2026-2028 Putnam County Community Health Improvement Plan

Partners for a Healthy Putnam County
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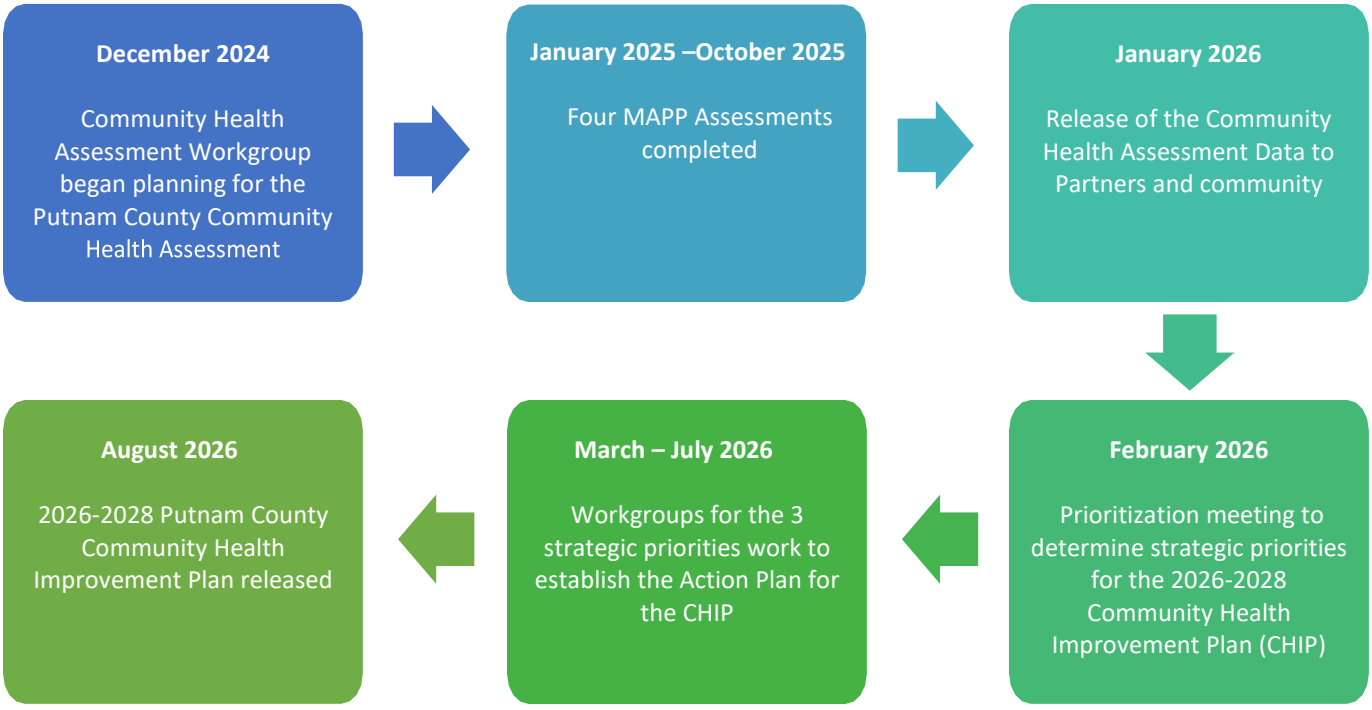
Introduction

During a meeting in December 2024, the Partners for a Healthy Putnam County determined the need for a comprehensive community health assessment to provide updated primary, secondary, qualitative and quantitative data regarding the health of our community. The Putnam County Health Department facilitated the process to conduct the community health assessment, determine the priorities of the community and develop an improvement plan.

The graphic below describes the timeline for completing the Mobilizing for Action through Planning and Partnership 2.0 (MAPP) process, which includes the completion of the *2026-2028 Putnam County Community Health Improvement Plan* (CHIP).

With data available from the 2025 Community Health Assessment, the Partners for a Healthy Putnam County, along with interested community members, came together to identify the strategic priorities for our community. Workgroups then met over a five-month period to develop the Action Plan to address the strategic priorities.

The MAPP 2.0 process, data related to the identified strategic priorities and the Action Plan to address those priorities are provided in more detail in this plan.



The Partners

The 2026-2028 Putnam County Community Health Improvement Plan was developed by representatives from partnering agencies and community members within the county. The Partners for a Healthy Putnam County were actively involved in the community health assessment, prioritization of health needs in our community and the development of the action plan to address the identified needs. The Partners for a Healthy Putnam County include:

Putnam County Health Department - Kim Rieman, Health Commissioner, Sherri Recker, Andrew Burwell, Sarah Nsiah, Dolores Garcia

Putnam County Job and Family Services - John Folk

Putnam County Council on Aging - Jodi Warnecke, Michelle Williamson

Pathways Counseling Center - Katie Walker

Go Ottawa - Jacqueline Langhals

Putnam County Family and Children First - Beth Tobe

Putnam County Community Improvement Corp. - Amy Sealts

Putnam County Home Care & Hospice - Krista Pruitt

Putnam County YMCA - Aaron Baumgartner

Mercy St. Rita's - Tyler Smith, Catherine Lusky

Leipsic Community Center - Amanda Schroeder

Putnam County Educational Service Center - Nick Verhoff

Community Members - Rebecca Dersham, Grace Dickman

Alcohol, Drug and Mental Health Services Board - Jennifer Horstman

Area Agency on Aging - Leann Unverferth, Shelby Poling

Crime Victim Services - Greg Recker, Erin Burkhart-Osting, Josephine Rodriguez

Rural Health Connects - Anne Dunn

Lima Memorial Hospital - Jacob Rigali

United Way of Putnam County - Ashley Baumgartner

Many of these partners participated in workgroups to develop the Action Plan for the Community Health Improvement Plan and have committed to continuing work to implement the plan.

The Process

Overview Of The Mapp 2.0 Framework

The Partners for a Healthy Putnam County implemented the Mobilizing for Action through Planning and Partnership 2.0 (MAPP) model to complete the Community Health Assessment and the Community Health Improvement Plan (CHIP). The Putnam County Health Department led the Partners through the process.

The MAPP 2.0 Framework is an evidence-based, community-driven approach to community health improvement that emphasizes partnership, data-informed decision-making, and continuous action to advance health equity.

MAPP 2.0 was developed by the National Association for County and City Health Officials (NACCHO) and organizes community health improvement into three phases:

- Phase 1: Build the Community Health Improvement Foundation
- Phase 2: Tell the Community Story
- Phase 3: Continuously Improve the Community

Phase 1: Build the Community Health Improvement Foundation

To begin the MAPP 2.0 process, the Putnam County Health Department Health Promotion Division met a series of times in the fall of 2024 to complete Phase 1. Active coalitions, agency partners, and groups that

represent the diversity of Putnam County were identified. All options were explored to establish a group of individuals to participate in Phase 2 and 3. The past CHA and CHIP reports were reviewed to identify past priorities, data points, and resources currently available. The NACCHO endorsed Community Health Assessment platform Metopio was reviewed and solicited for a demonstration. The benefits of Metopio, the price of the platform, and applicability to Putnam County became part of the workplan and budget proposed to the Partners for a Healthy Putnam County in December 2024.

Phase 2: Tell The Community Story

The Partners for a Healthy Putnam County met in December 2024 and agreed there was a need to conduct the MAPP process to update the community health assessment and the current CHIP. It was also agreed that the Putnam County Health Department (PCHD) would facilitate the process and work collaboratively with partners, Metopio, and the community to update the Community Health Assessment and the CHIP.

The Partners then began meeting in January to complete Phase 2, which focuses on developing a comprehensive understanding of community health, system capacity, and the conditions that influence health and well-being. Phase 2 integrates findings from three coordinated assessments to describe health from multiple perspectives. Together, these assessments examine community partnerships and capacity, population-level health status, and the broader social, economic, environmental, and systemic factors that shape health outcomes. This approach allows for a more complete understanding of health needs, strengths, and inequities within Putnam County. The three assessments include:

- **Community Partner Assessment** evaluates how well the local public health system functions as a unified system.
- **Community Context Assessment** identifies what is important to community members, how quality of life is perceived and what strengths and assets the community have that can be used to improve community health.
- **Community Status Assessment** identifies key health, socioeconomic, environmental, quality of life outcomes, and populations experiencing inequities.

Community Partner Assessment

Evaluates how well community partners function as a unified system by:

- Assessing organizational capacity, resources, and gaps.
- Identifying how partnerships, power, and data are shared.
- Determining the extent to which equity is embedded in policies and practices.
- Strengthening relationships and cross-sector collaboration.

Between January and March 2025, the Putnam County Health Department (PCHD) led the Community Partner Assessment (CPA) as part of Phase II of the MAPP 2.0 framework. The CPA examined how organizations across sectors—healthcare, education, social services, local government, and business—work together to promote health equity and strengthen the Local Public Health System (LPHS).

The Partner Survey was completed by 16 organizations representing health, education, social services, and government sectors. Survey insight showed that Putnam County's LPHS is highly collaborative yet must invest in equity structures, shared data systems, and policy coordination to achieve deeper systematic impact.

The key partner activities such as Essential Public Health Services, "On the River", and Rich Picture analysis revealed:

- Shared determinants of health—poverty, transportation, housing, and stigma.
- Root causes—family stress, employment strain, and isolation.
- System needs—behavioral health expansion, early childhood support, and workforce development.

During the partner assessment, the group developed a statement that reflects the shared values that will guide all future community health efforts which is "*Residents have a choice to fair and just opportunities to be as happy, independent, and healthy as possible. To achieve this, we must collaborate to remove barriers and stigma to optimal health and their consequences.*"

Overall, the partner assessment revealed several implications:

- Strong Collaborative Infrastructure: Putnam County's LPHS is grounded in trusted relationships and cross-sector engagement.
- Need for Upstream Investment: Partners recognize the need to influence policy, systems, and environments to sustain impact.
- Commitment to Health Equity: Equity is a unifying value; implementation capacity must now match intent.
- Community Readiness: Partners exhibit motivation, maturity, and shared accountability to sustain equity-driven progress.

Community Context Assessment

Collect qualitative data to add insight, perceptions, and depth from community members on:

- Community strengths and assets
- Built environment
- Forces of change

A combination of focus group discussions with a variety of groups in the community, key informant surveys, and forces of change were used to conduct the Community Context Assessment. To obtain a good picture of the health of the community from the viewpoint of our residents, focus group discussions were conducted with a number of different groups including senior citizens, elected officials, law enforcement, Family Children First Council, community center members, and residents of low-income geographic areas.

The focus groups were asked to consider the most important health issues in Putnam County, barriers to care and assistance, ways to improve access to care, and resources or activities they would like to see more of in the county. Participants emphasized the importance of family, hard work, and community bonds while also highlighting significant health issues such as drinking, smoking, and exposure to farm chemicals. Access to healthcare emerged as a major concern, with long wait times for doctors and specialists, high costs of care, lack of public transportation, and a lack of local services being frequently mentioned. These themes highlight the community's concerns and suggest areas for improvement in health services and infrastructure. The key themes are summarized as:

- Mental Health
- Substance Use and Abuse
- Access to care
- Overall health

A key informant survey was also completed as part of the Community Context Assessment. The survey was provided electronically to healthcare providers and mental health providers. These individuals were asked to respond to a series of questions relating to health issues in Putnam County, barriers to care, resources they would like to see more of, and suggestions to improve access to health-related services and programs.

The responses focused on mental health, alcohol use, and diabetes as primary health concerns. The responses underscored the challenges posed by social stigma, limited transportation, and inadequate funding in accessing necessary health services. Providers suggested increasing family-oriented events, promoting health education, and providing more affordable health resources to address these issues**.** These themes underscore the importance of addressing healthcare access and socioeconomic factors to improve community health.

The Forces of Change assessment was completed as an in-person meeting of partners on April 2025. Participants were asked to identify trends (patterns over time), factors (discrete elements such as a rural setting or population demographics) and events (one-time occurrences such as a natural disaster) and how these can contribute to inequities.

A worksheet was provided prior to the meeting for participants to gather their and others' thoughts on three topic areas:

- Social/Health
- Economic/Political
- Environmental/Technological

The results are summarized below in each topic:

Social/Health:

- Aging population including more services needed, less family availability, more health issues will need care
- Food security includes access and affordability to healthy, nutritious food items
- Gaps in programming for all ages. Elderly with social isolation. Adults for healthy activities with no alcohol
- Childcare access and affordability
- Vaccine hesitancy
- Language barriers
- Housing and rent increases
- Mental health both adult and youth

Environmental/Technological:

- Natural disasters – flooding, tornado, severe weather, climate events
- Social media – older generation transitioning to apps, cyber bullying, parents not knowing social media apps
- Rural access for healthcare – telehealth, internet reliability, tech savvy enough for tele-visit
- Transportation – no public transportation, rural
- Artificial Intelligence (AI)
- More work from home
- Uncertainty of funding especially if government funded
- More places for outdoor activity such as nature walkways, kayaks, parks, keeping kids engaged

Economic/Political:

- Federal cuts including grants, senior benefits, public health, prevention services, food assistance
- Medicaid cuts
- Inflation
- Government negativity
- Housing costs and affordable rent
- Immigration policy
- Economic insecurity
- Healthcare shortage

Community Status Assessment

- What does the status of the community look like, including key health, socioeconomic, environmental, and quality of life issues?
- What populations are experiencing inequities across health, socioeconomic, environmental, and quality of life outcomes?

The Community Status Assessment (CSA) was conducted by a self-selected subcommittee of Partners for a Healthy Putnam County. All community partners were invited to participate in the 2025 Community Health Assessment kick-off meeting, during which the methodology for the CSA was introduced. At this meeting, the use of an Artificial Intelligence (AI)–supported data platform, Metopio, endorsed by the National Association of County and City Health Officials (NACCHO) was proposed to enhance the assessment process.

Metopio is a comprehensive analytics platform that aggregates curated data from public and proprietary sources, providing population-level information on health behaviors, health risks, health outcomes, healthcare utilization, and community-level drivers of health. Where available, data are disaggregated by race, ethnicity, and gender, allowing for deeper examination of health patterns and disparities. In this assessment, Metopio data were used to supplement primary data and provide broader context for health indicators and conditions in Putnam County.

The Community Status Assessment subcommittee finalized the assessment methodology and selected questions for the community resident survey. Survey topics included health behaviors, mental health, and questions related to living or working in the Putnam County service area. The survey was distributed through multiple channels to maximize reach with an emphasis on sampling difficult to reach populations through distribution in the laundromats, community center, food pantries, and free clinic.

Key themes that emerged from the status assessment:

Access and Infrastructure: Substantially fewer primary care physicians, dentists, and mental health providers per capita than state and national averages.

Health Behaviors and Lifestyles: Many residents consume insufficient fruits and vegetables, and survey findings show regular consumption of sugary drinks and frequent restaurant or takeout meals. While most adults engage in some physical activity, barriers such as motivation, time, and energy remain prominent.

Health Outcomes: Obesity affects 40% of adults, higher than state and national averages. High blood pressure, high cholesterol, arthritis, diabetes, and coronary heart disease remain common, with heart disease occurring at notably higher rates locally.

Mental Health and Substance Misuse: Rates of depression, poor mental health days, and loneliness reflect significant emotional and psychological strain. Binge drinking remains higher than Ohio and national averages.

Socio-Economic Factors: Strong economic stability relative to state and national benchmarks, with a higher median household income, lower poverty rate, and a smaller proportion of ALICE (Asset Limited, Income Constrained, Employed) households; however, disparities persist across census tracts, with certain communities experiencing higher levels of poverty, transportation burden, and social vulnerability.

Presenting The Findings Of MAPP 2.0 Assessments

After conducting the Phase 2 MAPP 2.0 assessments, the Partners met in January 2026 to release the findings of the data. A final report of the Community Health Assessment was presented at a public meeting on January 22, 2026. Members of the Partners for a Healthy Putnam County, stakeholders and community members were invited to attend. This data was valuable as the Partners determined the strategic priorities, goals, objectives and strategies for the Community Health Improvement Plan. The Community Health Assessment report is available on the Putnam County Health Department website at www.putnamhealth.com.

A breakdown of health issues of the population, related health disparities among the population, and identified populations with an inequitable share of poorer health outcomes is provided in the assessment via heat maps by census tract. This data allowed for consideration of these issues as the priorities for the next community health improvement plan were determined.

CHA data results were also provided at presentations to community members in social clubs such as the Rotary and Kiwanis, and to business owners/managers at the Putnam County Community Improvement Corporation's monthly meeting. At these presentations, a worksheet was provided to attendees to capture their thoughts about each of 5 themes. Community members were asked what data stood out to them, any additional data needed, and if this area should be an area of focus for the CHIP. The community's opinion on future focus areas was provided at the CHIP prioritization meeting on March 12, 2026.

Youth data from the 2025 PRIDE survey was not available until after the prioritization meeting but was used during CHIP subcommittee meetings to determine goals, strategies, and activities.

Phase 3: Continuously Improve The Community

Identify Strategic Priorities

In February 2026, Partners met for a prioritization meeting to identify the top issues and themes. The CHA findings were reviewed at the beginning of the meeting along with a summary document. A discussion regarding the impact of these issues and the effects on the population, especially those with health disparities and those that experience health inequity, occurred during this meeting.

During the prioritization process, community partners reviewed six issue profiles developed from the 2025 Community Health Assessment. Each profile included quantitative health data, community feedback, system patterns, and health equity considerations. Participants then evaluated each issue using five standardized criteria: magnitude (how many residents are affected), severity (the seriousness of the issue and its impact on health and quality of life), health disparities (whether the issue disproportionately affects certain populations), feasibility (the community's ability to make a meaningful impact through local action), and community readiness (existing partner capacity and momentum).

In addition, participants considered how each issue aligned with the Ohio State Health Improvement Plan (SHIP) and national public health priorities to ensure local efforts supported broader evidence-based initiatives. Each criterion was scored on a scale of 1–5, group scores were averaged, and the rankings were reviewed through a facilitated consensus-building discussion before the final priority areas were selected.

Using a structured nominal group process, participants scored and ranked the six identified issue areas based on the established prioritization criteria. Average scores from each group were used to rank the issues, followed by a facilitated consensus-building exercise to confirm the final priorities. Through this process, three strategic priorities were selected for the 2026–2029 Community Health Improvement Plan.

Three strategic priorities identified:

- Mental Health and Substance Misuse
- Community Conditions
- Chronic Disease and Healthy Behaviors

To help identify all potential stakeholders and partner agencies, another meeting was held with the Partners for a Healthy Putnam County in March 2026. From the ideas generated at this meeting and volunteer agency personnel, workgroups were formed.

Formulated Goals and Strategies

Workgroups were then tasked to develop an Action Plan with goals, objectives and activities for each of the strategic priorities. Evidence-based public health practices, policy, environmental and systems change, as well as the state and national priorities, were considered as the workgroups developed the Action Plan. Priorities in the State of Ohio's Health Improvement Plan (SHIP) that are linked to the Putnam County plan are identified in the Action Plan. National priorities from Healthy People 2030 were also considered during the development of the Action Plan. As the workgroups met to develop the Action Plan, health inequities and social determinants of health were considered in the planning.

The workgroups met for several months and upon completion of this phase, the health department compiled the Action Plan from all of the priorities into the *2026-2028 Putnam County Community Health Improvement Plan* (CHIP).

This plan is presented to the Partners, stakeholders and community members as a working document to address the needs of our community. Partners, stakeholders and community members are encouraged to take an active role in implementing the goals and strategies identified in this plan.

Action Cycle

Now that the *2026-2028 Putnam County Community Health Improvement Plan* (CHIP) is complete, it is time to put the plan into practice. Transparency and communication are vital in this phase, as different individuals, agencies and organizations are all working together to successfully implement the plan. If there are existing committees or task forces already working to address some of the identified priorities, those groups will help to guide the implementation of this plan. If new committees are needed, they will be developed to address the needs.

Evaluation is a key part of the Action Cycle. It is important to know how well Partners are meeting the goals and objectives of the CHIP. Therefore, Partners workgroups will provide quarterly updates on the

progress of CHIP strategies. The progress will be recorded and tracked in the CHIP Action Plan and communicated via Clear Impact. The Clear Impact Performance Management System is a performance management tool that helps community coalitions organize, implement, monitor, and improve their work. The system will allow coalition members to track progress on action items, assign responsibilities, establish timelines, document accomplishments, identify barriers, and monitor performance measures over time. Quarterly review of this information will help the workgroups make informed decisions, adjust strategies when needed, celebrate successes, and remain focused on achieving the desired health outcomes. In addition, the CHIP Clear Impact Scorecard will be linked to the PCHD website for partner and public viewing.

Annually, the Partners for a Healthy Putnam County will convene a public meeting to review the CHIP's progress related to each objective, share the previous year's progress, barriers, and provide updates for the upcoming year.

Alignment with State and National Priorities

State Of Ohio Health Improvement Plan (SHIP)

In the guidance from the Ohio Department of Health, local health partners are encouraged to collaborate to develop an improvement plan that aligns with Ohio's State Health Improvement Plan. The use of the MAPP Framework is also encouraged during the assessment and planning phases. The MAPP Framework was implemented in Putnam County as encouraged by the Ohio Department of Health and the National Association of County and City Health Officials (NACCHO).

Ohio's 2020-2022 State Health Improvement Plan (SHIP) is a tool to strengthen state and local efforts improve health, well-being, and economic vitality in Ohio. SHIP identifies three priority factors and three priority health outcomes that affect the overall health and well-being of children, families, and adults of all ages.

The three priority factors are:

- Community Conditions
- Health Behaviors
- Access to care

The three priority health outcomes are:

- Mental Health and Addiction
- Chronic Disease
- Maternal and Infant Health

By focusing on these priority topics, the goal of the SHIP is that all Ohioans reach their full health potential.

To align with the SHIP, local health departments and partners are encouraged to take a leadership role by identifying at least one priority factor and at least one priority health outcome as part of the local CHIP. The selection of these priorities should be guided by the needs that are identified through data collection and analysis and chosen through a collaborative process. The local entity should also address health equity by identifying priority populations for objectives and selecting strategies likely to reduce disparities and inequities whenever possible.

Through the MAPP framework and process for developing the *2026-2028 Putnam County Community Health Improvement Plan*, the following SHIP priority factors, priority outcomes and indicators were selected for alignment with the state plan:

Priority Factors/ Outcomes	Ohio Priority Topic	Ohio Indicator	Putnam County CHIP Strategy
Health Behaviors/Chronic Disease	Suicide	MHA3. Youth suicide deaths. Number of deaths due to suicide for youth, ages 8-17, per 100,000 population (ODH Vital Statistics)	• School based prevention program • Digital kindness campaign
		MHA4. Adult suicide deaths. Number of deaths due to suicide for adults, ages 18 and older, per 100,000 population (ODH Vital Statistics)	• Stigma reduction and awareness of treatment resources campaign
	Youth tobacco/nicotine use	HB2. Youth all tobacco/nicotine use. Percent of high school students who have used cigarettes, smokeless tobacco, cigars, pipe tobacco, hookah, bidis, e-cigarettes or other vaping products during the past 30 days (OYTS)	• School-based prevention programs • Youth led prevention and cessation interventions • Youth led media awareness campaign
	Youth alcohol use	MHA5. Youth alcohol use. Percent of high school students who have used alcohol within the past 30 days (YRBS)	• School-based prevention programs • Youth led prevention activities • Youth led media awareness campaign
Health Behaviors/ Chronic Disease	Physical Activity	HB6. Adult physical activity. Percent of adults, age 18 and older, reporting no leisure time physical activity (BRFSS)	• Implement Walk With A Doc programming • Promote walking/running clubs throughout Putnam County • Conduct community-wide physical activity and step challenges • Develop and maintain a Parks, Trails, and Recreation Resource Guide

Health Behaviors/ Chronic Disease	Nutrition	• HB3. Youth fruit consumption. Percent of high school students who did not eat fruit or drink 100% fruit juices during past 7 days (YRBS) • HB4. Youth vegetable consumption. 10.6% Short-term target (2021) 10.4% Intermediate target (2025) Long-term target (2029) 10% 8.7% Percent of high school students who did not eat vegetables (excluding french fries, fried potatoes or potato chips) during past 7 days (YRBS)	• Expand SNAP, WIC, FMNP, and Produce Perks Participation • Develop and maintain partnerships with local food pantries and food assistance programs • Develop and distribute a countywide Food Resource Guide
Access to Care/ Chronic Disease	Local access to healthcare providers	• AC3. Primary care health professional shortage areas. Percent of Ohioans living in a primary care health professional shortage area* (HRSA, as compiled by KFF) • CD1. Coronary heart disease. Percent of adults, ages 18 and older, ever diagnosed with coronary heart disease (BRFSS) • CD2. Premature death - heart disease. Years of potential life lost before age 75 due to heart disease, per 100,000 population (age adjusted) (ODH Vital Statistics) • CD3. Hypertension. Percent of adults, ages 18 and older, ever diagnosed with hypertension (BRFSS)	• Conduct blood pressure screenings at community events • Develop and maintain a provider resource directory • Promote Preventive Health Screenings and Annual Wellness Visits
Community Conditions	Adverse Childhood Experiences	CC6: Percent of children, ages 0-17, who have experienced two or more adverse experiences (NSCH) – no target percentage identified	• Adult awareness and resources outreach campaign • School based prevention programming

Healthy People 2030

To align with national standards, the Partners also considered information from the Healthy People 2030. Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

To reach those goals, the Healthy People 2030 plan of action prioritizes setting national goals and measurable objectives to guide evidence-based policies, programs, and other actions to improve health and well-being. Putnam County will align with these national goals to improve health and well-being for people of all ages and the communities in which they live by utilizing evidence-based programs and policies that are replicable, scalable, and sustainable.

The following table describes the areas of the CHIP which align with the Healthy People 2030 objectives.

Healthy People 2030 Objective	Putnam County CHIP Mental Health & Substance Misuse Strategy
1. Increase the proportion of people with substance use and mental health disorders who get treatment for both-SU-01	• Support efforts of mental health providers to raise awareness of local resources and explore innovative services for the community
1. Reduce the proportion of adolescents who drank alcohol in the past month-SU-10	• Partner with agencies to promote messaging to youth on alcohol use prevention

1. Increase the proportion of adults with depression who get treatment-MHMD-05 2. Increase the proportion of children with mental health problems who get treatment-MHMD-03	• Work with EAP and local businesses to raise awareness of behavioral health benefits and local resources • Self-screening tools available • School based counselors in every school • Increase awareness of support services/skills for youth
1. Reduce current use of any tobacco products among adolescents-TU-04 2. Reduce the proportion of adolescents who drank alcohol in the past month – SU-04	• Youth-led prevention campaign for underage tobacco and alcohol consumption
Healthy People 2030 Objective	**Putnam County CHIP Chronic Disease & Healthy Behaviors Strategy**
1. Reduce household food insecurity and hunger — NWS-01 2. Increase fruit consumption by people aged 2 years and over — NWS-06 3. Increase vegetable consumption by people aged 2 years and older — NWS-07	• Expand SNAP, WIC, FMNP, and Produce Perks Participation. • Develop and maintain partnerships with local food pantries and food assistance programs. • Develop and distribute a countywide Food Resource Guide.
1. Reduce the proportion of adults who do no physical activity in their free time — PA-01 2. Increase the proportion of adults who do enough aerobic physical activity for substantial health benefits — PA-02	• Promote walking/running clubs throughout Putnam County • Conduct Community-Wide Physical Activity and step challenges • Develop & Maintain a Parks, Trails, and Recreation Resource Guide

1. Increase the number of community organizations that provide prevention services — ECBP-D07	• Conduct blood pressure screenings at community events. • Develop and maintain a provider resource directory. • Promote Preventive Health Screenings and Annual Wellness Visits.
Healthy People 2030 Objective	**Putnam County CHIP Community Conditions Strategy**
1. Increase the proportion of adolescents who have an adult they can talk to about serious problems – AH-03	• Provide community evidence-based trainings on building healthy relationships with youth
2. Increase the proportion of adults who talk to family or friends about their health – HC/HIT-R04	• Raise awareness of community engagement and volunteer opportunities • Evaluate social connectedness frameworks for community implementation
1. Reduce sexual or physical adolescent dating violence – IVP-18 2. Reduce intimate partner violence – IVP-004	• Expand school-based prevention programs so all students have the opportunity to attend • Provide bystander empowerment and education on how to recognize and intervene when someone needs help • Engage with local businesses, schools, and community agencies to assist with implementation of zero tolerance violence policy

Putnam County Assets and Resources

The ratio of population to primary care physicians is higher in Putnam County than the state; however, 94.7% of residents identify at least one person or group that they think of as their personal health care provider. There are 2 places that provide mental health services in Putnam County. One has a psychiatrist on staff while the other has psychologists or licensed counselors only. The mental health providers per capita are 93.2/100,000 while Ohio is 640.0/100,000 population. There are 7 dentists in the county, which makes Putnam have a significantly lower ratio of dentists per capita.

There are no registered hospitals located in Putnam County. Hospitals in surrounding areas include Blanchard Valley Hospital, Mercy Health St. Rita's, Lima Memorial Health System, ProMedica Defiance Regional Hospital, and Ohio Health in Van Wert to serve patients from Putnam County. However, there is Mercy Ambulatory Care in Putnam County.

There are 9 school districts in the county with a graduation rate higher than the state, 95% compared to 91.6%. Guidance counselors are in each school to assist with student referrals for services. Even though there are no institutions of higher learning located in the county, there are several colleges located in adjacent counties and limitless on-line options.

There are fitness facilities, boutique specialty facilities, two YMCA locations, and a community center with an indoor track located in the county. Some schools also open their weight room to the public at designated hours and allow people to walk in the halls after school for indoor activity. There are organized youth and adult sporting activities at the facilities including volleyball, basketball, pickleball, and group fitness classes. There is also an outdoor park with play equipment located in each town in the county with two communities having organized Run Clubs. Public park improvements have been prioritized by local governments, social groups, and public health through grant activities.

Putnam County was ranked the fifth highest county in the state for residents with religious affiliation. There are many denominations located within Putnam County. Faith leaders are involved in coalitions and partnership with healthcare and social agencies to promote programming.

There are 5 food pantries, several food distribution sites for donated food including affiliation with the West Ohio Food Bank, WIC, Meals on Wheels, and weekend food programs associated with the schools along with school gardens.

There are numerous coalitions in the county to promote social and health programming for adults and youth. Key agencies involved in these coalitions include Pathways Counseling Center, HHWP Community Action Coalition, Help Me Grow, Health Dept., Job & Family Services, Crime Victim Services, WIC, YMCA, ADAMHS Board, Leipsic Community Center, Head Start, Council on Aging, Mercy Health, Educational Service Center, OSU Extension, Law Enforcement representatives, community members, school representatives, and Area Agency on Aging.

The top employers in Putnam County include Midway Products Group Inc., Kalida Manufacturing Inc., Pro-Tec Coating Company Inc., Trilogy Health Services, LLC, Unverferth Manufacturing, and Whirlpool Inc.

The following section describes the three strategic priorities of the *2026-2028 Community Health Improvement Plan* in more detail.

Priority Topic: Mental Health & Substance Misuse Action Plan

Priority Outcome: Improve utilization of local behavioral health services				
Goal: *Increase access to screening tools for health care professionals and residents*.				
Objective: *By December 2028, at least 75% of primary care providers in Putnam County will screen patients with a standardized tool annually and the standardized tool will be available for self-assessment on at least 3 agency websites.*				
Strategies	**Timeline**	**Person/Agency Responsible**	**ODH SHIP Strategies**	**Status**
Standardize the current mental health screening processes and tools used by local primary care providers A. Develop a survey to distribute to primary care providers asking about current behavioral health screenings and prescribing practice used during visits B. Distribute survey and analyze results C. Develop standardized tool D. Promote assessment tool and processes to all primary care providers **Develop and implement self-screening resources** A. Investigate evidence-informed online screening tools B. Determine appropriate screening tool C. Conduct an awareness campaign with community partners to raise awareness of self-screening tool and access site D. Evaluate effectiveness of campaign by # of self-assessments done and # stating they will follow-up with provider	July 2026 – December 2027 January 2027-December 2028	Pathways Counseling Center Health Dept. Friends of Mental Health Prevention Coalition Council on Aging Mental Health, Alcohol & Drug Addiction Recovery Board of Putnam County	Coordinated care for behavioral health – Integration of behavioral health services into primary care Digital access to treatment services and crisis supports	

Priority Topic: Mental Health & Substance Misuse Action Plan

Priority Outcome: Improve utilization of local behavioral health services				
Goal: Increase awareness of behavioral health treatment resources among adults in Putnam County				
Objective: *By December 2028, the percentage of adults who report being aware of drug or alcohol addiction treatment will increase from 49.5% (in 2025) to 55% as evidenced by the community survey.*				
Strategies	**Timeline**	**Person/Agency Responsible**	**ODH SHIP Strategies**	**Status**
Assess Employee Assistance Programs offered at Putnam County employers A. Partner with Chamber of Commerce and Community Improvement Corp. to identify employers and contact information B. Develop assessment tool for businesses C. Distribute tool to HR specialists in targeted businesses D. Evaluate results of assessment to identify EAP programs in Putnam County	June 2026 – June 2027	Pathways Counseling Center Health Dept. Friends of Mental Health Prevention Coalition	Comparable insurance coverage for behavioral health	
Facilitate education to employees in at least 4 businesses on their behavioral health benefits and available local resources A. Work with HR specialists in targeted businesses to facilitate employee education from EAP on the available benefits for insured and dependents B. Coordinate with HR specialists and/or EAP for education of adults on importance of taking care of your mental health	July 2027 – December 2028	Council on Aging Mental Health, Alcohol & Drug Addiction Recovery Board of Putnam County	Comparable insurance coverage for behavioral health Mental health education	
Conduct at least 2 outreach events annually to educate trusted messengers and residents about available treatment services and how to access them A. CHIP Subcommittee will communicate at quarterly meetings and discuss upcoming events planned to attend per agency	June 2026 – December 2028			

B. Coordinate materials to be distributed to ensure consistency C. Update committee to confirm distribution after event				

Priority Topic: Mental Health & Substance Misuse Action Plan

Priority Outcome: *Improve Youth behavioral health and resilience in Putnam County*				
Goal: Reduce suicidal thoughts among youth				
Objective: By March 30, 2028, the incidence of suicidal thoughts among youth will be reduced by 2% from 9.2% on the PRIDE survey in 2025 to 7% in 2027.				
Strategies	**Timeline**	**Person/Agency Responsible**	**ODH SHIP Strategies**	**Status**
Implement evidence-based youth digital programs regarding digital literacy, healthy use of social media, and crisis response (988) A. Assess available programs for applicability to Putnam County youth B. Develop plan for offering and implementation in schools and youth programs C. Pilot the program with targeted youth prior to widespread implementation D. Collect youth feedback, adjust program as needed E. Implement programming F. Evaluate change in knowledge, attitude, or behaviors with youth attending the program	June 2026 – December 2028	Pathways Counseling Center Health Dept. Friends of Mental Health Prevention Coalition	Digital access to treatment services and crisis response	
Support at least 3 youth-led initiatives that promote positive messaging, kindness, and behavioral health awareness A. Assess current initiatives to analyze expansion applicability, needs, and gaps B. Develop plan for offering and implementation in schools and youth programs C. Collect youth feedback, adjust initiatives as needed D. Implement initiatives E. Evaluate change in knowledge, attitude, or behaviors with youth attending the program	June 2026 – December 2028	Mental Health, Alcohol & Drug Addiction Recovery Board of Putnam County	Social and emotional instruction	

Priority Topic: Mental Health & Substance Misuse Action Plan

Priority Outcome: Reduced prevalence of underage substance misuse by youth in Putnam County				
Goal: Increase the number of youth that do not use alcohol and nicotine				
Objective: By March 30, 2028, the percentage of high school students reporting they have not drunk alcohol in the past year will increase from 67% on the PRIDE survey in 2025 to 69% in 2027 and have not used tobacco will increase from 91% in 2025 to 92% in 2027.				
Strategies	**Timeline**	**Person/Agency Responsible**	**ODH SHIP Strategies**	**Status**
Expand youth engagement by supporting at least 3 youth-led prevention groups to promote substance-free lifestyles (PARTY, PYTA, YEG) A. Collaborate with schools, youth centers, faith-based organizations, and local nonprofits to recruit members. B. Give youth a voice in planning events and setting priorities C. Provide mini-grants or stipends for prevention groups to organize events D. Highlight youth achievements through community events, newsletters, and local media. E. Offer awards and certificates for leadership and prevention efforts.	August 2026 – December 2028	Pathways Counseling Center Health Dept. Family & Children First Council ADAMHS Board	Youth resilience programs, and K-12 drug prevention education	
Conduct a mass media campaign targeted at youth and parents on the harmful effects of underage nicotine and alcohol usage A. Determine effective strategies for targeted messaging B. Determine method and timing of campaign C. Support youth groups in creating social media campaigns promoting healthy lifestyles. D. Encourage youth-created videos, podcasts, and digital content highlighting positive alternatives to substance use E. Implement campaign F. Evaluate effectiveness of campaign the number of people reached	January 2027 – December 2028		K-12 drug prevention education, and Parental Engagement	

Priority Topic: Community Conditions

Priority Outcome: *Improve community connectedness*				
Goal: *Reduce social isolation and lonliness*				
Objective: *By December 31, 2028, the percentage of adults who report sometimes or more frequent feelings of loneliness will decrease from 25% to 20%.*				
Strategies	**Timeline**	**Person/Agency Responsible**	**Healthy People 2030 Goal**	**Status update**
Assess how residents get information about community events by surveying attendees at a minimum of 5 various events. A. Determine various events in the community to represent diverse populations (Kids Fest, COA event, 3 others?) B. Develop short survey to distribute at events C. Analyze results and report to CHIP subcommittee **Develop an outreach campaign promoting opportunities for community engagement and volunteerism** A. Based on assessment results, develop methodology to reach at risk populations B. Implement campaign C. Evaluate effectiveness of campaign by monitoring attendance at 5 community events **Assess type of available community activities and target populations to determine gaps** A. Look for opportunities of financial support for a paid student internship to assess the community activities B. Apply for funding for a student intern C. Interview and choose candidate for internship D. Develop assessment methodology E. Create report of assessment findings and provide results to subcommittee	August 2026 – March 2027 April 2027 – December 2028 August 2026 – December 2028	Health Dept. Go Ottawa Council on Aging Putnam County HomeCare & Hospice Area Agency on Aging Job & Family Services	Social and Community Context goal to increase social and community support and improve social connectedness as a key social determinant of health	

Implement at least 3 intergenerational activities that engage youth, older adults, and vulnerable populations with at least 100 total participants A. Determine existing events feasibility to become intergenerational B. Develop intergenerational activity C. Advertise activity D. Implement activity E. Evaluate activity and share results with subcommittee **Develop programming for a caregivers support group** A. Form a committee of local agencies invested in caregiving support B. Plan programming and support group meeting cadence C. Advertise caregivers support sessions D. Implement program E. Evaluate and share results with committee	August 2026 – December 2028 June 2026 – December 2028			

Priority Topic: Community Conditions

Priority Outcome: *Improve community connectedness*				
Goal: *Improve knowledge of community members on prevalence of social isolation and awareness of consequences to health*				
Objective: *By December 31, 2028, at least 200 community members will receive information and/or attend a presentation on social isolation and loneliness*				
Strategies	**Timeline**	**Person/Agency Responsible**	**Healthy People 2030 Goal**	**Status update**
Develop presentation and handout on social isolation and associated health consequences A. Assess evidence on the health consequences of isolation and loneliness for applicability to Putnam County demographics B. Determine target audiences C. Determine information to be in the presentation and handout D. Develop presentation and handout E. Schedule presentations F. Evaluate reach of information to the public	March 2027 – December 2028	Crime Victim Services Health Dept. Putnam County HomeCare & Hospice Council on Aging Job & Family Services Area Agency on Aging	Social and Community Context goal to increase social and community support and improve social connectedness as a key social determinant of health	

Priority Topic: Community Conditions

Priority Outcome: Improve community connectedness				
Goal: Evaluation of community engagement frameworks				
Objective: *By December 31, 2028, determine applicability of a community engagement framework to implement in Putnam County*				
Strategies	**Timeline**	**Person/Agency Responsible**	**Healthy People 2030 Goal**	**Status update**
Evaluate community engagement frameworks that would be applicable and realistic for Putnam County A. Assess community agencies and leaders' awareness of frameworks B. Conduct an internet search of evidence-based community engagement frameworks for rural counties C. Convene a work group of community leaders to review applicability of frameworks	January 2028 – December 2028	Crime Victim Services Health Dept. Go Ottawa Council on Aging Job & Family Services Putnam County HomeCare & Hospice Area Agency on Aging	Social and Community Context goal to increase social and community support and improve social connectedness as a key social determinant of health	

Priority Topic: Community Conditions

Priority Outcome: *Decrease interpersonal violence*				
Goal: Influence *adults to create a protective environment through healthy interpersonal relationships and community connection*				
Objective: *By December 31, 2028, the percentage of adults who report improved communication skills regarding interpersonal violence after attending educational presentation will be at least 50%.*				
Strategies	**Timeline**	**Person/Agency Responsible**	**Healthy People 2030 Goal**	**Status update**
Deliver at least 3 community evidence-based trainings on building healthy relationships with youth, such as CARING adult or Building Resiliency with Youth: A How To Guide for Safe Adults A. Determine training cadence, site, and time B. Schedule and publicize training C. Conduct and evaluate training **Engage influential adults through training on Bystander Intervention and Men and Boys as Allies in prevention** A. Determine feasibility to offer Bystander Intervention and prevention program targeting men in Putnam County B. Develop handout to highlight the programs C. Discuss applicability of programming in the faith community by attending inter-denominational clergy meeting D. Schedule trainings E. Evaluate reach of training relating to age and gender **Increase the number of worksites that have a zero-tolerance for violence policy** A. Assess existing policies regarding violence on-site including verbal, physical, sexual, emotional abuse B. Target or prioritize working with businesses that have limited to no policy. Would also assist businesses with strengthening existing policy **C.** Work with leadership at worksites to develop and implement the policy	August 2026 – December 2028 August 2026 – December 2028 January 2027 – December 2028	Crime Victim Services Health Dept. Job & Family Services Putnam County HomeCare & Hospice	Reduce intimate partner violence (IVP-D04) — a developmental objective aimed at reducing contact sexual violence, physical violence, and stalking across the lifespan.	

Priority Topic: Community Conditions

Priority Outcome: *Decrease interpersonal violence*				
Goal: Influence *youth attitudes and behaviors which result in a decrease in risk factors and an increase in protective factors related to interpersonal violence*				
Objective: *By December 31, 2028, the percentage of youth participating in healthy relationship and anti-interpersonal violence education sessions will increase by 10%.*				
Strategies	**Timeline**	**Person/Agency Responsible**	**Healthy People 2030 Goal**	**Status update**
Expand youth engagement in primary prevention curriculum for interpersonal violence, covering: • Healthy and unhealthy relationship characteristics • Boundary setting • Asking for and receiving consent A. Assess current school program offering B. Develop a plan to engage more schools to participate in programming C. Evaluate effectiveness of campaigns to engage more schools by number of schools participating **Expand youth engagement in educational programming on digital safety and anti-violence strategies in virtual spaces.** A. Assess current school program offering B. Develop a plan to engage more schools to participate in programming C. Evaluate effectiveness of campaigns to engage more schools by number of schools participating	August 2026 – December 2028 August 2026 – December 2028	Crime Victim Services Health Dept. Job & Family Services Putnam County HomeCare & Hospice	Reduce intimate partner violence (IVP-D04) — a developmental objective aimed at reducing contact sexual violence, physical violence, and stalking across the lifespan.	

Priority Topic: Healthy Behaviors

Priority Outcome: Reduce Chronic Disease Risk				
Goal: Increase Physical Activity Opportunities and Participation				
Objective: By December 31, 2028, decrease the percentage of Putnam County adults reporting no leisure-time physical activity from 21.7% to 20.0%.				
Strategies	**Timeline**	**Person/Agency Responsible**	**ODH priority factor**	**Status**
Implement Walk With A Doc programming. A. Establish a local Walk With A Doc chapter B. Recruit physician and healthcare champions C. Conduct monthly walks April–October D. Rotate educational topics (heart health, diabetes prevention, cancer prevention, mental health, fall prevention, healthy aging) E. Promote through healthcare providers, social media, employers, and community organizations F. Track attendance and participant satisfaction	July 2026 – December 2028	Putnam County Health Department (PCHD), Mercy Health, Lima Memorial Health System, Local Health Providers/Alternative Providers, Putnam County YMCA	Adult Physical Activity	
Promote walking/running clubs throughout Putnam County. A. Identify existing walking clubs, walking groups, and organized walking opportunities throughout Putnam County. B. Develop and maintain an inventory of existing walking groups, including locations, schedules, and contact information C. Promote existing walking groups through healthcare providers, employers, schools, faith-based organizations, senior organizations, and community partners	July 2026 – December 2028	PCHD, Putnam County YMCA, Council on Aging, Leipsic Community Center, Senior Center	Adult Physical Activity	

D. Include walking club information in the Parks, Trails, and Recreation Resource Guide E. Highlight walking groups through social media, websites, newsletters, and community events F. Encourage healthcare providers and community organizations to refer individuals to existing walking groups G. Track the number of walking groups promoted and participation data when available				
Conduct community-wide physical activity and step challenges. A. Develop annual step challenge, to take place once per year (2026, 2027 and 2028) B. Utilize smartphone apps or paper tracking options C. Recruit teams from businesses, schools, healthcare organizations, and community groups D. Offer incentives and recognition E. Share success stories through social media F. Evaluate participation and completion rates	July 2026 – December 2028	PCHD, Putnam County YMCA, Mercy Health, Lima Memorial Health System, Employers, Local Schools	Adult Physical Activity	
Develop and maintain a Parks, Trails, and Recreation Resource Guide. A. Inventory parks, trails, walking routes, fitness centers, playgrounds, and recreational programs B. Develop printed and electronic versions C. Distribute through healthcare providers, libraries, schools, employers, and community agencies D. Update annually E. Promote through social media and community events	July 2026 – December 2028	PCHD, Park Boards, Villages, Putnam County YMCA, Leipsic Community Center	Child Physical Activity; Adult Physical Activity	

Priority Outcome: Reduce Chronic Disease Risk				
Goal: Improve Access to Healthy Foods and Nutrition Education				
Objective: By December 31, 2028, increase the percentage of Putnam County adults who report consuming fruits and vegetables two or more times per day from 35.7% to 40.0%.				
Strategies	**Timeline**	**Person/Agency Responsible**	**ODH priority factor**	**Status**
Expand SNAP, WIC, FMNP, and Produce Perks Participation. A. Identify barriers to participation and enrollment B. Coordinate enrollment assistance opportunities at community events and partner agency locations throughout Putnam Count C. Identify and promote year-round locations where residents can receive enrollment assistance D. Train partner agencies on eligibility requirements, available benefits, and referral processes E. Partner with agencies that provide eligibility screening and application assistance F. Promote benefits through healthcare providers, schools, food pantries, faith-based organizations, and social service agencies G. Encourage community partners to refer eligible individuals and families to enrollment assistance services H. Promote Produce Perks and farmers market incentive programs	July 2026 – December 2028	PCHD, Farmers Market, Mercy Health, Leipsic Community Center, Local Food Pantries	Youth Fruit Consumption; Youth Vegetable Consumption	

I. Track outreach efforts, enrollment referrals, participation, and opportunities for improvement				
Develop and maintain partnerships with local food pantries and food assistance programs. A. Collaborate with local food pantries and food assistance programs to increase access to healthy foods for residents experiencing food insecurity B. Conduct and promote annual healthy food drives to support local food pantries and meal programs C. Increase the availability of fresh fruits and vegetables through partnerships with farmers markets, community gardens, produce donations, and local growers D. Assess transportation and accessibility barriers and identify alternative food distribution methods for underserved populations E. Promote food assistance resources and referral opportunities through healthcare providers, schools, faith-based organizations, and community partners F. Convene food access partners annually to identify community needs, coordinate services, and share resources G. Connect individuals and families to additional food assistance programs, including SNAP, WIC, FMNP, Produce Perks, and local nutrition education opportunities	July 2026 – December 2028	PCHD, Mercy Health, Council on Aging, Leipsic Community Center, Farmers Market	Youth Fruit Consumption; Youth Vegetable Consumption	
Develop and distribute a countywide Food Resource Guide. A. Develop and maintain a comprehensive countywide Food Resource Guide	July 2026 – December 2028	PCHD, Mercy Health, Council on Aging, Leipsic Community	Youth Fruit Consumption; Youth Vegetable Consumption	

B. Include SNAP, WIC, FMNP, Produce Perks, food pantries, meal programs, community gardens, farmers markets, and other local food resources C. Create both print and digital versions of the guide D. Distribute the guide through healthcare providers, schools, libraries, employers, food pantries, faith-based organizations, and social service agencies E. Promote the guide through community events, websites, newsletters, and social media platforms F. Review and update the guide annually to ensure accuracy and relevance		Center, Local Food Pantries		

Priority Outcome: Increase Preventive Health Participation				
Goal: Increase Screening Participation & Resource Navigation				
Objective: By December 31, 2028, increase the percentage of Putnam County adults who report receiving a routine medical checkup within the past year from 78.6% to 85.0%.				
Strategies	**Timeline**	**Person/Agency Responsible**	**ODH priority factor**	**Status**
Conduct blood pressure screenings at community events. A. Offer screenings at farmers markets, senior centers, health fairs, community festivals, and food distribution events B. Provide education regarding blood pressure management C. Refer individuals with elevated readings to healthcare providers D. Distribute resource information on lifestyle modification E. Track screenings, referrals, and follow-up opportunities	January 2027 – December 2028	PCHD, Mercy Health, Lima Memorial Health System, Local Health Providers/Alternative Providers, Council on Aging	Access to Care; Chronic Disease Prevention	
Develop and maintain a provider resource directory. A. Create a centralized directory for healthcare providers B. Include referral pathways for food insecurity, transportation, physical activity opportunities, chronic disease programs, and social services C. Provide annual updates D. Promote utilization through provider education and coalition meetings	July 2026 – December 2028	PCHD, Mercy Health, Lima Memorial Health System, Local Health Providers/Alternative Providers, Pathways	Access to Care	

Promote Preventive Health Screenings and Annual Wellness Visits. A. Develop and distribute educational materials promoting preventive health services and annual wellness visits B. Promote recommended screenings, including blood pressure, cholesterol, diabetes, colorectal cancer, breast cancer, cervical cancer, and other age-appropriate screenings C. Share preventive health messages through social media, websites, newsletters, employers, healthcare providers, and community organizations D. Promote available screening events and wellness opportunities throughout Putnam County E. Encourage healthcare providers and community partners to reinforce the importance of preventive care F. Increase awareness of insurance-covered preventive services and available assistance programs G. Utilize community events to distribute educational materials and connect residents to preventive health resources H. Track outreach activities and community engagement	July 2026 – December 2028	PCHD, Mercy Health, Lima Memorial Health System, Local Health Providers/Alternative Providers, Council on Aging, Employers	Access to Care; Chronic Disease Prevention	