

2024-2027 Lucas County Community Health Improvement Plan

Released January 2025

HEALTHY LUCAS COUNTY

Table of Contents

Executive Summary 2
- Community Partners 4
- Vision and Mission 5
- Public Health Accreditation Board (PHAB) Requirements 5
- Inclusion of Vulnerable Populations (Health Disparities) 5
- Mobilizing for Action through Planning and Partnerships (MAPP) 5
- Alignment with Regional, State, and National Standards 6
- Community Health Improvement Planning Process 9
- Recommended Action Steps 10

Community Health Needs Assessment & Trend Summaries 11
Key Issues 36
Priorities Chosen 41
Community Themes and Strengths Assessment (CTSA) 42
- Open-ended Questions to the Participants 42
- Quality of Life Survey 46
- Quality of Life Survey, continued 49

Forces of Change Assessment 50
Local Public Health System Assessment 56
Gap Analysis, Strategy Selection, Evidence-Based Practices, Resources, and Terminology 58
Priority Health Outcome #1: Mental Health and Addiction 60
Priority Health Outcome #2: Chronic Disease 62
Priority Health Outcome #3: Maternal and Infant Health 64
Priority Factor #1: Community Conditions 66
Priority Factor #2: Health Behaviors 68
Priority Factor #3: Access to Care 70
Progress and Measuring Outcomes 72
Appendix I: Gaps and Potential Strategies 73
Appendix II: Links to Websites 79

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

Executive Summary

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

The Healthy Lucas County community health improvement coalition is pleased to release the 2024-2027 Lucas County Community Health Improvement Plan (CHIP). The plan outlines strategies, priorities and action steps to improve community health and wellbeing among Lucas County residents. Many sources of information concerning the health and social challenges that Lucas County adults, youth and children may be facing were reviewed – including the 2022/2023 Lucas County Community Health Assessment (CHA) – before priority issues were selected. Three priority outcomes (mental health and addiction, chronic disease, maternal & infant health) and three priority factors (community conditions, health behaviors, access to care), all of which focus on achieving health equity and align perfectly with state and national priorities. The Healthy Lucas County Executive Committee leadership has recommended specific actions steps that they hope many agencies, organizations, and coalitions will embrace to address the priority outcomes and priority factor in the next three years. Each strategy has at least one coordinating agency, which will work with all partners and track progress with policies, environment and systems change. **The specific strategies begin on page 60**.

In 1999, Healthy Lucas County began conducting community health assessments (CHA) to measure and address health status. The most recent assessment, released in December 2023, was cross-sectional in nature and included a written survey of adults, youth, and children within Lucas County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention (CDC) for the national and state Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), and National Survey of Children's Health (NSCH). This has allowed Lucas County to compare the data collected in the Lucas County CHA to national, state and local health trends.

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

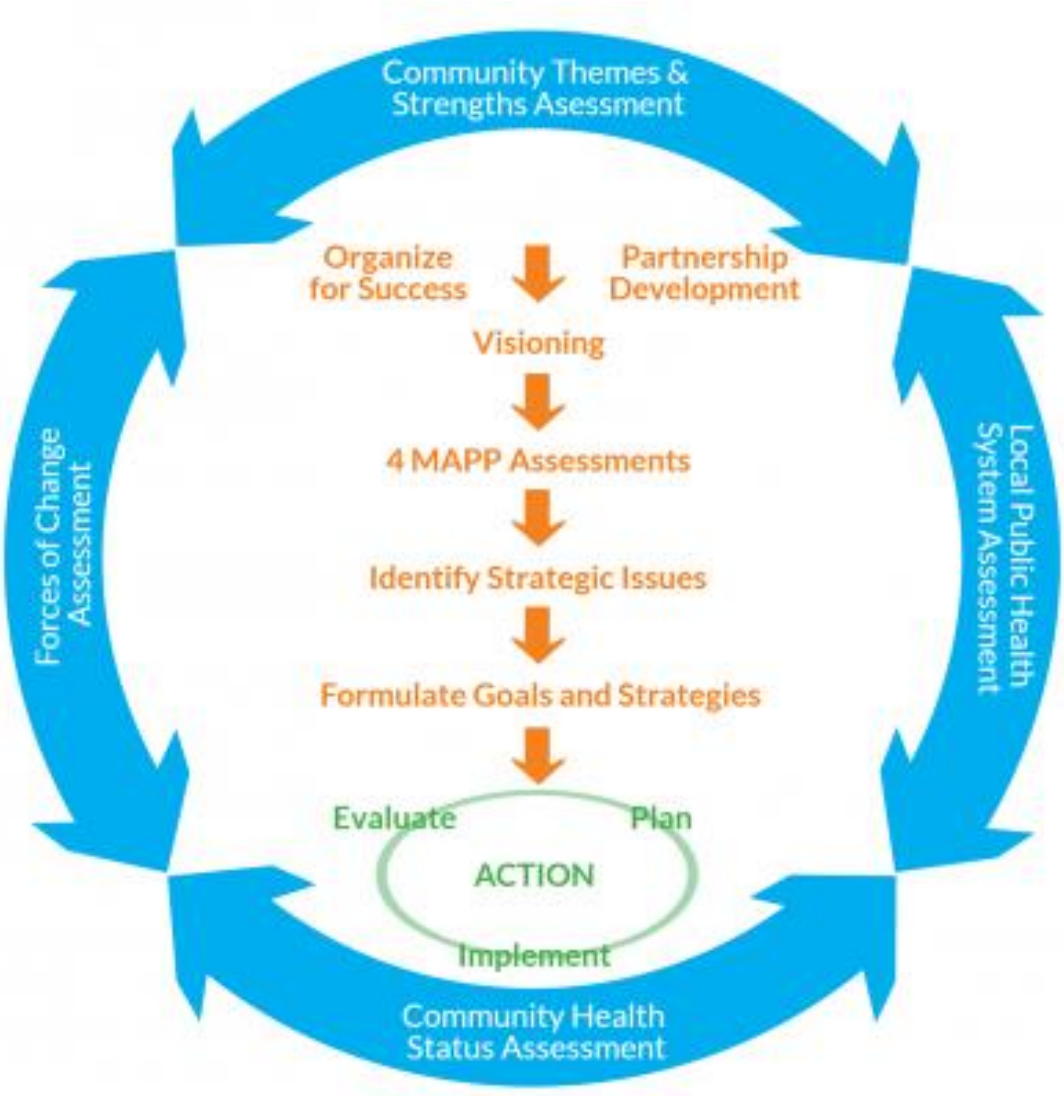
From the beginning phases of the CHA, community leaders were actively engaged in the planning process and helped define the content, scope, and sequence of the project. Active engagement of community members throughout the planning process is regarded as an important step in completing a valid needs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

The Lucas County CHA has been utilized as a vital tool for creating the Lucas County CHIP. The Public Health Accreditation Board (PHAB) defines a CHIP as a long-term, systematic effort to address health problems based on 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 Healthy Lucas County Executive Committee contracted with the Hospital Council of Northwest Ohio (HCNO) to facilitate the community health improvement process. Key community leaders and decision makers were invited to participate in an organized planning process to improve the health of Lucas County residents. The National Association of County and City Health Official's (NACCHO) strategic planning tool, Mobilizing for Action through Planning and Partnerships (MAPP), was used throughout this process.

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

Figure 1.1 The MAPP model



Community Partners

The 2024-2027 Lucas County Community Health Improvement Plan was drafted by agencies and service providers within Lucas County. From March 2024 through June 2024, Healthy Lucas County Executive Committee members, proxies, and partners reviewed many sources of information concerning the health and social challenges that Lucas County adults, youth and children may be facing. They determined strategies and priority issues, which if addressed, could improve future outcomes; determined gaps in current programming and policies; and examined best practices and solutions. The Healthy Lucas County Executive Committee has approved the plan and is recommending specific actions steps that they hope many agencies and organizations will embrace to address the strategies and priority issues in the coming months and years.

Healthy Lucas County Executive Committee

Advocates for Basic Legal Equality
Advocating Opportunity
Anthem BCBS
Area Office on Aging of Northwestern Ohio
City of Toledo
CWA Local 4319
Family and Child Abuse Prevention Center
Greater Toledo Community Foundation
Hospital Council of Northwest Ohio
Kidney Foundation of Northwest Ohio
Latino Alliance
Lucas County Department of Job & Family Services
Lucas County Suicide Prevention Coalition
Medical-Legal Partnership for Children
Mental Health & Recovery Services Board of Lucas County
Mercy Health
NAACP 3204
Ohio State University Extension
ProMedica
Ronald McDonald House Charities of Northwest Ohio
Sofia Quintero Arts & Cultural Center
The University Church
Toledo/Lucas County CareNet
Toledo-Lucas County Health Department
Toledo Lucas County Homelessness Board
Toledo Public Schools
United Way of Greater Toledo
University of Toledo Medical Center
Wood County Educational Service Center
YMCA of Greater Toledo
YWCA of Northwest Ohio

The community health improvement planning process was facilitated by Gabrielle (Gabbey) Mackinnon, MPH, Community Health Improvement Manager, and Jodi Franks, MPH, Community Health Improvement Manager, from the Hospital Council of Northwest Ohio.

Vision and Mission

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

The Mission of Healthy Lucas County

Healthy Lucas County's mission is to enhance the health and quality of life for Lucas County residents through data and collaborative partnerships to plan and implement strategies that promote equitable and optimal health.

The Vision of Healthy Lucas County

The vision of Healthy Lucas County is to unite for greater health and health equity for all Lucas County residents.

Public Health Accreditation Board (PHAB) Requirements

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

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

Inclusion of Vulnerable Populations (Health Disparities)

Approximately 19.1% of Lucas County residents were below the poverty line, according to the Ohio Poverty Report, 5-year averages 2014-2018. For this reason, data is broken down by income (less than $25,000 a year and greater than $25,000 a year throughout the report to show disparities. Sections and trend summary tables were created for the African American and Latino populations to identity disparities among the African American and Latino communities.

Mobilizing for Action through Planning and Partnerships (MAPP)

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

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

Alignment with Regional, State, and National Standards

The 2024-2027 Lucas County Community Health Improvement Plan priorities align perfectly with regional, state and national priorities. Lucas County will be addressing the following priority health outcomes: chronic disease, mental health and addiction, and maternal and infant health. Additionally, Lucas County will be addressing the following priority health factors: community conditions, health behaviors, and access to care. All priorities will focus on achieving health equity.

Healthy People 2030

Lucas County's priorities also fit specific Healthy People 2030 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 2030** for a complete list of goals and objectives.

Ohio State Health Improvement Plan (SHIP)

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

The SHIP includes a strategic set of measurable outcomes that the state will monitor on an annual basis. Given that the overall goal of the SHIP is to ensure all Ohioans 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 Lucas County CHIP was required to select at least 1 priority factor, 1 priority health outcome, 1 indicator for each identified priority, and 1 strategy for each selected priority to align with the 2020-2022 SHIP.

Note: This symbol  will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2020-2022 SHIP. Whenever possible, the Lucas County CHIP identifies strategies likely to reduce disparities and inequities. This symbol √ will be used throughout the report when a strategy is

identified as likely to reduce disparities and inequities. Throughout the report, hyperlinks will be highlighted in **bold, gold text**.

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

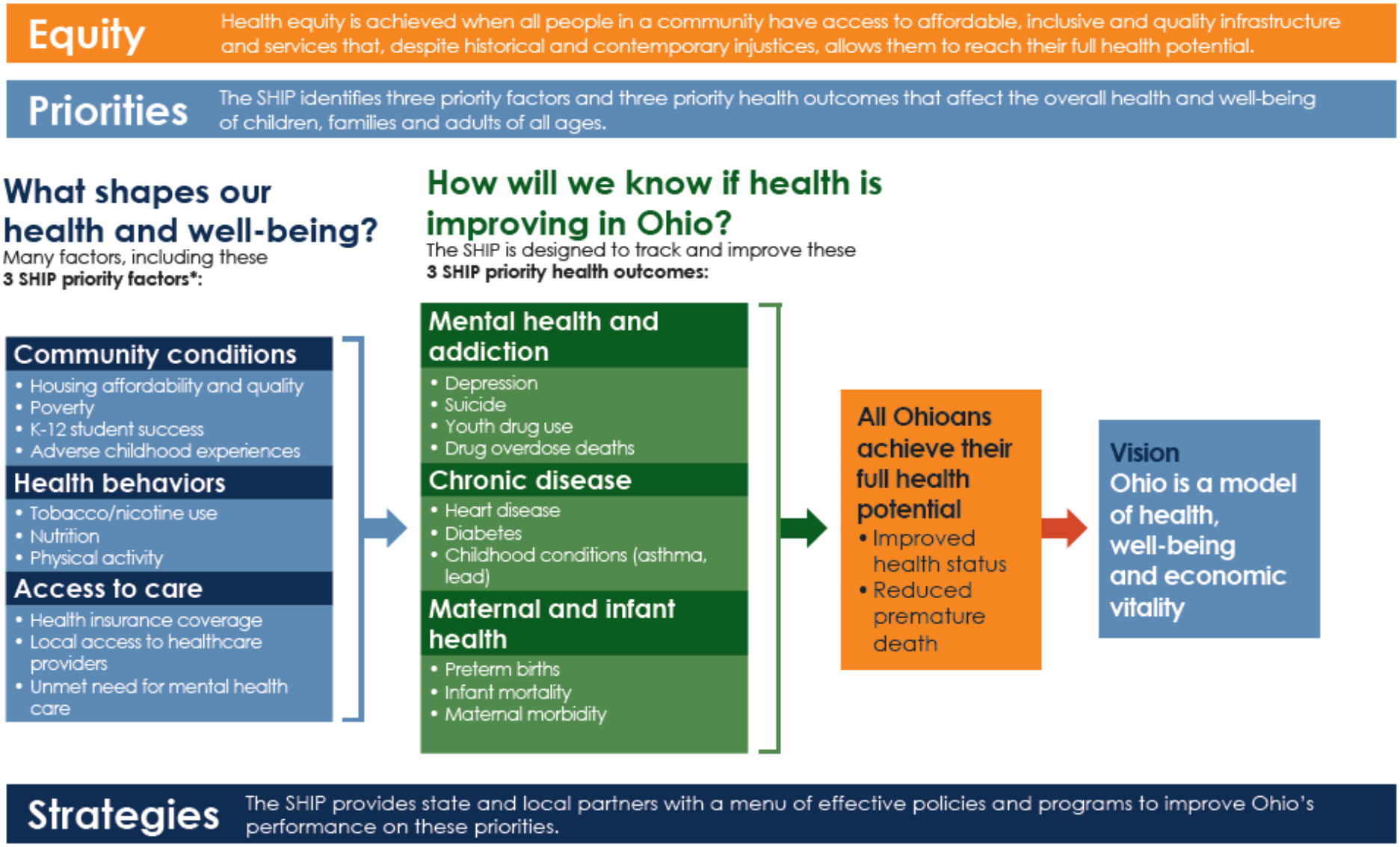
Figure 1.2: 2024-2027 Lucas County CHIP Alignment with the 2020-2022 SHIP

Priority Health Outcomes	Priority Indicators	Strategies to Impact Priority Indicators	Additional Aligned Strategies
Mental Health and Addiction	• Reduce suicide deaths	• Mental health education	• School-based social and emotional instruction
Chronic Disease	• Reduce diabetes • Reduce hypertension	• Prediabetes screening and referral • Hypertension screening and referral	• N/A
Maternal and Infant Health	• Reduce infant mortality	• Early childhood home visiting programs and Toledo-Lucas County Getting to 1 • Care coordination and access to well-woman care	• N/A
Priority Factors	**Priority Indicators**	**Strategies to Impact Priority Indicators**	**Additional Aligned Strategies**
Community Conditions	• Reduce adverse childhood experiences (ACEs) • Improve housing affordability and quality	• Housing Choice Voucher Program	• N/A
Health Behaviors	• N/A	• N/A	• N/A
Access to Care	• N/A	• N/A	• N/A

N/A – Not Available

Alignment with National and State Standards, continued

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



Community Health Improvement Planning Process

Beginning in March 2024, Healthy Lucas County met four (4) times and completed the following planning steps:

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

Recommended Action Steps

All of the recommended action steps focus on achieving health equity:

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

1. School-based social and emotional instruction
2. Mental health education

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

1. Prediabetes screening and referral
2. Hypertension screening and referral

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

1. Early childhood home visiting programs and Toledo-Lucas County Getting to 1 √
2. Care coordination and access to well-woman care √

To work toward improving **community conditions**, the following strategies are recommended:

1. Housing Choice Voucher Program √
2. The Toledo Black Agenda

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

1. Exercise prescriptions from health care providers
2. Fruit and vegetable incentive programs √

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

1. County-wide non-emergency transportation coordination
2. Advocate for policies that expand health care coverage and access to affordable health care services

Community Health Needs Assessment & Trend Summaries

Phase 3 of the MAPP process, the 2022/2023 Lucas County Community Health Assessment, or CHA, is a 300+ page report that includes primary data with over 100 indicators and hundreds of data points related health and well-being, including social determinants of health. Over 50 sources of secondary data are also included throughout the report. The CHA serves as the baseline data in determining key issues that lead to priority selection. The full report can be found at **https://lucascountyhealth.com/hlc/**. Below is a summary of county primary data and the respective state and national benchmarks.

***See next page**

Adult Trend Summary

Adult Variables	Lucas County 2007	Lucas County 2011	Lucas County 2014	Lucas County 2017	Lucas County 2020	Lucas County 2023	Ohio 2021	U.S. 2021
Health Status and Coverage								
Rated health as excellent or very good	51%	48%	45%	49%	45%	42%	51%	53%
Rated general health as fair or poor	14%	18%	18%	14%	17%	16%	17%	15%
Rated mental health as not good on four or more days (in the past month)	26%	25%	26%	37%	34%	39%	31%	29%
Rated physical health as not good on four or more days (in the past month)	N/A	N/A	22%	24%	25%	28%	21%	20%
Average number of days that mental health was not good (in the past month) (County Health Rankings)	N/A	N/A	4.3	6.0	5.5	5.9	5.2*	4.5*
Average number of days that physical health not good (in the past month) (County Health Rankings)	N/A	N/A	4.0	4.8	4.2	4.4	4.2*	3.9*
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past month)	N/A	N/A	N/A	35%	35%	42%	N/A	N/A
Uninsured	12%	13%	14%	6%	8%	6%	6%	7%
Visited a doctor for a routine checkup (in the past 12 months)	N/A	N/A	N/A	N/A	N/A	75%	77%	76%
Visited a doctor for a routine checkup (5 or more years ago)	N/A	N/A	N/A	N/A	N/A	8%	5%	5%
Had one or more persons they thought of as their personal health care provider	N/A	N/A	N/A	N/A	N/A	86%	86%	87%
Arthritis, Asthma, and Diabetes								
Ever diagnosed with arthritis	27%	19%	19%	23%	18%	21%	30%	25%
Ever diagnosed with asthma	12%	13%	13%	10%	13%	12%	15%	15%
Ever diagnosed with diabetes	12%	13%	15%	12%	13%	14%	13%	11%
Cardiovascular Health								
Ever diagnosed with angina or coronary heart disease	7%	3%	5%	2%	4%	3%	5%	4%
Ever diagnosed with a heart attack, or myocardial infarction	N/A	3%	5%	5%	4%	3%	5%	4%
Ever diagnosed with a stroke	N/A	2%	3%	3%	3%	3%	4%	3%
Had ever been diagnosed with high blood pressure	35%	34%	37%	34%	39%	38%	36%	32%
Had ever been diagnosed with high blood cholesterol	34%	27%	25%	25%	27%	27%	36%	36%
Had their blood cholesterol checked within the last five years	72%	76%	80%	77%	81%	83%	85%	85%

N/A - Not Available
**2019 BRFSS as compiled by 2022 County Health Rankings*
Indicates alignment with the Ohio State Health Assessment

Adult Trend Summary, *Continued*

Adult Variables	Lucas County 2007	Lucas County 2011	Lucas County 2014	Lucas County 2017	Lucas County 2020	Lucas County 2023	Ohio 2021	U.S. 2021
Weight Status								
Normal weight (BMI of 18.5 – 24.9)	29%	28%	29%	25%	27%	23%	28%	30%
Overweight (BMI of 25.0 – 29.9)	37%	36%	34%	38%	34%	32%	33%	34%
Obese (includes severely and morbidly obese, BMI of 30.0 and above)	33%	35%	36%	36%	38%	43%	38%	34%
Alcohol Consumption								
Current drinker (had at least one drink of alcohol within the past month)	57%	57%	54%	65%	60%	59%	53%	53%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	18%	23%	21%	24%	22%	26%	17%	15%
Drove after having perhaps too much alcohol to drink (in the past month)	N/A	N/A	N/A	8%	12%	10%	3%†	2%†
Tobacco Use								
Current smoker (smoked on some or all days)	23%	24%	19%	14%	15%	12%	18%	14%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	25%	23%	25%	23%	25%	24%	27%	28%
Tried to quit smoking in the past year	85%	75%	74%	50%	56%	60%	50%†	51%†
Used chewing tobacco or snuff in the past year	N/A	N/A	3%	3%	2%	3%	N/A	N/A
Current e-cigarette user (vaped on some or all days)	N/A	N/A	N/A	N/A	4%	9%	8%	7%
Former e-cigarette user	N/A	N/A	N/A	N/A	N/A	14%	N/A	N/A
Drug Use								
Adults who used marijuana in the past six months	9%	11%	10%	12%	7%	6%¥	N/A	N/A
Adults who misused prescription drugs in the past six months	6%	8%	10%	6%	8%	6%	N/A	N/A
Reproductive Health								
Had a clinical breast exam in the past two years (women ages 40 and older)	N/A	N/A	72%	70%	71%	66%	N/A	N/A
Had a mammogram within the past two years (women ages 40 and older)	73%	74%	73%	75%	76%	73%	71%†	72%†
Had a Pap smear in the past three years (women ages 21-65)	77%*	72%*	73%*	68%*	77%	54%	77%†	78%†
Had a PSA test within the past two years (men ages 40 and older)	N/A	N/A	N/A	N/A	N/A	53%	32%†	32%†

N/A - Not Available
†2020 BRFSS Data
¥Updated question in 2023 – adults who used inly recreational marijuana in the past month
**Includes all women regardless of age*
Indicates alignment with the Ohio State Health Assessment

Adult Trend Summary, *Continued*

Adult Variables	Lucas County 2007	Lucas County 2011	Lucas County 2014	Lucas County 2017	Lucas County 2020	Lucas County 2023	Ohio 2021	U.S. 2021
Quality of Life								
Limited in some way because of physical, mental, or emotional problem	42%	N/A	47%	43%	37%	51%	N/A	N/A
Mental Health								
Considered attempting suicide in the past year	3%	3%	3%	2%	5%	4%	N/A	N/A
Oral Health								
Visited a dentist or a dental clinic (within the past year)	66%	68%	66%	64%	64%	63%	65%†	66%†

Indicates alignment with the Ohio State Health Assessment
N/A - Not Available
† *2020 BRFSS Data*

Minority Adult Trend Summary

Adult Variables	Lucas County Whites 2023	Lucas County Latinos 2023	Lucas County African American 2023	Lucas County 2023	Ohio 2021	U.S. 2021
Health Status and Coverage						
Rated health as excellent or very good	48%	35%	34%	42%	51%	53%
Rated general health as fair or poor	13%	19%	19%	16%	17%	15%
Rated mental health as not good on four or more days (in the past month)	35%	46%	51%	39%	31%	29%
Rated physical health as not good on four or more days (in the past month)	25%	35%	32%	28%	21%	20%
Average number of days that mental health was not good (in the past month) (County Health Rankings)	5.6	7.1	6.7	5.9	5.2*	4.5*
Average number of days that physical health not good (in the past month) (County Health Rankings)	4.5	5.6	4.0	4.4	4.2*	3.9*
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past month)	26%	45%	47%	42%	N/A	N/A
Uninsured	4%	3%	12%	6%	6%	7%
Visited a doctor for a routine checkup (in the past 12 months)	76%	69%	72%	75%	77%	76%
Visited a doctor for a routine checkup (5 or more years ago)	9%	5%	5%	8%	5%	5%
Had one or more persons they thought of as their personal health care provider	89%	82%	80%	86%	86%	87%
Arthritis, Asthma, and Diabetes						
Ever diagnosed with arthritis	21%	15%	21%	21%	30%	25%
Ever diagnosed with asthma	12%	14%	14%	12%	15%	15%
Ever diagnosed with diabetes	12%	19%	13%	14%	13%	11%

N/A - Not Available
**2019 BRFSS as compiled by 2022 County Health Rankings*
Indicates alignment with the Ohio State Health Assessment

Minority Adult Trend Summary, *Continued*

Adult Variables	Lucas County Whites 2023	Lucas County Latinos 2023	Lucas County African American 2023	Lucas County 2023	Ohio 2021	U.S. 2021
Cardiovascular Health						
Ever diagnosed with angina or coronary heart disease	3%	4%	3%	3%	5%	4%
Ever diagnosed with a heart attack, or myocardial infarction	3%	2%	3%	3%	5%	4%
Ever diagnosed with a stroke	3%	3%	3%	3%	4%	3%
Had ever been diagnosed with high blood pressure	37%	32%	41%	38%	36%	32%
Had ever been diagnosed with high blood cholesterol	30%	22%	24%	27%	36%	36%
Had their blood cholesterol checked within the last five years	84%	71%	84%	83%	85%	85%
Weight Status						
Normal weight (BMI of 18.5 – 24.9)	26%	19%	18%	23%	28%	30%
Overweight (BMI of 25.0 – 29.9)	37%	29%	23%	32%	33%	34%
Obese (includes severely and morbidly obese, BMI of 30.0 and above)	36%	50%	57%	43%	38%	34%
Alcohol Consumption						
Current drinker (had at least one drink of alcohol within the past month)	58%	61%	64%	59%	53%	53%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	25%	29%	31%	26%	17%	15%
Drove after having perhaps too much alcohol to drink (in the past month)	8%	8%	11%	10%	3%†	2%†
Tobacco Use						
Current smoker (smoked on some or all days)	12%	5%	14%	12%	18%	14%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	30%	20%	9%	24%	27%	28%
Tried to quit smoking in the past year	35%	67%	76%	60%	50%†	51%†
Used chewing tobacco or snuff in the past year	4%	1%	0%	3%	N/A	N/A
Current e-cigarette user (vaped on some or all days)	9%	14%	9%	9%	8%	7%
Former e-cigarette user	14%	16%	13%	14%	N/A	N/A

N/A - Not Available
†2018 BRFSS Data
Indicates alignment with the Ohio State Health Assessment

Minority Adult Trend Summary, *Continued*

Adult Variables	Lucas County Whites 2023	Lucas County Latinos 2023	Lucas County African American 2023	Lucas County 2023	Ohio 2021	U.S. 2021
Drug Use						
Adults who used marijuana in the past six months	6%¥	4%¥	9%¥	6%¥	N/A	N/A
Adults who misused prescription drugs in the past six months	6%	9%	6%	6%	N/A	N/A
Reproductive Health						
Had a clinical breast exam in the past two years (women ages 40 and older)	68%	65%	76%	66%	N/A	N/A
Had a mammogram within the past two years (women ages 40 and older)	75%	82%	75%	73%	71%†	72%†
Had a Pap smear in the past three years (women ages 21-65)	57%	63%	60%	54%	77%†	78%†
Had a PSA test within the past two years (men ages 40 and older)	46%	46%	60%	53%	32%†	32%†
Quality of Life						
Limited in some way because of physical, mental, or emotional problem	50%	53%	50%	51%	N/A	N/A
Mental Health						
Considered attempting suicide in the past year	4%	9%	3%	4%	N/A	N/A
Oral Health						
Visited a dentist or a dental clinic (within the past year)	68%	61%	57%	63%	65%†	66%†

N/A – Not Available
† 2020 BRFSS Data
¥ Updated question in 2023 – adults who used only recreational marijuana in the past month

Latino Adult Trend Summary

Adult Variables	Lucas County Latinos 2007	Lucas County Latinos 2011	Lucas County Latinos 2014	Lucas County Latinos 2017	Lucas County Latinos 2020	Lucas County Latinos 2023	Ohio Latinos 2021	U.S. Latinos 2021
Health Status and Coverage								
Rated health as excellent or very good	55%	38%	39%	29%	45%	35%	51%	42%
Rated general health as fair or poor	15%	20%	17%	25%	15%	19%	N/A	22%
Rated their mental health as not good on four or more days (in the past month)	23%	33%	38%	34%	33%	46%	N/A	N/A
Rated physical health as not good on four or more days (in the past month)	19%	32%	20%	34%	23%	35%	N/A	N/A
Average number of days that mental health was not good (in the past month) (County Health Rankings)	N/A	N/A	N/A	6.5	4.9	7.1	N/A	N/A
Average number of days that physical health not good (in the past month) (County Health Rankings)	N/A	N/A	N/A	7.5	3.5	5.6	N/A	N/A
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past month)	N/A	N/A	N/A	41%	27%	45%	N/A	N/A
Uninsured	13%	17%	19%	10%	10%	3%	27%	23%
Visited a doctor for a routine checkup (in the past 12 months)	N/A	N/A	N/A	N/A	N/A	69%	71%	66%
Visited a doctor for a routine checkup (5 or more years ago)	N/A	N/A	N/A	N/A	N/A	5%	9%	6%
Had one or more persons they thought of as their personal health care provider	N/A	N/A	N/A	N/A	N/A	82%	70%	69%
Arthritis, Asthma, and Diabetes								
Ever diagnosed with arthritis	18%	15%	13%	20%	11%	15%	16%	14%
Ever diagnosed with asthma	13%	13%	15%	7%	13%	14%	15%	13%
Ever diagnosed with diabetes	11%	17%	21%	16%	13%	19%	13%	12%
Cardiovascular Health								
Ever diagnosed with angina or coronary heart disease	4%	2%	5%	3%	2%	4%	N/A	2%
Ever diagnosed with a heart attack, or myocardial infarction	N/A	3%	4%	3%	6%	2%	4%	3%
Ever diagnosed with a stroke	N/A	4%	2%	6%	5%	3%	N/A	2%
Had ever been diagnosed with high blood pressure	21%	33%	28%	33%	32%	32%	24%	24%

N/A - Not Available

Indicates alignment with the Ohio State Health Assessment

Latino Adult Trend Summary, Continued

Adult Variables	Lucas County Latinos 2007	Lucas County Latinos 2011	Lucas County Latinos 2014	Lucas County Latinos 2017	Lucas County Latinos 2020	Lucas County Latinos 2023	Ohio Latinos 2021	U.S. Latinos 2021
Cardiovascular Health, continued								
Had ever been diagnosed with high blood cholesterol	29%	25%	17%	17%	21%	22%	27%	31%
Had their blood cholesterol checked within the last five years	64%	68%	73%	69%	82%	71%	76%	83%
Weight Status								
Normal weight (BMI of 18.5 – 24.9)	30%	21%	21%	20%	17%	19%	26%	25%
Overweight (BMI of 25.0 – 29.9)	35%	37%	30%	38%	29%	29%	39%	36%
Obese (includes severely and morbidly obese, BMI of 30.0 and above)	33%	42%	49%	42%	51%	50%	35%	37%
Alcohol Consumption								
Current drinker (had at least one drink of alcohol within the past month)	47%	57%	51%	57%	53%	61%	55%	47%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	N/A	29%	25%	41%	37%	29%	23%	17%
Drove after having perhaps too much alcohol to drink (in the past month)	N/A	N/A	N/A	6%	12%	8%	N/A	4%†
Tobacco Use								
Current smoker (smoked on some or all days)	26%	25%	11%	26%	14%	5%	19%	11%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	18%	17%	22%	19%	30%	20%	16%	16%
Tried to quit smoking in the past year	N/A	N/A	N/A	41%	42%	67%	N/A	64%†
Used chewing tobacco or snuff in the past year	N/A	N/A	N/A	1%	1%	1%	N/A	N/A
Current e-cigarette user (vaped on some or all days)	N/A	N/A	N/A	N/A	N/A	14%	N/A	N/A
Former e-cigarette user	N/A	N/A	N/A	N/A	N/A	16%	N/A	N/A
Drug Use								
Adults who used marijuana in the past six months	10%	10%	11%	9%	7%	4%¥	N/A	N/A
Adults who misused prescription drugs in the past six months	4%	7%	11%	6%	6%	9%	N/A	N/A

N/A - Not Available
† 2020 BRFSS Data
¥ Updated question in 2023 – adults who used only recreational marijuana in the past month
Indicates alignment with the Ohio State Health Assessment

Latino Adult Trend Summary, Continued

Adult Variables	Lucas County Latinos 2007	Lucas County Latinos 2011	Lucas County Latinos 2014	Lucas County Latinos 2017	Lucas County Latinos 2020	Lucas County Latinos 2023	Ohio Latinos 2021	U.S. Latinos 2021
Reproductive Health								
Had a clinical breast exam in the past two years (women ages 40 and older)	77%	64%	70%	69%	87%	65%	N/A	N/A
Had a mammogram within the past two years (women ages 40 and older)	67%	74%	80%	64%	94%	82%	66%†	68%†
Had a Pap smear in the past three years (women ages 21-65)	N/A	N/A	62%*	69%*	89%	63%	77%†	77%†
Had a PSA test within the past two years (men ages 40 and older)	N/A	N/A	N/A	N/A	N/A	46%	N/A	22%†
Quality of Life								
Limited in some way because of physical, mental, or emotional problem	41%	N/A	46%	40%	35%	53%	N/A	N/A
Mental Health								
Considered attempting suicide in the past year	N/A	7%	8%	7%	4%	9%	N/A	N/A
Oral Health								
Visited a dentist or a dental clinic (within the past year)	68%	56%	61%	39%	58%	61%	61%†	56%†

Indicates alignment with the Ohio State Health Assessment
N/A - Not Available
†2020 BRFSS Data
**Includes all women regardless of age*

African American Adult Trend Summary

Adult Variables	Lucas County African Americans 2007	Lucas County African Americans 2011	Lucas County African Americans 2014	Lucas County African Americans 2017	Lucas County African Americans 2020	Lucas County African Americans 2023	Ohio African Americans 2021	U.S. African Americans 2021
Health Status and Coverage								
Rated health as excellent or very good	37%	36%	29%	44%	36%	34%	42%	45%
Rated general health as fair or poor	25%	26%	29%	20%	25%	19%	21%	20%
Rated their mental health as not good on four or more days in the previous month	30%	29%	32%	33%	43%	51%	N/A	N/A
Rated physical health as not good on four or more days (in the past month)	31%	34%	22%	26%	30%	32%	N/A	N/A
Average number of days that mental health was not good (in the past month) (County Health Rankings)	N/A	N/A	N/A	6.0	6.1	6.7	N/A	N/A
Average number of days that physical health not good (in the past month) (County Health Rankings)	N/A	N/A	N/A	6.5	4.9	4.0	N/A	N/A
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past month)	N/A	N/A	N/A	38%	34%	47%	N/A	N/A
Uninsured	12%	25%	25%	3%	11%	12%	6%	8%
Visited a doctor for a routine checkup (in the past 12 months)	N/A	N/A	N/A	N/A	N/A	72%	81%	81%
Visited a doctor for a routine checkup (5 or more years ago)	N/A	N/A	N/A	N/A	N/A	5%	6%	3%
Had one or more persons they thought of as their personal health care provider	N/A	N/A	N/A	N/A	N/A	80%	84%	85%
Arthritis, Asthma, and Diabetes								
Ever diagnosed with arthritis	31%	22%	18%	22%	23%	21%	27%	26%
Ever diagnosed with asthma	15%	14%	15%	14%	19%	14%	17%	17%
Ever diagnosed with diabetes	22%	17%	21%	22%	15%	13%	13%	16%

N/A – Not Available

Indicates alignment with the Ohio State Health Assessment

African American Adult Trend Summary, *Continued*

Adult Variables	Lucas County African Americans 2007	Lucas County African Americans 2011	Lucas County African Americans 2014	Lucas County African Americans 2017	Lucas County African Americans 2020	Lucas County African Americans 2023	Ohio African Americans 2021	U.S. African Americans 2021
Cardiovascular Health								
Ever diagnosed with angina or coronary heart disease	10%	1%	5%	2%	5%	3%	3%	3%
Ever diagnosed with a heart attack, or myocardial infarction	N/A	1%	8%	4%	5%	3%	3%	4%
Ever diagnosed with a stroke	N/A	2%	4%	6%	4%	3%	4%	5%
Had ever been diagnosed with high blood pressure	54%	44%	49%	44%	55%	41%	42%	43%
Had ever been diagnosed with high blood cholesterol	37%	21%	23%	24%	31%	24%	29%	33%
Had their blood cholesterol checked within the last five years	75%	69%	79%	68%	84%	84%	88%	89%
Weight Status								
Normal weight (BMI of 18.5 – 24.9)	18%	24%	23%	14%	21%	18%	23%	24%
Overweight (BMI of 25.0 – 29.9)	37%	28%	35%	27%	34%	23%	33%	32%
Obese (includes severely and morbidly obese, BMI of 30.0 and above)	44%	47%	39%	58%	45%	57%	43%	43%
Alcohol Consumption								
Current drinker (had at least one drink of alcohol within the past month)	40%	43%	46%	42%	46%	64%	53%	48%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	N/A	21%	21%	32%	20%	31%	18%	12%
Drove after having perhaps too much alcohol to drink (in the past month)	N/A	N/A	N/A	7%	5%	11%	N/A	2%†
Drug Use								
Adults who used marijuana in the past six months	9%	17%	20%	7%	11%	9%¥	N/A	N/A
Adults who misused prescription drugs in the past six months	10%	8%	11%	11%	9%	6%	N/A	N/A

N/A - Not Available

Indicates alignment with the Ohio State Health Assessment

† 2020 BRFSS Data

¥ Updated questions in 2023 – adults who used only recreational marijuana in the past month

African American Adult Trend Summary, *Continued*

Adult Variables	Lucas County African Americans 2007	Lucas County African Americans 2011	Lucas County African Americans 2014	Lucas County African Americans 2017	Lucas County African Americans 2020	Lucas County African Americans 2023	Ohio African Americans 2021	U.S. African Americans 2021
Tobacco Use								
Current smoker (smoked on some or all days)	26%	25%	33%	17%	21%	14%	20%	16%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	20%	17%	15%	18%	18%	9%	17%	16%
Tried to quit smoking in the past year	N/A	N/A	N/A	67%	63%	76%	60%†	64%†
Used chewing tobacco or snuff in the past year	N/A	N/A	N/A	1%	3%	0%	N/A	N/A
Current e-cigarette user (vaped on some or all days)	N/A	N/A	N/A	N/A	3%	9%	N/A	N/A
Former e-cigarette user	N/A	N/A	N/A	N/A	N/A	13%	N/A	N/A
Reproductive Health								
Had a clinical breast exam in the past two years (women ages 40 and older)	78%	79%	74%	81%	68%	76%	N/A	N/A
Had a mammogram within the past two years (women ages 40 and older)	78%	76%	79%	80%	76%	75%	75%†	79%†
Had a Pap smear in the past three years (women ages 21-65)	N/A	N/A	78%*	77%*	77%	60%	85%†	83%†
Had a PSA test within the past two years (men ages 40 and older)	N/A	N/A	N/A	N/A	N/A	60%	23%†	30%†
Quality of Life								
Limited in some way because of physical, mental, or emotional problem	53%	N/A	49%	56%	45%	50%	N/A	N/A
Mental Health								
Considered attempting suicide in the past year	N/A	3%	5%	2%	9%	3%	N/A	N/A
Oral Health								
Visited a dentist or a dental clinic (within the past year)	55%	60%	51%	63%	44%	57%	59%†	60%†

N/A - Not Available
† 2020 BRFSS Data
**Includes all women regardless of age*
Indicates alignment with the Ohio State Health Assessment

Youth Trend Summary

Youth Variables	Lucas County 2022 (6th-12th)	Lucas County 2011 (9th-12th)	Lucas County 2013/14 (9th-12th)	Lucas County 2016/17 (9th-12th)	Lucas County 2019 (9th-12th)	Lucas County 2022 (9th –12th)	Ohio 2021 (9th-12th)	U.S. 2021 (9th-12th)
Weight Control								
Obese	20%	15%	13%	15%	19%	18%	19%	16%
Overweight	16%	11%	11%	12%	12%	19%	13%	16%
Described themselves as slightly or very overweight	27%	25%	25%	30%	33%	27%	N/A	32%
Exercised to lose weight (in the past month)	35%	43%	48%	42%	36%	45%	N/A	N/A
Ate less food, fewer calories, or foods lower in fat to lose weight (in the past month)	29%	28%	31%	26%	30%	28%	N/A	N/A
Went without eating for 24 hours or more (in the past month)	9%	7%	6%	4%	6%	7%	N/A	N/A
Took diet pills, powders, or liquids without a doctor's advice (in the past month)	1%	3%	2%	1%	2%	2%	N/A	N/A
Vomited or took laxatives (in the past month)	3%	3%	3%	1%	3%	5%	N/A	N/A
Ate one to four servings of fruits and vegetables per day	61%	82%	81%	87%	70%	69%	N/A	N/A
Physically active at least 60 minutes per day on every day in past week	21%	28%	28%	23%	20%	26%	26%	24%
Physically active at least 60 minutes per day on five or more days in past week	35%	43%	50%	44%	40%	45%	49%	45%
Did not participate in at least 60 minutes of physical activity on any day in the past week	29%	15%	15%	14%	18%	20%	16%	16%
Watched three or more hours of television (on an average school day)	33%	40%	34%	18%	18%	31%	N/A	N/A

N/A – Not Available

Indicates alignment with the Ohio State Health Assessment

Youth Trend Summary, *Continued*

Youth Variables	Lucas County 2022 (6th-12th)	Lucas County 2011 (9th-12th)	Lucas County 2013/14 (9th-12th)	Lucas County 2016/17 (9th-12th)	Lucas County 2019 (9th-12th)	Lucas County 2022 (9th –12th)	Ohio 2021 (9th-12th)	U.S. 2021 (9th-12th)
Unintentional Injuries and Violence								
Were in a physical fight (in past year)	38%	28%	25%	23%	26%	25%	N/A	18%
Carried a weapon on school property (in the past month)*	7%	N/A	9%	N/A	2%	5%	N/A	3%
Threatened or injured with a weapon on school property (in past year)	10%	N/A	7%	7%	8%	8%	N/A	7%
Ever purposefully hurt themselves	32%	23%	10%	N/A	31%	29%	N/A	N/A
Did not go to school because they felt unsafe (at school or on their way to or from school in the past 30 days)	18%	6%	6%	4%	17%	15%	9%	9%
Electronically bullied (in past year)	11%	15%	12%	12%	11%	10%	19%	16%
Bullied (in past year)	35%	43%	38%	35%	33%	23%	N/A	N/A
Bullied on school property (in past year)	31%	N/A	22%	17%	17%	19%	20%	15%
Mental Health								
Seriously considered attempting suicide (in the past year)	11%	16%	18%	14%	19%	13%	22%	22%
Attempted suicide (in past year)	8%	4%	8%	8%	11%	8%	10%	10%
Suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (during the past year)	6%	N/A	N/A	N/A	N/A	7%	2%	3%
Felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities in the past 12 months)	34%	24%	29%	29%	45%	32%	43%	42%
Alcohol Consumption								
Current drinker (at least one drink of alcohol on at least one day during the past month)	12%	39%	28%	27%	19%	21%	26%	29%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion within the past 30 days)	7%	23%	21%	13%	12%	14%	13%	14%
Obtained the alcohol they drank by someone giving it to them (of youth drinkers)	43%	21%	14%	N/A	31%	46%	N/A	41%

N/A – Not Available

Indicates alignment with the Ohio State Health Assessment

**2022 indicator wording was slightly different than previous surveys – please use caution when interpreting comparison data*

Youth Trend Summary, *Continued*

Youth Variables	Lucas County 2022 (6th-12th)	Lucas County 2011 (9th-12th)	Lucas County 2013/14 (9th-12th)	Lucas County 2016/17 (9th-12th)	Lucas County 2019 (9th-12th)	Lucas County 2022 (9th-12th)	Ohio 2021 (9th-12th)	U.S. 2021 (9th-12th)
Alcohol Consumption, Continued								
Rode with a driver who had been drinking alcohol (in a car or other vehicle on one or more occasion during the past month)	20%	25%	21%	19%	14%	21%	N/A	17%
Drove when they had been drinking alcohol (of youth drivers on one or more occasion during the past month)	9%	9%	5%	6%	4%	7%	N/A	5%
Drank for the first time before age 13 (of all youth)	15%	18%	12%	8%	8%	12%	16%	15%
Tobacco Use								
Currently smoked cigarettes (on at least one day during the past month)	2%	18%	9%	5%	4%	2%	3%	4%
First tried cigarette smoking before the age of 13 (even one or two puffs)	9%	6%	5%	4%	4%	7%	6%	6%
Currently frequently smoked cigarettes (on 20 or more days during the past month)	<1%	N/A	N/A	2%	1%	1%	1%	1%
Currently used an electronic vapor product (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on at least one day during the past month)	14%	N/A	N/A	N/A	N/A	20%	20%	18%
Usually got their own electronic vapor products by buying them in a store (such as a convenience store, supermarket, discount store, gas station, or vape store, including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, during the past month, among students who currently used electronic vapor products)	11%	N/A	N/A	N/A	N/A	23%	11%	7%

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

Youth Trend Summary, *Continued*

Youth Variables	Lucas County 2022 (6th-12th)	Lucas County 2011 (9th-12th)	Lucas County 2013/14 (9th-12th)	Lucas County 2016/17 (9th-12th)	Lucas County 2019 (9th-12th)	Lucas County 2022 (9th-12th)	Ohio 2021 (9th-12th)	U.S. 2021 (9th-12th)
Tobacco Use, Continued								
Did not try to quit using all tobacco products (including cigarettes, cigars, smokeless tobacco, shisha or hookah tobacco, and electronic vapor products, during the past year, among students who used any tobacco products during the past year)	56%	N/A	N/A	N/A	N/A	48%	N/A	46%
Sexual Behavior								
Ever had sexual intercourse	12%	63%	53%	42%	32%	34%	33%	33%
Participated in anal sex	2%	16%	6%	8%	5%	6%	N/A	N/A
Participated in oral sex	7%	46%	44%	35%	30%	20%	N/A	N/A
Participated in sexting	10%	40%	34%	37%	31%	25%	N/A	N/A
Had viewed pornography	13%	N/A	37%	42%	31%	27%	N/A	N/A
Used a condom (during last sexual intercourse)*	22%	75%	68%	58%	24%	38%	N/A	N/A
Used birth control pills (during last sexual intercourse)*	5%	20%	26%	15%	9%	12%	29%	21%
Used an IUD (during last sexual intercourse)*	1%	8%	7%	1%	7%	4%	8%	8%
Used a shot, patch or birth control ring (during last sexual intercourse)*	0%	8%	7%	3%	5%	0%	43%	42%
Did not use any method to prevent pregnancy during last sexual intercourse*	4%	7%	10%	13%	5%	4%	8%	8%
Had sexual intercourse with four or more persons (of all youth during their life)	3%	27%	21%	15%	8%	9%	N/A	N/A
Had sexual intercourse before the age 13 (for the first time of all youth)	5%	12%	10%	7%	2%	6%	2%	2%

Indicates alignment with the Ohio State Health Assessment
N/A – Not Available
**2022 indicator wording was slightly different than previous surveys – please use caution when interpreting comparison data*
Note – The 2022 sample size for the sexual behavior section is smaller than the full sample as two school districts removed sexual behavior questions

Youth Trend Summary, *Continued*

Youth Variables	Lucas County 2022 (6th-12th)	Lucas County 2011 (9th-12th)	Lucas County 2013/14 (9th-12th)	Lucas County 2016/17 (9th-12th)	Lucas County 2019 (9th-12th)	Lucas County 2022 (9th-12th)	Ohio 2021 (9th-12th)	U.S. 2021 (9th-12th)
Drug Use								
Currently used marijuana (in the past month)	9%	26%	19%	18%	16%	20%	13%	16%
Ever used cocaine (in their lifetime)	2%	4%	3%	2%	<1%	1%	2%	3%
Ever used heroin (in their lifetime)	1%	2%	1%	1%	0%	1%	N/A	1%
Ever used methamphetamines (in their lifetime)	1%	3%	2%	1%	0%	1%	2%	2%
Ever took steroids without a doctor's prescription (in their lifetime)	1%	4%	4%	1%	1%	2%	N/A	N/A
Ever used inhalants (in their lifetime)	2%	9%	5%	3%	2%	1%	N/A	8%
Ever used ecstasy (also called MDMA in their lifetime)	1%	N/A	3%	2%	1%	1%	N/A	3%
Social Determinants of Health								
Visited a dentist within the past year (for a check-up, exam, teeth cleaning, or other dental work)	57%	79%	77%	76%	68%	57%	98%	99%

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

Minority Youth Trend Summary

Youth Variables	Lucas County White 2022 (6th-12th)	Lucas County African Americans 2022 (6th-12th)	Lucas County Latinos 2022 (6th-12th)	Lucas County 2022 (6th-12th)	Lucas County White 2022 (9th-12th)	Lucas County African Americans 2022 (9th-12th)	Lucas County Latinos 2022 (9th-12th)	Lucas County 2022 (9th-12th)
Weight Control								
Obese	16%	21%	17%	20%	14%	18%	21%	18%
Overweight	13%	17%	25%	16%	14%	23%	29%	19%
Described themselves as slightly or very overweight	29%	26%	29%	27%	29%	24%	44%	27%
Exercised to lose weight (in the past month)	42%	35%	33%	35%	46%	46%	38%	45%
Ate less food, fewer calories, or foods lower in fat to lose weight (in the past month)	33%	27%	30%	29%	32%	20%	35%	28%
Went without eating for 24 hours or more (in the past month)	7%	10%	15%	9%	7%	4%	18%	7%
Took diet pills, powders, or liquids without a doctor's advice (in the past month)	1%	0%	2%	1%	2%	0%	6%	2%
Vomited or took laxatives (in the past month)	3%	2%	2%	3%	6%	2%	6%	5%
Ate one to four servings of fruits and vegetables per day	61%	54%	67%	68%	78%	54%	82%	69%
Physically active at least 60 minutes per day on every day in past week	25%	22%	21%	21%	24%	29%	25%	26%
Physically active at least 60 minutes per day on five or more days in past week	42%	33%	40%	35%	41%	49%	50%	45%
Did not participate in at least 60 minutes of physical activity on any day in the past week	12%	38%	28%	29%	15%	22%	25%	20%
Watched three or more hours of television (on an average school day)	18%	31%	28%	33%	16%	34%	19%	31%

N/A - Not Available

Indicates alignment with the Ohio State Health Assessment

Minority Youth Trend Summary, *Continued*

Youth Variables	Lucas County White 2022 (6th-12th)	Lucas County African Americans 2022 (6th-12th)	Lucas County Latinos 2022 (6th-12th)	Lucas County 2022 (6th-12th)	Lucas County White 2022 (9th-12th)	Lucas County African Americans 2022 (9th-12th)	Lucas County Latinos 2022 (9th-12th)	Lucas County 2022 (9th-12th)
Unintentional Injuries and Violence								
Were in a physical fight (in past year)	30%	40%	41%	38%	17%	29%	24%	25%
Carried a weapon on school property (in the past month)*	4%	3%	9%	7%	5%	0%	17%	5%
Threatened or injured with a weapon on school property (in past year)	7%	11%	7%	10%	10%	5%	6%	8%
Ever purposefully hurt themselves	34%	29%	31%	32%	33%	22%	35%	29%
Did not go to school because they felt unsafe (at school or on their way to or from school in the past 30 days)	11%	24%	16%	18%	12%	16%	22%	15%
Electronically bullied (in past year)	10%	13%	12%	11%	13%	7%	11%	10%
Bullied (in past year)	35%	32%	29%	35%	32%	11%	29%	23%
Bullied on school property (in past year)	29%	26%	30%	31%	27%	13%	22%	19%
Mental Health								
Seriously considered attempting suicide (in the past year)	15%	9%	10%	11%	19%	4%	19%	13%
Attempted suicide (in past year)	9%	6%	7%	8%	9%	5%	18%	8%
Suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (during the past year)	2%	1%	3%	6%	0%	0%	12%	7%
Felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities in the past 12 months)	32%	29%	44%	34%	33%	23%	47%	32%

N/A - Not Available

**2022 indicator wording was slightly different than previous surveys – please use caution when interpreting comparison data*

Indicates alignment with the Ohio State Health Assessment

Minority Youth Trend Summary, *Continued*

Youth Variables	Lucas County White 2022 (6th-12th)	Lucas County African Americans 2022 (6th-12th)	Lucas County Latinos 2022 (6th-12th)	Lucas County 2022 (6th-12th)	Lucas County White 2022 (9th-12th)	Lucas County African Americans 2022 (9th-12th)	Lucas County Latinos 2022 (9th-12th)	Lucas County 2022 (9th-12th)
Alcohol Consumption								
Current drinker (at least one drink of alcohol on at least one day during the past month)	12%	10%	17%	12%	19%	21%	28%	21%
Binge drinker (males having five or more drinks on one occasion, females having four or more drinks on one occasion within the past 30 days)	5%	10%	8%	7%	11%	15%	11%	14%
Obtained the alcohol they drank by someone giving it to them (of youth drinkers)	6%	5%	10%	43%	9%	6%	29%	46%
Rode with a driver who had been drinking alcohol (in a car or other vehicle on one or more occasion during the past month)	14%	18%	31%	20%	13%	29%	30%	21%
Drove when they had been drinking alcohol (of youth drivers on one or more occasion during the past month)	1%	3%	8%	9%	3%	2%	10%	7%
Drank for the first time before age 13 (of all youth)	15%	16%	13%	15%	16%	9%	13%	12%
Tobacco Use								
Currently smoked cigarettes (on at least one day during the past month)	3%	2%	2%	2%	3%	0%	6%	2%
First tried cigarette smoking before the age of 13 (even one or two puffs)	8%	9%	8%	9%	5%	6%	8%	7%
Currently frequently smoked cigarettes (on 20 or more days during the past month)	0%	1%	2%	<1%	0%	0%	6%	1%
Currently used an electronic vapor product (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on at least one day during the past month)	12%	17%	13%	14%	19%	20%	17%	20%

Indicates alignment with the Ohio State Health Assessment

Minority Youth Trend Summary, *Continued*

Youth Variables	Lucas County White 2022 (6th-12th)	Lucas County African Americans 2022 (6th-12th)	Lucas County Latinos 2022 (6th-12th)	Lucas County 2022 (6th-12th)	Lucas County White 2022 (9th-12th)	Lucas County African Americans 2022 (9th-12th)	Lucas County Latinos 2022 (9th-12th)	Lucas County 2022 (9th-12th)
Tobacco Use, Continued								
Usually got their own electronic vapor products by buying them in a store (such as a convenience store, supermarket, discount store, gas station, or vape store, including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, during the past month, among students who currently used electronic vapor products)	1%	3%	2%	11%	4%	6%	6%	23%
Did not try to quit using all tobacco products (including cigarettes, cigars, smokeless tobacco, shisha or hookah tobacco, and electronic vapor products, during the past year, among students who used any tobacco products during the past year)	8%	16%	14%	56%	11%	19%	12%	48%
Sexual Behavior								
Ever had sexual intercourse	13%	11%	13%	12%	39%	33%	42%	34%
Participated in anal sex	2%	0%	2%	2%	6%	0%	8%	6%
Participated in oral sex	7%	8%	4%	7%	22%	17%	17%	20%
Participated in sexting	11%	10%	13%	10%	26%	20%	33%	25%
Had viewed pornography	24%	11%	9%	13%	47%	16%	17%	27%
Used a condom (during last sexual intercourse)*	9%	9%	6%	22%	25%	20%	9%	38%
Used birth control pills (during last sexual intercourse)*	4%	0%	2%	5%	9%	0%	9%	12%
Used an IUD (during last sexual intercourse)*	1%	1%	0%	1%	3%	2%	0%	4%
Used a shot, patch or birth control ring (during last sexual intercourse)*	0%	0%	0%	0%	0%	0%	0%	0%

N/A - Not Available

**2022 indicator wording was slightly different than previous surveys – please use caution when interpreting comparison data*

Indicates alignment with the Ohio State Health Assessment

Note – The 2023 sample size for sexual behavior section is smaller than the full sample as two school districts removed sexual behaviors questions

Minority Youth Trend Summary, *Continued*

Youth Variables	Lucas County White 2022 (6th-12th)	Lucas County African Americans 2022 (6th-12th)	Lucas County Latinos 2022 (6th-12th)	Lucas County 2022 (6th-12th)	Lucas County White 2022 (9th-12th)	Lucas County African Americans 2022 (9th-12th)	Lucas County Latinos 2022 (9th-12th)	Lucas County 2022 (9th-12th)
Sexual Behavior, Continued								
Did not use any method to prevent pregnancy during last sexual intercourse*	0%	2%	2%	4%	0%	2%	9%	4%
Had sexual intercourse with four or more persons (of all youth during their life)	3%	3%	2%	3%	9%	9%	8%	9%
Had sexual intercourse before the age 13 (for the first time of all youth)	3%	6%	5%	5%	0%	11%	5%	6%
Drug Use								
Currently used marijuana (in the past month)	8%	11%	8%	9%	14%	23%	18%	20%
Ever used cocaine (in their lifetime)	1%	1%	0%	2%	0%	0%	0%	1%
Ever used heroin (in their lifetime)	0%	1%	2%	1%	0%	0%	6%	1%
Ever used methamphetamines (in their lifetime)	0%	2%	0%	1%	0%	0%	0%	1%
Ever took steroids without a doctor's prescription (in their lifetime)	1%	0%	3%	1%	2%	0%	6%	2%
Ever used inhalants (in their lifetime)	1%	1%	3%	2%	2%	0%	0%	1%
Ever used ecstasy (also called MDMA in their lifetime)	0%	0%	2%	1%	0%	0%	6%	1%
Social Determinants of Health								
Visited a dentist within the past year (for a check-up, exam, teeth cleaning, or other dental work)	63%	51%	65%	57%	63%	53%	53%	57%

N/A - Not Available
**2022 indicator wording was slightly different than previous surveys – please use caution when interpreting comparison data*
Indicates alignment with the Ohio State Health Assessment
Note – The 2023 sample size for sexual behavior section is smaller than the full sample as two school districts removed sexual behaviors questions

Child Trend Summary

Child Comparisons	Lucas County 2017 Ages 0-5	Lucas County 2020 Ages 0-5	Lucas County 2023 Ages 0-5	Ohio 2021 Ages 0-5	U.S. 2021 Ages 0-5	Lucas County 2017 Ages 6-11	Lucas County 2020 Ages 6-11	Lucas County 2023 Ages 6-11	Ohio 2021 Ages 6-11	U.S. 2021 Ages 6-11
Health and Functional Status										
Rated health as excellent or very good	98%	99%	92%	94%	93%	97%	95%	88%	94%	91%
Dental care visit (in past year)	61%	4%	64%	42%**	59%**	94%	92%	94%	81%	88%
Diagnosed with asthma	5%	4%	1%	3%	3%	15%	14%	5%	10%	11%
Diagnosed with ADHD/ADD	0%	1%	10%	4%*	2%*	12%	22%	17%	12%	10%
Diagnosed with behavioral or conduct problems	0%	4%	9%	5%*	5%*	9%	9%	8%	12%	10%
Diagnosed with depression	0%	4%	1%	1%*	<1%*	2%	6%	3%	1%	2%
Diagnosed with epilepsy	0%	0%	0%	N/A	1%	1%	1%	0%	N/A	1%
Diagnosed with a head injury	0%	0%	0%	N/A	N/A	2%	1%	0%	N/A	N/A
Diagnosed with anxiety problems	0%	3%	11%	4%*	3%*	10%	15%	12%	9%	8%
Diagnosed with developmental delay	3%	0%	7%	6%*	8%*	10%	0%	3%	6%	8%
Diagnosed with learning disability	0%	0%	4%	4%*	4%*	6%	8%	6%	7%	8%
Diagnosed with speech or language disorder	15%	10%	14%	9%*	12%*	11%	16%	7%	6%	11%
Two or more health conditions	N/A	6%	20%	7%	7%	N/A	N/A	17%	24%	21%
Health Care Access										
Had public insurance	28%	17%	26%	31%	31%	26%	20%	18%	29%	30%
Been to doctor for preventive care (in past year)	96%	100%	97%	84%	85%	92%	93%	92%	74%	75%
Received all the medical care they needed	99%	94%	82%	N/A	N/A	96%	86%	81%	N/A	N/A
Had a personal doctor or nurse	88%	84%	84%	73%	72%	85%	84%	91%	74%	72%

N/A – Not Available
***Ages 1-5*
**Ages 3-5*
Indicates alignment with the Ohio State Health Assessment

Child Trend Summary, *Continued*

Child Comparisons	Lucas County 2017 Ages 0-5	Lucas County 2020 Ages 0-5	Lucas County 2023 Ages 0-5	Ohio 2021 Ages 0-5	U.S. 2021 Ages 0-5	Lucas County 2017 Ages 6-11	Lucas County 2020 Ages 6-11	Lucas County 2023 Ages 6-11	Ohio 2021 Ages 6-11	U.S. 2021 Ages 6-11
Family and Community Characteristics										
Neighborhood is usually or always safe	90%	95%	87%	N/A	N/A	91%	94%	94%	N/A	N/A
Child experienced two or more ACEs	N/A	0%	9%	9%	10%	N/A	10%	14%	16%	17%
Parent or family member quit a job, did not take a job, or greatly changed job because of problems with childcare for child (in past year)	N/A	6%	21%	13%	13%	N/A	5%	6%	N/A	N/A
Primary language spoken at home was dialect other than English	N/A	1%	4%	9%	15%	N/A	1%	1%	9%	15%
Early Childhood (0-5 Year Olds)										
Never breastfed their child	22%	16%	14%	26%	18%	N/A	N/A	N/A	N/A	N/A
Child put to bed on their back	81%	90%	80%	N/A	79%*	N/A	N/A	N/A	N/A	N/A
Middle Childhood (6-11 Year Olds)										
Child participated in one or more activities	N/A	N/A	N/A	N/A	N/A	N/A	92%	89%	70%	69%
Parent Health										
Parent/guardian's mental or emotional health is fair/poor	10%	7%	15%	N/A	N/A	9%	13%	11%	N/A	N/A
Parent/guardian's physical health status is fair/poor	6%	11%	5%	N/A	N/A	6%	8%	8%	N/A	N/A

Indicates alignment with the Ohio State Health Assessment

**Respondents of the 2021 National Survey of Children's health were asked: "In which position do you most often lay this baby down to sleep now, age 0-12 months?"*

N/A – Not Available

Key Issues

Healthy Lucas County and its partners reviewed the 2022/2023 Lucas County Health Assessment. The detailed primary data for each individual priority area can be found in the section it corresponds to. Each organization completed an "Identifying Key Issues and Concerns" exercise via an online survey. The following tables were the group results.

What are the most significant health issues or concerns identified in the 2022/2023 health assessment report? Examples of how to interpret the information include: 43% of Lucas County adults were obese including 51% of those between the ages of 30-64 years old.

Primary Data from 2022/2023 Lucas County Community Health Assessment:

Key Issue or Concern	**Percent of Population At risk**	**Age Group Most at Risk** *(if applicable)*	**Gender or Income Most at Risk** *(if applicable)*	**Race Most at Risk** *(if applicable)*
Mental Health (6 votes)				
Adults who had a period of two or more weeks in the past year when they felt so sad or hopeless every day that they stopped doing usual activities	15%	<30 (25%)	Females (18%) <$25K (20%)	African Americans (22%) Latinos (21%)
Youth who felt sad or hopeless almost every day for two weeks or more in a row in the past year	34%	<13, 14-16, 17+ (34%)	Females (42%)	Latinos 9th-12th (47%) African Americans 6th-12th (29%)
Youth who attempted suicide in the past year	8%	14-16 (11%)	Males & Females (7%)	Latinos 9th-12th (18%)
Social Determinants of Health (6 votes)				
Adult who experienced 4+ adverse childhood experiences (ACEs)	16%	<30 (21%)	Female (18%) <$25K (22%)	Latino (29%)
Youth who experienced 3+ adverse childhood experiences (ACEs)	22%	17+ (31%)	Females (25%)	N/A
Adults who had one or more food insecurity issues	19%	N/A	N/A	Latinos & African Americans (30%)
Adults who reported their neighborhood was not safe at all	7%	N/A	N/A	Latinos (13%) African Americans (6%)

N/A- Not Available

Key Issue or Concern	Percent of Population At risk	Age Group Most at Risk *(if applicable)*	Gender or Income Most at Risk *(if applicable)*	Race Most at Risk *(if applicable)*
Weight Status (5 votes)				
Obese adults	43%	30-64 (51%)	Females (46%) <$25K (50%)	African Americans (57%)
Overweight adults	32%	<30 (40%)	Males (41%) $25K+ (35%)	Whites (37%)
Obese youth	20%	<13 (21%)	Males (24%)	African Americans 6th – 12th (21%)
Overweight youth	16%	14-16 (20%)	Females (26%)	Latinos 9th – 12th (29%)
Youth who did not exercise at all in the past week	29%	N/A	N/A	N/A
Quality of Life (4 votes)				
Adults who were limited in some way because of a physical, mental, or emotional problem	51%	<30 (60%)	Females (54%) <$25K (66%)	Latinos (53%) African Americans (50%)
Hypertension (2 votes)				
Adults who had ever been diagnosed with high blood pressure	38%	65+ (60%)	Males (44%) <$25K (50%)	African Americans (41%)
Diabetes (2 votes)				
Adults who were diagnosed with diabetes at some time in their lifetime	14%	65+ (25%)	Males (16%) <$25K (22%)	Latinos (19%) African Americans (13%)
Uninsured (1 vote)				
Adults who were uninsured	6%	<30 (22%)	Males (7%) <$25K (10%)	African Americans (12%)
Parent Health (1 vote)				
Parents who reported having more than one difficulty in regard to day-to-day demands of parenthood/raising children	33%	N/A	<$25K (75%)	N/A

N/A- Not Available

Key Issue or Concern	Percent of Population At risk	Age Group Most at Risk *(if applicable)*	Gender or Income Most at Risk *(if applicable)*	Race Most at Risk *(if applicable)*
Maternal & Infant Health (1 vote)				
Women who were pregnant within the past 5 years did the following: took a multi-vitamin with folic acid	41%	N/A	N/A	N/A
Women who were pregnant within the past 5 years did the following: received WIC services	18%	N/A	N/A	N/A
Oral Health (1 vote)				
Adults who visited a dentist or dental clinic within the past year	63%	<30 (42%)	Males (63%) <$25K (48%)	African Americans (57%)
Asthma (1 vote)				
A doctor, health professional, or health educator told Lucas County parents their child had the following: asthma	4%	0-5 (1%) 6-11 (5%)	N/A	N/A
Adults who had ever been diagnosed with asthma	12%	<30 (17%)	Females (15%)	Latinos and African Americans (14%)
Housing (1 vote)				
Adults who rented their home	22%	N/A	N/A	African Americans (45%) Latinos (25%)
Adults who had some other arrangement for housing	8%	N/A	N/A	African Americans (15%) Latinos (4%)

N/A- Not Available

Secondary Data:

Key Issue or Concern	Percent of Population At risk	Age Group Most at Risk *(if applicable)*	Gender or Income Most at Risk *(if applicable)*	Race Most at Risk *(if applicable)*
Maternal & Infant Health (3 votes)				
Ohio Sleep-Related Infant Deaths by Age in Months, 2016-2020 *(ODH, Ohio Child Fatality Review, 21st Annual Report)*	N/A	1 month (116) 2 months (117) 3 months (101)	N/A	N/A
Live births were born preterm in Ohio, 2022 *(March of Dimes)*	10.8%	N/A	N/A	N/A
Live births were low birthweight in Ohio, 2022 *(March of Dimes)*	8.7%	N/A	N/A	N/A
Infant mortality rate *(Resident Birth and Mortality Files from the Ohio Department of Health Bureau of Vital Statistics; U.S. Census Bureau, 2019-2021 American Community Survey 5-Year Estimates; TLCHD Annual Report WIC stats)*	11.5%	N/A	N/A	African American (15.7%)
Health Care Discrimination (1 vote)				
Discrimination when seeking health care in a medical setting – treated with less courtesy or respect than other people all/most/some of the time *(Ohio Coalition on Black Civic Participation/Ohio Unity Coalition-Hospital Anti-Racism Project)*	N/A	N/A	Black Females (62%) Black Males (54%)	N/A
Housing (1 vote)				
According to the 2021 American Community Survey 1-year Estimates, in Lucas County, there were 200,846 housing units. Of all housing units in Lucas County, 92% (184,315) were occupied. Among occupied housing units in Lucas County, 63% (115,791) were owner-occupied. Rent in Lucas County cost an average of $788 per month *(U.S. Census Bureau, 2021 American Community Survey 1-year Estimate).*	N/A	N/A	N/A	N/A

N/A- Not Available

Additional feedback with no specific data/indicators reported:

1 vote

- Healthy Lucas County – Focus Groups and Interviews with Community Members Regarding the Lucas County CHIP: Address Root Problems & System Barriers:
    - The Black Community
        - Theme #1: Address the Root Causes in Addition to Symptoms
        - Theme #2: Lack of Trust and Negative Experiences with Health Care (Medical) Providers and Institutions
    - The Latinx Community
        - Theme #1: Increase the Number of Bi-Lingual Speakers in Organizations
        - Theme #2: Increase Hispanic Presence Across Institutions
        - Theme #3: Engage and Invest in Hispanic Led Organizations to Build Productive Partnerships
    - Those Affected by Disabilities
        - Right to Work to Our Full Ability and Capacity without Penalty
        - Continued and Persistent Barriers to Access for the Special Needs Community
        - Need for Readily Accessible Information
        - The Power of Words

- Maternal Health – Ohio Department of Health
    - African American women are 3X more likely to die after childbirth

- Hypertension – Toledo-Lucas County Health Department Vitals Data
    - Annual report shows heart disease as #1 cause of death in the past 5 years

- Culturally Competent Health Care Access - American Board of Pediatrics for Youth Access

Priorities Chosen

Based on the 2022/2023 County Health Assessment, key issues were identified for adults, youth, and children. Overall, there were 13 key issues identified by Healthy Lucas County. Healthy Lucas County came to a consensus on the priority areas Lucas County will focus on over the next three years. The key issues and their corresponding votes are described in the table below.

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

Key Issues	Votes
1. Mental Health	6
2. Social Determinants of Health	6
3. Weight Status	5
4. Maternal & Infant Health	4
5. Quality of Life	4
6. Hypertension	2
7. Diabetes	2
8. Housing	2
9. Uninsured	1
10. Parent Health	1
11. Oral Health	1
12. Health Care Discrimination	1
13. Asthma	1

Lucas County will focus on the following 6 priorities over the next three years:

Priority Health Outcome(s):

1. **Mental Health and Addiction** (including depression and suicide deaths)
2. **Chronic Disease** (including heart disease, diabetes, and harmful childhood conditions)
3. **Maternal and Infant Health** (including infant mortality)

Priority Factor(s):

4. **Community Conditions** (including housing affordability and quality)
5. **Health Behaviors** (including nutrition and physical activity)
6. **Access to Care** (including local access to health care services)

Community Themes and Strengths Assessment (CTSA)

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

Open-ended Questions to the Participants

1. **What do you believe are the 2-3 most important characteristics of a healthy community?**
    - Access to prevention and health care services (9)
    - Safe and affordable housing (6)
    - Access to healthy food and exercise opportunities (5)
    - Physical activity (4)
    - Access to employment opportunities (3)
    - Safe and sustainable environment (3)
    - Access to necessary resources (3)
    - Equity (2)
    - Strong social connections (2)
    - Access to quality education (2)
    - Free outdoor family friendly activities (2)
    - Access to transportation (2)
    - Low crime
    - Being proactive
    - Diversity
    - Access to consistent/stable mental health services
    - Youth health and safety
    - Low fetal/infant/maternal mortality rates
    - Community involvement – from all different classes and ethnic groups

2. **What makes you most proud of our community?**
    - Collaborations and strategic partnerships (6)
    - Metroparks (5)
    - Supports diversity and inclusion (4)
    - Community-committed health care providers (2)
    - Community resilience (2)
    - Community development/neighborhood improvement projects (2)
    - Support social justice
    - Current economic resurgence
    - Support schools, parks, libraries, mental health, area office on aging and disability centers
    - Spiritual support for one another
    - Availability of resources
    - Innovative initiatives
    - TARTA
    - Access to health care facilities
    - Breastfeeding, maternity leave, child welfare programs

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

- Local community groups/organizations (5)
- Toledo Lucas County Health Department (4)
- Healthy Lucas County (3)
- Sofia Quintero Art & Cultural Center (SQAC) (3)
- CareNet (2)
- Mayor's Office of Neighborhood Safety and Engagement (2)
- Toledo Office on Minority Health
- Getting to 1
- Toledo Public Schools
- Connecting Kids to Meals
- Local food banks
- Urban Wholistics
- Water for Ischmael
- Regional Growth Partnership
- Health Partners of Northwest Ohio
- Mental Health & Recovery Services Board of Lucas County
- National Alliance on Mental Illnesses of Greater Toledo
- Compassion Health
- The community improvement zones
- Collaborative work in healthy food access
- Organizations to improve financial literacy for youth
- Research institutions
- Network of community health workers
- Family council
- Diversity/equity/inclusion collaborations
- Hospital Council of Northwest Ohio
- City of Toledo
- Reinvest Toledo – lead poisoning prevention
- Land bank
- Letters of support for community partnerships to receive grant funding
- East Toledo Family Center
- Frederick Douglas Center
- Coldwell Center
- The Art Tatum Zone
- Dr. Paat free health clinics at Cedar Creek
- YMCA
- YWCA
- Doula Xperience
- Toledo Area Cultural Leaders
- Toledo Jobs with Justice
- Latino Alliance of Northwest Ohio
- Board of DD
- Ability Center
- Lucas County Department of Job and Family Services
- Latins United

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?**

    - Addressing food insecurity (6)
    - Safe/affordable housing (5)
    - Access to quality, culturally competent, affordable health care (4)
    - Public transportation/connectivity (4)
    - Reducing gun violence/crime (3)
    - Promoting healthy lifestyles – safe physical activity space (3)
    - Maternal/Infant health – vulnerable population focus (3)
    - Address/improve SDOH (2)
    - Obesity/Overweight (2)
    - Reduce stigma around mental health (2)
    - One comprehensive system that is consistently updated for resource and referral (2)
    - Improving trust in the health care system and providers
    - Racism and biases embedded in institutions and organizations
    - Lack of medical specialists, especially pediatric specialists in the region
    - Developing community-based health programs
    - Forming municipal and nonprofit partnerships
    - Reduce ACEs/build child resiliency
    - Building trust in the community and empowering community members with education and self-advocacy
    - Financial literacy
    - Homelessness/poverty
    - Substance abuse
    - Medicaid gaps of service coverage
    - Programs for vulnerable populations
    - Chronic diseases – diabetes, cardiovascular health
    - Environmental and water quality/pollutants
    - Shelter options for individuals with medical needs
    - Child care, especially for medically fragile children
    - Elder care

5. **What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?**
    - Organizations are working in silos, not truly collaborating for the greater good (7)
    - Lack of coordination/commitment (5)
    - Lack of financial resources (5)
    - Public trust and buy in (2)
    - Limited community engagement (2)
    - Lack of stability - Social Determinants of Health (2)
    - Systematic inequities
    - Legacy of racism and politics that keeps change from occurring
    - Culture/beliefs
    - Cliques/those who appear to be in power in smaller groups only supporting each other
    - Transportation barriers
    - Increased rate of poverty
    - Big corporations are sending their jobs elsewhere due to ability to get cheaper labor without paying for healthcare coverage for the workers
    - Lack of resources
    - Sedentary lifestyle
    - Competition for funding and resources
    - Distrust/lack of transparency between organizations
    - Community burnout/lack of interest
    - Inflation/increasing costs of healthy food

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

- Access to nutritious food (4)
- Addressing SDOH as a universal approach to health care (3)
- Investing in preventative health care (2)
- Affordable housing (2)
- Starting community-based free wellness programs
- Incentives for individuals/families to get routine vaccines and annual exams
- Evening/weekend access to pcp and non-emergency mental health
- Doulas being paid by Medicaid funding
- Recruit for more specialty medical providers
- Comprehensive/integrated care clinics
- Listening to the needs of the community by creating surveys
- Community building for marginalized/historically excluded communities
- Black mothers to aide in reduced infant mortality rates
- Reducing the number of health disparities
- Reduced monthly TARTA pass for income eligible individuals
- Free family friendly activities
- Placing caps on rental units based on size or discount on taxes for landlords who participate in section 8
- Community empowerment and participation
- More comprehensive services provided at TLCHD
- Fund county-wide comprehensive resource and referral system
- Increase networking opportunities for cross collaborative partnerships
- High level coordination at the county level that focuses on the top issues and aligns funding in a way that all efforts are working in a coordinated fashion
- More green spaces
- Participating in our community health improvement plan
- Build up employment market by offering technical/trades certification in high schools
- Collaborate with researchers on specific public health concerns
- Antiviolence programs
- Access to public transportation
- Evidence based programming
- Advocating for doulas to be paid for their services
- Consistent action planning in real time to address current issues

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

- Collaboration and involvement with organizations (5)
- Changes to policies that impact marginalized groups (2)
- New and innovative strategies which can improve health (2)
- Action/working groups as opposed to large group committees
- Seeing transparent collaborations by community stakeholders/decision makers including elected officials, public health, heads of hospital systems, universities, etc.
- Aligning efforts of all disparate groups towards common community goals
- Seek to address health care access and SDOH
- Teaching high school students how to provide medical, emotional, spiritual care for themselves, loved ones and children thus future of our community
- Meaningful impact
- Addressing generational trauma
- Inclusive engagement
- Seeing a positive impact linked from known contributions
- Campaigns around being physically active in schools and workplaces

Quality of Life Survey

Healthy Lucas County urged community members to fill out a short Quality of Life Survey via SurveyMonkey. There were 690 Lucas County community members who completed the survey. The chart below shows the Likert scale average response for Lucas County compared to the 2017-2018 and 2020-2021 Lucas County CHIP quality of life results. 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.

Quality of Life Questions	Likert Scale Average Response		
	2017-2018 (n=412)	2020-2021 (n=757)	2023-2024 (n=690)
1. Are you satisfied with the quality of life in our community? (Consider your sense of safety, well-being, participation in community life and associations, etc.) [IOM, 1997]	3.13	3.25	3.26
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.23	3.22	3.00
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.15	3.24	3.24
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.)	2.99	3.08	3.04
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.)	2.97	3.11	3.13
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?)	2.85	3.06	2.87
7. Are there networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, or organizations) during times of stress and need?	3.20	3.28	3.28
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.09	3.01	3.01
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	2.68	2.79	2.71
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	2.89	2.95	3.03
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	2.78	2.79	2.85
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?)	2.68	2.73	2.74

Quality of Life Survey, continued

Demographics

- Age of survey respondents:
  - Younger than 20 years old (<1%)
  - 20-29 years old (7%)
  - 30-29 years old (17%)
  - 40-49 years old (21%)
  - 50-59 years old (18%)
  - 60 years old or older (37%)

- Race of survey respondents:
  - White (89%)
  - Black or African-American (8%)
  - American Indian/Alaska Native (2%)
  - Asian (2%)
  - Native Hawaiian/other Pacific Islander (<1%)
  - Other (3%)

- Four percent (4%) of survey respondents were Hispanic or Latino.

- Ninety-five percent (95%) of survey respondents lived in Lucas County.

- Sixty-eight percent (68%) of survey respondents worked in Lucas County.

COVID-19

- Adults reported the COVID-19 pandemic negatively impacted their or their family's health or well-being in the following ways:
  - Change in mental health (40%)
  - Change in physical health (27%)
  - Financial instability (25%)
  - Death or serious illness of loved one(s) (19%)
  - Educational challenges (i.e., children transitioned to online academics or homeschooling, or adults unable to pursue further education) (13%)
  - Lost job(s) (10%)
  - Unable to afford food (10%)
  - Housing instability (9%)
  - Unable to afford basic needs, such as personal, household, or baby care (8%)
  - Unable to afford medicine (6%)
  - Lack of childcare (5%)
  - Lack of Internet access (3%)
  - Other (10%)

Additional open-ended responses included:

"Increase in substance abuse."
"Pricing increases on everything, food, rent, etc."
"Isolation and loss of socialization."
"Post-traumatic stress disorder."
"Lack of workers."
"Family dynamics were interrupted and changed."
"Housing instability."
"Loss of convenient transportation."
"Decline in overall mental health."
"Remaining health issues after having COVID."

Quality of Life Survey, continued

Discrimination

- In the past year, adults experienced racial discrimination:
  - In the workplace (7%)
  - In stores/restaurants (7%)
  - On the street or in my neighborhood (7%)
  - When using public or social services (6%)
  - When seeking/obtaining health care (5%)
  - In dealing with police/fire/emergency/court/government officials (4%)
  - At school/university (3%)
  - On public transportation (3%)
  - Other (10%)

  Additional open-ended responses included:

  "In traffic"
  "At hospital emergency room."
  "At a community event."
  "By City Council members"
  "Seen discriminating language on posters during election."
  "Age discrimination."
  "At a job interview."

- In the past year, adults experienced any type of discrimination (other than racial discrimination):
  - In the workplace (15%)
  - When seeking/obtaining health care (13%)
  - In stores/restaurants (12%)
  - On the street or in my neighborhood (8%)
  - When using public or social services (7%)
  - In dealing with police/fire/emergency/court/government officials (5%)
  - At school/university (3%)
  - On public transportation (1%)
  - Other (7%)

  Additional open-ended responses included:

  "Age discrimination"
  "Towards my daughter with disabilities."
  "Sexism"
  "Antisemitism"
  "Pay disparities"
  "Transphobia/homophobia"
  "Against women's rights"

Quality of Life Survey, continued

Healthy Lucas County added one open-ended question to the Quality of Life Survey. Below are common responses.

When asked what the main quality of life concern in Lucas County is, the following was reported:

"Gun violence."

"Safety of my family and children."

"Adequate pay for employees."

"Availability and access to health care for all."

"Affordable housing."

"Accessibility for older residents."

"The roads are terrible and embarrassing."

"Education."

"Access for people with disabilities."

"Lack of communication for resources available."

"Community caring instead of individuals who look out for themselves."

"Food deserts."

"Mentorship/leadership opportunities for intercity youth, father figures."

"Urban decay."

"Economic opportunities for those living at or below the poverty level."

"Air quality."

"Water pollution."

"Lucas County isn't as diverse as other regions of the state or the country, and it's starting to become a true detriment to my mental health. I feel trapped here, and anything I wish to see, I need to build from the ground up but I'm tired."

"Homelessness."

"Access to transportation."

"Activities and resources for teens and young adults."

"The opiate epidemic is an increasing problem and we need more treatment options available to all."

"Access to groceries and walkable neighborhoods."

Forces of Change Assessment

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

Force of Change	Threats Posed	Opportunities Created
1. Mental health providers/services (4)	• Increase in unemployment (2) • Increase in crime/law enforcement (2) • Increase in substance abuse (2) • Job loss/retention • Food insecurity • Greater demand for services • Increased ED/inpatient hospitalizations • Stigma attached to asking for help • Less follow-through from consumers	• Increased awareness (2) • Funding for services needed within populations • Reduction of stigma around mental health and seeking help (treatment) • Opportunities for agencies to partner • Student loan forgiveness for therapist/counselors that stay with a provider for a minimum of 2-3 years • Increased community collaboration
2. Access to healthy foods (3)	• Greater risk of chronic disease (2) • Obesity rates continuing to increase • Impact learning and health behaviors • Stigma attached to asking for assistance • Lack of knowledge on how to access community resources	• Wellness programs (2) • Expanded education and outreach within communities (populations) in need (2) • Community garden jobs • Food insecurity screenings • Business development opportunities • Opportunity for agency collaboration

Force of Change	Threats Posed	Opportunities Created
3. Obesity (3)	• Increased chronic conditions (3) • Lack of early interventions and/or treatment (2) • Lower life expectancy • Impacting younger age groups and specific populations of need	• Funding for programs for youth and children (2) • Community-based programs for exercise and nutritional services • Opportunities for ongoing support and treatment services as needed • Collaborate on wellness and physical activity options • Expansion of nutrition education programs in schools and communities • Promotion of physical activity initiatives for children and families • Development of healthy food access initiatives in underserved areas
4. Climate change (3)	• Increased frequency and severity of natural disasters (2) • Spread of vector-borne diseases • Impact on air quality	• Climate resilience and adaptation • Public health education and awareness • Collaboration and innovation in healthcare • Working with locally available land and other resources to grow and preserve food in our community
5. Economic trends (2)	• Continued inflation and rising cost for food, housing, healthcare, and other goods • Increased rates of employment and homelessness	• Increased federal and local support/grants • Increased focus on increasing jobs • Increased services for affordable housing
6. Changes in health insurance (2)	• Disruption of care - clients may not seek out a new provider and/or needed care may be delayed if an insurance carrier is dropped. • Increased experiences • Health care systems shifting to for-profit system • Less accountability to community they serve • Exploitation of health care workers	• Increased medical care and resources
7. Lack of mobile screenings for disease	• Sustained disparity in minoritized health outcomes	• Creating a screening system

Force of Change	Threats Posed	Opportunities Created
8. Artificial intelligence	• It may be used to create further barriers to care or services. Many insurers are already using it to deny authorization of care.	• It could make simple straightforward care easier and less expensive to obtain
9. Influence of social media	• Influx of false information that makes education difficult	• Public health participation in social media to leverage the false information
10. Cybersecurity incidences	• Threats to all agencies, hospital, government, etc.	• Collaborate on ways to increase security
11. Increasing speed of scientific discoveries	• These discoveries may lead to better health or just become part of the progressive profit seeking with worsening barriers to care related to affordability	• We could discover new cures that can improve population health
12. Increasing amounts of known and new pollutants into waterways	• Increasing cancer rates • Exacerbation of chronic disease conditions • Negative effects on reproductive health	• Opportunities for research • Policy changes • Increased education to the general public
13. Technological advancements in healthcare	• Privacy and security risks • Healthcare inequality	• Improved healthcare access and efficiency • Personalized medicine and data-driven insights
14. The genocide in Palestine	• The elimination of Palestine & continued rise of Zionism	• A radical expulsion of Zionists from public positions of power
15. Affordable housing	• Fewer landlords • Fewer section 8 housing vouchers • Higher number of unhoused individuals/families • Increase ED visits	• Partnerships between local government/landlords to stabilize costs • Local organization and government rehabbing dilapidated housing for lower income families
16. Aging population	• Lack of adequate care • Lack of available workforce	• Aging in place programs • Telehealth
17. Lack of trust in public health	• Ignoring public health suggestions such as vaccinations, quarantine, guidance	• Opportunity to point out history of public health and how it works for the public and not against
18. COVID-19 being largely dismissed as "over"	• Continued infection which leads to long term health effects and disability	• A push to care about our fellow man more
19. Political wielding of transphobia	• Denial of medical care, fleeing the state, increased rates of depression and suicide	• Hopefully society showing politicians that this will not be tolerated

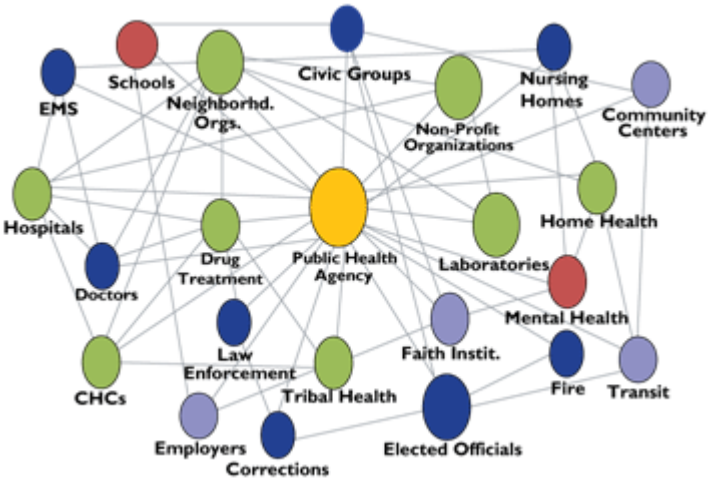
Force of Change	Threats Posed	Opportunities Created
20. For-profit sector taking over much of healthcare	• Ever increasing costs and barriers to care	• Create a health care system that integrates social services that addresses the SDOH, supports primary care, and removes barriers to care
21. St. Luke's closure; hospitals facing financial challenges	• Lack of local care options	• Telehealth • Mobile health
22. Control of the health system could become even less responsive to our local community.	• Mergers and acquisition driven by profit may lead to healthcare with even less accountability	• Greater demand by communities and their governments for transparency and accountability
23. Poverty	• Increase homelessness • Unemployment • Access to services and treatment • Transportation to medical services	• Increased development of social services and providing access to services to meet the need of the population
24. Money leaving educational systems	• A less educated population • Overworked staff • Decreased opportunities for graduates and nongraduates	• A closer look at where money is going and a rearrangement of priorities
25. Lack of nutritional education	• Increase in chronic disease	• Wellness program opportunities
26. Gun violence	• Children and adults coping with trauma.	• Train professionals on trauma and approaches to working with trauma reactive people. • Create support for victims of violence to help ease their burdens and increase resiliency. • Provide community support for areas exposed to increased levels of gun violence.
27. Cost of living	• Decreased access to already limited safe, affordable housing • Increased food insecurity • Decreased access to quality medical care and education opportunities	• Improving community access to quality educational opportunities and employment opportunities making wages that support the cost of living in our community

Force of Change	Threats Posed	Opportunities Created
28. Decreased access to quality educational opportunities	• Increased homelessness • Higher rates of chronic disease and mental health conditions • Limited job and economic growth	• Improving community support for students, families, and school districts
29. Increase in median maternal age	• Higher risk of pregnancy complications, including gestational diabetes and hypertension • Increased likelihood of chromosomal abnormalities, potential for higher rates of cesarean deliveries	• Demand for specialized prenatal care for older mothers • Development of age-specific fertility treatments and support services • Opportunities for research into maternal health outcomes associated with advanced maternal age.
30. Mental health problems during pregnancy and postpartum	• Increased risk of perinatal depression and anxiety • Potential impact on maternal-infant bonding and child development • Heightened risk of adverse birth outcomes such as preterm birth and low birth weight • Increased risk of lack of prenatal care	• Expansion of perinatal mental health services • Implementation of screening programs for early detection and intervention • Development of support networks and peer counseling initiatives for expectant and new mothers.
31. Increase in infant mortality rates	• Higher risk of death for infants during the first year of life • Potential for adverse health outcomes in surviving infants • Negative impact on family well-being and community health	• Strengthening maternal and child health services • Improving access to prenatal care and infant healthcare • Implementing community-based interventions to address social determinants of health influencing infant mortality
32. Loss of funding to support SDOH	• Most food donation centers lack nutritious options • Lack of meal planning/education for residents experiencing food insecurity • Weather as a barrier to physical activity and disease prevention/management • Lack of health provider offices with wraparound services to support SDOH in addition to needed medications	• Identify evidenced based programs that support chronic disease management, assess accessibility to those services demographically (i.e., are bus lines near these places, are there places that provide support more than once a month?) • Treating the family home to prevent chronic disease in children
33. Current political climate	• Polices developed that threaten health and well being	• Advocating for fair policies • Correcting gerrymandering • Reduce political divisiveness and be more neutral

Force of Change	Threats Posed	Opportunities Created
34. Lack of public exercise facilities	• Sustained disparity of obesity in low-income areas	• Creating city-wide exercise initiatives
35. Continued opioid epidemic	• Continued negative outcomes for families, individuals, and communities	• Harm reduction and support services
36. Ohio Medicaid no longer funds Doula support coverage	• Increase in maternal fetal issues and infant mortality loss rates • Lack of support for BIPOC families	• Systemic call to action for Medicaid coverage, more than one Doula provider for the area for people to have options
37. Reduction in federal funding for supportive Public Health Services	• Elimination of programs that support public health.	• Local leaders must come together to support common interests and funding and support effective programming through blended funding streams.

The Local Public Health System

Public health systems are commonly defined as "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction." This concept ensures that all entities' contributions to the health and well-being of the community or state are recognized in assessing the provision of public health services.



The public health system includes:

- Public health agencies at state and local levels
- Healthcare providers
- Public safety agencies
- Human service and charity organizations
- Education and youth development organizations
- Recreation and arts-related organizations
- Economic and philanthropic organizations
- Environmental agencies and organizations

The 10 Essential Public Health Services

The 10 Essential Public Health Services describe the public health activities that all communities should undertake and serve as the framework for the NPHPS instruments.

Public health systems should:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

(Source: **Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services**)

The Local Public Health System Assessment (LPHSA)

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

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

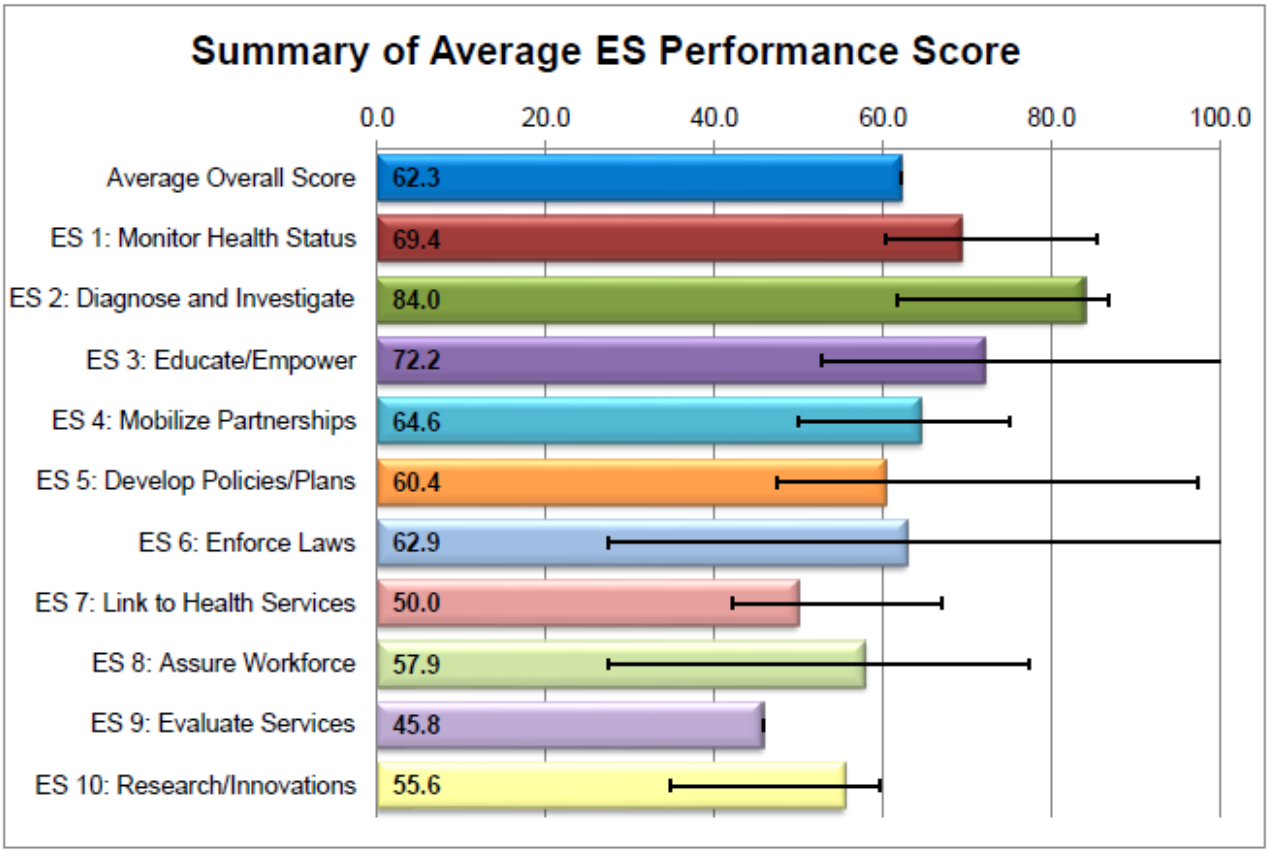
Members of the Toledo-Lucas County Health Department completed the performance measures instrument. The LPHSA results were then presented to Healthy Lucas County for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard 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.

Healthy Lucas County identified 5 indicators that had a status of "minimal" and 0 indicators that had a status of "no activity." The remaining indicators were all moderate, significant or optimal.

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

For questions regarding the LPHSA, please contact Brandon Palinski, Director of Innovation, Quality, and Informatics at the Toledo-Lucas County Health Department at palinskb@co.lucas.oh.us.

Lucas County Local Public Health System Assessment 2024 Summary



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

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

Gaps Analysis

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

Strategy Selection

Based on the chosen priorities, Healthy Lucas County was asked to identify strategies for each priority area. Considering all previous assessments, including but not limited to the CHA, CTSA, quality of life survey and gap analysis, participants determined strategies that best suited the needs of the community. Participants referenced a list of evidence-based strategies recommended by the Ohio SHIP, as well as brainstormed for other impactful strategies.

Evidence-Based Practices

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

Resource Inventory

Based on the chosen priorities, Healthy Lucas County was asked to identify resources for each strategy. The resource inventory allowed the participants to identify existing community resources, such as programs, policies, services, and more. Each resource inventory can be found with its corresponding strategy.

Strategic Planning Terminology

Goal: A broad, long-term outcome that provides direction and purpose.

Objective: A specific, measurable step(s) taken to achieve a goal.

Action Steps: The specific steps that need to be taken to meet the goals and objectives.

Timeline: The timeframe in which activities will take place.

Priority Population(s): The population the strategy focuses on, with emphasis on specific populations at higher risk or impact (based on Key Issues).

Indicators: The specific metric(s) used to measure long term progress and success of the strategy.

Lead Contact/Agency: Who will be responsible for ensuring the objective is met?

Strategy identified as likely to decrease disparities: Strategy has been rated by **What Works for Health** as "likely to decrease disparities" and/or recommended by **The Community Guide** as effective strategies for achieving health equity. These sources consider potential impact on disparities and inequities by racial/ethnic, socio-economic, geographic, or other characteristics. This symbol **√** will be used throughout the report when a strategy is identified as likely to reduce disparities and inequities.

Evidence Ratings: The strategy has been rated by **What Works for Health** based on the amount, type, and quality of evidence available regarding the strategy.

Policy development of enforcement strategies: Evidence-based health policies can help prevent disease and promote health. The Public Health Accreditation Board (PHAB) requires at least two strategies or activities to include a policy recommendation, one of which must be aimed at alleviating the causes of health inequities. Strategies fitting this criteria marked with a  icon throughout the CHIP.

Priority Health Outcome #1: Mental Health and Addiction

Strategic Plan of Action

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

Priority Outcome: Mental Health and Addiction				
Strategy 1: School-based social and emotional instruction				
Goal: Reduce youth depression				
Objective: By September 30, 2027, expand social and emotional instruction throughout Lucas County school districts.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Determine the need for **social and emotional instruction** expansion within local school districts, consider expanding programming to grades 6-8 in TPS. Schedule meetings with Catholic school administrators to discuss expansion efforts. Determine current programming, lessons learned, and the feasibility of expansion. Consider the following: Children specific examples include **The PAX Good Behavior Game** and **The Incredible Years.** Youth specific (high and middle school) examples include **The Second Step Social-Emotional Learning (SEL) Program**. Explore the need for greater alignment and cross-training within current school-based curriculum and practice. Assist schools with best practices and evidence-based programming to implement and research sustainable funding opportunities. If feasible, implement social and emotional programming in additional county school districts or community settings. Adopt a formalized approach to ensure programming is meeting cultural standards.	October 1, 2024 to September 30, 2027	Children Youth (specifically, grades 6-12, females, and the African American/Latino population)	**Priority Outcome:** 1. Reduce youth depression **Priority Indicator**: 1. Youth who felt sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities.	Toledo Public Schools
Resources to address strategy: Certified prevention agencies' PAX trainers, Toledo Public Schools, Mental Health and Recovery Services Board of Lucas County, Lucas County school districts, Area Office on Aging of Northwestern Ohio's Kinship Navigator program, United Way of Greater Toledo funded agencies, United Way 2-1-1, TANF-funded programs, The Ability Center, OSU Extension Lucas County, Lucas County Suicide Prevention Coalition, Toledo Catholic Schools				

Priority Outcome: Mental Health and Addiction				
Strategy 2: Mental health education				
Goal: Reduce suicide deaths				
Objective: By September 30, 2027, increase audience and participant reach of mental health first aid and QPR trainings.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Obtain baseline data on the number of **mental health first aid, mental health first aid youth, mental health first aid teens,** and **Question Persuade Refer (QPR)** trainings that have taken place in the county. Identify gaps in existing programs and determine additional program needs (example: digital training/online platform opportunities). Determine effective marketing techniques among community organizations to promote the identified trainings within schools and workplaces. Identify specific priority populations (African Americans, Latino youth population). Market the training to identified target populations. Identify opportunities to increase participation (example: free or reduced cost or incentives). Track audience and participant reach of programming.	October 1, 2024 to September 30, 2027	Adults (specifically, African American and Latino populations, those 65 and older) Youth (specifically, grades 9-12, females, and the Latino population)	**Priority Outcome:** 1. Increase knowledge of local resources to reduce adult depression 2. Increase knowledge of local resources to reduce suicide deaths **Priority Indicator**: 1. Adults who felt sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities. 2. Number of deaths due to suicide, per 100,000 population *(Ohip Department of Health).*	The University of Toledo Mental Health & Recovery Services Board of Lucas County
Resources to address strategy: Mental Health and Recovery Services Board of Lucas County (train the trainer model), The University of Toledo, Mercy Health QPR (Question, Persuade and Refer) Training, ProMedica, Zepf Center, Lucas County Suicide Prevention Coalition				

Priority Health Outcome #2: Chronic Disease

Strategic Plan of Action

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

Priority Outcome: Chronic Disease				
Strategy 1: Prediabetes screening and referral				
Goal: Reduce prediabetes				
Objective: By September 30, 2027, increase awareness of prediabetes screening, identification, and referral through dissemination of the prediabetes risk assessment.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Determine the baseline number of organizations in the county that currently screen for prediabetes. Raise awareness of prediabetes screening, identification and referral through dissemination of the **Prediabetes Risk Assessment** (or similar assessment) and/or the **Prevent Diabetes STAT Toolkit**. Partner with local organizations and providers to administer Prediabetes Risk Assessment. Promote free screening events throughout the county. Provide targeted training sessions and resources to health care providers to enhance their ability to deliver effective diabetes prevention programs. Establish a referral network to connect organizations and providers with community resources available (ex: diabetes education/management programs, Diabetes Prevention Program).	October 1, 2024 to September 30, 2027	Adults (specifically, those with household incomes less than $25,000, those 65 and older, and the African American and Latino populations)	**Priority Outcomes:** 1. Reduce prediabetes 2. Reduce diabetes **Priority Indicators**: 1. Percent of adults, ages 18 and older, ever diagnosed with prediabetes. 2. Percent of adults, ages 18 and older, ever diagnosed with diabetes.	YMCA of Greater Toledo
Resources to address strategy: United Way of Greater Toledo funded agencies, United Way 2-1-1, TANF-funded programs, Mercy Health Community Health Screening and Education Programs, ProMedica Diabetes 101, Area Office on Aging of Northwestern Ohio, The Ability Center, The Toledo Clinic, Kidney Foundation of Northwest Ohio				

Priority Outcome: Chronic Disease				
Strategy 2: Hypertension screening and referral				
Goal: Reduce hypertension				
Objective: By September 30, 2027, reduce hypertension rates in the community through increased awareness, regular screenings, and improved access and support services				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Determine the baseline number of organizations in the county that are currently screening for hypertension and using evidence-based programming for hypertension. Partner with local health care providers and organizations to establish a referral network for individuals with high blood pressure. Implement educational campaigns to raise awareness about the risks of hypertension and promote lifestyle changes for prevention and management. Evaluate program's effectiveness through regular follow-up and adjust based on community feedback.	October 1, 2024 to September 30, 2027	Adults (specifically, those with household incomes less than $25,000, those 65 and older, and the African American and Latino populations) Youth and Children (specifically those with household incomes less than $25,000 and the African American and Latino populations)	**Priority Outcomes:** 1. Reduce hypertension **Priority Indicators**: 1. Percent of adults, ages 18 and older, ever diagnosed with high blood pressure.	YMCA of Greater Toledo
Resources to address strategy: United Way of Greater Toledo funded agencies, United Way 2-1-1, TANF-funded programs, Mercy Health Community Health Screening and Education Programs, ProMedica Diabetes 101, Area Office on Aging of Northwestern Ohio, The Ability Center, Kidney Foundation of Northwest Ohio				

Priority Health Outcome #3: Maternal and Infant Health

Strategic Plan of Action

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

Priority Outcome: Maternal and Infant Health				
Strategy 1: Early childhood home visiting programs and Toledo-Lucas County Getting to 1 √				
Goal: Reduce infant mortality				
Objective: By September 30, 2027, provide community members with access to most appropriate early childhood home visiting programs, as well as increase awareness of infant mortality.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Continue collaboration among **early childhood home visiting programs** and raise awareness about them through coordinated messaging so families are enrolled in the most appropriate program that meets their needs. Work through the Toledo-Lucas County Getting to 1 coalition to increase education and awareness, community engagement, and collaboration on the issue of infant mortality and addressing the social determinants of health. Further strengthen data collection and data-sharing within partner organizations. Develop quarterly score cards to track and share infant mortality indicators with residents and community leaders. Host roundtable discussions on home visiting programs to support the governor's initiatives. Implement a hybrid work model for home visitors, allowing them to work from home for administrative tasks and participate in flexible scheduling to enhance work-life balance. Promote awareness of support groups to provide emotional and professional assistance, promoting a collaborative and supportive work environment.	October 1, 2024 to September 30, 2027	Children (specifically those with household incomes less than $25,000 and the African American and Latino populations)	**Priority Outcomes:** 1. Reduce infant mortality **Priority Indicators**: 1. Number of deaths for infants under age 1, per 1,000 live births *(Ohio Department of Health).*	Lucas County Home Visiting Advisory Council Toledo-Lucas County Getting to 1
Resources to address strategy: Lucas County Home Visiting Advisory Council, Toledo-Lucas County Getting to 1, United Way of Greater Toledo funded agencies, United Way 2-1-1, TANF-funded programs, Area Office on Aging of Northwestern Ohio, The Ability Center				

Priority Outcome: Maternal and Infant Health				
Strategy 2: Care coordination and access to well-woman care √				
Goal: Reduce infant mortality among African Americans and other families				
Objective: By September 30, 2027, train and maintain a culturally competent workforce of CHWs/home visitors.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Provide training so interested individuals can become culturally competent community health workers (CHWs)/home visitors. Continue training on **cultural competency** and other topics so CHWs/home visitors can continue to provide care coordination with a whole-person approach to pregnant women, women of childbearing age, and their families. Maintain certification of the Pathways HUB. Secure funding to ensure CHWs/home visitors and the care coordination agencies that employ them receive outcome payments. Host roundtable discussions on home visiting programs to support the governor's initiatives. Develop a comprehensive resource guide for CHWs/home visitors and offer additional training sessions on relevant topics to enhance their skills. Create a detailed list of clinics offering various services and host more pop-up/mobile clinics to increase community access to health care.	October 1, 2024 to September 30, 2027	Adult (specifically women, those with household incomes less than $25,000, and the African American and Latino populations) Children (specifically, those with household incomes less than $25,000 and the African American and Latino populations)	**Priority Outcomes:** 1. Reduce infant mortality **Priority Indicators**: 1. Number of deaths for infants under age 1, per 1,000 live births *(Ohio Department of Health).*	Northwest Ohio Pathways HUB
Resources to address strategy: Northwest Ohio Pathways HUB, United Way of Greater Toledo funded agencies, United Way 2-1-1, TANF-funded programs, Area Office on Aging of Northwestern Ohio, The Ability Center, Lucas County Home Visiting Council, Toledo Lucas County Health Department, Health Partners of Northwest Ohio, Mercy Childhood Dependency Program, Federally Qualified Health Centers				

Priority Factor #1: Community Conditions

Strategic Plan of Action

To work toward improving community conditions, the following strategies are recommended:

Priority Factor: Community Conditions				
Strategy 1: Housing Choice Voucher Program √				
Goal: Improve housing affordability and quality				
Objective: By September 30, 2027, provide Housing Choice Vouchers for priority populations and collaborate to expand affordable housing options for all populations.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Lucas Metropolitan Housing will provide vouchers for pregnant women through the Northwest Ohio Pathways HUB, clients of Toledo Lucas County Homelessness Board's Housing First program and/or other permanent supportive housing partners that continue to maximize their program utilization above the 95% standard required by Lucas Metropolitan Housing. Collaborate with Executive Committee Member Organizations Lucas Metropolitan Housing, Toledo Lucas County Homelessness Board, and United Way of Greater Toledo to expand affordable housing programs and direct assistance to renters with lowest incomes. Advocate for policies and procedures to streamline the process of providing rental assistance to eligible families, ensuring equitable access to housing support services.	October 1, 2024 to September 30, 2027	Children and families (specifically those with household incomes less than $25,000 and the African American and Latino populations)	**Priority Outcomes:** 1. Improve housing affordability and quality 2. Reduce adverse childhood experiences (ACEs) **Priority Indicators**: 1. Number of affordable and available units per 100 renters with income below 50% of Area Median Income *(National Low-Income Housing Coalition analysis of the American Community Survey, as compiled by OHFA).* 2. Sustain 95% utilization rate for allocated vouchers *(Lucas Metropolitan Housing).* 3. Percent of adults who experienced four or more ACEs in their lifetime. 4. Percentage of residents who knew someone who lived in a hotel. 5. Percentage of residents who had someone homeless living with them or sleeping on their couch. 6. Percentage of homeless residents. 7. Percentage of families at risk for losing their homes.	Lucas Metropolitan Housing Healthy Lucas County Executive Committee
Resources to address strategy: Lucas Metropolitan Housing, Healthy Lucas County Executive Committee, Toledo Lucas County Homelessness Board, United Way of Greater Toledo, United Way of Greater Toledo funded agencies, United Way 2-1-1, TANF-funded programs, Area Office on Aging of Northwestern Ohio, The Ability Center				

Priority Factor: Community Conditions				
Strategy 2: The Toledo Black Agenda				
Goal: Increase awareness of and address racism and lack of health equity				
Objective: By September 30, 2027, support and align with recommendations in The Toledo Black Agenda.				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Support and align with recommendations in The Toledo Black Agenda, such as incorporating the Health in All Policies (HiAP) methodology in all areas of social determinants of health and engaging with Blacks to develop programs created to serve the Black Community. Determine additional indicators to measure throughout the CHIP cycle to align with recommended strategies. Increase awareness of racism and health equity, such as through the YWCA of Northwest Ohio and Healthy Lucas County lunch and learns. Gather baseline data about doctors/health care providers (including behavioral health providers) who have received training about the following topics: culturally competent care/unconscious bias. Provide additional culturally competent/unconscious bias trainings to doctors/health care providers.	October 1, 2024 to September 30, 2027	African Americans and other People of Color	**Priority Outcome:** 1. Reduce racism and health disparities **Priority Indicators**: 1. Percentage of adults who felt emotionally upset as a result of how they were treated based on skin color/ethnicity. 2. Percent of adults who reported their experience seeking health care was worse than people of other races. 3. Number of adults with increased awareness of racism and health equity *(YWCA of Northwest Ohio and Healthy Lucas County evaluations)*.	YWCA of Northwest Ohio Healthy Lucas County Executive Committee's Health Equity Task Force
Resources to address strategy: YWCA of Northwest Ohio, Healthy Lucas County Executive Committee's Health Equity Task Force, United Way of Greater Toledo funded agencies, United Way 2-1-1, TANF-funded programs, Area Office on Aging of Northwestern Ohio, The Ability Center, Hospital Council of Northwest Ohio				

Priority Factor #2: Health Behaviors

Strategic Plan of Action

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

Priority Outcome: Health Behaviors				
Strategy 1: Exercise prescriptions from health care providers				
Goal: Reduce obesity				
Objective: By September 30, 2027, expand implementation of exercise prescription program into local primary care offices				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Research **exercise prescriptions** to understand best practices and address obstacles (i.e., transportation barriers). Create a plan for integrating exercise prescriptions into primary care, incorporating solutions such as home-based exercises and partnerships with local transportation services. Partner with local organizations to determine referral options and provide support systems, ensuring patients have accessible opportunities for physical activity. Create inventory of local parks, trails, etc., and develop website/app for health care providers to share with patients. Expand implementation of exercise prescription programs into local primary care offices.	October 1, 2024 to September 30, 2027	Adults (specifically, those with household incomes less than $25,000 and the African American and Latino populations) Youth (specifically, 6-12th graders)	**Priority Outcomes:** 1. Reduce obesity 2. Reduce overweight **Priority Indicators**: 1. Percent of adults and youth who were classified as obese by BMI. 2. Percent of adults and youth who were classified as overweight by BMI. 3. Percent of adults who reported no physical activity	YMCA of Greater Toledo
Resources to address strategy: YMCA of Greater Toledo, Metroparks Toledo, city parks, physician partners, school-based health centers, practitioner education and guidance (ex: "Exercise is Medicine"), Mercy Health partnership with Metroparks Toledo, Area Office on Aging of Northwestern Ohio, United Way of Greater Toledo funded agencies, United Way 2-1-1, TANF-funded programs, The Ability Center, University of Toledo Medical Center				

Priority Factor: Health Behaviors				
Strategy 2: Fruit and vegetable incentive programs √				
Goal: Reduce obesity				
Objective: By September 30, 2027, increase community fruit and vegetable consumption through access and educational programming				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Research **fruit and vegetable incentive programs** to understand best practices and address obstacles (i.e., barriers to access). Partner with local farmers' markets, grocery stores, corner stores, and other community organizations to improve access to fresh produce, especially in underserved areas. Implement educational campaigns and programs that encourage healthy eating habits through cooking demonstrations. Evaluate program's impact through surveys and adjust campaigns and programming based on feedback.	October 1, 2024 to September 30, 2027	Adults (specifically, those with household incomes less than $25,000 and the African American and Latino populations) Youth (specifically, 6-12th graders)	**Priority Outcomes:** 1. Reduce obesity 2. Reduce overweight **Priority Indicators**: 1. Percent of adults and youth who were classified as obese by BMI. 2. Percent of adults and youth who were classified as overweight by BMI.	YMCA of Greater Toledo
Resources to address strategy: YMCA of Greater Toledo, Metroparks Toledo, city parks, physician partners, school-based health centers, practitioner education and guidance (ex: "Exercise is Medicine"), Mercy Health partnership with Metroparks Toledo, Area Office on Aging of Northwestern Ohio, United Way of Greater Toledo funded agencies, United Way 2-1-1, TANF-funded programs, The Ability Center, Toledo Lucas County Health Department				

Priority Factor #3: Access to Care

Strategic Plan of Action

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

Priority Factor: Access to Care				
Strategy 1: County-wide non-emergency transportation coordination				
Goal: Increasing transportation efforts				
Objective: By September 30, 2027, establish a county-wide non-emergency transportation coordination system to improve access to essential services				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Create inventory of available transportation supportive services available in area to determine capacity and gaps. Establish partnerships with local transportation providers and organizations that provide non-emergency medical transportation services for patients. Assist agencies with searching for and securing grants/funding. Support promotional campaigns to improve awareness regarding transportation service support available to residents in Lucas County. Advocate for agencies to revise eligibility criteria for transportation services support to be more inclusive of residents (regardless of income, insurance type, etc.) and purposes (i.e., grocery store). Consider implementing, or assisting with development, of a triage workflow that could improve residents' connection to transportation support (e.g., digital platform for streamlined booking and scheduling). Conduct regular evaluations to identify and address workflow bottlenecks.	October 1, 2024 to September 30, 2027	Adults (specifically, those with household incomes less than $25,000 and the African American and Latino populations)	**Priority Outcome:** 1. Improve local access to health providers 2. Improve local access to resources that support health **Priority Indicators**: 1. Percent of adults who did not get medical care in the past year due to no transportation. 2. Percent of adults who did not visit a dentist in the past year due to no transportation. 3. Percent of adults who reported transportation as a barrier to consuming fruits and vegetables. 4. Percent of adults who were unable to exercise due to no transportation to a gym or other exercise opportunity. 5. Percent of adults who reported transportation as a reason for not using a program or services to help with an alcohol or drug problem. 6. Percent of adults reporting transportation issues.	United Way of Greater Toledo University of Toledo Medical Center
Resources to address strategy: ABLE, Kidney Foundation of Northwest Ohio, TARPS/TARTA, United Healthcare, EPSDT, Care Source, Kidney Foundation of Northwest Ohio				

Priority Factor: Access to Care				
Strategy 2: Advocate for policies that expand health care coverage and access to affordable health care services				
Goal: Expand affordable health care coverage and services				
Objective: By September 30, 2027, support a series of policies to expand health care coverage and enhance accessibility to affordable health care services for underserved communities				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Identify specific areas of focus for advocacy efforts (i.e., paid-sick leave work policies, expanded Medicaid eligibility, etc.). Research relevant health policy organizations (i.e., **Health Policy Institute of Ohio, Groundwork Ohio, Policy Matters Ohio, Alliance for Health Policy**) and establish partnerships with health policy organizations that support expansion of health care coverage and access to affordable health care services. Support policy efforts of health policy organizations by: • Mobilizing community members through grassroots campaigns, petitions, and other outreach events. • Utilizing media channels to share stories and data highlighting the impact of high health care costs • Collaborating with like-minded organizations to amplify advocacy efforts and build coalitions. • Engaging with policymakers through meetings, letters, and public testimony. Monitor progress and adjust advocacy strategies as needed.	October 1, 2024 to September 30, 2027	Adults (specifically, those with household incomes less than $25,000 and the African American and Latino populations)	**Priority Outcome:** 1. Improve utilization of primary/preventive care **Priority Indicators**: 1. Percent of adults who had health care coverage 2. Percent of adults who visited a doctor for a routine checkup in the past year 3. Percent of adults who had at least one person they though of as their personal doctor or health care provider 4. Percent of adults who reported "cost/no insurance" as a barrier to not getting medical care in the past year 5. Percent of adults who used the emergency room for health care services	Toledo Lucas County Health Department University of Toledo Medical Center
Resources to address strategy: Health Policy Institute of Ohio, Groundwork Ohio, Policy Matters Ohio, Alliance for Health Policy				

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. A Healthy Lucas County Executive Committee Task Force will regularly meet with the lead agencies for each action step so they can report out any progress. Action steps, responsible person/agency, and timelines will be reviewed at least annually by the Executive Committee to keep the plan on task and hold organizations accountable. Edits and revisions will be made accordingly.

Healthy Lucas County will continue facilitating a community health assessment every three years to collect and track data. Primary data will be collected for adults, youth, and children using national sets of questions to not only compare trends in Lucas County, but also to be able to compare to the state, nation, and Healthy People 2030. This data will serve as measurable outcomes for each priority area. Indicators have already been defined throughout this report.

In addition to outcome evaluation, process evaluation will also be used on a continuous basis to focus on the success of the strategies. Areas of process evaluation that Healthy Lucas County will monitor include the following: number of participants, location(s) where services are provided, number of policies implemented, economic status and racial/ethnic background of those receiving services (when applicable), and intervention delivery (quantity and fidelity).

Contact Us

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

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Appendix I: Gaps and Potential Strategies

The following tables indicate priority related gaps and potential strategies that were identified by the Healthy Lucas County members. The committee identified gaps and potential strategies via an online platform (SurveyMonkey). The results were compiled and presented to the committee. Additional gaps and potential strategies were identified and incorporated.

Note: parentheses indicate the number of organizations who reported the same or similar gaps/potential strategies

Priority Health Outcome: Mental Health and Addiction

Priority Health Outcome #1: Mental Health and Addiction (including depression and suicide deaths)	
Gaps	**Potential Strategies**
1. Depression (3)	• Mental health first aid training • Social emotional instruction • mHealth/telehealth for mental health services • Digital access to treatment services and crisis response - better awareness of 988 and crisis response teams
2. Lack of mental health providers (2)	• Tele-mental health services • Increase reimbursement for Medicaid
3. Suicide prevention/support (2)	• Mental health first aid training • Boost Lucas County suicide prevention coalition capacity
4. Access to treatment for substance users	• Increase insurance coverage for in/outpatient care

= Ohio SHIP supported strategy
√ = likely to decrease disparities
* Aligned with previous Lucas County CHIP

Priority Health Outcome: Chronic Disease

Priority Health Outcome #2: Chronic Disease (including heart disease, diabetes, and asthma)	
Gaps	**Potential Strategies**
1. Diabetes (2)	• Continue prediabetes screening and referral efforts from current CHIP plan √* (3) • Community glucose screening • Health insurance coverage for DPP
2. Adults diagnosed with high BP/heart disease (2)	• Blood pressure screening programs
3. Childhood conditions - lead	• Targeted outreach in communities at risk - I believe there is an effort underway

= Ohio SHIP supported strategy
√ = likely to decrease disparities
* Aligned with previous Lucas County CHIP

Priority Health Outcome: Maternal and Infant Health

Priority Health Outcome #3: Maternal and Infant Health (including infant mortality)	
Gaps	**Potential Strategies**
1. Preterm birth and infant mortality (3)	• Care coordination and access to well woman care - continue current CHIP efforts √* • Getting to 1 efforts to education community about infant mortality √* • Community health workers √ • Pathways HUB • WIC educating parents about spacing of births birth control • Help me grow
2. Maternal morbidity (2)	• Continue current CHIP - early childhood home visiting √* (2)

= Ohio SHIP supported strategy
√ = likely to decrease disparities
* Aligned with previous Lucas County CHIP

Priority Factor: Community Conditions

Priority Factor #1: Community Conditions (including housing affordability and quality)	
Gaps	**Potential Strategies**
1. Housing affordability and quality (4)	• Continue voucher program and integration with community agencies such as the pathways HUB of NW Ohio √* • Rental assistance • Neighborhood improvements • Increase # of landlords willing to accept section 8 vouchers • Address lead issues in rental and owner occupied • Address accessibility issues of homes to enable individuals to age in place and/or enable individuals with disabilities to reside in the community
2. K-12 student success - chronic absenteeism	• Continue current strategies of social emotional instruction in current CHIP
3. Knowledge of existing resources	• Community awareness to what is available, i.e.: catalog of resources, strengthening and promoting 211 or something similar

= Ohio SHIP supported strategy
√ = likely to decrease disparities
* Aligned with previous Lucas County CHIP

Priority Factor: Health Behaviors

Priority Factor #2: Health Behaviors (including nutrition and physical activity)	
Gaps	**Potential Strategies**
1. Physical activity (3)	• Continue current efforts related to exercise prescriptions * *(located in Chronic Disease of 2021-2024 CHIP)* (2) • Safe routes to school • Walking school buses • Complete streets/active transportation • Metro parks strategy • Creating affordable activities and sports equipment to encourage activity and then communicating what is available and where
2. Nutrition (3)	• Healthy food options available at food banks √ • Farm-to-school • Fruit & vegetable incentive programs (Produce Perks) • Produce prescription • Outreach and advocacy to maintain or increase enrollment in federal food assistance programs - I believe many agencies in Lucas County already do this - maybe just more emphasis and coordination

= Ohio SHIP supported strategy
√ = likely to decrease disparities
* Aligned with previous Lucas County CHIP

Priority Factor: Access to Care

Priority Factor #3: Access to Care (including local access to health care services)	
Gaps	**Potential Strategies**
1. Local access to healthcare providers (4)	• Community health workers √ (2) • Culturally competent workforce in underserved communities - capitalize on current work of FQHC's √ • Ability to provide Medicaid patients transportation options beyond contracted vendors • Human translators • Non-traditional office hours • Mobile health care units
2. Unmet need for mental health care (4)	• Telehealth for mental health - several agencies are now doing it - focus on expansion √ (3)
3. Lack of specialty providers for pediatrics	• Educate and recruit current university students in pediatric mental and physical health options and opportunities √
4. Access for children with medical handicaps	• Community programs and services for children with chronic disease or those with physical needs (inclusive programs, daycare, etc.)

= Ohio SHIP supported strategy
√ = likely to decrease disparities
* Aligned with previous Lucas County CHIP

Appendix II: Links to Websites

Title of Link	Website URL
Alliance for Health Policy	https://www.allhealthpolicy.org/
Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services	http://www.cdc.gov/nphpsp/essentialservices.html
Cultural Competency	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/cultural-competence-training-for-health-care-professionals
Early Childhood Home Visiting Programs	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/early-childhood-home-visiting-programs
Exercise Prescriptions	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/exercise-prescriptions
Fruit & Vegetable Consumption	https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/fruit-vegetable-incentive-programs
Groundwork Ohio	https://www.groundworkohio.org/
Health Policy Institute of Ohio (HPIO)	https://www.healthpolicyohio.org/
Healthy Lucas County	https://lucascountyhealth.com/hlc/
Healthy People 2030	https://health.gov/healthypeople/objectives-and-data/browse-objectives
Mental Health First Aid	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/mental-health-first-aid
Mental Health First Aid – Teen	https://www.mentalhealthfirstaid.org/population-focused-modules/teens/
Mental Health First Aid - Youth	https://www.mentalhealthfirstaid.org/population-focused-modules/youth/
Policy Matters Ohio	https://www.policymattersohio.org/
Prediabetes Risk Assessment	http://www.diabetes.org/are-you-at-risk/diabetes-risk-test/
Prevent Diabetes STAT Toolkit	https://preventdiabetesstat.org/index.html
Question, Persuade, Refer Training	https://qprinstitute.com/
Social and Emotional Instruction	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/school-based-social-and-emotional-instruction
The Community Guide	https://www.thecommunityguide.org/
The Incredible Years	http://www.incredibleyears.com/
The PAX Good Behavior Game	http://www.hazelden.org/HAZ_MEDIA/gbg_insert.pdf
The Second Step Social-Emotional Learning (SEL) Program	http://www.secondstep.org/second-step-social-emotional-learning
What Works for Health	https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies