and resources that empower individuals to take an active role in their own health
- Outdoor recreational activities
- Support of local individuals
- Funding to provide services to the public
- Low mortality rates
- Safe emergency shelter for homeless people
- Programs to support the vulnerable populations (e.g., youth, elderly)
- Activities for families to participate

2. What makes you most proud of your community?

- Strong sense of collaboration and dedication among many agencies (e.g., businesses, schools, civic groups, government, local providers, volunteers) to improve the health and safety of the community (5)
- Generous community that helps those in need (4)
- Rich local history, culture, and heritage (2)
- Small town culture (2)
- School system (2)
- Strong/resilient community (2)
- Access to a lot of resources for people of all walks and ages (2)
- Unique events that draw residents and visitors together (e.g., Summer Moon Festival, Halloween Parade, etc.)
- A spirit of volunteerism and commitment to making Wapakoneta and Auglaize County a better place to live, work, and do business
- Agricultural contributions
- New businesses and revitalization efforts in Wapakoneta and St. Mary's
- Hospital in St. Mary's (award-winning)
- Park

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

- Nonprofits, faith-based groups, volunteer groups, and food pantries working alongside healthcare providers to address food insecurity, youth mentoring, and basic needs (5)
- Local schools and Grand Lake Health System partnering to provide school and sports physicals, flu vaccines, and health education (4)
- The Homelessness Coalition of Auglaize County (4)
- Family & Children First (3)
- Collaboration with community organizations to host health fairs, screenings, and wellness programs (2)
- Auglaize County Community Health Engagement Committee (2)
- Partnerships between the Chamber, schools, and local employers to strengthen workforce development and retain young professionals
- Collaboration with the City of Wapakoneta, Downtown Wapakoneta Partnership, and county officials to enhance downtown vitality and improve infrastructure
- Working with the YMCA to house primary care on-site
- WOCAP partners with the YMCA in Wapakoneta to bring Nurturing Parenting classes to Auglaize County.
- Coleman Professional Services and the Auglaize DD with braided funding for mutually served individuals
- With the use of ARPA grants, Auglaize Board of Developmental Disabilities partnered with 22 different organizations to fund 13 projects to make Auglaize County more accessible. These projects included: 15 playground communication boards, accessible playground equipment at Grand Lake St. Mary's Park, adaptive recreational equipment at Lake Laramie, automatic door openers at New Bremen Senior Center, accessibility renovations at Generations of Love, six universal changing tables, two ADA compliant restrooms, lift systems and signage.
- Family Stability Team (FAST)
- School partnerships with various organizations throughout the County
- Expanding the park and the schools working together to provide for our youth.
- Weekend meals for students

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?

- Access to affordable housing (7)
- Expand mental health resources (3)
- Reliable childcare for working families (2)
- Workforce development, recruitment, and retention (e.g., health care providers, mental health providers) (2)
- Managing and reducing chronic disease risk factors such as hypertension, diabetes, and obesity (2)
- Cost-of-living (2)
- Affordable prescriptions, health insurance, health care (2)
- Access to affordable health care without the hoops of insurance requirements.
- Accessible health and community resources
- Lack of substance use treatment facilities per capita
- Reducing stigma around seeking help for mental health help
- Transportation to community events and to medical appointments in and out of the county
- Funding
- Physical health
- Stress management
- Improving vaccine hesitancy
- Improving the public's trust in government agencies
- Homelessness
- Programing for youth
- Continued support of the community especially our schools, law enforcement, emergency services
- Strong parenting/families
- Daycare for the elderly

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

- Funding (4)
- Workforce shortages (e.g., healthcare, education, childcare, social services) (3)
- Small, rural community with limited resources (3)
- Communication/coordination among multiple organizations and service providers
- Low number of providers to patients
- Awareness
- Stigma
- Cultural barriers
- Limited access, especially for behavioral health and long-term support
- Gaps in awareness or education about preventive care
- Transportation and access challenges affecting residents in rural areas
- Local communities lack control over healthcare costs or pharmaceutical company pricing- the cost of entry into these markets is high
- The spread of incorrect information across social media
- Too many people want to ignore the problem of homelessness instead of addressing it
- People are working longer because of health insurance needs, if we could have more affordable health care/insurance then these individuals would love to retire and could volunteer to mentor youth, help in classrooms, serve as role models

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

- Investment in workforce (2)
- Food access/healthy food availability for families - pantries, free meals, community gardens (2)
- Investment in housing (e.g., low-income housing) (2)
- Policy support for affordable housing and food security programs
- County officials could partner with Certified HUD agencies to provide Fair Housing and other HUD programs
- Re-examining housing zoning laws
- Policies that encourage public-private partnerships to address health and wellness needs
- More mobile health clinic options for Auglaize County through ONU
- Grants or incentives to recruit and retain healthcare providers locally
- Fund providers to take on rural patient care
- Support shared funding models
- Incorporate CHWs into Auglaize County
- Increased funding for preventive care and wellness initiatives
- Continue work on community-based health education tailored to local needs of schools (nutrition, exercise, substance abuse, mental health)
- Work to normalize mental health in schools
- Investment in mental health resources, including both inpatient and outpatient services
- Funding tobacco cessation efforts with local organizations and the schools
- Funding to lower infant mortality rates
- Action to reduce elevated iron blood levels in infants
- Funding to support infants who are born with drug/alcohol addiction
- Investment in expanded childcare options to support families and employers

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

- Collaborative, hands-on initiatives that link business growth with community health, foster strong regional partnerships, improve quality of life, and make Wapakoneta/Auglaize County a more attractive place to live, work, and invest (4)
- Seeing measurable improvements in community health outcomes (e.g., reduced chronic disease rates or increased preventive care participation) would be motivating (2)
- Time (2)
- Initiatives focused on improving the lives of residents
- Initiatives focused on improving access to care for the community
- Outdoor recreational opportunities for individuals with disabilities that promote inclusion

Quality of Life Survey

The Auglaize County Community Health Engagement Committee urged community members to fill out a short Quality of Life Survey via SurveyMonkey. There were 47 Auglaize County community members who completed the survey. The table below incorporates responses from the previous Auglaize County CHIPs 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 choice was considered a non-response, which was not used in averaging responses or calculating descriptive statistics.

Quality of Life Questions	Likert Scale Average Response		
	2018 (n=51)	2021* (n=47)	2025 (n=47)
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]	4.29	4.30	4.11
2.Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.59	3.45	3.30
3.Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	4.20	4.52	4.09
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.)	4.12	3.89	3.57
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.)	4.02	3.70	3.33

**Results of the 2021 assessment were collected during the COVID-19 pandemic*

Quality of Life Survey, continued

Quality of Life Questions	Likert Scale Average Response		
	2018 (n=51)	2021* (n=47)	2025 (n=47)
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?)	4.32	4.46	4.11
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?	4.20	3.87	3.55
8.Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.84	3.91	3.45
9.Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.54	3.79	3.35
10.Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.55	3.64	3.28
11.Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.79	3.61	3.26
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?)	3.69	3.83	3.51

**Results of the 2021 assessment were collected during the COVID-19 pandemic*

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 Auglaize County Community Health Engagement Committee 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 Auglaize County in the future. The table below summarizes the forces of change agent and its potential impacts:

Forces of Change	Threats	Opportunities
Political & Legislative Forces		
Decrease in government funding/potential property tax repeal (4)	• Reduction in emergency services • Loss of services for the Senior Center Services • Decrease in services and less resources for the public • Threat to rural services and healthcare	• Discussion for reform efforts instead of repeal • Education to the public of the impacts that would occur property taxes were eliminated • Looking to outside organizations for grant opportunities • Find unique ways to fund services • Form new connections with community partners
More strict legislation	• More strict guidelines & requirements • Limited care access or opportunity	• Improved care and care quality due to improved policies • Less or better legislation and government regulation
Development & Environmental Forces		
Workforce shortages (3)	• Longer wait times for healthcare/behavioral healthcare (2) • Businesses departing the area • Cost of services increasing • Decreased access for healthcare/behavioral healthcare • Burnout among healthcare providers • Decreased quality of healthcare • Rural areas left underserved for healthcare	• Increase pay for those willing to remain in the workforce • Workforce development activities (e.g., outreach to local universities, application for workforce grants, retention activities) • New training pipelines with schools/colleges • Incentives to recruit/retain providers • Growth of nurse practitioner/PA roles • Community health worker programs

Forces of Change	Threats Posed	Opportunities Created
Development & Environmental Forces (continued)		
Homelessness (3)	• People being forced to live with family or friends • Health and safety of those living without safe shelter • Lack of affordable housing • Lack of infrastructure to support unhoused populations	• Identify the need for additional housing • Develop a homeless shelter within Auglaize County • Form new connections with community partners
Housing availability and affordability (3)	• Increase in homelessness (2) • Health and safety of those facing homelessness • Increase in crime • Mental health concerns • Limited access to employment • Loss of housing stability leading to reduced access to healthcare • Financial strain preventing families from seeking medical treatment • Increased risk of poor health outcomes due to unmet basic needs	• Developing new low-income housing projects in the county • Innovation in housing solutions • Allocate public land for housing solutions • Partnering with community organizations to address housing and health together • Developing programs that reduce barriers to care for those facing high living costs • Advocating for resources that support both stable housing and access to healthcare
Economic Development & Industry Growth	• Housing shortages • Increased infrastructure demand • Risk of uneven access to new jobs	• Job creation • Workforce training programs • Stronger taxbase for public health • Employer partnerships for employee wellness
Limited public transportation options	• Missed medical appointments • Reduced access to jobs • Reduced access to healthy foods • Social isolation for seniors and low-income residents	• Advocacy for rural transit funding • Employer-based transportation support • Volunteer ride-share program • Collaboration with regional transit providers

Forces of Change Assessment

Forces of Change	Threats Posed	Opportunities Created
Development & Environmental Forces (continued)		
Pharmacies closing down within Auglaize County	• Difficulty for some to access their medications	• *None noted*
Lack of childcare	• Unsupervised children • High caregiver to child ratios	• More childcare facilities
Technology Expansion & Digital Divide	• Inequities in access to broadband • Privacy concerns • Seniors and low-income populations left behind	• Telehealth expansion • Online workforce development • Improved data collection for health systems • Digital literacy programs
Increased social media influences on youth	• Mental health implications for youth	• Programing to combat using social media platforms
Technology advancements	• False information • Lack of ability for people to understand advanced technology	• Improved health care system • Opportunities for better advanced care
General Health Forces		
Lack of affordable healthcare/health insurance (3)	• Increasing reliance and demand on emergency/urgent/school care as primary care (3) • Uninsured • Threats to individual's mental and physical health due to not seeking treatment • Lack of standard care for those not able to afford, locate, or receive adequate care • Limited access to preventive screenings and early interventions • Late diagnoses of chronic conditions (e.g., hypertension & diabetes)	• Affordable health care options • Low-income medical and mental health clinics • Increase additional opportunities for those not able to afford, locate, or receive adequate care • Connecting the unconnected (i.e., comprehensive, wrap-around services) • Offering more accessible screening events • Integrating preventive services into primary care visits • Building stronger outreach efforts to underserved populations • Increasing awareness about lifestyle changes that reduce risk

Forces of Change Assessment

Forces of Change	Threats Posed	Opportunities Created
General Health Forces (continued)		
Rise in chronic disease risk factors (e.g., hypertension, diabetes, obesity) (2)	• Increased long-term healthcare costs (2) • Higher rates of complications (e.g., heart disease & kidney disease) • Reduced quality of life for affected individuals • Reduced workforce productivity • Premature death	• Expansion of preventive health and wellness programs • Community education initiatives on nutrition, exercise, & screenings • Early detection and intervention strategies to reduce complications • Employer based wellness programs • Preventive screenings • Community fitness initiatives • Nutrition and lifestyle education
Decrease in community members who qualify for Medicaid	• Decrease in those who seek health care when they need it • Increase in MHRSB funds to support those without insurance	• Utilizing telehealth if less costly • Increased focus on preventative health
Increase in distrust of government agencies	• Increase in chronic diseases & vaccine preventable diseases	• Outreach programs and creation of different means of communication
Societal changes impacting healthcare	• More bias in health care • More controversial issues	• Better understanding and care for non-typical social issues as they relate to healthcare
Connecting the unconnected	• Insurance coverage concerns • Individuals delaying or forgoing preventive care and vaccines • Widening gaps in healthcare access for vulnerable populations	• Expanding access to resources and information • Building stronger referral networks • Creating easier pathways for individuals to connect with needed care and community services
Lack of nutrition education	• Obesity • Lack of budgeting for foods	• Nutrition education

Forces of Change Assessment

Forces of Change	Threats Posed	Opportunities Created
General Health Forces (continued)		
Student free/reduced meals	• Education not a priority • Students can't concentrate • Potential behavioral issues	• Services to assist families in finding jobs, food, and needs of their children
COVID-19 pandemic	• Multiple people getting sick	• Getting people the medical help that is needed
Increase in toddler Autism diagnosis (birth to 2 years)	• Lack of medical professionals to conduct early diagnosis • Lack of pre-school support in place to support Kindergarten Readiness • Lack of parental support to navigate medical and social support programs	• Auglaize DD local Autism Diagnosis Education Project (ADEP) in partnership with Mercer County Pediatric Physician • Autism family/caregiver/sibling support groups
Mental & Behavioral Health Forces		
Poor mental health	• Unemployment • Social isolation • Stigma • Access to care	• Stigma reduction activities • Create community events for social activity
Youth mental health	• Violence • Unruly students • Attendance issues • Education not a priority	• Services • Support from law
Addiction	• Overdose deaths • Workforce absenteeism • Increased family instability • Strain on local health and law enforcement systems	• Expansion of local counseling and recovery program • Integration of behavioral health into primary care

Forces of Change Assessment

Forces of Change	Threats Posed	Opportunities Created
Mental & Behavioral Health Forces (continued)		
Youth vaping	• Increased risk of nicotine dependence • Poor mental health outcomes • Reduced physical activity • Long-term health costs	• School based wellness programs • Youth peer leadership initiatives • Strong school-health department collaboration • Grant opportunities for prevention education
Economic Forces		
Increasing cost of living	• Lack of food • Increased utility costs • Increased cost in rent	• Recognize the need for grants and other support to help vulnerable populations (e.g., seniors)
Demographic Forces		
Shifts in population & migration	• Outmigration of young professionals	• Attraction strategies for families and workers • Cultural diversity and enrichment • Potential for new community services
Increasing immigrant population in nearby counties	• Lack of translation services and infrastructure to handle	• Form new connections with community partners

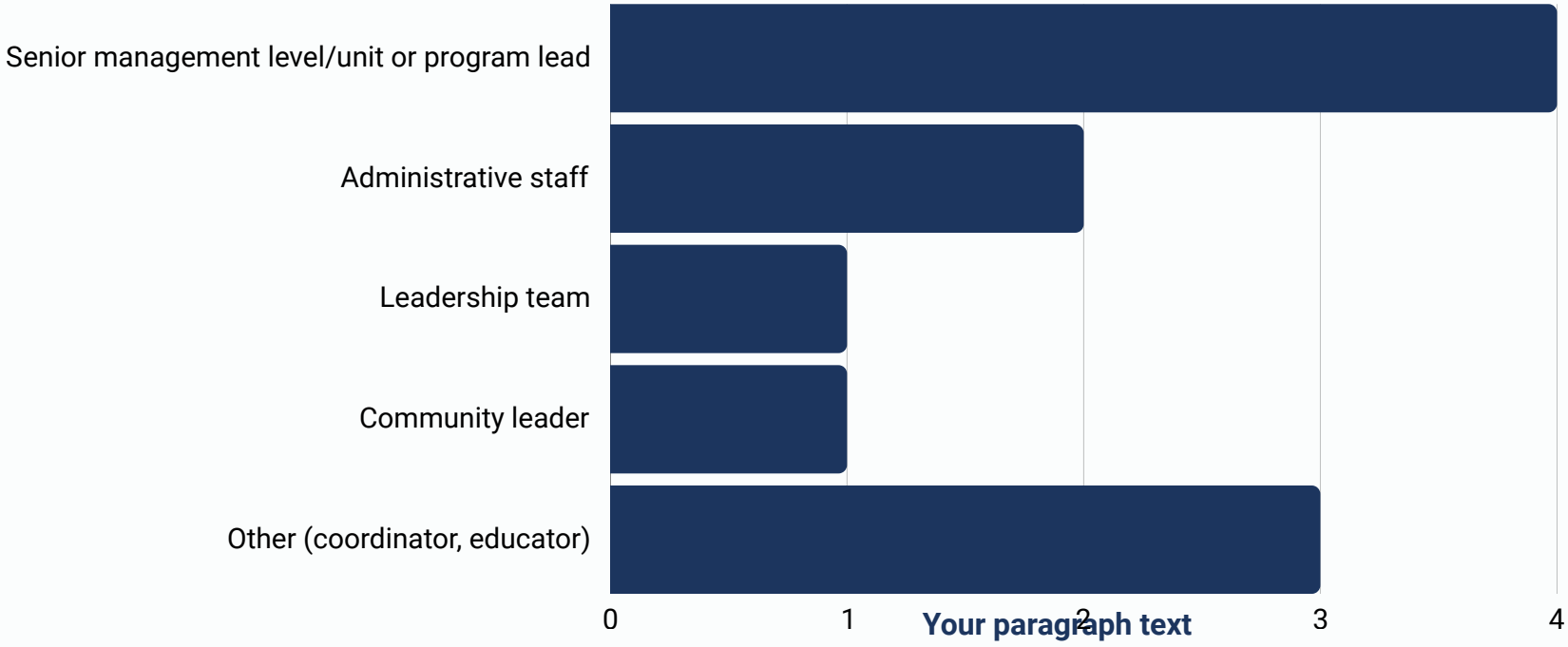
Community Partner Assessment

The Community Partner Assessment (CPA) aids in identifying the organizations engaged in the community health improvement process, including the populations they serve, their activities, and their capabilities and expertise in supporting local health improvement efforts. The CPA helps name strengths as a community and opportunities for greater impact. The Auglaize County Community Health Engagement Committee (CHEC) was asked to complete a series of multiple choice and open-ended questions pertaining to their specific role and organization. Below are the results:

Total survey respondents = 11

1.Which best describes your position or role in your organization?

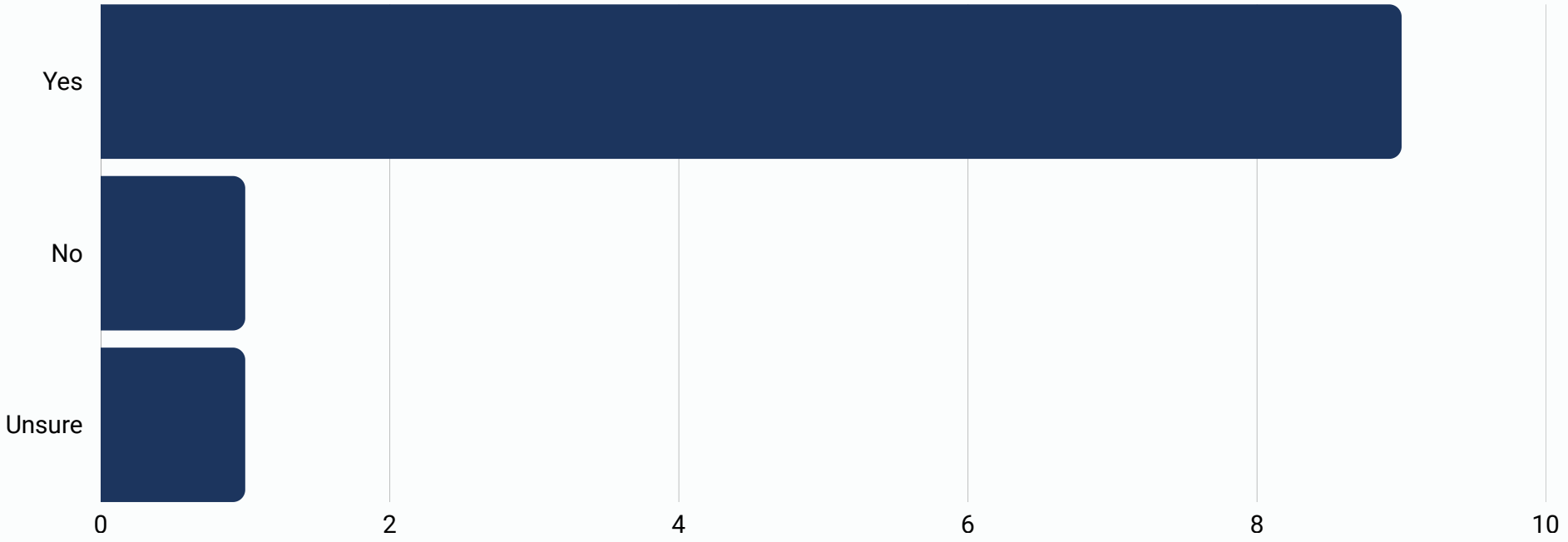
- Senior management level/unit or program lead (4)
- Administrative staff (2)
- Leadership team (1)
- Community leader (1)
- Other (3)
  - Coordinator
  - Educator



Community Partner Assessment

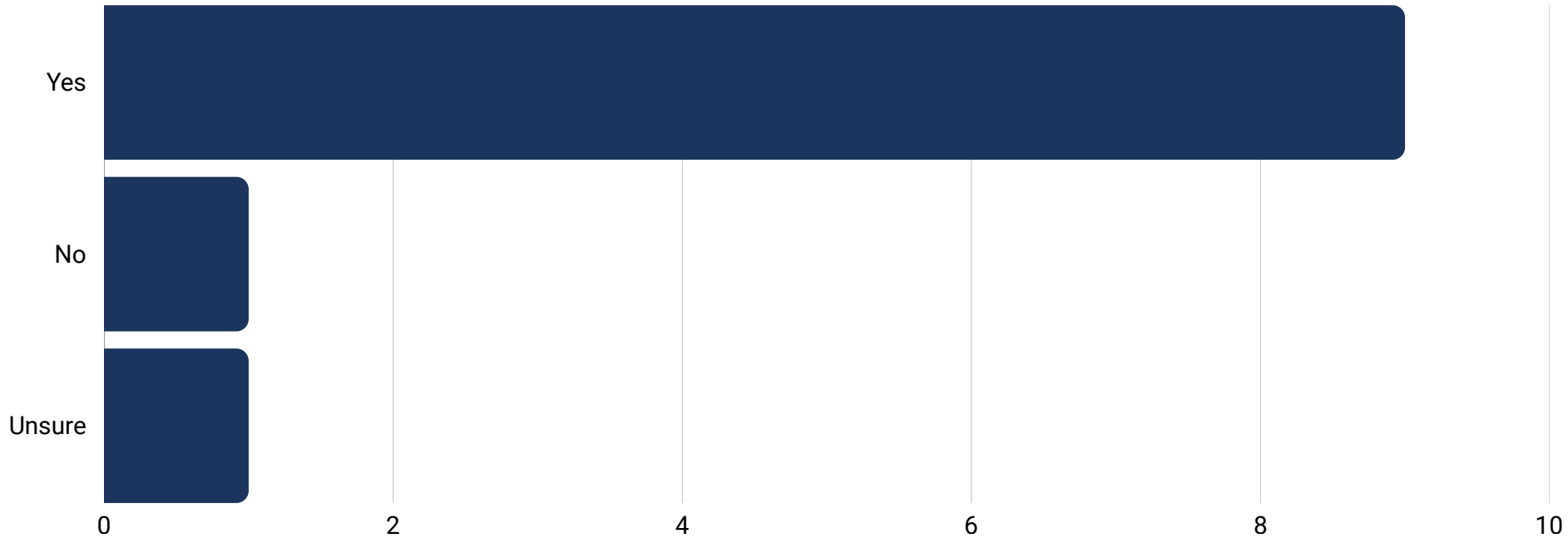
2.Has your organization ever participated in a community health improvement process?

- Yes (9)
- No (1)
- Unsure (1)



3.Has your organization ever participated in or facilitated community-led decision-making around policies, actions, or programs?

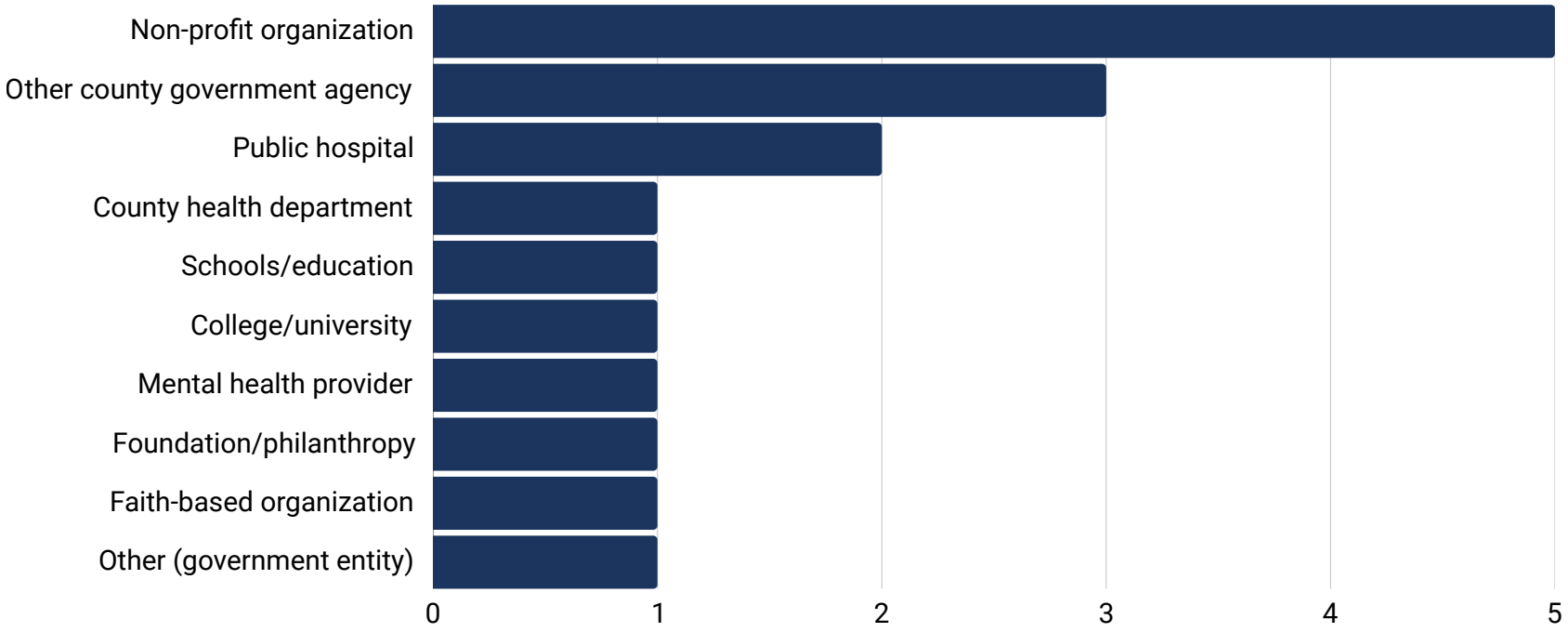
- Yes (9)
- No (1)
- Unsure (1)



4.Which of the following describes your organization?

Note: Respondents were able to select more than one option

- Non-profit organization (5)
- Other county government agency (3)
- Public hospital (2)
- County health department (1)
- Schools/education (1)
- College/university (1)
- Mental health provider (1)
- Foundation/philanthropy (1)
- Faith-based organization (1)
- Other (1)
  - Government entity



5.What are your organization's top interests in joining a community health improvement partnership?

Note: Respondents were able to select more than one option

- Deliver programs effectively and efficiently and avoid duplicated efforts (8)
- Pool resources (6)
- Increase communication among groups (5)
- Plan and launch community-wide initiatives (4)
- Create long-term, permanent social change (4)
- Build networks and friendships (3)
- Improve line of communication from communities to government decision-making (1)
- Improve line of communication from government to communities (1)
- Obtain or provide services (1)

6.What are the top reasons why your organization is interested in participating in a community health initiative?

Note: Respondents were able to select more than one option

- Improving conditions for members/constituents (8)
- Connections to other organizations (7)
- Access to data (4)
- Connections to decision-makers (2)
- Positive publicity (e.g., our organization supports community health) (2)
- Helps achieve requirements for public health accreditation (2)
- Connections to potential funders (1)
- Helps achieve requirements for IRS non-profit tax status (1)
- Other (increased education) (1)

7.What resources might your organization contribute to support Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) activities?

Note: Respondents were able to select more than one option

- Staff time to participate in CHA and CHIP meetings and activities (8)
- Staff time to support community engagement and involvement (6)
- Policy/advocacy skills (5)
- Social media capacities (5)
- Funding to support assessment activities (e.g., data collection, analysis) (4)
- Physical space to hold meetings (4)
- Staff time to support focus group facilitation or interviews (4)
- Staff time to help implement CHIP priorities (4)
- Media connections (3)
- Staff time to support relationship-building between CHIP staff and other organizations (e.g., introductions to government agencies or organizers) (3)
- Staff time to help plan CHA and CHIP meetings and activities (3)
- Funding to support community engagement (e.g., stipends, gift cards) (1)
- Food for community meetings (1)
- Technology to support virtual meetings (1)
- Staff time to help analyze quantitative data (1)
- Staff time to help facilitate CHA and CHIP meetings and activities (1)
- Note-taking support during qualitative data collection (1)
- Staff time to transcribe meeting notes/recordings (1)

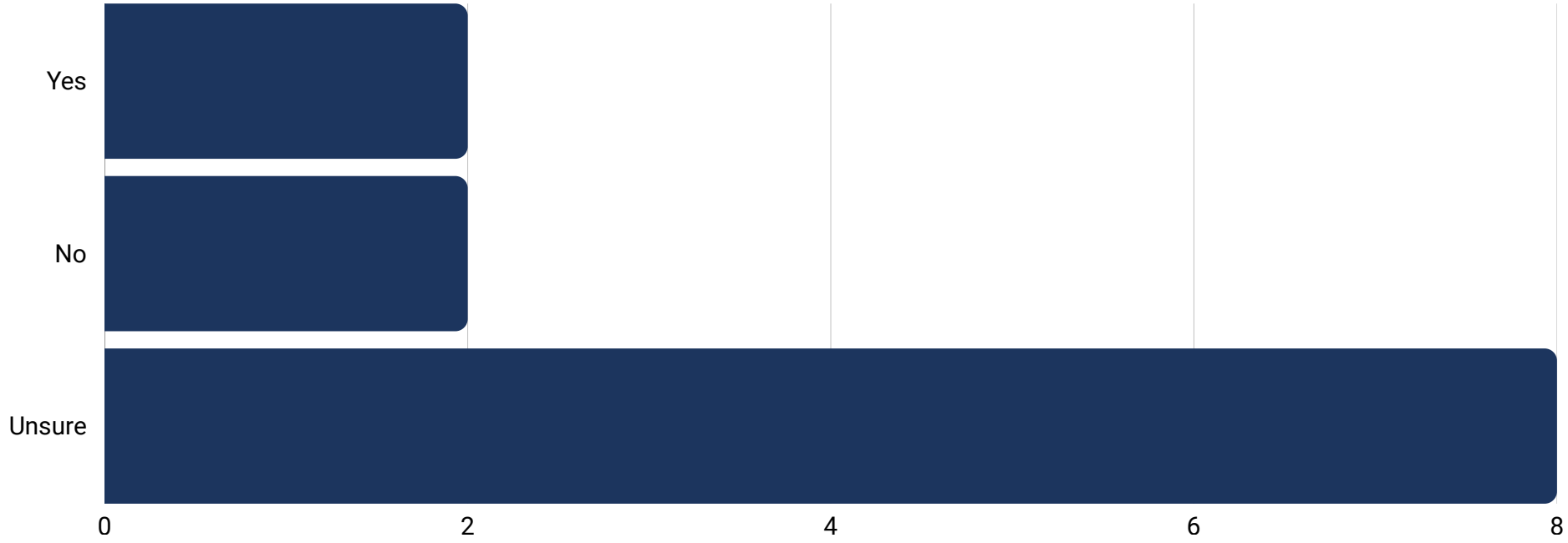
8.What racial/ethnic populations does your organization work with?

Note: Respondents were able to select more than one option

- Black/African American (7)
- Latinx/Hispanic (7)
- White/European (7)
- Asian American (6)
- Pacific Islander/Native Hawaiian (6)
- African (5)
- Native American/Indigenous/Alaska Native (5)
- Asian (5)
- Middle Eastern/North African (4)
- Other (All) (3)

9.Does your organization work with immigrants, refuges, asylum seekers, and other populations who speak English as a second language?

- Yes (2)
- No (2)
- Unsure (8)



10.Does your organization offer services specifically for people with disabilities?

- Yes—we provide services specifically for people with disabilities (6)
- Somewhat—we are wheelchair accessible and compliant with the American Disabilities Act but are not specifically designed to serve people with disabilities (3)
- No—our organization is not specifically designed to serve people with disabilities (4)

11.Who are your priority populations?

Note: Respondents were able to select more than one option

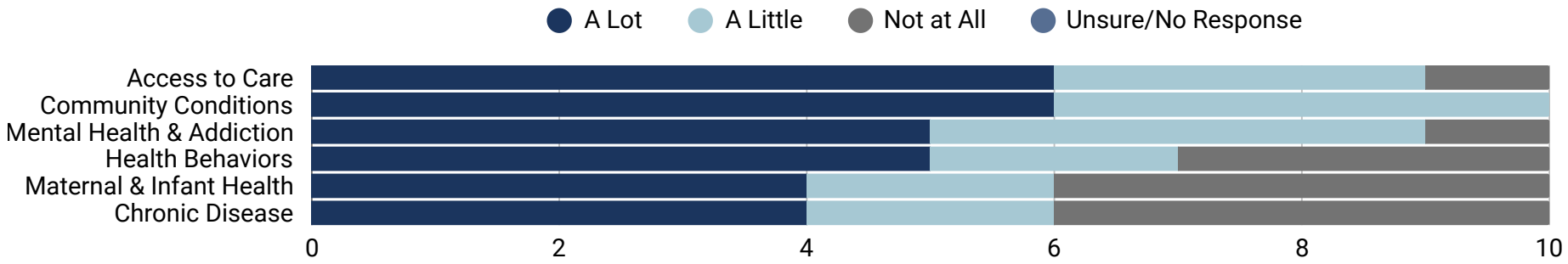
- Auglaize County/Wapakoneta Area residents (4)
- Underserved/low-income (2)
- Children (2)
- Individuals of all ages with developmental disabilities (1)
- Those with mental illness and substance abuse concerns (1)
- Families needing access to services and supports (1)

12.What do you do to reach/engage/work with your clientele or community?

Note: Respondents were able to select more than one option

- *W*ork closely with community organizations from our target populations (8)
- Have done existence outreach to our target populations (6)
- Support leadership development in our target populations (5)
- Receive many clients from our target populations (5)
- Receive many referrals from our target populations (4)
- Organization is physically located in neighborhood/s of our target populations (3)
- Hire staff from specific racial/ethnic groups that mirror our target populations (2)
- Have leadership who speak the language/s of our target populations (2)
- Hire staff/interpreters who speak the language/s of our target populations (1)
- Other (available to all) (1)
- Other (schools have to work with multiple entities) (1)

13.How much does your organization focus on each of the following topics?



14.Which of the following categories does your organization work on/with?

Note: Respondents were able to select more than one option

- Education (9)
- Family well-being (8)
- Food access and affordability (e.g., food bank) (8)
- Housing (8)
- Public health (8)
- Businesses and for-profit organizations (7)
- Early childhood development/childcare (7)
- Healthcare access/utilization (7)
- Disability/independent living (6)
- Community economic development (6)
- Parks, recreation, and open space (6)
- Transportation (6)
- Youth development and leadership (6)
- Criminal legal system (5)
- Faith communities (5)
- Financial institutions (e.g., banks, credit unions) (5)
- Government accountability (5)
- Human services (5)
- Public safety/violence (4)
- Arts and culture (4)
- Utilities (4)
- Food service/restaurants (3)
- Jobs/labor conditions/wages and income (3)
- Seniors/elder care (3)
- Economic security (2)
- Gender discrimination/equity (2)
- Land use planning/development (2)
- LGBTQIA+ discrimination/equity (2)
- Veterans' issues (2)
- Violence (2)
- Environmental justice/climate change (1)
- Immigration (1)

15.Which of the following health topics does your organization work on?

Note: Respondents were able to select more than one option

- Health insurance/Medicare/Medicaid (6)
- Immunizations and screenings (5)
- Healthcare access/utilization (5)
- Injury and violence prevention (4)
- HIV/STD prevention (4)
- Mental or behavioral health (e.g., PTSD, anxiety, trauma) (4)
- Physical activity (4)
- Tobacco and substance use and prevention (4)
- Chronic disease (e.g., asthma, diabetes/obesity, cardiovascular disease) (3)
- Family/maternal health (3)
- Infectious disease (3)
- Health equity (3)
- Cancer (2)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)/food stamps (2)
- None of the above/Not applicable (4)

16.Select whether your organization regularly does the following activities.

Note: Respondents were able to select more than one option

- Community Engagement and Partnerships: My organization works to strengthen, support, and mobilize communities and partnerships to improve health and well-being. (9)
- Assessment: My organization conducts assessments of living and working conditions and community needs and assets. (7)
- Communication and Education: My organization works to communicate effectively to inform and educate people about health or well-being, factors that influence well-being, and how to improve it. (7)
- Legal and Regulatory Authority: My organization has legal or regulatory authority to protect health and well-being and uses legal and regulatory actions to improve and protect the public's health and well-being. (7)
- Workforce: My organization supports workforce development and can help build and support a diverse, skilled workforce. (7)
- Investigation of Hazards: My organization investigates, diagnoses, and addresses health problems and hazards affecting the population. (6)
- Policies, Plans, Laws: My organization works to create, champion, and apply policies, plans, and laws that impact health and well-being. (6)
- Access to Care: My organization provides healthcare and social services to individuals or works to ensure equitable access and an effective system of care and services. (6)
- Evaluation and Research: My organization conducts evaluation, research, and continuous quality improvement and can help improve or innovate functions. (5)
- Organizational Infrastructure: My organization is helping build and maintain a strong organizational infrastructure for health and well-being. (4)

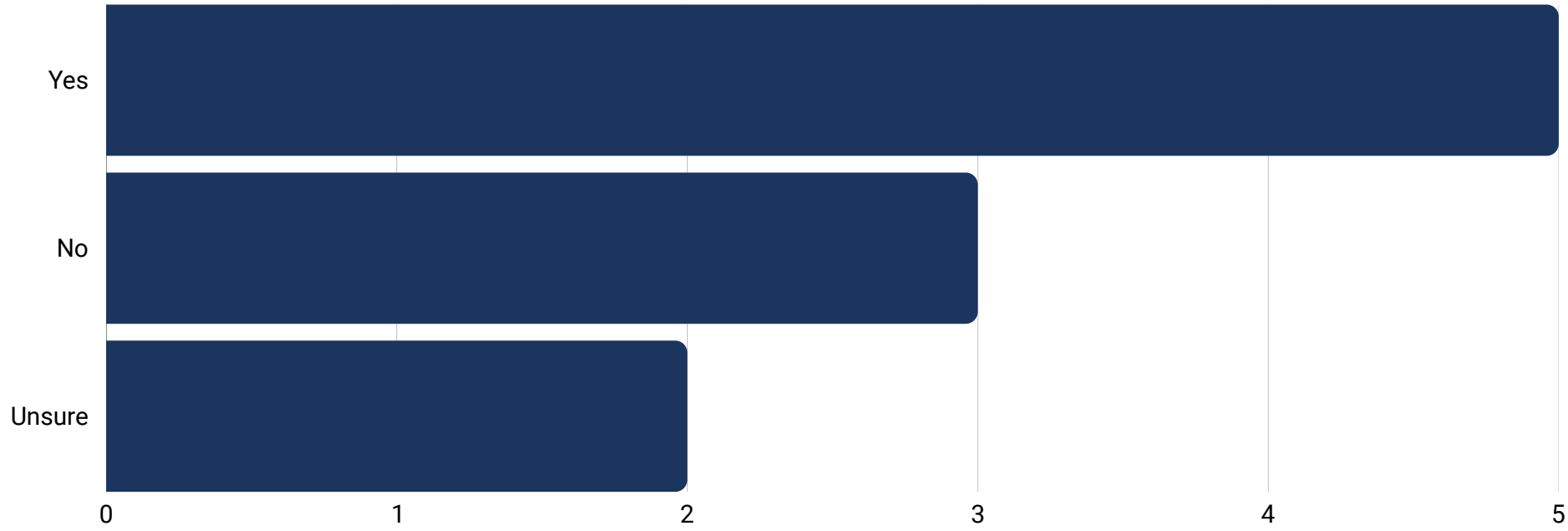
17.Of the activities and capacities listed in questions #16, which do you identify as your organization's top 1-3 competencies or strengths?

Note: Respondents were able to select more than one option

- Community Engagement and Partnerships (6)
- Assessment (4)
- Communication and Education (3)
- Access to Care (3)
- Legal and Regulatory Authority (1)
- Investigation of Hazards (1)
- Organizational Infrastructure (0)

18.Does your organization have sufficient capacity to meet the needs of your clients/members?

- Yes (5)
- No (3)
- Unsure (2)
    - Looking to fulfill open job positions, need for professionals with lived experience



19. Which of the following strategies does your organization use to do your work?

Note: Respondents were able to select more than one option

- Communications: Messaging that resonates with communities, connects them to an issue, or inspires them to act. (7)
- Leadership Development: Equipping leaders with the skills, knowledge, and experiences to play a greater role within their organization or movement. (6)
- Alliance and Coalition-Building: Building collaboration among groups with shared values and interest. (6)
- Research and Policy Analysis: Gathering and analyzing data to create credibility and inform policies, projects, programs, or coalitions. (5)
- Social and Health Services: Providing services that reach clients and meet their needs (including clinical and healthcare services). (5)
- Organizing: Involving people in efforts to change their circumstances by changing the underlying structures, decision making processes, policies, and priorities that produce inequities. (4)
- Advocacy and Grassroots Lobbying: Targeting public officials either by speaking to them or mobilizing constituents to influence legislative or executive policy decisions. (4)
- Healing: Addressing personal and community trauma and how they connect to larger social and economic inequalities. (4)
- Campaigns: Using organized actions that address a specific purpose, policy, or change. (3)
- Inside-Outside Strategies: Coordinating support from organizations on the "outside" with a team of like-minded policymakers on the "inside" to achieve common goals. (3)
- Integrated Voter Engagement: Connecting organizing and voter-engagement strategies to build a strong base over multiple election cycles. (3)
- Narrative Change: Harnessing arts and expression to replace dominant assumptions about a community or issue with dignified narratives and values. (3)
- Litigation: Using legal resources to reach outcomes that further long-term goals. (2)
- Arts and Culture: Nurturing the multiple skills of an individual through the arts and encouraging connection through shared experiences. (2)
- Movement-Building: Scaling up from single organizations and issues to long-term initiatives, perspectives, and narratives that seek to change systems. (2)

20. What type of community-engagement practices does your organization do most often?

- Inform: Provide the community with relevant information. (7)
- Collaborate: Ensure community capacity to play a leadership role in implementation of decisions. (2)
- Involve: Ensure community needs and assets are integrated into process and inform planning. (1)

21.Which of the following methods of community engagement does your organization use most often?
Note: Respondents were able to select more than one option

- Community forums/events (7)
- Social media (7)
- Presentations (6)
- Customer/patient satisfaction surveys (4)
- Videos (4)
- Fact sheets (4)
- Billboards (3)
- Public comment (3)
- Surveys (3)
- Memorandums of understanding (MOUs) with community-based organizations (3)
- Focus groups (2)
- Community organizing (2)
- Advocacy (2)
- Polling (2)
- Open houses (1)
- Interactive workshops (1)
- Community-driven planning (1)
- Participatory budgeting (1)
- Other (2)
  - Newsletters
  - Regular meetings

22.What policy/advocacy work does your organization do?
Note: Respondents were able to select more than one option

- Develop close relationships with elected officials (7)
- Educate decision-makers and respond to their questions (6)
- Use relationships to access decision-makers (6)
- Advocate for policy change (6)
- Respond to requests from decision-makers (5)
- Build capacity of impacted individuals/communities to advocate for policy change (2)
- Voter outreach and education (2)
- Write or develop policy (1)
- Lobby for policy change (1)

23.Describe if and how your organization would like to be involved in or support policy, advocacy, or communications in the CHIP process.

Note: Respondents were able to select more than one option

- Communications: Assisting with outreach by sharing CHIP updates, initiatives, and educational materials through our communication channels to ensure the community stays informed and engaged. (2)
- Support CHIP process (2)
- Policy: Offering input on policies that impact community health and aligning organizational practices with CHIP priorities. (1)
- Advocacy: Partnering with community stakeholders to raise awareness of key health issues and promote equitable access to care. (1)
- Provide input as representative in the DD field. (1)

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

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

Evidence-Based Practices

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

Resource Inventory

Based on the chosen priorities, the Auglaize County Community Health Engagement 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. The Auglaize County Community Health Engagement Committee was then asked to determine whether a policy, program, or service was evidence-based, a best practice, or had no evidence indicated. Each resource inventory can be found with its corresponding strategy.

Priority #1: Access to Care

Strategy #1: Insurance literacy and enrollment assistance

Action Steps

Build collaborative relationships with local insurance navigators, plan representatives, and community health workers to support coordinated enrollment and education efforts.

Gather and review existing partner materials on Marketplace, Medicaid, and private insurance, including general insurance literacy resources. Identify missing or unclear information and create supplemental tools such as explanations of key insurance terms and guidance on selecting and using primary care.

Work with partners to set up on-site insurance enrollment and education stations at community events such as health fairs, festivals, food pantries, and school-based activities.

Promote enrollment services through partner communication channels, social media, local media outlets, and targeted outreach in neighborhoods with high levels of uninsured residents.

Conduct an annual review of insurance literacy and enrollment activities to assess effectiveness, identify underserved populations or geographic gaps, and guide future program expansion.

Timeline

January 1, 2026 - December 31, 2028

Priority Population

Adult, youth, and children

Outcome

Increase the number of insured adults, youth, & children in Auglaize County

Indicator(s) to Measure Impact of Strategy

Uninsured adults: Percent of adults, ages 19-64, who are uninsured (ACS estimates)

Uninsured children: Percent of children, ages 0-18, who are uninsured (ACS estimates)

Lead Agency

Auglaize County Health Department
Grand Lake Health System

Resources to Address Strategy:

Insurance navigators
Insurance representatives
Mercy Health System

- Ohio SHIP aligned priority/strategy/indicator

Priority #2: Community Conditions

Strategy #1: Housing availability and affordability

Action Steps

Strengthen partnerships with local housing agencies by coordinating referrals, sharing information, and increasing community awareness of available home repair, rental assistance, and tax credit programs.

Collaborate with county commissioners and city government to stay aligned with their efforts to improve overall housing stock, helping share updates and gather community input as needed.

Support initiatives that increase housing inventory by assisting with the removal of vacant or blighted structures, promoting brownfield remediation, and contributing to related grant applications.

Advocate for policies and development projects that expand affordable and diverse housing options by engaging residential developers and elevating data that demonstrates community need.

Advance housing options for older adults by assessing current capacity, identifying gaps, and supporting the development of assisted living and other long-term housing solutions.

Pursue and leverage relevant grant funding to address blight, property vacancies, and infrastructure improvements that contribute to a stronger local housing supply.

Timeline

January 1, 2026 - December 31, 2028

Priority Population

Adult

Outcome

Increase the housing stock in Auglaize County

Indicator(s) to Measure Impact of Strategy

Housing stock: Total number of housing units (ACS estimates)

Occupied housing stock: Percent of occupied housing units (ACS estimates)

Lead Agency

Wapakoneta Area Economic Development Council (WAEDC)

- Ohio SHIP aligned priority/strategy/indicator

- policy development, enforcement, or advocacy strategy

Resources to Address Strategy:

Residential Development Revolving Loan Program
Community Reinvestment Area (CRA) Tax Abatement
Tax Increment Financing (TIF) Districts

Priority #3: Mental Health and Addiction

Strategy #1: Mental Health First Aid

Action Steps

Maintain ongoing availability of Mental Health First Aid (MHFA) trainings throughout Auglaize County.

Promote MHFA training opportunities to diverse community groups, including local churches, schools, Rotary clubs, law enforcement agencies, chambers of commerce, city councils, and college students. Tailor promotional efforts to reach adults who work with diverse populations, including youth and older adults.

Conduct an annual review of the number and reach of MHFA trainings in Auglaize County to determine whether expansion is needed and, if so, identify priority populations or settings for additional training.

Timeline

January 1, 2026 - December 31, 2028

Priority Population

Adult and youth

Outcome

Decrease the number of suicide deaths among adults and youth in Auglaize County

Indicator(s) to Measure Impact of Strategy

Adult suicide deaths: Number of deaths due to suicide for adults, ages 18 and older, per 100,000 population (ODH Vital Statistics)

Youth suicide deaths: Number of deaths due to suicide for youth, ages 8-17, per 100,000 population (ODH Vital Statistics)

Lead Agency

Mental Health Recovery Service Board

Resources to Address Strategy:

Prevention Awareness Support Services (PASS)

- Ohio SHIP aligned priority/strategy/indicator

Priority #3: Mental Health and Addiction

Strategy #2: Universal school-based alcohol prevention programs

Action Steps

Review existing substance abuse prevention programs currently implemented in Auglaize County schools (grades 6–12).

Identify gaps in programming, such as specific schools, grades, or topics.

Explore evidence-based prevention programs (e.g., **Refuse, Remove, Reasons**, **Too Good for Drugs**, **Catch My Breath**) that could address identified gaps, and pilot universal programs in one school. Evaluate the pilot's outcomes and determine whether broader implementation is appropriate and feasible.

Conduct an annual evaluation of school-based prevention programming to reassess current efforts, identify ongoing gaps, and determine opportunities to enhance or expand programming.

Advocate for schools to participate in the yearly **Ohio Healthy Youth Environments Survey (OHYES!)** to ensure access to timely data on youth substance use and to support data-driven program planning.

Timeline

January 1, 2026 - December 31, 2028

Priority Population

Youth

Outcome

Decrease substance use among youth

Indicator(s) to Measure Impact of Strategy

Youth alcohol use: Percent of high school students who have used alcohol within the past 30 days (YRBS)

Lead Agency

Mental Health Recovery Service Board

Resources to Address Strategy:

Prevention Awareness Support Services (PASS)
Local school districts

- Ohio SHIP aligned priority/strategy/indicator

- policy development, enforcement, or advocacy strategy

Priority #3: Mental Health and Addiction

Strategy #3: Question Persuade Refer (QPR) training

Action Steps

Determine interest among businesses of implementing QPR trainings. Work with employers and healthcare providers to assess what information and/or materials they are lacking to provide better care/support for employees or patients with mental health issues.

Recruit at least one business to participate in the QPR Online Gatekeeper Training. Begin offering depression and suicide specific trainings/education to employers and healthcare providers to provide better care for employees and patients with mental health issues.

Continue and strengthen the use of **Positive Peer Advocates** in Auglaize County middle schools and high schools to promote mental health awareness, reduce stigma, and encourage help-seeking behaviors among youth.

Conduct an annual evaluation of QPR training to reassess current efforts, identify ongoing gaps, and determine opportunities to enhance or expand QPR trainings.

Timeline

January 1, 2026 - December 31, 2028

Priority Population

Adult and youth

Outcome

Decrease the number of suicide deaths among adults and youth in Auglaize County

Indicator(s) to Measure Impact of Strategy

Adult suicide deaths: Number of deaths due to suicide for adults, ages 18 and older, per 100,000 population (ODH Vital Statistics)

Youth suicide deaths: Number of deaths due to suicide for youth, ages 8-17, per 100,000 population (ODH Vital Statistics)

Lead Agency

Mental Health Recovery Service Board

Resources to Address Strategy:

Prevention Awareness Support Services (PASS)

- Ohio SHIP aligned priority/strategy/indicator

Priority #3: Mental Health and Addiction

Strategy #4: Education for parents on how to build youth resilience

Action Steps

Implement evidence-based youth mental health and trauma-informed programming, such as the Northwest Ohio Resilient Youth Program, to strengthen mental health, build resilience, and promote trauma-responsive practices among adults who work with or care for youth by:

- engaging schools and community partners by introducing programming and identifying pilot sites
- providing training for staff and caregivers on ACEs, adolescent development, and trauma-informed practices
- sharing and promoting local, state, and national mental health resources for youth and caregivers
- monitoring and evaluating outcomes to refine programming and support expansion

Timeline

January 1, 2026 - December 31, 2028

Priority Population

Youth

Outcome

Decrease the number of suicide deaths among youth in Auglaize County

Indicator(s) to Measure Impact of Strategy

Youth suicide deaths: Number of deaths due to suicide for youth, ages 8-17, per 100,000 population (ODH Vital Statistics)

Lead Agency

Auglaize County Health Department

Resources to Address Strategy:

Faith-based organizations
First responders
Youth mentors

- Ohio SHIP aligned priority/strategy/indicator

Priority #4: Chronic Disease

Strategy #1: Affordable Wellness Opportunities Campaign

Action Steps

Develop a coordinated outreach campaign to increase community awareness of free or low-cost wellness opportunities, including:
- Physical activity programs such as Walk with a Doc, local park promotions, Move Your Way, Road to Fitness, and the Grand Health Challenge
- Nutrition and food security resources such as local food banks
- General wellness services such as the ONU mobile clinic

Assess the campaign's effectiveness annually and adjust outreach strategies based on results.

Timeline

January 1, 2026 - December 31, 2028

Priority Population

Adult & youth

Outcome

Increase fruit/vegetable consumption & physical activity among adults & youth

Decrease obesity among adults & youth

Indicator(s) to Measure Impact of Strategy

Adult physical activity: Percent of adults who did not engage in physical activity in the past week (Auglaize CHA)

Adult nutrition: Percent of adults who consumed 3 or more servings of fruits and/or vegetables daily (Auglaize CHA)

Adult obesity: Percentage of adults with a BMI of 30 and above (Auglaize CHA)

Lead Agency

Auglaize County Health Department

Resources to Address Strategy:

Grand Lake Health System

- Ohio SHIP aligned priority/strategy/indicator

Priority #4: Chronic Disease

Strategy #2: Blood lead level screening

Action Steps

Strengthen and expand the existing referral network to ensure timely blood lead level testing for pregnant women and children at risk of lead exposure by:

- aligning outreach and communication efforts with the Department of Children & Youth's lead-awareness campaign to promote consistent messaging across the community
- leveraging available grant funding to expand blood lead level screening to children ages 5–6, particularly those who may have missed earlier screenings or remain at elevated risk
- encouraging parents and caregivers to complete recommended blood lead level testing when their child is identified as at risk, including providing follow-up reminders and support to help families complete testing
- offering screening materials and testing kits at health fairs, community events, and clinics to reduce barriers and increase access to blood lead level testing
- improving coordination among healthcare providers, community organizations, early childhood programs, and public health partners to streamline referrals and ensure timely testing

Track emerging legislation related to lead exposure and advocate for **policies that reduce environmental lead risks**—such as reducing lead in drinking water, addressing lead-based paint hazards, and increasing enforcement of the EPA's Renovation, Repair, and Painting Rule—through letters of support, outreach to elected officials, and other appropriate advocacy efforts.

Timeline

January 1, 2026 - December 31, 2028

Priority Population

Pregnant women, children

Outcome

Decrease the number of pregnant women and children exposed to lead

Indicator(s) to Measure Impact of Strategy

Child lead poisoning: Percent of children, ages 0-5, with elevates blood lead levels (ODH)

Lead Agency

Auglaize County Health Department

Resources to Address Strategy:

WIC
Mercy Health System - St.Ritas
Grand Lake Health System
Board of Developmental Disabilities
Early Intervention

- Ohio SHIP aligned priority/strategy/indicator

- policy development, enforcement, or advocacy strategy

Progress and Measuring Outcomes

The progress of meeting the local priorities will be monitored with measurable indicators identified for each strategy found within the action step and recommendation tables within each of the priority sections. Most indicators align directly with the SHIP. The individuals that are working on action steps will meet on an as needed basis. The full committee will meet quarterly to report out the progress. The committee will form a plan to disseminate the Community Health Improvement Plan to the community. Action steps, responsible agencies, and timelines will be reviewed at the end of each year by the committee. Edits and revisions will be made accordingly.

Auglaize County will continue facilitating Community Health Assessments every three years to collect and track data. Primary data will be collected for adults using national sets of questions to not only compare trends in Auglaize County, but also be able to compare to the state, the nation, and Healthy People 2030. This data will serve as measurable outcomes for each of the priority areas. 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 an ongoing basis to focus on how well action steps are being implemented. Areas of process evaluation that the CHIP committee will monitor will include the following: number of participants, location(s) where services are provided, number of policies implemented, economic status and racial/ethnic background of those receiving services (when applicable), and intervention delivery (quantity and fidelity).

Furthermore, all action steps have been incorporated into a Progress Report template that can be completed at all future Auglaize County Health Partners 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:

Auglaize County Health Department
813 Defiance Street
Wapakoneta, OH 45895
(419) 738-3410

Appendix I: Gaps and Strategies

The following tables indicate access to care, community conditions, mental health and addiction, and chronic disease gaps and potential strategies that were compiled by the Auglaize County Community Health Engagement Committee.

Priority Factor #1: Access to Care (health insurance coverage, local access to healthcare providers)	
Gaps	**Potential Strategies**
Affordable healthcare coverage (2)	• Expand **government involvement limiting pharmaceutical costs and regulations** ^. • Utilize Service Coordinators to **maximize enrollment in Ohio Medicaid for currently eligible infants/toddlers** to link and refer as an Early Intervention Program service. Service Coordinators also understand system of payments and how to support families with braided funding, insurance, ACBDD funding, community partners, etc. to meet critical needs of the family. • Prioritize preventive care to reduce long term costs.
Insurance literacy and enrollment assistance	• Provide **insurance enrollment assistance** during community events. • Partner with organizations that can provide information to improve knowledge on insurance, Medicaid, & Medicare.
Availability of providers that are trained/comfortable to work with disabled and vulnerable populations	• Partner with local healthcare systems and the health department to expand **telehealth services for medical, behavioral, and therapy appointments** ★. • Collaborate with local providers and educational institutions to offer disability-specific training for healthcare professionals and encourage **rural provider recruitment** . • Support **care coordination and navigation services (i.e., medical homes)** to assist individuals and families in understanding and scheduling needed healthcare services.
Transportation to appointments	• Share resource information that can assist with travel to appointments or funding for travel.

- aligned with 2020-2022 SHIP

★ *- aligned with 2022-2024 Auglaize County CHIP*

^ *- policy development, enforcement, or advocacy strategy*

Appendix I: Gaps and Strategies, continued

Priority Factor #1: Access to Care (health insurance coverage, local access to healthcare providers), continued	
Gaps	**Potential Strategies**
Dentists accepting Medicaid	• Distribute list of dentist offices accepting Medicaid clients.
Access to specialty providers (e.g., developmental pediatric healthcare)	• Currently being implemented: The Auglaize County Board of Developmental Disabilities (ACBDD) supports the State of Ohio's Autism Diagnosis Evaluation Project and has a team of experts who are qualified to evaluate for suspected Autism and has a Mercer County Developmental Pediatrician as the team's medical consultant for diagnosis determination for children eligible for county board services.

- aligned with 2020-2022 SHIP

- aligned with 2022-2024 Auglaize County CHIP

- policy development, enforcement, or advocacy strategy

Appendix I: Gaps and Strategies, continued

Priority Factor #2: Community Conditions (housing availability & quality)	
Gaps	**Potential Strategies**
Affordable housing (6)	• Expand **Section 8 Housing** ^ . • Partner with local government to provide **tax credits** ^ for low-income families. • Work with community partners to increase access to affordable and accessible housing units, including **Housing Choice Voucher** and **Housing Trust Fund** programs. • Pursue partnerships with the Ohio Housing Finance Agency for **rental assistance** and **housing repair grants**. • Provide funding to offset higher rental rates (i.e., **rental assistance**). • Coordinate with HUD to provide **rent vouchers** to qualifying families. • Recruit investors to purchase and **provide more opportunities for affordable housing**. • Collaborate with local developers to rehabilitate vacant or blighted homes. • Develop new housing. • Increase wages to align better with cost of living in the area.
Housing safety and accessibility	• **Collaborate with local governments and housing coalitions to prioritize inclusive housing development** ^ and neighborhood improvement projects. • Support home modification and **repair programs** that improve housing safety and accessibility for individuals with disabilities.
Economic stability	• Create **childcare workforce incentives** ^ and **advocate for flexible childcare hours** ^. • Implement career and technical education and sector-based workforce initiatives. • Partner with Rhodes State, Apollo Career Center, and OhioMeansJobs to connect residents to credential programs. • Support financial literacy programs through local banks and libraries.

- aligned with 2020-2022 SHIP

- aligned with 2022-2024 Auglaize County CHIP

^ *- policy development, enforcement, or advocacy strategy*

Appendix I: Gaps and Strategies, continued

Priority Outcome #1: Mental Health & Addiction (mental health & suicide, substance use)	
Gaps	**Potential Strategies**
Mental health education/awareness (2)	• Expand **Mental Health First Aid** ★.
Mental health professional shortage (2)	• Provide **telehealth services** ★ to families in mental health crisis. • Provide **telemedicine** ★ for behavioral health. • Host a recruitment health career fair. • Expand workforce development. • Coordinate with existing primary care and mental health facilities to develop a stronger workforce focused on specific populations (e.g., children).
Youth mental health (2)	• Implement **evidence based programming in schools** (e.g., DBT, Lifelines). • Implement universal behavioral health screenings in schools.
Youth substance use (2)	• Implement **evidence based programming in schools** ★(e.g., Catch my Breath, RRR). • Incorporate **parent education** nights on vaping, alcohol, and drug awareness. • Standardize youth prevention curricula across districts through partnerships with Family Resource Center or Prevention Awareness Support Services. • Collaborate with law enforcement on compliance checks and community education.
Parental engagement	• Provide **parent education on building youth resilience and youth protective factors**. • Provide **parent education on communicating with their children about alcohol & other drugs**
Access to mental health services	• **Provide mental health services/screenings at places of employment** ^. • **Improve insurance coverage for mental health services & supports** ^.
Supports for system-involved children/youth	• Develop a team that works with children affected by parent mental health issues.

- aligned with 2020-2022 SHIP

★ *- aligned with 2022-2024 Auglaize County CHIP*

^ *- policy development, enforcement, or advocacy strategy*

Appendix I: Gaps and Strategies, continued

Priority Outcome #1: Mental Health & Addiction (mental health & suicide, substance use), continued	
Gaps	**Potential Strategies**
Stigma	• Implement a community outreach campaign to help destigmatize mental health care.
Individuals with developmental disabilities and their families experience higher stress levels, limited access to mental health providers familiar with disability-related needs, and growing concerns about substance use among caregivers and community members.	• Expand integrated behavioral health supports within developmental disability services, ensuring access to trauma-informed, disability-competent counseling. • Support community-based peer mentoring and family support groups to reduce isolation and promote early mental health intervention. • Partner with schools, ADAMH boards, and community organizations on suicide prevention, resilience, and coping-skills education. • Increase substance use prevention education for families and providers through collaboration with public health and behavioral health partners.
Mental Health professionals specializing in early intervention ages (birth to 3 years) to support children and families/caregivers.	• Currently being implemented: The ACBDD has access to an Early Childhood Mental Health Consultant (ECHMC) contracted through the Ohio Department of Children and Youth (DCY), who supports children and families in the Early Intervention program. Evidence-based home/virtual visiting works with families/caregivers to promote positive child growth and development using on-going developmental screenings and activities for parents to complete with their babies to enhance social and emotional development not only for the child, but for the family/caregiver. Early intervention cares not only about the child, but the family.

- aligned with 2020-2022 SHIP

- aligned with 2022-2024 Auglaize County CHIP

- policy development, enforcement, or advocacy strategy

Appendix I: Gaps and Strategies, continued

Priority Outcome #2: Chronic Disease (heart disease, diabetes, childhood lead exposure)	
Gaps	**Potential Strategies**
Increasing chronic conditions (e.g., heart disease, diabetes, obesity) (4)	• Provide **healthy food at food banks** ★. • Provide **healthy school lunches**. • **Partner with local grocers or farmers markets to highlight healthy food options**. • Provide healthy eating opportunities. • Expand affordable access to healthy food options in the community. • Increase outreach on nutrition and healthy habits. • Provide **community exercise programs**. • Improve awareness of exercise opportunities to the public that are free or low cost. • Expand community walking and biking programs and promote park usage. • Partner with schools and **employers for health literacy workshops** (e.g., nutrition labels, stress management, preventive screenings). • Encourage **workplaces to implement wellness challenges** and standing desks. • Make education more accessible. • Develop a county-wide "Healthy Auglaize" campaign promoting small, sustainable lifestyle changes. • Collaborate with YMCA, OSU Extension, and health departments to deliver free or low-cost wellness classes.
Screening for chronic conditions (2)	• Implement testing and referral to **Diabetes Prevention Program** as part of standard care practices ^. • Increase blood pressure screening.
Comprehensive/coordinated care	• Provide preventive care delivered through patient-centered **medical homes**.

- aligned with 2020-2022 SHIP

★ *- aligned with 2022-2024 Auglaize County CHIP*

^ *- policy development, enforcement, or advocacy strategy*

Appendix I: Gaps and Strategies, continued

Priority Outcome #2: Chronic Disease (heart disease, diabetes, childhood lead exposure), continued	
Gaps	**Potential Strategies**
Adults/Children with developmental disabilities often face increased risk for chronic conditions such as heart disease and diabetes due to limited access to preventive care, nutrition education, and physical activity opportunities.	• Partner with local health departments and providers to offer **mobile health screenings for blood pressure, cholesterol, and diabetes risk**. • Promote participation in community wellness and nutrition programs, such as Healthy U Ohio or **Diabetes Prevention Programs**. • Collaborate with day and residential providers to incorporate physical activity and healthy meal planning into daily supports. • Support education and outreach for caregivers on promoting healthy habits and preventive care access for individuals they serve.
Elevated Lead Blood Levels	• Early Intervention Service Coordinators can support families with children with elevated blood lead levels by: connecting them to resources to **get rid of lead and access safe housing** ; supporting the family in improving the child's natural learning environment where their child lives and plays; helping the family manage their child's behaviors and physical health concerns; supporting their child's healthy nutrition & environment needs. • Currently being implemented: In 2026 and in collaboration with DCY, the ACBDD will be running public awareness campaigns regarding Lead Exposure to include a family/caregiver card in the Welcome Packet and 2 cable television provider Public Service Announcements regarding lead exposure, what happens if the child has elevated blood lead levels, what to do next, how to make a referral and how Early Intervention can help. • Currently being implemented: Early Intervention staff conduct outreach to Auglaize County physician offices. If a child's blood lead level is 5 mcg/dL or higher, the child is automatically eligible for Early Intervention services and we collaborate with physician office staff to receive referrals to the EI program, knowing that children under the age of 3 are at the greatest risk of lead poisoning.

- aligned with 2020-2022 SHIP

- aligned with 2022-2024 Auglaize County CHIP

- policy development, enforcement, or advocacy strategy