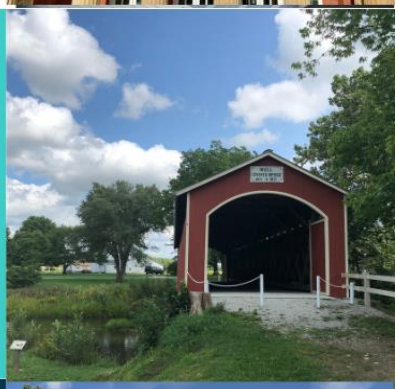
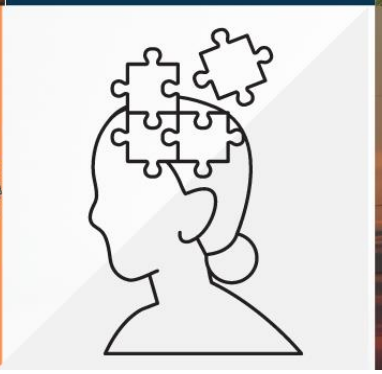
Sandusky County Community Health Improvement Plan

2023-2026





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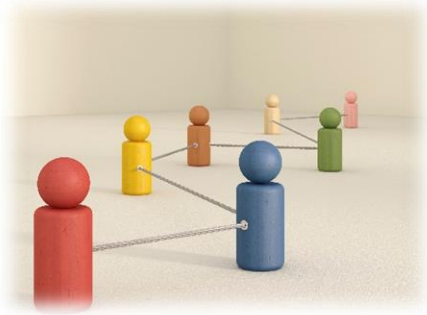
EXECUTIVE SUMMARY

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. The 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.

Sandusky County Health Partners have been conducting CHAs since 2001 to measure community health status. The most recent CHA was completed and released in April 2023. The questions are 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.

Sandusky County Public Health contracted with Tim Wasserman, Wass Works Consulting, 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 CHIP Committee 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. PHAB is a voluntary national accreditation program, however the State of Ohio requires all local health departments to become accredited by 2020, making it imperative that all PHAB requirements are met. Sandusky County Public Health was accredited in November 2018.

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 Tim Wasserman, Wass Works Consulting and various local community partners representing a variety of sectors.

Inclusion of Vulnerable Populations (Health Disparities)

Approximately, 10.4% of Sandusky County residents were below the poverty line, according to the U.S. Census Bureau, 2020 Poverty and Median Income Estimates. For this reason, data is broken down by income (less 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 (LPHSA) and the community health status assessment. These four assessments were used by the CHIP Committee to prioritize specific health issues and population groups which are the foundation of this plan. Figure 1.1 illustrates how each of the four assessments contributes to the MAPP process.

Figure 1.1 The MAPP model

Alignment with National and State Standards

The 2023-2026 Sandusky County Community Health Improvement Plan priorities align with regional, state and national priorities. Sandusky County will be addressing the following priority health outcomes: mental health, substance abuse, and chronic disease. Additionally, Sandusky County will be addressing the following priority health factor: social determinants of health.

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 SHIP 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 SHIP 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.*
**The new 2023 SHIP was not released at the time of this CHIP being completed.*

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

Figure 1.2 2023-2026 Sandusky CHIP Alignment with the 2020-2022 SHIP

Priority Factors	Priority Indicators	Strategies to Impact Priority Indicators	Additional Aligned Strategies
Social Determinants of Health	• Adult/Youth ACEs (Adverse Childhood Experiences) • Access to Care	• Home visiting programs • Telehealth services	
Priority Health Outcomes	**Priority Indicators**	**Strategies to Impact Priority Indicators**	**Additional Aligned Strategies**
Mental Health	• Adult depression • Youth depression • Suicide deaths	• Mental health trainings (QPR) Question, Persuade, Refer • Suicide Death Review Board • Community outreach and education	• Trauma informed care education • Peer recovery services
Substance Abuse	• Access to providers • Overdose deaths	• Expand SBIRT trainings (Screening Brief Intervention Referral Treatment) • Narcan trainings/education • Mentoring programs	
Chronic Disease	• Adult Hypertension • Adult Diabetes	• Education programs	

SHIP Framework

Figure 1.3 2020 - 2022 State Health Improvement Plan

Equity Health equity is achieved when all people in a community have access to affordable, inclusive and quality infrastructure and services that, despite historical and contemporary injustices, allows them to reach their full health potential.

Priorities The SHIP identifies three priority factors and three priority health outcomes that affect the overall health and well-being of children, families and adults of all ages.

What shapes our health and well-being?
Many factors, including these
3 SHIP priority factors*:

Community conditions
- Housing affordability and quality
- Poverty
- K-12 student success
- Adverse childhood experiences

Health behaviors
- Tobacco/nicotine use
- Nutrition
- Physical activity

Access to care
- Health insurance coverage
- Local access to healthcare providers
- Unmet need for mental health care

How will we know if health is improving in Ohio?
The SHIP is designed to track and improve these
3 SHIP priority health outcomes:

Mental health and addiction
- Depression
- Suicide
- Youth drug use
- Drug overdose deaths

Chronic disease
- Heart disease
- Diabetes
- Childhood conditions (asthma, lead)

Maternal and infant health
- Preterm births
- Infant mortality
- Maternal morbidity

All Ohioans achieve their full health potential
- Improved health status
- Reduced premature death

Vision
Ohio is a model of health, well-being and economic vitality

Strategies The SHIP provides state and local partners with a menu of effective policies and programs to improve Ohio's performance on these priorities.

* These factors are sometimes referred to as the social determinants of health or the social drivers of health

Vision and Mission Statement

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 serves and how it accomplishes its goals.

Sandusky County Health Partners

Vision Statement

A community which all people have equitable access to a healthy lifestyle.

Mission Statement

A consortium of organizations working together to improve the health outcomes of all Sandusky County residents.

Community Partners

The CHIP was planned by various agencies, community partners, and service providers within Sandusky County. Sandusky County Health Partners completed and released the Community Health Assessment in April 2023. The planning process for the CHIP was completed from March 2023-July 2023. Other community partners were invited to be a part of the CHIP planning process and reviewed 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 priority issues. We would like to recognize these organizations and thank them for their dedication to this process.

CHIP Committee Community Partners

Bellevue City Schools
City of Fremont
City of Fremont-Fire Department
City of Fremont-Police Department
Community Health Services
Firelands Counseling and Recovery
Fremont City School District
Gibsonburg School District
Great Lakes Community Action Partnership
Mental Health Board of Seneca, Ottawa, Sandusky & Wyandot counties
NAMI Northwest Ohio
Ohio State University Extension
ProMedica Memorial Hospital
Sandusky County Board of Developmental Disabilites
Sandusky County Economic Development
Sandusky County Family and Children First
Sandusky County Homeless Coalition
Sandusky County Jobs and Family Services
Sandusky County Public Health
The Bellevue Hospital
United Way of Sandusky County
Y.M.C.A. of Sandusky County

Facilitator

The community health improvement process was facilitated by Tim Wasserman of Wass Works Consulting LLC.

Community Health Improvement Process

Beginning in April 2023, the Sandusky County Community Health Improvement Plan Committee held a series of three meetings to complete the following planning steps:

01 Initial Meetings

- Review process and timeline
- Secure consultant to assist in planning
- Finalize CHIP development committee

02 Choose Priorities

- Utilizing Community Health Assessment to prioritize target impact areas.

03 Rank Priorities

- Chip Committee ranks priorities based on magnititude, seriousness of consequences and feasibility of correcting.

04 Community Themes and Strengths Assessment

- Open ended questions on community themes and strengths

05 Forces of Change Assessment

- Open ended questions on forces of changes

06 Local Public Health Assessment

- Review results of Local Public Health Assessment with Chip Commmitte

07 Gaps Analysis

- Determine discrepancies between community needs and viable community resources to address local priorities.
- Identify strengths, weaknesses and evaluation strategies.

08 Quality of Life Survey

- Chip Committee ranks priorities based on magnititude, seriousness of consequences and feasibility of correcting.

09 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 all steps taken
- Write plan that explains the CHIP process and illustrates the the selected priorities and strategies to accomplish those goals.

Community Health Status Assessment

Phase 3 of the MAPP Process, the Community Health Status Assessment, or CHA is a 100 plus page report that includes primary data with over 100 indicators and hundreds of data points related to health and well being, including social determinants of health. CHA serves as the baseline data in determining key issues that lead to priority selection. The full report can be found at www.scpublichealth.com/CHA. 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	Sandusky County 2022/ 2023	Ohio 2021	U.S. 2021
Health Care Coverage, Access, and Utilization									
Uninsured	14%	7%	14%	16%	8%	4%	3%	6%	7%
Had one or more persons they thought of as their personal health care provider	N/A	N/A	N/A	N/A	88%	90%	89%	86%	84%
Visited a doctor for a routine checkup (in the past year)	N/A	64%	59%	62%	64%	74%	73%	77%	76%
Preventive Medicine									
Had a pneumonia vaccination (age 65 and over)	N/A	N/A	66%	52%	65%	73%	64%	71%	71%
Had a flu vaccine in the past year (age 65 and over)	N/A	N/A	N/A	76%	78%	77%	76%	66%	69%
Ever had a shingles or zoster vaccine	N/A	N/A	N/A	7%	13%	22%	23%	29%*	29%*
Women's Health									
Had a mammogram within the past two years (ages 40 and over)	72%	70%	68%	68%	69%	68%	71%	71%**	72%**
Had a Pap smear in the past three years (ages 21-65)	N/A	78%‡	66%‡	67%‡	71%‡	66%	63%	77%	78%
Had a clinical breast exam in the past two years (ages 40 and older)	N/A	72%	68%	66%	66%	59%	56%	N/A	N/A
Men's Health									
Had a PSA test within the past two years (ages 40 and over)	N/A	N/A	N/A	N/A	N/A	N/A	61%	32%**	32%**
Oral Health									
Visited a dentist or a dental clinic (within the past year)	55%	57%	62%	62%	72%	70%	63%	65%**	67%**

Indicates alignment with the Ohio State Health Assessment (SHA)
**2017 BRFSS*
***2020 BRFSS*
‡Pap smear was reported for women ages 19 and over
N/A – Not Available

Adult Trend Summary, Continued

Adult Variables	Sandusky County 2001	Sandusky County 2005	Sandusky County 2009	Sandusky County 2013	Sandusky County 2016	Sandusky County 2019	Sandusky County 2022/ 2023	Ohio 2021	U.S. 2021
Health Status Perceptions									
Rated general health as excellent or very good	49%	49%	49%	50%	44%	44%	45%	52%	53%
Rated general health as fair or poor	15%	15%	12%	16%	12%	13%	14%	17%	15%
Rated mental health as not good on four or more days (in the past month)	N/A	21%	19%	22%	27%	30%	39%	31%	29%
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	6.4	4.8*	4.1*
Rated physical health as not good on four or more days (in the past month)	N/A	21%	19%	22%	21%	20%	20%	21%	20%
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	4.7	4.1*	3.7*
Weight Status									
Overweight	31%	36%	35%	29%	33%	39%	36%	33%	34%
Obese	33%	36%	34%	35%	42%	39%	41%	38%	34%
Tobacco Use									
Current smoker (smoked on some or all days)	36%	23%	19%	19%	19%	17%	15%	18%	14%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	20%	25%	24%	26%	24%	30%	28%	25%	25%
Tried to quit smoking (on at least one day in the past year)	N/A	54%	41%	60%	39%	60%	59%	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%	11%	8%	7%
Former e-cigarette user	N/A	N/A	N/A	N/A	N/A	15%	13%	19%**	16%**

Indicates alignment with the Ohio State Health Assessment (SHA)
N/A – Not Available
**2019 BRFSS as compiled by 2022 County Health Rankings*
***2017 BRFSS Data*

Adult Trend Summary, Continued

Adult Variables	Sandusky County 2001	Sandusky County 2005	Sandusky County 2009	Sandusky County 2013	Sandusky County 2016	Sandusky County 2019	Sandusky County 2022/ 2023	Ohio 2021	U.S. 2021
Alcohol Consumption									
Current drinker (had at least one drink of alcohol within the past month)	53%	33%	56%	51%	62%	56%	58%	53%	53%
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%	33%	17%	15%
Drug Use									
Used recreational marijuana or hashish in the past six months	7%	7%	7%	7%	5%	6%	8%	N/A	N/A
Misused prescription drugs in the past six months	5%	5%	5%	7%	10%	16%	6%	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%	21%	N/A	N/A
Seriously considered attempting suicide in the past year	3%	2%	2%	6%	1%	6%	8%	N/A	N/A
Attempted suicide in the past year	N/A	N/A	0%	1%	0%	2%	1%	N/A	N/A
Cardiovascular Disease									
Ever diagnosed with angina or coronary heart disease	N/A	7%	4%	8%	4%	4%	4%	5%	4%
Ever diagnosed with a heart attack or myocardial infarction	4%	5%	4%	5%	6%	3%	4%	5%	4%
Ever diagnosed with a stroke	4%	3%	4%	3%	2%	3%	2%	4%	3%
Had been told they had high blood pressure	25%	37%	34%	31%	33%	38%	41%	36%	32%
Had been told their blood cholesterol was high	22%	33%	27%	35%	34%	37%	36%	36%	36%
Had their blood cholesterol checked within the last five years	N/A	N/A	N/A	80%	75%	84%	80%	85%	85%

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

Adult Trend Summary, Continued

Adult Variables	Sandusky County 2001	Sandusky County 2005	Sandusky County 2009	Sandusky County 2013	Sandusky County 2016	Sandusky County 2019	Sandusky County 2022/ 2023	Ohio 2021	U.S. 2021
Sexual Behavior									
Had more than one sexual partner in past year	N/A	6%	3%	9%	6%	7%	7%	N/A	N/A
Ever been tested for HIV	N/A	N/A	25%	20%	23%	29%	20%	33%	35%
Diabetes									
Ever been told by a doctor they have diabetes (not pregnancy-related)	11%	11%	12%	10%	18%	14%	11%	13%	11%
Had been diagnosed with pre-diabetes or borderline diabetes	N/A	N/A	N/A	6%	N/A	8%	10%	2%	2%

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

Youth (OHYES!) Trend Summary

Youth Variables	Sandusky County 2011 (6th-12th)	Sandusky County 2013 (6th-12th)	Sandusky County 2016 (6th-12th)	Sandusky County 2019 (6th-12th)	Sandusky County 2022 OHYES! (7th-12th)	Sandusky County 2022 OHYES! (9th-12th)	Ohio YRBS 2019 (9th-12th)	U.S. YRBS 2019 (9th-12th)
Weight Status								
Obese	14%	13%	23%	22%	23%	23%	17%	16%
Overweight	12%	17%	11%	11%	18%	17%	12%	16%
Physically active at least 60 minutes per day on every day in past week	62%	69%	30%	28%	23%	24%	77%	77%
Physically active at least 60 minutes per day on 5 or more days in past week	38%	43%	49%	47%	44%	47%	57%	56%
Did not participate in at least 60 minutes of physical activity on any day in past week	8%	12%	13%	18%	13%	14%	21%	17%
Tobacco/Electronic Vapor Product Use								
Current smoker (smoked on at least 1 day during the past 30 days)	13%	11%	7%	7%	1%	2%	5%	6%
Current cigar smoker (cigars, cigarillos, or little cigars, on at least 1 day during the 30 days)	N/A	N/A	N/A	N/A	1%	2%	30%	33%
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	14%	10%	13%	7%	6%
Current smokeless tobacco user (chewing tobacco, snuff, dip, snus, or dissolvable tobacco products—such as Redman, Levi Garrett, Beechnut, Skoal, Skoal Bandits, Copenhagen, Camel Snus, Marlboro Snus, General Snus, Ariva, Stonewall, or Camel Orbs—not counting any electronic vapor products, on at least 1 day during the 30 days)	N/A	N/A	N/A	3%	1%	1%	16%	11%

N/A – Not Available

Youth (OHYES!) Trend Summary, Continued

Youth Variables	Sandusky County 2011 (6th-12th)	Sandusky County 2013 (6th-12th)	Sandusky County 2016 (6th-12th)	Sandusky County 2019 (6th-12th)	Sandusky County 2022 OHYES! (7th-12th)	Sandusky County 2022 OHYES! (9th-12th)	Ohio YRBS 2019 (9th-12th)	U.S. YRBS 2019 (9th-12th)
Alcohol Consumption								
Current Drinker (at least one drink of alcohol on at least 1 day during the past 30 days)	24%	19%	17%	16%	8%	12%	26%	29%
Binge drinker (drank 5 or more drinks within a couple of hours on at least 1 day during the past 30 days)	13%	13%	7%	11%	3%	5%	13%	14%
Drank for the first time before age 13 (of all youth)	N/A	25%	12%	17%	16%	13%	16%	15%
Obtained the alcohol they drank by someone giving it to them (of current drinkers)	N/A	58%	41%	39%	43%	45%	N/A	17%
Rode with a driver who had been drinking alcohol (in a car or other vehicle on 1 or more occasions during the past 30 days)	20%	20%	16%	17%	11%	11%	N/A	5%
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)	4%	6%	7%	3%	1%	1%	26%	29%
Drug Use								
Currently use marijuana (in the past month)	13%	8%	11%	12%	6%	8%	16%	22%
Tried marijuana for the first time before age 13	N/A	N/A	N/A	N/A	4%	3%	N/A	6%
Ever used methamphetamines (in their lifetime)	1%	1%	0%	1%	<1%	0%	N/A	2%
Ever used cocaine (in their lifetime)	3%	4%	1%	1%	1%	1%	4%	4%

N/A – Not Available

Youth (OHYES!) Trend Summary, Continued

Youth Variables	Sandusky County 2011 (6th-12th)	Sandusky County 2013 (6th-12th)	Sandusky County 2016 (6th-12th)	Sandusky County 2019 (6th-12th)	Sandusky County 2022 OHYES! (7th-12th)	Sandusky County 2022 OHYES! (9th-12th)	Ohio YRBS 2019 (9th-12th)	U.S. YRBS 2019 (9th-12th)
Drug Use, Continued								
Ever used heroin (in their lifetime)	<1%	2%	0%	<1%	<1%	<1%	2%	2%
Ever used inhalants (in their lifetime)	10%	10%	5%	6%	1%	2%	8%	4%
Ever used ecstasy (also called MDMA in their lifetime)	5%	3%	1%	1%	<1%	<1%	N/A	4%
Ever took steroids without a doctor's prescription (in their lifetime)	N/A	1%	1%	1%	<1%	<1%	N/A	2%
Were offered, sold, or given an illegal drug on school property (in the past 12 months)	7%	6%	4%	5%	6%	9%	15%	22%
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)	25%	25%	28%	35%	36%	41%	33%	37%
Seriously considered attempting suicide (in the past 12 months)	N/A	N/A	N/A	N/A	18%	20%	16%	19%
Attempted suicide (in the past 12 months)	6%	8%	7%	10%	7%	8%	7%	9%
Suicide attempt results in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (in the past 12 months)	N/A	N/A	N/A	N/A	1%	2%	3%	3%
Social Determinants of Health								
Visited a doctor or health care professional (for a routine checkup in the past year)	67%	73%	64%	64%	50%	51%	N/A	N/A
Visited a dentist in the past year (for a check-up, exam, teeth cleaning, or other dental work)	74%	74%	66%	71%	62%	61%	N/A	N/A

N/A – Not Available

Youth (OHYES!) Trend Summary, Continued

Youth Variables	Sandusky County 2011 (6th-12th)	Sandusky County 2013 (6th-12th)	Sandusky County 2016 (6th-12th)	Sandusky County 2019 (6th-12th)	Sandusky County 2022 OHYES! (7th-12th)	Sandusky County 2022 OHYES! (9th-12th)	Ohio YRBS 2019 (9th-12th)	U.S. YRBS 2019 (9th-12th)
Unintentional Injuries and Violence								
Were in a physical fight (in the past 12 months)	N/A	N/A	N/A	N/A	14%	12%	19%	22%
Were in a physical fight on school property (in the past 12 months)	N/A	N/A	N/A	N/A	6%	5%	N/A	8%
Threatened or injured with a weapon on school property (in the past 12 months)	6%	7%	8%	11%	12%	11%	N/A	7%
Did not go to school because they felt unsafe (at school or on their way to or from school in the past 30 days)	6%	5%	6%	6%	20%	19%	N/A	9%
Bullied on school property (in past year)	N/A	36%	27%	26%	22%	21%	14%	20%
Electronically bullied (bullied through e-mail, chat rooms, instant messaging, websites or texting in the past year)	11%	13%	15%	12%	15%	15%	13%	16%
Experienced physical dating violence (including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with in the past 12 months)	N/A	N/A	N/A	N/A	7%	8%	10%	8%

N/A – Not Available

Key Issues

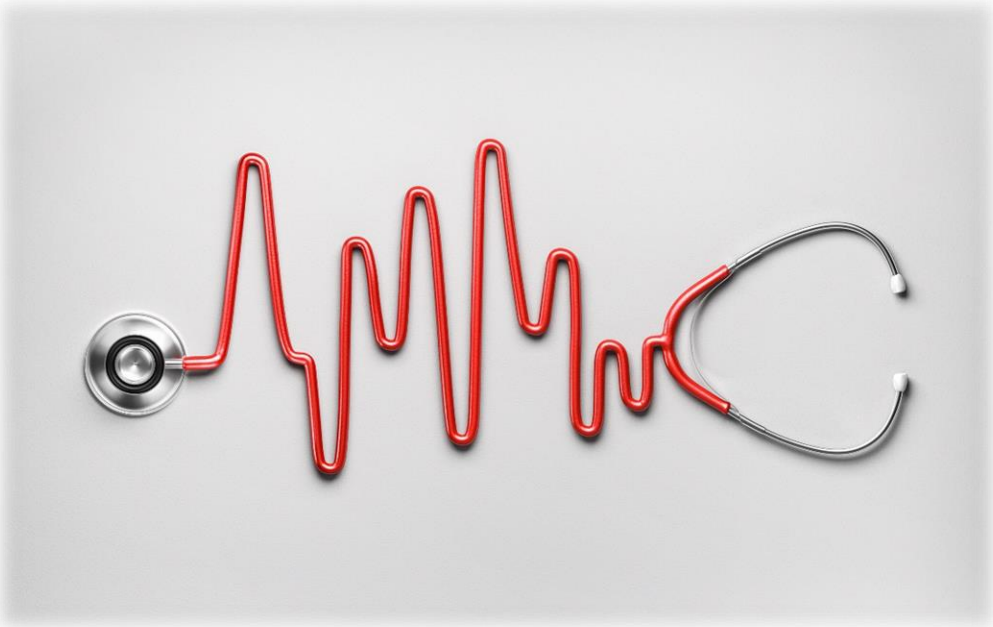
The CHIP Committee reviewed the 2022/2023 Sandusky County Health Assessment. The detailed primary data for each individual priority area can be found in the sectionin which it corresponds. Each committee member completed the "Identifying Key Issues and Concerns" worksheet. The following tables were the group results.

Key Issues or Concern	Percentage of Population at risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Youth Substance Abuse (13)			
Youth used an electronic vapor product in their lifetime	18%	N/A	N/A
Youth used an electronic vape product in the last 30 days	10%	17 and older (17%)	Female (12%)
Youth had their first drink before the age of 13	16%	N/A	N/A
Youth who were current drinkers	8%	17 and older (19%)	Male/Female (8%)
Youth used marijuana in the past month	6%	17 and older (10%)	Male (6%)
Youth Depression (13)			
Youth felt sad or hopeless almost every day for 2 or more weeks	36%	17 and older (42%) 14-16 yr. olds (40%)	Female (44%)
Adult ACEs (11)			
Adults who experienced 4 or more ACEs in their lifetime	20%	Income less than $25,000 (39%)	Female (21%)
Youth Overweight (10)			
Youth who were classified as obese or overweight	42%	13 and younger (45%)	Males (50%)
Adult Access to Care (7)			
Adults visited a doctor for a routine checkup in the past year	73%	Under age of 30 (50%)	Male (71%)
Adult had one or more persons they thought of as their personal health provider	89%	N/A	N/A
Key Issues or Concern	**Percentage of Population at risk**	**Age Group (or Income Level) Most at Risk**	**Gender Most at Risk**
Youth Suicide (6)			

Youth had attempted suicide in the past 12 months	7%	14-16 years old (8%)	Females (8%)
Youth reported they had considered attempting suicide in the past year	18%	17 years and older (21%)	N/A
Adult Prescription Drug Misuse (3)			
Adults had used drugs not prescribed for them or took more than prescribed to feel good or high	6%	Under the age of 30 (7%)	Males (8%)
Adult Marijuana (3)			
Adults had used recreational marijuana in the past 6 months	8%	Under the age of 30 (21%)	Males (13%)
Youth Feeling Safe (3)			
Youth did not go to school on one or more days in the past month because they did not feel safe at school or on their way	20%	N/A	N/A
Youth reported they had been physically hurt on purpose by someone they were dating	7%	N/A	N/A
Youth had been bullied in the past year	37%	13 years and younger (43%)	Females (44%)
Adult Binge Drinking (2)			
Adults report they had five or more alcoholic drinks on occasion in the past month	33%	N/A	N/A
Adults had a least one alcoholic drink in the past month	58%	N/A	N/A

Key Issues or Concern	Percentage of Population at risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Adult Hypertension (2)			
Adults were diagnosed with high blood pressure	41%	65 years old and older (55%) Income less than $25,000 (44%)	Male (44%)
Adults had their blood pressure checked within the past year	86%	N/A	N/A
Adult Depression (2)			
Adults felt sad or hopeless for two or more weeks in a row	21%	Under 30 years old (60%) Income less than $25,000 (41%)	Females 22%)
Adults seriously considered attempting suicide in the past year	8%	N/A	N/A
Youth Electronic Use (2)			
Youth reported parents never limited the times of day or length of time they used their electronic devices	45%	N/A	N/A
Adult Oral Health (2)			
Adult visited a dentist within the past year	63%	Under 30 years (40%)	Females (58%)
Adults did not visit a dentist in the last year due to cost	23%	N/A	N/A
Adult Diabetes (1)			
Adults have been diagnosed with diabetes	11%	65 years and older (19%)	Males (16%)
Adults have been diagnosed with pre-diabetes or borderline diabetes	10%	N/A	N/A
Adults were diagnosed with cancer	14%	65 years and older 28%	N/A

Key Issues or Concern	Percentage of Population at risk	Age Group (or Income Level) Most at Risk	Gender Most at Risk
Adult Food Insecurity (1)			
Adults had to choose between paying bills and buying food in the last year	17%	N/A	N/A
Adults did not have enough food to eat at least 1 day per week	14%	N/A	N/A



Priorities Chosen

Based on the 2022-2023 Sandusky County Health Assessment, key issues were identified for adults and youth. Overall, there were 17 key issues identified by the CHIP Committee. The CHIP Committee 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. Youth Substance Abuse	13
2. Youth Depression	13
3. Adult ACEs	11
4. Youth Overweight	10
5. Access to Care	7
6. Youth Suicide Attempts	6
7. Adult Prescription Drug Misuse	3
8. Adult Marijuana	3
9. Youth Feeling Safe	3
10. Adult Binge Drinking	2
11. Adult Hypertension	2
12. Adult Depression	2
13. Youth Electronic Use	2
14. Adult Oral Health	2
15. Adult Diabetes	1
16. Adult Cancer	1
17. Adult Food Insecurity	1

Focus Areas

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

Priority Health Outcome(s)

Priority Factor:

Community Themes and Strengths Assessment

The Community Themes and Strengths Assessment (CTSA) provides a deep understanding of the issues that residents felt were important by answering the questions listed below. The CTSA consisted of two parts: open-ended questions to the committee and the Quality-of-Life Survey. Below are the results:

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

- Economic Stability
- Strong Collaboration
- Bikeability/Walkability/Mobility
- Access to Services
- Safety
- Positive and Engaged Leadership
- Population growth
- Faith-Based community
- Inclusion
- Private/public partnerships/involvement
- Reach into the community
- Parks and Schools

2. What makes you most proud of our community?

- Modern schools
- Acknowledging, focusing and working toward inclusivity and diversity.
- Workplace/employment base
- Tourism attractions
- Collaboration of agencies
- Businesses and safety in the community
- Informal networks
- Advancement of the public transportation system
- Community resources
- Agricultural community
- Park system
- Strong healthcare system
- Interest in our youth
- Mental health levy

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

- United Way
- GLCAP – Great Lakes Community Action Partnership
- COE – (Community of Excellence)
- Schools/Colleges
- Service Organizations
- Health departments
- Homeless Coalition
- Share and Care
- HFH
- Family Children First
- CHS (Community Health Services)
- Chamber of Commerce
- EDC – (Economic Development Corporation
- DJFS
- City of Fremont
- YMCA
- Promedica Memorial Hospital
- Firelands
- The Bellevue Hospital
- MHRB – Mental Health Recovery Board
- NAMI Coalitions

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?

- Mental Health Access to Care
- Dental – Access to Care
- Obesity
- Education Opportunities
- Health Care Access
- Inclusion of diverse populations
- Housing
- Transportation
- Workforce engagement
- Racial and social disparities
- Financial stability

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

- Exposure to opportunities
- Lack of motivation
- Access to care
- Finances
- Institutional language barriers
- Programs to the community
- Home-based services
- Peer support/Accountability
- Participation of workforce
- Confidence
- Fear of lifestyle change

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

- Healthy eating initiatives
- Safety in neighborhoods
- Safety in schools
- Active living initiatives
- Building resiliency
- Economic development
- Health equity initiatives
- Increased access to health care
- Countywide collaboration

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

- Community participation and buy in from all segments of community
- Resources - financial and human resources
- Employer support
- Seeing positive results/outcomes
- Engaging private sector
- Townhall meetings
- Engaging new sectors of the community

Quality of Life Survey

The Sandusky County CHIP committee urged community members to fill out a short Quality of Life Survey via SurveyMonkey. There were 235 Sandusky County community members who completed the survey. The table below incorporates 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 blank response, the choice was a non-response with zero value.

Quality of Life Questions	Likert Scale Average Response	
	2021 (n=383)	2023 (n=235)
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]	3.54	3.86
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.18	3.32
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.55	3.78
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.)	3.45	3.48
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.)	3.19	3.58
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?)	3.49	3.61
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?	3.47	3.58
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.38	3.50
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.17	3.31
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.18	3.40
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.26	3.36
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?)	3.16	3.32

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:

Forces of Change	Threats Posed	Opportunities Created
COVID-19	▪ Misinformation from social media ▪ Decrease in benefits ▪ Long term medical issues ▪ Workforce – work-life balance	▪ Community Collaboration ▪ Work/life balance ▪ Use of technology ▪ Creative out-of-box thinking
Policy in healthcare legislation	▪ Decrease in support for social services, healthcare ▪ Government division – lack of compromise ▪ Not having right people at the table ▪ Funding	▪ Education ▪ Lobbying ▪ Voter turnout and participation
Creation of illegal drugs	▪ Death ▪ Lag of treatment/keeping up ▪ Strain on law enforcement/behavioral health ▪ Acceptance of marijuana "not that bad" ▪ Legalization of medical marijuana	▪ Job security for behavioral health providers ▪ Education and treatment
Racism/Inequalities	▪ Shifting the mindset from Access to Care to Reach to Care	▪ Recognizing it ▪ Systematic change ▪ Education/reframing
Social Media	▪ Inaccurate ▪ Negative content can reach large populations ▪ Loss of life skills (troubleshooting, socialization)	▪ Access to large populations
Medicaid	▪ Lack of healthcare coverage ▪ Food insecurity	▪ Education ▪ Path to employment
Sexual Orientation/Identity	▪ Isolation ▪ Mental Health ▪ Lack of care ▪ Lack of knowledge ▪ Lack of acceptance ▪ Inaccurate data collection	▪ Education for public and health professionals ▪ Equity training ▪ Promotion of safe space ▪ Acceptance education at younger age

Economy/Inflation	▪ Increased costs ▪ Lack of supply ▪ Lack of funds ▪ Lack of loans	▪ Entry into entrepreneurship & workforce ▪ Increased wages
Lack of Funding	▪ Lack of political education ▪ Deficit in programming /resources	▪ Creative partnering ▪ Compliance with funding
Distrust in health care	▪ Misinformation ▪ Not accessing care ▪ Safety of public/community ▪ Lack of healthcare workers	▪ Education ▪ Community collaboration
Gun Violence	▪ Safety ▪ Mental health ▪ Hesitation to attend events ▪ Extremes in politics ▪ Loss of life	▪ Education ▪ Training ▪ Advocacy to legislation ▪ Compromise/work together
Hospital Crisis	▪ Facility closing ▪ Loss of care/quality of care ▪ Decline in health status ▪ Reduction in local services	▪ New partnerships ▪ Innovation in providing services
Generation Gap	▪ Challenge to communicate messaging across multiple generations ▪ Disparity in Healthcare needs across generations	▪ Learning across generations ▪ Collaborating around differing perspectives (blended views)
Decline in population	▪ Workforce ▪ Changes in family dynamics ▪ Effects on rural communities (schools – public services, etc)	▪ Revamping hiring strategies/requirements ▪ Efficiencies in merging entities/systems
Misinformation	▪ Misguided & uninformed decisions ▪ Anger & mistrust ▪ Conspiracy theorists	▪ Opportunity to educate ▪ Redirect with accurate data
Senior Citizens	▪ Lack of care takers ▪ Technology scams ▪ Housing ▪ Fixed incomes	▪ TRIPS program ▪ New development (housing) ▪ Enrichment programs
Political beliefs	▪ Spread of false information ▪ Unwilling to see both sides ▪ Following blindly	▪ Online access ▪ More education ▪ Legislators roundtable
Lack of health care	▪ Chronic disease ▪ Time to get an appointment ▪ Lack of local specialists ▪ Affordability	▪ Education ▪ Telehealth
Technology	▪ Access to care ▪ Senior Citizens ▪ Costs ▪ Cyber security ▪ Internet	▪ Coffee with Giants ▪ Library ▪ GLCAP senior center ▪ State broadband program

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)

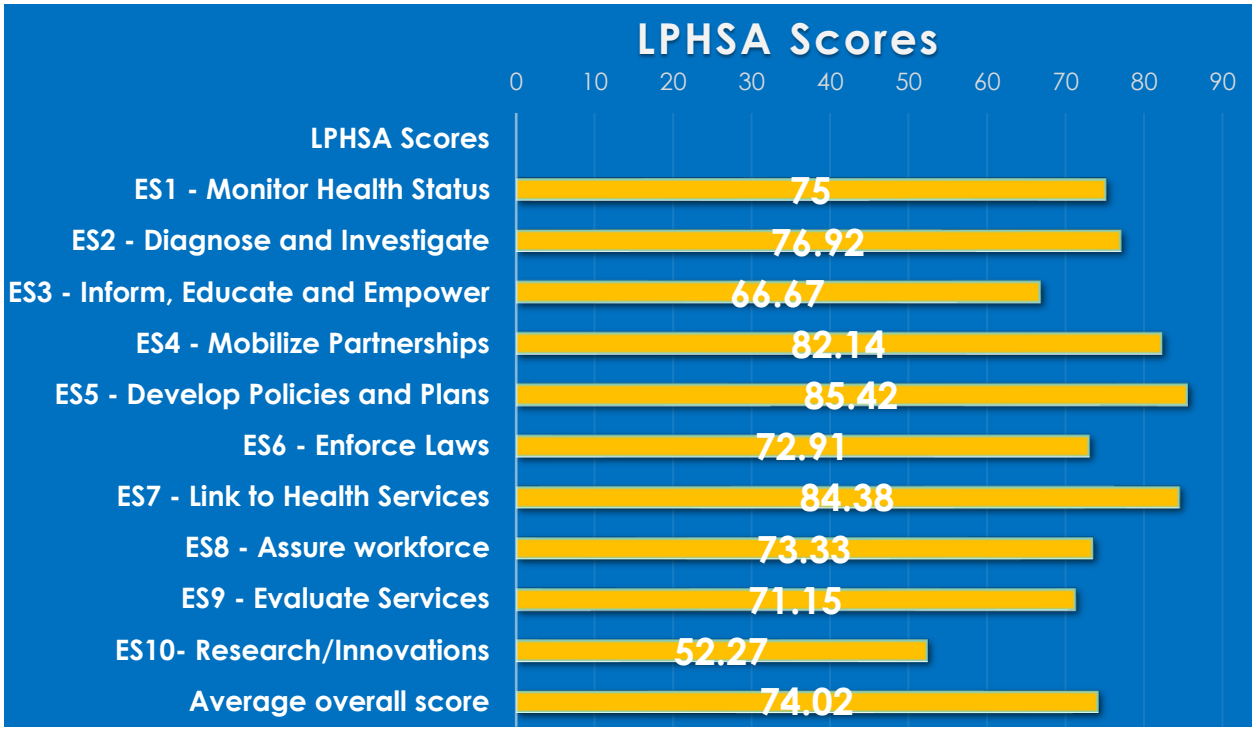
The LPHSA answers the questions, "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services being provided to our community?"

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

Members of the Sandusky County Public Health completed the performance measures instrument. 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 LPHSA results were then presented to the Sandusky County CHIP Committee.

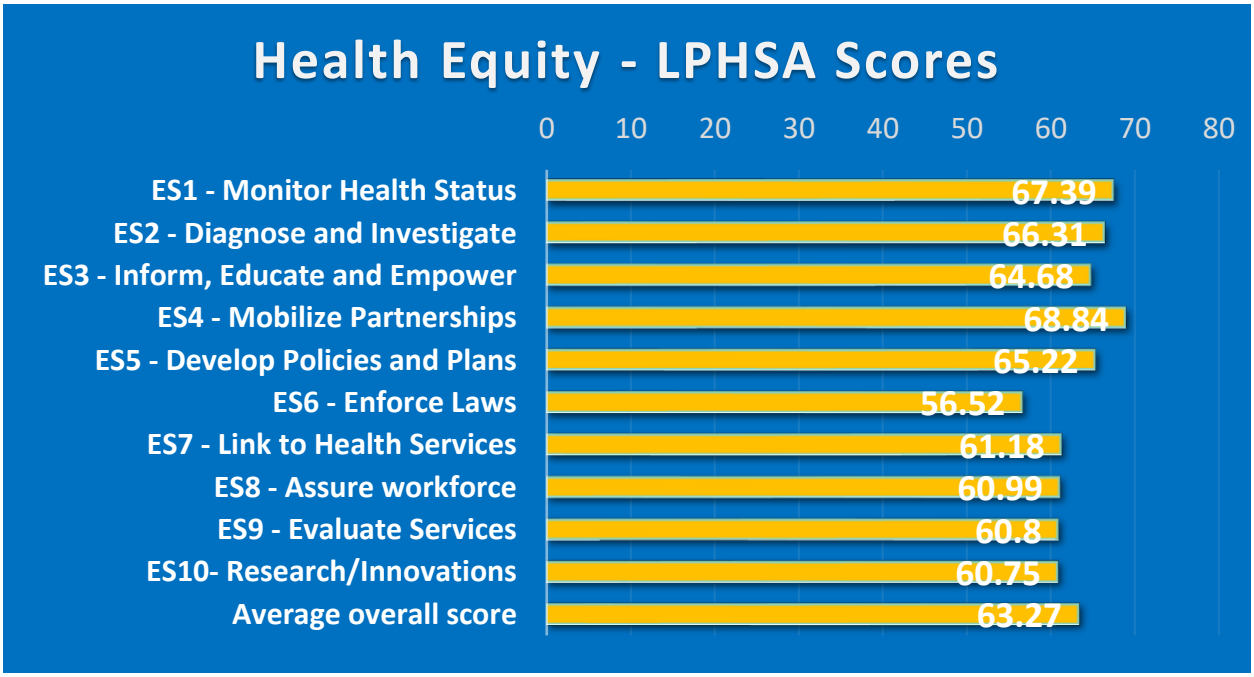
Sandusky County Public Health identified 0 indicators that had a status of "minimal" and "no activity." The remaining indicators were all moderate, significant or optimal.

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



Local Public Health Equity Assessment

The Sandusky County CHIP Committee completed a survey to identify how well the Local Public Health System acknowledges and addresses health inequities. The following graph shows the results.



Sandusky County Public Health 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, MSN, RN Health Commissioner from Sandusky County Public Health at (419) 334-6377.

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 CHIP Committee was 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.

Strategy Selection

Based on the chosen priorities, the CHIP Committee 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 CHIP Committee 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 CHIP Committee was 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 CHIP Committee 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.

Gaps and Strategies

The following table indicates Mental Health, Substance Abuse, Chronic Disease, Social Determinants of Health gaps and potential strategies compiled by the CHIP committee.

Priority Health Outcome: Mental Health

Gaps	Potential Strategies
Adult Depression	• QPR (Question, Persuade, Refer) suicide trainings • Trauma informed leave • Medication management • Long term Facility help
Youth Suicide Attempts	• Support groups • QPR trainings • Trauma-informed care
Youth Depression	• Support groups • Hire more staff support • Counseling agencies come into schools • Facility care
Lack of Providers	• Understanding benefits • Knowledge of community resources • Utilize navigator/MRST

Priority Health Outcome: Substance Abuse

Gaps	Potential Strategies
Adult Binge Drinking	• Education • Change what "fun" looks like • Teach Healthy Coping Strategies • Peer support
Adult Recreational Marijuana	• Community Education • Media Campaign • Educate parents on youth exposure
Drug Overdose	• Narcan trainings/distribution • Nalox boxes in community • Peer Support • MAT
Youth Substance Abuse	• Increase positive role models • Education parents/students • Start Talking education • Parents Host Lose the Most campaign • Vaping presentations • Cessation education

Priority Health Outcomes: Chronic Disease

Gaps	Potential Strategies
Adult Hypertension	• Worksite wellness programs • Complete Streets program • Community gardens • Produce Prescriptions • Food service guidelines • Pedestrian infrastructure
Adult Cancer	• Smoking cessation • Increase cancer screenings
Adult Diabetes	• Coffee with experts at ProMedica • Diabetes education • Support groups
Youth Obesity	• Healthy Kids Program • Summer meals program • Community garden • Park programs

Priority Factor: Social Determinants of Health

Gaps	Potential Strategies
Adult Food Insecurity	• Addressing stigma • Coaching/wraparound services • Food drives • Senior nutrition/home delivery • SNAP (Supplemental Nutrition Assistance Benefits)
Adult/Youth ACES	• Parenting classes • Prevention education in schools • Help Me Grow • Head Start • Children Services
Adult Access to Care	• Telehealth • Increased transportation • Education on medical homes
Adult Oral Health	• Oral health education • Recruitment of providers
Youth Electronic Devices	• Parent's nights • Marketing Campaign • Education for students
Youth Feel Unsafe at School	• Education on counseling services • In school trainings • Mentors

Priority 1 – Mental Health

Strategy 1 – Mental Health Education

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact and/or Agency
Year 1: ▪ Obtain data on number of local partners trained in suicide prevention using QPR (Question, Persuade and Refer) ▪ Provide at least 4 QPR trainings	8/1/23 – 7/31/24	Adult/Youth	Reduce percentage for Youth and Adult Depression Youth and Adult Suicide Attempts	NAMI Northwest Ohio
Year 2: ▪ Continue efforts from year one ▪ Provide at least 3 QPR trainings. ▪ Market the training to include support staff	8/1/24 – 7/31/25			
Year 3: ▪ Continue efforts from year one and two ▪ Provide at least two QPR trainings ▪ Continue to expand marketing to other sectors	8/1/25 – 7/31/26			

Strategy identified as likely to decrease disparities?

- Yes
- ✓ No
- ✓ SHIP Identified

Resources to address strategy:

Mental Health & Recovery Services Board, NAMI (National Alliance of Mental Ilness), Firelands, SCPH

Outcome:

Increase number of staff/trained in suicide prevention

Priority 1 – Mental Health

Strategy 2 – Community Outreach and Education

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact and/or Agency
Year 1: ▪ Obtain baseline data on resources in the community for Behavioral Health and Substance Abuse ▪ Create template for public awareness campaigns	8/1/23 – 7/31/24	Adult	Adults who report not receiving care	MHRSB - Mental Health Recovery Services Board
Year 2: ▪ Continue efforts from year one ▪ Implement public awareness campaign ▪ Reassess community resources	8/1/24 – 7/31/25			
Year 3: ▪ Continue efforts from year one and two ▪ Evaluate public awareness campaign	8/1/25 – 7/31/26			

Strategy identified as likely to decrease disparities?

- ✓ Yes
- No
- ✓ SHIP Identified

Resources to address strategy:
MHRSB and local mental health agencies

Outcome:
Increase mental health public awareness campaigns

Priority 1 – Mental Health

Strategy 3 – Surveillance and Data Collection

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact and/or Agency
Year 1: ▪ Assess and review current Drug Overdoes and Suicide Review team procedures and members ▪ Collect relevant data on suicide ▪ Analyze data for decision making	8/1/23 – 7/31/24	Youth/Adults	Youth and Adult suicide attempts Youth and adult suicide death rate numbers	Sandusky County Public Health
Year 2: ▪ Continue efforts from year one ▪ Look for funding for one strategy ▪ Implement one strategy	8/1/24 – 7/31/25			
Year 3: ▪ Continue efforts from year one and two ▪ Reassess members on Drug Overdoes and Suicide Review team ▪ Evaluate implemented strategy	8/1/25 – 7/31/26			

Strategy identified as likely to decrease disparities?

- ✓ Yes
- No
- ✓ SHIP Identified

Resources to address strategy:

Members of Drug Overdoes and Suicide Review team

Outcome:

Increase number of suicide prevention strategies in Sandusky County

Priority 2 - Substance Abuse

Strategy 1 - Expand SBIRT Screenings

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact and/or Agency
Year 1: ▪ Promote the SBIRT (Screening Brief Intervention & Referral to Treatment) ▪ Sign MOU's in SBIRT process ▪ Provide Training	8/1/23 – 7/31/24	Youth/Adults	Adults used a program or service to help with drug or alcohol problem for themselves or loved ones Youth reported they have ever visited a doctor, nurse or therapist, social worker, or counselor for a mental health problem	Sandusky County Public Health
Year 2: ▪ Continue efforts from year one ▪ Five percent increase in SBIRT screening tools used	8/1/24 – 7/31/25			
Year 3: ▪ Continue efforts from year one and two ▪ Increases by 10 percent SBIRT screening tools used	8/1/25 – 7/31/26			

Strategy identified as likely to decrease disparities?

- ✓ Yes
- No
- ✓ SHIP Identified

Resources to address strategy:

Promedica Memorial Hospital, The Bellevue Hospital, Firelands Counseling, Community Health Services

Outcome:

Increase number of providers offering SBIRT Screening Tools

Priority 2 - Substance Abuse

Strategy 2 - Expand Narcan Training/Naloxbox Distribution

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact and/or Agency
Year 1: ▪ Media campaign for Project DAWN, create Good Samaritan Law awareness. ▪ Reaching out to community agencies for Narcan and Naloxbox training. ▪ Gather baseline data	8/1/23 – 7/31/24	Youth/Adults	Adults indicated they or an immediate family member overdosed and required EMS/ hospitalization.	Sandusky County Public Health
Year 2: ▪ Continue efforts from year one ▪ Five percent increase in Naloxbox placement.	8/1/24 – 7/31/25			
Year 3: ▪ Continue efforts from year one and two ▪ Additional five percent increase in Naloxbox placement.	8/1/25 – 7/31/26			

Strategy identified as likely to decrease disparities?

- ✓ Yes
- No
- ✓ SHIP Identified

Resources to address strategy:

Health Department, ODH and Project DAWN

Outcome:

Increased number of people trained and increase of Naloxboxes in the community

Priority 2 - Substance Abuse

Strategy 3 – Compliance Checks

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact and/or Agency
Year 1: ▪ Increase rate of retailer compliance from 2022 ▪ Compliance check baseline for tobacco and alcohol	8/1/23 – 7/31/24	Youth	Youth drinkers reported obtaining their alcohol at a liquor store, convenience store, supermarket, discount store or gas station	Sheriff Department of Sandusky County
Year 2: ▪ Continue efforts of year one: complete 1 set of alcohol and 1 set of tobacco compliance checks ▪ Increase compliance by 10%	8/1/24 – 7/31/25			
Year 3: ▪ Continue efforts from year one and two	8/1/25 – 7/31/26			

Strategy identified as likely to decrease disparities?

- ✓ Yes
- No
- ✓ SHIP Identified

Resources to address strategy:

Health Department, Ohio Investigative Unit, Sheriff's department

Outcome:

Decrease in underage sales and increase in number of vendors trained in proper ID check

Priority 2 - Substance Abuse

Strategy 4 – Parental Engagement – "Start Talking"

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact and/or Agency
Year 1: ▪ Distribution of "Start Talking" Materials/Social Media Posts/Media Campaign ▪ Partner with two schools ▪ Research organizations that would distribute campaign	8/1/23 – 7/31/24	Adults	Youth have talked with at least one of their parents about the dangers of tobacco, alcohol, or drug use in the past 12 months	Sandusky County Public Health
Year 2: ▪ Continue year one initiatives ▪ Increase campaign to three additional schools	8/1/24 – 7/31/25			
Year 3: ▪ Continue efforts from year one and two ▪ Increase school participation in campaign across the county	8/1/25 – 7/31/26			

Strategy identified as likely to decrease disparities?

- ✓ Yes
- No
- ✓ SHIP Identified

Resources to address strategy:

Health Department, Media, School Districts and Community Agencies

Outcome:

Increase number of partners distributing Start Talking Campaign

Priority 2 - Substance Abuse

Strategy 5 – Mentoring Program – ACE (Assisting Children to Excel)

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact and/or Agency
Year 1: ▪ Increase awareness of ACE (Assisting Children to Excel) programming and continue to recruit students for mentoring program.	8/1/23 – 7/31/24	Youth	Youth have talked with at least one of their parents about the dangers of tobacco, alcohol, or drug use in the past 12 months	Fremont City Schools
Year 2: ▪ Continue year one initiatives and increase adult mentors to 55	8/1/24 – 7/31/25			
Year 3: ▪ Continue year two, increase one to one mentor/mentee ratio	8/1/25 – 7/31/26			

Strategy identified as likely to decrease disparities?

- ✓ Yes
- No
- ✓ SHIP Identified

Resources to address strategy:

Fremont City Schools, United Way

Outcome:

Increase youth talking to an adult they trust.

Priority 3 - Chronic Disease

Strategy 1 – Chronic Disease Preventive Education

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact and/or Agency
Year 1: ▪ Gather baseline data to see which organization are implementing/ providing chronic disease (ex. – diabetes, hypertension) education and prevention in Sandusky County. ▪ Identify partnering organizations to host chronic disease prevention education in Sandusky County ▪ Identify gaps in education programs	8/1/23 – 7/31/24	Youth/Adults	Youth was classified as overweight Adults rate their health as fair or poor.	YMCA
Year 2: ▪ Implement one chronic disease program (diabetes or hypertension)	8/1/24 – 7/31/25			
Year 3: ▪ Continue efforts from year one and two	8/1/25 – 7/31/26			

Strategy identified as likely to decrease disparities?

- ✓ Yes
- No
- ✓ SHIP Identified

Resources to address strategy:

YMCA, The Bellevue Hospital, Promedica Memorial Hospital, Creating Healthy Communities Coalition

Outcome:

Increase the days adults rated their health as excellent or very good.

Priority 3 - Chronic Disease

Strategy 2 – School Based Preventative Education

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact and/or Agency
Year 1: ▪ Gather baseline data to see what organizations are providing nutrition education to youth. ▪ Select nutrition education curriculum for target audiences ▪ Identify and implement nutrition education to youth-based organizations	8/1/23 – 7/31/24	Youth	Measure youth fruit and vegetable consumption: youth consuming 5 or more servings of fruit and vegetable servings a day	Creating Healthy Communities Coalition
Year 2: ▪ Increase number of nutritional education provided to youth	8/1/24 – 7/31/25			
Year 3: ▪ Continue efforts from year one and two	8/1/25 – 7/31/26			

Strategy identified as likely to decrease disparities?

✓ Yes
No
SHIP Identified

Resources to address strategy:
The Bellevue Hospital and Promedica Memorial Hospital, Creating Health Communities Coalition, OSU Extension, GLCAP and WIC

Outcome:
Increase the nutrition education opportunities provided for youth in the community

Priority 3 - Chronic Disease

Strategy 3 – Complete Streets

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact and/or 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 a comprehensive Complete Streets policy	8/1/23 – 7/31/24	Adult/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.	Creating Healthy Communities Coalition (CHC)
Year 2 ▪ Provide technical assistance to jurisdictions to write and adopt Complete Streets policies.	8/1/24 – 7/31/25			
Year 3 ▪ Continue efforts from year one and two	8/1/25 – 7/31/26			

Strategy identified as likely to decrease disparities?

- Yes
- ✓ No
- ✓ SHIP Identified

Resources to address strategy:
SCPH, Cities and Villages, CHC

Outcome:
Increase opportunities for physical activity

Priority 3 - Chronic Disease

Strategy 4 – Nicotine Recovery

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact and/or Agency
Year 1: ▪ Educate providers on the importance of tobacco cessation for themselves and/or clients. ▪ Train 1 provider to become a Certified Tobacco Treatment Specialists (CTTS)	8/1/23 – 7/31/24	Adult/Youth	Adults that are current smokers Youth used an electronic vapor product in the past 30 days	Sandusky County Public Health
Year 2: ▪ Continue efforts from year one ▪ Increase providers to become CTTS by 2	8/1/24 – 7/31/25			
Year 3: ▪ Continue efforts from year one and two	8/1/25 – 7/31/26			

Strategy identified as likely to decrease disparities?

- ✓ Yes
- No
- SHIP Identified

Resources to address strategy:

Sandusky County Public Health, Prevention Partnership Coalition, and Mental Health and Recovery Services Board of Seneca, Ottawa, Sandusky, and Wyandot Counties.

Outcome:

Increase cessation services available in Sandusky County as evidenced by having 3 new individuals trained as Certified Tobacco Treatment Specialists (CTTS)

Priority 4 – Social Determinants of Health

Strategy 1 – Access to Care

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact and/or Agency
Year 1: ▪ Through a collaborative group effort, develop a Tele-Health education and promotion campaign	8/1/23 – 7/31/24	Adult	Increase in utilization of Tele-Health Visits	Health Partners
Year 2: ▪ Implement Tele-Health education and promotion campaign	8/1/24 – 7/31/25			
Year 3: ▪ Evaluate effectiveness of campaign	8/1/25 – 7/31/26			

Strategy identified as likely to decrease disparities?

- ✓ Yes
- No
- ✓ SHIP Identified

Resources to address strategy:

Health Care providers and Health Insurance Providers

Outcome:

Increase education and promotion campaign concerning tele-health utilization

Priority 4 – Social Determinants of Health				
Strategy 2 – Youth ACEs (Adverse Childhood Experiences)				
Action Step	**Timeline**	**Priority Population**	**Indicator(s) to measure impact of strategy:**	**Lead Contact and/or Agency**
Year 1: ▪ Continue to promote early childhood home visiting program opportunities ▪ Explore development of a pilot program to provide intervention and support to at-risk elementary youth and their families	8/1/23 – 7/31/24	Prenatal to 3	Reduced number of youth reporting 3 or more ACES	Family Children First Council
Year 2: ▪ Continue efforts from Year1 ▪ Initiate pilot program to begin services to targeted population	8/1/24 – 7/31/25			
Year 3: ▪ Continue effort from year one and two ▪ Evaluate pilot program	8/1/25 – 7/31/26			
Strategy identified as likely to decrease disparities? ✓ Yes No ✓ SHIP Identified				
Resources to address strategy: Health Department, GLCAP, FCFC, Schools, JFS, Hospitals				
Outcome: Increase early childhood home visiting program referrals and visits				

Priority 4 – Social Determinants of Health

Strategy 3 – Workforce Shortage

Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact and/or Agency
Year 1: ▪ Identify local employer challenges with hiring and retention ▪ Increase access for employee education on job to increase employment ▪ Share career trainings and jobs with high school students	8/1/23 – 7/31/24	Adult	Unemployment rate Labor force participant rate	Sandusky County Economic Development Corporation
Year 2: ▪ Continue efforts from year one	8/1/24 – 7/31/25			
Year 3: ▪ Continue efforts from year one and two	8/1/25 – 7/31/26			

Strategy identified as likely to decrease disparities?

Yes
✓ No
SHIP Identified

Resources to address strategy:
Sandusky County Economic Development Corporation, local business, schools and Ohio Means Jobs

Outcome:
Increase number of new hires and job retention rates

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 CHIP Committee will meet twice a year to report out progress. The CHIP Committee 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 leaders of each priority. As this CHIP is a living document, edits and revisions will be made accordingly. This three year cycle will be from August 1, 2023 to August 1, 2026.

Sandusky County Health Partners 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 SHIP.

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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