2025-2028 Wyandot County Community Health Improvement Plan

Commissioned by the Wyandot County Health Alliance

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

Executive Summary

Introduction

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

The Wyandot County Health Alliance has been conducting CHAs since 2003 to measure community health status. The most recent Wyandot County CHA was cross-sectional in nature and included a written survey of adults within Wyandot County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention (CDC) for their national and state Behavioral Risk Factor Surveillance System (BRFSS). This has allowed Wyandot County to compare their CHA data to national, state and local health trends. Community stakeholders were actively engaged in the early phases of CHA planning and helped define the content, scope, and sequence of the project.

Youth survey development and administration, as well as data collection, was conducted by Ohio Healthy Youth Environments Survey (**OHYES!**), which is a collaborative effort of the Ohio Department of Education, Ohio Department of Health, Ohio Department of Mental Health and Addiction Services, Ohio National Guard, and representatives from higher education, juvenile courts, foundations, and community services providers.

Wyandot County Public Health contracted with the Hospital Council of Northwest Ohio (HCNO), a neutral, regional, nonprofit hospital association, to facilitate the CHA and CHIP. The health department then invited various community stakeholders to participate in community health improvement process. Data from the most recent CHA was carefully considered and categorized into community priorities with accompanying strategies. This was done using the National Association of County and City Health Officials' (NACCHO) national framework, Mobilizing for Action through Planning and Partnerships (MAPP) 2.0. Over the next three years, these priorities and strategies will be implemented at the county-level with the hope to improve population health and create lasting, sustainable change. It is the hope of The Wyandot County Health Alliance that each agency in the county will tie their internal strategic plan to at least one strategy in the CHIP.

Hospital Requirements

Internal Revenue Services (IRS)

The Wyandot County CHA and CHIP fulfills national mandated requirements for hospitals in the county. The H.R. 3590 Patient Protection and Affordable Care Act (ACA), enacted in March 2010, added new requirements in Part V, Section B, on 501 (c)(3) organizations that operate one or more hospital facilities. Each 501 (c)(3) hospital organization must conduct a CHNA and adopt an implementation strategy at least once every three years in order to maintain tax-exempt status. To meet these requirements, the hospital shifted their definition of "community" to encompass the entire county, and collaboratively completed the CHA and CHIP, compliant with IRS requirements. This will result in increased collaboration, less duplication, and sharing of resources. This report serves as the implementation strategy for Wyandot Memorial Hospital and documents the hospital's efforts to address the community health needs identified in the CHA.

Hospital Mission Statement

Wyandot Memorial Hospital

Mission: Keeping our promise to be *YOUR* hospital

Public Health Accreditation Board (PHAB) Requirements

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

PHAB standards also require that a community health improvement model is utilized when planning CHIPs. This CHIP was completed using NACCHO's MAPP 2.0 process. MAPP 2.0 is a national, community-driven planning process for improving community health. This process was facilitated by HCNO in collaboration with various local agencies representing a variety of sectors.

Inclusion of Vulnerable Populations (Health Disparities)

Approximately 8% of Wyandot County residents were below the poverty line, according to the 2019-2023 American Community Survey 5-year estimates. For this reason, data is broken down by income (less than $25,000 and greater than $25,000) throughout the report to show disparities.

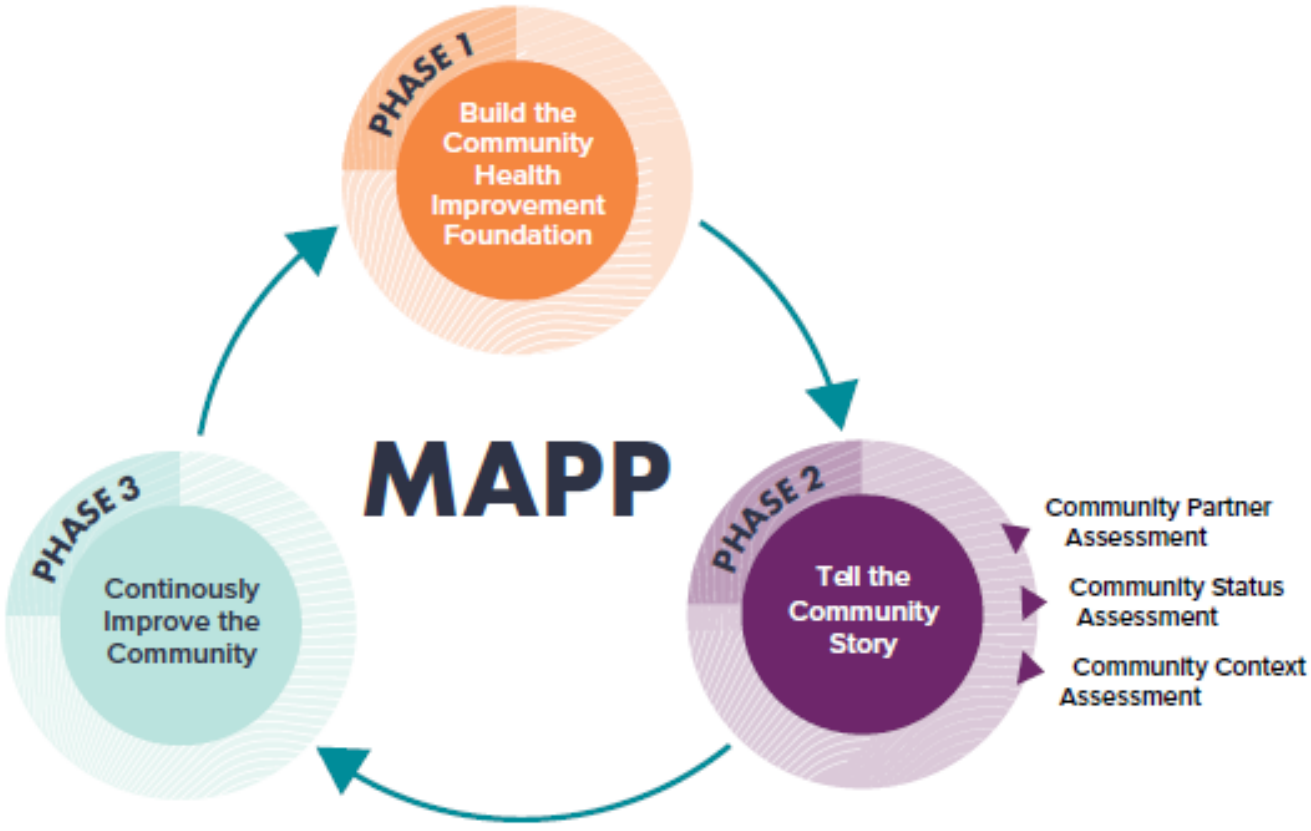
Mobilizing for Action through Planning and Partnerships (MAPP) 2.0

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

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

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

Figure 1.1 The MAPP 2.0 Model



Alignment with National and State Standards

The 2025-2028 Wyandot County Community Health Improvement Plan priorities align perfectly with regional, state, and national priorities. Wyandot County will be addressing the following priority factors: health behaviors. Wyandot County will be addressing the following priority health outcomes: mental health and addiction as well as chronic disease. Additionally, Wyandot County will be addressing risky behaviors.

Healthy People 2030

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

- Nutrition and Healthy Eating (NWS) – 03: Reduce the proportion of adults with obesity
- Heart Disease and Stroke (HDS) – 01: Improve cardiovascular health in adults
- Mental Health and Mental Disorder (MHMD) – 01: Reduce the suicide rate
- Injury Prevention (IVP) – 03: Reduce unintentional injury deaths

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

Ohio State Health Improvement Plan (SHIP)

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

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

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

The three priority factors include the following:

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

The three priority health outcomes include the following:

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

The Wyandot County CHIP was required to select at least 1 priority factor, 1 priority health outcome, 1 indicator for each identified priority, and 1 strategy for each selected priority to align with the 2020-2022 SHIP.

Note: This symbol will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2020-2022 SHIP. Whenever possible, the Wyandot County CHIP identifies strategies likely to reduce disparities and inequities. This symbol √ will be used throughout the report when a strategy is identified as likely to reduce disparities and inequities. Throughout the report, hyperlinks will be highlighted in **bold, gold text**.

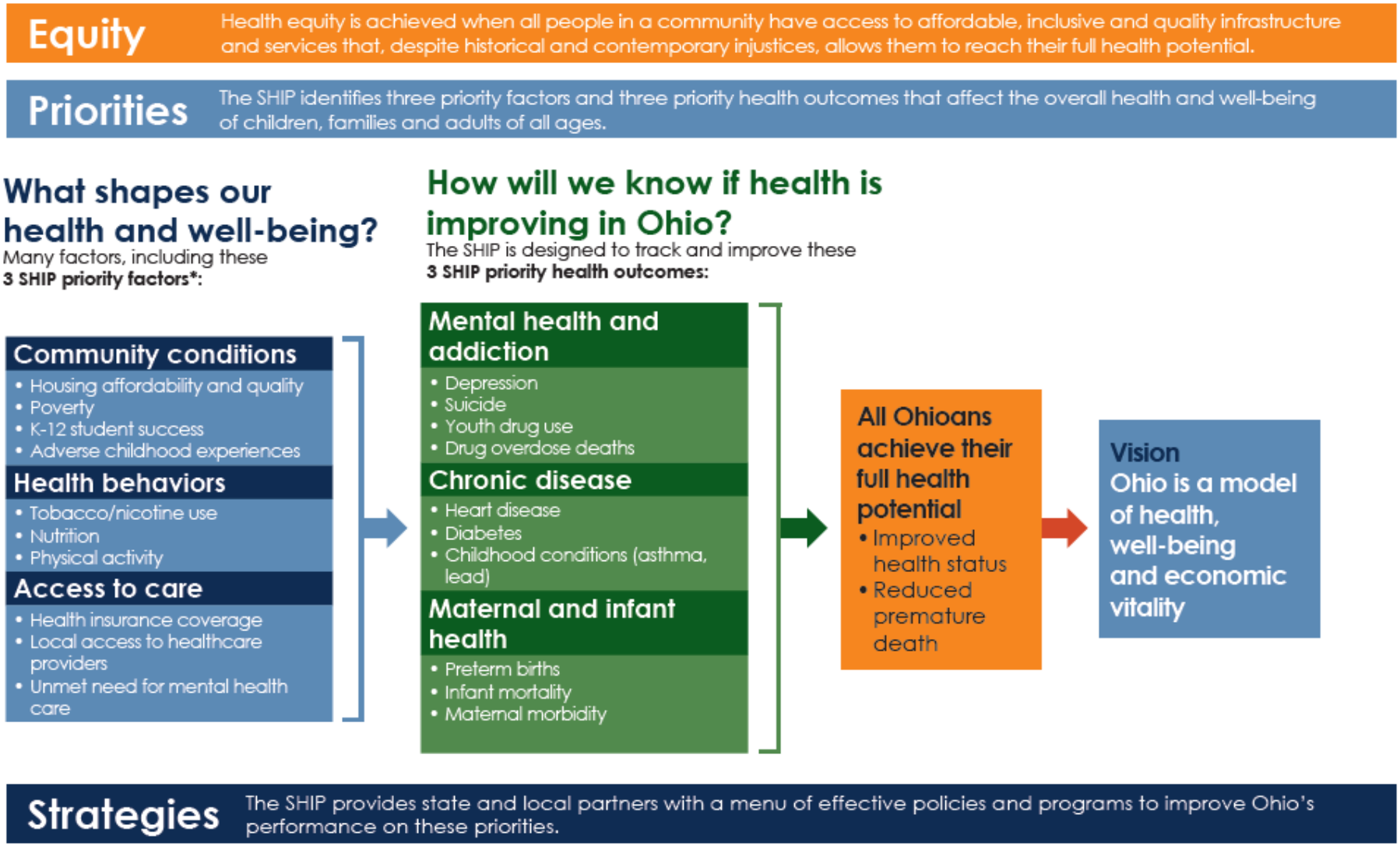
The following Wyandot County priority factors, priority indicators, and strategies very closely align with the 2020-2022 SHIP:

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

Priority Factors	Priority Indicators	Strategies to Impact Priority Indicators
Health Behaviors	• Youth vegetable consumption • Youth fruit consumption • Adult cigarette smoking • Youth cigarette smoking • Youth e-cigarette use • Youth cigar, cigarillo, & little cigar use • Youth smokeless tobacco use	• Community gardens • School nutrition standards in after-school events • Mass media campaigns against tobacco use • School-based tobacco prevention skill-building programs
Priority Health Outcomes	Priority Indicators	Strategies to Impact Priority Indicators
Mental Health and Addiction	• Youth alcohol use • Youth marijuana use • Unintentional drug overdose deaths	• Education for parents on how to build youth resilience and protective factors and how to communicate with their children about alcohol and other drugs • Naloxone education and distribution programs
Chronic Disease	• Hypertension • Coronary heart disease • Diabetes	• Hypertension screening and follow-up • Diabetes Prevention Program
Other	Priority Indicators	Strategies to Impact Priority Indicators
Risky Behaviors	• N/A	• N/A

Alignment with National and State Standards, continued

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



Vision and Mission

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

The Vision of The Wyandot County Health Alliance

A robust and healthy Wyandot County

The Mission of The Wyandot County Health Alliance

Mobilizing partnerships to improve community wellness and quality of life

Community Partners

The CHIP was planned by various agencies and service-providers within Wyandot County. From January 2025 to May 2025, The Wyandot County Health Alliance reviewed many data sources concerning the health and social challenges that Wyandot County residents are facing. They determined priority issues which, if addressed, could improve future outcomes; determined gaps in current programming and policies; examined best practices and solutions; and determined specific strategies to address identified priority issues. We would like to recognize these individuals and thank them for their dedication to this process:

The Wyandot County Health Alliance

Alzheimer's Association of Wyandot County
Arrowhead Behavioral Health
Carey Chamber of Commerce
Carey Exempted Village School District
Charlie Health
Custom Glass Solutions LLC
Daily Chief Union
Family & Children First Council
Family and Children First Council
First Citizens National Bank
First National Bank of Sycamore
Freedom Caregivers
Harbor
Harbor (Ohio RISE)
Mental Health and Recovery Services Board Levy Funds
Mohawk Local School District
Open Door Resource Center
OSU Extension, SNAP Ed Program
Turning Point
United Way of North Central Ohio
Upper Sandusky Exempted Village School District
Upper Sandusky Rotary Club
Wyandot County Board of Developmental Disabilities
Wyandot County Chamber of Commerce
Wyandot County Commissioners
Wyandot County Council on Aging
Wyandot County Department of Job and Family Services
Wyandot County Job and Family Services
Wyandot County Office of Economic Development
Wyandot County Prosecutor
Wyandot County Public Health
Wyandot County Safe Communities Grant
Wyandot County Skilled Nursing and Rehabilitation
Wyandot Memorial Hospital

Hospital Council of Northwest Ohio (HCNO)

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

Community Health Improvement Process

Beginning in January 2025, the Wyandot County Health Alliance met four (4) times and completed the following planning steps:

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

Community Health Status Assessment

Included in phase 3 of the MAPP 2.0 process, the Community Health Status Assessment, or CHA, is a 100+ page report that includes primary data with over 100 indicators and hundreds of data points related health and well-being, including social determinants of health. Over 50 sources of secondary data are also included throughout the report. The CHA serves as the baseline data in determining key issues that lead to priority selection. The full report can be found at **http://www.wyandothealth.com/**. Below is a summary of county primary data and the respective state and national benchmarks.

Adult Trend Summary

Adult Variables	Wyandot County 2012	Wyandot County 2015	Wyandot County 2018	Wyandot County 2021	Wyandot County 2024	Ohio 2022	U.S. 2022
Health Care Coverage, Access, and Utilization							
Uninsured	12%	5%	7%	10%	8%	6%	7%
Visited a doctor for a routine checkup in the past year	57%	63%	69%	70%	81%	79%	77%
Had at least one person they thought of as their personal doctor or health care provider	N/A	N/A	N/A	N/A	94%	86%	84%
Preventive Medicine							
Had a flu vaccine in the past year (ages 65 and older)	N/A	71%	74%	69%	75%	65%	68%
Ever had a pneumonia vaccine in lifetime (ages 65 and older)	47%	59%	79%	66%	71%	71%	71%
Female Health							
Had a clinical breast exam in the past two years (ages 40 and older)	66%	79%	67%	60%	61%	N/A	N/A
Had a mammogram within the past two years (ages 40 and older)	66%	80%	73%	71%	68%	68%*	70%*
Had a Pap smear in the past three years (ages 21-65)	67%¥	64%¥	67%	65%	53%	77%*	78%*
Male Health							
Had a digital rectal exam within the past year	30%	34%	33%	16%	9%	N/A	N/A
Had a PSA test in the past two years (ages 40 and over)	61%	58%	58%	62%	59%	32%*	32%*

N/A - Not Available
**2020 BRFSS Data*
¥ Trend data includes all women regardless of age
Indicates alignment with the Ohio State Health Assessment

Adult Trend Summary Continued

Adult Variables	Wyandot County 2012	Wyandot County 2015	Wyandot County 2018	Wyandot County 2021	Wyandot County 2024	Ohio 2022	U.S. 2022
Oral Health							
Visited a dentist or a dental clinic (within the past year)	56%	65%	60%	62%	61%	64%	65%
Health Status							
Rated health as excellent or very good	47%	48%	46%	46%	39%	49%	50%
Rated general health as fair or poor	15%	15%	15%	14%	18%	19%	17%
Weight Status							
Overweight (BMI of 25.0 – 29.9)	37%	29%	37%	28%	24%	33%	34%
Obese (includes severely and morbidly obese, BMI of 30.0 and above)	40%	48%	42%	55%	59%	38%	34%
Tobacco Use							
Current smoker (currently smoked on some or all days)	20%	15%	19%	14%	13%	17%	14%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	27%	26%	26%	28%	26%	26%	25%
Tried to quit smoking in the past year (among current smokers)	78%	46%	38%	43%	27%	N/A	N/A
Current e-cigarette user (currently vaped on some or all days)	N/A	N/A	N/A	N/A	8%	9%	8%
Alcohol Consumption							
Current drinker (had at least one drink of alcohol within the past month)	47%	49%	56%	54%	58%	53%	53%
Binge drinker (had four or more drinks (among females) or five or more drinks (among males) on at least one occasion in the past month)	19%	18%	22%	18%	20%	18%	17%
Drove after having perhaps too much alcohol to drink (in the past month)	4%	N/A	N/A	3%	2%	N/A	N/A

N/A - Not Available

Indicates alignment with the Ohio State Health Assessment

Adult Trend Summary Continued

Adult Variables	Wyandot County 2012	Wyandot County 2015	Wyandot County 2018	Wyandot County 2021	Wyandot County 2024	Ohio 2022	U.S. 2022
Drug Use							
Adults who used recreational marijuana in the past six months	3%*	3%*	6%	3%	8%	N/A	N/A
Adults who misused prescription medication in the past six months	7%	11%	7%	8%	6%	N/A	N/A
Sexual Behavior							
Had more than one sexual partner in past year	5%	3%	4%	4%	7%	N/A	N/A
Had ever engaged in sexual activity following alcohol or other drug use	12%	11%	13%	11%	12%	N/A	N/A
Mental Health							
Considered attempting suicide in the past year	2%	2%	3%	4%	2%	N/A	N/A
Cardiovascular Health							
Ever diagnosed with angina	8%	5%	6%	5%	3%	6%	4%
Ever had a heart attack	5%	4%	5%	5%	7%	5%	5%
Ever had a stroke	4%	8%	4%	3%	8%	4%	3%
Ever been diagnosed with high blood pressure	44%	46%	38%	39%	51%	36%**	32%**
Ever been diagnosed with high blood cholesterol	41%	43%	41%	39%	47%	36%**	36%**
Had their blood cholesterol checked within the last five years	75%	79%	81%	82%	87%	85%**	85%**
Arthritis, Asthma, and Diabetes							
Ever diagnosed with arthritis	37%	37%	38%	38%	46%	31%	27%
Ever diagnosed with asthma	10%	11%	16%	15%	17%	16%	16%
Ever diagnosed with diabetes	14%	16%	12%	13%	25%	13%	12%
Quality of Life							
Limited in some way because of physical, mental or emotional problem	27%	18%	28%	21%	30%	N/A	N/A

**includes any marijuana use (i.e., medical or recreational marijuana)*
***2021 BRFSS*
N/A - Not Available
Indicates alignment with the Ohio State Health Assessment

Youth Trend Summary

Youth Variables	Wyandot County 2009 (6th-12th)	Wyandot County 2012 (6th-12th)	Wyandot County 2015 (6th-12th)	Wyandot County 2018 (6th-12th)	Wyandot County OHYES 2021 (7th-12th)	Wyandot County OHYES 2024 (7th-12th)	Wyandot County OHYES 2024 (9th-12th)	Ohio 2021 (9th-12th)	U.S. 2021 (9th-12th)
Weight Control									
Obese	14%	21%	21%	19%	20%	14%	15%	19%	16%
Overweight	13%	14%	16%	11%	21%	16%	17%	16%	16%
Physically active at least 60 minutes per day on every day in past week	28%	26%	35%	29%	29%	38%	35%	26%	24%
Physically active at least 60 minutes per day on 5 or more days in past week	51%	51%	60%	52%	56%	61%	58%	49%	45%
Did not participate in at least 60 minutes of physical activity on any day in the past week	13%	11%	9%	18%	12%	8%	9%	16%	16%
Tobacco/Electronic Vapor Product Use									
Current cigarette smoker (smoked cigarettes on at least one day during the past 30 days)	14%	16%	9%	6%	4%	2%	3%	3%	4%
Current cigar smoker (smoked cigars, cigarillos, or little cigars, on at least 1 day during the past 30 days)	N/A	N/A	N/A	N/A	2%	2%	2%	3%	3%
Current electronic vapor product user (used e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, or hookah pens on at least 1 day during the past 30 days)	N/A	N/A	13%	14%	15%	5%	6%	20%	18%
Current smokeless tobacco user (used chewing tobacco, snuff, dip, snus, or dissolvable tobacco products—such as Redman, Levi Garrett, Beechnut, Skoal, Skoal Bandits, Copenhagen, Camel Snus, Marlboro Snus, General Snus, Ariva, Stonewall, or Camel Orbs—not counting any electronic vapor products, on at least 1 day during the 30 days)	N/A	N/A	N/A	N/A	2%	2%	2%	2%	3%

N/A – Not Available

Indicates alignment with the Ohio State Health Assessment

Youth Trend Summary Continued

Youth Variables	Wyandot County 2009 (6th-12th)	Wyandot County 2012 (6th-12th)	Wyandot County 2015 (6th-12th)	Wyandot County 2018 (6th-12th)	Wyandot County OHYES 2021 (7th-12th)	Wyandot County OHYES 2024 (7th-12th)	Wyandot County OHYES 2024 (9th-12th)	Ohio 2021 (9th-12th)	U.S. 2021 (9th-12th)
Alcohol Consumption									
Current drinker (had at least one drink of alcohol on at least 1 day during the past 30 days)	30%	24%	20%	13%	16%	7%	8%	23%	23%
Binge drinker (drank 4 or more drinks (females) or 5 or more drinks (males) within a couple of hours on at least 1 day during the past 30 days)	17%	16%	13%	9%	9%	3%	4%	13%	11%
Drank for the first time before age 13 (of all youth)	30%	19%	12%	17%	12%	13%	12%	11%	15%
Rode with a driver who had been drinking alcohol (in a car or other vehicle on one or more occasion during the past 30 days)	21%	21%	13%	11%	9%	11%	10%	N/A	14%
Obtained the alcohol they drank by someone giving it to them (of youth drinkers)	N/A	36%	40%	38%	29%	24%	24%	N/A	40%
Drug Use									
Currently use marijuana (in the past 30 days)	9%	6%	7%	3%	5%	2%	2%	13%	16%
Prescription medication abuse (in the past 30 days)	N/A	7%	5%	2%	1%	1%	1%	N/A	6%
Used methamphetamines (in the past 12 months)	1%*	1%*	1%*	1%*	0%	1%	1%	2%*	2%*
Used cocaine (in the past 12 months)	4%*	5%*	2%	1%*	1%	1%	1%	2%*	3%*
Used heroin (in the past 12 months)	1%*	1%*	1%*	0%*	0%	<1%	<1%	N/A	1%*
Used inhalants (in the past 12 months)	8%*	12%*	6%*	2%*	1%	1%	1%	N/A	8%*
Took steroids without a doctor's prescription (in the past 12 months)	N/A	N/A	N/A	0%*	0%	<1%	<1%	N/A	N/A
Used ecstasy (also called MDMA in the past 12 months)	N/A	3%*	3%*	1%*	1%	1%	1%	N/A	3%*
Were offered, sold, or given an illegal drug on school property (in the past 12 months)	5%	8%	6%	4%	5%	3%	4%	N/A	14%

N/A – Not Available
**Ever used in their lifetime*

Youth Trend Summary Continued

Youth Variables	Wyandot County 2009 (6th-12th)	Wyandot County 2012 (6th-12th)	Wyandot County 2015 (6th-12th)	Wyandot County 2018 (6th-12th)	Wyandot County OHYES 2021 (7th-12th)	Wyandot County OHYES 2024 (7th-12th)	Wyandot County OHYES 2024 (9th-12th)	Ohio 2021 (9th-12th)	U.S. 2021 (9th-12th)
Mental Health									
Felt sad or hopeless (almost every day for 2 or more weeks in a row that they stopped doing some usual activities in the past 12 months)	28%	18%	20%	29%	28%	24%	25%	43%	42%
Seriously considered attempting suicide (in the past 12 months)	14%	11%	14%	14%	16%	11%	12%	22%	22%
Attempted suicide (in the past 12 months)	6%	6%	4%	11%	7%	5%	5%	10%	10%
Social Determinants of Health									
Visited a dentist within the past year (for a check-up, exam, teeth cleaning, or other dental work)	64%	67%	77%	71%	68%	70%	70%	N/A	N/A
Visited a doctor for a routine checkup in the past year	58%	51%	70%	68%	49%	58%	58%	N/A	N/A
Violence									
Were in a physical fight (in the past 12 months)	26%	26%	16%	19%	13%	12%	10%	N/A	18%
Did not go to school because they felt unsafe (at school or on their way to or from school in the past 30 days)	4%	7%	3%	7%	6%	15%	15%	9%	9%
Threatened or injured with a weapon on school property (in the past 12 months)	5%	7%	5%	11%	13%	11%	11%	N/A	7%
Experienced physical dating violence (including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with in the past 12 months)	7%	7%	4%	2%	5%	7%	7%	5%	9%
Electronically bullied (in the past year)	9%	11%	10%	11%	12%	15%	13%	19%	16%
Bullied (in the past year)	47%	45%	45%	44%	29%	39%	38%	N/A	N/A
Were bullied on school property (during the past 12 months)	N/A	N/A	28%	30%	18%	22%	20%	20%	15%

N/A – Not Available

Key Issues

The Wyandot County Health Alliance reviewed the 2024 Wyandot County Health Assessment. Each organization completed an "Identifying Key Issues and Concerns" exercise via an online survey. The following tables were the group results. The detailed primary data for each individual priority area can be found in the section it corresponds to.

What are the most significant health issues or concerns identified in the 2024 health assessment report? Examples of how to interpret the information include: 25% of Wyandot County adults had ever been diagnosed with diabetes, including 28% of males, 38% of adults ages 65+, and 66% of adults with annual household incomes less than $25,000.

Key Issue or Concern	Percent of Population At risk	Gender Most at Risk	Age Group Most at Risk	Income Level Most at Risk
Adult weight status (6 votes)				
Categorized as obese (including severely and morbidly obese) according to BMI	59%	Males (67%)	30-64 (61%)	<$25K (63%)
Categorized as overweight according to BMI	24%	Females (31%)	<30 (36%)	$25K+ (25%)
Adult cardiovascular health (6 votes)				
Diagnosed with high blood pressure (in their lifetime)	51%	Males (66%)	65+ (67%)	<$25K (78%)
Youth mental health (4 votes)				
Seriously considered attempting suicide in the past year	11%	Females (14%)	14-16 (13%)	N/A
Attempted suicide in the past year	5%	Females (7%)	14-16 (6%)	N/A
Adult diabetes (3 votes)				
Diagnosed with diabetes (not pregnancy-related) in their lifetime	25%	Males (28%)	65+ (38%)	<$25K (66%)
Youth bullying/violence (3 votes)				
Bullied in the past year	39%	Females (45%)	<13 (43%)	N/A
Did not go to school on one or more days in the past month because they felt unsafe	15%	Females (19%)	17+ (17%)	N/A

N/A – Data not available

- aligned with 2020-2022 SHIP

- aligned with 2022-2025 Wyandot County CHIP

- aligned with priorities identified from 2024 Wyandot County CHA community stakeholder perceptions feedback

Key Issue or Concern	Percent of Population At risk	Gender Most at Risk	Age Group Most at Risk	Income Level Most at Risk
Youth drug use (2 votes)				
Perceived great risk of smoking marijuana once or twice a week	36%	Females (35%)	17+ (30%)	N/A
Perceived no risk of smoking marijuana once or twice a week	15%	Males (19%)	17+ (23%)	N/A
Youth weight status (1 vote)				
Categorized as obese according to BMI	14%	Males (17%)	14-16 (16%)	N/A
Categorized as overweight according to BMI	16%	Males (17%)	14+ (18%)	N/A
Youth nicotine use (1 vote)				
Perceived that friends would feel it was very wrong for them to use electronic vapor products	56%	Females (54%)	17+ (47%)	N/A
Adult nicotine use (1 vote)				
Current cigarette smoker (smoked at least 100 cigarettes in their lifetime and currently smoked on some or all days)	13%	Males (14%)	30-64 (14%)	<$25K (20%)
Adult drug use (1 vote)				
Used recreational marijuana in the past 6 months	8%	Males (11%)	<30 (19%)	$25K+ (10%)
Adult asthma (1 vote)				
Diagnosed with asthma in their lifetime	17%	Males (20%)	30-64 (18%)	<$25K (44%)
Women's health (1 vote)				
Had a pap smear within the past 3 years (ages 21-65)	53%	N/A	N/A	N/A

N/A – Data not available

- aligned with 2020-2022 SHIP

- aligned with 2022-2025 Wyandot County CHIP

- aligned with priorities identified from 2024 Wyandot County CHA community stakeholder perceptions feedback

Priorities Chosen

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

Key Issues	Votes
1. Adult weight status	6
2. Adult cardiovascular health	6
3. Youth mental health	4
4. Adult diabetes	3
5. Youth bullying/violence	3
6. Youth drug use	2
7. Youth weight status	1
8. Youth nicotine use	1
9. Adult nicotine use	1
10. Adult drug use	1
11. Adult asthma	1
12. Women's health	1

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

Priority Factor(s):

1) Health Behaviors

Priority Health Outcome(s):

1) Mental Health and Addiction
2) Chronic Disease

Other:

1) Risky Behaviors

Community Themes and Strengths Assessment (CTSA)

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

Open-ended Questions to the Committee

1. **What do you believe are the 2-3 most important characteristics of a healthy community?**
    - Community collaborations (5)
    - Access to healthcare (3)
    - Healthy behaviors (3)
    - Access to resources (2)
    - Community pride/involvement (2)
    - Preventive healthcare and wellness (2)
    - Empathy
    - Economic viability/health
    - Strong local institutions (public & private)
    - Physical and mental health
    - Committed community members
    - Active outside the home (encouraging to see others out)
    - Investment in programs geared towards children
    - Strong knowledge of factors important in healthy development and lives

2. **What makes you most proud of our community?**
    - Collaborations (i.e., interagency resource, public and private sectors) (4)
    - Community pride
    - Hospital system
    - Safe place to live/raise a family
    - A small, personally connected community
    - Local institutions supporting local efforts
    - Local organizations are welcoming and allow individuals to get involved
    - Strong commitment to helping each other and supporting every member of the community

3. **What are some specific examples of people or groups working together to improve the health and quality of life in our community?**
    - Wyandot Health Alliance (2)
    - Family and Children First Council/Prevention (2)
    - Local service clubs (i.e., Rotary, Kiwanis, Lions, Masons, Young Professionals) (2)
    - Health Department (WIC, Help Me Grow Home Visiting, Boo to the Flu at Trinity Evangelical) (2)
    - Wyandot Memorial Hospital (three harm reduction machines deployed into the community with locations at WMH, some supplies from FCFC/prevention, and labor/ machines from the Health Department) (2)
    - Star Theater
    - Local farmers markets
    - Downtown events
    - Major health events (i.e., local runs and walks)
    - Wyandot County Office of Economic Development
    - Mental health resources (i.e., 988) provided to local schools
    - Thrive Local (local group of investors trying to make this a place people want to live/raise a family)
    - John Stewart Methodist Church (putting on an event where proceeds went to Open Door a local nonprofit)
    - Rotary Club (hosting a pancake breakfast at John Stewart Methodist Church proceeds assist Rotary's various programs)
    - Food Policy Council (meetings focusing on issues related to food insecurity and incorporating people from multiple types of organizations)
    - Upper's Winter Fantasy of Lights (brings the whole community together as local organizations and businesses come together to put on beautiful light displays and take turns volunteering to work the lights. The proceeds from donations collected go to help local organizations in the community.)
    - Wyandot County Council on Aging, INC. offering transportation services to medical appointments as well as providing home delivered meals and dine in meal options for seniors

4. **What do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life in our community?**
    - Adult and youth mental health (4)
    - Physical activity programs (3)
    - Vaping (2)
    - Overweight/obesity (2)
    - Teaching healthy eating habits (2)
    - Drug use
    - Housing availability
    - Incentivize preventive healthcare
    - Increase in communication and knowledge of resources
    - Encouragement to use services to improve one's own condition
    - Cardiovascular health (through diabetes, weight, and blood pressure management)

5. **What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?**
    - Resources for youth and mental health stigma (2)
    - Poor generational nutrition habits/not knowing how to eat well for long-term health (2)
    - Lack of access to services for certain populations
    - Stable revenues, rising costs challenge resource provision
    - The community needs to be engaged and involved
    - Access to resources for healthy but convenient food choices, opportunity for physical activity, specifically on poor weather days

6. **What actions, policy, or funding priorities would you support to build a healthier community?**
    - Incentivize preventive healthcare/wellness activities and services (4)
    - Healthy nutrition education and habits for children (2)
    - Incentivizing population growth
    - Prevention funding from the legalization of marijuana sales
    - More collaboration across various organizations/agencies
    - Updated policies around school suspensions relating to vaping (policies that encourage youth to get assistance with tobacco cessation and work to allow them to obtain a healthier life)

7. **What would excite you enough to become involved (or more involved) in improving our community?**
    - Already involved in various efforts (2)
    - Events and tabling opportunities
    - More physical challenge events through the year
    - Enjoy meeting and working alongside people who want the best for others and themselves
    - I would be interested in a bicycling group during the warm months where I can bicycle potentially with others on the bike trail in Upper Sandusky that leads up to the reservoir. This may require securing things like spare bike helmets and arranging a weekly or every other week after work bike session.

Quality of Life Survey

The Wyandot County Health Alliance urged community members to fill out a short Quality of Life Survey via SurveyMonkey. There were 147 Wyandot County community members who completed the survey. The table below incorporates responses from the previous Wyandot County CHIP for comparison purposes. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1. For all responses of "Don't Know," or when a respondent left a response blank, the choice was a non-response and was assigned a value of 0 (zero). The non-response was not used in averaging response or calculating descriptive statistics.

Quality of Life Questions	Likert Scale Average Response		
	2018 *(n=207)*	2022* *(n=131)*	2025 *(n=147)*
1. Are you satisfied with the quality of life in our community? (Consider your sense of safety, well-being, participation in community life and associations, etc.) [IOM, 1997]	4.20	3.99	3.89
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.81	3.49	3.63
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	4.28	4.00	3.80
4. Is this community a good place to grow old? (Consider elder-friendly housing, transportation to medical services, churches, shopping; elder day care, social support for the elderly living alone, meals on wheels, etc.)	4.17	3.82	3.83
5. Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)	3.46	3.24	3.19
6. Is the community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?)	4.29	4.33	4.08
7. Are there networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, or organizations) during times of stress and need?	4.03	3.80	3.67
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.90	3.56	3.51
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.60	3.44	3.33
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.59	3.39	3.31
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.71	3.61	3.31
12. Is there an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments? (Are citizens working towards the betterment of their community to improve life for all citizens?)	3.74	3.46	3.40

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

Forces of Change Assessment

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

Force of Change	Threats Posed	Opportunities Created
Economic Forces		
1. Suspension of federal funding, grants, programs (3)	• Lack of funding and support • Limits to services • Change/decrease in SNAP/WIC benefits • Decreased nutritional status of low income • Ability to fulfill grant deliverables	• Identifying alternative sources of funding (e.g., state funding) • Keeping up-to-date with federal changes and being flexible to ensure compliance
2. Downturn in economic conditions	• Unemployment and need for services.	• Streamline delivery of services
Mental/Behavioral Health Forces		
3. Marijuana legalization/Delta 8 availability (3)	• Deregulation of marijuana to those 21+ may increase access to those <21 (2) • Delta 8 is widely available to those <21 • Normalization of marijuana due to recent legal status	• Resources explaining harmful effects & how to get help for a drug use issue (2) • Ease of availability to those that legitimately use THC and its derivatives for medicinal uses • Prevention funds • Stress the importance of securement of marijuana in the household
4. Youth mental health (2)	• Lack of resources/services (2) • Suicide • Depression • Bullying	• Increase wellness/prevention programming (2)
5. Vaping	• Ease of obtaining products	• Resources explaining harmful effect, especially on youth

Force of Change	Threats Posed	Opportunities Created
Political Forces		
6. Political environment (2)	• Could change government agencies and programs	• Lower prices • Stronger economy • Find new ways to tell our stories
7. Insufficient information from government	• Lack of trust or willingness to follow guidelines and recommendations	• N/A
Demographic Forces		
8. Decreasing population (2)	• Less community resources to combat negative health trends • Declining health of community • Increased communicable disease • Pressure on local businesses and economic growth	• Less population may result in less need for community assistance • Focus on workforce development and recruitment
9. Increasing aging population (2)	• Diminished resources • Changing roles in life (not sure when to stop driving, adults taking care of their aging parents)	• Possible increased community support • Programs needed to help people navigate these changes
10. Increase in migrant populations (2)	• Communication difficulties • Unaware of community resources • Other misconceptions • Housing	• New lines of communication between health and other community services among these "new" populations • Need for increased housing
11. Rural county	• Isolation • Services not reaching into small towns	• Close-knit community • Desire to help each other

Force of Change	Threats Posed	Opportunities Created
General Health Forces		
12. Increase in overweight and obesity rates	• Increase in chronic health conditions and therefore increase cost of treating these diseases	• Wellness program opportunities • Increased investments in preventing disease rather than treating disease and disease symptoms
13. Increase in sedentary lifestyle of youth	• Healthy habits are forced into competition with unhealthy ones which could result in learned sedentary behavior	• Increase in community activity that involves youth • Find a way to get youth familiarized with their local gym • Social media education on healthy habits
14. Vaccine hesitancy	• Decrease vaccination rates which could lead to increased illness in community leading to hospitalization, loss of productivity, injury, or death. These threats have an increased impact on people with chronic diseases.	• Increase outreach, education in both community and online
15. Increase in prevalence of children diagnosed with autism spectrum disorder	• Lack of resources in child care and local schools	• Increased awareness and increased commitment of evidence-based programming and resources
Environmental Forces		
16. Natural disasters	• Decreased housing • Food availability • Clean water	• Housing opportunities • Food and clean water resources
17. Convenient availability of processed foods, unhealthy snacks, and fast food	• Unhealthy food options become staple part of community member meals • High salt concentration foods contribute to hypertension • Soda pop ease of consumption could lead to health issues	• Farmer markets • Community gardens • Limiting soda pop vending in schools

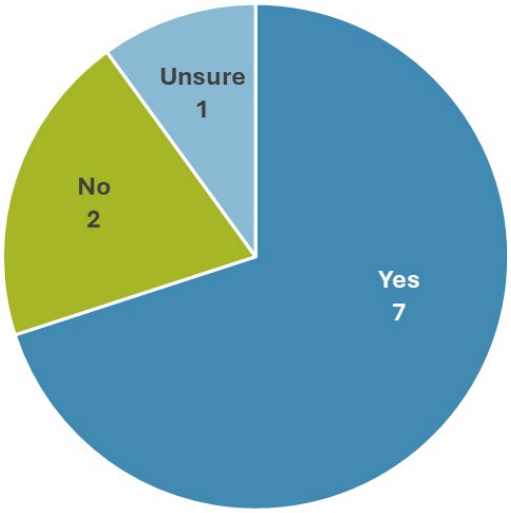
Force of Change	Threats Posed	Opportunities Created
Development Forces		
18. Housing shortage	• Inability to attract workers and grow population	• Incentive for developers to increase supply
19. Growth of Columbus area	• Attract Wyco workers to back-fill positions in Marion and other counties as their workers migrate South	• Local businesses become suppliers to the Columbus market
20. Behavioral health workforce shortages	• Limited access to services • Gaps in service during turnover	• Leveraging telehealth as a viable option for care
21. Nursing shortage	• Inability to admit full capacity • Inability to handle special conditions	• Increased opportunity to attract workforce (pay, benefits) • Contracted services / working with other agencies to cover the need

Community Partner Assessment

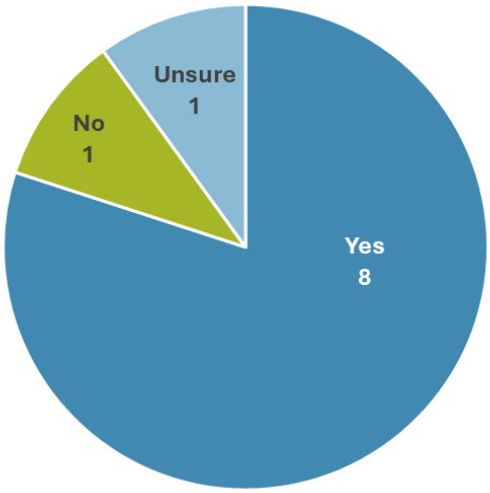
The Community Partner Assessment (CPA) aids in identifying the organizations engaged in the community health improvement process, including the populations they serve, their activities, and their capabilities and expertise in supporting local health improvement efforts. The CPA helps name strengths as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

1. **Which best describes your position or role in your organization?**
    - Front life staff (2)
    - Senior management level/unit or program lead (2)
    - Administrative staff (1)
    - Other (3)
        - Community outreach coordinator
        - Mid-level director
        - Safety liaison

2. **Has your organization ever participated in a community health improvement process?**
    - Yes (7)
    - No (2)
    - Unsure (1)



3. **Has your organization ever participated in or facilitated community-led decision-making around policies, actions, or programs?**
    - Yes (8)
    - No (1)
    - Unsure (1)



4. **Which of the following describes your organization?**
    - Non-profit organization (6)
    - Other county government agency (3)
    - Social service provider (2)
    - County health department (1)
    - Other state government agency (1)
    - Private hospital (1)
    - Public hospital (1)
    - Mental health provider (1)
    - Other (1)
        - WIC services

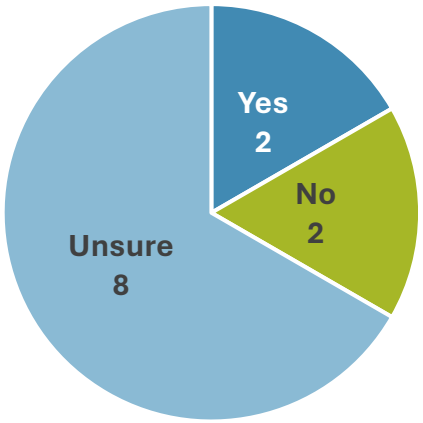
5. **What are your organization's top interests in joining a community health improvement partnership?**
    - To increase communication among groups (6)
    - To plan and launch community-wide initiatives (5)
    - To deliver programs effectively and efficiently and avoid duplicated efforts (5)
    - To build networks and friendships (4)
    - To obtain or provide services (3)
    - To pool resources (1)
    - To break down stereotypes (1)
    - To create long-term, permanent social change (1)
    - To develop and use political power to gain services or other benefits for the community (1)
    - Other (1)
        - The Center is responsible for assisting local schools and first responders with preventing, preparing for, and responding to threats and acts of violence, including self-harm, through a holistic, solutions-based approach to improving school safety.

6. **What are the top reasons why your organization is interested in participating in a community health initiative?**
    - Connections to other organizations (10)
    - Improving conditions for members/constituents (7)
    - Connections to communities with lived experience (5)
    - Access to data (3)
    - Connections to decision-makers (2)
    - Helps achieve requirements for public health accreditation (2)

7. **What resources might your organization contribute to support Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) activities?**
    - Social media capacities (6)
    - Policy/advocacy skills (5)
    - Staff time to help implement CHIP priorities (5)
    - Staff time to support community engagement and involvement (5)
    - Staff time to participate in CHA and CHIP meetings and activities (5)
    - Staff time to help analyze quantitative data (4)
    - Staff time to help plan CHA and CHIP meetings and activities (4)
    - Staff time to support relationship-building between CHIP staff and other organizations (e.g., introductions to government agencies or organizers) (4)
    - Physical space to hold meetings (3)
    - Staff time to help analyze qualitative data (3)
    - Media connections (2)
    - Staff time to transcribe meeting notes/recordings (2)
    - Note-taking support during qualitative data collection (2)
    - Staff time to support focus group facilitation or interviews (2)
    - Technology to support virtual meetings (1)
    - Lending interpretation equipment for use during meetings (1)
    - Staff time to help facilitate CHA and CHIP meetings and activities (1)
    - Funding to support community engagement (e.g., stipends, gift cards) (1)
    - Funding to support assessment activities (e.g., data collection, analysis) (1)

8. **What racial/ethnic populations does your organization work with?**
    - Latinx/Hispanic (9)
    - White/European (9)
    - Black/African American (8)
    - Asian American (7)
    - Asian (6)
    - Native American/Indigenous/Alaska Native (6)
    - African (5)
    - Middle Eastern/North African (5)
    - Pacific Islander/Native Hawaiian (5)

9. **Does your organization work with immigrants, refuges, asylum seekers, and other populations who speak English as a second language?**
    - Yes (2)
    - No (2)
    - Unsure (8)

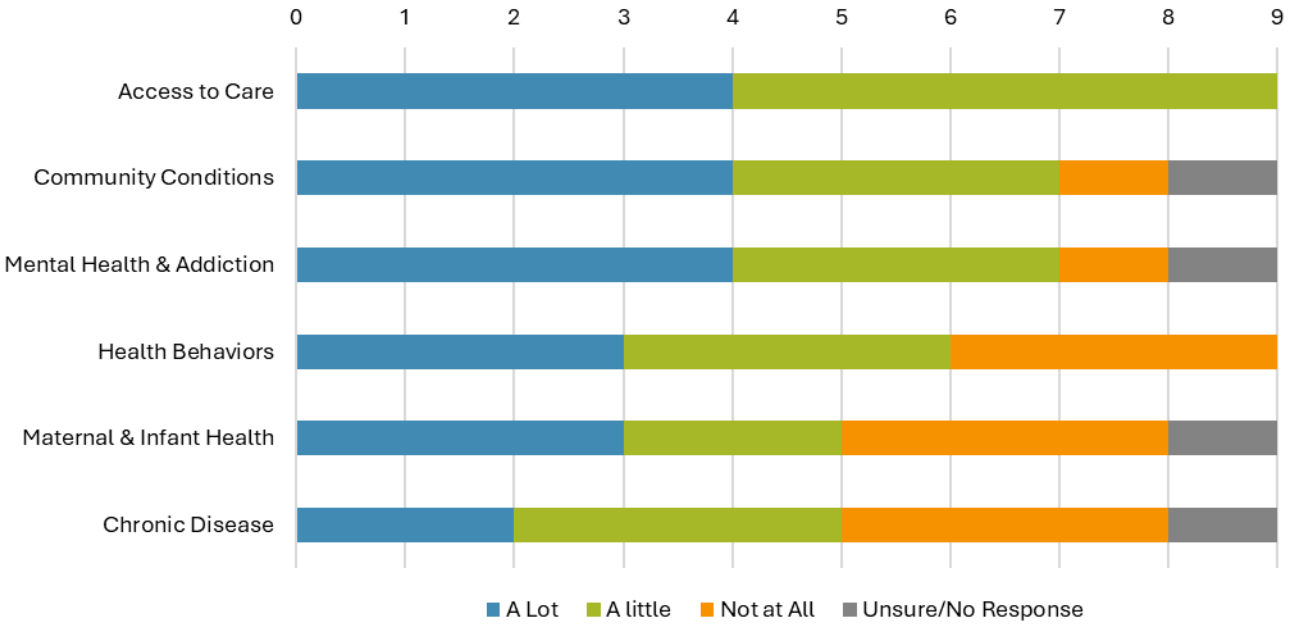


10. **Does your organization offer services specifically for people with disabilities?**
    - Yes—we provide services specifically for people with disabilities (6)
    - Somewhat—we are wheelchair accessible and compliant with the American Disabilities Act but are not specifically designed to serve people with disabilities (2)
    - No—our organization is not specifically designed to serve people with disabilities (1)

11. **Who are your priority populations?**
    - The elderly (60+) (3)
    - People with intellectual and developmental disabilities and their families (3)
    - Low-income families (2)
    - Youth and adults with mental health and/or substance use disorders (2)
    - Children (1)
    - Veterans (1)
    - All ages (1)
    - WIC clients (1)
    - The entire community (1)
    - Local businesses (1)
    - Public leadership (1)

12. **What do you do to reach/engage/work with your clientele or community?**
    - We work closely with community organizations from our target populations (6)
    - We receive many referrals from our target populations (5)
    - We receive many clients from our target populations (4)
    - We support leadership development in our target populations (4)
    - We have done extensive outreach to our target populations (2)
    - We hire staff/interpreters who speak the language/s of our target populations (2)
    - Our organization is physically located in neighborhood/s of our target populations (2)
    - We have leadership who speak the language/s of our target populations (1)

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



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

- Healthcare access/utilization (6)
- Housing (5)
- Family well-being (5)
- Education (4)
- Early childhood development/childcare (4)
- Businesses and for-profit organizations (4)
- Public health (3)
- Seniors/elder care (3)
- Transportation (3)
- Human services (3)
- Food service/restaurants (3)
- Disability/independent living (3)
- Community economic development (3)
- Utilities (2)
- Veterans' issues (2)
- Criminal legal system (2)
- Economic security (2)
- Faith communities (2)
- Food access and affordability (e.g., food bank) (2)
- Jobs/labor conditions/wages and income (2)
- Land use planning/development (1)
- LGBTQIA+ discrimination/equity (1)
- Youth development and leadership (1)
- Other (1)
  - ➢ We do not provide direct services to clients, but we link them to resources in these categories

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

- Healthcare access/utilization (6)
- Family/maternal health (5)
- Physical activity (4)
- Health insurance/Medicare/Medicaid (4)
- Tobacco and substance use and prevention (4)
- Immunizations and screenings (3)
- Infectious disease (3)
- Mental or behavioral health (e.g., PTSD, anxiety, trauma) (3)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)/food stamps (3)
- Cancer (2)
- Injury and violence prevention (2)
- Chronic disease (e.g., asthma, diabetes/obesity, cardiovascular disease) (2)
- HIV/STD prevention (1)
- Health equity (1)
- Other (1)
  - Intellectual/developmental disability

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

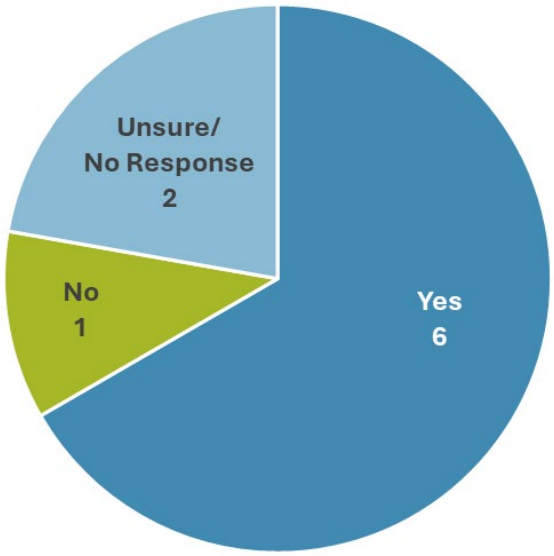
- Communication and Education: My organization works to communicate effectively to inform and educate people about health or well-being, factors that influence well-being, and how to improve it. (6)
- Community Engagement and Partnerships: My organization works to strengthen, support, and mobilize communities and partnerships to improve health and well-being. (6)
- Access to Care: My organization provides healthcare and social services to individuals or works to ensure equitable access and an effective system of care and services. (6)
- Assessment: My organization conducts assessments of living and working conditions and community needs and assets. (4)
- Policies, Plans, Laws: My organization works to create, champion, and apply policies, plans, and laws that impact health and well-being. (4)
- Workforce: My organization supports workforce development and can help build and support a diverse, skilled workforce. (3)
- Investigation of Hazards: My organization investigates, diagnoses, and addresses health problems and hazards affecting the population. (3)
- Evaluation And Research: My organization conducts evaluation, research, and continuous quality improvement and can help improve or innovate functions. (2)
- Organizational Infrastructure: My organization is helping build and maintain a strong organizational infrastructure for health and well-being. (2)
- Legal and Regulatory Authority: My organization has legal or regulatory authority to protect health and well-being and uses legal and regulatory actions to improve and protect the public's health and well-being. (1)

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

- Assessment (2)
- Access to Care (2)
- Communication and Education (2)
- Community Engagement and Partnerships (2)
- Workforce (1)
- Evaluation & Research (1)
- Other (1)
  - Nursing
  - WIC
  - Environmental Health
  - 4th being Vital Statistics

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

- Yes (6)
- No (1)
- Unsure (1)
  - Yes, but the funding is highly dependent upon grants and the renewal of our levy loss of these have huge impact on what we can do to staff our organization.



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

- Communications: Messaging that resonates with communities, connects them to an issue, or inspires them to act. (8)
- Organizing: Involving people in efforts to change their circumstances by changing the underlying structures, decision making processes, policies, and priorities that produce inequities. (6)
- Social and Health Services: Providing services that reach clients and meet their needs (including clinical and healthcare services). (5)
- Alliance and Coalition-Building: Building collaboration among groups with shared values and interest. (4)
- Research and Policy Analysis: Gathering and analyzing data to create credibility and inform policies, projects, programs, or coalitions. (4)
- Leadership Development: Equipping leaders with the skills, knowledge, and experiences to play a greater role within their organization or movement. (4)
- Advocacy and Grassroots Lobbying: Targeting public officials either by speaking to them or mobilizing constituents to influence legislative or executive policy decisions. (2)
- Healing: Addressing personal and community trauma and how they connect to larger social and economic inequalities. (2)
- Campaigns: Using organized actions that address a specific purpose, policy, or change. (1)
- Inside-Outside Strategies: Coordinating support from organizations on the "outside" with a team of like-minded policymakers on the "inside" to achieve common goals. (1)
- Movement-Building: Scaling up from single organizations and issues to long-term initiatives, perspectives, and narratives that seek to change systems. (1)
- Narrative Change: Harnessing arts and expression to replace dominant assumptions about a community or issue with dignified narratives and values. (1)

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

- Collaborate: Ensure community capacity to play a leadership role in implementation of decisions. (4)
- Involve: Ensure community needs and assets are integrated into process and inform planning. (3)
- Inform: Provide the community with relevant information. (1)

21. Which of the following methods of community engagement does your organization use most often?

- Presentations (6)
- Social media (5)
- Surveys (4)
- Community forums/events (4)
- Fact sheets (3)
- Open houses (3)
- Customer/patient satisfaction surveys (3)
- Advocacy (2)
- Public comment (2)
- Citizen advisory committees (2)
- Billboards (1)
- Focus groups (1)
- Community organizing (1)
- Community-driven planning (1)
- Memorandums of understanding (MOUs) with community-based organizations (1)
- Other (2)
  - Public meetings
  - Annual reports

22. What policy/advocacy work does your organization do?

- Develop close relationships with elected officials (5)
- Advocate for policy change (4)
- Use relationships to access decision-makers (4)
- Educate decision-makers and respond to their questions (4)
- Unsure (3)
- Respond to requests from decision-makers (3)
- Mobilize public opinion on policies via media/communications (2)
- Write or develop policy (1)
- Lobby for policy change (1)
- Build capacity of impacted individuals/communities to advocate for policy change (1)

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

- All of the above.
- Provide space for meetings, provide staff for meetings, and work on strategies.
- Sharing information that is important to the aging population.
- Sharing resources and communications via our social media, websites, and emails.
- We can reach out to state level above for assistance and we have counterparts in our region that we can rely on when looking into strategies that may work.

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

Gaps Analysis

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

Strategy Selection

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

Evidence-Based Practices

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

Resource Inventory

Based on the chosen priorities, the Wyandot County Health Alliance was asked to identify resources for each strategy. The resource inventory allowed the committee to identify existing community resources, such as programs, policies, services, and more. The Wyandot County Health Alliance was then asked to determine whether a policy, program or service was evidence-based, a best practice, or had no evidence indicated. Each resource inventory can be found with its corresponding strategy.

Priority #1: Health Behaviors

Strategic Plan of Action

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

<table>
<tr><td colspan="5">Priority #1: Health Behaviors</td></tr>
<tr><td colspan="5">Strategy 1: Community gardens</td></tr>
<tr><td>Action Step</td><td>Timeline</td><td>Priority Population</td><td>Indicator(s) to measure impact of strategy:</td><td>Lead Contact/Agency</td></tr>
<tr><td>Year 1: Explore engagement opportunities to increase participation in community gardens. Provide community education on how to utilize fresh produce, such as taste testing and cooking demonstrations at community gardens and other public events.

Continue to partner with local food pantries to provide fresh produce from community gardens to residents who are food insecure.

Ensure Wyandot Helps website is regularly updated with information about community gardens and food pantries available.

Research grants and other funding opportunities to support community gardens and healthy options in food pantries in Wyandot County.</td><td>May 31, 2026</td><td rowspan="3">Adults and youth</td><td rowspan="3">Percent of adults who did not eat fruits or vegetables during the past week
(Wyandot CHA)

Percent of adults reporting no access to healthy foods as a barrier to consuming healthy foods
(Wyandot CHA)

Percent of youth who did not eat fruit or vegetables on an average day in the past week
(Wyandot CHA/ OHYES!)</td><td rowspan="3">Callan McMillion
Wyandot County Public Health

Tami Baumberger
OSU Extension, SNAP Ed Program

Scott Moore
Open Door Resource Center</td></tr>
<tr><td>Year 2: Continue efforts from year 1.</td><td>May 31, 2027</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2.</td><td>May 31, 2028</td></tr>
<tr><td colspan="5">Resources to address strategy:
Wyandot County Public Health, Carey Link, Christian Food Center, Open Door Resource Center, Wyandot Memorial Hospital</td></tr>
<tr><td colspan="5">Outcome:
Increase fruit and vegetable consumption, with a focus on residents who are facing food insecurity</td></tr>
</table>

- Ohio SHIP aligned priority/strategy/indicator

Priority #1: Health Behaviors				
Strategy 2: School nutrition standards in after-school events				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Recruit local school stakeholders (e.g., school PTO & booster members, school board members, principals, superintendents) to gather feedback and buy-in regarding nutrition standards at after-school events. Advocate for healthy initiatives at school sporting events and concession stands such as: • **Competitive pricing for healthy foods** • **Child-focused advertising restrictions for unhealthy foods & beverages** • **Build on federal standards to expand sugar-sweetened beverage restrictions in youth-oriented settings** • **Free water access** Identify one local school district to pilot nutrition standards into after-school events.	May 31, 2026	Youth	Percent of youth who did not eat fruit or vegetables on an average day in the past week *(Wyandot CHA/OHYES!)* Percent of youth who drank soda 1 time per day or more in the past week *(Wyandot CHA/OHYES!)* Percent of youth who were obese *(Wyandot CHA/OHYES!)*	**Brooke Higgins** Wyandot Memorial Hospital **Tami Baumberger** OSU Extension, SNAP Ed Program
Year 2: Continue efforts from year 1. Expand nutrition standards to an additional school district.	May 31, 2027			
Year 3: Continue efforts from years 1 and 2. Evaluate progress annually and determine additional opportunities to expand initiatives.	May 31, 2028			
Resources to address strategy: Schools, School Boosters, Wyandot Memorial Hospital				
Outcome: Increase youth fruit and vegetable consumption, decrease youth sugar-sweetened beverage consumption				

- Ohio SHIP aligned priority/strategy/indicator

- Policy development, enforcement, or advocacy strategy

Priority #1: Health Behaviors				
Strategy 3: Support the Wyandot County Food Policy Council				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Ensure consistent representation from the Wyandot County Health Alliance on the Wyandot County Food Policy Council. Advocate for local access to nutritious, affordable options by: • Establishing **WIC and Senior Citizen Vouchers for Farmers' Markets** • Participating in state-wide advocacy days, informing government officials of nutrition-related gaps in Wyandot County	May 31, 2026	Adults and Youth	Percent of adults who did not eat fruits or vegetables during the past week *(Wyandot CHA)* Percent of adults reporting no access to healthy foods as a barrier to consuming healthy foods *(Wyandot CHA)* Percent of youth who did not eat fruit or vegetables on an average day in the past week *(Wyandot CHA/OHYES!)*	**Krystina Auble** Wyandot County Public Health **Tami Baumberger** OSU Extension, SNAP Ed Program Wyandot County Council on Aging Christian Food Center
Year 2: Continue efforts from year 1. Evaluate progress annually and determine additional opportunities to expand initiatives.	May 31, 2027			
Year 3: Continue efforts from years 1 and 2.	May 31, 2028			
Resources to address strategy: Wyandot Memorial Hospital, Carey Link, Wyandot County Farmer's Market, Wyandot County Food Policy Council, Wyandot County Council on Aging, INC.				
Outcome: Increase fruit and vegetable consumption, with a focus on vulnerable populations (low-income, seniors)				

- *Policy development, enforcement, or advocacy strategy*

Priority #1: Health Behaviors				
Strategy 4: Promote available fitness program benefits				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research eligibility criteria (e.g., insurance provider, age, income, etc.) for various fitness programs that offer discounted or free gym access (e.g., **Silver Sneakers**, **Prime**). Create promotional materials that inform residents of eligibility criteria, potential benefits, and local sites accepting fitness plan members. Distribute promotional materials with local agencies, such as the Chambers of Commerce and Wyandot County Council on Aging.	May 31, 2026	Adults	Percent of adults who did not participate in any physical activity in the past week *(Wyandot CHA)* Percent of adults who indicated they could not afford a gym membership as a barrier to exercising *(Wyandot CHA)* Percent of adults reporting no leisure time physical activity (*County Health Rankings)*	**Brooke Higgins** Wyandot Memorial Hospital
Year 2: Continue efforts from year 1. Evaluate available programs and eligibility criteria annually, and update as needed.	May 31, 2027			
Year 3: Continue efforts from years 1 and 2.	May 31, 2028			
Resources to address strategy: Wyandot County Council on Aging, Wyandot County Chamber of Commerce, Carey Area Chamber of Commerce, Local fitness centers, Wyandot County Transportation Advisory Committee, Wyandot County Council on Aging, INC.				
Outcome: Increase physical activity among adults				

Priority #1: Health Behaviors

Strategy 5: Mass media campaigns against tobacco use

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue implementing the following tobacco prevention mass-reach communication initiatives: • Share messages and engage audiences on social networking sites. • Deliver messages through different websites and stakeholders communications. • Generate free press through public service announcements. • Pay to place adds on TV, radio, billboards, online platforms, and/or print media. Focus on strategies that motivate tobacco users to quit, protect people from the harm of secondhand smoke exposure, and prevent tobacco use and vaping initiation. Maintain promotion and awareness efforts of the **Ohio Tobacco Quit Line**. Promote available cessation services and programs in the county. Continue to evaluate youth tobacco use by utilizing OHYES! annual county reports, focusing on smoking/vaping rates and age of onset. Sustain awareness initiatives of the **Tobacco 21** law.	May 31, 2026	Adults and Youth	Percent of adults that are current cigarette smokers *(County Health Rankings)* Percent of adults who are current e-cigarette users (currently vape on some or all days) *(Wyandot CHA)* Percent of youth who are current cigarette smokers (smoked all or part of a cigarette within the past month) *(Wyandot CHA/ OHYES!)* Percent of youth who are current e-cigarette users (used an electronic vapor product in the past month) *(Wyandot CHA/ OHYES!)* Percent of youth who smoked cigars, cigarillos, or little cigars in the past month *(Wyandot CHA/ OHYES!)* Percent of youth who used chewing tobacco, snuff, dip, snus, or dissolvable tobacco products in the past month *(Wyandot CHA/ OHYES!)*	**Justin Swartz** Wyandot County Family and Children First Council Wyandot County Prevention Coalition Mental Health and Recovery Services Board
Year 2: Continue efforts from year 1.	May 31, 2027			
Year 3: Continue efforts from years 1 and 2.	May 31, 2028			

Resources to address strategy:
Wyandot Memorial Hospital, Mental Health and Recovery Services Board

Outcome:
Decrease current cigarette smoker and e-cigarette user rates

- Ohio SHIP aligned priority/strategy/indicator

- Policy development, enforcement, or advocacy strategy

Priority #1: Health Behaviors				
Strategy 6: School-based tobacco prevention skill-building programs				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to assess the types of tobacco prevention programs being offered in schools. Stay up-to-date with various evidence-based **school-based tobacco prevention programs**, and consider implementing new programs as needed. Ensure all youth tobacco prevention policies and programs include emphasis on e-cigarettes/nicotine addiction. Consider expanding the scope of programming to other substance use, such as marijuana and alcohol. Work with schools to maintain policies that provide alternatives to suspension for students who are found with tobacco products, (e.g., evidence-based programming, cessation services, therapy, mentorship) ^. Continue to encourage schools to participate in the **Youth Risk Behavior Survey/Ohio Youth Tobacco Survey**.	May 31, 2026	Youth	Percent of youth who are current cigarette smokers (smoked all or part of a cigarette within the past month) *(Wyandot CHA/ OHYES!)* Percent of youth who are current e-cigarette users (used an electronic vapor product in the past month) *(Wyandot CHA/ OHYES!)* Percent of youth who smoked cigars, cigarillos, or little cigars in the past month *(Wyandot CHA/ OHYES!)* Percent of youth who used chewing tobacco, snuff, dip, snus, or dissolvable tobacco products in the past month *(Wyandot CHA/ OHYES!)*	**Justin Swartz** Wyandot Prevention Coalition
Year 2: Continue efforts from year 1.	May 31, 2027			
Year 3: Continue efforts from years 1 and 2.	May 31, 2028			
Resources to address strategy: Schools, School Resource Officers, Ram Squad, Wyandot County Public Health, Wyandot County Sheriff's Office, Mental Health & Recovery Services Board				
Outcome: Decrease tobacco use among youth				

- Ohio SHIP aligned priority/strategy/indicator

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

Priority #2: Mental Health and Addiction

Strategic Plan of Action

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

<table>
<tr><td colspan="5">Priority #2: Mental Health and Addiction</td></tr>
<tr><td colspan="5">Strategy 1: School-based violence and bullying prevention programs</td></tr>
<tr><td>Action Step</td><td>Timeline</td><td>Priority Population</td><td>Indicator(s) to measure impact of strategy:</td><td>Lead Contact/Agency</td></tr>
<tr><td>Year 1: Continue offering evidence-based bullying prevention and mentoring programming in all schools throughout Wyandot County. Ensure buy-in from youth by gathering and incorporating feedback from youth.</td><td>May 31, 2026</td><td rowspan="3">Youth</td><td>Percent of youth who have experienced two or more adverse experiences (Wyandot CHA/OHYES!)</td><td rowspan="3">Justin Swartz
Wyandot Prevention Coalition</td></tr>
<tr><td>Year 2: Continue efforts from year 1.
Evaluate progress annually and determine additional opportunities to expand initiatives.</td><td>May 31, 2027</td><td>Percent of youth who report ever being bullied electronically (Wyandot CHA/OHYES!)</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2.</td><td>May 31, 2028</td><td>Percent of youth who report being bullied on school property within the past year (Wyandot CHA/OHYES!)</td></tr>
<tr><td colspan="5">Resources to address strategy:
Schools, School Resource Officers</td></tr>
<tr><td colspan="5">Outcome:
Reduce bullying in Wyandot County</td></tr>
</table>

Priority #2: Mental Health and Addiction

Strategy 2: Education for parents on how to build youth resilience and protective factors and how to communicate with their children about alcohol and other drugs

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to offer existing parenting programs, such as Hidden in Plain Sight. Secure funding for staff training, program materials, and initial implementation of **Triple P Parenting Program**. Identify and enroll staff in Triple P provider training and certification.	May 31, 2026	Youth	Percent of high school students who have used alcohol within the past month *(Wyandot CHA/ OHYES!)* Percent of high school students who have used marijuana within the past month *(Wyandot CHA/ OHYES!)* Percent of youth who felt sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities *(Wyandot CHA/ OHYES!)* Percent of youth who experienced three or more adverse childhood conditions *(Wyandot CHA/ OHYES!)*	**Justin Swartz** **Wyandot County** Family and Children First Council
Year 2: Establish internal infrastructure to support delivery by assigning a program coordinator and setting up a referral system. Launch awareness campaign around parenting stress, family resilience, and the upcoming availability of Triple P in the community. Build partnerships with schools, pediatric clinics, social services, and early childhood centers for referrals and co-promotion. Launch Triple P parenting program. Track participation and outcomes using Triple P's built-in evaluation tools to measure impact and areas for improvement.	May 31, 2027			
Year 3: Apply for ongoing funding to expand reach. Train additional staff members to become certified Triple P providers, expanding the organization's ability to serve more families. Broaden the program's reach by adding additional Triple P levels (e.g., Teen Triple P, Triple P Online) or culturally tailored modules. Engage local media to feature success stories and highlight the program's benefits. Evaluate outcomes annually and determine opportunities for expansion, including addition of other evidence-based parenting programs.	May 31, 2028			

Resources to address strategy:
Ohio RISE, Firelands, Wyandot County Job and Family Services, Wyandot County Child Protective Services, Wyandot Counseling, Charlie Health, Wyandot Memorial Hospital

Outcome:
Improve youth mental health and reduce risky behaviors

- Ohio SHIP aligned priority/strategy/indicator

Priority #2: Mental Health and Addiction				
Strategy 3: Naloxone education and distribution programs				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Identify current locations that offer Narcan/naloxone for free and when/where **naloxone trainings** occur within the county. Based on information collected, determine where Narcan/naloxone distribution and trainings are most needed and can expand. Assess distribution and utilization data annually and identify opportunities for expansion or piloting new programs.	May 31, 2026	Adults	Number of deaths due to unintentional drug overdose, per 100,000 population (age adjusted) *(ODH Vital Statistics)*	Wyandot County Public Health
Year 2: Continue efforts from year 1.	May 31, 2027			
Year 3: Continue efforts from years 1 and 2.	May 31, 2028			
Resources to address strategy: Mental Health & Recovery Services Board, Ohio Department of Transportation, Project DAWN, Wyandot Memorial Hospital, Pharmacies, Wyandot County Sheriff's Office, Wyandot County Fatality Review Board				
Outcome: Decrease drug overdose deaths				

- Ohio SHIP aligned priority/strategy/indicator

Priority #2: Mental Health and Addiction				
Strategy 4: Bridges Out of Poverty/Getting Ahead in a Just Getting by World				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Offer classes from Bridges out of Poverty and evaluate enrollment with class completion numbers.	May 31, 2026	Adults	Percent of adults who indicated financial stress caused them anxiety, stress, or depression *(Wyandot CHA)* Percent of adults who indicated poverty/no money caused them anxiety, stress, or depression *(Wyandot CHA)* Percent of adults who experienced more than one food insecurity issue in the past year *(Wyandot CHA)* Class enrollment numbers *(Program Evaluation Data)* Class Completion Percentage *(Program Evaluation Data)*	**Scott Moore** Open Door Resource Center
Year 2: Continue efforts of year 1. If certifications are required for more training options, evaluate enrollment numbers and determine opportunities to enroll more students in program.	May 31, 2027			
Year 3: Continue efforts from years 1 and 2.	May 31, 2028			
Resources to address strategy: Bridges out of Poverty/Getting Ahead educational literature, Wyandot County Public Health, Buckeye Ridge Habitat for Humanity, local schools and church associations				
Outcome: Increase financial literacy and empower clients/students to become equipped with the tools required to get out of poverty.				

Priority #3: Chronic Disease

Strategic Plan of Action

To work toward improving chronic disease, the following strategies are recommended:

Priority #3: Chronic Disease				
Strategy 1: Hypertension screening and follow up				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Gather baseline data on the number and location of hypertension screening events currently being offered throughout the year. Identify gaps in location or time in which additional hypertension screenings could be offered. Partner with local organizations to administer hypertension screenings and to raise awareness of hypertension. Promote and market free/reduced cost screening events within the county (ex: health fairs, hospital screening events, etc.). Explore evidence-based hypertension strategies, such as **A Million Hearts tools** for clinicians, public health practitioners, and employers. Identify at least one initiative to pilot.	May 31, 2026	Adults	Percent of adults ever diagnosed with hypertension *(Wyandot CHA)* Percent of adults ever diagnosed with coronary heart disease *(Wyandot CHA)*	**Brooke Higgins** Wyandot Memorial Hospital
Year 2: Continue efforts from year 1. Assess piloted evidence-based hypertension strategy and identify opportunities for expansion or consider other evidence-based strategies to pilot.	May 31, 2027			
Year 3: Continue efforts from years 1 and 2.	May 31, 2028			
Resources to address strategy: Wyandot County Public Health, Wyandot Council on Aging, City of Upper Sandusky, Wyandot County Employee Health Fair, City of Upper Sandusky Health Fair, Wyandot County Council on Aging, INC.				
Outcome: Increase access to hypertension screening and support				

- Ohio SHIP aligned priority/strategy/indicator

Priority #3: Chronic Disease				
Strategy 2: Diabetes Prevention Program				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Launch the **CDC's National Diabetes Prevention Program (DPP)**. Promote the DPP to at-risk populations through partnerships with primary care physicians (PCPs), community-based organizations, and local media. Include targeted outreach to at-risk populations (e.g., low-income, older adults, uninsured, etc.). Introduce and promote the **Lark App** as a free, digital lifestyle change tool for those at risk of type 2 diabetes. Distribute access and eligibility information during screenings, PCP visits, and community events. Work with PCP offices to understand their gaps in diabetic/pre-diabetic resources and strengthen referral systems to DPP, Lark, and **diabetes self-management education and support (DSMES)**.	May 31, 2026	Adults	Percent of adults ever diagnosed with diabetes *(Wyandot CHA)*	**Brooke Higgins** Wyandot Memorial Hospital
Year 2: Scale DPP outreach and enrollment by deepening partnerships with referral sources (e.g., PCPs, employers, pharmacies) and promoting DPP via screening events, social media, local news, etc. Evaluate DPP implementation: enrollment metrics, participant feedback, and outcomes to guide improvement. Boost Lark App utilization by training health care partners to refer eligible patients and by including Lark in all diabetes prevention materials.	May 31, 2027			
Year 3: Continue expanding DPP participation through targeted outreach and enhanced referral pathways. Strengthen referral systems for screenings, education, and digital tools by collaborating with electronic health record systems and local health care providers. Increase Lark App integration by encouraging long-term engagement for behavior change maintenance. Partner with employers to promote use.	May 31, 2028			

Monitor and evaluate outcomes to inform future funding and community health priorities.				
Resources to address strategy: Wyandot Memorial Hospital – Diabetes Education Coordinator				
Outcome: Reduce pre-diabetes and diabetes morbidity				

 *- Ohio SHIP aligned priority/strategy/indicator*

Priority #4: Risky Behaviors

Strategic Plan of Action

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

<table>
<tr><td colspan="5">Priority #4: Risky Behaviors</td></tr>
<tr><td colspan="5">Strategy 1: Increase community awareness and education of risky driving behaviors</td></tr>
<tr><td>Action Step</td><td>Timeline</td><td>Priority Population</td><td>Indicator(s) to measure impact of strategy:</td><td>Lead Contact/Agency</td></tr>
<tr><td>Year 1: Plan a community awareness campaign to increase education regarding risky driving behaviors (i.e. texting and driving, drinking and driving, etc.).

Determine best ways to educate community (social media, newspaper, school websites, television, etc.).</td><td>May 31, 2026</td><td rowspan="3">Adults and Youth</td><td rowspan="3">Adult average number of drinks consumed per drinking occasion (Wyandot CHA)

Percent of adults who reported texting while driving (Wyandot CHA)

Youth current drinker (drank alcohol at least once in the past month) (Wyandot CHA/OHYES!)

Percent of youth who had driven a car in the past month after they had been drinking alcohol (Wyandot CHA/OHYES!)

Percent of youth who reported texting while driving in the past month (Wyandot CHA/OHYES!)</td><td rowspan="3">Callan McMillion
Wyandot County Public Health</td></tr>
<tr><td>Year 2: Partner with local organizations (i.e. law enforcement) and plan at least 2 awareness programs and/or workshops focusing on populations most at risk.

Attain media coverage for programs and workshops.</td><td>May 31, 2027</td></tr>
<tr><td>Year 3: Continue efforts of years 1 and 2.</td><td>May 31, 2028</td></tr>
<tr><td colspan="5">Resources to address strategy:
Wyandot County Safe Communities Coalition, Wyandot County Public Health, Wyandot County Transportation Advisory Committee</td></tr>
<tr><td colspan="5">Outcome:
Decrease risky driving behaviors</td></tr>
</table>

Progress and Measuring Outcomes

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

Wyandot County will continue facilitating Community Health Assessments every three years to collect and track data. Primary data will be collected for adults and youth using national sets of questions to not only compare trends in Wyandot County, but also be able to compare to the state, the nation, and Healthy People 2030. This data will serve as measurable outcomes for each of the priority areas. Indicators have already been defined throughout this report and are identified with the icon.

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

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

Contact Us

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

Wyandot County Public Health
127-A South Sandusky Ave.
Upper Sandusky, OH 43351-1451
(419) 294-3852
Fax (419) 294-6424

Appendix I: Gaps and Strategies

The following tables indicate health behaviors, mental health and addiction, and chronic disease gaps and potential strategies that were compiled by the Wyandot County Health Alliance.

Priority Factor #1: Health Behaviors (focus: adult/youth weight status, adult/youth tobacco use)	
Gaps	**Potential Strategies**
1. Adult/youth tobacco use (4)	• Mass media campaign on dangers of vaping (2) * • Raise awareness and enforcement of Tobacco 21 law (2) • Emphasis on e-cigarettes/nicotine addiction in youth prevention policies and programs * • Smoke-free policies • School-based vaping prevention programs * • Promote Ohio Tobacco Quit Line • Tobacco cessation access • Tobacco phone cessation programs (e.g., quit lines, text message base health interventions, phone applications) • Alternative solutions for students found with tobacco (e.g., cessation/intervention instead of suspension)
2. Adult/youth nutrition (4)	• Senior citizen farmers market vouchers • Partner with a school to implement health food concessions at events * • Expand community gardens • Healthy, affordable food options available in the community • Nutrition interventions in preschool and child care • WIC nutrition education • WIC breastfeeding education and support • WIC supplemental, highlight nutritious foods and fortified infant formula • WIC referrals to prenatal and pediatric health care & human service programs
3. Adult/youth physical activity (3)	• Expand upon current active transportation opportunities • Community-wide physical activity campaigns • Classroom-based physical activity breaks • Education/promotion of multi-access fitness passes (e.g., Silver Sneakers, Prime)

Ohio SHIP supported strategy
* Aligned with previous Wyandot County CHIP
Policy development, enforcement, or advocacy strategy

Priority Outcome #1: Mental Health & Addiction (focus: adult/youth mental health & suicide, adult/youth marijuana use, youth alcohol use, youth bullying)	
Gaps	**Potential Strategies**
1. Adult/youth mental health (5)	• Promote crisis lines in schools, hospitals, doctor's offices (3) * • Standardized depression screening in schools with follow-up/referral * • Targeted cognitive behavioral therapy interventions for depression and anxiety in schools • Address workforce job stress – encourage employers to allow professional development opportunities about mental health, self-care, resources • Encouragement to seek professional help and use resources available through insurance, workplace, etc.
2. Youth substance use (5)	• Youth-led prevention (2) • School-based alcohol and drug prevention programs * • Parental education on building youth resilience & protective factors, communicating with children about alcohol/drugs * • Complete the **Positive Parenting Program** certification process to allow for continued use of the program * • **Sober Truth** * • Increase awareness of available parenting programs in the county * • Identify ways to promote the **24/7 Dads** program • Identify areas of concern using **Youth Risk Behavior Survey/Ohio Youth Tobacco Survey** and research youth tobacco, vaping, marijuana prevention programs • Improve parental awareness through the **Hidden in Plain Sight** program • Promote drug-free life
3. Youth bullying (2)	• School-based social and emotional instruction • Anti-bullying programs in schools (e.g., Ram Squad, See Me Hear Me)

Ohio SHIP supported strategy
* Aligned with previous Wyandot County CHIP
Policy development, enforcement, or advocacy strategy

Priority Health Outcome #2: Chronic Disease (focus: adult hypertension, adult diabetes)	
Gaps	**Potential Strategies**
1. Adult hypertension - especially among lower income population (6)	• Screening in adults 18+ * • Yearly screening for adults 40+ and/or at increased risk * • SNAP benefits at farmer's markets • Healthy options in food banks • SNAP benefits at local grocery stores • Linking community resources and clinical services that support systemic referrals, self-management, and lifestyle changes • **A Million Hearts** program • Self-measured blood pressure monitoring interventions to improve blood pressure control • Promote physical activity • Access to care/knowledge of available care & screenings
2. Adult diabetes - especially among lower income population (4)	• Diabetes Prevention Program/Lark App * • Healthy options in food banks • SNAP benefits at farmer's markets • SNAP benefits at local grocery stores • Promote physical activity • Access to care/knowledge of available care & screenings

Ohio SHIP supported strategy
* Aligned with previous Wyandot County CHIP
Policy development, enforcement, or advocacy strategy

Additional Priority #1: Risky Behaviors (focus: risky driving behaviors)	
Gaps	**Potential Strategies**
1. Driving under the influence of alcohol/drugs among adults/teens (3)	• Education/outreach via public events, social media * • Awareness of consequences (e.g., legal matters, incarceration, possible death) • Provide transportation (e.g., shuttles)
2. Distracted driving among adults/teens	• Education surrounding driving laws via public events, social media *

* Aligned with previous Wyandot County CHIP

Appendix II: Links to Websites

Title of Link	Website URL
A Million Heart tools	https://millionhearts.hhs.gov/tools-protocols/action-guides/index.html
Build federal standards to expand sugar-sweetened beverage restrictions in youth-oriented settings	https://www.changelabsolutions.org/sites/default/files/Sugary_Drink_Playbook_FINAL_20180906.pdf3page=28
CDC's National Diabetes Prevention Program (DPP)	https://www.cdc.gov/diabetes-prevention/programs/what-is-the-national-dpp.html
Child-focused advertising restrictions for unhealthy foods & beverages	https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/child-focused-advertising-restrictions-for-unhealthy-foods-beverages
Community gardens	http://www.countyhealthrankings.org/policies/community-gardens
Competitive pricing for health foods	https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/competitive-pricing-for-healthy-foods
Crisis lines	https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/crisis-lines
Diabetes Self-Management Education and Support (DSMES)	https://www.cdc.gov/diabetes/education-support-programs/index.html
Food pantries	http://www.countyhealthrankings.org/policies/healthy-food-initiatives-food-banks
Free water access	https://www.changelabsolutions.org/sites/default/files/Sugary_Drink_Playbook_FINAL_20180906.pdf#page=35
Health Communications in Tobacco Prevention and Control	https://www.cdc.gov/tobacco/stateandcommunity/bp-health-communications/pdfs/health-communications-508.pdf
Healthy People 2030	https://health.gov/healthypeople/objectives-and-data
Hidden in Plain Sight	https://scholarworks.uvm.edu/fmclerk/72/
Lark App	https://www.lark.com/
LifeSkills Training Program	https://www.lifeskillstraining.com/
Mass reach communication initiatives	https://www.cdc.gov/policy/hst/hi5/tobaccointerventions/index.html
Naloxone education and distribution programs	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/naloxone-education-distribution-programs
Ohio Healthy Youth Environments Survey	https://ohyes.ohio.gov/
Ohio Tobacco Quit Line	https://ohio.quitlogix.org/en-US/
PAX Good Behavior Game	http://www.hazelden.org/HAZ_MEDIA/gbg_insert.pdf
Positive Parenting Program (Triple P)	https://www.triplep.net/glo-en/home/
Prime	https://www.primemember.com/

Produce Perks at local stores to offer discounted fresh products	https://produceperks.org/
QPR (Question, Persuade, Refer)	https://qprinstitute.com/about-qpr
Recovery housing	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/housing-first
ROX (Ruling Our Experience)	https://rulingourexperiences.com/#!about_us/csgz
School-based tobacco prevention skill-building programs	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/school-based-tobacco-prevention-skill-building-programs
Silver Sneakers	https://tools.silversneakers.com/
Sober Truth	https://sobertruth4youth.org/
Steps to Respect	https://youth.gov/content/steps-respect%25C2%25AE
Strengthening Families	https://www.strengtheningfamiliesprogram.org/
Taste testing	https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/fruit-vegetable-taste-testing
The Incredible Years	http://www.incredibleyears.com/about/
Tobacco cessation treatments	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/tobacco-cessation-therapy-affordability
Tobacco 21	https://tobacco21.org/state-by-state/
WIC and Senior Citizen Vouchers for Farmers' Markets	https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/wic-senior-farmers-market-nutrition-programs
Wyandot County Health Status Assessment	http://www.wyandothealth.com/
Wyandot Helps	https://wyandothelps.org/
Youth Risk Behavior Study/Ohio Youth Tobacco Survey	https://data.ohio.gov/wps/portal/gov/data/view/youth-risk-behavior-survey-_--youth-tobacco-survey-info
24/7 Dads	https://www.fatherhood.org/program-24-7-dad