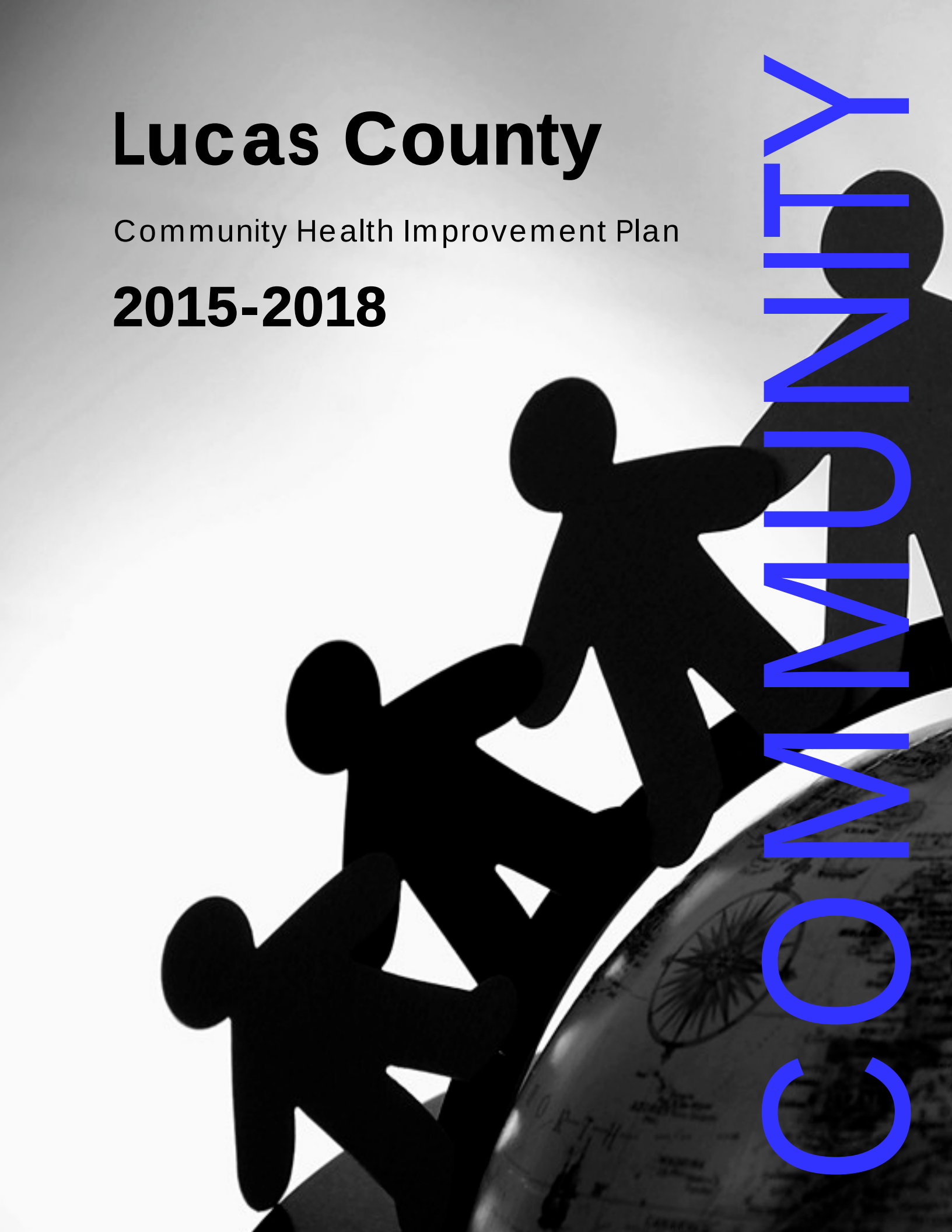
Lucas County

Community Health Improvement Plan

2015-2018



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Executive Summary

Since 2007, Healthy Lucas County has conducted community health assessments (CHA) for the purpose of measuring and addressing health status. The most recent Lucas County Health Assessment was cross-sectional in nature and included a written survey of adults, adolescents, and parents within Lucas County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention for their national and state *Behavioral Risk Factor Surveillance System* (BRFSS) and *Youth Risk Behavior Surveillance System* (YRBSS) and the *National Survey of Children's Health* (NSCH) developed by the Child and Adolescent Health Measurement Initiative. This has allowed Lucas County to compare the data collected in their CHA to national, state and local health trends.

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

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

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

To facilitate the Community Health Improvement Process, the Toledo-Lucas County Health Department along with the local hospitals, invited key community leaders to participate in an organized process of strategic planning to improve the health of residents of the county. The National Association of City County Health Officer's (NACCHO) strategic planning tool, Mobilizing for Action through Planning and Partnerships (MAPP), was used throughout this process.

The MAPP Framework includes six phases which are listed below

- Organizing for success and partnership development
- Visioning
- Conducting the MAPP assessments
- Identifying strategic issues
- Formulating goals and strategies
- Taking action: planning, implementing, and evaluation

Executive Summary, continued

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 the Lucas County CHIP Committee 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.

Strategies:

Priority Health Issues for Lucas County
1. Increase healthy weight status
2. Decrease chronic disease
3. Decrease youth mental health issues and bullying
4. Decrease infant mortality
5. Increase school readiness

Target Impact Areas:

To increase healthy weight status, Lucas County will focus on the following target impact areas: 1) Increase access to healthy food options, 2) Increase breastfeeding, 3) Implement OHA Healthy Hospital Initiative, 4) Implement a Complete Streets Policy, 5) Expand Safe Routes to School, 6) Implement a community-based walking program and 7) Increase nutrition/physical education materials being offered to patients by primary care providers

To decrease chronic disease, Lucas County will focus on the following target impact areas: 1) Increase prevention/intervention programs and access to healthcare, 2) Decrease exposure to second hand smoke and 3) Increase the recruitment of nurse practitioners and physician assistants

To increase access and awareness of youth mental health issues and decrease bullying, Lucas County will focus on the following target impact areas: 1) Increase the number of health care providers who screen for adolescent depression during office visits, 2) Increase early identification of mental health needs among youth, 3) Increase awareness of available youth mental health services, 4) Implement evidence based bullying prevention programs and 5) Increase awareness of Trauma Informed Care (an organizational structure and treatment framework that involves understanding, recognizing and responding to the effects of all types of trauma).

Executive Summary, continued

To decrease infant mortality, Lucas County will focus on the following target impact areas: 1) Increase the use of safe sleep practices, 2) Increase maternal, preconception, prenatal & inter-conception health, 3) Increase access to care for pregnant women and 4) Increase breastfeeding practices.

To increase school readiness, Lucas County will focus on the following target impact areas: 1) Increase the number of children enrolled in a Head Start, Early Head Start, pre-school education or Help Me Grow program and 2) Increase the number of Star-Rated Step Up to Quality Child Care Programs in Lucas County.

Trans-strategies that will work toward addressing all five priority areas include: 1) Increase cultural competency, 2) Increase efforts to address social determinants of health and 3) Increase public and partner education messages promoted improved health.

Partners

The 2015-2018 Community Health Improvement Plan was drafted by agencies and service providers within Lucas County. During the past several months, the committee reviewed many sources of information concerning the health and social challenges Lucas County adults, youth and children may be facing. They determined priority issues which if addressed, could improve future outcomes, determined gaps in current programming and policies and examined best practices and solutions. The committee has recommended specific actions steps they hope many agencies and organizations will embrace to address the priority issues in the coming months and years. We would like to recognize these individuals and thank them for their devotion to this process and this body of work:

The LUCAS County CHIP Planning Committee

Adam Klugh, Toledo Fire and Rescue Department
Alcy Barakat, Toledo-Lucas County Health Department Intern
Alia Kadri, Toledo-Lucas County Health Department
Alicia Komives, Lucas County Juvenile Court
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Barbara Gunning, Toledo-Lucas County Health Department
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Brandon Palinski, Toledo-Lucas County Health Department
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Partners, continued

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Linda Alvorado-Arce, City of Toledo, Board of Community Relations
Angelo Smith, ProMedica
Kathy Didion, The Zepf Center

This strategic planning process was facilitated by Britney Ward, Director of Community Health Improvement and Michelle Von Lehmden, Health Assessment Coordinator from the Hospital Council of Northwest Ohio.

Vision

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

The Vision of Healthy Lucas County:
Creating a healthy Lucas County

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

Goals of Healthy Lucas County:
Healthy Lucas County exists to measure health status and to promote health improvement planning in Lucas County.

Alignment with National and State Standards

The 2015-2018 Lucas County Health Improvement Plan priorities align perfectly with state and national priorities. Lucas County will be addressing the following priorities: weight status, mental health, infant mortality, chronic diseases and school readiness.

Lucas County priorities very closely mirror the following 2012-2014 Ohio State Health Improvement Plan priorities: access to care, chronic disease, injury and violence, and integration of physical and behavioral health.

The Lucas County Plan also aligns with six of the National Prevention Strategies for the U.S. population: tobacco free living, healthy eating, active living, reproductive and sexual health, injury and violence free living, and mental and emotional well-being.

Lucas County's priorities also fit specific Healthy People 2020 goals. For example:

- Nutrition and Weight Status(NWS)-8: Increase the proportion of adults who are at a healthy weight
- Mental Health and Mental Disorders (MHMD)-2: Reduce suicide attempts by adolescents
- Injury and Violence Prevention (IVP)-35: Reduce bullying among adolescents
- Maternal, Infant and Child Health (MICH)-10: Increase the proportion of pregnant women who receive early and adequate prenatal care
- Adolescent Health (AH)-5: Increase educational achievement of adolescents and young adults
- Access to Health Services (AHS)-5: Increase the proportion of persons who have a specific source of ongoing care

There are 11 other mental health objectives, 9 access to health services objectives, 21 weight control objectives and 21 maternal, infant & child objectives that support the work of the Lucas County CHIP. These objectives can be found in each individual section.

Strategic Planning Model

Beginning in December 2014, Healthy Lucas County met eight (8) 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

Needs Assessment

Healthy Lucas County reviewed the 2013/14 Lucas County Health Assessment. Each member completed an "Identifying Key Issues and Concerns" worksheet. The following tables were the group results.

What are the most significant <u>ADULT</u> health issues or concerns identified in the 2013/14 assessment report?

Key Issue or Concern	% of Population Most at Risk	Age Group/ Income Level Most at Risk	Gender Most at Risk	Race/ Ethnicity Most at Risk
1. Obesity/Overweight (17 votes)	70%	Age: 30-64	Female	Hispanic/AA
2. Heart Disease (14 votes)				AA
High Blood Pressure	37%	Age: 65+	Male	
Cholesterol	25%	Age: 65+	Male	
Heart Attack	5%	Age: 65+	--	
Stroke	3%	Age: 65+	Male	
3. Diabetes (12 votes)	15%	Age: 65+	Female	Hispanic/AA
4. Depression (11 votes)	19%	Age: <30	Female	AA
5. Health Disparities (9 votes)				
Sought assistance for basic needs	27%	Income: <$25k	--	AA
6. Infant Mortality (8 votes)	8.98/1,000 13.52/1,000 AA			AA
7. Food Insecurity (7 votes)	14%			
Concerned about having enough food	36% low-income			
8. Smoking/Tobacco (6 votes)	19% current	Age: 30-64	Male	AA
9. Cancer Screening (6 votes)				
Mammogram in past two years	73%	Age: 40+	Female	
Pap smear in past three years	43%	Age: 40+	Female	
PSA test in past year	22%	--	Male	
Colorectal	31%	65+	Male	
10. Heroin/Rx (opiates) (6 votes)	<1% (Heroin)	--	--	
11. Alcohol Consumption (5 votes)	21% Binge drinking 39% Frequent drinking 32% Drink and drive **(1 vote)**	Age: <30	Male	AA
12. Oral Health (3 votes)				
Not been to the dentist	34%	Age: 30-64	Female	
13. Quality of Life (3 votes)		Income:		Hispanic/AA
Limited in some way	47%	<$25k Age: 65+	Female	
14. Arthritis (3 votes)	19%	Age: 65+	Female	
15. Asthma (2 votes)	13%	Income: <$25k	Females	
16. Pneumonia Vaccine (1 vote)	56%	Age: 65+	--	
17. Increase fruits and vegetables (1 vote)	90% 1-4 serving per day	--	--	

Needs Assessment, continued

What are the most significant <u>YOUTH</u> health issues or concerns identified in the 2013/14 assessment report?

Key Issue or Concern	% of Population Most at Risk	Age Group Most at Risk	Gender Most at Risk
1. Mental Health (17 votes)			
Depressed	28% (7-12)	Age: 17+	Female
Attempted suicide	7% (7-12)		
No one to talk too	32%		
2. Alcohol Consumption (14 votes)			
Binge drinking	69% of those who drank	Age: 17+	Male
3. Sexual Behavior (14 votes)			
Multiple Sexual Partners	14% 4+	--	--
	63% of those	--	--
Teen birth rates	*14.4 (Rate per 1,000)	--	--
4. Rx Drug Use (13 votes)	9% (9-12)	--	--
5. Weight Control (12 votes)			
Obese	13% (7-12)	Age: 17+	Male
No physical activity	15% (7-12)	--	--
6. Bullying (10 votes)	43% (7-12)	<13	Female
7. Infant Mortality (8 votes)	8.98/1,000	--	Female
	13.52/1,000 AA		
8. Social Determinants of Health (6 votes)	--	--	--
9. Tobacco Use (6 votes)	8% current users	Age: 17+	--
10. Drug Use (4 votes)			
Marijuana	15% current users (7-12)	Age: 17+	Female
11. Food Insecurity (4 votes)			
Went to bed hungry	11%	--	
	25% Source: *(Feeding America)*		
12. Distracted Driving (2 votes)			
Talked	48%	--	--
Texted	41%	--	--
13. Violence (1 vote)			
Carried a weapon	8%	17+	Male
Physical fight	26%	--	--
Fight at home	--	--	--
14. Ride with someone who was drinking (1 vote)	21% past month	Age: High school 9-12	--
15. Multiple Risk Factors/2 or more risky behaviors (1 vote)			

**ODH Information Warehouse, 2012*

Needs Assessment, continued

What are the most significant <u>CHILD</u> health issues or concerns identified in the 2013/14 assessment report?

Key Issue or Concern	% of Population Most at Risk	Age Group Most at Risk	Gender Most at Risk
1. Obesity (11 votes)	24%	Age: 0-11	--
Nutrition	87% 1-4 servings		
Physical Activity	87%	Age: 6-11	
Screen time	4.8 hours total		
2. Asthma (8 votes)	17%	Age: 6-11	--
Environment	--	--	
Smoke in the home is not allowed	86%	Income <$25k	
Smoking in the car is not allowed	80%	--	
3. Bullying (8 votes)	36%	Age: 6-11	--
4. Infant Mortality (8 votes)			Female
Low birth weight	9.6%		
Pre-term	--		
Safe sleep **(7 votes)**	68% on back		
5. Safety/Family Functioning (6 votes)			
Always safe	52%	Income: <$25k	
Usually	41%	--	
Lead poisoning	43% tested	Age: 0-11	
Guns in the home	26%	Age: 0-11	
6. School Readiness/Early Intervention (6 votes)	33%	--	
Parent reads to child everyday	40%	Age: 6-11	
Child care (star-rated)	27%	Age: 0-5	
Kindergarten ready	33% *(Source: Aspire)*	--	
7. Never breastfeed (6 votes)	29%	<$25k	Female
Didn't try	4%		
Didn't want to	22%		
8. No personal Doctor (5 votes)	43%	Income: <$25k	
ER use	30%	Age: 0-5	
	17%	Age: 6-11	
9. Oral health (3 votes)			
No problems with teeth	67%	Age: 0-5	
Tooth decay by 3rd grade	51%		
10. Not attended religious services (1 vote)	31%	Age: 6-11	--
11. Child passenger safety (booster) (1 vote)	39% of children under the age of 8 years old and less than 4 feet, 9 inches always rode in a booster seat	Age: 6-11	
12. Vision problems (1 vote)	2%	--	--

Priorities Chosen

Healthy Lucas County completed an exercise where they ranked the key issues based on the magnitude of the issue, seriousness of the consequence, and the feasibility of correcting the issue. A total score was given to each priority. The max score was 30. All committee members' scores were combined and then average numbers were produced.

The rankings were as follows:

Issue	Average Score
Adult Weight Control (Obese, nutrition, physical activity)	24.9
Heart Disease (HBP, Cholesterol, Heart Attack, Stroke)	24.2
Child Weight Control (Obese, nutrition, physical activity, screen time)	23.6
Youth Mental Health (Attempted suicide, Depressed, etc.)	23.3
Youth Weight Control (Obese, nutrition, physical activity)	23.2
Infant Mortality (LBW, Pre-term, Safe sleep) (Child)	23.0
Child Bullying	22.7
Youth Bullying	22.6
School Readiness (Parent reads to child, child care, etc.)	22.6
Youth Sexual Behavior (Multiple sexual partners, teen birth rates)	21.8
Infant Mortality (Youth)	21.7
Adult Diabetes	21.7
Health Disparities	21.7
Infant Mortality (Adult)	21.7
Adult Depression (and other mental health issues)	21.6
Youth Alcohol Consumption (Binge drinking, etc.)	21.6
Safety/Family Functioning (Neighborhood safety, lead poisoning, guns in the home, etc.)	21.5
Youth Drug Use (illegal drugs, prescription, OTC, etc.)	20.8
Asthma (Environment, Smoking in home/car)	20.6
Food Insecurity	20.2

Adult, Youth and Child issues were then combined.

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

- Adult, Youth and Child Weight Status
- Youth/Child Mental Health and Bullying
- Heart Disease and other Chronic Diseases
- School Readiness
- Infant Mortality

Forces of Change

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

Forces of Change	Impact
Republican controlled congress	• Funding and policies for mental health, infant mortality and school readiness have been cut • Could lead to Medicaid expansion and an increase in mental health programming
Status of Medicaid Expansion in Ohio	• Has to be approved in the biennial budget by June • If it doesn't pass there will be a reduction in access to care • If it does pass, it will increase access to care
Affordable Care Act	• It has positively affected the number of people obtaining insurance
Shift in population/aging population	•
Increase availability of SNAP subsidies	• Increasing accesses to healthier food options
State budget cuts	• Negatively affects programming • Reduction in federal money coming into the community
Shift in reimbursement for prevention	• Increasing access to care • Increases prevention services • Hospitals are penalized for readmissions
Changes in Step up to Quality program standards	• Higher quality day care/child care facilities
ODH MedTap program	• Increase health care providers in underserved populations
Legalization of marijuana	• Increase use by adults and youth • Youth received mixed messages
Doctors over-prescribing narcotics	• Need increased education for prescribers • New legislation is being introduced to increase addiction treatment opportunities
Telemedicine	• Increasing access to care • Gives doctors greater ability to follow patients and refer to specialists
Increase in community health care workers	• Increasing access to care
Increase in free community clinics (run by UT medical students)	• Increasing access to care
Community paramedicine	• Legislation is being introduced to increase the roles of paramedics • If passed will increase access to care • Needs to have a developmental model created • Can become a vital solution
Abundance of fast food restaurants compared to healthy options	• Increase in the population being obese/overweight • Less consumption of fruits/vegetables
Increase in awareness of the importance of healthy eating and exercise	• More healthy food options becoming available in restaurants • Walking programs for youth (Toledo Fire; Walk with a fireman program) • Increased use of Metro Parks
Increase in integrated care	• Health/mental health clinics are beginning to open up in schools (services available for youth)
Shift to a focus on population health	• Community hubs in 4 TPS schools focusing on community needs
Affordable Care Act	• Increasing the number of people with insurance • Mandated hospitals to complete a Community Health Needs Assessment (CHNA) and an implementation plan

Forces of Change , continued

Forces of Change	Impact
Prevalence of high deductible insurance plans	• Dis-incentive to get care
Changes to local hospital systems	• ProMedica moving downtown
Shortage in Primary Care Physicians	• Decreases in access • Hard to recruit for primary care (low Medicaid reimbursement) • Need to increase opportunities for residency opportunities
NHA is building a new facility	• Some services have been consolidated • Going to address some homeless care issues that will relive burden from Emergency Rooms
Workforce issues	• Skill sets are not being met (lack of skilled workers)
Electronic Health Records	• Some doctors/nurses are hesitant to move forward with new technology • No funds available for training • Expensive to implement
Media imbalance between pharmaceutical commercials and education on prescription drug abuse	• Some doctors continue to over-prescribe • Drugs continue to be viewed as a quick fix
Increase in programming offered by Area Office of Aging	• Increasing access to care • Increases prevention/screening services
Racism/racial disparities	• Income disparities • Opiate epidemic was viewed differently in inner city compared to the suburbs • Need to collect more data in selected areas
Transportation issues	• Public transportation is not available to all areas of Lucas County • Unable to get to appointments/services

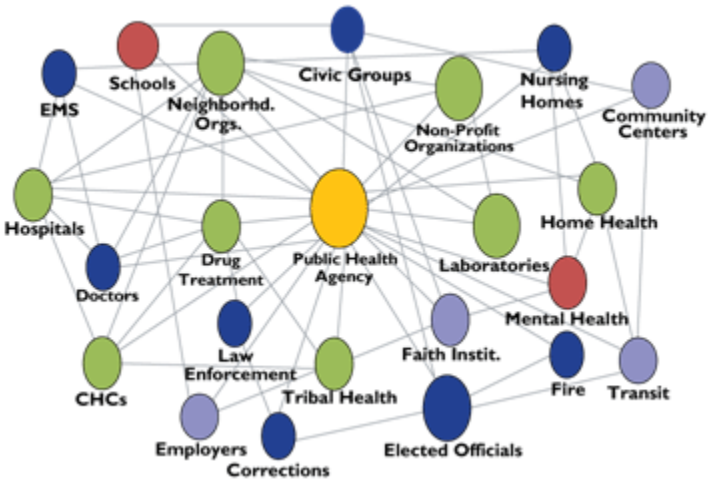
Local Public Health System Assessment

The 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

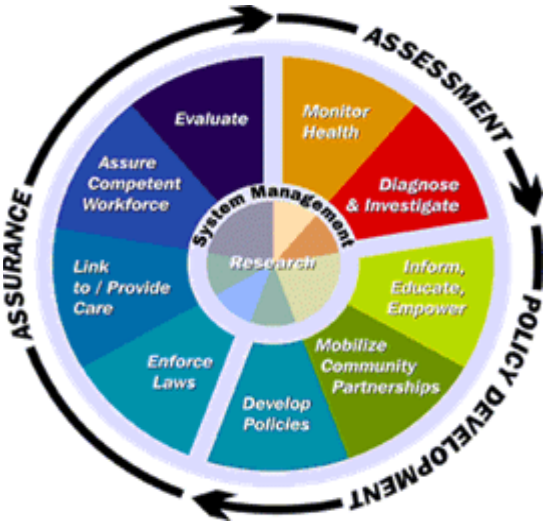


The 10 Essential Public Health Services

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; http://www.cdc.gov/nphpsp/essentialservices.html)

Local Public Health System Assessment, continued

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**.

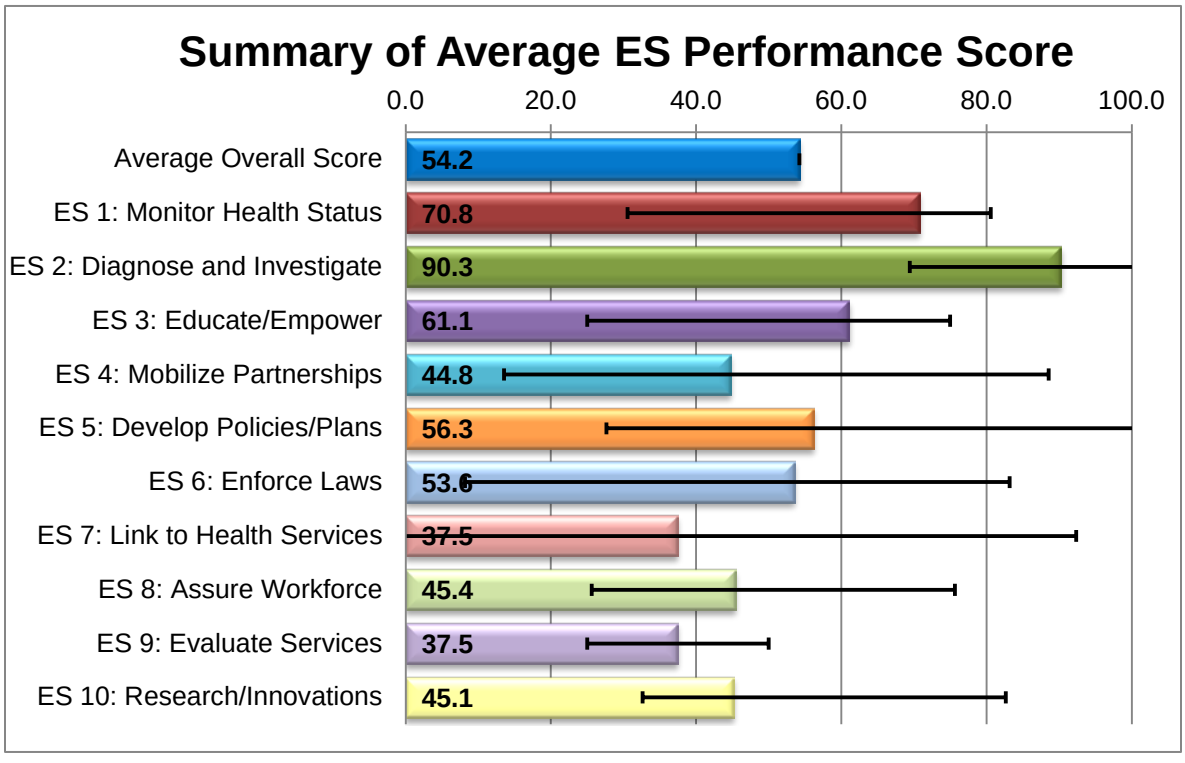
Members of the Toledo-Lucas County Health Department completed the performance measures instrument. The LPHSA results were then presented to the full CHIP committee for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard 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 27 indicators that had a status of "minimal" and 4 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 see the full results of the LPHSA, please contact Jodi Sheaves from the Toledo-Lucas County Health Department at sheavesj@co.lucas.oh.us.

Lucas County Local Public Health System Assessment
2015 Summary



Community Themes and Strengths

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

Lucas County community members believed the most important characteristics of a healthy community were:

- Access to affordable healthy food
- Transportation
- Access to education/quality schools
- Economic opportunity
- Safety

Lucas County community members were most proud of the following regarding their community:

- Partnerships/collaboration
- Revitalization of downtown
- Caring and helpful people

The following were specific examples of people or groups who have worked together to improve the health and quality of life in the community:

- The water crisis
- Toledo/Lucas County CareNet
- Healthy Lucas County
- Aspire
- Live Well Greater Toledo
- Collaborations with universities

The most important issues that Lucas County residents believed must be addressed to improve the health and quality of life in the community were:

- Addressing disparities (racial, economic, health)
- Accessibility to services
- Closing gaps on who is available for services (ages 19-59)

The following were barriers that have kept our community from doing what needs to be done to improve health and quality of life:

- Lack of prevention
- Lack of tax revenue dollars
- The needs are identified, but not always addressed

Lucas County residents believed the following actions, policies, or funding priorities would support a healthier community:

- Increasing taxes on cigarettes
- Medicaid expansion
- Tax incentives for stores offering healthy food options located downtown

Lucas County residents were most excited to get involved or become more involved in improving the community through:

- Create an action plan and follow through with it
- Increase positive public relations-let the community know about successes
- Shift from interventions to creating more pro-active health policies

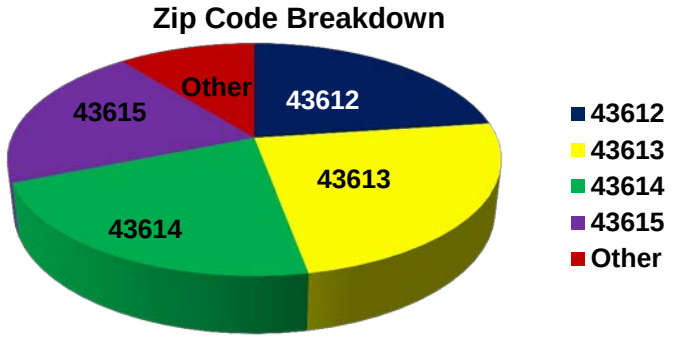
Quality of Life

Healthy Lucas County urged community members to fill out a short Quality of Life Survey via Survey Monkey. There were 1,739 Lucas County community members who completed the survey.

QUALITY OF LIFE RANKINGS SECTION

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, 93% lived in Lucas County and 71% worked in Lucas County.



Quality of Life Questions	
1. What is your age? □ Less than 20 years old (1.33%) □ 20-29 years old (12.97%) □ 30-39 years old (22.47%) □ 40-49 years old (20.73%) □ 50-59 years old (22.35%) □ 60 years old or older (20.15%)	**Likert Scale Average Response** (1 - 5, 5 most positive)
2. Which one or more of the following would you say is your race? □ American Indian/Alaska Native (1.92%) □ Asian (0.64%) □ Black or African-American (7.32%) □ Native Hawaiian/other Pacific Islander (0.17%) □ White (88.39%) □ Don't know (1.05%) □ Other (3.77%)	
3. Are you Hispanic or Latino? □ Yes (4.24%) □ No (94.46%) □ Don't know (1.30%)	
4. 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]	2.76
5. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.07
6. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	2.75
7. 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.)	2.64
8. 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.)	2.57

Quality of Life, continued

9. Is the community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, the mall. Do neighbors know and trust one another? Do they look out for one another?)	2.52
10. Are there networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, organizations) during times of stress and need?	2.98
11. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	2.86
12. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	2.46
13. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	2.60
14. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	2.44
15. 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?)	2.45

Strategy #1: Increase Healthy Weight Status
Weight Status Indicators

The 2014 Health Assessment identified that 70% of Lucas County adults were overweight or obese based on Body Mass Index (BMI). Nearly half (48%) of adults were trying to lose weight. 13% of Lucas County 7th-12th grade youth were obese, according to Body Mass Index (BMI) by age. When asked how they would describe their weight, 25% of Lucas County youth reported they were slightly or very overweight. 24% of children ages 0-11 were classified as obese by Body Mass Index (BMI) calculations.

Adult Weight Status

In 2014, the health assessment indicated that more than two-thirds (70%) of Lucas County adults were either overweight (34%) or obese (36%) by Body Mass Index (BMI). This puts them at elevated risk for developing a variety of diseases.

Nearly half (48%) of adults were trying to lose weight, 31% were trying to maintain their current weight or keep from gaining weight, and 5% were trying to gain weight.

Lucas County adults did the following to lose weight or keep from gaining weight: ate less food, fewer calories, or foods low in fat (51%), exercised (46%), ate a low-carb diet (13%), used a weight loss program (4%), smoked cigarettes (3%), took diet pills, powders or liquids without a doctor's advice (3%), went without eating 24 or more hours (2%), took prescribed medications (2%), took laxatives (1%), participated in a prescribed dietary or fitness program (1%), bariatric surgery (<1%), and vomited (<1%).

46% of adults described themselves as being either slightly or very overweight. 6% of adults described themselves as obese.

15% of Lucas County adults engaged in binge eating on some days and <1% did so every day. 81% did not binge eat at all.

In Lucas County, 50% of adults were engaging in some type of physical activity or exercise for at least 30 minutes 3 or more days per week. 22% of adults were exercising 5 or more days per week. One-quarter (25%) of adults were not participating in any physical activity in the past week, including 4% who were unable to exercise.

Lucas County adults spent the most time doing the following physical activities in the past year: walking (37%), running/jogging (6%), exercise machines (4%), cycling (3%), strength training (3%), swimming (<1%), and other (7%). 39% of adults engaged in multiple types of exercise. 11% of adults did not exercise at all, including 2% who were unable to do so.

Reasons for not exercising included: weather (29%), time (24%), too tired (17%), laziness (17%), pain/discomfort (17%), could not afford a gym membership (9%), chose not to exercise (8%), safety (5%), no childcare (3%), did not know what activity to do (3%), no sidewalks (2%), no gym available (1%), doctor advised them not to exercise (1%), no walking/biking trails (1%), and other (5%).

Lucas County adults had access to a wellness program through their employer or spouse's employer with the following features: free/discounted gym membership (17%), health risk assessment (11%), lower insurance premiums for participation in wellness program (8%), on-site fitness facility (8%), on-site health screenings (7%), gift cards or cash for participation in wellness program (5%), healthier food options in vending machines or cafeteria (5%), free/discounted weight loss program (4%), free/discounted smoking cessation program (4%), on-site health education classes (4%), lower insurance premiums for positive changes in health status (3%), gift cards or cash for positive changes in health status (1%), and other (4%).

30% of Lucas County adults did not have access to any wellness programs, and 16% had access to more than one wellness program.

Lucas County adults spent an average of 3.2 hours watching TV, 1.5 hours on their cell phone, 1.4 hours on the computer (outside of work), and 0.4 hours playing video games on an average day of the week.

Strategy #1: Increase Healthy Weight Status
Weight Status Indicators, continued

In 2014, 6% of adults were eating 5 or more servings of fruits and vegetables per day. 90% were eating between 1 and 4 servings per day. The American Cancer Society recommends that adults eat at least 2 ½ cups of fruits and vegetables per day to reduce the risk of cancer and to maintain good health. The 2009 BRFSS reported that only 21% of Ohio adults and 23% nationwide were eating the recommended number of servings of fruits and vegetables.

Lucas County adults purchased their fruit and vegetables from the following places: large grocery store (74%), local grocery store (43%), farmer's market (29%), restaurants (11%), food pantry (4%), Consumer Supported Agricultural (CSA) (1%), corner/convenience stores (1%), and other places (7%).

Adults reported the following barriers to consuming fruits and vegetables: too expensive (13%), did not like the taste (5%), transportation (2%), did not know how to prepare (2%), no variety (2%), did not take EBT (<1%), and other barriers (4%).

Lucas County adults reported the following reasons they chose the types of food they ate: taste (67%), enjoyment (57%), cost (53%), healthiness of food (48%), ease of preparation (43%), availability (42%), food they were used to (33%), time (29%), calorie content (29%), what their spouse prefers (24%), what their child prefers (15%), health care provider's advice (6%), and other (4%).

Youth Weight Status

In 2013/14, 13% of youth were classified as obese by Body Mass Index (BMI) calculations (2013 YRBS reported 13% for Ohio and 14% for the U.S.). 10% of youth were classified as overweight (2013 YRBS reported 16% for Ohio and 17% for the U.S.). 78% were normal weight, and 3% were underweight.

25% of youth described themselves as being either slightly or very overweight (2013 YRBS reported 28% for Ohio and 31% for the U.S.).

42% of all youth were trying to lose weight, increasing to 58% of Lucas County female youth (compared to 27% of males). (2013 YRBS reported 47% for Ohio and 48% for the U.S.).

14% of Lucas County youth ate 5 or more servings of fruits and vegetables per day. 79% ate 1 to 4 servings of fruits and vegetables per day.

Lucas County youth got most of their food from the following places: home (87%), convenience store (11%), fast food (8%), restaurant (7%), and school (5%).
(Percentages may be greater than 100% due to more than one option being chosen.)

18% of youth reported they drank a can, bottle, or glass of soda pop such as Coke, Pepsi, or Sprite one or more times per day during the past week (2013 YRBS reports 21% for Ohio and 27% for the U.S.).

11% of youth reported they went to bed hungry because their family did not have enough money for food at least one night per week. 1% of youth went to bed hungry every night of the week.

69% of Lucas County youth participated in at least 60 minutes of physical activity on 3 or more days in the past week. 48% did so on 5 or more days in the past week (2013 YRBS reports 48% for Ohio and 47% for the U.S.), and 26% did so every day in the past week. (2013 YRBS reports 28% for Ohio and 27% for the U.S.).15% of youth did not participate in at least 60 minutes of physical activity on any day in the past week (2013 YRBS reports 13% for Ohio and 15% for the U.S.).

Over one-third (34%) of youth spent 3 or more hours watching TV on an average day of the week (2013 YRBS reported 28% for Ohio and 33% for the U.S.).

Strategy #1: Increase Healthy Weight Status
Weight Status Indicators, continued

Child Weight Status

In 2014, 24% of children were classified as obese by Body Mass Index (BMI) calculations. 13% of children were classified as overweight, 52% were normal weight, and 11% were underweight.

10% of Lucas County children ate 5 or more servings of fruits and vegetables per day. 87% ate 1 to 4 servings of fruits and vegetables per day.

Lucas County children spent an average of 2.4 hours watching TV, 1.4 hours on the computer/tablet/cellphone, and 1.0 hours playing video games an average day of the week.

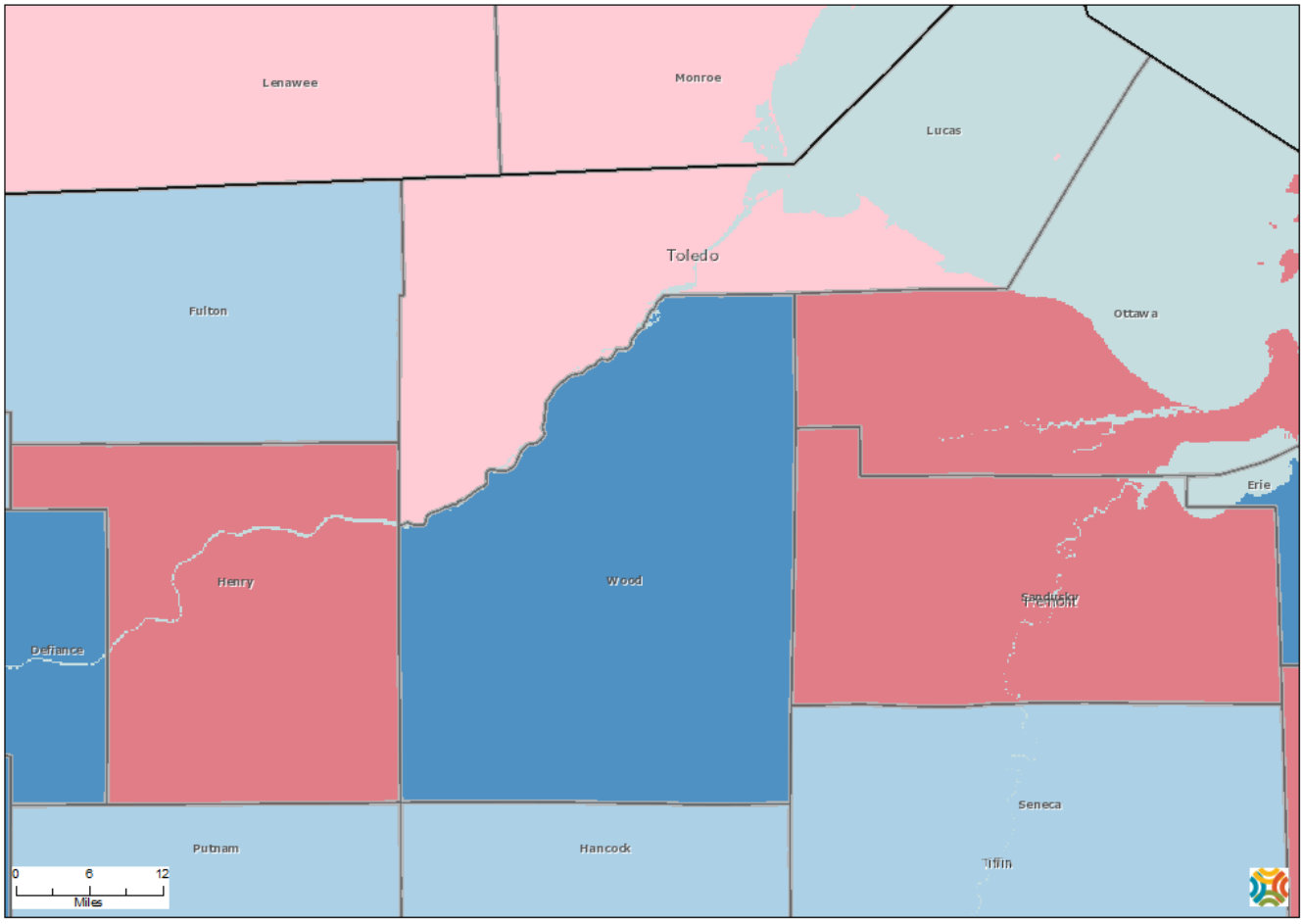
Adult Comparisons	Lucas County 2007	Lucas County 2011	Lucas County 2014	Ohio 2012	U.S. 2012
Obese	33%	35%	36%	30%	28%
Overweight	37%	36%	34%	35%	36%

Youth Comparisons	Lucas County 2011 (9th-12th)	Lucas County 2013/14 (5th-6th)	Lucas County 2013/14 (7th-8th)	Lucas County 2013/14 (9th-12th)	Ohio 2013 (9th-12th)	U.S. 2013 (9th-12th)
Obese	15%	9%	14%	13%	13%	14%
Overweight	11%	11%	10%	11%	16%	17%
Described themselves as slightly or very overweight	25%	17%	25%	25%	28%	31%
Trying to lose weight	42%	40%	39%	44%	47%	48%
Exercised to lose weight	43%	48%	46%	48%	61%*	61%*
Ate less food, fewer calories, or foods lower in fat to lose weight	28%	16%	28%	31%	43%*	39%*
Went without eating for 24 hours or more	7%	1%	5%	6%	10%	13%
Took diet pills, powders, or liquids without a doctor's advice	3%	<1%	1%	2%	5%	5%
Vomited or took laxatives	3%	0%	1%	3%	5%	4%
Ate 1 to 4 servings of fruits and vegetables per day	82%	74%	76%	81%	85%*	78%*
Drank pop or soda one or more times per day during the past 7 days	N/A	17%	20%	17%	21%	27%
Physically active at least 60 minutes per day on every day in past week	28%	27%	21%	28%	26%	27%
Physically active at least 60 minutes per day on 5 or more days in past week	43%	48%	43%	50%	48%	47%
Watched TV 3 or more hours per day	40%	30%	35%	34%	28%	35%

*N/A – Not available * Comparative YRBSS data for Ohio is 2007 and U.S. is 2009*

Strategy #1: Increase Healthy Weight Status
Weight Status Indicators, continued

Lucas County and Surrounding Areas with Adult Obesity, CHR 2014



Map Legend

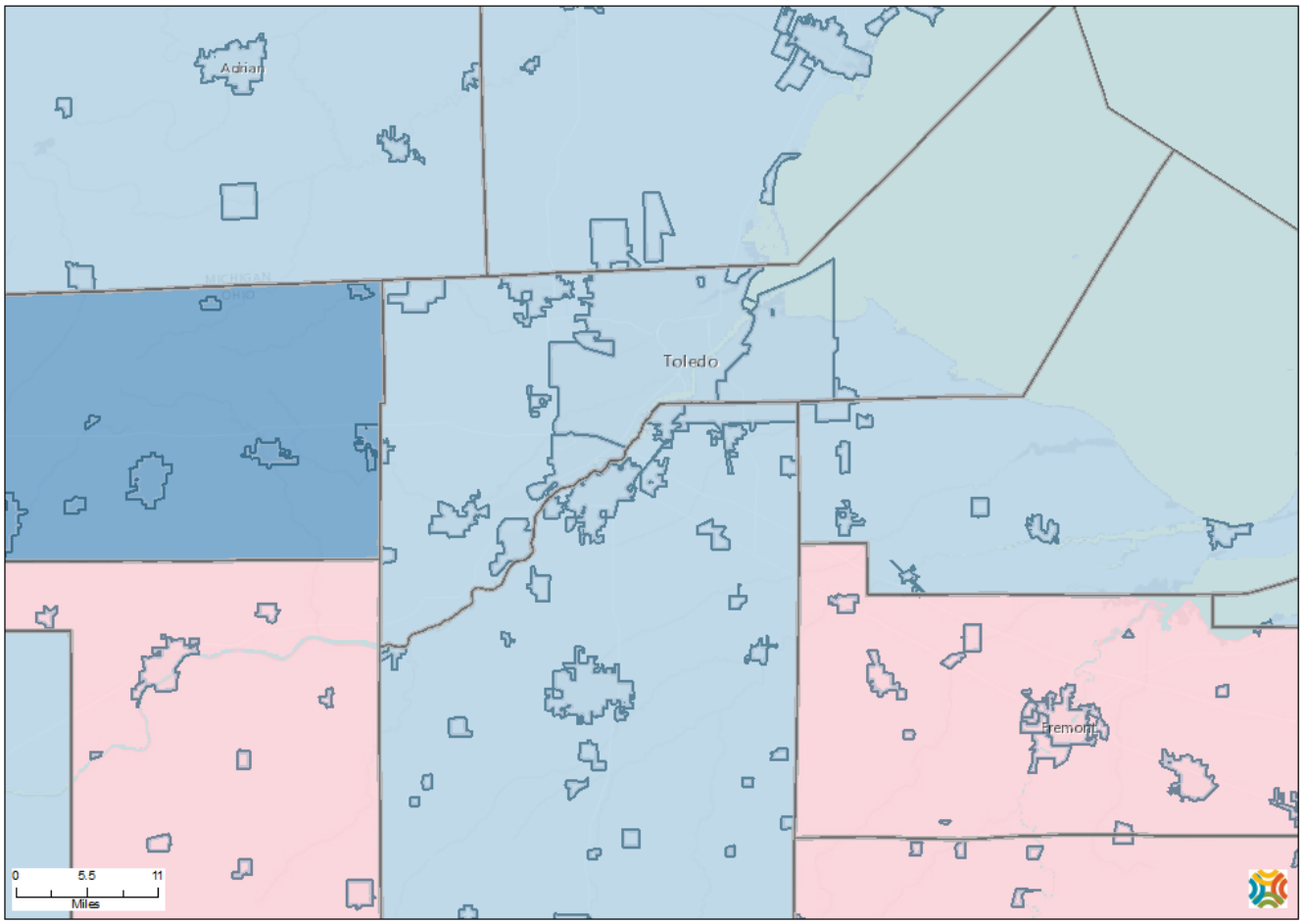
Adult Obesity (BMI >= 30), Rank by County, CHR 2014

- 1st Quartile (Top 25%)
- 2nd Quartile
- 3rd Quartile
- 4th Quartile (Bottom 25%)
- Bottom Quintile (Rhode Island Only)
- No Data or Data Suppressed; -1

Community Commons, 2/19/2015

Strategy #1: Increase Healthy Weight Status
Weight Status Indicators, continued

Adult Physical Inactivity, CHR 2014



Map Legend

Physical Inactivity, Rank by County, CHR 2014

- 1st Quartile (Top 25%)
- 2nd Quartile
- 3rd Quartile
- 4th Quartile (Bottom 25%)
- Bottom Quintile (Rhode Island Only)
- No Data or Data Suppressed; -1

Community Commons, 2/19/2015

Strategy #1: Increase Healthy Weight Status
Resource Assessment

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Silver Sneakers Program	YMCA	Seniors	Prevention	Best practice
Mercy Weight Management Center (Surgical, Non-surgical and adolescent weight loss programs)	Mercy	Adult & youth	Early intervention and treatment	
Mercy Kids in Action	Mercy	Youth & children	Prevention	Pre/Post Survey
Kohl's Kids in Action	Mercy	Youth & children	Prevention	
Center for Health Promotion	Mercy	Adults	Prevention, early intervention and treatment	
Safe Routes to School	Live Well	Youth grades K-8	Prevention	Best practice
Corner store program	Live Well	All ages	Prevention	
Mobile A	Food for Thought	All ages	Prevention	
The Farm Toledo Grows	Toledo Botanical Gardens	All Works closely with juvenile court	Prevention	Best practice
Pediatric weight management program	UTMC	Children & adolescents	Treatment	Outcomes measured
Adolescent medicine	UTMC	Adolescents	Treatment	Outcomes measured
Health Kids Conversation Maps	ProMedica	Youth grades 1-6	Prevention	
Healthy Eating in the Real World	ProMedica	Adults with children	Prevention	
Fitness & physical activity	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			
Boxing/wrestling	Soul City	All	Prevention	
Healthy U Program	Area Office on Aging/Mercy	Seniors	Prevention	

Strategy #1: Increase Healthy Weight Status
Resource Assessment, continued

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Food pantry/assistance	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			
Food stamps/SNAP application/food vouchers/fresh food	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			
Nutrition Education	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			
Super Fitness Kids program	Super Fitness Gym	3-13 years old	Prevention	
Cooking kitchen/garden	Toledo Seagate Food Bank	All	Prevention	
Club Recreation	Catholic Club	0-19 years old	Prevention	Pre/post tests
Health By Choice (healthy eating program)	Friendly Center & MLK Kitchen for the Poor	North Toledo residents	Prevention/early intervention	
Community Hubs (multiple services provided)	United Way	TPS Schools: Leverett, Pickett, Scott, Robinson	Prevention	Community Hubs (multiple services provided)
Nutrexity Game	ProMedica	All public schools	Prevention	Nutrexity Game
Weekender Program	Mobile Meals	School aged elementary students	Prevention/early intervention	
School nutrition support (universal breakfast)	Children's Hunger Alliance	School aged students	Prevention/early intervention	
Employee wellness programs	Lucas County	County employees	Prevention	Best practice

Strategy #1: Increase Healthy Weight Status
Resource Assessment, continued

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Catch Kids Club (Nutrition education and exercise after school)	Children's Hunger Alliance	School-aged youth	Prevention	
Cycling programs	PEAC	All	Prevention	
Parks	Multiple locations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf	All	Prevention	
Recreation centers	Multiple locations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf	All	Prevention	
Nutrition education	Sofia Quintero Community Center	All	Prevention	
School gardens & fitness programs (Reynolds)	TPS/UT	Elementary students	Prevention	
Fitness/cooking classes	Zepf Wellness Center	Youth	Prevention	
Super Fitness Kids program	Super Fitness Gym	3-13 years old	Prevention	
Healthy Living Center	Thomas Wernert Center	Adults with mental illness	Prevention	
Matter Of Balance	Area Office on Aging	Seniors	Prevention	
Fun Bus program, summer/day camps/ family wellness programs, group fitness,	YMCA (monthly rates based on household income)	All ages	Prevention	Best practice
Diabetes Programs, LEAP Youth Obesity Program, Worksite health screenings, worksite wellness presentations	YMCA (monthly rates based on household income)	All Ages	Prevention	Best practice
Food programs & Summer food programs	YMCA (monthly rates based on household income)	All Ages	Prevention	Best practice

Strategy #1: Increase Healthy Weight Status
Resource Assessment, continued

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Available to Members: • Free fitness classes • Use any Y in Ohio at no extra charge • Group Fitness classes • 9 area YMCA and JCC branches • Free babysitting while you work out • Reduced prices on Y child care • 7 indoor and 2 outdoor pools • 10 fitness centers with state-of-the-art equipment • 8 gymnasiums • 4 family adventure centers • Climbing wall • Racquetball courts • Saunas, steam rooms, whirlpool • Gymnastics Center • Youth sports, swim lessons	YMCA (monthly rates based on household income)	All ages		Best practice
CareNet Link: Community Health Worker utilizing Pathways for Care Coordination	Toledo/Lucas County CareNet	Low income individuals who are either uninsured or Medicaid	Prevention, early intervention and treatment	Too New
Bariatric program	ProMedica			
Life steps	ProMedica St. Luke's			
Scale Down, DIET FREE	ProMedica Wellness			
Fitness Center, Script4Fitness	ProMedica Wildwood			

Strategy #1: Increase Healthy Weight Status
Gaps & Potential Strategies

Gaps	Potential Strategies
Food Access	• Expand healthy corner store program • Work with legislators to bring small grocery stores into the city • Use available GPS data to track progress and food deserts • Increase the supply of healthy food options and promote their purchase
Complete streets (bike lanes, walking lane, islands)	• Regional complete street policy - TMACOG and City of Toledo (change in parking rules/regulations)
Cultural competency	• Increase culturally relevant community strategies • Look at toolkits currently available • Focus on social marketing for certain populations
Access to affordable weight control treatment	• Explain what procedures are covered by insurance to the public • Increase education • Increase education on essential health benefit (EHB) benchmarks • Send information out to Medicaid and eligibility (by BMI)
Insurance	• Lobby insurance companies to increase outcome based programs • Increase education on prevention services now covered
Standardized health options and messages	• Good 4 You program (toolkit for businesses) • Develop messages to be presented to the community
Safe Routes to School	• Expand to more schools • Businesses and residents are not taking care of sidewalks - City Council members working on solutions for snow removal. • Campaigns to increase efforts – snow shoveling app, community service for teens, using inmates.
Community-based physical activity	• Provide social support for physical activity • Community-based walking programs
Teaching adults and children to read food labels	• Work with families to increase education and family programming • Increase the use of My Plate • Increase awareness (coaches, teachers, etc…) • Engage local celebrities, athletes at the community level • Prizes for healthy packed lunches – school age children

Strategy #1: Increase Healthy Weight Status
Best Practices

Best Practices

1. Health Insurance Incentives & Penalties: The number of employers offering financial rewards for participating in wellness programs rose by 50 percent from 2009 to 2011. In 2012, four out of five companies plan to offer some type of financial health incentive. The use of penalties among employers more than doubled from 2009 to 2011, rising from 8 percent to 19 percent. It could double again next year when 38 percent of companies plan to have penalties in place. Requiring smokers to pay a higher portion of the health insurance premium is among the most common penalties. A growing number of employers also base rewards on actual outcomes, such as reaching targeted healthy weights or cholesterol levels, rather than simply rewarding participation.

A provision in the federal health care reform law will let employers offer greater incentives for participating in wellness programs starting in 2014. Under current rules, employers can provide incentives of up to 20 percent of the total health insurance premium per person. The 2010 Patient Protection and Affordable Care Act boosts the threshold to 30 percent and, in cases approved by federal health and labor officials, up to 50 percent in 2014.

Employer programs often reward employees who exercise, lose weight or participate in disease management programs. Incentives may include cash awards, gift cards, higher employer contributions toward the health insurance premium, contributions toward employee health savings accounts, or the chance to compete in a sweepstakes. A lot of research shows people are very much motivated by the potential of a large prize. Some employers offer both individual awards and team awards.

Some employers have found rescission of a reward especially effective. For instance, an employer might offer a $500 health insurance premium discount to everyone and rescind the reward for employees who choose not to participate in the care management program.

2. Worksite Obesity Prevention Interventions: Worksite nutrition and physical activity programs use educational, environmental, and behavioral strategies to improve health-related behaviors and health outcomes. These programs may include written materials, skill-building (e.g., cue control), individual or group counseling, improved access to healthy foods (e.g., changing cafeteria or vending machine options), and opportunities to be more active at work (e.g., on-site facilities for exercise or standing/walking workstations) (CG-Obesity).

Expected Beneficial Outcomes

- Increased fruit & vegetable consumption
- Increased physical activity
- Increased weight loss

Evidence of Effectiveness

There is strong evidence that worksite nutrition and physical activity programs increase physical activity, weight loss (Verweij 2011, CG-Obesity), and fruit and vegetable consumption among employees (Verweij 2011).

Worksite nutrition and physical activity programs that utilize multiple components appear to be more successful than programs that utilize only one component (CG-Obesity). Successful programs have been shown to enhance self-confidence for participants, and benefit employers through increased employee productivity and reduced medical care costs (CG-Obesity).

Worksite programs appear to be cost effective strategies to increase physical activity and improve weight status (CG-Obesity).

Impact on Disparities

No impact on disparities likely

Strategy #1: Increase Healthy Weight Status
Best Practices, continued

3. Breastfeeding Promotion Programs: Breastfeeding promotion programs aim to increase breastfeeding initiation, exclusive breastfeeding, and duration of breastfeeding.

Evidence of Effectiveness

There is strong evidence that breastfeeding promotion programs increase initiation, duration and exclusivity of breastfeeding. Breastfeeding has also been shown to provide health benefits to mother and child, including reduced rates of breast and ovarian cancer for women; fewer ear infections, lower respiratory tract infections, and gastrointestinal infections for children; and lower likelihood of childhood obesity, type 2 diabetes, and asthma *(USPSTF-Breastfeeding, 2008)*. Education interventions increase breastfeeding initiation rates, particularly in low income women. Face to face support and tailored education increase the effectiveness of support efforts. Combining pre- and post-natal interventions increases initiation and duration more than pre- or post-natal efforts alone. Support from health professionals, lay health workers, and peers have demonstrated positive effects, including increasing initiation, duration, and exclusivity. Implementing components of the Baby Friendly Hospitals Initiative, as a whole or individually, has been shown to increase breastfeeding rates. This includes practices in maternal care such as rooming in, staff training to support breastfeeding, and maternal education. For employed mothers, supportive work environments increase the duration of breastfeeding.

The Affordable Care Act includes provisions to encourage breastfeeding, including requiring insurance coverage of supplies and support, and requiring employers to provide unpaid time and private space for nursing mothers to pump breast milk at work *(AMCHP-Breastfeeding, 2012)*. Forty-five states and Washington DC have laws that allow women to breastfeed in any public or private location *(NCSL-Breastfeeding)*. For more information go to:
http://www.countyhealthrankings.org/policies/breastfeeding-promotion-programs

4. Healthy Hospitals Initiatives/Dietary Guidelines for Americans, 2010: The Dietary Guidelines for Americans are evidence-based recommendations intended to help people choose an overall healthy diet. The 2010 Dietary Guidelines include 23 key recommendations for the general population and 6 additional key recommendations for specific population groups, such as pregnant women.

Developed By: USDA/CNPP, HHS/OASH

For more information go to:
http://www.cnpp.usda.gov/Publications/DietaryGuidelines/2010/PolicyDoc/PolicyDoc.pdf

5. 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

Evidence of Effectiveness

There is strong evidence that multi-component school-based obesity prevention programs increase physical activity (Nixon 2012, Cochrane-Dobbins 2009, Demetriou 2012), improve weight status (Khambalia 2012, Cochrane-Waters 2011, Katz 2008), and improve dietary habits (Kropski 2008, Van Cauwenberghe 2012, Cawley J, Cisek-Gillman L, Roberts R, et al. Effect of HealthCorps, a high school peer mentoring program, on youth diet and physical activity. Childhood Obesity. 2011;7(5):364–71. Link to original source (journal subscription may be required for access)Cawley 2011). However, there is significant variability in program design and effect (Brown 2009, Harris 2009a, CG-Obesity). Additional evidence is needed to confirm effects on body mass index (BMI) and characteristics of successful programs.For more information go to:
http://www.countyhealthrankings.org/policies/school-based-obesity-prevention-interventions

Strategy #1: Increase Healthy Weight Status
Best Practices, continued

6. **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.

Impact on Disparities

No impact on disparities likely

For more information go to: http://www.countyhealthrankings.org/policies/safe-routes-schools-srts

7. **Social Support in Community Settings:** Community-based social support interventions focus on changing physical activity behavior through building, strengthening, and maintaining social networks that provide supportive relationships for behavior change (e.g., setting up a buddy system or a walking group to provide friendship and support).

Expected Beneficial Outcomes

- Increased physical activity
- Increased physical fitness

Evidence of Effectiveness

There is strong evidence that community-based social support interventions increase physical activity and physical fitness among adults. Middle-aged women enrolled in a weight loss program, for example, have been shown to be more likely to lose weight if they experience social support from friends and family. Community-based social support interventions are considered cost effective.

Impact on Disparities

No impact on disparities likely

For more information go to**: http://www.countyhealthrankings.org/policies/social-support-community-settings**

8. **Improve Streetscape Design:** Improvements to streetscape design can include increased street lighting, enhanced street landscaping, increased sidewalk coverage and connectivity of pedestrian walkways, street crossing safety features, and traffic calming measures. Streetscape design improvement projects typically include elements from more than one of these categories.

Expected Beneficial Outcomes (Rated)

- Increased physical activity
- Increased pedestrian and cyclist safety

Other Potential Beneficial Outcomes

- Increased active transportation
- Reduced obesity rates
- Improved sense of community
- Improved neighborhood safety
- Reduced stress
- Reduced vehicle miles traveled

Evidence of Effectiveness

There is strong evidence that improvements to streetscape design increase physical activity, particularly when implemented as part of a multi-component intervention

For more information go to: http://www.countyhealthrankings.org/policies/improve-streetscape-design

Healthy People 2020 Goals include:

- Increase the proportion of primary care physicians who regularly measure the body mass index of their patients
- Increase the proportion of physician office visits that include counseling or education related to nutrition or weight
- (Developmental) Increase the proportion of worksites that offer nutrition or weight management classes or counseling
- Increase the proportion of adults who are at a healthy weight
- Reduce the proportion of adults who are obese
- Reduce the proportion of children and adolescents who are considered obese
- (Developmental) Prevent inappropriate weight gain in youth and adults
- Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older
- Increase the proportion of adults who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity
- Increase the proportion of adolescents who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity
- Increase the proportion of the Nation's public and private schools that require daily physical education for all students
- Increase the proportion of physician office visits that include counseling or education related to physical activity
- (Developmental) Increase the proportion of trips made by walking
- (Developmental) Increase the proportion of trips made by bicycling
- (Developmental) Increase legislative policies for the built environment that enhance access to and availability of physical activity opportunities

Strategy #1: Increase Healthy Weight Status
Action Step Recommendations & Action Plan

Action Step Recommendations

To work toward increasing wellness, the following action steps are recommended:

1. Increase access to healthy food options
2. Increase breastfeeding
3. Implement OHA Healthy Hospitals Initiative
4. Implement a Complete-Streets Policy
5. Expand Safe Routes to School
6. Implement a community-based walking program
7. Increase nutrition/physical education materials being offered to patients by primary care providers

Action Plan

Increase Healthy Weight Status		
Action Step	Responsible Person/Agency	Timeline
Increase Access to Healthy Food Options in Lucas County		
Year 1: Collaborate with Live Well Greater Toledo, the Creating Healthy Communities Program and Healthy Lucas County to implement the Healthy Food Retail Initiative. Survey customers and community members to assess community needs for healthy food items. Hire a health educator to lead the Healthy Food Retail Initiative. Recruit an additional 10 corner stores to participate in the initiative.	Beth Deakins, Live Well Greater Toledo	2016
Year 2: Initiate contact with local legislatures to begin efforts to bring local grocery stores into food desert areas within Lucas County. Recruit an additional 15 corner stores to participate in the initiative.		2017
Year 3: Continue efforts of years 1 and 2. Recruit an additional 15 corner stores to participate in the initiative.		2018
Increase Breastfeeding		
Year 1: Survey Lucas County employers about current breastfeeding policies and provide education and sample policies. Gather baseline data on hospital policies regarding giving formula to new mothers. Introduce the *Ten Steps to Successful Breastfeeding* from the Baby Friendly Hospital Initiative to Lucas County hospitals.	Carly Miller, Hospital Council of Northwest Ohio	2016
Year 2: Assist in implementing breastfeeding policies in at least 10 businesses/organizations in Lucas County. Pilot the *Ten Steps to Successful Breastfeeding* with one hospital or birthing center.		2017
Year 3: Assist in implementing breastfeeding policies in at least 10% of the businesses/organizations in Lucas County. Implement the *Ten Steps to Successful Breastfeeding* in all hospitals or birthing centers.		2018

Strategy #1: Increase Healthy Weight Status
Action Step Recommendations & Action Plan

Increase Healthy Weight Status		
Action Step	Responsible Person/Agency	Timeline
Implement OHA Healthy Hospitals Initiative		
Year 1: Hospitals should join Good4You educational webinars hosted by OHA and HCNO Complete all Assessment Tools provided by OHA to gather baseline information on current food and beverages in the hospital cafeterias, vending, meetings, and gift shops. Implement the Good 4 You Initiative in at least one of the following priority areas: • Healthy Cafeterias/Cafes • Healthy Vending Machines • Healthy Meetings and Events • Healthy Outside Vendors and Franchises Use marketing materials (posters, table tents, stickers, etc.) to better brand the program	Carly Miller, Hospital Council of Northwest Ohio	2016
Year 2: Implement the Good4You Initiative in all four priority areas within each hospital		2017
Year 3: Introduce the program into other areas of the community (businesses, schools, churches, etc.)		2018
Implement a Complete Streets Policy		
Year 1: Raise awareness in Lucas County of TMACOG's Complete Streets Policy and recommend that all local jurisdictions adopt comprehensive complete streets policies, consistent with the Regional Complete Streets Policy. Gather baseline data on all of the Complete Streets Policy objectives.	Beth Deakins, Live Well Greater Toledo	2016
Year 2: Begin to implement the following Complete Streets Objectives: • Increase in the percentage of project applications that request TMACOG-attributable federal funding and which include complete streets elements. • 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 the percentage of transit stops accessible via sidewalks and curb ramps. • Increase in member jurisdictions which adopt complete streets policies. Increase in number of jurisdictions in the region achieving or pursuing Bike-Friendly Community status from the League of American Bicyclists, or Walk-Friendly Community status from walkfriendly.org.		2017
Year 3: Continue efforts from years 1 and 2.		2018

Strategy #1: Increase Healthy Weight Status
Action Step Recommendations & Action Plan

Increase Healthy Weight Status		
Action Step	Responsible Person/Agency	Timeline
Expand Safe Routes to School		
Year 1: Collect baseline data on current Safe Routes programs in Lucas County. Gather information on what types of activities are offered, how many people attend the activities, how often activities take place, and where the programs are located. Identify key stakeholders throughout Lucas County to collaborate and develop a plan to 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.	Beth Deakins, Live Well Greater Toledo	2016
Year 2: Recruit individuals to serve as walking/biking leaders. Decide on the locations, walking routes and number of walking/biking groups throughout Lucas County. Link the walking/biking groups with existing organizations to increase participation. Consider the following: • Faith-based organizations • Schools • Community-based organizations • Health care providers Begin implementing the program with 2 new school districts		2017
Year 3: Raise awareness and promote the Safe Routes programs. Evaluate program goals. Increase the number of Safe Routes programs by 25%		2018

Strategy #1: Decrease Obesity
Action Step Recommendations & Action Plan

Increase Healthy Weight Status		
Action Step	Responsible Person/Agency	Timeline
Initiate a Community – Based Walking Program		
Year 1: Collect baseline data on current walking programs in Lucas County. Gather information on what types of activities are offered, how many people attend the activities, how often activities take place, and where the programs are located. Identify key stakeholders throughout Lucas County to collaborate and develop a plan to create community walking programs. Develop program goals and an evaluation process for tracking outcomes. Look for funding sources to incentivize participation in the walking program.	Celeste Smith, Toledo- Lucas County Health Department	2016
Year 2: Recruit individuals to serve as walking leaders. Decide on the locations, walking routes and number of walking groups throughout Lucas County. Link the walking groups with existing organizations to increase participation. Consider the following: • Faith-based organizations • Schools • Community-based organizations • Health care providers Begin implementing the program		2017
Year 3: Raise awareness and promote the walking programs. Evaluate program goals. Increase the number of walking groups by 25%.		2018
Increase Nutrition/Physical Education Materials Being Offered to Patients by Primary Care Providers		
Year One: Work with primary care physician offices to assess what information and/or materials they are lacking to provide better care for overweight and obese patients**.**	Ann Mary Mercier, MedTAPP HCA Initiative Core Team Gaye Martin, ProMedica Jessica Shultz, Mercy	2016
Year Two: Offer trainings for primary care physicians and/or staff such as nutrition counseling and/or other practice-based changes to provide better care for obese/overweight patients. Provide participants with referral and educational materials. Enlist at least 10 primary care physician offices.		2017
Year Three: Offer additional trainings to reach at least 50% of the primary care physician offices in the county.		2018

Strategy #2: Decrease Heart Disease and other Chronic Diseases
Cardiovascular Health Indicators

Heart disease (28%) and stroke (6%) accounted for 34% of all Lucas County adult deaths from 2006-2008 (Source: ODH Information Warehouse). The 2014 Lucas County Health Assessment found that 5% of adults had survived a heart attack and 3% had survived a stroke at some time in their life. Nearly two-fifths (37%) of Lucas County adults had been diagnosed with high blood pressure, 36% were obese, 25% had high blood cholesterol, and 19% were smokers, four known risk factors for heart disease and stroke.

Heart Disease and Stroke

In 2014, 5% of Lucas County adults reported they had survived a heart attack or myocardial infarction, increasing to 10% of those over the age of 65.

5% of Ohio and U.S. adults reported they had a heart attack or myocardial infarction in 2011 *(Source: 2012 BRFSS).*

3% of Lucas County adults reported they had survived a stroke, increasing to 6% of those over the age of 65.

3% of Ohio and U.S. adults reported having had a stroke in 2012 *(Source: 2012 BRFSS).*

5% of adults reported they had angina, increasing to 6% of those over the age of 65.

5% of Ohio and 4% of U.S. adults reported having had angina or coronary heart disease in 2012 *(Source: 2012 BRFSS).*

7% of adults reported they had heart disease, increasing to 22% of those over the age of 65.

Of those who reported having any of the above conditions, treatment was received for the following: heart disease (92%), heart attack (65%), stroke (59%), and angina (44%).

High Blood Pressure (Hypertension)

Almost two-fifths (37%) of adults had been diagnosed with high blood pressure. The 2011 BRFSS reports hypertension prevalence rates of 33% for Ohio and 31% for the U.S.

86% of adults with high blood pressure reported receiving treatment for their high blood pressure.

89% of adults had their blood pressure checked within the past year.

Lucas County adults diagnosed with high blood pressure were more likely to:
- Have rated their overall health as fair or poor (63%)
- Have been age 65 years or older (62%)
- Have been classified as obese by Body Mass Index-BMI (49%)

High Blood Cholesterol

One-fourth (25%) of adults had been diagnosed with high blood cholesterol. The 2011 BRFSS reported that 39% of Ohio adults and 38% of U.S. adults have been told they have high blood cholesterol.

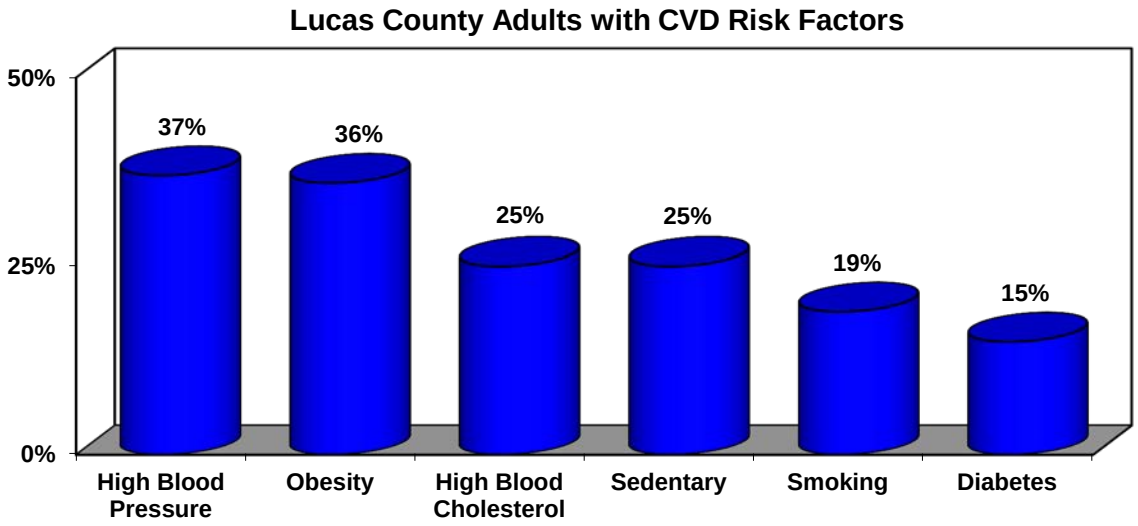
81% of adults with high blood cholesterol reported receiving treatment for their high blood cholesterol.

Four-fifths (80%) of adults had their blood cholesterol checked within the past 5 years. The 2011 BRFSS reported 76% of Ohio and U.S. adults had their blood cholesterol checked within the past 5 years.

Lucas County adults with high blood cholesterol were more likely to:
- Have been age 65 years or older (45%)
- Have rated their overall health as fair or poor (40%)
- Have been classified as obese by Body Mass Index-BMI (31%)

Strategy #2: Decrease Heart Disease and other Chronic Diseases
Cardiovascular Health Indicators, continued

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



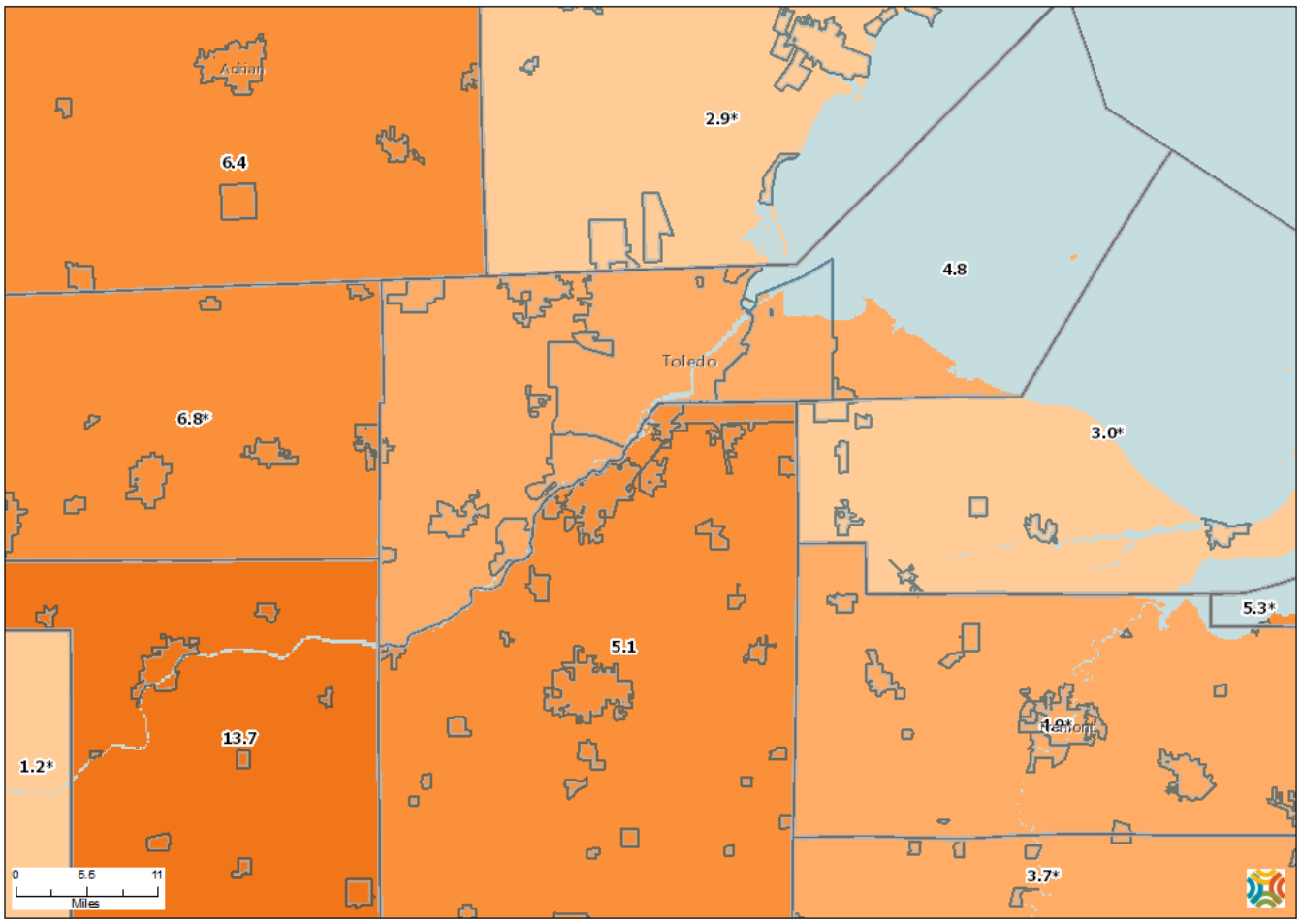
(Source: 2014 Lucas County Health Assessment)

Adult Comparisons	Lucas County 2007	Lucas County 2011	Lucas County 2014	Ohio 2012	U.S. 2012
Had angina	7%	3%	5%	5%	4%
Had a heart attack	N/A	3%	5%	5%	5%
Had a stroke	N/A	2%	3%	3%	3%
Had high blood pressure	35%	34%	37%	33%*	31%*
Had high blood cholesterol	34%	27%	25%	39%*	38%*
Had blood cholesterol checked within past 5 years	72%	76%	80%	76%*	76%*

** 2011 BRFSS Data N/A – Not available*

Strategy #2: Decrease Heart Disease and other Chronic Diseases
Cardiovascular Health Indicators, continued

Adults Diagnosed with Heart Disease, BRFSS 2011-2012



Map Legend

Heart Disease (Diagnosed), Percent of Adults Age 18+ by County, BRFSS 2011-12

- Over 7.0%
- 5.1 - 7.0%
- 3.1 - 5.0%
- Under 3.1%
- No Data or Data Suppressed

Community Commons, 2/19/2015

Strategy #2: Decrease Heart Disease and other Chronic Diseases
Resource Assessment

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
CPR Training & Instruction	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			Best practice
CPR App for smartphones	Lucas County Fire and EMS	All ages	Prevention /early intervention	Best practice
Primary care and Specialty Network	Toledo/Lucas County CareNet	Lucas County residents with household income at or below 200% of FPL not eligible for public/private health coverage	Prevention, early intervention and treatment	Decreased emergency department usage and decreased in patient days
CareNet Link: Community Health Worker utilizing Pathways for Care Coordination	Toledo/Lucas County CareNet	Low income individuals who are either uninsured or Medicaid	Prevention, early intervention and treatment	Too New
Adult Pathways Care Coordination through the Northwest Ohio Pathways HUB	Hospital Council of Northwest Ohio	Low Income Adults with chronic disease or risk factors for chronic disease with a focus on 43604, 43605, 43607, 43608, 43609 and 43620	Prevention, early intervention and treatment	Based on evidence of Pathways Care Coordination reducing the number of low birth weight babies.
Lucas County Wellness Program (screenings)	Lucas County	County employees	Prevention	Best practice
Wellness programs	Multiple employers/ organizations	Employees	Prevention	Best practice
Health clinics & free clinics	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			

Strategy #2: Decrease Heart Disease and other Chronic Diseases
Resource Assessment, continued

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Multiple specialty clinics	UT Cardiovascular Center	Adults	Treatment	Outcomes measured
General Internal Medicine (hypertension)	UTMC	Adults	Treatment	Outcomes measured
Heart Institute	ProMedica	Adults	Treatment	Outcomes measured
Diabetes care	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			
Youth diabetes education	Diabetes youth services	Youth	Treatment	Outcomes measured
Diabetes support	Thomas M. Wernert Center of Mental Health Recovery and Support	Adults with mental illness	Treatment	Outcomes measured
AIDS/HIV counseling, prevention & free testing	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			Best practice
AIDS/HIV testing (mobile van) Other screenings provided as well	Nuestra Gente/Mercy St. Charles	Latino population	Prevention/early intervention	Best practice
Various programs	Aids Resource Center			Best practice
The Ryan White Program	UTMC	Adults	Prevention/early intervention/ treatment	Best practice
Screenings	Kidney Foundation	Adults	Prevention/early intervention	Best practice
African American Male Wellness Walk Initiative	Toledo Fire & Rescue	All ages	Prevention/early intervention	Best practice

Strategy #2: Decrease Heart Disease and other Chronic Diseases
Resource Assessment, continued

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
AED machines in Lucas County offices	Lucas County EMS	County employees	Prevention/early intervention	Best practice
Screenings and medication monitoring	Toledo-Lucas County Health Department/ Area Office on Aging	Seniors	Prevention/early intervention	Best practice
Multiple programs	Area Office on Aging	Seniors	Prevention/early intervention	Best practice
Parish nurses education/screening programs	Local churches	Seniors	Prevention/early intervention	Best practice
Various programs and services at clinics	Toledo-Lucas County Health Department	All ages	Prevention/early intervention	Best practice
Various programs and services at clinics	Neighborhood Health Association	All ages/low income	Prevention/early intervention/treatment	Best practice
Various programs	Mercy	All ages	Prevention/early intervention/ treatment	Best practice
Silver Sneakers Program	YMCA	Seniors	Prevention	Best practice
Increasing access to care (health insurance programs and assistance)	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo			
Increasing access to care (public transportation)	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			
Breast exams and mammograms	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			

Strategy #2: Decrease Heart Disease and other Chronic Diseases
Resource Assessment, continued

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Diabetes Education	Mercy	Adults	Treatment	Recognized by the American Diabetes Association for Quality Self-Management Education. Certified Diabetes Educators.
Starting Fresh	Mercy	Adults	Treatment	Using the Stanford education model of Healthy U, monitoring D5 scores.
Healthy U Diabetes and Chronic Disease Self-Management Program	Mercy with the Area Office on Aging	Adults	Early intervention/ treatment	Stanford Model, pre/post survey
Community Health Affairs Department	Mercy	Adults	Prevention/early intervention	Free cholesterol, blood sugar, blood pressure screening
Parish Nurse Program	Mercy	Adults	Prevention/early intervention	Health screenings and exercise program to various churches.
Mercy Be Well Within	Mercy	Adults	Prevention/early intervention/treatment	Mercy's employee Wellness Program
Mercy St. Charles Mobile Health Van	Mercy	Adults	Prevention/early intervention	Free health screenings throughout the community
Mercy Outreach Program	Mercy	Adults	Prevention/early intervention/treatment	Mercy Outreach provides in-home interventions to adults who have chronic illness and are at risk for repeated, preventable emergency room and hospital admissions due to a wide range of social/economic problems. The results of the project have been outstanding, reducing hospital/emergency room visits by 50% and improving quality of life.

Strategy #2: Decrease Heart Disease and other Chronic Diseases
Resource Assessment, continued

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Tobacco Cessation	Mercy	Adults and youth	Treatment	Certified Tobacco Treatment Specialist
Cardiac Services; diagnostic testing, heart failure clinic, cardiac rehab	Mercy	Adults	Early intervention/ treatment	
Coumadin Clinic	Mercy	Adults	Treatment	
Wound Care Clinic	Mercy	Adults	Treatment	
Pain Clinic	Mercy	Adults	Treatment	
Palliative Care	Mercy	Adults, youth and children	Treatment	
Children's Pulmonary Center	Mercy	Youth and children	Treatment	
Pulmonary Rehab	Mercy	Adults	Treatment	
Sleep Clinic	Mercy	Adults, youth and children	Treatment	
Podiatry Clinic	Mercy	Adults	Treatment	
Cancer Center	Mercy	Adults, youth and children	Treatment	
Mercy MAP (Mammogram Assistance Program)	Mercy & Koman	Adults	Early intervention	
Check It Out	HADASSAH & Mercy	Youth	Prevention	Presentations at area high school for breast and testicular cancer awareness
Nutrition & Diabetes Counseling with Dietitian	Mercy	Adults, youth and children	Treatment	
Pulmonary Function Lab	Mercy	Adults, youth and children	Early intervention/ treatment	
Respiratory Therapy	Mercy	Adults, youth and children	Treatment	
Vascular Lab	Mercy	Adults	Early intervention/ treatment	
Fun Bus program, summer/day camps/ family wellness programs, group fitness,	YMCA (monthly rates based on household income)	All ages	Prevention	Best practice
Diabetes Programs, LEAP Youth Obesity Program, Worksite health screenings, worksite wellness presentations	YMCA (monthly rates based on household income)	All Ages	Prevention	Best practice

Strategy #2: Decrease Heart Disease and other Chronic Diseases
Resource Assessment, continued

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Available to Members: • Free fitness classes • Use any Y in Ohio at no extra charge • Group Fitness classes • 9 area YMCA and JCC branches • Free babysitting while you work out • Reduced prices on Y child care • 7 indoor and 2 outdoor pools • 10 fitness centers with state-of-the-art equipment • 8 gymnasiums • 4 family adventure centers • Climbing wall • Racquetball courts • Saunas, steam rooms, whirlpool • Gymnastics Center • Youth sports, swim lessons	YMCA (monthly rates based on household income)	All ages		Best practice
Tobacco Cessation Program	ProMedica Toledo Hospital, St. Luke's Hospital		Treatment	
Cardiac services, Coumadin, wound care, pain, children's pulmonary, pulmonary rehab, sleep, cancer center	ProMedica	All Ages	Treatment	

Strategy #2: Decrease Heart Disease and other Chronic Diseases
Gaps and Potential Strategies

Gaps	Potential Strategies
Lack of access to primary care physicians	• Use EMT/Fire as a resource to hand out pamphlets about what services are available (Health Department sliding fee scale, community health workers, 2-1-1) • Support fire departments to collect data electronically (target non-emergency calls) • Increase Community Health Workers to target high risk zip codes and decrease barriers to care • Paramedicine (state level decision) • Increase opportunities for EMS to provide advanced care
Increase the use of Nurse Practitioners (NP) and Physician Assistants (PA)	• Gather data on how many NP and PA are currently practicing • Use NP, PA students – find preceptors/placement sites for the students
Unnecessary hospitalizations	• Develop a protocol for acute conditions and increase the use of telemedicine in rehab facilities and skilled nursing homes (currently used in 3 nursing homes)
Lack of focus on assisting adults with preventing and managing chronic disease by addressing medical and social needs.	• Work with partners and local government to develop a comprehensive approach to developing policy for Community Health Workers (CHWs) that includes financing mechanisms for sustainable employment, workforce development, occupational regulation, etc. • The Northwest Ohio Pathways HUB provides stipends to organizations to hire Community Health Workers (CHW's) to canvas and find individuals at greatest risk or diagnosed with a chronic disease(s) as well as provides outcome oriented payments. • Organizations (hospitals, clinics, social service agencies, etc.) can hire and fund CHW's within their organization to provide services (transportation, linkage to resources, housing, food, etc.) that help remove barriers that extend beyond the hospital/clinic.
Limited efforts to address social determinants of health (transportation)	• CHW's educate clients on Managed care/Medicaid transportation services and help to arrange services. • Work with partners and local government to adopt policies that promote active transportation. • Work with manage care/Medicaid and local government to help create new policies that extend transportation services to those with chronic diseases/or high risk for additional preventive services (eye doctor, podiatrist, educational programs, Lab, dietician, fitness training, etc.) • Expand outreach/ mobile services currently within Lucas County as well as create more outreach/mobile programs for those with chronic diseases and limited transportation options. • CDC Grant/CHW can provide bus tokens for clients at risk or diagnosed with a chronic disease(s) that do not have transportation services. • CHW's can provide transportation to those enrolled in adult pathways.
Lack of accessible preventive services/programs within the communities with great disparities (43604, 43605, 43607, 43608, 43609, and 43620).	• Increasing preventive/intervention programs that are walking distance for clients (Starting Fresh @ Mercy FCC, TLCHD, YMCA, etc.) • CHW's can help provide transportation to preventive/intervention programs for individuals that are enrolled in Adult Pathways. • Community organizations develop marketing/advertising tools for preventive/intervention services within the community and distribute them within the community.

Strategy #2: Decrease Heart Disease and other Chronic Diseases
Best Practices

Best Practices

1. **Chronic disease self-management programs (CDSM):** Chronic disease self-management (CDSM) programs are education and behavioral interventions that support patients' active management of their condition in their daily life. Programs may focus on self-monitoring and medical management, decision making, or adoption and maintenance of health-promoting behaviors to minimize disability and delay the progress of chronic disease. Programs are usually delivered in health care settings by health professionals, but may also be delivered by lay individuals in community settings or via computer or phone applications or messaging. The components of self-management interventions vary by specific chronic disease.

   Expected Beneficial Outcomes (Rated)
   - Improved health outcomes

   Other Potential Beneficial Outcomes
   - Increased healthy behaviors
   - Improved quality of life
   - Improved mental health
   - Reduced hospital utilization
   - Improved chronic disease management

2. **Systems Navigators and Integration (E.g., Patient Navigators):** Patient navigators provide culturally sensitive assistance and care-coordination, guiding patients through available medical, insurance, and social support systems. These programs seek to reduce racial, ethnic, and economic disparities in access to care and disease outcomes.

   Expected Beneficial Outcomes:
   - Increased use of preventive services
   - Increased cancer screening
   - Improved birth outcomes
   - Improved maternal health

   Evidence of Effectiveness
   - There is strong evidence that patient navigator programs improve cancer screenings, especially for breast cancer. Additional evidence is needed to confirm effects for programs focused on other health outcomes.

   Impact on Disparities:
   Likely to decrease disparities

   For more information go to: http://www.countyhealthrankings.org/policies/systems-navigators-and-integration-eg-patient-navigators

3. **Expand Use of Community Health Workers (CHW):** Community health workers (CHW), sometimes called lay health workers, serve a variety of functions, including: providing outreach, education, referral and follow-up, case management, advocacy and home visiting services. They may work autonomously or as part of a multi-disciplinary team; training varies widely with intended role and location. CHW services are often targeted at women who are at high risk for poor birth outcomes.

   Expected Beneficial Outcomes
   - Increased patient knowledge
   - Increased access to care

- Increased use of preventive services
- Improved health behaviors

Evidence of Effectiveness

- There is some evidence that CHWs improve patient knowledge and access to health care, especially for minority women and individuals with low incomes.
- CHWs have been shown to improve access to care for patients that my not otherwise receive care.
- CHWs appear as effective as, and sometimes more effective than, alternate approaches to disease prevention, asthma management, efforts to improve colorectal cancer screening, chronic disease management, and maternal and child health.

Impact on Disparities:
Likely to decrease disparities

For more information go to: http://www.countyhealthrankings.org/policies/expand-use-community-health-workers-chw

In Best Practices for Comprehensive Tobacco Control Programs, the Centers for Disease Control and Prevention (CDC) recommends statewide programs that combine and coordinate community-based interventions that focus on the following areas.

1. Preventing initiation of tobacco use among youth and young adults
2. Promoting quitting among adults and youth
3. Eliminating exposure to secondhand smoke, and
4. Identifying and eliminating tobacco-related disparities among population groups

Healthy People 2020 Goals include:

- Increase overall cardiovascular health in the U.S. population
- Reduce coronary heart disease deaths
- Reduce stroke deaths
- Increase the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high
- Reduce the proportion of persons in the population with hypertension
- Reduce the proportion of children and adolescents with hypertension
- Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years
- Reduce the proportion of adults with high total blood cholesterol levels
- Reduce the mean total blood cholesterol levels among adults
- (Developmental) Increase the proportion of adults with hypertension who meet the recommended guidelines
- Increase the proportion of adults with hypertension who are taking the prescribed medications to lower their blood pressure
- Increase the proportion of adults with hypertension whose blood pressure is under control
- (Developmental) Increase the proportion of adults with elevated LDL cholesterol who have been advised by a health care provider regarding cholesterol-lowering management, including lifestyle changes and, if indicated, medication

Strategy #2: Decrease Heart Disease and other Chronic Diseases
Best Practices, continued

- (Developmental) Increase the proportion of adults with elevated LDL-cholesterol who adhere to the prescribed LDL-cholesterol lowering management lifestyle changes and, if indicated, medication
- (Developmental) Increase aspirin use as recommended among adults with no history of cardiovascular disease
- Increase the proportion of adults aged 20 years and older who are aware of the symptoms of and how to respond to a heart attack
- Increase the proportion of adults aged 20 years and older who are aware of the symptoms of and how to respond to a stroke
- (Developmental) Increase the proportion of out-of-hospital cardiac arrests in which appropriate bystander and emergency medical services (EMS) were administered
- Increase the proportion of eligible patients with heart attacks or strokes who receive timely artery-opening therapy as specified by current guidelines
- (Developmental) Increase the proportion of adults with coronary heart disease or stroke who have their low-density lipoprotein (LDL) cholesterol level at or below recommended levels
- (Developmental) Increase the proportion of adults with a history of cardiovascular disease who are using aspirin or antiplatelet therapy to prevent recurrent cardiovascular events
- (Developmental) Increase the proportion of adult heart attack survivors who are referred to a cardiac rehabilitation program at discharge
- (Developmental) Increase the proportion of adult stroke survivors who are referred to a stroke rehabilitation program at discharge
- Reduce hospitalizations of older adults with heart failure as the principal diagnosis

Strategy #2: Decrease Heart Disease and other Chronic Diseases
Action Step Recommendations & Action Plan

Action Step Recommendations

To work toward decreasing heart disease and other chronic diseases:

1. Increase prevention/intervention programs and access to healthcare
2. Decrease exposure to second hand smoke
3. Increase the recruitment of nurse practitioners and physician assistants

Action Plan

Decrease Heart Disease and other Chronic Diseases		
Action Step	Responsible Person/Agency	Timeline
Increase Prevention/Intervention Programs & Access To Healthcare		
Year 1: Coordinate efforts between hospitals, community clinics, and the health department with Fire and EMS Departments to increase community outreach and education on available health services (many of which are free or at a reduced cost). Create a resource pamphlet that highlights all organizations providing free or reduced cost healthcare services. Provide pamphlets to all Fire and EMS Departments to distribute when they are already providing services in the community. Hire Community Health Workers to target high risk zip codes and decrease barriers to care. Work with state and local representatives to advocate for Medicaid Expansion. Work with the healthcare systems in Lucas County to create or enhance non-physician teams in patient centered medical homes serving targeted populations with community health care workers (CHW) engaged in patient chronic disease prevention and management. Create system and policy changes so that CHWs can link the targeted populations to services using the Pathways Community HUB Model. Link over 1,500 people to resources to reduce the burden of chronic disease.	LaTarsha Cook, Hospital Council of Northwest Ohio Jessica Shultz, Mercy Nancy Brown-Schott, CareNet Adam Klugh, Toledo Fire and Rescue Mike Ramm, Sylvania Township Fire	2016
Year 2: Increase community outreach efforts involving Fire and EMS. Increase the number of Community Health Workers by 25% from baseline Increase the number of Primary Care Providers with CHWs using the Pathways model from 2 to 5.		2017
Year 3: Continue efforts of years 1 and 2 and expand outreach		2018
Decrease Exposure to Second Hand Smoke		
Year 1: Collect baseline data on which organizations, multi-unit housing facilities, schools and other businesses currently have tobacco-free policies. Hire 2 Tobacco Prevention Health Educators to build partnerships with the local public housing authority and multi-unit housing complexes. Provide education to residents to assist with the transition of the multi-unit housing complexes to a smoke-free policy and create a resident advisory council. Implement the smoke-free policy in at least 10 multi-unit housing complexes.	DaShe Frieson, Toledo-Lucas County Health Department	2016
Year 2: Continue efforts of year 1. Target 10 additional multi-unit housing complexes to adopt a smoke-free housing policy. Continue education efforts.		2017
Year 3: Continue efforts of years 1 and 2. Target 10 additional multi-unit housing complexes to adopt a smoke-free housing policy. Begin efforts to adopt a smoke-free policy in Lucas County parks.		2018

Strategy #2: Decrease Heart Disease and other Chronic Diseases
Action Step Recommendations & Action Plan, continued

Decrease Heart Disease and other Chronic Diseases		
Action Step	Responsible Person/Agency	Timeline
Increase Recruitment for Nurse Practitioners and Physician Assistants		
Year 1: Collect baseline data on the number of nurse practitioners and physician assistant's practicing in Lucas County and the need for more. Work with NP and PA schools in Lucas County to address the need for a school loan reimbursement program if students stay in Lucas County to work after their schooling is finished. Increase the number of preceptors/placement sites for students in Lucas County.	Ann Mary Mercier, MedTAPP HCA Initiative Core Team	2016
Year 2: Continue to work with NP and PA schools in Lucas County. Increase the number of preceptors/placement sites for students by 25%.		2017
Year 3: Continue efforts of years 1 and 2.		2018

Strategy #3: Decrease Youth Mental Health Issues and Bullying
Mental Health/Bullying Indicators

In 2013/14, the Health Assessment results indicated that 16% of Lucas County 7th-12th grade youth had seriously considered attempting suicide in the past year and 7% admitted actually attempting suicide in the past year. 43% of youth had been bullied in the past year and 28% had been bullied on school property. 36% of parents reported their child was bullied at some time in the past year.

Youth Mental Health/Bullying Issues

In 2013/14, over one-quarter (28%) 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 (2013 YRBS reported 26% for Ohio and 30% for the U.S.).

16% of youth reported they had seriously considered attempting suicide in the past 12 months, increasing to 22% of females. The 2013 YRBS reported 17% for U.S. youth and 14% for Ohio youth.

In the past year, 7% of Lucas County youth had attempted suicide and 3% had made more than one attempt. The 2013 YRBS reported a suicide attempt prevalence rate of 8% for U.S. youth and a 6% rate for Ohio youth.

When Lucas County youth were dealing with personal problems or feelings of depression or suicide they usually talked to the following: best friend (49%), parents (27%), girlfriend/boyfriend (27%), brother/sister (17%), professional counselor (8%), school counselor (6%), coach (5%), pastor/priest (3%), teacher (3%), youth minister (2%), scout master/club advisor (1%), and other (12%). 32% reported they have no one to talk to.

43% of 7th-12th grade youth had been bullied in the past year. The following types of bullying were reported:

- 32% were verbally bullied (teased, taunted or called harmful names)
- 23% were indirectly bullied (spread mean rumors about or were kept out of a "group")
- 12% were cyber bullied (teased, taunted or threatened by e-mail or cell phone, or other electronic methods) (2013 YRBS reported 15% for Ohio and 15% for the U.S.)
- 10% were physically bullied (were hit, kicked, punched or people took their belongings)
- 3% were sexually bullied (someone used nude or semi-nude pictures to pressure them to have sex when they do not want to, blackmailed, intimidated or exploited by another person)

In the past year, 28% of youth had been bullied on school property (2013 YRBS reported 21% for Ohio and 20% for the U.S.).

Child Mental Health/Bullying Issues

13% of children in Lucas County had an emotional, developmental, or behavioral problem for which they need treatment or counseling.

A doctor told Lucas County parents their 0-11 year old child had the following conditions:

- Behavioral/conduct problems (5%)
- Anxiety Problems (5%)
- Depression Problems (2%)

36% of parents reported their child was bullied in the past year. The following types of bullying were reported:

- 24% were verbally bullied (teased, taunted or called harmful names)
- 9% were indirectly bullied (spread mean rumors about or kept out of a "group")
- 6% were physically bullied (they were hit, kicked, punched or people took their belongings)
- 1% were cyber bullied (teased, taunted or threatened by e-mail or cell phone)
- <1% were sexually bullied (used nude or semi-nude pictures to pressure someone to have sex that did not want to, blackmail, intimidate, or exploit another person)

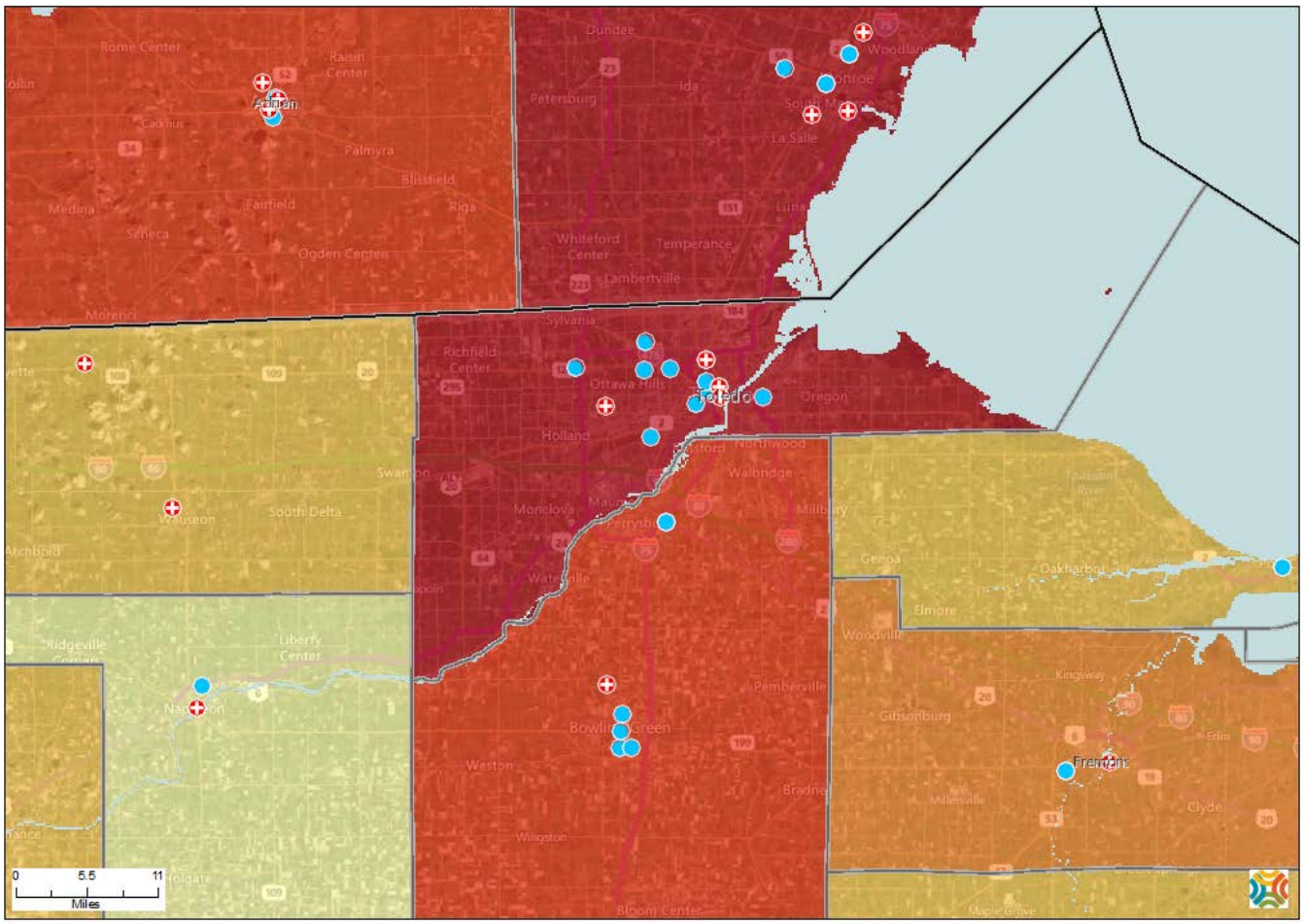
6% of parents reported they did not know if their child was bullied.

Strategy #3: Decrease Youth Mental Health Issues and Bullying
Mental Health Indicators, continued

Youth Comparisons	Lucas County 2011 (9th-12th)	Lucas County 2013/14 (5th-6th)	Lucas County 2013/14 (7h-8th)	Lucas County 2013/14 (9th-12th)	Ohio 2013 (9th-12th)	U.S. 2013 (9th-12th)
Youth who seriously considered attempting suicide in the past year	16%	6%	14%	18%	14%	17%
Youth who had attempted suicide in the past year	4%	4%	5%	8%	6%	8%
Youth who felt sad or hopeless almost every day for 2 or more weeks in a row	24%	14%	25%	29%	26%	30%
Electronically/cyber bullied in past year	15%	4%	13%	12%	15%	15%
Bullied in past year	43%	46%	52%	38%	N/A	N/A
Bullied on school property in past year	N/A	35%	38%	22%	21%	20%

Strategy #3: Decrease Youth Mental Health Issues and Bullying
Mental Health Indicators, continued

Lucas County Suicide Mortality with Youth Mental Health Facilities



Map Legend

Substance Abuse Treatment Facilities by Location, SAMHSA Nov. 2014

Mental Health Facilities - Youth Services by Location, SAMHSA Nov. 2014

Suicide Mortality, Total Deaths by County, NVSS 2006-10

- Over 87
- 42 - 87
- 25 - 41
- 16 - 24
- Under 16
- No Data or Data Suppressed

Community Commons, 2/19/2015

Strategy #3: Decrease Youth Mental Health Issues and Bullying Resource Assessment

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Assessment center	Lucas County Juvenile Court	Youth involved with the juvenile court system	Early intervention/ treatment	
Dose of Reality (overnight program)	Young Men and Women for Change	Youth ages 8+	Prevention/early intervention	
Incredible Years	UTMC Kobacker Center	Grades K-4	Prevention	Evidence-based
Mental health counseling, assessments & services	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			
Mentoring services for youth	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			
Community Centers	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			
Specialized counseling	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			
Youth issues hotlines	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			

Strategy #3: Decrease Youth Mental Health Issues and Bullying
Resource Assessment, continued

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Bullying prevention, education & reporting	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			
Padua Center Academic assistance and development of alternative ways of dealing with conflict	Toledo Diocese	School aged youth	Prevention/ early intervention	
Bullying prevention programs	Various schools	School aged youth	Prevention	
Second Chance Program	Toledo Area Ministries	Youth affected by or at risk for involvement in sex trafficking or sexual exploitation	Prevention/ early intervention/ treatment	
Advocacy and Education Parenting classes and support for children with mental illness	NAMI of Greater Toledo	Parents of mentally ill children	Prevention/ early intervention	
Behavioral Health Institute	Mercy		Treatment	
Bullying Coalition	UT and multiple organizations	Youth	Prevention	
Transitional Case/Care Management, Adolescent/Youth Counseling, Anger Management, Child Abuse Counseling	Zepf Center	Youth		
General Crisis Intervention Hotlines, Youth Suicide Prevention Hotline, Bullying Prevention	Young Men and Women for Change	Youth		
Outpatient Mental Health Facilities, Child Abuse Counseling	Specialized Alternatives for Families and Youth of Ohio	Families, Youth		

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Self-esteem Workshops for Youth, Anger Management, Adolescent/Youth Counseling, Family Counseling, Mental Health Halfway Houses *youth	A Renewed Mind	Family, Youth		
General Crisis Intervention Hotlines, Runaway/Homeless Youth Helplines, Suicide Prevention Hotlines, Youth Issues Lines	Boys Town National Hotline	All ages		
Bullying Prevention (National Bullying Prevention Center)	PACER Center	All ages		
Adolecent/Youth Counseling, General Crisis Intervention Hotlines	Comprehensive Crisis Care	All ages		
Bullying Prevention (Lucas County Bullying Hotline)	Lucas County Sheriff's Office	Youth		
Anger Management	Operation Re-Seed Christian Ministries	All ages		
Adolescent/Youth counseling, Group Counseling, Central Intake/Assessment for Psychiatric Services, Psychiatric Case Management	CHOICES Behavioral Health Care	Youth		
Anger Management	Sarah Outreach and Recovery Center	All ages		
Mental Health Assessments and Treatment	Court Diagnostic and Treatment Center	All ages (persons referred by the court, the Probation Department or self-referred)		
Sexual Assault Counseling, Child Abuse Counseling, Child Abuse Support Groups, Child Sexual Abuse Counseling	Nirvana Now!	All victims, survivors, and co-survivors or incent, child sexual abuse or rape		
Children's Psychiatric In-patient Unit, General Crisis Intervention Hotline, In person Crisis Intervention	Rescue Incorporated	Youth		
Children's Psychiatric In-patient Unit	ProMedica Toledo Hospital	Ages 9-18		
Child Abuse Counseling	Toledo-Lucas County Victim Witness Program	Youth		
Family Counseling, Home Based Mental Health Services	Unison Behavioral Health Group	Children with serious emotional disabilities and their families		

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Family, Adolescent/Youth Counseling	Family Service of Northwest Ohio	Youth, Family		
Life Coaching, Adolescent/Youth Counseling, Youth/Student Support Groups	Paraclete Social Outreach	Youth		
Infant and Early Childhood Mental Health, Clinical Psychiatric Evaluation, Psychiatric Medication Monitoring, Family Counseling, Psychiatric Day Treatment	Harbor	Youth, Child		
Children's Out of Home Respite Care	Providence Center for Social and Economic Empowerment	Family, Child		
Child Abuse Prevention, Counseling for Children affected by Domestic Violence, Child Abuse Counseling, Child Sexual Abuse Counseling, In person Crisis Intervention, Transitional Case/Care Management	Family and Child Abuse Prevention Center Lucas County	Child		
Adolescent/Youth Counseling, Family Counseling	Cullen Center for Children, Adolescents and Families	Family, Youth		
Adolescent/Youth Counseling, Family Counseling	Center for Solutions in Brief Therapy	Family, Youth		
Adolescent/Youth Counseling	Twelve of Ohio, Inc.	Youth		
Runaway/Homeless Youth Counseling and Helplines	National Runaway Safe line	Age 18-21		
Adolescent/Youth Counseling, Clinical Psychiatric Evaluation, Clinical Psychiatric Evaluation, Individual Counseling, Psychiatric Day Treatment, Adolescent and Child Psychiatric In-patient Units, Adolescent and Child Mental Health Hotlines	Kobacker Center	Youth, Child		
Self-esteem Workshops	Toledo Mountain Mentors	At risk teens, ages 13-16		
Alcohol Dependency Support Groups (Teenage Alcoholics)	Al-Anon/Alateen	Teenagers		

Strategy #3: Decrease Youth Mental Health Issues and Bullying
Gaps & Potential Strategies

Gaps	Potential Strategies
Bullying prevention programming	• Diana Anti- Bullying Campaign • Sylvania schools – peer mentors program • TPS - Teen PEP (peers educating peers)/grant funded • Focus on middle school or younger
Awareness of bullying and mental health issues	• Educate availability of bullying coalition to make presentations • Increase awareness of teen hotline numbers
More targeted bullying campaigns	• ROX – Ruling Our Experiences. Girls only, middle school. • Butterfly Project – high school • Girl Scouts – grade school • More information on cyberbullying
Mental health services at community colleges/smaller universities	• Increase information being provided during orientation type classes for freshman
Community education	• Bullying sometimes misinterpreted as "bad behavior"
Healthy relationships	• Curriculum focusing on healthy vs. unhealthy relationships • Assemblies in school led by those who have been bullied, abused, etc…
Suicide Prevention Hotline	• Put information in girls restrooms (stalls) • Looking into options to text instead of calling hotlines
Trauma informed care	• Increase participation and awareness of the Lucas County Trauma coalition (deals with the root of the problem) • Adverse childhood experiences (ACE) • Focus on trauma informed care

Strategy #3: Decrease Youth Mental Health Issues and Bullying
Best Practices

Best Practices

1. **PHQ-9:** The PHQ-9 is the nine item depression scale of the Patient Health Questionnaire. The PHQ-9 is a powerful tool for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment. The primary care clinician and/or office staff should discuss with the patient the reasons for completing the questionnaire and how to fill it out. After the patient has completed the PHQ-9 questionnaire, it is scored by the primary care clinician or office staff.
   There are two components of the PHQ-9:
   - Assessing symptoms and functional impairment to make a tentative depression diagnosis
   - Deriving a severity score to help select and monitor treatment

   The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV). Through proven and promising best practices, effective programs will be better able to help achieve the Healthy People 2020 Mental Health and Mental Disorders Objectives to improve mental health through prevention and ensure access to appropriate, quality mental health services.

2. **SOS Signs of Suicide®:** The Signs of Suicide Prevention Program is an award-winning, nationally recognized program designed for middle and high school-age students. The program teaches students how to identify the symptoms of depression and suicidality in themselves or their friends, and encourages help-seeking through the use of the ACT® technique (Acknowledge, Care, Tell).

   The SOS High School program is the only school-based suicide prevention program listed on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices that addresses suicide risk and depression, while reducing suicide attempts. In a randomized control study, the SOS program showed a reduction in self-reported suicide attempts by 40% (BMC Public Health, July 2007). For more information go to:
   http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/

3. **The Incredible Years®:** The Incredible Years programs for parents and teachers reduce challenging behaviors in children and increase their social and self-control skills. The Incredible Years training programs give parents and teachers strategies to manage behaviors such as aggressiveness, ongoing tantrums, and acting out behavior such as swearing, whining, yelling, hitting and kicking, answering back, and refusing to follow rules. Through using a range of strategies, parents and teachers help children regulate their emotions and improve their social skills so that they can get along better with peers and adults, and do better academically. It can also mean a more enjoyable family life. The Incredible Years programs have been evaluated by the developer and independent investigators. Evaluations have included randomized control group research studies with diverse groups of parents and teachers. The programs have been found to be effective in strengthening teacher and parent management skills, improving children's social competence and reducing behavior problems. Evidence shows that the program have turned around the behaviors of up to 80 percent of the children of participating parents and teachers. If left unchecked these behaviors would mean those children are at greater risk in adulthood of unemployment, mental health problems, substance abuse, early pregnancy/early fatherhood, criminal offending, multiple arrests and imprisonment, higher rates of domestic violence and shortened life expectancy.. For more information go to: http://www.incredibleyears.com

4. **The Olweus Bullying Prevention Program-** The Olweus Bullying Prevention Program is a universal intervention for the reduction and prevention of bully/victim problems. The main arena for the program is the school, and school staff has the primary responsibility for the introduction and implementation of the program.
   For more information go to http://www.violencepreventionworks.org/public/index.page

Strategy #3: Decrease Youth Mental Health Issues and Bullying
Best Practices, continued

5. **The PAX Good Behavior Game** is a proven, research-based classroom management model designed for use in grades K–6. Based on a strategy developed by a classroom teacher 40 years ago, the PAX Game involves student teams "competing against" each other to earn rewards for refraining from disruptive, inattentive, or aggressive behavior. Approximately 20 published studies have shown that use of this model results in decreased classroom disruptions (by 50–90%), a greater number of students fully engaged in learning (by 20–50%), decreased referrals and suspensions (by 30–60%), and more time for teaching and learning (by 25%). Longitudinal studies have also shown that children who experienced the Good Behavior Game in elementary school were less likely to be involved in violent behaviors later in life and were less likely to use tobacco or other drugs later in life. For more information go to: http://www.hazelden.org/HAZ_MEDIA/gbg_insert.pdf

6. **Telemedicine**: Telemedicine, sometimes called telehealth, uses telecommunications technology to deliver consultative, diagnostic, and health care treatment services via videoconferencing, transmission of still images, remote monitoring of vital signs, or other modalities (ATA). Telemedicine can supplement health care services for patients who would benefit from frequent monitoring or provide services to individuals in areas with limited access to care.

   Expected Beneficial Outcomes
   - Increased access to care
   - Improved health outcomes

   For more information go to: http://www.countyhealthrankings.org/policies/telemedicine

7. **Mental Health First Aid**: Mental Health First Aid is an adult public education program designed to improve participants' knowledge and modify their attitudes and perceptions about mental health and related issues, including how to respond to individuals who are experiencing one or more acute mental health crises (i.e., suicidal thoughts and/or behavior, acute stress reaction, panic attacks, and/or acute psychotic behavior) or are in the early stages of one or more chronic mental health problems (i.e., depressive, anxiety, and/or psychotic disorders, which may occur with substance abuse).

   The intervention is delivered by a trained, certified instructor through an interactive 12-hour course, which can be completed in two 6-hour sessions or four 3-hour sessions. The course introduces participants to risk factors, warning signs, and symptoms for a range of mental health problems, including comorbidity with substance use disorders; builds participants' understanding of the impact and prevalence of mental health problems; and provides an overview of common support and treatment resources for those with a mental health problem. Participants also are taught a five-step action plan, known as ALGEE, for use when providing Mental Health First Aid to an individual in crisis:
   - A--Assess for risk of suicide or harm
   - L--Listen nonjudgmentally
   - G--Give reassurance and information
   - E--Encourage appropriate professional help
   - E--Encourage self-help and other support strategies

   For more information go to: http://www.mentalhealthfirstaid.org/cs/

Strategy #3: Decrease Youth Mental Health Issues and Bullying Best Practices, continued

Healthy People 2020 Goals include:

- Reduce the suicide rate
- Reduce suicide attempts by adolescents
- Reduce the proportion of adults aged 18 and older who experience major depressive episodes (MDEs)
- Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral
- Increase the proportion of persons with serious mental illness (SMI) that are employed
- Increase the proportion of adults aged 18 years and older with serious mental illness who receive treatment
- Increase the proportion of adults aged 18 years and older with major depressive episodes (MDEs) who receive treatment
- Increase the proportion of primary care physicians who screen adults aged 19 years and older for depression during office visits
- Increase the proportion of homeless adults with mental health problems who receive mental health services

The following evidence-based community interventions come from the **Guide to Community Preventive Services, Centers for Disease Control and Prevention (CDC)** and help to meet the Healthy People 2020 Objectives:

Collaborative care for the management of depressive disorders is a multicomponent, healthcare system-level intervention that uses case managers to link primary care providers, patients, and mental health specialists. This collaboration is designed to:

1. Improve the routine screening and diagnosis of depressive disorders
2. Increase provider use of evidence-based protocols for the proactive management of diagnosed depressive disorders
3. Improve clinical and community support for active patient engagement in treatment goal setting and self-management

Strategy #3: Decrease Youth Mental Health Issues and Bullying
Action Step Recommendations & Action Plan

Action Step Recommendations

To work toward **increasing access and awareness of mental health issues** the following actions steps are recommended:

1. Increase the number of health care providers who screen for adolescent depression during office visits
2. Increase early identification of mental health needs among youth
3. Increase awareness of available youth mental health services
4. Implement evidence based bullying prevention programs
5. Increase awareness of Trauma Informed Care (an organizational structure and treatment framework that involves understanding, recognizing and responding to the effects of all types of trauma)

Action Plan

Decrease Youth Mental Health Issues and Bullying		
Action Step	Responsible Person/ Agency	Timeline
Increase the Number Health Care Providers Screening and Making Referrals for Adolescent Depression During Office Visits		
Year 1: Collect baseline data on the number of primary care offices and OBGYN offices that currently screen and make referrals for adolescent depression and/or mental health issues during office visits.	Ann Mary Mercier, MedTAPP HCA Initiative Core Team	2016
Year 2: Introduce the Patient Health Questionnaire Modified for Teens (PHQ-9 Modified) or the Center for Epidemiological Studies Depression Scale for Children (CES-DC) to physicians' offices and hospital administration, along with education on how to bill for the screenings. Pilot the protocol with one primary care office and OBGYN office.		2017
Year 3: Increase the number of primary care and OBGYN offices using the (PHQ-9 Modified) or CES-DC screening tool and making referrals by 25% from baseline.		2018
Increase Early Identification of Mental Health Needs Among Youth		
Year 1: Collect baseline data on any mental health screening tools or programs that are currently being used by Lucas County Schools and/or Juvenile Court. Work with school district administrators and wellness committees to create Behavioral Intervention Teams that assist in assessing if a student is at risk for suicide and/or targeted violence. Train at least one school district on identifying warning signs on how to communicate with students at risk.	Lisa Kovach, UT Alicia Komives, Lucas County Juvenile Court	2016
Year 2: Train 2 additional school districts on identifying warning signs on how to communicate with students at risk.		2017
Year 3: Double the number of schools with Behavioral Intervention Teams		2018

Strategy #3: Increase access and awareness of mental health issues
Action Step Recommendations & Action Plan, continued

Decrease Youth Mental Health Issues and Bullying		
Action Step	Responsible Person/ Agency	Timeline
Increase Awareness of Available Youth Mental Health Services		
Year 1: Coordinate efforts to form a youth mental health committee to increase awareness of services available to Lucas County youth and families. Increase awareness of the Mental Health First Aid training. Market the training to Lucas County area churches, schools, Rotary Clubs, Law Enforcement, Chamber of Commerce, City Councils, college students majoring in social work/mental health, etc. and provide at least 2 trainings. Educate school personnel, guidance counselors and social workers in at least three local school districts on the availability of youth mental health services. Create a presentation of available youth mental health services and present to Lucas County area churches, Law Enforcement, Chamber of Commerce, City Councils, college students majoring in social work, etc. Support and disseminate an informational brochure that highlights all organizations in Lucas County that provide youth mental health services. Include information regarding services that are free or offered at a reduced cost to clients. Make information available to 2-1-1.	Stephanie Speck, Harbor	2016
Year 2: Educate school personnel and social workers in all local school districts on the availability of youth mental health services. Provide 3 additional Mental Health First Aid trainings and continue marketing efforts. Continue presentations of available youth mental health services to Lucas County groups. Enlist organization to update the brochure on an annual basis.		2017
Year 3: Continue efforts of years 1 and 2 and expand outreach. Determine on an annual basis, who will update the brochures for the next 3 years.		2018
Implement Evidence-Based Bullying Prevention Programs		
Year 1: Gather baseline data on which bullying prevention programs are currently being implemented (in which districts and which grade levels). Explore evidence based prevention programs such as PAX Good Behavior Games, LifeSkills, The Incredible Years, and ROX!- Ruling Our Experiences. Decide which program(s) will be offered and are sustainable.	Lisa Kovach, UT	2016
Year 2: Introduce or re-introduce the evidence based program(s) to the school districts. Pilot any new programs in at least one district. Expand any current programming to other districts or grade levels.		2017
Year 3: Expand programming to all districts in all grade levels.		2018

Strategy #3: Increase access and awareness of mental health issues
Action Step Recommendations & Action Plan, continued

Decrease Youth Mental Health Issues and Bullying		
Action Step	Responsible Person/ Agency	Timeline
Increase Awareness of Trauma Informed Care		
Year 1: Work to increase awareness and support the goals of the Lucas County Trauma Coalition. Facilitate an assessment among clinicians in Lucas County on their awareness and understanding of trauma informed care. Survey community members of their awareness and understanding of trauma. Facilitate a training to increase education and understanding of trauma.	Alicia Komives, Lucas County Juvenile Court	2016
Year 2: Facilitate trainings for Lucas County teachers on trauma and Adverse Childhood Experiences. Develop and implement a trauma screening tool for social service agencies who work with at risk youth.		2017
Year 3: Continue efforts of years 1 and 2 Increase the use of trauma screening tools by 25%.		2018

Strategy #4: Decrease Infant Mortality
Infant Mortality Indicators

The following information was reported by parents of 0-5 year olds. In 2014, 94% of mothers got prenatal care within the first three months during their last pregnancy. 8% of mothers smoked during their last pregnancy. 68% of parents put their child to sleep on his/her back. 29% of mothers never breastfed their child.

Early Childhood

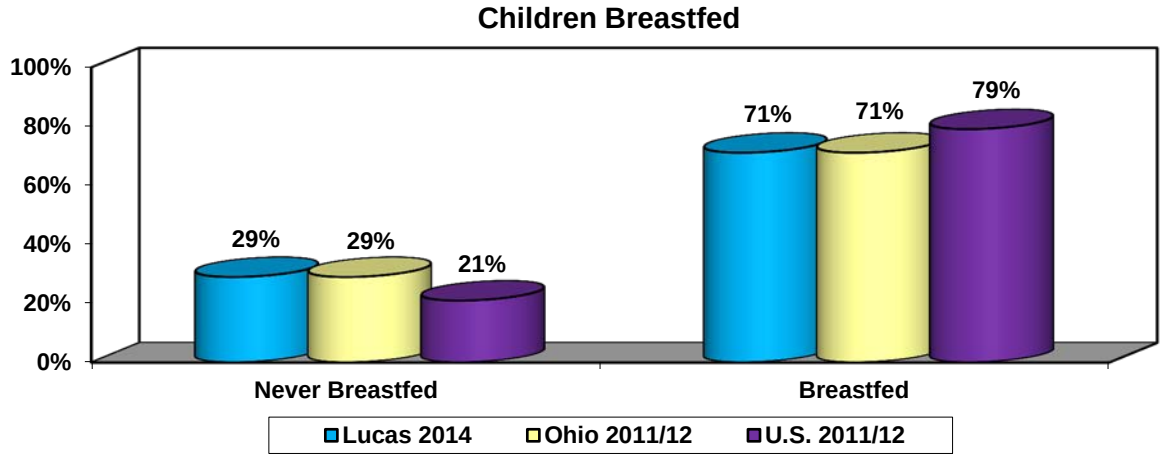
During their last pregnancy, mothers did the following: got prenatal care within the first 3 months (94%), took a multi-vitamin (89%), took folic acid (42%), smoked cigarettes (8%), used alcohol (5%), experienced depression during or after pregnancy (3%), experienced domestic violence (3%), used marijuana (2%), took more medication that prescribed or differently than prescribed (1%), and used drugs not prescribed for them (1%).

When asked how parents put their child to sleep as an infant, 68% said on their back, 17% said on their side, 8% said on their stomach, and 5% said various methods.

Children were put to sleep in the following places: crib/bassinette (92%), pack n' play (43%), swing (40%), in bed with parent or another person (37%), car seat (33%), couch or chair (12%), and floor (6%).

Mothers breastfed their child: more than 9 months (20%), 4 to 9 months (17%), 7 weeks to 3 months (17%), 3 to 6 weeks (8%), 2 weeks or less (7%), still breastfeeding (2%), and never breastfed (29%). Of those with incomes less than $25,000, 44% never breastfed their child.

Parents reported their child was not breastfed for the following reasons: they did not want to (22%), latching issues (5%), they did not try (4%), were unable to breastfeed (3%), medical issues with their child (2%), medical issues with the mother (1%), and some other reason (1%). 7% of parents reported multiple reasons.



Child Comparisons	Lucas County 2011 0-5 years	Lucas County 2014 0-5 years	Ohio 2011/12 0-5 years	U.S. 2011/12 0-5 years
Never breastfed their child	27%	29%	29%	21%

Strategy #4: Decrease Infant Mortality
Resource Assessment

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care	Evidence of Effectiveness
Pathways: Lucas County Initiative to Improve Birth Outcomes	Hospital Council of Northwest Ohio coordinates with the following seven participating agencies: • Adelante • The East Toledo Family Center • Mercy St. Vincent Family Care Center • Neighborhood Health Association • Toledo-Lucas County Health Department • ProMedica Toledo Hospital • The Providence Center	Low income pregnant women with multiple risk factors for poor birth outcomes who are either uninsured or on a Medicaid Managed Care plan that contracts with the Initiative (Buckeye, Paramount, United Health Care)	Early Intervention/ Prevention of additional pregnancies to allow for healthy birth spacing	A recent publication in the Maternal and Child Health Journal indicated a more than 60% reduction in low birth weight and greater than 500% return on investment was found utilizing the Pathways Community HUB Model for this population in the State of Ohio http://link.springer.com/article/10.1007/s10995-014-1554-4?sa_campaign=email/event/articleAuthor/onlineFirst
Cribs for Kids Safe sleep initiative	Toledo-Lucas County Health Department	Women in the 3rd trimester of pregnancy or who have a child 4 months or younger (must be referred)	Prevention	Best practice
Healthy Start Program	Toledo-Lucas County Health Department	Pregnant women	Prevention	
Prenatal clinics	Multiple Organizations (Toledo-Lucas County Health Department, Neighborhood Health Association, hospitals)	Pregnant woman	Prevention/Early Intervention/ Treatment	Outcomes measured
Mother and child dependency programs (Suboxone treatment)	Mercy, Zepf Center	Mothers on opiates when pregnant	Treatment	Best practice
First Haven	UMADOP of Lucas County	Pre and post-treatment services for African American adult and adolescent females geared to help them overcome chemical dependency and addiction Also provides services for their children	Prevention/Early Intervention/Treatment	
Nosotras prenatal education, health and developmental classes	Adelante	Hispanic pregnant women	Prevention	
Parenting classes	East Toledo Family Center	Birth-age 3	Prevention	

Strategy #4: Decrease Infant Mortality
Resource Assessment, continued

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care	Evidence of Effectiveness
WIC Program (8 sites)	Toledo-Lucas County Health Department	WIC serves low-income pregnant, postpartum and breastfeeding women, and infants and children up to age **5** who are at nutrition risk.	Prevention	Best practice
Education, workshops, support groups	Double ARC	Children with Fetal Alcohol Syndrome (FAS) and their families	Prevention/ Early Intervention	
Early intervention and home visiting services	Lucas County Help Me Grow	Help Me Grow is a state-wide program for expectant parents, newborns, infants, and toddlers that provides health and developmental services so that children start school healthy and ready to learn.		
Pregnancy support center/ education	Heartbeat of Toledo	Pregnant women and families	Prevention	
The Sudden Unexpected Death Enhancement Act	Legislation Introduced by Sherrod Brown	Infants/parents	Prevention	
NICU	Mercy Children's Hospital	Newborn	Treatment	
Vermont Oxford Network	Mercy along with many other organizations			Mission to improve the quality and safety of medical care for newborn infants and their families through a coordinated program of research, education, and quality improvement projects.
Ohio Perinatal Quality Collaborative	Mercy along with many other organizations			A statewide consortium of perinatal clinicians, hospitals, and policy makers and governmental entities that aims, through the use of improvement science, to reduce preterm births and improve birth outcomes across Ohio.
Help Me Grow	Mercy with ODH		Early intervention	

Strategy #3: Decrease Infant Mortality
Gaps & Potential Strategies

Gaps	Potential Strategies
African American babies – low birth weight or pre term (Economic issues)	• Pathways model • ABC's (Alone Back Crib) – safe sleep initiative • Increase Pre conception health – Reproductive Life Plan (RLP) • Address racism/economic/educational issues • Care coordinators at women's shelters • Geographic barriers – north end, east side • Community Health Workers – need of preceptors (focus on Medicaid patients) • Increase PSA's on safe sleep
Breastfeeding	• Community Health Workers educating women • Hospitals not giving out formula • Breastfeeding policies in the workplace

Strategy #4: Decrease Infant Mortality
Best Practices

Best Practices

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. HRSA 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 monitoring fetal heart rate.
   For more information, go to:
   http://www.hrsa.gov/quality/toolbox/measures/prenatalfirsttrimester/part3.html

2. **Expand Use of Community Health Workers (CHW):** Community health workers (CHW), sometimes called lay health workers, serve a variety of functions, including: providing outreach, education, referral and follow-up, case management, advocacy and home visiting services. They may work autonomously or as part of a multi-disciplinary team; training varies widely with intended role and location. CHW services are often targeted at women who are at high risk for poor birth outcomes.

   Expected Beneficial Outcomes
   - Increased patient knowledge
   - Increased access to care
   - Increased use of preventive services
   - Improved health behaviors

   Evidence of Effectiveness
   - There is some evidence that CHWs improve patient knowledge and access to health care, especially for minority women and individuals with low incomes.
   - CHWs have been shown to improve access to care for patients that my not otherwise receive care.
   - CHWs appear as effective as, and sometimes more effective than, alternate approaches to disease prevention, asthma management, efforts to improve colorectal cancer screening, chronic disease management, and maternal and child health.

Strategy #4: Decrease Infant Mortality
Best Practices, continued

Impact on Disparities:
Likely to decrease disparities
For more information go to: http://www.countyhealthrankings.org/policies/expand-use-community-health-workers-chw

Healthy People 2020 Goals include:

- Reduce the rate of maternal mortality
- delivery)
- Reduce low birth weight (LBW) and very low birth weight (VLBW)
- Increase the proportion of pregnant women who receive early and adequate prenatal care
- Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women
- Increase the proportion of women delivering a live birth who received preconception care services and practiced key recommended preconception health behaviors
- (Developmental) Increase the proportion of women giving birth who attend a postpartum care visit with a health worker
- Increase the proportion of infants who are breastfed
- Increase the proportion of employers that have worksite lactation support programs
- Reduce maternal illness and complications due to pregnancy (complications during hospitalized labor and
- Reduce the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life
- Reduce the rate of fetal deaths at 20 or more weeks of gestation

Strategy #4: Decrease Infant Mortality
Action Step Recommendations & Action Plan

Action Step Recommendations

To work toward decreasing **infant mortality,** the following actions steps are recommended:

1. Increase the use of safe sleep practices
2. Increase maternal, preconception, prenatal & inter-conception health
3. Increase access to care for pregnant women
4. Increase breastfeeding practices

Decrease Infant Mortality		
Action Step	Responsible Person/Agency	Timeline
Increase the Use of Safe Sleep Practices		
Year 1: Work with local churches to train community members to be safe sleep ambassadors. Develop safe sleep "tent cards" to be distributed by Fire & EMS to all homes with a child under the age of 1. Work with hospitals to start talking about safe sleep practices from the initial prenatal visit. Implement a community wide safe sleep campaign focused on stores that sell cribs and baby items. Work with stores that sell cribs to promote safe sleep practices.	Celeste Smith/ April Snelling, Toledo-Lucas County Health Department Carly Miller, Northwest Ohio Pathways HUB Getting to One, Ohio Equity Institute	2016
Year 2: Train additional community members to serve as safe sleep ambassadors. Expand distribution of safe sleep tent cards to Fire & EMS in outlying areas of Lucas County. Work with Lucas County Commissioners to create a resolution to ban bumper pad sales in Lucas County.		2017
Year 3: Initiate the enforcement of the bumper pad ban.		2018
Increase Maternal, Preconception, Prenatal, & Inter-conception Health		
Year 1: Work with hospital systems and the local health department to embed CHWs into clinics to enroll women of childbearing age (13-44) into Healthy Start and complete a Reproductive Life Plan. Connect women of childbearing to a health insurance and a medical home, and remove barriers to care to allow them to continue receiving needed care. Increase birth spacing for women who have delivered <18 months ago. Incorporate counseling on long-acting reversible contraception as part of preventive care, postpartum visits and other program interventions.	Celeste Smith/ April Snelling, Toledo-Lucas County Health Department Carly Miller, Northwest Ohio Pathways HUB	2016
Year 2: Increase efforts of year 1		2017
Year 3: Increase efforts of years 1 & 2		2018

Strategy #4: Decrease Infant Mortality
Action Step Recommendations & Action Plan

Decrease Infant Mortality		
Action Step	Responsible Person/Agency	Timeline
Improve Access to Care for Pregnant Women		
Year 1: Work with hospital systems to develop and distribute a pregnancy lifestyle risk assessment to identify needs and barriers to care for pregnant women as early in their pregnancy as possible. Based on results of the assessment, refer any high risk pregnant women to the HUB for care coordination services. Increase enrollment into Pathways Program. Connect women of childbearing to a health insurance and a medical home, and remove barriers to care to allow them to continue receiving needed care.	Celeste Smith/ April Snelling, Toledo-Lucas County Health Department Carly Miller, Northwest Ohio Pathways HUB	2016
Year 2: Hire a new Pathways Care Coordinator for North Toledo.		2017
Year 3: Increase efforts of years 1 & 2.		2018
Increase Breastfeeding Practices		
Year 1: Hire a breastfeeding peer educator to work with WIC clients to encourage breastfeeding practices. Standardize breastfeeding education across all providers countywide during pregnancy and postpartum.	Celeste Smith/ April Snelling, Toledo-Lucas County Health Department Carly Miller, Northwest Ohio Pathways HUB	2016
Year 2: Hire and incorporate breastfeeding peer educators into the hospital labor and delivery units.		2017
Year 3: Increase efforts of years 1 & 2.		2018

Strategy #5: Increase School Readiness
School Readiness Indicators

The following information was reported by parents of 0-5 year olds. In 2014, 33% of parents read to their child every day.

Early Childhood

Parents reported their child regularly attended the following: nursery school, pre-school, or kindergarten (49%), child care in their home provided by a relative other than a parent/guardian (44%), child care outside of their home provided by a relative (41%), elementary school (16%), accredited or star-rated child care center (27%), child care in their home provided by a baby sitter (27%), accredited or star-rated family-based child care outside of home (10%), Head Start program (9%), non-accredited or star-rated family-based child care outside of home (7%), and non-accredited or star–rated child care center (3%).

Parents reported they or someone in the family reads to their 0-5 year old child: every day (33%), almost every day (36%), a few times a week (25%), a few times a month (5%), and a few times a year (1%). 1% of parents reported their child read to him/herself, and 1% reported never reading to their child due to lack of interest from the child.

Child Comparisons	Lucas County 2011 0-5 years	Lucas County 2014 0-5 years	Ohio 2011/12 0-5 years	U.S. 2011/12 0-5 years
Parent reads to child every day	33%	33%	53%	48%

Strategy #5: Increase School Readiness
Resource Assessment

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care	Evidence of Effectiveness
Uses Lucas County data track which initiatives are working (children enter Kindergarten ready to succeed)	Aspire	Youth (cradle to career)		Outcomes measured
Head Start Early Head Start	TPS/WSOS Community Action	Early Head Start- Prenatal-3 years Head Start- Ages 3-5	Prevention/Early Intervention	Outcomes measured
Head Start Early Head Start	Brightside Academy (3 locations in Toledo)	Ages 0-5	Prevention/Early Intervention	Outcomes measured
Step Up To Quality Programs	Various accredited daycare programs	Children	Prevention	Outcomes measured
Child development programs	YMCA	Youth		
Free books	Juvenile Court	Youth	Prevention	
Free books/ reading programs	Various libraries/ OCALI lending library-ships books home	Youth	Prevention	
Reach Out to Read Literacy Program	UT Foundation	6 months- 5 years old (provides free books at well checks)	Prevention	
Early learning/school readiness/parent involvement	State Support Team Region 1/ ODE	Youth	Prevention/Early Intervention	
Incredible Years	UT Kobacker Center	Grades K-4	Prevention	Evidence-based
Early childhood development/education	Harbor	Preschool educators & parents with children who have developmental disabilities	Prevention/Early Intervention	
Creating Family Readers Program	Read for Literacy	Parents & children all ages	Prevention	
Leamos Juntos	Adelante	Spanish-monolingual children ages 0-5 and their parents		
Dolly Parton Imagination Library	United Way	Children ages 0-5 (low income families)	Prevention	
Early childhood resource and referral	YWCA	Provides resources to child care facilities		
Building Roads to the Future Parenting classes	Polly Fox	Pregnant/parenting teens	Prevention	
Educational advocacy programs	Bright Horizons & Ability Center			

Strategy #5: Increase School Readiness
Resource Assessment

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care	Evidence of Effectiveness
Early childhood education	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			
Libraries/Literacy-learn to read	Multiple organizations *For a complete list go to the 2014/2015 Community Resources Of Greater Toledo http://www.promedica.org/workfiles/patient_resources/promedica/ProMedica-Community-Resources-of-Greater-Toledo.pdf			
Early Head Start Home Visitation	Mercy with Head Start		Prevention/early intervention	
Healthy Connections Home Visitation Program	Mercy	Underserved Hispanic/Latino and Spanish speaking families in Lucas County that do not meet the Help Me Grow criteria. The program may serve up to 25% of families who do not meet these criteria. Services begin during pregnancy or when the baby is under four months of age and end when the child turns 5 years of age.	Early intervention	Home visitors conduct developmental screenings and develop an Individualized Family Service Plan for each family. Home visitors also refer families to helpful community resources. The program is based on the nationally recognized evidence-based Healthy Families America (HFA) home-visiting model and utilizes the Growing Great Kids and Growing Great Families Curriculum. HFA is designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment
Help Me Grow	Mercy with ODH		Early intervention	
YMCA Childcare Sites (25 sites), Leadership development program, arts & humanities classes	YMCA	Youth & children		

Strategy #5: Increase School Readiness
Gaps & Potential Strategies

Gaps	Potential Strategies
Increase Early Head Start enrollments	• Work with ASPIRE, Family Council and Early Head Start

Strategy #5: Increase School Readiness
Best Practices

Best Practices

1. **Early Head Start (EHS):** Early Head Start (EHS) is a federally funded program for low income pregnant women and children ages 0 to 3. EHS' comprehensive approach includes child care, parent education, health and mental health services, and family support. EHS programs can be home-based, center-based, or offer a mix of home and center services (PPN).

   Expected Beneficial Outcomes (Rated)
   - Improved cognitive skills
   - Improved social emotional skills
   - Improved family functioning

   Other Potential Beneficial Outcomes
   - Reduced aggression
   - Reduced stress
   - Improved parenting
   - Increased school readiness
   - Increased family income
   - Reduced hospital utilization

   Impact on Disparities:
   Likely to decrease disparities

   For more information go to: http://www.countyhealthrankings.org/policies/early-head-start-ehs

2. **Preschool Education Programs**: Preschool education programs are center-based interventions that foster the cognitive and social-emotional development of children. Programs are usually targeted at children who are at least three years old but not yet old enough to enter formal schooling (Burger 2010).

   Expected Beneficial Outcomes (Rated)
   - Improved cognitive skills
   - Improved social emotional skills
   - Increased academic achievement

   Other Potential Beneficial Outcomes
   - Increased high school graduation
   - Reduced delinquent behavior

   For more information go to : http://www.countyhealthrankings.org/policies/preschool-education-programs

Strategy #5: Increase School Readiness
Best Practices, continued

Healthy People 2020 Goals include:

- (Developmental) Increase the proportion of children who are ready for school in all five domains of healthy development: physical development, social-emotional development, approaches to learning, language, and cognitive development
- Increase the proportion of parents who use positive parenting and communicate with their doctors or other health care professionals about positive parenting

Strategy #5: Increase School Readiness
Action Step Recommendations & Action Plan

Action Step Recommendations

To work toward increasing school readiness:

1. Increase the number of children enrolled in a Head Start, Early Head Start, pre-school education or Help Me Grow program
2. Increase the number of Star-Rated Step Up to Quality Child Care Programs in Lucas County

Action Plan

Increase School Readiness		
Action Step	Responsible Person/Agency	Timeline
Increase the Number of Children Enrolled in a Head Start, Early Head Start, Pre-School Education or Help Me Grow Program		
Year 1: Gather baseline data on the number of Lucas County children enrolled in a Head Start, Early Head Start of pre-school education program. Increase Public Awareness and access to early intervention programs.	Kristi Hannnan, Lucas County Family Council Diandria Barber & Lizze Friedman, Brightside Academy	2016
Year 2: Increase the number of Lucas County children enrolled in an early intervention program by 5%.		2017
Year 3: Increase efforts of years 1 & 2.		2018
Increase the Number of Step Up to Quality Child Care Programs in Lucas County		
Year 1: Gather baseline data on the child care facilities that are Star-Rated. Identify resources/training opportunities for childcare providers/centers to become Star-Rated. Implement training opportunities among licensed child care providers/centers.	Heidi Rober, YWCA	2016
Year 2: Increase the number of Star-Rated child care centers by 5% from baseline.		2017
Year 3: Increase efforts of years 1 & 2.		2018

Action Step Recommendations

To work toward addressing all five priority areas:

1. Increase cultural competency
2. Increase efforts to address social determinants of health
3. Increase public and partner education messages promoting improved health

Trans-strategies		
Action Step	Responsible Person/Agency	Timeline
Increase Cultural Competency		
Year 1: Educate/inform local businesses, organizations and health care providers on county demographics and the importance of becoming culturally competent. Offer a county-wide training/workshop on cultural competence. Expand the number of Cost of Poverty Simulations and Bridges Out of Poverty Workshops being offered in Lucas County.	Celeste Smith, Toledo-Lucas County Health Department Linda Alvorado-Arce, City of Toledo, Board of Community Relations	2016
Year 2: Enlist 2 organizations to adopt culturally competent principles, policies and/or practices within their organization. Increase the number of training/workshops by 25%.		2017
Year 3: Increase the number of organizations adopting cultural competency policies by 50% from baseline.		2018
Increase Efforts to Address Social Determinants of Health		
Year 1: Use Community Health Workers (CHW's) to educate clients on Managed Care/Medicaid transportation services and help to coordinate transportation services. Publicly report racial disparities on infant mortality report card to raise awareness and accountability for closing the gap. Work with community leaders and organizations to provide advice and insight on ways to effectively engage the black community. Build capacity among community, neighborhood leaders and service providers by providing training on structural racism designed to give leaders insight into underlying causes and strategies to change policy and practice to promote equity.	Celeste Smith, Toledo-Lucas County Health Department	2016
Year 2: Work with community leaders to develop neighborhood- and community-level strategies for addressing the effects of race and racism. Conduct community conversations regarding racism as a social determinant of health.		2017
Year 3: Increase efforts of years 1 & 2		2018

Trans-Strategies, continued

Trans-strategies		
Increase Public and Partner Education Messages Promoting Improved Health		
Year 1: Develop a culturally relevant strategic communications plan to address priority health areas. Create a Healthy Lucas County logo. Create a framework for a Healthy Lucas County website with a page dedicated to adult pathways including information for healthcare providers. Create a social media presence promoting improved health including health areas such as the importance of smoke-free environments, improving access to healthy food and beverage options and chronic disease prevention.	Julie McKinnon, Hospital Council of Northwest Ohio	2016
Year 2: Increase efforts of year 1.		2017
Year 3: Increase efforts of years 1 & 2.		2018

Progress and Measuring Outcomes

The progress of meeting the local priorities will be monitored with measurable indicators identified by Healthy Lucas County. The individuals that are working on action steps will meet on an as needed basis. The full committee will meet monthly to report out the progress. The committee will form a plan to disseminate the Community Health Improvement Plan to the community. Action steps, responsible person/agency, and timelines will be reviewed at the end of each year by the committee. Edits and revisions will be made accordingly.

Lucas County will continue facilitating a Community Health Assessment every 3 years to collect and track data. Primary data will be collected for both adults and youth 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:

- To evaluate **increasing healthy weigh status**, the indicators found on pages 21-23 will be collected every 3 years.
- To evaluate **decreasing chronic disease**, the indicators found on pages 39-40 will be collected every 3 years.
- To evaluate **decreasing youth mental health issues and bullying**, the indicators found on pages 54-55 will be collected every 3 years.
- To evaluate **decreasing infant mortality**, the indicators found on page 68 will be collected every 3 years.
- To evaluate **increasing school readiness**, the indicators found on page 75 will be collected every 3 years.

In addition to outcome evaluation, process evaluation will also be used on an ongoing basis to focus on how well action steps are being implemented. Areas of process evaluation that the CHIP committee will monitor will include the following: number of participants, location(s) where services are provided, 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 serving 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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