Franklin County
Public Health

2017–2019

COMMUNITY HEALTH ASSESSMENT

YOUR HEALTH, YOUR COMMUNITY

ACKNOWLEDGEMENTS

This Community Health Assessment was possible thanks to the collaborative efforts of numerous members of Franklin County Public Health staff, local stakeholders, partners and community residents. Their contributions, expertise, time and resources played a critical part in the completion of this assessment. The FCPH Board of Health, Health Commissioner and Senior Leadership would like to acknowledge and thank everyone for their contribution to this process.

Contributors to the Franklin County Public Health CHA

Kyle Idahosa, FCPH Lead Epidemiologist for the CHA
- Special thanks for all your effort
FCPH Planning Committee
FCPH Communications
FCPH Community Forum Facilitators
FCPH Board of Health
Health Works Franklin County Steering Committee
(representatives from 38 different local agencies)
Stakeholder Community Forum Facilitators
Nationwide Children's Hospital
Mount Carmel East Hospital
Doctors Hospital OhioHealth
Healthy New Albany
Madison Township Community Center
Ohio University-Dublin
Mighty Crow Media, LLC
Community Research Partners
Dr. Kevin Dixon, ADAMH
Chuck Buck, District Advisory Council (Board of Trustees, Norwich Township)
Carmen Allen, IMPACT
Marty Miller, Heart of Ohio Family Health Care Center (FQHC)
Ben Kessler, Central Ohio Mayors and City Managers Association
Charles Noble, Franklin County Jobs and Family Services
Kythryn Carr Hurd, ADAMH
Scott Perry, Solid Waste Authority of Central Ohio
Pastor Nancy Day-Achauer, St. Marks UMC
Kim Welter, Equality Ohio
Michael Trego, Educational Service Center
Jeff Klinger, Central Ohio Hospital Council
Chief Brad Shull, Fire Chief Association
Sherri Kovach, Central Ohio Trauma System
Carrie Baker, Healthcare Collaborative of Greater Columbus
Darrel Koerber, FC Emergency Management and Homeland Security
Becky Becker, Franklin County Office on Aging
Robert "Buck" Bramlish, Franklin County Veteran's Service Commission

Franklin County
Public Health

FROM THE FRANKLIN COUNTY BOARD OF HEALTH PRESIDENT

November 2017

The Franklin County Public Health department set as its mission to improve the health of our communities by preventing disease, promoting healthy living and protecting against public health threats through education, policies and partnerships. This community health assessment provides data and information that we hope will be embraced by local communities served by FCPH. This snapshot of the health and well-being of residents in Franklin County serves as a road map for addressing those health and health related issues impacting the overall health of our communities.

The FCPH Board of Health commends our health department for the collaborative approach they took in creating this assessment. This report was made possible because of the many local residents, partner agencies, stakeholders and FCPH Board of Health members whom all participated in some part of this process. Their individual and collective contributions of expertise, time or resources enabled crucial input necessary for this assessment.

In the appendices of this report you will find information from regional community forums which includes feedback from local communities highlighting what community members identified as the greatest assets of their community, the things they are most proud of and finally the most important health concerns impacting their community. We hope communities across FCPH jurisdiction will find this information as valuable as we have and will use it to set their own course for improvement.

We look forward to more collaboration as we embark on the next steps of this process, the development of our Community Health Improvement Plan.

Sincerely,

Jack Bope, Board President

BOARD OF HEALTH:

Jack Bope (Board President)
Thomas Rudge, Ph.D. (Vice President)
Jerry Lupfer
ArthurJames, M.D.
Roy Barnewall, Ph.D.

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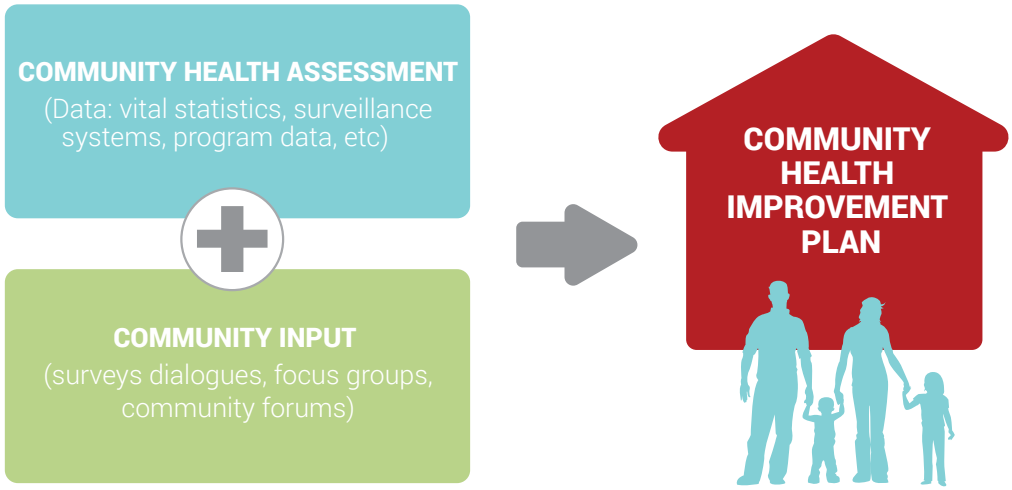
INTRODUCTION
What is a Community Health Assessment?

A community health assessment, or CHA, is a process that uses mixed methods to systematically collect and analyze data to understand health within a specific community. A CHA is used to identify key health needs and issues related to a state, tribal, or local community. The data from a CHA is used to inform community decision making, the prioritization of health problems, and the development, implementation, and evaluation of community health improvement plans.

The CHA is an important piece in the development of a community health improvement plan, (CHIP) because it helps the community understand the health and health related issues that need addressed. It also provides the most current and reliable information about the health status of a community and where gaps may exist in achieving optimal health. The CHA is a collaborative effort based on the community's intimate knowledge of its health issues and identified needs that drive the efforts of the local health department, community partners, and residents in determining specific health improvements to target. Figure 1 below, show's where the community health assessment fits into the community health improvement process.

Community health assessments are the foundation for improving and promoting the health of community members. The role of community assessment is to identify factors that affect the health of a population and determine the availability of resources within the community to adequately address these factors.

Figure 1: The Community Health Improvement Plan Process



An ideal assessment will include:

- Participation from a variety of sectors.
- Demographic information.
- Information on risk factors, quality of life, mortality, morbidity, community assets, social determinants of health and health inequity.
- Descriptions of health issues, specific populations and any health disparities, factors contributing to health challenges, community assets and/or resources.
- Data from a variety of sources and in a variety of forms (qualitative, quantitative, primary, and secondary).
- Variety of data collection methods (i.e. surveys, focus groups, etc.).

A successful CHA and CHIP are often developed using the concept of collective impact. Collective impact is based on the idea that in order for organizations to create lasting solutions to social problems, they need to coordinate their efforts and work together around a specific goal. Collective impact moves away from organizations working in isolation and supports organizations forming cross-sector coalitions in order to have sustainable progress. Ongoing support for collective impact work is provided by a backbone organization dedicated to the initiative. The backbone organization plays six roles in moving the initiative forward:

1. **Guide Vision and Strategy**
2. **Support Aligned Activity**
3. **Establish Shared Measurement Practices**
4. **Build Public Will**
5. **Advance Policy**
6. **Mobilize Funding**

The back bone organization for the Community Health Assessment and Community Health Improvement Plan is the Franklin County Public Health department.

Franklin County Public Health Department (FCPH)

Vision Statement

Franklin County Public Health leads our communities in achieving optimal health for all.

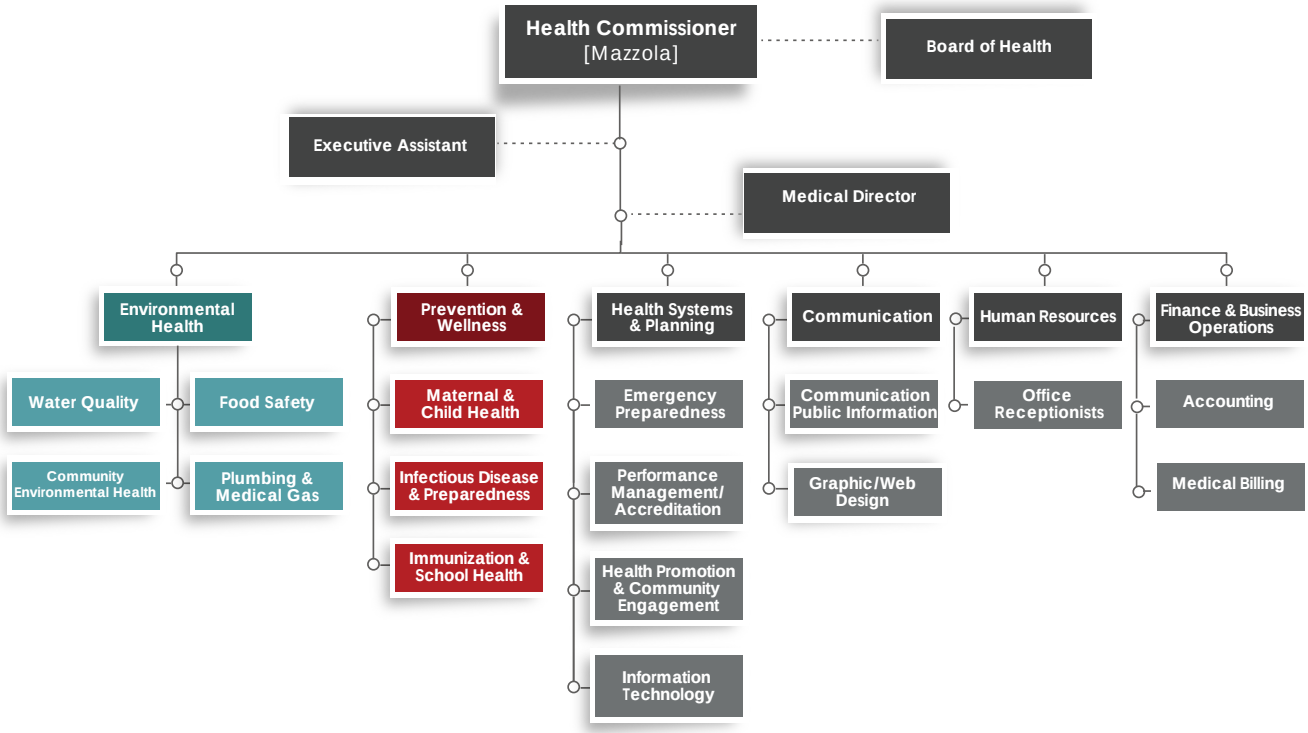
Mission

Franklin County Public Health improves the health of our communities by preventing disease, promoting healthy living and protecting against public health threats through education, policies, programs, and partnerships.

FCPH Structure

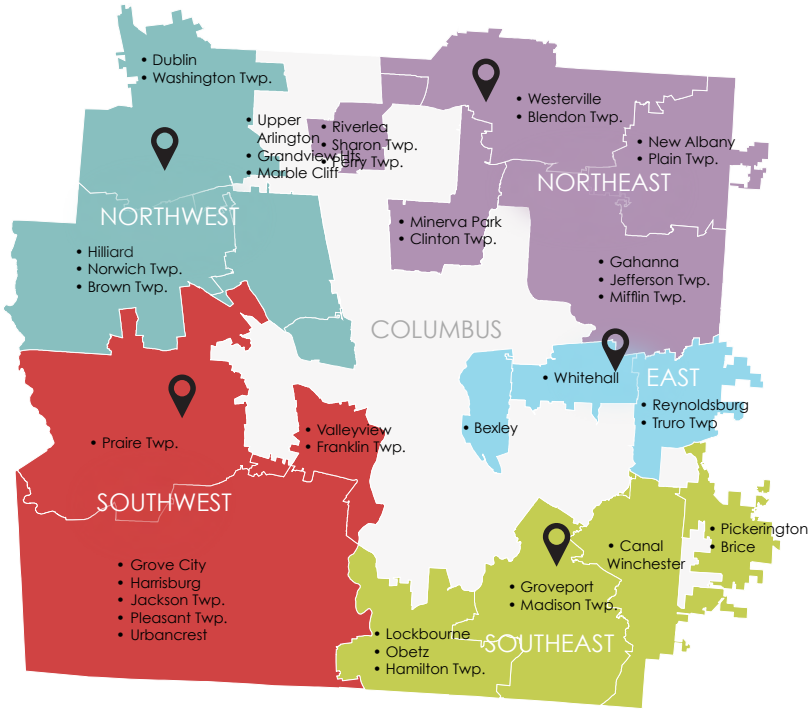
The authority of any health department in the State of Ohio is granted by law and is specifically detailed in the Ohio Revised Code. A five member Board appoints a Health Commissioner who oversees the day-to-day operations of the department. The Board of Health has fiduciary authority over the budget and is the policy-making, rule-making and judicatory body for Franklin County Public Health. The organizational structure of FCPH is depicted below in the current table of organization.

Figure 2: FCPH Table of Organization



Franklin County Public Health

Figure 3: FCPH Jurisdictions



Today we serve a population of

428,976

In our on-going efforts to serve local communities, FCPH has a commitment to systematically evaluate and improve the quality of programs, processes and services to achieve a high level of efficiency, effectiveness and customer satisfaction. To achieve this culture of continuous improvement, Quality Improvement (QI) efforts should target the department level ("Big QI") as well as the program or project level ("Small QI"). Community-based responsibilities and objectives traditionally provided both our organization's purpose and a framework for accountability.

Franklin County has grown over the past few decades. The county is slightly younger than Ohio and the nation, with a greater percentage of residents in the 18-64 year age range, and children under 5 years. Likewise, the area is experiencing the same trend as across the country with an increase in aging baby boomers. Franklin County has a slightly higher per capita income than Ohio while, at the same time, has higher poverty rates for families and individuals. Diversity is reflected throughout the county with its urban inner city surrounded by suburban cities and townships. The Demographic information below provides a snapshot of Franklin County.

Franklin County, Ohio

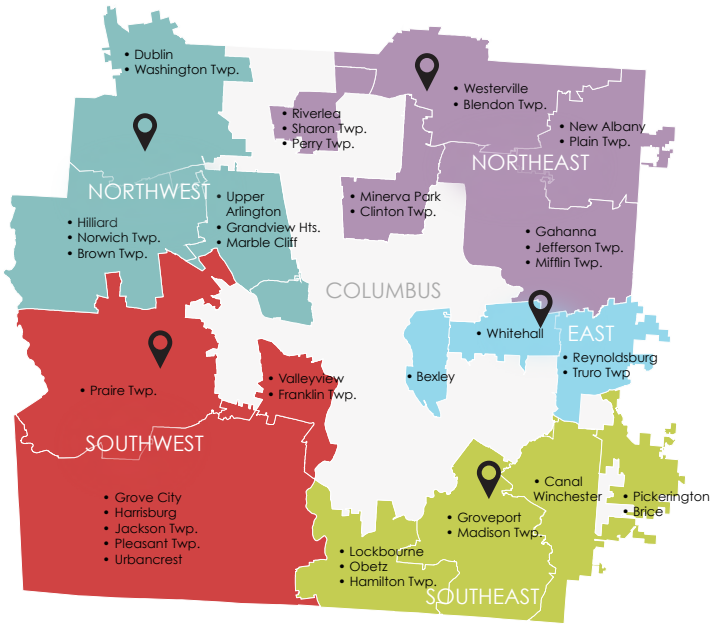
On March 30, 1803, the State of Ohio authorized the creation of Franklin County. The county originally was part of Ross County. The county was named in honor of Benjamin Franklin. Franklin County had a population of 1,068,978 in 2000, which was an increase of 11% from 1990. Franklin County's 540 square miles averaged 1,980 people per square mile in 2000. Despite this dense population, Franklin County still had six hundred farms, averaging 170 acres apiece, in 2000. The total population of Franklin County in 2015 was 1,251,722.

The largest employers in Franklin County are service industries with sales establishments finishing a relatively close second. Government and manufacturing positions finish third and fourth respectively. Franklin County has changed throughout the twentieth century as the economy of the United States has changed as well. Nationwide Insurance, The Limited, Cardinal Health and other major businesses now employ most of the county's residents. Columbus is the birthplace of Wendy's International, Inc. and the longtime home of White Castle System, Inc.

POPULATION

1,251,722

(as of 2015*)



Methodology

Data presented in the Community Profile report is presented in the same way and the same specificity as it appeared in the original data source. The data may appear in different formats, however, citations are made within each page indicating the source of the data. Detailed sources and notes are listed in the source section that follows the report. Wherever possible the most current data from existing sources has been reported.

*Census, U.S. Census Bureau, 2010

Franklin County Public Health

Franklin County, Ohio Demographics

A number of major educational institutions are located in Franklin County. They include Capital University, Columbus State Community College, Franklin University and Ohio Dominican University. The largest of these institutions is The Ohio State University. Major research service organizations such the Battelle Memorial Institute, Online Computer Library Center (OCLC), Inc., and Chemical Abstracts Service are also based in Franklin County and are considered major employers. The most notable employers* in Franklin County are:

- Abbott Laboratories
- American Electric Power Co
- Battelle Memorial Institute
- Cardinal Health Inc
- Huntington Bancshares Inc
- JP Morgan Chase & Co
- Nationwide Mutual Insurance Co
- Ohio State University
- OhioHealth
- Schottenstein Stores Corp
- State of Ohio Government
- Wendy's Company

Within this profile, Franklin County Public Health (FCPH) will focus on some of the health and health related issues across Franklin County, (inclusive of the cities of Columbus and Worthington). FCPH will produce a community profile with data and information that is specific to the local jurisdictions we serve. Where an individual lives, works and plays has a direct impact on their health and wellness. This profile provides a brief, point in time, overview of health and wellness in Franklin County and identifies contributing factors. This profile is not meant to be a comprehensive report.

Franklin County Public Health

Demographics and Community Characteristics

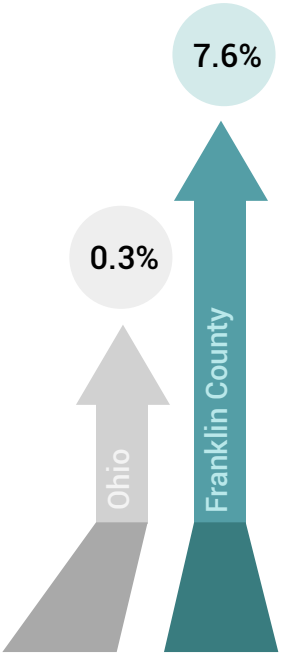
This profile section provides statistical data about the characteristics of the Franklin County population, such as the age, gender, education and income of the population. The primary source for this data comes from the United States Census Bureau which collects data every 10 years, therefore the census data used for this profile is 2010 and the next census will occur in 2020. Program specific information is primarily based on complete data for 2015.

COMMUNITY GROWTH

Total Population and Percentage Estimate Population Change for Franklin County and the State of Ohio

TOTAL POPULATION			
LOCATION	2010	2014	POPULATION CHANGE
Franklin County	1,163,545	1,251,722	7.6% ▲
Ohio	11,536,725	11,575,977	0.3%

Franklin County's population is increasing



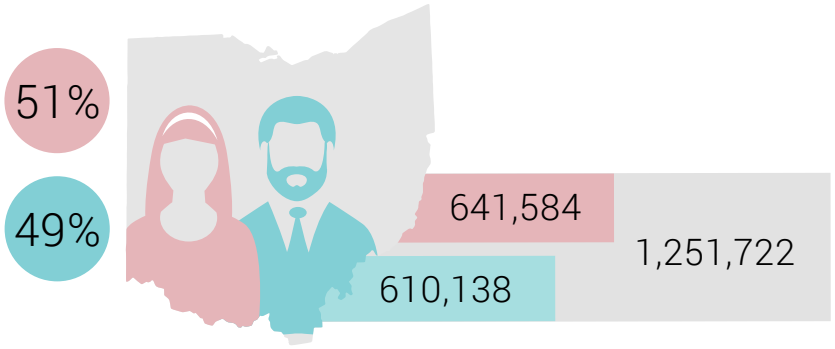
*Source United States Census Bureau 2010, American Community Survey 2011-2015
The estimated population change is from April 1, 2010 to July 1, 2015 and based on Franklin County population

Franklin County Community Assessment

Franklin County, Ohio Demographics

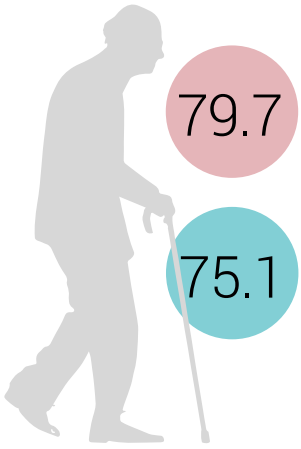
GENDER

Franklin County, 2015*



LIFE EXPECTANCY

Franklin County, 2013-2015*



AGE, RACE AND ETHNICITY

Franklin County, 2015**

AGE	MALE	FEMALE	TOTAL
Under 18 years	24.7%	22.6%	23.6%
18 to 64 years	66.1%	65.4%	65.7%
65 years and over	9.2%	12.0%	10.7%
RACE | ETHNICITY			
White Alone	68.7%	69.9%	68.3%
Black Alone	23.1%	21.8%	22.7%
Asian Alone	4.7%	4.8%	4.9%
Some Other Race (alone, or, two or more)	5.0%	4.9%	3.9%
Hispanic	4.9%	5.5%	5.0%

*Notes: Life expectancy is the average expected number of years of life remaining from a given age, in a given population, according to the current mortality experience (age-adjusted death rates) of a person in the same population. Life expectancy is calculated from a "Life Table" and is expressed as the life expectancy from birth.
Source: Ohio Department of Health Vital Statistics
**Source: U.S. Census, American Community Survey.

Franklin County Public Health

Franklin County Community Assessment

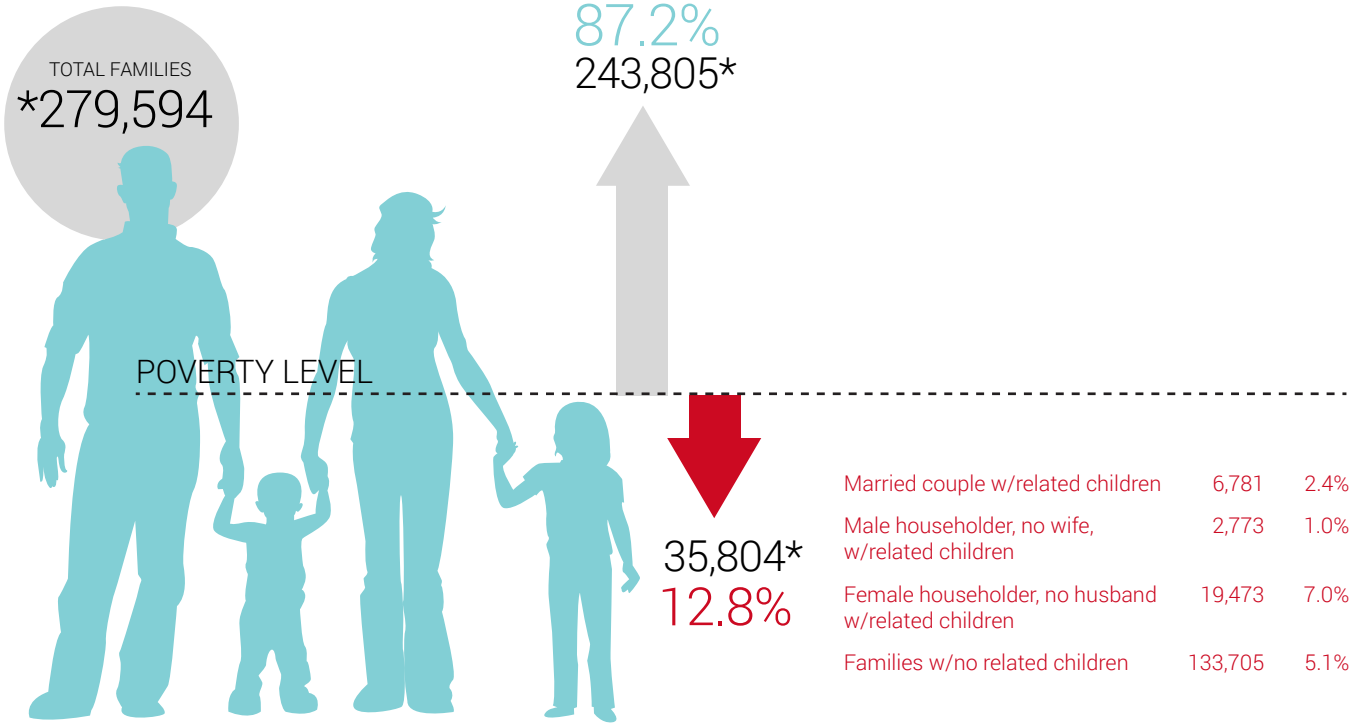
Franklin County, Ohio Demographics

ECONOMIC PROFILE

Percentage Estimates of Socioeconomic Indicators for Franklin County and the State of Ohio*

LOCATION	BELOW POVERTY LEVEL 150% FPL	AVERAGE HOUSEHOLD INCOME	COLLEGE DEGREE OR HIGHER
Franklin County	**18.0%**	$52,341	37.6%
Ohio	15.9%	$49,429	26.1%

POVERTY STATUS OF FAMILIES BY FAMILY TYPE BY PRESENCE OF RELATED CHILDREN**



Married couple w/related children	6,781	2.4%
Male householder, no wife, w/related children	2,773	1.0%
Female householder, no husband w/related children	19,473	7.0%
Families w/no related children	133,705	5.1%

Franklin County Public Health

*Source: United States Census Bureau, American Community Survey 2010-2014
**Source: U.S. Census, American Community Survey. Percentages may not sum to 100% due to rounding

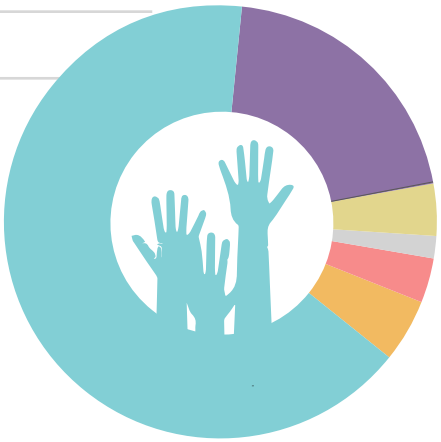
Franklin County Community Assessment

Franklin County, Ohio Demographics

DIVERSE POPULATIONS

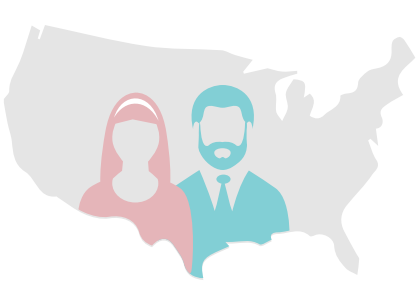
Percentage Estimates of Foreign Born and Race for Franklin County*

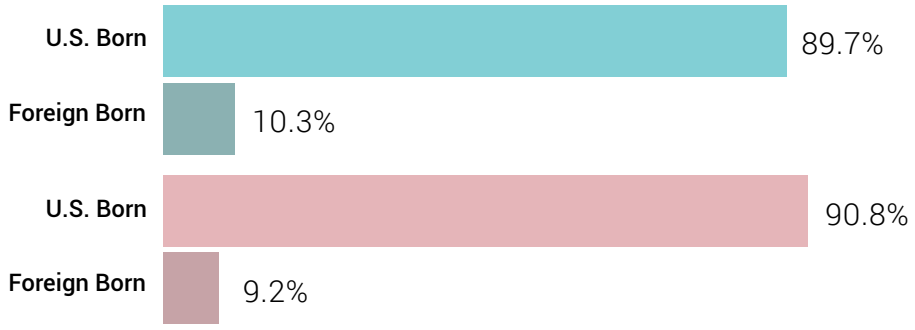
	FRANKLIN COUNTY	PERCENT
White	836,912	68.8%
African-American	259,534	21.3%
Native American	1,991	0.2%
Asian	52,431	4.3%
Pacific islander	424	~0.0%
Other	20,139	1.7%
Two or more races	44,288	3.6%
Hispanic (may be of any race)	60,943	5.0%
Total minorities	**406,810**	**32.5%**



PLACE OF BIRTH*

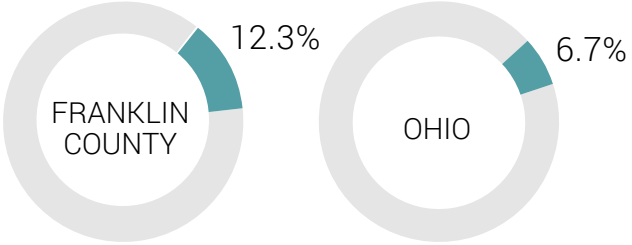
Percentage Estimates of Foreign or U.S. Born for Franklin County*





ENGLISH NOT SPOKEN AT HOME*

(English as a second language)



Franklin County Public Health

*Source United States Census Bureau, American Community Survey 2011 - 2015, 5-Year Estimates
Note: (~) notation for approximately

FINANCIAL CHARACTERISTICS :
HOUSEHOLD INCOME IN THE PAST 12 MONTHS OF OCCUPIED HOUSING UNITS*

Description	Percentage Estimate	Population Estimate
Less than $5,000	4.3%	20,681
$5,000 to $9,999	4.0%	19,238
$10,000 to $14,999	5.0%	24,047
$15,000 to $19,999	4.8%	23,085
$20,000 to $24,999	5.2%	25,009
$25,000 to $34,999	10.3%	49,537
$35,000 to $49,999	14.1%	67,813
$50,000 to $74,999	18.6%	89,456
$75,000 to $99,999	12.0%	57,713
$100,000 to $149,999	12.6%	60,599
$150,000 or more	9.1%	43,766

VETERANS

OHIO
806,531*

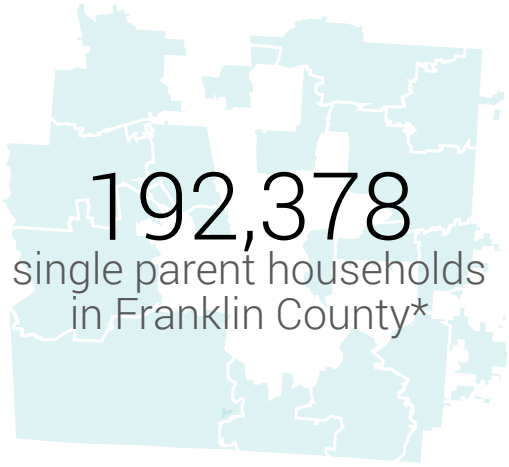
FRANKLIN COUNTY
67,576**

Franklin County Public Health

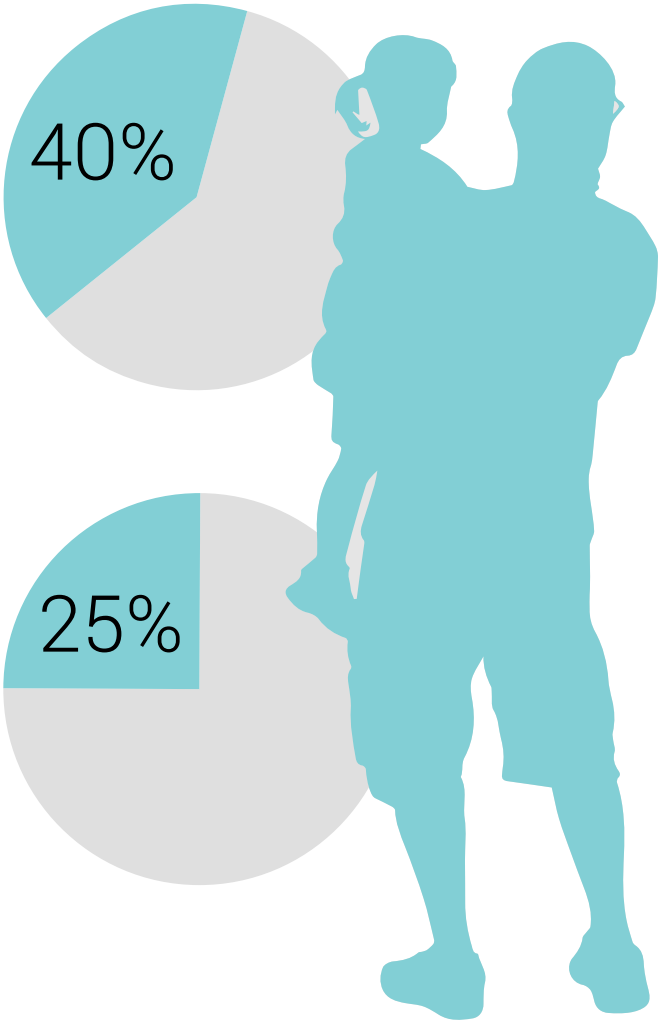
* Source: U.S. Census Bureau, 2011-2015, American Community Survey 5-Year Estimates
**Source United States Census Bureau, American Community Survey 2010-2014

Franklin County, Ohio Demographics

FAMILY AND SOCIAL SUPPORT PROFILE*



192,378
single parent households
in Franklin County*



Franklin County
Single-parent household**

Franklin County
Children Living in Poverty**

Franklin County Public Health

*Source United States Census Bureau, American Community Survey 2011-2015
** Source County Health Rankings, 2017

Community Health Assessment Filters

Franklin County Public Health, like health departments across the state and nation is redefining itself to focus on core capabilities and services while remaining committed to our strong roots of a clear mission, vision and values. We strive to prevent disease by administering evidence-based public health services. We engage our partners across the public health system related to data, planning and policy efforts. We plan for and respond to potential risks across our communities and we continue to rethink how to be more effective and efficient with our resources.

Where you live shouldn't determine how healthy you are and Public Health departments serve as the unique and essential component of an integrated health system that works for the population as a whole, rather than focusing on the health outcomes of individuals alone. FCPH is committed to strengthening its role in working with communities with a greater focus on efficient, effective practices, organization structures, finance, delivery of public health services and on-going research to identify new evidence based practice and approaches for addressing population health care needs.

Through use of the "Foundational Capabilities" model, FCPH believes it can assume a greater level of accountability for the identification, implementation, coordination and evaluation of programs and overall strategic planning for improving health in communities. The foundational area capabilities will be used to frame the process and findings of this CHA. Use of the foundational capabilities model as a frame helps determine whether or not key public health services are being adequately addressed across communities. The 5 foundational areas include:

- **Access to and Linkage with Clinical Care**
- **Chronic Disease and Injury Prevention**
- **Communicable Disease Control**
- **Environmental Public Health**
- **Maternal, Child and Family Health**

Where you live shouldn't determine how healthy you are

Franklin County Public Health

In addition, the CHA will also highlight 3 critical issues under each of the 5 foundational capability areas to ensure a holistic approach is use for addressing population health needs.

THE 3 CRITICAL ISSUES ARE:

- **a life course perspective**
- **health equity**
- **social determinants of health**

The information below highlights the importance of each of these issues.

LIFE COURSE PERSPECTIVE

A life course perspective is defined as a multidisciplinary approach to understanding the mental, physical, and social health of individuals, which incorporates both life span and life stage concepts that determine the health trajectory. This perspective came from research documenting the important role early life events play in shaping an individual's health trajectory. The outcomes of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition influence health throughout an individual's lifetime.

Health Trajectory: Health development over a lifetime that can be positively or negatively impacted by protective and risk factors.

Protective Factors: Factors that improve health and contribute to healthy development (e.g. conflict resolution skills, steady employment, good peer group, community engagement, etc.).

Risk Factors: Factors that diminish health and make it more difficult to reach one's full potential (e.g. low self-esteem, drug abuse, family distress, low literacy, etc.).

Figure 4: Life Course

HEALTH EQUITY

Health Equity is the study of differences in the quality of health and health care across different populations. This may include differences in the presence of disease, health outcomes, or access to health care across racial, ethnic, sexual orientation, disability, and socioeconomic groups. Creating health equity requires the increased capacity of state health departments and their partners to work with and through communities to implement effective responses to improve population health issues where a health disparity exist.

> **Health disparities** are particular types of health differences that are closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health and/or a clean environment based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

SOCIAL DETERMINANTS OF HEALTH (SDOH)

A model that proposes a person's health status is determined by the physical and social environment they are exposed to and that is formed through the distribution of money, power, and resources at global, national, and local levels and by the policies that influence the distribution of these factors.

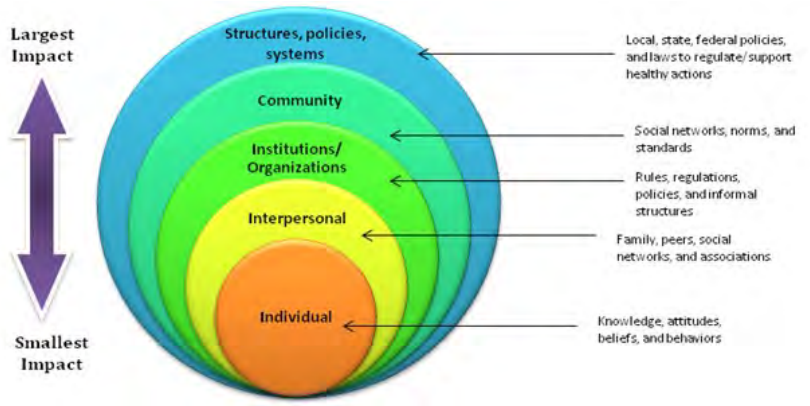


Figure 5:
The Social Ecological Model focuses on policy and environmental level interventions which are more likely to have a greater population impact on health disparities than individual-level interventions. Policy and environmental level interventions can cut across the outer three circles of this model:
1) Structures, policies, systems,
2) Community, and
3) Institutions/Organizations
(adapted from the health impact pyramid).

Social determinants are the root cause of health disparities

Franklin County Public Health

Community Health Assessment Process

Data Collection and Analysis

In order to produce a comprehensive community health assessment, FCPH began a collaborative process in the summer of 2015. FCPH utilized the Association for Community Health Improvement, Community Health Assessment Toolkit as our model in planning and conducting the CHA process. The CHA Toolkit consisted of the following steps:

Step 1: Reflect and Strategize
Step 2: Identify and Engage Stakeholders
Step 3: Define the Community
Step 4: Collect and Analyze Data
Step 5: Prioritize Community Health Issues
Step 6: Document and Communicate
Step 7: Plan Implementation Strategies
Step 8: Implement Strategies
Step 9: Evaluate Progress

The health department started with a series of internal meetings in order to: begin creating awareness around the importance of a community health assessment; engage staff and create buy-in; determine available data internally that could contribute to an assessment; and to review existing health assessments in order to assess the strengths and weaknesses of the CHAs. FCPH also gathered data from over 10 external data bases which were used as a source of information for data collection and analysis of health outcomes in Franklin County.

In addition to the internal meetings, a survey was sent out to FCPH's external partners in order to gain a greater Community Health Assessment Process understanding of what type of information the community would like to see included in the assessment. As a result of these internal meetings and the external feedback from the survey, FCPH created an outline for its community health assessment as well as a template for local community health profiles. The local community health profiles provide the different communities in Franklin County information at the zip code level when possible.

Since that time FCPH has been working to gather and analyze additional data for the CHA and created 19 individual community health profiles for the jurisdiction we serve. FCPH has included primary quanititive and qualitative data and information in its CHA. During the summer of 2016, FCPH worked with a local research firm, Community Research Partners (CRP), in order to create a community health survey. The survey was conducted during October of 2016. A total of 2,486 Franklin County residents completed the survey. The survey was predominantly completed online however, there were some respondents who filled out a paper survey (6%).

The survey collected basic socio-demographic information (age, gender, family size, income, etc.) as well as feedback on five topic areas. The five topic areas were: physical activity; healthcare; dental care; mental and behavioral health; and healthy food access. Survey respondents were asked to define the priority level these topics have in their lives and any barriers in accessing them they might experience. For full results of this survey, please refer to the Community Health Survey section or Appendix A of the CHA.

Access to Physical Activity

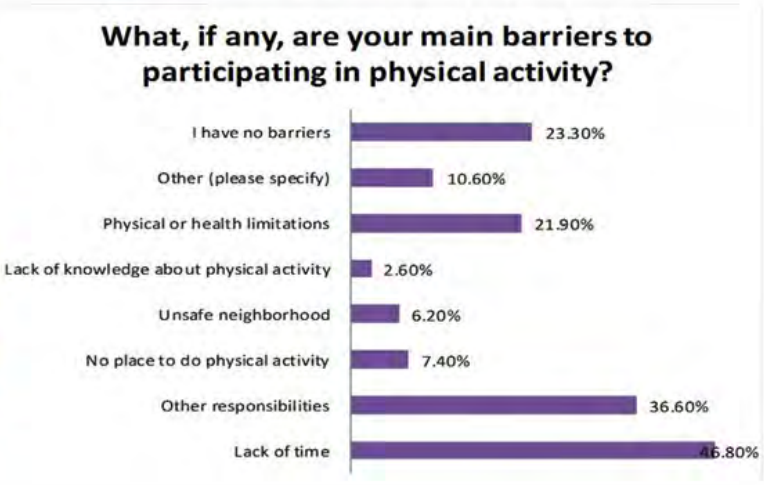
How much of a priority do you place on physical activity for yourself? (N=2,472)

Value	Percent
Very low priority	2.1%
Low priority	10.3%
Neutral	28.2%
High priority	46.3%
Very high priority	13.0%

How would you rate your access to physical activity? (N=2,466)

Value	Percent
Very low access	1.9%
Low access	10.1%
Neutral	24.6%
High Access	46.8%
Very High Access	16.6%

How do you define physical activity?



Community Engagement

The essential ingredients of this CHA are community engagement and collaborative participation. The CHA is an important piece in the development of a Community Health Improvement Plan (CHIP) because it helps the community understand the health and health related issues that need addressed. It also provides the most current and reliable information about the health status of a community and where gaps may exist in achieving optimal health.

In July of 2017, FCPH collaborated with 5 community partners: Mount Carmel East; Ohio Health Doctors Hospital; Ohio University Dublin Integrated Education Center; Madison Township Community Center; and Healthy New Albany to host Regional Forums. The information in this report represents the process and outcomes of the Northeast Regional Forum hosted by Healthy New Albany. FCPH would like to express our thanks and appreciation to Healthy New Albany for their generous contributions and support of the forums. The community forum would not have been possible without this support.

The 5 Community Forums kicked off with a welcome, introduction and overview of FCPH by the Health Commissioner. This was followed by a presentation through another collaborative partnership with Nationwide Children's Hospital (NCH). The Director and a Senior Research Scientist, from the Center for Population Health and Equity Research, Research Institute at Nationwide Children's Hospital provided information that supports why achieving health equity leads to optimal health for everyone.

FCPH collaborated with five community partners to initiate five regional health forums

NCH indicates health equity means that everyone has a fair opportunity to live a long, healthy life. It implies that health should not be compromised or disadvantaged because of an individual or population group's race, ethnicity, gender, income, sexual orientation, neighborhood or other social condition. In conjunction with health equity, social determinants of health play a large role in determining health outcomes. Social determinants of health are environmental factors in one's place of residence, work, worship, or play that affect one's quality of life and health outcomes. For example, the chart on the next page illustrates why clinical care alone isn't enough to improve health outcomes, as well as the significant importance of addressing the social determinants of health which creates an environment for achieving health equity.

At the conclusion of this presentation, forum participants broke into groups for breakout sessions where community members engaged in a dialogue and provided feedback regarding the most pressing health care needs impacting their communities. The breakout sessions process is highlighted below.

Methodology

In order to understand the health concerns of each community, breakout sessions were established and run by a facilitator. As part of the breakout sessions, a volunteer scribe was identified to write down group responses on a flip chart to keep track of all responses. A packet of questions was supplied to participants in the breakout sessions.

There were three parts to every breakout session:

- **Breakout Session Part 1** - identifying the community's assets and strengths.
- **Breakout Session Part 2** - identifying the top priority needs of their community.
- **Breakout Session Part 3** - identifying strategies to address the top five needs of the community.

Top Priority Needs

Below lists the top priority needs that were discussed the most and eventually identified as a priority by each region, in no specific order.

1. Mental health issues
2. Drug and alcohol abuse
3. Employment, poverty and income
4. Nutrition
5. Education
6. Physical activity
7. Increased access to Healthcare
8. Obesity

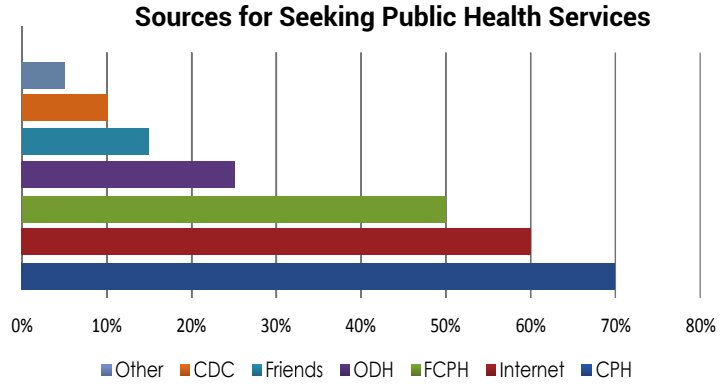
Stakeholder Interviews

Given the impact social determinants of health has on health outcomes, FCPH felt it was also important to reach out to our local partners and stakeholder agencies to obtain feedback from them on what they view as the key priority needs impacting the populations we jointly serve. In order to have a neutral party conduct a series of interviews with 20 key stakeholder agencies FCPH reached out to Mighty Crow Media, LLC to facilitate the Stakeholder Interview process. There was a two prong approach to the stakeholder interviews. Individuals from the 20 key stakeholder agencies were sent a brief survey to complete in advance of the phone interview in order for Mightly Crow Media, LLC to learn a little about the agency and determine how much the agency knew about the services provided by FCPH.Of the 20 stakeholders 95% of respondents (19 people) identified the scope as work for their agency as Local, 40% (8 people) identified their scope as State, and 15% (3 people) identified their scope as National. Breakdown by stakeholder demonstrates:

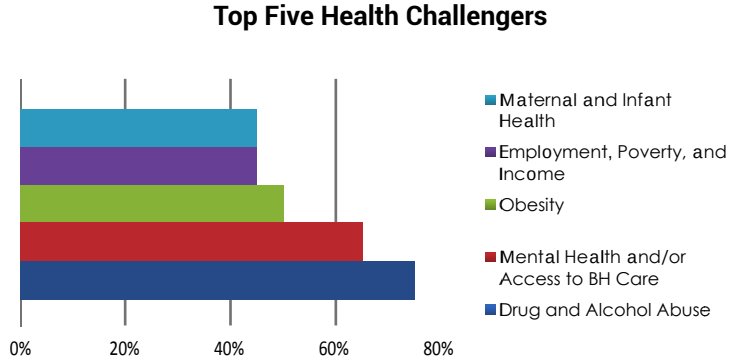
- 11 respondents identified their scope as Local only
- 5 respondents identified their scope as Local and State
- 3 respondents identified their scope as Local, State, and National

When asked ***"Where do you think people served by your organization go to seek public health services?"*** Stakeholders provided the following response:

Choices included: Franklin County Public Health (FCPH), Columbus Public Health (CPH), Ohio Department of Health (ODH), Centers for Disease Control (CDC), Friends who work in healthcare settings (Friends), and Other.



When specifically asked about the needs of the local community ***"What do you see as the TOP FIVE primary health challenges for the jurisdictions served by FCPH?*** the chart below represents stakeholder responses.



Stakeholders were asked to complete a phone interview as a follow-up to their online survey. The phone interviews lasted between 30 to 45 minutes on average and each stakeholder was asked the same series of eleven questions. Information presented below is aggregated across the 19 participants, with emerging themes identified. A total of 19 (out of 20) stakeholders completed the phone interview. During the phone interviews stakeholders were asked, "What do you believe are the main causes of the top 5 health challenges identified by the survey?" to see the full stakeholder responses to this question see Appendix C.

Community Health Profile

This section is a snapshot of the overall health and wellness of the community. While health refers to a physical body being free from diseases, wellness is an overall balance of your physical, social, spiritual, emotional, intellectual, environmental, and occupational well-being.

Health and Wellness

BIRTHS

The Counts and Rates of Births for Franklin County and the State of Ohio from 2013-2015†

	Years					
Location	**2013**		**2014**		**2015***	
	Count	**Rate /1,000 people**	**Count**	**Rate /1,000 people**	**Count**	**Rate /1,000 people**
Franklin County	24,881	20.47*	25,006	20.26*	25,521	20.39*
Ohio	139,753	12.08^	140,540	12.12^	140,121	12.07^

†Source Ohio Vital Statistics, These data were provided by the Ohio Department of Health. The Department specifically disclaims responsibility of any analyses, interpretations or conclusions.
*Rates based on 2013, 2014 and 2015 population estimates of Franklin County*and the State of Ohio^ United States Census Bureau

DEATHS

The Counts and Rates of Mortalities for Franklin County and the State of Ohio from 2013-2015†

	Years					
Location	**2013**		**2014**		**2015***	
	Count	**Rate /1,000 people**	**Count**	**Rate /1,000 people**	**Count**	**Rate /1,000 people**
Franklin County	8,836	7.28*	8,970	7.28*	9,678	7.73*
Ohio	113,296	9.79*	114,523	9.88*	118,011	10.07*

†Source Ohio Vital Statistics. These data were provided by the Ohio Department of Health. The Department specifically disclaims responsibility of any analyses, interpretations or conclusions.
*Rates based on 2013, 2014 and 2015 population estimates of Franklin County*and the State of Ohio^ United States Census Bureau

Franklin County Public Health

FRANKLIN COUNTY LEADING CAUSES OF DEATH*

FEMALES

1. Cancer
2. Heart Disease
3. Chronic Lower Respiratory Disease
4. Stroke
5. Accidents
6. Alzheimer's Disease
7. Diabetes
8. Influenza and Pneumonia
9. Sepsis
10. Chronic Kidney Disease

MALES

1. Heart Disease
2. Cancer
3. Accidents
4. Chronic Lower Respiratory Disease
5. Stroke
6. Diabetes
7. Suicide
8. Influenza and Pneumonia
9. Chronic Liver Disease
10. Homicide

FRANKLIN COUNTY

1. Cancer
2. Heart Disease
3. Accidents (Injuries & Motor Vehicle)
4. Chronic Lower Respiratory Disease
5. Stroke
6. Diabetes
7. Alzheimer's Disease
8. Influenza and Pneumonia
9. Chronic Kidney Disease
10. Suicide

FRANKLIN COUNTY OTHER CAUSES OF DEATH 2013–2015**

	AVG. NUMBER	ADR†	AVG. NUMBER	ADR†
Motor Vehicle Traffic Deaths	102	8.0	1,108	9.2

†Age-adjusted Death Rates

Franklin County Public Health

*Ohio Department of Health Vital Statistics
**Source: Ohio Department of Health Vital Statistics

CHRONIC DISEASES | 2015*

	Male (18+)	Female (18+)	TOTAL Franklin County (18+)
Overweight or Obese	**67.4%**	**62.7%**	**65.0%**
Diabetes	10.9%	10.7%	10.8%
Currently Have Asthma	7.7%	13.8%	10.9%
Coronary Heart Disease	2.2%	2.0%	2.1%
Depression	17.0%	25.1%	21.2%

Over 50% of Franklin County residents are overweight*

COMMUNICABLE DISEASES | 2015*

Indicator	Franklin County	Ohio
Incidence Rate (# of new cases per 100,000)		
Chlamydia (STD)	**788.4**	**491.4**
Gonorrhea (STD)	**272.5**	**43.6**
Syphilis - primary and secondary cases (STD)	30.3	4.9
Tuberculosis (TB)	3.2	1.2
Pertussis	18.4	7.1
Prevalence Rate		
Persons living with HIV/AIDS - 2014 (STD)	377.0	186.4

Maternal and Child Health

This section will highlight health and health related issues that impact women and infants, children, youth and children with special healthcare needs. Of special significance is the issue of infant deaths, referred to as infant mortality. Infant mortality rates are a widely accepted measure of a community's well-being. Although Franklin County is considered to be one of the more prosperous, well-educated and progressive communities, it has one of the highest infant mortality rates in the country. The infant mortality rate for black babies is two-and-a-half times that of white babies in Franklin County. Not only are too many babies dying before they reach their first birthday, too many babies in Franklin County are born too early. Disorders related to prematurity and low birth weights are the leading causes of infant deaths, and those same disorders can cause ongoing challenges for babies who survive.

Most infant deaths in Franklin County occurred when babies:

- were born too early (pre-term births are those born before 37 weeks gestation), which accounted for 54.7 percent of infant death reviews.*
- were born with a serious birth defect, which accounted for 16.3 percent of infant death reviews.*
- died due to a sleep-related cause, including asphyxia and Sudden Infant Death Syndrome (SIDS), which accounted for 13.9 percent of infant death reviews in 2015.*

INFANT DEATHS

Neonatal^ and Postneonatal^ Infant Mortality Rates for Franklin County and the State of Ohio 2013-2015**

	2013		2014		2015	
	Neonatal Deaths /1,000	Postneonatal Deaths /1,000	Neonatal Deaths /1,000	Postneonatal Deaths /1,000	Neonatal Deaths /1,000	Postneonatal Deaths /1,000
Franklin County	4.50	1.69	▲ **4.56**	▼ 1.60	▼ 3.96	▲ **1.72**
Ohio	5.21†	2.12†	▲ **4.92**	▼ 1.87	▼ 4.76	▲ **2.41**

^Neonatal - deaths before reaching 28 days, Post - neonatal deaths after 28 days but before 1 year
†Data Missing

Franklin County Public Health

* Source: Ohio Department of Health, Bureau of Vital Statistics, Franklin County Infant Mortality Profile 2015
** Source Ohio Vital Statistics, United States Census Bureau

BIRTH WEIGHTS*

Franklin County	2013	2014	2015
<3.30lbs.	2.24%	↓ 2.20%	↓ 1.98%
3.30 - 5.50lbs.	7.92%	↓ 7.29%	↑ **7.81%**
Ohio			
<3.30lbs.	1.61%	↓ 1.60%	↓ 1.48%
3.30 - 5.50lbs.	6.97%	↓ 6.93%	↑ **7.02%**

PREVIOUS PRETERM BIRTHS*

Women who delivered a live birth in a given year and reported having a previous preterm live birth that was more than three weeks before the due date

	2013	2014	2015
Franklin County	4.97%	↑ **6.14%**	↑ **7.08%**
Ohio	5.08%	↑ **5.46%**	↑ **5.57%**

MOTHER'S SMOKING STATUS, OHIO RESIDENT BIRTHS | 2015*†

	OHIO			FRANKLIN COUNTY			FRANKLIN • WIC RECIPIENTS		
	ALL RACES	WHITE	BLACK						
Smoked Pre-pregnancy	20.2%	22.0%	17.4%	15.8%	17.9%	16.6%	22.9%	36.3%	18.2%
Smoked First Trimester	14.8%	16.4%	12.2%	10.6%	12.3%	10.8%	16.3%	28.3%	11.5%
Smoked Second Trimester	12.7%	14.1%	10.0%	8.9%	10.5%	8.7%	13.8%	24.6%	9.2%
Smoked Third Trimester	12.1%	13.6%	9.3%	8.3%	10.0%	7.9%	12.7%	23.3%	8.1%
Any Smoking Before or During Pregnancy	20.4%	22.2%	17.8%	16.1%	18.1%	17.4%	23.4%	36.7%	18.9%
Quit Smoking in Third Trimester*	40.8%	39.1%	48.3%	48.7%	44.9%	55.2%	45.8%	36.6%	57.5%

*Source: Ohio Department of Health, Bureau of Vital Statistics. These data were provided by the Ohio Department of Health. The Department specifically disclaims responsibility of any analyses, interpretations or conclusions.

† Percent of women who reported smoking before pregnancy or during the first two trimesters and who did not report smoking during the third trimester

Franklin County Public Health

MATERNAL AND CHILD HEALTH | 2015*

Indicator	Franklin County	Ohio
Infant Mortality Rate (# per 1,000 live births)	7.7	7.2
Teen Birth Rate (# per 1,000 females age 15-17)	11.6	10.0
Low Birth Weight (% of all births)	8.9%	8.5%

Teen Pregnancy Prevention

9,893 teen births occurred in Franklin County, 2016**

82% of teen pregnancy is unintended**

This means that the vast majority of teens who got pregnant did not want to get pregnant at that time. Being pregnant as a teenager puts you at higher risk for having a baby born too early, with a low birth weight and more at risk of death before birth.

Tips for talking with your teen

Having "The Talk" can be hard, for both teen and parent.

For more information on talking with your teen access the links below:

www.nationwidechildrens.org/bc4teens

www.thenationalcampaign.org

Franklin County Public Health

*Ohio Department of Health Vital Statistics
**Source: County Health Rankings, 2016 Ohio

Environmental Health Factors

Environmental health is the branch of public health that is concerned with all aspects of the natural and built environment that may affect human health. Creating good health requires the practice, and study of a humans well-being related to preventing illnesses and human injuries. Environmental health includes the assessment and control of those environmental factors that can potentially affect health. This environmental health section focuses on those issues in Franklin County communities targeted towards preventing disease and creating health-supportive environments.

Homes built before 1979 may have lead-based paint*

CHILDREN'S ENVIRONMENTAL HEALTH CONCERNS*

This Community Profile includes maps that chart the number of elevated blood lead level (EBLL) reports for children ages 6 and younger.

Lead enters the body when children:

- Put their hands or other items contaminated with lead dust in their mouths
- Eat peeling lead-based paint or dirt that contains lead
- Breathe in lead dust

Lead poisoning can cause hyperactivity, language deficiency, hearing loss, aggression, and learning disabilities.

Common sources of lead:

- Paint that has deteriorated or has been disturbed through remodeling or renovation
- In soil, water, toys and jewelry
- From hobbies or occupations that come in contact with lead
- In ethnic homes, items such as folk remedies or cosmetics (Ohio Department of Health)

Franklin County Public Health

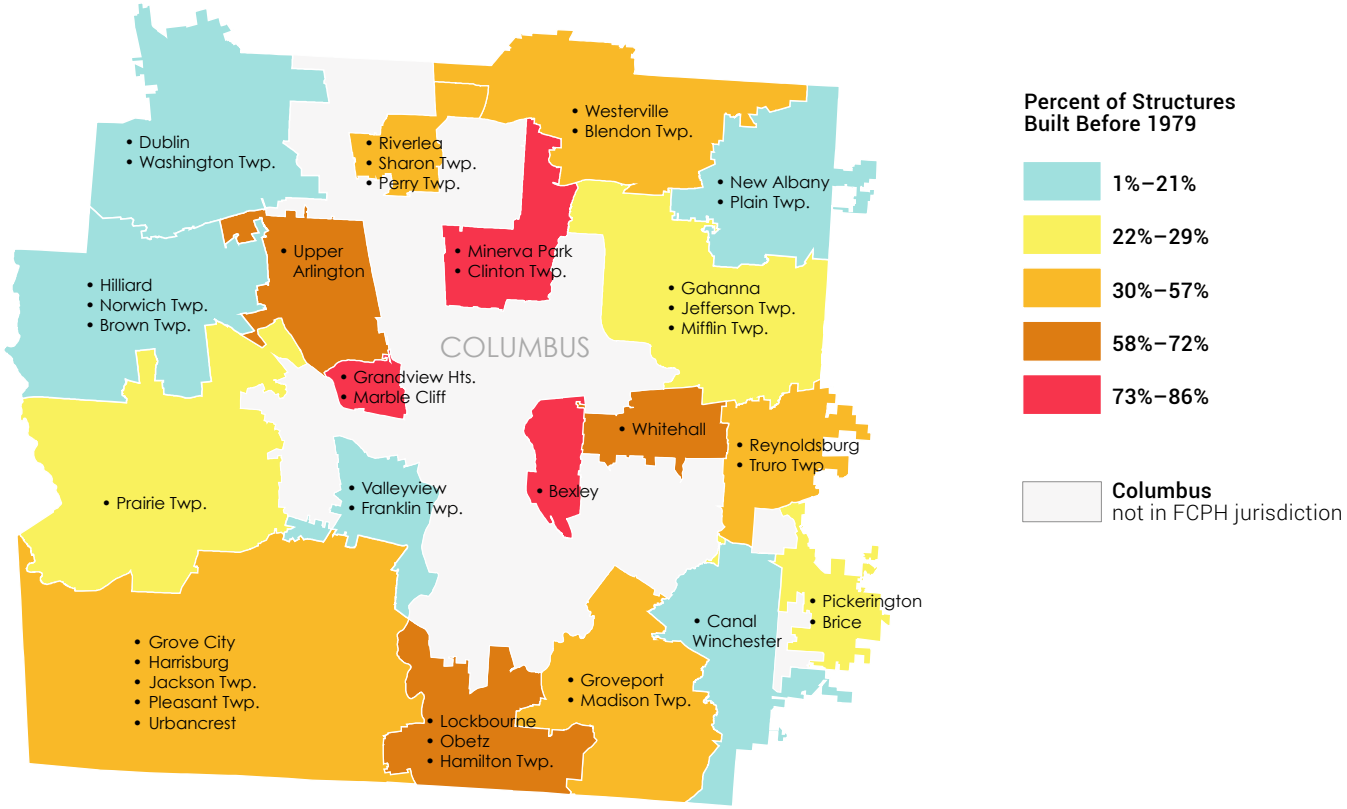
*Source: Ohio Department of Health, Healthy Homes Lead Program

LEAD LEVELS IN CHILDREN

These data represent blood lead levels confirmed by blood sample testing only. Three categories of elevated blood lead levels are represented in the chart for each year: 5-9µg/dl (micrograms per deciliter), 10-14µg/dl, and 15µg/dl and above. This data comes from the Ohio Department of Health who currently categorizes EBLL cases in two distinct categories 5-9 and 10+; there is no separate category for 15 and above.

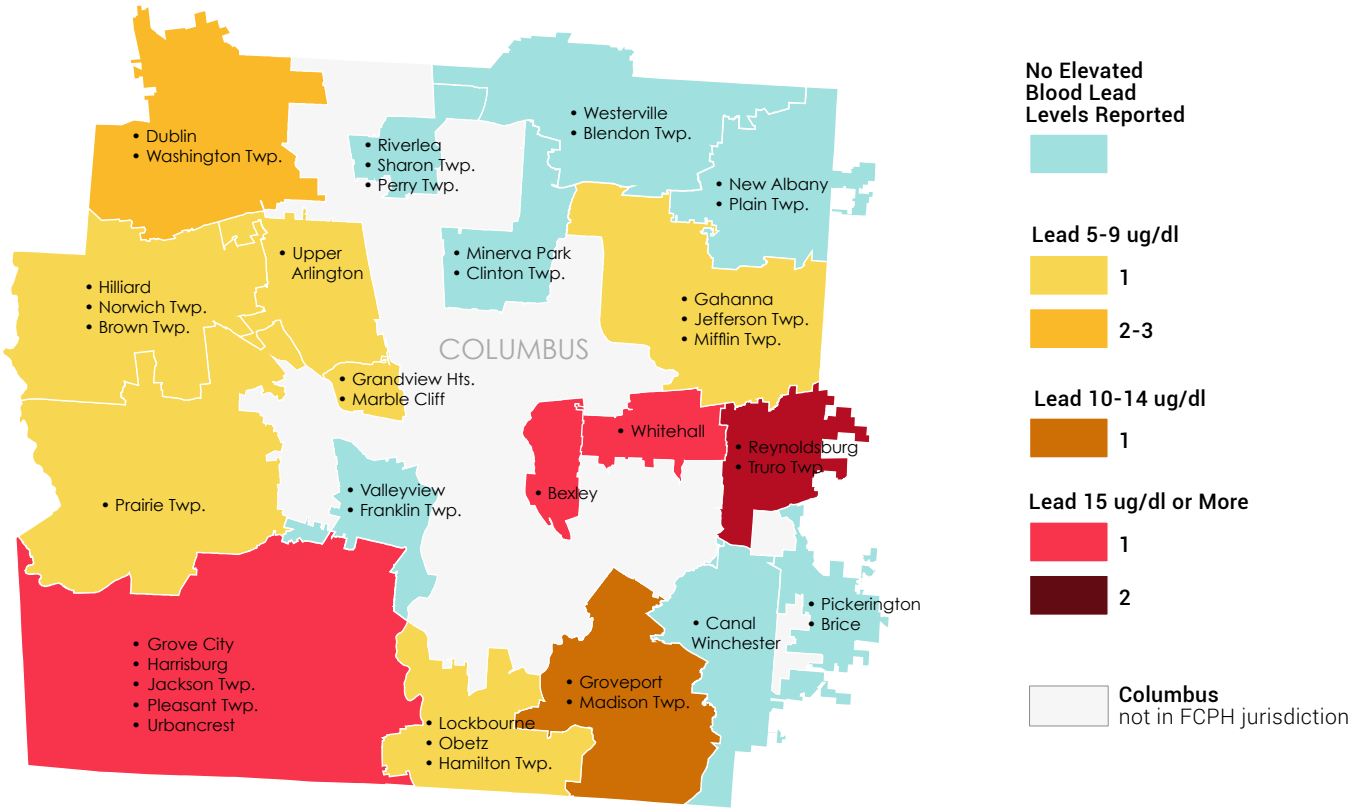
These numbers represent unique blood test dates, but not necessarily unique individuals. Children with identified, elevated blood lead levels are regularly monitored until their level drops below 5µg/dl or the child ages out of monitoring.

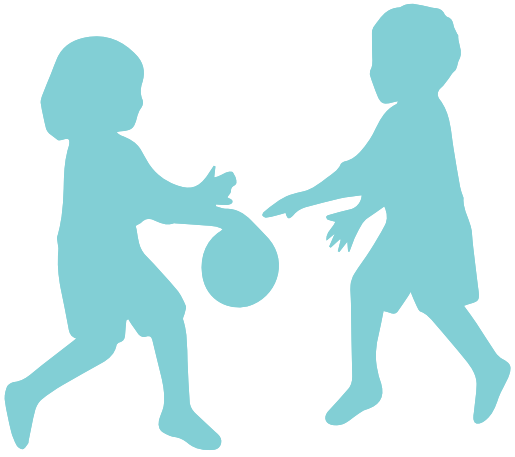
PERCENT OF HOUSING STOCK BUILT BEFORE 1979 INCREASING EXPOSURE LEAD RISK



Source: Ohio Department of Health, Healthy Homes Lead Program

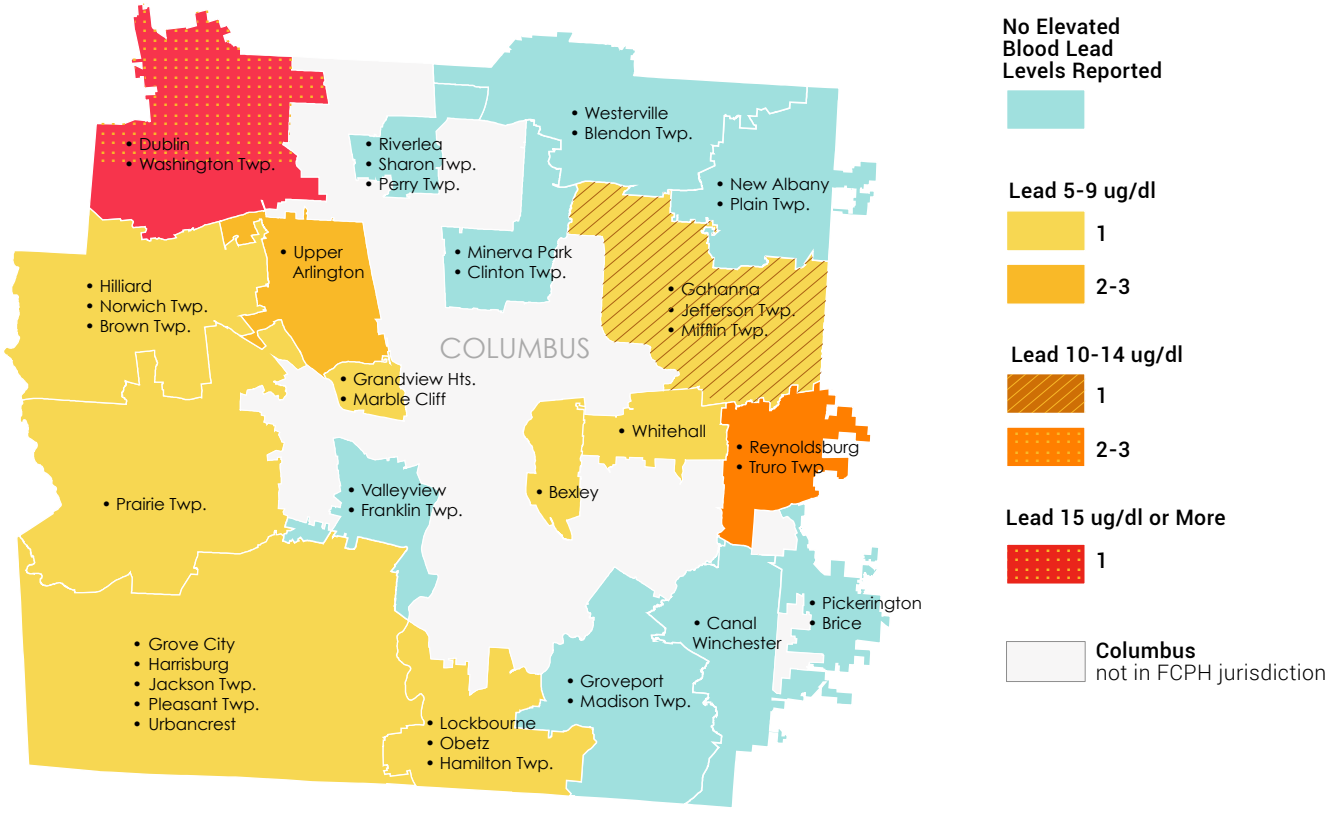
ELEVATED BLOOD LEVEL REPORTS
FOR CHILDREN AGES 6 YEARS AND YOUNGER | 2015





Source: Ohio Department of Health, Healthy Homes Lead Program

ELEVATED BLOOD LEVEL REPORTS FOR CHILDREN AGES 6 YEARS AND YOUNGER | 2016



Source: Ohio Department of Health, Healthy Homes Lead Program

Franklin County Public Health

FOOD SAFETY

Number of Food Safety Inspections in Franklin County*

Year	Number of Inspections	Number of Follow-Ups	Overall Total	Percent Increase
2016	6822	671	7493	13.48%
2015	6011	592	6603	-2.67%
2014	6401	383	6784	5.26%
2013	6117	328	6445	3.15%

The overall inspections that have been conducted in the Food Safety Program have risen nearly every year since 2013. However, due to staffing vacancies in 2015, the program saw a brief decrease in the overall total of inspection that were conducted. Since November 2015, the program has operated at full staffing levels, and continues to see an upward trend in the number of inspections conducted.

Food Safety Complaints*

Year	Complaint Investigations/Inspections (on site)	Complaints Received
2016	290	294
2015	227	238
2014	196	224
2013	211	211

Additionally, the Food Safety Program continues to see an increase in the overall number of complaints received by our department. Our program responds to every complaint that is received by our department within 48 business hours.

Temporary Licenses Issued*

Year	Temporary Licenses Issued
2016	446
2015	410
2014	390

Each year, our program conducts temporary food service inspection throughout all of our communities. The number of temporary food vendors receiving licenses has increased nearly 15% since 2014.

*Source: Franklin County Public Health, Division of Environmental Public Health, Current as of 04/04/17

POOLS, SPA AND SPECIAL USE POOLS IN FRANKLIN COUNTY*

	2015 Inspection Totals	2015 Violation Totals	2016 Inspection Totals	2016 Violation Totals
Dublin/ Washington Twp.	87	138	92	149
Sharon Twp./ Perry Twp./ Riverlea	6	20	7	8
Clinton Twp. & Minerva Park	2	5	2	3
Westerville/ Blendon Twp.	34	39	50	68
New Albany/ Plain Twp.	15	28	25	35
Gahanna/ Jefferson Twp. / Mifflin Twp.	59	122	67	120
Reynoldsburg/ Truro Twp.	39	81	33	70
Pickerington/ Brice	22	41	16	30
Canal Winchester	6	9	6	12
Groveport/ Madison Twp.	3	5	3	3
Lockbourne/ Hamilton Twp./ Obetz	8	28	9	22
Grove City/ Jackson Twp./Pleasant Twp./ Urbancrest/ Harrisburg	69	121	65	111
Whitehall	8	15	16	46
Bexley	8	13	9	10
Grandview Heights/ Marble Cliff	11	20	17	28
Upper Arlington	26	48	26	38
Franklin Twp./ Valleyview	10	28	2	4
Lincoln Village - Prairie Twp.	6	13	3	10
Hilliard/ Norwich Twp./ Brown Twp.	60	135	50	78
OVERALL TOTALS	**479**	**909**	**498**	**845**

The total number of pools licensed by Franklin County Public Health continues to increase each year resulting in increased number of inspections. The total number of violations cited each year varies however the 5 most commonly cited violations for 2015 to 2016* are as follows:

1. pH outside acceptable range of 7.2 - 7.8
2. Total alkalinity greater than 60ppm
3. Missing USCG Type IV personal flotation device with a throw line.
4. Meters and gauges not properly maintained
5. Cyanuric acid level exceeding 70ppm

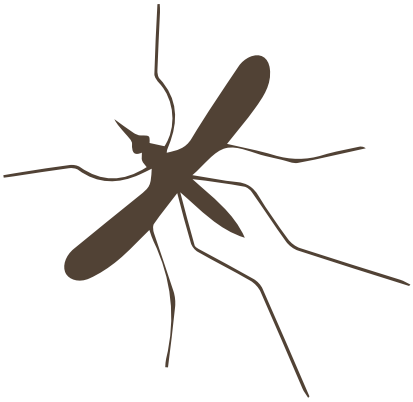
Franklin County Public Health

*Source: Franklin County Public Health, Division of Environmental Public Health, as of 04/04/17

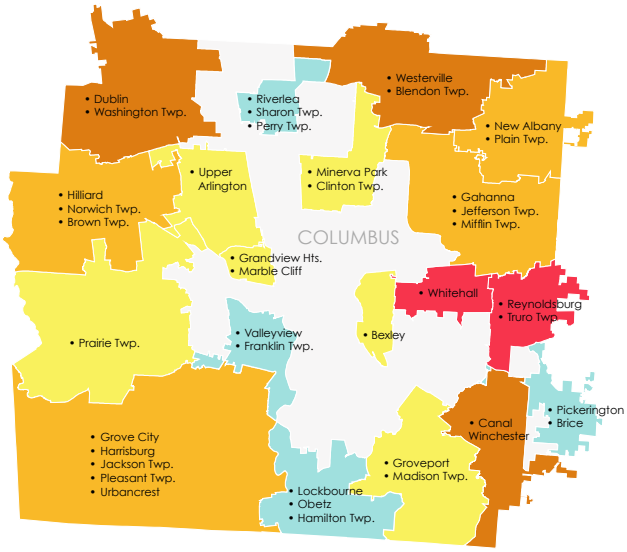
MOSQUITO-BORNE ILLNESSES

WEST NILE VIRUS

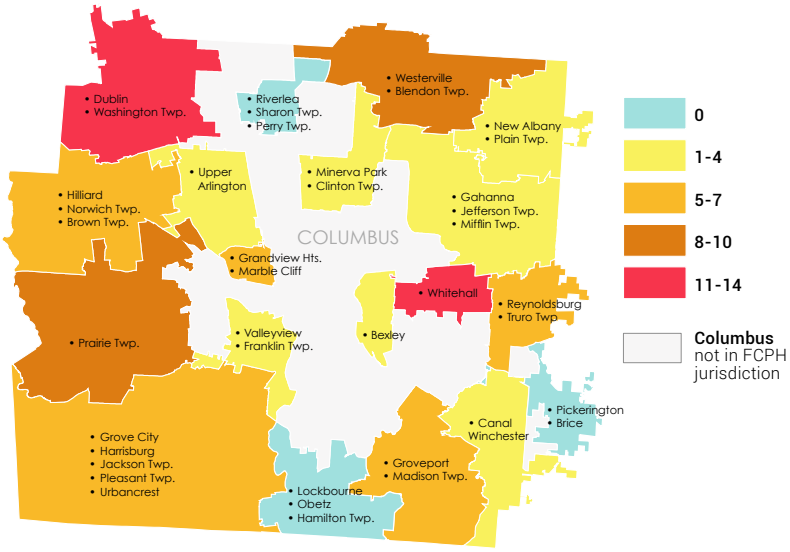
West Nile (WNV) virus is a disease transmitted to people from the bite of an infected mosquito. It has been commonly found in humans, birds and other animals in Africa, Europe, Western Asia and the Middle East. WNV is most commonly transmitted to humans by mosquitoes. The virus attacks the central nervous system causing symptoms ranging from fever and headaches to encephalitis which can be fatal. For most people the risk of catching WNV is low. People over 50 and those with compromised immune systems are the most likely to display symptoms. You can reduce your risk of being infected with WNV by using insect repellent and wearing protective clothing to prevent mosquito bites. There are no medications to treat or vaccines to prevent WNV infection.



2015 Mosquito Pools† Testing Positive for WNV*



2016 Mosquito Pools† Testing Positive for WNV*



Franklin County Public Health

† a pool is up to 50 mosquitoes

Source: Franklin County Public Health. Description: 2015 West Nile Positive Mosquito Pools by Community Profile Group

LACROSSE ENCEPHALITIS*

La Crosse Encephalitis is a viral disease spread by infected mosquitoes. It is native to the upper Midwest and Appalachia, and was first diagnosed in La Crosse, Wisconsin in 1963. The virus can cause symptoms including fever, headache, nausea, fatigue, and vomiting. More severe effects usually occur in children and can include seizures, coma, paralysis, and permanent brain damage. These symptoms typically occur 5 to 15 days after being bitten. Children under sixteen and those with compromised immune systems are at the greatest risk.

TICK-BORNE DISEASE*

What diseases do ticks transmit? In Ohio, there are three (3) diseases that are of concern: Lyme disease, Rocky Mountain spotted fever and Ehrlichiosis. Ticks are abundant in the spring and summer months and it is important to protect yourself from tick bites and reduce your risk of tick borne diseases. Ticks are most commonly found in wooded and bushy areas and where there is high grass. Avoiding these areas is the best prevention, but insect repellents and wearing light colored clothing is also important to protect yourself.

VECTOR-BORNE DISEASE**

	2014 Confirmed and Probable		2014 All Statuses		2015 Confirmed and Probable		2015 All Statuses		2016 Confirmed and Probable		2016 All Statuses	
Population	**1,231,393**				**1,251,722**				**1,264,518**			
Disease Name	**Cases**	**Rate††**	**Cases**	**Rate††**	**Cases**	**Rate††**	**Cases**	**Rate††**	**Cases**	**Rate††**	**Cases**	**Rate††**
Eastern equine encephalitis virus disease	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
La Crosse virus disease (other California serogroup virus disease)	1	0.1	2	0.2	0	0.0	0	0.0	0	0.0	0	0.0
Lyme disease	**19**	**1.5**	**43**	**3.5**	**21**	**1.7**	**44**	**3.5**	**19**	**1.5**	**51**	**4.0**
Spotted fever rickettsiosis, including Rocky Mountain spotted fever (RMSF)	1	0.1	7	0.6	1	0.1	4	0.3	2	0.2	6	0.5
St. Louis encephalitis virus disease	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
West Nile virus infection	0	0.0	0	0.0	7	0.6	7	0.6	2	0.2	3	0.2
Western equine encephalitis virus disease	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

†† Rate per 100,000population

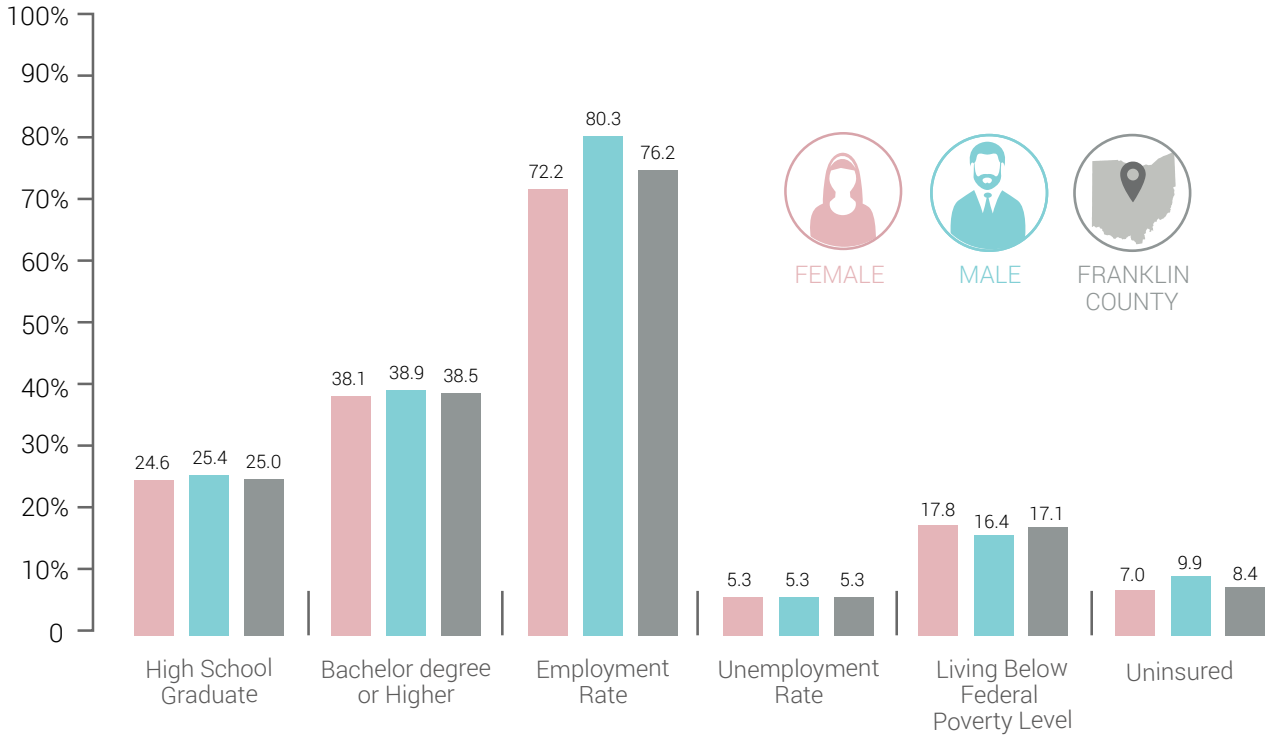
† a pool is up to 50 mosquitoes
*Source: Franklin County Public Health. Description: 2015 West Nile Positive Mosquito Pools by Community Profile Group
**Franklin County/City of Columbus Annual Summary of Reportable Diseases, 2016

Social Determinants of Health

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships.

The conditions in which we live explain in part why some individuals are healthier than others. The data in this section highlights some of social factors in Franklin County communities that contribute to or hinder good health.

SOCIAL DETERMINANTS FRANKLIN COUNTY, 2015*



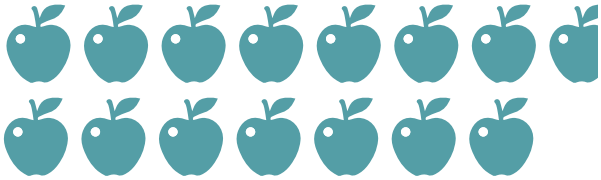
Franklin County Public Health

*Data Source: U.S. Census, American Community Survey 2015

HOUSEHOLDS RECEIVING SNAP-BENEFITS

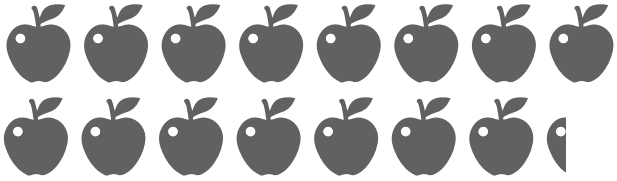
Supplemental Nutrition Assistance Program

Franklin County Households Receiving SNAP*



14.89%

Ohio Households Receiving SNAP*



15.03%

HOUSING

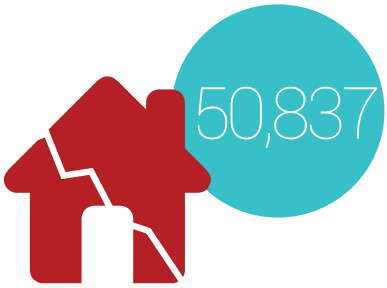
Percentage of households (2008-2012) with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities†

Franklin County Public Health

*Data Source: US Census Bureau, American Community Survey. 2011-15. Source geography: Tract
†Source: County Health Rankings, 2016 Ohio data

CRIME RATE IN FRANKLIN COUNTY

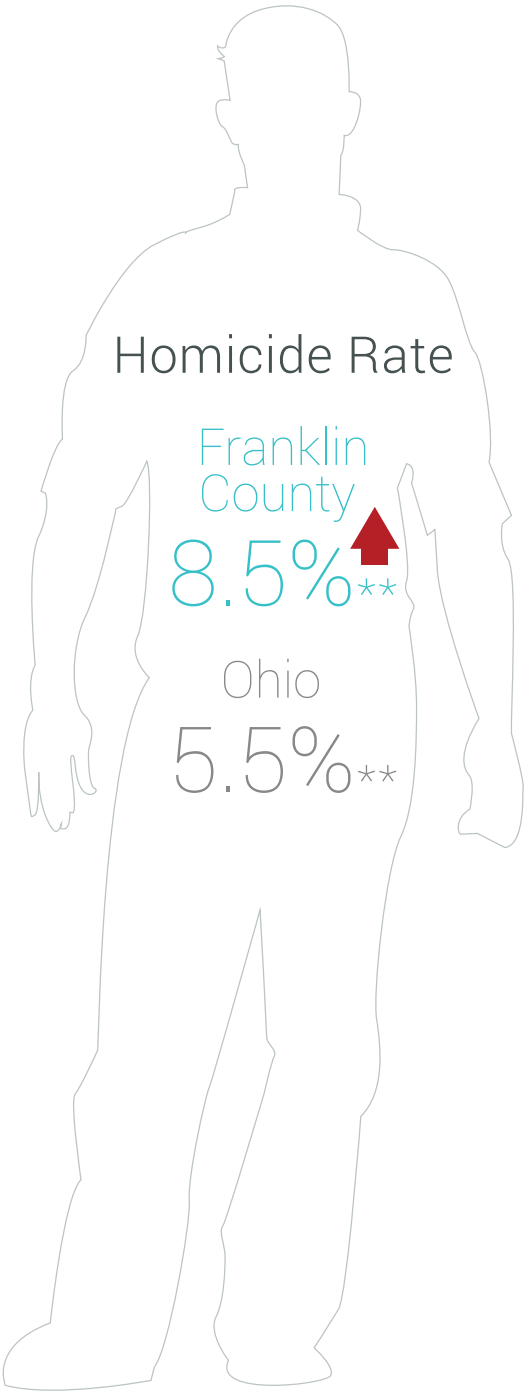
Property crime



Violent crimes

Arson

Homicide Rate



Franklin County Public Health

*Data Source: US Census Bureau, American Community Survey. 2011-15. Source geography: Tract
**Source: Centers for Disease Control and Prevention, National Vital Statistics System

Community Health Behaviors

A community's health behavior's are made up of a combination of knowledge, practices, and attitudes that together contribute to motivate the actions individuals take regarding their health. A health behavior is an action taken by a person to maintain, attain, or regain good health and/or to prevent illness. Health behavior reflects a person's health beliefs. Some common health behaviors are exercising regularly, eating a balanced diet, and obtaining necessary immunizations. This profile section highlights some of the health behaviors of the Franklin County community.

UNHEALTHY BEHAVIORS AND CONDITIONS*

- Of the 88 Counties in Ohio, Franklin county is ranked 58th for Quality of Life
- Although, 95% of Franklin County residents have access to exercise opportunities, only 22% say they have time for physical activity.
- 38% of Adults in Franklin County get insufficient sleep
- Franklin County has 105,600 uninsured adults

SMOKING*

Behavior Prevalence (18 years and older)	Franklin County	Ohio
Current smokers	25.2%	21.6%

NUTRITION BEHAVIORS**

- 72,903 residents have limited access to healthy foods
- 20% of Franklin county residents participate in excessive drinking

The Rate of Access in Franklin County to Fast Food Restaurants**

Report Area	Total Population	Number of Establishments	Establishments Rate per 100,000 Population
Franklin County	1,163,414	1,123	**96.53**
Ohio	11,536,504	9,117	79.03
United States	312,846,570	233,392	74.6

The Rate and Number of Grocery Stores in Franklin County**

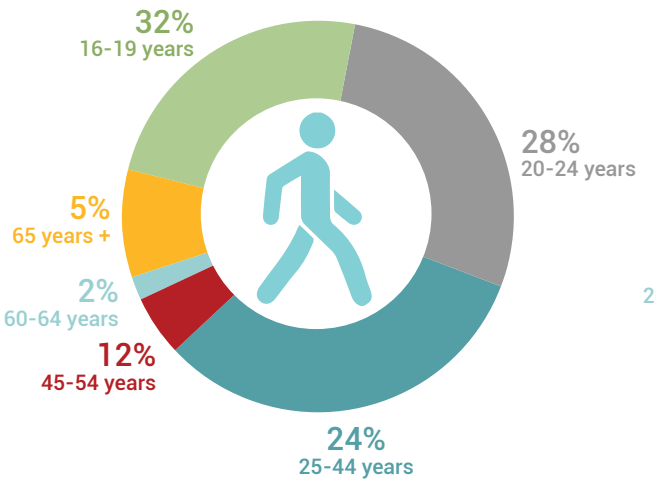
Report Area	Total Population	Number of Establishments	Establishments Rate per 100,000 Population
Franklin County	1,163,414	258	22.18
Ohio	11,536,504	2,033	79.03
United States	312,846,570	233,392	17.62

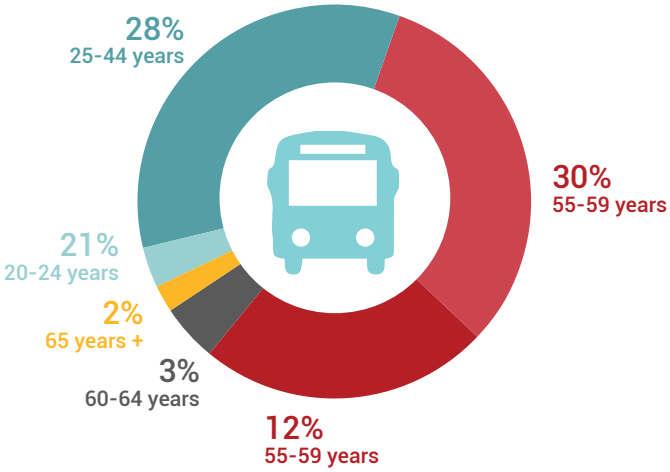
*Source: Ohio Department of Health Vital Statistics, 2015. These data were provided by the Ohio Department of Health. The Department specifically disclaims responsibility of any analyses, interpretations or conclusions.

**Note: This indicator is compared with the state average.
Data Source: US Census Bureau, HYPERLINK "http://www.census.gov/econ/cbp/" \t "_blank" County Business Patterns. Additional data analysis by HYPERLINK "http://cares.missouri.edu/" \t "_blank" CARES. 2015. Source geography: County

Franklin County Public Health

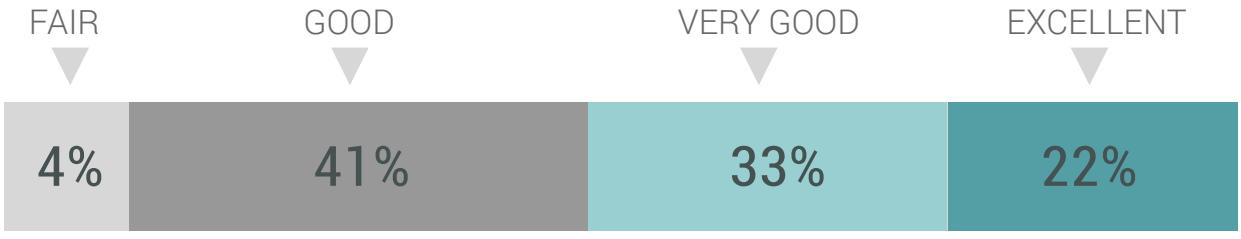
ACTIVE TRANSPORTATION - WALKING OR PUBLIC*





ADULTS WITH GOOD OR BETTER HEALTH**

Self-rated health refers to a question such as "in general, would you say that your health is excellent, very good, good, fair, or poor?" in a survey questionnaire in which participants assess their own health. This survey technique is commonly used in health research for its ease of use and its power in measuring health. The self-rated health question is purposely vague so as to seize people's own assessment of health according to their own definition of health. Although the answer to the self-rated health question is based on what people think—and thus is subjective—it is a statistically powerful predictor of mortality in the general population.†



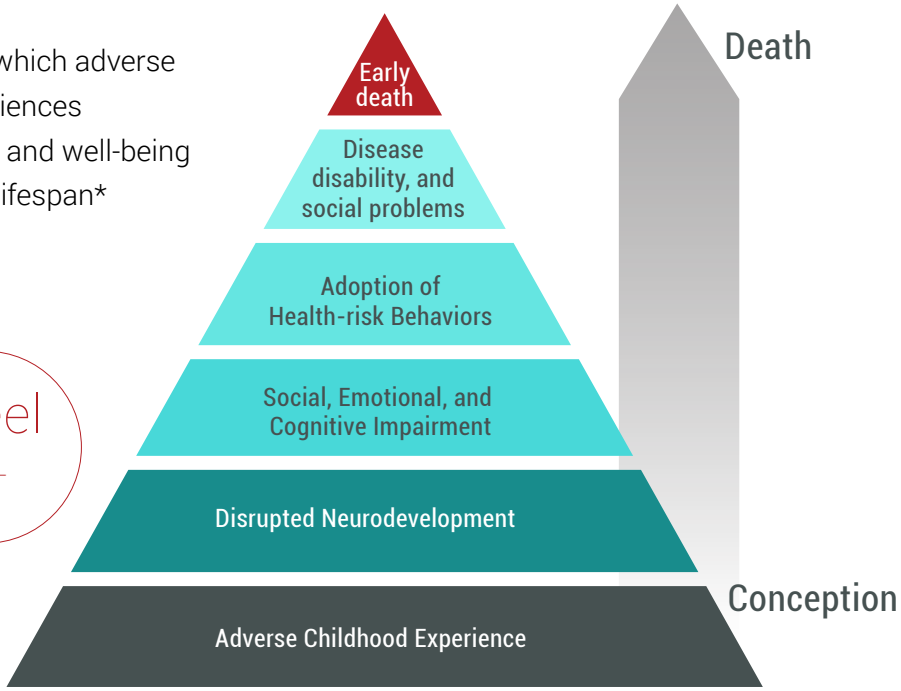
*Source: US Census Bureau, 2011-2015 American Community Survery 5-Year Estimates
**Source: CDC, Behavioral Risk Factor Surveillance System, 2016
† Idler, Ellen L; Benyamini, Yael (1997). "Self-rated health and mortality: a review of twenty-seven community studies." *Journal Of Health And Social Behavior*. 38 (1): 21–37. doi:10.2307/2955359.

Franklin County Public Health

Mental Health and Addiction

A community that is steadily growing and becoming increasingly diverse may experience challenges which have an impact on its residents. The Mid-Ohio Regional Planning Commission anticipates that dramatic changes will occur in the Central Ohio region in the next 20 years. Over 500,000 new people are expected to move into the region, raising the total number of residents to approximately 2.5 million by 2030. These figures imply significant change and challenges for all communities of the region in coming years. These challenges may present in various forms such as increased: crime, poverty, drug use, etc. Cities should be prepared to address these issues.

Mechanism by which adverse childhood experiences influence health and well-being throughout the lifespan*



12% of youth feel disconnected†

OTHER CAUSES OF DEATH**

Indicator	2013 - 2015			
	AVG. NUMBER	ADR†	AVG. NUMBER	ADR†
Suicide	147	11.8	1,553	13.0
Unintentional Overdose	224	17.5	2,563	23.0

†Age-adjusted Death Rates

*Source: https://www.cdc.gov/violenceprevention/acestudy/about.html

**Source: Ohio Department of Health Vital Statistics. These data were provided by the Ohio Department of Health. The Department specifically disclaims responsibility of any analyses, interpretations or conclusions.

†Source: County Health Rankings, 2016 Ohio Data

Franklin County Public Health

DRUG DROP BOX

Recognizing that rates of prescription drug abuse in the United States are alarmingly high and difficult to address, communities may want to consider implementing a Drug Drop Box Program to combat legally prescribed drugs for illegal sales and abuse.

The program provides a safe and convenient manner in which the residents can dispose of expired or unneeded prescribed or over the counter medications, many of which are controlled substances.

NALOXONE

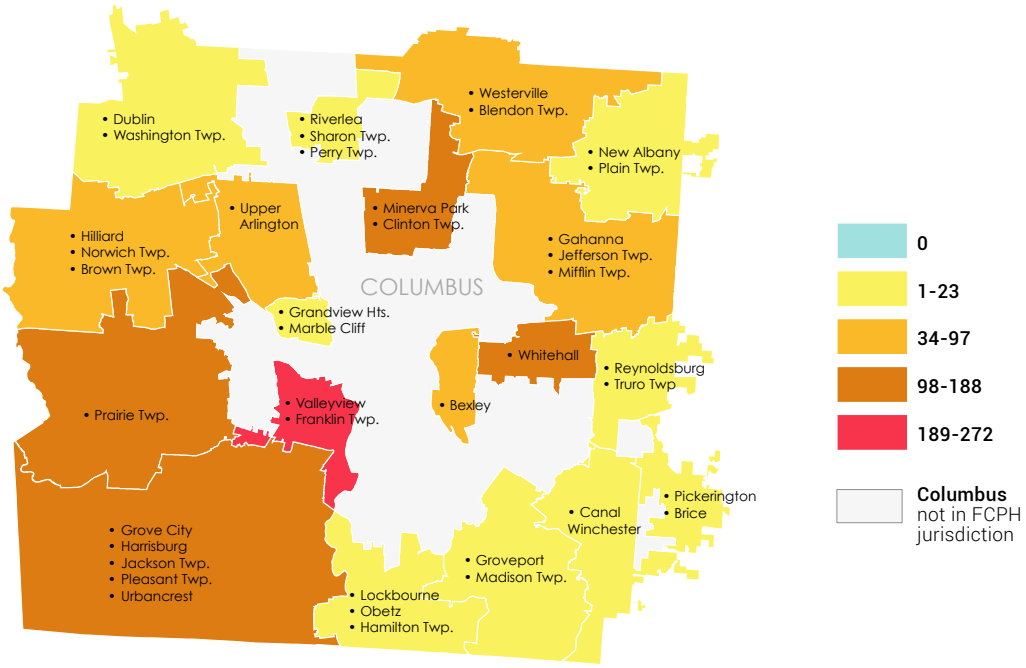
Naloxone is a medication designed to rapidly reverse opioid overdose. It is an opioid antagonist—meaning that it binds to opioid receptors and can reverse and block the effects of other opioids. It can very quickly restore normal respiration to a person whose breathing has slowed or stopped as a result of overdosing with heroin or prescription opioid pain medications.

Franklin County Public Health offers free training courses in the community that teach how to administer Naloxone to someone who has overdosed.

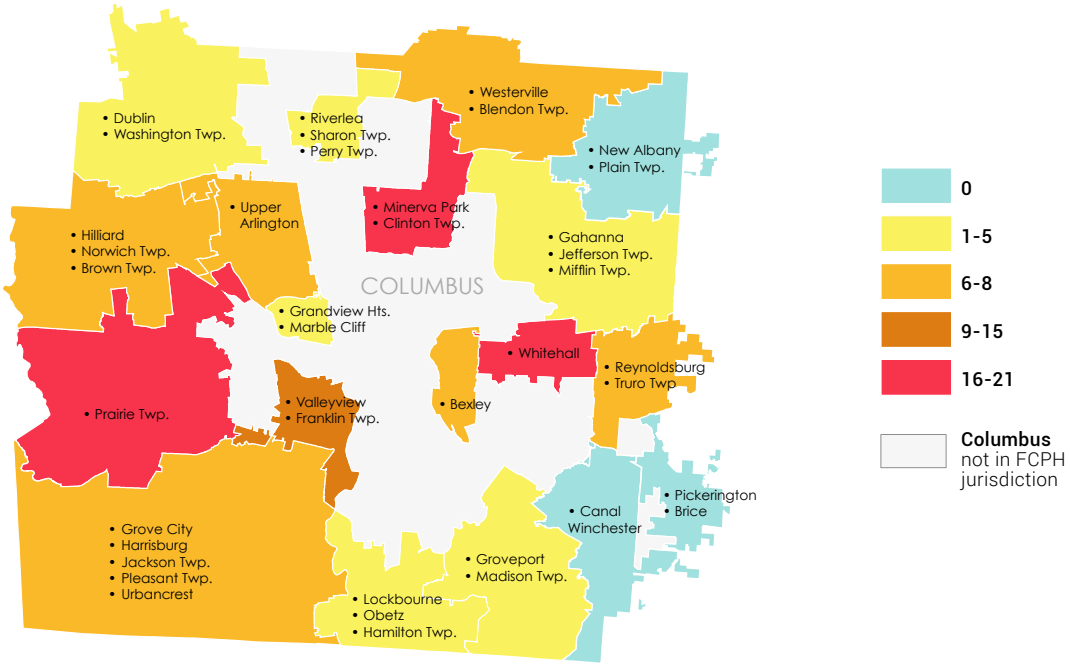
Franklin County Public Health

DRUG AND OPIOID MANAGEMENT

2015 EMS Naloxone Administrations*



2015 Unintentional Opioid Overdose Deaths **



Franklin County Public Health

*Source: Ohio Department of Public Safety
** Ohio Department of Health, Bureau of Vital Statistics, Ohio Certificates of Death

Conclusion and Next Steps

Understanding the chronic health conditions, barriers in access to care, and other social determinants of health concerns can help direct resources where they will have the biggest impact on ensuring that Franklin County residents have good health outcomes. The intent of FCPH in conducting community forums is to get direct feedback from individuals that live, work and play in the communities we serve about the factors that impact health. In addition, feedback generated from the Community Health Assessment process will be shared with a wide range of stakeholders, leaders of Franklin County agencies, Health Works Franklin County, and the public, with the intent that the report will be used to identify areas where: more data and analysis is needed; to inform local planning efforts; and to direct resources.
Please note: In creating a community profile with data specific to a county there were some limitations that FCPH would like to acknowledge:

1. Zip code level populations are determined by the U.S. Census data every 10 years through statistical methods, data during years outside of the official census at the zip code level tends to be population estimates because zip codes were originally created to facilitate mail delivery.

2. Zip codes can cross city or county boundaries which is why some of the counts are higher than city estimates. Rates and percentages used in this profile are calculated as approximations based upon this knowledge and final counts.

3. Data only represents the population during a specified period of time. Therefore, some of the rates were calculated based specifically on the 2010 census, and estimated population counts after 2010 where complete data is available, we are not able to account for certain years (such as 2016) when the full data is not available or is preliminary.

Overall, Franklin County shows a diverse community that is growing. Specific health and health related areas to watch are the number of homicides; risk factors related to infant deaths such as the mother smoking before and during pregnancy; and unintentional drug related or opiate deaths. Our next steps will be to utilize the information, data and feedback from the Surveys, Community Forums and Stakeholder Interviews to identify the top priorities, FCPH and its partners will collaboratively focus on in drafting the Community Health Improvement Plan.

Sources and Notes

1. Source: Ohio Department of Health Vital Statistics, Analysis by Columbus Public Health.
   Notes: 1Ranking based on number of cases. 2 pages included.

2. **COMMUNICABLE DISEASE DATA**
   Source: **Pertussis**: Pertussis, Franklin County: Columbus Public Health and Franklin County Public Health. Annual Summary of Reportable Diseases, 2015. *http://idrsinfo.org/pdfs/ Annual%20Summaries%202015_9.14.2015.pdf.* Ohio (preliminary): Ohio Department of Health, Bureau of Infectious Disease. Reported Cases of Selected Notifiable Diseases - Ohio: 2015 Quarter 4. *http://www.odh.ohio.gov/healthstats/disease/idann/idann.aspx*.

   Notes:
   The incidence rate is reported for Syphilis (primary & secondary cases combined), Chlamydia, Gonorrhea, and Tuberculosis. The incidence rate is the number of new confirmed cases reported in a given year per 100,000 population. This information may include persons younger than 18 years of age.
   Pertussis rates include confirmed and probable cases.
   The prevalence rate is reported for persons living with HIV/AIDS. This represents persons diagnosed and reported with HIV or AIDS as of June 30, 2015 who have not been reported as having died as of Dec. 31, 2014. The rate is the number of persons per 100,000 population (using 2014 Census). Data reported through December 31, 2014.
   Diagnosis of HIV infection include persons with a diagnosis of HIV infection (not AIDS), a diagnosis of HIV infection and later AIDS diagnosis, and concurrent diagnoses of HIV infection and AIDS.

3. **MATERNAL AND CHILD HEALTH DATA**
   Source:
   Ohio Department of Health Vital Statistics Data Analyzed by Columbus Public Health. Ohio Department of Health Population Data for Calculating Rates

   Notes:
   Infant Mortality Rate is the number of deaths to infants under 1 year of age (364 days and younger) per 1,000 live births in a given year.
   Teen Birth Rate is number of births to those ages 15 - 17 years per 1,000 females ages 15-17 years.
   Low Birth Weight Birth: A low birth weight birth is a birth to a baby who weighs less than 2,500 grams.

4. **UNHEALTHY BEHAVIORS & CONDITIONS DATA**
   Source:
   Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2015.

   Notes:
   Due to changes made to the Behavioral Risk Factor Surveillance System(BRFSS) weighting structure for 2011, data for 2011 and after CANNOT be compared to 2010 or earlier data.
   Overweight or obese indicates those with a body mass index (BMI) of 25 or higher.
   Indicators are percent of adults ages 18 and older reporting these behaviors and conditions.

5. "US Gazetteer files 2010". United States Census Bureau. Retrieved 2013-01-06 Sies, Mary Corbin; Silver, Christopher (1996). Planning the twentieth-century American city. *JHU Press*. p. 234. ISBN 0-8018-5164-5
6. Ohio Department of Health's Quality Indicators Report, 2015
7. National Center for Education Statistics, 2013-2014
8. Ohio Department of Education's Enrollment Data, 2014
9. Franklin County Public Health, Division of Environmental Health, 2015
10. HandsOn Central Ohio, 2015

References

Frieden, T.R. (2010). A framework for public health action: The Health Impact Pyramid. *American Journal of Public Health*, 100(4):590-595.

U.S. Department of Health and Human Services, Office of Minority Health (Draft). National partnership for action to end health disparities. Chapter 1: Introduction. s.l. : Retrieved from http://www.minorityhealth.hhs.gov/npa/templates/browse.aspx?&lvl=2&lvlid=34.

(2011), National Partnership for Action to End Health Disparities. Frequently asked questions. s.l.: Retrieved from http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=a&lvlid=5.

The Impact of Early Adversity on Children's Development, 2009. Cambridge, MA. Harvard Center on the Developing Child

Kotelchuck, M. Building on Life-Course Perspective in Maternal and Child Health Maternal and Child Health Journal 2003;7(1): 1-74

Halfon N Hochstein M. Life course health development: An integrated framework for developing health policy, and research The Milbank Quarterly 2002;80(3):433-479.

Franklin County Community Profile

Table 1.
1. United States. Census Bureau, American Community Survey 1 Year Estimates; 2013
2. United States. Census Bureau, American Community Survey; 2013
3. United States Census Bureau, American Community Survey 1 Year Estimates; 2013

Table 2.
1. United States Census Bureau, 2010 Census;
2. United States Census Bureau, American Community Survey 1 Year Estimates; 2013
3. United States Census Bureau, American Community Survey 1 Year Estimates; 2013
4. United States Census Bureau, American Community Survey; 2013

Social Determinants of Health For Franklin County

Table 3.
1. United States Census Bureau, American Community Survey; 2013
2. United States Census Bureau, American Community Survey 1 Year Estimates; 2013
3. United States Census Bureau, American Community Survey; 2013

Table 4.
1. United States Census Bureau, American Community Survey; 2013

Table 5.
1. United States. Census Bureau, American Community Survey; 2013
2. United States Census Bureau, American Community Survey 1 Year Estimates; 2013
3. United States. Census Bureau, American Community Survey; 2013
4. Feeding America; 2012
5. United States Department of Agriculture; 2010

Health Topic Areas, Franklin County Indicators

Table 1.
1. Ohio Department of Health Vital Statistics Data; 2015
2. State Hospital Discharge Data; 2008,
3. Healthy People, developed by the U. S. Department of Health and Human Services, www.healthypeople.gov
3. Linked Birth/Infant Death Data Set; Centers for Disease Control and Prevention, National Center for Health Statistics (CDC/NCHS); 2006
4. Ohio Department of Health Vital Statistics Data; 2015
5. Ohio Department of Health Oral Health Surveillance System
6. Ohio Department of Health Vital Statistics Data; 2006-2008 year estimates
7.
8. Centers for Disease Control and Prevention (CDC). MMWR Morb Mortal Wkly Rep. 2005 Jan 14; 54(1):1-3.

References

Health Topic Areas, Franklin County Indicators (contd.)

Table 2.
1. Ohio Department of Health, Office of Vital Statistics; 2008 -2011
2. Ohio Department of Health, Office of Vital Statistics; 2014
3 ."Injury Among Older Adults in Ohio, 2004–2009"

Table 3.
1. U.S. Bureau of Labor Statistics, U.S. Department of Labor, Survey of Occupational Injuries and Illnesses in cooperation with participating state agencies; 2015

Table 4.
1. Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2015
2. Ohio Department of Health Cancer Incidence Surveillance System; 2011-2013
3. Franklin County Community Health Risk Assessment; 2005-2006

Table 5.
1. FC YNA Youth Survey, Community Research Partners; 2016
2. Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2015
3. Franklin County Community Health Risk Assessment; 2005-2006
4. Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2013

Table 6.
1. Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2015
2. Franklin County Community Health Risk Assessment; 2005-2006

Table 7.
1.U.S. Census Bureau; 2011-2015 American Community Survey 5-Year Estimates

Table 8.
1. U.S. Census Bureau; 2015 American Community Survey 1-Year Estimates
2. Feeding America; Map the Meal Gap Report; 2016
3. Feeding America; 2012
4. Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2015
5. Franklin County Community Health Risk Assessment; 2005-2006

Table 9.
1. United States Environmental Protection Agency; 2015
2. Ohio Environmental Protection Agency; 2014
3. Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2015

Table 10.
1.Office of Criminal Justice Services; 2012
2.Ohio Department of Health, Vital Statistics; 2010-2012
3.Centers for Disease Control and Prevention, National Center for Health Statistics; 2010-2012

Table 11.
1. U.S. Census Bureau; 2015 American Community, 1 year estimates
2. Ohio Department of Administrative Services; 2014
3. Ohio Chemical Dependency Professionals Board; 2014
4. Franklin County Community Health Risk Assessment; 2005-2006

Appendix A:

Community Research Partners Survey Data Franklin

COMMUNITY RESEARCH PARTNERS

Franklin County Public Health

Community Health Assessment: Survey Analysis

November 2016

Community Research Partners

Lynnette Cook, Ph.D., Executive Director
Megan Johanson, Ph.D., Director of Research and Data Services
Becky Zwickl, MPH, Senior Research Associate
Jacob Cunliffe, MSc, Research Associate

399 E. Main St., Suite 100
Columbus, OH 43215
t: 614-224-5917 f: 614-224-8132
www.researchpartners.org

CRP is a non-profit research, evaluation, and data center based in Columbus, Ohio, with a mission to strengthen communities through data, information, and knowledge. CRP is a partnership of the City of Columbus, United Way of Central Ohio, The Ohio State University, and the Franklin County Commissioners. CRP is also central Ohio's data intermediary, and a partner in the Urban Institute's National Neighborhood Indicators Partnership. Since its inception, CRP has undertaken hundreds of projects in central Ohio, statewide, and across the country.

Contents

Data notes:

- Franklin County Public Health (FCPH) and Community Research Partners (CRP) developed the survey to supplement FCPH's ongoing Community Health Assessment.
- The survey was distributed mainly via email. FCPH also distributed paper copies.
- Emails with the survey link went out to FCPH and CRP's contact lists. The survey link was also posted on the NextDoor website, which seemed to drive a lot of traffic. Only 6% of respondents filled out paper surveys.
- Survey was open September – October 2016
- CRP utilized SurveyGizmo's data cleaning features to remove 20 respondents from the analysis who responded so quickly that it is unlikely they read the questions before responding (measured by looking at average time spent per question answered).
- CRP removed responses from people who only answered demographic questions.
- All responses captured in this document are considered "complete", though Ns may vary by question. The N for each question is specified in the table of contents and the visualizations below.
- Comparisons of demographic information to Franklin County information (Questions 1-4) are included for informational purposes/further direction. CRP did not conduct tests for statistical significance, though we pointed out areas where the sample likely differs from Franklin County as a whole. All Franklin County demographic data comes from American Community Survey (ACS) 2015 1-year estimates.
- SurveyGizmo automatically generated Word clouds; CRP did not do any qualitative coding due to the limited time available for data analysis. The word clouds provide a fair assessment of the words used most frequently in responses but do not necessarily capture themes of responses, since the responses were not coded by CRP prior to being placed in the word clouds. So, for instance, "access" and "accessible" might both appear in a single word cloud though the respondents are saying the same thing – access defines good healthcare.
- Total complete responses: 2,486
- All 2,486 responses included responded affirmatively to first 2 questions:
    - Do you live in Franklin County, Ohio?
    - Are you 18 years or older?
    - *Therefore, the underlying assumption is that all respondents reside in the target county and are over the age of 18. Some zip codes appear to be typos. All zip codes with >/= 30 participants are verified Franklin County zip codes.*

Zip code	Response count
43119	221
43228	167
43026	154
43123	139
43081	116
43017	98
43235	89
43221	87
43214	79
43016	76
43204	74
43004	68
43230	62
43209	56
43068	46
43206	46
43207	46
43220	46
43212	43
43054	41
43229	41
43085	31
43110	30
43201, 43202, 43213, 43224, 43125, 43232, 43215, 43219, 43227, 43211, 43065*, 43205, 43223, 43231, 43203, 43137, 43146*, 43222, 43328, 43024*, 43028*, 43208*, 43314*, 43327*, 44206*, 45016*	< 30 responses each Total responses in these zip codes = 311

Total respondents with identified zip codes: 2,167

Non-Franklin County zips (either out of region or possible typos) are indicated with a *

Key themes:

- The sample appears to be skewed towards women (73.9% of respondents) and White or Caucasian respondents (89.2%) compared to the general population of Franklin County
- Cost is the main concern or barrier to care.
- Access to physical, dental, and behavioral/mental healthcare is overall rated as high; however, with many respondents also reporting concerns about cost, respondents may be reporting high access while still struggling to pay bills or deal with costs of care.
- Low access is disproportionately common among households earning less than $25,000/year.

Topic area	**% reporting high or very high *priority***	**% reporting high or very high *access***
Physical activity	59.3%	63.4%
Healthcare	91.1%	81.5%
Dental care	82.9%	79.9%
Mental or behavioral healthcare	63.1%	46.8%
Healthy food	86.7%	81.4%

Highest priority area: Healthcare
Highest access area: Healthcare and healthy food

Lowest priority area: Physical activity
Lowest access area: Mental or behavioral healthcare

By topic area:

Physical activity

- Respondents defined physical activity both in terms of specific activities, e.g., walking, running, swimming, and in terms of the effects, e.g., raising the heart rate
- Over half of people place a high or very high priority on physical activity (59.3%)
- A majority of people reported high or very high access to physical activity (63.4%)
    - Main barriers include lack of time and other responsibilities

Healthcare

- ”Access” was used most frequently by respondents to describe good healthcare, though many respondents also used words like “doctor”, “needed”, “insurance”, “preventative”, and “professionals”.
- Nearly all respondents believe healthcare is a high or very high priority (91.0%)
- Access was reported to be surprisingly high given some of the issues reported with insurance and cost in the main barriers question. 81.5% of people reported high or very high access.
- Six out of ten respondents said they have no barriers to healthcare. Of the people reporting barriers, most mentioned the cost of seeing a doctor.
- Although 76.8% of respondents said they would go to a primary care or general practitioner for non-emergency healthcare, 6.8% said they would not go to a doctor unless it was an emergency and 1.1% said they would go straight to the emergency room.

Dental care

- Dentists were a key component of defining good dental care, as were “checkups” and “daily” tasks such as brushing and flossing.
- Fewer people named dental care as a high or very high priority than did so with healthcare, but 82.9% of respondents still said dental care is a high or very high priority.
- Most people (over 80%) also reported high or very high access to dental care.

- Once again, 60% of respondents said they have no barriers to dental care. Cost rose to the top as the most named barrier among participants with barriers to care.

Mental and behavioral health

- Many people used the word “access” to define good mental and behavioral healthcare. Respondents also mentioned “affordable”, “needed”, and “easy”, among other related terms.
- Far fewer people prioritized mental and behavioral health than dental and general healthcare. Only 63.1% of respondents place a high or very high priority on mental and behavioral health services.
- There is a clear gap in mental/behavioral healthcare access. Only 46.8% of respondents said they have high or very high access, again much lower than the dental or general healthcare responses.
- Main barriers to mental/behavioral healthcare include cost of seeing a doctor and the stigma of mental illness.
- About one in ten people were not sure where they would go for a non-emergency mental or behavioral health concern. About half said they would go to a general practitioner and close to one-third said they would go to a specialist like a psychologist or psychiatrist.

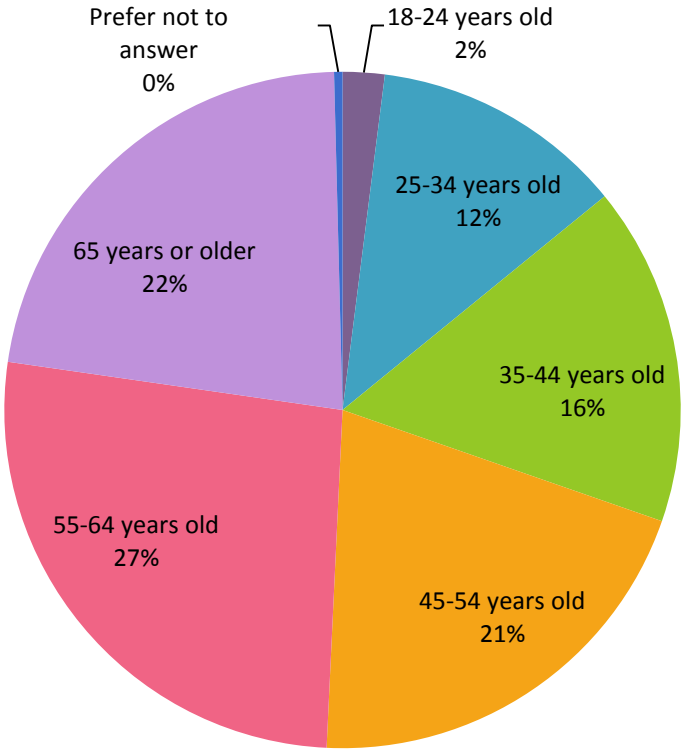
Healthy food access

- People who defined healthy food access mainly did so in the form of traits, i.e., “organic”, and not “processed”. They also mentioned produce, meats, fruits, and options.
- Healthy food access is a high or very high priority to over 85% of respondents.
- Healthy food is also accessible to most survey respondents – over 80% said they have high or very high access.
- Over 30% of respondents, however, said that the cost of healthy food is too high and about 15% said the cost of food in general is too high. A few people also noted that they live far away from stores or the stores close by do not carry fresh fruits and vegetables.
- Of respondents reporting very low access, 36.4% reported household incomes of less than $25,000 a year. Only 7% of survey respondents overall reported household incomes of less than $25,000, so limited healthy food access very disproportionately affects low income families.

Biggest health concern

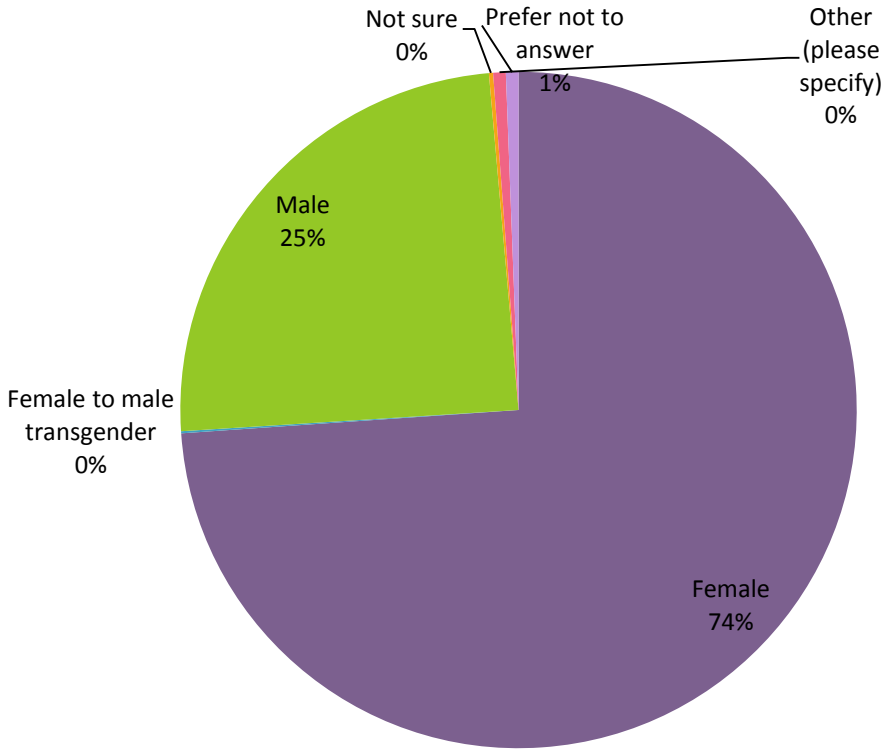
- The most frequently used words include:
    - Care
    - Healthy
    - Cost
    - Insurance
    - Access
    - Mental
- In addition, there was a fair amount of concern regarding some specific physical issues, including:
    - Cancer
    - Aging
    - “High” numbers like cholesterol and blood pressure

Question 1: What is your age? (N=2,480)



Value	Percent	Count
18-24 years old	2.0%	50
25-34 years old	12.1%	301
35-44 years old	16.2%	402
45-54 years old	20.4%	507
55-64 years old	26.5%	657
65 years or older	22.3%	554
Prefer not to answer	0.4%	9

Question 2: What is your gender identity? (N=2,471)



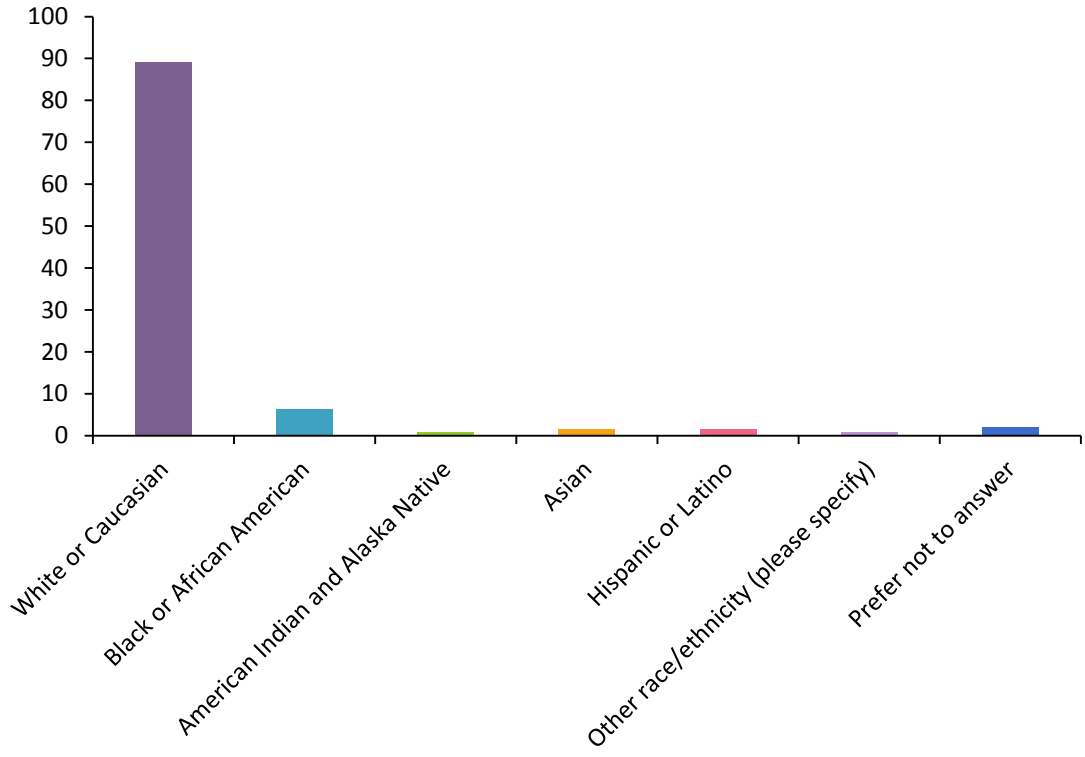
Value	Percent	Count
Female	73.9%	1,825
Female to male transgender	0.1%	3
Male	24.6%	607
Not sure	0.2%	5
Other (please specify)	0.6%	15
Prefer not to answer	0.6%	16

COMPARISON OF SURVEY SAMPLE AGE AND GENDER WITH FRANKLIN COUNTY

Franklin County			Survey sample (over 18)		
		% of total over 18			
Male over 18	459982	48.1%	Male	607	24.4%
Female over 18	496014	51.9%	Female	1837	73.9%
			Female to male transgender	3	0.1%
			Other	3	0.1%
			Not sure/Unknown/Prefer not to answer	21	1.4%
Total 18-24	124243	13.0%	18-24 years old	50	2.0%
Total 25-34	224520	23.5%	25-34 years old	301	12.1%
Total 35-44	167517	17.5%	35-44 years old	402	16.2%
Total 45-54	157982	16.5%	45-54 years old	507	20.4%
Total 55-64	143204	15.0%	55-64 years old	657	26.4%
Total 65 and over	138530	14.5%	65 years or older	554	22.3%
			Unknown/Prefer not to answer	15	0.6%
Grand total	955996		Grand total	2480	

Men were likely under represented in the survey sample.

Question 3: What is your race and/or ethnicity? Select all that apply. (N=2,471 – respondents could select multiple responses)



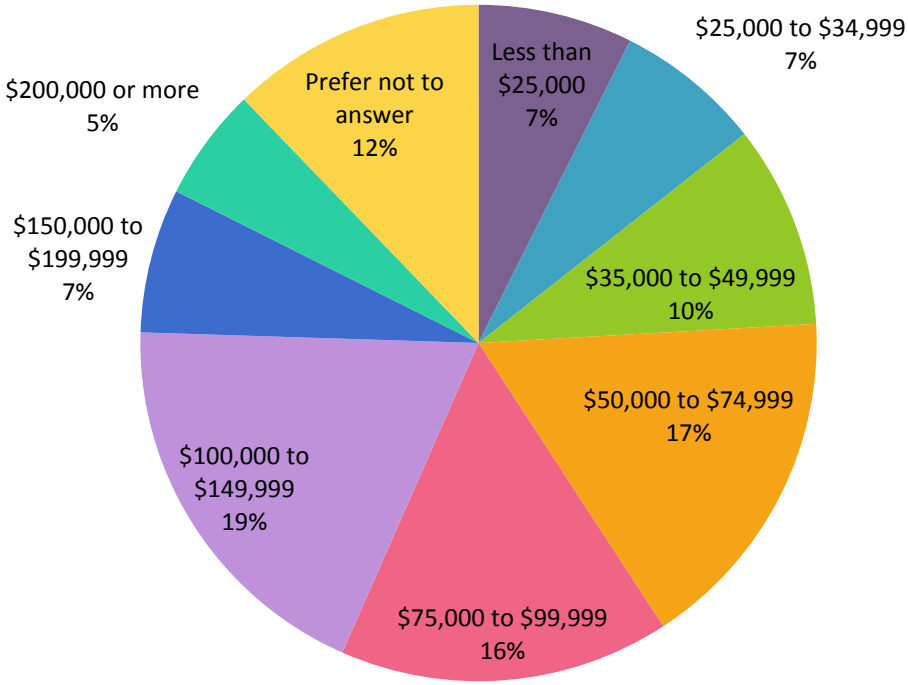
Value	Percent	Count
White or Caucasian	89.2%	2,203
Black or African American	6.3%	156
American Indian and Alaska Native	0.8%	21
Asian	1.6%	39
Native Hawaiian and Other Pacific Islander	0.0%	1
Hispanic or Latino	1.5%	36
Other race/ethnicity (please specify)	0.9%	23
Prefer not to answer	2.1%	52

COMPARISON OF SURVEY SAMPLE RACE AND ETHNICITY WITH FRANKLIN COUNTY

Franklin County			Survey sample		
White alone	853416	68.2%	White or Caucasian	2203	89.2%
Black or African American alone	272019	21.7%	Black or African American	156	6.3%
American Indian and Alaska Native alone	2143	0.2%	American Indian and Alaska Native	21	0.8%
Asian alone	58135	4.6%	Asian	39	1.6%
Native Hawaiian and Other Pacific Island alone	328	0.0%			
Some other race alone	19572	1.6%	Other race/ethnicity	23	0.9%
Two or more races	46109	3.7%			
			Unknown/Prefer not to answer	52	2.1%
Hispanic or Latino	65019	5.2%	Hispanic or Latino	36	1.5%
Total by race	1251722		Total by race	2471	100.0%

White or Caucasian residents appear to be over represented in the survey sample and minority populations, especially Black or African Americans, appear to be under represented.

Question 4: What is your annual household income before taxes? (N=2,464)



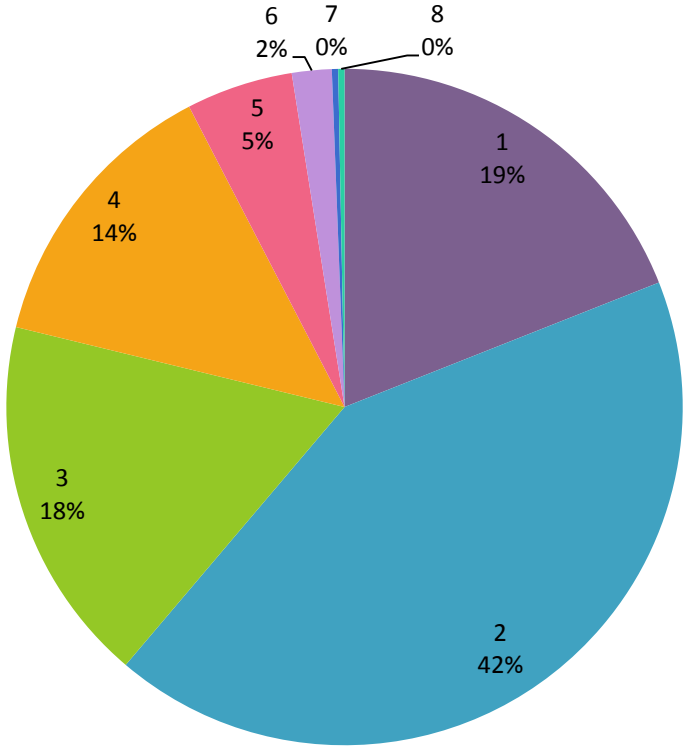
Value	Percent	Count
Less than $25,000	7.4%	183
$25,000 to $34,999	7.0%	173
$35,000 to $49,999	9.7%	239
$50,000 to $74,999	16.7%	411
$75,000 to $99,999	15.8%	390
$100,000 to $149,999	18.9%	465
$150,000 to $199,999	6.9%	169
$200,000 or more	5.4%	133
Prefer not to answer	12.2%	301

COMPARISON OF SURVEY SAMPLE HOUSEHOLD INCOME WITH FRANKLIN COUNTY

Franklin County		Survey sample		
Less than $25,000	22.2%	Less than $25,000	183	7.4%
$25,000 to $34,999	10.2%	$25,000 to $34,999	173	7.0%
$35,000 to $49,999	13.8%	$35,000 to $49,999	239	9.7%
$50,000 to $74,999	18.8%	$50,000 to $74,999	411	16.7%
$75,000 to $99,999	12.2%	$75,000 to $99,999	390	15.8%
$100,000 to $149,999	13.3%	$100,000 to $149,999	465	18.9%
$150,000 to $199,999	4.6%	$150,000 to $199,999	169	6.9%
$200,000 or more	4.9%	$200,000 or more	133	5.4%
		Prefer not to answer	301	12.2%

The sample appears to under represent the very low end of the income spectrum (< $25,000 per year for a household) but is fairly close on the other income levels.

Question 5: What is your current household size? Please only include people who live in the home and/or are supported by your household income. (N=2,449)



Value	Percent	Count
1	19.0%	466
2	42.2%	1,033
3	17.6%	430
4	13.6%	332
5	5.1%	124
6	1.9%	47
7	0.3%	8
8	0.3%	7
9	0.0%	1
10+	0.0%	1

COMPARISON OF HOUSEHOLD SIZE TO INCOME LEVEL

Household size: 1		
Income	**Count**	
Unknown/Prefer not to answer	50	10.7%
Less than $25,000	87	18.7%
$25,000 to $34,999	64	13.7%
$35,000 to $49,999	89	19.1%
$50,000 to $74,999	101	22.2%
$75,000 to $99,999	42	9.2%
$100,000 to $149,999	24	5.3%
$150,000 to $199,999	2	0.4%
$200,000 or more	4	0.9%
Grand Total	466	

Household size: 2		
Income	**Count**	
Unknown/Prefer not to answer	165	16.0%
Less than $25,000	39	3.8%
$25,000 to $34,999	55	5.3%
$35,000 to $49,999	82	7.9%
$50,000 to $74,999	175	16.9%
$75,000 to $99,999	182	17.6%
$100,000 to $149,999	207	20.0%
$150,000 to $199,999	76	7.4%
$200,000 or more	52	5.0%
Grand Total	1033	

Household size: 3		
Income	**Count**	
Unknown/Prefer not to answer	53	12.3%
Less than $25,000	26	6.0%
$25,000 to $34,999	25	5.8%
$35,000 to $49,999	28	6.5%
$50,000 to $74,999	70	16.3%
$75,000 to $99,999	73	17.0%
$100,000 to $149,999	99	23.0%
$150,000 to $199,999	31	7.2%
$200,000 or more	25	5.8%
Grand Total	430	

Household size: 4		
Income	**Count**	
Unknown/Prefer not to answer	34	10.2%
Less than $25,000	11	3.3%
$25,000 to $34,999	7	2.1%
$35,000 to $49,999	16	4.8%
$50,000 to $74,999	37	11.1%
$75,000 to $99,999	55	16.6%
$100,000 to $149,999	90	27.1%
$150,000 to $199,999	48	14.5%
$200,000 or more	34	10.2%
Grand Total	332	

Household size: 5		
Income	**Count**	
Unknown/Prefer not to answer	5	4.0%
Less than $25,000	10	8.1%
$25,000 to $34,999	10	8.1%
$35,000 to $49,999	12	9.7%
$50,000 to $74,999	11	8.9%
$75,000 to $99,999	25	20.2%
$100,000 to $149,999	30	24.2%
$150,000 to $199,999	10	8.1%
$200,000 or more	11	8.9%
Grand Total	124	

Household size: 6		
Income	**Count**	
Unknown/Prefer not to answer	5	10.6%
Less than $25,000	5	10.6%
$25,000 to $34,999	4	8.5%
$35,000 to $49,999	4	8.5%
$50,000 to $74,999	7	14.9%
$75,000 to $99,999	8	17.0%
$100,000 to $149,999	10	21.3%
$200,000 or more	4	8.5%
Grand Total	47	

Household size: 7		
Income	**Count**	
Less than $25,000	2	25.0%
$25,000 to $34,999	2	25.0%
$35,000 to $49,999	2	25.0%
$100,000 to $149,999	2	25.0%
Grand Total	8	

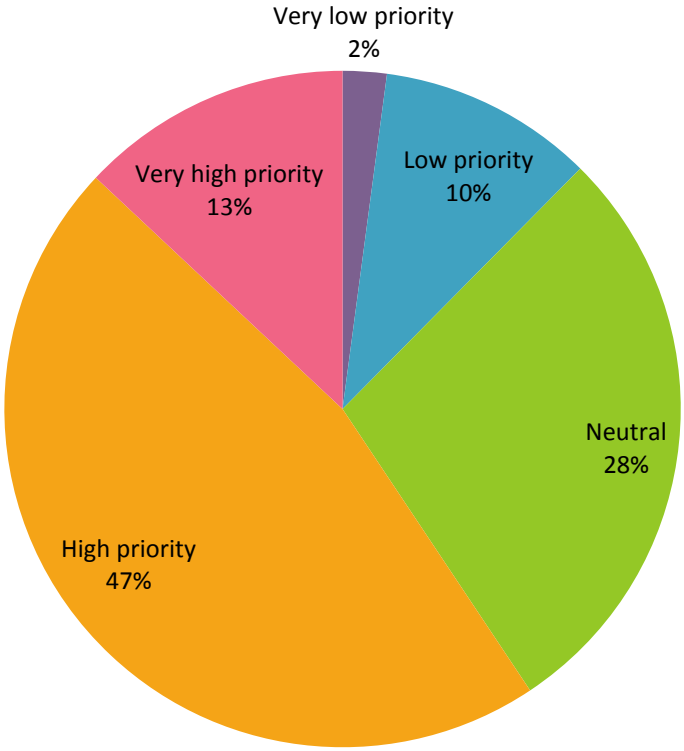
Household size: 8		
Income	**Count**	
Unknown/Prefer not to answer	1	14.3%
Less than $25,000	1	14.3%
$25,000 to $34,999	1	14.3%
$50,000 to $74,999	3	42.9%
$100,000 to $149,999	1	14.3%
Grand Total	7	

Household size: 9		
Income	**Count**	
$35,000 to $49,999	1	100.0%
Grand Total	1	

Household size: 10+		
Income	**Count**	
$200,000 or more	1	100.0%
Grand Total	1	

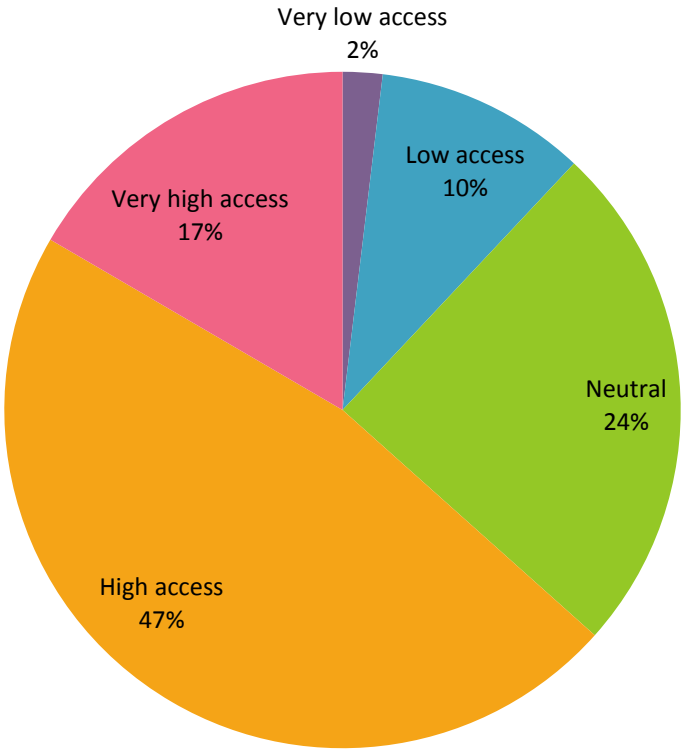
Question 6: How do you define physical activity? (N=2,211)

Question 7: How much of a priority do you place on physical activity for yourself? (N=2,472)



Value	Percent	Count
Very low priority	2.1%	53
Low priority	10.3%	254
Neutral	28.2%	698
High priority	46.3%	1,145
Very high priority	13.0%	322

Question 8: How would you rate your access to physical activity? (N=2,466)



Value	Percent	Count
Very low access	1.9%	47
Low access	10.1%	248
Neutral	24.6%	607
High access	46.8%	1,154
Very high access	16.6%	410

COMPARISON OF ACCESS LEVEL BY INCOME: PHYSICAL ACTIVITY

Very low access	47	
Less than $25,000	11	23.4%
$25,000 to $34,999	10	21.3%
$35,000 to $49,999	5	10.6%
$50,000 to $74,999	5	10.6%
$75,000 to $99,999	6	12.8%
$100,000 to $149,999	3	6.4%
$150,000 to $199,999	2	4.3%
$200,000 or more	1	2.1%
Prefer not to answer / Unknown	4	8.5%

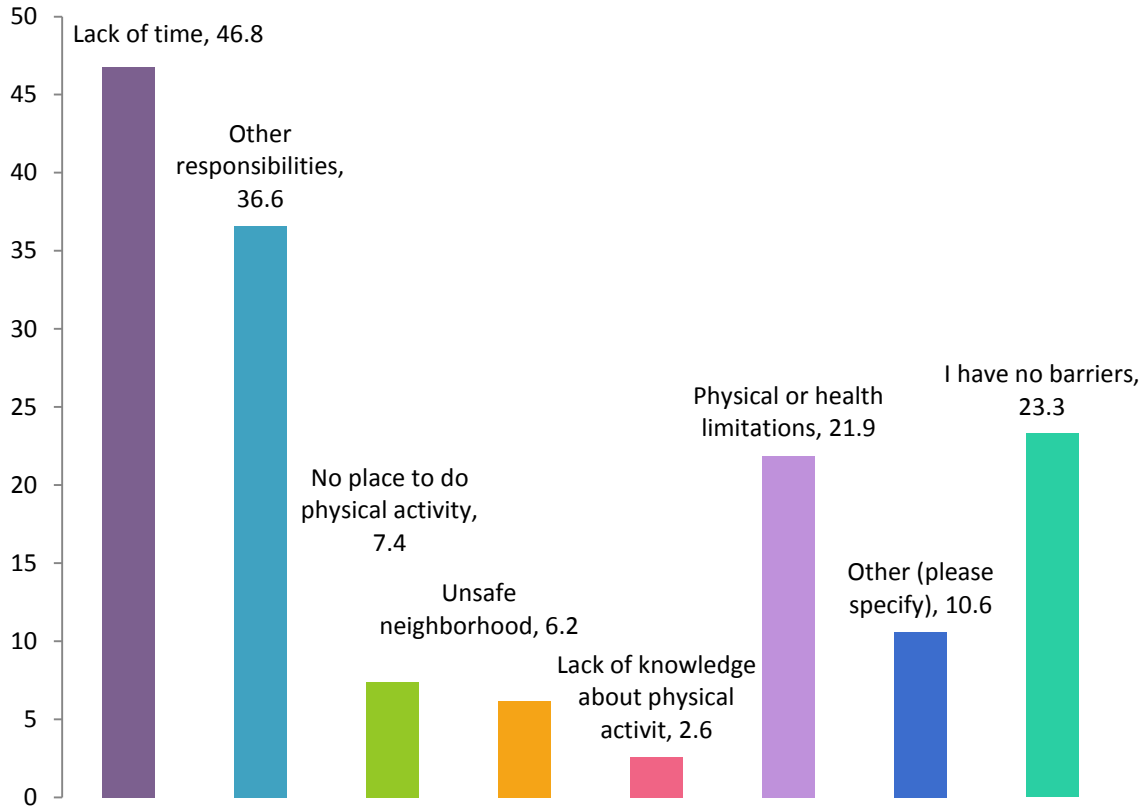
Low access	248	
Less than $25,000	35	14.1%
$25,000 to $34,999	20	8.1%
$35,000 to $49,999	31	12.5%
$50,000 to $74,999	51	20.6%
$75,000 to $99,999	34	13.7%
$100,000 to $149,999	37	14.9%
$150,000 to $199,999	9	3.6%
$200,000 or more	4	1.6%
Prefer not to answer / Unknown	27	10.9%

Neutral	607	
Less than $25,000	55	9.1%
$25,000 to $34,999	58	9.6%
$35,000 to $49,999	83	13.7%
$50,000 to $74,999	108	17.8%
$75,000 to $99,999	98	16.1%
$100,000 to $149,999	87	14.3%
$150,000 to $199,999	28	4.6%
$200,000 or more	19	3.1%
Prefer not to answer / Unknown	71	11.7%

High access	1154	
Less than $25,000	63	5.5%
$25,000 to $34,999	63	5.5%
$35,000 to $49,999	99	8.6%
$50,000 to $74,999	181	15.7%
$75,000 to $99,999	188	16.3%
$100,000 to $149,999	244	21.1%
$150,000 to $199,999	94	8.1%
$200,000 or more	64	5.5%
Prefer not to answer / Unknown	158	13.7%

Very high access	410	
Less than $25,000	17	4.1%
$25,000 to $34,999	19	4.6%
$35,000 to $49,999	20	4.9%
$50,000 to $74,999	63	15.4%
$75,000 to $99,999	62	15.1%
$100,000 to $149,999	93	22.7%
$150,000 to $199,999	36	8.8%
$200,000 or more	44	10.7%
Prefer not to answer / Unknown	56	13.7%

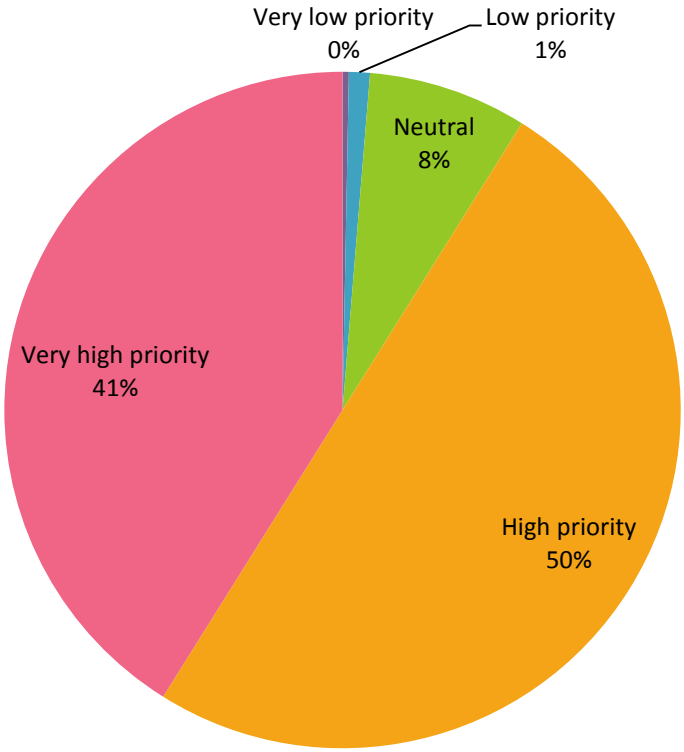
Question 9: What, if any, are your main barriers to participating in physical activity? Select all that apply. (N=2,467– respondents could select multiple responses)



Value	Percent	Count
Lack of time	46.8%	1,154
Other responsibilities	36.6%	903
No place to do physical activity	7.4%	183
Unsafe neighborhood	6.2%	152
Lack of knowledge about physical activity	2.6%	63
Physical or health limitations	21.9%	540
Other (please specify)	10.6%	262
I have no barriers	23.3%	575

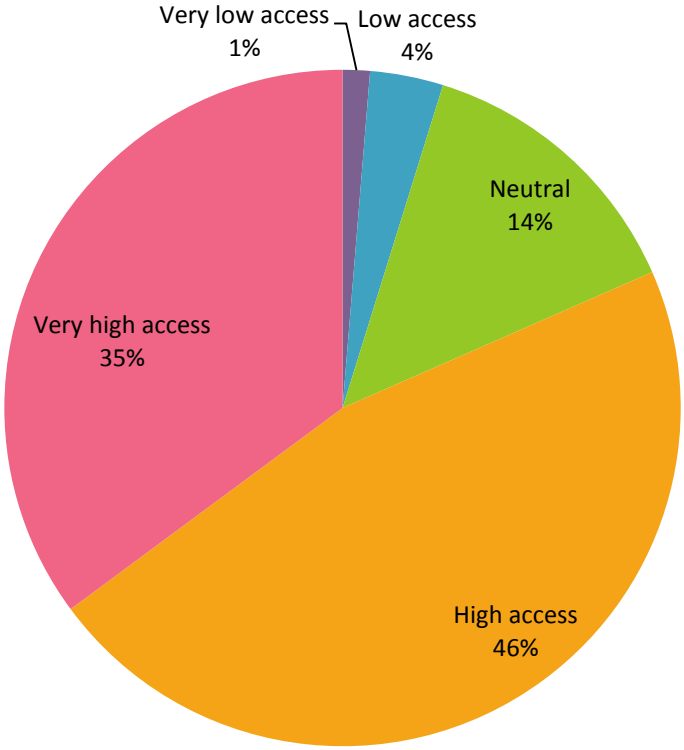
Question 10: How do you define good healthcare? (N=2,152)

Question 11: How much of a priority do you place on healthcare? (N=2,472)



Value	Percent	Count
Very low priority	0.3%	7
Low priority	1.0%	25
Neutral	7.6%	189
High priority	50.0%	1,235
Very high priority	41.1%	1,016

Question 12: How would you rate your current access to healthcare? (N=2,468)



Value	Percent	Count
Very low access	1.3%	33
Low access	3.5%	87
Neutral	13.6%	335
High access	46.4%	1,146
Very high access	35.1%	867

COMPARISON OF ACCESS LEVEL BY INCOME: HEALTHCARE

Very low access	33	
Less than $25,000	11	33.3%
$25,000 to $34,999	5	15.2%
$35,000 to $49,999	5	15.2%
$50,000 to $74,999	3	9.1%
$75,000 to $99,999	2	6.1%
$100,000 to $149,999	2	6.1%
$150,000 to $199,999	0	0%
$200,000 or more	0	0%
Prefer not to answer	5	15.2%

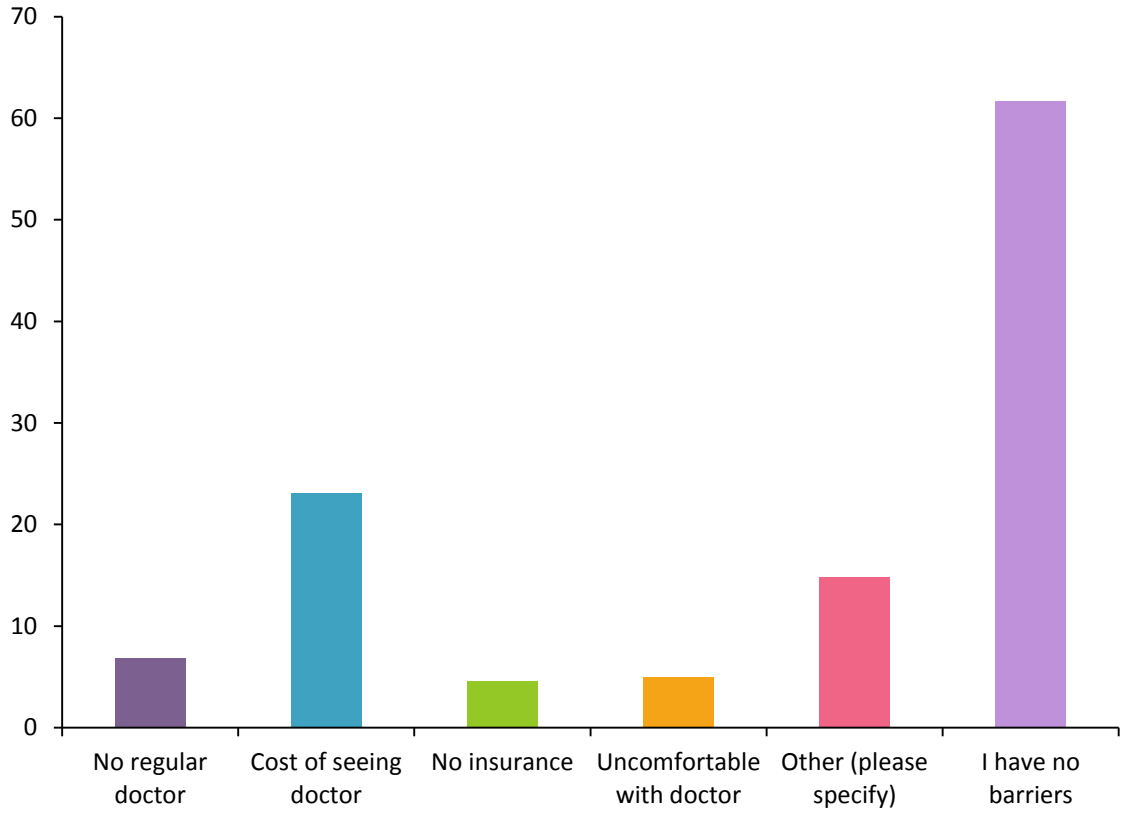
Low access	87	
Less than $25,000	13	14.9%
$25,000 to $34,999	6	6.9%
$35,000 to $49,999	8	9.2%
$50,000 to $74,999	22	25.3%
$75,000 to $99,999	13	14.9%
$100,000 to $149,999	12	13.8%
$150,000 to $199,999	2	2.3%
$200,000 or more	1	1.1%
Prefer not to answer	10	11.5%

Neutral	335	
Less than $25,000	37	11.0%
$25,000 to $34,999	37	11.0%
$35,000 to $49,999	43	12.8%
$50,000 to $74,999	63	18.8%
$75,000 to $99,999	48	14.3%
$100,000 to $149,999	37	11.0%
$150,000 to $199,999	15	4.5%
$200,000 or more	6	1.8%
Prefer not to answer/Unknown	49	14.6%

High access	1146	
Less than $25,000	73	6.4%
$25,000 to $34,999	77	6.7%
$35,000 to $49,999	117	10.2%
$50,000 to $74,999	188	16.4%
$75,000 to $99,999	188	16.4%
$100,000 to $149,999	219	19.1%
$150,000 to $199,999	89	7.8%
$200,000 or more	55	4.8%
Prefer not to answer/Unknown	140	12.2%

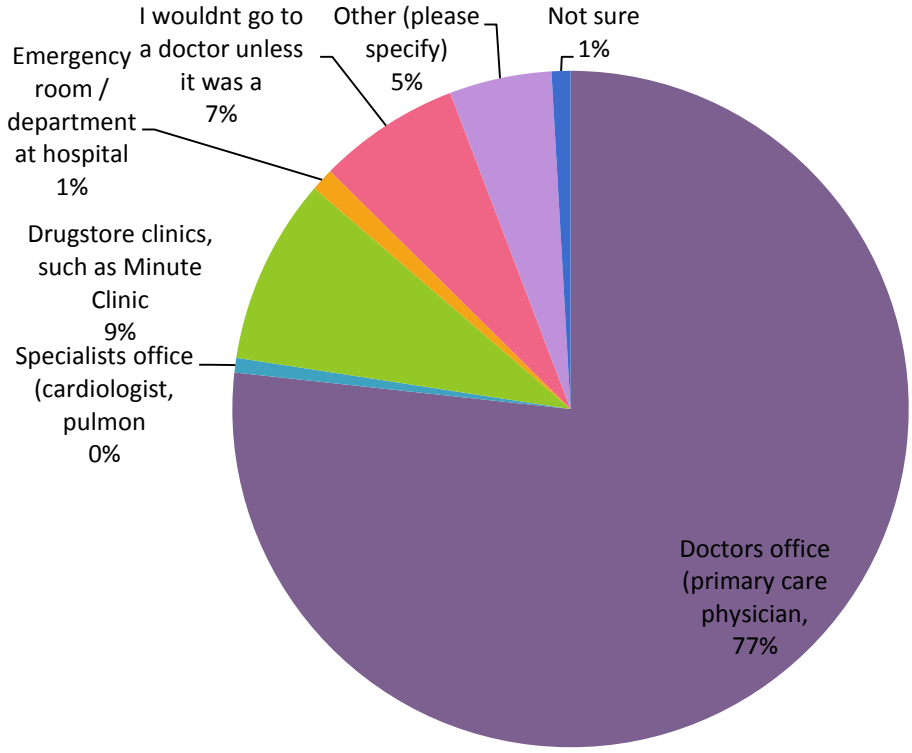
Very high access	867	
Less than $25,000	47	5.4%
$25,000 to $34,999	46	5.3%
$35,000 to $49,999	65	7.5%
$50,000 to $74,999	135	15.6%
$75,000 to $99,999	137	15.8%
$100,000 to $149,999	192	22.1%
$150,000 to $199,999	62	7.2%
$200,000 or more	71	8.2%
Prefer not to answer/Unknown	112	12.9%

Question 13: What, if any, are the main barriers to accessing healthcare? Select all that apply. (N=2,451 – respondents could select multiple responses)



Value	Percent	Count
No regular doctor	6.8%	166
Cost of seeing doctor	23.1%	567
No insurance	4.6%	113
Uncomfortable with doctor	5.0%	123
Other (please specify)	14.8%	362
I have no barriers	61.7%	1,513

Question 14: If you were sick, where would you go first for treatment? Assume that this is not an emergency situation. (N=2,468)



Value	Percent	Count
Doctor's office (primary care physician, family physician, internist, pediatrician, etc.)	76.8%	1,895
Specialist's office (cardiologist, pulmonologist, endocrinologist, etc.)	0.7%	18
Drugstore clinics, such as Minute Clinic at CVS or Walgreens clinic	8.9%	219

Emergency room / department at hospital	1.1%	27
I wouldn't go to a doctor unless it was an emergency	6.8%	167
Other (please specify)	4.9%	121
Not sure	0.9%	21

COMPARISON BY INCOME LEVEL

Less than $25,000	183	
Unknown/Prefer not to say	2	1.1%
Doctor's office (primary care physician, family physician, internist, pediatrician, etc.)	126	68.9%
Drugstore clinics, such as Minute Clinic at CVS or Walgreen's clinic	3	1.6%
Emergency room / department at hospital	9	4.9%
I wouldn't go to a doctor unless it was an emergency	16	8.7%
Not sure	7	3.8%
Other (please specify)	18	9.8%
Specialist's office (cardiologist, pulmonologist, endocrinologist, etc.)	2	1.1%

$25,000 to $34,999	173	
Doctor's office (primary care physician, family physician, internist, pediatrician, etc.)	128	74.0%
Drugstore clinics, such as Minute Clinic at CVS or Walgreen's clinic	8	4.6%
Emergency room / department at hospital	1	0.6%
I wouldn't go to a doctor unless it was an emergency	20	11.6%
Not sure	1	0.6%
Other (please specify)	13	7.5%
Specialist's office (cardiologist, pulmonologist, endocrinologist, etc.)	2	1.2%

$35,000 to $49,999	239	
Unknown/Prefer not to say	2	0.8%
Doctor's office (primary care physician, family physician, internist, pediatrician, etc.)	173	72.4%
Drugstore clinics, such as Minute Clinic at CVS or Walgreen's clinic	21	8.8%
Emergency room / department at hospital	6	2.5%
I wouldn't go to a doctor unless it was an emergency	23	9.6%
Not sure	1	0.4%
Other (please specify)	13	5.4%

$50,000 to $74,999	411	
Unknown/Prefer not to say	3	0.7%
Doctor's office (primary care physician, family physician, internist, pediatrician, etc.)	307	74.7%
Drugstore clinics, such as Minute Clinic at CVS or Walgreen's clinic	42	10.2%
Emergency room / department at hospital	2	0.5%
I wouldn't go to a doctor unless it was an emergency	38	9.2%
Other (please specify)	14	3.4%
Specialist's office (cardiologist, pulmonologist, endocrinologist, etc.)	5	1.2%

$75,000 to $99,999	390	
Unknown/Prefer not to say	2	0.5%
Doctor's office (primary care physician, family physician, internist, pediatrician, etc.)	284	72.8%
Drugstore clinics, such as Minute Clinic at CVS or Walgreen's clinic	56	14.4%
Emergency room / department at hospital	2	0.5%
I wouldn't go to a doctor unless it was an emergency	20	5.1%
Not sure	3	0.8%
Other (please specify)	18	4.6%
Specialist's office (cardiologist, pulmonologist, endocrinologist, etc.)	5	1.3%

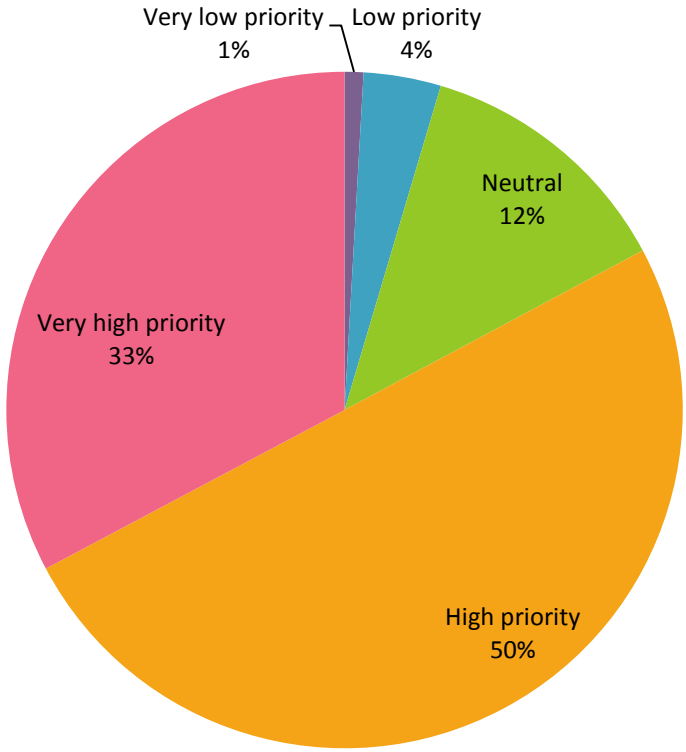
$100,000 to $149,999	465	
Unknown/Prefer not to say	2	0.4%
Doctor's office (primary care physician, family physician, internist, pediatrician, etc.)	375	80.6%
Drugstore clinics, such as Minute Clinic at CVS or Walgreen's clinic	42	9.0%
I wouldn't go to a doctor unless it was an emergency	17	3.7%
Not sure	3	0.6%
Other (please specify)	25	5.4%
Specialist's office (cardiologist, pulmonologist, endocrinologist, etc.)	1	0.2%

$150,000 to $199,999	169	
Unknown/Prefer not to say	1	0.6%
Doctor's office (primary care physician, family physician, internist, pediatrician, etc.)	135	79.9%
Drugstore clinics, such as Minute Clinic at CVS or Walgreen's clinic	17	10.1%
Emergency room / department at hospital	1	0.6%
I wouldn't go to a doctor unless it was an emergency	8	4.7%
Other (please specify)	6	3.6%
Specialist's office (cardiologist, pulmonologist, endocrinologist, etc.)	1	0.6%

$200,000 or more	133	
Doctor's office (primary care physician, family physician, internist, pediatrician, etc.)	103	77.4%
Drugstore clinics, such as Minute Clinic at CVS or Walgreen's clinic	17	12.8%
Emergency room / department at hospital	2	1.5%
I wouldn't go to a doctor unless it was an emergency	4	3.0%
Not sure	2	1.5%
Other (please specify)	5	3.8%

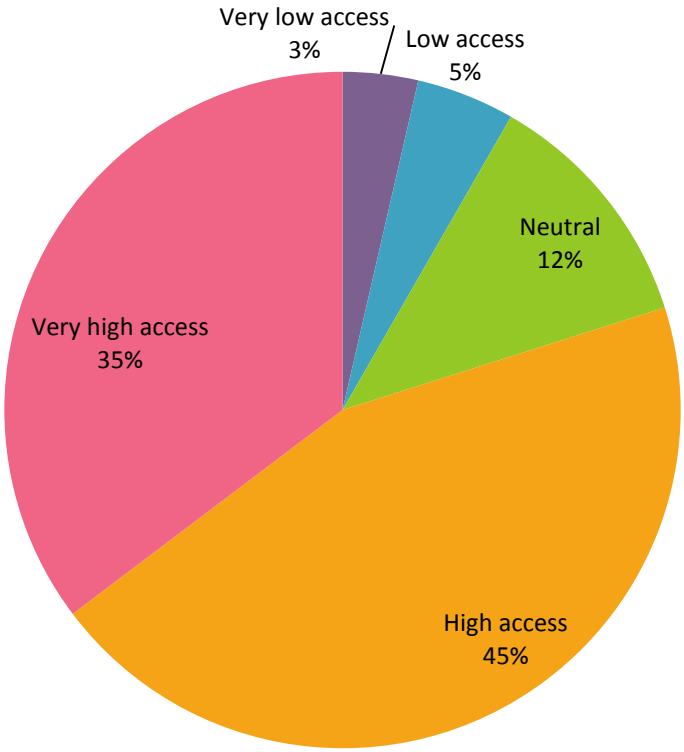
Question 15: How do you define good dental care? (N=2,138)

Question 16: How much of a priority do you place on dental care? (N=2,470)



Value	Percent	Count
Very low priority	0.9%	21
Low priority	3.7%	92
Neutral	12.6%	311
High priority	50.1%	1,237
Very high priority	32.8%	809

Question 17: How would you rate your current access to dental care? (N=2,468)



Value	Percent	Count
Very low access	3.6%	88
Low access	4.7%	117
Neutral	11.8%	292
High access	44.6%	1,100
Very high access	35.3%	871

COMPARISON OF ACCESS BY INCOME LEVEL: DENTAL CARE

Very low access	88	
Less than $25,000	35	39.8%
$25,000 to $34,999	12	13.6%
$35,000 to $49,999	14	15.9%
$50,000 to $74,999	12	13.6%
$75,000 to $99,999	6	6.8%
$100,000 to $149,999	1	1.1%
$150,000 to $199,999	0	0%
$200,000 or more	0	0%
Prefer not to answer	8	9.1%

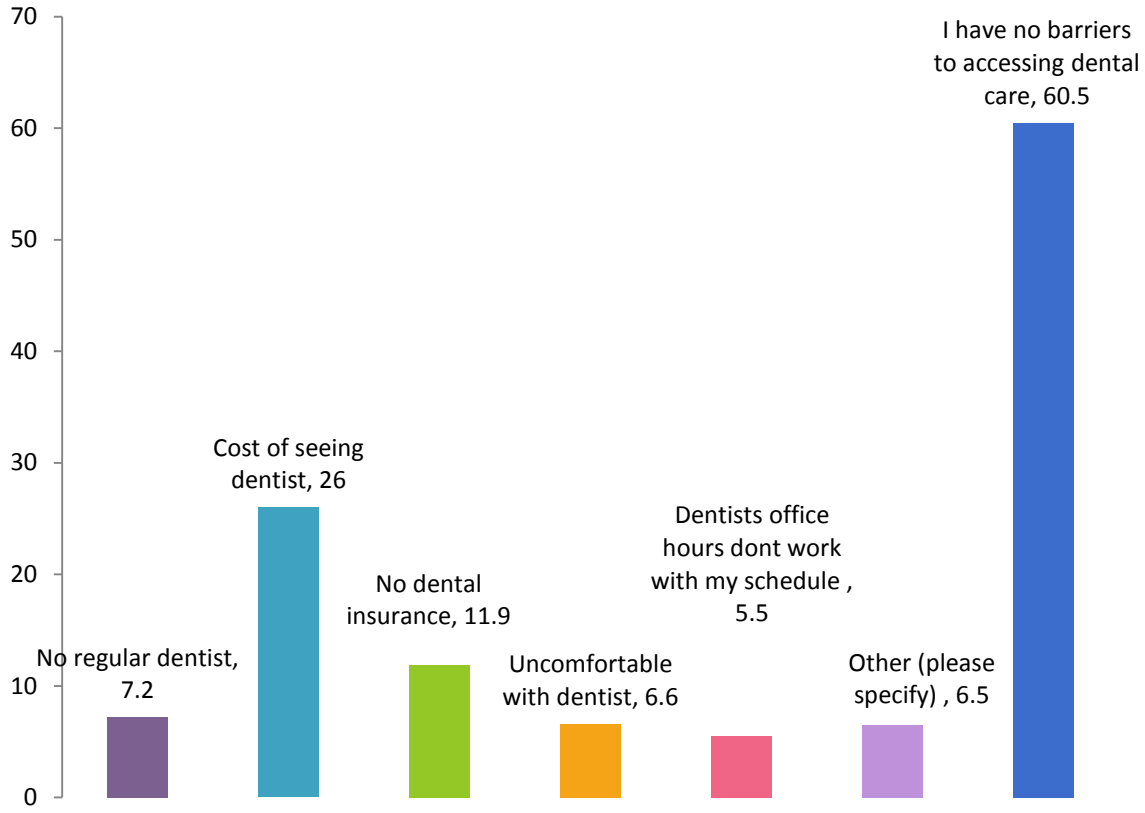
Low access	117	
Less than $25,000	30	25.6%
$25,000 to $34,999	16	13.7%
$35,000 to $49,999	16	13.7%
$50,000 to $74,999	26	22.2%
$75,000 to $99,999	9	7.7%
$100,000 to $149,999	7	6.0%
$150,000 to $199,999	3	2.6%
Prefer not to answer	10	8.5%

Neutral	292	
Less than $25,000	40	13.7%
$25,000 to $34,999	30	10.3%
$35,000 to $49,999	36	12.3%
$50,000 to $74,999	58	19.9%
$75,000 to $99,999	45	15.4%
$100,000 to $149,999	33	11.3%
$150,000 to $199,999	11	3.8%
$200,000 or more	2	0.7%
Prefer not to answer	37	12.7%

High access	1100	
Less than $25,000	45	4.1%
$25,000 to $34,999	81	7.4%
$35,000 to $49,999	112	10.2%
$50,000 to $74,999	183	16.6%
$75,000 to $99,999	175	15.9%
$100,000 to $149,999	216	19.6%
$150,000 to $199,999	83	7.5%
$200,000 or more	50	4.5%
Prefer not to answer/Unknown	155	14.1%

Very high access	871	
Less than $25,000	30	3.4%
$25,000 to $34,999	32	3.7%
$35,000 to $49,999	61	7.0%
$50,000 to $74,999	130	14.9%
$75,000 to $99,999	153	17.6%
$100,000 to $149,999	206	23.7%
$150,000 to $199,999	72	8.3%
$200,000 or more	81	9.3%
Prefer not to answer/Unknown	106	12.2%

Question 18: What, if any, are the main barriers to accessing dental care? Select all that apply. (N=2,453 – respondents could select multiple responses)

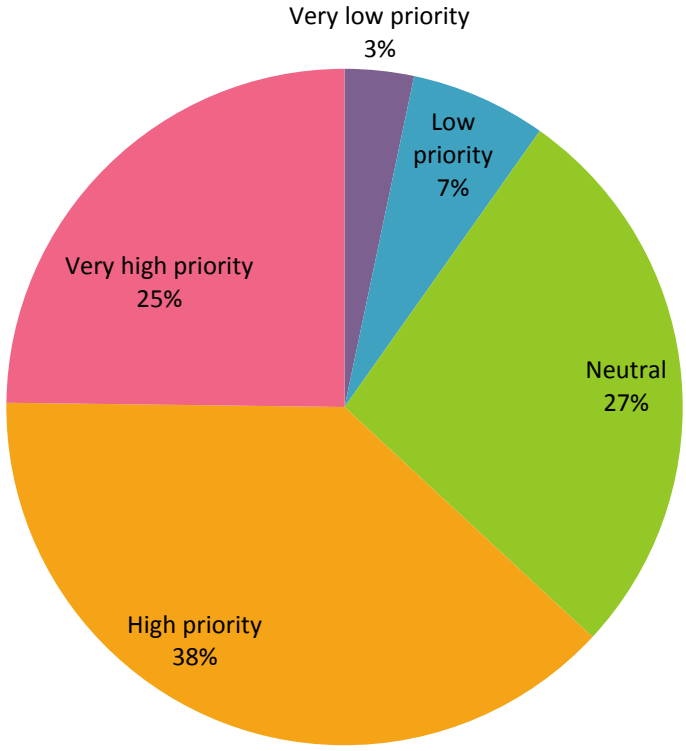


Value	Percent	Count
No regular dentist	7.2%	177
Cost of seeing dentist	26.0%	638
No dental insurance	11.9%	292
Uncomfortable with dentist	6.6%	161
Dentist’s office hours don’t work with my schedule	5.5%	135
Other (please specify)	6.5%	160
I have no barriers to accessing dental care	60.5%	1,484

Question 19: How do you define good mental or behavioral health services?

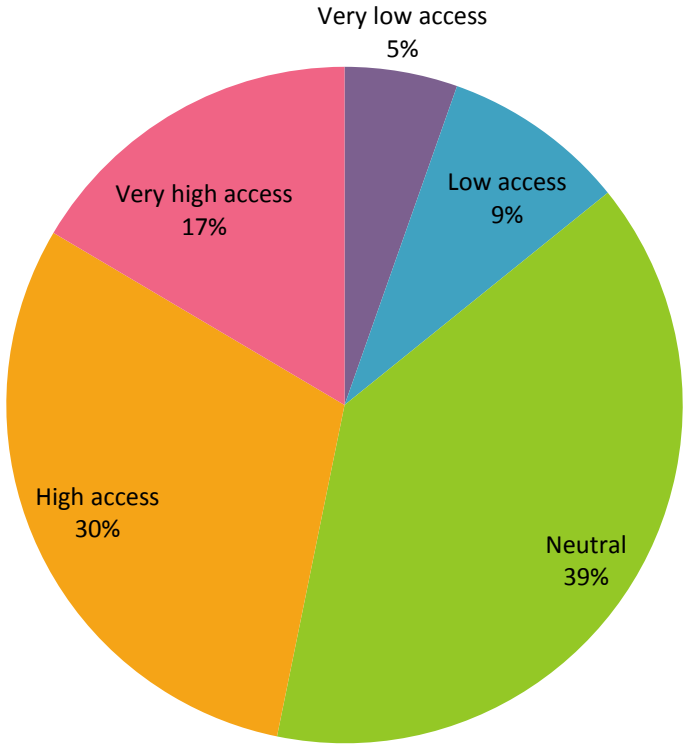
(N=1,997)

Question 20: How much of a priority do you place on mental or behavioral health services? (N=2,455)



Value	Percent	Count
Very low priority	3.3%	81
Low priority	6.5%	160
Neutral	27.1%	665
High priority	38.3%	941
Very high priority	24.8%	608

Question 21: How would you rate your current access to mental or behavioral health services? (N=2,442)



Value	Percent	Count
Very low access	5.4%	131
Low access	8.8%	214
Neutral	39.0%	952
High access	30.3%	741
Very high access	16.5%	404

COMPARISON OF ACCESS BY INCOME LEVEL: MENTAL OR BEHAVIORAL HEALTH

Very low access	131	
Less than $25,000	22	16.8%
$25,000 to $34,999	14	10.7%
$35,000 to $49,999	13	9.9%
$50,000 to $74,999	13	9.9%
$75,000 to $99,999	22	16.8%
$100,000 to $149,999	17	13.0%
$150,000 to $199,999	9	6.9%
$200,000 or more	6	4.6%
Prefer not to answer	15	11.5%

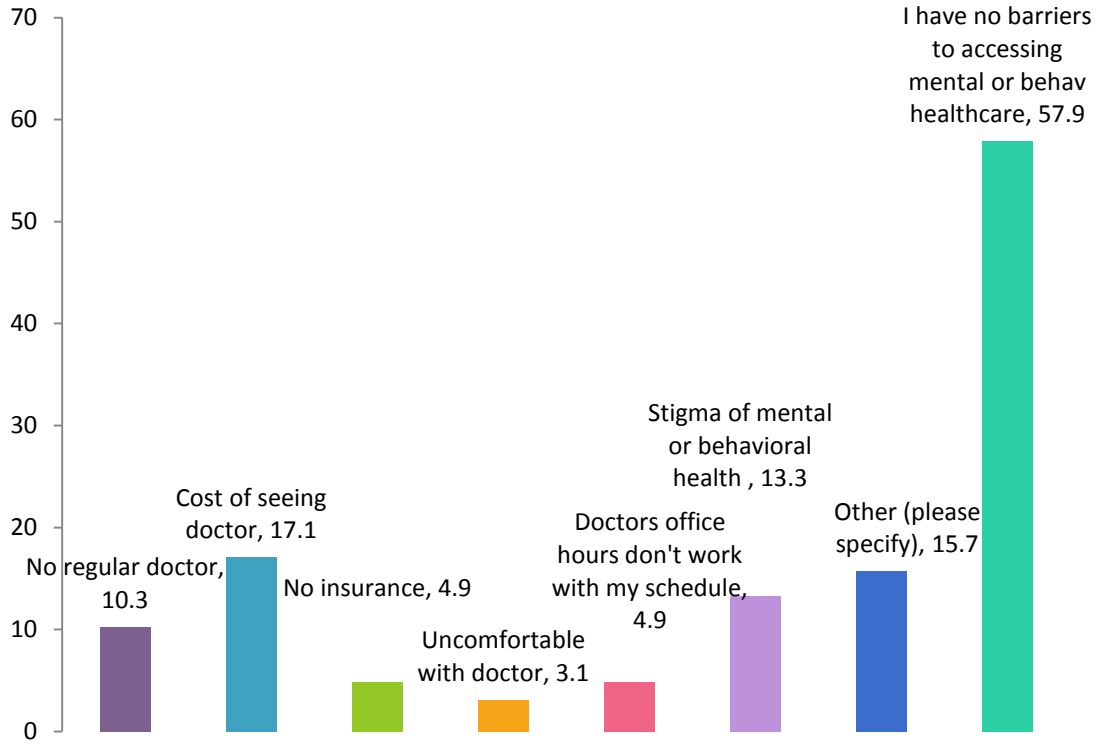
Low access	214	
Less than $25,000	13	6.1%
$25,000 to $34,999	11	5.1%
$35,000 to $49,999	28	13.1%
$50,000 to $74,999	45	21.0%
$75,000 to $99,999	39	18.2%
$100,000 to $149,999	37	17.3%
$150,000 to $199,999	14	6.5%
$200,000 or more	5	2.3%
Prefer not to answer	22	10.3%

Neutral	952	
Less than $25,000	82	8.6%
$25,000 to $34,999	62	6.5%
$35,000 to $49,999	107	11.2%
$50,000 to $74,999	167	17.5%
$75,000 to $99,999	135	14.2%
$100,000 to $149,999	162	17.0%
$150,000 to $199,999	64	6.7%
$200,000 or more	47	4.9%
Prefer not to answer/Unknown	126	13.2%

High access	741	
Less than $25,000	33	4.5%
$25,000 to $34,999	57	7.7%
$35,000 to $49,999	57	7.7%
$50,000 to $74,999	126	17.0%
$75,000 to $99,999	126	17.0%
$100,000 to $149,999	157	21.2%
$150,000 to $199,999	53	7.2%
$200,000 or more	39	5.3%
Prefer not to answer/Unknown	93	12.6%

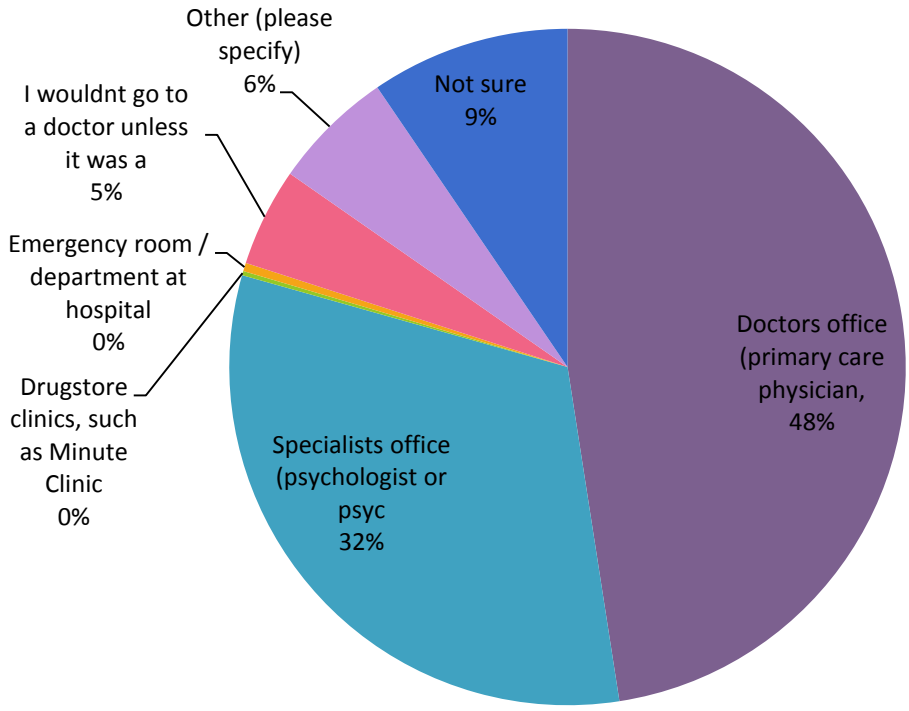
Very high access	404	
Less than $25,000	26	6.4%
$25,000 to $34,999	26	6.4%
$35,000 to $49,999	31	7.7%
$50,000 to $74,999	55	13.6%
$75,000 to $99,999	65	16.1%
$100,000 to $149,999	87	21.5%
$150,000 to $199,999	27	6.7%
$200,000 or more	34	8.4%
Prefer not to answer/Unknown	53	13.1%

Question 22: What, if any, are your main barriers to accessing mental or behavioral health services if needed? Select all that apply. (N=2,434 – respondents could select multiple responses)



Value	Percent	Count
No regular doctor	10.3%	251
Cost of seeing doctor	17.1%	417
No insurance	4.9%	119
Uncomfortable with doctor	3.1%	75
Doctors office hours don’t work with my schedule	4.9%	120
Stigma of mental or behavioral health / nervous about admitting I have a mental or behavioral health concern	13.3%	324
Other (please specify)	15.7%	381
I have no barriers to accessing mental or behavioral health care	57.9%	1,409

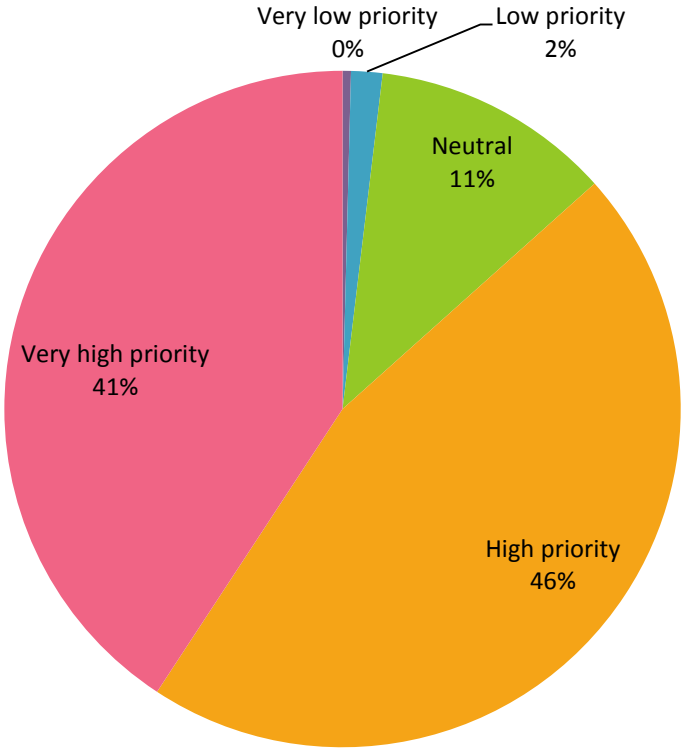
Question 23: If you required mental or behavioral health services, where would you go first for treatment? Assume that this is not an emergency situation. (N=2,455)



Value	Percent	Count
Doctor's office (primary care physician, family physician, internist, pediatrician, etc.)	47.5%	1,166
Specialist's office (psychologist or psychiatrist, etc.)	31.8%	780
Drugstore clinics, such as Minute Clinic at CVS or Walgreens clinic	0.2%	6
Emergency room / department at hospital	0.4%	11
I wouldn't go to a doctor unless it was an emergency	4.7%	116
Other (please specify)	5.8%	143
Not sure	9.5%	233

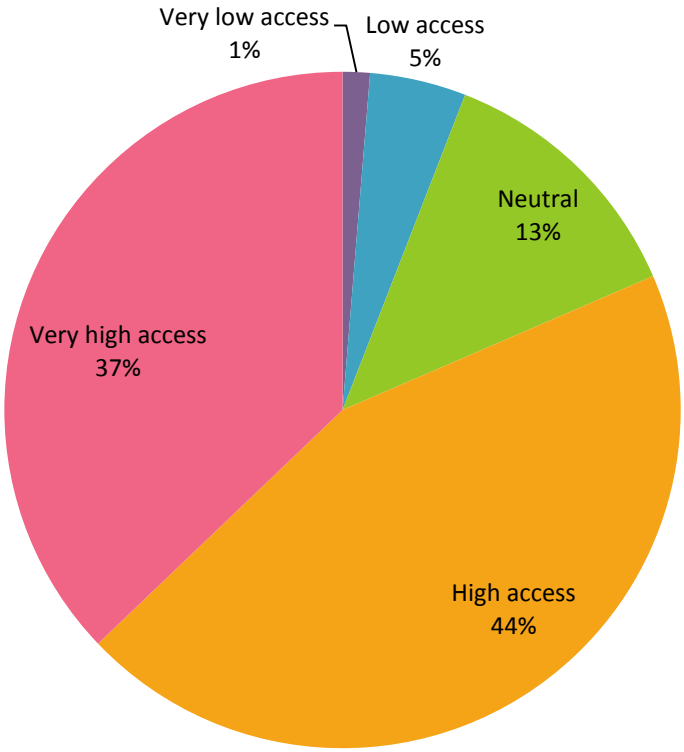
Question 24: How do you define healthy food access? (N=2,080)

Question 25: How much of a priority do you place on healthy food access? (N=2,466)



Value	Percent	Count
Very low priority	0.4%	10
Low priority	1.5%	37
Neutral	11.5%	283
High priority	45.9%	1,131
Very high priority	40.8%	1,005

Question 26: How would you rate your current access to healthy food? (N=2,460)



Value	Percent	Count
Very low access	1.3%	33
Low access	4.6%	113
Neutral	12.6%	311
High access	44.3%	1,090
Very high access	37.1%	913

COMPARISON OF ACCESS BY INCOME LEVEL: HEALTHY FOOD

Very low access	33	
Less than $25,000	12	36.4%
$25,000 to $34,999	2	6.1%
$35,000 to $49,999	4	12.1%
$50,000 to $74,999	7	21.2%
$75,000 to $99,999	2	6.1%
$100,000 to $149,999	1	3.0%
$150,000 to $199,999	1	3.0%
$200,000 or more	1	3.0%
Prefer not to answer	3	9.1%

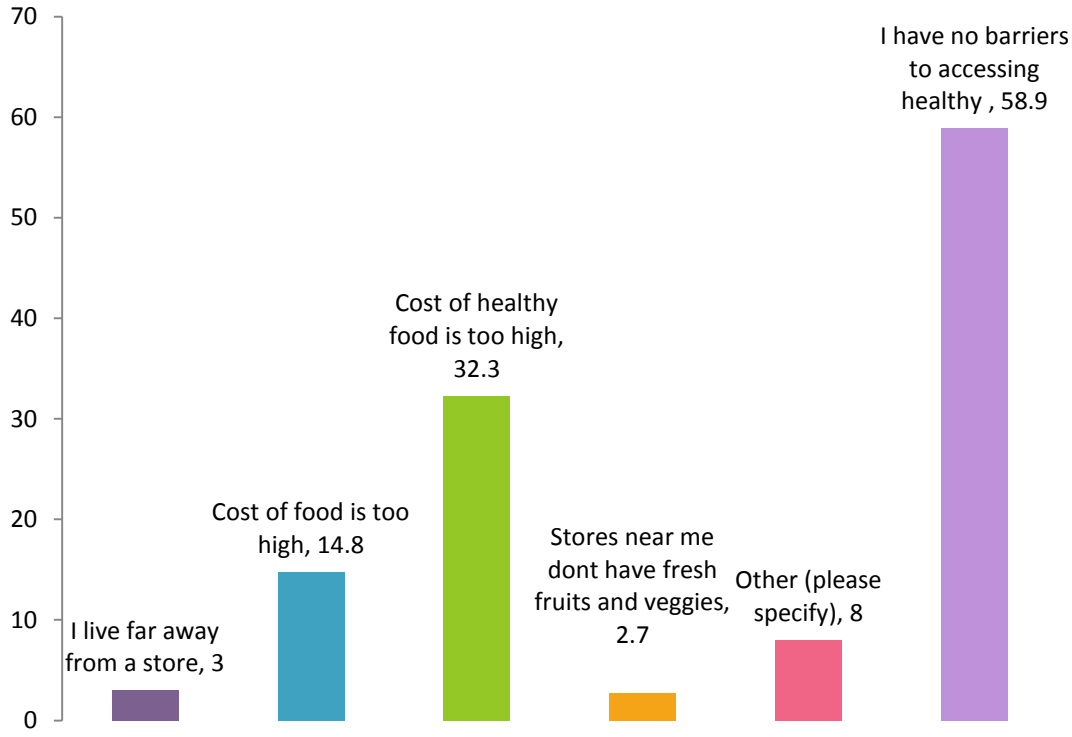
Low access	113	
Less than $25,000	23	20.4%
$25,000 to $34,999	18	15.9%
$35,000 to $49,999	12	10.6%
$50,000 to $74,999	20	17.7%
$75,000 to $99,999	11	9.7%
$100,000 to $149,999	17	15.0%
$150,000 to $199,999	2	1.8%
$200,000 or more	1	0.9%
Prefer not to answer	9	8.0%

Neutral	311	
Less than $25,000	44	14.1%
$25,000 to $34,999	37	11.9%
$35,000 to $49,999	45	14.5%
$50,000 to $74,999	42	13.5%
$75,000 to $99,999	42	13.5%
$100,000 to $149,999	39	12.5%
$150,000 to $199,999	17	5.5%
$200,000 or more	7	2.3%
Prefer not to answer/Unknown	38	12.2%

High access	1090	
Less than $25,000	68	6.2%
$25,000 to $34,999	74	6.8%
$35,000 to $49,999	109	10.0%
$50,000 to $74,999	206	18.9%
$75,000 to $99,999	168	15.4%
$100,000 to $149,999	202	18.5%
$150,000 to $199,999	68	6.2%
$200,000 or more	47	4.3%
Prefer not to answer/Unknown	148	13.6%

Very high access	913	
Less than $25,000	32	3.5%
$25,000 to $34,999	35	3.8%
$35,000 to $49,999	67	7.3%
$50,000 to $74,999	136	14.9%
$75,000 to $99,999	164	18.0%
$100,000 to $149,999	206	22.6%
$150,000 to $199,999	79	8.7%
$200,000 or more	75	8.2%
Prefer not to answer/Unknown	119	13.0%

Question 27: What, if any, are the main barriers to accessing healthy food? Select all that apply. (N=2,460 – respondents could select multiple responses)



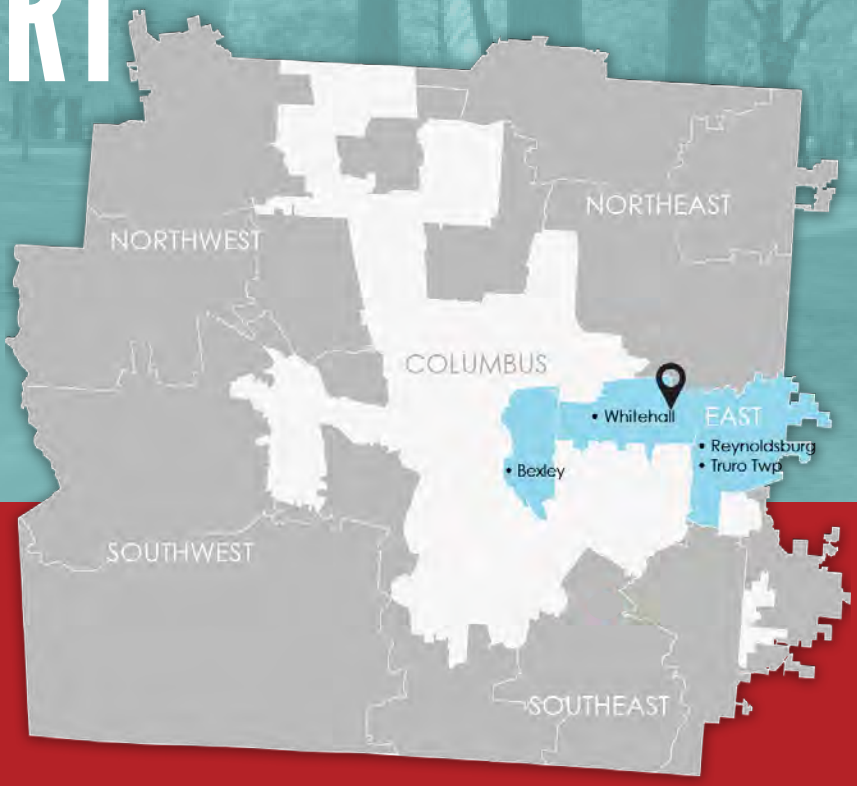
Value	Percent	Count
I live far away from a store	3.0%	73
Cost of food is too high	14.8%	363
Cost of healthy food is too high	32.3%	795
Stores near me don't have fresh fruits and vegetables, only packaged foods	2.7%	66
Other (please specify)	8.0%	198
I have no barriers to accessing healthy food	58.9%	1,449

Question 28: What is your single most important health-related concern? (N=2,147)

Appendix B:
Regional Community Forum Reports

Franklin County
Public Health

EAST REGION FORUM REPORT 2017



Franklin County Community Health Forum

The vision of Franklin County Public Health is to lead our communities in achieving optimal health for all. We believe the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) are major steps in fulfilling our role as the public health Chief Health Strategist by working in structured, cross-sector partnerships, addressing the social determinants of health, and making timely, reliable, and actionable data accessible to communities.

Franklin County Public Health (FCPH) would like to thank its local communities for your participation in our 2017 Community Forums. These forums were conducted as a part of a Community Health Assessment process. State and local health departments use the CHA as a way to identify key health needs and concerns through a comprehensive data collection and analysis effort. A CHA includes collaboration that supports shared ownership for phases of community health improvement, such as assessment, planning, investment, implementation, and evaluation.

An ideal health assessment includes:

- Participation from a variety of sectors such as local community members, businesses, faith based organizations, stakeholders and other public health organizations.
- Demographic information.
- Information on risk factors, quality of life, mortality, morbidity, community assets, social determinants of health and health inequity.
- Descriptions of health issues for specific populations and any health disparities, factors contributing to health challenges, community assets and/or resources.
- Data from a variety of sources and in a variety of forms (qualitative, quantitative, primary, and secondary).
- A variety of data collection methods (i.e. surveys, interviews, focus groups, or community forums, etc.).

Franklin County Community Health Forum

One of the essential ingredients of this CHA is community engagement and collaborative participation. The CHA is an important piece in the development of a CHIP because it helps the community understand the health and health related issues that need addressed. It also provides the most current and reliable information about the health status of a community and where gaps may exist in achieving optimal health.

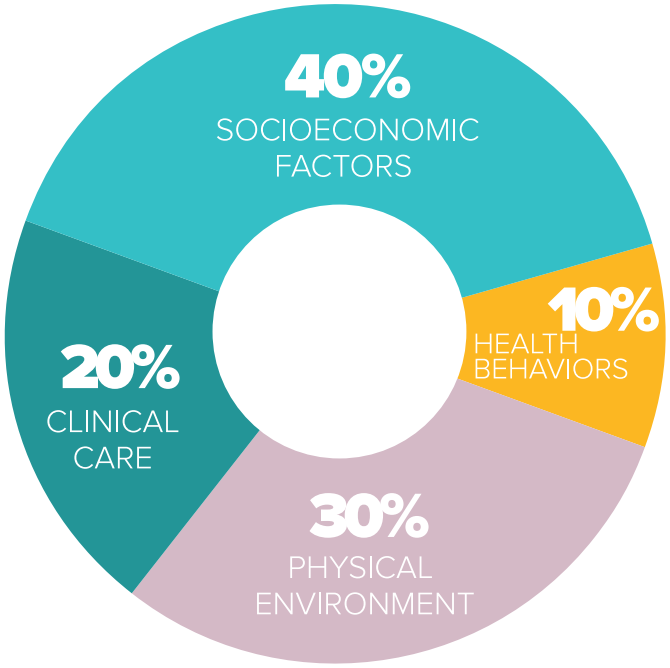
In July of 2017, FCPH collaborated with 5 community partners: Mount Carmel East; Ohio Health Doctors Hospital; Ohio University Dublin, Integrated Education Center; Madison Township Community Center; and Healthy New Albany to host the forums. The information in this report represents the process and outcomes of the East Regional Forum hosted by Mount Carmel East. FCPH would like to express our thanks and appreciation to Mount Carmel East for their generous contributions and support of the forum. The community forum would not have been possible without this support.

COMMUNITY FORUM OVERVIEW AND PRESENTATIONS

The East Region Community Forum was kicked off with a welcome, introduction and overview of FCPH by the Health Commissioner. A PowerPoint presentation highlighted information about the role of the health department including it being accredited by the Public Health Accreditation Board (PHAB); its mandates, priorities, initiatives, and an overview of who we serve in Franklin County. This was followed by a presentation given by the Director and a Senior Research Scientist, from the Center for Population Health and Equity Research, Research Institute at Nationwide Children's Hospital (NCH) provided information about why achieving health equity leads to optimal health for everyone.

Achieving health equity leads to optimal health for everyone

NCH indicates health equity means that everyone has a fair opportunity to live a long, healthy life. It implies that health should not be compromised or disadvantaged because of an individual or population group's race, ethnicity, gender, income, sexual orientation, neighborhood or other social condition. For example, the chart on the next page illustrates why clinical care alone isn't enough to improve health outcomes, as well as the significant importance of addressing the social determinants of health which creates an environment for achieving health equity.



Clinical care alone isn't enough to improve health outcomes*

At the conclusion of this presentation, instructions were given for the breakout sessions and community participants engaged in a dialogue and provided feedback regarding the most pressing health care needs impacting their communities. The breakout sessions process is highlighted below.

BREAKOUT SESSION

In order to understand the health concerns of each community, breakout sessions were established and run by a facilitator. As part of the breakout sessions, a volunteer scribe was identified to write down group responses on a flip chart to keep track of all responses. A packet of questions and directions pertaining to each breakout session were handed to all community members participating in the breakout sessions.

There are three parts to each breakout session:

- **Part 1**
  focused on the community's themes and strengths
- **Part 2**
  focused on identifying the top priority needs of their community
- **Part 3**
  focused on strategies to address the top five needs of the community

*Source: Health Equity Presentation, 2017

PART 1 | RESULTS

Breakout Session Part 1 started with two questions to help FCPH identify what community members believed were the greatest assets of their community:

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

What makes you proud of your community?

After providing a few minutes for thoughtful answers, facilitators then created a discussion surrounding what members had written down.

Upon reflecting on answers and creating a group consensus of 2-3 answers, the volunteer scribe wrote down answers for collection purposes.

EMERGING THEMES

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

- Safety and community engagement
- Reliable infrastructure
- Accessibility to food

Safety and community engagement

- Gun violence
- Drug free neighborhoods
- Population longevity for all groups
- Access to medical facilities
- Community health fairs
- Encouragement of socializing with neighbors to foster safety and security

Reliable Infrastructure

- Swimming pools
- Walking and biking paths to encourage fitness and healthy living

Access to food

- Establishing more food banks
- Increasing resources for those in need
- Creating access to nutritious food options at an affordable cost

2 What makes you proud of your community?

- Great medical facilities
- Positive interactions between citizens
- Increased green space for walking and hiking, and the establishment of places such as the Columbus Commons

PART 2 | RESULTS

Focus on the selection of community health priorities. FCPH created a list of 30 health priorities, 15 of which were health concerns, and 15 of which were environmental concerns. The list of community health priorities are as follows:

HEALTH CONCERNS

Cardiovascular Disease: such as, heart disease, hypertension, coronary artery disease, congestive heart disease, heart failure,heart attack (MI), and stroke.

Diabetes: such as pre-diabetes, diabetes mellitus 1, diabetes mellitus 2, insulin dependent diabetes, and non-insulin dependent diabetes.

Chronic Respiratory Disease: such as asthma, COPD, and childhood or adult lung disease.

Obesity: such as overweight, obesity, morbid obesity, healthy weight, and weight reduction, childhood or adult.

Cancer: such as lung, breast, prostate, cervical, or any other type of cancer.

Infectious Diseases: such as sexually transmitted infections (STIs), influenza, hospital-acquired novel virus, HIV, hepatitis C, and access to and completion of recommended immunizations.

Maternal and Infant Health: such as prenatal care through the first year of life, focusing on infant mortality, low birth weight, and prematurity.

Oral Health: such as dental care/treatment, cavities, and extractions.

Drug and Alcohol Abuse: such as addiction, abuse, misuse, or dependence of alcohol, marijuana, prescription drugs, opioids, heroin, and MDMA.

Mental Health: such as depression, PTSD, bipolar disorder, schizophrenia, stress, emotional well-being, coping skills, suicide, and other behavioral health concerns.

Tobacco: such as use of cigarettes, cigars, hookah, e-cigarettes, chew, and flavored products.

Physical Activity: such as fitness, exercise, sedentary lifestyle, and active living with a focus on individual behaviors.
Nutrition: such as diet, junk food consumption, and healthy eating with focus on individual behaviors.

Sexual and Reproductive Health: such as sexual activity, condom use, prevention of unplanned pregnancy/teen pregnancy, and use of contraception.

Violence: such as physical and emotional violence, relationship or intimate partner violence, domestic violence, child abuse, elder abuse, sexual violence, street violence, and bullying.

ENVIRONMENTAL CONCERNS

Injury: such as motor vehicle/motorcycle, bicycle, occupational safety, gun-related injuries or deaths, and falls.

Employment, Poverty, and Income: such as concerns in unemployment rate, poverty rate, wages, and working conditions.

Education: such as preschool enrollment, school readiness, academic success, high school graduation, and educational attainment.

Family and Social Support: such as social-emotional support, social capital and cohesion, single-parent households, and racism.

Housing: such as concerns in affordable housing, housing conditions (mold, heat), and residential segregation.

Transportation: such as access to active and public transportation, commute times, driving alone to work/carpool, and transportation to healthcare services.

Air, Water, and Toxic Substances: such as pollution, secondhand smoke, drinking water, fluoridation, and lead poisoning.

Food Environment: such as healthy food access, food safety, food insecurity, and farmers markets.

Active Living Environments: such as green space, fitness opportunities, complete streets, trail, children walking/biking to school, and parks.

Coverage and Affordability: such as uninsured, underinsured, out of pocket expenses, high deductible health plans, medication coverage and cost.

Access to Health Care/Medical Care: such as number of providers, distribution of providers, access to patient-centered medical home, access to primary care, access to specialty care (not including dental or behavioral health), and wait time.

Access to Behavioral Health Care: such as number of providers, distribution of providers, access to behavioral health / treatment specialists (includes mental health and a substance use treatment providers).

Access to Dental Care: such as number of providers, distribution of providers, specific dental coverage, and access to dental clinics.

Equality/Disparities: such as one group of people having worse health conditions than others.

After reading through all thirty community priorities, participants were asked to rank their top 10 priorities (1 = highest priority; 10 = lowest priority). After determining the top 10 priorities, the volunteer scribe tallied up votes for each of the 30 health concerns in a large poster listing each item. The items with the highest number of tallies were selected to narrow down popular health concerns amongst community members.

EAST REGION TOP PRIORITY CONCERNS

1. **Obesity**
2. **Drug and Alcohol Abuse**
3. **Mental Health**
4. **Nutrition**
5. **Employment, Poverty and Income**
6. **Education**
7. **Housing**
8. **Access To Health Care/Medical Care**

Using an evidence-based prioritization method from the National Association of County and City Health Officials (NACCHO), American Society of Quality (ASQ), and various state and local health departments, FCPH engaged participants in a multivoting process to narrow down the top priorities to no more than 3 – 5 priorities. The multivoting process is employed to reduce a long list of ideas and identify the most important items on a list. The multivoting process was conducted as follows:

1. **Round 1:** Present the list of health problems. Each participant must vote for their top ten priority items individually out of the list of 30 health and environmental concerns.
2. **Update List:** Health problems are eliminated if the vote count does not meet the minimum vote count requirement. The minimum number of votes needed to advance to the next round of voting varies with the number of group participants. The voting process used can be seen in Table 1.

Number of Group Members	Items to be Eliminated
5 or fewer members	2 or fewer votes
6 to 15 members	3 or fewer votes
More than 15 members	4 or fewer votes

Table 1. Voting Elimination Process.

These tallies were marked on a poster with the health concerns. Discuss the highest priority items on the condensed list.

3. **Round 2:** Each participant voted for their highest priority items of this condensed list.

EAST REGION KEY PRIORITIES IDENTIFIED

MAJOR PRIORITY CONCERNS

Obesity

Major concerns regarding Priority 1

- Obesity leads to many other diseases
- Obesity is a huge problem in the United States. Franklin County data suggests that 60% of people are obese
- Affects family structure

Drug and Alcohol Abuse

Major concerns regarding Priority 2

- Begin taking responsibility for drug and alcohol abuse
- View it as a behavioral issue
- Families are heavily affected (i.e. parents who are drug users
  that can affect children and their perception towards drug use and alter genetic predispositions)
- Many news stories are related to drug and alcohol abuse
- Economic impact on communities
- Research and education towards addictions, diseases, and impacts of drug and alcohol abuse

Mental Health

Major concerns regarding Priority 3

- Still a taboo topic
- Educating others on mental health
- Combating stigma
- Addressing gender inequality
- Creating affordable access to medications
- Increasing access to behavioral care

Nutrition

Major concerns regarding Priority 4

- Adds to one's overall sense of health, both mentally and physically
- Increased accessibility and affordability of poor nutritious choices compared to healthy options
- Community education towards affordable nutritious food options
- Lowering costs of healthy food and groceries
- Catering nutritious options to those with other problems such as obesity and diabetes

The four priorities listed above emerged as the major areas of concern for the East Region, and were the priorities used in the breakout session part three strategy identification. However, the report includes all the priorities that community members felt were important. Listed below are the remaining priorities identified by the group and a brief overview of their importance to community members.

IMPORTANT PRIORITIES

Employment, Poverty, and Income

Priority 5

East Region participants expressed concerns about high taxation and property taxes which has an impact on a community's socioeconomic status. Participants also mentioned how lack of employment led to lack of income which in turn leads to poverty. Another area of concern was the welfare system and the need to increase opportunities for livable wages. Participants also mentioned housing, and the need for basic living conditions to be established and maintained throughout a community.

Education

Priority 6

Current education system needs overhauling and its need to become better regulated across all ranges – whether it is elementary, middle, high, or university level schooling.

Access to Health Care

Priority 7

Lack of access to primary care providers, being unable to utilize healthcare, and increased rates of ER use leading to increased costs associated with healthcare.

PART 3 | RESULTS

Breakout Session Part 3 focused on finalizing the top 3 - 5 priorities and getting consensus around the order and description of the concern. As a result the East Region decided to focus on Nutrition vs. Obesity as one of the major health concerns. After reaching consensus, participants discussed potential strategies to help address these health concerns.

EAST REGION TOP PRIORITY FOCUS

1. **Nutrition**
2. **Mental Health**
3. **Employment, Poverty and Income**
4. **Access To Health Care/Medical Care**

Given the small size of this community forum there was only 1 breakout group and the results were discussed within the group.

Nutrition | PRIORITY 1

POTENTIAL SOLUTIONS:

- Education
- Removing soda machines
- Increasing the number of farmers markets
- Establishing community gardens
- Removing the food pyramid
- Educating new generations to support healthier food options
- Providing community support for both mental and emotional support
- Educate others on genetics and obesity

Mental Health | PRIORITY 2

POTENTIAL SOLUTIONS:

- Combine efforts for mental health diseases and access to medical care
- Reducing stigma
- Increasing hotlines
- Creating support groups
- Providing education at places such as churches
- Consistent messaging across groups

Employment, Poverty, and Income | PRIORITY 3

POTENTIAL SOLUTIONS:

- Advocate for the change to school curriculum
- Encourage teaching students skill based training and trade skills
- Providing tax abatements for employers
- Providing parenting support for families

Increase Access to Healthcare | PRIORITY 4

POTENTIAL SOLUTIONS:

- Advocating the use of small clinics
- Decreasing costs associated with healthcare

LEARN MORE

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BECAUSE OF YOU
MOUNT CARMEL

Franklin County
Public Health

Franklin County Public Health
280 East Broad Street
Columbus, Ohio 43215-4562

Phone: (614) 525-3160
Email: fcph@franklincountyohio.gov
Web: myfcph.org

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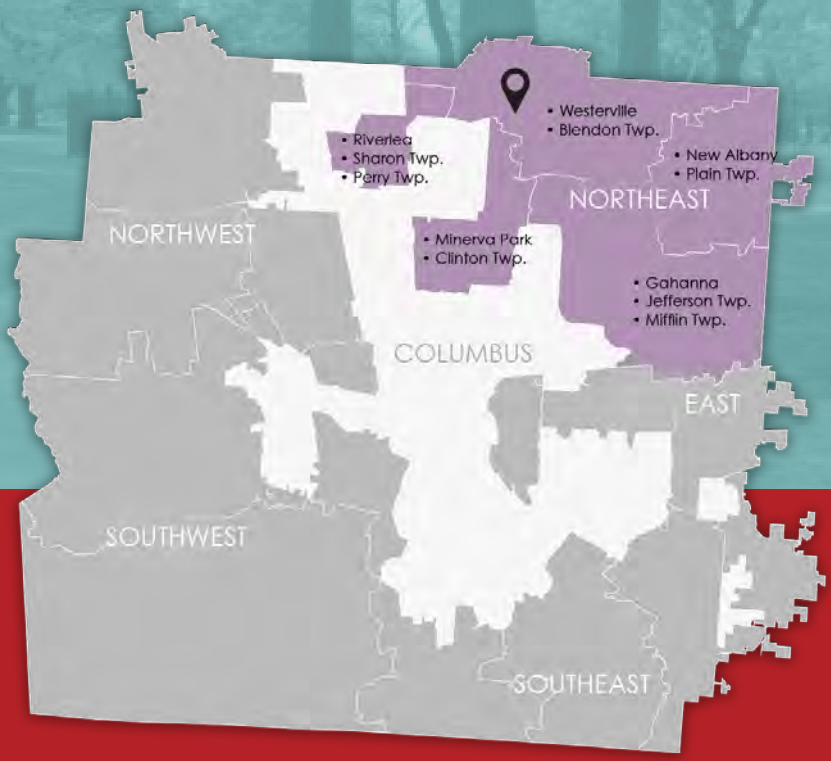
Public Health

NORTHEAST REGION FORUM REPORT 2017



Franklin County Community Health Forum

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Franklin County Public Health would like to thank its local communities for your participation in our 2017 Community Forums. These forums were conducted as a part of a CHA process. State and Local Health Departments use the CHA as a way to identify key health needs and concerns through a comprehensive data collection and analysis effort. A CHA includes collaboration that supports shared ownership for phases of community health improvement, such as assessment, planning, investment, implementation, and evaluation.

An ideal health assessment includes:

- Participation from a variety of sectors such as local community members, businesses, faith based organizations, stakeholders and other public health organizations.
- Demographic information.
- Information on risk factors, quality of life, mortality, morbidity, community assets, social determinants of health and health inequity.
- Descriptions of health issues for specific populations and any health disparities, factors contributing to health challenges, community assets and/or resources.
- Data from a variety of sources and in a variety of forms (qualitative, quantitative, primary, and secondary).
- A variety of data collection methods (i.e. surveys, interviews, focus groups, or community forums, etc.).

Franklin County Community Health Forum

The essential ingredients of this CHA are community engagement and collaborative participation. The CHA is an important piece in the development of a CHIP because it helps the community understand the health and health related issues that need addressed. It also provides the most current and reliable information about the health status of a community and where gaps may exist in achieving optimal health.

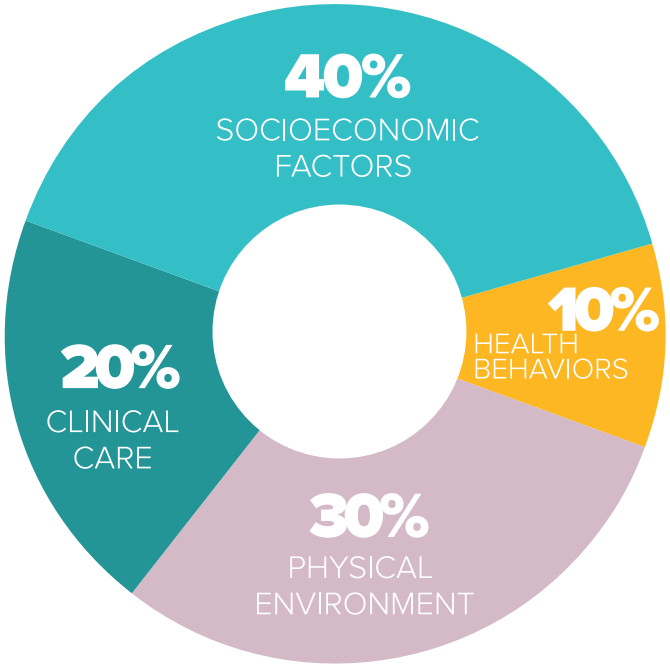
In July of 2017, FCPH collaborated with 5 community partners: Mount Carmel East; Ohio Health Doctors Hospital; Ohio University Dublin Integrated Education Center; Madison Township Community Center; and Healthy New Albany to host Regional Forums. The information in this report represents the process and outcomes of the Northeast Regional Forum hosted by Healthy New Albany. FCPH would like to express our thanks and appreciation to Healthy New Albany for their generous contributions and support of the forums. The community forum would not have been possible without this support.

COMMUNITY FORUM OVERVIEW AND PRESENTATIONS

The Northeast Region Community Forum was kicked off with a welcome, introduction and overview of FCPH by the Health Commissioner. A PowerPoint presentation highlighted information about the role of the health department including it being accredited by the Public Health Accreditation Board (PHAB); its mandates, priorities, initiatives, and an overview of who we serve in Franklin County. This was followed by a presentation given by the Director and a Senior Research Scientist, from the Center for Population Health and Equity Research, Research Institute at Nationwide Children's Hospital (NCH) provided information about why achieving health equity leads to optimal health for everyone.

Achieving health equity leads to optimal health for everyone

NCH indicates health equity means that everyone has a fair opportunity to live a long, healthy life. It implies that health should not be compromised or disadvantaged because of an individual or population group's race, ethnicity, gender, income, sexual orientation, neighborhood or other social condition. In conjunction with health equity, social determinants of health play a large role in determining health outcomes. Social determinants of health are environmental factors in one's place of residence, work, worship, or play that affect one's quality of life and health outcomes. For example, the chart on the next page illustrates why clinical care alone isn't enough to improve health outcomes, as well as the significant importance of addressing the social determinants of health which creates an environment for achieving health equity.



Clinical care alone isn't enough to improve health outcomes*

At the conclusion of this presentation, instructions were given for the breakout sessions and community participants engaged in a dialogue and provided feedback regarding the most pressing health care needs impacting their communities. The breakout sessions process is highlighted below.

BREAKOUT SESSION

In order to understand the health concerns of each community, breakout sessions were established and run by a facilitator. As part of the breakout sessions, a volunteer scribe was identified to write down group responses on a flip chart to keep track of all responses. A packet of questions and directions pertaining to each breakout session were handed to all community members participating in the breakout sessions.

There are three parts to every breakout session:

There are three parts to each breakout session:

- **Part 1**
  focused on the community's themes and strengths
- **Part 2**
  focused on identifying the top priority needs of their community
- **Part 3**
  focused on strategies to address the top five needs of the community

*Source: Health Equity Presentation, 2017

PART 1 | RESULTS

Breakout session Part 1 started with two questions to help FCPH identify what community members believed were the greatest assets of their community:

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

What makes you proud of your community?

After providing a few minutes for thoughtful answers, facilitators then created a discussion surrounding what members had written down.

Upon reflecting on answers and creating a group consensus of 2-3 answers, the volunteer scribe wrote down answers for collection purposes.

EMERGING THEMES

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

- Safety
- Community Engagement
- Education

For this community forum, participants were separated into two groups. Each group provided responses regarding various aspects of healthy communities.

GROUP 1

- Instersectionality
- Greenspace
- Access to food and healthcare
- Equity
- Community health education
- Vibrant community

GROUP 2

- Access to food, shelter, and healthcare
- Community connections
- Physical activity
- Healthy environments
- Education focused on health prevention
- Community recreational places
- Proactive leadership
- Equal access / opportunities

EMERGING THEMES

2 What makes you proud of your community?

- Safe and engaged communities
- Community effort to improve
- Community activities

GROUP 1

- The Ohio State University
- Cultural arts
- Volunteerism
- Neighborhood connections
- Cleanliness and aesthetically pleasing
- Civic engagement

GROUP 2

- Emphasis on health goal of being the healthiest city
- Institutional actors and their involvement to work together
- Availability of services
- Leadership in the city
- Recreational centers
- Physical activity
- Community collaboration

PART 2 | RESULTS

Breakout Session Part 2 focused on the selection of community health priorities. FCPH created a list of 30 health priorities, 15 of which were health concerns, and 15 of which were environmental concerns. The list of community health priorities are as follows:

HEALTH CONCERNS

Cardiovascular Disease: such as, heart disease, hypertension, coronary artery disease, congestive heart disease, heart failure,heart attack (MI), and stroke.

Diabetes: such as pre-diabetes, diabetes mellitus 1, diabetes mellitus 2, insulin dependent diabetes, and non-insulin dependent diabetes.

Chronic Respiratory Disease: such as asthma, COPD, and childhood or adult lung disease.

Obesity: such as overweight, obesity, morbid obesity, healthy weight, and weight reduction, childhood or adult.

Cancer: such as lung, breast, prostate, cervical, or any other type of cancer.

Infectious Diseases: such as sexually transmitted infections (STIs), influenza, hospital-acquired novel virus, HIV, hepatitis C, and access to and completion of recommended immunizations.

Maternal and Infant Health: such as prenatal care through the first year of life, focusing on infant mortality, low birth weight, and prematurity.

Oral Health: such as dental care/treatment, cavities, and extractions.

Drug and Alcohol Abuse: such as addiction, abuse, misuse, or dependence of alcohol, marijuana, prescription drugs, opioids, heroin, and MDMA.

Mental Health: such as depression, PTSD, bipolar disorder, schizophrenia, stress, emotional well-being, coping skills, suicide, and other behavioral health concerns.

Tobacco: such as use of cigarettes, cigars, hookah, e-cigarettes, chew, and flavored products.

Physical Activity: such as fitness, exercise, sedentary lifestyle, and active living with a focus on individual behaviors.
Nutrition: such as diet, junk food consumption, and healthy eating with focus on individual behaviors.

Sexual and Reproductive Health: such as sexual activity, condom use, prevention of unplanned pregnancy/teen pregnancy, and use of contraception.

Violence: such as physical and emotional violence, relationship or intimate partner violence, domestic violence, child abuse, elder abuse, sexual violence, street violence, and bullying.

ENVIRONMENTAL CONCERNS

Injury: such as motor vehicle/motorcycle, bicycle, occupational safety, gun-related injuries or deaths, and falls.

Employment, Poverty, and Income: such as concerns in unemployment rate, poverty rate, wages, and working conditions.

Education: such as preschool enrollment, school readiness, academic success, high school graduation, and educational attainment.

Family and Social Support: such as social-emotional support, social capital and cohesion, single-parent households, and racism.

Housing: such as concerns in affordable housing, housing conditions (mold, heat), and residential segregation.

Transportation: such as access to active and public transportation, commute times, driving alone to work/carpool, and transportation to healthcare services.

Air, Water, and Toxic Substances: such as pollution, secondhand smoke, drinking water, fluoridation, and lead poisoning.

Food Environment: such as healthy food access, food safety, food insecurity, and farmers markets.

Active Living Environments: such as green space, fitness opportunities, complete streets, trail, children walking/biking to school, and parks.

Coverage and Affordability: such as uninsured, underinsured, out of pocket expenses, high deductible health plans, medication coverage and cost.

Access to Health Care/Medical Care: such as number of providers, distribution of providers, access to patient-centered medical home, access to primary care, access to specialty care (not including dental or behavioral health), and wait time.

Access to Behavioral Health Care: such as number of providers, distribution of providers, access to behavioral health / treatment specialists (includes mental health and a substance use treatment providers).

Access to Dental Care: such as number of providers, distribution of providers, specific dental coverage, and access to dental clinics.

Equality/Disparities: such as one group of people having worse health conditions than others.

After reading through all thirty community priorities, participants were asked to rank their top 10 priorities (1 = highest priority; 10 = lowest priority). After determining the top 10 priorities, the volunteer scribe tallied up votes for each of the 30 health concerns in a large poster listing each item. The items with the highest number of tallies were selected to narrow down popular health concerns amongst community members.

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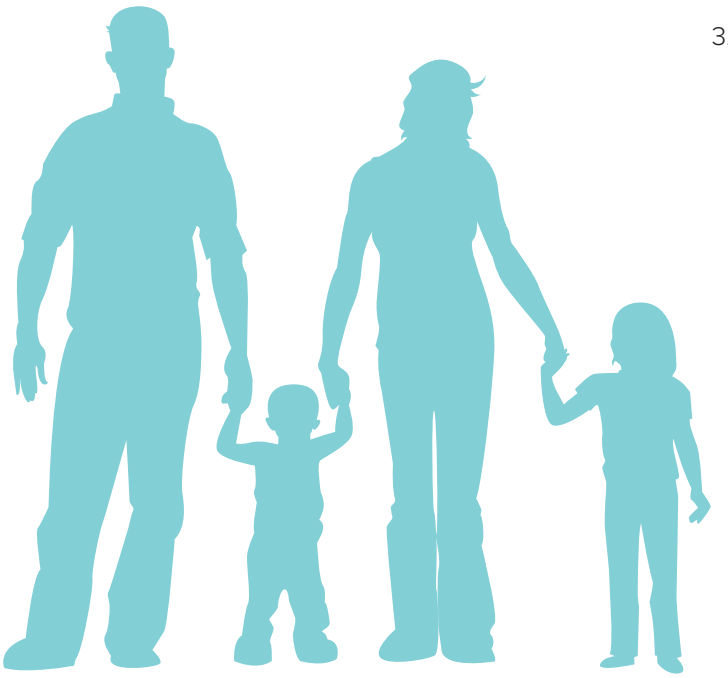

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Number of Group Members	Items to be Eliminated
5 or fewer members	2 or fewer votes
6 to 15 members	3 or fewer votes
More than 15 members	4 or fewer votes

Table 1. Voting Elimination Process.

These tallies were marked on a poster with the health concerns. Discuss the highest priority items on the condensed list.

3. **Round 2:** Each participant votes for their highest priority items of this condensed list. In this round, participants can vote a number of times equivalent to one-third the number of health problems on the list (e.g. if six items remain on the list, each participant can cast two votes). Repeat process until 3 – 5 priority items are identified.

Group 1 Priorities

FOOD ENVIRONMENT
HOUSING
ACCESS TO HEALTHCARE
EDUCATION
PHYSICAL ACTIVITY

MAJOR CONCERNS

Priority 1 | Food Environment

- Basic need
- Healthy options
- Food deserts
- Education on nutrition (i.e. how to use what you have in a healthy way and make money stretch)
- Operational appliances
- Food access grading / transparency
- Local suppliers (volunteers bringing awareness)
- Food is healthcare

Priority 2 | Housing

- Foundational – Housing is a basic need
- Housing first model
- Security
- Childhood development
- Healthy homes = safe homes
- Working appliances

Priority 3 | Access to Healthcare

- Include mental, dental, and vision care
- Holistic care
- Prevention first model
- Difficulty in fulfilling other needs (i.e. mental health)
- Build a relationship with provider to ask questions
- Health equity
- Cultural understanding by physicians

Priority 4 | Education

- Foundational, present
- Breaks poverty cycle
- Knowledge is power and encourages social skills
- Helps mental health

Priority 5 | Physical Activity

- Linked to chronic illnesses (preventative)
- Active living environment encourages
- Self-care
- Community engagement
- Cost effective

Group 2 Priorities

EDUCATION
PHYSICAL ACTIVITY
CARDIOVASCULAR DISEASE
OBESITY
MENTAL HEALTH
NUTRITION
ACTIVE LIVING ENVIRONMENT
COVERAGE & AFFORDABILITY
ACCESS TO HEALTHCARE
ACCESS TO BEHAVIORAL CARE

MAJOR CONCERNS

Priority 1 | Education

- Umbrella determinant of health
- Information

Priority 2 | Physical Activity

- Cure to getting old
- Addresses many health conditions
- Preventative treatment

Priority 3 | Nutrition

- Diet and exercise

The priorities listed above emerged as the major areas of concern for Group 2, and were the priorities used in the breakout session for strategy identification. The following are the remaining priorities identified by the group and a brief overview of their importance to community members.

Priority 4 | Cardiovascular Disease

Participants mentioned that it is the number one killer.

Priority 5 | Obesity

Group 2 participants in the Northeast Region expressed concerns about how this issue correlates with many chronic conditions. In addition, malnutrition is another concern with this issue.

Priority 6 | Mental Health

Participants believe it is important to seek help and increase awareness and education. They also mentioned the number of homeless individuals who are affected by mental health. They also were concerned about its increased prevalence and the lack of understanding behind mental health illnesses.

Priority 7 | Active Living Environment

Active living environments are important to promote healthy living.

Priority 8 | Coverage and Affordability

No coverage leads to lack of care. Coverage needs to be addressed

Priority 9 | Access to Healthcare

Having access to healthcare can relieve the stress and anxiety associated with finding medical care. Additionally, increasing availability and access is important.

Priority 10 | Access to Behavioral Care

Increases in suicide rates need to be addressed. School systems need to increase education and availability associated with behavioral care.

PART 3 | RESULTS

Breakout Session Part 3 focused on finalizing the top 3 - 5 priorities and getting consensus around the order and description of the concern. After reaching consensus, participants identified current gaps and provided potential strategies to help address these health concerns.

Group 1 Priorities

Food Environment | PRIORITY 1

POTENTIAL SOLUTIONS:

- Make healthy eating habits a part of the message in churches, schools, and community centers
- Healthy meeting foods
- Model behavior
- Community recipes and cost breakdown
- Hospitals should model healthy behaviors
- Leveraging power as the community to leave bad foods out
- Leveraging with education

Housing | PRIORITY 2

POTENTIAL SOLUTIONS:

- Awareness and accountability
- Bring groups to fairs and community events
- Housing segregation exists = must address housing segregation
- Connecting with resources
- Voice for voiceless in decision making
- Community ownership for vacant housing
- Community development corporations – shave belt practices

Access to Healthcare | PRIORITY 3

POTENTIAL SOLUTIONS:

- Equity
- Employment
- Look upstream (culture)
- Schools, churches, and community centers should engage medical providers
- Change nature of physicians such as the required paperwork and the limited times
- Put “care” back in healthcare
- Lobbying
- Stop “public shaming” associated with pharmacies

Education | PRIORITY 4

POTENTIAL SOLUTIONS:

- Educate the community on voting
- Lobby the state and bring community together
- Bring in local organizations

Physical Activity | PRIORITY 5

POTENTIAL SOLUTIONS:

- Educating people on options
- Being grateful and knowing you can work out and be active
- Make it practical such as taking stairs, placing bike racks at work, bike rentals, and showers
- Integrating into other social activities
- Normalize

PART 3 | RESULTS

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Group 2 Priorities

Education | PRIORITY 1

POTENTIAL SOLUTIONS:

- Place physical fitness facilities close to schools and educate children on healthy lifestyles
- Place clinics in school that are made up of various health care professionals to bring education and health services such as doctors, social workers, counselors, etc.

Physical Activity | PRIORITY 2

POTENTIAL SOLUTIONS:

- Workplace interventions
- Physical activities for workers and schools
- Incentivize fitness programs
- Increase awareness of benefits of physical activity and increase education

Nutrition | PRIORITY 3

POTENTIAL SOLUTIONS:

- Educate food workers
- Produce prescriptions in food pantries
- Educate healthier choices at fast food locations
- Increase cooking classes and provide healthy food recipes
- Calorie notifications on menus
- Increase parental control over child food intake

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HEALTHY NEW ALBANY

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Public Health

Franklin County Public Health
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Phone: (614) 525-3160
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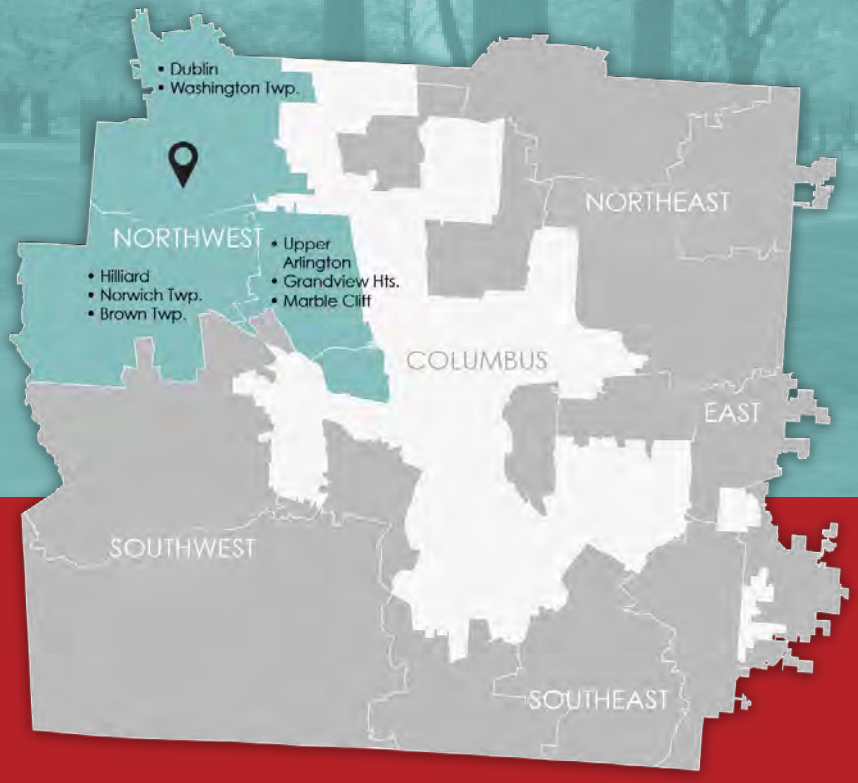
NORTHWEST REGION FORUM REPORT 2017



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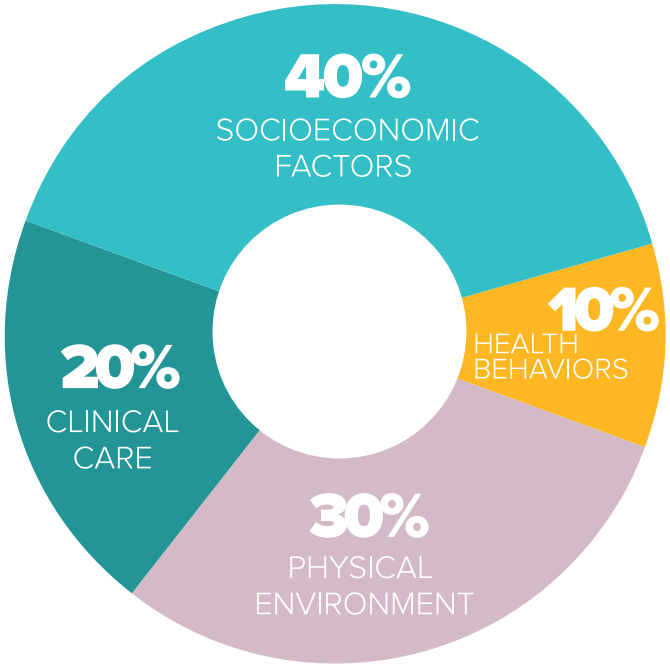

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BREAKOUT SESSION

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There are three parts to every breakout session:

There are three parts to each breakout session:

- **Part 1**
  focused on the community's themes and strengths
- **Part 2**
  focused on identifying the top priority needs of their community
- **Part 3**
  focused on strategies to address the top five needs of the community

*Source: Health Equity Presentation, 2017

PART 1 | RESULTS

Breakout session Part 1 started with two questions to help FCPH identify what community members believed were the greatest assets of their community:

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

What makes you proud of your community?

After providing a few minutes for thoughtful answers, facilitators then created a discussion surrounding what members had written down.

Upon reflecting on answers and creating a group consensus of 2-3 answers, the volunteer scribe wrote down answers for collection purposes.

EMERGING THEMES

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

- Safety
- Community Engagement
- Accessibility to Health Care

For this community forum, participants were separated into two groups. Each group provided responses regarding various aspects of healthy communities.

GROUP 1

- Engagement in physical activity
- Safe environment
- Access to medical facilities (i.e. hospitals, mental health care)
- Access to healthy food and eradicating food deserts
- Increase in youth programs supporting healthy lifestyles and physical activity

GROUP 2

- Safe environment
- Community belonging / engagement
- Increase in education and jobs
- Increase in healthcare access

EMERGING THEMES

2 What makes you proud of your community?

- Safe and engaged communities
- Community effort to improve
- Community activities

GROUP 1

- Ample green space for community members
- Community activities such as Fourth of July
- Supportive and caring people in the community
- Needs are listened to

GROUP 2

- Engaged and safe
- Strong school system
- Drive to improve
- Diversity
- Physical and social activities for community members

PART 2 | RESULTS

Breakout Session Part 2 focused on the selection of community health priorities. FCPH created a list of 30 health priorities, 15 of which were health concerns, and 15 of which were environmental concerns. The list of community health priorities are as follows:

HEALTH CONCERNS

Cardiovascular Disease: such as, heart disease, hypertension, coronary artery disease, congestive heart disease, heart failure,heart attack (MI), and stroke.

Diabetes: such as pre-diabetes, diabetes mellitus 1, diabetes mellitus 2, insulin dependent diabetes, and non-insulin dependent diabetes.

Chronic Respiratory Disease: such as asthma, COPD, and childhood or adult lung disease.

Obesity: such as overweight, obesity, morbid obesity, healthy weight, and weight reduction, childhood or adult.

Cancer: such as lung, breast, prostate, cervical, or any other type of cancer.

Infectious Diseases: such as sexually transmitted infections (STIs), influenza, hospital-acquired novel virus, HIV, hepatitis C, and access to and completion of recommended immunizations.

Maternal and Infant Health: such as prenatal care through the first year of life, focusing on infant mortality, low birth weight, and prematurity.

Oral Health: such as dental care/treatment, cavities, and extractions.

Drug and Alcohol Abuse: such as addiction, abuse, misuse, or dependence of alcohol, marijuana, prescription drugs, opioids, heroin, and MDMA.

Mental Health: such as depression, PTSD, bipolar disorder, schizophrenia, stress, emotional well-being, coping skills, suicide, and other behavioral health concerns.

Tobacco: such as use of cigarettes, cigars, hookah, e-cigarettes, chew, and flavored products.

Physical Activity: such as fitness, exercise, sedentary lifestyle, and active living with a focus on individual behaviors.
Nutrition: such as diet, junk food consumption, and healthy eating with focus on individual behaviors.

Sexual and Reproductive Health: such as sexual activity, condom use, prevention of unplanned pregnancy/teen pregnancy, and use of contraception.

Violence: such as physical and emotional violence, relationship or intimate partner violence, domestic violence, child abuse, elder abuse, sexual violence, street violence, and bullying.

ENVIRONMENTAL CONCERNS

Injury: such as motor vehicle/motorcycle, bicycle, occupational safety, gun-related injuries or deaths, and falls.

Employment, Poverty, and Income: such as concerns in unemployment rate, poverty rate, wages, and working conditions.

Education: such as preschool enrollment, school readiness, academic success, high school graduation, and educational attainment.

Family and Social Support: such as social-emotional support, social capital and cohesion, single-parent households, and racism.

Housing: such as concerns in affordable housing, housing conditions (mold, heat), and residential segregation.

Transportation: such as access to active and public transportation, commute times, driving alone to work/carpool, and transportation to healthcare services.

Air, Water, and Toxic Substances: such as pollution, secondhand smoke, drinking water, fluoridation, and lead poisoning.

Food Environment: such as healthy food access, food safety, food insecurity, and farmers markets.

Active Living Environments: such as green space, fitness opportunities, complete streets, trail, children walking/biking to school, and parks.

Coverage and Affordability: such as uninsured, underinsured, out of pocket expenses, high deductible health plans, medication coverage and cost.

Access to Health Care/Medical Care: such as number of providers, distribution of providers, access to patient-centered medical home, access to primary care, access to specialty care (not including dental or behavioral health), and wait time.

Access to Behavioral Health Care: such as number of providers, distribution of providers, access to behavioral health / treatment specialists (includes mental health and a substance use treatment providers).

Access to Dental Care: such as number of providers, distribution of providers, specific dental coverage, and access to dental clinics.

Equality/Disparities: such as one group of people having worse health conditions than others.

After reading through all thirty community priorities, participants were asked to rank their top 10 priorities (1 = highest priority; 10 = lowest priority). After mining the top 10 priorities, the volunteer scribe l up votes for each of the 30 health concerns arge poster listing each item. The items with the nighest number of tallies were selected to narrow down popular health concerns amongst community members.

Using an evidence-based prioritization method from the National Association of County and City Health Officials (NACCHO), American Society of Quality (ASQ), and various state and local health departments, FCPH engaged participants in a multivoting process to narrow down the top priorities to no more than 3 – 5 priorities. The multivoting process is employed to reduce a long list of ideas and identify the most important items on a list. The multivoting process was conducted as follows:

1. **Round 1:** Present the list of health problems. Each participant must vote for their top ten priority items individually out of the list of 30 health and environmental concerns.
2. **Update List:** Health problems are eliminated if the vote count does not meet the minimum vote count requirement. The minimum number of votes needed to advance to the next round of voting varies with the number of group participants. The voting process used can be seen in Table 1.

Number of Group Members	Items to be Eliminated
5 or fewer members	2 or fewer votes
6 to 15 members	3 or fewer votes
More than 15 members	4 or fewer votes

Table 1. Voting Elimination Process.

These tallies were marked on a poster with the health concerns. Discuss the highest priority items on the condensed list.

3. **Round 2:** Each participant votes for their highest priority items of this condensed list. In this round, participants can vote a number of times equivalent to one-third the number of health problems on the list (e.g. if six items remain on the list, each participant can cast two votes). Repeat process until 3 – 5 priority items are identified.

Group 1 Priorities

DRUG AND ALCOHOL ABUSE	**NUTRITION**	**HOUSING**
MENTAL HEALTH	**VIOLENCE**	**ACCESS TO BEHAVIORAL HEALTH CARE**
OBESITY	**FAMILY AND SOCIAL SUPPORT**	

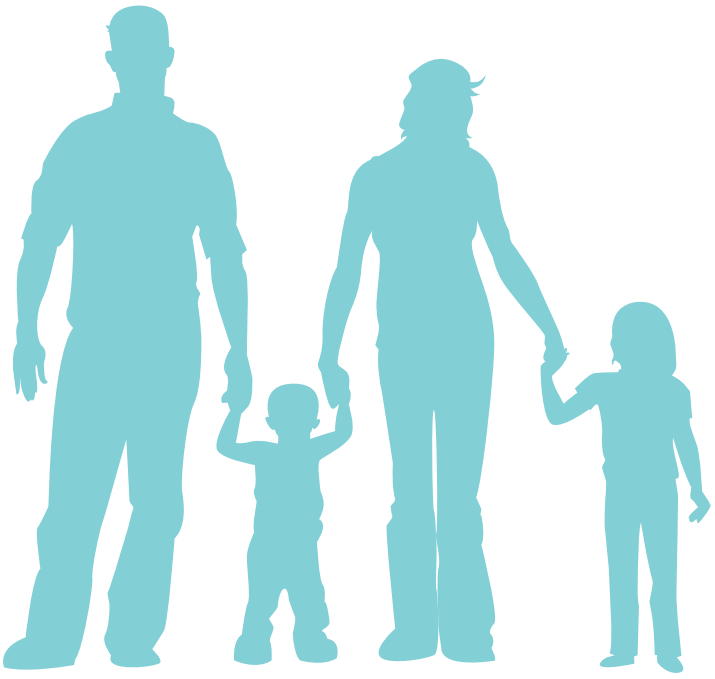
MAJOR CONCERNS

Priority 1 | Drug and Alcohol Abuse

- Opioid epidemic
- Youth access to drugs, alcohol, and prescriptions within households
- Lack of youth education on the impact of opioid use
- Introduction of gateway drugs
- Cheap
- Rates vary among various socioeconomic statuses (SES) (i.e. higher SES = higher prices)

Priority 2 | Mental Health

- Stigma
- Lack of recognition
- Media downplay
- Parental and peer pressure



Group 2 Priorities

SEXUAL AND REPRODUCTIVE HEALTH
EDUCATION
HOUSING
PHYSICAL ACTIVITY
OBESITY
FOOD ENVIRONMENT

MAJOR CONCERNS

Priority 1 | Sexual and Reproductive Health

- Need for empowerment
- Immaturity when raising children
- Important to prevent infections
- Physical, social, and economic opportunities may be impacted

Priority 2 | Education

- Good education reduces all negative health outcomes
- Key to control

Priority 3 | Housing

- Underlies many health problems
- Unaffordable

Priority 4 | Physical Activity

- Underlies many health problems
- Unaffordable

The 4 priorities listed to the left emerged as the major areas of concern for Group 2 in the Northwest Region, and were the priorities used in the breakout session part 3 strategy identification. However, the report includes all the priorities that community members felt were important. Listed below are the remaining priorities identified by the group and a brief overview of their importance to community members

Priority 5 | Obesity

Participants expressed concerns about how common this issue is. They mentioned how this issue is foundational to one's health and must be addressed.

Priority 6 | Food Environment

Participants mentioned the need to control food intake to control one's health outcomes. They also mentioned emphasizing a child's diet outside the academic year to maintain their health.

PART 3 | RESULTS

Breakout Session Part 3 focused on finalizing the top 3 - 5 priorities and getting consensus around the order and description of the concern. After reaching consensus, participants identified current gaps and provided potential strategies to help address these health concerns.

Group 1 Priorities

Drug and Alcohol Abuse | PRIORITY 1

POTENTIAL SOLUTIONS:

- Providing Narcan / naloxone in police cruisers and providing community trainings
- Providing education for children and parents
- Naloxone trainings for families

Mental Health | PRIORITY 2

POTENTIAL SOLUTIONS:

- Education such as coping strategies and down time
- Increase in community resources
- Increased hotlines
- Promote mental health in schools and the community

PART 3 | RESULTS

Breakout Session Part 3 focused on finalizing the top 3 - 5 priorities and getting consensus around the order and description of the concern. After reaching consensus, participants identified current gaps and provided potential strategies to help address these health concerns.

Group 2 Priorities

Sexual and Reproductive Health | PRIORITY 1

POTENTIAL SOLUTIONS:

- Sex Positive Education
- Increased sex education in class
- Evidence-based education such as the positive physical and mental health outcomes
- Information on contraception access – create dispensers in school bathrooms

Education | PRIORITY 3

POTENTIAL SOLUTIONS:

- Access to vetted information
- County-wide access to summer programs
- Community education at fairs / festivals / camps
- Business-run summer programs

Housing | PRIORITY 3

POTENTIAL SOLUTIONS:

- Access to legal counsel for bad landlords
- Knowledge for tenants of conditions of home
- Inspection checklists / resource banks from local health departments

Physical Activity | PRIORITY 4

POTENTIAL SOLUTIONS:

- Free access to recreational facilities
- Eliminate pay to play
- Increased scholarships
- Develop more parks
- Organize free activities at parks
- Promote healthy programs
- Promote shared roadways

LEARN MORE

FCPH shared with participants that the results of the community forum process would be compiled into a report and made available to anyone attending the community forum as well as being posted to the FCPH webpage. All handouts and reports associated with the CHA will be posted to *myfcph.org/cha*.

In addition to the individual report for the Northwest Region, all 5 community forum reports have been compiled into one comprehensive report, also found at the above website.

Health Works Franklin County is another resource for individuals, families and agencies concerned with population health in Franklin County. It provides information about community health data, services, laws, news, model practices, as well as communication tools and other features. Visit *www.healthworksfranklincountyohio.org*.

FCPH would like to thank our partners who hosted the forum event and everyone that contributed to the Community Forum process and the compiling of this report.

1804 OHIO UNIVERSITY | DUBLIN

Franklin County
Public Health

Franklin County Public Health
280 East Broad Street
Columbus, Ohio 43215-4562

Phone: (614) 525-3160
Email: fcph@franklincountyohio.gov
Web: myfcph.org

Franklin County
Public Health

SOUTHEAST REGION FORUM REPORT 2017

Franklin County Community Health Forum

The vision of Franklin County Public Health (FCPH) is to lead our communities in achieving optimal health for all. We believe the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) are major steps in fulfilling our role as the public health Chief Health Strategist by working in structured, cross-sector partnerships, addressing the social determinants of health, and making timely, reliable, and actionable data accessible to communities.

Franklin County Public Health would like to thank its local communities for your participation in our 2017 Community Forums. These forums were conducted as a part of a CHA process. State and Local Health Departments use the CHA as a way to identify key health needs and concerns through a comprehensive data collection and analysis effort. A CHA includes collaboration that supports shared ownership for phases of community health improvement, such as assessment, planning, investment, implementation, and evaluation.

An ideal health assessment includes:

- Participation from a variety of sectors such as local community members, businesses, faith based organizations, stakeholders and other public health organizations.
- Demographic information.
- Information on risk factors, quality of life, mortality, morbidity, community assets, social determinants of health and health inequity.
- Descriptions of health issues for specific populations and any health disparities, factors contributing to health challenges, community assets and/or resources.
- Data from a variety of sources and in a variety of forms (qualitative, quantitative, primary, and secondary).
- A variety of data collection methods (i.e. surveys, interviews, focus groups, or community forums, etc.).

Franklin County Community Health Forum

One of the essential ingredients of this CHA is community engagement and collaborative participation. The CHA is an important piece in the development of a CHIP because it helps the community understand the health and health related issues that need addressed. It also provides the most current and reliable information about the health status of a community and where gaps may exist in achieving optimal health.

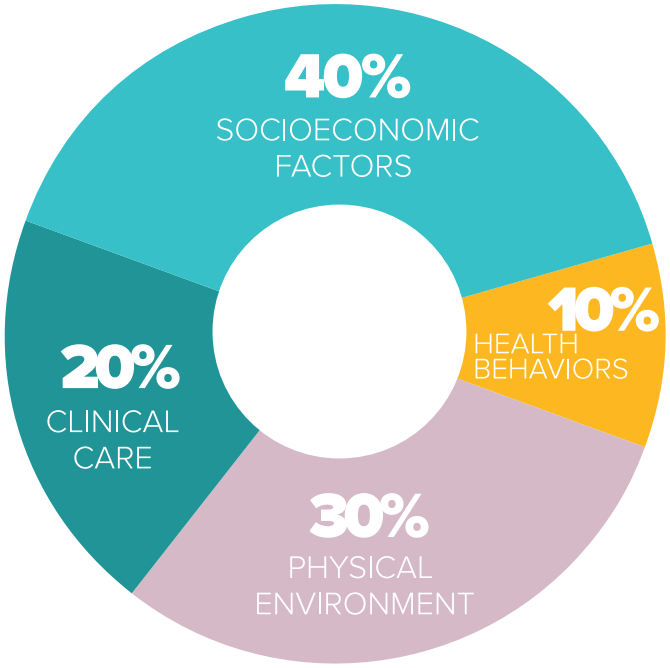
In July of 2017, FCPH collaborated with 5 community partners: Mount Carmel East; Ohio Health Doctors Hospital; Ohio University Dublin Integrated Education Center; Madison Township Community Center; and Healthy New Albany to host Regional Forums. The information in this report represents the process and outcomes of the Southeast Regional Forum hosted by the Madison Township Community Center. FCPH would like to express our thanks and appreciation to the Madison Township Community Center for their generous contributions and support of the forums. The community forum would not have been possible without this support.

COMMUNITY FORUM OVERVIEW AND PRESENTATIONS

The Southeast Region Community Forum was kicked off with a welcome, introduction and overview of FCPH by the Health Commissioner. A PowerPoint presentation highlighted information about the role of the health department including it being accredited by the Public Health Accreditation Board (PHAB); its mandates, priorities, initiatives, and an overview of who we serve in Franklin County. This was followed by a presentation given as a result of another collaborative partnership with Nationwide Children's Hospital (NCH). The Director and a Senior Research Scientist, from the Center for Population Health and Equity Research, Research Institute at Nationwide Children's Hospital provided information about why achieving health equity leads to optimal health for everyone.

Achieving health equity leads to optimal health for everyone

NCH indicates health equity means that everyone has a fair opportunity to live a long, healthy life. It implies that health should not be compromised or disadvantaged because of an individual or population group's race, ethnicity, gender, income, sexual orientation, neighborhood or other social condition. In conjunction with health equity, social determinants of health play a large role in determining health outcomes. Social determinants of health are environmental factors in one's place of residence, work, worship, or play that affect one's quality of life and health outcomes. For example, the chart on the next page illustrates why clinical care alone isn't enough to improve health outcomes, as well as the significant importance of addressing the social determinants of health which creates an



Clinical care alone isn't enough to improve health outcomes*

At the conclusion of this presentation, instructions were given for the breakout sessions and community participants engaged in a dialogue and provided feedback regarding the most pressing health care needs impacting their communities. The breakout sessions process is highlighted below.

BREAKOUT SESSION

In order to understand the health concerns of each community, breakout sessions were established and run by a facilitator. As part of the breakout sessions, a volunteer scribe was identified to write down group responses on a flip chart to keep track of all responses. A packet of questions and directions pertaining to each breakout session were handed to all community members participating in the breakout sessions.

There are three parts to every breakout session:

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- **Part 1**
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  focused on identifying the top priority needs of their community
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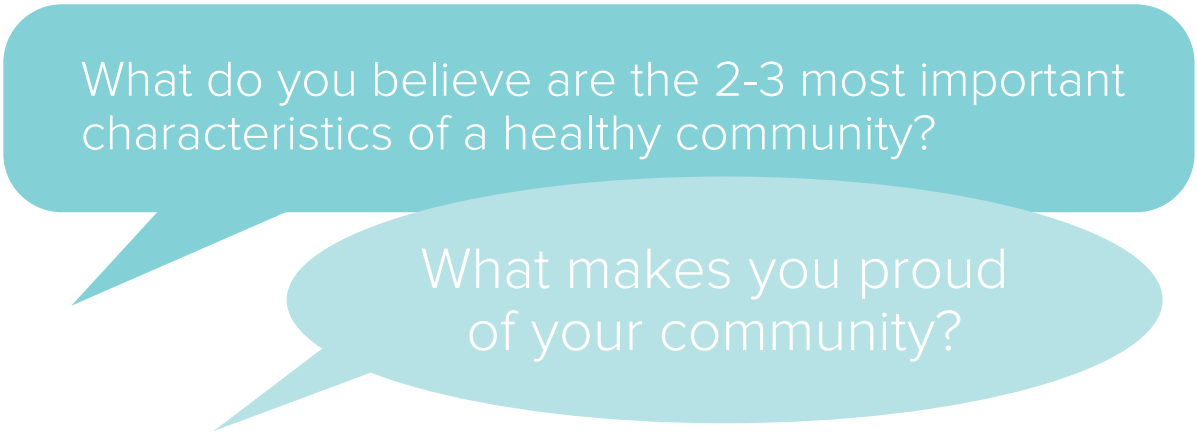
  focused on strategies to address the top five needs of the community

*Source: Health Equity Presentation, 2017

PART 1 | RESULTS

Breakout session Part 1 started with two questions to help FCPH identify what community members believed were the greatest assets of their community:



After providing a few minutes for thoughtful answers, facilitators then created a discussion surrounding what members had written down.

Upon reflecting on answers and creating a group consensus of 2-3 answers, the volunteer scribe wrote down answers for collection purposes.

EMERGING THEMES

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

- Safety
- Community Support
- Jobs

For this community forum, participants were separated into three groups. Each group provided responses regarding various aspects of healthy communities.

GROUP 1

- Strong support system
- Greenspace
- Strong social networks
- Access to basic needs
- Safe environment
- Good schools

GROUP 2

- Low crime rate
- Informal CHATs
- Safety
- Connections
- Community support
- Jobs
- Amenities

GROUP 3

- Jobs
- Opportunity for outside
- Proximity to services
- Socioeconomic Status
- Grocery stores with healthy foods
- Access to education

EMERGING THEMES

2 What makes you proud of your community?

- Safe and engaged communities
- Schooling
- Community activities

GROUP 1

- Safe
- Community engagement
- Friendly and diverse
- Small community
- Supportive local government
- Growing

GROUP 2

- Employment
- Children playing outside
- Community members involved in health initiatives
- Affordable healthcare and medication
- Greenspace and places for socialization
- Clean and quality food
- Transportation
- Water and sanitation

GROUP 3

- Safe
- Schools
- Proximity to goods and services
- Working together

PART 2 | RESULTS

Breakout Session Part 2 focused on the selection of community health priorities. FCPH created a list of 30 health priorities, 15 of which were health concerns, and 15 of which were environmental concerns. The list of community health priorities are as follows:

HEALTH CONCERNS

Cardiovascular Disease: such as, heart disease, hypertension, coronary artery disease, congestive heart disease, heart failure,heart attack (MI), and stroke.

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ENVIRONMENTAL CONCERNS

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Equality/Disparities: such as one group of people having worse health conditions than others.

After reading through all thirty community priorities, participants were asked to rank their top 10 priorities (1 = highest priority; 10 = lowest priority). After determining the top 10 priorities, the volunteer scribe tallied up votes for each of the 30 health concerns in a large poster listing each item. The items with the highest number of tallies were selected to narrow down popular health concerns amongst community members.

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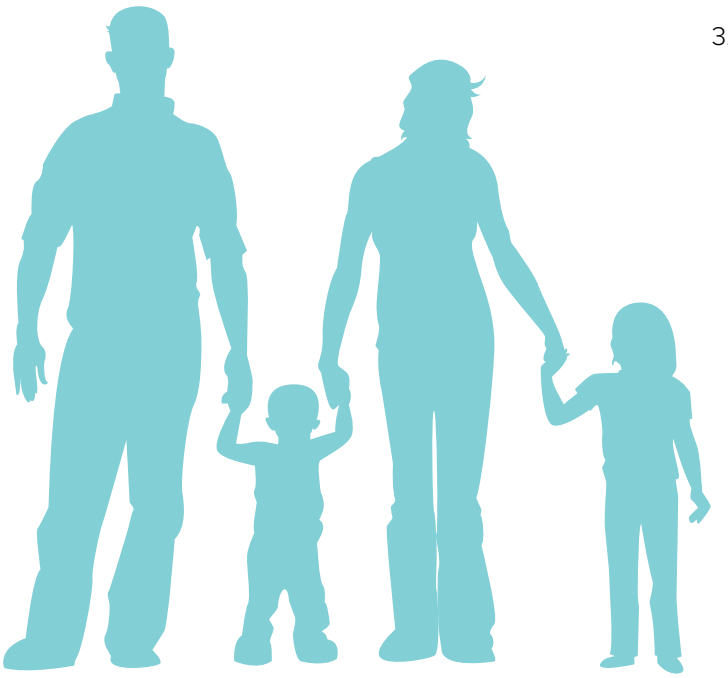

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Table 1. Voting Elimination Process.

These tallies were marked on a poster with the health concerns. Discuss the highest priority items on the condensed list.

3. **Round 2:** Each participant votes for their highest priority items of this condensed list. In this round, participants can vote a number of times equivalent to one-third the number of health problems on the list (e.g. if six items remain on the list, each participant can cast two votes). Repeat process until 3 – 5 priority items are identified.

Group 1 Priorities

HOUSING	**OBESITY**	**TOBACCO**
NUTRITION	**CANCER**	**VIOLENCE**
PHYSICAL ACTIVITY	**DRUG AND ALCOHOL ABUSE**	

MAJOR CONCERNS

Priority 1 | Transportation

- Need affordable housing
- Impacts choices for school, work, and community
- Safe options
- Not enough available

Priority 2 | Nutrition

- Kids don't eat vegetables or understand healthy eating
- Schools may offer healthy options but can't get kids to eat
- Healthy food = expensive and labor intensive
- No free lunch stigma is important

Priority 3 | Physical Activity

- Key to helping other issues
- Less access to physical activity
- Bike Paths / yoga / variety
- Physical activity now has to be focused on because it's not automatic

The priorities listed to the left emerged as the major areas of concern for Group 1, and were the priorities used in the breakout session for strategy identification. The following are the remaining priorities identified by the group and a brief overview of their importance to community members.

Priority 4 | Obesity

Obesity is a problem for youth and adults and needs intervention. A lot of underlying issues can be solved and can also help solve other health issues.

Priority 5 | Cancer

Many people in the community have cancer. The cause of cancer is a concern. There are high rates of cancer at the air force base and there are larger rates of cancer at a younger age. Cancer has financial, emotional, and physical concerns.

Priority 6 | Drug and Alcohol Abuse

Drug and alcohol abuse affects the entire family. This issue must be addressed at the local level. There is a social stigma surrounding drug and alcohol abuse and the prevalence is alarming. There needs to be early intervention in schools and churches. Must expand treatment services for all.

Priority 7 | Tobacco

There needs to be a focus on prevention for children, the resurgence is alarming. E-cigarettes are just as bad as normal cigarettes and they are marketed to kids to make it seem different. There is a vicious cycle of those who are least able to afford cigarettes are the ones smoking. Tobacco is also socially accepted.

Priority 8 | Violence

Bullying and child abuse is growing. Domestic violence ineeds to be more access to resources. Violence seems to be growing and is close to home.

Group 2 Priorities

TRANSPORTATION

EDUCATION

EMPLOYMENT, POVERTY, AND INCOME

ACCESS TO HEALTHCARE

MAJOR CONCERNS

Priority 1 | Transportation

- Social interaction
- Prevents isolation
- Workforce accessibility

Priority 2 | Education

- Future of children
- Need improvements
- Reasoning skills – allows individuals to work together for a better cause
- Breaks cycle of poverty
- Re-education opportunities
- Increased career centers

Priority 3 | Employment, Poverty, & Income

- Access to education, health care, and transportation

The priorities listed to the left emerged as the major areas of concern for Group 2, and were the priorities used in the breakout session for strategy identification. The following are the remaining priorities identified by the group and a brief overview of their importance to community members.

Priority 4 | Access to Healthcare

Participants mentioned that preventative care is important. This can be intertwined with transportation. Insurance allows for affordable medical care. Costs for healthcare can make affording other things such as nutritious foods more difficult.

Group 3 Priorities

CARDIOVASCULAR DISEASE
DRUG AND ALCOHOL ABUSE
MENTAL HEALTH
EMPLOYMENT, POVERTY, AND INCOME
ACCESS TO HEALTHCARE
EDUCATION
VIOLENCE
BEHAVIORAL HEALTH CARE
EQUITY AND DISPARITIES

MAJOR CONCERNS

Priority 1 | Cardiovascular Disease
- Multiple families affected by it, someone from your family may have passed away
- Potential risk factors leading to cardiovascular disease

Priority 2 | Drug and Alcohol Abuse
- Seen most frequently
- More prevalent to see drug abuse, especially prescription drug use, heroin, and other street drugs
- Patients often come in with the same complaints so drug abuse becomes easy to identify
- Physician prescribing is monitored to try and reduce rates in Ohio
- High prescribing does lead to dependence
- Cheaper to get heroin
- Newer drugs on market

Priority 3 | Mental Health
- Can be caused by drugs
- Increase access to caregivers and behavioral health
- Stigma

Priority 4 | Employment, Poverty, and Income
- No employment + no income = poverty
- Cost of living is expensive
- Affects everything such as healthcare or not having enough money to purchase healthy foods

Priority 5 | Access to Healthcare
- No access or no access to preventive medicine
- Need more attention on preventive measures
- Employers need to incentivize preventive medicine

The priorities listed to the left emerged as the major areas of concern for Group 3, and were the priorities used in the breakout session for strategy identification. The following are the remaining priorities identified by the group and a brief overview of their importance to community members.

Priority 6 | Education
Participants mentioned the importance of starting kids off earlier in school. Preschool is necessary for social interaction and education helps function in society with others and is an important aspect of healthy development. .

Priority 7 | Violence
It's a big deal that violence is not an issue in this community and that others can assume that a child is safe. However, not all areas have this luxury.

Priority 8 | Behavioral Healthcare
There is a stigma associated with using medications. In order to remove the stigma, there needs to be an increase in access. No formula for behavioral health, for any age group. Stress is another factor associated with not being able to access behavioral health care.

Priority 9 | Equity and Disparities
Socioeconomic status and poverty largely affect various factors in life. It can affect access to healthcare, food, shelter, and are many times not treated well. Individuals with mental illness but no drug history or are from low socioeconomic status are all treated differently.

PART 3 | RESULTS

Breakout Session Part 3 focused on finalizing the top 3 - 5 priorities and getting consensus around the order and description of the concern. After reaching consensus, participants identified current gaps and provided potential strategies to help address these health concerns.

Group 1 Priorities

Nutrition | PRIORITY 1

POTENTIAL SOLUTIONS:

- Farmers Markets
- Public transportation
- Connections to local farmers
- Community gardens
- Adding cooking / nutrition to the school curriculum
- Marketing restrictions on unhealthy foods

Housing | PRIORITY 2

POTENTIAL SOLUTIONS:

- Annex more land
- Make multifamily properties more attractive for families
- Townhouses with a yard instead of small apartments
- Transportation to increase options
- Jobs are available but not enough housing

Physical Activity | PRIORITY 3

POTENTIAL SOLUTIONS:

- Increase bike and walking trails and connect them
- Local governments working together to expand
- Lack of sports leagues because of grades = encourage more community leagues
- Promote options in better ways
- Options for improving what is there
- Incentivize activity

PART 3 | RESULTS

Breakout Session Part 3 focused on finalizing the top 3 - 5 priorities and getting consensus around the order and description of the concern. After reaching consensus, participants identified current gaps and provided potential strategies to help address these health concerns.

Group 2 Priorities

Education | PRIORITY 1

POTENTIAL SOLUTIONS:

- 1:1 computers in schools
- Community wi-fi accessibility
- Community provide parents with support, education, and tools
- Community tutoring
- Encourage supportive community

Transportation | PRIORITY 2

POTENTIAL SOLUTIONS:

- Work with insurance companies to underwrite cost of getting a license
- Driver's education should have instructors count hours
- MORPC complete streets agenda and encourage advocacy
- Work with communities on building safe stops and sidewalks

Employment, Poverty, and Income | PRIORITY 3

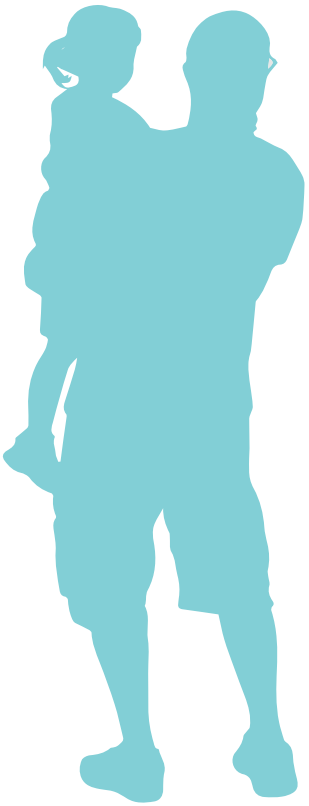
POTENTIAL SOLUTIONS:

- Modifying point system to become more employee friendly
- Get more employees to modify
- Recruit more people for higher waged jobs
- Increase the living wage
- Build new businesses who hire at a reasonable wage and revitalize cost of living

PART 3 | RESULTS

After reaching consensus, participants in Group 3 identified current gaps and provided potential strategies to help address these health concerns.

Group 3 Priorities



Cardiovascular Disease | PRIORITY 1

POTENTIAL SOLUTIONS:

- Health fair + prevention education
- Memberships to rec center
- Walking clubs such as dance and walking clubs

Drug and Alcohol Abuse | PRIORITY 2

POTENTIAL SOLUTIONS:

- Find ways to get rid of the source
- Marijuana leads to bad business – need to educate community
- Need programs around heroin to educate the community
- REACT program – engage medical professionals for immediate overdose assistance
- Disperse Narcan®, suboxone, and methadone
- Provide early education on drugs and alcohol
- Affects all socioeconomic status

Mental Health | PRIORITY 3

POTENTIAL SOLUTIONS:

- Having conversations with others to let them know it's okay
- Have a community level conversation
- Align mental health with physical health and show parallels

Employment, Poverty, and Income | PRIORITY 4

POTENTIAL SOLUTIONS:

- Increase jobs
- Many times, it's the individual that prevents their own job prospects through issues such as drug addiction and mental health
- Provide resume tailoring services
- Increase library resources
- Everything is online
- HR computer process allows for individuals to get screened out automatically

Access to Healthcare | PRIORITY 5

POTENTIAL SOLUTIONS:

- Know your resources
- Have a job that offers health insurance
- Lower middle class is suffering
- Not a choice

LEARN MORE

FCPH shared with participants that the results of the community forum process would be compiled into a report and made available to anyone attending the community forum as well as being posted to the FCPH webpage. All handouts and reports associated with the CHA will be posted to *myfcph.org/cha*.

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MADISON TOWNSHIP COMMUNITY CENTER

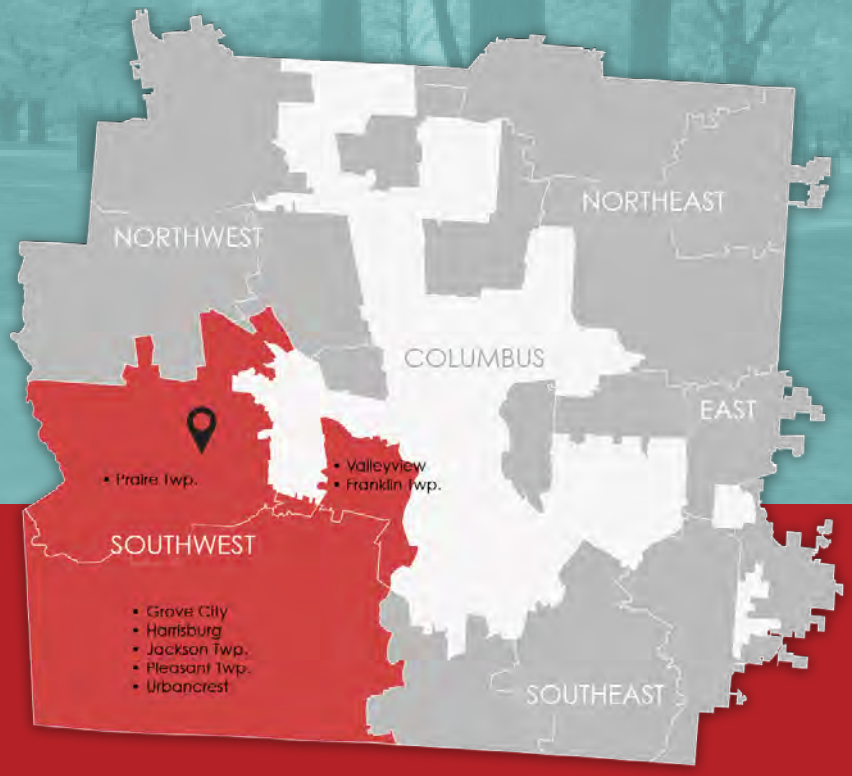
Franklin County
Public Health

Franklin County Public Health
280 East Broad Street
Columbus, Ohio 43215-4562

Phone: (614) 525-3160
Email: fcph@franklincountyohio.gov
Web: myfcph.org

Franklin County
Public Health

SOUTHWEST REGION FORUM REPORT 2017



Franklin County Community Health Forum

The vision of Franklin County Public Health (FCPH) is to lead our communities in achieving optimal health for all. We believe the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) are major steps in fulfilling our role as the public health Chief Health Strategist by working in structured, cross-sector partnerships, addressing the social determinants of health, and making timely, reliable, and actionable data accessible to communities.

Franklin County Public Health would like to thank its local communities for your participation in our 2017 Community Forums. These forums were conducted as a part of a Community Health Assessment process. State and local health departments use the CHA as a way to identify key health needs and concerns through a comprehensive data collection and analysis effort. A CHA includes collaboration that supports shared ownership for phases of community health improvement, such as assessment, planning, investment, implementation, and evaluation.

An ideal health assessment includes:

- Participation from a variety of sectors such as local community members, businesses, faith based organizations, stakeholders and other public health organizations.
- Demographic information.
- Information on risk factors, quality of life, mortality, morbidity, community assets, social determinants of health and health inequity.
- Descriptions of health issues for specific populations and any health disparities, factors contributing to health challenges, community assets and/or resources.
- Data from a variety of sources and in a variety of forms (qualitative, quantitative, primary, and secondary).
- A variety of data collection methods (i.e. surveys, interviews, focus groups, or community forums, etc.).

Franklin County Community Health Forum

One of the essential ingredients of this CHA is community engagement and collaborative participation. The CHA is an important piece in the development of a CHIP, because it helps the community understand the health and health related issues that need addressed. It also provides the most current and reliable information about the health status of a community and where gaps may exist in achieving optimal health.

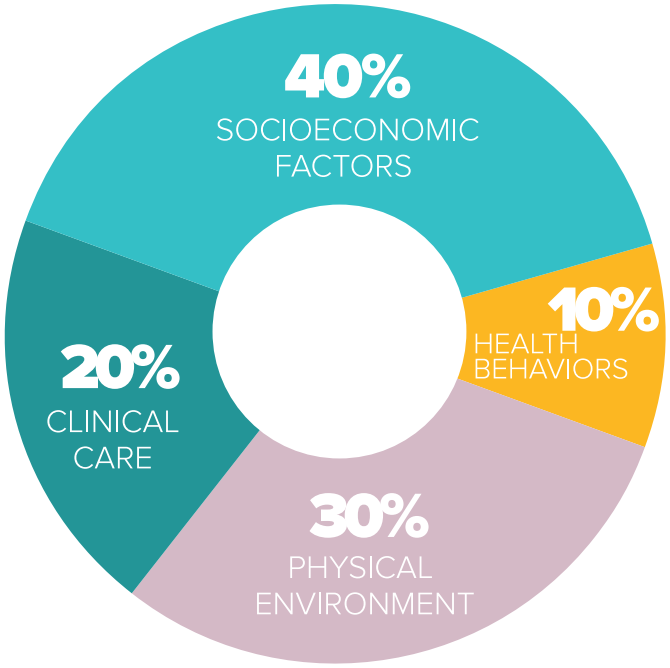
In July of 2017, FCPH collaborated with 5 community partners: Mount Carmel East; Ohio Health Doctors Hospital; Ohio University Dublin, Integrated Education Center; Madison Township Community Center; and Healthy New Albany to host the forums. The information in this report represents the process and outcomes of the Southwest Regional Forum hosted by OhioHealth Doctors Hospital. FCPH would like to express our thanks and appreciation to OhioHealth Doctors Hospital for their generous contributions and support of the forums. The community forum would not have been possible without this support.

COMMUNITY FORUM OVERVIEW AND PRESENTATIONS

The Southwest Region Community Forum was kicked off with a welcome, introduction and overview of FCPH by the Health Commissioner. A PowerPoint presentation highlighted information about the role of the health department including it being accredited by the Public Health Accreditation Board (PHAB); its mandates, priorities, initiatives, and an overview of who we serve in Franklin County. This was followed by a presentation given as a result of another collaborative partnership with Nationwide Children's Hospital (NCH). The Director and a Senior Research Scientist, from the Center for Population Health and Equity Research, Research Institute at Nationwide Children's Hospital provided information about why achieving health equity leads to optimal health for everyone.

Achieving health equity leads to optimal health for everyone

NCH indicates health equity means that everyone has a fair opportunity to live a long, healthy life. It implies that health should not be compromised or disadvantaged because of an individual or population group's race, ethnicity, gender, income, sexual orientation, neighborhood or other social condition. In conjunction with health equity, social determinants of health play a large role in determining health outcomes. Social determinants of health are environmental factors in one's place of residence, work, worship, or play that affect one's quality of life and health outcomes. For example, the chart on the next page illustrates why clinical care alone isn't enough to improve health outcomes, as well as the significant importance of addressing the social determinants of health which creates an environment for achieving health equity.



Clinical care alone isn't enough to improve health outcomes*

At the conclusion of this presentation, instructions were given for the breakout sessions and community participants engaged in a dialogue and provided feedback regarding the most pressing health care needs impacting their communities. The breakout sessions process is highlighted below.

BREAKOUT SESSION

In order to understand the health concerns of each community, breakout sessions were established and run by a facilitator. As part of the breakout sessions, a volunteer scribe was identified to write down group responses on a flip chart to keep track of all responses. A packet of questions and directions pertaining to each breakout session were handed to all community members participating in the breakout sessions.

There are three parts to every breakout session:

There are three parts to each breakout session:

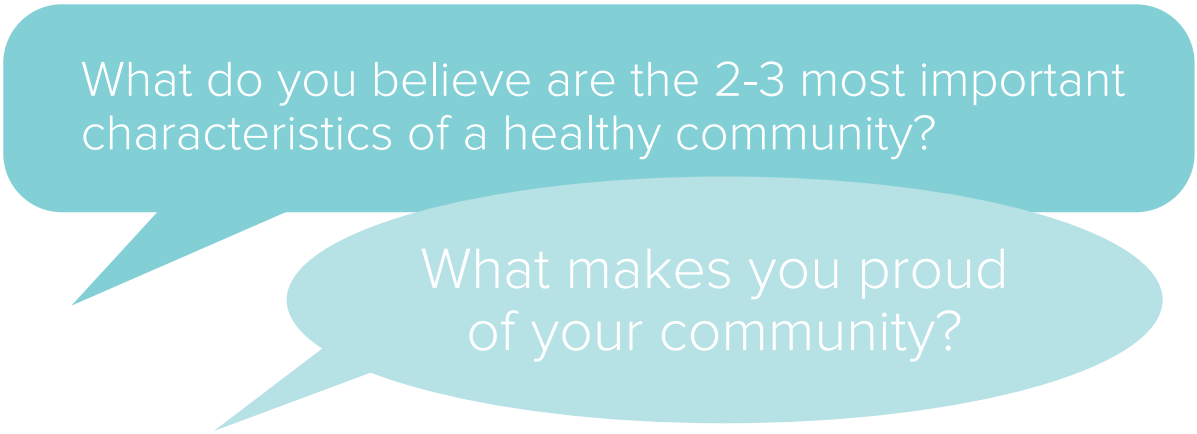
- **Part 1**
  focused on the community's themes and strengths
- **Part 2**
  focused on identifying the top priority needs of their community
- **Part 3**
  focused on strategies to address the top five needs of the community

*Source: Health Equity Presentation, 2017

Franklin County Public Health

PART 1 | RESULTS

Breakout session Part 1 started with two questions to help FCPH identify what community members believed were the greatest assets of their community:



After providing a few minutes for thoughtful answers, facilitators then created a discussion surrounding what members had written down.

Upon reflecting on answers and creating a group consensus of 2-3 answers, the volunteer scribe wrote down answers for collection purposes.

EMERGING THEMES

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

- Safety and community engagement
- Reliable infrastructure
- Accessibility to food

For this community forum, participants were separated into three groups. Each group provided responses regarding various aspects of healthy communities.

GROUP 1

- Good schools, parks and recreation
- Communication and support with neighbors
- Access to healthy food, becoming involved and participating within the community
- Access to reliable transportation

GROUP 2

- Social support system
- Common goal towards community improvement
- Access to affordable and quality healthcare
- Access to green space and community centers
- Increasing safety by eliminating workplace violence and toxic environments

GROUP 3

- Community events and services
- Celebrating racial diversity
- Selling goods and services
- Community resources such as recreation and mental health support groups.

EMERGING THEMES

2 What makes you proud of your community?

- Parks and recreation
- Community engagement and inclusion
- Safety

GROUP 1

- Community resilience and their ability to work together
- Encouraging curb appeal such as decorating houses with flowers and gardening
- Creating community gardens
- Accessibility to congregations

GROUP 2

- Collaboration of community leaders
- Parks and access to bike paths and walking
- Quality of service providers
- School systems and great libraries
- Enhancing community partnerships through partnering with casinos and other recreational centers

GROUP 3

- Recreational facilities
- Walkability
- Engaged community

PART 2 | RESULTS

Breakout Session Part 2 focused on the selection of community health priorities. FCPH created a list of 30 health priorities, 15 of which were health concerns, and 15 of which were environmental concerns. The list of community health priorities are as follows:

HEALTH CONCERNS

Cardiovascular Disease: such as, heart disease, hypertension, coronary artery disease, congestive heart disease, heart failure,heart attack (MI), and stroke.

Diabetes: such as pre-diabetes, diabetes mellitus 1, diabetes mellitus 2, insulin dependent diabetes, and non-insulin dependent diabetes.

Chronic Respiratory Disease: such as asthma, COPD, and childhood or adult lung disease.

Obesity: such as overweight, obesity, morbid obesity, healthy weight, and weight reduction, childhood or adult.

Cancer: such as lung, breast, prostate, cervical, or any other type of cancer.

Infectious Diseases: such as sexually transmitted infections (STIs), influenza, hospital-acquired novel virus, HIV, hepatitis C, and access to and completion of recommended immunizations.

Maternal and Infant Health: such as prenatal care through the first year of life, focusing on infant mortality, low birth weight, and prematurity.

Oral Health: such as dental care/treatment, cavities, and extractions.

Drug and Alcohol Abuse: such as addiction, abuse, misuse, or dependence of alcohol, marijuana, prescription drugs, opioids, heroin, and MDMA.

Mental Health: such as depression, PTSD, bipolar disorder, schizophrenia, stress, emotional well-being, coping skills, suicide, and other behavioral health concerns.

Tobacco: such as use of cigarettes, cigars, hookah, e-cigarettes, chew, and flavored products.

Physical Activity: such as fitness, exercise, sedentary lifestyle, and active living with a focus on individual behaviors.
Nutrition: such as diet, junk food consumption, and healthy eating with focus on individual behaviors.

Sexual and Reproductive Health: such as sexual activity, condom use, prevention of unplanned pregnancy/teen pregnancy, and use of contraception.

Violence: such as physical and emotional violence, relationship or intimate partner violence, domestic violence, child abuse, elder abuse, sexual violence, street violence, and bullying.

ENVIRONMENTAL CONCERNS

Injury: such as motor vehicle/motorcycle, bicycle, occupational safety, gun-related injuries or deaths, and falls.

Employment, Poverty, and Income: such as concerns in unemployment rate, poverty rate, wages, and working conditions.

Education: such as preschool enrollment, school readiness, academic success, high school graduation, and educational attainment.

Family and Social Support: such as social-emotional support, social capital and cohesion, single-parent households, and racism.

Housing: such as concerns in affordable housing, housing conditions (mold, heat), and residential segregation.

Transportation: such as access to active and public transportation, commute times, driving alone to work/carpool, and transportation to healthcare services.

Air, Water, and Toxic Substances: such as pollution, secondhand smoke, drinking water, fluoridation, and lead poisoning.

Food Environment: such as healthy food access, food safety, food insecurity, and farmers markets.

Active Living Environments: such as green space, fitness opportunities, complete streets, trail, children walking/biking to school, and parks.

Coverage and Affordability: such as uninsured, underinsured, out of pocket expenses, high deductible health plans, medication coverage and cost.

Access to Health Care/Medical Care: such as number of providers, distribution of providers, access to patient-centered medical home, access to primary care, access to specialty care (not including dental or behavioral health), and wait time.

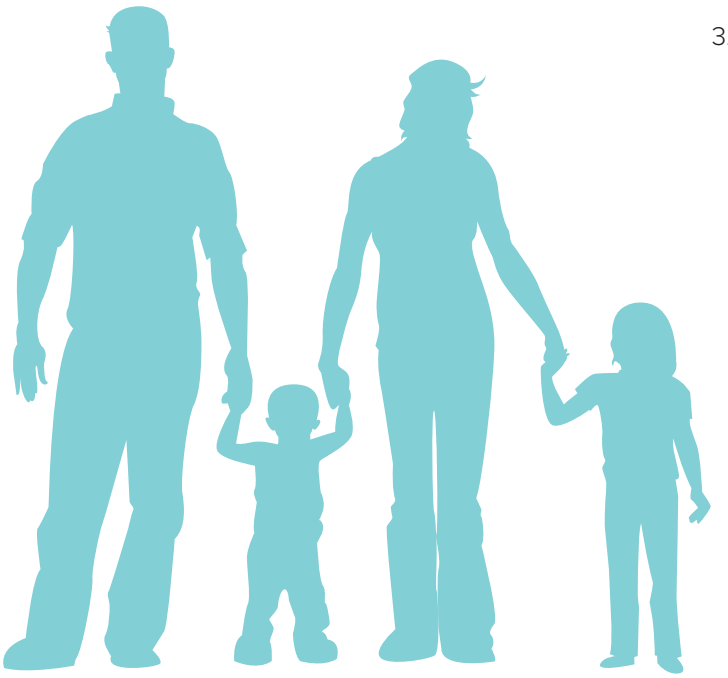
Access to Behavioral Health Care: such as number of providers, distribution of providers, access to behavioral health / treatment specialists (includes mental health and a substance use treatment providers).

Access to Dental Care: such as number of providers, distribution of providers, specific dental coverage, and access to dental clinics.

Equality/Disparities: such as one group of people having worse health conditions than others.

After reading through all thirty community priorities, participants were asked to rank their top 10 priorities (1 = highest priority; 10 = lowest priority). After determining the top 10 priorities, the volunteer scribe tallied up votes for each of the 30 health concerns in a large poster listing each item. The items with the highest number of tallies were selected to narrow down popular health concerns amongst community members.

Using an evidence-based prioritization method from the National Association of County and City Health Officials (NACCHO), American Society of Quality (ASQ), and various state and local health departments, FCPH engaged participants in a multivoting process to narrow down the top priorities to no more than 3 – 5 priorities. The multivoting process is employed to reduce a long list of ideas and identify the most important items on a list. The multivoting process was conducted as follows:



1. **Round 1:** Present the list of health problems. Each participant must vote for their top ten priority items individually out of the list of 30 health and environmental concerns.
2. **Update List:** Health problems are eliminated if the vote count does not meet the minimum vote count requirement. The minimum number of votes needed to advance to the next round of voting varies with the number of group participants. The voting process used can be seen in Table 1.

Number of Group Members	Items to be Eliminated
5 or fewer members	2 or fewer votes
6 to 15 members	3 or fewer votes
More than 15 members	4 or fewer votes

Table 1. Voting Elimination Process.

These tallies were marked on a poster with the health concerns. Discuss the highest priority items on the condensed list.

3. **Round 2:** Each participant votes for their highest priority items of this condensed list. In this round, participants can vote a number of times equivalent to one-third the number of health problems on the list (e.g. if six items remain on the list, each participant can cast two votes). Repeat process until 3 – 5 priority items are identified.

Group 1 Priorities

DRUG AND ALCOHOL ABUSE

VIOLENCE

EMPLOYMENT, POVERTY, AND INCOME

COVERAGE AND AFFORDABILITY

MAJOR CONCERNS

Priority 1 | Drug and Alcohol Abuse

- Need more training regarding naloxone
- Stigma
- Not enough community outreach

Priority 2 | Violence

- Unequal access to mental healthcare – unresolved mental health issues can lead to violent actions
- Need more awareness towards domestic violence
- Presence of gun laws

Priority 3 | Employment, Poverty, and Income

- Unemployment
- Low income families not able to afford food or medications
- Working part-time, leading to no full-time benefits eligibility

Priority 4 | Coverage and Affordability.

- Unable to afford medications
- Employment affecting income
- High costs of insurance

Group 2 Priorities

MENTAL HEALTH

PHYSICAL ACTIVITY

EDUCATION

ACCESS TO BEHAVIORAL HEALTH CARE

OBESITY

NUTRITION

EMPLOYMENT, POVERTY, AND INCOME

ACTIVE LIVING ENVIRONMENTS

ACCESS TO HEALTH CARE/ MEDICAL CARE

MAJOR CONCERNS

Priority 1 | Mental Health

- Shortage of professionals
- Stigma
- Unequal access
- Stigma

Priority 2 | Physical Activity

- Solves many / lots of problems
- Behavioral benefits

Priority 3 | Education

- Education leads to better jobs
- Better decisions are made by individuals who are educated

Priority 4 | Access to Behavioral Health

- Harder to find access in rural / suburban areas
- Shortage of mental health professionals

The 4 priorities listed left emerged as the major areas of concern for Group 2 in the Southwest Region, and were the priorities used in the breakout session part 3 strategy identification. However, the report includes all the priorities that community members felt were important. Listed below are the remaining priorities identified by the group and a brief overview of their importance to community members.

Priority 5 | Obesity

Group 2 participants in the Southwest Region expressed concerns about food affordability. They mentioned how typically cheaper food alternatives were less nutritious (i.e. fast food restaurants as opposed to grocery shopping for healthier foods). The readily available cheaper food alternatives lead to more unhealthy eating habits and can lead to obesity.

Priority 6 | Nutrition

Participants mentioned the need for increased education towards nutrition, increasing nutritious foods availability, and the current lack of healthy food sources.

Priority 7 | Employment, Poverty, and Income

There is unequal access to benefits and low affordability when it comes to poverty. Employment and income can affect the affordability of choices and can inc4rease the access to benefits such as health care and nutritious food options.

Priority 8 | Active Living Environments

Inclusion of parks, bike paths, and trails can assist in having an engaged active living environment. It also has an environmental impact and can improve neighborhood living areas.

Group 3 Priorities

OBESITY

DRUG AND ALCOHOL ABUSE

MENTAL HEALTH

EMPLOYMENT, POVERTY, AND INCOME

EDUCATION

FAMILY AND SOCIAL SUPPORT

ACCESS TO HEALTH CARE / MEDICAL CARE

ACCESS TO BEHAVIORAL HEALTH

MAJOR CONCERNS

Priority 1 | Obesity

- Obesity encompasses a vast range of health concerns that lead to large consequences
- Both children and adults are affected by obesity
- Morbid obesity has increasingly become an issue
- Obesity is correlated to diabetes
- Economic impacts means less room for nutritious food options

Priority 2 | Drug and Alcohol Abuse

- Long standing issue that needs a change in intervention
- There are legal and family level affects
- Economic impact equals rise in crime rates and violence
- Sexual health is a concern / especially sex workers
- Mental health effects

Priority 3 | Mental Health

- Everyone has been affected by it
- Certain mental health issues have stronger stigma (i.e. depression and suicide)
- Anxiety in children can lead to substance abuse later on
- Stressors including children around drugs and violence
- Lack of support for the homeless affected by mental health
- Mental health is triggered by various factors such as diet and housing, as well as medical conditions

Priority 4 | Employment, Poverty, and Income

- Affected by mental health, and can affect access to medical care
- When people choose to stay in poverty it turns into a vicious cycle
- Generational poverty

Listed below are the remaining additional priorities and their importance to community members.

Priority 5 | Education

Members expressed that education has an impact on all aspects of one's future, behavior, job prospects, etc. Environment and nutrition can affect learning ability. Homelessness in children affects education and self image; can lead to neglect and ultimately affects job prospects.

Priority 6 | Family and Social Support

Mental health, employment, poverty, income, and education are all connected to family and social support. Staying in school can become difficult with lack of family support and can lead to impacts on the future. Low self-esteem inflicted by family members and lack of social support can lead to cycles of abuse. Issues that are kept within the family can become stressful and ultimately lead to dysfunctional and unsupportive family structures.

Priority 7 | Access to Health Care

Despite assumptions, not everyone has access. More programs need to emerge that provide charity care (through mobile clinics) and medical coverage for children.

Priority 8 | Access to Behavioral Healthcare.

It is a struggle to define. There are lots of clinics and hospitals that are accessible by transportation but there is an underlying prioritization for low-income families and they cannot afford it. Many are unaware of where they can get care and there are long wait times for appointments.

PART 3 | RESULTS

Breakout Session Part 3 focused on finalizing the top 3 - 5 priorities and getting consensus around the order and description of the concern. After reaching consensus, participants identified current gaps and provided potential strategies to help address these health concerns.

Group 1 Priorities

Drug and Alcohol Abuse | PRIORITY 1

POTENTIAL SOLUTIONS:

- Community Outreach
- Training on Naloxone and preventative measures
- Stress coping mechanisms

Violence | PRIORITY 2

POTENTIAL SOLUTIONS:

- Stricter gun laws
- Awareness towards domestic violence
- Increasing timely access to behavioral and medical health care
- Involvement by organizations such as Nationwide Children's Hospital in the community for education and prevention services

Employment, Poverty, and Income | PRIORITY 3

POTENTIAL SOLUTIONS:

- Increase food banks, pantries, and mobile pantries
- Increase deliveries and transportation to food pantries
- Drug prevention services
- Job training and resource centers
- Increase availability of computers and libraries

Coverage and Affordability | PRIORITY 4

POTENTIAL SOLUTIONS:

- Installment of discounted medical programs
- Educating physicians and providing more samples
- Charitable pharmacies
- Mail-in discounts and mail order Rx

PART 3 | RESULTS

Breakout Session Part 3 focused on finalizing the top 3 - 5 priorities and getting consensus around the order and description of the concern. After reaching consensus, participants identified current gaps and provided potential strategies to help address these health concerns.

Group 2 Priorities

Mental Health | PRIORITY 1

POTENTIAL SOLUTIONS:

- Reduce stigma in the community regarding mental health
- Fellowships for mental health as a specialty
- Helping with educational debt
- Including continuous public education
- Increase number of communities who receive support from ADAMH

Physical Activity | PRIORITY 2

POTENTIAL SOLUTIONS:

- Organized walking groups
- Fully integrated into educational curriculum
- Employee benefits for “gym” memberships
- Increase youth leagues
- Lack of sidewalks

Education | PRIORITY 3

POTENTIAL SOLUTIONS:

- Get more community involvement
- Increase awareness of veterans programs
- Make educational opportunities readily available
- Increase health literacy

Access to Behavioral Healthcare | PRIORITY 4

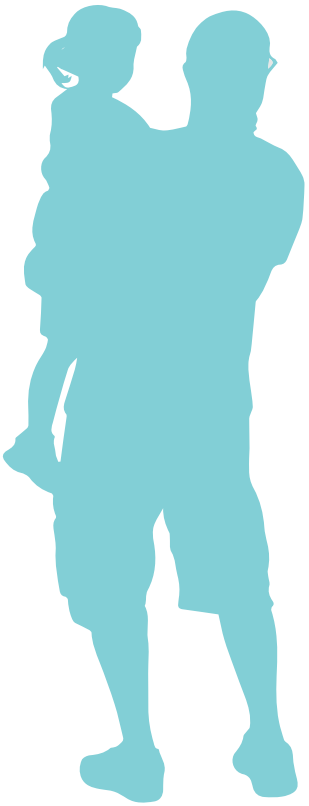
POTENTIAL SOLUTIONS:

- Increase telemedicine
- Increase care coordination

PART 3 | RESULTS

After reaching consensus, participants in Group 3 identified current gaps and provided potential strategies to help address these health concerns.

Group 3 Priorities



Obesity | PRIORITY 1

POTENTIAL SOLUTIONS:

- Changes in snack options at schools, such as healthier options in vending machines
- Increase affordability of healthy food options
- Increased marketing and campaigning for exercise

Drug and Alcohol Abuse | PRIORITY 2

POTENTIAL SOLUTIONS:

- Include law enforcement
- Eliminate stigma through education
- Involve organizations (both faith-based and other community groups) to create support groups
- Work with existing partnerships to help lower drug and alcohol abuse

Mental Health | PRIORITY 3

POTENTIAL SOLUTIONS:

- Increase in the number of support groups available
- Compassionate approaches towards individuals suffering from mental health illnesses

Employment, Poverty, and Income | PRIORITY 4

POTENTIAL SOLUTIONS:

- Affordable housing
- Generate stability for families and individuals to build strength and confidence within communities
- Increase number of high school graduates

Family and Social Support | PRIORITY 5

POTENTIAL SOLUTIONS:

- Increase awareness of social support programs
- Increased access for food pantries and clothing programs for families
- Increase school activities for children and families

LEARN MORE

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Doctors Hospital OhioHealth

Franklin County
Public Health

Franklin County Public Health
280 East Broad Street
Columbus, Ohio 43215-4562

Phone: (614) 525-3160
Email: fcph@franklincountyohio.gov
Web: myfcph.org

Appendix C:
Stakeholder Interview Report

Stakeholder Interview Findings

Method: Stakeholders were asked to complete a phone interview as a follow-up to their online survey. The phone interviews lasted between 30 to 45 minutes on average and each stakeholder was asked the same series of eleven questions. Information presented below is aggregated across the 19 participants, with emerging themes identified. A total of 19 (out of 20) stakeholders completed the phone interview.

1. In your survey, you chose five issues as pressing. Let's talk about each one. What do you believe are the main causes of these health challenges?

In the online survey, the top five primary health challenges selected included:

1. **Drug and Alcohol Abuse (75%)**
2. **Mental Health and/or Access to Behavioral Health Care (65%)**
3. **Obesity (50%)**
4. **Employment, Poverty, and Income (45%)**
5. **Maternal and Infant Health (45%)**

Other challenges in addition to these five were selected. The themes from the top five are provided first, followed by other identified health challenges.

(1) Drug and Alcohol Abuse:

Four stakeholders mentioned the opiate crisis and its impact on the community as being a major health challenge to address. Other stakeholders discussed addiction in more general terms, explaining that drug and alcohol use is always an issue and is influenced by the community and culture. Stakeholders indicated communities that are struggling and are in despair seem to experience more drug use and may be self-medicating by using more drugs. Stakeholders recognized an increasing supply of drugs into the Franklin County community is an issue.

(2) Mental Health and/or Access to Behavioral Health Care:

Stakeholders recognized that challenges with health care coverage are a major issue to accessing behavioral health care. Some of these challenges are related to coverage (e.g. people having it or not having it), potential legislative changes in health care (resulting in potential change of coverage or loss of coverage), and continued confusion about benefits, etc. Stakeholders report that Medicaid is not a good payor for mental health services. Lack of funding for behavioral healthcare, as well as reductions in funding were cited by stakeholders as reasons why many people with behavioral health issues are being served in the criminal justice system rather than the mental health system.

For those seeking services, there were several issues identified as challenges. For those with health care coverage, having limited income to pay for services still becomes an issue. Some communities may lack access to transportation to and from appointments, and also lack providers within close proximity (i.e. the West Side). Stakeholders report that wait lists and culturally competent care are both challenging, especially for immigrant communities (e.g. Somali, Bhutanese, and Nepalese). Stigma around mental illness is still an issue in seeking care and receiving long-term care. As one stakeholder said, "It's not like getting a broken leg fixed. It is going to take a lot longer and be more expensive." Although significant work has been done to reduce stigma around mental illness, and more people seem to be seeking treatment, this issue seems to remain present.

(3) Obesity:

Stakeholders acknowledged two major factors at play as it relates to obesity: (1) a lack of accessibility to food, especially nutritious food, and (2) a lack of activity in the lives of children and adults.

Stakeholders reported that healthier foods are often more expensive, and the healthiest food may only be available in certain, more expensive grocery stores (ex. Whole Foods). Most stores and restaurants that sell these healthy food choices are located in nicer, more affluent parts of town, so they are not accessible to most communities. Unhealthy foods are seen as cheaper overall, and being more readily available in most communities. Stakeholders report that consuming too much of these types of foods is contributing to the issue of obesity.

Stakeholders reported that in unhealthy communities, there might be a lack of resources to engage physical activity. Stakeholders reported that obesity may be more highly connected to areas of town where there are fewer safe outdoor spaces like parks, bike and walking trails, etc. Some Stakeholders are seeing a divestment of resources in activities and activity spaces in many communities, further limiting the options available.

(4) Employment, Poverty, and Income:

Stakeholders cited poverty as "an umbrella" under which many other health challenges exist. Stakeholders report poverty is fueled by a lack of meaningful employment, underemployment or unemployment. Without good employment and a stable or reasonable income, other issues like housing, medical care, access to food, behavioral healthcare, and transportation become worse. One stakeholder shared how poverty, employment and housing are commonplace in the lives of transgender and gender non-conforming persons in Franklin County. They are often discriminated against in employment and housing and are not protected from this discrimination in state laws.

Stakeholders recognize that not being employed is stressful. Stress, alone, can causes health problems, and can prevent people from keeping reliable jobs. Stakeholders acknowledge that feelings of being involved in a never-ending cycle of stress can manifest into mental health or physical health issues.

(5) Maternal and Child Health:

Stakeholders discussing maternal and child health recognized that this issue is a pressing one for the community and that despite many efforts we are still struggling to make a difference. The opiate crisis and other systemic issues (like poverty and low SES) were seen as impacting this health challenge.

(6) Violence:

Stakeholders saw violence as interconnected with poverty and addiction. Violence was seen as impacting poorer communities (e.g. Linden, Weinland Park) more so than affluent communities. Stakeholders sensed that there was an escalation in violence, crime, and homicides in the community.

(7) Nutrition and/or Food Environment:

Stakeholders reported access to meals is an issue for many people in the county, especially senior citizens. A concern expressed by one stakeholder had to deal with choosing between food and medication. A second stakeholder indicated another group struggling with food and nutrition are those with behavioral health disorders who are too young to qualify for programs like Meals on Wheels.

(8) Diabetes:

Stakeholders reported family history, societal practices, and costs associated with eating healthy were all causes of diabetes in Franklin County. As one stakeholder stated, "Obesity and diabetes go hand in hand. It is difficult for nuclear family to eat healthy, at stores... items in the chip aisles are cheaper than produce aisles." Stakeholders also reported that in some low-income communities, there was a lack of awareness about nutrition and healthy food choices.

(9) Housing:

Stakeholders reported that options for affordable housing seem limited and corporations are not investing in affordable housing projects. One stakeholder shared, "Veterans with limited income also face housing challenges and have trouble paying for bills related to health care."

(10) Access to Health Care/Medical Care:
Stakeholders report that access to health care/medical care is impacted by cost and cultural competence.

Several stakeholders discussed the expensive costs of healthcare and the overall confusing system. For example, seniors, "...don't understand they need Medicare Part A, Part B, and prescription coverage, dental, vision, etc. Folks cannot afford the Medicare supplemental plans. Managed care is making it more complicated." Stakeholders report that even with the focus on getting everyone insured, insurance may be inadequate to meet their needs and the overall cost is high.

Stakeholders report that issues of cultural competence particularly impact persons who are foreign born, persons for whom English is second language, and persons from the LGBTQ community. One stakeholder mentioned, "Engaging with the healthcare community is often not a helpful situation; they [the above mentioned groups of people] get negative responses from healthcare providers about their presentation. Healthcare providers will tell them, 'I don't know anything about transgender care,' and then not provide services." When persons have negative experiences, such as this one, they may be less likely to return for services.

(11) Coverage and Affordability:
Stakeholders report that health care coverage and affordability are connected to access. The cost also impacts organizations as one of the stakeholders shared, " My organization cannot even get healthcare that covers transgender employees. Maybe if we were a larger organization we could, but for now we can't." As stated in earlier responses, the cost of insurance coverage is expensive, combined with the confusion about coverage and potential legislative changes.

(12) Equity/Disparities:

"Equity and disparities are the underlying issue – we can't seem to get our arms around it. We are making some progress, but it is slow and very expensive."

The issue of equity/disparity came up several times during the stakeholder interviews. Stakeholders recognize the differences in the "haves" and the "have-nots" within our communities. Stakeholders report Socioeconomic Status (SES) is an issue connected to many health challenges. Stakeholders reported that the zip code in which a person lives in plays a major part in health and education. Stakeholders recognized that changes in technology and our lifestyles as young people seem to be more isolated and depressed. Continued racism is also seen as a disparity impacting many people in the community.

(13) Family and Social Support:

Two Stakeholders identified [lack of] family and social support as a health challenge. As one stakeholder said, "The more family support they have, the easier they move through the world. When support is missing, that's when folks tend to lose their power in the world."

(14) Transportation:

Transportation was seen as a health challenge for many Stakeholders, whether it was being transported for appointments or not feeling safe using public transportation. For example, busses can be unsafe places for transgender people who may experience violence or threats of violence while waiting or riding on the bus.

(15) Tobacco and COPD:

Stakeholders recognize that tobacco use remains a health challenge. One stakeholder mentioned that "Providers may be screening for tobacco, but linkage to resources is inadequate or resources are not even available." Stakeholders believe tobacco use rates and COPD are seen as interconnected.

(16) Cancer:

One stakeholder spoke directly about cancer being a health challenge by stating, "[cancer] rates seem really high (top five reasons we are dying); Cancer can be fueled by stress."

(17) Cardiovascular Disease:

A few stakeholders recognize diet and exercise or diet and lack of exercise as health challenges. Another stakeholder mentioned lack of access to preventative care as one of the causes of high rates of cardiovascular disease.

Underlying Causes Across Health Challenges:

" So many things can be under the umbrella of poverty…even as people are thriving, we are DYING at an alarming rate…There's not one singular thing that determines all of this – there is not one root. Even people with access to care are dying too."

Some respondents discussed the main causes of health challenges as interconnected between the issues and did not separate out their answers. Stakeholders indicated "there is not just one main cause." Root causes in general that seemed to bridge across the identified issues:

- A need to provide the right resources in the areas where people can access them; an example is the FQHC model;
- Information gaps – getting information to the people who are in need in ways that they can understand that information;
- Social determinants of health as influencing environmentally;
- A lack of access or knowledge about services that may be available;
- Community neglect: Not all communities have the services they need (e.g. a health center)
- Social causes: Obesity, smoking, drug and alcohol abuse have social causes – how someone is raised can be impactful, and geography can be impactful as well.
- A lack of activity, especially for children who seem to not be playing outside anymore or not having enough activities to keep them away from drug use. As one stakeholder said, "The only thing left to do is to get in trouble because we've taken all the programs out of the community."

2. How would you describe the health status of the communities FCPH serves?

"Communities are drastically different within the county. Some communities have a lot of access to fresh food, but not others. Some areas have better access to housing, exercise, food, recreation, health care facilities, etc."

This question was asked on the online survey through a ranking of 1 to 11, with 1 indicating "Very Poor" and 11 indicating "Very Good." The average score was 6.05, which ranks as "**Fair**." Stakeholders were also asked this same question in the in-person interview to allow them to expand upon their answer from the online survey.

Stakeholders recognized diversity within the county, stating, "…there are some zip codes that are doing quite well and some that are poverty stricken. Depends on where you live and what you have access to," and "People in certain communities are running, biking, etc. None of that happens in other communities because of the area. High poverty rates drive down the health of the community." They also recognized the inequity across the community – we are diverse and unequal. Some saw the health status of the community as a correlate with socioeconomic status or gender identification, or age, or diagnosis (e.g. being mentally ill or chronically ill) or as related to Veteran status. For example, "LBGTQ people, trans people and gender non-conforming people, they are underemployed and unemployed and therefore have lower health status." Stakeholders noted disparity in people having access to the kind of health services they need. For example, on the county's west side, there are few medical specialists. The west side also has a huge cultural mix and barriers related to language translation within healthcare settings.

Stakeholders recognized that resources vary across the county. Resources may include access to housing, health, education, etc. As one stakeholder noted, "Communities are drastically different within the county. Some communities have a lot of access to fresh food, but not others. Some areas have better access to housing, exercise, food, recreation, health care facilities, etc." Pockets of poverty are being seen as growing and experiencing poorer health outcomes.

"For people with resources there is a wide range of options available and for those people, their health status is above average. For those who are poor, they find that less providers take Medicaid and that Medicaid does not pay for a lot of prevention and wellness services. I would stay their health status is below average."

Stakeholders identified Franklin County's challenges with obesity, infant mortality, suicide and violence. Rates for other diseases including cancer and diabetes were characterized by one stakeholder as "ALARMING" and something that we should be on "red alert" about as a community.

3. What is your understanding of the services administered by FCPH (Meaning, what do you think FCPH does for the community?)

The majority of stakeholders could identify some high-profile programs that FCPH administers, including mosquito spraying, emergency preparedness and immunizations. Three people stated that they have no clear idea of what FCPH does. There was a general consensus that stakeholders were not aware of the range of services FCPH provides; none were confident that they could list them in entirety. Four people indicated that the online survey, which provided the list of services, surprised them as to the breadth of services provision. Nine stakeholders mentioned that they were mostly aware of the services FCPH administered as related to their jobs and their organization's interactions with them. For example, some knew about restaurant inspections and others knew about immunizations because they had come across them in their work, but they had only a vague awareness of other services.

4. What is your understanding of the role of FCPH in relationship to Columbus Public Health (CPH)?

All stakeholders agreed that there is overlap between the two agencies; most agreed that they collaborate on issues, but few could indicate how or when. The exception being that several people believed their collaboration is most visible when there is a crisis; it is at these times that they see a united front. Three were concerned with unnecessary overlap in services; stating that funds could be more efficiently use if roles were clearly defined. Three others reported the collaboration between the two agencies was productive and well-run. At least half of the respondents talked about jurisdictional areas being one of the differences, in that FCPH serves a wider area than CPH, and one mentioned this as a problem, as they viewed CPH as taking the lead on most things, when truly it should be the county agency that does so. Two stakeholders described FCPH as being more of an educational body, while CPH does more direct service work. In general, there is a consensus that stakeholders would like to be more aware of the relationship between the two agencies.

5. How would you describe or define the terms "health equity" and "social determinants of health"?

Five people could not offer a definition of health equity. The majority of other respondents described it in terms of having access to "equal health" or "leveling the playing field" across all populations and socio-economic groups. There was agreement around the concept that some people have better health than others, in terms of access to care, awareness of healthy habits, and resources available to them. Additionally, that there is a responsibility to raise the health equity of those whose life circumstances make theirs lower. Two respondents had a different idea of health equity: one said that it was what people have done to manage their own health; the other that it meant "are we generally healthy or are we not?"

Four people could not offer a definition of social determinants of health. All but one of the other respondents had similar answers. Social determinants of health were defined as "other" factors (economic status, class, race, living environment, culture, etc.) that influence a person's health status, whether for better or for worse. Most mentioned that it is important to take these into account when looking at an individual and/or community, as they can offer background information on the case. There was one outlier respondent who indicated that social determinants of health relate more to whether an individual has chosen to make healthy choices (eg. smoking, immunizations, etc.).

6. What role does health equity and the social determinants play in FCPH jurisdictions?

There were a variety of answers to this question, though some common themes arose. The largest consensus was the idea that FCPH should use data and knowledge that is gathered regarding healthy equity and the social determinants of health to inform their work. Seven stakeholders believe that FCPH should work to decrease the inadequacies across communities, while a further six spoke of **FCPH as being a lynchpin**: an organization in position to bring both other organizations and communities together to address health inadequacies.

"Get us all around the table and get this conversation going. Hold us accountable once that conversation starts."

Answers outside of this consensus varied. Four respondents said they were not sure what role these two factors play. One respondent indicated that they believe that majority of the community FCPH serves is healthy. Another noted that FCPH should be cautious when drawing the line between "supporting" ailing communities and "enabling" them. Two respondents spoke of a call to action in terms of cultural programming: one expressed a need to look outside programming aimed at white, middle class Appalachians; another spoke specifically to the LGBT community not having a voice in the development or receipt of FCPH programming, leading to messaging they disagree with.

7. What do you believe are the reasons certain groups of people have health disparities or that their quality of life is not as good as others?

"People aren't poor because they make bad decisions, people make bad decisions because they are poor."

The overwhelming majority of Stakeholders responded that a person's life circumstances lead to health disparities and quality of life. The impact of poverty was listed as a catalyst for poor health outcomes in many different ways: the stress it puts on body systems, the lack of control, the lack of healthy choices available, the lack of access to care and the hierarchy of needs in that any food and shelter take priority over medical care. Education was mentioned ten times, typically entwining the way a person's culture or upbringing lacked health education with a dearth of health education programming reaching these populations now. A fear of doctors and the medical establishment was mentioned twice as a consequence of this lack of education.

Four respondents, however, indicated a **level of choice** being a cause for some health disparities. One noted that even in affluent communities, where health education has purportedly taken place, individuals make detrimental health choices. Others noted that, in general, people can be given information and still make poor health choices. One respondent noted that those with mental illness often have poor quality of life because they do not have the competence to maintain a healthy lifestyle.

8. What do you think would encourage and support more community involvement and advocacy around health issues?

The diversity of responses was particularly evident in this question, with no more than two or three respondents thinking of any given strategy. What was most universal, with five stakeholders acknowledging it, was that community involvement and advocacy are a difficult thing to implement and that they themselves continue to struggle with them.

Ideas to encourage community involvement and advocacy included:

- Going beyond traditional health fairs- tailor activities to communities (mentioned 2x)
- Going into schools
- Involving big corporations (mentioned 2x)
- Using the media- both traditional and social (mentioned 3x). One advised not letting the media overhype stories.
- Implementing a task force
- Creating intergenerational/intercommunity awareness
- Increasing transparency
- Allowing space to fail
- Offering incentives
- The city and county joining forces to negotiate with health systems
- Being proactive/preventative vs. reactive (mentioned 2x)
- Outreach
- Building trust in communities; solving problems from the inside (mentioned 3x)
- Education (mentioned 2x)
- Putting restriction on public funding (eg. food stamps)
- Mobilizing affluent communities to help less fortunate communities

9. What specific actions, policy, or funding priorities would you support because they would contribute to a healthier Franklin county?

Stakeholders had a variety of ideas in response to this question, but several broad categories emerged.

(1) Education. Two stakeholders stressed the importance of health education in schools; two others advocated the importance of continuing health education with all ages and stages.

(2) Protecting vulnerable populations. Seven stakeholders addressed this in some way, from increasing services for seniors, the mentally ill or those struggling with drug and alcohol addiction, to supporting the need for more caseworkers across all social service agencies.

(3) Accessibility. Five stakeholders indicated they would support efforts to increase access in communities with lower health outcomes. Ideas mentioned included putting grocery stores, healthier restaurant options and other social services agencies in lower income communities.

(4) Data. Five stakeholders advocated for a more effective use of data and data management. In two interviews, this came about in a discussion of finding and using best practices to increase health outcomes. Another stakeholder mentioned they would support work using the results of this survey. The final two stakeholders discussed making sure the data being used to make decisions is of good quality and taking a close look at how policies perform once they are actually implemented.

(5) Other. Other ideas that stakeholders would support included: private technology funding, innovation funding, other funding levys, cultural competency training (mentioned 2x), incentives, food industry regulation, media regulation and food stamp regulation.

10. What role should FCPH play in addressing these health challenges?

"The County should be a leader."

Nearly all of the stakeholders interviewed expressed their belief that FCPH should use their platform and position in the County to do things that other providers cannot; namely, in the form of leadership and coordinating services. Eight stakeholders want FCPH to act as a leader in countywide health initiatives, using the data they collect to inform best practices and solutions tailored to fit individual communities. Five noted that FCPH has the benefit of a "bird's eye view" that allows them to identify broader-scale priorities. Four stakeholders would specifically like FCPH to be a communication channel; passing on the results of their findings, aggregate data about the county and other items of importance. Two stakeholders urged FCPH to use their position to advocate for the populations they serve to a higher level, be it state, regional or federal. Two encouraged FCPH to look internally and ensure their own staffing and policies are in line with their mission statement before looking externally. Finally, three stakeholders continued to stress the theme of education: FCPH has the ability, and thus the responsibility, to reach large groups of people and educate them not only on healthy lifestyle choices, but what the various health systems and social service providers are doing, what services are available and what the county's strategic initiatives are.

11. Franklin County is diverse in terms of socioeconomics, education, race and ethnicity, and resources. Some areas FCPH serves are more affluent (e.g. UA, Dublin, New Albany) and will naturally have more resources they can tap into, versus others such as Obetz, Groveport, Madison have more poverty and lack resources**. In thinking about these communities, what do you see as their strengths and challenges?**

Stakeholders were in agreement that strengths of affluent communities lay in their resources. They are, in general, better educated, more connected to services and better able to leverage the resources they have. One respondent spoke of the John Maloney Health Center in New Albany. Members of that community were able to get the city and OSU to underwrite the cost. These communities have influential business-persons with influence over elected officials living in them. Four respondents also noted that affluent communities have healthier food options and safer neighborhoods and gathering spaces for activities.

Some challenges in affluent communities that were noted were that, even with education and money, individuals may still make poor health choices. This was spoken of in terms of physical health issues (Type II diabetes, smoking, etc.) and substance use disorders. Three respondents spoke of the unawareness that affluent communities have of health issues of the broader community. A further three respondents believed that there is a sense of "it won't happen to me" in more affluent communities, but public health crises eventually touch everyone. In addition, some health problems, such as the opiate epidemic, have been shown to be rampant regardless of social class.

On the flip side, the challenges in the less affluent communities were often the same one listed as strengths in wealthier areas. Six stakeholders stated that these communities have fewer resources across the board: not only are there less available in their areas, it is difficult for them to get to them. Three stakeholders spoke about the infrastructure of these communities: it is often

dilapidated and unsafe for gathering; outdoor exercise options are limited due to neighborhood violence. One respondent spoke of the negative effect violence, stress and trauma has on health outcomes, while another mentioned that a lack of healthy food options is a detriment. Two stakeholders noted that the political influence of less affluent communities is not very strong.

Several of the same strengths were repeated when discussing less affluent communities. There is a consensus that communities are more bonded, more cohesive, in families, neighborhoods and faith groups. Three stakeholders mentioned that personal strength could be greater in less affluent communities, as members of them have had to withstand many challenges. Further, they are more creative with resources that are available, a skill that would be beneficial to other areas. One person noted that there are strong community organizers in these areas and that is who should be called upon by governing bodies, as trust with the community is already established. Another respondent stated that there is a large population who can enter the workforce, if some of their barriers are lifted.

Six respondents noted that it is a challenge to serve both affluent and less-affluent communities at the same time. Two spoke of the difficulties in getting different communities to interact with each other, though they believe it is highly necessary. It was stated by one that both types of communities have resources, but they are different and can benefit each other. Others noted that the negotiation and distribution of resources is a difficult balancing act, on the one hand ensuring that no community gets neglected, but also leveraging them in a way to bring all up to the same level of care. Two stakeholders saw this as both a challenge and a strength, stating:

"[The] strength is having the resources to do what needs to be done…the challenge, of course, is dealing with a diverse population and different values."

and

"We have an advantage in this community in being able to collaborate and let someone free up resources to help communities in need."

Franklin County Public Health
280 East Broad Street
Columbus, Ohio 43215-4562

Phone: (614) 525-3160
Email: fcph@franklincountyohio.gov
Web: myfcph.org

www. myfcph.org