2020

Magruder Hospital Community Health Needs Assessment Implementation Strategy

Released on November 1, 2020

MAGRUDER HOSPITAL
It's How We Care

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Executive Summary

In 2001, Magruder Hospital and the Ottawa County Health Partners began conducting community health assessments (CHAs) for measuring and addressing the health status of the Ottawa County community. The most recent 2020 Magruder Hospital Community Health Needs Assessment (CHNA) 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 Magruder Hospital to compare the data collected in their CHNA to national, state and local health trends. HCNO also incorporated secondary data from multiple sites, including county-level data, whenever possible (ex: HCNO utilized sites such as the Ohio Public Health Data Warehouse, numerous CDC sites, U.S. Census data, Healthy People 2020, among other national and local sources).

Magruder Hospital's CHNA also fulfills nationally mandated requirements for hospitals. 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 CHNA 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 CHNA, community leaders and public health officials 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 Magruder Hospital CHNA has been utilized as a vital tool for creating the Magruder Hospital Implementation Plan (IP). This plan is used by health, human services, governmental, educational, and other community agencies, in collaboration with Magruder Hospital, to set priorities, coordinate and target resources. An IP 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 manner. The purpose of the Magruder Hospital CHNA and IP is not to duplicate, but to offer adult and adolescent population data and strategies to compliment data and planning needs.

Magruder Hospital contracted with the Hospital Council of Northwest Ohio, a neutral non-profit regional hospital association, to facilitate the process. Magruder Hospital then invited key community leaders to participate in an organized process of strategic planning to improve the health of Ottawa County. The following priorities and priority factors were selected: chronic disease, mental health and addiction, and access to care. Figure 1.1. (below) outlines the priorities and outcomes that will be discussed later in this plan.

Amid the planning process, Ottawa County was struck by COVID-19 along with the rest of the country. Immediately, issues including food insecurity, mental health, and access to care became more pronounced. As the State of Ohio works to mitigate the impact of COVID-19, there is uncertainty around funding for Medicaid and education, both critical to the health of Ottawa County residents. Community leaders expressed great concern over the impact of COVID-19 on Ottawa County and therefore this Implementation Plan considers the changing and unknown environment brought about by COVID-19.

Figure 1.1: 2020-2022 Magruder Hospital Implementation Strategy Plan Priorities and Outcomes

Priorities	
Chronic Disease	Mental Health and Addiction
Outcome(s)	
• Reduce heart disease • Reduce prediabetes/diabetes • Reduce obesity • Reduce hypertension • Increase prediabetes screening	• Reduce depression • Reduce suicide deaths • Reduce prescription medication abuse • Reduce unintentional drug overdose deaths
Priority Factor	
Access to Care	
Outcome(s)	
• Increase health insurance coverage	

Partners

The 2020-2022 Implementation Plan was drafted by agencies and service providers within Ottawa County. During August 2020, the committee reviewed many sources of information concerning the health and social challenges Ottawa County adults and adolescents may face. The committee determined priority issues which represented gaps in current programming and policies and examined best practices and solutions to address these gaps which, if addressed, could improve future outcomes. The committee has recommended specific actions for Magruder Hospital and community partners to address in the coming months and years. We would like to recognize these individuals and thank them for their devotion to this process and this body of work:

Ottawa County Health Partners

Board of DD/Family & Children First Council – Margaret Osborne
Choices Behavioral Health – Anthony Lash
Family Advocacy Center – Connie Cornett
Firelands Counseling & Recovery – Laura Miller
Joyful Connections – Shanna Strouse
Magruder Hospital – Rachel Fall & Kimberly Schreiner
Mental Health & Recovery Board – Brenda Cronin & Diane Taylor
OSU Extension – Katie Schlagheck
Ottawa County Health Department – Jerry Bingham
United Way – April Schalk

The community health improvement process was facilitated by Emily Stearns, Community Health Improvement Manager, and Gabbey MacKinnon, Community Health Improvement Coordinator, from the Hospital Council of Northwest Ohio.

Vision and Mission

Vision statements define 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 Magruder Hospital

We envision our community as one where all people achieve their full potential for health and well-being.

The Mission of Magruder Hospital

Improving Lives Together.

The Community Health Needs Assessment and subsequent Implementation Plan is critical to the mission and vision of Magruder Hospital.

Community Served by Magruder Hospital

The community has been defined as Ottawa County. In 2019, 85% of Magruder Hospital discharges were residents of Ottawa County. This includes discharge from the emergency department, urgent care, and the inpatient unit (inpatient/observation/swing). In addition, Magruder Hospital collaborates with multiple stakeholder, most of which provide services at the county-level. For these two reasons, the county was defined as the community.

Alignment with Regional, State, and National Standards

The 2020-2022 Magruder Hospital Implementation Plan priorities align perfectly with regional, state and national priorities. Magruder Hospital will be addressing the following priority health outcomes: chronic disease and mental health and addiction. Additionally, Magruder Hospital will be addressing the following priority health factor: access to care.

2018-2021 Ottawa County Community Health Improvement Plan (CHIP)

The Magruder Hospital Implementation Plan aligns with each priority indicated in the Ottawa County CHIP: chronic disease and mental health and addiction. To view, please visit: **https://www.magruderhospital.com/ottawa-county-health-assessment**

Healthy People 2020

Magruder Hospital priorities also fit specific Healthy People 2020 goals. For example:

- Mental Health and Mental Disorder (MHMD) – 2: Reduce suicide attempts by adolescents
- Nutrition and Weight Status (NWS) – 10: Reduce the proportion of adolescents who are considered obese

Please visit **Healthy People 2020** 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).

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

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 SHIP also takes a comprehensive approach to improving Ohio's greatest health priorities by identifying 3 priority factors that impact the 3 priority health outcomes: community conditions, health behaviors and access to care. The three priority factors include the following:

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

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

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

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

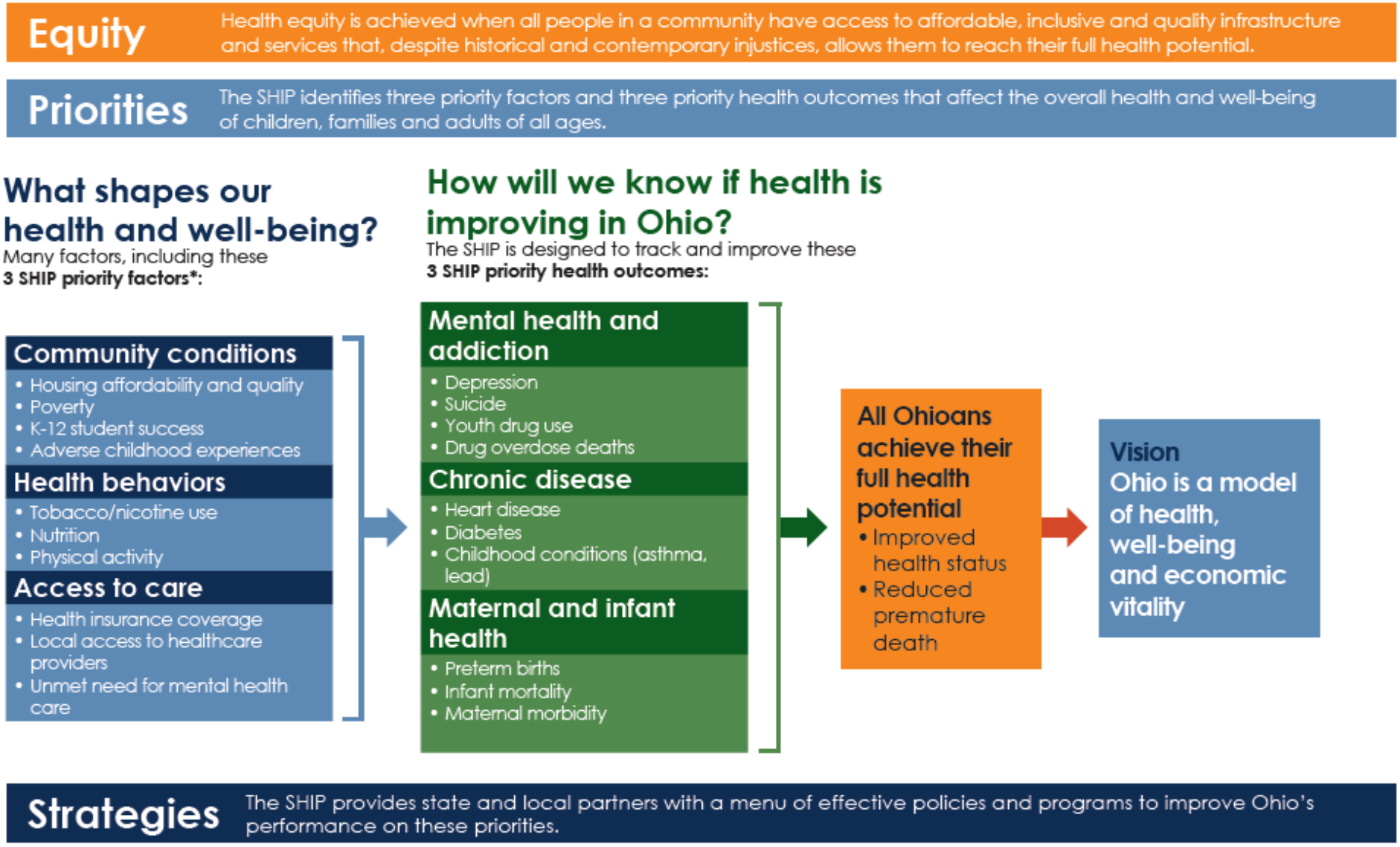
Figure 1.2: 2020-2022 Magruder Hospital IP Alignment with the 2020-2022 SHIP

Priority Outcomes	Priority Indicators	Strategies to Impact Priority Indicators	Additional Aligned Strategies
Mental Health and Addiction	• Youth suicide deaths • Adult suicide deaths • Adult depression • Youth depression	• Mental health education	• N/A
Chronic Disease	• Coronary heart disease • Hypertension • Diabetes	• Increase prediabetes screening and referral for treatment • Hypertension screening and follow up	• Community-wide wellness campaign • Implement healthy food initiatives
Priority Factor	**Priority Indicators**	**Strategies to Impact Priority Indicators**	**Additional Aligned Strategies**
Access to Care	• Uninsured adults	• Health insurance enrollment and outreach	• N/A

N/A – Not Available

Alignment with National and State Standards, continued

Figure 1.3: 2020-2022 State Implementation Plan (SHIP) Overview



Strategic Planning Model

Beginning in August 2020, Magruder Hospital and the Ottawa County Health Partners held a series of virtual meetings 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. **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
4. **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
5. **Best Practices:** Review of best practices and proven strategies, evidence continuum, and feasibility continuum
6. **Draft Plan:** Review of all steps taken; action step recommendations based on one or more the following: enhancing existing efforts, implementing new programs or services, building infrastructure, implementing evidence-based practices, and feasibility of implementation

Recommended Action Steps

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

1. Mental health education
2. Increase safe disposal of prescription drugs
3. Support and enhance socialization and mentoring programs within Ottawa County

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

1. Implement healthy food initiatives √
2. Increase prediabetes screening and referral for treatment
3. Hypertension screening and follow up
4. Community-wide wellness campaign

To work toward improving **access to care**, the following strategies are recommended:

1. Health insurance enrollment and outreach √

Needs Assessment

The Ottawa County Health Partners reviewed the 2020 Magruder Hospital Community Health Needs Assessment. The detailed primary and secondary data for each individual priority area can be found in the section it corresponds to. The full report can be found at **https://www.magruderhospital.com/ottawa-county-health-assessment**. Each member completed an "Identifying Key Issues and Concerns" via an online platform "SurveyMonkey." The following tables were the group results.

Key Issue or Concern	**Percent of Population**	**Age Group Most at Risk** *(if applicable)*	**Gender or Income Level Most at Risk** *(if applicable)*
Mental Health (7 votes)			
Adults who considered attempting suicide in the past year	3%	N/A	N/A
Adults who felt sad or hopeless for two or more weeks in a row in the past year	9%	Age: 30-65 (10%)	Income: <$25K (25%)
Youth who attempted suicide in the past year	6%	Age: 17 and older (9%)	Gender: Female (8%)
Youth who considered attempting suicide in the past year	14%	Age: 17 and older (17%)	Gender: Female (20%)
Youth who felt sad or hopeless for two or more weeks in a row in the past year	26%	Grade: 9th-12th (27%)	N/A
Weight Status (6 votes)			
Overweight adults	36%	Age: 65+ (38%)	Income: >$25K (37%)
Obese adults	41%	Age: 30-64 (46%)	Income: <$25K (47%)
Obese youth	20%	Grade: 9th-12th (23%) Ages: 17+ (22%)	N/A
Alcohol Use (6 votes)			
Adult drinkers who binge drank in the past month	41%	Age: 30-64 (48%)	Gender: Male (42%) Income: >$25K (43%)
Youth who ever tried alcohol	45%	Age: 17-18 (67%) Grade: 9th -12th (52%)	Gender: Female (46%)
Youth current drinkers	20%	Age: 17-18 (36%)	Gender: Female (22%)
Youth binge drinkers	10%	Age: 17-18 (23%)	Gender: Female (14%)

N/A – Not Available

Key Issue or Concern	Percent of Population	Age Group Most at Risk *(if applicable)*	Gender or Income Level Most at Risk *(if applicable)*
Chronic Disease (4 votes)			
Adults diagnosed with high blood pressure	42%	Age: 65+ (61%)	Gender: Male (51%) Income: <$25K (52%)
Adults diagnosed with high blood cholesterol	40%	Age: 65+ (55%)	Gender: Male (44%) Income: <$25K (41%)
Adults diagnosed with diabetes	11%	Age: 65+ (17%)	Gender: Male (13%) Income: <$25K (13%)
Access to Care (4 votes)			
Uninsured adults	7%	Age: 30-64 (10%)	Income: <$25K (8%) Gender: Female (8%)
Adults who went outside of Ottawa County for health care in the past year	83%	N/A	N/A
Lifestyle support – adults in need of meditation services *(Source: Magruder Hospital community wellness survey, 2019)*	40%	N/A	N/A
Adults who visited a doctor for a routine checkup in the past year	62%	Age: 30-64 (58%)	Gender: Female (59%)
Drug Use (3 votes)			
Youth who used medications not prescribed for them or took more than prescribed to feel good or to get high at some time in their lives	5%	N/A	N/A
Youth marijuana use in the past month	6%	Age: 17+ (11%)	Gender: Female (9%)
Unintentional drug overdose deaths among Ottawa County Residents *(Source: Ohio Department of Health, 2018)*	13 deaths	N/A	N/A

N/A – Not Available

Key Issue or Concern	Percent of Population	Age Group Most at Risk *(if applicable)*	Gender or Income Level Most at Risk *(if applicable)*
Tobacco use (1 vote)			
Adult current smokers	15%	Age: 30-64 (18%)	Gender: Male (17%) Income: <25K (24%)
Youth current smokers	4%	Age: 17+ (8%)	Gender: Female (5%)
Youth physical self-harm (1 vote)			
Youth who purposefully hurt themselves by cutting, scratching, burning, hitting, or biting	20%	N/A	Gender: Female (29%)
Community Conditions (1 vote)			
High housing costs specifically in Oak Harbor *(Source: Not provided – top request from United Way)*	N/A	N/A	N/A

N/A – Not Available

Priorities Selected

Magruder Hospital invited key community leaders to participate in an organized process of strategic planning to improve the health of Ottawa County residents. Based on the 2020 Magruder Hospital Community Health Needs Assessment, key issues were identified for adults and youth via an online platform (SurveyMonkey). Overall, there were 9 key issues identified by the community partners. Each organization was given 5 votes. The key issues and their corresponding votes are described in the table below.

The results were compiled and shared with the Ottawa County Health Partners. The group analyzed the results, discussed options, and came to a consensus on the priority areas the hospital will focus on over the next three years.

Key issues	**Votes**
1. Mental health	7
2. Weight status	6
3. Alcohol consumption	6
4. Chronic disease	4
5. Access to care	4
6. Drug use	3
7. Tobacco use	1
8. Youth physical self-harm	1
9. Community conditions	1

Magruder Hospital will focus on the following priority health outcomes over the next three years:

1. **Mental health and addiction** (includes depression, suicide, and drug use)
2. **Chronic disease** (includes obesity, cardiovascular disease, and diabetes)

Magruder Hospital will focus on the following priority factor over the next three years:4

3. **Access to Care** (includes access to health care services and uninsured)

Resource Assessment

Based on the chosen priorities, the 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 there is 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 and applicability to other settings is insufficient. A **non-evidence-based practice** has neither no documentation that it has ever been used (regardless of the principles it is based upon) nor has been implemented successfully with evaluation.

Existing resources were incorporated into the IP where possible.

The resource assessment can be found at the following website:

https://www.magruderhospital.com/ottawa-county-health-assessment

Mental Health and Addiction Indicators

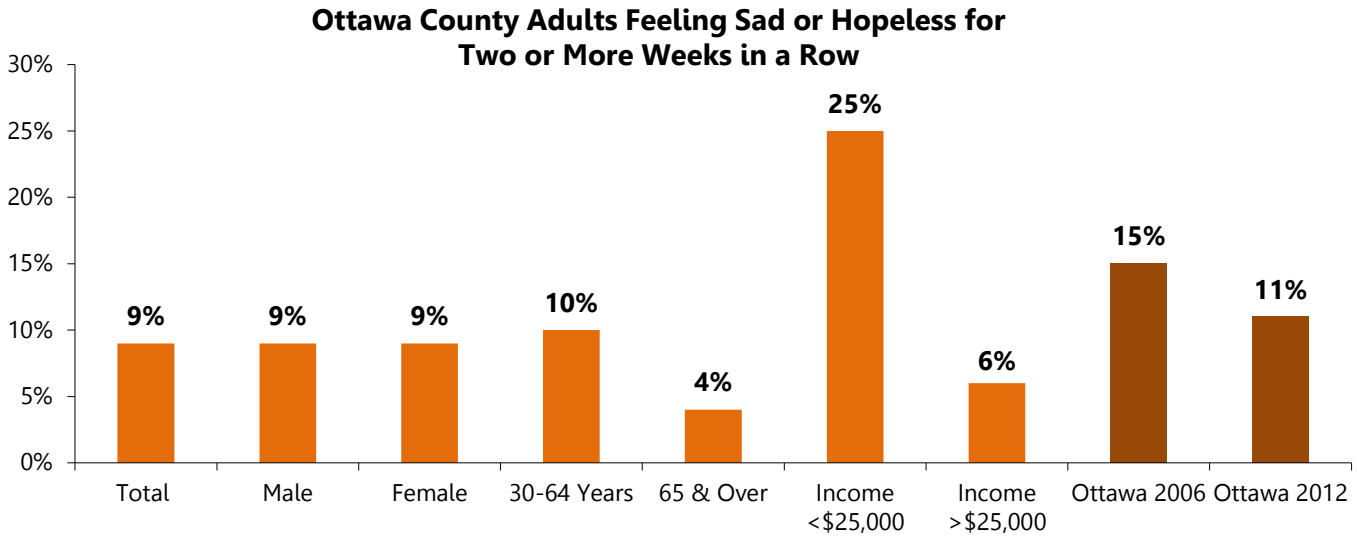
Adult Mental Health

Nine percent (9%) of Ottawa County adults felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities, increasing to 25% of those with incomes less than $25,000.

Three percent (3%) of Ottawa County adults considered attempting suicide in the past year.

Less than one percent (<1%) of adults reported attempting suicide in the past year.

The following graph shows Ottawa County adults who felt sad or hopeless for two or more weeks in a row in the past year. Examples of how to interpret the information include: 9% of all Ottawa County adults felt sad or hopeless for two or more weeks in a row, including 9% of males and 9% of females.



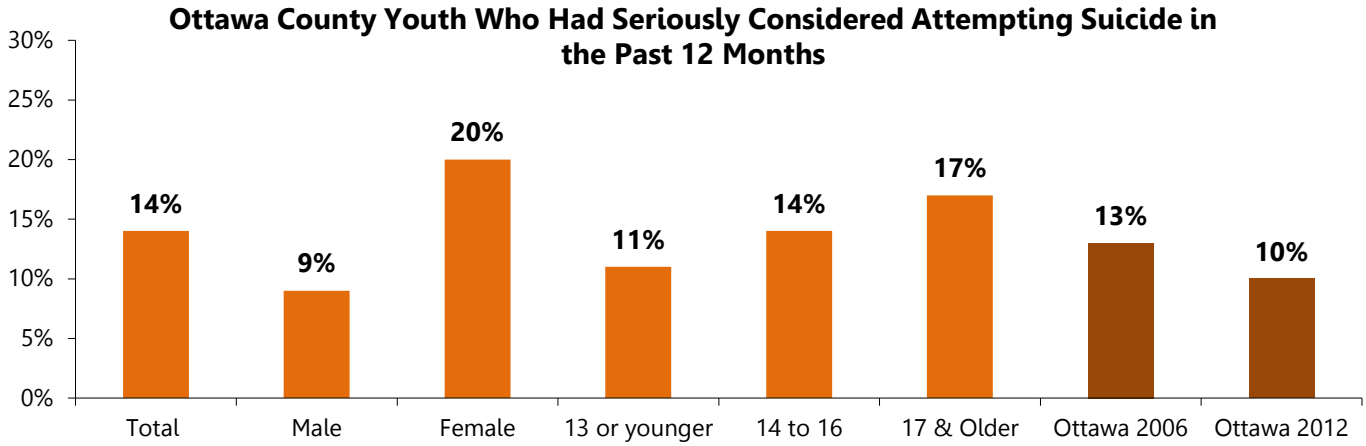
Adult Comparisons	Ottawa County 2006	Ottawa County 2012	Ottawa County 2017	Ohio 2018	U.S. 2018
Felt sad or hopeless for two or more weeks in a row	15%	11%	9%	N/A	N/A
Considered attempting suicide in the past year	3%	5%	3%	N/A	N/A

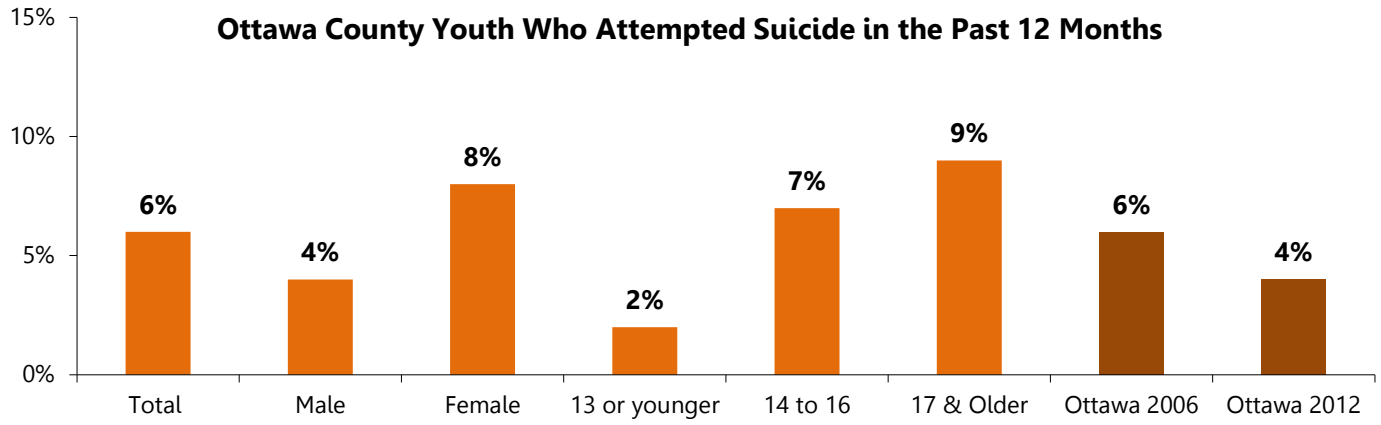
N/A – Not Available

Youth Mental Health

In 2017, over 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 32% for the U.S. in 2017).

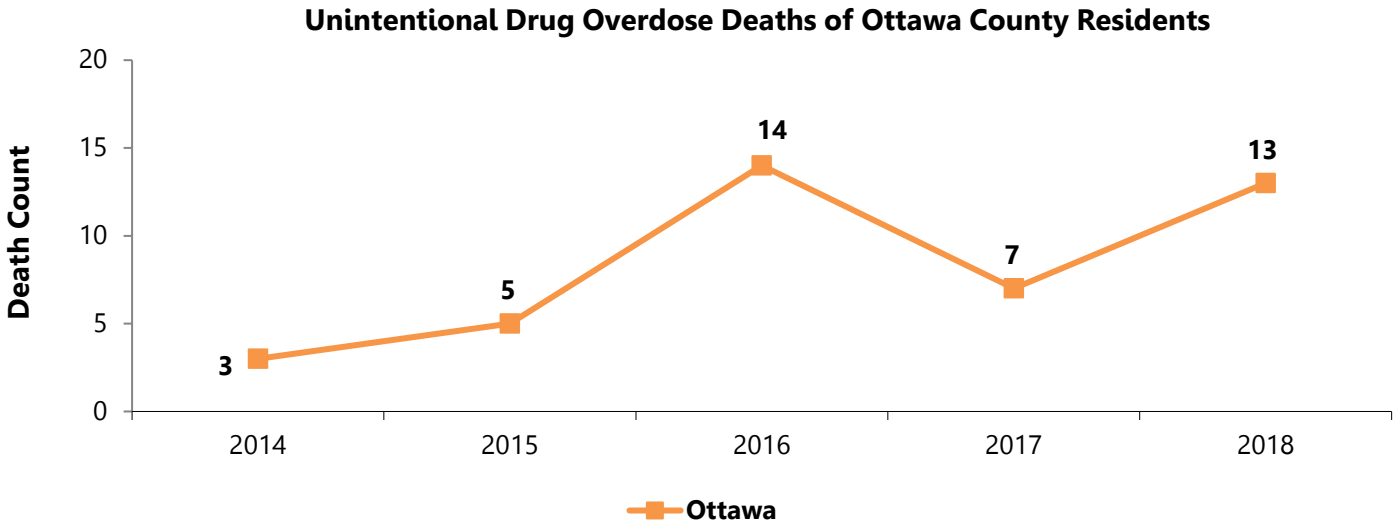
The following graphs show Ottawa County youth who had seriously considered attempting suicide in the past year and those who attempted suicide in the past year. Examples of how to interpret the information includes: 14% of all Ottawa County youth seriously considered attempting suicide, including 9% of males and 20% of females.





Youth Comparisons	Ottawa County 2006 (6th-12th)	Ottawa County 2012 (6th-12th)	Ottawa County 2017 (6th-12th)	Ottawa County 2017 (9th-12th)	U.S. 2017 (9th-12th)
Youth who felt sad or hopeless almost every day for 2 or more weeks in a row	21%	24%	26%	27%	32%
Youth who had seriously considered attempting suicide in the past year	13%	10%	14%	15%	17%
Youth who had attempted suicide in the past year	6%	4%	6%	7%	7%

Addiction



(Source: ODH, Ohio Resident Mortality Data, 2014-2018)

Youth Comparisons	Ottawa County 2006 (6th-12th)	Ottawa County 2012 (6th-12th)	Ottawa County 2017 (6th-12th)	Ottawa County 2017 (9th-12th)	U.S. 2017 (9th-12th)
Youth who used marijuana in the past month	14%	9%	6%	11%	20%
Ever misused medications	15%	14%	5%	7%	N/A

N/A – Not Available

Gaps and Potential Strategies

Following the key issues activity and priority selection, the committee discussed gaps surrounding the selected priority areas. The committee discussed potential strategies or areas of improvement to bridge those gaps. Following this exercise, additional strategies were discussed and noted if they met any of the following criteria: evidence based, likely to decrease disparities, alignment with the state health improvement plan, and alignment with the 2018-2021 Ottawa County Community Health Improvement Plan (CHIP).

Gaps and potential strategies around mental health and addiction can be identified below.

Gaps	Potential Strategies
1. Not available	• Continue current improvement plan for screening and referral improvement
2. Offseason doesn't have enough work or activity to keep people occupied thus increasing depression rates, dissatisfaction, and drug and alcohol use	• Free or low-cost activity or community center
3. People are too connected to electronics	• Education focused on disconnecting from devices - Injury prevention partnership
4. Youth mental health (depression, self-harm, attempting suicide)	• Mentoring • Social/emotional instruction • Training for teachers and others in schools (coaches, etc.) on mental health/trauma • Increase peer support • Telehealth services
5. Increase in youth using medications not prescribed to them	• Public awareness campaign with schools (youth-led)
6. Increase in adult depression	• Mental Health First Aid • Social/emotional instruction • Telehealth • Utilize ways to increase socialization, even during pandemic • Can we utilize the senior center to do zoom programs?
7. Increased drug use in Ottawa County (and in senior population)	• Ottawa County needs more mental health professionals (financial incentives for health professionals serving underserved areas) • Engage seniors at point of contact with Dr., if possible, to talk about the issues associated with addictions

Best Practices

The Ottawa County Health Partners reviewed best practices for potential inclusion in the action plan. The following programs and policies have been reviewed and have proven strategies to **improve mental health and addiction** outcomes:

Mental Health First Aid (MHFA) is a training course to help laypeople know how to assist individuals with mental health problems or at risk for problems such as depression, anxiety, and substance use disorders. Courses last 8 to 12 hours and include information about signs and symptoms of mental health problems and appropriate responses, as well as interactive activities using MHFA's five-step action plan: assess risk of self-harm, listen non-judgmentally, reassure and share information, encourage self-help, and encourage professional help. The MHFA curriculum has been adapted for various populations, including youth, older adults, college students, members of the military, and veterans and is often implemented in rural communities.

Expected beneficial outcomes:
- Increased knowledge of mental health
- Reduced stigma

Trauma-informed care is a framework that entails 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, trauma informed care usually includes universal trauma precautions and practice changes for patients with a known trauma history.

Expected beneficial outcomes:
- Improved quality of care
- Improved health outcomes
- Improved mental health
- Reduced post-traumatic stress

(Source: County Health Rankings, What Works for Health, 2020)

Action Step Recommendations & Plan

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

1. Mental health education
2. Increase safe disposal of prescription drugs
3. Support and enhance mentoring and socialization programs within Ottawa County

Action Plan

<table>
<tr><th colspan="5">Priority Topic: Mental Health and Addiction</th></tr>
<tr><th colspan="5">Strategy 1: Mental health education</th></tr>
<tr><th>Action Step</th><th>Priority Outcome & Indicator</th><th>Priority Population</th><th>Person/ Agency Responsible</th><th>Timeline</th></tr>
<tr><td>Year 1: Obtain baseline data on the number of mental health trainings and education available to Magruder Hospital clinicians and staff.

Identify gaps in existing programs and determine training needs (ex: Crisis Intervention Training, Mental Health First Aid, Question Persuade and Refer [QPR], trauma informed care).

Partner with community agencies, such as the Mental Health and Recovery Board to assist with training opportunities.</td><td rowspan="3">Priority Outcomes:
1. Reduce adult and youth depression
2. Reduce suicide deaths

Priority Indicators:
1. Percent of adults and youth who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities
2. Number of deaths due to suicide per 100,000 populations (age-adjusted)</td><td rowspan="3">Adult and youth</td><td rowspan="3">Magruder Hospital</td><td>November 1, 2021</td></tr>
<tr><td>Year 2: Continue efforts of year 1.

Market available trainings to hospital staff. Explore incentive options for participation.

Increase number of mental health training and education available to Magruder staff by 25% from baseline.</td><td>November 1, 2022</td></tr>
<tr><td>Year 3: Continue efforts of year 2.

Increase number of mental health training and education available to Magruder staff by 50% from baseline.</td><td>November 1, 2023</td></tr>
</table>

Priority Topic: Mental Health and Addiction				
Strategy 2: Increase safe disposal of prescription drugs				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Gather baseline data on the number of local practitioners and pharmacies providing information on prescription drug abuse and collection locations.	**Priority Outcomes:** 1. Reduce prescription medication abuse 2. Reduce unintentional drug overdose deaths **Priority Indicators:** 1. Percent of youth who misused prescription medication in their lifetime 2. Age-adjusted deaths due to unintentional drug overdoses per 100,000 population	Adult and youth	Magruder Hospital	November 1, 2021
Year 2: Increase the number of local practitioners and pharmacies providing information on prescription drug abuse and collection locations by 25%. Promote the use of dissolvable prescription bags (i.e., Deterra) and provide education regarding safe disposal.				November 1, 2022
Year 3: Continue efforts of years 1 and 2. Increase the number of local practitioners and pharmacies providing information on prescription drug abuse and collection locations by 50%.				November 1, 2023

<table>
<tr><th colspan="5">Priority Topic: Mental Health and Addiction</th></tr>
<tr><th colspan="5">Strategy 3: Support and enhance mentoring and socialization programs within Ottawa County</th></tr>
<tr><th>Action Step</th><th>Priority Outcome & Indicator</th><th>Priority Population</th><th>Person/ Agency Responsible</th><th>Timeline</th></tr>
<tr><td>Year 1: Work with local organizations to determine the baseline number of mentoring and socialization programs in Ottawa County.

Work with local organizations to perform a gap analysis regarding current programming and the need/interest for additional programming.</td><td rowspan="3">Priority Outcomes:
1. Reduce adult and youth depression

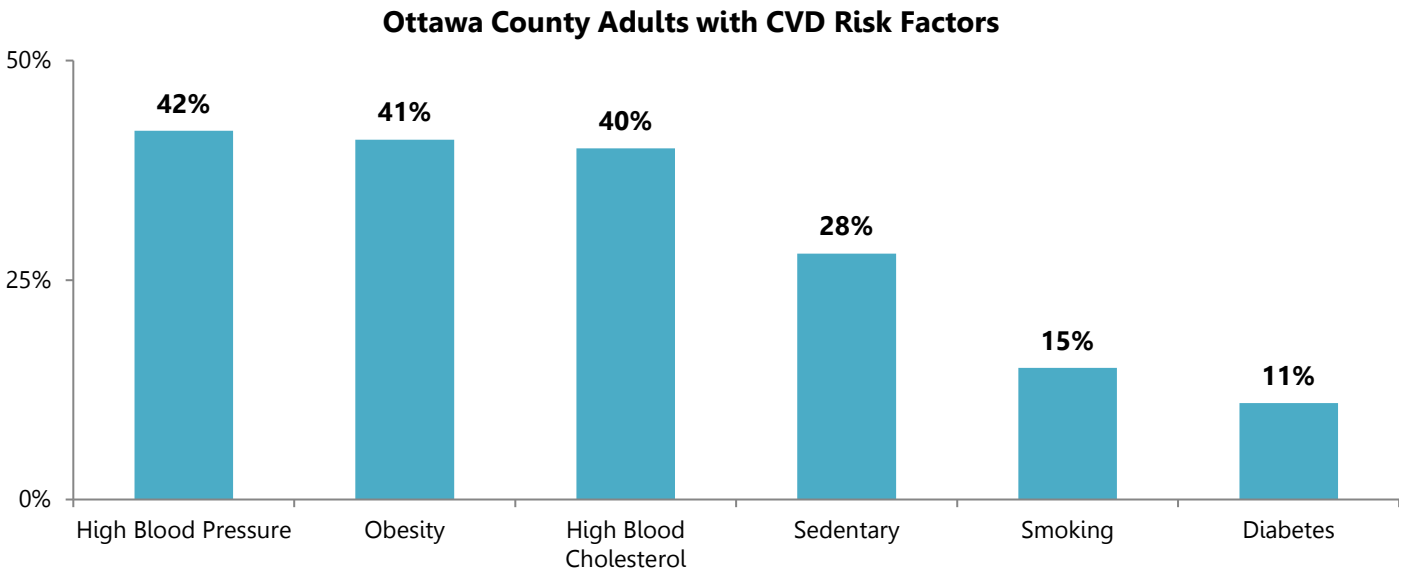
Priority Indicators:
1. Percent of adults who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities</td><td rowspan="3">Adult and youth</td><td rowspan="3">Magruder Hospital

Family Advocacy Center

Local School Districts</td><td>November 1, 2021</td></tr>
<tr><td>Year 2: Research and determine feasibility of community initiatives to engage residents. For example:
Compiling and promoting low cost activities within the county (ex: hospital sponsored youth engagement events)
MyHello (a loneliness intervention that increases social connectedness and reach people who are alone and facing stress and anxiety)
Mentoring programs (ex: Ottawa County Family Advocacy -TNT Mentoring Program to support one-to-one relationships between adult role models and youth facing personal, social, and academic challenges)
Support and/or enhance current or additional programming needs.</td><td>November 1, 2022</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2.</td><td>November 1, 2023</td></tr>
</table>

Chronic Disease Indicators

The following graph demonstrates the percentage of Ottawa County adults who had major risk factors for developing cardiovascular disease (CVD).



Adult Comparisons	Ottawa County 2006	Ottawa County 2012	Ottawa County 2017	Ohio 2018	U.S. 2018
Had angina	N/A	6%	6%	5%	4%
Had a heart attack	4%	7%	7%	6%	5%
Had a stroke	1%	1%	2%	4%	3%
Had high blood pressure	32%	40%	42%	35%*	32%*
Had high blood cholesterol	31%	38%	40%	33%*	33%*
Had blood cholesterol checked within past 5 years	74%	76%	81%	85%*	86%*
Diagnosed with diabetes	8%	11%	11%	12%	11%

Gaps and Potential Strategies

Following the key issues activity and priority selection, the committee discussed gaps surrounding the selected priority areas. The committee discussed potential strategies or areas of improvement to bridge those gaps. Following this exercise, additional strategies were discussed and noted if they met any of the following criteria: evidence based, likely to decrease disparities, alignment with the state health improvement plan, and alignment with the 2018-2021 Ottawa County Community Health Improvement Plan (CHIP).

Gaps and potential strategies around chronic disease can be identified below.

Gaps	Potential Strategies
1. Seniors not educated in chronic diseases	• Offer education classes through the Senior Centers
2. Diabetic teaching	• Diabetes prevention programs/screening. Offer programs at locations not in the Hospital, for example, senior centers
3. Ottawa County adult obesity higher than the state and nation	• County-wide program to encourage physical activity and healthy eating • Heathy foods at food banks • Improve nutrition and increase physical activity
4. Limited in locations for people to be physically active, especially during the winter	• Free or low-cost activity or community center – Rec center
5. Access to healthy food options in more rural areas of the county	• Provide healthier options for food in food desert areas
6. Increase obesity and chronic disease diagnoses	• Fruit and vegetable access education/fruit and vegetable initiatives • Community fitness programs
7. Lack of community health screens	• Offer screenings via Project Connect
8. Percentage of adults with high cholesterol or high blood pressure (ex: adults diagnosed with high blood pressure 42% vs. 35% and 32% Ohio and increasing trend of adults diagnosed with high cholesterol)	• Screenings and follow up • Education on healthy eating • Offer opportunities for blood pressure screening and referral to PCP for management • Screenings and incentives at community events

Best Practices

The Ottawa County Health Partners reviewed best practices for potential inclusion in the action plan. The following programs and policies have been reviewed and have proven strategies to **improve chronic disease**:

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
- Increased food security
- Increased healthy foods in food deserts
- Reduced obesity rates
- Improved mental health
- Improved sense of community
- Improved neighborhood safety

A **farmers market** is a multiple vendor farm-to-consumer retail operation, where producers sell goods directly to consumers at a set outdoor or indoor location. Farmers markets usually sell fresh fruit and vegetables, though meat, dairy, grains, prepared foods, and other items may also be available. Markets are usually held once a week and vary in size from a few stalls to several city blocks. Most farmers markets are organized and operated by community organizations, public agencies, or public/private collaborations with volunteer support.

Expected Beneficial Outcomes:

- Increased access to fruits & vegetables
- Increased healthy foods in food deserts
- Increased fruit & vegetable consumption
- Strengthened local & regional food systems
- Improved local economy

Healthy food initiatives in food banks and food pantry 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:

- Increased healthy food consumption
- Increased food security
- Improved nutrition
- Improved weight status

Electronic Benefit Transfer (EBT) payment at farmers markets is the electronic payment system of debit cards that the government uses to issue Supplemental Nutrition Assistance Program (SNAP) benefits to eligible recipients. SNAP benefits used to be paper-based and easy to redeem at farmers markets; when the EBT mandate passed, benefit redemption at farmers markets declined dramatically. Farmers markets enabled to accept EBT re-establish an opportunity for low income shoppers to access fresh, locally grown foods. EBT is in pilot stages for other government nutrition assistance programs.

Expected Beneficial Outcomes:

- Increased access to fruits & vegetables
- Increased fruit & vegetable consumption

Community-wide physical activity campaigns many community sectors work together to implement community-wide campaigns to increase physical activity using highly visible, broad-based, multicomponent strategies (e.g., social support, risk factor screening, health education). Campaigns may focus on physical activity alone or include other cardiovascular disease risk factors such as nutrition and tobacco use.

The National **Diabetes Prevention Program** (National DPP) is an evidence-based intervention that allows purchasers, payers, and providers to help their patients with prediabetes or at high risk for type 2 diabetes prevent or delay onset of type 2 diabetes. The intervention is founded on the science of the Diabetes Prevention Program research study and multiple translation studies. These studies showed that making modest behavior changes helped participants lose 5% to 7% of their body weight and reduced the risk of developing type 2 diabetes by 58% in adults with prediabetes (71% for people over 60 years old).

The National DPP's lifestyle change program

- Is a year-long structured program (in-person group, online, or combination) consisting of:
  - An initial six-month phase offering at least 16 sessions over 16-24 weeks and
  - A second six-month phase offering at least one session a month (at least six sessions)
- Is facilitated by a trained lifestyle coach.
- Uses a CDC-approved curriculum.
- Includes regular opportunities for direct interaction between the lifestyle coach and participants.
- Focuses on behavior modification, managing stress, and peer support.

(Source: County Health Rankings, What Works for Health, 2020)

Action Step Recommendations & Plan

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

1. Implement healthy food initiatives √
2. Increase prediabetes screening and referral for treatment
3. Hypertension screening and follow up
4. Community-wide wellness campaign

Action Plan

Priority Topic: Chronic Disease				
Strategy 1: Implement healthy food initiatives √				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Obtain baseline data regarding which cities, towns, school districts, churches, and organizations currently have **community gardens** and/or farmers markets and which local **food pantries** have fresh produce available. Create and distribute a map of all available farmers markets, community gardens, and food pantries in Ottawa County. Update the map on an annual basis. Assist additional organizations in applying for grants to obtain funding for a community garden or farmers market.	**Priority Outcomes:** 1. Reduce adult obesity 2. Reduce youth obesity 3. Reduce diabetes **Priority Indicators:** 1. Percent of adults that report body mass index (BMI) greater than or equal to 30 2. Percent of youth who were obese 3. Percent of adults ever told by a health professional that they had diabetes	Adult and youth	Magruder Hospital	November 1, 2021
Year 2: Continue efforts of year 1. Work with local organizations to ensure food pantries offer fresh produce. Continue to research and provide education regarding the use of **SNAP/EBT (Electronic Benefit Transfer) at farmers' markets**.				November 1, 2022
Year 3: Continue efforts of years 1 and 2.				November 1, 2023

Priority Topic: Chronic Disease				
Strategy 2: Increase prediabetes screening and referral for treatment				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Complete provider training and education to raise awareness of prediabetes screening, identification and referral to appropriate programing (i.e., Diabetes Program [DPP]) through dissemination of evidence based prediabetes screening using risk assessment tool (CDC or ADA) Obtain baseline data of Magruder employees and MMG patients to determine eligibility for the program to trial CDC DPP. Begin enrollment of pilot program.	**Priority Outcomes:** 1. Reduce adult diabetes 2. Reduce adult prediabetes 3. Increase 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	Magruder Hospital	November 1, 2021
Year 2: Continue efforts of year 1. Promote DPP (once lifestyle coaching training completed) in the community. Determine feasibility of virtual options for DPP sessions for community participants. Monitor Hospital DPP participants for 5% weight loss, 150 minutes physical activity weekly – via lifestyle interventions including healthy food choices and physical activity.				November 1, 2022
Year 3: Continue efforts of years 1 and 2. Begin conducting DPP for community members. Measure post-program efficacy with a goal of 5-7% weight loss from baseline, 150 minutes per week of physical activity for program participants; at end of program using continual tracking of data required by CDC to show maintenance with lifestyle interventions, i.e., healthy food, increased physical activity and behavior changes.				November 1, 2023

Priority Topic: Chronic Disease				
Strategy 3: Hypertension screening and follow up				
Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Person/ Agency Responsible**	**Timeline**
Year 1: Administer hypertension screening at hospital and community health events and at MMG physician offices. Promote and market free/reduced cost screening events within the county (health fairs, hospital screening events etc.) Develop a campaign to encourage screening participants and MMG patients to Know Your Numbers (blood pressure, cholesterol, etc.) and the signs and symptoms of heart disease. Educate local providers about the Know Your Numbers campaign.	**Priority Outcomes:** 1. Reduce hypertension **Priority Indicators:** 1. Percent of adults diagnosed with high blood pressure	Adults	Magruder Hospital	November 1, 2021
Year 2: Continue efforts of year 1. Increase the number of participants in the Know Your Numbers campaign by 25% from year 1. Increase the number of supplemental offerings to participants (lab, pharmacy, diabetes prevention, find a physician, etc.).				November 1, 2022
Year 3: Continue efforts from years 1 and 2. Increase the number of participants in the Know Your Numbers campaign by 50% from year 1.				November 1, 2023

<table>
<tr><th colspan="5">Priority Topic: Chronic Disease</th></tr>
<tr><th colspan="5">Strategy 4: Community-wide wellness campaign</th></tr>
<tr><th>Action Step</th><th>Priority Outcome & Indicator</th><th>Priority Population</th><th>Person/ Agency Responsible</th><th>Timeline</th></tr>
<tr><td>Year 1: Collaborate with local organizations, for example, OSU Extension, to create a community-wide wellness campaign.
Establish a campaign and identify strategies to implement unified wellness initiatives and messaging within the county (ex: nutrition, self-care, physical activity, etc.).
Determine campaign goals, objectives, and strategies.</td><td rowspan="3">Priority Outcome:
1. Reduce adult obesity
2. Reduce youth obesity
3. Reduce heart disease

Priority Indicator:
1. Percent of adults that report body mass index (BMI) greater than or equal to 30
2. Percent of youth who were obese
3. Percent of adults ever diagnosed with coronary heart disease</td><td rowspan="3">Adult and youth</td><td rowspan="3">Magruder Hospital</td><td>November 1, 2021</td></tr>
<tr><td>Year 2: Continue efforts from year 1.
Implement campaign. Participants will increase physical activity or fruit/vegetable intake by 25% at end of campaign.</td><td>November 1, 2022</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2.
Review campaign goals, objectives, and strategies.
Increase number of participants by 25%. Participants will increase physical activity or fruit/vegetable intake by 25% at end of campaign.</td><td>November 1, 2023</td></tr>
</table>

Access to Care Indicators

Health Insurance

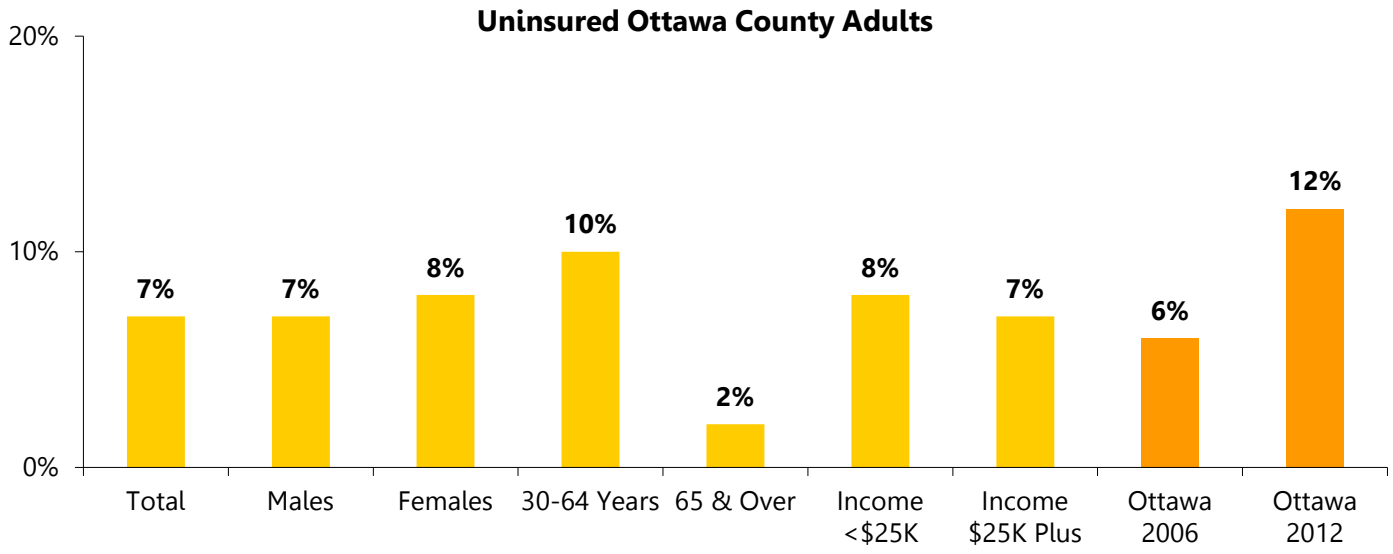
More than three-fifths (62%) of Ottawa County adults visited a doctor for a routine checkup in the past year.

Adults with health care coverage were more likely to have visited a doctor for a routine checkup in the past year (64%), compared to 40% of those without health care coverage.

More than four-fifths (83%) of adults went outside of Ottawa County for the following health care services in the past year: dental services (32%), specialty care (28%), primary care (24%), obstetrics/ gynecology (18%), cardiac care (10%), orthopedic care (10%), pediatric care (8%), cancer care (7%), pediatric therapies (4%), mental health care/counseling (3%), addiction services (2%), hospice/palliative care (1%), and other services (13%).

Ottawa County adults had the following issues regarding their health care coverage: deductibles were too high (39%), premiums were too high (29%), co-pays were too high (26%), high HSA account deductible (10%), opted out of certain coverage because they could not afford it (9%), could not understand their insurance plan (7%), working with their insurance company (6%), opted out of certain coverage because they did not need it (3%), and did not know how to sign up or enroll (1%).

The following graph shows the percentages of Ottawa County adults who were uninsured by demographic. Examples of how to interpret the information in the graph include: 7% of all Ottawa County adults were uninsured, including 8% of adults with incomes less than $25,000 and 10% of adults ages 30-64. The pie chart below shows sources of Ottawa County adults' health care coverage.



Adult Comparisons	Ottawa County 2006	Ottawa County 2012	Ottawa County 2017	Ohio 2018	U.S. 2018
Uninsured	6%	12%	7%	7%	11%

Gaps and Potential Strategies

Following the key issues activity and priority selection, the committee discussed gaps surrounding the selected priority areas. The committee discussed potential strategies or areas of improvement to bridge those gaps. Following this exercise, additional strategies were discussed and noted if they met any of the following criteria: evidence based, likely to decrease disparities, alignment with the state health improvement plan, and alignment with the 2018-2021 Ottawa County Community Health Improvement Plan (CHIP).

Gaps and potential strategies around access to care can be identified below.

Gaps	Potential Strategies
1. Percentage of adults going outside of county for care	• More availability of specialists in the county (financial incentives for health professionals serving underserved areas) • Telehealth • Doctor's office should have one day that they stay open past 4 or 5 pm so adults do not go to out of town doctors for care
2. Adults not going to primary care physician for annual check up	• Telehealth • Offer free screenings/services at community event
3. Uninsured or under-insured adults	• Assistance in health care enrollment – give all patients without insurance the resources to obtain insurance – a lot of people do not know what is available to them • Utilizing Senior Centers to make sure seniors are insured • Offer free screenings/services at community events
4. Breast Screening (54% in Ottawa County vs. 74% OH and 72% US)	• Improve Magruder technology to 3D and seek funding opportunities/advertise as such
5. No Labor and Delivery and limited prenatal care in Ottawa County	• Offer delivery services at a local hospital
6. Physicians not accepting new patients/ health care providers not available	• More physicians in the area or create a "one-stop shop" facility for people to get all of their health care needs
7. Location of Hospital not in the middle of the county	• Proposed satellite offices in the middle of the county

Best Practices

The planning committee reviewed best practices for potential inclusion in the action plan. The following programs and policies have been reviewed and have proven strategies to **improve access to care:**

Health insurance enrollment outreach and support programs assist individuals whose employers do not offer affordable coverage, who are self-employed, or unemployed with health insurance needs. Such programs can be offered by a variety of organizations, including government agencies, schools, community-based or non-profit organizations, health care organizations, and religious congregations. Outreach activities vary greatly and can include community health worker (CHW) efforts, other person-to-person outreach, mass media and social media campaigns, school-based efforts, case management, or efforts in health care settings. Outreach can occur at local events, via hotlines, or at fixed locations (e.g., community centers, non-profit offices, etc.) and are often supported through grants from federal agencies or private foundations.

Expected Beneficial Outcomes

- Increased health insurance coverage
- Increased awareness of health insurance availability

(Source: County Health Rankings, What Works for Health, 2020)

Action Step Recommendations & Plan

To improve **access to care**, the following strategies are recommended:

1. Health insurance enrollment and outreach √

<table>
<tr><th colspan="5">Priority Factor: Access to Care</th></tr>
<tr><td colspan="5">Strategy 1: Health insurance enrollment outreach and support √</td></tr>
<tr><th>Action Step</th><th>Priority Outcome & Indicator</th><th>Priority Population</th><th>Person/ Agency Responsible</th><th>Timeline</th></tr>
<tr><td>Year 1: Research resources available to assist consumers navigate the Health Insurance Marketplace and enroll uninsured residents.
Determine outreach methods (i.e., social media campaigns, school-based efforts, community events, health care settings, etc.).
Develop educational materials targeting those most likely to be uninsured. Include information regarding what is included in plans and the value of insurance.</td><td rowspan="3">Priority Outcomes:
1. Increase health insurance coverage

Priority Indicators:
1. Percent of adults who were uninsured</td><td rowspan="3">Adult</td><td rowspan="3">Magruder Hospital</td><td>November 1, 2021</td></tr>
<tr><td>Year 2: Continue efforts from year 1.</td><td>November 1, 2022</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2.</td><td>November 1, 2023</td></tr>
</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 quarterly to report out on action steps. The full committee will meet yearly to report out the progress. The committee will form a plan to disseminate the Implementation 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.

Magruder Hospital will continue facilitating a Community Health Needs Assessments 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 region, state, 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 within each strategy.

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 IP 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 planning 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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Written comments:

Individuals are encouraged to submitted written comments, questions or other feedback about the Magruder Hospital Implementation Plan to **rfall@magruderhospital.com**.