



VAN WERT COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN

2026-2028

Prepared by
Van Wert County General Health District
Approved and Adopted September 29, 2026

In collaboration with
Van Wert County Health Collaborative and Community Partners

Community-driven • Data-informed • Equity-focused • Collaborative

Purpose of this document

This CHIP translates the 2025 Community Health Assessment (CHA), 2025 Community Behavioral Health Assessment (CBHA), community prioritization process, and partner action plans into a single countywide improvement plan. It is structured to support implementation, accountability, evaluation, health equity, and documentation for public health accreditation.

Executive Summary

The Van Wert County Community Health Improvement Plan (CHIP) is a three-year, community-driven plan for improving population health and quality of life across Van Wert County. The plan is informed by the 2025 Community Health Assessment (CHA) and Community Behavioral Health Assessment (CBHA) and reflects collaborative planning among the health department, healthcare, behavioral health, schools, social services, local government, community organizations, and residents.

Community Health Snapshot

Community Indicator	Value
Population	28,931
Adults 65+	19.5%
Poverty Rate	9.0%
Mental Health Provider Ratio	630:1
Dentist Ratio	2,210:1
Adult Obesity	49.7%
Diabetes Prevalence	20.1%
Overdose Death Rate	27.7/100,000

Three county priorities were selected through a structured process using impact, severity, disparities, feasibility, and community readiness:

1. Mental Health & Substance Misuse
2. Chronic Disease & Healthy Living
3. Oral Health

Access to care and youth health are cross-cutting considerations. The plan emphasizes measurable objectives, named implementation responsibility, timeframes, policy/systems/environmental change, health equity, continuous quality improvement, and transparent reporting.

This Community Health Improvement Plan was developed through a collaborative, community-driven process utilizing findings from the 2025 Community Health Assessment (CHA), Community Behavioral Health Assessment (CBHA), stakeholder engagement activities, and the Mobilizing for Action Through Planning and Partnerships (MAPP 2.0) framework. The CHIP establishes community priorities, measurable objectives, implementation strategies, performance measures, and evaluation processes to improve health outcomes and advance health equity in Van Wert County.

Introduction

Vision

Van Wert County is a healthy, thriving community where all residents have equitable opportunities to achieve optimal physical, mental, and oral health.

Mission

Through collaboration, shared accountability, and evidence-based strategies, community partners will improve health outcomes and quality of life for all Van Wert County residents.

Guiding Principles

Principle	Application in the CHIP
Health Equity	Prioritize populations experiencing barriers and monitor reach and outcomes by priority population when data permits.
Community Engagement	Maintain a collaborative planning and implementation structure and incorporate community and partner feedback.
Shared Ownership	Assign lead and partner organizations to objectives and activities.
Data-Driven Decision Making	Use baseline, process, output, outcome, partnership, and equity measures.
Evidence-Based Practice	Use evidence-based or practice-based approaches where available and document the rationale for innovative approaches.
Continuous Quality Improvement	Review performance regularly and adjust strategies based on results and feedback.
Sustainability	Build partnerships, resource alignment, funding strategies, infrastructure, and policy supports that can continue beyond 2029.

Community Profile

Population Characteristics			
28,931 POPULATION	23.2% YOUTH UNDER 18	19.5% ADULTS AGE 65+	\$67,917 MEDIAN HOUSEHOLD INCOME
Measure		Van Wert County	
Population		28,931	
Youth under 18		23.2%	
Adults age 65+		19.5%	
Veterans		6.5%	
Persons with disabilities under age 65		14.3%	
Median household income		\$67,917	
Poverty Rate		9.0%	
Service area		Predominantly rural county with 410 square miles of service area	
Hispanic/Latino population		3.8%	

Health Care Environment

Health Professional Shortage Area: Van Wert County is federally designated as a Health Professional Shortage Area for primary care, mental health, and dental services. Provider availability remains a significant challenge across all priority areas.

Primary Care Physician Ratio	2,400:1
Mental Health Provider Ratio	630:1
Dentist Ratio	2,210:1

Community Health Improvement Planning Process

The Van Wert County Community Health Improvement Plan was developed through the Mobilizing for Action through Planning and Partnerships (MAPP 2.0) framework. The MAPP process provided a structured approach for engaging residents, community organizations, healthcare providers, schools, behavioral health partners, local government, and other stakeholders in identifying community health priorities and developing strategies for improvement.

The process included:

Building the Community Health Improvement Foundation

The Van Wert County General Health District partnered with the Van Wert County Health Collaborative to establish leadership structures, engage community stakeholders, review existing resources, and develop a shared vision for improving health outcomes.

Understanding the Community Story

Community input was gathered through:

- 427 adult CHA surveys
- Youth listening sessions
- Community Behavioral Health Assessment surveys
- Focus groups
- Key informant interviews
- Community Context Assessment activities
- Health Collaborative discussions

These activities provided both quantitative and qualitative data regarding health status, community strengths, health inequities, and social determinants of health.

The CHIP is directly informed by the 2025 CHA and CBHA. The assessment findings cited in the draft include behavioral health concerns, chronic disease burden, oral-health access barriers, and social determinants such as housing instability, transportation, food insecurity, workforce shortages, and limited awareness of available resources.

Area	Key assessment finding documented in draft
Behavioral health	20% of adults report 14+ poor mental-health days per month; mental health was the top concern for 64% of local youth; provider access is limited; overdose mortality is 27.7 per 100,000.
Chronic disease	Heart disease mortality exceeds Ohio averages; diabetes mortality increased; cancer mortality remains high; nearly half of adults report high blood pressure; adult obesity is 49.7%.
Oral health	County is identified as a dental HPSA; dental provider ratio is 2,210:1; barriers include cost, transportation, workforce shortages, and awareness.
Social determinants	Housing instability, transportation, food insecurity, workforce shortages, and limited awareness of resources affect health outcomes.

Planning Process

The CHIP Steering Committee convened May 13, 2026, to review assessment findings, apply a structured prioritization process, and select the three priorities. The draft identifies impact, severity, disparities, feasibility, and community readiness as prioritization criteria.

Planning partners identified in the source documents include:

- Van Wert County General Health District
- OhioHealth Van Wert Hospital
- Family Health Care of Northwest Ohio
- Tri County ADAMHS Board
- Crestview Local Schools and Van Wert City Schools
- Area Agency on Aging 3 and Council on Aging
- Van Wert County Foundation and City of Van Wert Parks Department
- Rural HEALTH Connect
- Stay Another Day Alliance
- Community and faith-based organizations, local governments, behavioral health providers, dental providers, and social service agencies

Community Voice & Engagement

Community members consistently expressed concern regarding mental health, substance use, chronic disease, housing, transportation, and access to healthcare services.

Residents identified several community strengths including collaboration, faith-based support systems, schools, parks, arts and culture, healthcare resources, and the willingness of residents to support one another during times of need.

Community members also identified key challenges:

- Housing affordability
- Transportation barriers
- Lack of awareness of available resources
- Mental health stigma
- Workforce shortages
- Rising cost of living
- Access to behavioral healthcare

Representative comments included:

“People come together to help one another.”

“There are not enough providers, especially for kids.”

“There just doesn't seem to be enough affordable housing.”

Community Engagement

Methods Used

- Community Health Assessment survey
- Community Behavioral Health Assessment survey
- Stakeholder interviews
- Steering Committee meetings
- Health Collaborative meetings
- Workgroup planning sessions
- Community presentations

Participation of Priority Populations

Special effort was made to include:

- Youth
- Older adults
- Rural residents
- Individuals with behavioral health concerns
- Low-income households
- Transportation-limited populations

How Feedback Was Used

Survey results and stakeholder feedback informed priority selection, objective development, and implementation strategies.

Community Strengths and Assets

The Community Health Improvement Plan builds upon significant local assets identified through the Community Health Assessment, Community Behavioral Health Assessment, and Community Context Assessment.

Community Strengths

Residents consistently identified the following strengths:

- Strong culture of collaboration
- Caring and compassionate residents
- Strong faith community
- Strong educational systems
- Growing sense of community pride
- Robust arts and cultural opportunities
- Strong parks and recreation system
- Resilient community members
- Strong healthcare and social service partnerships
- Active volunteerism and philanthropy

Major Community Assets

Healthcare Assets

- OhioHealth Van Wert Hospital
- Family Health Care of Northwest Ohio
- Van Wert County General Health District
- Westwood Behavioral Health Center
- Foundations Behavioral Health Services
- EMS agencies and healthcare providers throughout the county

Education Assets

- Van Wert City Schools
- Crestview Local Schools
- Lincolnview Local Schools
- Vantage Career Center

Community Assets

- Van Wert County Foundation
- United Way of Van Wert County
- Area Agency on Aging 3
- Council on Aging
- Rural HEALTH Connect
- Faith-based organizations
- Community volunteer networks

Community Context and Forces of Change

Several emerging trends and conditions are expected to influence health outcomes throughout the implementation period of this CHIP.

Housing Challenges

Community stakeholders identified housing as one of the most significant challenges affecting health outcomes.

Issues include:

- Limited affordable housing inventory
- Aging housing stock
- Rising rental costs
- Housing insecurity among older adults
- Homelessness and housing instability
- Increased demand resulting from economic growth and development activities

Workforce Capacity

- Healthcare provider shortages
- Behavioral health workforce shortages
- Childcare workforce shortages
- Transportation workforce challenges

Economic and Development Pressures

Major economic development activities are anticipated to increase demand for:

- Healthcare services
- Housing
- Transportation
- Social services
- Childcare resources

Post-COVID Community Impacts

Stakeholders reported continuing impacts related to:

- Social isolation
- Mental health concerns
- Delayed preventive care
- Vaccine hesitancy
- Trust in institutions
- Increased reliance on telehealth services

Health Equity Framework

Van Wert County recognizes that health outcomes are influenced by economic, social, environmental, and systemic factors. Health disparities exist among residents who experience barriers related to income, transportation, geography, disability, housing, behavioral health conditions, and access to healthcare.

The CHIP seeks to address these disparities by intentionally prioritizing populations who experience disproportionate barriers and by monitoring implementation outcomes through an equity lens.

Priority Population	Key Barrier
Youth	Mental health access
Older Adults	Transportation
Low-Income Households	Cost of care
Rural Residents	Provider access
Veterans	Behavioral health needs
Individuals with Disabilities	Access barriers

Health Equity Commitments

For every CHIP strategy, partners will:

- Monitor participation among priority populations.
- Identify barriers to participation and access.
- Implement culturally appropriate outreach.
- Review equity impacts during quarterly progress reviews.
- Utilize community feedback to improve services.
- Incorporate continuous quality improvement approaches to reduce disparities.

Priority Selection Process

Assessment findings were reviewed using the following criteria:

Priority Selection Criteria	Description
Magnitude	Number of residents affected
Severity	Impact on health outcomes
Health Equity	Effect on disproportionately affected populations
Community Readiness	Community willingness to address issue
Feasibility	Availability of effective interventions
Resources	Existing community capacity

Using these criteria, community partners selected three priorities for the 2026-2028 CHIP cycle.

Why These Priorities Were Selected

Steering Committee reviewed combined impact, actionability, priority scoring, community readiness, and available partner capacity.		
1. MENTAL HEALTH & SUBSTANCE MISUSE Strongest prioritization signal Mental Health & Suicide Risk ranked #1 with the highest total priority score of 172. Substance Use also scored highly at 159 and was placed in the matrix's top-priority quadrant. Ready for coordinated action The county has an extensive network of supportive behavioral health, prevention, recovery, healthcare, school, law-enforcement, and community partners. Existing Community Assets • Stay Another Day Alliance • Tri County ADAMHS Board • Westwood Behavioral Health • Foundations Behavioral Health Services • Peer support programs • Faith communities	2. CHRONIC DISEASE & HEALTHY LIVING High impact with actionable strategies Chronic Disease & Cardiometabolic Health ranked #2 with a total priority score of 166. Healthy Weight, Nutrition & Physical Activity also scored 159, reinforcing the need to address disease burden and healthy behaviors together. Broad community capacity Healthcare, public health, schools, parks, fitness, nutrition, aging, employer, and local-government partners can support prevention and healthy-living strategies. Existing Community Assets • OhioHealth Van Wert Hospital • Family Health Care of Northwest Ohio • Area Agency on Aging • Parks Department • Community Health Worker planning initiatives	3. ORAL HEALTH Critical access gap Oral & Dental Health received a total priority score of 135. Although its numerical rank was #7, the priority matrix placed it in the high-impact, high-actionability top-priority quadrant. Clear path to implementation Family Health Care, schools, private practices, primary care, ODH programs, WIC, and emergency care partners offer a practical foundation for prevention, referral, and expanded access. Existing Community Assets • Family Health Care Mobile Dental Services • School partnerships • Rotary Club support • Local dental providers
Cross-cutting commitments: Access to care will be addressed within every priority area, and youth will be a special population across all strategies.		

Social Determinants of Health

The Community Health Assessment and Community Behavioral Health Assessment identified several social and environmental factors influencing health outcomes across all priority areas.

Social Determinant	Community Impact
Housing	Limited affordable and quality housing
Transportation	Significant barrier to healthcare access
Economic Stability	Financial stress contributes to poor health outcomes
Childcare	Availability and affordability concerns
Food Access	Child food insecurity remains a challenge
Healthcare Access	Ongoing workforce shortages
Broadband Access	Limits telehealth and resource access for some residents
Social Isolation	Significant contributor to poor mental health outcomes

Alignment with State and National Priorities

Van Wert County's 2026-2028 CHIP priorities are consistent with the most current state and national planning frameworks available as of September 2026. Ohio's 2025 State Health Assessment, released July 24, 2025, is intended to guide the 2025-2029 State Health Improvement Plan; the Ohio Department of Health continues to identify that SHIP as under development. Accordingly, this CHIP aligns its local priorities with the assessment-driven direction of the emerging SHIP, current ODH programs and the ODH 2026-2030 Strategic Plan, while retaining flexibility to crosswalk objectives to the final SHIP when it is issued. At the national level, Healthy People 2030 remains the principal data-driven framework for health improvement and health equity. The local priorities directly support its objectives for mental health, substance-use prevention and treatment, cardiovascular health, diabetes, nutrition, physical activity, preventive care, health-care access and oral health. The CHIP's emphasis on cross-sector partnerships, measurable outcomes, policy, systems and environmental change, social determinants of health, and equitable reach also reflects the shared state and national expectation that communities address both health outcomes and the conditions that shape them.

Local CHIP priority	Ohio alignment	National alignment	CHIP contribution
Mental Health and Substance Misuse	Supports Ohio's assessment-driven focus on behavioral health, suicide and overdose prevention, health equity and access to care. It also advances ODH priorities for strategic partnerships, performance management and stronger public-health capacity.	Healthy People 2030 Mental Health and Mental Disorders; Drug and Alcohol Use; Addiction; Health Care Access and Quality. CDC priorities include primary prevention, youth mental health, suicide prevention, overdose surveillance, naloxone access, treatment linkage and stigma reduction.	Expands public awareness and 988 visibility, evidence-based training, youth and community connectedness, safe-storage practices, referral pathways and partnerships that support prevention, treatment and recovery.
Chronic Disease and Healthy Living	Matches ODH's current emphasis on reducing Ohio's high burden of heart disease, stroke, diabetes and cancer; promoting healthy eating and active living; expanding screening and navigation; and using evidence-based strategies for high-burden and underserved populations.	Healthy People 2030 Heart Disease and Stroke; Diabetes; Overweight and Obesity; Nutrition and Healthy Eating; Physical Activity; Preventive Care; Social Determinants of Health.	Increases access to screenings, prevention and self-management programs, physical-activity opportunities, healthy-food resources, community health workers and policy, systems and environmental improvements.
Oral Health	Advances Ohio's broader goals for health-care access, prevention, workforce capacity and disparity reduction, particularly for children,	Healthy People 2030 Oral Conditions and Health Care Access and Quality objectives emphasize preventive services, dental visits,	Builds dental homes, expands school-based preventive and restorative services, strengthens referral and charity-

Local CHIP priority	Ohio alignment	National alignment	CHIP contribution
	Medicaid-enrolled families, rural residents and communities affected by dental provider shortages.	reduction of untreated decay and improved access for vulnerable and underserved populations.	care pathways and addresses transportation, affordability and specialty-care barriers.
Cross-Cutting: Equity, Access and Accountability	Consistent with the Ohio SHA/SHIP approach of addressing health outcomes together with housing, poverty, education, trauma and other factors, and with ODH's 2026-2030 focus on partnerships, capacity, infrastructure and performance management.	Healthy People 2030 overarching goals call for eliminating disparities, improving health literacy, creating supportive social, physical and economic environments and engaging multiple sectors.	Uses priority-population measures, community engagement, cross-sector governance, annual reporting, continuous quality improvement and policy, systems and environmental strategies across all priorities.

Current-framework note: This crosswalk reflects the Ohio Department of Health State Health Assessment and SHIP webpages, the ODH 2026-2030 Strategic Plan, current ODH chronic-disease programs, Healthy People 2030 topic objectives, and CDC mental-health and overdose-prevention priorities available in September 2026. Because Ohio reports that the 2025-2029 SHIP remains under development, the Health Collaborative will review this alignment annually and update the crosswalk after the final SHIP is published.

Priority Area 1: Mental Health and Substance Misuse

Why This Priority Matters

Mental health emerged as one of the most significant concerns identified through the Community Health Assessment and Community Behavioral Health Assessment.

Key findings include:

Indicator	Current Status
Adults reporting 14+ poor mental health days/month	20%
Mental health provider ratio	630:1
Youth identifying mental health as top concern	64%
Overdose death rate	27.7 per 100,000

Priority Populations Most Affected

- Youth
- Low-income households
- Individuals with substance use disorders
- Individuals experiencing social isolation
- Individuals with transportation barriers

Root Causes

Community stakeholders identified:

- Stigma
- Transportation barriers
- Workforce shortages
- Housing instability
- Social isolation
- Adverse childhood experiences
- Financial insecurity

Goal

To improve the overall health and quality of life of Van Wert County residents by promoting mental wellness, preventing substance misuse, and increasing access to support and resources. To reduce overdose and suicide death rates in Van Wert County.

Long-Term Outcome Indicators

Measure	Baseline	2029 Target
Poor Mental Health Days	20%	18%
Overdose Death Rate	27.7	24.0
Mental Health Resource Awareness	TBD	Increase

Objectives and Strategies

#	Measurable objective	Lead/partners	Timeframe	Core measures
1	By Dec. 2028, implement a community media & outreach campaign reaching at least 5,000 individuals with mental health/substance misuse warning signs and prevention, treatment,	Foundations Behavioral Health Services; Keith Hough & Kimberley Smith; Vantage Multimedia, United Way of Van Wert County – Ashley Bultemeier, Van Wert County Job & Family Services – Erinn Sellers.	2027–2028	Website/digital presence; 12 education posts/month; 3 community sites sharing materials; 5,000 impressions/reach.

#	Measurable objective	Lead/partners	Timeframe	Core measures
	recovery, and safe-storage resources.	Prevention Awareness Support Services – Donna Dickman		
2	By Dec. 2028, provide at least one evidence-based community training annually and use participant feedback to improve future trainings.	The Marsh Foundation – Bailey Carder; Angel Intervention Services; VA Healthcare of Northern Indiana; Tri County ADAMHS Board – Dani Duncan; Area Agency on Aging 3 – Anna Hairston, PASS.	2027–2028	≥1 training/year; ≥25 participants/year; participant feedback.
3	By Dec. 2028, establish/sustain monthly community connectedness activities with 6 active partner organizations and 12 activities annually.	Westwood Behavioral Health Center & United for Sobriety – Jane Schmid; Foundations Behavioral Health Services – Keith Hough, Angel Intervention Services; PLC Health Clinic/Langdyn House; Challenged Higher Drop-In Center; Area Agency on Aging 3 – Anna Hairston; The Brumback Library – Nellie Schmidt; Van Wert County Common Pleas Probation;	2027–2028	Monthly calendar; 6 partners; 12 activities/year; attendance and feedback.
4	By Dec. 2027, complete a feasibility study for a regional NAMI presence serving Mercer, Van Wert, and Paulding Counties and, if feasible, pursue affiliation; by Dec. 2028, strengthen youth-serving participation in Stay Another Day Alliance.	Tri County ADAMHS Board- Dani Duncan; Foundations Behavioral Health Services – Kimberley Smith; Alliance members; Westwood Behavioral Health Center; Mercer/Paulding partners; youth-serving organizations.	2026–2028	Feasibility study; affiliation decision; youth-serving organizations participating; partnerships and referral/resource communications.
5	By Dec. 2028, implement a Stay Another Day Alliance recognition/incentive program and publicly recognize organizations demonstrating progress in training, resource promotion, referral practices, or youth engagement.	Foundations Behavioral Health Services- Kimberley Smith; Tri County ADAMHS Board – Dani Duncan; YWCA – Jamie Evans; Van Wert County Job & Family Services – Erinn Sellers; Alliance members.	2026–2028	Recognition program established; ≥1 organization recognized annually; ≥4 communications/year.
6	By Dec. 2028, install 25 permanent 988 signs in strategic parks, trails, and public locations.	Van Wert County Health Department – Anne Dunn; City of Van Wert Parks Department; County Commissioners; Vantage; Ohio Suicide Prevention Foundation; VA; Challenged Higher Drop-In Center.	2026–2028	25 signs; ≥8 partners; \$2,000 funding target; maintenance monitoring.
7	By Dec. 2028, implement and sustain two PSE strategies: regular school mental-wellbeing announcements in at least two school districts and achievement of Store It Safe Community Designation.	PASS – Donna Dickman; Van Wert County Health Department – Anne Dunn; YWCA – Jamie Evans; Westwood Behavioral Health Center – Jane Schmid; Van Wert County Common Pleas Probation;	2026–2028	2 schools; ≥80% planned announcements delivered; 1 Store It Safe designation; ≥5 partners; annual outreach.

Priority Area 2: Chronic Disease and Healthy Living

Why This Priority Matters

Chronic diseases continue to be among the leading causes of illness, disability, and death in Van Wert County. Findings from the Community Health Assessment indicate rates of obesity, diabetes, hypertension, heart disease, and cancer exceed state and national benchmarks in several areas. These conditions significantly affect quality of life, healthcare costs, workforce productivity, and life expectancy.

Community members also identified obesity, diabetes, heart disease, access to healthy foods, and opportunities for physical activity as significant concerns affecting individual and community well-being. Residents consistently expressed a desire for increased opportunities for recreation, healthier food options, improved walkability, and greater access to preventive health resources.

Key Findings

Indicator	Van Wert County	Comparison
Adult Obesity	49.7%	Higher than Ohio (36.9%)
Diagnosed Diabetes	20.1%	Higher than Ohio (13.1%)
High Blood Pressure	50.9%	Higher than Ohio (37.2%)
Heart Disease Mortality	194.6 per 100,000	Higher than Ohio
Cancer Mortality	164.3 per 100,000	Higher than Ohio
Adults reporting no physical activity	16.3%	Significant concern
Access to Exercise Opportunities	65%	Below Ohio average of 84%

What We Heard From the Community

Residents identified several opportunities to improve healthy living:

“Being able to go to a facility to exercise that lower income can afford.”

“More locally grown foods or farmers markets.”

“Make current paths more shaded and add water stations.”

“Community gardens and healthy food options would help residents stay healthy.”

Stakeholders also emphasized the importance of preventive education, increased physical activity opportunities, community health worker services, and improved access to screenings.

Root Causes and Contributing Factors

Community assessments identified several upstream contributors to chronic disease:

- Limited access to healthy foods
- High rates of food insecurity among vulnerable populations
- Limited access to exercise opportunities
- Transportation barriers
- Lack of health education and wellness awareness
- Financial barriers to healthy lifestyles
- Chronic stress related to economic stability
- Limited preventive screening utilization
- Rural access challenges
- Healthcare workforce shortages

Health Equity Considerations

The following populations experience increased risk for chronic disease or barriers to prevention:

- Low-income households
- Rural residents
- Older adults
- Individuals with disabilities
- Residents experiencing transportation barriers
- Individuals with food insecurity
- Uninsured and underinsured residents

Strategies within this priority area will prioritize equitable access to screenings, education, physical activity opportunities, nutrition resources, and navigation services.

Community Strengths Supporting Improvement

- Strong parks system
- Existing trails
- Recreation programs
- Community hospitals
- Interest in Community Health Worker services

Goal

Improve the overall health and quality of life of Van Wert County residents by reducing the burden of chronic disease and increasing opportunities for healthy living through education, prevention, policy change, environmental improvements, and coordinated community action.

Long-Term Outcome Indicators

Indicator	Baseline	2029 Target
Adult Obesity	49.7%	Decrease
Diagnosed Diabetes	20.1%	Decrease
Heart Disease Mortality	194.6 per 100,000	Decrease
Cancer Mortality	164.3 per 100,000	Decrease
Preventive Screening Participation	Baseline TBD	Increase
Physical Activity Participation	Baseline TBD	Increase

Policy, Systems, and Environmental Strategies

Van Wert County partners will pursue strategies including:

- Expansion of walking and trail connectivity
- Increased access to community recreation opportunities
- Community garden and local food initiatives
- Community Health Worker integration
- Healthy food access initiatives
- Community planning efforts supporting active living
- Screening and referral system improvements

Objectives and Strategies

#	Measurable objective	Lead/partners	Timeframe	Core measures
1	By Dec. 2028, collaborate with at least 5 partners to increase monthly distribution of healthy-living education/resources from a documented baseline to at least 500 individuals monthly, with ≥25% of reach among priority populations.	OhioHealth Van Wert Hospital; Family Health Care; COA; DD; Challenged Higher; United Way; Chamber; schools.	2026–2028	5 partners; 500/month; ≥25% priority-population reach.
2	By Dec. 2028, train at least 8 instructors and implement at least 2 evidence-based health education programs, adding 6 sessions at new community sites.	OhioHealth Van Wert Hospital; Area Agency on Aging 3; COA; Family Health Care; community hosts.	2026–2028	8 instructors; 2 programs; 6 additional sessions; ≥75% completion; ≥30% participants from priority populations; 2 new sites.
3	By Dec. 2028, increase participation in prevention/management activities by at least 20% compared with 2026 baseline through physical activity, navigation, and community resource strategies.	OhioHealth Van Wert Hospital; City Parks; Rural HEALTH Connect; Van Wert County Health Department; Pathways Hub and partners.	2026–2028	Participation change; program sessions; walking-program participation; resource-network participation; CHW services/referrals.
4	By Dec. 2028, establish at least 4 community partnerships supporting 2 screening/outreach events annually and advance at least 2 local policy, planning, or funding initiatives promoting community health.	Rural HEALTH Connect; OhioHealth Van Wert Hospital; Family Health Care; United Way; faith/community partners; local officials/planners.	2026–2028	≥4 screening partners; ≥2 events/year; ≥100 people screened/year; ≥70% events in priority/underserved locations; ≥2 policy/planning/funding initiatives.

Priority Area 3: Oral Health

Why This Priority Matters

Oral health is an essential component of overall health and well-being. Poor oral health contributes to pain, infection, missed school days, reduced productivity, chronic disease complications, and increased healthcare costs. Van Wert County experiences significant oral health access challenges due to provider shortages, transportation barriers, affordability concerns, and workforce limitations. The county is federally designated as a Dental Health Professional Shortage Area and has fewer available dental providers than state and national averages. Children and low-income families experience the greatest barriers to receiving preventive and restorative dental care.

Key Findings

Indicator	Van Wert County
Dental Provider Ratio	2,210:1
Dental HPSA Designation	Yes
Medicaid Student Dental Visit Rate	38.4%
Community Concern	Cost, transportation, provider shortages

What We Heard From the Community

Residents and stakeholders identified recurring barriers to oral healthcare access, including:

- Limited provider availability
- Transportation challenges
- Cost of services
- Insurance limitations
- Difficulty establishing a dental home
- Lack of specialty pediatric dental services

Community partners expressed strong support for school-based services and increased prevention efforts.

Root Causes and Contributing Factors

Key contributors include:

- Dental workforce shortages
- Transportation barriers
- Lack of local specialty providers
- Cost and affordability concerns
- Limited insurance coverage
- Rural access barriers
- Lack of preventive care utilization
- Limited awareness of available services

Health Equity Considerations

Priority populations include:

- Children and youth
- Medicaid-enrolled families
- Low-income households
- Rural residents
- Uninsured and underinsured residents
- Individuals experiencing transportation barriers

All oral health strategies will focus on reducing access barriers and increasing equitable utilization of services.

Why Focus on Children

Children were prioritized because:

- School-based services are feasible.
- Early intervention prevents lifelong oral health problems.
- Existing school partnerships create opportunities for outreach.
- Access barriers disproportionately affect low-income students.

Goal

Increase equitable access to preventive, restorative, and specialty oral health services for children and families experiencing barriers to care.

Long-Term Outcome Indicators

Indicator	Baseline	2029 Target
Children with Dental Home	TBD	Increase
Students Receiving Preventive Services	TBD	Increase
Preventive Dental Visit Rate	38.4%	Increase
School-Based Services Participation	TBD	Increase
Specialty Referral Completion	TBD	Increase

Policy, Systems, and Environmental Strategies

Partners will pursue:

- Expansion of school-based oral health services
- Standardized referral pathways
- Improved transportation support processes
- Coordination among healthcare, education, and oral health partners
- Development of sustainable charity-care funding models
- Workforce recruitment and retention initiatives

Objectives and Strategies

#	Measurable objective	Lead/partners	Timeframe	Core measures
1	By June 2028, increase the percentage of Van Wert Elementary students without a dental home who establish a dental home from baseline to 80%.	Family Health Care of Northwest Ohio; Van Wert City Schools; Dr. Laing; Van Wert Rotary Club.	2026–2028	% screened; % referred establishing dental home; % completing dental visit.
2	By June 2028, provide preventive or restorative dental services to at least 175 elementary students annually through school-based mobile dental clinics.	Family Health Care; Van Wert City Schools; community partners.	2026–2028	Service model approved; schedule; first clinic; students served; % receiving preventive services; quarterly QI reviews.
3	By 2028, investigate and plan expansion of school-based dental services to additional county school districts.	Family Health Care; local school districts.	2027–2028	≥3 stakeholder meetings; expansion plan completed/presented; implementation status.
4	Develop and implement a charity-care program so children with complex dental needs can access pediatric specialty services regardless of ability to pay.	Family Health Care; school districts; pediatric dental specialists; Dr. Laing; Rotary; donors.	2026–2029	≥10 children identified; eligibility criteria implemented; funding secured; % completing specialty treatment; quarterly tracking.

Governance, Implementation, and Accountability

Role	Primary responsibility
Van Wert County General Health District	Lead agency; convenes/coordinates CHIP process, supports data and reporting, and facilitates accountability.
Van Wert County Health Collaborative	Countywide oversight, coordination, accountability, priority alignment, and review of progress.
Priority Workgroups	Implement activities, monitor measures, document barriers, conduct CQI, and recommend changes.
Lead Organizations	Accept responsibility for assigned objectives/activities and report progress.
Partner Organizations	Contribute implementation capacity, resources, outreach, expertise, data, and community connections.
Community/Resident Voice	Inform priorities, implementation design, barriers, and interpretation of progress; strengthen this function through a documented engagement process.

Performance Management and Evaluation

The Van Wert County Health Collaborative and the CHIP Steering Committee will monitor implementation through a countywide CHIP performance management system.

Each year the Health Collaborative & Steering Committee will:

- Review performance measures
- Assess achievement of objectives
- Evaluate health equity impacts
- Modify strategies when needed
- Publish an annual progress report

Measure type	Definition	Minimum documentation
Process	Was the planned activity completed?	Activity, date, responsible party, status.
Output	What was delivered/reached?	Participants, events, trainings, signs, referrals, services, partners.
Outcome	What changed?	Defined numerator/denominator, baseline, target, data source, collection period.
Partnership	Did collaboration strengthen?	Partners engaged, roles, participation, satisfaction, new collaborations.
Health equity	Who benefited and who remains underserved?	Priority population reach/outcomes, disaggregated where feasible, barriers, corrective actions.

Reporting Schedule

Activity	Frequency
Workgroup Review	Quarterly
Progress Reporting	Semi-Annual
Community Report	Annual
CHIP Evaluation	Annual
Final Evaluation	2029

Supporting Documentation:

- Meeting minutes
- Attendance records
- Performance dashboards
- Annual progress reports
- Quality improvement records

Sustainability and Communication

Sustainability will be supported through ongoing partnership development, resource alignment, grant opportunities, annual strategy review, performance monitoring, and continuous quality improvement. Each workgroup should identify the resources required to maintain successful strategies beyond the CHIP period.

Sustainability element	Required action
People	Identify staff/partner capacity required to continue each strategy.
Funding	Identify current funding, funding gaps, potential grants, and local/community investments.
Infrastructure	Document systems, referral pathways, communication platforms, data tools, and facilities needed.
Policy	Institutionalize successful practices through policy, procedure, agreements, or routine operations where appropriate.
Partnerships	Identify core partners, role expectations, and succession/continuity needs.
Community trust	Maintain transparent reporting and meaningful community feedback.

Communication and Public Reporting

- Van Wert County Health Collaborative meetings.
- Annual CHIP progress reports.
- Community presentations.
- Partner websites/social media.
- Public dashboards when feasible.
- Publicly available CHIP updates and revisions.

Resources & Appendix

Documentation	Location
Community Health Assessment	2025 Van Wert County Community Health Assessment
Community Behavioral Health Assessment	Board Documents – Tri County ADAMHS Board
Prioritization Results	Appendix A
Steering Committee Roster	Appendix B
Community Engagement Documentation	Appendix C
Annual Progress Report Template	Appendix D
Quality Improvement Documentation	Appendix E

Appendix A: Prioritization Results

Community health priorities were identified through a structured, multi-step process that integrated quantitative data analysis with stakeholder input to ensure the final priorities reflect both objective community need and community consensus.

First, identified health issues were quantitatively assessed using a standardized scoring tool. Each issue was scored across five criteria: magnitude of the problem, severity, health disparities, feasibility of intervention, and community readiness. Scores were summed to produce a total composite score for each issue, allowing for comparison of overall population-level impact. Second, stakeholders independently ranked health issues based on perceived urgency and importance. To ensure fairness and reduce bias, individual rankings were adjusted to account for the number of participants ranking each issue, preventing issues ranked by only a small number of respondents from being disproportionately elevated.

Finally, the quantitative scores and participation-adjusted ranking results were normalized and combined using equal weighting. This reconciliation approach ensured that final priority rankings reflected both data-driven impact and broad stakeholder agreement.

Based on this combined analysis, Mental Health and Suicide Risk, Chronic Disease and Cardiometabolic Health, and Youth Health and Well-being emerged as the highest priority issues for the Community Health Improvement Plan.

Step 1: Identification of Community Health Issues

Community health issues were identified through analysis of Community Health Assessment (CHA) findings, including epidemiologic data, secondary data sources, and partner input. Issues reflected conditions with demonstrated burden, disparities, or emerging concern across the population.

Step 2: Quantitative Scoring of Health Issues

Each identified health issue was evaluated using a standardized scoring tool across five criteria commonly recognized in public health planning and consistent with PHAB expectations:

- **Magnitude** (scope and prevalence of the issue)
- **Severity** (impact on morbidity, mortality, and quality of life)
- **Health Disparities** (disproportionate impact on priority populations)
- **Feasibility** (availability of evidence-based interventions and resources)
- **Community Readiness** (existing support, partnerships, and capacity)

Scores were assigned using a common numeric scale and summed up to produce a total quantitative priority score for each issue.

Step 3: Stakeholder Ranking and Community Input

Stakeholders representing health, education, social services, and community organizations were asked to independently rank priority issues based on perceived urgency and importance to the community. To ensure equitable consideration of stakeholder input, rankings were adjusted based on the number of participants ranking each issue, strengthening priorities supported by broader consensus.

Step 4: Reconciliation and Final Priority Selection

Quantitative scores and adjusted stakeholder rankings were normalized and combined using equal weighting. This reconciliation method ensured that final priorities reflect both objective data and collective community perspective, consistent with PHAB guidance to integrate data-driven analysis with authentic engagement.

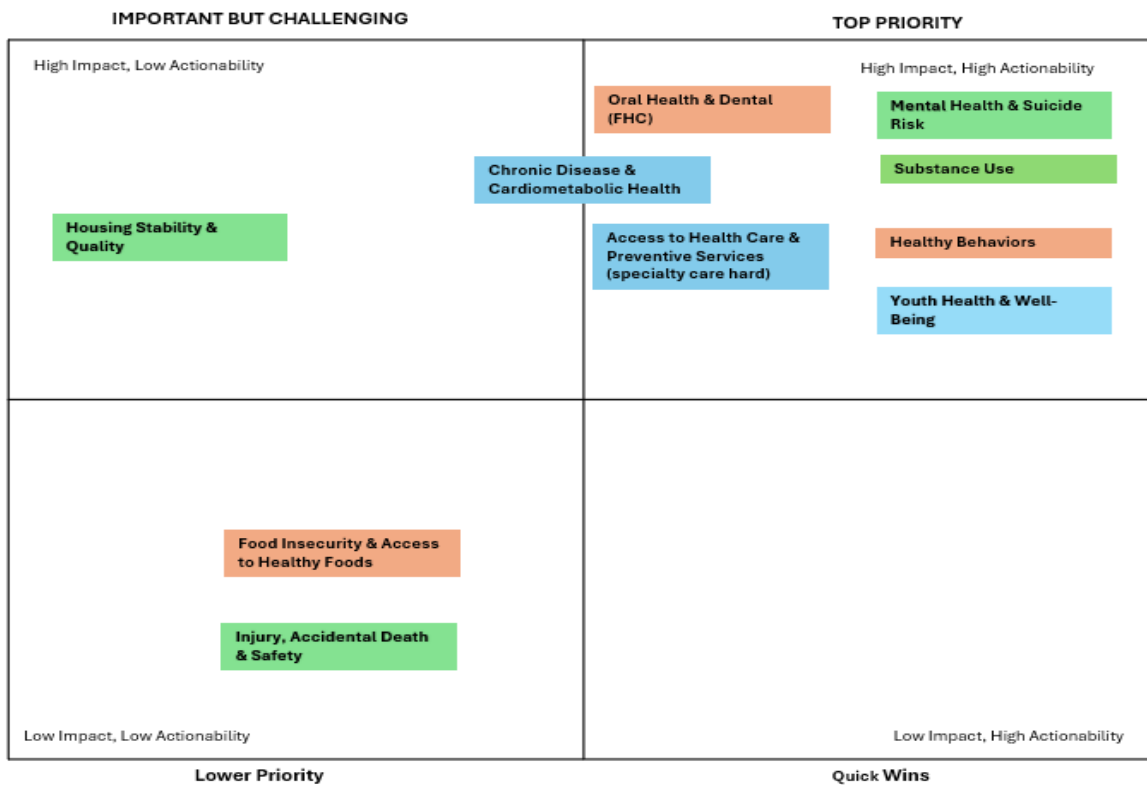
Based on this integrated process, final CHIP priorities were selected and approved for action planning, implementation, and evaluation.

Prioritization Results & Confirmation

Impact Score	Sum of Magnitude + Severity + Disparities
Actionability Score	Sum of Feasibility + Community Readiness
Priority Rank	Rank from 1-10 based on Total Priority Score

Issue	Total Priority Score	Average	Median	Impact Score	Actionability Score	Priority Rank
Chronic Disease & Cardiometabolic Health	166	33.2	31	111	55	2
Mental Health & Suicide Risk	172	34.4	33	108	64	1
Substance Use (alcohol, drugs, youth vaping)	159	31.8	31	100	59	4
Access to Health Care & Preventive Services	135	27	27	85	50	7
Healthy Weight, Nutrition, Physical Activity	159	31.8	31	99	60	4
Food insecurity & Access to Healthy Foods	140	28	27	86	54	6
Housing Stability & Quality	146	29.2	27	93	53	5
Youth Health & Well-being	162	32.4	33	93	69	3
Oral & Dental Health	135	27	27	84	51	7
Injury & Accidental Death & Safety	116	23.2	23	72	44	8

The group reviewed the prioritization scores and rankings and completed a priority matrix to confirm priority areas for the CHIP.



Justification for Combining Priority Areas

The CHIP Steering Committee reviewed the community health assessment findings, prioritization scores, and priority matrix results and determined that several closely related health issues could be more effectively addressed through integrated priority areas rather than as separate topics. 2026.5.13 CHIP Steering Committee minutes

Mental Health and Substance Misuse were combined because behavioral health and substance use disorders are highly interconnected, share many common risk and protective factors, and often require coordinated prevention, treatment, recovery, and support services. Both issues ranked among the highest community priorities and involved many of the same stakeholders, service providers, and evidence-based strategies. Combining these areas promotes a comprehensive approach to improving behavioral health outcomes across the community. 2026.5.13 CHIP Steering Committee minutes

Chronic Disease and Healthy Living were combined because healthy behaviors such as nutrition, physical activity, tobacco avoidance, and preventive care are foundational to preventing and managing chronic diseases. Addressing these issues together allows the community to focus on upstream prevention strategies while also improving outcomes for individuals already living with chronic conditions. Both topics received high prioritization scores and share many community partners and resources. 2026.5.13 CHIP Steering Committee minutes

Oral Health was retained as a distinct priority area because of its unique health challenges, workforce and access barriers, and specialized prevention and treatment needs. The prioritization process identified oral health as an important community concern that warrants focused attention and dedicated strategies. Maintaining oral health as a separate priority also recognizes its significant impact on overall health, quality of life, chronic disease outcomes, and school and workplace success. 2026.5.13 CHIP Steering Committee minutes

Final Priority Areas

1. Mental Health and Substance Use
2. Chronic Disease and Healthy Living
3. Oral Health

*Access to Care will have a strategy in each priority area.

*Youth will be a special population with strategies in all areas to target.

Appendix B: Steering Committee Roster

The Community Health Improvement Plan (CHIP) Steering Committee provided leadership, oversight, and strategic direction throughout the community health improvement planning process. Membership was intentionally selected to reflect diverse sectors of the community, including public health, healthcare, behavioral health, education, social services, local government, and community residents. The Steering Committee reviewed assessment findings, identified priority health issues, established goals and strategies, monitored implementation progress, and provided guidance to ensure community-wide engagement and accountability.

Organization	Name	Sector Represented
Area Agency on Aging 3	Dre White, Vice President of Community Living Services	Older Adult Services
City of Van Wert Parks Department	Kyle Klinker, Director	Government, Recreation
Crestview Local Schools	Matt Dube, Superintendent Trent Kreischer, Principal	Education
Family Health Care of Northwest Ohio	Jennifer Smith, Executive Director	Healthcare
OhioHealth Van Wert Hospital	Paula Stabler, President Emily Lichtenberger, Practice Manager Kristen Price, CNP	Healthcare
The Marsh Foundation	Bailey Carder, Chief Advancement Officer	Behavioral Health
Tri County ADAMHS Board	Kathy Miller, Executive Director Alicia Bruce, Deputy Director Danielle Duncan, Program Director	Behavioral Health
United Way of Van Wert County	Ashley Bultemeier, Executive Director	Social Services
Van Wert City Schools	Mark Bagley, Superintendent	Education
Van Wert County Board of Developmental Disabilities	Cody Bowersock, Superintendent	Disability Services
Van Wert County Council on Aging	Kevin Matthews, Executive Director	Older Adult Services
Van Wert County Foundation	Laney Nofer, Director of Philanthropy	Philanthropy
Van Wert County General Health District	Dr. Daryl Dowdy, Health Commissioner Kathy Will, Director of Nursing Britt Menchhofer, Director of Environmental Services Andrea Shafer, Finance Director Anne Dunn, Accreditation Coordinator	Public Health
Van Wert Family Physicians	Courtney Temple, Clinical/Clerical/Quality Manager	Healthcare

Appendix C: Community Engagement Documentation

Community Engagement Process

Development of the 2026-2028 Community Health Improvement Plan (CHIP) was guided by a collaborative community engagement process designed to ensure priorities and strategies reflect the needs, concerns, and perspectives of Van Wert County residents and community partners. Input was gathered through community surveys, stakeholder meetings, coalition discussions, and review of the Community Health Assessment (CHA).

Community partners representing healthcare, public health, behavioral health, education, social services, local government, disability services, and community organizations participated in the review of community health data, identification of key health concerns, and selection of priority areas. Community input was considered alongside local health indicators, health disparities, available resources, and opportunities for collective action.

Engagement Activities Summary

Activity	Purpose
Community Health Assessment Review	Identified health needs, trends, and disparities
Community Feedback	Gathered resident perspectives on health concerns and priorities
Stakeholder and Coalition Meetings	Discussed community needs and potential solutions
Priority-Setting Process	Selected CHIP priority areas based on data and community input
Strategy Development Sessions	Through priority area workgroups, developed goals, objectives, and evidence-based strategies

How Community Input Shaped the CHIP

Community Feedback	CHIP Response
Mental health and substance use were identified as significant community concerns.	Mental Health and Substance Misuse was established as a priority area, engaging pre-existing Alliance to lead efforts.
Residents expressed concern regarding chronic disease prevention and healthy lifestyle opportunities.	Chronic Disease and Healthy Living was established as a priority area.
Community members identified barriers to accessing preventive and restorative dental care.	Oral Health was established as a priority area.

Supporting documentation, including meeting agendas, attendance records, meeting minutes, survey instruments, survey results, and prioritization materials, is maintained by the Van Wert County Health Department and is available upon request.

Appendix D: Annual Progress Report Template

Annual Progress Report Template

Reporting Period: January 1, 20XX – December 31, 20XX

Date Prepared: _____

Prepared By: _____

Executive Summary

Provide a brief overview of implementation progress during the reporting period.

Highlights:

- Number of strategies implemented: _____
- Objectives achieved/on track: _____
- Community partners engaged: _____
- Major accomplishments

Challenges Encountered

Priority Area Progress Summary

Priority Area	Status	Overall Progress
Mental Health & Substance Misuse	☐ On Track ☐ Needs Attention ☐ Completed	____%
Chronic Disease & Healthy Living	☐ On Track ☐ Needs Attention ☐ Completed	____%
Oral Health	☐ On Track ☐ Needs Attention ☐ Completed	____%

Priority Area 1: Mental Health & Substance Misuse

Goal: To improve the overall health and quality of life of Van Wert County residents by promoting mental wellness, preventing substance misuse, and increasing access to support and resources. To reduce overdose and suicide death rates in Van Wert County.

Progress Toward Objectives

Objective	Baseline	Current Status	Progress
Objective 1			
Objective 2			
Objective 3			
Objective 4			
Objective 5			
Objective 6			
Objective 7			

Key Activities Completed

Successes and Accomplishments: Describe significant achievements, partnerships, or outcomes.

Barriers/Challenges: Describe barriers affecting implementation.

Next Steps

Priority Area 2: Chronic Disease & Healthy Living

Goal: *To improve the overall health and quality of life in Van Wert County by reducing chronic disease and promoting healthy living through regular physical activity and healthy eating.*

Progress Toward Objectives

Objective	Baseline	Current Status	Progress
Objective 1			
Objective 2			
Objective 3			
Objective 4			

Key Activities Completed

Successes and Accomplishments

Barriers/Challenges

Next Steps

Priority Area 3: Oral Health

Goal: *Increase equitable access to preventive, restorative, and specialty oral health services for children experiencing barriers related to income, transportation, insurance status, or geographic location.*

Progress Toward Objectives

Objective	Baseline	Current Status	Progress
Objective 1			
Objective 2			
Objective 3			
Objective 4			

Key Activities Completed

Successes and Accomplishments

Barriers/Challenges

Next Steps

Community Partner Engagement

Describe collaboration that occurred during the reporting period.

Partner Type	Role in Implementation
Healthcare Organizations	
Schools	
Behavioral Health Agencies	
Community Organizations	
Local Government	

Engagement Highlights

Lessons Learned and Quality Improvement

What Worked Well

Areas for Improvement

Recommended CHIP Modifications

- ☐ No modifications recommended
- ☐ Minor modifications recommended
- ☐ Significant modifications recommended

If modifications are recommended, describe below:

Approval and Review

The Community Health Improvement Plan Annual Progress Report was reviewed by the CHIP Steering Committee and community partners.

Review Date: _____

Attendance:

Appendix E: Quality Improvement Documentation

Monitoring and Quality Improvement

Implementation of the Community Health Improvement Plan will be monitored on an ongoing basis by the CHIP Steering Committee and lead partners. Progress will be reviewed at least annually using performance measures identified in the workplan. Data, implementation progress, and community feedback will be used to identify successes, barriers, and opportunities for improvement.

When progress is not occurring as planned, partners will identify contributing factors, develop corrective actions, and revise implementation approaches as appropriate. Results of monitoring activities will be documented through annual progress reports and periodic review of the CHIP workplan.

Performance Monitoring Framework

Area Monitored	Method
Strategy Implementation	Review of workplan activities and milestones
Performance Measures	Tracking of indicators and target attainment
Community Partnerships	Review of partner participation and engagement
Barriers and Challenges	Identification of implementation obstacles
Quality Improvement Actions	Development of corrective actions and process improvements

Annual progress reports will summarize accomplishments, challenges, performance measure updates, and recommended modifications to the CHIP.