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.

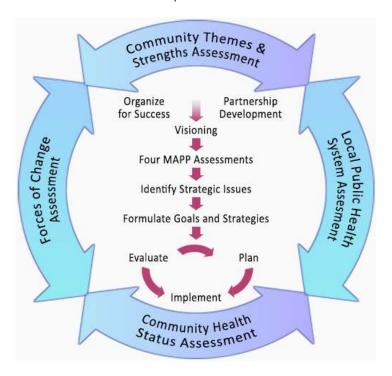


Figure 1.1 2017-2020 Sandusky County CHIP Overview

Overall Health Outcomes				
1 Increase Health Statu	JS	↓ Decrease Premature Death		
	Priority Topics			
Mental Health and Addiction Chronic Disease Maternal and Infant Health				
Priority Outcomes				
 Decrease adult and youth drug use Decrease adult and youth alcohol use Decrease adult and youth depression Decrease adult and youth suicide 	and child	e adult, youth d obesity e adult diabetes	 Decrease infant mortality Decrease preterm births 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
- 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 Boya. 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

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Cathy Glassford, Sandusky County Family and Children First Council

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

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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

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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 Chronic disease Maternal and infant health 	 Depression Suicide death Unintentional drug overdose Diabetes Infant mortality Preterm births Very preterm births 	 Public health system, prevention and health behaviors Social determinants of health Healthcare system and access 		

ALIGNMENT WITH NATIONAL AND STATE STANDARDS, continued

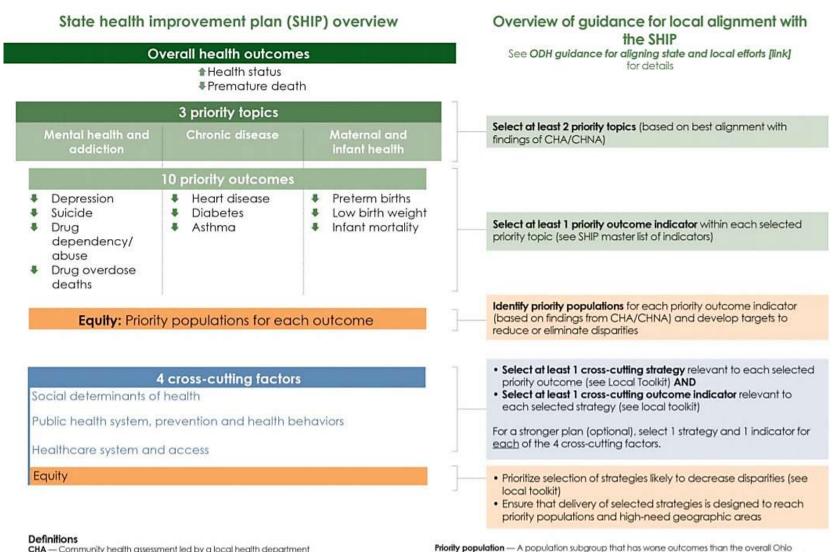
Figure 1.2 2017-2019 State Health Improvement Plan (SHIP) Overview

CHNA — Community health needs assessment led by a hospital

Outcome — A desired result. Example: Reduced suicide deaths.

Indicator — A specific metric or measure used to quantify an outcome, typically expressed as a

number, percent or rate, Example: Number of deaths due to suicide per 100,000 population.



Priority population — A population subgroup that has worse outcomes than the overall Ohio population and should therefore be prioritized in SHIP strategy implementation, Examples include racial/ethnic, age or income groups; people with disabilities; and residents of rural or low-income geographic areas.

Target — A specific number that quantifies the desired outcome. Example: 12.51 suicide deaths per 100,000 population in 2019.

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 W
- 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:

- 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	10%	Age: 30-64; Income: \$25K+	Male
during past 6 months			
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	4%	N/A	N/A
by someone on school property in past year			
Used prescription drugs that were not	4%	N/A	N/A
prescribed to them in past month			
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	35%	N/A	N/A
(of drinkers)			
Drank for the first time before age 13 (of all	37%	N/A	N/A
youth)			
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	13%	N/A	N/A
physical activity on any day in the past week			

NEEDS ASSESSMENT, continued

What are the most significant \underline{YOUTH} 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 <u>CHILD</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. Obesity (26 votes)	0.47		
Obese Overweight	36% 15%	N/A N/A	N/A N/A
Underweight	6%	N/A	N/A
2. Infant Mortality (17 votes)	0,0	14//	1477
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 Parent took child to ER for other sick visits	2% 23%	N/A N/A	N/A N/A
7. Asthma (4 votes)	25/0	IN/ A	IN/ A
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
	20/0	14//1	14//1
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	 No interest in field Burnout rate is high Tough work Pay is decent Especially in mental health
2. Generational poverty	Poverty continues over time
3. Shortened attention span	 Average person pays attention for a maximum of 15 minutes Lack of research and detail No more investigating Ex: Voting
4. Opiate epidemic	Increase in addiction and overdose deaths
5. Medicinal marijuana	Potential increase in marijuana use
6. Budget cuts from government7. Possible closures in the area (Davis Besse)	Healthcare providers Feanamia change
7. Possible closures in the area (Davis Besse)8. Shortage of providers	 Economic change Health care is not easily accessible
Number of children affected by opiates	 Increase in adverse childhood experiences and functioning
10. Proximity to river might bring economic opportunities	Possible increase in business and revenue
11. Technology	 Lack of socialization Development issues Too much screen time Interpersonal communications
12. Climate change	IndustryEnvironment
13. Loss of time with recess	Lack of social interaction and physical activity
Lack of faith-based involvement Lack of time in schools	 No church attendance and programs at schools Teachers need to meet requirements No time to have social conversations regarding health topics
16. Decrease in farming	Less employmentNo interest in farmingPricing
17. Infrastructure	Lack of sidewalks and physical activity
18. Millennials	Changes in health messaging
19. Society is "busy"	No time for volunteerism Decrease in family time
20. Scheduling conflicts	School exams clash with church timesDecrease in faith interaction

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

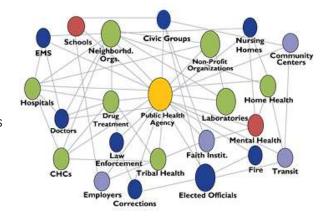
LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

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; https://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**.

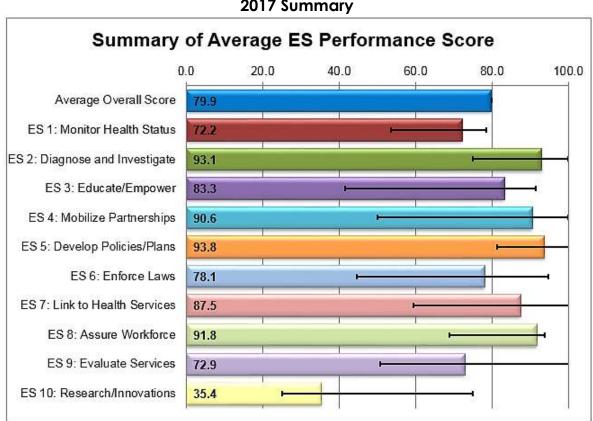
Members of the Sandusky County Health Department completed the performance measures instrument. The LPHSA results were then presented to the full CHIP committee for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard 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 sqibson@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 (selfempowerment)
- 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
- Fundina
- 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
	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/

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. ■

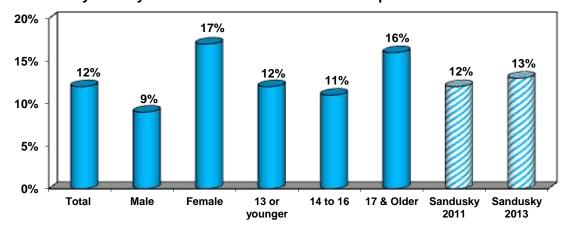
Four percent (4%) of youth used prescription drugs that were not prescribed for them during the past 30 days.♥

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

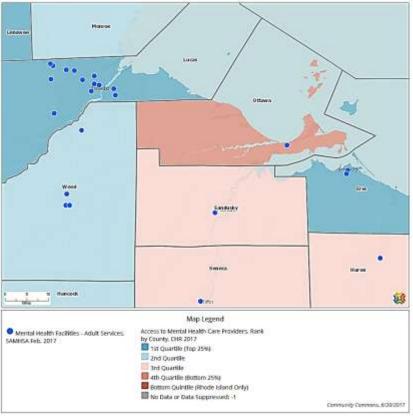
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*Data is considered incomplete and may be updated in the future

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

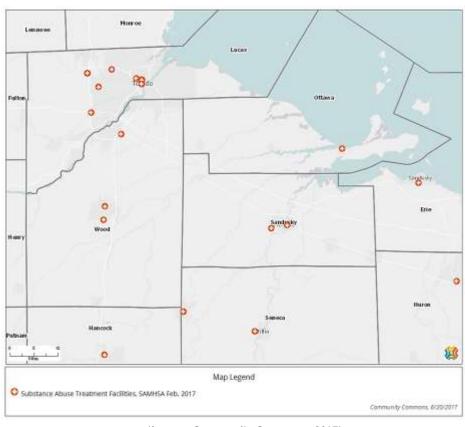


Access to Mental Health Care Providers, Rank by County, CHR 2017



(Source: Community Commons, 2017)

Substance Abuse Treatment Facilities, SAMHSA 2017



(Source: Community Commons, 2017)

Gaps and Potential Strategies

Gaps	Potential Strategies
Lack of staffing (psychologists, therapists)	 Work with SCEDC to assist with staffing recruitment to community
2. Mental health stigma	Education awarenessRole modelingSchool programs
3. Lack of faith representation	Bring it backAfter school options, such as "Lindsey Community"

Lack of engagement with youth to identify their problems	 Create survey Disseminate handouts at schools Distribute help text line bracelets Utilize text help line data 	
5. Media negativity	None identified	
Lack of mental health services for the incarcerated	 Bring counselors to adult facilities (similar to juvenile) Increase funding 	
7. Lack of knowledge of prevention/services	 Market importance of prevention to the community and community partners Whole child approach 	
8. Lack of pediatric psychiatry	 Develop a list to refer parents outside of county to services 	
9. Lack of communicating local resources	 Create a community calendar/resource app for cell phones Update community agency websites with resources 	
Lack of actions at the state and federal level	Advocate for local needs	
Lack of detox programs for outpatient and inpatient	 EMS continues to assist those in need after opiate call. Need to expand services. 	
12. Lack of access to public transportation	Cost effectiveRecruit drivers, volunteersIncrease taxi cabs	

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

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

Priority Topic: Mental Health and Addiction					
Strategy 1: Increase Awareness of Trauma Informed Care♥					
Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline	
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. Administer a training to increase education and	youth	Adults and youth	Sandusky County FCFC	August 18, 2018	
understanding of trauma informed care.	Priority Indicator: 1. Number of deaths due to				
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%.	suicide per 100,000 populations (age adjusted) (per SHIP) 2. Percent of youth who report that they ever seriously			August 18, 2019	
Year 3: Continue efforts from years 1 and 2. Increase the use of trauma screening tools by 25%.	considered attempting suicide within the past 12 months (per SHIP)			August 18, 2020	

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

Priority Topic: Mental Health and Addiction

Strategy 3: Expand Community Collaboration to Increase Awareness and Coordination of Mental Health and Substance Abuse Services

Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
Year 1: Work with the mental nealth/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.	Priority Outcomes: 1. Reduce adult unintentional drug overdose deaths 2. Reduce youth marijuana use 3. Reduce youth alcohol use 4. Reduce suicide deaths in adults 5. Reduce suicide ideation in youth			August 18, 2018
Tear 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 a formation on transportation options and which organizations offer free services, a liding fee scale, and which insurance plans are accepted. Update on a quarterly basis. Create a presentation on available mental health/substance abuse services and present to Sandusky County area churches, law enforcement, chamber of commerce, city council, service clubs, and businesses. Include a formation on mental health stigma, and work to increase community awareness and education of stigma and how it is a barrier to reatment.	1. Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted) (per SHIP) 2. Percent of youth who report using marijuana one or more time within the past 30 days (per SHIP) 3. Percent of youth who drank one or more drinks of an alcoholic beverage in the past 30 days (per SHIP) 4. Number of deaths due to suicide per 100,000 populations (age adjusted) (per SHIP)	Adults and youth	Mental Health and Recovery Services Board of Seneca, Sandusky and Wyandot Counties	August 18, 2019

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). Offer the training to local healthcare providers.	Cross-cutting Outcome: Sales of opioid pain relievers 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. Increase the number of trainings by 10%.		, taon		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 for 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.

■

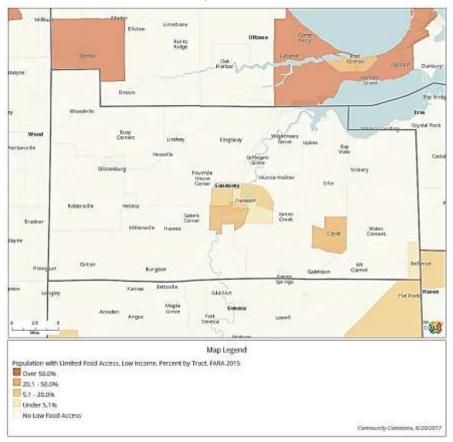
Child Chronic Disease

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 an vegetables.

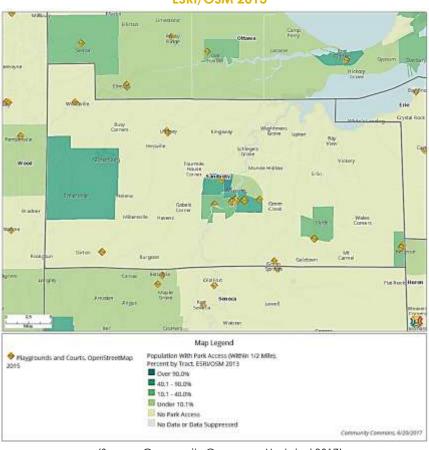
Priority #2 | Chronic Disease

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



(Source: Community Commons, Updated 2017)

Population with Park Access (Within $\frac{1}{2}$ 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	Increase funding	
2. Lack of education	Improve health literacyPrevention	
3. Healthcare costs	Decrease ER/Urgent care visitsIncrease primary care provider referralsHealthcare coordination	
4. Access to health foods	 In-home nutritionist support "Shop with a doctor or nutritionist day" Hunger screenings Food pharmacy Sampling food at food pantries with fruits and vegetables Cooking classes Community gardens Healthy food promotion in local grocery stores Increase awareness Healthier options at food pantries Accept EBT at farmer's markets Healthy corner stores 	
5. Lack of infrastructure (active transportation)	 Design and create streets and sidewalks/bike trails/bike racks Complete streets policies 	
6. Lack of resource communication	Community calendar application	
7. Marketing strategies with fast food restaurants	Education	

Priority #2 | Chronic Disease

Best Practices

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

 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

Priority Topic: Chronic Disease				
Strategy 1: Inc	rease Healthy Eating Through Fost	ering Self-Efficacy	1	
Action Step	Priority Outcome & Indicator	Priority Population	Person/ Agency Responsible	Timeline
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.	Priority Outcomes: 1. Reduce diabetes 2. Reduce adult obesity 3. Reduce youth obesity 4. Reduce child obesity			August 18, 2018
Work with at least one additional organization to pilot a 6-week course of the Cooking Matters program. Measure knowledge gained through evaluations.	Priority Indicators: 1. Percent of adults who have been told by a health professional that they have diabetes 2. Percent of adults that report		OSU Extension	
Year 2 : Continue efforts to implement at least one Cooking Matters class per quarter.		Adult, youth and		
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. Measure knowledge gained through evaluations.		children		August 18, 2019
Year 3: Continue efforts from years 1 and 2. Measure knowledge gained through evaluations.				August 18, 2020

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

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%).

Gaps and Potential Strategies

Gaps	Potential Strategies
1. Resource awareness	Community calendar/cell phone app
2. Transportation	 Increase access similar to "Mommy and Me Ride Free" program
3. Lack of education	 Motivate parents about family presence Incorporate certain "life skills" classes back into schools
4. Second-hand smoke exposure	 Promote prevention 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)	Partner with OSU extension office
6. Lack of maternal mental health crisis interventions	SBIRT in hospital setting/OB units and schools
7. Promote early prenatal care for motherhood	 Work with Medicaid plans to support healthy birth outcomes

Best Practices

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

DHA'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

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: 1. Reduce infant mortality Priority Indicators: 1. Rate of infant deaths per 1,000 live births (per SHIP)	Children	Sandusky County	August 18, 2018
Year 2: Continue to raise awareness and promote safe sleep practices through coordinated messages.			Health Department	August 18, 2019
Year 3: Continue efforts from years 1 and 2.				August 18, 2020

Pri	ority Topic: Maternal and Infant H	ealth		
Strate	gy 2: Increase First Trimester Pren	atal 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. Incorporate components of preconception health into existing local public health and related programs. When necessary, connect women to health care coverage and increase care coordination.	Priority Outcomes: 1. Reduce infant mortality 2. Reduce preterm births 3. Reduce very preterm births Priority Indicators: 1. Rate of infant deaths per 1,000 live births (per SHIP) 2. Percent of live births that are preterm: <37 weeks gestation (per SHIP) 3. Percent of live births that are very preterm: <32 weeks	Children	Infant Mortality Coalition 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%.	gestation (per SHIP)			August 18, 2020

Priority Topic: Maternal and Infant Health				
Stro	ategy 3: Implement Smoke-Free	Policies V		
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.	Reduce infant mortality Children exposed to			
Appoint/hire 2 Tobacco Prevention Health Educators to build partnerships with the local public housing authority and multi-unit housing complexes.				
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.	Priority Indicators: 1. Rate of infant deaths per 1,000 live births (per SHIP) 2. Percent of children who live	Children	Creating Healthy Communities Coalition	August 18, 2018
Implement the smoke-free policy in at least 1-2 multi- unit housing complexes.	in a home where someone uses tobacco or smokes inside the home (per SHIP)			
Begin efforts to adopt a smoke-free policy in Sandusky County parks, schools, and other locations.	3. In development: Number of smoke-free/tobacco-free			
Year 2: Continue efforts of year 1. Target 5 additional multi-unit housing complexes to adopt a smoke-free housing policy. Continue education efforts.	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)			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 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

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.aprinstitute.com/about-apr

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

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/

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: Inc	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.	Cross-cutting Outcome: Reduce suicide ideation		Mental Health and Recovery Services Board of Seneca, Sandusky and Wyandot Counties			
Introduce QPR (Question, Persuade, Refer) prevention program to school district administrators and wellness committees. Secure funding for the program.	Cross-cutting Indicator: Percent of youth who report	Youth				
Year 2: Implement QPR in at least two school districts.	within the past 12 months (per SHIP)			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 **Priority** Person/ Cross-cutting Outcome & Indicator **Action Step Timeline Population Agency Responsible Year 1:** Continue to implement the LifeSkills **Cross-cutting Outcomes:** Training, **PAX Good Behavior Game**, or 1. Reduce marijuana use **Developmental Assets** programs in Sandusky 2. Reduce non-prescribed County schools. Introduce at least one program to prescription drug use August 18, one additional school district administration 3. Reduce alcohol use 2018 (superintendent, principals, and guidance **Cross-cutting Indicators:** counselors). Implement the program in one 1. Percent of youth who report additional Sandusky County school district. usina marijuana one or more time Prevention Partnership Youth **Year 2:** Introduce and implement the programs in within the past 30 days (per SHIP) Coalition August 18, two additional school districts, or expand current 2. Percent of youth who used 2019 services to additional grade levels. prescription drugs not prescribed to them in the past 30 days (per **Year 3:** Implement the programs in all Sandusky SHIP) County school districts. Expand education to all 3. Percent of youth who drank one August 18, appropriate grade levels (contingent on the or more drinks of an alcoholic 2020 scope of the program). beverage in the past 30 days (per SHIP)

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

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).					
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.	Cross-cutting Outcome: Reduce child overweight and obesity Cross-cutting Indicator:		Sandusky County Health Department	August 18, 2018	
"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.		Children			
Year 2: Continue efforts from year 1 in at least two additional elementary schools, or expand curriculum to reach additional grade levels.	Percent of children who are overweight or obese by BMI				
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.				August 18, 2019	
75% of students will show increased knowledge of healthy habits.					
Year 3 : Continue efforts from years 1 and 2 in all elementary schools in Sandusky County,				August 18, 2020	
90% of students will show increased knowledge of healthy habits.				August 10, 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. Gather baseline data on all the Complete Streets	Cross-cutting Outcomes: 1. Reduce physical inactivity among adults 2. Reduce physical			August 18, 2018	
Policy objectives.					
 Year 2: Begin to implement the following Complete Streets Objectives: Increase in total number of miles of onstreet bicycle facilities, defined by streets and roads with clearly marked or signed bicycle accommodations. Increase in member jurisdictions which adopt complete streets policies. 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. 	inactivity among youth Cross-cutting Indicators: 1. Percentage of adults aged 18 and over reporting no leisure time physical activity (per SHIP) 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)		Sandusky County Park District	August 18, 2019	
Year 3: Continue efforts from years 1 and 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 Cross-cutting Outcome & Person/ **Priority Population Action Step Timeline** Indicator **Agency Responsible** Year 1: Research the Fuel Up to Play 60 (FUTP60) program and determine which school(s) should apply for a FUTP60 grant. Work with the food service providers of selected school(s) to create organized programming and activities from the FUTP60 playbook that increases August 18, 2018 youth physical activity and healthy eating. Create a school-based awareness campaign using the FUTP60 program to educate students and **Cross-cutting Outcomes:** families on the benefits of increasing physical Reduce youth obesity activity and healthy eating habits. Disseminate Cross-cutting Indicators: educational information. Percent of youth who were **Year 2**: Continue efforts from Year 1. Youth Fremont City Schools obese (>95th percentile for BMI, based on sex- and Implement activities from the FUTP60 Playbook in at age-specific reference least 2-3 school districts. August 18, 2019 data from the 2000 CDC Continue educating students and families on the growth charts) (per SHIP) importance of increasing physical activity and healthy eating habits. **Year 3**: Continue efforts from Years 1 and 2. Implement activities from the FUTP60 Playbook in at least 3-4 school districts. August 18, 2020 Continue educating students and families on the importance of increasing physical activity and healthy eating habits.

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

Cross Cutting Factor: Healthcare system and access						
Strategy 8:	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.						
Develop a marketing strategy focused on recruiting mental health providers.						
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 Cross-cutting Indicators: Ratio of population to	Adult and youth	ProMedica Memorial Hospital Firelands Counseling &	August 18, 2018		
Year 2: Continue to collaborate with local colleges, universities and the EDC. Begin implementing recruitment strategies.	mental health providers (per SHIP)		Recovery Services	August 18, 2019		
Increase the number of placement sites (midlevel providers, etc.) for students by 5%.						
Year 3: Continue efforts from years 1 and 2.						
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 vicon.

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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