Ottawa County
Community Health Improvement Plan

Adopted on 05.01.2018
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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.*
In 2001, the Ottawa County Health Partners began conducting community health assessments (CHA) for the purpose of measuring and addressing health status. The most recent Ottawa County Community Health Assessment was cross-sectional in nature and included a written survey of adults and adolescents within Ottawa County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention for their national and state Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Surveillance System (YRBSS). This has allowed Ottawa County to compare the data collected in their CHA to national, state and local health trends.

The Ottawa County CHA also fulfills national mandated requirements for the hospitals in our county. H.R. 3590 Patient Protection and Affordable Care Act states that in order to maintain tax-exempt status, not-for-profit hospitals are required to conduct a community health needs assessment at least once every three years, and adopt an implementation strategy to meet the needs identified through the assessment.

From the beginning phases of the CHA, community leaders were actively engaged in the planning process and helped define the content, scope, and sequence of the project. Active engagement of community members throughout the planning process is regarded as an important step in completing a valid needs assessment.

The Ottawa County CHA has been utilized as a vital tool for creating the Ottawa County Community Health Improvement Plan (CHIP). The Public Health Accreditation Board (PHAB) defines a CHIP as a long-term, systematic effort to address health problems on the basis of the results of assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A CHIP is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community inclusively and should be done in a timely way.

The Ottawa County Health Department contracted with the Hospital Council of Northwest Ohio, a neutral regional non-profit hospital association, to facilitate the process. The health department then invited key community leaders to participate in an organized process of strategic planning to improve the health of residents of the county. The National Association of City County Health Officer’s (NACCHO) strategic planning tool, Mobilizing for Action through Planning and Partnerships (MAPP), was used throughout this process.

The MAPP Framework includes six phases which are listed below:

- Organizing for success and partnership development
- Visioning
- Conducting the MAPP assessments
- Identifying strategic issues
- Formulating goals and strategies
- Taking action: planning, implementing, and evaluation
The MAPP process includes four assessments: Community Themes & Strengths, Forces of Change, the Local Public Health System Assessment and the Community Health Status Assessment. These four assessments were used by Ottawa County Health Partners to prioritize specific health issues and population groups which are the foundation of this plan. The diagram below illustrates how each of the four assessments contributes to the MAPP process.

![Diagram of the MAPP process]

**Figure 1.1 2018-2021 Ottawa County CHIP Overview**

<table>
<thead>
<tr>
<th>Overall Health Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>↑ Increase Health Status</td>
</tr>
<tr>
<td>↓ Decrease Premature Death</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Addiction</td>
</tr>
<tr>
<td>Chronic Disease</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>↓ Decrease adult and youth depression</td>
</tr>
<tr>
<td>↓ Decrease adult and youth suicide</td>
</tr>
<tr>
<td>↓ Decrease unintentional drug overdose deaths</td>
</tr>
<tr>
<td>↓ Decrease adult diabetes</td>
</tr>
<tr>
<td>↓ Decrease adult and youth obesity</td>
</tr>
</tbody>
</table>
Partners

The 2018-2021 Community Health Improvement Plan was drafted by agencies and service providers within Ottawa County. From February 2018 to April 2018, the committee reviewed many sources of information concerning the health and social challenges that Ottawa County residents may be facing. They determined priority issues which if addressed, could improve future outcomes; determined gaps in current programming and policies; and examined best practices and solutions. The committee has recommended specific action steps they hope many agencies and organizations will embrace to address the priority issues in the coming months and years. We would like to recognize these individuals and thank them for their devotion to this process and body of work:

**Ottawa County Health Partners**

Brenda Cronin - Mental Health & Recovery Board of Erie and Ottawa County  
Rachel Fall - Magruder Hospital  
Chris Galvin – United Way of Ottawa County  
Lori Koethe – Magruder Hospital  
Diane Kokinda – Ottawa County Health Department  
Stephanie Kowal – Ottawa County Job & Family Services  
Rebecca Lamour – Ottawa County Health Department  
Katie LaPlant – OSU Extension Office  
Jack Nitz – Port Clinton City School District  
Nancy Osborn – Ottawa County Health Department  
Angie Reineck – Port Clinton City School District  
James Sass – Ottawa County Commissioner  
Melinda Slusser – Ottawa County Board of Developmental Disabilities

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

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2. Dr. Reginald D. Noble, Director Schedel Arboretum and Gardens  
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4. Brenda Weidner, Graytown, Ohio
Mission and Vision

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 Ottawa County
Working together to improve the health of individuals, families, and our community by shifting our focus from treatment to prevention and wellness.

The Mission of Ottawa County
Bring people and organizations together to empower residents of Ottawa County and promote overall wellness.

Alignment with National and State Standards

The 2018-2021 Ottawa County CHIP priorities align with state and national priorities. Ottawa County will be addressing the following priorities: mental health and addiction, and chronic disease.

Ohio State Health Improvement Plan (SHIP)

Note: This symbol 🛑 will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2017-2019 SHIP.

The 2017-2019 State Health Improvement Plan (SHIP) serves as a strategic menu of priorities, objectives, and evidence based strategies to be implemented by state agencies, local health departments, hospitals and other community partners and sectors beyond health including education, housing, employers, and regional planning.

The SHIP includes a strategic set of measurable outcomes that the state will monitor on an annual basis. Given that the overall goal of the SHIP is to improve health and well-being, the state will track the following health indicators:

- **Self-reported health status** (reduce the percent of Ohio adults who report fair or poor health)
- **Premature death** (reduce the rate of deaths before age 75)

In addition to tracking progress on overall health outcomes, the SHIP will focus on three priority topics:

1. **Mental health and addiction** (includes emotional wellbeing, mental illness conditions and substance abuse disorders)
2. **Chronic Disease** (includes conditions such as heart disease, diabetes and asthma, and related clinical risk factors-obesity, hypertension and high cholesterol, as well as behaviors closely associated with these conditions and risk factors- nutrition, physical activity and tobacco use)
3. **Maternal and Infant Health** (includes infant and maternal mortality, birth outcomes and related risk and protective factors impacting preconception, pregnancy and infancy, including family and community contexts)

The SHIP also takes a comprehensive approach to improving Ohio’s greatest health priorities by identifying cross-cutting factors that impact multiple outcomes: health equity, social determinants of health, public health system, prevention and health behaviors, and healthcare system and access.
The 2018-2021 Ottawa County CHIP is required to select at least 2 priority topics, 1 priority outcome indicator, 1 cross cutting strategy and 1 cross-cutting outcome indicator to align with the 2017-2019 SHIP. The following Ottawa County CHIP priority topics, outcomes and cross cutting factors very closely align with the 2017-2019 SHIP priorities:

<table>
<thead>
<tr>
<th>Priority Topics</th>
<th>Priority Outcomes</th>
<th>Cross-Cutting Factors</th>
<th>Cross-Cutting Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health and addiction</td>
<td>• Decrease depression&lt;br&gt;• Decrease suicide&lt;br&gt;• Decrease unintentional drug overdose deaths</td>
<td>• Public health system, prevention and health behaviors&lt;br&gt;• Healthcare system and access</td>
<td>• Reduce suicide ideation of adults and youth&lt;br&gt;• Unintentional drug overdose deaths</td>
</tr>
<tr>
<td>Chronic Disease</td>
<td>• Decrease adult diabetes&lt;br&gt;• Decrease adult and youth obesity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To align with and support *mental health and addiction*, Ottawa County will work to increase screenings for depression, substance abuse, naloxone access, and will increase trauma-informed care as a cross cutting factor.

To align with and support *chronic disease*, Ottawa County will work to implement healthy food initiatives, such as community gardens, farmers markets, and increasing access to fresh food in food pantries.

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

The Ottawa County Community Health Improvement Plan also aligns with three of the National Prevention Strategies for the U.S. population: healthy eating, mental and emotional well-being and preventing drug abuse.

**Healthy People 2020**

Ottawa County’s priorities also fit specific Healthy People 2020 goals. For example:

- Mental Health and Mental Disorders (MHMD)-1: Reduce the suicide rate
- Diabetes (D)-15: Increase the proportion of persons with diabetes whose condition has been diagnosed
Alignment with National and State Standards, continued

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

State health improvement plan (SHIP) overview

Overall health outcomes
- Health status
- Premature death

3 priority topics
- Mental health and addiction
- Chronic disease
- Maternal and infant health

10 priority outcomes
- Depression
- Suicide
- Drug dependency/abuse
- Drug overdose deaths
- Heart disease
- Diabetes
- Asthma
- Preterm births
- Low birth weight
- Infant mortality

Equity: Priority populations for each outcome

4 cross-cutting factors
- Social determinants of health
- Public health system, prevention and health behaviors
- Healthcare system and access

Definitions
- CHA — Community health assessment led by a local health department
- CHNA — Community health needs assessment led by a hospital
- Indicator — A specific metric or measure used to quantify an outcome, typically expressed as a number, percent or rate. Example: number of deaths due to suicide per 100,000 population.
- Outcome — A desired result. Example: Reduced suicide deaths.

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

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

Overview of guidance for local alignment with the SHIP
See ODH guidance for aligning state and local efforts [link] for details

Select at least 2 priority topics (based on best alignment with findings of CHA/CHNA)

Select at least 1 priority outcome indicator within each selected priority topic (see SHIP master list of indicators)

Identify priority populations for each priority outcome indicator (based on findings from CHA/CHNA) and develop targets to reduce or eliminate disparities

- Select at least 1 cross-cutting strategy relevant to each selected priority outcome (see Local Toolkit) AND
- Select at least 1 cross-cutting outcome indicator relevant to each selected strategy (see local toolkit)

For a stronger plan (optional), select 1 strategy and 1 indicator for each of the 4 cross-cutting factors.

- Prioritize selection of strategies likely to decrease disparities (see local toolkit)
- Ensure that delivery of selected strategies is designed to reach priority populations and high-need geographic areas.
Strategic Planning Model

Beginning in February 2018, Ottawa County Health Partners met four (4) times and completed the following planning steps:

1. **Initial Meeting**: Review of process and timeline, finalize committee members, create or review vision
2. **Choosing Priorities**: Use of quantitative and qualitative data to prioritize target impact areas
3. **Ranking Priorities**: Ranking the health problems based on magnitude, seriousness of consequences, and feasibility of correcting
4. **Resource Assessment**: Determine existing programs, services, and activities in the community that address the priority target impact areas and look at the number of programs that address each outcome, geographic area served, prevention programs, and interventions
5. **Forces of Change and Community Themes and Strengths**: Open-ended questions for committee on community themes and strengths
6. **Gap Analysis**: Determine existing discrepancies between community needs and viable community resources to address local priorities; identify strengths, weaknesses, and evaluation strategies; and strategic action identification
7. **Local Public Health Assessment**: Review the Local Public Health System Assessment with committee
8. **Quality of Life Survey**: Review results of the Quality of Life Survey with committee
10. **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
Action Steps

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

*Mental Health*

1. Implement assisted outpatient treatment (AOT)
2. Screen for clinical depression for all patients 12 or older using a standardized tool

*Addiction*

1. Increase access to naloxone
2. Screening, brief intervention and referral to treatment

To work toward **improving chronic disease outcomes**, the following strategies are recommended:

1. Increase healthy eating practices through fostering self-efficacy
2. Increase prediabetes screening and referral for treatment
3. Implement healthy food initiatives

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

1. Increase awareness of trauma informed care
2. Create a sequential intercept map (SIM)
Ottawa County Health Partners reviewed the 2017 Ottawa County Health Assessment. The detailed primary data for each individual priority area can be found in the section it corresponds to. Each member completed an “Identifying Key Issues and Concerns” worksheet. The following tables were the group results.

What are the most significant ADULT health issues or concerns identified in the 2017 assessment report? Examples of how to interpret the information include: 7% of Ottawa County adults were uninsured: 10% of those ages 30-64, 8% of those with an income less than $25,000, and 8% of females.

<table>
<thead>
<tr>
<th>Key Issue or Concern</th>
<th>Percent of Population At risk</th>
<th>Age Group (or Income Level) Most at Risk</th>
<th>Gender Most at Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to healthcare (10 votes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
<td>7%</td>
<td>Age: 30-64 (10%); Income: &lt;$25K (8%)</td>
<td>Females (8%)</td>
</tr>
<tr>
<td>Adults went outside of Ottawa County for healthcare services</td>
<td>83%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Adults looked for a program to assist in care for the elderly (either in-home or out-of-home for either themselves or a loved one)</td>
<td>11%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Women had been pregnant in the past 5 years</td>
<td>14%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Addiction (10 votes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misused prescription drugs in the past 6 months</td>
<td>5%</td>
<td>Age: 65+ (6%); Income: &lt;$25K (12%)</td>
<td>Males (5%)</td>
</tr>
<tr>
<td>Marijuana use in the past 6 months</td>
<td>6%</td>
<td>Age: 30-64 (6%); Income: &lt;$25K (7%)</td>
<td>Males (6%)</td>
</tr>
<tr>
<td>Drug overdoses (9 votes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug overdoses</td>
<td>24*</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Mental health (9 votes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Considered attempting suicide</td>
<td>3%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Feld sad, blue, or depressed</td>
<td>9%</td>
<td>Age: 30-64 (10%); Income: &lt;$25K (25%)</td>
<td>Males/Females (9%)</td>
</tr>
<tr>
<td>Diabetes (9 votes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosed with diabetes</td>
<td>11%</td>
<td>Age: 65+ (17%); Income: &lt;$25K (13%)</td>
<td>Males (13%)</td>
</tr>
<tr>
<td>Diagnosed with pre-diabetes</td>
<td>9%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Obesity (8 votes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obese</td>
<td>41%</td>
<td>Age: 30-64 (46%); Income: &lt;$25K (47%)</td>
<td>Males (45%)</td>
</tr>
<tr>
<td>Overweight</td>
<td>36%</td>
<td>Age: 65+ (38%); Income: $25K+ (37%)</td>
<td>Males (39%)</td>
</tr>
<tr>
<td>Did not participate in any physical activity</td>
<td>28%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Ate 5 or more servings of fruits and vegetables per day</td>
<td>6%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Key Issue or Concern</td>
<td>Percent of Population At risk</td>
<td>Age Group (or Income Level) Most at Risk</td>
<td>Gender Most at Risk</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------</td>
<td>------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td><strong>Blood pressure (8 votes)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosed with high blood pressure</td>
<td>42%</td>
<td>Age: 65+ (61%) Income: &lt;$25K (52%)</td>
<td>Male (51%)</td>
</tr>
<tr>
<td>Told they were prehypertensive/borderline high</td>
<td>8%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Safe sleep (6 votes)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents put their child to sleep as an infant in bed with them or another person</td>
<td>12%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Parents put their child to sleep as an infant on their stomach</td>
<td>15%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Blood cholesterol (6 votes)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosed with high blood cholesterol</td>
<td>40%</td>
<td>Age: 65+ (55%); Income: &lt;$25K (41%)</td>
<td>Males (44%)</td>
</tr>
<tr>
<td><strong>Alcohol use (5 votes)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current drinkers</td>
<td>62%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Binge drinkers (of all adults)</td>
<td>26%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Binge drinkers (of current drinkers)</td>
<td>41%</td>
<td>Age: 30-64 (48%); Income: $25K+ (43%)</td>
<td>Males (42%)</td>
</tr>
<tr>
<td><strong>Preventive health screenings (2)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy/sigmoidoscopy in the past 5 years</td>
<td>49%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Mammogram in the past year</td>
<td>37%</td>
<td>Age: 40+ (45%); Income: &lt;$25K (29%)</td>
<td>Females</td>
</tr>
<tr>
<td>Breast exam in the past year</td>
<td>53%</td>
<td>Age: 40+ (45%); Income: &lt;$25K (35%)</td>
<td>Females</td>
</tr>
<tr>
<td>Pap smear in the past year</td>
<td>38%</td>
<td>Age: 40+ (26%); Income: &lt;$25K (20%)</td>
<td>Females</td>
</tr>
<tr>
<td>Prostate-Specific Antigen (PSA) test in the past year</td>
<td>45%</td>
<td>Age: Under 50 (2%); Income: &lt;$25K (22%)</td>
<td>Males</td>
</tr>
<tr>
<td>Digital Rectal exam in the past year</td>
<td>17%</td>
<td>Age: Under 50 (2%); Income: &lt;$25K (14%)</td>
<td>Males</td>
</tr>
<tr>
<td><strong>Arthritis (2 votes)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosed with arthritis</td>
<td>40%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Cancer (1 vote)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever diagnosed with cancer</td>
<td>18%</td>
<td>Ages: 65+ (34%)</td>
<td>N/A</td>
</tr>
<tr>
<td>Of those diagnosed with cancer, the following had breast cancer</td>
<td>28%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*There were 24 drug overdoses in Ottawa County in 2017. (Source: Magruder Hospital)*
What are the most significant YOUTH health issues or concerns identified in the 2017 assessment report? Examples of how to interpret the information include: 26% of all Ottawa County youth felt sad or hopeless every day for two or more weeks in a row. 27% of those in grades 9-12, and 40% of females.

<table>
<thead>
<tr>
<th>Key Issue or Concern</th>
<th>Percent of Population At risk</th>
<th>Age Group (or Grade Level) Most at Risk</th>
<th>Gender Most at Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Suicide (10 votes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt sad or hopeless every day for two or more weeks in a row</td>
<td>26%</td>
<td>Grade Level: 9-12 (27%)</td>
<td>Female (40%)</td>
</tr>
<tr>
<td>Seriously considered attempting suicide</td>
<td>14%</td>
<td>Age: 17+ (17%)</td>
<td>Female (20%)</td>
</tr>
<tr>
<td>Made a plan to attempt suicide</td>
<td>3%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td>6%</td>
<td>Age: 17+ (9%)</td>
<td>Female (8%)</td>
</tr>
<tr>
<td>Obesity (10 votes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obese</td>
<td>20%</td>
<td>Age: 14+ (22%)</td>
<td>Female (21%)</td>
</tr>
<tr>
<td>Overweight</td>
<td>12%</td>
<td>Age: &lt;13 (18%)</td>
<td>Female (18%)</td>
</tr>
<tr>
<td>Exercised for at least 60 minutes every day of the week</td>
<td>28%</td>
<td>Grade Level: 9-12 (25%)</td>
<td>N/A</td>
</tr>
<tr>
<td>Violence (10 votes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bullied in the past year</td>
<td>41%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Alcohol (10 votes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever tried alcohol</td>
<td>45%</td>
<td>Age: 17+ (67%); Grades 9th.-12th (52%)</td>
<td>Female (46%)</td>
</tr>
<tr>
<td>Current drinker</td>
<td>20%</td>
<td>Age: 17+ (36%); Grades 9th.-12th (25%)</td>
<td>Female (22%)</td>
</tr>
<tr>
<td>Binge Drinker</td>
<td>10%</td>
<td>Age: 17+ (23%); Grades 9th.-12th (14%)</td>
<td>Female (14%)</td>
</tr>
<tr>
<td>Binge Drinker (of current drinkers)</td>
<td>61%</td>
<td>N/A</td>
<td>Female (66%)</td>
</tr>
<tr>
<td>Kindergarten readiness (9 votes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No indicator identified</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Sexual behaviors (7 votes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever had sexual intercourse</td>
<td>34%</td>
<td>Age: 17+ (61%); Grade Level: 9-12 (42%)</td>
<td>Female (39%)</td>
</tr>
<tr>
<td>Had four or more sexual partners (of all youth)</td>
<td>6%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Oral sex</td>
<td>25%</td>
<td>Age: 17+ (46%)</td>
<td>Female (30%)</td>
</tr>
<tr>
<td>Did not use any method to prevent pregnancy during last sexual intercourse</td>
<td>4%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Priorities Chosen

Based on the 2017 Ottawa County Health Assessment, key issues were identified for adults and youth. Committee members then completed a ranking exercise, giving a score for magnitude, seriousness of the consequence and feasibility of correcting, resulting in an average score for each issue identified. Committee members’ rankings were then combined to give an average score for the issue.

The rankings were as follows:

<table>
<thead>
<tr>
<th>Health Issue</th>
<th>Average Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth mental health</td>
<td>24.7</td>
</tr>
<tr>
<td>Adult drug overdose</td>
<td>24.6</td>
</tr>
<tr>
<td>Adult obesity</td>
<td>24.2</td>
</tr>
<tr>
<td>Youth violence</td>
<td>23.7</td>
</tr>
<tr>
<td>Adult addiction</td>
<td>23.6</td>
</tr>
<tr>
<td>Youth kindergarten readiness</td>
<td>23.3</td>
</tr>
<tr>
<td>Adult access to healthcare</td>
<td>22.2</td>
</tr>
<tr>
<td>Adult depression</td>
<td>22.0</td>
</tr>
<tr>
<td>Youth obesity</td>
<td>21.7</td>
</tr>
<tr>
<td>Adult diabetes</td>
<td>21.2</td>
</tr>
<tr>
<td>Youth alcohol use</td>
<td>20.6</td>
</tr>
</tbody>
</table>

**Ottawa County will focus on the following two priority area over the next three years:**

1. Mental health and addiction (includes adult and youth depression; suicide; drug overdoses, including deaths; and addiction)
2. Chronic disease (includes adult and youth obesity, and adult diabetes)
Ottawa County Health Partners was 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 Ottawa County in the near future. The table below summarizes the forces of change agent and its potential impacts.

<table>
<thead>
<tr>
<th>Force of Change</th>
<th>Potential Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nuclear power plant is devalued</td>
<td>• Economic erosion</td>
</tr>
<tr>
<td></td>
<td>• Bankruptcy</td>
</tr>
<tr>
<td></td>
<td>• Loss of jobs</td>
</tr>
<tr>
<td>2. Levy support</td>
<td>• Potential positive or negative impact on schools</td>
</tr>
<tr>
<td>3. Infrastructure</td>
<td>• Affects jobs, community activity, health etc.</td>
</tr>
<tr>
<td>4. Algae bloom</td>
<td>• Tourism</td>
</tr>
<tr>
<td></td>
<td>• Water drinkability</td>
</tr>
<tr>
<td>5. School shooting in Parkland, FL</td>
<td>• May change school operation surrounding security</td>
</tr>
<tr>
<td></td>
<td>• Political change nationally</td>
</tr>
<tr>
<td>6. Increasing senior populations</td>
<td>• Lack of access to specific healthcare and other services</td>
</tr>
<tr>
<td>7. Millennials</td>
<td>• Changes in consumerism/how they consume media</td>
</tr>
<tr>
<td></td>
<td>• Changes in how they obtain health services/technology based</td>
</tr>
<tr>
<td></td>
<td>• Culture is different than previous generations</td>
</tr>
<tr>
<td>8. Social media</td>
<td>• Ever changing media outlets</td>
</tr>
<tr>
<td>9. Medicare funding</td>
<td>• Many services threatened to be cut</td>
</tr>
<tr>
<td>10. State and federal funding</td>
<td>• All going deliverable-based</td>
</tr>
<tr>
<td></td>
<td>• Entities may not be able to afford to provide services in order to get reimbursed</td>
</tr>
<tr>
<td>11. Medicaid block grant for states</td>
<td>• Changes in services and reimbursement</td>
</tr>
<tr>
<td>12. Transition from Medicaid to managed care</td>
<td>• Changes in services and accessibility</td>
</tr>
<tr>
<td>13. Walking trail being built</td>
<td>• Increased physical activity opportunities</td>
</tr>
<tr>
<td>14. Connecting the inland bike trail</td>
<td>• Increased physical activity opportunities</td>
</tr>
<tr>
<td>15. Women in Conservation sessions</td>
<td>• Kayaking</td>
</tr>
<tr>
<td></td>
<td>• Paddle boats</td>
</tr>
<tr>
<td></td>
<td>• Bee keeping</td>
</tr>
<tr>
<td></td>
<td>• Increased outdoor opportunities</td>
</tr>
<tr>
<td>16. Growth of nonprofit communities</td>
<td>• Constantly fundraising and tapping resources</td>
</tr>
<tr>
<td>17. Community collaboration</td>
<td>• Momentum in treating drug and opiate issues</td>
</tr>
</tbody>
</table>
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) 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 Ottawa County Health Department completed the performance measures instrument. The LPHSA results were then presented to the full CHIP committee for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard was discussed and the group came to a consensus on responses for all questions. The challenges and opportunities that were discussed were used in the action planning process.

The CHIP committee identified 4 indicators that had a status of “minimal” and 1 indicator that had a status of “no activity.” The remaining indicators were all moderate, significant or optimal.

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

To view the full results of the LPHSA, please contact Nancy Osborn from the Ottawa County Health Department at (419) 734-6800.

**Ottawa County Local Public Health System Assessment 2018 Summary**

### Summary of Average ES Performance Score

| ES 1: Monitor Health Status | 88.9 |
| ES 2: Diagnose and Investigate | 95.1 |
| ES 3: Educate/Empower | 72.2 |
| ES 4: Mobilize Partnerships | 92.7 |
| ES 5: Develop Policies/Plans | 91.7 |
| ES 6: Enforce Laws | 92.8 |
| ES 7: Link to Health Services | 71.9 |
| ES 8: Assure Workforce | 60.1 |
| ES 9: Evaluate Services | 66.7 |
| ES 10: Research/Innovations | 44.4 |

Average Overall Score: 77.6
Community Themes and Strengths Assessment

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

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

   - Smiling people
   - Strong economic base
   - Community collaboration
   - Community support
   - Availability of healthy choices
   - Infrastructure for healthy living
   - Fewer bars
   - Security/safety/low crime levels
   - Affordability of housing and resources
   - Access to preventive care
   - Strong education system
   - Job opportunities that offer health benefits such as health insurance
   - Things for youth and children to do

2. **What makes you most proud of our community?**

   - Access to the lake
   - Opportunities to connect with nature
   - People take care of each other
   - Tight knit community/community connectiveness
   - Strong community collaboration across a variety of sectors
   - Endurance of the community
   - Law enforcement/Crisis response
   - Emergency planning/preparedness
   - Education system/alumni involvement
   - Community pride
   - Caring community
   - Community outreach
   - Variety of resources
   - Thriving community shared agriculture (CSA)
   - Lake Erie islands
   - Tourism
   - Various trails along the lake
   - Lake Erie transportation system

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

   - Board of Social Concerns
   - Business Advisory Council
   - FCFC (Wrap Around, Opiate Taskforce, Ottawa County Task Force on Aging)
   - Juvenile Court Advisory Committee
   - Board of Mental Health
   - Job and Family Services
   - Tornado recovery/emergency response
   - Building new community center – Lakeside Association (Methodist community)
   - Port Clinton Fullbackers Association
   - Project Connect (one-day event to get people connected with various services – focuses on health and seniors)
   - 2-1-1
   - Leadership Ottawa County
   - Walking trail being built
   - Chamber of Commerce
   - Art walks/festivals
   - Light House Sober Living
   - Sister city relationship/Jamao al Norte (Dominican Republic)
   - After school/out of school programs
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 and addiction
- Chronic disease
- Skilled workforce needed/economic development
- Those with a family income of less than $25,000 a year are not doing well
- Aging populations
- Specialty physicians/medical care
- Aging populations have custodial needs that are not addressed

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

- How to get people who are not accessing care to connect them to available resources
- Accountability of patients/indifference
- Lack of patient responsibility/no incentive to “get better”
- Generational issues
- Financial issues

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

- More investment in creating visible outdoor spaces, such as parks/ “curb appeal”
- Opiate funding
- Project Connect
- Generation Rx
- Food pharmacies
- Universal quality preschool
- Change policy regarding nursing/medical practice
- Diabetes prevention programming
- Pillars of health
- Occupational health looking to partner with local businesses

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

- All of the above
- Momentum
- Visible excitement
Ottawa County Health Partners urged community members to fill out a short quality of life survey via Survey Monkey. There were 140 Ottawa County community members who completed the survey. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of “Very Satisfied” = 5, “Satisfied” = 4, “Neither Satisfied or Dissatisfied” = 3, “Dissatisfied” = 2, and “Very Dissatisfied” = 1. For all responses of “Don’t Know,” or when a respondent left a response blank, the choice was a non-response and was assigned a value of 0 (zero). The non-response was not used in averaging response or calculating descriptive statistics.

<table>
<thead>
<tr>
<th>Quality of Life Questions</th>
<th>Likert Scale Average Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>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]</td>
<td>3.68</td>
</tr>
<tr>
<td>2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)</td>
<td>3.65</td>
</tr>
<tr>
<td>3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)</td>
<td>3.91</td>
</tr>
<tr>
<td>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.)</td>
<td>3.60</td>
</tr>
<tr>
<td>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.)</td>
<td>2.60</td>
</tr>
<tr>
<td>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?)</td>
<td>3.89</td>
</tr>
<tr>
<td>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?</td>
<td>3.65</td>
</tr>
<tr>
<td>8. Do all individuals and groups have the opportunity to contribute to and participate in the community’s quality of life?</td>
<td>3.49</td>
</tr>
<tr>
<td>9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?</td>
<td>3.16</td>
</tr>
<tr>
<td>10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)</td>
<td>3.16</td>
</tr>
<tr>
<td>11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?</td>
<td>3.19</td>
</tr>
<tr>
<td>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?)</td>
<td>3.11</td>
</tr>
</tbody>
</table>
Based on the chosen priorities, Ottawa County Health Partners were asked to complete a resource inventory for each priority. The resource inventory allowed the committee to identify existing community resources, such as programs, exercise opportunities, free or reduced cost health screenings, and more. The committee was then asked to determine whether a program or service was evidence-based, a best practice, or had no evidence indicated based on the following parameters:

An **evidence-based practice** has compelling evidence of effectiveness. Participant success can be attributed to the program itself and have evidence that the approach will work for others in a different environment. A **best practice** is a program that has been implemented and evaluation has been conducted. While the data supporting the program is promising, its scientific rigor is insufficient. A **non-evidence based practice** has no documentation that it has ever been used (regardless of the principals it is based upon) nor has it been implemented successfully with evaluation.

Each resource assessment can be found at the following websites:

http://www.ottawahealth.org
Priority 1: Mental Health and Addiction

Mental Health Indicators

Adult Mental Health

In 2017, 9% of adults reported they felt sad or hopeless for two weeks or more in a row.

The 2017 Community Health Assessment reported that 3% of Ottawa County adults considered attempting suicide in the past year.

According to the Ohio Department of Health, there were seven (7)* adult suicide deaths in Ottawa County in 2017.

Youth Mental Health

In 2017, about one-quarter (26%) of youth reported they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities, increasing to 40% of females (YRBS reported 26% for Ohio in 2013 and 30% for the U.S. in 2015).

Fourteen percent (14%) of youth reported they had seriously considered attempting suicide in the past 12 months, increasing to 20% of females (2013 YRBS reported 14% for Ohio and 18% for the U.S. in 2015).

The 2017 Community Health Assessment reported that 6% of Ottawa County youth had attempted suicide, increasing to 9% of those 17 and older. The 2015 YRBS reported a suicide attempt prevalence rate of 9% for U.S. youth and a 2013 YRBS rate of 6% for Ohio youth.

In 2017, 41% of youth reported being bullied in the past year.

In 2017, 11% of youth were cyber bullied, or bullied by electronic means.

*Years are considered partial and may be incomplete per Ohio Department of Health

The table below indicates correlations between those who contemplated suicide in the past 12 months and participating in risky behaviors, as well as other activities and experiences. Examples of how to interpret the information include: 73% of those who contemplated suicide were bullied in the past year, compared to 36% of those who did not contemplate suicide.

Behaviors of Ottawa County Youth

Contemplated Suicide vs. Did Not Contemplate Suicide

<table>
<thead>
<tr>
<th>Youth Behaviors</th>
<th>Contemplated Suicide</th>
<th>Did Not Contemplate Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Been bullied in any way in the past year</td>
<td>73%</td>
<td>36%</td>
</tr>
<tr>
<td>Experienced 3 or more adverse childhood experiences (ACEs) in their lifetime</td>
<td>67%</td>
<td>15%</td>
</tr>
<tr>
<td>Had at least one drink of alcohol in the past 30 days</td>
<td>35%</td>
<td>17%</td>
</tr>
<tr>
<td>Smoked cigarettes in the past 30 days</td>
<td>15%</td>
<td>2%</td>
</tr>
<tr>
<td>Used marijuana in the past 30 days</td>
<td>19%</td>
<td>4%</td>
</tr>
</tbody>
</table>

*Contemplated suicide* indicates youth who self-reported seriously considering attempting suicide in the past year.
Map: Access to Mental Health Care Providers
Access to Mental Health Care Providers, Rank by County, CHR 2018

Source: University of Wisconsin Population Health Institute, County Health Rankings: 2018, as compiled by Community Commons
## Gaps and Potential Strategies

<table>
<thead>
<tr>
<th>Gaps</th>
<th>Potential Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. People who need services the most are not the ones using them.</td>
<td>• Early detection services (through JFS) and referral</td>
</tr>
<tr>
<td></td>
<td>• Mental health court</td>
</tr>
<tr>
<td>2. Awareness of mental health and drug services</td>
<td>• Coalition</td>
</tr>
<tr>
<td></td>
<td>• Care/referral coordination</td>
</tr>
<tr>
<td></td>
<td>• Mental health directory</td>
</tr>
<tr>
<td></td>
<td>• Marketing of services to the community, such as the hotline</td>
</tr>
<tr>
<td></td>
<td>• Awareness campaign</td>
</tr>
<tr>
<td></td>
<td>• Campaign to reduce stigma</td>
</tr>
<tr>
<td>3. Connection to appropriate services</td>
<td>• Inform community of assisted outpatient treatment and receive community buy-in</td>
</tr>
<tr>
<td></td>
<td>• Commit to collaboration</td>
</tr>
<tr>
<td>4. Trauma informed care</td>
<td>• First training is March 16</td>
</tr>
<tr>
<td></td>
<td>• Expand trainings</td>
</tr>
<tr>
<td>5. Mental health/addiction services in schools</td>
<td>• Place mental health therapists, counselors, or social workers in schools</td>
</tr>
<tr>
<td>6. Screenings</td>
<td>• Implement screenings in schools and primary care offices</td>
</tr>
</tbody>
</table>

## Best Practices

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

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

   There are two components of the PHQ-9:
   
   • Assessing symptoms and functional impairment to make a tentative depression diagnosis
   • Deriving a severity score to help select and monitor treatment

   The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV).
2. **Assisted Outpatient Treatment (AOT)**, also known as outpatient commitment, is state-mandated outpatient treatment, which is delivered under court order to adults with severe mental illness who are found by a judge, in consideration of prior history, to be unlikely to adhere voluntarily to prescribed treatment.

State laws and regulations combined with local practice determine the procedures used for implementing AOT. As a result, the application of this practice varies slightly from state to state. This program profile is based upon the application of AOT in New York, which in 1999 established Section 9.60 of the Mental Hygiene Law (Kendra’s Law), under which court-ordered outpatient commitment can be mandated for certain individuals with mental illness and a history of multiple hospitalizations or violence toward self or others.

AOT is intended for those who suffer from anosognosia (lack of insight) in addition to severe mental illness, often reject outpatient treatment, and have been repeatedly hospitalized or arrested as a consequence of treatment non-adherence. For these individuals, the mechanism of change is believed to be the use of a court order and the expectation that treatment providers are vigilant in maintaining individuals in treatment. A court order violation can result in the individual being removed from the community and hospitalized to determine whether they need inpatient care and treatment. Individuals receiving AOT also have priority access to certain services, including intensive case management, housing, and outpatient clinical services.

Through the ritual of a court hearing and the symbolic weight of a judge’s order, AOT seeks to motivate the individual to regard treatment adherence as a legal obligation and impress upon treatment providers that the individual requires close monitoring and comprehensive services. Ultimately, the goal of the practice is not to punish individuals, but to intervene before they can become dangerous to themselves and others.
Action Step Recommendations & Plan

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

1. Implement assisted outpatient treatment (AOT)
2. Screen for clinical depression for all patients 12 or older using a standardized tool 📊

**Action Plan**

<table>
<thead>
<tr>
<th>Priority Topic: Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 1: Implement assisted outpatient treatment (AOT)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Priority Outcomes &amp; Indicators</th>
<th>Priority Population</th>
<th>Person/Agency Responsible</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 1:</strong> Meet with Ottawa County officials, including local prosecutors, judges, law enforcement, hospital officials and county commissioners, to discuss the implementation of <strong>Assisted Outpatient Treatment (AOT)</strong> in Ottawa County. Discuss the benefits AOT and how court-ordered mental health treatment could positively affect individuals and the community. Gain community buy-in.</td>
<td><strong>Priority Outcome:</strong> Reduce the number of individuals with Severe and Persistent Mental Illness who are incarcerated and/or hospitalized</td>
<td>Adult</td>
<td>Brenda Cronin, Mental Health and Recovery Board of Erie and Ottawa Counties</td>
<td>May 15, 2019</td>
</tr>
<tr>
<td><strong>Year 2:</strong> Research grants that would support AOT, including rotating grants from SAMHSA, and apply for funding. Once funding has been secured, identify a mentoring county to provide technical assistance and create an implementation plan for AOT in Ottawa County. Create measurable goals, objectives, and evaluation strategies.</td>
<td><strong>Priority Indicator:</strong> The number of incarcerations and hospitalizations of those with Severe and Persistent Mental Illness</td>
<td></td>
<td></td>
<td>May 15, 2020</td>
</tr>
<tr>
<td><strong>Year 3:</strong> Implement AOT in Ottawa County. Measure success and create a sustainability plan for future implementation.</td>
<td></td>
<td></td>
<td></td>
<td>May 15, 2021</td>
</tr>
</tbody>
</table>
### Priority Topic: Mental Health

**Strategy 2: Screen for clinical depression for all patients 12 or older using a standardized tool**

| Year 1 | Collect baseline data on the number of hospital emergency department and hospital inpatient departments that currently screen for depression during visits. Introduce the Patient Health Questionnaire (PHQ-9), or another screening tool, to healthcare providers. Pilot the screening tool at hospital emergency department and inpatient unit. Conduct one educational session on mental health identification and/or resources for community. Measure post education efficacy with goal of 80% indicating improved understanding at the end of the session. | Priority Outcomes: 1. Reduce adult depression 2. Reduce youth depression | Adult and youth | Lori Koethe, Magruder Hospital | May 15, 2019 |
| Year 2 | Continue efforts from year 1. Increase the number of healthcare providers using PHQ-9, or another screening tool, by 25% from baseline. Introduce to Magruder employed primary care providers. Conduct one educational session on mental health identification and/or resources for community. Measure post education efficacy with goal of 85% indicating improved understanding at the end of the session. | Priority Indicators: 1. Percent of adults who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities 2. Percent of youth who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities | | | May 15, 2020 |
| Year 3 | Continue efforts from years 1 and 2. Increase the number of healthcare providers using PHQ-9, or another screening tool, by 50% from baseline. Conduct one educational session on mental health identification and/or resources for community. Measure post education efficacy with goal of 90% indicating improved understanding at the end of the session. | | | | May 15, 2021 |
Addiction Indicators

Adult Addiction

In 2017, there were 24 drug overdose cases in Ottawa County, 21 of which were unintentional. (Source: Magruder Hospital).

According to the Ohio Department of Health, there were six (6)* adult drug overdose deaths in Ottawa County in 2017.

Six percent (6%) of Ottawa County adults had used marijuana in the past 6 months, increasing to 7% of those with incomes less than $25,000.

Two percent (2%) of Ottawa County adults reported using other recreational drugs in the past six months such as cocaine, synthetic marijuana/K2, heroin, LSD, inhalants, Ecstasy, bath salts, and methamphetamines.

Five percent (5%) of adults had used medication not prescribed for them or they took more than prescribed to feel good or high and/or more active or alert during the past 6 months, increasing to 12% of those with incomes less than $25,000.

Youth Addiction

In 2017, 6% of all Ottawa County youth had used marijuana at least once in the past 30 days, increasing to 11% of those over the age of 17. The 2013 YRBS found a prevalence of 21% for Ohio youth and a prevalence of 22% for U.S. youth in 2015.

Five percent (5%) of Ottawa County youth used medications that were not prescribed for them or took more than prescribed to feel good or get high at some time in their lives, increasing to 8% of those over the age of 17.

During the past 12 months, 6% of all Ottawa County youth reported that someone had offered, sold, or given them an illegal drug on school property (YRBS reports 20% for Ohio in 2013 and 22% for the U.S. in 2015).

*Years are considered partial and may be incomplete per Ohio Department of Health

The table below indicates correlations between marijuana use and participating in risky behaviors, as well as other activities and experiences. Examples of how to interpret the information include: 90% of current marijuana users participated in extracurricular activities, compared to 92% of non-current marijuana users.

Behaviors of Ottawa County Youth

<table>
<thead>
<tr>
<th>Current Marijuana User</th>
<th>Non-Current Marijuana User</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participated in extracurricular activities</td>
<td>90%</td>
</tr>
<tr>
<td>Drank alcohol in the past 30 days</td>
<td>82%</td>
</tr>
<tr>
<td>Smoked cigarettes in the past 30 days</td>
<td>27%</td>
</tr>
<tr>
<td>Experienced 3 or more adverse childhood experiences (ACEs) in their lifetime</td>
<td>68%</td>
</tr>
<tr>
<td>Ever misused medications</td>
<td>23%</td>
</tr>
<tr>
<td>Seriously considered attempting suicide in the past 12 months</td>
<td>43%</td>
</tr>
<tr>
<td>Attempted suicide in the past 12 months</td>
<td>24%</td>
</tr>
</tbody>
</table>

*Current marijuana use* indicates youth who self-reported using marijuana at any time during the past 30 days.
Map: Drug Overdose Deaths
Drug Overdose Deaths, Rate (Per 100,000 Population) by County, NVSS 2013-2015

Gaps and Potential Strategies

<table>
<thead>
<tr>
<th>Gaps</th>
<th>Potential Strategies</th>
</tr>
</thead>
</table>
| 1. People who need services the most are not the ones using them. | • Early detection services (through JFS) and referral  
• Diversion programs, such as DART |
| 2. Awareness of mental health and drug services | • Coalition  
• Sequential mapping  
• Care/referral coordination  
• Marketing of services to the community, such as the hotline  
• Awareness campaign |
| 3. Inpatient detox facilities | • Referrals to detox facility in Erie County  
• Referrals to Bloomville detox facility for women  
• Referrals to residential treatment in Bloomville  
• Increase awareness of the services that are available |
| 4. Mental health/addiction services in schools | • Place mental health therapists, counselors, or social workers in schools |
| 5. Screenings | • Implement screenings in schools and PCP offices |

Best Practices

The following programs and policies have been reviewed and have proven strategies to improve addiction:

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

   a) Out-of-treatment adults who are visiting a walk-in health clinic for routine medical care and have a positive screening result for cocaine and/or opiate use. Project ASSERT aims to reduce or eliminate their cocaine and/or opiate use through interaction with peer educators (substance abuse outreach workers who are in recovery themselves for cocaine and/or opiate use and/or are licensed alcohol and drug counselors).

   b) Adolescents and young adults who are visiting a pediatric ED for acute care and have a positive screening result for marijuana use. Project ASSERT aims to reduce or eliminate their marijuana use through interaction with peer educators (adults who are under the age of 25 and, often, college educated).

   c) Adults who are visiting an ED for acute care and have a positive screening result for high-risk and/or dependent alcohol use. Project ASSERT aims to motivate patients to reduce or eliminate their unhealthy use through collaboration with ED staff members (physicians, nurses, nurse practitioners, social workers, or emergency medical technicians).

On average, Project ASSERT is delivered in 15 minutes, although more time may be needed, depending on the severity of the patient’s substance use problem and associated treatment referral needs. The face-to-face component of the intervention is completed during the course of medical care, while the patient is waiting for the doctor, laboratory results, or medications.
2. **Naloxone access:** Naloxone is a prescription medication that reverses overdoses caused by opioids such as heroin, Vicodin, and OxyContin; it is not a controlled substance and does not have potential for abuse. As of January 2017, 47 states and Washington, DC have expanded access to naloxone through legislation that permits prescriptions to people who are likely to encounter someone who might overdose (i.e., third party prescription) or standing orders by health care providers. States and communities can further expand access to naloxone through education, training, and distribution programs that reach drug users and their families and friends and efforts to ensure that all first responders, including EMTs, firefighters, and law enforcement officers, are trained and authorized to administer naloxone.
**Action Step Recommendations & Plan**

To work toward **improving addiction outcomes**, the following strategies are recommended:

1. Increase access to naloxone
2. Screening, brief intervention and referral to treatment

**Action Plan**

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Priority Outcomes &amp; Indicators</th>
<th>Priority Population</th>
<th>Person/Agency Responsible</th>
<th>Timeline</th>
</tr>
</thead>
</table>
| **Strategy 1: Increase access to naloxone** | **Priority Outcome:** Unintentional drug overdose deaths  
**Priority Indicator:** Number of deaths due to unintentional drug overdoses per 100,000 population (age adjusted) | Adult and youth | Nancy Osborn, Ottawa County Health Department | May 15, 2019 |

**Year 1:** Apply for funding from the Ohio Department of Health to implement Project Dawn in Ottawa County. Once funding is received, work with local law enforcement to train responders and increase the number of naloxone sites in Ottawa County. Implement grant deliverables as specified by the Ohio Department of Health.

**Year 2:** Continue efforts from year 1.

**Year 3:** Continue efforts from years 1 and 2.
### Priority Topic: Addiction

**Strategy 2: Screening, brief intervention and referral to treatment**

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Priority Outcome &amp; Indicator</th>
<th>Priority Population</th>
<th>Person/Agency Responsible</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 1:</strong> Collect baseline data on the number of hospital emergency department and hospital inpatient departments that currently screen for substance abuse during visits. Implement and evidence-based screening to healthcare providers. Pilot the screening tool at hospital emergency department and inpatient unit. Conduct one educational session on addiction disease process and/or resources for community. Measure post education efficacy with goal of 80% indicating improved understanding at the end of the session.</td>
<td><strong>Priority Outcomes:</strong> 1. Reduce unintentional overdose 2. Reduce illicit drug use</td>
<td>Adult and youth</td>
<td>Lori Koethe, Magruder Hospital</td>
<td>May 15, 2019</td>
</tr>
<tr>
<td><strong>Year 2:</strong> Continue efforts from year 1. Increase the number of healthcare providers using an evidence-based tool by 25% from baseline. Introduce to Magruder employed primary care providers. Conduct one educational session on substance abuse disease process and/or resources for community. Measure post education efficacy with goal of 85% indicating improved understanding at the end of the session.</td>
<td><strong>Priority Indicators:</strong> 1. Number of deaths due to unintentional drug overdoses per 100,000 population (age adjusted) 2. Percent of individuals aged 12+ with illicit drug use in the past month</td>
<td>Adult and youth</td>
<td>Lori Koethe, Magruder Hospital</td>
<td>May 15, 2020</td>
</tr>
<tr>
<td><strong>Year 3:</strong> Continue efforts from years 1 and 2. Increase the number of healthcare providers using an evidence-based screening tool, by 50% from baseline. Conduct one educational session on substance abuse disease process and/or resources for community. Measure post education efficacy with goal of 90% indicating improved understanding at the end of the session.</td>
<td></td>
<td>Adult and youth</td>
<td>Lori Koethe, Magruder Hospital</td>
<td>May 15, 2021</td>
</tr>
</tbody>
</table>
Priority 2: Chronic Disease

Chronic Disease Indicators

Adult Obesity
In 2017, 41% of adults were classified as obese by Body Mass Index (BMI) calculations (BRFSS reported 30% for Ohio and 30% for the U.S. in 2016). 36% of adults were classified as overweight (BRFSS reported 37% for Ohio and 36% for the U.S. in 2016).

Youth Obesity
In 2017, 20% of youth were classified as obese by Body Mass Index (BMI) calculations (YRBS reported 13% for Ohio in 2013 and 14% for the U.S. in 2015). 12% of youth were classified as overweight (YRBS reported 16% for Ohio in 2013 and 16% for the U.S. in 2015).

Adult Diabetes
In 2017, 11% of adults reported they had been diagnosed with diabetes, compared to 11% of Ohio and 11% of U.S. adults in 2016.

Nine percent (9%) of adults had been diagnosed with pre-diabetes.

Ottawa County Adults with Cardiovascular Disease Risk Factors

- High Blood Pressure: 42%
- Obesity: 41%
- High Blood Cholesterol: 40%
- Sedentary: 28%
- Smoking: 15%
- Diabetes: 11%
Map: Access to Exercise Opportunities
Access to Exercise Opportunities, Rank by County, CHR 2018

Map Legend
Access to Exercise Opportunities, Rank by County, CHR 2018
- 1st Quartile (Top 25%)
- 2nd Quartile
- 3rd Quartile
- 4th Quartile (Bottom 25%)
- Bottom Quintile (Rhode Island Only)
- No Data or Data Suppressed: -1

Sources: University of Wisconsin Population Health Institute, County Health Rankings: 2018 as compiled by Community Commons
Map: Fruit and Vegetable Expenditures

Fruit and Vegetable Expenditures, Percent of Food-At-Home Expenditures, State Rank by Tract, Nielsen 2014

Map Legend

- Major Supermarkets, USDA Dec. 2017
- Fruit and Vegetable Expenditures, Percent of Food-At-Home Expenditures, National Rank by Tract, Nielsen 2014
  - 1st Quintile (Highest Expenditures)
  - 2nd Quintile
  - 3rd Quintile
  - 4th Quintile
  - 5th Quintile (Lowest Expenditures)
  - No Data or Data Suppressed

Sources: Nielsen, Nielsen SiteReports: 2014; USDA 2017, as compiled by Community Commons
## Gaps and Potential Strategies

<table>
<thead>
<tr>
<th>Gaps</th>
<th>Potential Strategies</th>
</tr>
</thead>
</table>
| 1. Uninsured population - Those who may need the services the most are not receiving/utilizing them | • Mobile education/services, such as Dining with Diabetes  
• One-on-one case management  
• Project Connect |
| 2. No grocery stores in Port Clinton City limits                      | • Mobile food pantry  
• Various farmers markets and fruit stands–spread awareness  
• CSA available—spread awareness  
• Circle of influence  
• Community gardens  
• OSU Extension programs |
| 3. Limited specialists in the County, such as gerontology, nephrology, etc. | • Increased referral system  
• Physician recruitment  
• Transportation |
| 4. Dialysis services                                                   | • Transportation  
• Increase awareness of transportation options in the community and what is covered by Medicaid, etc. |
| 5. Youth programming - Cost and transportation are barriers to physical activity | • Bring Cooking Matters to families at schools  
• FUTP 60 in schools  
• School wellness councils in all the schools  
• Summer lunch program  
• Snack and study program at Bistro 163  
• Beacon program |
| 6. No adult weight loss programs                                       | • Offer a weight loss support group through local agency |

## Best Practices

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

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

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

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

2. **Community Gardens**: A community garden is any piece of land that is gardened or cultivated by a group of people, usually for home consumption. Community gardens are typically owned by local governments, not-for-profit groups, or faith-based organizations; gardens are also often initiated by groups of individuals who clean and cultivate vacant lots. Local governments, non-profits, and communities may support gardens through community land trusts, gardening education, distribution of seedlings and other materials, zoning regulation changes, or service provision such as water supply or waste disposal.

**Expected Beneficial Outcomes**
- Increased access to fruits and vegetables
- Increased fruit and vegetable consumption
- Increased physical activity

**Other Potential Beneficial Outcomes**
- Increased food security
- Increased healthy foods in food deserts
- Reduced obesity rates
- Improved mental health
- Improved sense of community
- Improved neighborhood safety

3. **Healthy Food Initiatives in Food Banks**: Food bank and food pantry healthy food initiatives combine hunger relief efforts with nutrition information and healthy eating opportunities for low-income individuals and families. Such initiatives offer clients healthy foods such as fruits, vegetables, whole grains, low-fat dairy products, and lean proteins. Initiatives can include fruit and vegetable gleaning programs, farm Plant-a-Row efforts, and garden donations. Healthy food initiatives can also modify the food environment via efforts such as on-site cooking demonstrations and recipe tastings, produce display stands, or point-of-decision prompts. Some food banks and food pantries establish partnerships with health and nutrition professionals to offer screening for food insecurity and medical conditions (e.g., diabetes), provide nutrition and health education, and health care support services as part of their healthy food initiatives.

**Expected Beneficial Outcomes (Rated)**
- Increased healthy food consumption
- Increased food security

**Other Potential Beneficial Outcomes**
- Improved nutrition
- Improved weight status
**Action Step Recommendations & Plan**

To work toward **improving chronic disease outcomes**, the following strategies are recommended:

1. Increase healthy eating practices through fostering self-efficacy
2. Increase prediabetes screening and referral for treatment
3. Implement healthy food initiatives

**Action Plan**

<table>
<thead>
<tr>
<th>Priority Topic: Chronic Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 1: Increase healthy eating practices through fostering self-efficacy</strong></td>
</tr>
<tr>
<td><strong>Action Step</strong></td>
</tr>
<tr>
<td>Year 1: Start to implement the Share Our Strength’s <strong>Cooking Matters</strong> program to SNAP-eligible adults through the Ohio State University Extension. Work with at least one new organization, such as a school, senior center, or community center, to pilot an additional 6-week course of the Cooking Matters program. Offer the program to all adults and families. Measure knowledge gained through evaluations.</td>
</tr>
<tr>
<td>Year 2: Continue efforts to implement at least one <strong>Cooking Matters</strong> class per quarter. Using the Cooking Matters Grocery Store Tour framework, conduct quarterly grocery store tours by a Registered Dietitian or Health Educator in grocery stores throughout Ottawa County. Measure knowledge gained through evaluations.</td>
</tr>
<tr>
<td>Year 3: Continue efforts from years 1 and 2. Measure knowledge gained through evaluations.</td>
</tr>
</tbody>
</table>
## Priority Topic: Chronic Disease

### Strategy 2: Increase prediabetes screening and referral for treatment

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Priority Outcome &amp; Indicator</th>
<th>Priority Population</th>
<th>Person/Agency Responsible</th>
<th>Timeline</th>
</tr>
</thead>
</table>
| **Year 1:** Introduce provider training and education to raise awareness of prediabetes screening, identification and referral to appropriate program through dissemination of evidence based **Prediabetes Risk Assessment.**  
Conduct one educational session on diabetes disease and management for community. Measure post education efficacy with goal of 80% indicating improved understanding at the end of the session.  
Develop baseline A1C levels of participants involved in Magruder Hospital DSME program. | **Priority Outcomes:**  
1. Reduce adult diabetes  
2. Reduce adult prediabetes  
3. Prediabetes screening  

**Priority Indicators:**  
1. Percent of adults diagnosed with diabetes  
2. Percent of adults diagnosed with prediabetes  
3. Percent of overweight or obese patients aged 40 to 70 years who had appropriate screening for abnormal blood glucose | Adult              | Rachel Fall, Magruder Hospital | May 15, 2019 |
|----------------------------------------------------------------------------|------------------------------------------------------------------|---------------------|-----------------------------------------------|--------------|
| **Year 2:** Continue efforts from year 1. Increase the number of providers screening for prediabetes by 25% from baseline.  
Conduct 1 educational session on diabetes disease and management for community. Measure post education efficacy with goal of 85% indicating improved understanding at the end of the session.  
Monitor Magruder Hospital DSME program participants for 5% improvement in A1C. | | | | May 15, 2020 |
| **Year 3:** Continue efforts from years 1 and 2. Increase number of providers screening for prediabetes by 50% from baseline.  
Conduct 1 educational session on diabetes disease and management for community. Measure post education efficacy with goal of 90% indicating improved understanding at the end of the session.  
Monitor Magruder Hospital DSME program participants for 10% improvement in A1C. | | | | May 15, 2021 |
### Priority Topic: Chronic Disease

#### Strategy 3: Implement healthy food initiatives

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Priority Outcome &amp; Indicator</th>
<th>Priority Population</th>
<th>Person/Agency Responsible</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 1:</strong> Obtain baseline data regarding which cities, towns, school</td>
<td>Priority Outcomes:</td>
<td>Adult</td>
<td>Rachel Fall, Magruder Hospital</td>
<td>May 15, 2019</td>
</tr>
<tr>
<td>districts, churches, and organizations currently have community gardens</td>
<td>1. Reduce adult obesity</td>
<td></td>
<td></td>
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<tr>
<td>and/or farmers markets.</td>
<td>2. Reduce adult hypertension</td>
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<tr>
<td>Obtain baseline data regarding which local food pantries have fresh</td>
<td>3. Reduce adult diabetes</td>
<td></td>
<td></td>
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<tr>
<td>produce available.</td>
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<tr>
<td>Research grants and other funding opportunities to increase the number of</td>
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<tr>
<td>community gardens and/or farmer’s markets in Ottawa County.</td>
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<tr>
<td>Create and distribute a map of all available farmers markets, community</td>
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<tr>
<td>gardens, and food pantries in Ottawa County. Update the map on an annual</td>
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<td>basis.</td>
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<tr>
<td><strong>Year 2:</strong> Assist churches, libraries, and other organizations in</td>
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<td></td>
<td>May 15, 2020</td>
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<tr>
<td>applying for grants to obtain funding for a community garden or farmers</td>
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<tr>
<td>market.</td>
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<tr>
<td>Work with food pantries to offer fresh produce and assist pantries in</td>
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<tr>
<td>seeking donations from local grocers.</td>
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<tr>
<td>Explore the use of SNAP/EBT (Electronic Benefit Transfer) at farmers’</td>
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<tr>
<td>markets.</td>
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</tr>
<tr>
<td><strong>Year 3:</strong> Implement community gardens in various locations and increase</td>
<td></td>
<td></td>
<td></td>
<td>May 15, 2021</td>
</tr>
<tr>
<td>the number of organizations with community gardens and/or farmer’s markets</td>
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<tr>
<td>by 25% from baseline.</td>
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<tr>
<td>Increase the number of food pantries offering fresh produce by 25% from</td>
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<tr>
<td>baseline.</td>
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<tr>
<td>Implement the use of WIC and SNAP/EBT benefits in all farmer’s markets.</td>
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</tbody>
</table>

**Priority Outcomes:**
- Reduce adult obesity
- Reduce adult hypertension
- Reduce adult diabetes

**Priority Indicators:**
- Percent of adults that report body mass index (BMI)
- Percent of adults ever diagnosed with hypertension
- Percent of adults who have been told by a health professional that they have diabetes
**Cross-cutting Strategies**

**Cross-cutting Outcomes**

In addition to tracking progress on the CHIP priority outcome objectives, the county will evaluate the impact of strategies implemented by also measuring progress on a set of cross-cutting outcome objectives. Examples of cross-cutting outcomes are listed below. See the master list of SHIP indicators for the complete list of the SHIP cross-cutting outcome indicators and the community toolkits for a recommended set of aligned community indicators to track progress related to each CHIP strategy.

**Social determinants of health: Examples of crosscutting outcomes that address all priorities**

- Improve third grade reading proficiency
- Reduce chronic absenteeism in school
- Reduce high housing cost burden
- Reduce secondhand smoke exposure for children

**Prevention, public health system and health behaviors: Examples of cross-cutting outcomes that address all priorities**

- Increase adult vegetable consumption
- Reduce adult physical inactivity
- Reduce adult smoking
- Reduce youth all-tobacco use

**Healthcare system and access: Examples of cross-cutting outcomes that address all priorities**

- Reduce percent of adults who are uninsured
- Reduce percent of adults unable to see a doctor due to cost
- Reduce primary care health professional shortage areas

**Specific, measurable objectives for selected cross-cutting outcomes will be included in the following action plans.**
Best Practices

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

1. **Trauma-informed care**: Trauma informed care (TIC) is a framework that requires change to organizational practices, policies, and culture that reflect an understanding of the widespread impact of trauma and potential paths for recovery, and actively seek to prevent re-traumatization. In health care, TIC usually includes universal trauma precautions and practice changes for patients with a known trauma history. Universal trauma precautions emphasize patient-centered communication and care, often with careful screening for trauma, safe clinical environments (e.g., quiet waiting areas), and shared decision making for all patients. Under a trauma-informed clinical approach, providers collaborate across disciplines, use streamlined referral pathways, and remain aware of their own trauma histories and stress levels when they know patients have experienced trauma. TIC can also be implemented in oral health settings.

2. **Sequential Intercept Model**: Given the high prevalence of people with mental and substance use disorders involved with the justice system, SAMHSA has prioritized this population. Recognizing that behavioral health treatment and recovery support services are critical but also need to be balanced with the community priority of public safety, SAMHSA has created an array of programs, technical assistance centers, resources, and policy initiatives that take these issues into consideration.

SAMHSA’s criminal justice work is organized around a framework for intervention referred to as the Sequential Intercept Model. This model identifies five key points for “intercepting” individuals with behavioral health issues, linking them to services and preventing further penetration into the criminal justice system. This model builds on collaboration between the criminal justice and behavioral health systems; highlights where to intercept individuals as they move through the criminal justice system; identifies critical decision-makers who can authorize movement away from the justice system and into treatment; and delineates essential partnerships among mental health, substance abuse, law enforcement, pre-trial services, courts, judges, jails, community corrections, social services, and others. Through its criminal justice initiatives, SAMHSA aims to:

- Bring about strategic linkages with community-based behavioral health providers, the criminal justice system and community correctional health
- Promote effective diversion and reentry programs
- Foster policy development at the intersection of behavioral health and justice issues
**Action Step Recommendations & Plan**

To work toward **improving health outcomes**, the following cross-cutting strategies are recommended:

1. Increase awareness of trauma informed care
2. Create a sequential intercept map (SIM)

**Action Plan**

<table>
<thead>
<tr>
<th>Cross-cutting Topic: Healthcare System and Access</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 1: Increase awareness of Trauma Informed Care</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Cross-cutting Outcome &amp; Indicator</th>
<th>Priority Population</th>
<th>Person/Agency Responsible</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 1:</strong> Facilitate an assessment among healthcare providers, teachers, coaches, social service providers, and other community members on their awareness and understanding of trauma informed care, including toxic stress and adverse childhood experiences. Administer a training to increase education and understanding of trauma informed care.</td>
<td><strong>Cross-cutting Outcomes:</strong> 1. Reduce suicide ideation in adults 2. Reduce suicide ideation in youth</td>
<td>Adult and youth</td>
<td>Brenda Cronin, Mental Health and Recovery Board of Erie and Ottawa Counties</td>
<td>May 15, 2019</td>
</tr>
<tr>
<td><strong>Year 2:</strong> Continue efforts from year 1. Develop and implement a trauma screening tool for social service agencies who work with at-risk adults and youth. Increase the use of trauma screening tools by 25%.</td>
<td><strong>Cross-cutting Indicator:</strong> 1. Percent of adults with suicidal thoughts within the past year 2. Percent of youth who report that they ever seriously considered attempting suicide within the past 12 months</td>
<td>Adult and youth</td>
<td>Brenda Cronin, Mental Health and Recovery Board of Erie and Ottawa Counties</td>
<td>May 15, 2020</td>
</tr>
<tr>
<td><strong>Year 3:</strong> Continue efforts from years 1 and 2. Increase the use of trauma screening tools by 50%.</td>
<td></td>
<td></td>
<td></td>
<td>May 15, 2021</td>
</tr>
</tbody>
</table>
# Cross-cutting Topic: Public Health System, Prevention and Health Behaviors

## Strategy 2: Create a sequential intercept map (SIM)

<table>
<thead>
<tr>
<th>Action Step</th>
<th>Cross-cutting Outcome &amp; Indicator</th>
<th>Priority Population</th>
<th>Person/Agency Responsible</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 1:</strong> Research the <a href="#">sequential intercept model</a> and determined the feasibility of implementing it in the community.</td>
<td><strong>Cross-cutting Outcomes:</strong> 1. Reduce opioid use 2. Reduce the number of opioid overdoses and deaths 3. Unintentional drug overdose deaths <strong>Cross-cutting Indicators:</strong> 1. Percent of adults using opioids 2. Percent of adults who overdose or whose death is the result of an opioid overdose 3. Number of deaths due to unintentional drug overdoses per 100,000 population (age adjusted)</td>
<td>Adults</td>
<td>Brenda Cronin, Mental Health and Recovery Board of Erie and Ottawa Counties</td>
<td>May 15, 2019</td>
</tr>
<tr>
<td>Meet with Ottawa County officials, including local prosecutors, judges, law enforcement, hospital officials jail officials and county commissioners, to discuss sequential intercept mapping for Ottawa County and the potential benefits it could yield if completed.</td>
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</tr>
<tr>
<td><strong>Year 2:</strong> Determine funding that may be necessary to complete SIM and secure funding (if applicable). Create and execute a plan to produce a sequential intercept map for Ottawa County by:</td>
<td></td>
<td></td>
<td></td>
<td>May 15, 2020</td>
</tr>
<tr>
<td>• Developing a comprehensive map of how individuals with substance abuse and mental health (SAMH) disorders flow through five distinct intercept points of the county’s criminal justice system: law enforcement an emergency services, initial detention and first appearance, jails and courts, reentry, and community corrections.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Identify resources, gaps in services, and opportunities at each intercept for individuals with SAMH disorders involved in the criminal justice system (target population).</td>
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<tr>
<td>• Development of priorities and an action plan to improve the system and service level responses for individuals in the target population.</td>
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</tr>
<tr>
<td><strong>Year 3:</strong> Continue efforts from years 1 and 2. Begin to implement the sequential intercept map in conjunction with appropriate evaluation measures.</td>
<td></td>
<td></td>
<td>May 15, 2021</td>
<td></td>
</tr>
</tbody>
</table>
Progress and Measuring Outcomes

The progress of meeting the local priorities will be monitored with measurable indicators identified for each strategy found within the action step and recommendation tables within each of the priority sections. Most indicators align directly with the SHIP. The individuals that are working on action steps will meet on an as needed basis. The full committee will meet quarterly to report out the progress. The committee will form a plan to disseminate the Community Health Improvement Plan to the community. Action steps, responsible agencies, and timelines will be reviewed at the end of each year by the committee. Edits and revisions will be made accordingly.

Ottawa County will continue facilitating a Community Health Assessment every three years to collect and track data. Primary data will be collected for adults and youth using national sets of questions to not only compare trends in Ottawa County, but also be able to compare to the state, the nation, and Healthy People 2020. This data will serve as measurable outcomes for each of the priority areas. Indicators have already been defined throughout this report and are identified with the 🌐 icon.

In addition to outcome evaluation, process evaluation will also be used on an ongoing basis to focus on how well action steps are being implemented. Areas of process evaluation that the CHIP committee will monitor will include the following: number of participants, location(s) where services are provided, number of policies implemented, economic status and racial/ethnic background of those receiving services (when applicable), and intervention delivery (quantity and fidelity).

Furthermore, all action steps have been incorporated into a Progress Report template that can be completed at all future Ottawa County Health Partners meetings, keeping the committee on task and accountable. This progress report may also serve as meeting minutes.

Contact Us

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

**Nancy C. Osborn, RN, MPA**
Health Commissioner
Ottawa County Health Department
1856 E. Perry St.
Port Clinton, OH 43452
(419) 734-6800
Fax (419) 734-6888
# Appendix I: Links to Websites

<table>
<thead>
<tr>
<th>Title of Link</th>
<th>Website URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted Outpatient Treatment (AOT)</td>
<td><a href="https://nrepp.samhsa.gov/ProgramProfile.aspx?id=214">https://nrepp.samhsa.gov/ProgramProfile.aspx?id=214</a></td>
</tr>
<tr>
<td>Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services</td>
<td><a href="http://www.cdc.gov/nphpsp/essentialservices.html">http://www.cdc.gov/nphpsp/essentialservices.html</a></td>
</tr>
<tr>
<td>Community gardens</td>
<td><a href="http://www.countyhealthrankings.org/policies/community-gardens">http://www.countyhealthrankings.org/policies/community-gardens</a></td>
</tr>
<tr>
<td>Cooking Matters (No Kid Hungry Center for Best Practices)</td>
<td><a href="https://cookingmatters.org/courses">https://cookingmatters.org/courses</a></td>
</tr>
<tr>
<td>Cooking Matters at the Store</td>
<td><a href="https://cookingmatters.org/node/2274">https://cookingmatters.org/node/2274</a></td>
</tr>
<tr>
<td>Food pantries</td>
<td><a href="http://www.countyhealthrankings.org/policies/healthy-food-initiatives-food-banks">http://www.countyhealthrankings.org/policies/healthy-food-initiatives-food-banks</a></td>
</tr>
<tr>
<td>Implement Assisted Outpatient Treatment (AOT)</td>
<td><a href="http://www.treatmentadvocacycenter.org/fixing-the-system/promoting-assisted-outpatient-treatment">http://www.treatmentadvocacycenter.org/fixing-the-system/promoting-assisted-outpatient-treatment</a></td>
</tr>
<tr>
<td>Master list of SHIP indicators</td>
<td><a href="http://www.odh.ohio.gov/sha-ship">http://www.odh.ohio.gov/sha-ship</a></td>
</tr>
<tr>
<td>Naloxone access</td>
<td><a href="http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/naloxone-education-distribution-programs">http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/naloxone-education-distribution-programs</a></td>
</tr>
<tr>
<td>Project DAWN</td>
<td><a href="https://www.odh.ohio.gov/health/vipp/drug/ProjectDAWN.aspx">https://www.odh.ohio.gov/health/vipp/drug/ProjectDAWN.aspx</a></td>
</tr>
<tr>
<td>Screen for clinical depression for all patients 12 or older using a standardized tool</td>
<td><a href="http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression">http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression</a></td>
</tr>
<tr>
<td>Screening, brief intervention, and referral to treatment (SBIRT)</td>
<td><a href="http://www.integration.samhsa.gov/clinical-practice/sbirt">http://www.integration.samhsa.gov/clinical-practice/sbirt</a></td>
</tr>
<tr>
<td>Sequential Intercept Model</td>
<td><a href="https://www.samhsa.gov/criminal-juvenile-justice/samhsas-efforts">https://www.samhsa.gov/criminal-juvenile-justice/samhsas-efforts</a></td>
</tr>
<tr>
<td>SNAP/EBT (Electronic Benefit Transfer) at farmers’ markets</td>
<td><a href="http://www.countyhealthrankings.org/policies/electronic-benefit-transfer-payment-farmers-markets">http://www.countyhealthrankings.org/policies/electronic-benefit-transfer-payment-farmers-markets</a></td>
</tr>
<tr>
<td>Trauma-informed Care</td>
<td><a href="http://www.countyhealthrankings.org/policies/trauma-informed-health-care">http://www.countyhealthrankings.org/policies/trauma-informed-health-care</a></td>
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