# 2017-2020

## Sandusky County

# Community Health Improvement Plan

Adopted on: August 18, 2017

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# EXECUTIVE SUMMARY

In 2001, the Sandusky County Community Partners began conducting community health assessments (CHA) for the purpose of measuring and addressing health status. The most recent assessment, released in April 2017, was cross-sectional in nature and included a written survey of adults, adolescents, and children within Sandusky 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), Youth Risk Behavior Surveillance System (YRBSS), and National Survey of Children's Health (NSCH). This has allowed Sandusky County to compare the data collected in their CHA to national, state and local health trends.

The Sandusky 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 Sandusky County CHA has been utilized as a vital tool for creating the Sandusky 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 Sandusky County Health Department contracted with the Hospital Council of Northwest Ohio, a neutral regional non-profit hospital association, to facilitate the Community Health Improvement 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:

- Organizing for success and partnership development
- Visioning
- Conducting the MAPP assessments
- Identifying strategic issues
- Formulating goals and strategies
- 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 Sandusky County Community Partners 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 2017-2020 Sandusky County CHIP Overview***

| **Overall Health Outcomes** | | |
|---|---|---|
| ↑ Increase Health Status | ↓ Decrease Premature Death | |
| **Priority Topics** | | |
| Mental Health and Addiction | Chronic Disease | Maternal and Infant Health |
| **Priority Outcomes** | | |
| ↓ Decrease adult and youth drug use<br>↓ Decrease adult and youth alcohol use<br>↓ Decrease adult and youth depression<br>↓ Decrease adult and youth suicide | ↓ Decrease adult, youth and child obesity<br>↓ Decrease adult diabetes | ↓ Decrease infant mortality<br>↓ Decrease preterm births<br>↓ Very preterm births |

# STRATEGIC PLANNING MODEL

Beginning in May 2017, the Sandusky County Community Partners 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 the following: enhancing existing efforts, implementing new programs or services, building infrastructure, implementing evidence based practices, and feasibility of implementation.

# PARTNERS

The 2017-2020 Community Health Improvement Plan was drafted by agencies and service providers within Sandusky County. During May-July 2017, the committee reviewed many sources of information concerning the health and social challenges Sandusky County adults, youth and children 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 actions 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 this body of work:

**Deb Agee**, Sandusky County Health Department
**Jody Amor**, Fremont City Schools
**Iracema Arevalo**, ProMedica Memorial Hospital
**Mandi Artino**, The Bellevue Hospital
**Gabriele Beck**, Goodwill Industries
**Elizabeth Bentz**, WSOS Community Action Agency
**Abby Berndt**, Fremont City Schools
**Cody Bischoff**, City of Fremont, OH
**Dawn Bova**, The Bellevue Hospital
**Tom Bowlus**, Sandusky County Communities Foundation
**David Brewer**, ProMedica Memorial Hospital
**Bethany Brown**, Sandusky County Health Department
**Janisha Buck**, The Bellevue Hospital
**Cathy Dull**, ProMedica Memorial Hospital
**Clayton Finken**, Sandusky County Emergency Medical Services
**Jordan Garza**, US Attorney General's Office
**Stacey Gibson**, Sandusky County Health Department
**Cathy Glassford**, Sandusky County Family and Children First Council
**Mircea Handru**, Mental Health and Recovery Services Board of Seneca, Sandusky and Wyandot Counties
**Terrie Hopkins**, Terra State Community College
**Stacey Kruse**, The Bellevue Hospital
**Katie LaPlant**, Ohio State University Extension
**Mary Anne Mayle**, CareSource Medicaid Managed Care
**Wendy McNelly**, Sandusky County Health Department
**Vicki Meade**, ProMedica Hospice Clyde
**Scott Miller**, Sandusky County Commissioner
**Vivica Montgomery-Gibson**, CareSource Medicaid Managed Care
**Paula Olds**, Sandusky County Department of Job and Family Services
**Annette Overmyer**, ProMedica Memorial Hospital
**Denise Reiter**, YMCA
**Kay Reiter**, Sandusky County Commissioner
**Angie Ruth**, Sandusky County Health Department
**Clara Schermerhorn**, Pediatrician
**Charlie Schwochow**, Sandusky County Commissioner
**Dr. Paul Silcox**, Silcox Acupuncture & Chiropractic
**Abby Slemmer**, United Way
**Jason Smith**, Fremont City Schools
**Charlotte Stonerook**, Sandusky County Health Department
**Jenna Stull**, Sandusky County Health Department
**Betsy Sweeney**, YMCA
**Allison Thomas**, Sandusky County Health Department
**Tiffany Tipple**, Community Health Services
**Nicole Twarek**, Mental Health and Recovery Services Board of Seneca, Sandusky and Wyandot Counties
**JoAnn Ventura**, The Bellevue Hospital
**Jeff Vogel**, Parkview Physicians Group Behavioral Health
**Carol Wattley**, Sandusky County Common Pleas Court
**Melanie White**, National Alliance on Mental Illness
**Timothy Wise**, Firelands Counseling & Recovery Services
**Madison Woodard**, The Bellevue Hospital
**Joli Yeckley**, Sandusky County Health Department
**Laurie Young**, Sandusky County Communities Foundation
**Sarah Zimmerman**, Sandusky County Board of Developmental Disabilities

*The community health improvement process was facilitated by Emily Golias, MPH, CHES, Community Health Improvement Coordinator, from the Hospital Council of Northwest Ohio.*

# VISION

Vision statements define a mental picture of what a community wants to achieve over time.

### The Vision of Sandusky County:

Sandusky County will be a community that always chooses health first by embracing the belief that health is more than merely the absence of disease.

# ALIGNMENT WITH NATIONAL AND STATE STANDARDS

The 2017-2020 Sandusky County CHIP priorities align perfectly with state and national priorities. Sandusky County will be addressing the following priorities: mental health and addiction, chronic disease, and maternal and infant health.

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

The Sandusky County CHIP also aligns with five of the National Prevention Strategies for the U.S. population: healthy eating, active living, mental and emotional well-being, preventing drug abuse and excessive alcohol use.

### Healthy People 2020

Sandusky County's priorities also fit specific Healthy People 2020 goals. Examples include but are not limited to:

- ***Nutrition and Weight Status (NWS)-8:*** Increase the proportion of adults who are at a healthy weight.
- ***Mental Health and Mental Disorders (MHMD)-9:*** Increase the proportion of adults with mental health disorders who receive treatment.
- ***Substance Abuse (SA)-2****:* Increase the proportion of adolescents never using substances.

### Ohio State Health Improvement Plan

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 Ohio Department of Health contracted with the Health Policy Institute of Ohio (HPIO) to conduct the 2017-2018 Sate Health Improvement Plan. HPIO sub-contracted with the Hospital Council of Northwest Ohio to collect data, facilitate regional forums, and assist with the SHIP strategies.

# ALIGNMENT WITH NATIONAL AND STATE STANDARDS, *continued*

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.

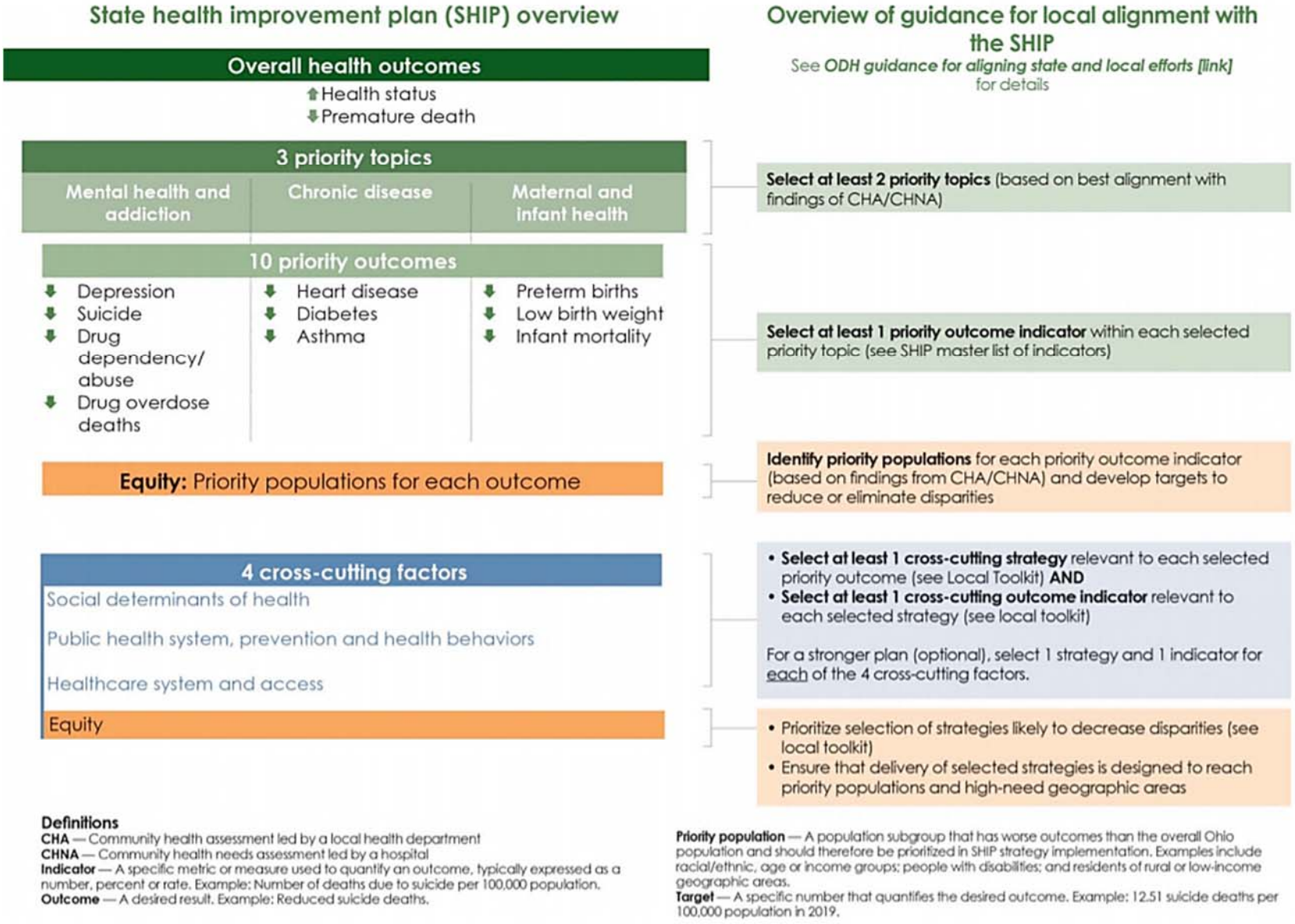
***This symbol will be used throughout the CHIP when a strategy or indicator directly aligns with the 2017-2019 SHIP. Throughout the report, hyperlinks will be highlighted in dark red text.***

The 2017-2020 Sandusky County CHIP had 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 State Health Improvement Plan. The following Sandusky County CHIP priority topics, outcomes and cross cutting factors very closely align with the 2017-2019 State Health Improvement Plan (SHIP) priorities:

| ***2017-2020 Sandusky County CHIP Alignment*** | | |
|---|---|---|
| ***Priority topics*** | ***Priority outcomes*** | ***Cross-cutting factors*** |
| • Mental health and addiction<br>• Chronic disease<br>• Maternal and infant health | • Depression<br>• Suicide death<br>• Unintentional drug overdose<br>• Diabetes<br>• Infant mortality<br>• Preterm births<br>• Very preterm births | • Public health system, prevention and health behaviors<br>• Social determinants of health<br>• Healthcare system and access |

## ALIGNMENT WITH NATIONAL AND STATE STANDARDS, *continued*

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



## *Action Steps:*

To work toward **improving mental health and decreasing addiction**, the following actions steps are recommended:

1. Increase Awareness of Trauma Informed Care
2. Expand the Number of Primary Care Providers Screening for Depression During Office Visits
3. Expand Community Collaboration to Increase Awareness and Coordination of Mental Health Services
4. Increase Provider Training on Opioid Prescribing Guidelines

To work toward **decreasing chronic disease**, the following action steps are recommended:

1. Increase Healthy Eating Through Fostering Self-Efficacy
2. Implement Healthy Food Initiatives

To work toward **improving maternal and infant health**, the following actions steps are recommended:

1. Increase the Use of Safe Sleep Practices
2. Increase First Trimester Prenatal Care
3. Implement Smoke-Free Policies

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

1. Increase Early Identification of Mental Health Needs Among Youth
2. Implement School-based Alcohol and Other Drug Prevention Programs
3. Implement Shared Use (Joint Use Agreements)
4. Implement School-Based Nutrition Education Programs
5. Implement Complete Streets
6. School-Based Physical Activity Programs and Policies
7. Increase Access to Transportation
8. Increase Recruitment for Mental Health Professionals

# NEEDS ASSESSMENT

The Sandusky County Community Partners reviewed the 2016-2017 Sandusky 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 2016-2017 health assessment report?**

| Key Issue or Concern | Percent of Population at risk | Age Group (or Income Level) Most at Risk | Gender Most at Risk |
|---|---|---|---|
| **1. Obesity (27 votes)** | | | |
| Obese | 42% | Age: <30; Income<$25K | Female |
| Overweight | 33% | Age: <30; Income: $25K+ | Male |
| No physical activity in past week | 20% | N/A | N/A |
| Nutrition (ate 5+ fruits and vegetables per day) | 4% | N/A | N/A |
| **2. Drug Use (20 votes)** | | | |
| Used marijuana in the past 6 months | 5% | Age: <30; Income:<$25K | Male |
| Used other recreational drugs in past 6 months | 2% | N/A | N/A |
| Used medication not prescribed for them during past 6 months | 10% | Age: 30-64; Income: $25K+ | Male |
| **3. Alcohol use (18 votes)** | | | |
| Drank and drove | 9% | Income: $25K+ | N/A |
| Binge drank in the past month (of all adults) | 29% | N/A | N/A |
| Adult drinkers who binge drank in past month | 49% | Age: <30; Income: <$25K | Male |
| **4. Mental Health/Suicide (16 votes)** | | | |
| Felt sad or hopeless 2+ weeks in a row | 9% | Age: 65+; Income: <$25K | Female |
| Considered suicide | 1% | N/A | N/A |
| **5. Diabetes (14 votes)** | | | |
| Diagnosed with diabetes | 18% | Age: 30-64; Income: <$25K | Males |
| **6. Tobacco Use (13 votes)** | | | |
| Current Smoker | 19% | Age: <30; Income: <$25K | Female |
| Former Smoker | 24% | Age: 65+; Income: $25K+ | Male |
| **7. Cardiovascular Health (6 votes)** | | | |
| Had been diagnosed with high blood pressure | 33% | Age: 65+; Income: <$25K | Male |
| Had been diagnosed pre-hypertension | 7% | N/A | N/A |
| Heart disease | 4% | Age: 65+ | N/A |
| **8. Quality of life (5 votes)** | | | |
| Limited in some way due to physical, mental or emotional problems | 21% | Age: <30; Income: <$25k | Female |

# NEEDS ASSESSMENT, *continued*

**What are the most significant <u>YOUTH</u> health issues or concerns identified in the 2016-2017 health assessment report?**

| Key Issue or Concern | Percent of Population at risk | Age Group Most at Risk | Gender Most at Risk |
|---|---|---|---|
| **1. Mental Health (36 votes)** | | | |
| Felt sad or hopeless two or more weeks in a row | 28% | Age: 17+ | Female |
| Seriously considered suicide | 13% | N/A | N/A |
| Attempted suicide | 7% | Age: 14-16 | Female |
| Made a plan to attempt suicide in past month | 12% | Age: 17+ | Female |
| **2. Drug Use (35 votes)** | | | |
| Used marijuana in past month | 11% | Age: 17+ | N/A |
| Ever used K2/spice | 2% | N/A | N/A |
| Ever used inhalants | 5% | N/A | N/A |
| Ever been offered sold, or given an illegal drug by someone on school property in past year | 4% | N/A | N/A |
| Used prescription drugs that were not prescribed to them in past month | 4% | N/A | N/A |
| **3. Sexual Behaviors (31 votes)** | | | |
| Ever had sexual intercourse | 26% | Age: 17+ | Male |
| Used a condom at last intercourse | 67% | N/A | N/A |
| Oral sex | 21% | Age: 17+ | Male |
| Anal sex | 8% | Age: 17+ | Male |
| Sexting | 26% | Age: 17+ | Male |
| Viewed pornography | 29% | Age: 17+ | Male |
| Had four or more sexual partners (of all youth) | 11% | N/A | N/A |
| **4. Alcohol Use (30 votes)** | | | |
| Current drinker | 17% | Age: 17+ | Male |
| Binge drinker (of all youth) | 12% | N/A | N/A |
| Binge drinker (of current drinkers) | 40% | N/A | Male |
| Obtained alcohol by parent giving it to them (of drinkers) | 35% | N/A | N/A |
| Drank for the first time before age 13 (of all youth) | 37% | N/A | N/A |
| Ever tried alcohol | 59% | Age: 17+ | Male |
| Drove after drinking alcohol in past month | 7% | N/A | N/A |
| **5. Obesity (25 votes)** | | | |
| Obese | 23% | Age: 14-16 | Female |
| Overweight | 11% | Age: 14-16 | Female |
| Nutrition (ate 5+ fruits and vegetables per day) | 6% | N/A | N/A |
| Did not participate in at least 60 minutes of physical activity on any day in the past week | 13% | N/A | N/A |

# NEEDS ASSESSMENT, *continued*

**What are the most significant <u>YOUTH</u> health issues or concerns identified in the 2016-2017 health assessment report?**

| Key Issue or Concern | Percent of Population at risk | Age Group Most at Risk | Gender Most at Risk |
|---|---|---|---|
| **6. Bullying (22 votes)** | | | |
| Bullied in past year | 42% | N/A | N/A |
| Bullied on school property in past year | 27% | N/A | N/A |
| Electronically/cyber bullied in past year | 15% | N/A | N/A |
| **7. ACES (22 votes)** | | | |
| 3 or more ACES | 25% | N/A | N/A |
| **8. Distracted Driving (18 votes)** | | | |
| Texting while driving in past month | 15% | N/A | N/A |
| Talked on their cell phone while driving in past month | 22% | N/A | N/A |
| Drove while tired or fatigue in past month | 22% | N/A | N/A |
| Used marijuana while driving in past month | 4% | N/A | N/A |
| Ate while driving in the past month | 35% | N/A | N/A |
| **9. Technology (15 Votes)** | | | |
| Had a social network account | 90% | N/A | N/A |
| Average hours of cell phone use | 3.6* | N/A | N/A |

**Indicates hours of usage*

# NEEDS ASSESSMENT, *continued*

**What are the most significant CHILD health issues or concerns identified in the 2016-2017 health assessment report?**

| Key Issue or Concern | Percent of Population at risk | Age Group Most at Risk | Gender Most at Risk |
|---|---|---|---|
| **1. Obesity (26 votes)** | | | |
| Obese | 36% | N/A | N/A |
| Overweight | 15% | N/A | N/A |
| Underweight | 6% | N/A | N/A |
| **2. Infant Mortality (17 votes)** | | | |
| Number of infant deaths | 7* | N/A | N/A |
| **3. Family Meals (14 votes)** | | | |
| Family eats a meal together 7 days a week | 33% (0-5); 34% (6-11) | N/A | N/A |
| **4. Behavior (14 votes)** | | | |
| Child has behavior/conduct problems | 3% | N/A | N/A |
| **5. Reading (8 votes)** | | | |
| Parent reads to child every day | 16% (0-5) | N/A | N/A |
| **6. Emergency Room Use (6 votes)** | | | |
| Parent took child to ER for primary care | 3% | N/A | N/A |
| Parent took child to ER for mental health care | 2% | N/A | N/A |
| Parent took child to ER for other sick visits | 23% | N/A | N/A |
| **7. Asthma (4 votes)** | | | |
| Have been diagnosed with asthma by a health professional | 14% | N/A | N/A |
| **8. Tobacco use (4 votes)** | | | |
| Someone in the household smoked tobacco | 20% | N/A | N/A |
| **9. Allergies (2 votes)** | | | |
| Environmental allergies | 22% | N/A | N/A |
| Animal allergies | 7% | N/A | N/A |
| Peanut allergies | 3% | N/A | N/A |
| **10. Mental Health (1 votes)** | | | |
| Child sometimes felt unhappy | 64% | N/A | N/A |

**Number indicates total infant deaths in Sandusky County in 2015. Rates based on fewer than 20 infant deaths are unstable and not reported. Source: 2015 Ohio Infant Mortality Data: General Findings.*

# PRIORITIES CHOSEN

Based on the 2016-2017 Sandusky County Health Assessment, key issues were identified for adults, youth and children. Committee members' rankings were then combined to give an average score for the issue.

| Health Issue | Average Score |
|---|---|
| 1. Adult and Youth Drugs Use | 25.4 |
| 2. Adult, Youth, and Child Obesity | 24.9 |
| 3. Adult, Youth, and Child Mental Health | 24.6 |
| 4. Youth ACES (3+) | 21.8 |
| 5. Distracted Driving | 21.6 |
| 6. Diabetes | 21.5 |
| 7. Technology | 21.1 |
| 8. Infant Mortality | 21.0 |
| 9. Youth Sexual Behavior | 19.9 |
| 10. Youth Bullying | 19.8 |

**Sandusky County will focus on the following four priorities over the next 3 years:**

1. Mental Health and Addiction, including adult and youth alcohol use, drug use, depression and suicide
2. Chronic Disease, including adult, youth and child obesity and adult diabetes
3. Maternal and Infant Health, including infant mortality

# FORCES OF CHANGE

The Sandusky County Community Partners were asked to identify positive and negative forces which could impact community health improvement and overall health of this community over the next three to five years. This group discussion covered many local, state, and national issues and change agents which could be factors in Sandusky County in the near future. The table below summarizes the forces of change agent and its potential impacts.

| Force of Change | Impact |
|---|---|
| **1. Staffing** | o No interest in field<br>o Burnout rate is high<br>o Tough work<br>o Pay is decent<br>o Especially in mental health |
| **2. Generational poverty** | o Poverty continues over time |
| **3. Shortened attention span** | o Average person pays attention for a maximum of 15 minutes<br>o Lack of research and detail<br>o No more investigating<br>o Ex: Voting |
| **4. Opiate epidemic** | o Increase in addiction and overdose deaths |
| **5. Medicinal marijuana** | o Potential increase in marijuana use |
| **6. Budget cuts from government** | o Healthcare providers |
| **7. Possible closures in the area (Davis Besse)** | o Economic change |
| **8. Shortage of providers** | o Health care is not easily accessible |
| **9. Number of children affected by opiates** | o Increase in adverse childhood experiences and functioning |
| **10. Proximity to river might bring economic opportunities** | o Possible increase in business and revenue |
| **11. Technology** | o Lack of socialization<br>o Development issues<br>o Too much screen time<br>o Interpersonal communications |
| **12. Climate change** | o Industry<br>o Environment |
| **13. Loss of time with recess** | o Lack of social interaction and physical activity |
| **14. Lack of faith-based involvement** | o No church attendance and programs at schools |
| **15. Lack of time in schools** | o Teachers need to meet requirements<br>o No time to have social conversations regarding health topics |
| **16. Decrease in farming** | o Less employment<br>o No interest in farming<br>o Pricing |
| **17. Infrastructure** | o Lack of sidewalks and physical activity |
| **18. Millennials** | o Changes in health messaging |
| **19. Society is "busy"** | o No time for volunteerism<br>o Decrease in family time |
| **20. Scheduling conflicts** | o School exams clash with church times<br>o Decrease in faith interaction |

# FORCES OF CHANGE, *continued*

| | |
|---|---|
| **21. Education** | o No impact identified |
| **22. Health Department Levy** | o Changes in funding and programs |
| **23. Changes in funding** | o Funding is not consistent |
| **24. Affordable Care Act changes** | o Insurance reimbursements |
| **25. Regionalization in public health** | o Consolidation<br>o Changes funding distribution |

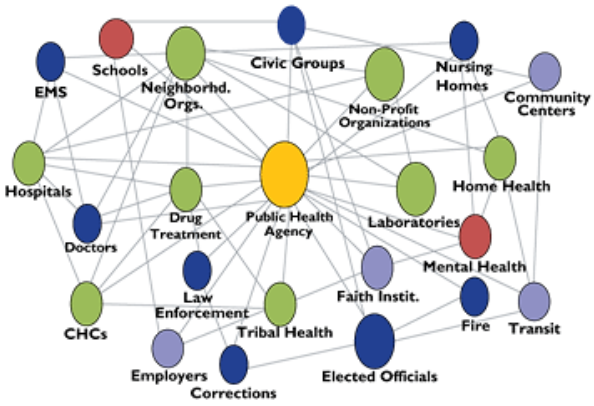
# LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

## 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; **http://www.cdc.gov/nphpsp/essentialservices.html**)*

# *LOCAL PUBLIC HEALTH SYSTEM, continued*

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**.

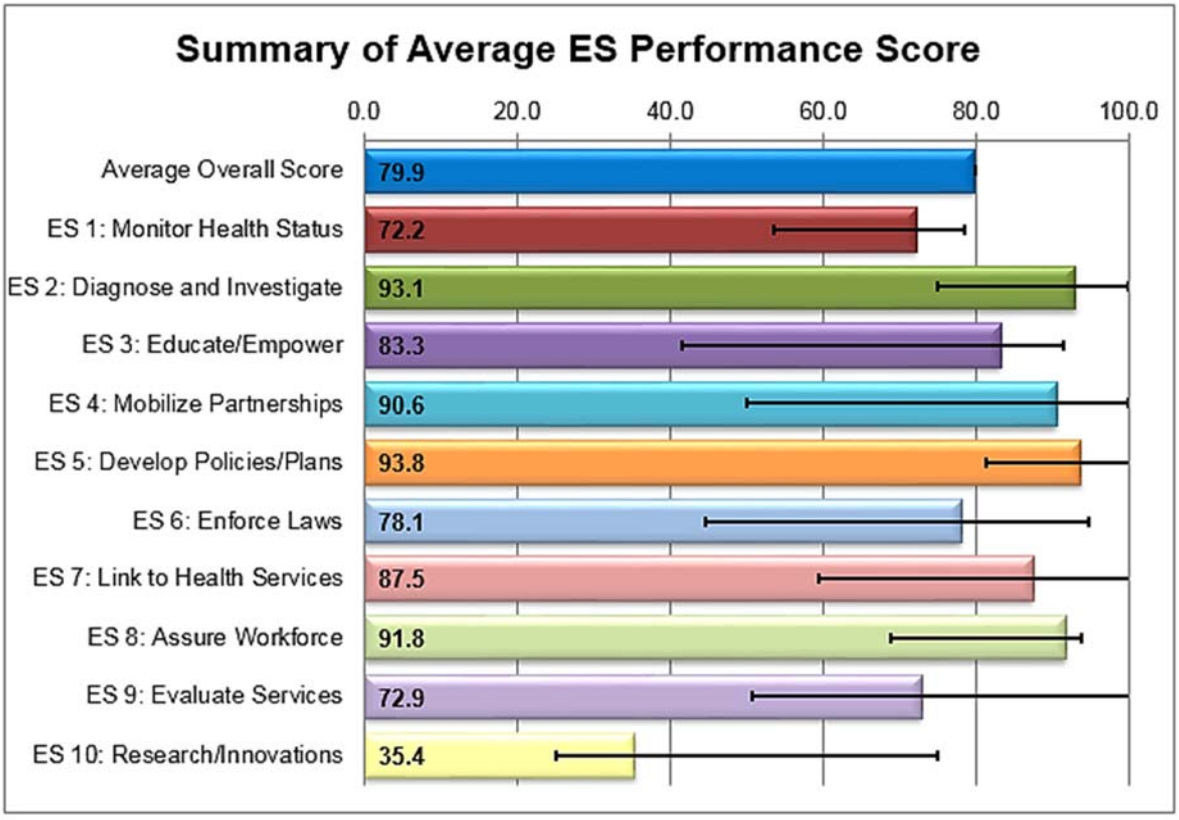
Members of the Sandusky County Health Department completed the performance measures instrument. The LPHSA results were then presented to the full CHIP committee for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard 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 seven indicators that had a status of "minimal" and zero 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 Stacey Gibson from the Sandusky County Health Department at 419-334-6395 or at **sgibson@sanduskycohd.org**.

**Sandusky County Local Public Health System Assessment**
**2017 Summary**



# COMMUNITY THEMES AND STRENGTHS

The Sandusky County Community Partners participated in an exercise to discuss community themes and strengths. The results were as follows:

**Sandusky County community members believed the most important characteristics of a healthy community were:**

- Provider availability
- Employment opportunity
- Communication
- Strength of community partners
- Reliable transportation services
- Network of first responders
- Strong tax base
- Involvement from faith community
- Recreational activities for adult and youth
- Involvement from political leaders
- Strong schools
- Low dropout rate for high school
- Multiprong approach
- Rehabilitation services for the incarcerated
- Access to healthy options
- Employment
- Recognition of diversity
- Acceptance of change
- Strong partnerships with external resources
- Boundaries and expectations

**Community members were most proud of the following regarding their community:**

- Strong partnerships
- Ample amount of community resources
- Community response to philanthropic goals
- Generous community
- Farming community
- Diversity
- Parks system
- Unity during time of crisis
- Volunteerism
- Faith based organizations
- Music and arts
- Community mobilization around issues

**The following were specific examples of people or groups who have worked together to improve the health and quality of life in the community:**

- Service groups
- FCFC
- I-Team
- CHIP coalitions
- Health Partners
- Prevention Partnership
- Creating Healthy Communities
- United Way
- Chamber Health/Wellness Coalition
- Health and Wellness Community
- Fremont City Schools Healthy Schools Leadership Institute
- First Call for Help
- Cohesion between community groups
- FCS/ProMedica/Grace/Terra
- Suicide Prevention Coalition
- Drug Task Force
- Mental Health Coalition
- Government representation
- Nutritionist in City Schools
- Bike Trail committee
- Safety Council

# *COMMUNITY THEMES AND STRENGTHS, continued*

**The most important issues that Sandusky County residents believed must be addressed to improve the health and quality of life in their community were:**

- Transportation
- Health literacy
- Nutrition
- Drug/opioid epidemic
- Prevention
- Education
- Health promotion
- Employment resources
- Pregnancy outcomes
- Staffing issues
- Stigma regarding mental health
- Lack of motivation (self-empowerment)
- Healthy parenting
- Coping skills
- Culture wants "quick fix"

**The following were barriers that have kept the community from doing what needs to be done to improve health and quality of life:**

- Adversity to change
- Self-focused
- Unwillingness to break bad habits
- Funding
- Lack of personnel
- Difficulty reaching population
- Taking on too much (not efficient)
- Lacking prevention
- Policy changes
- Jumping through too many hoops to get services
- Society is not proactive
- Understanding poverty
- Need to stay alert of all problems at the table

**Sandusky County residents believed the following actions, policies, or funding priorities would support a healthier community:**

- Ban on marijuana dispensers
- Drug screenings/welfare benefits
- Offer treatment to those who have drug problems
- Centralized resource for all the community resources (website)
- High School graduation requirements (job, college acceptance, military, etc.)
- Community calendar
- College discount to those who stay and work in the area
- Complete streets policy
- Sidewalks/walkability
- Support health department levy
- Increase number of mental health facilities
- Funding
- Public transportation

**Sandusky County residents were most excited to get involved or become more involved in improving the community through:**

- Community engagement
- Open communication about various health topics (i.e. sexual health)
- Data
- Success stories
- Evidence based feedback
- Teaching self-respect and modesty
- Funding

# QUALITY OF LIFE SURVEY

The Sandusky County Community Partners encouraged community members to fill out a short Quality of Life Survey via Survey Monkey. There were 307 Sandusky 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 |
|---|---|
| 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] | 3.56 |
| 2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.) | 3.29 |
| 3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.) | 3.62 |
| 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.) | 3.41 |
| 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.) | 3.11 |
| 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?) | 3.45 |
| 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? | 3.58 |
| 8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life? | 3.48 |
| 9. Do all residents perceive that they — individually and collectively — can make the community a better place to live? | 3.07 |
| 10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide) | 3.22 |
| 11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals? | 3.29 |
| 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?) | 3.18 |

# RESOURCE ASSESSMENT

Based on the chosen priorities, Sandusky County Community Partners 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.

The resource assessment can be found at the following link: **http://www.alwayschoosehealth.com/**

# Priority #1 | Mental Health & Addiction

## *Mental Health Indicators*

*Note: Additional data can be found in the full 2016-2017 Sandusky County Community Health Assessment, as well as requesting local primary data from county agencies.*

### Adult Mental Health and Addiction

One in eleven (9%) adults felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities, increasing to 14% of females and 15% of those with incomes less than $25,000.

In 2016, there were 6 suicide deaths in Sandusky County. *(Source: Sandusky County Coroner & Medical Examiner, 2016)*

In 2016, there were 22 unintentional drug overdose deaths in Sandusky County.* *(Source: Sandusky County Coroner & Medical Examiner, 2016)*

More than one-fourth (29%) of all Sandusky County adults were considered binge drinkers (consuming five or more alcoholic drinks (for males) or 4 or more drinks (for females) on an occasion in the last month).

### Youth Mental Health and Addiction

In 2016, over one-quarter (28%) 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 37% of females and 43% of those ages 17 and older.

In the past year, 7% of youth had attempted suicide, increasing to 11% of females.

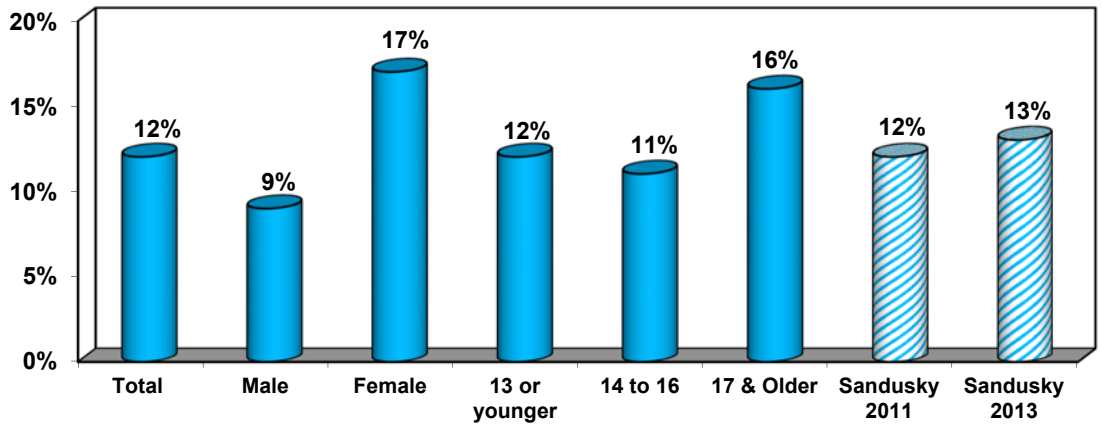
In 2016, 11% of all Sandusky County youth had used marijuana at least once in the past 30 days, increasing to 21% of those over the age of 17.

*Four percent (4%) of youth used prescription drugs that were not prescribed for them during the past 30 days.*

*Seven percent (7%) of all youth were defined as binge drinkers, increasing to 12% of high school youth.*

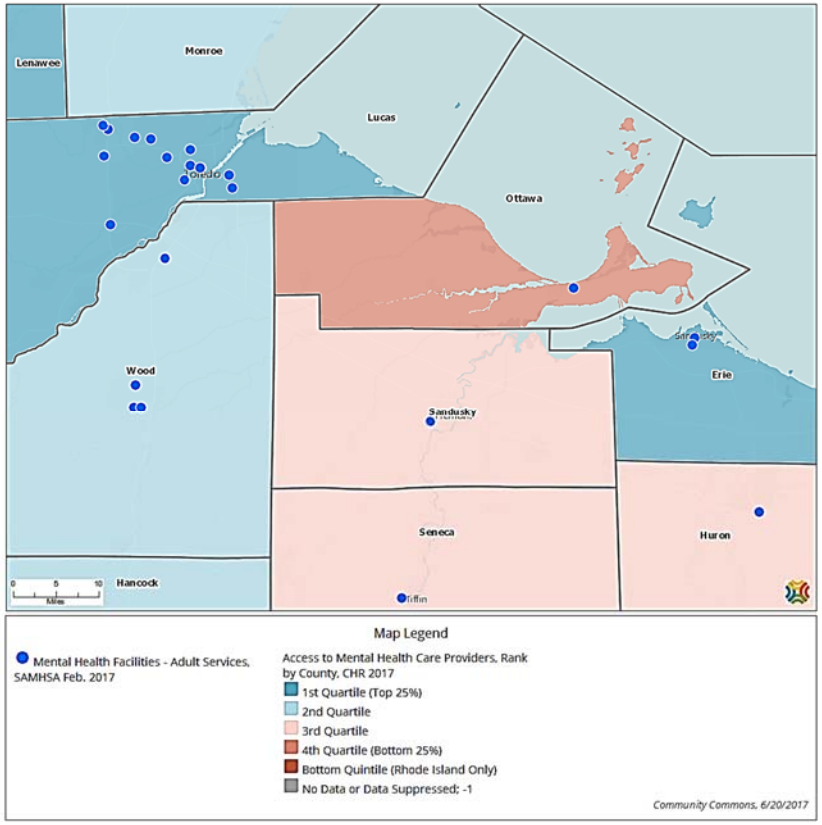
**Data is considered incomplete and may be updated in the future*

**Sandusky County Youth Who Made a Plan to Attempt Suicide in the Past 12 Months**



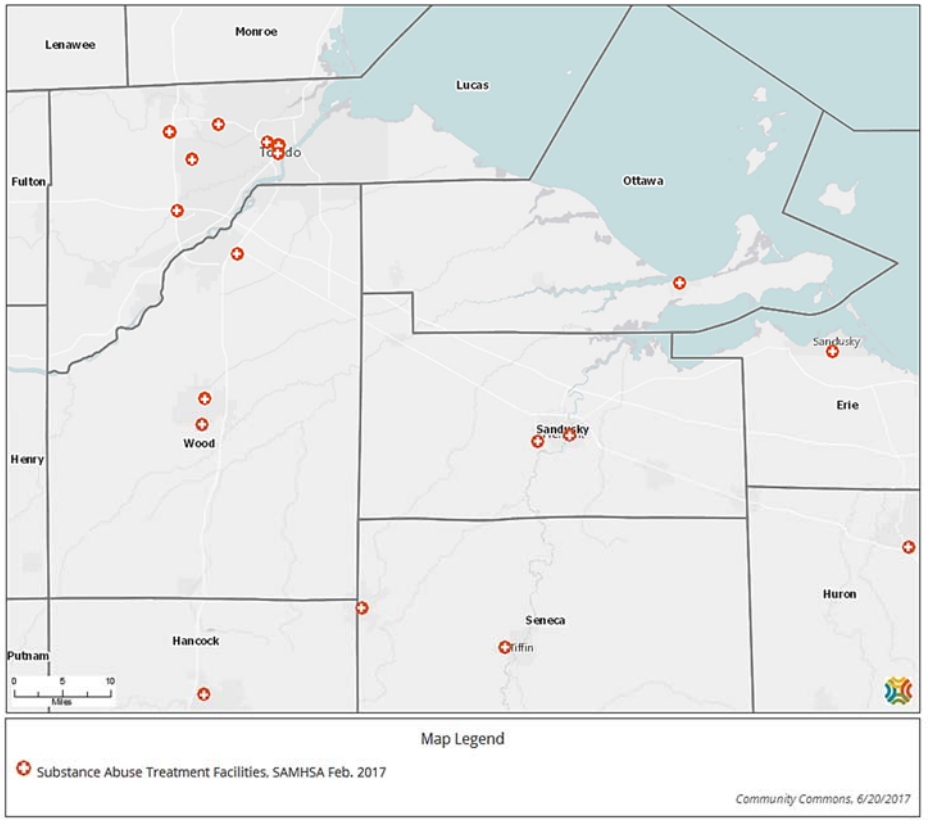
# **Priority #1** | Mental Health & Addiction

## Access to Mental Health Care Providers, Rank by County, CHR 2017




*(Source: Community Commons, 2017)*

## Substance Abuse Treatment Facilities, SAMHSA 2017




*(Source: Community Commons, 2017)*

# **Priority #1** | Mental Health & Addiction

## *Gaps and Potential Strategies*

| Gaps | Potential Strategies |
|---|---|
| **1. Lack of staffing (psychologists, therapists)** | o Work with SCEDC to assist with staffing recruitment to community |
| **2. Mental health stigma** | o Education awareness<br>o Role modeling<br>o School programs |
| **3. Lack of faith representation** | o Bring it back<br>o After school options, such as "Lindsey Community" |
| **4. Lack of engagement with youth to identify their problems** | o Create survey<br>o Disseminate handouts at schools<br>o Distribute help text line bracelets<br>o Utilize text help line data |
| **5. Media negativity** | o None identified |
| **6. Lack of mental health services for the incarcerated** | o Bring counselors to adult facilities (similar to juvenile)<br>o Increase funding |
| **7. Lack of knowledge of prevention/services** | o Market importance of prevention to the community and community partners<br>o Whole child approach |
| **8. Lack of pediatric psychiatry** | o Develop a list to refer parents outside of county to services |
| **9. Lack of communicating local resources** | o Create a community calendar/resource app for cell phones<br>o Update community agency websites with resources |
| **10. Lack of actions at the state and federal level** | o Advocate for local needs |
| **11. Lack of detox programs for outpatient and inpatient** | o EMS continues to assist those in need after opiate call. Need to expand services. |
| **12. Lack of access to public transportation** | o Cost effective<br>o Recruit drivers, volunteers<br>o Increase taxi cabs |

# Priority #1 | Mental Health & Addiction

## *Best Practices*

1. **PHQ-9:** The PHQ-9 is the nine-item depression scale of the Patient Health Questionnaire. The PHQ-9 is a powerful tool for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment. The primary care clinician and/or office staff should discuss with the patient the reasons for completing the questionnaire and how to fill it out. After the patient has completed the PHQ-9 questionnaire, it is scored by the primary care clinician or office staff.

   There are two components of the PHQ-9:
   - Assessing symptoms and functional impairment to make a tentative depression diagnosis, and
   - Deriving a severity score to help select and monitor treatment
     The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV).

   For more information go to: **http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression**

2. **Project ASSERT**: Project ASSERT (Alcohol and Substance Abuse Services, Education, and Referral to Treatment) is a screening, brief intervention, and referral to treatment (SBIRT) model designed for use in health clinics or emergency departments (EDs). Project ASSERT targets three groups:

   a. Out-of-treatment adults who are visiting a walk-in health clinic for routine medical care and have a positive screening result for cocaine and/or opiate use. Project ASSERT aims to reduce or eliminate their cocaine and/or opiate use through interaction with peer educators (substance abuse outreach workers who are in recovery themselves for cocaine and/or opiate use and/or are licensed alcohol and drug counselors).
   b. Adolescents and young adults who are visiting a pediatric ED for acute care and have a positive screening result for marijuana use. Project ASSERT aims to reduce or eliminate their marijuana use through interaction with peer educators (adults who are under the age of 25 and, often, college educated).
   c. Adults who are visiting an ED for acute care and have a positive screening result for high-risk and/or dependent alcohol use. Project ASSERT aims to motivate patients to reduce or eliminate their unhealthy use through collaboration with ED staff members (physicians, nurses, nurse practitioners, social workers, or emergency medical technicians).

   On average, Project ASSERT is delivered in 15 minutes, although more time may be needed, depending on the severity of the patient's substance use problem and associated treatment referral needs. The face-to-face component of the intervention is completed during the course of medical care, while the patient is waiting for the doctor, laboratory results, or medications.

   For more information go to: **http://www.integration.samhsa.gov/clinical-practice/sbirt**

# Priority #1 | Mental Health & Addiction

## Action Step Recommendations & Action Plan

To work toward **improving mental health and decreasing addiction**, the following actions steps are recommended:

1. Increase Awareness of Trauma Informed Care
2. Expand the Number of Primary Care Providers Screening for Depression During Office Visits
3. Expand Community Collaboration to Increase Awareness and Coordination of Mental Health Services
4. Increase Provider Training on Opioid Prescribing Guidelines

<table>
<tr><th colspan="5">Priority Topic: Mental Health and Addiction</th></tr>
<tr><th colspan="5">Strategy 1: Increase Awareness of Trauma Informed Care</th></tr>
<tr><th>Action Step</th><th>Priority Outcome & Indicator</th><th>Priority Population</th><th>Person/<br>Agency Responsible</th><th>Timeline</th></tr>
<tr><td>Year 1: Facilitate an assessment among clinicians, teachers and community members on their awareness and understanding of trauma informed care, including toxic stress and adverse childhood experiences.<br><br>Administer a training to increase education and understanding of trauma informed care.</td><td rowspan="3">Priority Outcomes:<br>1. Reduce suicide deaths in adults<br>2. Reduce suicide ideation in youth<br><br>Priority Indicator:<br>1. Number of deaths due to suicide per 100,000 populations (age adjusted) (per SHIP)<br>2. Percent of youth who report that they ever seriously considered attempting suicide within the past 12 months (per SHIP)</td><td rowspan="3">Adults and youth</td><td rowspan="3">Sandusky County FCFC</td><td>August 18, 2018</td></tr>
<tr><td>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%.</td><td>August 18, 2019</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2. Increase the use of trauma screening tools by 25%.</td><td>August 18, 2020</td></tr>
</table>

| Priority Topic: Mental Health and Addiction | | | | |
|---|---|---|---|---|
| **Strategy 2: Expand the Number of Primary Care Providers Screening for Depression During Office Visits** | | | | |
| **Action Step** | **Priority Outcome & Indicator** | **Priority Population** | **Person/ Agency Responsible** | **Timeline** |
| **Year 1:** Collect baseline data on the number of primary care providers that currently screen for depression during office visits.<br><br>Continue to educate providers regarding **PHQ-2 and PHQ-9** screening tools. Increase the number of primary care providers using the PHQ-2 and PHQ-9 screening tools by 10% from baseline. | **Priority Outcomes:**<br>1. Reduce adult depression<br>2. Reduce adolescent depression<br><br>**Priority Indicators:**<br>1. Percentage of adults that felt sad or hopeless for two or more weeks in a row (alternate county indicator per SHIP)<br>2. Percentage of adolescents that felt sad or hopeless for two or more weeks in a row (alternate county indicator per SHIP) | Adults and youth | Sandusky County Health Department | August 18, 2018 |
| **Year 2:** Continue efforts from year 1. Increase the number of primary care providers using the PHQ-2 and PHQ-9 screening tools by 20% from baseline. | | | | August 18, 2019 |
| **Year 3**: Continue efforts from years 1 and 2. Increase the number of primary care providers using the PHQ-2 and PHQ-9 screening tools by 30% from baseline. | | | | August 18, 2020 |

<table>
<tr><th colspan="5">Priority Topic: Mental Health and Addiction</th></tr>
<tr><th colspan="5">Strategy 3: Expand Community Collaboration to Increase Awareness and Coordination of Mental Health and Substance Abuse Services</th></tr>
<tr><th>Action Step</th><th>Priority Outcome & Indicator</th><th>Priority Population</th><th>Person/<br>Agency Responsible</th><th>Timeline</th></tr>
<tr><td>Year 1: Work with the mental health/substance abuse combined coalition and Prevention Partnership to invite faith-based leaders, local businesses, community organizations and mental health/substance abuse service providers to have a round-table discussion. Compile comprehensive baseline data on what programs and services (Mental Health First Aid, Narcan, Vivitrol, prevention, Seller/Server training, detox, First Call for Help etc.) are offered within or near Sandusky County, and address gaps in care coordination.</td><td rowspan="3">Priority Outcomes:<br>1. Reduce adult unintentional drug overdose deaths<br>2. Reduce youth marijuana use<br>3. Reduce youth alcohol use<br>4. Reduce suicide deaths in adults<br>5. Reduce suicide ideation in youth<br><br>Priority Indicators:<br>1. Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted) (per SHIP)<br>2. Percent of youth who report using marijuana one or more time within the past 30 days (per SHIP)<br>3. Percent of youth who drank one or more drinks of an alcoholic beverage in the past 30 days (per SHIP)<br>4. Number of deaths due to suicide per 100,000 populations (age adjusted) (per SHIP)<br>5. Percent of youth who report that they ever seriously considered attempting suicide within the past 12 months (per SHIP)</td><td rowspan="3">Adults and youth</td><td rowspan="3">Mental Health and Recovery Services Board of Seneca, Sandusky and Wyandot Counties</td><td>August 18, 2018</td></tr>
<tr><td>Year 2: Continue efforts from year 1. Create an informational brochure/app/online guide that highlights all organizations in Sandusky County that provide mental health/substance abuse programs and services. Include information on transportation options and which organizations offer free services, a sliding fee scale, and which insurance plans are accepted. Update on a quarterly basis.<br><br>Create a presentation on available mental health/substance abuse services and present it to Sandusky County area churches, law enforcement, chamber of commerce, city council, service clubs, and businesses. Include information on mental health stigma, and work to increase community awareness and education of stigma and how it is a barrier to treatment.</td><td>August 18, 2019</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2.</td><td>August 18, 2020</td></tr>
</table>

| Priority Topic: Mental Health and Addiction | | | | |
|---|---|---|---|---|
| **Strategy 4: Increase Provider Training on Opioid Prescribing Guidelines** | | | | |
| **Action Step** | **Priority Outcome & Indicator** | **Priority Population** | **Person/ Agency Responsible** | **Timeline** |
| **Year 1**: Develop a training on opioid prescribing guidelines and the use of OARRS (Ohio Automated Rx Reporting System).<br>Offer the training to local healthcare providers. | **Cross-cutting Outcome:** Sales of opioid pain relievers<br><br>**Cross-cutting Indicator:** Kilograms of opioid pain relievers sold per 100,000 population | Adult | ProMedica Memorial Hospital | August 18, 2018 |
| **Year 2:** Continue to market the training to local healthcare providers.<br>Increase the number of trainings by 10%. | | | | August 18, 2019 |
| **Year 3:** Continue efforts from year 2. Increase the number of trainings by 15%. | | | | August 18, 2020 |

# **Priority #2** | Chronic Disease

## Chronic Disease Indictors

*Note: Additional data can be found in the full 2016-2017 Sandusky County Community Health Assessment, as well as requesting local primary data from county agencies.*

### Adult Chronic Disease

In 2016, the health assessment indicated that three-fourths (75%) of Sandusky County adults were either overweight (33%) or obese (42%) by Body Mass Index (BMI).

Four percent (4%) of adults ate 5 or more servings of fruits and vegetables per day; 18% ate 3 to 4 servings; 70% ate 1 to 2 servings; and 8% ate 0 servings of fruits and vegetables per day.

Three percent (3%) of the population have limited access to healthy foods (n=1,565) (Source: USDA Food Atlas via Community Health Rankings).

More than two-thirds (68%) of adults did not exercise for at least 30 minutes on 5 or more days per week.

One-fifth (20%) of adults did not participate in any physical activity in the past week, including 5% who were unable to exercise.

The 2016 health assessment has identified that 18% of Sandusky County adults had been diagnosed with diabetes, increasing to 24% of those ages 30-64.

### Youth Chronic Disease

In 2016, 23% of youth were classified as obese by Body Mass Index (BMI) calculations and 11% of youth were classified as overweight.

More than one-tenth (13%) of youth did not participate in at least 60 minutes of physical activity on any day in the past week.

Six percent (6%) of youth ate 5 or more servings of fruits and vegetables per day; 24% ate 3 to 4 servings; 60% ate 1 to 2 servings; and 10% ate 0 servings of fruits and vegetables per day.

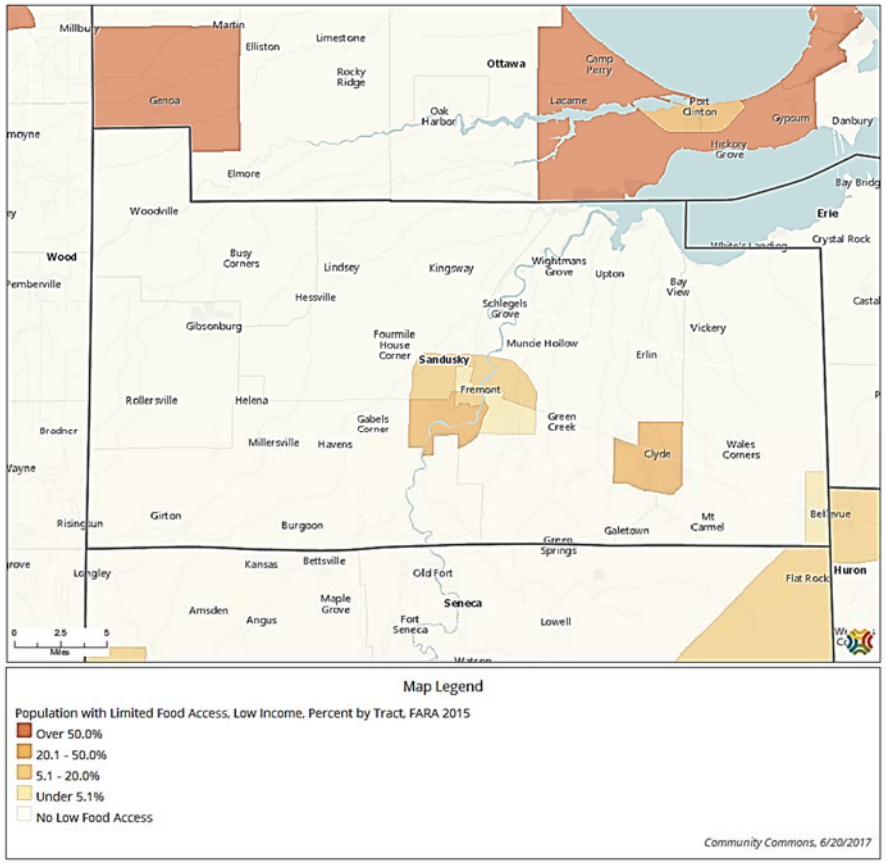
### Child Chronic Disease

Over one-third (36%) of children were classified as obese by Body Mass Index (BMI) calculations and 15% of children were classified as overweight.

Five percent (5%) of children ate 5 or more servings of fruits and vegetables per day; 36% ate 3 to 4 servings; and 58% ate 1 to 2 servings of fruits and vegetables per day. Two percent (2%) of parents reported that their child did not eat fruits and vegetables.

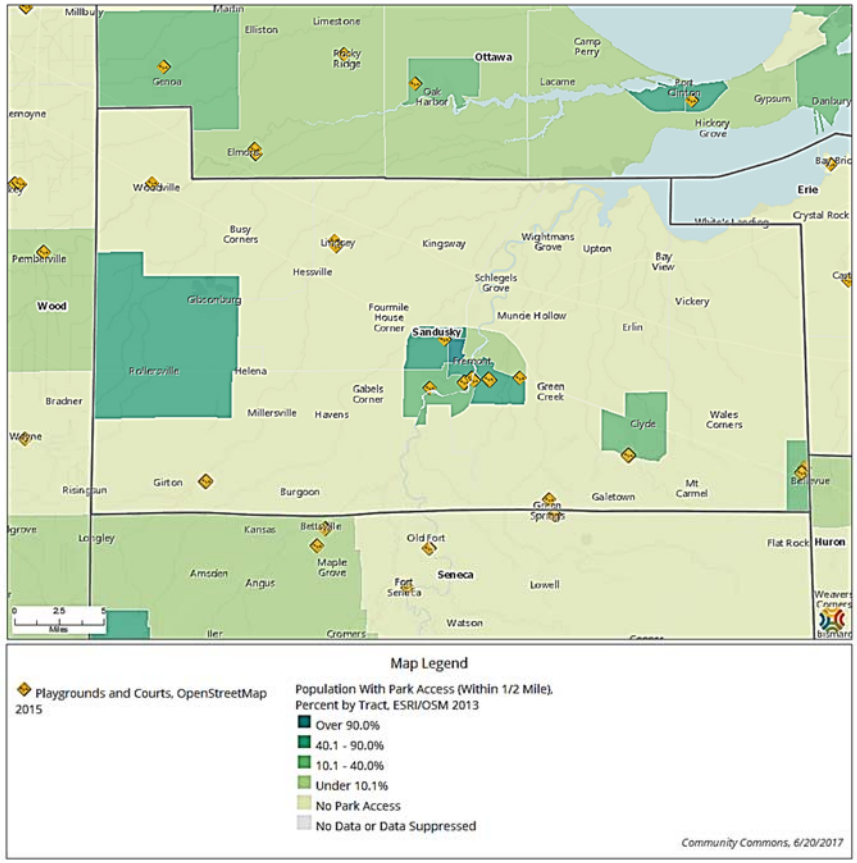
# **Priority #2** | Chronic Disease

**Population with Limited Food Access, Low income, Population by Tract, FARA 2015**




*(Source: Community Commons, Updated 2017)*

**Population with Park Access (Within ½ Mile), Percent by Tract, ESRI/OSM 2013**




*(Source: Community Commons, Updated 2017)*

# **Priority #2** | Chronic Disease

## *Gaps and Potential Strategies*

| Gaps | Potential Strategies |
|---|---|
| **1. Transportation** | o Increase funding |
| **2. Lack of education** | o Improve health literacy<br>o Prevention |
| **3. Healthcare costs** | o Decrease ER/Urgent care visits<br>o Increase primary care provider referrals<br>o Healthcare coordination |
| **4. Access to health foods** | o In-home nutritionist support<br>o "Shop with a doctor or nutritionist day"<br>o Hunger screenings<br>o Food pharmacy<br>o Sampling food at food pantries with fruits and vegetables<br>o Cooking classes<br>o Community gardens<br>o Healthy food promotion in local grocery stores<br>o Increase awareness<br>o Healthier options at food pantries<br>o Accept EBT at farmer's markets<br>o Healthy corner stores |
| **5. Lack of infrastructure (active transportation)** | o Design and create streets and sidewalks/bike trails/bike racks<br>o Complete streets policies |
| **6. Lack of resource communication** | o Community calendar application |
| **7. Marketing strategies with fast food restaurants** | o Education |

# **Priority #2** | Chronic Disease

## Best Practices

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

1. **Cooking Matters** (No Kid Hungry Center for Best Practices): Cooking Matters hands-on courses empower families with the skills to be self-sufficient in the kitchen. In communities across America, participants and volunteer instructors come together each week to share lessons and meals with each other. Cooking Matters is an evidence-based program.

   Courses meet for two hours, once a week for six weeks and are team-taught by a volunteer chef and nutrition educator. Lessons cover meal preparation, grocery shopping, food budgeting and nutrition. Participants practice fundamental food skills, including proper knife techniques, reading ingredient labels, cutting up a whole chicken, and making a healthy meal for a family of four on a $10 budget. Adults and teens take home a bag of groceries after each class so they can practice the recipes taught that day.

   Community partners that serve low-income families offer six-week Cooking Matters courses to adults, kids and families. Share Our Strength provides seven specialized curricula that cover nutrition and healthy eating, food preparation, budgeting and shopping. Cooking Matters' culinary and nutrition volunteers teach these high-quality, cooking-based courses at a variety of community-based agencies—including Head Start centers, housing centers and after-school programs—with neighborhood locations that make it easy for families to attend.

   For more information go to: **http://cookingmatters.org/courses**

# Priority #2 | Chronic Disease

## Action Step Recommendations & Plan

To work toward decreasing **chronic disease**, the following actions steps are recommended:

1. Increase Healthy Eating Through Fostering Self-Efficacy
2. Implement Healthy Food Initiatives

<table>
<tr><th colspan="5">Priority Topic: Chronic Disease</th></tr>
<tr><th colspan="5">Strategy 1: Increase Healthy Eating Through Fostering Self-Efficacy</th></tr>
<tr><th>Action Step</th><th>Priority Outcome & Indicator</th><th>Priority Population</th><th>Person/<br>Agency Responsible</th><th>Timeline</th></tr>
<tr><td>Year 1: Continue to implement Share Our Strength's Cooking Matters program and explore the feasibility of expanding the program in Sandusky County. Collect baseline data of existing cooking classes taking place in Sandusky County.<br><br>Work with at least one additional organization to pilot a 6-week course of the Cooking Matters program. Measure knowledge gained through evaluations.</td><td rowspan="3">Priority Outcomes:<br>1. Reduce diabetes<br>2. Reduce adult obesity<br>3. Reduce youth obesity<br>4. Reduce child obesity<br><br>Priority Indicators:<br>1. Percent of adults who have been told by a health professional that they have diabetes<br>2. Percent of adults that report body mass index (BMI) greater than or equal to 30 (per SHIP)<br>3. Percent of youth who were obese (>95th percentile for BMI, based on sex- and age-specific reference data from the 2000 CDC growth charts) (per SHIP)<br>4. Percent of children who are overweight or obese by BMI</td><td rowspan="3">Adult, youth and children</td><td rowspan="3">OSU Extension</td><td>August 18, 2018</td></tr>
<tr><td>Year 2: Continue efforts to implement at least one Cooking Matters class per quarter.<br><br>Utilizing the Cooking Matters at the Store framework, conduct quarterly grocery store tours by a Registered Dietitian or Health Educator in grocery stores throughout Sandusky County. Invite seniors and disabled populations to attend, along with the public.<br><br>Measure knowledge gained through evaluations.</td><td>August 18, 2019</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2.<br><br>Measure knowledge gained through evaluations.</td><td>August 18, 2020</td></tr>
</table>

| Priority Topic: Chronic Disease | | | | |
|---|---|---|---|---|
| **Strategy 2: 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** and/or farmer's markets.<br><br>Obtain baseline data regarding which local **food pantries** have fresh produce available.<br><br>Research grants and other funding opportunities to increase the number of community gardens and/or farmer's markets in Sandusky County. | **Priority Outcomes:**<br>1. Reduce diabetes<br>2. Reduce adult obesity<br>3. Reduce youth obesity<br>4. Reduce child obesity<br><br>**Priority Indicators:**<br>1. Percent of adults who have been told by a health professional that they have diabetes<br>2. Percent of adults that report body mass index (BMI) greater than or equal to 30 (per SHIP)<br>3. Percent of youth who were obese (>95th percentile for BMI, based on sex- and age-specific reference data from the 2000 CDC growth charts) (per SHIP)<br>4. Percent of children who are overweight or obese by BMI | Adult, youth and children | Creating Healthy Communities Coalition | August 18, 2018 |
| **Year 2**: Assist churches, libraries, and other organizations in applying for grants to obtain funding for a community garden or farmer's market.<br><br>Work with food pantries to offer fresh produce and assist pantries in seeking donations from local grocers.<br><br>Encourage the use of **SNAP/EBT (Electronic Benefit Transfer) at farmers' markets**.<br><br>Offer fresh food sampling (with recipe cards, etc.) at food pantries and farmer's markets. | | | | August 18, 2019 |
| **Year 3**: Implement community gardens in various locations and increase the number of organizations with community gardens and/or farmer's markets by 20% from baseline.<br><br>Increase the number of food pantries offering fresh produce by 20% from baseline.<br><br>Implement the use of WIC and SNAP/EBT benefits in all farmer's markets.<br><br>Continue to offer fresh food sampling (with recipe cards, etc.) at food pantries and farmer's markets. | | | | August 18, 2020 |

# **Priority #3** | Maternal and Infant Health

## Maternal and Infant Health Indicators

*Note: Additional data can be found in the full 2016-2017 Sandusky County Community Health Assessment, as well as requesting local primary data from county agencies.*

### *Maternal and Infant Health*

In 2015, there were 7* infant deaths. *(Source: 2015 Ohio Infant Mortality Data: General Findings)*

From 2011-2014, an average of 8% of Sandusky County women had preterm births (less than 37 weeks of pregnancy). *(Source: National Center for Health Statistics, final natality data. Retrieved July 07, 2017, from www.marchofdimes.org/peristats.)*

From 2011-2014, an average of 1% of Sandusky County women had very preterm births (less than 32 weeks of pregnancy). *(Source: National Center for Health Statistics, final natality data. Retrieved July 07, 2017, from www.marchofdimes.org/peristats.)*

One-fifth (20%) of parents reported someone in their household used cigarettes, cigars or pipe tobacco, increasing to 29% of those with incomes less than $25,000.

The 2016 health assessment indicated that 4% of mothers of 0-5 year olds smoked during pregnancy.

According to the 2016 health assessment, parents of 0-5 year olds put their child to sleep as an infant: on their back (69%), on their stomach (10%), in bed with them or another person (9%), various methods (8%), and on their side (4%).

According to the 2016 health assessment, children ages 0-5 were put to sleep in the following places: crib/bassinette without bumper, blankets, or stuffed animals (68%); pack n' play (53%); in bed with parent or another person (44%); car seat (41%); crib/bassinette with bumper, blankets, or stuffed animals (36%); swing (35%); couch or chair (18%); and the floor (8%).

# **Priority #3** | Maternal and Infant Health

## Gaps and Potential Strategies

| Gaps | Potential Strategies |
|---|---|
| **1. Resource awareness** | o Community calendar/cell phone app |
| **2. Transportation** | o Increase access similar to "Mommy and Me Ride Free" program |
| **3. Lack of education** | o Motivate parents about family presence<br>o Incorporate certain "life skills" classes back into schools |
| **4. Second-hand smoke exposure** | o Promote prevention<br>o Smoke free policies in various settings (housing, worksites, public places, schools) |
| **5. Lack of life skills education in high schools (i.e. finances, balancing checkbooks, cooking, etc)** | o Partner with OSU extension office |
| **6. Lack of maternal mental health crisis interventions** | o SBIRT in hospital setting/OB units and schools |
| **7. Promote early prenatal care for motherhood** | o Work with Medicaid plans to support healthy birth outcomes |

# **Priority #3** | Maternal and Infant Health

## *Best Practices*

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

1. **OHA's Safe Sleep is Good4Baby Initiative:** Safe sleep education and outreach is a major priority for the Ohio Department of Health (ODH), the Ohio Collaborative to Prevent Infant Mortality (OCPIM), the Ohio Injury Prevention Partnership (OIPP), Child Fatality Review (CFR), Fetal and Infant Mortality Review, March of Dimes, the American Academy of Pediatrics (AAP), Ohio Medicaid and many other organizations. OHA is providing the logistics to deploy a statewide hospital-led education and cultural awareness campaign on the importance of safe sleep. Working with ODH and a number of constituents represented by OCPIM, the Foundation began implementation of a coordinated and targeted campaign in Spring 2014. Using the local hospital as a focus for education and distribution, new mothers and their families received safe sleep counseling and products, such as a safe sleep jumper. More importantly, hospitals were asked to participate in the campaign by naming an internal sleep champion, developing safe sleep committees and infrastructure, adopting (and auditing) in-hospital safe sleep practices and instructing employees, parents, families and the community on appropriate safe sleep practices. OHA continues track these initiatives' processes and outcomes metrics through a regional score card.

   The program promotes the following message (ABC's of safe sleep):

   **Alone:** Always put baby in crib alone. They shouldn't sleep in a bed or have anyone else in theirs.
   **Back:** Always put the baby on their back to sleep—at night or even when they're just napping.
   **Crib:** Always make sure the only thing on their firm mattress is a fitted sheet. No blankets or stuffed animals.

   For more information, go to: **http://ohiohospitals.org/safesleep/**

2. **Prenatal Care in The First Trimester**: Accessing prenatal care in the first trimester by 10 to 12 weeks is vital to improve pregnancy outcomes. HRSA recommends the way to increase the rate of early access to prenatal care is to increase awareness of the importance of prenatal care and to standardize preconception health as part of the routine health care for women of childbearing age. Adequate prenatal care includes counseling, education, along with identification and treatment of potential complications. There are no evidence-based guidelines regarding the content of prenatal visits, but they usually include evaluation of blood pressure, weight, protein levels in the urine, and monitoring fetal heart rate.

   For more information, go to:
   **http://www.hrsa.gov/quality/toolbox/measures/prenatalfirsttrimester/part3.html**

# Priority #3 | Maternal and Infant Health

## Action Step Recommendations & Plan

To work toward improving **maternal and infant health**, the following action steps are recommended:

1. Increase the Use of Safe Sleep Practices
2. Increase First Trimester Prenatal Care
3. Implement Smoke-Free Policies

| Priority Topic: Maternal and Infant Health | | | | |
|---|---|---|---|---|
| **Strategy 1: Increase the Use of Safe Sleep Practices** | | | | |
| **Action Step** | **Priority Outcome & Indicator** | **Priority Population** | **Person/ Agency Responsible** | **Timeline** |
| **Year 1**: Continue to implement the Cribs for Kids program. Work with local hospitals, FQHC's and other organizations to integrate safe sleep practices (i.e. The ABC's of Safe Sleep, Cribs for Kids) into the community. Disseminate **ODH materials** targeted at education and awareness. | **Priority Outcomes:**<br>1. Reduce infant mortality<br><br>**Priority Indicators:**<br>1. Rate of infant deaths per 1,000 live births (per SHIP) | Children | Sandusky County Health Department | August 18, 2018 |
| **Year 2:** Continue to raise awareness and promote safe sleep practices through coordinated messages. | | | | August 18, 2019 |
| **Year 3**: Continue efforts from years 1 and 2. | | | | August 18, 2020 |

| Priority Topic: Maternal and Infant Health | | | | |
|---|---|---|---|---|
| **Strategy 2: Increase First Trimester Prenatal Care** | | | | |
| **Action Step** | **Priority Outcome & Indicator** | **Priority Population** | **Person/ Agency Responsible** | **Timeline** |
| **Year 1:** Enlist primary care, OB/GYN, family physician offices, and FQHC's to educate women of childbearing age on prenatal health, such as taking vitamins and folic acid before getting pregnant. Distribute pregnancy educational materials when a patient confirms a pregnancy.<br><br>Incorporate components of preconception health into existing local public health and related programs<br><br>When necessary, connect women to health care coverage and increase care coordination. | **Priority Outcomes:**<br>1. Reduce infant mortality<br>2. Reduce preterm births<br>3. Reduce very preterm births<br><br>**Priority Indicators:**<br>1. Rate of infant deaths per 1,000 live births (per SHIP)<br>2. Percent of live births that are preterm: <37 weeks gestation (per SHIP)<br>3. Percent of live births that are very preterm: <32 weeks gestation (per SHIP) | Children | Infant Mortality Coalition<br><br>ProMedica Memorial Hospital | August 18, 2018 |
| **Year 2:** Increase the number of offices offering education and care coordination by 25%. | | | | August 18, 2019 |
| **Year 3:** Increase the number of offices offering education and care coordination by 50%. | | | | August 18, 2020 |

| Priority Topic: Maternal and Infant Health | | | | |
|---|---|---|---|---|
| **Strategy 3: Implement Smoke-Free Policies** | | | | |
| **Action Step** | **Priority Outcome & Indicator** | **Priority Population** | **Person/ Agency Responsible** | **Timeline** |
| **Year 1:** Collect baseline data on which organizations, multi-unit housing facilities, schools and other businesses currently have tobacco-free policies.<br><br>Appoint/hire 2 Tobacco Prevention Health Educators to build partnerships with the local public housing authority and **multi-unit housing complexes**.<br><br>Provide education to residents to assist with the transition of the multi-unit housing complexes to a smoke-free policy and create a resident advisory council.<br><br>Implement the smoke-free policy in at least 1-2 multi-unit housing complexes.<br><br>Begin efforts to adopt a smoke-free policy in Sandusky County **parks, schools, and other locations**. | **Priority Outcomes:**<br>1. Reduce infant mortality<br>2. Children exposed to secondhand smoke at home<br>3. Tobacco-free policies enacted<br><br>**Priority Indicators:**<br>1. Rate of infant deaths per 1,000 live births (per SHIP)<br>2. Percent of children who live in a home where someone uses tobacco or smokes inside the home (per SHIP)<br>3. In development: Number of smoke-free/tobacco-free policies enacted for k-12 schools, multi-unit housing and other spaces (ODH is developing updated database and will further define this indicator and source in the future) (per SHIP) | Children | Creating Healthy Communities Coalition | August 18, 2018 |
| **Year 2:** Continue efforts of year 1. Target 5 additional multi-unit housing complexes to adopt a smoke-free housing policy. Continue education efforts. | | | | August 18, 2019 |
| **Year 3:** Continue efforts of years 1 and 2. Target 5 additional multi-unit housing complexes to adopt a smoke-free housing policy. | | | | August 18, 2020 |

# Cross-Cutting Strategies

## *Cross-cutting Outcomes*

In addition to tracking progress on the CHIP priority outcome objectives, the Sandusky County Community Partners 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 IP strategy. Indicators measured in each action step may be found in each corresponding priority section (mental health and addiction, chronic disease, and maternal and infant health).

### Social Determinants of Health: Examples of Cross-Cutting 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 short
- age areas

# Cross-Cutting Strategies

## *Best Practices*

1. **Building the Fully Coordinated Transportation System:** Leaders in communities and states across the country have greatly improved mobility for millions of people over the last several decades. The shift away from providing rides to managing mobility is driving the success of fully coordinated transportation systems.

The strategy coordinates human service agencies that support transportation with public and private transit providers. Such systems have gone far in meeting the needs of consumers who must have access to healthcare, jobs or job training, education and social networks. Coordinated transportation systems also increase the ability of government officials, at all levels, to make the most efficient and effective use of limited resources.

The Framework for Action: Building the Fully Coordinated Transportation System helps stakeholders realize a shared perspective and build a roadmap for moving forward together. The Framework for Action was developed by analyzing the transportation coordination efforts in states and communities and successful models, with the advice and guidance of an expert panel. The assessment tool can be used by itself, or it can be an essential element of developing a work plan, a strategic plan, or some other plan.

For more information, go to:
**http://www.incog.org/transportation/coordinatedplan/UnitedWeRideFramework.pdf**

2. **QPR:** 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.

For more information go to: **https://www.qprinstitute.com/about-qpr**

3. **LifeSkills Training (LST):** 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).

For more information go to: **http://www.lifeskillstraining.com**

# Cross-Cutting Strategies

## *Best Practices, continued*

4. **Serving Up MyPlate: A Yummy Curriculum** (USDA Nutritional Guidelines): Serving Up MyPlate is a collection of classroom materials that helps elementary school teachers integrate nutrition education into Math, Science, English Language Arts, and Health. This "yummy curriculum" introduces the importance of eating from all five food groups using the MyPlate icon and a variety of hands–on activities. Students also learn the importance of physical activity to staying healthy. Serving Up MyPlate provides teacher lesson plans, activities, posters, parent education handouts, and additional games and resources.

For more information go to: **http://www.fns.usda.gov/tn/serving-myplate-yummy-curriculum**

5. **Complete Streets:** Complete streets are designed and operated to enable safe access for all users, including pedestrians, bicyclists, motorists and transit riders of all ages and abilities. Complete Streets make it easy to cross the street, walk to shops, and bicycle to work.

Creating Complete Streets means transportation agencies must change their approach to community roads. By adopting a Complete Streets policy, communities direct their transportation planners and engineers to routinely design and operate the entire right of way to enable safe access for all users, regardless of age, ability, or mode of transportation. This means that every transportation project will make the street network better and safer for drivers, transit users, pedestrians, and bicyclists – making your town a better place to live.

Changing policy to routinely include the needs of people on foot, public transportation, and bicycles would make walking, riding bikes, riding buses and trains safer and easier. People of all ages and abilities would have more options when traveling to work, to school, to the grocery store, and to visit family.

For more information go to: **https://smartgrowthamerica.org/program/national-complete-streets-coalition/**

6. **Fuel Up to Play 60 (National Dairy Council & National Football League):** Fuel Up to Play 60 encourages youth to eat healthy and move more — and studies suggest that well-nourished, physically active kids can be better students. Better nutrition, including eating a healthy breakfast each day, helps students get the nutrients they need and may help improve their academic performance. What's more, being physically active may help students improve self-esteem, cognitive function and test scores.

With Fuel Up to Play 60, healthy students can have more fun! By participating in the program, youth have the opportunity to earn rewards and prizes. Those students who help build the program may benefit even more. In fact, researchers say peer group interaction may help to influence healthy choices, and student involvement can lead to motivation and engagement in learning. Schools have the chance to receive $4,000 through a competitive, nationwide funding program to help implement the program successfully.

For more information go to: **https://www.fueluptoplay60.com/**

# Cross-Cutting Strategies

## Action Step Recommendations & Plan

To work toward all three priority areas, the following cross-cutting strategy is recommended:

1. Increase Early Identification of Mental Health Needs Among Youth
2. Implement School-based Alcohol and Other Drug Prevention Programs
3. Implement Shared Use (Joint Use Agreements)
4. Implement School-Based Nutrition Education Programs
5. Implement Complete Streets
6. School-Based Physical Activity Programs and Policies
7. Increase Access to Transportation
8. Increase Recruitment for Mental Health Professionals

| Cross Cutting Factor: Public Health System, Prevention and Health Behaviors | | | | |
|---|---|---|---|---|
| **Strategy 1: Increase Early Identification of Mental Health Needs Among Youth** | | | | |
| **Action Step** | **Cross-cutting Outcome & Indicator** | **Priority Population** | **Person/ Agency Responsible** | **Timeline** |
| **Year 1:** Gather baseline data on any mental health screening tools that are currently being used by Sandusky County Schools.<br>Introduce **QPR (Question, Persuade, Refer)** prevention program to school district administrators and wellness committees. Secure funding for the program. | **Cross-cutting Outcome:** Reduce suicide ideation<br>**Cross-cutting Indicator:** Percent of youth who report that they ever seriously considered attempting suicide within the past 12 months (per SHIP) | Youth | Mental Health and Recovery Services Board of Seneca, Sandusky and Wyandot Counties | August 18, 2018 |
| **Year 2:** Implement QPR in at least two school districts. | | | | August 18, 2019 |
| **Year 3:** Implement QPR in all school districts. | | | | August 18, 2020 |

| Cross Cutting Factor: Public Health System, Prevention and Health Behaviors | | | | |
|---|---|---|---|---|
| **Strategy 2: Implement School-based Alcohol and Other Drug Prevention Programs** | | | | |
| **Action Step** | **Cross-cutting Outcome & Indicator** | **Priority Population** | **Person/ Agency Responsible** | **Timeline** |
| **Year 1:** Continue to implement the **LifeSkills** Training, **PAX Good Behavior Game**, or **Developmental Assets** programs in Sandusky County schools. Introduce at least one program to one additional school district administration (superintendent, principals, and guidance counselors). Implement the program in one additional Sandusky County school district. | **Cross-cutting Outcomes:**<br>1. Reduce marijuana use<br>2. Reduce non-prescribed prescription drug use<br>3. Reduce alcohol use<br><br>**Cross-cutting Indicators:**<br>1. Percent of youth who report using marijuana one or more time within the past 30 days (per SHIP)<br>2. Percent of youth who used prescription drugs not prescribed to them in the past 30 days (per SHIP)<br>3. Percent of youth who drank one or more drinks of an alcoholic beverage in the past 30 days (per SHIP) | Youth | Prevention Partnership Coalition | August 18, 2018 |
| **Year 2:** Introduce and implement the programs in two additional school districts, or expand current services to additional grade levels. | | | | August 18, 2019 |
| **Year 3:** Implement the programs in all Sandusky County school districts. Expand education to all appropriate grade levels (contingent on the scope of the program). | | | | August 18, 2020 |

| Cross Cutting Factor: Public Health System, Prevention and Health Behaviors | | | | |
|---|---|---|---|---|
| **Strategy 3: Implement Shared Use (Joint Use Agreements)** | | | | |
| **Action Step** | **Cross-cutting Outcome & Indicator** | **Priority Population** | **Person/ Agency Responsible** | **Timeline** |
| **Year 1**: Assess how many Sandusky County schools, churches, businesses and other organizations currently offer shared use of their facilities (gym, track, etc).<br>Create an inventory of known organizations that possess physical activity equipment, space, and other resources. | **Cross-cutting Outcomes:**<br>1. Reduce physical inactivity among adults<br>2. Reduce physical inactivity among youth<br>**Cross-cutting Indicators:**<br>1. Percentage of adults aged 18 and over reporting no leisure time physical activity (per SHIP)<br>2. Percent of youth who did not participate in at least 60 minutes of physical activity on at least 1 day in the past seven days (per SHIP) | Adult and youth | Creating Healthy Communities | August 18, 2018 |
| **Year 2**: Collaborate with local organizations to create a proposal for a shared-use agreement.<br>Initiate contact with potential organizations from the inventory. Implement at least one shared-use agreement for community use. Publicize the agreement and its parameters. | | | | August 18, 2019 |
| **Year 3**: Continue efforts from year 1.<br>Implement 2-3 shared-use agreements for community use in Sandusky County. | | | | August 18, 2020 |

| Cross Cutting Factor: Public Health System, Prevention and Health Behaviors | | | | |
|---|---|---|---|---|
| **Strategy 4: Implement School-Based Nutrition Education Programs** | | | | |
| **Action Step** | **Cross-cutting Outcome & Indicator** | **Priority Population** | **Person/ Agency Responsible** | **Timeline** |
| **Year 1**: Assess Sandusky County schools to determine which schools are currently utilizing **Serving Up MyPlate: A Yummy Curriculum** *(grades 1 through 6).*<br><br>Work with at least one additional elementary school to conduct a "healthy habit" parent survey (pre-test) to collect baseline data of nutrition and physical activity habits among children. By utilizing the *Serving Up MyPlate* framework, implement various educational activities and programming, including parent education.<br><br>"Healthy habit" post-tests will be given at the end of each year to measure knowledge gained. 50% of students will show increased knowledge of healthy habits. | **Cross-cutting Outcome:** Reduce child overweight and obesity<br><br>**Cross-cutting Indicator:** Percent of children who are overweight or obese by BMI | Children | Sandusky County Health Department | August 18, 2018 |
| **Year 2**: Continue efforts from year 1 in at least two additional elementary schools, or expand curriculum to reach additional grade levels.<br><br>Work with schools to offer "Veggie U" fruit and vegetable taste testing for children *and/or* work with at least 1-2 schools to host a parent and family education night.<br><br>75% of students will show increased knowledge of healthy habits. | | | | August 18, 2019 |
| **Year 3**: Continue efforts from years 1and 2 in all elementary schools in Sandusky County,<br><br>90% of students will show increased knowledge of healthy habits. | | | | August 18, 2020 |

| Cross Cutting Factor: Social determinants of health | | | | |
|---|---|---|---|---|
| **Strategy 5: Implement Complete Streets** | | | | |
| **Action Step** | **Cross-cutting Outcome & Indicator** | **Priority Population** | **Person/ Agency Responsible** | **Timeline** |
| **Year 1:** Present the Complete Streets Initiative to transportation stakeholders and gain their support. Raise awareness of Complete Streets Policy and recommend that all local jurisdictions adopt comprehensive complete streets policies.<br><br>Gather baseline data on all the Complete Streets Policy objectives. | **Cross-cutting Outcomes:**<br>1. Reduce physical inactivity among adults<br>2. Reduce physical inactivity among youth<br><br>**Cross-cutting Indicators:**<br>1. Percentage of adults aged 18 and over reporting no leisure time physical activity (per SHIP)<br>2. Percent of youth who did not participate in at least 60 minutes of physical activity on at least 1 day in the past seven days (per SHIP) | Adult and youth | Sandusky County Park District | August 18, 2018 |
| **Year 2:** Begin to implement the following Complete Streets Objectives:<br>• Increase in total number of miles of on-street bicycle facilities, defined by streets and roads with clearly marked or signed bicycle accommodations.<br>• Increase in member jurisdictions which adopt complete streets policies.<br>• Increase in number of jurisdictions achieving or pursuing Bike-Friendly Community status from the League of American Bicyclists, or Walk-Friendly Community status from www.walkfriendly.org. | | | | August 18, 2019 |
| **Year 3**: Continue efforts from years 1and 2. knowledge of healthy habits. | | | | August 18, 2020 |

| Cross Cutting Factor: Public Health System, Prevention and Health Behaviors | | | | |
|---|---|---|---|---|
| **Strategy 6: School-Based Physical Activity Programs and Policies** | | | | |
| **Action Step** | **Cross-cutting Outcome & Indicator** | **Priority Population** | **Person/ Agency Responsible** | **Timeline** |
| **Year 1**: Research the **Fuel Up to Play 60 (FUTP60)** program and determine which school(s) should apply for a FUTP60 grant.<br><br>Work with the food service providers of selected school(s) to create organized programming and activities from the FUTP60 playbook that increases youth physical activity and healthy eating.<br><br>Create a school-based awareness campaign using the FUTP60 program to educate students and families on the benefits of increasing physical activity and healthy eating habits. Disseminate educational information. | **Cross-cutting Outcomes:** Reduce youth obesity<br><br>**Cross-cutting Indicators:** Percent of youth who were obese (>95th percentile for BMI, based on sex- and age-specific reference data from the 2000 CDC growth charts) (per SHIP) | Youth | Fremont City Schools | August 18, 2018 |
| **Year 2**: Continue efforts from Year 1.<br><br>Implement activities from the FUTP60 Playbook in at least 2-3 school districts.<br><br>Continue educating students and families on the importance of increasing physical activity and healthy eating habits. | | | | August 18, 2019 |
| **Year 3**: Continue efforts from Years 1 and 2.<br><br>Implement activities from the FUTP60 Playbook in at least 3-4 school districts.<br><br>Continue educating students and families on the importance of increasing physical activity and healthy eating habits. | | | | August 18, 2020 |

| Cross Cutting Factor: Healthcare system and access | | | | |
|---|---|---|---|---|
| **Strategy 7: Increase Access to Transportation** | | | | |
| **Action Step** | **Cross-cutting Outcome & Indicator** | **Priority Population** | **Person/ Agency Responsible** | **Timeline** |
| **Year 1:** Collaborate with local transportation providers and community stakeholders to develop a fully coordinated transportation system.<br><br>Create survey to gather public input on identifying gaps in transportation services. Increase outreach efforts of the survey to include input from older adults, those with disabilities, low-income and veterans.<br><br>Analyze results of survey. Develop a locally developed, coordinated public transit/human service plan (coordinated plan).<br><br>Begin implementing strategies identified in coordinated plan. | **Cross-Cutting Outcome:** Reduce transportation as a barrier to health care<br><br>**Cross-Cutting Indicator:** No transportation or difficult to find transportation in order to receive health care (Sandusky County CHA) | Adult, youth and child | WSOS Community Action Commission, Inc. | August 18, 2018 |
| **Year 2:** Update coordinated plan.<br><br>Invite community stakeholders to attend a meeting to analyze outcomes from Year 1 and discuss transportation issues in Sandusky County.<br><br>Modify goals and strategies as necessary in the annual coordinated plan update. Address strategies that increase the use of public and other transportation sources.<br><br>Begin implementing strategies identified in updated coordinated plan. | | | | August 18, 2019 |
| **Year 3:** Analyze performance and review Year 1 and 2 efforts. Continue to seek stakeholder input and update coordinated plan transportation strategies.<br><br>Administer evaluation surveys to gauge the public's response to strategies that have been implemented and collect outcome measures. | | | | August 18, 2020 |

| Cross Cutting Factor: Healthcare system and access | | | | |
|---|---|---|---|---|
| **Strategy 8: 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 Sandusky County and determine the need for more.<br><br>Develop a marketing strategy focused on recruiting mental health providers.<br><br>Work with local colleges, universities, and the Sandusky County Economic Development Corporation (EDC) to increase the number of preceptors or placement sites. Explore the feasibility of school loan reimbursement if the students stay to work in Sandusky County after their education is complete. | **Cross-cutting Outcomes:** Increase provider availability-mental health providers<br><br>**Cross-cutting Indicators:** Ratio of population to mental health providers (per SHIP) | Adult and youth | ProMedica Memorial Hospital<br><br>Firelands Counseling & Recovery Services | August 18, 2018 |
| **Year 2:** Continue to collaborate with local colleges, universities and the EDC. Begin implementing recruitment strategies.<br><br>Increase the number of placement sites (midlevel providers, etc.) for students by 5%. | | | | August 18, 2019 |
| **Year 3:** Continue efforts from years 1 and 2.<br><br>Increase the number of placement sites (midlevel providers, etc.) for students by 10%. | | | | August 18, 2020 |

# 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 agencies that are working on action steps will meet on an as needed basis. The full committee will hold a midyear conference call and an annual update to report out the progress. All members must be present. The committee will form a plan to disseminate the Community Health Improvement Plan to the community. Action steps, responsible person/agency, and timelines will be reviewed at the end of each year by the committee. Edits and revisions will be made accordingly.

Sandusky County will continue facilitating a Community Health Assessment every 3 years to collect and track data. Primary data will be collected for adults, youth, and children using national sets of questions to not only compare trends in Sandusky 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 Sandusky County Community 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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