Wyandot County

Community Health Improvement Plan

2018-2021

Adopted on

May 31st, 2018

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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

In 2003, the Wyandot County Health Alliance began conducting community health assessments (CHA) for the purpose of measuring and addressing health status. The most recent Wyandot County Community Health Assessment was cross-sectional in nature and included a written survey of adults and adolescents within Wyandot County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention for their national and state Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Surveillance System (YRBSS). This has allowed Wyandot County to compare the data collected in their CHA to national, state and local health trends.

The Wyandot County CHA also fulfills national mandated requirements for the hospitals in our county. H.R. 3590 Patient Protection and Affordable Care Act states that in order to maintain tax-exempt status, not-for-profit hospitals are required to conduct a community health needs assessment at least once every three years and adopt an implementation strategy to meet the needs identified through the assessment.

From the beginning phases of the CHA, community leaders were actively engaged in the planning process and helped define the content, scope, and sequence of the project. Active engagement of community members throughout the planning process is regarded as an important step in completing a valid needs assessment.

The Wyandot County CHA has been utilized as a vital tool for creating the Wyandot County Community Health Improvement Plan (CHIP). The Public Health Accreditation Board (PHAB) defines a CHIP as a long-term, systematic effort to address health problems on the basis of the results of assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A CHIP is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community inclusively and should be done in a timely way.

The Wyandot County Health Department contracted with the Hospital Council of Northwest Ohio, a neutral regional non-profit hospital association, to facilitate the process. The health department then invited key community leaders to participate in an organized process of strategic planning to improve the health of residents of the county. The National Association of City County Health Officer's (NACCHO) strategic planning tool, Mobilizing for Action through Planning and Partnerships (MAPP), was used throughout this process.

The MAPP Framework includes six phases which are listed below:

1. Organizing for success and partnership development
2. Visioning
3. Conducting the MAPP assessments
4. Identifying strategic issues
5. Formulating goals and strategies
6. Taking action: planning, implementing, and evaluation

The MAPP process includes four assessments: Community Themes & Strengths, Forces of Change, the Local Public Health System Assessment and the Community Health Status Assessment. These four assessments were used by Wyandot County Health Alliance to prioritize specific health issues and population groups which are the foundation of this plan. The diagram below illustrates how each of the four assessments contributes to the MAPP process.

Figure 1.1 2018-2021 Wyandot County CHIP Overview

Overall Health Outcomes	
↑ Increase Health Status	↓ Decrease Premature Death
Priority Topics	
Mental Health and Addiction	Chronic Disease
Priority Outcomes	
↓ Decrease adult and youth depression ↓ Decrease adult and youth suicide ↓ Decrease adult and youth substance abuse ↓ Decrease youth alcohol use ↓ Decrease youth bullying ↓ Decrease youth sexual behavior	↓ Decrease adult and youth obesity ↓ Decrease adult diabetes ↓ Decrease adult heart disease ↑ Increase adult nutrition ↓ Decrease adult and youth food insecurity

Partners

The 2018-2021 Community Health Improvement Plan was drafted by agencies and service providers within Wyandot County. From April to May 2018, the committee reviewed many sources of information concerning the health and social challenges that Wyandot County residents may be facing. They determined priority issues which if addressed, could improve future outcomes; determined gaps in current programming and policies; and examined best practices and solutions. The committee has recommended specific action steps they hope many agencies and organizations will embrace to address the priority issues in the coming months and years. We would like to recognize these individuals and thank them for their devotion to this process and body of work:

Wyandot County Health Alliance

Tami Baumberger, OSU Extension, SNAP Ed Program
Fortune Bormuth, Wyandot Memorial Hospital
Michelle Clinger, Firelands
Jamie Delaney, Hospice of Wyandot County and Home Health
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Jenny Koge, Fairhaven/United Church Homes
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Barbara Mewhorter, Wyandot County Health Department
Gregory Moon, Wyandot County Office of Economic Development
Scott Moore, Open Door Resource Center
Robin Reeves, Mental Health and Recovery Board
Jeff Ritchey, Wyandot County Safe Communities Coalition
Arlene Schriner, Wyandot County Health Department
Darlene Steward, Wyandot County Health Department
Nicole Twarek, Mental Health and Recovery Board
Charla Van Osdol, Firelands
Pam Zimmerly, HHWP Community Action Commission

The community health improvement process was facilitated by Tessa Elliott, Community Health Improvement Coordinator, and Alyssa Miller, Graduate Assistant, from the Hospital Council of Northwest Ohio.

Mission and Vision

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

Alignment with National and State Standards

The 2018-2021 Wyandot County CHIP priorities align with state and national priorities. Wyandot County will be addressing the following priorities: mental health and addiction, and chronic disease.

Ohio State Health Improvement Plan (SHIP)

Note: This symbol will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2017-2019 SHIP.

The 2017-2019 State Health Improvement Plan (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 improve health and wellbeing, the state will track the following health indicators:

- **Self-reported health status** (reduce the percent of Ohio adults who report fair or poor health)
- **Premature death** (reduce the rate of deaths before age 75)

In addition to tracking progress on overall health outcomes, the SHIP will focus on three priority topics:

1. **Mental health and addiction** (includes emotional wellbeing, mental illness conditions and substance abuse disorders)
2. **Chronic Disease** (includes conditions such as heart disease, diabetes and asthma, and related clinical risk factors-obesity, hypertension and high cholesterol, as well as behaviors closely associated with these conditions and risk factors- nutrition, physical activity and tobacco use)
3. **Maternal and Infant Health** (includes infant and maternal mortality, birth outcomes and related risk and protective factors impacting preconception, pregnancy and infancy, including family and community contexts)

The SHIP also takes a comprehensive approach to improving Ohio's greatest health priorities by identifying cross-cutting factors that impact multiple outcomes: health equity, social determinants of health, public health system, prevention and health behaviors, and healthcare system and access.

The 2018-2021 Wyandot County CHIP is required to select at least 2 priority topics, 1 priority outcome indicator, 1 cross cutting strategy and 1 cross-cutting outcome indicator to align with the 2017-2019 SHIP. The following Wyandot County CHIP priority topics, outcomes and cross cutting factors very closely align with the 2017-2019 SHIP priorities:

2018-2021 Wyandot CHIP Alignment with the 2017-2019 SHIP			
Priority Topics	*Priority Outcomes*	*Cross-Cutting Factors*	*Cross-Cutting Indicators*
Mental and addiction	• Decrease depression • Decrease suicide • Decrease unintentional drug overdose deaths	• Social Determinants of Health • Public Health System, Prevention and Health Behavior • Healthcare System and Access	• Increase mental health provider availability • Increase kindergarten readiness • Reduce obesity
Chronic Disease	• Decrease diabetes • Decrease heart disease		

To align with and support ***mental health and addiction***, Wyandot County will work to administer school-based mental health services, raise awareness of the cell phone-based support program, increase awareness of Trauma Informed Care, continue medication assisted treatment (MAT) and increase continuing education for primary care and substance use disorder providers. Additionally, Wyandot County will work to implement the following school-based programs: Question, Persuade, Refer (QPR); ROX (Ruling Our Experience); PAX Good Behavior Game; Steps to Respect; Life Skills; and the Sober Truth program. Lastly, Wyandot County will work to increase recruitment for mental health professionals as a cross-cutting strategy.

To align with and support ***chronic disease***, Wyandot County will work to establish a food insecurity screening and referral process, implement a fruit and vegetable prescription program (FVRx), implement the National Diabetes Prevention Program (DPP) and increase prediabetes screening and referral, implement healthy food initiatives including expanding community gardens, establish a shared use agreement, and implement community fitness programs and nutrition policies within the community. Lastly, Wyandot County will work to implement a community-wide physical activity campaign as a cross-cutting strategy.

U.S. Department of Health and Human Services National Prevention Strategies

The Wyandot County Community Health Improvement Plan also aligns with three of the National Prevention Strategies for the U.S. population: healthy eating, mental and emotional well-being and preventing drug abuse.

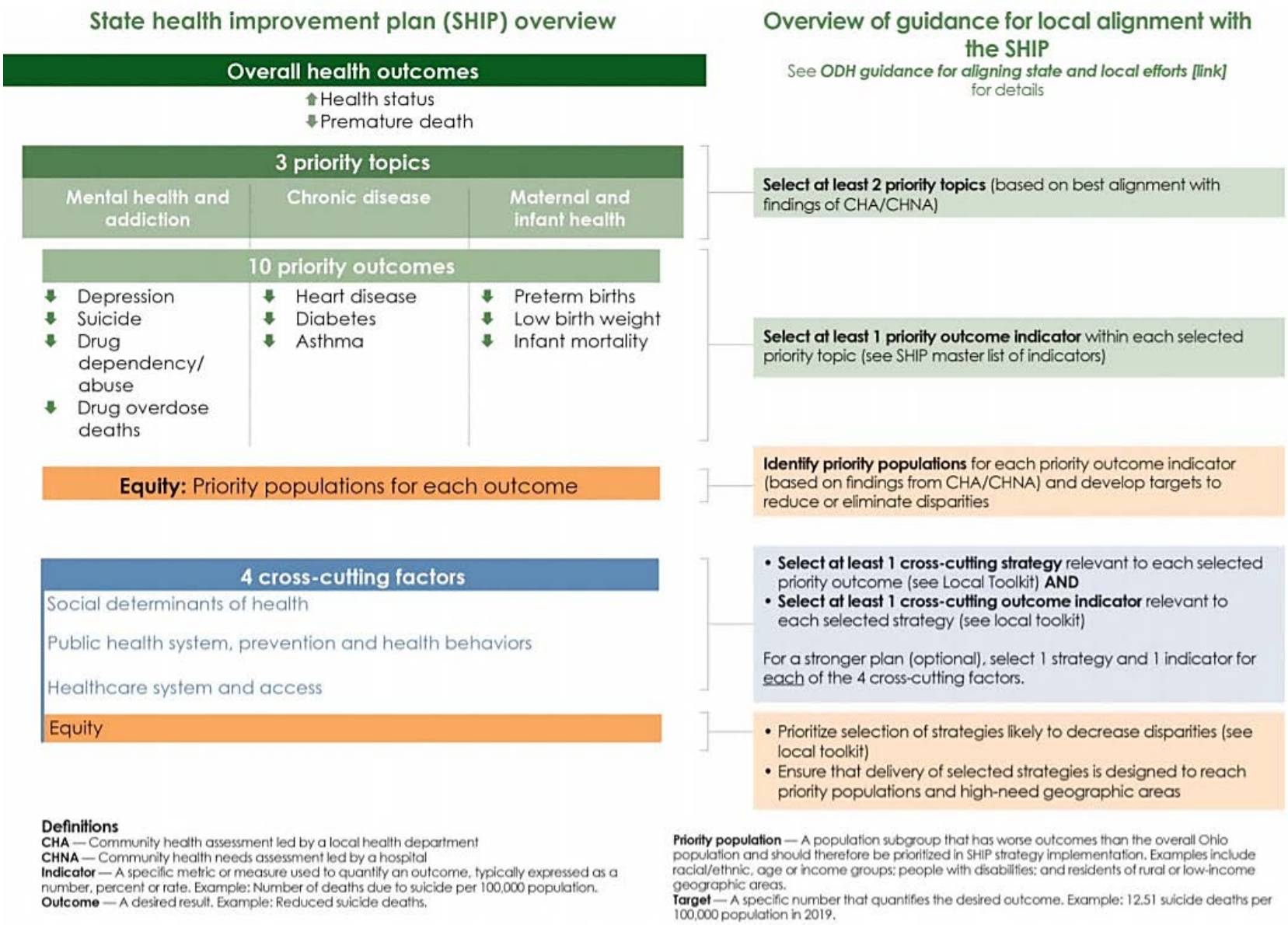
Healthy People 2020

Wyandot County's priorities also fit specific Healthy People 2020 goals. For example:

- Mental Health and Mental Disorders (MHMD)-1: Reduce the suicide rate
- Diabetes (D)-15: Increase the proportion of persons with diabetes whose condition has been diagnosed

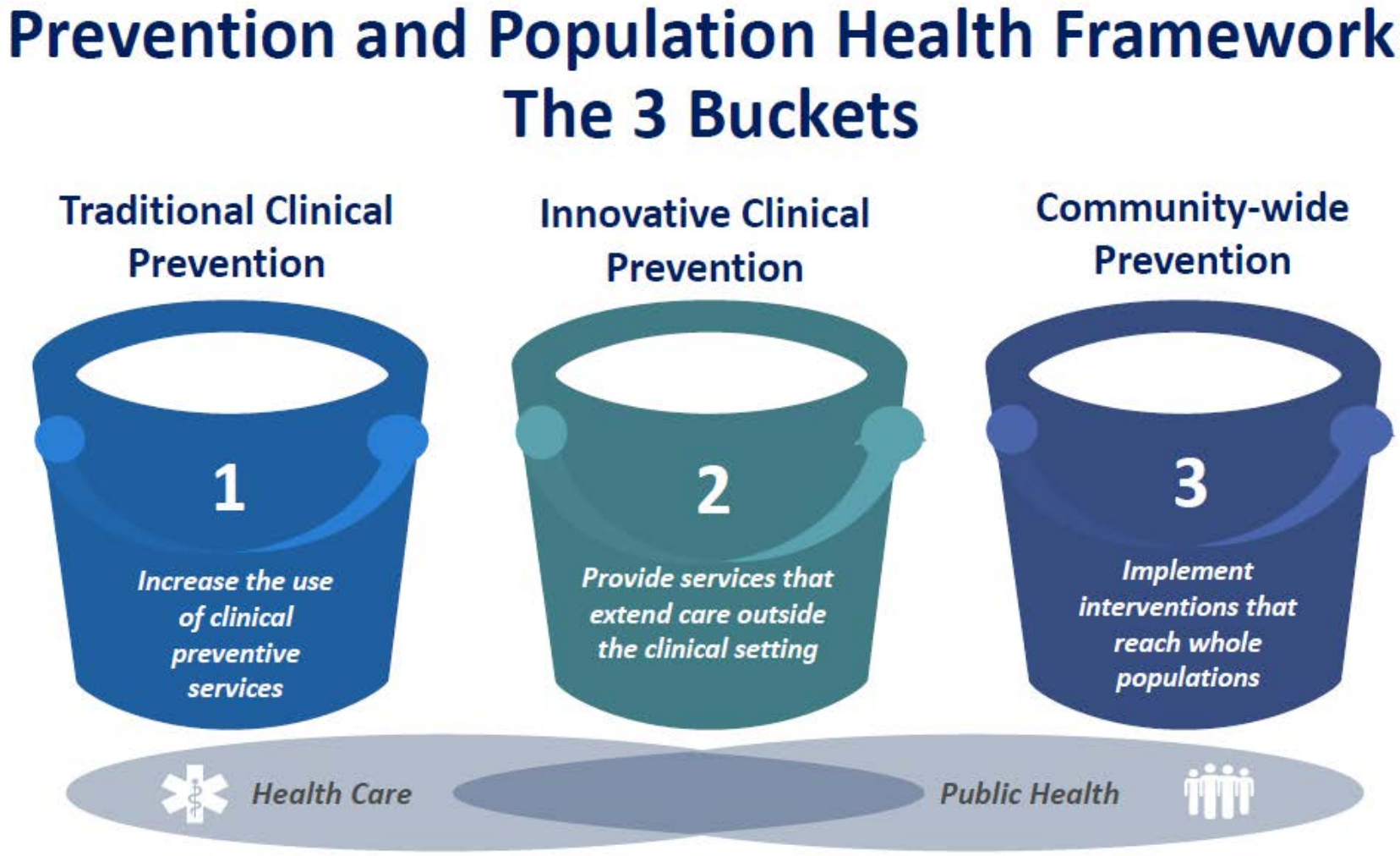
Alignment with National and State Standards, continued

Figure 1.2 2017-2019 State Health Improvement Plan (SHIP) Overview



Alignment with National and State Standards, continued

Figure 1.3 The 3 Buckets of Prevention Overview



(Source: Auerbach J. The 3 Buckets of Prevention. Journal of Public Health Management and Practice)

Strategic Planning Model

Beginning in April 2018, Wyandot County Health Alliance met four (4) times and completed the following planning steps:

1. **Initial Meeting:** Review of process and timeline, finalize committee members, create or review vision
2. **Choosing Priorities:** Use of quantitative and qualitative data to prioritize target impact areas
3. **Ranking Priorities:** Ranking the health problems based on magnitude, seriousness of consequences, and feasibility of correcting
4. **Resource Assessment:** Determine existing programs, services, and activities in the community that address the priority target impact areas and look at the number of programs that address each outcome, geographic area served, prevention programs, and interventions
5. **Forces of Change and Community Themes and Strengths:** Open-ended questions for committee on community themes and strengths
6. **Gap Analysis:** Determine existing discrepancies between community needs and viable community resources to address local priorities; identify strengths, weaknesses, and evaluation strategies; and strategic action identification
7. **Local Public Health Assessment:** Review the Local Public Health System Assessment with committee
8. **Quality of Life Survey:** Review results of the Quality of Life Survey with committee
9. **Best Practices:** Review of best practices and proven strategies, evidence continuum, and feasibility continuum
10. **Draft Plan:** Review of all steps taken; action step recommendations based on one or more of the following: enhancing existing efforts, implementing new programs or services, building infrastructure, implementing evidence based practices, and feasibility of implementation

Action Steps

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

Mental Health

1. Administer school-based mental health services
2. Implement universal school-based suicide awareness and education programs
3. Implement school-based social and emotional instruction
4. Implement school-based violence and bullying prevention programs
5. Raise awareness of cell phone-based support program
6. Increase awareness of Trauma Informed Care

Addiction

1. Medication Assisted Treatment (MAT)
2. Increase continuing education for primary care and substance use disorder providers
3. Implement school-based alcohol/other drug prevention programs

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

1. Food insecurity screening and referral
2. Implement a fruit and vegetable prescription program (FVRx)
3. Implement the National Diabetes Prevention Program (DPP) and Increase prediabetes screening and referral
4. Implement healthy food initiatives
5. Shared use (joint use agreements)
6. Implement community fitness programs
7. Implement nutrition policies within the community

To address **all priority areas**, the following cross-cutting strategies are recommended:

1. Increase awareness of transportation opportunities
2. Increase recruitment for mental health professionals
3. Early childhood home visiting program
4. Implement a community-wide physical activity campaign

Needs Assessment

Wyandot County Health Partners reviewed the 2018 Wyandot County Health Assessment. The detailed primary data for each individual priority area can be found in the section it corresponds to. Each member completed an "Identifying Key Issues and Concerns" worksheet. The following tables were the group results.

What are the most significant <u>ADULT</u> health issues or concerns identified in the 2018 assessment report? Examples of how to interpret the information include: 42% of Wyandot County adults were obese: 47% of those ages 30-64, 51% of those with an income less than $25,000, and 48% of females.

Key Issue or Concern	Percent of Population At risk	Age Group or Income Level Most at Risk	Gender Most at Risk
Weight Status (11 votes)			
Obese	42%	Age: 30-64 (47%), Income: <$25K (51%)	Female (48%)
Overweight	37%	Age: <30 (52%), Income: $25K Plus (39%)	Male (45%)
Mental Health (11 votes)			
Considered attempting suicide in the past year	3%	N/A	N/A
Adults who looked for a program specifically for depression or anxiety but did not find one	27%	N/A	N/A
Adults who looked for a program specifically for alcohol abuse but did not find one	33%	N/A	N/A
Had not thought about using a program or services for themselves or a loved one to help with depression, anxiety or emotional problems	9%	N/A	N/A
Drug Use (8 votes)			
Adults who used marijuana in the past 6 months	6%	Age: <30 (7%)	N/A
Adults who used recreational drugs in the past 6 months	3%	N/A	N/A
Alcohol Use (7 votes)			
Current drinker	56%	Income: $25K Plus (63%)	N/A
Cardiovascular Disease (CVD) (6 votes)			
Had angina or coronary heart disease	6%	Age: 65+ (11%)	N/A
Had a heart attack	5%	Age: 65+ (14%)	N/A
Had a stroke	4%	Age: 65+ (7%)	N/A
Had high blood pressure	38%	Age: 65+ (70%); Income <$25K (45%)	Male (42%)
Had high blood cholesterol	41%	Age: 65+ (55%); Income <$25K (55%)	Male (45%)

Key Issue or Concern	Percent of Population At risk	Age Group or Income Level Most at Risk	Gender Most at Risk
Diabetes (3 votes)			
Had been diagnosed with diabetes	12%	Age: 65+ (26%); Income<$25K (18%)	Female (13%)
Food Insecurity (2 votes)			
Had experienced at least one food insecurity issue in the past year	19%	N/A	N/A
Had to choose between paying bills and buying food	13%	N/A	N/A
Did not eat because they did not have enough money for food	3%	N/A	N/A
Nutrition (2 votes)			
Adults who ate 1 to 2 servings of fruit per day	74%	N/A	N/A
Adults who ate 1 to 2 servings of vegetables per day	76%	N/A	N/A
Prescription Medication Misuse (2 votes)			
Adults who misused prescription medication in the past 6 months	7%	Income: <$25K (11%)	Female (8%)
Quality of Life (1 vote)			
Limited in some way because of physical, mental, or emotional problems	28%	Age: 65+ (37%); Income: <$25K (40%)	Female (34%)
Tobacco Use (1 vote)			
Current smoker	19%	Age: 30-64 (25%); Income <$25K (28%)	Female (22%)
Women's Healthcare Access (1 vote)			
Had a clinical breast exam in the past two years (age 40 and over)	67%	N/A	N/A
Had a mammogram in the past two years (age 40 and over)	73%	N/A	N/A
Had a Pap smear in the past three years	58%	N/A	N/A
Health Status Perception (1 vote)			
Rated their health as fair poor	15%	Age: 65+ (20%); Income <$25K (27%)	N/A

What are the most significant YOUTH health issues or concerns identified in the 2018 assessment report? Examples of how to interpret the information include: 29% of all Wyandot County youth felt sad or hopeless every day for two or more weeks in a row: 31% of those ages 13 or younger, 30% of those in grades 9-12, and 38% of females.

Key Issue or Concern	Percent of Population At risk	Age Group or Grade Level Most at Risk	Gender Most at Risk
Mental Health and Suicide (13 votes)			
Felt sad or hopeless every day for two or more weeks in a row	29%	Age: 13 or younger (31%); Grade Level: 9-12 (30%)	Female (38%)
Seriously considered attempting suicide	14%	Age: 14-16 (17%); Grade Level: 9-12 (16%)	Female (19%)
Attempted suicide	11%	Age: 17+ (17%); Grade Level: 9-12 (13%)	Male (12%)
Weight Status (10 votes)			
Obese	19%	Age: 14-16 (21%)	Male (24%)
Overweight	11%	Age: 14-16 (13%)	Female (15%)
Tobacco Use (10 votes)			
Current smoker	6%	Age: 17+ (10%); Grade Level: 9-12 (9%)	Male (7%)
Ever tried cigarette smoking	22%	Age: 17+ (35%); Grade Level: 9-12 (31%)	N/A
Used an e-cigarette in the past year	14%	N/A	N/A
Tried an electronic vapor product for the first time before the age of 13 (of all youth)	3%	N/A	N/A
Substance Abuse (10 votes)			
Parent gave it to them (of those youth who misused prescription medications)	67%	N/A	N/A
Youth did not use drugs because their parents would be upset	60%	N/A	N/A
No risk associated with smoking marijuana once or twice a week	21%	N/A	N/A
Used marijuana in the past month	3%	Age: 17+ (8%)	N/A
Prescription medication abuse in the past month	2%	N/A	N/A
Sexual Behavior (9 votes)			
Ever had sexual intercourse	26%	Age: 17+ (69%); Grade Level: 9-12 (42%)	Female (29%)
Ever participated in oral sex	20%	Age: 17+ (52%)	Female (22%)
Ever participated in anal sex	5%	Age 17+ (13%)	N/A
Had sexual intercourse with four or more persons (of all youth during their life)	7%	Grade Level: 9-12 (11%)	N/A

Key Issue or Concern	Percent of Population At risk	Age Group or Grade Level Most at Risk	Gender Most at Risk
Bullying (7 votes)			
Bullied in the past year	44%	N/A	N/A
Bullied on school property in the past year	30%	N/A	N/A
Electronically bulled in the past year	11%	Age: 13 or younger (15%)	Female (16%)
Carried a weapon in the past 30 days	11%	Age: 13 or younger (14%)	Male (16%)
Threatened for injured with a weapon on school property in the past 12 months	11%	Grade Level: 9-12 (12%)	N/A
Alcohol Use (7 votes)			
Ever tried alcohol	43%	Age: 17+ (65%); Grade Level 9-12 (55%)	Female (45%)
Current drinker	13%	Age: 17+ (21%); Grade Level 9-12 (18%)	N/A
Binge Drinker	9%	Age: 17+ (17%); Grade Level 9-12 (13%)	Female (10%)
Binge Drinker (of current drinkers)	70%	Age: 17+ (80%)	N/A
A parent gave them alcohol (of current drinkers)	31%	N/A	N/A
Someone else gave them alcohol (of current drinkers)	38%	N/A	N/A
Body Image (2 votes)			
Described themselves as slightly or very overweight	32%	N/A	N/A
Tried to lose weight	52%	N/A	Female (61%)

Priorities Chosen

Based on the 2018 Wyandot County Health Assessment, key issues were identified for adults and youth. Committee members then completed a ranking exercise, giving a score for magnitude, seriousness of the consequence and feasibility of correcting, resulting in an average score for each issue identified. Committee members' rankings were then combined to give an average score for the issue.

The rankings were as follows:

Health Issue	**Average Score**
Youth mental health	26.5
Adult cardiovascular disease	24.7
Youth substance abuse (including tobacco use)	24.6
Adult mental health	24.4
Adult substance abuse	24.0
Youth obesity	23.6
Youth bullying	23.1
Youth alcohol use	22.4
Youth sexual behavior	21.2
Food insecurity and nutrition	20.9

Wyandot County will focus on the following two priority area over the next three years:

1. Chronic disease (*includes adult and youth obesity, adult diabetes, adult heart disease, adult nutrition, and food insecurity)*
2. Mental health and addiction *(includes adult and youth depression, suicide, adult and youth substance abuse, youth alcohol use, youth bulling and youth sexual behavior)*

Community Themes and Strengths Assessment

Wyandot County Health Alliance participated in an exercise to discuss community themes and strengths. The results were as follows:

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

   - Good employment opportunities
   - Easy access to healthcare
   - Citizens advocating for their own health needs
   - Community takes care of their vulnerable populations (i.e. the old, sick)
   - Agency collaboration
   - Safety
   - Appearance of the community (cleanliness, etc.)
   - Food security (food is easily accessible and affordable)
   - Parks, places for recreation, and sidewalks
   - A variety of local merchants

2. **What makes you most proud of our community?**

   - The appearance of the community (i.e. parks, walkability)
   - Wyandot Memorial Hospital
   - The history of Wyandot County
   - Wyandot County schools
   - A very warm and compassionate community
   - Good, local leaders
   - Collaboration of diverse people and organizations (i.e. economic development working with healthcare)

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

   - Wyandot County Health Alliance
   - Wyandot Memorial Hospital
   - Economic Development
   - Safety Council
   - Transportation coalition
   - Community service organizations (i.e. rotary, Kiwanis)
   - 4-H
   - Open Door
   - Family and Children First Council (FCFC)
   - Wyandot County Health Department
   - Wyandot County Home
   - Leading Age Ohio
   - Highway Clean Up
   - County Commissioners and other public leadership
   - Angel Line
   - Community Council

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?**

- Food insecurity
- Community isolation
- Access to quality and affordable food
- Lack of home ownership (increase in home rentals)
- Drug use within the community
- Lack of overall family support
- Younger adults are living in nursing homes
- Economic opportunity
- Lack of transportation
- Quality adult and child daycare

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

- Money and resources
- Lack of motivation (especially among those who need the services)
- Drug addiction among parents
- Decline of population in Wyandot County
- Additional people and organizations at the table from other areas
- Complacency
- Mandates at the national, state and local levels
- Central services located in just one area of the county

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

- Mental health levy
- Safe communities grant
- Funding for low income housing through the USDA
- Government incentivized health programming
- Walkability within the county
- Affordable housing
- Mentoring programs for youth

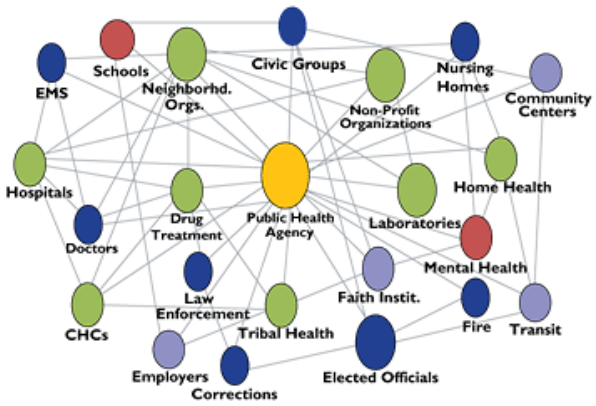
7. **What would excite you enough to become involved (or more involved) in improving our community?**

- Motivation from the community members
- Smaller communities within the county getting involved
- Having more community events to involve community members and organizations
- Leadership development opportunities

The Local Public Health System

Public health systems are commonly defined as "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction." This concept ensures that all entities' contributions to the health and well-being of the community or state are recognized in assessing the provision of public health services.

The public health system includes:

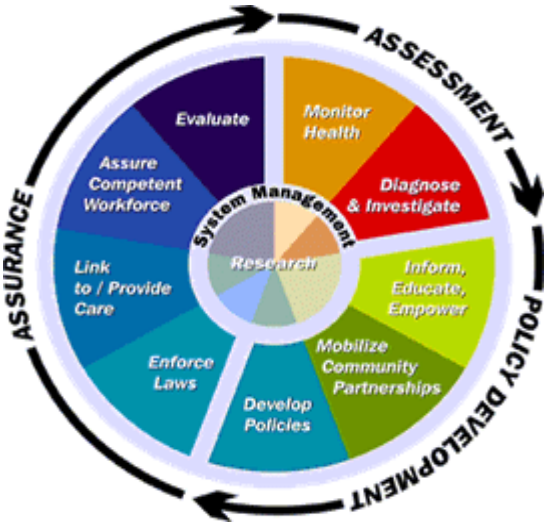


- Public health agencies at state and local levels
- Healthcare providers
- Public safety agencies
- Human service and charity organizations
- Education and youth development organizations
- Recreation and arts-related organizations
- Economic and philanthropic organizations
- Environmental agencies and organizations

The 10 Essential Public Health Services

The 10 Essential Public Health Services describe the public health activities that all communities should undertake and serve as the framework for the NPHPS instruments.

Public health systems should:



1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

(Source: **Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services**)

The Local Public Health System Assessment (LPHSA) answers the questions, "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services being provided to our community?"

This assessment involves the use of a nationally recognized tool called the **National Public Health Performance Standards Local Instrument.**

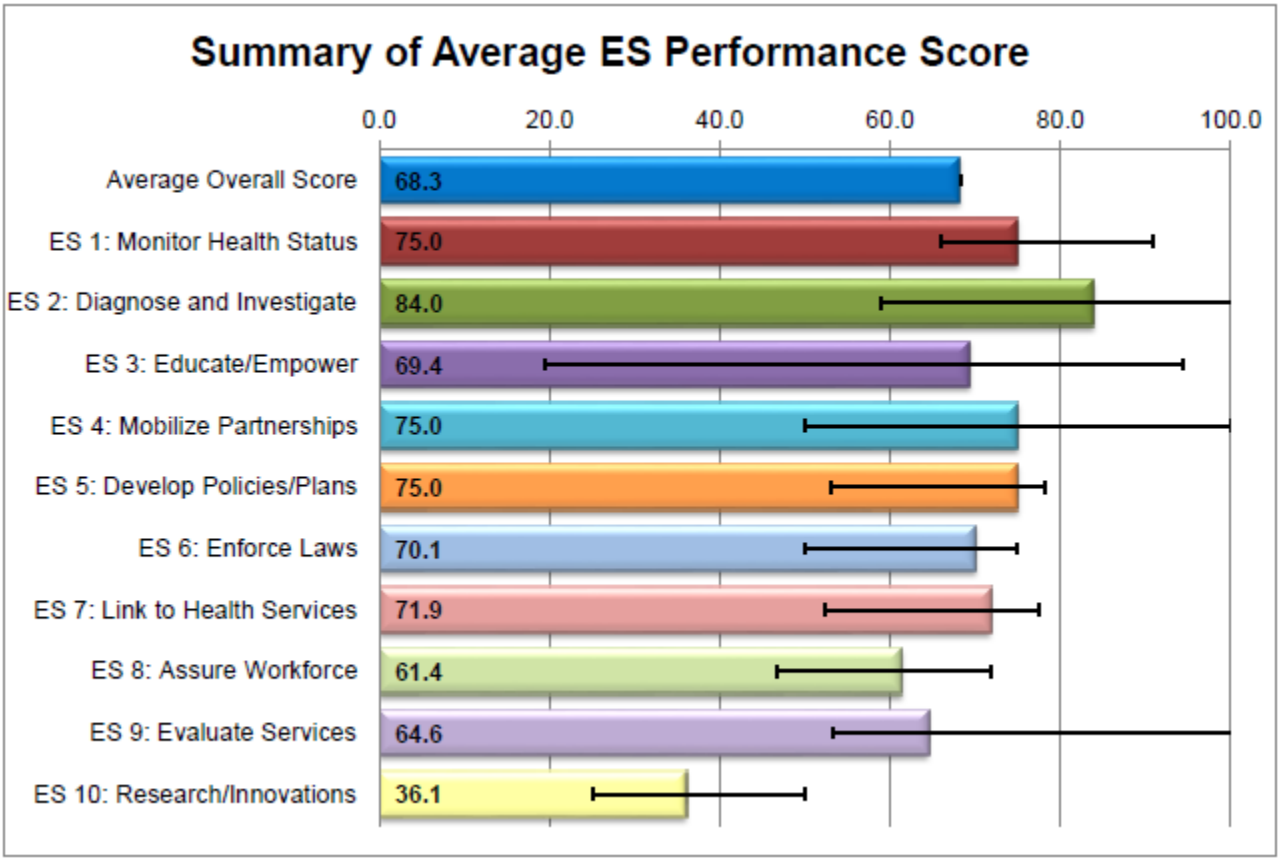
Members of the Wyandot County Health Department completed the performance measures instrument. The LPHSA results were then presented to the full CHIP committee for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard was discussed and the group came to a consensus on responses for all questions. The challenges and opportunities that were discussed were used in the action planning process.

The CHIP committee identified 7 indicators that had a status of "minimal" and 0 indicators that had a status of "no activity." The remaining indicators were all moderate, significant or optimal.

As part of minimum standards, local health departments are required to complete this assessment at least once every five years.

To view the full results of the LPHSA, please contact Barbara Mewhorter from the Wyandot County Health Department at (419) 294-3852.

Wyandot County Local Public Health System Assessment 2018 Summary



Forces of Change Assessment

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 near future. The table below summarizes the forces of change agent and its potential impacts.

Force of Change	Potential Impact
1. Declining population	• Program sustainability • Not as many young people in Wyandot County • Low birth rate: people choosing to have children later or not at all • Aging population: who will care for the older generation?
2. 2018 mid-term election	• New governor could have new policies or mandates • Also new directors at the state level (ODH, etc.)
3. Urgent care expansion	• An urgent care opened in Memorial Hospital a couple years ago and recently just extended their hours • Could also see a decrease in people using a primary care physician (PCP) and instead using the urgent care
4. Lack of mental health professionals, physicians and dentists	• People are not able to see a health professional within an adequate timeframe or seek care outside of county
5. Millennials	• Develop new ways to reach out and connect with the Millennial population; use more technology
6. Social media and technology	• Increases feelings of isolation, mental health issues and self esteem • Online shopping can have negative effects including financial crisis • Major supermarkets are engaging with new technology (i.e. scan and go, "Click list"); possibly no cashiers?
7. Transportation	• A robust transportation system could entice young people to live in the county including having driving apps like Uber and Lyft
8. Economy	• Increase in interest rates and consumer prices, gas prices are also increasing • People cannot pay their healthcare bills; healthcare facilities are losing money on Medicaid
9. Affordable Healthcare Act (ACA)	• There is still difficulty navigating the health insurance marketplace
10. Cost of education	• Education dictates what type of job a person will get and how much they then will contribute to the economy • Encourage high school students to take up a trade
11. Mental health and addiction	• Still a stigma associated with receiving help for mental health and addiction issues • Inability to cope with life stressors and pain management cause addiction, and specifically opiate addiction • Opiate crisis is causing an increase in the number of children in the foster care system
12. Medical marijuana legalization	• Normalization of marijuana (youth thinking marijuana is "OK" since it's medicine)
13. Excessive alcohol use	• Alcohol use is being ignored due to the opiate crisis

Quality of Life Survey

The Wyandot County Health Alliance urged community members to fill out a short quality of life survey via Survey Monkey. There were 207 Wyandot County community members who completed the survey. 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, was assigned a value of 0 (zero) and the response was not used in averaging response or calculating descriptive statistics.

Quality of Life Questions	**Likert Scale Average Response 2015** *n=112*	**Likert Scale Average Response 2018** *n=207*
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]	4.28	4.20
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.83	3.81
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	4.29	4.28
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.)	4.28	4.17
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.)	3.17	3.46
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?)	4.31	4.29
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?	4.13	4.03
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.96	3.90
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.16	3.60
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.51	3.59
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.79	3.71
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?)	3.78	3.74

Resource Assessment

Based on the chosen priorities, Wyandot County Health Alliance were asked to complete a resource inventory for each priority. The resource inventory allowed the committee to identify existing community resources, such as programs, exercise opportunities, free or reduced cost health screenings, and more. The committee was then asked to determine whether a program or service was evidence-based, a best practice, or had no evidence indicated based on the following parameters:

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. A **non-evidence based practice** has neither no documentation that it has ever been used (regardless of the principals it is based upon) nor has been implemented successfully with no evaluation.

Each resource assessment can be found at the following websites:

Mental Health and Recovery Services Board of Seneca, Sandusky and Wyandot Counties

Wyandot County Public Health

Mental Health Indicators

Adult Mental Health

Three percent (3%) of Wyandot County adults considered attempting suicide in the past year.

According to the Ohio Department of Health, there were three (3)* adult suicide deaths in Wyandot County in 2017.

Youth Mental Health

In 2018, over one-quarter (29%) of youth reported they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities, increasing to 38% of females (YRBS reported 26% for Ohio in 2013 and 30% for the U.S. in 2015).

Fourteen percent (14%) of youth reported they had seriously considered attempting suicide in the past 12 months, increasing to 19% of females (2013 YRBS reported 14% for Ohio and 18% for the U.S. in 2015).

Eleven percent (11%) of Wyandot County youth had attempted suicide in the past year. The 2015 YRBS reported a suicide attempt prevalence rate of 9% for U.S. youth and a 2013 YRBS rate of 6% for Ohio youth.

In the past year, 30% of youth had been bullied on school property (YRBS reported 21% for Ohio in 2013 and 20% for the U.S. in 2015)

Eleven percent (11%) of youth were electronically bulled in the past year.

Twenty-six percent (26%) of Wyandot County youth had sexual intercourse, increasing to 69% of those ages 17 and over.

**Years are considered partial and may be incomplete per Ohio Department of Health*

The table below indicates correlations between those who contemplated suicide in the past 12 months and participating in risky behaviors, as well as other activities and experiences. Examples of how to interpret the information include: 76% of those who contemplated suicide were bullied in the past 12 months, compared to 38% of those who did not contemplate suicide.

Behaviors of Wyandot County Youth

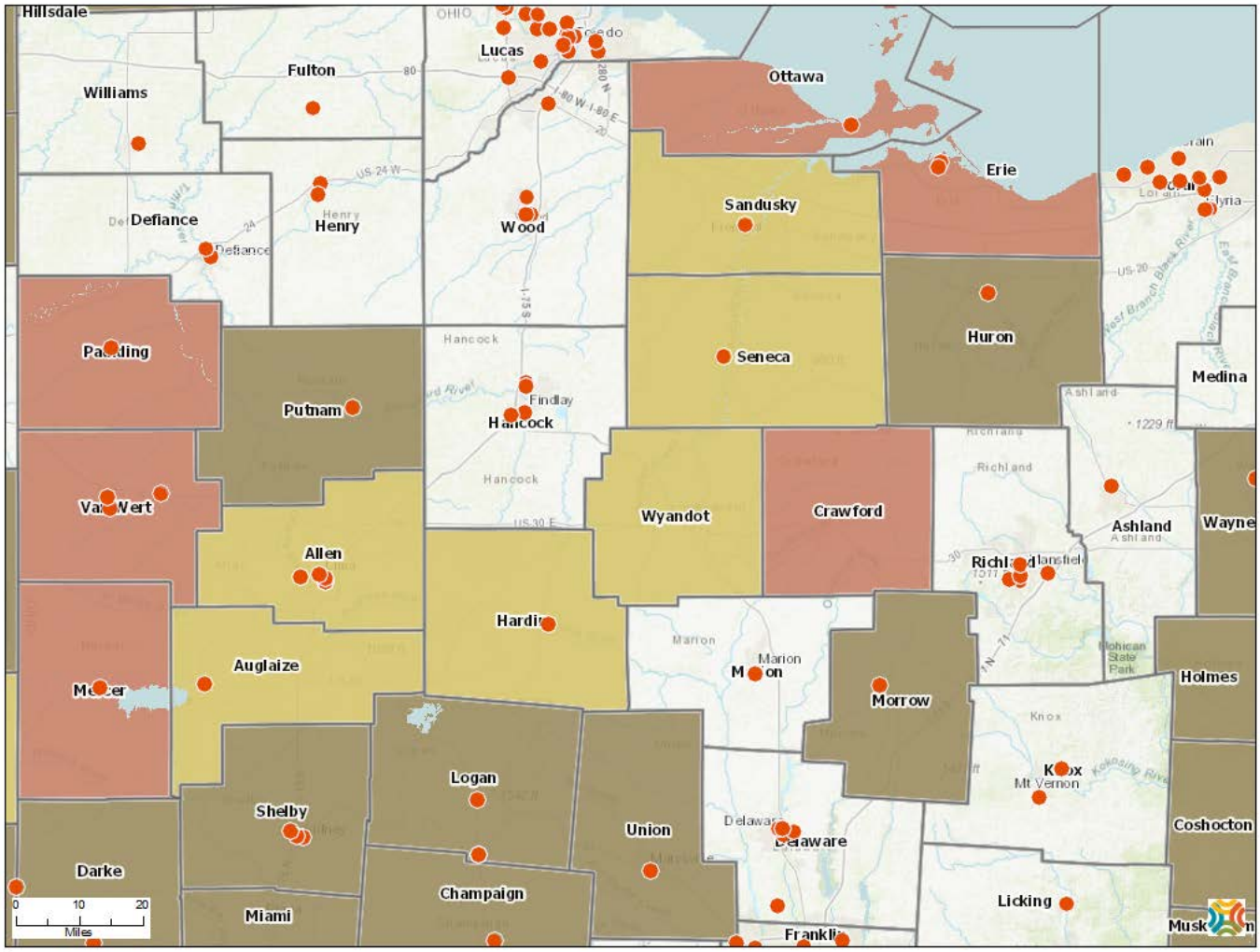
Contemplated Suicide vs. Did Not Contemplate Suicide

Youth Behaviors	Contemplated Suicide	Did Not Contemplate Suicide
Bullied (in the past 12 months)	76%	38%
Smoked cigarettes (in the past 30 days)	25%	3%
Had at least one drink of alcohol (in the past 30 days)	24%	11%
Used marijuana (in the past 30 days)	7%	2%

"Contemplated suicide" indicates youth who self-reported seriously considering attempting suicide in the past year.

Map: Health Professional Shortage Area

Health Professional Shortage Area – Mental Health, HRSA HPSA Database April 2016



Map Legend

- Mental Health Treatment Facilities, SAMHSA Feb. 2017

Health Professional Shortage Area - Mental, Designated Population Type by Shortage Area, HRSA HPSA Database April 2016

- HPSA Geographic High Needs
- HPSA Geographic
- HPSA Population

Community Commons, 5/14/2018

(Source: US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration: April 2016, as compiled by Community Commons; US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration: Feb. 2017, as compiled by Community Commons.)

Description of indicator: The map displays the location and characteristics of HPSAs or Health Professional Shortage Areas. HPSAs are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility).

Gaps and Potential Strategies

Gaps	Potential Strategies
Youth depression and mental health	• Expand youth mentoring program • Involve the schools in decision making process
Wait list for mental health services (for adults and youth)	• Consider having mental health specialty care at the Hospital (specialists that come from outside the county) • Enlist different strategies to recruit mental health and substance abuse providers into the county including providing incentives (i.e. sign-in bonuses) • Hire additional school counselors and mental health and substance abuse professionals into the schools
Lack of prevention programming	• CARSA coalition is not fully funded within Wyandot County • Hire a prevention program specialist • Expand the LifeSkills program
No beds for mental health within the county for adults or youth (plenty of beds for addiction and substance abuse)	• There are no child or adolescent mental health beds in county, need to travel outside county (Columbus, Akron, Cleveland) • Adult beds within county are based on availability
Transportation	• RSVP program is a volunteer driven program. Offer a transportation program where you must be 50 and older to drive and but can serve all ages. • Consider bringing Uber or Lyft services into the county; must encourage people to drive • Look at expanding transportation services from other counties
Help Me Grow (early home visiting)	• None noted

Best Practices

The following programs and policies have been reviewed and have proven strategies to **improve mental health:**

1. **Trauma-informed care** is a framework that requires change to organizational practices, policies, and culture that reflect an understanding of the widespread impact of trauma and potential paths for recovery, and actively seek to prevent re-traumatization. In health care, TIC usually includes universal trauma precautions and practice changes for patients with a known trauma history. Universal trauma precautions emphasize patient-centered communication and care, often with careful screening for trauma, safe clinical environments (e.g., quiet waiting areas), and shared decision making for all patients. Under a trauma-informed clinical approach, providers collaborate across disciplines, use streamlined referral pathways, and remain aware of their own trauma histories and stress levels when they know patients have experienced trauma. TIC can also be implemented in oral health settings.

2. **Cell phone-based support programs** cell phones, particularly smartphones, offer new opportunities to reach individuals with mental health concerns such as depression, anxiety, post-traumatic stress disorder, and substance abuse. Mobile phone applications (apps) can deliver a form of cognitive behavior therapy, link a user with a medical professional, or allow patients to regularly self-monitor their emotional state and easily share that information with a provider. Texting interventions can include provision of health information, automated reminders, or supportive messages sent to individuals participating in longer term mental health treatment.

3. **Universal school-based suicide awareness and education programs** deliver a curriculum-based approach to suicide prevention to all students, usually in middle or high school settings. Students learn to recognize warning signs of suicide in themselves and others. Programs are often based on a psychoeducational curriculum and use multimedia presentations, lectures, classroom discussion, interactive activities, and role-play.

Expected Beneficial Outcomes
- Reduced suicide
- Increased knowledge of suicide
- Improved coping skills

Other Potential Beneficial Outcomes
- Increased help-seeking behavior

4. **QPR** stands for Question, Persuade, and Refer — the 3 simple steps anyone can learn to help save a life from suicide. Just as people trained in CPR and the Heimlich maneuver help save thousands of lives each year, people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. QPR can be learned in the Gatekeeper course in as little as one hour. Per the Surgeon General's National Strategy for Suicide Prevention (2001), a gatekeeper is someone able to recognize a crisis and the warning signs that someone may be contemplating suicide. Gatekeepers can be anyone, but include parents, friends, neighbors, teachers, ministers, doctors, nurses, office supervisors, squad leaders, foremen, police officers, advisors, caseworkers, firefighters, and many others who are strategically positioned to recognize and refer someone at risk of suicide.

5. **School-based social and emotional instruction** aims to teach children skills such as recognizing and managing emotions and setting and reaching goals, as well as increasing ability to appreciate others' perspectives, establish and maintain relationships, and handle interpersonal situations constructively. Skills may be modeled, practiced, and then applied throughout the school day. Social and emotional learning (SEL) can also be called emotional literacy, emotional intelligence, mental health, resilience, life skills, or character education.

Expected Beneficial Outcomes
- Increased academic achievement
- Increased high school graduation
- Improved social emotional skills
- Increased school engagement
- Increased self-confidence
- Improved mental health
- Improved youth behavior

Other Potential Beneficial Outcomes
- Reduced violence
- Reduced bullying

6. **The Incredible Years®** program for parents and teachers reduce challenging behaviors in children and increase their social and self-control skills. The Incredible Years programs have been evaluated by the developer and independent investigators. Evaluations have included randomized control group research studies with diverse groups of parents and teachers.

The programs have been found to be effective in strengthening teacher and parent management skills, improving children's social competence and reducing behavior problems. Evidence shows that the program has turned around the behaviors of up to 80 percent of the children of participating parents and teachers. If left unchecked these behaviors would mean those children are at greater risk in adulthood of unemployment, mental health problems, substance abuse, early pregnancy/early fatherhood, criminal offending, multiple arrests and imprisonment, higher rates of domestic violence and shortened life expectancy.

Incredible Years training programs give parents and teachers strategies to manage behaviors such as aggressiveness, ongoing tantrums, and acting out behavior such as swearing, whining, yelling, hitting and kicking, answering back, and refusing to follow rules. Through using a range of strategies, parents and teachers help children regulate their emotions and improve their social skills so that they can get along better with peers and adults, and do better academically. It can also mean a more enjoyable family life.

7. **Universal school-based violence prevention programs** provide students and school staff with information about violence, change how youth think and feel about violence, and enhance interpersonal and emotional skills such as communication and problem-solving, empathy, and conflict management. These approaches are considered "universal" because they are typically delivered to all students in a grade or school. Focus may vary among prevention programs according to the ages of the target student population, and programs may focus on either general violence or specific forms of violence such as bullying or dating violence.

8. **ROX (Ruling Our Experience)** is a 501(c)(3) nonprofit organization that provides evidence-based empowerment programming for girls, delivers professional development to educators, teachers, and parents, and conducts research and evaluation focused on girls.

ROX helps girls develop the skills to deal with social, personal, and academic issues including: girl bullying and relational aggression, healthy dating and forming healthy relationships, cyberbullying, body image and the media, navigating social media, dealing with sexual harassment and violence, and leadership development for girls.

Licensed ROX facilitators work with small groups of 10-15 girls for 20 weeks. The validated curriculum provides the structure and content for girls to explore the tough things going on in their lives and develop new ways to communicate, stand up for themselves, and plan for their futures.

9. **Steps to Respect** teaches elementary students to recognize, refuse, and report bullying, be assertive, and build friendships. In fact, a recent study found that the program led to a 31 percent decline in bullying and a 70 percent cut in destructive bystander behavior. Steps to Respect lessons can help kids feel safe and supported by the adults around them, so they can build stronger bonds to school and focus on academic achievement. And the program supports your staff too, with school wide policies and training. Now everyone can work together to build a safe environment free from bullying.

10. **The PAX Good Behavior Game** is a proven, research-based classroom management model designed for use in grades K–6. Based on a strategy developed by a classroom teacher 40 years ago, the PAX Game involves student teams "competing against" each other to earn rewards for refraining from disruptive, inattentive, or aggressive behavior. Approximately 20 published studies have shown that use of this model results in decreased classroom disruptions (by 50–90%), a greater number of students fully engaged in learning (by 20–50%), decreased referrals and suspensions (by 30–60%), and more time for teaching and learning (by 25%). Longitudinal studies have also shown that children who experienced the Good Behavior Game in elementary school were less likely to be involved in violent behaviors later in life and were less likely to use tobacco or other drugs later in life.

Action Step Recommendations & Plan

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

1. Administer school-based mental health services
2. Implement universal school-based suicide awareness and education programs
3. Implement school-based social and emotional instruction
4. Implement school-based violence and bullying prevention programs
5. Raise awareness of cell phone-based support program
6. Increase awareness of Trauma Informed Care

Action Plan

<table>
<tr><th colspan="5">Priority Topic: Mental Health</th></tr>
<tr><th colspan="5">Strategy 1: Administer school-based mental health services</th></tr>
<tr><th>Action Step</th><th>Priority Outcome & Indicator</th><th>Priority Population</th><th>Person/ Agency Responsible</th><th>Timeline</th></tr>
<tr><td>Year 1: Implement at least one of the following mental health services in schools:
School-based mental health therapy
Care coordination
Increase awareness of these services. Work with the educational service center and mental health board to secure funding for each district to have their own school-based mental health counselor and/or care coordinator by creating a sustainability plan.</td><td rowspan="3">Priority Outcome:
1. Reduce youth depression
2. Reduce suicide ideation in youth

Priority Indicator:
1. Percent of youth who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities
2. Percent of youth who report that they ever seriously considered attempting suicide within the past 12 months</td><td rowspan="3">Youth</td><td rowspan="3">Nicole Twarek
Mental Health and Recovery Board</td><td>May 31, 2019</td></tr>
<tr><td>Year 2: Continue efforts from year 1.</td><td>May 31, 2020</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2.</td><td>May 31, 2021</td></tr>
</table>

Priority Topic: Mental Health				
Action Step	**Priority Outcomes & Indicators**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy 2: Implement universal school-based suicide awareness and education programs				
Year 1: Gather baseline data on any mental health screening tools that are currently being used by Wyandot County Schools. Continue to offer the **QPR (Question, Persuade, Refer)** prevention program to Wyandot County schools. Secure funding for the program.	**Priority Outcomes:** 1. Reduce suicide deaths 2. Reduce suicide ideation in youth **Priority Indicators:** 1. Number of deaths due to suicide per 100,000 populations (age-adjusted) 2. Percent of youth who report that they ever seriously considered attempting suicide within the past 12 months	Youth	**Darlene Steward** Wyandot County Health Department	May 31, 2019
Year 2: Continue efforts from year 1. Implement the QPR program in all school districts.				May 31, 2020
Year 3: Continue efforts from years 1 and 2.				May 31, 2021
Strategy 3: Implement school-based social and emotional instruction				
Year 1: Continue to introduce **The Incredible Years** program to schools, churches, parents and community members. Work with school administrators, guidance counselors, churches, and other community organizations to raise awareness of the program. Promote and expand the Wyandot County youth mentoring program. Consider appointing or hiring a prevention program specialist to oversee and implement additional prevention programming throughout the county.	**Priority Outcomes:** 1. Reduce youth depression 2. Increase social-emotional skills **Priority Indicators:** 1. Percent of youth who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities 2. Not currently available (per Ohio SHIP)	Youth	**Anne Denman** Family and Children First Council	May 31, 2019
Year 2: Increase awareness and participation of the program(s). Double the number of locations and or schools providing The Incredible Years program.				May 31, 2020
Year 3: Continue efforts from years 1 and 2.				May 31, 2021

Priority Topic: Mental Health				
Strategy 4: School-based violence and bullying prevention programs				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Gather baseline data on which bullying prevention programs are currently being implemented in the schools. Explore evidence-based prevention programs such as the **PAX Good Behavior Game** or **Steps to Respect**. Decide which program(s) will be offered and are sustainable. Work with the guidance counselor at Union Elementary and Middle School to continue to implement the **ROX (Ruling Our Experience)** program.	**Priority Outcome:** 1. Reduce electronic (cyber) bullying 2. Reduce bullying at school **Priority Indicator:** 1. Percent of youth who report being bullied through e-mail, chat rooms, instant messaging, websites, or texting during the past 12 months 2. Percent of youth who report being bullied on school property within the past 12 months	Youth	**Charla Van Osdol** CARSA Coalition, Firelands	May 31, 2019
Year 2: Introduce or re-introduce the evidence based program(s) to the school districts. Pilot any new programs in at least one district. Expand any current programming to other districts or grade levels.				May 31, 2020
Year 3: Expand programming to all districts in all grade levels.				May 31, 2021

Priority Topic: Mental Health				
Action Step	**Priority Outcomes & Indicators**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy 5: Raise awareness of cell phone-based support program				
Year 1: Promote and raise awareness of the Crisis Text Line (Text **4hope** to 741741) throughout the county.	**Priority Outcomes:** Reduce suicide deaths **Priority Indicators:** Number of deaths due to suicide per 100,000 populations (age-adjusted)	Adult and youth	**Nicole Twarek** Mental Health and Recovery Board	May 31, 2019
Year 2: Continue to promote and monitor the use of the Crisis Text Line. Work with school administrators, guidance counselors, churches, and other community organizations to promote the Crisis Text Line.				May 31, 2020
Year 3: Continue efforts from years 1 and 2.				May 31, 2021
Strategy 6: Increase awareness of Trauma Informed Care				
Year 1: Facilitate an assessment among healthcare providers, teachers, coaches, social service providers, and other community members on their awareness and understanding of trauma informed care, including toxic stress and adverse childhood experiences. Administer a training to increase education and understanding of trauma informed care.	**Priority Outcomes:** 1. Reduce suicide ideation in adults 2. Reduce suicide ideation in youth **Priority Indicator:** 1. Percent of adults with suicidal thoughts within the past year 2. Percent of youth who report that they ever seriously considered attempting suicide within the past 12 months	Adult and youth	**Michelle Clinger** Firelands	May 31, 2019
Year 2: Continue efforts from year 1. Develop and implement a trauma screening tool for social service agencies who work with at-risk adults and youth. Increase the use of trauma screening tools by 10%.				May 31, 2020
Year 3: Continue efforts from years 1 and 2. Increase the use of trauma screening tools by 15%.				May 31, 2021

Addiction Indicators

Adult Addiction

According to the Ohio Department of Health, there were three (3)* adult drug overdose deaths in Wyandot County in 2017.

Six percent (6%) of Wyandot County adults had used marijuana in the past 6 months.

Three percent (3%) of Wyandot County adults reported using other recreational drugs in the past six months such as cocaine, synthetic marijuana/K2, heroin, LSD, inhalants, Ecstasy, bath salts, and methamphetamines.

Seven percent (7%) of adults had used medication not prescribed for them or they took more than prescribed to feel good or high and/or more active or alert during the past 6 months, increasing to 11% of those with incomes less than $25,000.

Youth Addiction

In 2018, 13% of youth had at least one drink in the past 30 days, increasing to 21% of those ages 17 and older (YRBS reports 30% for Ohio in 2013 and 33% for the U.S. in 2015).

Thirty-one percent (31%) of youth drinkers reported they got the alcohol they drank from their parent.

Six percent (6%) of youth were current smokers, having smoked at some time in the past 30 days (YRBS reported 15% for Ohio in 2013 and 11% for the U.S. in 2015).

Three percent (3%) of all Wyandot County youth had used marijuana at least once in the past 30 days, increasing to 8% of those over the age of 17. The 2013 YRBS found a prevalence of 21% for Ohio youth and a prevalence of 22% for U.S. youth in 2015.

Two percent (2%) of Wyandot County youth reported using prescription drugs not prescribed for them in the past 30 days.

**Years are considered partial and may be incomplete per Ohio Department of Health*

The table below indicates correlations between current drinkers and participating in risky behaviors, as well as other activities and experiences. Examples of how to interpret the information include: 90% of current drinkers participated in extracurricular activities, compared to 90% of non-current drinkers.

Behaviors of Wyandot County Youth

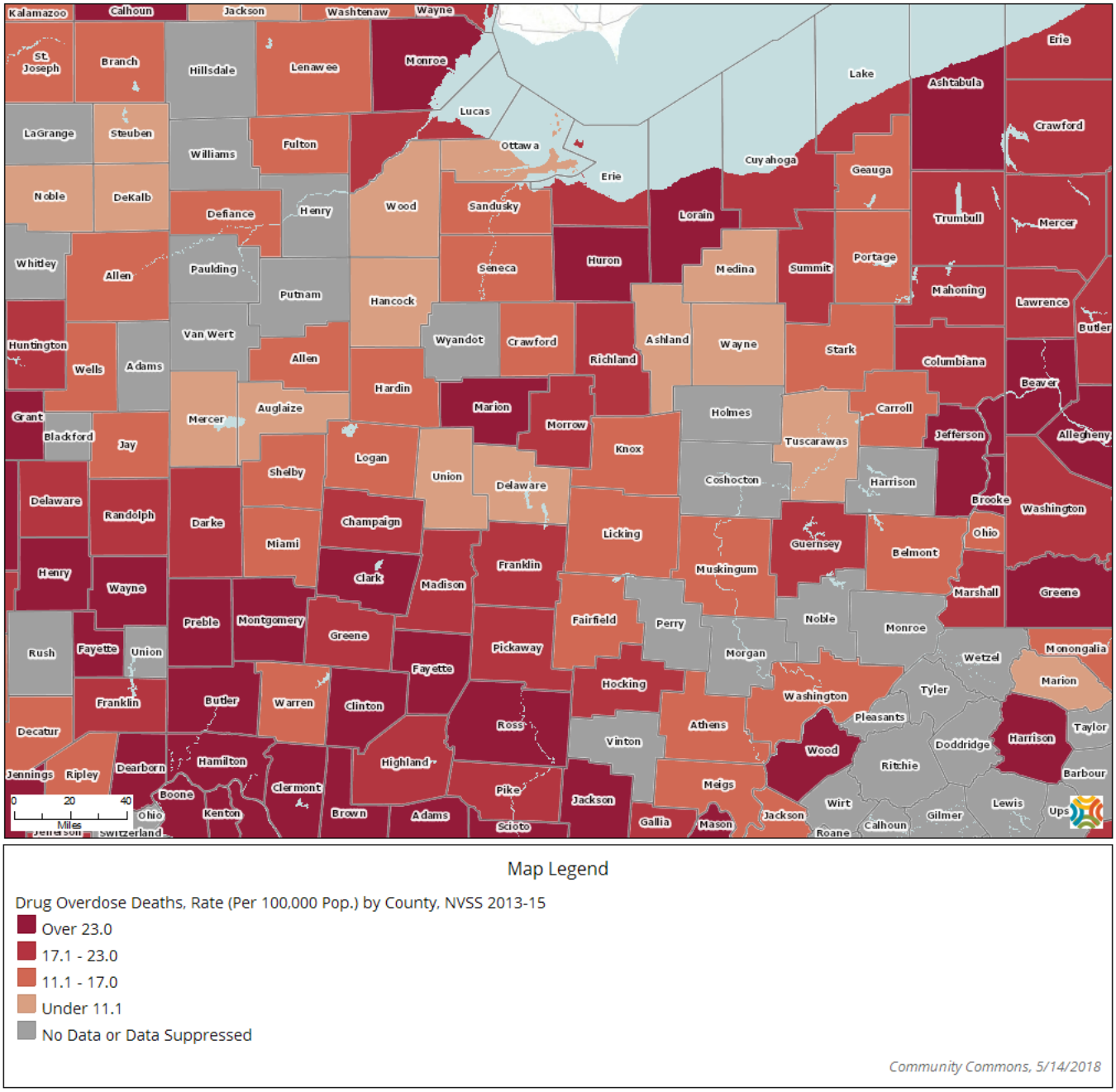
Current Drinker vs. Non-Current Drinker

Youth Behaviors	Current Drinker	Non-Current Drinker
Currently participate in extracurricular activities	90%	90%
Bullied (in the past 12 months)	62%	41%
Had sexual intercourse (in their lifetime)	58%	22%
Experienced 3 or more adverse childhood experiences (ACEs) (in their lifetime)	43%	20%
Seriously considered attempting suicide (in the past 12 months)	27%	12%
Smoked cigarettes (in the past 30 days)	21%	4%
Attempted suicide (in the past 12 months)	21%	10%
Used marijuana (in the past 30 days)	15%	1%
Misused prescription medication (in the past 30 days)	2%	1%

"Current drinker" indicate youth who self-reported having had at least one drink of alcohol during the past 30 days.

Map: Drug Overdose Deaths

Drug Overdose Deaths, Rate (per 100,000) by County, NVSS 2013-2015



Map Legend

Drug Overdose Deaths, Rate (Per 100,000 Pop.) by County, NVSS 2013-15

- Over 23.0
- 17.1 - 23.0
- 11.1 - 17.0
- Under 11.1
- No Data or Data Suppressed

Community Commons, 5/14/2018

(Source: Centers for Disease Control and Prevention, National Vital Statistics System: 2013-15 accessed via County Health Rankings complied by Community Commons.)

Description of indicator: This indicator displays the number and rate of drug overdose deaths per 100,000 population. Drug overdose deaths are deaths caused by poisoning, defined using ICD-10 codes X40-X44, X60-X64, X85, and Y10-Y14. These codes used cover accidental death, intentional death, and deaths of undetermined intention by poisoning and exposure to: 1) nonopioid analgesics, antipyretics and antirheumatics, 2) antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, 3) narcotics and psychodysleptics [hallucinogens], not elsewhere classified, 4) other drugs acting on the autonomic nervous system, and 5) other and unspecified drugs, medicaments and biological substances. Indicator data are from the National Vital Statistics System (NVSS) Compressed Mortality File (CMF). The CMF is a county-level national mortality and population database spanning the years 1968-2015. Data for this indicator are released as part of the County Health Rankings.

Gaps and Potential Strategies

Gaps	Potential Strategies
Lack of prevention programming	• CARSA coalition is not fully funded within Wyandot County • Hire a prevention program specialist • Expand the LifeSkills program
Transportation	• RSVP program is a volunteer driven program. Offer a transportation program where you must be 50 and older to drive and but can serve all ages. • Consider bringing Uber or Lyft services into the county; must encourage people to drive • Look at expanding transportation services from other counties

Best Practices

The following programs and policies have been reviewed and have proven strategies to **improve addiction:**

1. **LifeSkills Training (LST)** is a school-based program that aims to prevent alcohol, tobacco, and marijuana use and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. LST is based on both the social influence and competence enhancement models of prevention. Consistent with this theoretical framework, LST addresses multiple risk and protective factors and teaches personal and social skills that build resilience and help youth navigate developmental tasks, including the skills necessary to understand and resist pro-drug influences. LST is designed to provide information relevant to the important life transitions that adolescents and young teens face, using culturally sensitive and developmentally and age-appropriate language and content. Facilitated discussion, structured small group activities, and role-playing scenarios are used to stimulate participation and promote the acquisition of skills. Separate LST programs are offered for elementary school (grades 3-6), middle school (grades 6-9), and high school (grades 9-12).

2. **Prescription Drug Monitoring Programs (PDMP's)** are electronic databases, housed in state agencies, that track prescribing and dispensing of controlled substances. Most states monitor drugs on Schedules II - IV of the Drug Enforcement Administration's drug schedule; many also include drugs on Schedule V and other controlled substances. Schedule I drugs (e.g., heroin) are not included. PDMPs can be used by prescribers and pharmacists to view prescriptions written for and dispensed to individual patients, by law enforcement agencies to identify drug diversion or pill mills, or by state medical boards to identify potentially problematic prescribers. Drugs monitored, individuals authorized to use the system, functionality, and use varies from state to state.

3. **Medication-Assisted Treatment (MAT)** is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. There are three medications commonly used to treat opioid addiction: Methadone, Naltrexone, and Buprenorphine.

Action Step Recommendations & Plan

To work toward **improving addiction outcomes**, the following strategies are recommended:

1. Medication Assisted Treatment (MAT)
2. Increase continuing education for primary care and substance use disorder providers
3. Implement school-based alcohol/other drug prevention programs

Action Plan

<table>
<tr><th colspan="5">Priority Topic: Addiction</th></tr>
<tr><th>Action Step</th><th>Priority Outcomes & Indicators</th><th>Priority Population</th><th>Person/ Agency Responsible</th><th>Timeline</th></tr>
<tr><td colspan="5">Strategy 1: Medication Assisted Treatment (MAT)</td></tr>
<tr><td>Year 1: Research current available treatment options in Wyandot County.
Continue to provide the vivitrol (naltrexone) injection program through Firelands Physicians Group. Consider expanding the program to other locations.
Determine the feasibility of providing suboxone (buprenorphine) within the county.
Explore partnerships with local mental health providers, hospital and the health department to establish a referral system for treatment.
Explore other treatment options for detox, recovery housing, etc.</td><td rowspan="3">Priority Outcomes:
1. Reduce drug dependence or abuse
2. Reduce unintentional drug overdose deaths

Priority Indicators:
1. Percent of persons age 12+ who report past-year illicit drug dependence or abuse
2. Number of deaths due to unintentional drug overdoses per 100,000 population (age-adjusted)</td><td rowspan="3">Adult</td><td rowspan="3">Michelle Clinger
Firelands</td><td>May 31, 2019</td></tr>
<tr><td>Year 2: Plan and implement a community awareness campaign that will help those with substance use disorder, community members, and other stakeholders recognize signs of substance abuse and where to find treatment.</td><td>May 31, 2020</td></tr>
<tr><td>Year 3: Continue efforts of years 1 and 2.</td><td>May 31, 2021</td></tr>
</table>

Priority Topic: Addiction				
Action Step	**Priority Outcomes & Indicators**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy 2: Increase continuing education for primary care and substance use disorder providers				
Year 1: Work with primary care and substance use disorder providers to assess what information and/or materials they are lacking to provide better care for patients with substance use issues and disorders. Develop a training on opiod prescribing guidelines and the use of **OARRS (Ohio Automated Rx Reporting System)**. Offer the training to local primary care, dental and substance use disorder providers.	**Priority Outcomes:** 1. Reduce drug dependence or abuse 2. Reduce unintentional drug overdose deaths 3. Reduce sales of opioid pain relievers **Priority Indicators:** 1. Percent of persons age 12+ who report past-year illicit drug dependence or abuse 2. Number of deaths due to unintentional drug overdoses per 100,000 population (age-adjusted) 3. Kilograms of opioid pain relievers sold per 100,000 population	Adult	**Charla Van Osdol** CARSA Coalition, Firelands **Fortune Bormuth** Wyandot Memorial Hospital **Kendra Noyes** Wyandot Memorial Hospital	May 31, 2019
Year 2: Offer CME (Continuing Medical Education) trainings for primary care, dental and substance use disorder providers to provide better care for patients with substance abuse issues. Increase training opportunities for prescribers on safe opioid prescription practices and train at least 10 primary care physicians on the use of OARRS.				May 31, 2020
Year 3: Continue efforts from years 1 and 2. Increase the number of trainings by 15%.				May 31, 2021

Priority Topic: Addiction				
Strategy 3: Implement school-based alcohol/other drug prevention programs				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Continue to partner with Wyandot County schools to offer the **LifeSkills Training** program. Expand the program to grades 7-8 in every school district. Continue to provide the *Sober Truth* program to Wyandot County schools. Expand to Mohawk school district.	**Priority Outcomes:** 1. Reduce youth alcohol use 2. Reduce youth marijuana use 3. Reduce youth non-prescribed prescription drug use **Priority Indicators:** 1. Percent of youth who drank one or more drinks of an alcoholic beverage in the past 30 days 2. Percent of youth who report using marijuana one or more time within the past 30 days 3. Percent of youth who used prescription drugs not prescribed to them in the past 30 days	Youth	**Darlene Steward** Wyandot County Health Department **Charla Van Osdol** CARSA Coalition, Firelands	May 31, 2019
Year 2: Expand the LifeSkills Training program to grades 9-12 in at least one school district. Continue to provide the *Sober Truth* programs to all Wyandot County school districts.				May 31, 2020
Year 3: Continue efforts from years 1 and 2 for both programs. All school districts will offer the LifeSkills Training program to elementary, middle and high school students.				May 31, 2021

Priority 2: Chronic Disease

Chronic Disease Indicators

Adult Obesity

In 2018, 42% of adults were classified as obese by Body Mass Index (BMI) calculations (BRFSS reported 32% for Ohio and 30% for the U.S. in 2016). 37% of adults were classified as overweight (BRFSS reported 35% for Ohio and 35% for the U.S. in 2016).

Youth Obesity

19% of youth were classified as obese by Body Mass Index (BMI) calculations (YRBS reported 13% for Ohio in 2013 and 14% for the U.S. in 2015). 11% of youth were classified as overweight (YRBS reported 16% for Ohio in 2013 and 16% for the U.S. in 2015).

Adult Heart Disease

6% of adults reported they had angina or coronary heart disease, increasing to 11% of those over the age of 65.

Adult Nutrition

<1% of Wyandot County adults ate 5 or more servings of fruit per day. Nine percent (9%) ate 3 to 4 servings of fruit per day, and 74% ate 1 to 2 servings per day. Sixteen percent (16%) of adults did not eat any fruit.

1% of adults ate 5 or more servings of vegetables per day. Fifteen percent (15%) ate 3 to 4 servings of vegetables per day, and 76% ate 1 to 2 servings per day. Seven percent (7%) of adults did not eat any vegetables.

Adult Diabetes

12% of Wyandot County adults had been diagnosed with diabetes, increasing to 26% of those over the age of 65. The 2016 BRFSS reports an Ohio and U.S. prevalence of 11%.

6% of adults had been diagnosed with pre-diabetes.

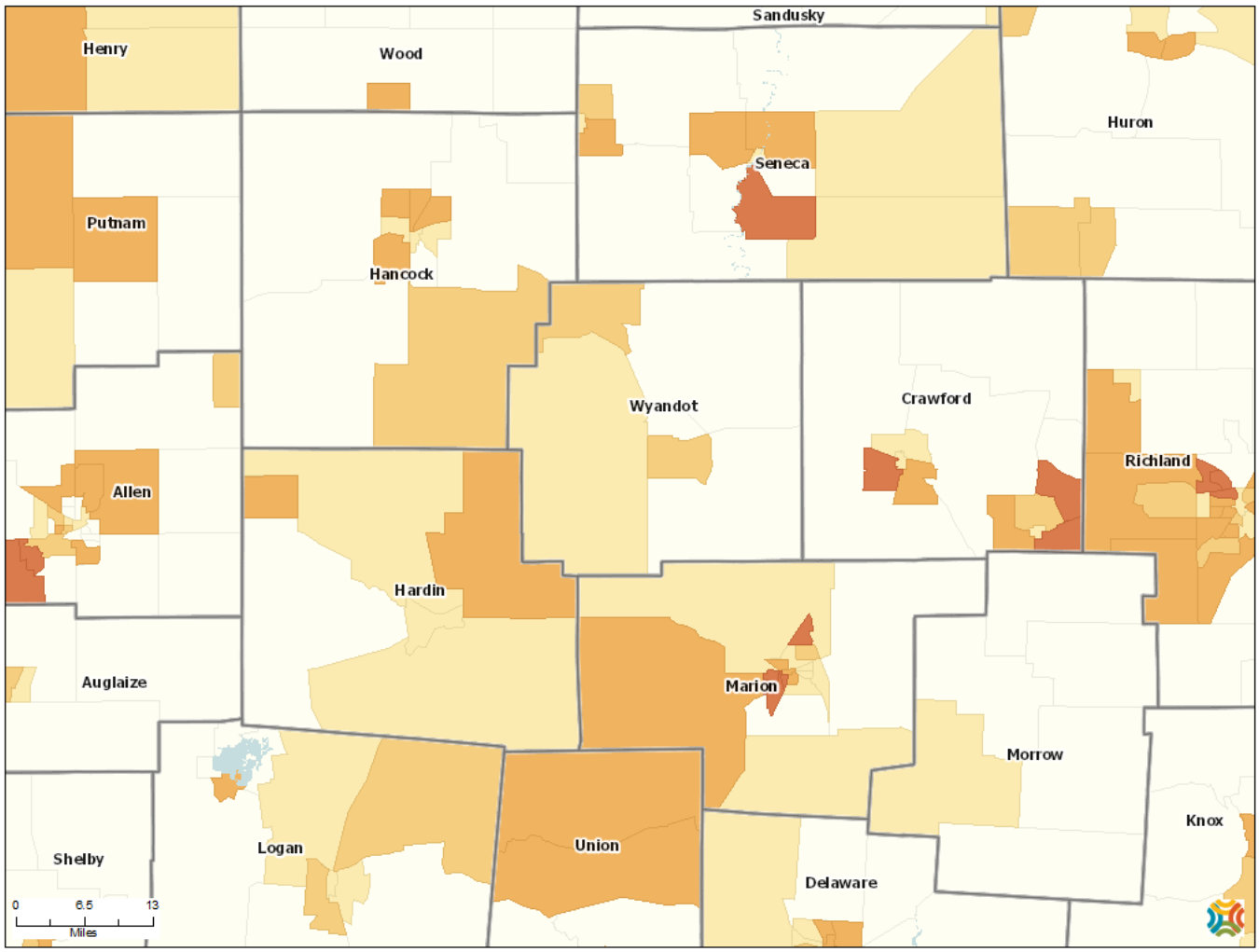
Food Insecurity

19% of adults experienced at least one of the following food insecurity issues in the past year: had to choose between paying bills and buying food (13%), worried food might run out (7%), their food assistance was cut (5%), went hungry/ate less to provide more food for their family (5%), did not eat because they did not have enough money for food (3%), and loss of income led to food insecurity issues (2%).

9% of youth reported they went to bed hungry on at least one day because their family did not have enough money for food. 2% of youth went to bed hungry every night of the week.

Map: Limited Food Access

Population with Limited Food Access, Children (Age 0-17), Percent by Tract, FARA 2015



Map Legend

Population with Limited Food Access, Children (Age 0-17), Percent by Tract, FARA 2015

- Over 20.0%
- 10.1 - 20.0%
- 2.1 - 10.0%
- Under 2.1%
- No Low Food Access

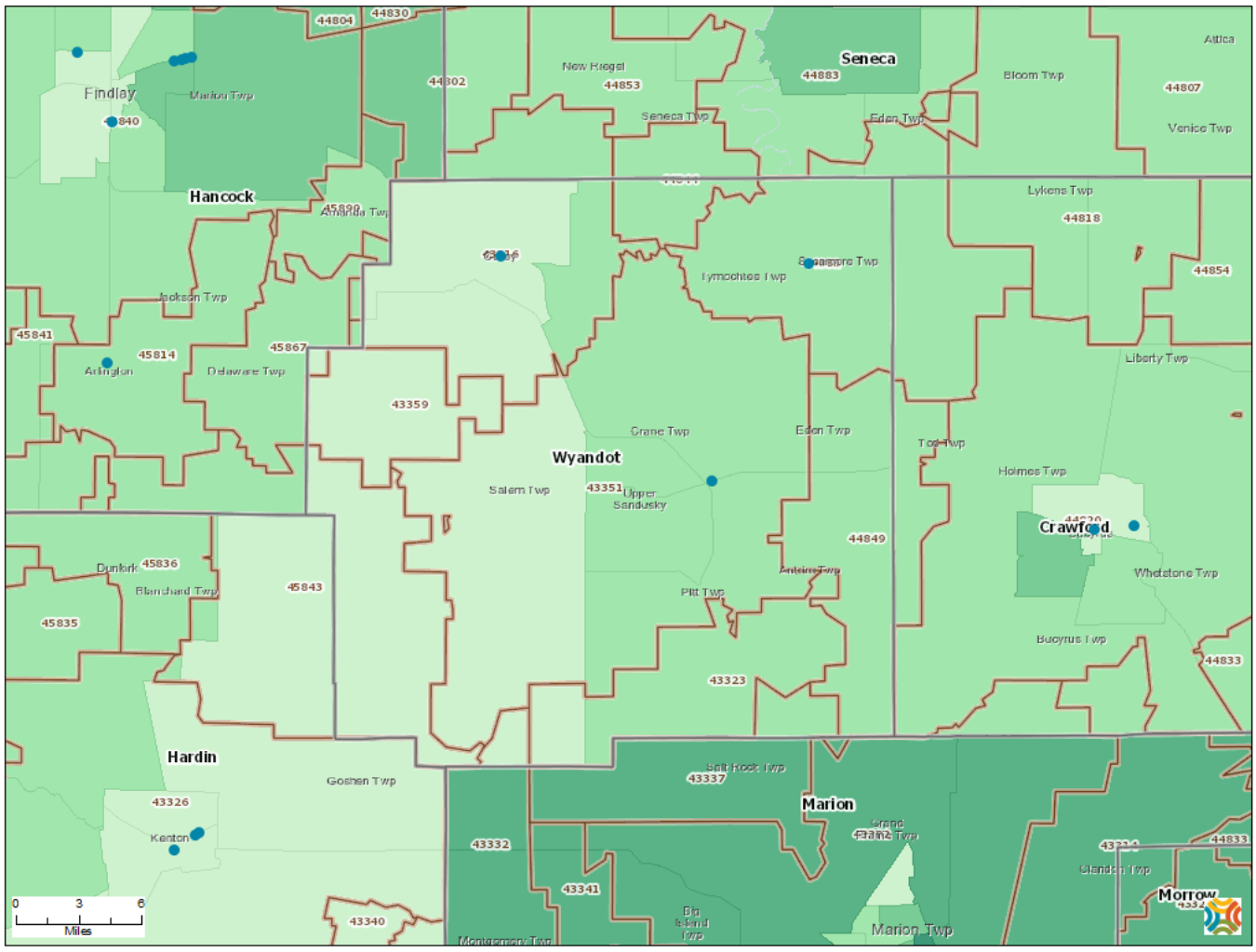
Community Commons, 5/7/2018

(Sources: U.S. Department of Agriculture, Economic Research Service, USDA-Food Access Research Atlas: 2015 as compiled by Community Commons)

Description of indicator: The Food Access Research Atlas (FARA) presents a spatial overview of food access indicators for populations using different measures of supermarket accessibility. The FARA is a compliment to the USDA's Food Environment Atlas, which houses county-level food related data. The FARA provides census-tract level detail of the food access measures, including food desert census tracts. Estimates in the latest version of the Food Access Research Atlas draw from various sources, including the 2015 STARS list of supermarkets, the Supplemental Nutrition Assistance Program (SNAP) Retailer Directory, the 2010 Decennial Census, and the 2010-14 American Community Survey.

Map: Fruit and Vegetable Expenditures*

Fruit and Vegetable Expenditures, Percent of Food-At-Home Expenditures, State Rank by Tract, Nielsen 2014



Map Legend

- Major Supermarkets, USDA Dec. 2017

Fruit and Vegetable Expenditures, Percent of Food-At-Home Expenditures, State Rank by Tract, Nielsen 2014

- 1st Quintile (Highest Expenditures)
- 2nd Quintile
- 3rd Quintile
- 4th Quintile
- 5th Quintile (Lowest Expenditures)
- No Data or Data Suppressed

Community Commons, 5/7/2018

(Sources: Nielsen, Nielsen SiteReports: 2014; USDA 2017, as compiled by Community Commons)

Description of indicator: To generate acceptable map output in compliance with the Nielsen terms of use agreement, percent expenditures for each tract were sorted and ranked; quintiles were assigned to each tract based on national rank and symbolized within the map.

**Fruit and vegetable expenditures included in this indicator are all fresh, frozen and canned fruits and vegetables purchased for consumption at home.*

Gaps and Potential Strategies

Gaps	Potential Strategies
1. Outlaying and rural areas don't have access to fresh, local foods	• Expand community gardens through volunteers.
2. Medication assistance/people can't afford their medications	• None noted
3. Difficulty navigating the health insurance marketplace	• Continue to utilize the hospital navigators and the office on aging.
4. Nutrition education in the classroom	• Used to have programming for pre-school and 2nd graders (i.e. Grow It, Like It, Try It) but funding taken away. • Look for outside funding and grant opportunities.
5. Diabetic prevention and education	• Continue "Living with Diabetes" program. CMS is now paying for program. Continue pre-diabetes and diabetes questionnaire and screening.
6. Motivation	• There needs to be incentives for people to participate in programming. • Consider having employer offer incentives like discounted health insurance.

Best Practices

The following programs and policies have been reviewed and have proven strategies to **reduce chronic disease:**

1. **Healthy Food Initiatives in Food Banks**: Food bank and food pantry healthy food initiatives combine hunger relief efforts with nutrition information and healthy eating opportunities for low-income individuals and families. Such initiatives offer clients healthy foods such as fruits, vegetables, whole grains, low-fat dairy products, and lean proteins. Initiatives can include fruit and vegetable gleaning programs, farm Plant-a-Row efforts, and garden donations. Healthy food initiatives can also modify the food environment via efforts such as on-site cooking demonstrations and recipe tastings, produce display stands, or point-of-decision prompts. Some food banks and food pantries establish partnerships with health and nutrition professionals to offer screening for food insecurity and medical conditions (e.g., diabetes), provide nutrition and health education, and health care support services as part of their healthy food initiatives.

Expected Beneficial Outcomes
- Increased healthy food consumption
- Increased food security

Other Potential Beneficial Outcomes
- Improved nutrition
- Improved weight status

2. **Community Gardens**: A community garden is any piece of land that is gardened or cultivated by a group of people, usually for home consumption. Community gardens are typically owned by local governments, not-for-profit groups, or faith-based organizations; gardens are also often initiated by groups of individuals who clean and cultivate vacant lots. Local governments, non-profits, and communities may support gardens through community land trusts, gardening education, distribution of seedlings and other materials, zoning regulation changes, or service provision such as water supply or waste disposal.

Expected Beneficial Outcomes

- Increased access to fruits and vegetables
- Increased fruit and vegetable consumption
- Increased physical activity

Other Potential Beneficial Outcomes

- Increased food security
- Increased healthy foods in food deserts
- Reduced obesity rates
- Improved mental health
- Improved sense of community
- Improved neighborhood safety

3. **Food Insecurity Screening and Referral:** Hospitals and clinics can play a central role in screening and identifying patients at risk for food insecurity and connecting families with needed community resources. It is important to advocate for federal and local policies that support access to adequate healthy food for an active and health life.

4. **Diabetes Prevention Program (DPP)**: The National Diabetes Prevention Program (National DPP) is an evidence-based intervention that allows purchasers, payers, and providers to help their patients with prediabetes or at high risk for type 2 diabetes prevent or delay onset of type 2 diabetes. The intervention is founded on the science of the Diabetes Prevention Program research study and multiple translation studies. These studies showed that making modest behavior changes helped participants lose 5% to 7% of their body weight and reduced the risk of developing type 2 diabetes by 58% in adults with prediabetes (71% for people over 60 years old).

The National DPP's lifestyle change program is a year-long structured program (in-person group, online, or combination) consisting of:

- An initial six-month phase offering at least one session a month (at least six sessions)
- Is facilitated by a trained lifestyle coach
- Uses a CDC-approved curriculum
- Includes regular opportunities for direct interaction between the lifestyle coach and participants
- Focuses on behavior modification, managing stress, and peer support

5. **School-Based Obesity Prevention Interventions:** School-based obesity prevention programs seek to increase physical activity and improve nutrition before, during, and after school.

Programs combine educational, behavioral, environmental, and other components such as health and nutrition education classes, enhanced physical education and activities, promotion of healthy food options, and family education and involvement. Specific components vary by program.

Expected Beneficial Outcomes
- Increased physical activity
- Increased physical fitness
- Improved weight status
- Increased consumption of fruit & vegetables

6. **Shared use agreements** shared use, joint use, open use, or community use agreements allow public access to existing facilities by defining terms and conditions for sharing the costs and risks associated with expanding a property's use. School districts, government entities, faith-based organizations, and private or nonprofit organizations may create shared use agreements to allow community access to their property before or after hours. Shared use agreements can be formal (i.e., based on a written, legal document) or informal (i.e., based on historical practice), and can be tailored to meet community needs.

Expected Beneficial Outcomes
- Increased access to places for physical activity

Other Potential Beneficial Outcomes
- Increased physical activity
- Increased access to public resources

7. **Community fitness programs** can be offered in a variety of community settings including fitness, community, senior, and community wellness centers. Program offerings vary by location, but often include exercise classes such as spinning/indoor cycling, aerobic dance classes, Zumba, Pilates, Yoga, and Tai Chi.

Expected Beneficial Outcomes
- Increased physical activity
- Improved physical fitness

Other Potential Beneficial Outcomes
- Improved mental health

8. **Fruit and Vegetable Prescription Program (FVRx)** was started by Wholesome Wave, a national program that makes fresh, locally grown fruits and vegetables affordable and available to communities. FVRx's evidence-based model offers a tangible solution to providers looking to help patients who are at risk of diet-related illness and cannot afford, or access, healthy food. FVRx has specifically benefited those living in medically underserved areas and food deserts. Participating providers prescribe vouchers to their patients to be redeemed for produce at local food retailers such as grocery stores and farmers markets. The vouchers are typically equivalent to $1 per day and help to lower the cost of healthy foods, creating incentives for a more balanced diet. FVRx programs have typically been funded through private foundations. However, state and federal agencies such as the U.S. Department of Agriculture have also started to invest in FVRx projects.

9. **OHA Good4You Healthy Hospital Initative** is a statewide initiative of Ohio hospitals, sponsored by the Ohio Hospital Association. Good4You seeks to help hospitals lead Ohioans to better health through healthy eating, physical activity, and other statewide population health initiatives.

As leaders in their communities and advocates of health and well-being, hospitals can model healthy eating to support the health of employees, visitors and the communities they serve. Hospitals can participate in this voluntary initiative by adopting the Good4You Eat Healthy nutrition criteria in four specific areas within the hospitals: vending machines, cafeterias and cafes, meetings and events, and outside vendors and franchises. Participation is easy, and tools and resources are available to help hospitals as they transition to an Eat Health environment.

Action Step Recommendations & Plan

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

1. Food insecurity screening and referral
2. Implement a fruit and vegetable prescription program (FVRx)
3. Implement the National Diabetes Prevention Program (DPP) and Increase prediabetes screening and referral
4. Implement healthy food initiatives
5. Shared use (joint use agreements)
6. Implement community fitness programs
7. Implement nutrition policies within the community

Action Plan

Priority Topic: Chronic Disease				
Strategy 1: Food insecurity screening and referral				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Research the 2-item Food Insecurity (FI) screening Tool and determine feasibility of implementing a food insecurity screening and referral program. Educate hospitals and clinics on food insecurity, it's impact on health, and the importance of screening and referral. Address food insecurity as part of routine medical visits on an individual and systems-based level. Implement the screening model in at least 1 location with accompanying evaluation measures.	**Priority Outcome:** Reduce the number of adults who are food insecure **Priority Indicator:** Percent of adults who had experienced at least one food insecurity issue in the past year	Adult and youth	**Jamie Delaney** Hospice of Wyandot County and Home Health	May 31, 2019
Year 2: Educate participating locations on existing community resources such as 2-1-1, WIC, SNAP, school nutrition programs, food pantries, etc. Continue efforts from year 1.				May 31, 2020
Year 3: Double the number of organizations offering food insecurity screening and referrals.				May 31, 2021

Priority Topic: Chronic Disease				
Strategy 2: Implement a fruit and vegetable prescription program (FVRx)				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Research fruit and vegetable prescription programs (FVRx), and gather baseline data documenting the need for one in Wyandot County. Recruit healthcare, food pantry, farmers market, and other potential partners to participate in the FVRx initiative. Meet with potential partners to discuss the need and feasibility of implementing a FVRx program. Determine and develop additional program materials that are needed.	**Priority Outcome:** 1. Reduce adult obesity 2. Reduce youth obesity 3. Reduce adult diabetes 4. Reduce heart disease **Priority Indicator:** 1. Percent of adults that report body mass index (BMI) greater than or equal to 30 2. Percent of youth who were obese 3. Percent of adults who have been told by a health professional that they have diabetes 4. Percent of adults ever diagnosed with coronary heart disease	Adult and youth	**Scott Moore** Open Door Resource Center **Fortune Bormuth** Wyandot Memorial Hospital **Arlene Schriner** Wyandot County Health Department	May 31, 2019
Year 2: Continue efforts from year 1. Finalize FVRx locations, vendors, and other details necessary for the implementation of the FVRx. Implement the FVRx program. Develop evaluation measures to determine program success.				May 31, 2020
Year 3: Continue efforts from years 1 and 2.				May 31, 2021

Priority Topic: Chronic Disease				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Strategy 3: Implement the National Diabetes Prevention Program (DPP) and Increase prediabetes screening and referral				
Year 1: Explore the **National Diabetes Prevention Program (DPP)** and determine the feasibility of implementing the program. Identify one healthcare agency or other organization to house the program. Recruit at-risk participants to join the DPP program. Collaborate with the local hospital for referrals and to assist in managed care reimbursement training. Increase provider training and education to raise awareness of prediabetes screening, identification and referral through dissemination of the **Prediabetes Risk Assessment**, and **Prevent Diabetes STAT Toolkit**.	**Priority Outcomes:** 1. Reduce adult diabetes 2. Reduce adult prediabetes 3. Prediabetes screening **Priority Indicators:** 1. Percent of adults diagnosed with diabetes 2. Percent of adults diagnosed with prediabetes 3. Percent of overweight or obese patients aged 40 to 70 years who had appropriate screening for abnormal blood glucose	Adult	**Fortune Bormuth** Wyandot Memorial Hospital	May 31, 2019
Year 2: Implement the Diabetes Prevention Program. Evaluate participant data after the 25 sessions have been delivered. Increase the number of providers screening for prediabetes by 10% from baseline.				May 31, 2020
Year 3: Increase program participation by 15%. Increase number of providers screening for prediabetes by 15% from baseline.				May 31, 2021

Priority Topic: Chronic Disease				
Strategy 4: Implement healthy food initiatives				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Obtain baseline data regarding which cities, towns, school districts, churches, and organizations currently have **community gardens**. Obtain baseline data regarding which local **food pantries** have fresh produce available. Research grants and other funding opportunities to increase the number of community gardens and/or farmer's markets in Wyandot County. Create and distribute a map of all available community gardens and food pantries in Wyandot County. Update the map on an annual basis.	**Priority Outcomes:** 1. Reduce adult obesity 2. Reduce youth obesity 3. Reduce adult diabetes 4. Reduce heart disease **Priority Indicators:** 1. Percent of adults that report body mass index (BMI) greater than or equal to 30 2. Percent of youth who were obese 3. Percent of adults who have been told by a health professional that they have diabetes 4. Percent of adults ever diagnosed with coronary heart disease	Adult	**Barbara Mewhorter** Wyandot County Health Department **Tammy Baumberger** OSU Extension, SNAP Ed Program	May 31, 2019
Year 2: Assist churches, libraries, and other organizations in applying for grants to obtain funding for a community garden. Focus on more rural areas of the county and areas within the county classified as a "food desert". Work with food pantries to offer fresh produce and assist pantries in seeking donations from local grocers				May 31, 2020
Year 3: Implement community gardens in various locations and increase the number of organizations with community gardens by 10% from baseline. Increase the number of food pantries offering fresh produce by 5% from baseline.				May 31, 2021

Priority Topic: Chronic Disease				
Strategy 5: Shared use (joint use agreements)				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Assess how many Wyandot County schools, churches, businesses and other organizations currently offer shared use of their facilities (gym, track, etc.). Create an inventory of known organizations that possess physical activity equipment, space, and other resources.	**Priority Outcomes:** 1. Reduce adult obesity 2. Reduce youth obesity 3. Reduce adult diabetes 4. Reduce heart disease **Priority Indicators:** 1. Percent of adults that report body mass index (BMI) greater than or equal to 30 2. Percent of youth who were obese 3. Percent of adults who have been told by a health professional that they have diabetes 4. Percent of adults ever diagnosed with coronary heart disease	Adults and youth	**Scott Moore** Open Door Resource Center	May 31, 2019
Year 2: Collaborate with local organizations to create a proposal for a shared-use agreement. Initiate contact with potential organizations from the inventory. Implement at least one shared-use agreement for community use. Publicize the agreement and its parameters.				May 31, 2020
Year 3: Continue efforts from years 1 and 2. Implement 2-3 shared-use agreements for community use in Wyandot County.				May 31, 2021

Priority Topic: Chronic Disease				
Strategy 6: Implement community fitness programs				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Research the **SuperKids Nutrition** organization and the various programs they offer. Determine if there will be a cost associated with the program. Recruit children to participate in the program. Implement the SuperKids Nutrition curriculum. Evaluate the program. Determine if the program will be continued.	**Priority Outcomes:** 1. Reduce youth obesity 2. Increase youth fruit consumption 3. Increase youth vegetable consumption **Priority Indicators:** 1. Percent of youth who were obese 2. Percent of youth who had 5 or more servings of fruit per day 3. Percent of youth who had 5 or more servings of vegetables per day	Youth	**John Elchert** Wyandot Memorial Hospital	May 31, 2019
Year 2: Continue efforts from year 1.				May 31, 2020
Year 3: Continue efforts from years 1 and 2.				May 31, 2021

Priority Topic: Chronic Disease				
Strategy 7: Implement nutrition policies within the community				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Continue efforts of the **OHA Good4You Healthy Hospitals Initiative**. Begin to introduce the Good4You initiative into other areas within the community including businesses, schools and churches. Choose at least one school district to implement a healthier choices campaign. Work with school wellness committees to introduce at least one priority area to focus on and implement: 1. Healthier snack options offered during school lunches 2. Healthier fundraising foods 3. Healthier options in vending machines 4. Healthier options at sporting events and concession stands 5. Reducing unhealthy food as rewards	**Priority Outcomes:** 1. Reduce youth obesity 2. Increase youth fruit consumption 3. Increase youth vegetable consumption **Priority Indicators:** 1. Percent of youth who were obese 2. Percent of youth who had 5 or more servings of fruit per day 3. Percent of youth who had 5 or more servings of vegetables per day	Youth	**Barbara Mewhorter** Wyandot County Health Department **Fortune Bormuth** Wyandot Memorial Hospital	May 31, 2019
Year 2: Continue efforts from year 1. Implement a healthier choices campaign in all school districts. Have each school choose 1-2 priority areas to focus on and implement. Expand the Good4You initiative to businesses and churches. Increase the number of businesses and churches participating in the Good4You initiative 10% from baseline.				May 31, 2020
Year 3: Continue efforts from years 1 and 2.				May 31, 2021

Cross-cutting Strategies

Cross-cutting Outcomes

In addition to tracking progress on the CHIP priority outcome objectives, the county will evaluate the impact of strategies implemented by also measuring progress on a set of cross-cutting outcome objectives. Examples of cross-cutting outcomes are listed below. See the **master list of SHIP indicators** for the complete list of the SHIP cross-cutting outcome indicators and the community toolkits for a recommended set of aligned community indicators to track progress related to each CHIP strategy.

Social determinants of health: Examples of crosscutting outcomes that address all priorities

- Improve third grade reading proficiency
- Reduce chronic absenteeism in school
- Reduce high housing cost burden
- Reduce secondhand smoke exposure for children

Prevention, public health system and health behaviors: Examples of cross-cutting outcomes that address all priorities

- Increase adult vegetable consumption
- Reduce adult physical inactivity
- Reduce adult smoking
- Reduce youth all-tobacco use

Healthcare system and access: Examples of cross-cutting outcomes that address all priorities

- Reduce percent of adults who are uninsured
- Reduce percent of adults unable to see a doctor due to cost
- Reduce primary care health professional shortage areas

Specific, measurable objectives for selected cross-cutting outcomes will be included in the following action plans.

Best Practices

The following programs and policies have been reviewed and have proven strategies to **improve health outcomes:**

1. **Higher education financial incentives for health professionals serving underserved areas** Financial incentive programs offer scholarships and loans with service requirements, educational loans with a service option, and loan repayment or forgiveness programs to encourage health care providers to serve in regions that are rural, underserved, or Health Professional Shortage Areas (HPSA). Such incentives are available to various types of providers, including physicians, nurse practitioners, physician assistants, nurses, dentists, and mental health providers, but typically focus on primary care and family medicine practitioners.

Expected Beneficial Outcomes

- Increased availability of health professionals in underserved areas

Other Potential Beneficial Outcomes

- Increased access to care

2. **Early childhood home visiting programs** in early childhood home visiting programs trained personnel regularly visit at-risk expectant parents and families with young children and provide them with information, support, and/or training regarding child health, development, and care based on families' needs. Home visitors can be nurses, social workers, parent educators, paraprofessionals, lay workers from within the community, or others. Home visiting often begins prenatally and continues during the child's first two years of life, but may also begin after birth, last only a few months, or extend until kindergarten.

Expected Beneficial Outcomes

- Reduced child maltreatment
- Reduced child injury
- Improved cognitive skills
- Improved social emotional skills
- Improved parenting
- Improved birth outcomes
- Improved maternal health
- Improved economic security

Other Potential Beneficial Outcomes

- Improved prenatal care
- Reduced hospital utilization
- Reduced rapid repeat pregnancies
- Increased use of contraception
- Reduced intimate partner violence

3. **Community-wide physical activity campaigns** involve many community sectors, include highly visible, broad-based, multi-component strategies (e.g., social support, risk factor screening or health education) and may address cardiovascular disease risk factors.

Expected Beneficial Outcomes

- Increased physical activity
- Improved physical fitness

Other Potential Beneficial Outcomes

- Improved weight status

Action Step Recommendations & Plan

To work toward **improving health outcomes**, the following cross-cutting strategies are recommended:

1. Increase awareness of transportation opportunities
2. Increase recruitment for mental health professionals
3. Early childhood home visiting program
4. Implement a community-wide physical activity campaign

Action Plan

<table>
<tr><th colspan="5">Cross-cutting Topic: Healthcare System and Access</th></tr>
<tr><th colspan="5">Strategy 1: Increase awareness of transportation opportunities</th></tr>
<tr><th>Action Step</th><th>Cross-cutting Outcome & Indicator</th><th>Priority Population</th><th>Person/ Agency Responsible</th><th>Timeline</th></tr>
<tr><td>Year 1: Conduct an environmental scan of all transportation opportunities, including public, regional, and private. Collect information regarding eligibility of services, cost, and other relevant information.
Create an informational brochure or online guide detailing transportation options that are available to Wyandot County residents.</td><td rowspan="3">Cross-cutting Outcome:
Increased access to transportation opportunities

Cross-cutting Indicator:
None identified</td><td rowspan="3">Adult and youth</td><td rowspan="3">Pam Zimmerly
Community Action Commission

Ariel Nearhood
RSVP</td><td>May 31, 2019</td></tr>
<tr><td>Year 2: Disseminate information regarding transportation opportunities in Wyandot County. Target businesses and agencies that serve at-risk populations, as well as seniors.
Collaborate with neighboring counties to discuss the plausibility of shared transportation services.</td><td>May 31, 2020</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2. Update the transportation guide on an annual basis.</td><td>May 31, 2021</td></tr>
</table>

Cross-cutting Factor: Healthcare System and Access				
Strategy 2: Increase recruitment for mental health professionals				
Action Step	**Cross-cutting Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Collect baseline data on the number of mental health providers practicing in Wyandot County and determine the need for more. Develop a marketing strategy focused on recruiting mental health providers. Work with local and neighboring colleges and universities to increase the number of preceptors or placement sites. Explore the feasibility of school loan reimbursement if the students stay to work in Wyandot County after their education is complete or providing a sign-on bonus.	**Cross-cutting Outcomes** Increase provider availability-mental health providers **Cross-cutting Indicators:** Ratio of population to mental health providers (per SHIP)	Adults and youth	**Michelle Clinger** Firelands	May 31, 2019
Year 2: Continue to collaborate with local and neighboring colleges and universities. Begin implementing recruitment strategies. Increase the number of placement sites (physicians, midlevel providers, etc.) for students by 10%.				May 31, 2020
Year 3: Continue efforts from years 1 and 2. Increase the number of placement sites for students by 20%.				May 31, 2021

Cross-cutting Factor: Social Determinants of Health				
Strategy 3: Early childhood home visiting program				
Action Step	**Cross-cutting Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Continue to offer the **Help Me Grow Home Visiting program** in Wyandot County. Evaluate effectiveness of the program by using the following measures: • Improvement in maternal and newborn health; • Reduction in child injuries, abuse, and neglect; • Improved school readiness and achievement; • Reduction in crime or domestic violence; • Improved family economic self-sufficiency; and • Improved coordination and referral for other community resources and supports	**Cross-cutting Outcome:** Kindergarten readiness **Cross-cutting Indicator:** Percent of kindergarten students demonstrating readiness (entered kindergarten with sufficient skills, knowledge and abilities to engage with kindergarten-level instruction)	Adults	**Darlene Steward** Wyandot County Health Department	May 31, 2019
Year 2: Continue to promote and monitor the Help Me Grow Home Visiting program.				May 31, 2020
Year 3: Continue efforts from years 1 and 2.				May 31, 2021

Cross-cutting Factor: Public Health System, Prevention and Health Behavior				
Strategy 4: Implement a community-wide physical activity campaign				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Collaborate with local schools, business, healthcare providers, religious organizations, and other organizations in Wyandot County to create a **community-wide physical activity campaign.** Appoint at least one representative from each organization to serve on a steering committee for the community campaign. Establish a brand for the campaign and identify strategies to implement unified physical activity initiatives and policies within Wyandot County. Meet with decision-makers from various businesses, schools, and other organizations to provide education on physical activity initiatives and types of wellness policies. Work with at least one Wyandot County organization to implement a physical activity initiative or policy.	**Cross-cutting Outcomes:** 1. Reduce adult obesity 2. Reduce youth obesity **Cross-cutting Indictor:** 1. Percent of adults that report body mass index (BMI) greater than or equal to 30 2. Percent of youth who were obese	Adult and youth	**Fortune Bormuth** Wyandot Memorial Hospital **Margie Kimmel** Waistline Risk Solutions **Gregory Moon** Wyandot County Office of Economic Development **Robert McClure** First Citizens National Bank **Kathy Graz** Upper Sandusky Chamber and Wyandot County Safety Council	May 31, 2019
Year 2: Continue efforts from year 1. Review campaign goals, objectives, and strategies. Work with at least 2 additional Wyandot County organizations to implement a physical activity initiative or policy.				May 31, 2020
Year 3: Continue efforts from years 1 and 2. Review campaign goals, objectives, and strategies. Work with at least 3 additional Wyandot County organizations to implement a physical activity initiative or policy.				May 31, 2021

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 a 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 2020. 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:

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Appendix I: Links to Websites

Title of Link	Website URL
"4HOPE" Ohio Crisis Text Line	http://mha.ohio.gov/Portals/0/assets/Prevention/Suicide/CTL-fact-sheet.pdf
Cell phone-based support programs	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/cell-phone-based-support-programs
Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services	www.cdc.gov/nphpsp/essentialservices.html
Community gardens	www.countyhealthrankings.org/policies/community-gardens
Community-wide physical activity campaigns	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/community-wide-physical-activity-campaigns
Community Fitness Programs	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/community-fitness-programs
Diabetes Prevention Program (DPP)	www.cdc.gov/sixeighteen/docs/6-18-evidence-summary-diabetes.pdf
Early childhood home visiting programs	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/early-childhood-home-visiting-programs
Food insecurity screening and referral	www.aappublications.org/content/early/2015/10/23/aapnews.20151023-1
Food insecurity assessment tool and resource list	www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Resources/InstantDownloads/FoodInsecurityAssessTool.pdf
Food pantries	www.countyhealthrankings.org/policies/healthy-food-initiatives-food-banks
Implement a fruit and vegetable prescription program (FVRx)	www.ruralhealthinfo.org/project-examples/897
Fuel Up to Play 60 (National Dairy Council & National Football League)	www.fueluptoplay60.com/
Healthy Food Initiatives in Food Banks	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/healthy-food-initiatives-in-food-banks
Help Me Grow Home Visiting	www.helpmegrow.ohio.gov/Professionals/For%20Professionals.aspx

Title of Link	Website URL
Higher education financial incentives for health professionals serving underserved areas	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/higher-education-financial-incentives-for-health-professionals-serving-underserved-areas
Increase prediabetes screening and referral	www.cdc.gov/sixeighteen/docs/6-18-evidence-summary-diabetes.pdf
Increase recruitment for mental health professionals	www.countyhealthrankings.org/policies/higher-education-financial-incentives-health-professionals-serving-underserved-areas
Incredible Years	www.incredibleyears.com/
LifeSkills Training (LST)	www.lifeskillstraining.com./
Master list of SHIP indicators	www.odh.ohio.gov/sha-ship
Medication Assisted Treatment (MAT)	www.wsipp.wa.gov/BenefitCost?topicId=7
Mental Health and Recovery Services Board of Seneca, Sandusky and Wyandot Counties	www.mhrsbssw.org/
Ohio Hospital Association Good4You Initiative	www.ohiohospitals.org/Good4You
PAX Good Behavior Game	www.hazelden.org/HAZ_MEDIA/gbg_insert.pdf
Prediabetes Risk Assessment	www.diabetes.org/are-you-at-risk/diabetes-risk-test/
Prescription drug monitoring programs (PDMPs)	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/prescription-drug-monitoring-programs-pdmps
Prevent Diabetes STAT Toolkit	https://preventdiabetesstat.org/index.html
ROX Ruling Our Experiences	https://rulingourexperiences.com/#!about_us/csgz
School-based Obesity Prevention Interventions	www.countyhealthrankings.org/policies/school-based-obesity-prevention-interventions
School-based physical activity programs and policies	www.cdc.gov/policy/hst/hi5/physicalactivity/index.html
School-based social and emotional instruction	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/school-based-social-and-emotional-instruction
Shared use agreements	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/shared-use-agreements
Steps to Respect	www.blueprintsprograms.com/factsheet/steps-to-respect
SuperKids Nutrition	www.superkidsnutrition.com/services/
Trauma-informed Care	www.countyhealthrankings.org/policies/trauma-informed-health-care

Title of Link	Website URL
Universal school-based suicide awareness and education programs	www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/universal-school-based-suicide-awareness-education-programs
Question, Persuade, Refer (QPR)	https://qprinstitute.com/about-qpr
Wyandot County Health Department	www.wyandothealth.com/