2018-2021

Lucas County Community Health Improvement Plan

HEALTHY LUCAS COUNTY

September 12, 2018

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

Executive Summary

The Healthy Lucas County community health improvement collaboration is pleased to release the 2018-2021 Lucas County Community Health Improvement Plan (CHIP). The plan outlines cross-cutting 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 2016/2017 Lucas County Community Health Assessment (CHA) – before cross-cutting strategies and priority issues were selected. The four priorities, which align perfectly with state and national priorities, are mental health, addiction/drug & opiate use, chronic disease/obesity, and maternal & infant health/infant mortality. Healthy Lucas County leadership has recommended specific actions steps that they hope many agencies, organizations, and coalitions will embrace to address the cross-cutting strategies and priority issues in the next three years. Each cross-cutting strategy and action step has at least one facilitating agency, which will work with all partners and track progress with policies, environment and systems change.

In 1999, Healthy Lucas County began conducting community health assessments (CHA) to measure and address health status. The most recent assessment, released in September 2017, was cross-sectional in nature and included a written survey of adults, adolescents, 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 their 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.

On behalf of Mercy Health-St. Anne Hospital, Mercy Health-St. Charles Hospital, Mercy Health-St. Vincent Medical Center, Mercy Health-Children's Hospital, ProMedica Bay Park Hospital, ProMedica Flower Hospital, ProMedica Toledo Children's Hospital, ProMedica Toledo Hospital, St. Luke's Hospital, University of Toledo Medical Center, Toledo-Lucas County Health Department, Mental Health & Recovery Services Board of Lucas County, Live Well Greater Toledo, and United Way of Greater Toledo, Healthy Lucas County 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 framework includes six phases:

1. Organizing for success and partnership development
2. Visioning
3. Conducting the MAPP assessments
4. Identifying strategic issues
5. Formulating goals and strategies
6. Taking action: planning, implementing, and evaluation

The MAPP process includes four assessments: Community Themes & Strengths, Forces of Change, the Local Public Health System Assessment and the Community Health Status Assessment. These four assessments were used by Healthy Lucas County to prioritize specific health issues and population groups, which are the foundation of this plan. The diagram below illustrates how each of the four assessments contributes to the MAPP process.

PARTNERS

The 2018-2021 Lucas County Community Health Improvement Plan was drafted by agencies and service providers within Lucas County. From October 2017 through February 2018, the committee reviewed many sources of information concerning the health and social challenges that Lucas County adults, youth and children may be facing. They determined cross-cutting 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 committee has recommended specific actions steps that they hope many agencies and organizations will embrace to address the cross-cutting strategies and priority issues in the coming months and years. Healthy Lucas County would like to recognize the following and thank them for their devotion to this process and body of work:

Angie Ackerman, University of Toledo Medical Center
Sam Adams, Mercy Health
Carrie Andrews, University of Toledo Medical Center
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Holly Ball, OSU Extension
Kyle Barry, Mercy Health
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Lindy Cree, United Way of Greater Toledo
Beth Deakins, YMCA of Greater Toledo/Live Well Greater Toledo
Amanda Dionyssiou, University of Toledo Medical Center
Heather Dunzweiler, YWCA of Northwest Ohio
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Janece Wooley, YWCA of Northwest Ohio
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The community health improvement process was facilitated by Britney Ward, MPH, Director of Community Health Improvement, and Selena Coley, MPH, Community Health Improvement Coordinator, from the Hospital Council of Northwest Ohio. Margaret Wielinski, MPH, Assistant Director of Community Health Improvement, and Erin Rauschenberg, Graduate Assistant, assisted with report writing.

MISSION AND VISION

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

The Mission of Healthy Lucas County:

Improving health and quality of life by mobilizing partnerships and taking strategic action in Lucas County.

The Vision of Healthy Lucas County:

Creating a healthy Lucas County.

ALIGNMENT WITH NATIONAL AND STATE STANDARDS

The 2018-2021 Lucas County CHIP's priorities align perfectly with state and national priorities. Lucas County will be addressing four priorities: mental health, addiction/drug & opiate use, chronic disease/obesity, and maternal & infant health/infant mortality. Additionally, 11 cross-cutting strategies were selected to address social determinants of health; healthcare system and access; and public health system, prevention and health behaviors.

Ohio State Health Improvement Plan

Ohio's 2017-2019 State Health Improvement Plan (SHIP) serves as a strategic menu of priorities, objectives, and evidence-based strategies. These strategies are 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 Ohio Department of Health contracted with the Health Policy Institute of Ohio (HPIO) to conduct the 2017-2019 State Health Improvement Plan. HPIO sub-contracted with the Hospital Council of Northwest Ohio to collect data, facilitate regional forums, and assist with the SHIP strategies.

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

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

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

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

Priority 1: **Mental health and addiction** (includes emotional wellbeing, mental illness conditions and substance abuse disorders)

Priority 2: **Chronic Disease** (includes conditions such as heart disease, diabetes and asthma, and related clinical risk factors-obesity, hypertension and high cholesterol, as well as behaviors closely associated with these conditions and risk factors- nutrition, physical activity and tobacco use)

Priority 3: **Maternal and Infant Health** (includes infant and maternal mortality, birth outcomes and related risk and protective factors impacting preconception, pregnancy and infancy, including family and community contexts)

As outlined in figure 1.2 on page 10, the SHIP also takes a comprehensive approach to improving Ohio's greatest health priorities by identifying **cross-cutting factors** that impact multiple outcomes: health equity; social determinants of health; public health system, prevention and health behaviors; and healthcare system and access.

Lucas County Alignment with Ohio's State Health Improvement Plan

The 2018-2021 Lucas County CHIP had to select at least two priority topics, one priority outcome indicator, one cross-cutting strategy and one cross-cutting outcome indicator to align with the 2017-2019 SHIP. As outlined in figure 1.1, the following Lucas County CHIP priority topics, outcomes and cross-cutting factors very closely align with the 2017-2019 SHIP priorities:

Figure 1.1 2018-2021 Lucas County CHIP Overview

<table>
<tr><th colspan="4">Ohio Health Outcomes</th></tr>
<tr><td colspan="4">↑ Health Status
↓ Premature Death</td></tr>
<tr><th colspan="4">Ohio Priority Topics</th></tr>
<tr><td colspan="2">Mental Health and Addiction</td><td>Chronic Disease</td><td>Maternal and Infant Health</td></tr>
<tr><th colspan="4">Lucas County Priority Topics</th></tr>
<tr><td>Mental Health</td><td>Addiction/
Drug and Opiate Use</td><td>Chronic Disease/Obesity</td><td>Maternal and Infant Health/
Infant Mortality</td></tr>
<tr><th colspan="4">Lucas County Priority Outcomes</th></tr>
<tr><td colspan="2">↓ Decrease adult and youth drug use
↓ Decrease adult and youth alcohol use
↓ Decrease adult and youth depression
↓ Decrease adult and youth suicide</td><td>↓ Decrease adult, youth and child obesity
↓ Decrease adult diabetes
↓ Decrease adult heart disease</td><td>↓ Decrease infant mortality
↓ Decrease preterm births
↓ Decrease low birth weight</td></tr>
<tr><td colspan="4">Equity: Priority population for each outcome above</td></tr>
</table>

Indicates alignment with Ohio State Health Improvement Plan (SHIP) priority indicators

There are 10 **cross-cutting strategies** that align with and support the work of the Ohio SHIP. These strategies can be found on pages 27-39. An example cross-cutting strategy aligned with the state is complete streets.

There are four **mental health and addiction strategies** that align with and support the work of the Ohio SHIP. These strategies can be found on pages 40-55. An example mental health and addiction strategy aligned with the state is trauma informed care.

There are nine **chronic disease strategies** that align with and support the work of the Ohio SHIP. These strategies can be found on pages 56-71. An example chronic disease strategy aligned with the state is Safe Routes to School.

There are six **maternal and infant health strategies** that align with and support the work of the Ohio SHIP. These strategies can be found on pages 72-78. An example maternal and infant health strategy aligned with the state is breastfeeding promotion programs.

Addressing Health Equity

Healthy Lucas County acknowledges there are many factors that shape a person's wellbeing and drive unsustainable healthcare spending. The CHIP committee drew upon the framework of the 2017-2019 State Health Improvement Plan (SHIP) to ensure that outcomes and strategies addressed the following cross-cutting factors:

- Health equity
- Social determinants of health
- Public health systems, prevention and health behaviors
- Healthcare system and access

Health equity is the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities. *(Source: 2017-2019 Ohio SHIP)*

Healthy Lucas County took a comprehensive approach to ensure that the community health improvement plan included strategies to help reduce disparities and inequities. Strategies that are indicated with a **√** have 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. *(Source: Ohio's 2017-2019 SHIP)*

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

The Lucas County CHIP also aligns with five of the National Prevention Strategies for the U.S. population: healthy eating, active living, mental and emotional well-being, preventing drug abuse, and excessive alcohol use.

Healthy People 2020

Lucas County's priorities also align with specific Healthy People 2020 goals. Some examples include:

- ***Nutrition and Weight Status (NWS)-8:*** Increase the proportion of adults who are at a healthy weight.
- ***Mental Health and Mental Disorders (MHMD)-9:*** Increase the proportion of adults with mental health disorders who receive treatment.
- ***Substance Abuse (SA)-2:*** Increase the proportion of adolescents never using substances.
- ***Maternal, Infant, and Child Health (MICH)-10:*** Increase the proportion of pregnant women who receive early and adequate prenatal care

There are nine other nutrition and weight status objectives, seven other mental health and mental disorders, nine other substance abuse objectives, and 12 other maternal, infant, and child health objectives that support the work of the Lucas County CHIP. These objectives can be found in each individual section.

The 3 Buckets of Prevention

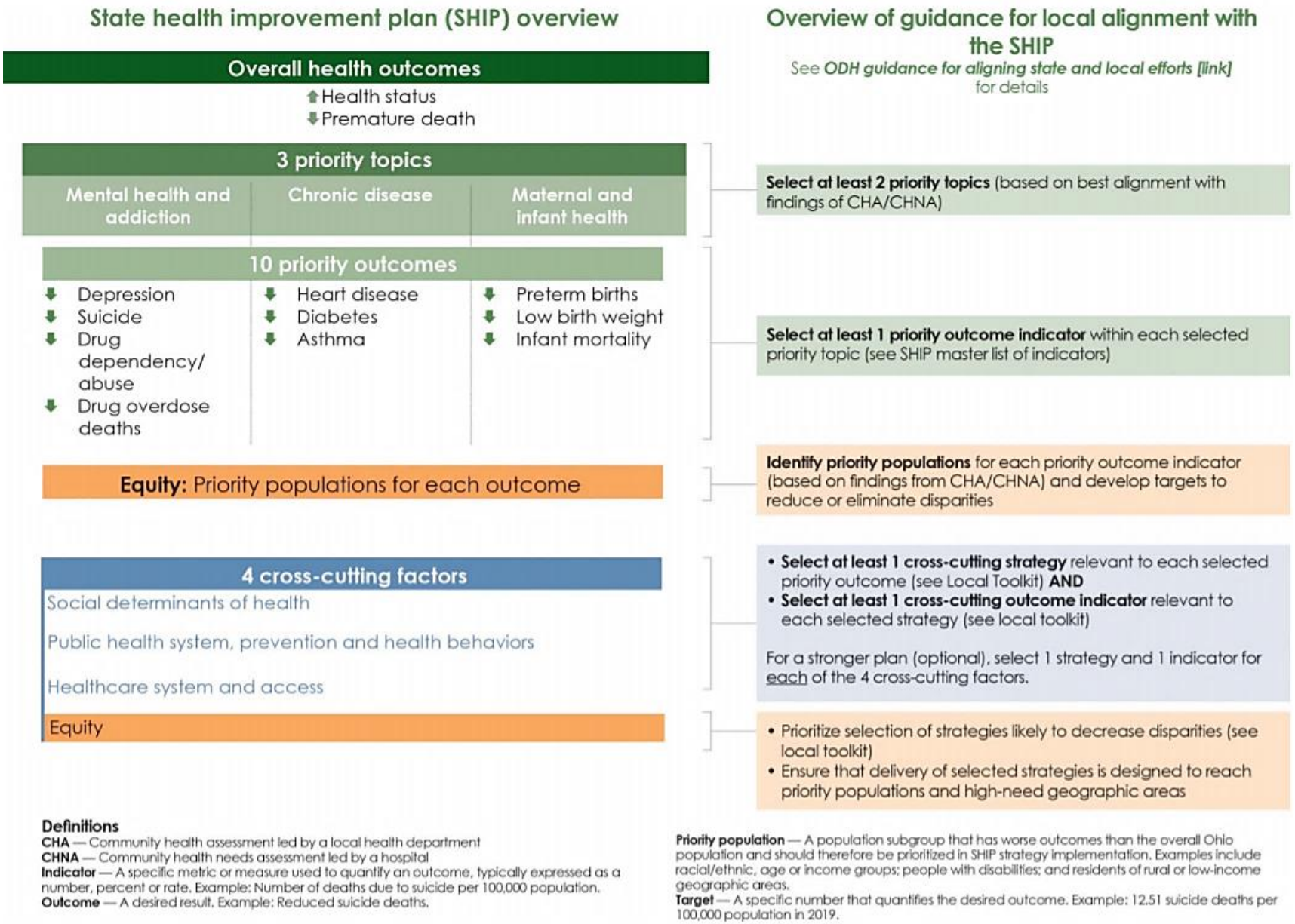
The Lucas County CHIP considered strategies that would fit into each of the 3 Buckets of Prevention and Population Health Framework (see Figure 1.3):

- ***Bucket 1:*** Increase the use of clinical preventive services.

- ***Bucket 2:*** Provide services that extend care outside the clinical setting.
- ***Bucket 3:*** Implement interventions that reach whole populations.

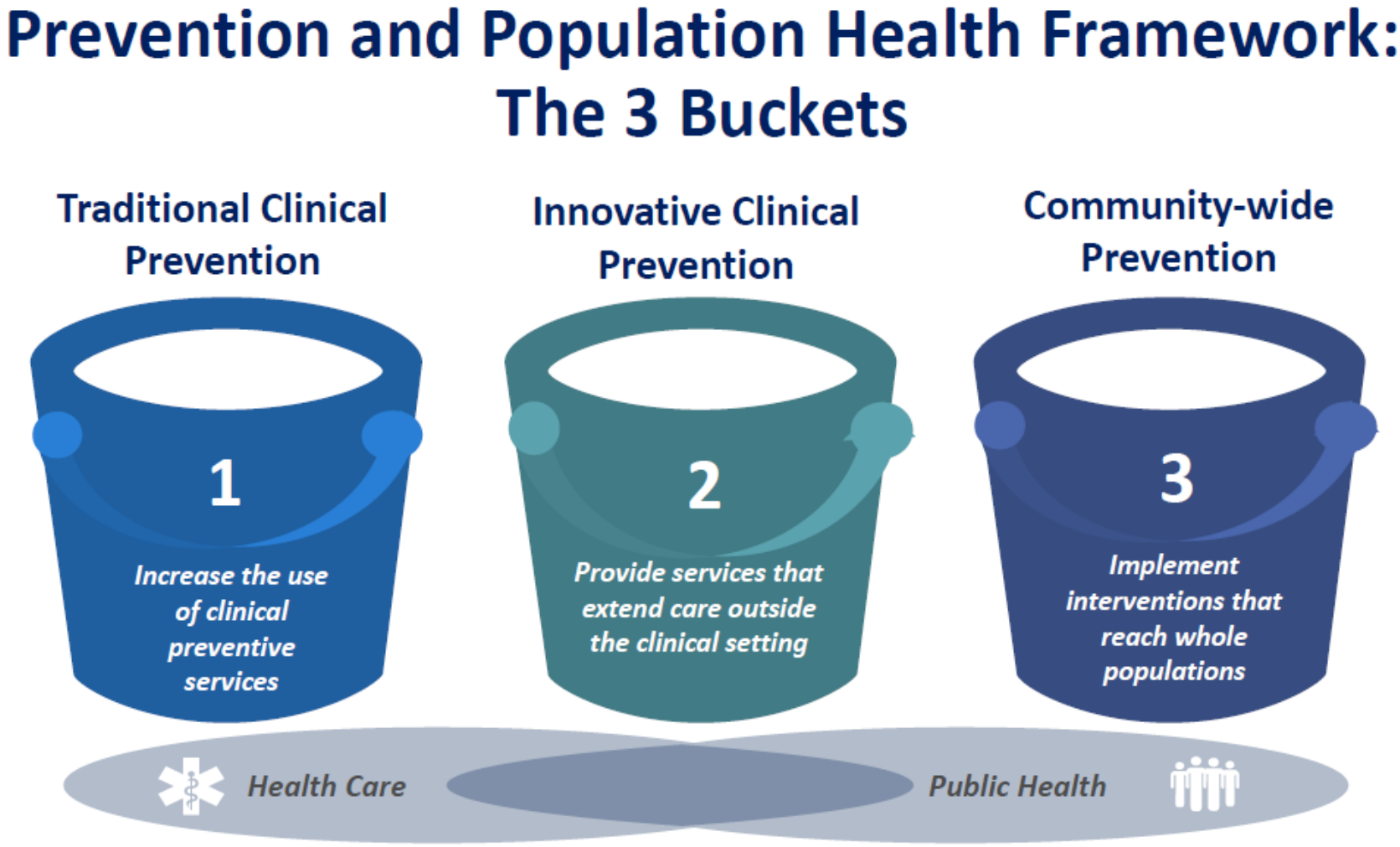
ALIGNMENT WITH NATIONAL AND STATE STANDARDS, continued

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



ALIGNMENT WITH NATIONAL AND STATE STANDARDS, continued

Figure 1.3 The 3 Buckets of Prevention Overview



(Source: Auerbach J. The 3 Buckets of Prevention. Journal of Public Health Management and Practice)

STRATEGIC PLANNING MODEL

Beginning in October 2017, Healthy Lucas County met five (5) times and completed the following planning steps:

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

STRATEGIES, all of which address health disparities:

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

1. Expand school-based health centers
2. Expand complete streets
3. Implement smoke-free policies
4. Increase health insurance enrollment and outreach efforts
5. Improve access to comprehensive primary care
6. Expand the use of community health workers (CHWs)
7. Increase care coordination using the Pathways Community HUB model
8. Implement cultural competency training for healthcare professionals
9. Implement policies to decrease availability of tobacco products (Tobacco 21)
10. Increase links to tobacco cessation support
11. Implement a universal screening and referral process

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

1. Implement school-based alcohol/other drugs, mental health, and tobacco prevention programs
2. Increase awareness of trauma-informed health care
3. Expand access to tobacco cessation treatments and medications

To work toward **decreasing addiction, including drug and opiate use**, the following actions steps are recommended:

1. Implement Generation Rx in grades K-12
2. Implement a community-based comprehensive program to reduce tobacco use
3. Implement an opioid harm reduction prevention program
4. Implement a clinical opioid disposal program
5. Explore feasibility of expanding the scope of the current referral coordination system
6. Implement a community-based comprehensive program to reduce alcohol and other drug misuse/abuse
7. Increase awareness of the Lucas County Opioid Coalition

To work toward **decreasing chronic disease, including obesity**, the following action steps are recommended:

1. Expand nutrition and physical activity interventions in preschool/childcare
2. Expand safe routes to school
3. Implement healthy home environment assessments
4. Increase school-based active recess and policies
5. Expand nutrition prescriptions
6. Increase healthy foods in convenience stores
7. Increase farmer's markets/stands
8. Increase awareness of the Diabetes Prevention Program (DPP)
9. Increase enrollment into the Diabetes Education and Empowerment Program (DEEP)

To work toward **improving maternal and infant health**, **including infant mortality**, the following actions steps are recommended:

1. Increase progesterone treatment
2. Provider counseling with patients about preconception health and reproductive life plans
3. Increase breastfeeding support at birthing facilities
4. Increase breastfeeding promotion programs
5. Increase coordination of home visiting programs
6. Provider counseling with patients about preconception health and prenatal/postnatal care

Strategies by Facilitating Agency

Facilitating Agency	Strategy
Area Office on Aging of Northwestern Ohio	○ Diabetes Education Empowerment Program (DEEP) ○ Diabetes Prevention Program (DPP) ○ Farmer's markets/stands
Toledo/Lucas County CareNet	○ Health insurance enrollment ○ Access to comprehensive primary care
Toledo-Lucas County Getting to 1	○ Preconception health and reproductive life plans counseling ○ Home visiting ○ Breastfeeding promotion programs ○ Preconception education interventions
Mercy Health-St. Anne Hospital, St. Charles Hospital, St. Vincent Medical Center, Children's Hospital, ProMedica-Bay Park Hospital, Flower Hospital, Toledo Children's Hospital, Toledo Hospital, St. Luke's Hospital, and University of Toledo Medical Center *(coordinated by the Hospital Council of Northwest Ohio, a regional hospital association)*	○ Community health workers (CHWs) ○ Pathways Community HUB model ○ Universal health screenings ○ Clinical opioid disposal program ○ Nutrition prescriptions ○ Progesterone treatments ○ Breastfeeding support at birthing facilities
Live Well Greater Toledo	○ Complete streets policies ○ Safe Routes to Schools ○ School-based recess policies ○ Healthy foods in convenience stores
Mental Health & Recovery Services Board of Lucas County	○ School-based prevention program assessment ○ Opioid referral coordination ○ Trauma Informed Care
Toledo Public Schools	○ School-based health centers ○ Generation Rx grades K-12 ○ Nutrition and physical activity interventions in preschool/child care
Toledo-Lucas County Health Department	○ School-based health centers ○ Smoke-free policies ○ Tobacco 21 ○ Links to cessation support ○ Compliance checks ○ Opioid harm reduction ○ Opioid misuse and abuse prevention ○ Lucas County Opioid Coalition ○ Access to tobacco cessation treatments and medications ○ Farmer's markets/stands ○ Cultural competency ○ Diabetes Prevention Program (DPP)
YMCA of Greater Toledo	○ Universal health screenings ○ Nutrition prescriptions ○ Access to tobacco cessation treatments and medications ○ Diabetes Prevention Program (DPP)

Needs Assessment

Healthy Lucas County reviewed the 2016/2017 Lucas County Community Health Assessment along with the collective responses from more than 300 community members who provided feedback at CHA data release events in September 2017. The committee identified the following top key issues and concerns. Detailed primary data for each individual priority area can be found in the section with which it corresponds.

What are the most significant health issues or concerns identified in the 2016-2017 CHA report?

Key Issue or Concern	% of Population At risk	Age Group, Race, or Income Level Most at Risk	Gender Most at Risk
Adult/Youth Mental Health (66 votes)			
Youth contemplated suicide in the past year	12%	Age: 14-16	Female
Youth attempted suicide in the past year	7%	Age: 14-16	Female
Youth depressed	24%	Age 17+	Female
Adult mental health not good on 4 or more days in the past month	37%	Age:<30	Male
Adult/Youth/Child Obesity & Nutrition (50 votes)			
Adult obese	36%	Race: African American	Female
Youth obese	13%		Male
Child obese	33%	--	--
Adult nutrition (ate 5+ fruits and vegetables per day)	4%	--	--
Youth nutrition (ate 5+ fruits and vegetables per day)	6%	--	--
Child nutrition (ate 5+ fruits and vegetables per day)	9%	--	--
Maternal Health/Infant Mortality (24 votes)			
Never breastfed	22%	--	--
Adult/Youth Drugs Use and Opiates (22 votes)			
Adult used marijuana in past 6 months	12%	Income: <$25K	--
Youth used marijuana in past month	10%	Age: 14-16	Female
Adult used opiates for more than 2 weeks	5%	--	--
Youth used prescription drugs that were not prescribed to them in past month	5%	--	--
Youth Sexual Behavior (20 votes)			
Youth ever had sexual intercourse	29%	Age: 17+	Male
Youth had four or more sexual partners (of all youth)	32%	--	--
Access to Healthcare (18 votes)			
Visited a doctor for health care services in past year	79%	--	--
Did not get prescriptions from their doctor filled in past year	35%	--	--
Child had been to a doctor for preventive care in past year	93%	Ages 0-11	--
Chronic Disease (17 votes)			
Had been diagnosed with high blood pressure	34%	Race: African American	Male
Had been diagnosed with arthritis	23%		Female
Diagnosed with other skin cancers	19%	Age: 65+; Income: $25K+	--

Key Issue or Concern	% of Population at risk	Age Group, Race, or Income Level Most at Risk	Gender Most at Risk
Youth Adverse Childhood Experiences (ACEs) (11 votes)			
3 or more ACES	19%	--	--
Social Determinants of Health (11 votes)			
Attempted to get assistance from a social service agency	22%	Income: <$25K	--
Abused in the past year	9%	--	
Concerned about having enough food for family in past 30 days	16%	Income: <$25K	--
			--
Firearms were unlocked and loaded	4%	--	--
Bullying (7 votes)			
Bullied in past year	34%	--	--
Threatened/injured with a weapon on school property in past year	23%	--	--
Electronically/cyber bullied in past year	11%	--	--

Priorities Chosen

Based on the 2016/2017 Lucas County Community Health Assessment, key issues were identified for adults, youth and children. Committee members' rankings were then combined to give an average score for the issue.

Health Issue	Average Score
1. Chronic Disease	25.8
2. Adult, Youth, and Child Obesity & Nutrition	25.5
3. Adult/Youth Mental Health	25.1
4. Adult/ Youth Drugs and Opiates	24.2
5. Social Determinants of Health	24.0
6. Maternal Health/Infant Mortality	23.0
7. Bullying	20.6
8. Youth Adverse Childhood Experiences	20.5
9. Access to Healthcare	20.5
10. Youth Sexual Behavior	19.8

Lucas County will focus on the following four priorities over the next 3 years:

1. Mental Health
2. Addiction/Drug & Opiate Use
3. Chronic Disease/Obesity
4. Maternal & Infant Health/Infant Mortality

Forces of Change Assessment

Healthy Lucas County identified positive and negative forces that could impact community health improvement and overall population health over the next three to five years. This group discussion covered many local, state, and national issues and change agents that could be factors in Lucas County in the near future. The table below summarizes each force of change agent and its potential impacts.

Force of Change	Impact
1. Medicaid expansion	○ Potential reduction
2. Racism	○ Decreased health equity
3. International conflict	○ Socio-economic development ○ Displaced citizens
4. Immigration	○ Increased healthcare services and facilities needed
5. Declining enrollment in early childhood and post-secondary programs	○ Overall health status
6. Lack of compensation for early-childhood teachers	○ Limited teachers
7. Federal regulations	○ Restrictions from mandates limiting abilities ○ Increased documentations needed
8. Social determinants of health	○ Decreased health equity
9. Generational poverty	○ Poverty continues over time
10. Water quality	○ Lack of standards for testing ○ Unknown effects of algae bloom exposure
11. Opiate epidemic	○ Increase in addiction and overdose deaths
12. Technology	○ Lack of socialization ○ Too much screen time ○ Lack of interpersonal communications
13. Health literacy	○ Lack of general understanding
14. Media	○ Creating unnecessary biases by only showing the negative issues
15. Data sharing	○ Collaborative efforts to improve population health
16. Privacy invasions	○ Citizens are more protective and guarded about providing information
17. Increased violence nationally	○ Desensitizing younger generation
18. Mental health as a key issue among current massacre events	○ Appropriate treatment and intervention needed sooner
19. Faith-based abuse of power	○ Decreased participation in the church
20. Human trafficking	○ No impact identified
21. Workplace sexual harassment	○ No impact identified
22. Unemployment rate	○ Decreasing health status due to limited access to healthcare services
23. Political climate change	○ Changes in funding and programs
24. Instability of access	○ No impact identified

Force of Change	Potential Impact
25. Funding priorities	◦ Changes in programs ◦ Possible budget cuts
26. New science/medicine	◦ Improved healthcare services
27. Disconnect between definition vs. reality	◦ Stigma
28. Legal influence on public health systems	◦ No impact identified
29. Tax reform	◦ Possible loss of long-term medical care tax deductions
30. Global influences	◦ Potential for future investors
31. Public transportation	◦ Limited access between city and county
32. Zoning ordinances	◦ Repurpose green space areas ◦ Lead paint exposure and safe housing
33. Aging population	◦ More isolated from the community ◦ Lack of resources available
34. Lack of veteran support	◦ No impact identified
35. Large medical competition	◦ Positive creation of change
36. Decreased funding for afterschool programs	◦ Less opportunities for school hubs

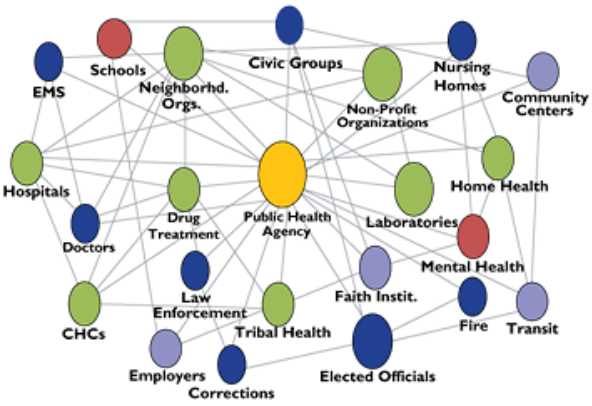
Local Public Health System Assessment

The Local Public Health System

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

The public health system includes:

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



The 10 Essential Public Health Services

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

Public health systems should:

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

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

The Local Public Health System Assessment (LPHSA) 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?"

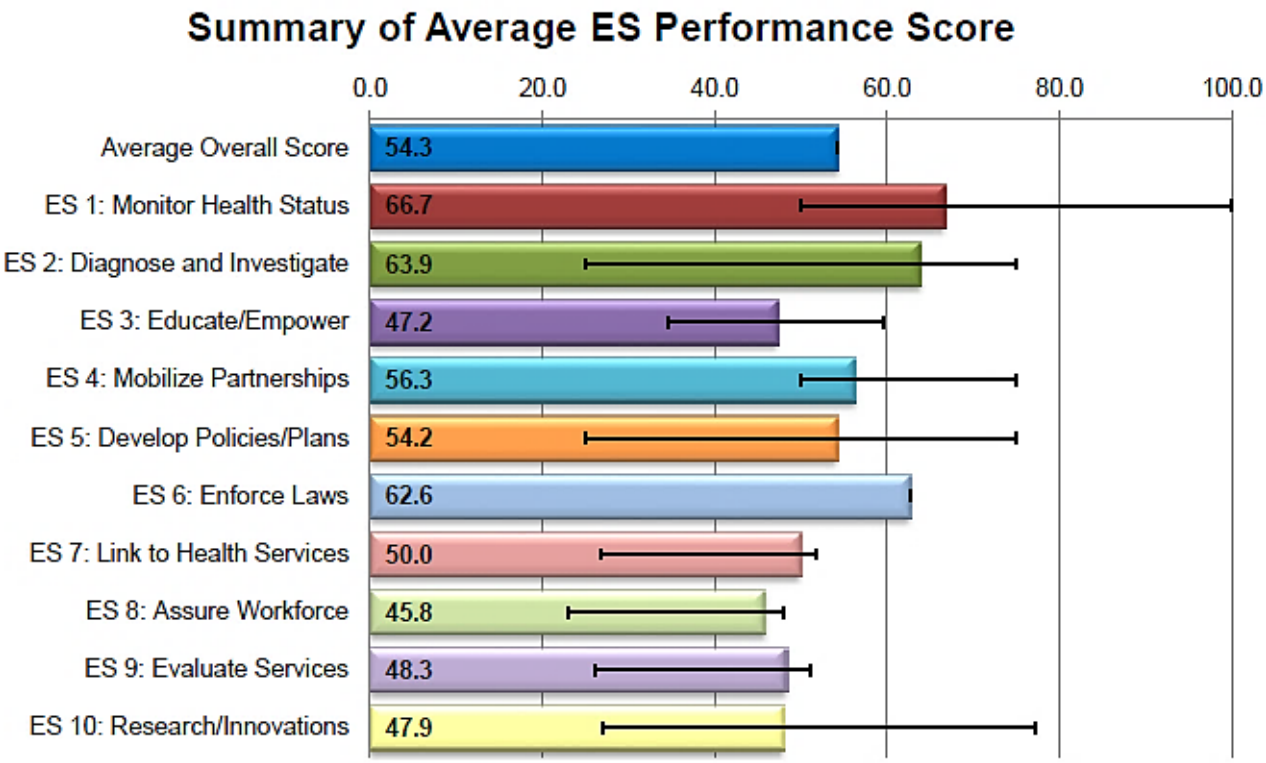
This assessment involves the use of a nationally recognized tool called the **National Public Health Performance Standards Local Instrument**.

Members of the Toledo-Lucas County Health Department completed the performance measures instrument. The LPHSA results were then presented to the full CHIP committee for discussion. The 10 Essential Public Health Services and how they are being provided within the community, as well as each model standard, was discussed and the group came to a consensus on responses for all questions the challenges and opportunities that were discussed were used in the action planning process.

The CHIP committee identified eight indicators that had a status of "minimal" and zero 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.

To view the full results of the LPHSA, please contact Kelly Burkholder-Allen from the Toledo-Lucas County Health Department at 419-213-2882 or at allenk@co.lucas.oh.us.

Lucas County Local Public Health System Assessment 2017 Summary



Community Themes and Strengths Assessment

Healthy Lucas County participated in an exercise to discuss community themes and strengths. The results were as follows:

1. **Lucas County community members believed the most important characteristics of a healthy community were:**
   - Access to healthy foods and grocery stores (2)
   - Access to healthcare services (2)
   - Outdoor space (i.e., bike paths and green space)
   - Access to education services
   - Engaged community key leaders
   - Holistic approaches to health
   - Inclusion (community support)
   - Infrastructure promoting healthy habits
   - Affordable, safe housing
   - Overall community safety
   - Healthy lifestyle education

2. **Community members were most proud of the following regarding their community:**
   - Revitalization of downtown area (2)
   - Collaboration (2)
   - Midwest values and pride (2)
   - Healthcare systems recognition of food deserts
   - Local arts (i.e., Toledo Zoo, Toledo Museum of Art, Toledo Arts Commission)
   - Available community resources
   - Low cost of living
   - Urban age movement

3. **The following were specific examples of people or groups who have worked together to improve the health and quality of life in the community:**
   - Live Well Greater Toledo (2)
   - NeighborWorks Toledo Region
   - Lucas Metropolitan Housing Authority (LMHA)
   - Area Office on Aging of Northwestern Ohio
   - Block watch groups (i.e., Eastside and Reynolds Corners)
   - ProMedica and Toledo Public Schools nurse/education system programs
   - Healthy Lucas County
   - Lucas County Extension
   - Toledo-Lucas County Getting to 1
   - United Way of Greater Toledo
   - Aspire
   - Criminal Justice System
   - Toledo Public Schools hubs
   - Toledo/Lucas County CareNet

4. **The most important issues that Lucas County residents believed must be addressed to improve the health and quality of life in their community were:**
    - Mental health illnesses
    - Chronic disease/obesity
    - Infant mortality
    - Addiction/drug and opiate Use
    - Health disparities/equity
    - Healthcare navigation/coordination
    - Language barriers

5. **The following were barriers that have kept the community from doing what needs to be done to improve health and quality of life:**
    - Unwillingness to break out of silos (2)
    - Apathy/excuses/overwhelmed
    - Lack of community engagement
    - Elected officials/policies
    - Funding
    - Policy changes
    - Lack of commitment to the task
    - Too time consuming
    - Duplication of services
    - Lack of communication among different systems
    - Inability to evaluate programs

6. **Lucas County residents believed the following actions, policies, or funding priorities would support a healthier community:**
    - Universal expansion of Pre-K/Early Head Start (2)
    - Infant mortality policies
    - Community Schools Model
    - Medicaid expansion
    - Affordable higher education
    - Available vocational studies
    - Workforce development
    - Effective community calendar
    - Data sharing

7. **Lucas County residents were most excited to get involved or become more involved in improving the community through:**
    - Sustainable and measurable impact (2)
    - Evidence of change occurring
    - More involvement from local businesses and county officials
    - Data sharing
    - Less overlap/duplication

Quality of Life Survey

Healthy Lucas County encouraged community members to fill out a short Quality of Life Survey via Survey Monkey. There were 412 Lucas County community members who completed the survey. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1. For all responses of "Don't Know," or when a respondent left a response blank, the choice was a non-response, was assigned a value of 0 (zero) and the response was not used in averaging response or calculating descriptive statistics.

Of all survey respondents, 96% lived in Lucas County and 72% worked in Lucas County.

Survey respondents were the following ages: less than 20 years old (<1%), 20-29 years old (15%), 30-39 years old (15%), 40-49 years old (22%), 50-59 (19%), and 60 years or older (28%).

Survey respondents identified as the following race: white (90%), Black or African-American (7%), American Indian/Alaska Native (2%), Asian (1%), Native Hawaiian/other Pacific Islander (<1%), and other (3%). Five percent (5%) of respondents were Hispanic or Latino. Responses may exceed 100% due to selecting more than one race.

Quality of Life Questions	Likert Scale Average Response
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
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. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.15
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
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
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
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
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.09
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	2.68
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide.)	2.89
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
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

Resource Assessment

Based on the chosen priorities, Healthy Lucas County was asked to complete a resource inventory for each priority topic area. Due to the large size of Lucas County and the vast number of ever-changing programs and services, the committee decided to focus on other areas such as built environment, local policy adoption, and geographic locations of services offered.

In addition, a detailed list of existing programs and services in Lucas County can be found by contacting the United Way of Greater Toledo's 2-1-1 resource database.

The committee's resource assessment can be found at **www.healthylucascounty.org/about-us/**

Cross-cutting Strategies

Cross-cutting strategies are those that will address all four priority areas.

Best Practices

1. **School-Based Obesity Prevention Interventions**: School-based obesity prevention programs seek to increase physical activity and improve nutrition before, during, and after school. Programs combine educational, behavioral, environmental, and other components such as health and nutrition education classes, enhanced physical education and activities, promotion of healthy food options, and family education and involvement. Specific components vary by program.

   Expected Beneficial Outcomes
   - Increased physical activity
   - Increased physical fitness
   - Improved weight status
   - Increased consumption of fruit & vegetables

2. **Complete Streets**: Complete streets are designed and operated to enable safe access for all users, including pedestrians, bicyclists, motorists, and transit riders of all ages and abilities. Complete streets make it easy to cross the street, walk to shops, and bicycle to work.

   Creating complete streets means transportation agencies must change their approach to community roads. By adopting a complete streets policy, communities direct their transportation planners and engineers to routinely design and operate the entire right of way to enable safe access for all users, regardless of age, ability, or mode of transportation. This means that every transportation project will make the street network better and safer for drivers, transit users, pedestrians, and bicyclists – making the town a better place to live.

   Changing policy to routinely include the needs of people on foot, public transportation, and bicycles would make walking, riding bikes, riding buses and trains safer and easier. People of all ages and abilities would have more options when traveling to work, to school, to the grocery store, and to visit family.

3. **Smoke-Free Policies for Multi-Unit Housing**: Smoke-free multi-unit housing policies prohibit smoking in apartments, duplexes, and similar residences. Policies can apply to both common areas and individual units, and often include adjacent outdoor areas. Private sector rules apply to privately owned rental properties and owner-occupied units such as condo complexes; state and local ordinances apply to public and subsidized housing. Non-smoking residents of multi-unit housing are often exposed to secondhand smoke in their homes from other units or common areas; the U.S, Surgeon General indicates there is no risk-free level of secondhand smoke exposure. Residents, especially children, can also be exposed to thirdhand smoke, tobacco residue on surfaces and furnishings in their home. Some local governments cannot enact smoke-free measures due to state preemption legislation.

   Expected Beneficial Outcomes:
   - Reduced exposure to secondhand smoke
   - Reduced exposure to thirdhand smoke
   - Reduced cigarette smoking
   - Increased quit rates
   - Reduced health care costs

4. **Community Health Workers (CHWs)**: Community health workers (CHWs), sometimes called lay health workers, community health representatives, or community health advisors, serve a variety of functions, including providing outreach, education, referral and follow-up, case management, advocacy, and home visiting services. CHWs may work autonomously in the community or as part of a multi-disciplinary team in primary or specialty care; training varies widely with intended role and location. CHW services are usually provided to underserved communities and to individuals at high risk of poor health outcomes. CHWs often work with individuals at risk for or suffering from chronic diseases such as diabetes or cardiovascular disease. They also work with women at high risk for poor birth outcomes, providing pregnant women and new mothers with emotional and practical support and education on topics such as family planning, pregnancy, childbirth, breastfeeding, and vaccination.

   Expected Beneficial Outcomes
   - Increased patient knowledge
   - Increased access to care
   - Increased healthy behaviors
   - Increased preventive care

   Other Potential Beneficial Outcomes
   - Reduced low birth weight babies
   - Increased breastfeeding rates
   - Improved mental health

5. **Cultural Competence Training for Health Care Professionals**: Cultural competence training for health care professionals focuses on skills and knowledge to value diversity, understand and respond to cultural difference, and increase awareness of providers' and care organizations cultural norms. Trainings can provide facts about patient cultures or include more complex interventions, such as intercultural communication skills training, exploration of potential barriers to care, and institution of policies that are sensitive to the needs of patients from culturally and linguistically diverse (CALD) backgrounds.

6. **Food Insecurity Screening and Referral**: Hospitals and clinics can play a central role in screening and identifying patients at risk for food insecurity and connecting families with needed community resources. It is important to advocate for federal and local policies that support access to adequate healthy food for an active and healthy life.

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

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

   The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV).

8. **Tobacco 21**: Established in 1996, the Preventing Tobacco Addiction Foundation strives to reduce the toll of smoking and tobacco use through a preventive effort. The focus of Tobacco 21 is to raise the legal minimum sales age to 21 for all nicotine and tobacco products. Nine out of 10 smokers started smoking by the age of 21. The chances of becoming a smoker after the age of 21 is only 2%. Decreasing the number of eligible tobacco buyers in high school will help reduce youth smoking rates by decreasing the access of tobacco products to students. A similar strategy with alcohol was highly successful in reducing youth alcohol consumption, decreased alcohol dependence, and decreased drunk driving fatalities. As of December 2017, there were nine cities in Ohio that adopted a Tobacco 21 ordinance.

9. **School-Based Health Alliance**: Founded in 1995, the nonprofit School-Based Health Alliance strives to improve the health of children and youth by bringing health care to where students are already spending most of their time: school.

   School-based health works to ensure that students have access to high-quality health care when needed. Onsite health care professionals collaborate with schools to help address a broad range of concerns and adverse experience that affect students' healthy development. Collaboration with school administrators, school nurses, teachers, and staff is very important to ensure the school-health partnership meets the needs of the students.

10. **Walk Friendly Communities**: Established in 2011, Walk Friendly Communities is a national program developed to encourage towns and cities in the United States to establish and commit to improving and sustaining walkability and pedestrian safety through comprehensive programs, plans, and policies. Communities must apply to the program to receive recognition in the form of a Bronze, Silver, Gold, or Platinum designation.

Cross-Cutting Strategies

Action Step Recommendations & Plan

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

1. Expand school-based health centers
2. Expand complete streets
3. Implement smoke-free policies
4. Increase health insurance enrollment and outreach efforts
5. Improve access to comprehensive primary care
6. Expand the use of community health workers (CHWs)
7. Increase care coordination using Pathways Community HUB model
8. Implement cultural competence training for healthcare professionals
9. Implement policies to decrease availability of tobacco products (Tobacco 21)
10. Increase links to tobacco cessation support
11. Implement a universal screening and referral process

Action Plan

SOCIAL DETERMINATES OF HEALTH	Priority Topic: Cross-cutting strategies				
	Strategy 1: Expand school-based health centers √				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Gather community leaders, stakeholders, local qualified healthcare providers, and mental health providers to discuss and assess the need for a school-based health center and determine the type of services it will provide to the students based on local schools. Use the **School-Based Health Alliance** website for applicable trainings and resource guides	**Priority Outcome:** 1. Reduce adult and youth obesity 2. Increase high school graduation rates 3. Increase child preventive care visits to a doctor 4. Define and address health disparities **Priority Indicator:** 1. Percent of youth who were obese 2. Percent of adults who were obese 3. Percent of children who visited a doctor for preventive care in the past 12 months	Adult, Youth, and Child	Toledo Public Schools and Toledo-Lucas County Health Department	July 1, 2018-June 30, 2019
	Year 2: Research and secure funding through the state, county health department, federally qualified heath centers (FQHC), local businesses, community providers, grants, and another fundraising.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from year 2 and start to plan to open one new school-based health center.				July 1, 2020- June 30, 2021

SOCIAL DETERMINATES OF HEALTH	Priority Topic: Cross-cutting strategies				
	Strategy 2: Expand Complete Streets				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Raise awareness of Complete Streets Policy, and recommend that all local jurisdictions adopt comprehensive complete streets policies for cities/towns/villages. Gather baseline data on all the Complete Streets Policy objectives.	**Priority Outcome:** 1. Reduce adult, youth and child obesity 2. Reduce adult hypertension 3. Reduce adult diabetes 4. Define and address health disparities **Priority Indicator:** 1. Percent of adults who were obese 2. Percent of adults diagnosed with hypertension 3. Percent of adults diagnosed with diabetes 4. Percent of youth who were obese 5. Percent of children who were obese	Adult, Youth, and Child	Live Well Greater Toledo	July 1, 2018-June 30, 2019
	Year 2: Begin to implement and track the following complete streets objectives: • Increase in total number of miles of on-street bicycle facilities, defined by streets and roads with clearly marked or signed bicycle accommodations. • Increase in member jurisdictions which adopt complete streets policies. Increase in number of jurisdictions achieving or pursuing Bike-Friendly Community status from the League of American Bicyclists, or Walk-Friendly Community status from **Walk Friendly Communities**				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from years 1 and 2.				July 1, 2020- June 30, 2021

SOCIAL DETERMINATES OF HEALTH	Priority Topic: Cross-cutting strategies				
	Strategy 3: Implement smoke-free housing policies √				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Collect data on multi-unit housing, outdoor spaces, and school districts existing smoke-free policies. Tobacco prevention team members will work to develop relationships with multi-unit housing owners, elected officials that have authority over outdoor spaces, such as parks, and local school districts. Provide information regarding smoke-free policies to decision makers and community stakeholders. Implement 100% smoke-free policy at one Lucas County local school district. Survey five multi-unit housing complexes regarding a smoke-free policy. Implement smoke-free policy in Lucas County parks and mental health facilities.	**Priority Outcome:** 1. Increase smoke-free policies 2. Reduce adult and youth tobacco use 3. Reduce adult and youth exposure to secondhand smoke in the home 4. Define and address health disparities **Priority Indicator:** 1. Percent of children exposed to secondhand smoke at home 2. Percent of adults exposed to secondhand smoke at home 3. Percent of adult smokers (past 30 days or lifetime) 4. Percent of youth smokers (past 30 days or lifetime)	Adult, Youth, and Child	Toledo-Lucas County Health Department	July 1, 2018-June 30, 2019
	Year 2: Continue efforts from year 1. Target five additional multi-unit housing complexes. Implement at least two smoke-free multi-unit housing policies and provide cessation education to residents. Help with pre-implementation efforts of smoke-free policy at Lucas County parks, mental health facilities, and local school district.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from years 1 and 2.				July 1, 2020- June 30, 2021

HEALTHCARE SYSTEM AND ACCESS	Priority Topic: Cross-cutting strategies				
	Strategy 4: Increase health insurance enrollment and outreach efforts √				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Continue to operate Toledo/Lucas County CareNet as a virtual free clinic for low-income, uninsured residents to have access to a medical home and needed healthcare services. Continue to provide healthcare coverage application assistance to low-income Lucas County residents for Medicaid and the Marketplace in coordination with CareNet's healthcare partner organizations and promote medical homes. Increase awareness and education on open enrollment and new Marketplace plans available.	**Priority Outcome:** 1. Reduce the number of uninsured adults, children, and pregnant women 2. Define and address health disparities **Priority Indicator:** 1. Percent of 18- to 64-year-olds who were uninsured 2. Percent of 0- to 17-year-olds who were uninsured 3. Percent of pregnant women who were uninsured	Adult	Toledo/Lucas County CareNet	July 1, 2018-June 30, 2019
	Year 2: Continue efforts from year 1. Train CHWs to be certified application counselors to assist with open enrollment, as well as assist patients with their healthcare needs. Host community enrollment events during Marketplace open enrollment periods. Begin educating and enrolling consumers. Continue quarterly community meetings with Lucas County Department of Job & Family Services. Refer eligible individuals to CareNet.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from years 1 and 2.				July 1, 2020- June 30, 2021

HEALTHCARE SYSTEM AND ACCESS	Priority Topic: Cross-cutting strategies				
	Strategy 5: Improve access to comprehensive primary care √				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Continue to operate Toledo/Lucas County CareNet as a virtual free clinic for low-income, uninsured residents to have access to a medical home and needed healthcare services. Provide healthcare coverage application assistance to low-income Lucas County residents for Medicaid and the Marketplace. Develop and keep updated a listing of free/sliding-fee-scale clinics to distribute to emergency departments (ED). Work with the Northwest Ohio Pathways HUB on tracking the number of pathways opened and completed for both obtaining health coverage and a medical home.	**Priority Outcome:** 1. Reduce number of adults unable to see a doctor due to cost 2. Reduce number of adults who don't have a personal healthcare provider 3. Increase number of adults who have a routine checkup in the past year 4. Define and address health disparities **Priority Indicator:** 1. Percent of adults who reported not seeing a doctor in the past 12 months because of cost 2. Percent of adults who don't have one (or more) person they think of as their personal healthcare provider 3. Percent of at-risk adults who have visited a doctor for a routine checkup in the past two years	Adult	Toledo/Lucas County CareNet	July 1, 2018-June 30, 2019
	Year 2: Continue efforts from year 1. Partner with all hospitals in Lucas County to provide ED patients with a listing of affordable options for medical homes and information on the community health worker program through the Northwest Ohio Pathways HUB. Explore available resources for health promotion in the top three languages (excluding English) for the limited English proficiency population.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from years 1 and 2.				July 1, 2020- June 30, 2021

HEALTHCARE SYSTEM AND ACCESS	Priority Topic: Cross-cutting strategies				
	Strategy 6: Expand the use of community health workers (CHWs) √				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Train at least 15 individuals to become certified CHWs to serve high risk populations. Embed CHWs into health systems and non-traditional settings, such as schools and homeless shelters.	**Priority Outcome:** 1. Reduce adult diabetes 2. Reduce the number of uninsured adults, children, and pregnant women 3. Define and address health disparities **Priority Indicator:** 1. Percent of 18- to 64-year-olds who were uninsured 2. Percent of 0- to 17-year-olds who were uninsured 3. Percent of pregnant women who were uninsured 4. Percent of adults diagnosed with diabetes	Adult, Youth, and Child	Hospital Council of Northwest Ohio	July 1, 2018-June 30, 2019
	Year 2: Generate community reports detailing effectiveness of CHWs in traditional and non-traditional settings. Provide continuing education to CHWs so they refine their skills and keep certification current.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from year 2. Provide additional certification classes based on funding to sustain a highly skilled workforce.				July 1, 2020- June 30, 2021
	Strategy 7: Increase care coordination through the Pathways HUB Model √				
	Year 1: The Northwest Ohio Pathways HUB will add 13 new CHWs to serve women of childbearing age. Train CHWs to do motivational interviewing to connect clients to mental health/addiction services. Secure one additional managed care contract to prevent and reduce chronic disease. Pilot a CHW in Toledo Public Schools.	**Priority Outcome:** 1. Reduce infant mortality 2. Reduce adult diabetes 3. Reduce the number of uninsured adults, children, and pregnant women 4. Define and address health disparities **Priority Indicator:** 1. Rate of infant deaths per 1,000 live births 2. Percent of 18- to 64-year-olds who were uninsured 3. Percent of 0- 17-year-olds who were uninsured 4. Percent of pregnant women who were uninsured	Adult, Youth, and Child	Hospital Council of Northwest Ohio	July 1, 2018-June 30, 2019
	Year 2: Continue enrolling clients into the Northwest Ohio Pathways HUB. Secure final managed care contract to prevent and reduce chronic disease. Increase the number of clients being connected to mental health/addiction services				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from year 2.				7/1/20-6/30/21

HEALTHCARE SYSTEM AND ACCESS	Priority Topic: Cross-cutting strategies				
	Strategy 8: Implement cultural competence training for healthcare professionals √				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Educate/inform local businesses, organizations and healthcare providers on county demographics and the importance of becoming culturally competent. Offer a county-wide training/workshop on cultural competence definitions and language barriers/access overview.	**Priority Outcome:** 1. Increase cultural understanding and skills 2. Define and address health disparities **Priority Indicator:** 1. Percent of organizations that demonstrate increased awareness and knowledge in being culturally competent 2. Number of education sessions completed 3. Number of organizations which incorporate cultural competency trainings into policy 4. Number of people that complete the organizational cultural competency trainings	Adult	Toledo-Lucas County Getting to 1 and Toledo-Lucas County Office on Minority Health	July 1, 2018-June 30, 2019
	Year 2: Enlist two organizations to adopt culturally competent principles, policies and/or practices within their organizations.				July 1, 2019-June 30, 2020
	Year 3: Establish compliance and measuring metrics for evaluating. Increase the number of organizations adopting cultural competency policies by 25% from baseline.				July 1, 2020- June 30, 2021

PUBLIC HEALTH SYSTEM, PREVENTION AND HEALTH BEHAVIORS	Priority Topic: Cross-cutting strategies				
	Strategy 9: Implement policies to decrease availability of tobacco products (Tobacco 21)				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Work with community partners to strategically plan a process for Tobacco 21 implementation. Meet with individual council members for Toledo, Sylvania, Oregon, and Maumee. Meet with the mayors of Toledo, Sylvania, Oregon, and Maumee regarding the Tobacco 21 initiative and create a memorandum of understanding with the four cities.	**Priority Outcome:** 1. Reduce adult and youth tobacco use 2. Reduce access to tobacco products 3. Define and address health disparities **Priority Indicator:** 1. Percent of adult smokers (past 30 days or lifetime) 2. Percent of youth smokers (past 30 days or lifetime) 3. Percent of youth tobacco users who bought tobacco products from a store or gas station	Adult and Youth	Toledo-Lucas County Health Department	July 1, 2018-June 30, 2019
	Year 2: Continue efforts from year 1. Implement Tobacco 21 in at least one city (Toledo, Sylvania, Oregon, or Maumee). Continue educating the community and gaining support for the Tobacco 21 initiative.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from year 1 and 2. Implementation of Tobacco 21 in Toledo, Sylvania, Maumee, and Oregon.				July 1, 2020- June 30, 2021

PUBLIC HEALTH SYSTEM, PREVENTION AND HEALTH BEHAVIORS	Priority Topic: Cross-cutting strategies				
	Strategy 10: Increase links to tobacco cessation support				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Assess current cessation providers in Lucas County and establish community partnerships with community organizations and health care providers. Hire community cessation initiative (CCI) team through Toledo-Lucas County Health Department (TLCHD) to begin work and complete certified tobacco treatment specialist (CTTS) training. Begin expansion of cessation services through TLCHD and CCI referral system.	**Priority Outcome:** 1. Reduce adult tobacco use 2. Increase adults who have quit smoking 3. Define and address health disparities **Priority Indicator:** 1. Percent of adult smokers (past 30 days or lifetime) 2. Percent of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period and who received cessation counseling intervention if identified as a tobacco user 3. Percent of adult smokers who have made a quit attempt in the past year	Adult	Toledo-Lucas County Health Department	July 1, 2018-June 30, 2019
	Year 2: Continue expansion of cessation services to residents within Lucas County, providing cessation services within a 10-mile radius from patient. Target to reach 500 patients for cessation services. Work towards billing for sustainability of CCI efforts beyond the grant.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from year 1 and 2.				July 1, 2020- June 30, 2021

PUBLIC HEALTH SYSTEM, PREVENTION AND HEALTH BEHAVIORS	Priority Topic: Cross-cutting strategies				
	Strategy 11: Implement a universal screening and referral process				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Conduct an assessment of screenings taking place in clinical settings for the following: • Chronic disease (diabetes, hypertension) • Mental health and addiction (depression, trauma, drug, and alcohol use) • Social determinants of health (food insecurity, transportation, housing, etc.) Assess which clinical settings are using CliniSync to integrate patient electronic health records (EHR) from multiple facilities to better coordinate care.	**Priority Outcome:** 1. Reduce adult and youth depression 2. Reduce adult and youth drug and alcohol use 3. Reduce adult hypertension 4. Reduce adults who experience food insecurity 5. Define and address health disparities **Priority Indicator:** 1. Percent of adults and youth who felt sad or hopeless almost every day for at least two consecutive weeks so that they stopped doing some usual activities during the past 12 months 2. Percent of households that are food insecure 3. Percent of adults and youth who used prescription drugs not prescribed to them in the past 30 days 4. Percent of adults diagnosed with hypertension	Adult and Youth	Hospital Council of Northwest Ohio, YMCA of Greater Toledo, and Toledo-Lucas County Health Department	July 1, 2018-June 30, 2019
	Year 2: Develop a universal screening tool to be used by all clinical settings. Develop a strategy to connect patients to resources to address results from screenings. Encourage use of CliniSync with providers within the region.				July 1, 2019-June 30, 2020
	Year 3: Implement universal screening tool and referral process. Continue encouragement of CliniSync.				July 1, 2020- June 30, 2021

Priority 1: Mental Health

Mental Health Indicators

Adult Mental Health

During the past year, 2% of Lucas County adults considered attempting suicide.

One percent (1%) of adults reported attempting suicide in the past year.

Thirty-two percent (32%) of adults did not get enough rest or sleep almost every day for two or more weeks in a row.

Fourteen percent (14%) of Lucas County adults had used a program or service to help with depression, anxiety, or other emotional problems for themselves or a loved one.

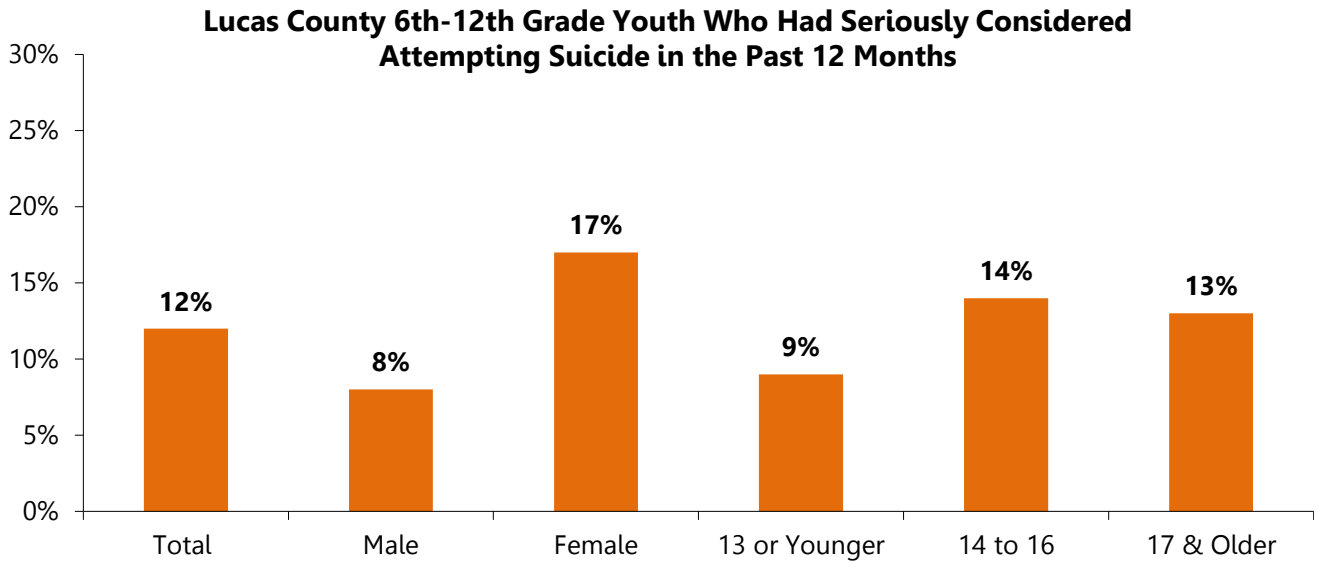
Youth Mental Health

About one-quarter (24%) of youth reported they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities, increasing to 32% of females.

Twelve percent (12%) of youth reported they had seriously considered attempting suicide in the past 12 months, increasing to 17% of females.

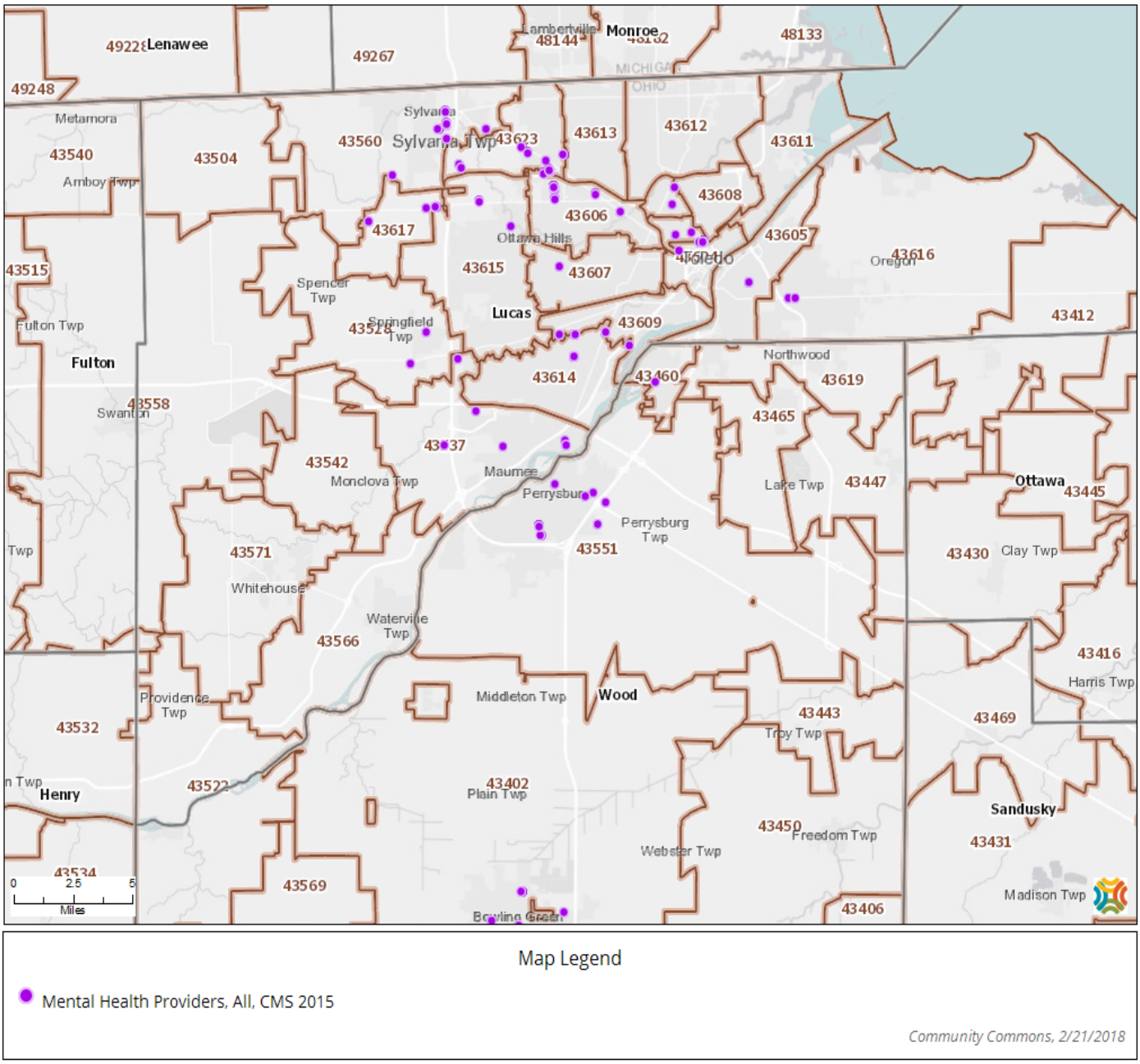
In the past year, 7% of youth had attempted suicide, increasing to 10% of females.

Of those who experienced three or more adverse childhood experiences (ACEs), 33% seriously considered attempting suicide compared to 4% of those who experienced zero ACEs.



Map: Mental Health Providers

Mental Health Providers, All, Centers for Medicare & Medicaid Services



Map Legend

Mental Health Providers, All, CMS 2015

Community Commons, 2/21/2018

Source: Centers for Medicare and Medicaid Services: 2015, as compiled by Community Commons, obtained on 2/21/18)

Priority 1: Mental Health

Gaps and Potential Strategies – Mental Health

Gaps	Potential Strategies
1. Lack of access and use of services by LBGTQ/incarcerated/homeless and other groups (2)	◦ Awareness ◦ Policy change ◦ Transportation ◦ Linkage to community mental health centers ◦ Improved coordination of care
2. Lack of accessible geographic locations for mental health services (2)	◦ Transportation services - TARTA ◦ Identification of services private vs. public ◦ Environmental scan ◦ Learning opportunities for mental health staff
3. Lack of youth prevention programs (2)	◦ Raising awareness ◦ Transition programs for children
4. Lack of prevention (i.e., bullying)	◦ Assess current programs ◦ Improve communication
5. Lack of resource listing/referral networks of all providers	◦ Look at 2-1-1 ◦ Utilize insurance companies to ensure listings are accurate ◦ Conduct annual reviews of resources
6. Lack of system knowledge	◦ Substance Abuse and Mental Health Administration (SAMSA) ◦ Educating providers ◦ Accrediting bodies
7. Lack of bilingual providers	◦ Work with and utilize mental health board strategic plan and diversity inclusion plan ◦ Improved coordination of care
8. Lack of access to mental health patients in jails/prisons	◦ Have the jail systems work on teaming up with the Lucas County Department of Job and Family Services (JFS) ◦ Obtain more funding
9. Lack of providers for rescue crisis/ urgent care	◦ Raising awareness
10. Policies restricting number of beds for inpatient treatment	◦ Creating partnership to develop/add inpatient services

Priority 1: Mental Health

Best Practices

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

Priority 1: Mental Health

Action Step Recommendations & Plan

To work toward **improving mental health,** the following action steps are recommended:
1. Implement school-based alcohol/other drugs, mental health, and tobacco prevention programs
2. Increase awareness of trauma-informed health care
3. Expand access to tobacco cessation treatments and medications

Action Plan

<table>
<tr><td rowspan="6">SOCIAL DETERMINATES OF HEALTH</td><td colspan="5">Priority Topic: Mental Health</td></tr>
<tr><td colspan="5">Strategy 1: Implement school-based alcohol/other drugs, mental health, and tobacco prevention programs</td></tr>
<tr><td>Action Step</td><td>Priority Outcome & Indicator</td><td>Priority Population</td><td>Facilitating Agency</td><td>Timeline</td></tr>
<tr><td>Year 1: Gather baseline data on which prevention programs and/or policies are currently being implemented in school districts.

Explore forming a Lucas County Youth Prevention Coalition to include schools, health organizations, social service agencies, law enforcement, churches, and other youth-based agencies.</td><td rowspan="3">Priority Outcome:
1. Reduce youth depression
2. Reduce youth contemplating suicide
3. Reduce youth tobacco, alcohol, and drug use
4. Define and address health disparities

Priority Indicator:
1. Percent of youth who felt sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the past 12 months
2. Percent of youth who contemplated suicide during the past 12 months
3. Percent of youth smokers (past 30 days or lifetime)
4. Percent of youth who used prescription drugs not prescribed to them in the past 30 days
5. Percent of youth drinkers (past 30 days)</td><td rowspan="3">Youth</td><td rowspan="3">Mental Health and Recovery Services Board of Lucas County</td><td>July 1, 2018-June 30, 2019</td></tr>
<tr><td>Year 2: Assist schools and/or coalition with the following:
• Coordination of meetings, agendas, and minutes.
• Research best practices and evidence-based programs and policies to implement county-wide.
• Research sustainable funding opportunities to assist with programming costs.
• Language for school-related policies for mental health and substance abuse.</td><td>July 1, 2019-June 30, 2020</td></tr>
<tr><td>Year 3: Continue efforts from year 2.</td><td>July 1, 2020- June 30, 2021</td></tr>
</table>

	Priority Topic: Mental Health				
	Strategy 2: Increase awareness of trauma informed care				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
HEALTHCARE SYSTEM AND ACCESS	**Year 1:** Work to increase awareness of the Lucas County Trauma Informed Care Coalition (LCTICC): • Attend relevant local community events. • Promote website http://lctraumacoalition.org/ • Increase the number of agencies that attend LCTICC monthly meetings. Facilitate trauma informed care trainings in the community to increase education and understanding of trauma and trauma informed practices. • Provide one-hour and two-hour trainings written by the state. Facilitate trauma informed care trainings specifically for schools at Toledo Public Schools and across Lucas County.	**Priority Outcome:** 1. Reduce adult and youth suicide 2. Define and address health disparities **Priority Indicator:** Number of deaths due to suicide per 100,000 populations (age adjusted)	Adult and Youth	Mental Health & Recovery Services Board of Lucas County	July 1, 2018-June 30, 2019
	Year 2: Continue efforts from year 1. Work to expand trainings to other Lucas County schools, including charter schools.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from years 1 and 2. Offer community trainings free to the public.				July 1, 2020- June 30, 2021
PUBLIC HEALTH SYSTEM,	**Strategy 3: Expand access to evidence-based tobacco cessation treatments and medications √**				
	Year 1: Refer patients to necessary healthcare providers who utilize evidence-based tobacco cessation and medications. Refer patients to the Ohio Tobacco Quit Line for those who have transportation or medical barriers.	**Priority Outcome:** 1. Reduce adult tobacco use 2. Define and address health disparities	Adult	Live Well Greater Toledo and Toledo-Lucas	July 1, 2018-June 30, 2019

	Year 2: Continue efforts of year 1. Work to expand referral system to more healthcare providers.	**Priority Indicators:** Percent of adult smokers (past 30 days or lifetime)		County Health Department	July 1, 2019-June 30, 2020
	Year 3: Continue efforts of years 1 and 2.				July 1, 2020- June 30, 2021

Priority 2: Addiction/Drug and Opiate Use

Addiction Indicators

Adult Tobacco Use

One-in-seven (14%) Lucas County adults were current smokers (those who indicated smoking at least 100 cigarettes in their lifetime and currently smoked some or all days).

Five percent (5%) of adults used e-cigarettes in the past year.

Adult Alcohol Use

Less than one-fourth (24%) of Lucas County adults were considered binge drinkers (consuming five or more alcoholic drinks (for males) or 4 or more drinks (for females) on an occasion in the last month.

In 2017, 8% of adults reported driving after believing they may have had too much to drink, increasing to 12% of males.

Adult Drug Use

Six percent (6%) of adults had used medication not prescribed for them or took more than prescribed to feel good or high and/or more active or alert during the past 6 months.

Five percent (5%) of adults had taken prescription opiates on a regular basis for more than 2 weeks.

Youth Tobacco Use

Three percent (3%) of Lucas County youth were current smokers, increasing to 6% of those ages 17 and older. Twenty percent (20%) of those who had smoked a whole cigarette did so at 10 years old or younger, and another 23% had done so by 12 years old.

Youth Alcohol Use

In 2016, 17% of youth had at least one drink in the past 30 days, increasing to 39% of those ages 17 and older (YRBS reports 30% for Ohio in 2013 and 33% for the U.S. in 2015).

Seven percent (7%) of all youth were defined as binge drinkers, increasing to 16% of high school youth.

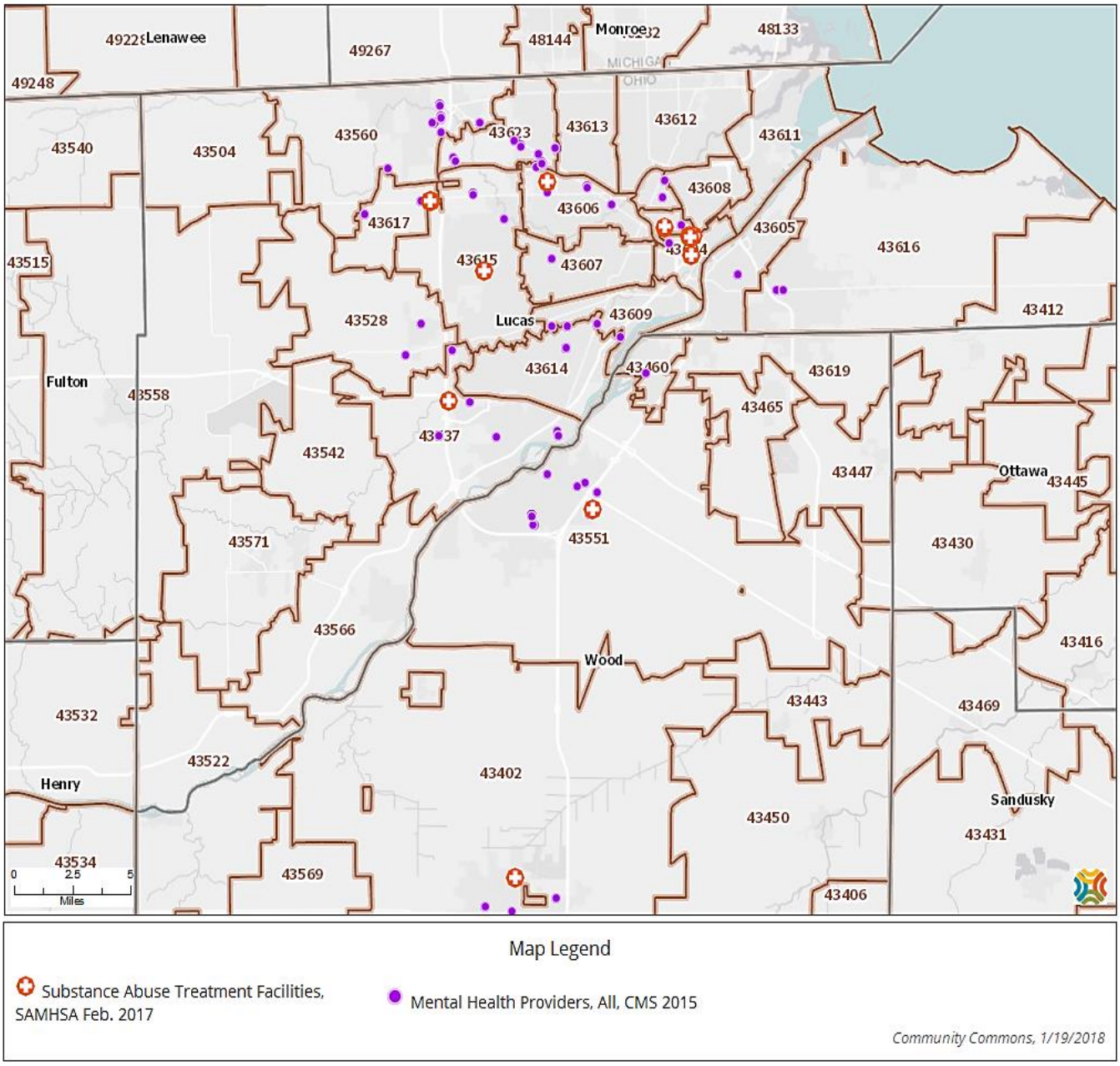
Youth Drug Use

In 2016, 10% of all Lucas County youth had used marijuana at least once in the past 30 days, increasing to 22% of those over the age of 17.

Four percent (5%) of youth used prescription drugs that were not prescribed for them during the past 30 days.

Map: Substance Abuse Treatment Facilities

Substance Abuse Treatment Facilities, SAMHSA February 2017



Source: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA): February 2017, as compiled by Community Commons, obtained on 1/19/18)

Priority 2: Addiction/Drug and Opiate Use

Gaps and Potential Strategies – Addiction/Drug and Opiate Use

Gaps	Potential Strategies
1. Deficiency in education and training for physician assistants and nurse practitioners for drug addiction	◦ None specified
2. Lack of identification of individuals at risk and appropriate interventions	◦ None specified
3. Lack of coordination of care/lack of resources	◦ None specified
4. Lack of resources for environmental conditions, education, and human trafficking	◦ None specified
5. Lack of policies for drug screening follow-ups post initial screenings	◦ Screening tool kits & trainings on how to use tools ◦ Develop a follow up process
6. Lack of universal definitions of drugs	◦ Education ◦ Policy guidelines ◦ Awareness ◦ Ohio Automated Rx Reporting System (OARRS) ◦ Partnerships ◦ Increasing access to opiate treatment
7. Transition process for youth who are no longer on their parent's insurance plan/continuity of care	◦ Education/awareness ◦ Funding ◦ Making insurance plans affordable ◦ Screening Brief Intervention Referral for Treatment (SBIRT)
8. Lack of Medicaid expansion/policies	◦ None specified
9. Utilize bilingual providers rather than translators	◦ Develop recruitment strategies and incentives ◦ University of Toledo working with social work services
10. Lack of resources for minority populations	◦ Provide services to accommodate minority groups ◦ Increase cultural competency ◦ Reduce language barriers ◦ Policy change
11. Barriers to accessing resources overall	◦ Develop policies that will deflect people with mental health and substance abuse to treatment vs. entering prison facilities ◦ Approach individuals and connect them to care rather than have people come to you
12. Lack of family support to those addicted	◦ Drug Abuse Response Team (DART)
13. Lack of early childhood interventions	◦ Toledo-Lucas County Health Department and Toledo Public Schools working together on school programs/ two generations
14. Lack of prescription medication control	◦ Policy change ◦ Pharmacy board ◦ Ohio Automated RX Reporting System (OARRS) ◦ Enforce prescription practices ◦ Shut down mail order of prescription drug supply

Priority 2: Addiction/Drug and Opiate Use

Best Practices

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

    - Out-of-treatment adults who are visiting a walk-in health clinic for routine medical care and have a positive screening result for cocaine and/or opiate use. Project ASSERT aims to reduce or eliminate their cocaine and/or opiate use through interaction with peer educators (substance abuse outreach workers who are in recovery themselves for cocaine and/or opiate use and/or are licensed alcohol and drug counselors).
    - Adolescents and young adults who are visiting a pediatric ED for acute care and have a positive screening result for marijuana use. Project ASSERT aims to reduce or eliminate their marijuana use through interaction with peer educators (adults who are under the age of 25 and, often, college educated).
    - Adults who are visiting an ED for acute care and have a positive screening result for high-risk and/or dependent alcohol use. Project ASSERT aims to motivate patients to reduce or eliminate their unhealthy use through collaboration with ED staff members (physicians, nurses, nurse practitioners, social workers, or emergency medical technicians).

    On average, Project ASSERT is delivered in 15 minutes, although more time may be needed, depending on the severity of the patient's substance use problem and associated treatment referral needs. The face-to-face component of the intervention is completed during medical care, while the patient is waiting for the doctor, laboratory results, or medications.

2. **Generation Rx**: The mission of Generation Rx is to educate people of all ages about the potential dangers of misusing prescription medications. In doing so, they strive to enhance medication safety among youth, college students, other adults in communities, and seniors. Prescription medications can help us live longer and healthier lives, but any medication has the potential to do harm – especially when misused.

    The core messages are simple:
    - Only use prescription medications as directed by a health professional.
    - Never share your prescription medications with others or use someone else's medications.
    - Always store your medications securely to prevent others from taking them, and properly dispose of medications that you no longer need.
    - Be a good example to those around you by modeling these safe medication-taking practices and discussing the dangers of misusing prescription drugs with your family, friends, colleagues, students, or patients.

    The Generation Rx curriculum offers a variety of online classes, as well as digital activities. The initiative also offers educational programs for schools, after-school organizations, religious youth groups, and sports teams, all of which anyone can implement by downloading the Generation Rx toolkit. The object of Generation Rx is to spread awareness and increase education about the proper use of prescription medications; the extent to which the initiative is implemented is determined by the Generation Rx coordinator. Online educational materials are also offered in the Spanish language.

Priority 2: Addiction/Drug and Opiate Use

Action Step Recommendations & Plan

To work toward **decreasing addiction, including drug and opiate use**, the following action steps are recommended:

1. Implement Generation Rx in grades K-12
2. Implement a community-based comprehensive program to reduce tobacco use
3. Implement an opioid harm reduction prevention program
4. Implement a clinical opioid disposal program
5. Explore feasibility of expanding the scope of the current referral coordination system
6. Implement a community-based comprehensive program to reduce alcohol and other drug misuse/abuse
7. Increase awareness of the Lucas County Opioid Coalition

Action Plan

<table>
<tr><td rowspan="6">SOCIAL DETERMINATES OF HEALTH</td><td colspan="5">Priority Topic: Addiction/Drug and Opiate Use</td></tr>
<tr><td colspan="5">Strategy 1: Implement Generation Rx in grades K-12</td></tr>
<tr><td>Action Step</td><td>Priority Outcome & Indicator</td><td>Priority Population</td><td>Facilitating Agency</td><td>Timeline</td></tr>
<tr><td>Year 1: Research the Generation Rx program.
Gather training materials needed for the program.
Pilot the program in one elementary school, one middle school, and one high school.</td><td rowspan="3">Priority Outcome:
1. Reduce youth drug use
2. Define and address health disparities
Priority Indicator:
Percent of youth who reported ever using prescription drugs</td><td rowspan="3">Youth</td><td rowspan="3">Toledo Public Schools</td><td>July 1, 2018-June 30, 2019</td></tr>
<tr><td>Year 2: Evaluate the results from the piloted schools.
Expand the program into two additional elementary schools, middle schools, and high schools.</td><td>July 1, 2019-June 30, 2020</td></tr>
<tr><td>Year 3: Continue efforts from years 1 and 2.</td><td>July 1, 2020- June 30, 2021</td></tr>
</table>

SOCIAL DETERMINATES OF HEALTH	Priority Topic: Addiction/Drug and Opiate Use				
	Strategy 2: Implement a community-based comprehensive program to reduce tobacco use				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Reach out to Ohio Investigative Unit (OIU) to gather any tobacco compliance check data they may have. Collaborate with OIU to conduct compliance checks throughout the county (number to be determined by OIU).	**Priority Outcome:** 1. Reduce youth tobacco use 2. Define and address health disparities **Priority Indicator:** Percent of youth smokers (past 30 days or lifetime)	Youth	Toledo-Lucas County Health Department	July 1, 2018-June 30, 2019
	Year 2: Provide retailer training to those who may be in violation to selling tobacco to those that are underage. In addition, offer trainings to other retailers or for new employees on a quarterly basis. Conduct second round of compliance checks.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from year 1 and 2.				July 1, 2020- June 30, 2021

HEALTHCARE SYSTEM AND ACCESS	Priority Topic: Addiction/Drug and Opiate Use				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Strategy 3: Implement an opioid harm reduction prevention program				
	Year 1: Work to increase the number of clinic sites. The Northwest Ohio Syringe Services (NOSS) will work on the following: • Reach out to minority faith-based organizations to establish Naloxone training and education programs. • Promote the program through outreach activities. • Work with the Human Trafficking Coalition to provide education and referrals for victims. • Provide Naloxone kits and trainings. • Provide contraceptives and/or pregnancy tests to women of childbearing age. Work to increase awareness in the community of Ohio Automated Rx Reporting System (OARRS). Continue to monitor data from EpiCenter, EMS, law enforcement, MHRSB, and other data sources to identify emerging trends in abuse and misuse. Provide Naloxone education to agencies/individuals seeking training and Naloxone kits. Map out Naloxone administration trained and equipped businesses and agencies to help identify gaps, especially in high risk ZIP codes. Develop a detailed plan to expand upon targeting Naloxone training/education by working with the Toledo Regional Chamber of Commerce, Toledo Area Small Business Association, etc.	**Priority Outcome:** 1. Reduce adult drug use 2. Define and address health disparities **Priority Indicator:** 1. Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted) 2. Number of Naloxone kits distributed	Adult	Toledo-Lucas County Health Department	July 1, 2018-June 30, 2019

	Year 2: Roll-out action plan for targeted Naloxone training efforts. Continue to increase awareness of the program. Continue to be responsive to the changing dynamics of the population using/abusing drugs and provide culturally competent programming and services with targeted delivery to the minority population.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from years 1 and 2.				July 1, 2020- June 30, 2021

HEALTHCARE SYSTEM AND ACCESS					
	Priority Topic: Addiction/Drug and Opiate Use				
	Strategy 4: Implement a clinical opioid disposal program				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Gather baseline data of current drug drop box locations for unused prescription medications. Gather information on which pharmacies are providing drug disposal bags or tablets with opiate prescriptions. Increase awareness with both physician offices and community on drug disposal options.	**Priority Outcome:** 1. Reduce adult drug use 2. Define and address health disparities **Priority Indicator:** Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted)	Adult	Hospital Council of Northwest Ohio	July 1, 2018-June 30, 2019
	Year 2: Increase number of drug drop box locations and/or number of pharmacy locations that provide drug disposal bags or tablets.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from year 2.				July 1, 2020- June 30, 2021

	Strategy 5: Explore feasibility of expanding the scope of the current referral coordination system				
	Year 1: Explore feasibility of expanding the Rescue Help Line to allow for primary care offices to arrange mental health or drug treatment appointments for patients during their visit.	**Priority Outcome:** 1. Reduce adult and youth drug use 2. Define and address health disparities **Priority Indicator:** Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted)	Adult	Mental Health and Recovery Services Board	July 1, 2018-June 30, 2019
	Year 2: Increase use of Rescue Help Line by educating primary care offices about the expanded coordination.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from years 1 and 2.				July 1, 2020- June 30, 2021

HEALTHCARE SYSTEM AND ACCESS	Priority Topic: Addiction/Drug and Opiate Use				
	Strategy 6: Implement a community-based comprehensive program to reduce alcohol and other drug misuse/abuse				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Maintain and expand linkages to the Mental Health & Recovery Services Board of Lucas County (MHRSB) and all agencies providing addiction and recovery services. Support, utilize, and promote the use of screening, brief intervention, and referral to treatment (SBIRT) to identify "at risk" individuals and expedite referrals to addiction treatment and recovery programs.	**Priority Outcome:** 1. Reduce adult drug use 2. Define and address health disparities **Priority Indicator:** Number of people provided with screening, brief intervention, and referral to treatment (SBIRT) and receiving treatment	Adult	Toledo-Lucas County Health Department	July 1, 2018-June 30, 2019
	Year 2: Continue efforts from year 1.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from years 1 and 2.				July 1, 2020- June 30, 2021

HEALTHCARE SYSTEM AND ACCESS	Priority Topic: Addiction/Drug and Opiate Use				
	Strategy 7: Increase awareness of the Lucas County Opioid Coalition				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Perform a gap analysis to identify gaps in membership and target recruiting efforts to provide a balanced membership. Work with coalition members and community stakeholders to identify a plan for targeted recruiting. Elevate community awareness of Lucas County Opioid Coalition and work towards common goals using media, social media, and TLCHD website. Conduct at least one community forum. Work collaboratively with coalition members and stakeholders to develop brochures and materials for distribution to the general public.	**Priority Outcome:** 1. Reduce adult drug use 2. Define and address health disparities **Priority Indicator:** Percent of adults who reported illegal drug use within the past six months	Adult	Toledo-Lucas County Health Department	July 1, 2018-June 30, 2019
	Year 2: Conduct community forums throughout high risk ZIP codes. Work collaboratively to build capacity and resilience by applying for funding opportunities.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from years 1 and 2.				July 1, 2020- June 30, 2021

Priority 3: Chronic Disease/Obesity

Chronic Disease/Obesity Indictors

Adult Obesity

In 2017, almost three-fourths (74%) of Lucas County adults were either overweight (38%) or obese (36%) by Body Mass Index (BMI).

One-fifth (20%) of adults did not participate in any physical activity in the past week, including 2% who were unable to exercise.

Four percent (4%) of adults ate 5 or more servings of fruits and vegetables per day; 24% ate 3 to 4 servings; 62% ate 1 to 2 servings; and 10% ate 0 servings of fruits and vegetables per day.

Adult Heart Disease

In 2017, 2% of adults reported they had angina or coronary heart disease, compared to 5% of Ohio and 4% of U.S. adults in 2016.

Five percent (5%) of Lucas County adults reported they had survived a heart attack or myocardial infarction, increasing to 16% of those over the age of 65. Five percent (5%) of Ohio and 4% of U.S. adults reported they had a heart attack or myocardial infarction in 2016.

More than one-third (34%) of adults had been diagnosed with high blood pressure in 2017. The 2015 BRFSS reports hypertension prevalence rates of 34% for Ohio and 31% for the U.S.

Adult Diabetes

In 2017, 12% of Lucas County adults had been diagnosed with diabetes, increasing to 28% of those over the age of 65.

Nearly two-fifths (38%) of adults with diabetes rated their health as fair or poor.

Youth Obesity

In 2016, 13% of youth were classified as obese by Body Mass Index (BMI) calculations and 11% of youth were classified as overweight.

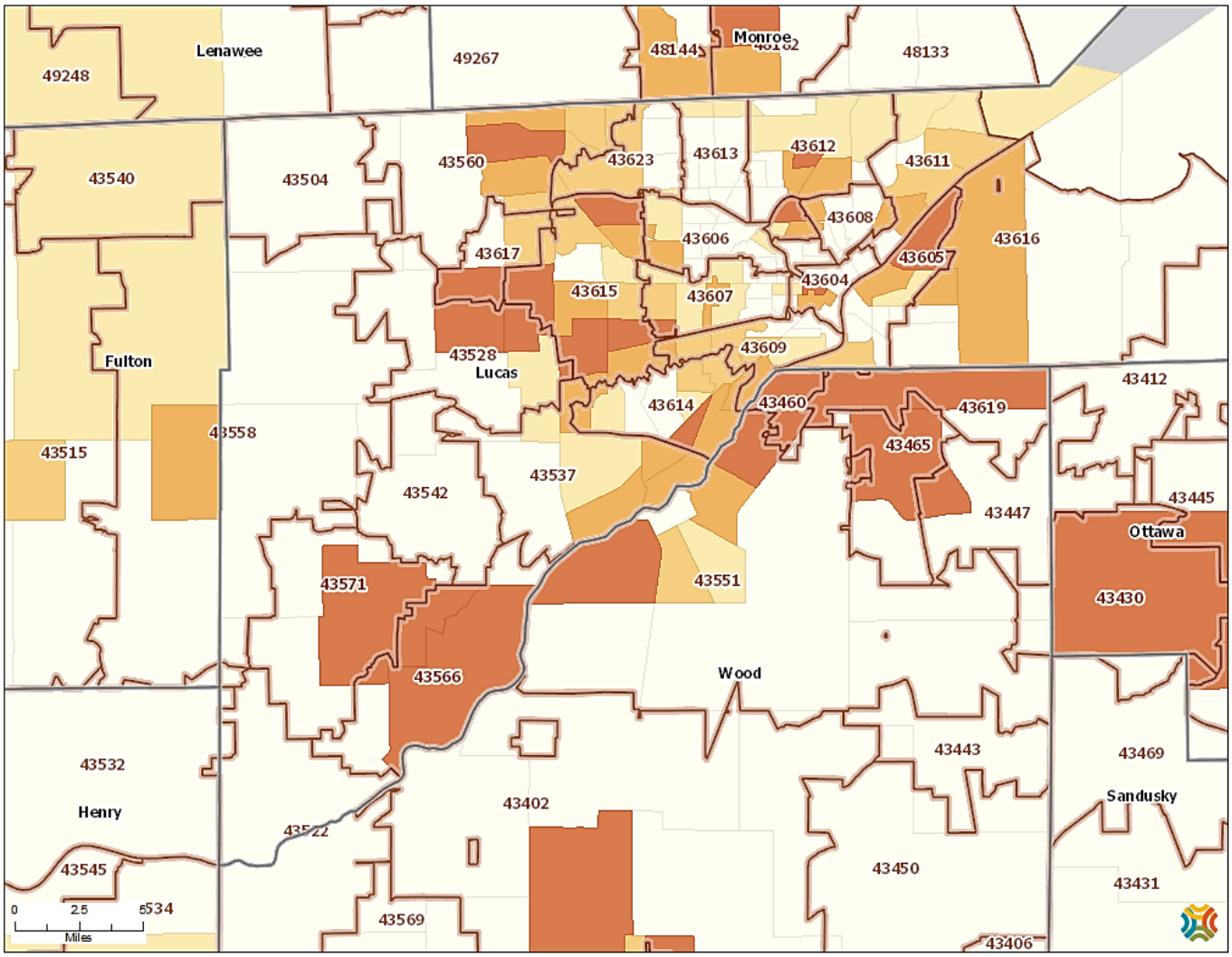
More than one-tenth (13%) of youth did not participate in at least 60 minutes of physical activity on any day in the past week.

Child Chronic Disease

One-third (33%) of children were classified as obese by Body Mass Index (BMI) calculations and 12% of children were classified as overweight.

Map: Population with Limited Food Access

Population with Limited Food Access, Low income, Population by Tract, FARA 2015



Map Legend

Population with Limited Food Access, Percent by Tract, FARA 2015

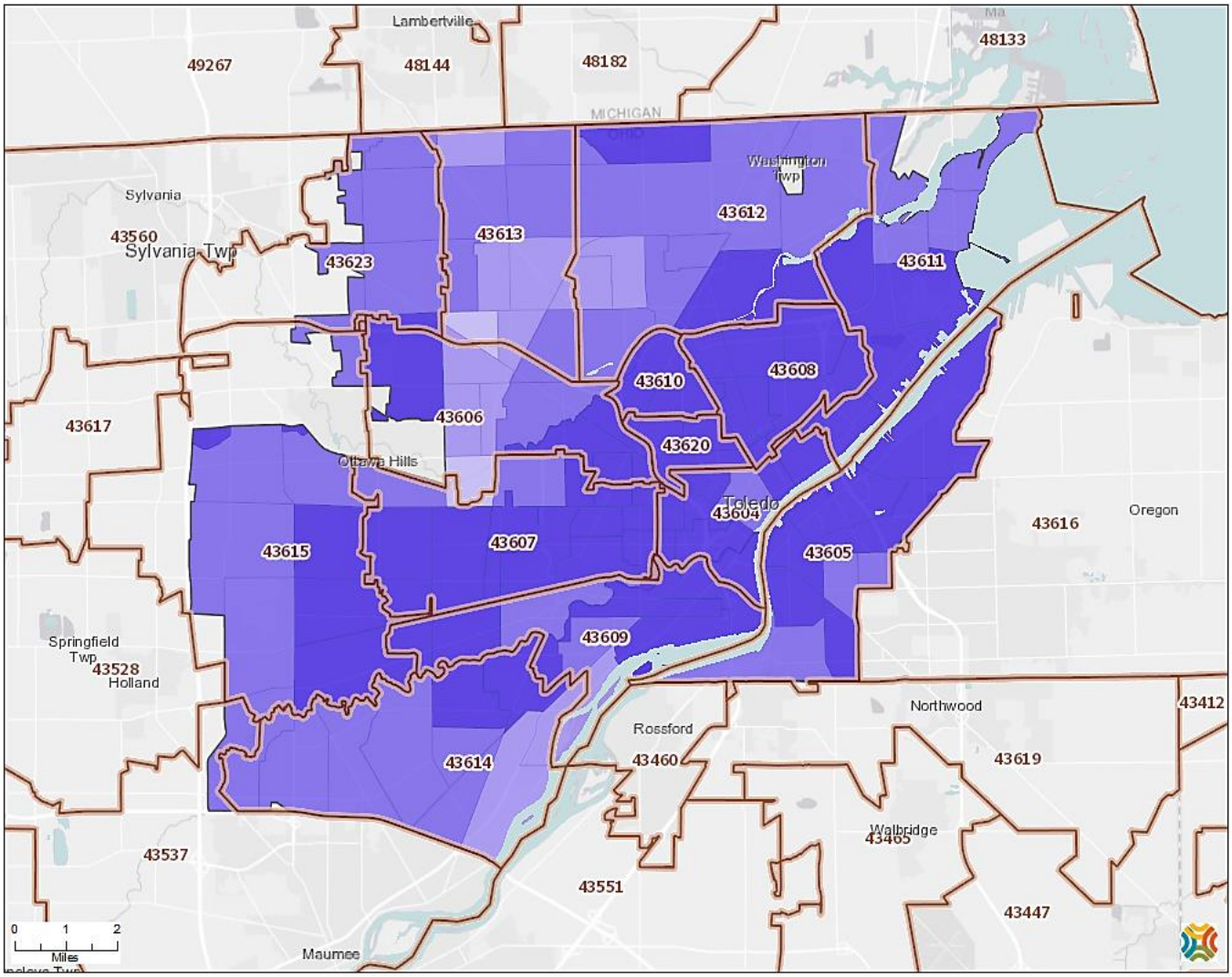
- Over 50.0%
- 20.1 - 50.0%
- 5.1 - 20.0%
- Under 5.1%
- No Low Food Access

Community Commons, 1/18/2018

(Source: US Department of Agriculture, Economic Research Service 2015, as compiled by Community Commons, obtained on 1/18/18)

Map: Diabetes Prevalence

Diabetes Prevalence Among Adults Age 18+
By Tract, BRFSS 500 Cities Project 2014



Map Legend

Diabetes, Prevalence Among Adults Age 18+ by Tract, BRFSS 500 Cities Project 2014

- Over 13.0%
- 10.1% - 13.0%
- 8.1% - 10.0%
- Under 8.1%
- No Data or Data Suppressed

Community Commons, 1/18/2018

(Source: US Department of Agriculture, Economic Research Service 2015, as compiled by Community Commons, obtained on 1/18/18)

Priority 3: Chronic Disease/Obesity

Gaps and Potential Strategies

Gaps	Potential Strategies
1. Lack of awareness of available health and wellness opportunities (2)	○ Increased coordination between physician offices and wellness management ○ Update resource guides annually
2. Lack of food literacy	○ Provide prevention programs in schools ○ Women, Infants, and Children (WIC) ○ Food destinations at farmer's market
3. Lack of community prevention programs for youth and adults	○ Boys & Girls Clubs of Toledo ○ Better school nutrition policy ○ Increased nutrition/physical activity education ○ Community gardens ○ Community cooking classes ○ Cooking Matters ○ Grocery store tours ○ Make programs more relatable and fun ○ Work with local grocery stores to promote and reach more people
4. Lack of overall knowledge within the medical community	○ Provide updated resources to physicians and healthcare providers
5. Curriculum that can be used with other groups (ex. Healthy Eating)	○ None specified
6. Improve approach to get more people involved in prevention programs	○ Healthy savings account/insurance programs ○ Incentives ○ Healthy eating policies
7. Lack of green space in various environments	○ Urban agriculture
8. Lack of transportation availability	○ County-wide policies
9. Lack of attendance at programs	○ None specified
10. Lack of social integration	○ Engage with communities/social leaders/find champions ○ People who speak the same language

Priority 3: Chronic Disease/Obesity

Best Practices

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

1. **Playworks**: Playworks helps schools and districts make the most of recess through on-site staffing, consultative support, professional development, free resources, and more. Playworks helps schools determine what works best for their school playgrounds.

   Playworks help schools find new ways to keep kids safe during while playing. The program encourages active engagement of all students during recess and build on a foundation of inclusiveness among kids. When all kids feel they can join in to play with others, more kids stay physically active during free time.

   At recess, students are encouraged to feel empowered to play on their own or to start activities with other students, which reinforces the idea of kids becoming natural leaders. The Playworks Junior Coach Leadership Program puts the recess culture into the hands of the upper-elementary students to take a more active leadership role.

2. **Healthy Home Environment Assessments**: Healthy home environment assessments engage home visitors – community health workers (CHWs), similarly trained asthma outreach workers, other professionals, paraprofessionals, or volunteers – to assess and remediate environmental health risks within the home. Programs typically focus on improving asthma management via low cost changes, such as improved ventilation, integrated pest management, and other forms of allergen control. Programs may also provide low emission vacuums, allergen-impermeable bedding covers, air filters, cleaning supplies, and supplies for cockroach abatement.

   Expected Beneficial Outcomes:
   - Reduced exposure to allergens
   - Reduced hospital utilization

   Evidence of Effectiveness
   - There is strong evidence that health home environment assessments encourage household behaviors that reduce asthma triggers and exposure to allergens and decrease use of urgent care and related health care costs.
   - Health home environment assessments conducted by CHWs or trained asthma outreach workers have been shown to improve asthma self-management, increase the number of asthma symptom free days, and improve quality of life for participating children and caregivers. Such interventions can also improve asthma symptoms for those living in lower quality housing.
   - Economic evaluations indicate healthy home environment assessments achieve high cost savings largely due to averted urgent care clinics visits, emergency room visits, and hospitalizations.

3. **Safe Routes to School**: Safe Routes to Schools (SRTS) is a federally supported program that promotes walking and biking to school through education and incentives. The program also targets city planning and legislation to make walking and biking safer.

   Expected Beneficial Outcomes:
   - Increased physical activity
   - Healthier transportation behaviors
   - Improved student health
   - Decreased traffic and emissions near schools
   - Reduced exposure to emissions

   Evidence of Effectiveness:
   - There is strong evidence that SRTS increases the number of students walking or biking to school. Establishing SRTS is a recommended strategy to increase physical activity among students.

   - Active travel to school is associated with healthier body composition and cardio fitness levels. SRTS has a small positive effect on active travel among children. By improving walking and bicycling routes, SRTS projects in urban areas may also increase physical activity levels for adults. SRTS has been shown to reduce the incidence of pedestrian crashes.

   - Replacing automotive trips with biking and walking has positive environmental impacts at relatively low cost, although the long-term effect on traffic reduction is likely minor. Surveys of parents driving their children less than two miles to school indicate that convenience and saving time prompt the behavior; SRTS may not be able to address these parental constraints.

4. **Fuel Up to Play 60 (National Dairy Council & National Football League)**: Fuel Up to Play 60 encourages youth to eat healthy and move more — and studies suggest that well-nourished, physically active kids can be better students. Better nutrition, including eating a healthy breakfast each day, helps students get the nutrients they need and may help improve their academic performance. What's more, being physically active may help students improve self-esteem, cognitive function and test scores.

   With Fuel Up to Play 60, healthy students can have more fun. By participating in the program, youth have the opportunity to earn rewards and prizes. Those students who help build the program may benefit even more. In fact, researchers say peer group interaction may help to influence healthy choices, and student involvement can lead to motivation and engagement in learning. Schools have the chance to receive $4,000 through a competitive, nationwide funding program to help implement the program successfully.

5. **Nutrition Prescriptions**: Nutrition prescriptions are a way for physicians and other healthcare providers to outline a healthy, balanced eating plan for patients. Based on U.S. Dietary Guidelines for adults, children, and adolescents, nutrition prescriptions establish achievable goals for patients and their families. Healthcare providers review progress at each office visit, and a nutrition specialist is consulted for dietary advice as needed. Some nutrition prescription programs partner with local farmer's markets; in these programs, prescriptions for fruit and vegetables are redeemed or invited at participating markets. Such prescriptions typically support the purchase of at least one serving of produce per day for each patient and their family members.

6. **Farmer's Markets/Stands**: A farmer's market is a multiple vendor market, where producers sell goods directly to consumers at a specific location. Farmer's markets most often sell fresh fruit and vegetables; meat, dairy, grains, prepared foods, and other items may also be available.

   Expected Beneficial Outcomes
   - Increased access to fruits and vegetables

   Other Potential Beneficial Outcomes
   - Increased healthy foods in food deserts
   - Increased fruit and vegetable consumption
   - Strengthened local and regional food systems
   - Improved local economy

7. **Healthy Food in Convenience Stores**: In many neighborhoods that lack supermarkets and grocery stores, families depend on corner stores and other small-scale stores to purchase food. The choices at these stores are often limited to packaged food and very little, if any, fresh produce. Improving the product mix at smaller stores and addressing other issues of viability — such as pricing, food quality/ freshness, and customer service — are strategies that build upon existing community resources to enhance access to healthy food in underserved communities. Corner stores are also frequent destinations for children, many of whom stop daily on the way to and from school for snacks. Corner stores are, therefore, a great place to make healthy food choices available and easy.

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

   The National DPP's lifestyle change program is a year-long structured program (in-person group, online, or combination) that:
   - Has an initial six-month phase offering at least one session a month (at least six sessions).
   - Is facilitated by a trained lifestyle coach.
   - Uses curriculum approved by the Centers for Disease Control and Prevention (CDC).
   - Includes regular opportunities for direct interaction between the lifestyle coach and participants.
   - Focuses on behavior modification, managing stress, and peer support.

9. **School-Based Nutrition Education Programs**: School-based nutrition education programs have educational components (e.g., classroom instruction by teachers, nutrition education integrated across curricula, peer training), environmental components (e.g., school menus, classroom snacks & special treats), and/or other components (e.g., family education and involvement, community involvement). Specific components vary by program. Some states regulate nutrition education programs, and the federal government sponsors others.

   Expected Beneficial Outcomes:
   - Improved dietary habits

   Other Potential Beneficial Outcomes:
   - Increased fruit and vegetable consumption
   - Reduced sweetened beverage consumption

10. **Grow It, Try It, Like It! Nutrition Education Kit Featuring MyPlate**: Grow It, Try It, Like It! is a garden-themed nutrition education kit for child care center staff. The kit includes seven booklets featuring fruits and vegetables with fun activities through the imaginary garden. The kit also includes a CD-ROM with supplemental information and a DVD about Puppy Pup's Picnic and Lunch Parties. Each lesson contains hands-on activities, planting activities, and nutrition education activities that introduce MyPlate.

Priority 3: Chronic Disease/Obesity

Action Step Recommendations & Plan

To work toward **decreasing chronic disease, including obesity**, the following action steps are recommended:

1. Expand nutrition and physical activity interventions in preschool/childcare
2. Expand safe routes to school
3. Implement healthy home environment assessments
4. Increase school-based active recess and policies
5. Expand nutrition prescriptions
6. Increase healthy foods in convenience stores
7. Increase farmer's markets/stands
8. Increase awareness of the Diabetes Prevention Program (DDP)
9. Increase enrollment into the Diabetes Education and Empowerment Program (DEEP)

Action Plan

SOCIAL DETERMINATES OF HEALTH	Priority Topic: Chronic Disease/Obesity				
	Strategy 1: Expand nutrition and physical activity interventions in preschool/child care				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Research current local practices/programs. Reach out to preschool/child care providers and obtain pledge of commitment from interested providers.	**Priority Outcome:** 1. Reduce child obesity 2. Define and address health disparities **Priority Indicator:** 1. Percent of children who were obese 2. Percent of children who ate 5 or more servings of fruits and vegetables per day	Child	Toledo Public Schools (Head Start)	July 1, 2018-June 30, 2019
	Year 2: Evaluate current local practices/programs and develop a plan for streamlining interventions.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from years 1 and 2. Develop implementation plan, including phases of implementation and recommendations for providers. Seek donations of fruits and vegetables. Provide program in at least 10% of preschools in the county.				July 1, 2020- June 30, 2021

SOCIAL DETERMINATES OF HEALTH	Priority Topic: Chronic Disease/Obesity				
	Strategy 2: Expand safe routes to school				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Collect baseline data on current **Safe Routes to School** programs in the county. Gather information on what types of activities are offered, how many people attend the activities, how often activities take place, and location. Identify key stakeholders to collaborate and develop a plan to start or expand Safe Routes Programs. Develop program goals and an evaluation process for tracking outcomes. Look for funding sources to incentivize participation in the Safe Routes program.	**Priority Outcome:** 1. Reduce youth and child obesity 2. Define and address health disparities **Priority Indicator:** Percent of youth and children who were obese	Youth and Child	Live Well Greater Toledo	July 1, 2018-June 30, 2019
	Year 2: Recruit individuals to serve as walking/biking leaders. Decide on the locations, walking routes and number of walking/biking groups. Link the walking/biking groups with existing organizations to increase participation. Consider faith-based organizations, schools, community-based organizations, and health care providers. Begin implementing the program with one new school district.				July 1, 2019-June 30, 2020
	Year 3: Raise awareness and promote the Safe Routes programs. Evaluate program goals. Increase the number of Safe Routes programs by 25%.				July 1, 2020- June 30, 2021

SOCIAL DETERMINATES OF HEALTH	Priority Topic: Chronic Disease/Obesity				
	Strategy 3: Implement healthy homes environment assessments √				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Research **Healthy Home Environment Assessments**. Partner with local community organizations and hospitals. Determine what organizations and hospitals will conduct Healthy Home Environment Assessments. Train appropriate staff (inspectors, CHW's, home visitation staff, Early Head Start, etc.). Utilize appropriate staff and volunteers to do the following using the assessment: • Identify health hazards in the home (i.e., dust, lead, household chemicals, mold and other air pollutants). • Use low cost methods to reduce risks. • Train families on the different ways to improve their home environment. • Provide education and resources to control asthma and allergen triggers in the home. Focus on low-income families with small children who have asthma. Search for grants and funding opportunities to support efforts.	**Priority Outcome:** 1. Reduce child asthma 2. Reduce child exposure to lead in the home 3. Define and address health disparities **Priority Indicator:** 1. Percent of children who had an asthma attack during the past 12 months 2. Percent of children who were tested for lead poisoning	Child	Toledo-Lucas County Health Department	July 1, 2018-June 30, 2019
	Year 2: Continue efforts from year 1.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from years 1 and 2.				July 1, 2020- June 30, 2021

SOCIAL DETERMINATES OF HEALTH	Priority Topic: Chronic Disease/Obesity				
	Strategy 4: Increase school-based active recess and policies				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Research evidence-based physical activity and recess programs for schools. Create an awareness campaign to educate superintendents, principals, and parents of the benefits of active play time in school. Gather local principals, teachers, and parents for a workshop that includes a demonstration of evidence-based programs. Pilot one of the evidence-based programs in at least one school district.	**Priority Outcome:** 1. Reduce youth and child obesity 2. Define and address health disparities **Priority Indicator:** Percent of youth and children who were obese	Child and Youth	Live Well of Greater Toledo	July 1, 2018-June 30, 2019
	Year 2: Continue educating superintendents, principals and parents on the importance of increasing active play time in school. Implement the program into two additional school districts.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from years 1 and 2.				July 1, 2020- June 30, 2021

HEALTHCARE SYSTEM AND ACCESS	Priority Topic: Chronic Disease/Obesity				
	Strategy 5: Expand nutrition prescriptions				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Continue reaching out to potential clinic and farmer's market partners. Schedule and attend meetings with potential partners. Increase capacity of existing prescription program.	**Priority Outcome:** 1. Reduce adult obesity 2. Reduce adult hypertension 3. Reduce adult diabetes 4. Define and address health disparities **Priority Indicator:** 1. Percent of adults who were obese 2. Percent of adults diagnosed with hypertension 3. Percent of adults diagnosed with diabetes	Adult	YMCA of Greater Toledo and Hospital Council of Northwest Ohio	July 1, 2018-June 30, 2019
	Year 2: Continue efforts from year 1. Work to increase the prescription program to three new locations.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from year 2.				July 1, 2020- June 30, 2021

PUBLIC HEALTH SYSTEM, PREVENTION & HEALTH BEHAVIORS	Priority Topic: Chronic Disease/Obesity				
	Strategy 6: Increase healthy food in convenience stores √				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Expand Eat Fresh, Live Well healthy corner store initiative. Identify funding opportunities to expand the program (grants, sponsorship, etc.) Survey customers and community members to assess community needs for healthy food items.	**Priority Outcomes:** 1. Reduce adult, youth and obesity 2. Reduce adult hypertension 3. Reduce adult diabetes 4. Reduce adult prediabetes 5. Define and address health disparities **Priority Indicators:** 1. Percent of adults who were obese 2. Percent of youth and children who were obese 3. Percent of adults diagnosed with hypertension 4. Percent of adults diagnosed with diabetes 5. Percent of adults diagnosed with prediabetes	Adult, Youth, and Child	Live Well Greater Toledo and Toledo-Lucas County Health Department	July 1, 2018-June 30, 2019
	Year 2: Continue efforts from year 1.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from years 1 and 2.				July 1, 2020- June 30, 2021

PUBLIC HEALTH SYSTEM, PREVENTION & HEALTH BEHAVIORS	Priority Topic: Chronic Disease/Obesity				
	Strategy 7: Increase farmer's markets/stands				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Obtain baseline data regarding which cities/towns, school districts, churches, and organizations currently have farmer's markets. Obtain baseline data regarding which farmer's markets are open year-round. Research funding opportunities to increase the number of farmer's markets.	**Priority Outcomes:** 1. Reduce adult, youth and child obesity 2. Reduce adult hypertension 3. Reduce adult diabetes 4. Reduce adult prediabetes 5. Define and address health disparities **Priority Indicators:** 1. Percent of adults who were obese 2. Percent of youth and children who were obese 3. Percent of adults diagnosed with hypertension 4. Percent of adults diagnosed with diabetes 5. Percent of adults diagnosed with prediabetes	Adult, Youth, and Child	YMCA of Greater Toledo, Toledo-Lucas County Health Department, and Area Office on Aging	July 1, 2018-June 30, 2019
	Year 2: Recruit at least one farmer's market to stay open year-round. Consider placing any additional farmer's markets in more rural locations throughout the county. Encourage the use of SNAP/EBT (electronic benefit transfer), WIC, and Senior Coupons at farmer's markets.				July 1, 2019-June 30, 2020
	Year 3: Double the number of farmer's markets from baseline. Implement the use of WIC and SNAP/EBT benefits in all farmer's markets.				July 1, 2020- June 30, 2021

PUBLIC HEALTH SYSTEM, PREVENTION & HEALTH BEHAVIORS	Priority Topic: Chronic Disease/Obesity				
	Strategy 8: Increase awareness of the Diabetes Prevention Program (DPP)				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Develop system-wide referrals into the Diabetes Prevention Program through the YMCA (CDC recognized, part of National Diabetes Prevention Program). Recruit at-risk participants to join the program. Collaborate with the local hospital for referrals and to assist in managed care reimbursement training.	**Priority Outcomes:** 1. Reduce adult obesity 2. Reduce adult diabetes 3. Reduce adult prediabetes 4. Define and address health disparities **Priority Indicators:** 1. Percent of adults who were obese 2. Percent of adults diagnosed with diabetes 3. Percent of adults diagnosed with prediabetes	Adult	YMCA of Greater Toledo, Toledo-Lucas County Health Department, and Area Office on Aging	July 1, 2018-June 30, 2019
	Year 2: Implement the Diabetes Prevention Program. Analyze participant data after the 25 sessions have been delivered.				July 1, 2019-June 30, 2020
	Year 3: Increase program participants by 25%.				July 1, 2020- June 30, 2021
	Strategy 9: Increase enrollment into the Diabetes Education and Empowerment Program (DEEP)				
	Year 1: Hold local trainings for DEEP leaders. Expand capacity by recruiting leaders to be trained. Enroll participants with diabetes into the program.	**Priority Outcomes:** 1. Reduce adult obesity 2. Reduce adult diabetes 3. Define and address health disparities **Priority Indicators:** 1. Percent of adults who were obese 2. Percent of adults diagnosed with diabetes 3. Percent of adults diagnosed with prediabetes	Adult	Area Office on Aging	July 1, 2018-June 30, 2019
	Year 2: Provide additional educational opportunities for leaders to be trained. Continue enrolling participants. Evaluate program outcomes (A1C, lipids, enrollment to completion, knowledge – pre/post assessment, ZIP code, demographics)				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from years 1 and 2.				July 1, 2020- June 30, 2021

Priority 4: Maternal and Infant Health/Infant Mortality

Maternal Health Indicators

Maternal and Infant Health

During their last pregnancies, mothers did the following: received prenatal care within the first 3 months (94%), took a prenatal vitamin with folic acid during pregnancy (96%), took a prenatal vitamin with folic acid pre-pregnancy (82%), had a dental exam (61%), received WIC services (30%), took folic acid during pregnancy (35%), took folic acid pre-pregnancy (26%), experienced depression during or after pregnancy (17%), smoked cigarettes or used other tobacco products (8%), consumed alcoholic beverages (5%), used any drugs not prescribed for them (1%), and received opiate replacement therapy (1%).

In 2017, mothers reported they breastfed their child for the following lengths of times: more than 12 months (17%), 10 to 12 months (8%), 7 to 9 months (8%), 4 to 6 months (15%), less than 3 months (24%), still breastfeeding (7%), and never breastfed (22%).

Parents gave the following reasons why their child was not breastfed for a year: did not produce enough milk (30%), did not want to (20%), inconvenient (18%), medical issue with baby (8%), medical issues with self (7%), did not have workplace support (4%), did not have adequate support (3%), did not have adequate education (3%), and other (11%). No one reported they did not have a breast pump or for cultural reasons.

Seventeen percent (17%) of mothers of 0- to 5-year-olds reported they smoked during pregnancy.

In 2017, parents of 0- to 5-year-olds put their children to sleep as an infant: on their back (81%), on their side (14%), and on their stomach (14%).

Children ages 0-5 were put to sleep in the following places: crib/bassinette without bumper, blankets, or stuffed animals (73%); pack n' play (30%); swing (28%); crib/bassinette with bumper, blankets, or stuffed animals (24%); in bed with parent or another person (24%); car seat (18%); floor (5%), and couch or chair (1%).

In 2015, there were 35 infant deaths. *(Source: 2015 Ohio Infant Mortality Data: General Findings)*

From 2012-2015, an average of 11% of Lucas County women had preterm births (less than 37 weeks of pregnancy). *(Source: National Center for Health Statistics, Final Natality Data. Retrieved July 07, 2017, from www.marchofdimes.org/peristats.)*

From 2012-2015, an average of 2% of Lucas County women had very preterm births (less than 32 weeks of pregnancy). *(Source: National Center for Health Statistics, Final Natality Data. Retrieved July 07, 2017, from www.marchofdimes.org/peristats.)*

Priority 4: Maternal and Infant Health/Infant Mortality

Gaps and Potential Strategies

Gaps	Potential Strategies
1. Social determinants of health (2)	◦ The Centering Program ◦ Peer education building accountability
2. Lack of community-based treatment	◦ Decreased health equity
3. Lack of education for sex education, pregnancy, safety checks, and prevention	◦ Compliance checks Senate Bill 332 state recommendations to reduce infant mortality
4. Lack of policies on breast feeding, maternity leave, and foster parents	◦ Genetic counseling
5. Generational thread of babies and lack of awareness of them	◦ Increase sex education ◦ Reduce tobacco in terms of conversation ◦ Increase awareness of resources
6. Safe sleep practice	◦ Education
7. Lack of awareness	◦ Education
8. Data sharing agreement	◦ None specified
9. Silos	◦ Integration ◦ Collective Impact ◦ Toledo-Lucas County Getting to 1
10. Lack of resources for homeless or drug addicted/pregnant women or mothers	◦ None specified

Priority 4: Maternal and Infant Health/Infant Mortality

Best Practices

The following policy has been reviewed and has proven strategies to **improve maternal and child health**:

1. **Prenatal Care in The First Trimester**: Accessing prenatal care in the first trimester (by 10 to 12 weeks) is vital to improve pregnancy outcomes. The Health Resources & Services Administration recommends the way to increase the rate of early access to prenatal care is to increase awareness of the importance of prenatal care and to standardize preconception health as part of the routine health care for women of childbearing age. Adequate prenatal care includes counseling, education, along with identification and treatment of potential complications. There are no evidence-based guidelines regarding the content of prenatal visits, but they usually include evaluation of blood pressure, weight, protein levels in the urine, and fetal heart rate monitoring.

Priority 4: Maternal and Infant Health/Infant Mortality

Action Step Recommendations & Plan

To work toward improving **maternal and infant health**, the following action steps are recommended:

1. Increase progesterone treatments
2. Increase provider counseling with patients about preconception health and reproductive life plans
3. Increase breastfeeding support at birthing facilities
4. Increase coordination of home visiting programs
5. Increase breastfeeding promotion programs
6. Implement preconception education interventions

Action Plan

HEALTHCARE SYSTEM AND ACCESS	Priority Topic: Maternal and Infant Health/Infant Mortality				
	Strategy 1: Increase progesterone treatments √				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Gather data from hospitals/health systems to identify how progesterone candidates are currently identified, as well as current barriers to progesterone distribution. Research evidence-based models to increase 1st trimester prenatal care Educate home visitors, Community Health Workers, and other credible messengers on progesterone. Educate providers about options for the uninsured/ underinsured.	**Priority Outcomes:** 1. Reduce infant mortality 2. Reduce total preterm birth 3. Reduce low birth weight 4. Define and address health disparities **Priority Indicators:** 1. Percent of live births that are preterm: <37 weeks gestation 2. Percent of births in which the newborn weighed <2,500 grams 3. Rate of infant deaths per 1,000 live births	Adult	Hospital Council of Northwest Ohio	July 1, 2018-June 30, 2019
	Year 2: Based on data collected in year 1, develop and implement a plan to increase the use of progesterone for eligible pregnant women.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from year 2.				July 1, 2020- June 30, 2021

HEALTHCARE SYSTEM AND ACCESS	Priority Topic: Maternal and Infant Health/Infant Mortality				
	Strategy 2: Increase provider counseling with patients about preconception health and reproductive life plans √				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Work with health systems and the local health department to identify current efforts around reproductive life planning with all women of childbearing age. Community health workers (CHWs) and home visitors will connect women of childbearing age to health insurance and a medical home, and remove barriers to care so they receive needed care. Increase birth spacing for women who have delivered <18 months ago. Offer provider and CHWs counseling on long-acting reversible contraception as part of preventive care, postpartum visits and other program interventions.	**Priority Outcomes:** 1. Reduce infant mortality 2. Reduce total preterm birth 3. Reduce low birth weight 4. Define and address health disparities **Priority Indicators:** 1. Percent of live births that are preterm: <37 weeks gestation 2. Percent of births in which the newborn weighed <2,500 grams 3. Rate of infant deaths per 1,000 live births	Adult	Getting to 1	July 1, 2018-June 30, 2019
	Year 2: Increase efforts from year 1.				July 1, 2019-June 30, 2020
	Year 3: Increase efforts from years 1 and 2.				July 1, 2020- June 30, 2021

HEALTHCARE SYSTEM AND ACCESS	Priority Topic: Maternal and Infant Health/Infant Mortality				
	Strategy 3: Increase breastfeeding support at birthing facilities √				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Work with local hospitals, the health department, and other organizations to appoint a breastfeeding peer educator. Designate the breastfeeding peer educator to work with WIC and other low-income clients to encourage breastfeeding practices. Standardize breastfeeding education across all county providers during pregnancy and postpartum.	**Priority Outcomes:** 1. Reduce infant mortality 2. Reduce total preterm birth 3. Reduce low birth weight 4. Define and address health disparities **Priority Indicators:** 1. Percent of live births that are preterm: <37 weeks gestation 2. Percent of births in which the newborn weighed <2,500 grams 3. Rate of infant deaths per 1,000 live births	Adult	Hospital Council of Northwest Ohio	July 1, 2018-June 30, 2019
	Year 2: Incorporate breastfeeding peer education into hospital labor & delivery units and birthing centers.				July 1, 2019-June 30, 2020
	Year 3: Increase efforts from years 1 and 2. Increase number of available lactation consultants available before and after hospital discharge				July 1, 2020- June 30, 2021
	Strategy 4: Increase coordination of home visiting programs				
	Year 1: Identify all home visitation programs that serve the prenatal population. Home visitation supervisors will work to develop the best way to coordinate which program is the best fit for different individuals. Home visitation programs will enroll all pregnant women in Lucas County in need of services.	**Priority Outcome:** 1. Reduce infant mortality 2. Reduce preterm birth 3. Reduce low birth weight 4. Define and address health disparities **Priority Indicator:** Percent of mothers who received a home visit to help them learn to care for their new baby or themselves	Adult	Getting to 1	July 1, 2018-June 30, 2019
	Year 2: Continue efforts from year 1.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from years 1 and 2.				July 1, 2020- June 30, 2021

PUBLIC HEALTH SYSTEM, PREVENTION AND HEALTH BEHAVIORS	Priority Topic: Maternal and Infant Health/Infant Mortality				
	Strategy 5: Increase breastfeeding promotion programs √				
	Action Step	**Priority Outcome & Indicator**	**Priority Population**	**Facilitating Agency**	**Timeline**
	Year 1: Identify existing community breastfeeding promotion programs. Provide education to home visiting programs, Community Health Workers and other credible messengers about the benefits of breastfeeding. Develop a breastfeeding resource guide.	**Priority Outcomes:** 1. Reduce infant mortality 2. Reduce total preterm birth 3. Reduce low birth weight 4. Define and address health disparities **Priority Indicators:** 1. Percent of live births that are preterm: <37 weeks gestation 2. Percent of births in which the newborn weighed <2,500 grams 3. Rate of infant deaths per 1,000 live births	Adult	Hospital Council of Northwest Ohio	July 1, 2018-June 30, 2019
	Year 2: Implement standardized breastfeeding education across the county. Identify current barriers for women who want to breast feed but were unable to. Identify reasons women chose not to breastfeed. Develop a community campaign around the promotion of breastfeeding				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from years 1 and 2.				July 1, 2020- June 30, 2021
	Strategy 6: Implement preconception education interventions √				
	Year 1: Research best practices around preconception education interventions and select methods to implement in Lucas County.	**Priority Outcomes:** 1. Reduce infant mortality 2. Reduce total preterm birth 3. Reduce low birth weight 4. Define and address health disparities **Priority Indicators:** 1. Percent of live births that are preterm: <37 weeks gestation 2. Percent of births in which the newborn weighed <2,500 grams 3. Rate of infant deaths per 1,000 live births	Adult	Getting to 1	July 1, 2018-June 30, 2019
	Year 2: Implement selected interventions.				July 1, 2019-June 30, 2020
	Year 3: Continue efforts from year 2.				July 1, 2020- June 30, 2021

Progress and Measuring Outcomes

The progress of meeting the local priorities will be monitored with measurable indicators identified for each strategy found within the action step and recommendation tables within each of the priority sections. Most indicators align directly with the SHIP. The Healthy Lucas County Executive Committee will meet with the facilitating agencies for each action step on a quarterly basis so they can report out any progress. The Executive Committee members, representing key sectors and organizations, must have decision-making authority for their organizations. The Executive Committee will form a plan to disseminate this CHIP to the community. Action steps, responsible person/agency, and timelines will be reviewed at least annually by the Executive Committee. Edits and revisions will be made accordingly.

Healthy Lucas County will continue to facilitate 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 be able to compare to the state, the nation, and Healthy People 2020. This data will serve as measurable outcomes for each of the priority areas. Indicators have already been defined throughout this report.

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

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

Contact Us

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

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Appendix I: Website Links

Title of Link	Website URL
Centers for Disease Control and Prevention; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services	http://www.cdc.gov/nphpsp/essentialservices.html
Complete streets	https://smartgrowthamerica.org/program/national-complete-streets-coalition/
Comprehensive primary care access	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/medical-homes
Community health workers (CHW)	http://www.countyhealthrankings.org/policies/community-health-workers
Decrease availability of tobacco products	http://tobaccocontrolnetwork.org/wp-content/uploads/2016/07/TCN-2016-Policy-Recommendations-Guide.pdf
Diabetes Prevention Program (DPP)	https://www.cdc.gov/sixeighteen/docs/6-18-evidence-summary-diabetes.pdf
Evidence-based tobacco cessation treatments and medications	https://www.cdc.gov/sixeighteen/docs/6-18-evidence-summary-tobacco.pdf
Farmer's markets/stands	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/farmers-marketsstands
Fuel Up to Play 60 (National Dairy Council & National Football League)	https://www.fueluptoplay60.com/
Generation Rx program	https://www.generationrx.org/
Grow it, Try it, Like it! Program	https://www.fns.usda.gov/tn/grow-it
Healthy food in convenience stores	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/healthy-food-in-convenience-stores
Health insurance enrollment and outreach	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/health-insurance-enrollment-outreach-support
Healthy home environment assessments	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/healthy-home-environment-assessments
Increase breastfeeding at birthing facilities	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/breastfeeding-promotion-programs
Increase breastfeeding promotion programs	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/breastfeeding-promotion-programs
Increase home visiting programs that begin prenatally	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/early-childhood-home-visiting-programs
Increase links to tobacco cessation	https://www.cdc.gov/sixeighteen/docs/6-18-evidence-summary-tobacco.pdf
Increase provider counseling with patients about preconception health and reproductive life plans	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/reproductive-life-plans

Title of Link	Website URL
Master list of SHIP indicators	http://www.odh.ohio.gov/sha-ship
Mental health first aid	https://www.mentalhealthfirstaid.org/
Nutrition and physical activity interventions in preschool/child care	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/nutrition-and-physical-activity-interventions-in-preschool-child-care
Nutrition prescriptions	http://www.countyhealthrankings.org/policies/nutrition-prescriptions
Pathways Community HUB model	https://innovations.ahrq.gov/qualitytools/connecting-those-risk-care-quick-start-guide-developing-community-care-coordination
PHQ-9: The PHQ-9	http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression
Preconception education interventions	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/preconception-education-interventions
Prevention and Population Health Framework: The 3 Buckets	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5558207/
Progesterone treatments	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/synthetic-progesterone-17p-access
Safe Routes to School	https://www.cdc.gov/policy/hst/hi5/saferoutes/index.html
School-based active recess	https://www.cdc.gov/policy/hst/hi5/physicalactivity/index.html
School-based alcohol/other drug prevention programs	http://www.countyhealthrankings.org/policies/universal-school-based-programs-alcohol-misuse-impaired-driving
School-based health centers	https://www.thecommunityguide.org/findings/promoting-health-equity-through-education-programs-and-policies-school-based-health-centers
School-based Health Alliance	http://www.sbh4all.org/
School-based nutrition education programs	http://www.countyhealthrankings.org/policies/school-based-nutrition-education-programs
Smoke-free polices	http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/smoke-free-policies-for-multi-unit-housing
Screening, brief intervention, and referral to treatment (SBIRT)	http://www.integration.samhsa.gov/clinical-practice/sbirt
Tobacco 21	https://tobacco21.org/
Trauma informed care	http://www.countyhealthrankings.org/policies/trauma-informed-health-care
Walk Friendly Communities	http://walkfriendly.org/