DELIVERED BY:

Moxley PUBLIC HEALTH

2026-2028 CRAWFORD COUNTY IMPLEMENTATION STRATEGY/ COMMUNITY HEALTH IMPROVEMENT PLAN

PUBLISHED NOVEMBER 2025

CCHP CRAWFORD COUNTY HEALTH PARTNERS

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A NOTE FROM **CRAWFORD COUNTY HEALTH PARTNERS**

Crawford County Health Partners (CCHP) strives to bring together people and organizations to improve community wellness. The community health assessment process is one way we can live out our mission. In order to fulfill this mission, we must be intentional about understanding the health issues that impact residents and work together to create a healthy community.

A primary component of creating a healthy community is assessing the community's needs and prioritizing those needs for impact. In 2025, CCHP partnered with Moxley Public Health and community-based organizations to conduct a comprehensive Community Health Needs Assessment (CHNA) to identify priority health issues and evaluate the overall current health status of the hospital and health department's service area. These findings were then used to develop an Implementation Strategy (IS)/ Improvement Plan (CHIP) to describe the response to the needs identified in the CHNA report.

The 2026-2028 Crawford County IS/CHIP would not have been possible without the help of numerous Crawford County organizations, acknowledged on the following pages. It is vital that assessments such as this continue, so partners know where to direct resources and how to use them in the most advantageous ways.

The goals of public health can only be accomplished through community members' commitment to themselves and to each other. CCHP believes that together, Crawford County can be a thriving community of health and well-being at home, work, school, and play.

Importantly, this report could not exist without the contributions of individuals in the community who participated in interviews and completed the community member survey. CCHP is grateful for those individuals who are committed to the health of the community, and took the time to share their health concerns, needs, behaviors, praises, and suggestions for future improvement.

Sincerely,

Cinda M. Kropka

Cinda M. Kropka, MHA
Corporate Compliance & Privacy Officer
Avita Health System

Kate Siefert

Kate Siefert, REHS, MPH
Health Commissioner
Crawford County Public Health

Andrea Cinadr

Andrea Cinadr, REHS
Health Commissioner
Galion City Health Department

ACKNOWLEDGMENTS

This IS/CHIP was made possible thanks to the collaborative efforts of Crawford County Health Partners (CCHP), community partners, local stakeholders, non-profit partners, and community residents. Their contributions, expertise, time, and resources played a critical part in the completion of this assessment.

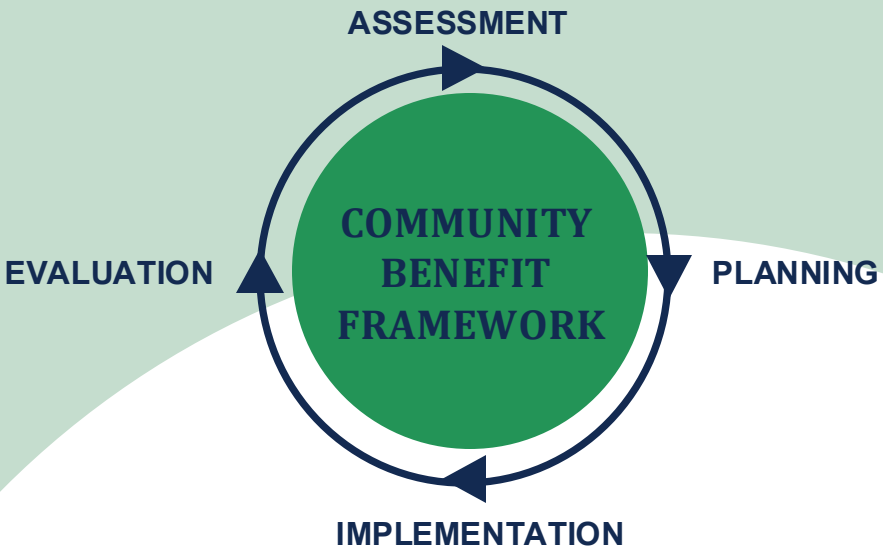
CCHP WOULD LIKE TO RECOGNIZE THE FOLLOWING ORGANIZATIONS FOR THEIR CONTRIBUTIONS TO THIS REPORT:

Alzheimer's Association—Northwest Ohio Chapter
Avita Health System*
Bucyrus Area Chamber of Commerce
Bucyrus City Schools
Bucyrus Outreach Restoration Network (BORN)
Bucyrus Public Library
Community Counseling Wellness Centers
Community Foundation for Crawford County
Crawford County Board of Developmental Disabilities*
Crawford County Child Protective Services
Crawford County Commissioner's Office
Crawford County Council on Aging
Crawford County Emergency Management Agency
Crawford County Help Me Grow
Crawford County Partnership for Education & Economic Development
Crawford County Public Health*
Crawford County School Districts
Crawford County Veterans Service Commission
Crawford County WIC
Crestline Nursing Home
Galion City Council
Galion City Fire & EMS Department
Galion City Health Department*
Galion City Schools
Galion Family Health Center
Galion Golden Age Center
Galion Public Library
Galion Theater
Family & Children First Council
Family Life Counseling & Psychiatric Services
Jobs & Family Services
Marion-Crawford ADAMH Board*
Marion Crawford Prevention Programs
NAMI Marion & Crawford Counties
Nationwide Children's Hospital
North Central State College
Ohio District 5 Area Agency on Aging
Ohio Heartland Community Action
Ohio Mutual Insurance Group
Pathways of Central Ohio
Project Noelle
Rally for Hope
Salvation Army
Third Street Family Health Services
Together We Hurt, Together We Heal*
Turning Point
United Way of North Central Ohio*
Voice of Hope
Wesley Chapel
YMCA

**Indicates funding partner.*

INTRODUCTION

WHAT IS AN IMPLEMENTATION STRATEGY (IS)/ IMPROVEMENT PLAN (CHIP)?



An **Implementation Strategy (IS)/Community Health Improvement Plan (CHIP)** is part of a framework that is used to guide community benefit activities, policy, advocacy, and program-planning efforts. For health departments, the Community Health Improvement Plan (CHIP) fulfills the mandates of the Public Health Accreditation Board (PHAB). For hospitals, the Implementation Strategy describes their plan to respond to the needs identified through the previous Community Health Needs Assessment (CHNA) process. It also fulfills a requirement mandated by the Internal Revenue Service (IRS) in Section 1.501(r)(3).

OVERVIEW
OF THE PROCESS

In order to develop an IS/CHIP, Crawford County Health Partners (CCHP) followed a process that included the following steps:

STEP 1: Plan and prepare for the IS/CHIP.

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

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

STEP 4: Select approaches with community partners.

STEP 5: Integrate IS/CHIP with community partner, health department, and hospital plans.

STEP 6: Develop a written IS/CHIP.

STEP 7: Adopt the IS/CHIP.

STEP 8: Update and sustain the IS/CHIP.

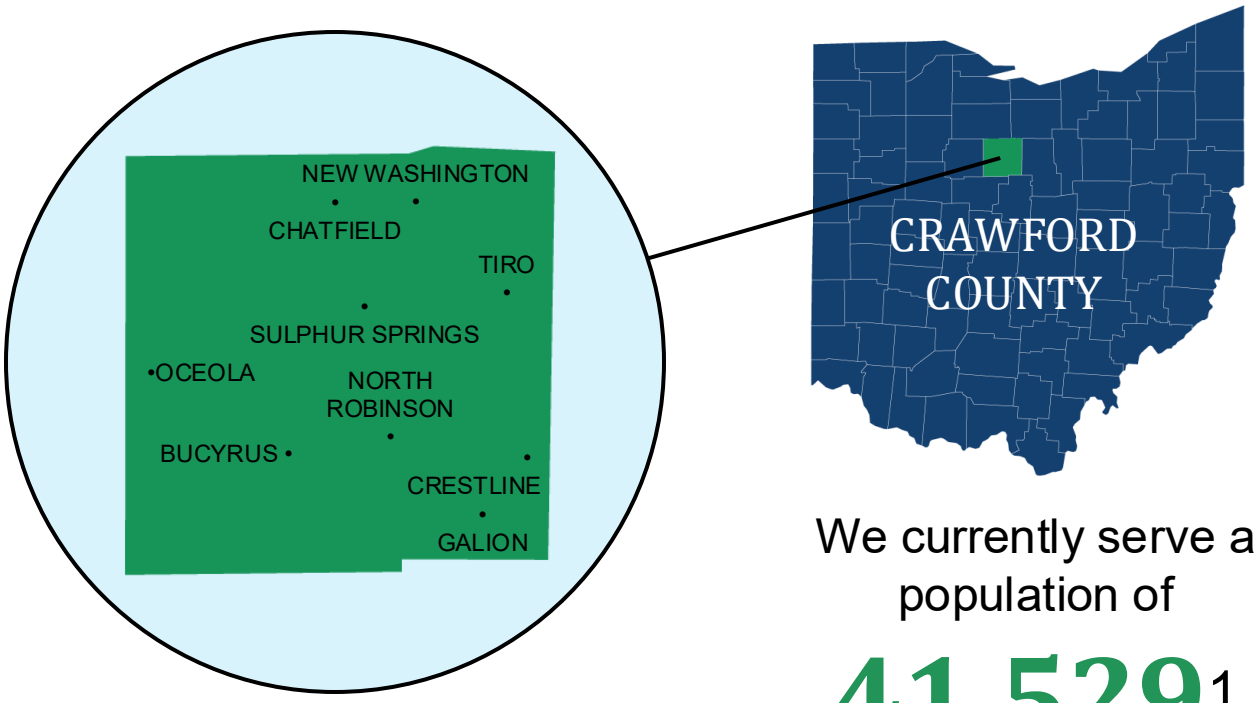
Within each step of this process, the guidelines and requirements of both the state and federal governments are followed precisely and systematically.

THE 2026-2028 CRAWFORD COUNTY IS/CHIP MEETS ALL IRS AND PUBLIC HEALTH ACCREDITATION BOARD (PHAB) REGULATIONS.

The Great American Crossroads Mural
Bucyrus, Ohio

DEFINING THE CRAWFORD COUNTY **SERVICE AREA**

For the purposes of this report, Crawford County defines their primary service area as being made up of Crawford County, Ohio.



We currently serve a population of

41,529[1]

CRAWFORD COUNTY SERVICE AREA			
GEOGRAPHIC AREA	**ZIP CODE**	**GEOGRAPHIC AREA**	**ZIP CODE**
Bucyrus	44820	North Robinson	44856
Chatfield	44825	Oceola	44860
Crestline	44827	Sulphur Springs	44881
Galion	44833	Tiro	44887
New Washington	44854		

CRAWFORD COUNTY
AT-A-GLANCE

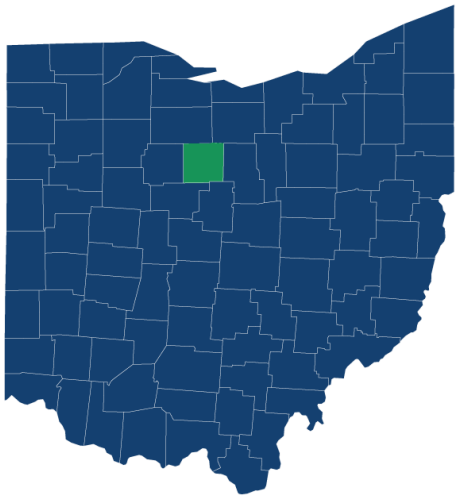
Crawford County's population is

41,529.

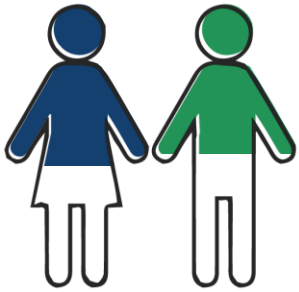
The populations of both Crawford County and Ohio **decreased slightly** from 2020 to 2023[1]

-1.2%
CRAWFORD COUNTY

-0.1%
OHIO

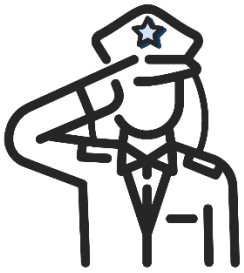


According to the 2024 County Health Rankings report, Crawford County measures **slightly worse** than the average county in Ohio for **health factors** (including health behaviors, clinical care, social and economic factors, and physical environment)[2]



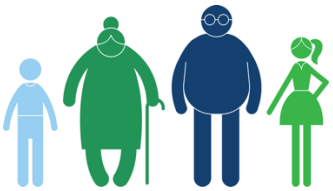
51% **49%**

The % of males and females is **approximately equal** (with females being slightly higher)[3]



7%

of Crawford County residents are **veterans**, about equal to the state rate[4]

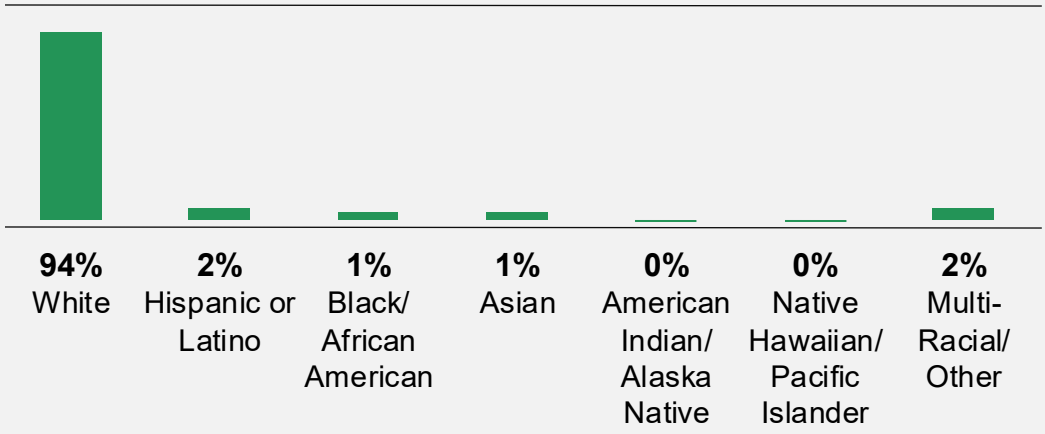


Youth ages 0-18 and seniors 65+ make up

43% of the population.

In the Crawford County service area, about **1 in 5 residents are ages 65+**[3]

The **majority (94%)** of the population in Crawford County identifies as **White** as their only race[3]



98% of the population in the Crawford County service area **speaks only English. 1% are foreign-born**[4]

The life expectancy in Crawford County of **73.9 years is 1.7 years shorter** than it is for the state of Ohio[2]

1 in 187

Crawford County residents will **die prematurely**, which is higher than the Ohio state rate[2]

PRIORITY HEALTH NEEDS
FOR CRAWFORD COUNTY

1 BEHAVIORAL HEALTH

- In the community member survey, **nearly one-third (30%)** of Crawford County respondents reported **substance use** as a top health concern.
- **32% of youth** experienced **poor mental health** (felt sad or hopeless almost every day for two weeks or more in a row during the past 12 months).[5]

2 CHRONIC DISEASE

- Heart disease is the **leading cause of death** in Crawford County.[6]
- **38%** of community survey respondents rated **heart disease** as a top need, and **42%** rated **diabetes** as a top need.

3 ACCESS TO HEALTHCARE

- **24%** of community survey respondents have **delayed or gone without medical care** due to being unable to get an appointment.
- **86%** of Crawford County's **low-income population** remains **unserved** by a health center.[7]

Avita Health System—Galion Hospital
Galion, Ohio

Avita Health System—Bucyrus Hospital
Bucyrus, Ohio

STEP 1

PLAN AND PREPARE FOR THE IMPLEMENTATION STRATEGY/ IMPROVEMENT PLAN

IN THIS STEP, CRAWFORD COUNTY HEALTH PARTNERS:

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

Crawford County Public Health
Bucyrus, Ohio

Galion City Health Department
Galion, Ohio

PLAN AND PREPARE

Secondary and primary data were collected to complete the 2025 Crawford County Community Health Needs Assessment (available at: https://crawfordhealth.org, https://avitahealth.org/about-us/ - community-wellness & https://galionhealth.org/community-health-assessment/). Secondary data were collected from a variety of local, county, and state sources to present community demographics, social determinants of health, healthcare access, birth characteristics, leading causes of death, chronic disease, health behaviors, mental health, substance use, and preventive practices. The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection.

Primary data were collected through key informant interviews with **26** experts from various organizations serving Crawford County, and included leaders and representatives of medically underserved, low-income, and minority populations, or local health or other departments or agencies. A community member survey was distributed via a QR code and link, with **1,137** responses. The survey responses (from community members) were used to prioritize the health needs, answer in-depth questions about the health needs in the county, and identify health disparities present in the community. Finally, there were **9** focus groups held across Crawford County, representing a total of **66** community members from priority populations. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets potentially available to address needs, and prioritize health needs. More details on methodology can be found in the 2025 Crawford County Community Health Needs Assessment.

> ***A community health assessment and improvement planning process involves an ongoing collaborative, community-wide effort to identify, analyze, and address health problems.***
>
> - Public Health Accreditation Board (PHAB)

STEP 2

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

IN THIS STEP, CRAWFORD COUNTY HEALTH PARTNERS:

- ✓ DEVELOPED GOALS FOR THE IS/CHIP BASED ON THE FINDINGS FROM THE COMMUNITY HEALTH NEEDS ASSESSMENT
- ✓ SELECTED INDICATORS TO ACHIEVE GOALS

OVERVIEW
OF THE PROCESS (CONTINUED)

Ohio Department of Health (ODH) Requirements

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

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

First, CCHP used the same language as the state of Ohio when assessing the factors and health outcomes of their community in the 2025 Crawford County Community Health Needs Assessment (CHNA).

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

Equity

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

Priorities

The SHIP identifies three priority factors (community conditions/social drivers of health) and three priority health outcomes that affect the overall health and well-being of children, families, and adults of all ages.

What shapes our health and well-being?

Many factors, including these **3 SHIP priority factors***:

Community Conditions
- Housing affordability and quality
- Poverty
- K-12 student success
- Adverse childhood experiences

Health Behaviors
- Tobacco/nicotine use
- Nutrition
- Physical activity

Access to Care
- Health insurance coverage
- Local access to healthcare providers
- Unmet need for mental healthcare

How will we know if health is improving in Ohio?

The SHIP is designed to track and improve these **3 SHIP priority health outcomes**:

Mental Health & Addiction
- Depression
- Suicide
- Youth drug use
- Drug overdose deaths

Chronic Disease
- Heart disease
- Diabetes
- Childhood conditions (asthma, lead exposure)

Maternal, Infant & Child Health
- Preterm births
- Infant mortality
- Maternal morbidity

All Ohioans achieve their full health potential
- Improved health status
- Reduced premature death

Vision:
Ohio is a model of health, well-being, and economic vitality

Strategies

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

** These factors are sometimes referred to as the social determinants of health or the social drivers of health.*

Next, with the data findings from the community health needs assessment process, Crawford County Health Partners used the following guidelines/worksheet to choose priority social determinants of health and priority health outcomes (worksheet/guidelines continued to next page).

ALIGNMENT WITH PRIORITIES & INDICATORS

STEP 1: Identify priority social determinants of health (SDOH) and health outcomes.

PRIORITY SDOH	PRIORITY HEALTH OUTCOMES
☑ Community Conditions	☑ Mental Health & Addiction
☑ Health Behaviors	☑ Chronic Disease
☑ Access to Care	☑ Maternal & Infant Health

STEP 2: Check the indicators that are being addressed for each identified priority SDOH.

PRIORITY SOCIAL DETERMINANTS OF HEALTH	
COMMUNITY CONDITIONS	
TOPIC	**INDICATOR NAME**
Housing Affordability & Quality	☐ Affordable & Available Housing
Poverty	☐ Child Poverty
	☐ Adult Poverty
K-12 Student Success	☐ Chronic Absenteeism (K-12 students)
	☐ Kindergarten Readiness
Adverse Childhood Experiences	☑ Adverse Childhood Experiences (ACEs)
	☐ Child Abuse & Neglects
Food Insecurity	☑ Food Insecurity
Environmental Conditions	☐ Air Quality
	☐ Water Quality
HEALTH BEHAVIORS	
TOPIC	**INDICATOR NAME**
Tobacco & Nicotine Use	☐ Adult Smoking
	☐ Youth All-Tobacco/Nicotine Use
Nutrition	☑Fruit Consumption
	☑Vegetable Consumption
Physical Activity	☑ Child Physical Activity
	☑ Adult Physical Activity
ACCESS TO CARE	
TOPIC	**INDICATOR NAME**
Health Insurance Coverage	☐Uninsured Adults
	☐ Uninsured Children
Local Access to Healthcare	☐ Primary Care Health Professional Shortage Areas
	☑ Mental Health Professional Shortage Areas
Unmet Need for Mental Healthcare	☑ Youth Depression Treatment Unmet Need
	☑ Adult Mental Healthcare Unmet Need

ALIGNMENT WITH PRIORITIES & INDICATORS (continued)

STEP 3: Check the indicators that are being addressed for each identified priority health outcome.

PRIORITY HEALTH OUTCOMES	
MENTAL HEALTH & ADDICTION	
TOPIC	**INDICATOR NAME**
Depression	☑ Youth Depression
	☑ Adult Depression
Suicide Deaths	☑ Youth Suicide Deaths
	☑ Adult Suicide Deaths
Youth Drug Use	☑ Youth Alcohol Use
	☑ Youth Marijuana Use
Drug Overdose Deaths	☐ Unintentional Drug Overdose Deaths
CHRONIC DISEASE	
TOPIC	**INDICATOR NAME**
Heart Disease	☑ Coronary Heart Disease
	☐ Premature Death – Heart Disease
	☑ Hypertension
Diabetes	☑ Diabetes
Harmful Childhood Conditions	☐ Child Asthma Morbidity
	☐ Child Lead Poisoning
MATERNAL & INFANT HEALTH	
TOPIC	**INDICATOR NAME**
Preterm Births	☑ Preterm Births
Infant Mortality	☑ Infant Mortality
Maternal Morbidity/Mortality	☐ Severe Maternal Morbidity/Mortality

ADDRESSING THE **HEALTH NEEDS**

The 2025 Community Health Needs Assessment (CHNA) identified the following significant health needs from an extensive review of the primary (community survey, interviews, and focus groups) and secondary data (existing data). The significant health needs were ranked as follows through the community member survey (1,137 responses from community members).

COMMUNITY CONDITIONS RANKING FROM COMMUNITY MEMBER SURVEY		
1	Access to mental healthcare	35%
2	Income/poverty and employment	35%
3	Substance misuse (alcohol and drugs)	30%
4	Access to childcare	21%
5	Environmental conditions	21%
6	Adverse childhood experiences (ACEs)	18%
7	Food insecurity	18%
8	Health insurance coverage	15%
9	Nutrition and physical health/exercise (includes overweight and obesity)	15%
10	Crime and violence	13%
11	Transportation	12%
12	Access to dental/oral healthcare	11%
13	Education	11%
14	Housing and homelessness	11%
15	Tobacco and nicotine use	8%
16	Access to primary healthcare	6%
17	Access to specialist healthcare	5%
18	Health literacy	4%
19	Preventive care and practices	4%
20	Internet/WIFI access	3%
21	Access to vision healthcare	2%

HEALTH OUTCOMES RANKING FROM COMMUNITY MEMBER SURVEY		
1	Mental health	72%
2	Cancer	55%
3	Diabetes	42%
4	Heart disease and stroke	38%
5	Dementia	25%
6	Maternal, infant, and child health	12%
7	Chronic Obstructive Pulmonary Disease (COPD)	10%
8	Injuries	8%
9	HIV/AIDS and Sexually Transmitted Infections (STIs)	6%
10	Kidney disease	5%
11	Chronic Liver Disease/Cirrhosis	4%
12	Parkinson's disease	2%

ADDRESSING THE **HEALTH NEEDS**

From the significant health needs, Crawford County Health Partners chose health needs that considered the health department, hospital, and community partners' capacity to address community needs, the strength of community partnerships, and those needs that correspond with the health department, hospital, and community partners' priorities.

The three Priority Health Needs that will be addressed in the 2026-2028 Implementation Strategy (IS)/Improvement Plan (CHIP) are:

PRIORITY AREA 1

BEHAVIORAL HEALTH

PRIORITY AREA 2

CHRONIC DISEASE

PRIORITY AREA 3

ACCESS TO HEALTHCARE

Crawford County Courthouse
Bucyrus, Ohio

STEPS 3 & 4

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

IN THIS STEP, CRAWFORD COUNTY HEALTH PARTNERS:

- ✓ SELECTED APPROACHES/ STRATEGIES TO ADDRESS THE CRAWFORD COUNTY PRIORITIZED HEALTH NEEDS, HEALTH DISPARITIES, AND SOCIAL DETERMINANTS OF HEALTH
- ✓ DEVELOPED A WRITTEN IS/CHIP REPORT

#1 Priority Area:
BEHAVIORAL HEALTH

Includes mental health, Adverse Childhood Experiences (ACEs), substance use disorder, and other addictions.

STRATEGIES

By 2028, increase the number of mental health professionals, including specialists in Substance Use Disorder, Child Development, Prevention, and General Therapies.

By 2028, improve the emotional well-being among adults and children who have experienced loss by funding Grief Recovery Method Training.

PARTNERS

Alcohol, Drug and Mental Health Board (ADAMH), National Alliance on Mental Illness (NAMI) Marion & Crawford Counties, Avita Health System, Marion-Crawford Prevention Programs, Crawford Partnership-Workforce Development, Mid-Ohio Educational Service Center, Crawford County Board of Developmental Disabilities, North Central State College

Avita Health System, Crawford County Public Health, Galion City Health Department

PRIORITY POPULATIONS

Youth, low-income, individuals with substance use disorders or mental health needs

Adults/children who have experienced loss and are grieving

DESIRED OUTCOMES OF STRATEGIES

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

OVERALL IMPACT OF STRATEGIES

- ↑ Mental health
- ↑ Quality of life
- ↓ Substance misuse
- ↓ Mental health and substance abuse ER visits
- ↓ Overdose deaths
- ↓ Death by suicide

ALL CRAWFORD COUNTY SERVICE AREA RESIDENTS ACHIEVE THEIR FULL HEALTH POTENTIAL

#2 Priority Area:
CHRONIC DISEASE

Includes food insecurity, nutrition, and physical health.

STRATEGIES

By 2028, increase economic access to healthy foods and improve nutrition, shopping, and cooking knowledge to decrease obesity, prevent or improve disease-related health conditions, and decrease food insecurity.	By 2028, develop a program to engage youth and seniors to include an emphasis on intergenerational nutrition and education.	By 2028, introduce at least one Farm to School strategy at Galion City Schools.

PARTNERS

Crawford County Public Health, Council on Aging, Local School Districts, YMCA's, Avita Health System, Faith Organizations, Farmers Market Organizers, Libraries, Community Garden/Garden Club Organizers, Alzheimer's Association	Crawford County Public Health, Galion City Health Department, Avita Health System, Retired Senior Volunteer Program (RSVP), Local Libraries, Crawford County Mentoring Program, YMCA's, City of Bucyrus, City of Galion	Galion City Health Department, Galion City Schools

PRIORITY POPULATIONS

Older adults, youth	Older adults, youth	Youth

DESIRED OUTCOMES OF STRATEGIES

- ↑ Education on chronic diseases & risk factors
- ↑ Chronic disease prevention, screening & management
- ↑ Nutrition, including fruit & vegetable consumption
- ↓ Food insecurity

OVERALL IMPACT OF STRATEGIES

- ↑ Access to primary care
- ↑ Quality of life
- ↑ Physical health
- ↓ Overweight and obesity
- ↓ Chronic disease
- ↓ Premature mortality

ALL CRAWFORD COUNTY SERVICE AREA RESIDENTS ACHIEVE THEIR FULL HEALTH POTENTIAL

#3 Priority Area:
ACCESS TO HEALTHCARE

Includes maternal and infant/child health, transportation, and income/poverty and employment.

STRATEGIES

By 2028, create a community resource guide available electronically, in print, via 211, and other channels, with updates at least annually.

PARTNERS

Pathways, United Way, Alcohol, Drug and Mental Health Board (ADAMH), Crawford County Chamber, Churches, Avita Health System, Ohio Heartland, Transportation Coalition, Mobility Management, City Services (dispatchers, police/fire, EMS), Area Agency on Aging, Social Service Agencies

PRIORITY POPULATIONS

Older adults, low-income population, maternal-infant population, all Crawford County residents

DESIRED OUTCOMES OF STRATEGIES

- ↓ Delayed care
- ↑ Access and utilization of non-emergency healthcare services and existing healthcare resources
- ↑ Education and access to healthcare resources

OVERALL IMPACT OF STRATEGIES

- ↑ Access to primary care
- ↑ Quality of life
- ↑ Physical health
- ↓ Chronic conditions
- ↓ Unmet care needs
- ↓ Premature mortality

ALL CRAWFORD COUNTY SERVICE AREA RESIDENTS ACHIEVE THEIR FULL HEALTH POTENTIAL

CURRENT RESOURCES
ADDRESSING PRIORITY HEALTH NEEDS
CRAWFORD COUNTY

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

Access to Childcare
Fairway School
Galion Community Center YMCA Inc. Early Childhood Center
Galion Community Center YMCA Inc. Early Learning Center
Sara Beegle Day Care Center
Sonshine Childcare & Preschool
Tiny Tots Childcare

Access to Healthcare/Public Health
Avita Health System
Crawford County Public Health
Dental offices
Galion City Health Department
Medical offices
OhioHealth
Third Street Clinic (FQHC in Bucyrus)

Community & Social Services
Bucyrus Chamber of Commerce
Community Foundation for Crawford County
Crawford Partnership for Education & Economic Development
Galion-Crestline Area Chamber of Commerce
Galion Port Authority
Ohio Heartland Community Action Commission
United Way of North Central Ohio

Disabilities & Support Services
Crawford County Board of Developmental Disabilities
Crawford County Council on Aging
Ohio District 5 Area Agency on Aging

Education & Literacy
All Crawford County school districts
Backpack program
Crawford Partnership for Education & Economic Development
Summer Feeding program
YMCA after-school programs

Environmental Conditions
Crawford County Conservation District

Food Insecurity & Nutrition
Aldi
Bucyrus Backpack Program
Bucyrus, Crestline, and New Washington Farmers Markets (spring through fall)
Buehler's Fresh Food
Crawford County SPROUTS Program (breastfeeding support)
DG (Dollar General) Market
Food banks and food pantries in county
Galion Discount DrugMart
Galion Farmer's Market
Kroger
Save A Lot
Walmart Supercenter
Women, Infants, and Children (WIC)

Housing & Homelessness
Crawford-Marion ADAMH Board
Crawford Metropolitan Housing Authority
Habitat for Humanity of Crawford County
Job and Family Services
Salvation Army
The Department of Veterans Affairs
WIC Program
United Way/211

Income & Employment
Avita Health System
Bureau of Vocational Rehab
Crawford County Job & Family Services
Crawford Success Center
Crawford Works
North Central State College
OhioHealth

Legal & Law Enforcement
Bucyrus, Crestline, Galion, and New Washington Police Departments
Crawford County Common Pleas
Crawford County Domestic Relations Court
Crawford County Probate/Juvenile Court
Crawford County Prosecutor's Office
Crawford County Sheriff's Office
Galion Municipal Court

CURRENT RESOURCES
ADDRESSING PRIORITY HEALTH NEEDS
CRAWFORD COUNTY

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

Mental Health & Addiction
Community Counseling & Wellness Centers
Crawford County Drug Overdose Prevention Coalition
Crawford County Suicide Prevention Coalition
Crawford-Marion ADAMH Board
Digital Footprint Program
Family & Children First Council
Family Life Counseling
Junior Teen Institute (JTI) & Teen Institute (TI)
Marion Crawford Prevention Programs
National Alliance on Mental Illness (NAMI) Marion & Crawford Counties
Project Noelle
Question, Persuade, Refer (QPR) Program
Signs of Suicide (SOS) Program
Together We Hurt, Together We Heal
Turning Point Domestic Violence
United Way of Crawford County
Wesley Chapel/Restore Ministries

Physical Health & Fitness
Anytime Fitness
Bike Trails
City Parks
Crawford County Park District
Galion Community Center YMCA Inc.
Silver Sneakers (Bucyrus Area YMCA)
Soccer Fields & Little League Fields
The Fitness Warehouse
YMCA of Bucyrus

Transportation
Crawford County Council on Aging
Johnson's Taxi Service
Seneca-Crawford Area Transportation (SCAT)

STEPS 5-8

INTEGRATE, DEVELOP, ADOPT, AND SUSTAIN IMPLEMENTATION STRATEGY/IMPROVEMENT PLAN

IN THIS STEP, CRAWFORD COUNTY HEALTH PARTNERS WILL:

- INTEGRATE IS/CHIP WITH COMMUNITY PARTNER, HOSPITAL, AND HEALTH DEPARTMENT PLANS
- ADOPT THE IS/CHIP
- UPDATE AND SUSTAIN THE IS/CHIP

CRAWFORD COUNTY
NEXT STEPS

The Community Health Needs Assessment (CHNA) and this resulting Implementation Strategy (IS)/ Improvement Plan (CHIP) identify and address significant community health needs and help guide community benefit activities. This IS/CHIP explains how Crawford County Health Partners (CCHP) plans to address the selected priority health needs identified by the CHNA.

This IS/CHIP report was adopted by CCHP leadership in November 2025. This report was also adopted by the Avita Board of Directors on November 5, 2025.

This report is widely available to the public on the following websites:

Avita Health System: https://avitahealth.org/about-us/ - community-wellness
Crawford County Public Health: www.crawfordhealth.org
Galion City Health Department: https://galionhealth.org/community-health-assessment/

Written comments on this report are welcomed and can be made by emailing: ckropka@avitahs.org, kate.siefert@crawfordhealth.org, or andrea.cinadr@galionhealth.org.

EVALUATION OF IMPACT

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

ADDITIONAL HEALTH NEEDS NOT DIRECTLY ADDRESSED

Since CCHP cannot directly address all the health needs present in the community, we will concentrate our resources on those health needs where we can effectively impact our region given our areas of focus and expertise. Taking existing organization and community resources into consideration, CCHP will not directly address the remaining health needs identified in the CHNA, including but not limited to access to childcare, education, tobacco and nicotine use, housing and homelessness, internet/Wi-Fi access, preventive care and practices, crime and violence, environmental conditions, injuries, and HIV/AIDS and STIs. We will continue to look for opportunities to address community needs where we can make a meaningful contribution. Community partnerships may support other initiatives that CCHP cannot independently lead in order to address the other health needs identified in the 2025 CHNA.

APPENDIX A

INTERNAL REVENUE SERVICE (IRS) REQUIREMENTS CHECKLIST: IMPLEMENTATION STRATEGY

MEETING THE IRS REQUIREMENTS FOR THE IMPLEMENTATION STRATEGY

The Internal Revenue Service (IRS) requirements for an Implementation Strategy serve as the official guidance for IRS compliance. The following pages demonstrate how this IS/CHIP meets those IRS requirements.

APPENDIX A:
IRS IMPLEMENTATION STRATEGY REQUIREMENTS CHECKLIST

INTERNAL REVENUE SERVICE REQUIREMENTS FOR IMPLEMENTATION STRATEGIES				
YES	**PAGE #**	**IRS REQUIREMENTS CHECKLIST**	**REGULATION SUBSECTION NUMBER**	**NOTES/ RECOMMENDATIONS**
✓	17-25	(2) Description of how the hospital facility plans to address the health needs selected, including: i. Actions the hospital facility intends to take and the anticipated impact of these actions; ii. Resources the hospital facility plans to commit; and iii. Any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need.	(c)(2) (c)(2)(i) (c)(2)(ii) (c)(2)(iii)	
✓	25	(3) Description of why a hospital facility is not addressing a significant health need identified in the CHNA. *Note: A "brief explanation" is sufficient. Such reasons may include resource constraints, other organizations are addressing the need, or a relative lack of expertise to effectively address the need.*	(c)(3)	
✓	Throughout report	(4) For those hospital facilities that adopted a joint CHNA report, a joint IS may be adopted that meets the requirements above. In addition, the joint IS must: i. Be clearly identified as applying to the hospital facility; ii. Clearly identify the hospital facility's role and responsibilities in taking the actions described in the IS and the resources the hospital facility plans to commit to such actions; and iii. Include a summary or other tool that helps the reader easily locate those portions of the strategy that relate to the hospital facility.	(c)(4) (c)(4)(i) (c)(4)(ii) (c)(4)(iii)	Strategies that hospitals are collaborating on are indicated throughout the report.
✓	3, 25	(5) An authorized body adopts the IS on or before the 15th day of the fifth month after the end of the taxable year in which the CHNA was conducted and completed, regardless of whether the hospital facility began working on the CHNA in a prior taxable year. **Exceptions (if applicable):** **Transition Rule (if applicable):**	(c)(5)	This IS/CHIP report was adopted by the Avita Board of Directors on November 5, 2025.

APPENDIX B

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

MEETING THE PHAB REQUIREMENTS FOR THE CHIP

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

APPENDIX B:
PHAB COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) REQUIREMENTS CHECKLIST

PUBLIC HEALTH ACCREDITATION BOARD (PHAB) REQUIREMENTS FOR CHIPs			
YES	**PAGE #**	**PHAB REQUIREMENTS CHECKLIST**	**NOTES/ RECOMMENDATIONS**
✓	19-21 19-21 19-21 22-23 25	**MEASURE 5.2.1 A: Adopt a community health improvement plan.** 1. A community health improvement plan (CHIP), which includes all of the following: a. At least two health priorities. b. Measurable objective(s) for each priority. c. Improvement strategy(ies) or activity(ies) for each priority. i. Each activity or strategy must include a timeframe and a designation of organizations or individuals that have accepted responsibility for implementing it. ii. At least two of the strategies or activities must include a policy recommendation, one of which must be aimed at alleviating causes of health inequities. d. Identification of the assets or resources that will be used to address at least one of the specific priority areas. e. Description of the process used to track the status of the effort or results of the actions taken to implement CHIP strategies or activities.	A detailed work plan (living document) has been developed that includes strategies, SMART objectives, annual activities, indicators, partners, and priority populations.
		MEASURE 5.2.2 A: Encourage and participate in collaborative implementation and revision of the community health improvement plan. 1. Implementation of a community health improvement plan (CHIP) strategy or activity, including: a. Which CHIP priority the example addresses. (This may be indicated in the Documentation Form.) b. The health department's role in the implementation. c. Results of the strategy or activity. 2. Community health improvement plan (CHIP) strategy or activity that was revised, in collaboration with partners. The CHIP must address the jurisdiction as described in the description of Standard 5.2.	Implementation activities will be monitored and documented over the cycle. Progress will be reported in the next CHA/CHNA report.
		MEASURE 5.2.3 A: Address factors that contribute to specific populations' higher health risks and poorer health outcomes. 1. Implementation of one strategy, in collaboration with stakeholders, partners, or the community, to address factors that contribute to specific populations' higher health risks and poorer health outcomes, or inequities. 2. Efforts taken that contribute to building environmental resiliency.	Implementation activities will be monitored and documented over the cycle. Progress will be reported in the next CHA/CHNA report.

APPENDIX C

REFERENCES

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REFERENCES

[1] U.S. Census Bureau, Population Estimates Program (PEP), V2023. https://www.census.gov/quickfacts/fact/table

[2] University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2024. www.countyhealthrankings.org.

[3] U.S. Census Bureau, American Community Survey, DP05, 2023 5-year estimate. http://data.census.gov/

[4] U.S. Census Bureau, American Community Survey, DP02, 2023 5-year estimate. http://data.census.gov

[5] Ohio Healthy Youth Environments Survey (OHYES!). (2023). Ohio Healthy Youth Environment Survey -OHYES!: Report for Crawford County -2022-2023. Ohio Department of Mental Health and Addiction Services. https://ohyes.ohio.gov

[6]Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html

[7]U.S. Department of Health & Human Services, HRSA Health Center Program GeoCareNavigator. https://geocarenavigator.hrsa.gov/https://www.findlayohio.gov/Home/Components/News/News/1491/

CCHP CRAWFORD COUNTY HEALTH PARTNERS

Moxley PUBLIC HEALTH

www.moxleypublichealth.com
stephanie@moxleypublichealth.com