2021-2023

Sandusky County Community Health Improvement Plan

Released on April 26th, 2021

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

Executive Summary

Introduction

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

The Sandusky County Health Partners have been conducting CHAs since 2001 to measure community health status. The most recent Sandusky County CHA was cross-sectional in nature and included a written survey of adults within Sandusky County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention (CDC) for their national and state Behavioral Risk Factor Surveillance System (BRFSS). This has allowed Sandusky County to compare their CHA data to national, state and local health trends. Community stakeholders were actively engaged in the early phases of CHA planning and helped define the content, scope, and sequence of the project.

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

Public Health Accreditation Board (PHAB) Requirements

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

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

Inclusion of Vulnerable Populations (Health Disparities)

Approximately 14% of Sandusky County residents were below the poverty line, according to the 2013-2017 American Community Survey 5 year estimates. For this reason, data is broken down by income (less than $25,000 and greater than $25,000) throughout the report to show disparities.

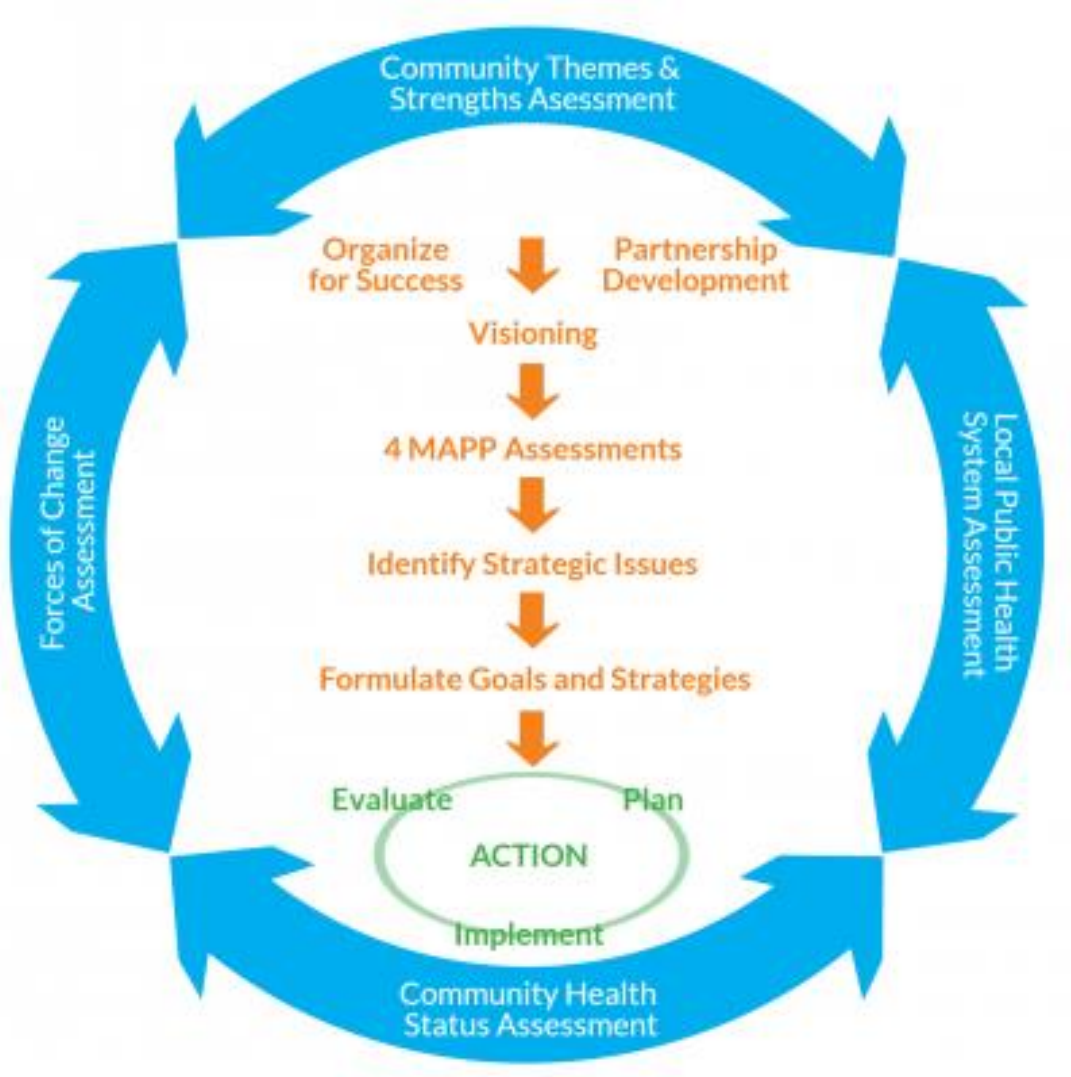
Mobilizing for Action through Planning and Partnerships (MAPP)

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

1. Organizing for success and partnership development
2. Visioning
3. The four assessments
4. Identifying strategic issues
5. Formulate goals and strategies
6. Action cycle

The MAPP process includes four assessments: community themes and strengths, forces of change, local public health system assessment, and the community health status assessment. These four assessments were used by the Sandusky County Health Partners to prioritize specific health issues and population groups which are the foundation of this plan. Figure 1.1 illustrate how each of the four assessments contributes to the MAPP process.

Figure 1.1 The MAPP model



Alignment with National and State Standards

The 2021-2023 Sandusky County Community Health Improvement Plan priorities align perfectly with regional, state and national priorities. Sandusky County will be addressing the following priority health outcomes: mental health and addiction and maternal and infant health. Additionally, Sandusky County will be addressing the following priority health factor: health behaviors.

Healthy People 2030

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

- Mental Health and Mental Disorder (MHMD) – 1: Reduce suicide attempts by adolescents
- Nutrition and Weight Status (NWS) – 10.4: Reduce the proportion of children and adolescents with obesity

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

Ohio State Health Improvement Plan (SHIP)

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

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

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

The three priority factors include the following:

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

The three priority health outcomes include the following:

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

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

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

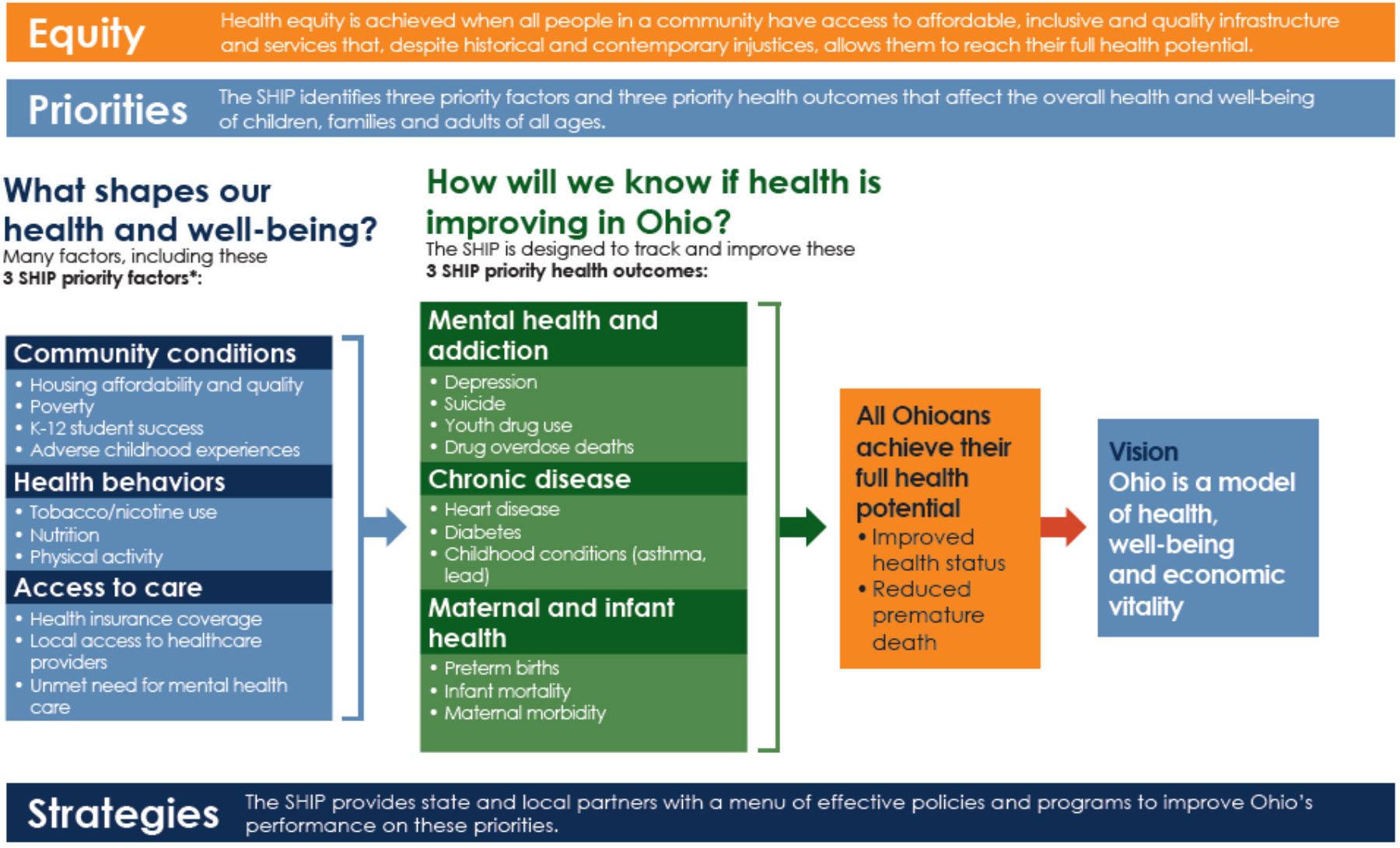
The following Sandusky County priority factors, priority indicators, and strategies very closely align with the 2020-2022 SHIP:

Figure 1.2 2021-2023 Sandusky CHIP Alignment with the 2022-2022 SHIP

Priority Factors	Priority Indicators	Strategies to Impact Priority Indicators	Additional Aligned Strategies
Health Behaviors	• Adult fruit/vegetable consumption • Youth fruit/vegetable consumption • Child physical activity • Adult physical activity • Adult smoking • Youth all tobacco/nicotine use	• Healthy food initiatives in food banks • Complete streets • Smoke-free policies for indoor areas • Mass media campaigns against tobacco use	• Nutrition prescriptions • Online community-wellness calendar • Links to cessation support
Priority Health Outcomes	**Priority Indicators**	**Strategies to Impact Priority Indicators**	**Additional Aligned Strategies**
Mental Health and Addiction	• Adult depression • Youth depression	• Mental health first aid • School-based social and emotional instruction	• Trauma informed care • Peer recovery services
Maternal and Infant Health	• Preterm births • Infant mortality	• Early childhood home visiting program	• Increase first trimester prenatal care

Alignment with National and State Standards, continued

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



Vision and Mission

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

The Vision of the Sandusky County Health Partners

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.

The Mission of the Sandusky County Health Partners

Working together to create a healthier Sandusky County.

Community Partners

The CHIP was planned by various agencies and service-providers within Sandusky County. From January 2021 to March 2021, the Sandusky County Health Partners reviewed many data sources concerning the health and social challenges that Sandusky County residents are facing. They determined priority issues which, if addressed, could improve future outcomes; determined gaps in current programming and policies; examined best practices and solutions; and determined specific strategies to address identified priority issues. We would like to recognize these individuals and thank them for their dedication to this process:

Sandusky County Health Partners

The Bellevue Hospital
Community Health Services
Firelands Counseling & Recovery Services
Fremont City School District
Great Lakes Community Action Partnership
Mental Health and Recover Services Board
ProMedica Memorial Hospital
Sandusky County Board of DD
Sandusky County Family and Children First Council
Sandusky County Job and Family Services
Sandusky County Juvenile and Probate Court
Sandusky County Public Health
United Way of Sandusky County

Hospital Council of Northwest Ohio (HCNO)

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

Community Health Improvement Process

Beginning in January 2021, the Sandusky County Health Partners met four (4) times and completed the following planning steps:

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

Community Health Status Assessment

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

Adult Trend Summary

Adult Variables	Sandusky County 2001	Sandusky County 2005	Sandusky County 2009	Sandusky County 2013	Sandusky County 2016	Sandusky County 2019	Ohio 2018	U.S. 2018
Healthcare Coverage								
Uninsured	14%	7%	14%	16%	8%	4%	7%	11%
Access and Utilization								
Had one or more persons they thought of as their personal health care provider	N/A	N/A	N/A	N/A	88%	90%	80%	77%
Visited a doctor for a routine checkup (in the past year)	N/A	64%	59%	62%	64%	74%	79%	77%
Preventive Medicine								
Had a pneumonia vaccination (age 65 and over)	N/A	N/A	66%	52%	65%	73%	74%	73%
Had a flu vaccine in the past year (age 65 and over)	N/A	N/A	N/A	76%	78%	77%	56%	55%
Ever had a shingles or zoster vaccine	N/A	N/A	N/A	7%	13%	22%	29%*	29%*
Women's Health								
Had a mammogram within the past two years (ages 40 and over)	72%	70%	68%	68%	69%	68%	74%	72%
Had a pap test in the past three years (ages 21-65)	N/A	78%‡	66%‡	67%‡	71%‡	66%	79%	80%
Had a clinical breast exam in the past two years (ages 40 and older)	N/A	72%	68%	66%	66%	59%	N/A	N/A
Oral Health								
Visited a dentist or a dental clinic (within the past year)	55%	57%	62%	62%	72%	70%	67%	68%

Indicates alignment with the Ohio State Health Assessment (SHA)
**2017 BRFSS*
‡Pap smear was reported for women ages 19 and over
N/A – Not Available

Adult Variables	Sandusky County 2001	Sandusky County 2005	Sandusky County 2009	Sandusky County 2013	Sandusky County 2016	Sandusky County 2019	Ohio 2018	U.S. 2018
Health Status Perceptions								
Rated general health as excellent or very good	49%	49%	49%	50%	44%	44%	49%	51%
Rated general health as fair or poor	15%	15%	12%	16%	12%	13%	19%	18%
Rated mental health as not good on four or more days (in the past month)	N/A	21%	19%	22%	27%	30%	26%	24%
Average number of days that mental health was not good (in the past month)	N/A	N/A	N/A	4.2	4.5	5.0	4.3*	3.8*
Rated physical health as not good on four or more days (in the past month)	N/A	21%	19%	22%	21%	20%	24%	23%
Average number of days that physical health was not good (in the past month)	N/A	N/A	N/A	4.3	3.8	3.9	4.0*	3.7*
Weight Status								
Overweight	31%	36%	35%	29%	33%	39%	34%	35%
Obese	33%	36%	34%	35%	42%	39%	34%	31%
Tobacco Use								
Current smoker (smoked on some or all days)	36%	23%	19%	19%	19%	17%	21%	16%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	20%	25%	24%	26%	24%	30%	25%	25%
Tried to quit smoking (on at least one day in the past year)	N/A	54%	41%	60%	39%	60%	N/A	N/A
Current e-cigarette user (vaped on some or all days)	N/A	N/A	N/A	N/A	N/A	6%	5%*	5%*
Former e-cigarette user	N/A	N/A	N/A	N/A	N/A	15%	19%*	16%*
Alcohol Consumption								
Current drinker (had at least one drink of alcohol within the past month)	53%	33%	56%	51%	62%	56%	52%	54%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	20%	18%	21%	22%	29%	29%	16%	16%

Indicates alignment with the Ohio State Health Assessment (SHA)
N/A – Not Available
**2017 BRFSS*
**2016 BRFSS as compiled by 2019 County Health Rankings*

Adult Variables	Sandusky County 2001	Sandusky County 2005	Sandusky County 2009	Sandusky County 2013	Sandusky County 2016	Sandusky County 2019	Ohio 2018	U.S. 2018
Drug Use								
Used recreational marijuana or hashish in the past six months	7%	7%	7%	7%	5%	6%	N/A	N/A
Misused prescription drugs in the past six months	5%	5%	5%	7%	10%	16%	N/A	N/A
Used recreational drugs in the past six months	N/A	7%	7%	1%	2%	1%	N/A	N/A
Sexual Behavior								
Had more than one sexual partner in past year	N/A	6%	3%	9%	6%	7%	N/A	N/A
Ever been tested for HIV	N/A	N/A	25%	20%	23%	29%	N/A	N/A
Mental Health								
Felt sad or hopeless for two or more weeks in a row in the past year	N/A	9%	9%	15%	9%	12%	N/A	N/A
Seriously considered attempting suicide in the past year	3%	2%	2%	6%	1%	6%	N/A	N/A
Attempted suicide in the past year	N/A	N/A	0%	1%	0%	2%	N/A	N/A
Cardiovascular Disease								
Ever diagnosed with angina or coronary heart disease	N/A	7%	4%	8%	4%	4%	5%	4%
Ever diagnosed with a heart attack or myocardial infarction	4%	5%	4%	5%	6%	3%	6%	4%
Ever diagnosed with a stroke	4%	3%	4%	3%	2%	3%	4%	3%
Had been told they had high blood pressure	25%	37%	34%	31%	33%	38%	35%*	33%*
Had been told their blood cholesterol was high	22%	33%	27%	35%	34%	37%	33%*	33%*
Had their blood cholesterol checked within the last five years	N/A	N/A	N/A	80%	75%	84%	85%*	87%*
Diabetes								
Ever been told by a doctor they have diabetes (not pregnancy-related)	11%	11%	12%	10%	18%	14%	12%	11%
Had been diagnosed with pre-diabetes or borderline diabetes	N/A	N/A	N/A	6%	N/A	8%	2%	2%

Indicates alignment with the Ohio State Health Assessment (SHA)
N/A – Not Available
**2017 BRFSS*

Youth Trend Summary

Youth Variables	Sandusky County 2009 (6th-12th)	Sandusky County 2011 (6th-12th)	Sandusky County 2013 (6th-12th)	Sandusky County 2016 (6th-12th)	Sandusky County 2019 (6th-12th)	Sandusky County 2019 (9th-12th)	U.S. 2017 (9th-12th)
Weight Status							
Obese	17%	14%	13%	23%	22%	23%	15%
Overweight	13%	12%	17%	11%	11%	11%	16%
Described themselves as slightly or very overweight	29%	27%	29%	33%	33%	33%	32%
Trying to lose weight	47%	52%	48%	48%	51%	48%	47%
Exercised to lose weight (in the past 30 days)	44%	32%	50%	42%	46%	43%	N/A
Ate less food, fewer calories, or foods lower in fat to lose weight (in the past 30 days)	18%	12%	31%	25%	31%	31%	N/A
Went without eating for 24 hours or more (in the past 30 days)	2%	2%	9%	4%	8%	7%	N/A
Took diet pills, powders, or liquids without a doctor's advice (in the past 30 days)	1%	0%	3%	1%	2%	3%	N/A
Vomited or took laxatives (in the past 30 days)	2%	0%	2%	1%	1%	2%	N/A
Physically active at least 60 minutes per day on every day in past week	N/A	62%	69%	30%	28%	27%	26%
Physically active at least 60 minutes per day on five or more days in past week	N/A	38%	43%	49%	47%	46%	46%
Did not participate in at least 60 minutes of physical activity on any day in past week	10%	8%	12%	13%	18%	17%	15%
Watched TV three or more hours per day (on an average school day)	40%	39%	27%	24%	19%	16%	21%

Indicates alignment with the Ohio State Health Assessment (SHA)
N/A – Not Available

Youth Variables	Sandusky County 2009 (6th-12th)	Sandusky County 2011 (6th-12th)	Sandusky County 2013 (6th-12th)	Sandusky County 2016 (6th-12th)	Sandusky County 2019 (6th-12th)	Sandusky County 2019 (9th-12th)	U.S. 2017 (9th-12th)
Tobacco Use							
Current smoker (smoked on at least 1 day during the past 30 days)	15%	13%	11%	7%	7%	8%	9%
First tried cigarette smoking before age 13 years (even one or two puffs)	N/A	N/A	N/A	6%	7%	4%	10%
Currently used an electronic vapor product (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pends, e-hookahs, and hookah pens on at least 1 day during the past 30 days)	N/A	N/A	N/A	N/A	14%	16%	13%
Used electronic vapor products frequently (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on 20 or more days during the past 30 days)	N/A	N/A	N/A	N/A	3%	4%	3%
Used electronic vapor products daily (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on all 30 days during the past 30 days)	N/A	N/A	N/A	N/A	3%	3%	2%
Alcohol Consumption							
Ever drank alcohol (at least one drink of alcohol on at least 1 day during their life)	53%	46%	43%	40%	49%	56%	60%
Current Drinker (at least one drink of alcohol on at least 1 day during the past 30 days)	27%	24%	19%	17%	16%	19%	30%
Binge drinker (drank 5 or more drinks within a couple of hours on at least 1 day during the past 30 days)	15%	13%	13%	7%	11%	14%	14%
Drank for the first time before age 13 (of all youth)	N/A	N/A	25%	12%	17%	12%	16%
Obtained the alcohol they drank by someone giving it to them (of current drinkers)	N/A	N/A	58%	41%	39%	34%	44%
Rode with a driver who had been drinking alcohol (in a car or other vehicle on 1 or more occasion during the past 30 days)	24%	20%	20%	16%	17%	14%	17%
Drove when they had been drinking alcohol (in a car or vehicle, 1 or more times during the 30 days before the survey, among youth who had driven a car or other vehicle)	5%	4%	6%	7%	3%	4%	6%

Indicates alignment with the Ohio State Health Assessment (SHA)
N/A – Not Available

Youth Variables	Sandusky County 2009 (6th-12th)	Sandusky County 2011 (6th-12th)	Sandusky County 2013 (6th-12th)	Sandusky County 2016 (6th-12th)	Sandusky County 2019 (6th-12th)	Sandusky County 2019 (9th-12th)	U.S. 2017 (9th-12th)
Drug Use							
Used marijuana (in the past month)	13%	13%	8%	11%	12%	13%	20%
Ever used methamphetamines (in their lifetime)	2%	1%	1%	0%	1%	1%	3%
Ever used cocaine (in their lifetime)	2%	3%	4%	1%	1%	2%	5%
Ever used heroin (in their lifetime)	2%	<1%	2%	0%	<1%	1%	2%
Ever used inhalants (in their lifetime)	11%	10%	10%	5%	6%	5%	6%
Ever used ecstasy (also called MDMA in their lifetime)	6%	5%	3%	1%	1%	2%	4%
Misused medications that were not prescribed to them or took more to get high and/or feel more alert (in the past month)	10%	12%	9%	6%	4%	4%	N/A
Ever took steroids without a doctor's prescription (in their lifetime)	3%	N/A	1%	1%	1%	2%	3%
Were offered, sold, or given an illegal drug on school property (in the past 12 months)	12%	7%	6%	4%	5%	4%	20%
Sexual Behavior							
Had sexual intercourse (in their lifetime)	31%	27%	24%	26%	21%	28%	40%
Had sexual intercourse with four or more persons (of all youth during their life)	6%	15%	6%	7%	6%	7%	10%
Had sexual intercourse before the age 13 (for the first time of all youth)	10%	13%	4%	3%	4%	3%	3%
Used a condom (during last sexual intercourse)	47%	69%	69%	59%	46%	54%	54%
Used birth control pills (during last sexual intercourse)	14%	36%	33%	29%	19%	22%	21%
Used an IUD (during last sexual intercourse)	N/A	N/A	N/A	2%	1%	7%	4%
Used a shot, patch or birth control ring (during last sexual intercourse)	N/A	8%	N/A	7%	<1%	6%	5%
Did not use any method to prevent pregnancy (during last sexual intercourse)	17%	N/A	8%	7%	9%	7%	14%

N/A – Not Available

Youth Variables	Sandusky County 2009 (6th-12th)	Sandusky County 2011 (6th-12th)	Sandusky County 2013 (6th-12th)	Sandusky County 2016 (6th-12th)	Sandusky County 2019 (6th-12th)	Sandusky County 2019 (9th-12th)	U.S. 2017 (9th-12th)
Mental Health							
Felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities in the past 12 months)	24%	25%	25%	28%	35%	35%	32%
Made a plan to attempt suicide (in the past 12 months)	9%	12%	13%	12%	15%	13%	17%
Attempted suicide (in the past 12 months)	4%	6%	8%	7%	10%	8%	7%
Social Determinants of Health							
Visited a doctor for a routine checkup in the past year	N/A	67%	73%	64%	64%	67%	N/A
Visited a dentist in the past year (for a check-up, exam, teeth cleaning, or other dental work)	N/A	74%	74%	66%	71%	73%	N/A
Violence							
Carried a weapon (in the past 30 days)	11%	13%	14%	6%	8%	9%	16%
Carried a weapon on school property (in the past 30 days)	2%	1%	4%	1%	2%	1%	4%
Threatened or injured with a weapon on school property (in the past 12 months)	5%	6%	7%	8%	11%	7%	6%
Did not go to school because they felt unsafe (at school or on their way to or from school in the past 30 days)	7%	6%	5%	6%	6%	4%	7%
Bullied (in past year)	54%	51%	51%	42%	37%	33%	N/A
Bullied on school property (in past year)	N/A	N/A	36%	27%	26%	21%	19%
Electronically bullied (in past year)	N/A	11%	13%	15%	12%	12%	15%

N/A – Not Available

Child Ages 0-5 Trend Summary

Child 0-5 Variables	Sandusky County 2010 Ages 0-5	Sandusky County 2013 Ages 0-5	Sandusky County 2016 Ages 0-5	Sandusky County 2019 Ages 0-5	Ohio 2017/18 Ages 0-5	U.S. 2017/18 Ages 0-5
Health and Functional Status						
Rated health as excellent or very good	85%	89%	97%	92%	92%	93%
Dental care visit (in the past year)	56%	46%	59%	45%	51%**	61%**
Diagnosed with asthma	12%	10%	7%	5%	4%	6%
Diagnosed with diabetes	0%	1%	0%	1%	N/A	<1%
Diagnosed with ADHD/ADD	2%	1%	1%	1%	1%*	2%*
Diagnosed with behavioral or conduct problems	3%	2%	3%	4%	3%*	5%*
Diagnosed with epilepsy or a seizure disorder	2%	1%	1%	1%	N/A	1%
Diagnosed with a brain injury, concussion, or head injury	3%	1%	1%	0%	N/A	1%
Diagnosed with depression	N/A	0%	0%	0%	0%*	<1%*
Diagnosed with cerebral palsy	N/A	0%	1%	0%	N/A	<1%
Diagnosed with anxiety problems	N/A	1%	0%	3%	1%*	2%*
Diagnosed with intellectual disability/mental retardation	N/A	1%	5%	0%	N/A	1%*
Diagnosed with learning disability	N/A	4%	5%	3%	1%*	2%*
Diagnosed with speech or language disorder	N/A	7%	8%	9%	6%*	10%*
Child had one or more health conditions	N/A	9%	17%	13%	N/A	N/A
Healthcare Access						
Had public insurance	24%	19%	22%	18%	32%	33%
Been to doctor for preventive care (in the past year)	88%	91%	96%	92%	92%¥	89%¥
Had a personal doctor or nurse	87%	86%	84%	89%	72%	72%
Two or more visits to the ER (in the past year)	13%	11%	6%	8%	5%	6%

Indicates alignment with the Ohio State Health Assessment (SHA)
¥2016/17 NSCH data
**Ages 3-5*
***Ages 1-5*
N/A – Not Available

Child 0-5 Variables	Sandusky County 2010 Ages 0-5	Sandusky County 2013 Ages 0-5	Sandusky County 2016 Ages 0-5	Sandusky County 2019 Ages 0-5	Ohio 2017/18 Ages 0-5	U.S. 2017/18 Ages 0-5
Early Childhood (Ages 0-5)						
Never breastfed their child	28%	21%	26%	12%	20%	20%
Parent or family members read to child every day (in the past week)	42%±	20%±	13%±	32%	44%	37%
Family and Community Characteristics						
Family eats a meal together every day of the week	41%	40%	33%	51%	57%	54%
Child never attends religious services	38%	39%	50%	42%	N/A	N/A
Someone living in the household uses cigarettes, cigars, or pipe tobacco	28%	31%	18%	15%	18%	14%
Two or more adverse childhood experiences (ACEs)	N/A	N/A	N/A	1%	6%	6%
Parent Health						
Mother's mental or emotional health is fair/poor	N/A	N/A	N/A	12%	9%	5%
Father's mental or emotional health is fair/poor	N/A	N/A	N/A	6%	7%	3%

± *Only included parent read to child*
N/A – Not Available

Child Ages 6-11 Trend Summary

Child 6-11 Variables	Sandusky County 2010 Ages 6-11	Sandusky County 2013 Ages 6-11	Sandusky County 2016 Ages 6-11	Sandusky County 2019 Ages 6-11	Ohio 2017/18 Ages 6-11	U.S. 2017/18 Ages 6-11
Health and Functional Status						
Rated health as excellent or very good	83%	89%	96%	95%	89%	90%
Dental care visit (in the past year)	82%	91%	89%	94%	90%	90%
Diagnosed with asthma	20%	15%	17%	13%	13%	13%
Diagnosed with diabetes	<1%	0%	0%	1%	N/A	<1%
Diagnosed with ADHD/ADD	9%	8%	9%	10%	14%	10%
Diagnosed with behavioral or conduct problems	7%	5%	4%	5%	13%	10%
Diagnosed with epilepsy or a seizure disorder	2%	1%	1%	1%	N/A	1%
Diagnosed with a brain injury, concussion, or head injury	2%	3%	4%	1%	N/A	3%
Diagnosed with depression	3%	1%	1%	2%	1%	2%
Diagnosed with cerebral palsy	N/A	1%	1%	0%	N/A	<1%
Diagnosed with anxiety problems	N/A	5%	7%	7%	9%	9%
Diagnosed with intellectual disability/mental retardation	N/A	2%	1%	0%	N/A	2%
Diagnosed with learning disability	N/A	6%	5%	5%	11%	9%
Diagnosed with speech or language disorder	N/A	10%	8%	7%	10%	10%
Child had one or more health conditions	N/A	18%	17%	21%	N/A	N/A
Healthcare Access						
Had public insurance	18%	13%	15%	15%	25%	32%
Been to doctor for preventive care (in the past year)	69%	73%	74%	88%	81%¥	80%¥
Had a personal doctor or nurse	85%	83%	90%	79%	77%	72%
Two or more visits to the ER (in the past year)	10%	9%	6%	6%	5%	4%

Indicates alignment with the Ohio State Health Assessment (SHA)
¥2016/17 NSCH data
N/A – Not Available

Child 6-11 Variables	Sandusky County 2010 Ages 6-11	Sandusky County 2013 Ages 6-11	Sandusky County 2016 Ages 6-11	Sandusky County 2019 Ages 6-11	Ohio 2017/18 Ages 6-11	U.S. 2017/18 Ages 6-11
Middle Childhood (Ages 6-11)						
Child participated in one or more activities	N/A	83%	84%	90%	78%	78%
Child did not miss any days of school because of illness or injury	17%	24%	27%	31%	28%	29%
Family and Community Characteristics						
Family eats a meal together every day of the week	N/A	31%	34%	39%	44%	45%
Child never attends religious services	N/A	27%	32%	34%	N/A	N/A
Someone living in the household uses cigarettes, cigars, or pipe tobacco	29%	20%	20%	16%	18%	15%
Two or more adverse childhood experiences (ACEs)	N/A	N/A	N/A	8%	21%	16%
Parent Health						
Mother's mental or emotional health is fair/poor	N/A	N/A	N/A	9%	9%	5%
Father's mental or emotional health is fair/poor	N/A	N/A	N/A	6%	4%	3%

N/A – Not Available

Key Issues

The Sandusky County Health Partners reviewed the 2019/2020 Sandusky County Health Assessment. The detailed primary data for each individual priority area can be found in the section it corresponds to. Each organization completed an "Identifying Key Issues and Concerns" worksheet. The following tables were the group results.

What are the most significant health issues or concerns identified in the 2019 health assessment report? Examples of how to interpret the information include: 39% of adults were obese, increasing to 53% of those under 30.

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Adult Mental Health (9 votes)			
Adults feeling so sad or hopeless almost every day for two weeks or more in a row that stopped them from doing usual activities (in the past year)	12%	Age: Under 30 (13%) Income: <$25K (16%)	Female (15%)
Adults considering attempting suicide (in the past year)	6%	N/A	N/A
Number of deaths by suicide – 2018 Sandusky County *(Source: ODH, Ohio Public Health Data Warehouse, Mortality, Leading Causes of Death, updated 1-12-20)*	9 deaths	N/A	N/A
Adult Drug Use (6 votes)			
Adults who had used medication not prescribed for them or took more than prescribed to feel good or high/or more active or alert (in the past 6 months)	16%	Age: Under 30 (31%) Income: <$25K (33%)	Females (20%)
Adults who had used recreational marijuana or hashish (in the past 6 months)	6%	Age: 30-64 (5%) Income: $25K Plus (7%)	Males (8%)
Adult Weight Status (5 votes)			
Obese adults (includes severely and morbidly obese, BMI of 30.0 and above)	39%	Age: Under 30 (53%) Income: <$25K (47%)	Males (41%)
Overweight adults	39%	Age: 30-64 (41%) Income: $25K Plus (40%)	Males (42%)

N/A- Not Available

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Adult Alcohol Consumption (3 votes)			
Adults who had at least one alcoholic drink (in the past month)	56%	Age: Under 30 (69%) Income: $25K Plus (62%)	Male (58%)
Adult binge drinking (males having 5 or more drinks on one occasion, females having four or more drinks on one occasion) (in the past month)	29%	N/A	N/A
Youth Drug Use (3 votes)			
Youth who had used marijuana (in the past month)	12%	Age: 17+ (18%) 14-16 (12%)	Male (14%)
Youth Mental Health (3 votes)			
Youth who felt so sad or hopeless for two or more weeks in a row (in the past year)	35%	Age: 14-16 (37%)	Female (43%)
Youth who made a plan about attempting suicide (in the past year)	15%	Age: 13 and younger (19%)	Female (16%)
Youth who actually attempted suicide (in the past year)	10%	Age: 17+ (14%) 13 and younger (13%)	Female (11%)
Youth Alcohol Consumption (2 votes)			
Youth who had at least one drink (in their lifetime)	49%	Age: 17+ (62%) 14-16 (53%)	Female (49%)
Youth who were current drinkers (in the past month)	16%	Age: 17+(24%) 14-16 (16%)	Female (17%)
Youth binge drinking (in the past month)	11%	Age: 17+ (21%) 14-16 (11%)	Male & Female (11%)
Adult Tobacco Use (2 votes)			
Adults who were current smokers (at least 100 cigarettes in their lifetime)	17%	Age: Under 30 (24%) Income: <$25K (22%)	Females (19%)
Cardiovascular Health (1 vote)			
Adults who had high blood pressure	38%	Age: 65+ (69%) Income: <$25K (57%)	Male (44%)
Adults who had high blood cholesterol	37%	Age: 65+ (60%) Income: $25K Plus (38%)	Male (47%)
Adults who had angina or coronary heart disease	4%	Age: 65+ (8%)	N/A

N/A- Not Available

Key Issue or Concern	Percent of Population At risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Infant Mortality (1 vote)			
Total live births (per year) – Sandusky 2018 *(Source: ODH Information Warehouse, updated 1-13-2020)*	639 births	N/A	N/A
Preterm births (<37 weeks gestation) (per year) – Sandusky 2018 *(Source: ODH Information Warehouse, updated 1-13-2020)*	56 births	N/A	N/A
Low birthweight (<2,500 grams or 5 lbs 8ozs, but greater than 3 lbs 4ozs) (per year) – Sandusky 2018 *(Source: ODH Information Warehouse, updated 1-13-2020)*	3 deaths	N/A	N/A
Social Determinants of Health (SDOH) (1 vote)			
Adults who had four or more Adverse Childhood Experiences (ACEs) (in their lifetime)	16%	Age: Under 30 (19%) Income: <$25K (23%)	Female (21%)
Healthcare Access and Utilization (1 vote)			
Uninsured adults	4%	Age: 30-64 (7%) Income: <$25K (10%)	Female (5%)
Access to affordable healthcare *(ex. of those adults who were uninsured, they reported losing their job or changed employers prevented them from getting medical care in the past year)*	31%	N/A	N/A
Early Childhood Issues (1 vote)			
Children ages 0-5 who had two or more adverse childhood experiences (ACEs) (in their lifetime)	1%	N/A	N/A
Children ages 0-5 who had been diagnosed with learning disability (in their lifetime)	3%	N/A	N/A
Children ages 0-5 who had been diagnosed with a speech or language disability (in their lifetime)	9%	N/A	N/A
Parenting Assistance (1 vote)			
Parent who had missed work due to their child's illness (in the past year)	46%	N/A	N/A

N/A- Not Available

Priorities Chosen

Based on the 2019/2020 Sandusky County Health Assessment, key issues were identified for adults and youth. Overall, there were 14 key issues identified by the Sandusky County Health Partners. The Sandusky County Health Partners then voted and came to a consensus on the priority areas Sandusky County will focus on over the next three years. The key issues and their corresponding votes are described in the table below.

Key Issues	Votes
1. Adult Mental Health	9
2. Adult Drug Use	6
3. Adult Weight Status	6
4. Adult Alcohol Consumption	3
5. Youth Drug Use	3
6. Youth Mental Health	3
7. Youth Alcohol Consumption	2
8. Adult Tobacco Use	2
9. Cardiovascular Health	1
10. Infant Mortality	1
11. Social Determinants of Health	1
12. Healthcare Access and Utilization	1
13. Early Childhood Issues	1
14. Parenting Assistance	1

Sandusky County will focus on the following three priority factors and priority health outcomes over the next three years:

Priority Factor(s):

1) Health Behaviors

Priority Health Outcome(s):

1) Mental Health and Addiction
2) Maternal and Infant Health

Community Themes and Strengths Assessment (CTSA)

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

Open-ended Questions to the Committee

1. **What do you believe are the 2-3 most important characteristics of a healthy community?**
    - Access to healthcare and providers (5)
    - Safe and clean environment (4)
    - Availability of resources (3)
    - Quality education/schools (3)
    - Employment opportunities (2)
    - Availability of active lifestyle (2)
    - Economy
    - Population
    - Affordable housing
    - Affordable childcare
    - Community awareness
    - Acceptance of diversity
    - Natural or green spaces
    - Access to mental health services
    - Historical and cultural heritage promotion and celebration
    - People moving into/staying in the community to live and work
    - Community participating in identifying local solutions to local problems

2. **What makes you most proud of our community?**
    - Community support and collaboration (7)
    - Leadership (2)
    - Park district (2)
    - Availability of resources (2)
    - Strong community partnerships (2)
    - New businesses
    - Fire departments
    - Government agencies
    - Revitalization of downtown

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

- Health partners (7)
- Family and Children First Council (7)
- Health department (3)
- Park district (2)
- United Way (2)
- Service clubs (2)
- Community health services (2)
- Fremont City
- Mental health coalition
- City-school partnerships
- Kiawanis Adaptive
- Sandusky County sheriff's office
- Fremont recreational department
- Mental health and recovery board
- Economic Development Corporation
- NAMI – Seneca, Sandusky, & Wyandot counties
- Commitment to the CHIP process and leadership at the table
- Village of Gibsonburg working to update/revitalize their downtown area

4. **What do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life in our community?**

- Promotion of active lifestyles (5)
- Healthcare access (3)
- Education opportunities (3)
- Drug use and overdoses (3)
- Improved mental health services (3)
- Improved health insurance coverage (3)
- Inclusion of diverse populations (2)
- Safe and healthy living conditions (2)
- Housing
- COVID-19
- Transportation
- Financial stability
- Workforce shortages
- Removing barriers to care
- Racial and social disparities
- Retention and growth of businesses

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

- Sustainable funding (3)
- COVID-19 pandemic (2)
- Minority involvement (2)
- Understanding poverty (2)
- Lack of workforce
- Lack of communication
- Unwillingness to change
- Priorities other than health
- Few child psychiatric services available
- Social factors related to health inequalities
- Community wide knowledge of risk factors
- Access to health care is not equal for all residents
- Insurance programs that do not meet needs for consumers

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

- Active living initiatives (3)
- Programs for underserved communities/population (2)
- Sales tax increase
- City development
- Economic development
- Quality care to residents
- Chronic disease programs
- Recruitment of child psychiatry or child advocacy center
- Employers providing wages/benefits that help sustain families

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

- Open forums
- Town hall meetings
- Community engagement
- Having the time to devote to a program
- Assist with mental health and chronic health issues
- Seeing new people come to the table to help address current issues in the county

*Quality of Life Survey

The Sandusky County Health Partners urged community members to fill out a short Quality of Life Survey via SurveyMonkey. There were 383 Sandusky County community members who completed the survey. The table below incorporate responses from the previous Sandusky County CHIP for comparison purposes. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1. For all responses of "Don't Know," or when a respondent left a response blank, the choice was a non-response and was assigned a value of 0 (zero). The non-response was not used in averaging response or calculating descriptive statistics. *89% of survey participants live in Sandusky County.*

Quality of Life Questions	Likert Scale Average Response	
	2017 (n=307)	2021 (n=383)
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	3.54
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.29	3.18
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.62	3.55
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	3.45
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	3.19
6. Is the community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?)	3.45	3.49
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	3.47
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.48	3.38
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.07	3.17
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.22	3.18
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	3.26
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	3.16

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

Forces of Change Assessment

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

Force of Change	Threats Posed	Opportunities Created
1. COVID-19 (8)	• Lack of access to care (4) • Depression (2) • Loss of lives (2) • Loss of income (2) • Increased demand on health systems (2) • Declined mental health of community (2) • Declined physical health of community (2) • Lack of food • Loss of utilities • Lack of housing • Increased hospital bills • Loss of educational progress	• Increased vaccination clinics for the public (3) • Increased use of tele-health and home health (2) • Further disaster preparedness • Getting projects done at home • Increase pay and benefits for healthcare providers • Increased awareness of community services
2. Growing aging population (4)	• Strain on healthcare system (2) • Inadequate housing options (2) • Lack of attorneys willing to be legal guardians (2) • Depression • Lack of food • Increased demand for services for resources • Agencies won't be able to keep up financially to service the aged • Lack of day care for seniors so their family member(s) can work	• New housing development • Increased medical providers • Increased senior care services • Conduct meetings with local attorneys to recruit them to help • Conduct meetings with nursing homes to open up day care programs

Force of Change	Threats Posed	Opportunities Created
3. Mental health (2)	• Increased domestic violence • Increased suicide & attempts • Increased child abuse/neglect	• Increase in mental health services (2)
4. Rural setting (2)	• Workforce shortage • Inability to attract new employers/businesses/industry • Lack of support for aging parents • Difficulty accessing care and health inequities	• Creation of innovative workforce development strategies • Development of cultural amenities in the community • Opportunities for more specialized or sub-population tailored health programming
5. Overweight population (2)	• Increased health care costs (2) • Poor diets	• Legislation requiring weight loss to be covered by insurance, wellness program opportunities (2) • Engage cities to offer walking competitions • Vanguard or Terra offer nutritional classes at a lower rate to teach healthy eating practices
6. Growing disillusionment with government	• Lack of trust towards prevention and intervention strategies for health	• Opportunities for more transparency in health programs to encourage community buy-in
7. Racism	• Negatively impacts health inequities among historically marginalized communities	• Recognizing racism as a barrier to care
8. Grant funding	• Loss of programs	• Innovative steps to secure funding i.e., local agencies
9. Evictions	• Homelessness	• Increased public housing
10. Legalization of marijuana	• Increased drug usage • Youth perception – okay to use	• Medical use
11. Infant day care	• Lack of proper day care so parents can work	• Conduct programs to educate possible day care providers to help lower infant mortality
12. Use of tele services/counseling	• Lack of services	• Funding toward technology to help assist with teleservices

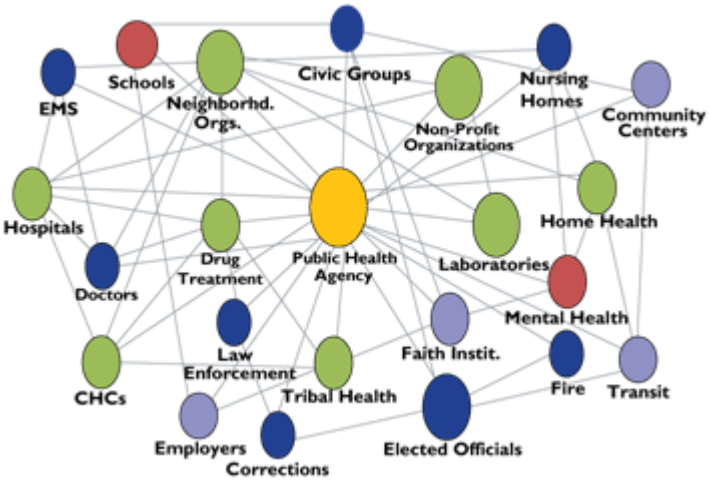
Force of Change	Threats Posed	Opportunities Created
13. Inflation	• More taxes • Loss of income • Healthcare reduction • Closure of businesses • Agencies wont be able to keep up financially to service the aged	• N/A
14. Increase in children's mental health issues	• Lack of child psychiatric services in the area	• Development of child advocacy center
15. Drug and opioid use during pregnancy	• Children separate from parents during treatment	• Drug treatment centers
16. Declining school enrollment	• Budget, staff, and service reduction	• N/A
17. State budget cuts	• Reduction of services	• N/A
18. State mandates, testing, evaluations, and licensing	• Strained resources and instructional time loss	• N/A
19. Lack of workforce/staffing in certain areas	• Limited services	• Better health outcomes
20. Increase in alcohol and substance abuse	• DORA	• Increased community education

N/A – Not available

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**)

The Local Public Health System Assessment (LPHSA)

The 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.**

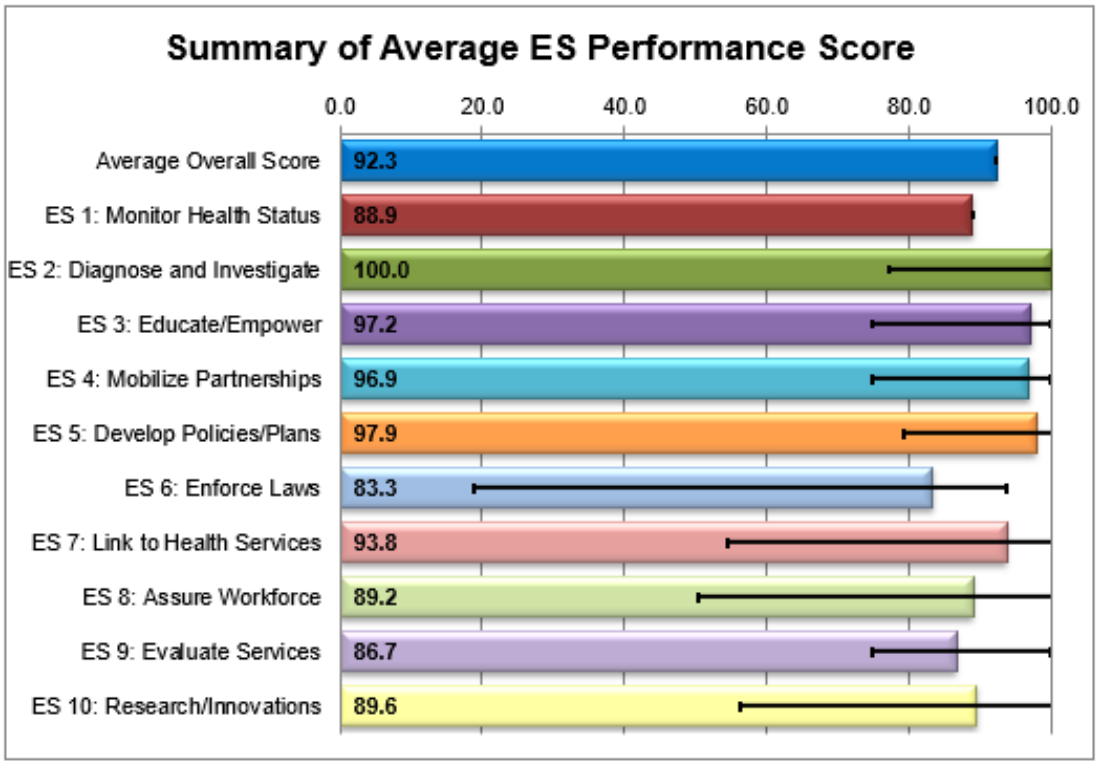
Members of the Sandusky County Health Partners completed the performance measures instrument. The LPHSA results were then presented to the Sandusky County Health Partners for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model 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 Sandusky County Health Partners identified 0 indicators that had a status of "minimal" and "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 Bethany Brown from Sandusky County Public Health at (419) 334-6377.

Sandusky County Local Public Health System Assessment 2021 Summary



Note: The black bars identify the range of reported performance score responses within each Essential Service

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

Gaps Analysis

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

Strategy Selection

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

Evidence-Based Practices

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

Resource Inventory

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

Priority #1: Health Behaviors

Strategic Plan of Action

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

Nutrition/Physical Activity Strategies

Priority #1: Health Behaviors				
Strategy 1: Healthy food initiatives in food banks				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
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. Research grants and other funding opportunities to increase the number of community gardens and/or farmer's markets in Sandusky County.	August 18, 2021	Adult, Youth and Child	Adult fruit/vegetable consumption: Percent of adults who did not eat fruits or vegetables during the past 7 days Youth fruit/vegetable consumption: Percent of youth who did not eat fruits or vegetables during the past 7 days	Creating Healthy Communities
Year 2: Assist churches, libraries, and other organizations in applying for grants to obtain funding for a community garden or farmer's market. Work with food pantries to offer fresh produce and assist pantries in seeking donations from local grocers. Encourage the use of SNAP/EBT (Electronic Benefit Transfer) at farmers' markets. Offer fresh food sampling (with recipe cards, etc.) at food pantries and farmer's markets.	August 18, 2022			
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. Increase the number of food pantries offering fresh produce by 20% from baseline. 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.	August 18, 2023			
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: Health Department and OSU Extension				
Outcome: Increase fruit and vegetable consumption				

Priority #1: Health Behaviors				
Strategy 2: Complete Streets				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
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 Policy objectives.	August 18, 2021	Adult, Youth, and Child	Child physical activity: Percent of children who are physically active 60 minutes per day Adult physical activity: Percent of adult reporting no leisure time physical activity Youth physical activity: Percent of youth who did not participate in at least 60 minutes per day	Creating Healthy Communities
Year 2: Begin to implement the following Complete Streets Objectives: • Increase in total number of miles of on street bicycle facilities, defined by streets and roads with clearly marked or signed bicycle accommodations. • Increase in member jurisdictions which adopt complete streets policies.	August 18, 2022			
Year 3: Continue efforts from years 1 and 2.	August 18, 2023			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Health Department				
Outcome: Increase physical activity				

Priority #1: Health Behaviors

Strategy 3: Nutrition prescriptions

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research the **Wholesome Rx program** (formerly known as the Fruit and Vegetable Prescription Program - FVRx) and gather baseline data documenting the need for one in the Sandusky County. Recruit healthcare, food pantry, farmers market, and other potential partners to participate in the Wholesome Rx initiative. Meet with potential partners to discuss the need and feasibility of implementing the Wholesome Rx program. Finalize Wholesome Rx locations, vendors, and other details necessary for the implementation of the program. Determine and develop additional program materials that are needed.	August 18, 2021	Adult and Youth	Adult fruit/vegetable consumption: Percent of adults who did not eat fruits or vegetables during the past 7 days Youth fruit/vegetable consumption: Percent of youth who did not eat fruits or vegetables during the past 7 days	Creating Healthy Communities
Year 2: Continue efforts from year 1. Implement the Wholesome Rx program. Develop evaluation measures to determine program success.	August 18, 2022			
Year 3: Continue efforts from years 1 and 2.	August 18, 2023			

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy:

Health Department

Outcome:

Increase fruit and vegetable consumption

Priority #1: Health Behaviors

Strategy 4: Online community wellness-calendar

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collaborate with organizations to create an online community wellness calendar. Include current information regarding nutrition, physical activity, high blood pressure, high blood cholesterol, and other chronic disease management opportunities in Sandusky County. Include information regarding community gardens, farmers markets, physical activity opportunities, and nutrition education, as well as senior programs. Highlight programs that are free or available at a reduced cost. Make sure the calendar is available on Facebook and other social network sites, as well as online. Update key words on search engines for easy access. Provide updated information to local radio stations and other news outlets. Print hard copies and make them available to senior centers, food pantries, and other relevant locations to reach populations that may not have internet access.	August 18, 2021	Adult and Youth	Adult physical activity: Percent of adult reporting no leisure time physical activity Youth physical activity: Percent of youth who did not participate in at least 60 minutes per day High blood pressure: Percent of adults who had high blood pressure High blood cholesterol: Percent of adults who had high blood cholesterol	Chamber of Commerce
Year 2: Keep the online wellness calendar updated on a quarterly basis. Work with community partners to tie the programs and activities into employee incentive programs.	August 18, 2022			
Year 3: Continue efforts from years 1 and 2. Determine on an annual basis who will update the calendar for the next 3 years.	August 18, 2023			

Strategy identified as likely to decrease disparities?

○ Yes ○ No ⊗ Not SHIP Identified

Resources to address strategy:

Creating Healthy Communities and Health Department

Outcome:

Increase awareness about health-related activities

Tobacco Use Strategies:

Priority #1: Health Behaviors				
Strategy 5: Smoke-free policies for indoor areas				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collect baseline data on which organizations, multi-unit housing facilities, schools and other businesses currently have tobacco-free policies. 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. Implement the smoke-free policy in at least 1-2 multiunit housing complexes. Begin efforts to adopt a smoke-free policy in Sandusky County parks, schools, and other locations.	August 18, 2021	Adult and Youth	Adult smoking: percent of adults that are current smokers Youth all tobacco/nicotine use: Percent of high school students who have used tobacco products in the past 30 days	Health Department
Year 2: Continue efforts of year 1. Target 3 additional multi-unit housing complexes to adopt a smoke-free housing policy. Continue education efforts.	August 18, 2022			
Year 3: Continue efforts of years 1 and 2. Target 3 additional multi-unit housing complexes to adopt a smoke-free housing policy.	August 18, 2023			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Health Department and Prevention Partnership Coalition				
Outcome: Decrease current smoker percentages				

Priority #1: Health Behaviors				
Strategy 6: Mass media campaigns against tobacco use				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Consider implementing the following **Mass-reach communication** strategies: • Share messages and engage audiences on social networking sites like Facebook and Twitter. • Deliver messages through different websites and stakeholders communications. • Generate free press through public service announcements. • Pay to place adds on TV, radio, billboards, online platforms and/or print media. The **strategies** should focus on motivating tobacco users to quit, protecting people from the harm of secondhand smoke exposure, and preventing tobacco use and vaping initiation. Raise awareness of the **Tobacco 21** law.	August 18, 2021	Adult and Youth	Adult smoking: Percent of adults that are current smokers Youth smoking: Current smoker rates	Health Department
Year 2: Continue efforts from year 1. Implement one mass-reach communication strategy.	August 18, 2022			
Year 3: Continue efforts from years 1 and 2.	August 18, 2023			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Health Department and Prevention Partnership Coalition				
Outcome: Decrease current smoker percentages				

Priority #1: Health Behaviors				
Strategy 7: Links to cessation support				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Research evidence-based tobacco cessation programs. Begin implementing a tobacco cessation program. Promote and raise awareness of the **Ohio Tobacco Quit Line**.	August 18, 2021	Adult	Adult smoking: percent of adults that are current smokers	Health Department
Year 2: Increase participation in the tobacco cessation program by 5% from baseline. Look for opportunities to reduce out of – pocket costs for cessation therapies. Tailor programming towards at risk populations (i.e., pregnant women)	August 18, 2022			
Year 3: Continue efforts from years 1 and 2.	August 18, 2023			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: Health Department and Prevention Partnership Coalition				
Outcome: Decrease current smoker percentages				

Priority #2: Mental Health and Addiction

Strategic Plan of Action

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

Mental Health Strategies

Priority #2: Mental Health and Addiction				
Strategy 1: Trauma informed care				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Provide 3 trainings to increase awareness and understanding of trauma informed care, including toxic stress and adverse childhood experiences. Promote the "Mind Wise" online screening tool (determine baseline) Develop and distribute a trauma screening tool for social service agencies who work with at-risk adults and youth.	August 18, 2021	Adult	Adult depression: adults feeling so sad or hopeless almost every day for two weeks or more that stopped them from doing usual activities (in the past year) Adult suicide attempts: adults considering attempting suicide (in the past year)	Mental Health and Recovery Services Board
Year 2: Continue efforts from year 1. Increase the use of trauma screening tool "Mind Wise" by 5%.	August 18, 2022			
Year 3: Continue efforts of years 1 and 2. Increase the use of trauma screening tool "Mind Wise" by 15%.	August 18, 2023			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: Family and Children First Council				
Outcome: Decrease depression percentages and suicide attempts				

Priority #2: Mental Health and Addiction

Strategy 2: Mental health first aid

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Obtain baseline data on the number of local partners trained in mental health first aid. Research available telemental health services and promote throughout trainings. Provide at least 2 MHFA trainings. Market the training to social services agencies, law enforcement, and health fields.	August 18, 2021	Adult	Adult depression: adults feeling so sad or hopeless almost every day for two weeks or more that stopped them from doing usual activities (in the past year) Youth depression: youth feeling so sad or hopeless almost every day for two weeks or more that stopped them from doing usual activities (in the past year)	Mental Health and Recovery Services Board
Year 2: Continue efforts from year 1. Provide at least 2 additional trainings and continue marketing the training. Market the training to local churches, schools, rotary clubs, and the Latino community. Increase the number of sectors trained by 5.	August 18, 2022			
Year 3: Continue efforts from years 1 and 2. Provide at least 2 additional trainings and continue marketing the training. Market the training to chamber of commerce, city councils, college students, and others. Increase the number of sectors trained by 5.	August 18, 2023			

Strategy identified as likely to decrease disparities?

○ Yes ⊗ No ○ Not SHIP Identified

Resources to address strategy:

Family and Children First Council

Outcome:

Reduce depression and suicide percentages

Priority #2: Mental Health and Addiction				
Strategy 3: School-based social and emotional instruction				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Obtain baseline data about current social/emotional programming available. • **The PAX Good Behavior Game** • **The Incredible Years** • **ROX (Ruling Our Experience)** Pilot the program(s) in at least one Sandusky County school district.	August 18, 2021	Youth	Youth depression: youth feeling so sad or hopeless almost every day for two weeks or more that stopped them from doing usual activities (in the past year)	Health Department
Year 2: Continue efforts from year 1. Implement the program(s) in 2 additional Sandusky County school districts.	August 18, 2022			
Year 3: Continue efforts from years 1 and 2. Implement the program(s) in 2 additional Sandusky County school districts.	August 18, 2023			
Strategy identified as likely to decrease disparities? ○ Yes ⊗ No ○ Not SHIP Identified				
Resources to address strategy: Local schools				
Outcome: Reduce depression percentages				

Addiction Strategy

Priority #2: Mental Health and Addiction				
Strategy 4: Peer recovery services				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Determine the need for **certified peer recovery coaches** in Sandusky County. Research funding sources to certify peer recovery coaches. Advocate for overall support, additional training opportunities, and financial support from the state level. Identify opportunities to recruit demographics with the most need. Offer technical assistance to ensure all aspects of the certification process are completed.	August 18, 2021	Adult	Unintentional drug overdose deaths: number of deaths due to unintentional drug overdose (per 100,000) ODH	Mental Health and Recovery Services Board
Year 2: Continue efforts of year 1. Identify opportunities to further involve peer recovery coaches with the treatment community.	August 18, 2022			
Year 3: Continue efforts of years 1 and 2. Continue to identify and train additional peer recovery coaches within the county.	August 18, 2023			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: Health Department				
Outcome: Increase the number of peer recovery coaches				

Priority #3: Maternal and Infant Health

Strategic Plan of Action

To work toward improving maternal and infant health, the following strategies are recommended:

Priority #3: Maternal and Infant Health				
Strategy 1: Increase first trimester prenatal care				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
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.	August 18, 2021	Child	Preterm births: 56 births (<37 weeks gestation, per year) Low birthweight (<2,500 grams or 5lbs 8ozs, bur greater than 3lbs 4ozs)	ProMedica Memorial Hospital Bellevue Hospital
Year 2: Increase the number of offices offering education and care coordination by 25%.	August 18, 2022			
Year 3: Increase the number of offices offering education and care coordination by 50%.	August 18, 2023			
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Not SHIP Identified				
Resources to address strategy: Family and Children First Council				
Outcome: Reduce the number of preterm births and infant mortalities				

Priority #3: Maternal and Infant Health				
Strategy 2: Early childhood home visiting programs				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Collect baseline data on any current early childhood programs in Sandusky County. Offer the **Help Me Grow Home Visiting program** in Sandusky County virtually and on-site. Evaluate effectiveness of the program by using the following measures: • Improvement in maternal and newborn health; • Reduction in child injuries, abuse, and neglect; • Improved school readiness and achievement; • Reduction in crime or domestic violence; • Improved family economic self-sufficiency; and • Improved coordination and referral for other community resources and supports	August 18, 2021	Child	Preterm births: 56 births (<37 weeks gestation, per year) Infant mortality: number of deaths for infants under 1 (per 1,000 live births)	Health Department
Year 2: Continue to promote and monitor the Help Me Grow Home Visiting program.	August 18, 2022			
Year 3: Continue efforts from years 1 and 2.	August 18, 2023			
Strategy identified as likely to decrease disparities? ⊗ Yes ○ No ○ Not SHIP Identified				
Resources to address strategy: Family and Children First Council				
Outcome: Reduce the number of preterm births and infant mortalities				

Progress and Measuring Outcomes

Progress will be monitored with measurable indicators identified for each strategy. Most indicators align directly with the SHIP. The individuals or agencies that are working on strategies will meet on an as- needed basis. The Sandusky County Health Partners will meet quarterly to report out progress. The Sandusky County Health Partners will create a plan to disseminate the CHIP to the community. Strategies, responsible agencies, and timelines will be reviewed at the end of each year by the committee. As this CHIP is a living document, edits and revisions will be made accordingly.

Sandusky County will continue facilitating CHAs every three years to collect data and determine trends. Primary data will be collected for adults and secondary data will be analyzed for youth using national sets of questions to not only compare trends in Sandusky County, but also be able to compare to the state and nation. This data will serve as measurable outcomes for each priority area. 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 a continuous basis to focus on the success of the strategies. Areas of process evaluation that the CHIP committee will monitor 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 strategies have been incorporated into a "Progress Report" template that can be completed at all future meetings, keeping the committee on task and accountable. This progress report may also serve as meeting minutes.

Contact Us

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

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Appendix I: Gaps and Strategies

The following tables indicate health behaviors, mental health and addiction, and maternal and infant health gaps and potential strategies that were compiled by the Sandusky County Health Partners.

Priority Factors: Health Behaviors

Gaps	Potential Strategies
1. Obese/overweight percentages (2)	• Complete Streets program • Comparable insurance coverage for weight loss • Community fitness programs • Healthy food initiatives in food banks • Exercise prescriptions from healthcare providers • Community-wide physical activity campaigns
2. High blood pressure and high cholesterol (adult) (2)	• Walk with a Doc program • Individually adapted physical activity programs • Tobacco cessation access • Fruit and vegetable incentive programs
3. Tobacco use for those under 30 (adults)	• Smoking cessation programs tailored for specific populations • Tobacco cessation affordability • Mass media campaigns against tobacco use

Priority Health Outcomes: Mental Health and Addiction

Gaps	Potential Strategies
1. Increased suicide attempts (2)	• Telemental health services (2) • Promote connectedness
2. Depression (2)	• Activity programs for older adults (2) • Mental health education/mental health first aid • Integration of behavioral health services into primary care
3. Drug use (adults) (2)	• Comparable insurance coverage for behavioral health • Prescription drug monitoring programs • Medication-assisted treatment access • Peer recovery organizations
4. Shortage of professionals	• Increase in pay (i.e., Medicaid and Insurance)
5. Alcohol consumption (youth)	• Media campaign to increase parent/adult communication with youth on negative effects/consequences
6. Mental health (youth)	• School-based social and emotional instruction • Depression screening

Priority Health Outcomes: Maternal and Infant Health

Gaps	Potential Strategies
1. Pre-term births	• Increase use of Prenatal Risk Assessments • Group maternity care
2. Maternal drug use	• Complete Plan of Safe Cares
3. Infant mortality	• Early childhood home visiting programs • Tobacco cessation tailored for pregnant women • Preconception education interventions

Appendix II: Links to Websites

Title of Link	Website URL
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
Certified Peer Recovery Supporters	https://mha.ohio.gov/Health-Professionals/About-Mental-Health-and-Addiction-Treatment/Peer-Support/Peer-Supporter-Certification-and-Recertification-Process
Health Communications in Tobacco Prevention and Control	https://www.cdc.gov/tobacco/stateandcommunity/bp-health-communications/pdfs/health-communications-508.pdf
Help Me Grow	https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/help-me-grow/help-me-grow
Nutrition prescription programs	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/nutrition-prescriptions
Ohio Tobacco Quit Line	https://ohio.quitlogix.org/en-US/
PAX Good Behavior Game	https://www.hazelden.org/HAZ_MEDIA/gbg_insert.pdf
ROX (Ruling Our Experience)	https://rulingourexperiences.com/#!about_us/csgz
The Incredible Years	http://www.incredibleyears.com/
Trauma informed care	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/trauma-informed-health-care
Tobacco 21	https://tobacco21.org/state-by-state/
Tobacco Control Interventions	https://www.cdc.gov/policy/hst/hi5/tobaccointerventions/index.html
Wholesome Rx	https://www.ruralhealthinfo.org/project-examples/897