DELIVERED BY:

2024 HANCOCK COUNTY COMMUNITY HEALTH ASSESSMENT

PUBLISHED FEBRUARY 2025

TABLE OF CONTENTS

NOTE FROM BE HEALTHY NOW HANCOCK COUNTY (BHNHC) 3
ACKNOWLEDGEMENTS 4
INTRODUCTION 5
WHAT IS A COMMUNITY HEALTH ASSESSMENT (CHA)?
OVERVIEW OF THE PROCESS
STEP 1: PLAN AND PREPARE FOR THE ASSESSMENT 8
BRIEF SUMMARY OF 2021 CHA
WRITTEN PUBLIC COMMENTS TO 2021 CHA
HANCOCK COUNTY'S 2021-2023 PRIORITY HEALTH NEEDS
AND IMPACT EVALUATION OF IMPLEMENTED STRATEGIES
STEP 2: DEFINE HANCOCK COUNTY'S SERVICE AREA 11
DEMOGRAPHICS AT-A-GLANCE
STEPS 3-5: IDENTIFY, UNDERSTAND AND INTERPRET THE DATA 14
PRIMARY & SECONDARY DATA COLLECTION
KEY INFORMANT INTERVIEWS
FOCUS GROUPS
THINGS PEOPLE LOVE ABOUT THE COMMUNITY
TOP COMMUNITY PRIORITIES
TOP FINDINGS FROM FOCUS GROUPS
COMMUNITY MEMBER SURVEY AND RANKING OF HEALTH NEEDS
2024 HEALTH NEEDS: COMMUNITY CONDITIONS (IN ORDER AS RANKED BY THE PUBLIC) 27
#1: HOUSING 28
#2: ACCESS TO HEALTHCARE 30
#3: TRANSPORTATION 32
#4: INCOME/POVERTY & EMPLOYMENT 34
#5: ACCESS TO CHILDCARE 36
#6: FOOD INSECURITY 38
#7: NUTRITION AND PHYSICAL HEALTH 40
#8: CRIME AND VIOLENCE 43
#9: ADVERSE CHILDHOOD EXPERIENCES 44
#10: TOBACCO AND NICOTINE USE 45
#11: EDUCATION 47
#12: PREVENTIVE CARE AND PRACTICES 49
#13: ENVIRONMENTAL CONDITIONS 51
#14: INTERNET/WI-FI ACCESS 52
2024 HEALTH NEEDS: HEALTH OUTCOMES (IN ORDER AS RANKED BY THE PUBLIC) 53
#1: MENTAL HEALTH 54
#2: SUBSTANCE USE 56
#3: CHRONIC DISEASES 58
#4: MATERNAL, INFANT, AND CHILD HEALTH 62
#5: INJURIES 64
#6: HIV/AIDS AND SEXUALLY TRANSMITTED INFECTIONS (STIs) 65
LEADING CAUSES OF DEATH IN HANCOCK COUNTY 67
IDEAS FOR CHANGE FROM OUR COMMUNITY 68
CURRENT PARTNERS AND RESOURCES ADDRESSING PRIORITY HEALTH NEEDS 71
STEP 6: DOCUMENT, ADOPT/POST AND COMMUNICATE RESULTS 73
CONCLUSION AND NEXT STEPS 75
APPENDICES
APPENDIX A: IMPACT AND PROCESS EVALUATION 77
APPENDIX B: BENCHMARK COMPARISONS 81
APPENDIX C: KEY INFORMANT INTERVIEW PARTICIPANTS 83
APPENDIX D: FOCUS GROUP PARTICIPANTS 86
APPENDIX E: COMMUNITY MEMBER SURVEY 89
APPENDIX F: PHAB CHA REQUIREMENTS CHECKLIST 103
APPENDIX G: IRS CHNA REQUIREMENTS CHECKLIST 105
APPENDIX H: REFERENCES 109

A NOTE FROM
BE HEALTHY NOW HANCOCK COUNTY

Be Healthy Now Hancock County (BHNHC) strives to bring together people and organizations to improve community wellness. The community health assessment process is one way we can live out our mission. In order to fulfill this mission, we must be intentional about understanding the health issues that impact residents and work together to create a healthy community.

A primary component of creating a healthy community is assessing the needs and prioritizing those needs for impact. In 2024, BHNHC partnered to conduct a comprehensive Community Health Assessment (CHA) to identify primary health issues, current health status, and other health needs. The results from the assessment provide critical information to those in a position to make a positive impact on the health of Hancock County's residents. The results also enable the community to measure impact and strategically establish priorities in order to develop interventions and align resources.

BHNHC and their many health partners conduct CHAs for measuring and addressing the health status of the Hancock County community. We have chosen to assess Hancock County as our community because this is where we, and those we serve, live and work. We collect both quantitative and qualitative data in order to make decisions on how to better meet the health needs of our community. We want to provide the best possible care for our residents, and we can use this report to guide us in our strategic planning and decision-making concerning future programs and health resources.

The 2024 Hancock County CHA would not have been possible without the help of numerous Hancock County organizations, acknowledged on the following pages. It is vital that assessments such as this continue so that we know where to direct our resources and use them in the most advantageous ways.

The work of public health is a community job that involves individual facets, including our community members and organizations, working together to be a thriving community that supports health and well-being at home, work, and play.

Conducting the CHA and publishing this report relies on the participation of many individuals in our community who committed to participating in interviews and focus groups, and completing our community member survey. We are grateful for those individuals who are committed to promoting the health of the community, just as we are, and take the time to share their health concerns and ideas for improvement.

Sincerely,

Lindsay Summit, MPH

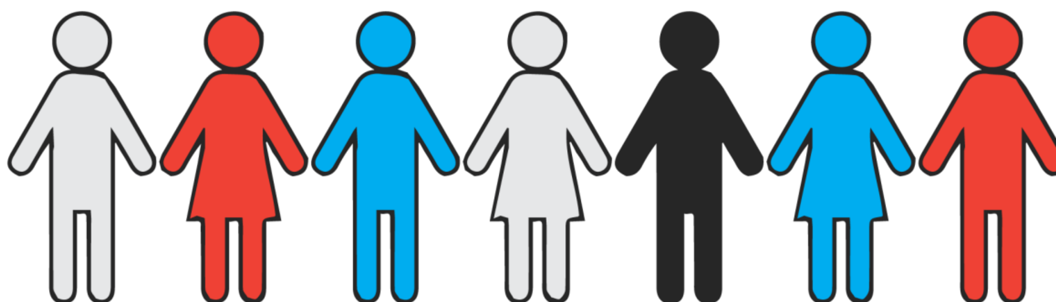
Lindsay Summit
Health Commissioner
Hancock Public Health

ACKNOWLEDGEMENTS

This Community Health Assessment (CHA) was made possible thanks to the collaborative efforts of Be Healthy Now Hancock County (BHNHC), community partners, local stakeholders, non-profit partners, and community residents. Their contributions, expertise, time, and resources played a critical part in the completion of this assessment.

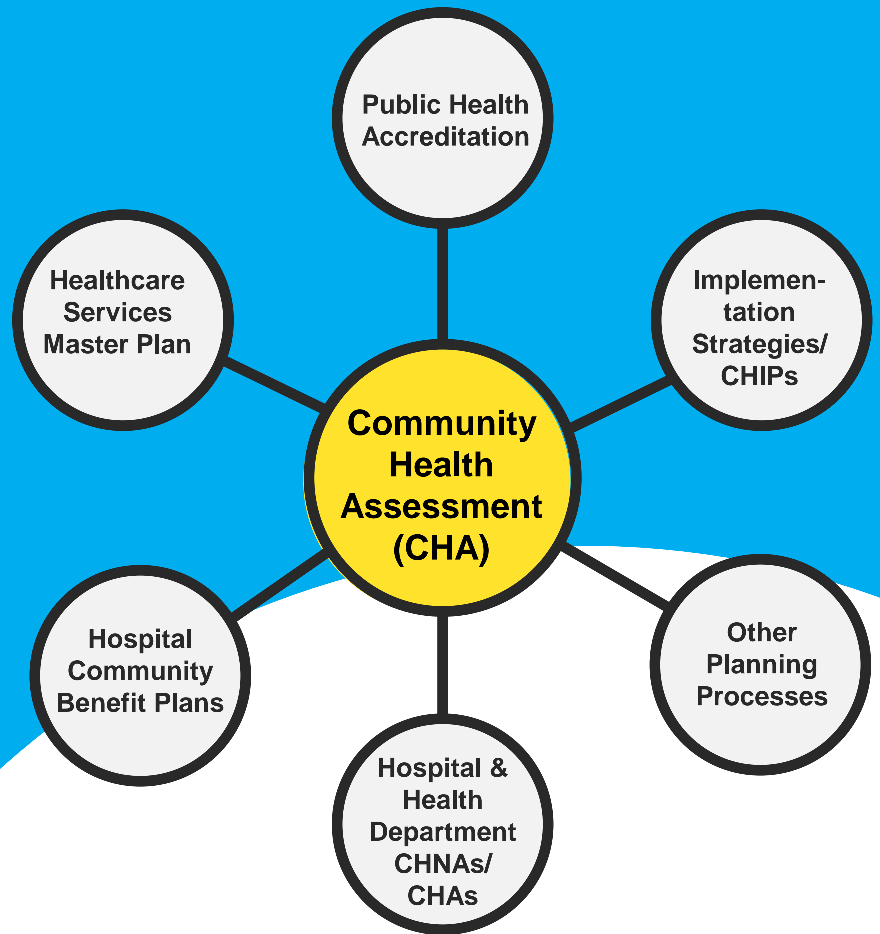
BHNHC WOULD LIKE TO RECOGNIZE THE FOLLOWING ORGANIZATIONS FOR THEIR CONTRIBUTIONS TO THIS REPORT:

Black Heritage Library & Multicultural Center
Blanchard Valley Health System
Children's Mentoring Connection
Church of the Living God
City Mission of Findlay
City of Findlay
City of Findlay Parks & Recreation
Family & Children First Council
Family Resource Center
Findlay City Schools
Findlay-Hancock County Community Foundation
Findlay YMCA
Findlay Hancock County Chamber of Commerce
Findlay Hancock County Public Library
FOCUS Recovery & Wellness Community/ Peer Advisory Partnership
Friends of Findlay
Hancock County Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board/ Community Partnership
Hancock County Coalition on Addiction
Hancock County Family and Children First Council
Hancock County Probate/Juvenile Court
Hancock County Schools and Educational Service Center
Hancock County Veteran Services
Hancock Public Health
Hancock Hardin Wyandot Putnam (HHWP) Community Action Commission
Hope House
LGBTQ+ Spectrum of Findlay
Mission Possible
Parent Advisory Group
Raise the Bar Hancock County
The Ohio State University Extension Office
United Way of Hancock County
University of Findlay
University of Findlay College of Pharmacy
West Ohio Food Bank
Whirlpool
50 North



INTRODUCTION

WHAT IS A COMMUNITY HEALTH ASSESSMENT?



A **Community Health Assessment (CHA)** is a tool that is used to guide community benefit activities and for several other purposes. For health departments, it is used to identify and address key health needs and supports the requirements for accreditation through the Public Health Accreditation Board (PHAB). The data from a CHA is also used to inform community decision-making: the prioritization of health needs and the development, implementation, and evaluation of an Improvement Plan (CHIP).

A CHA is an important piece in the development of a CHIP because it helps the community to understand the health-related issues that need to be addressed. To identify and address the critical health needs of the county, Be Healthy Now Hancock County (BHNHC) utilized the most current and reliable information from existing sources, in addition to collecting new data through interviews, focus groups, and surveys with community residents and leaders.

OVERVIEW

OF THE PROCESS

In order to produce a comprehensive Community Health Assessment (CHA), Be Healthy Now Hancock County (BHNHC) followed a process that included the following steps:

STEP 1: Plan and prepare for the assessment.

STEP 2: Define the community.

STEP 3: Identify data that describes the health and needs of the community.

STEP 4: Understand and interpret the data.

STEP 5: Define and validate priorities.

STEP 6: Document and communicate results.

Accreditation Requirements

The Public Health Accreditation Board (PHAB) Standards & Measures serves as the official guidance for PHAB national public health department accreditation and includes requirements for the completion of Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs) for local health departments.

Ohio Department of Health Requirements

The Ohio Department of Health (ODH) is required by state law to provide guidance to hospitals and local health departments on Community Health (Needs) Assessments (CHNAs/CHAs) and Implementation Strategies/Improvement Plans (CHIPs). In July 2016, HB 390 (ORC 3701.981) was enacted by Ohio in order to improve population health planning in the state by identifying health needs and priorities by conducting a CHNA/CHA and subsequently developing an Implementation Strategy/CHIP to address those needs in the community.

Affordable Care Act/IRS Requirements

Enacted on March 23, 2010, the Affordable Care Act (ACA) provided guidance at a national level for CHNAs for the first time. Federal requirements included in the ACA stipulate that hospital organizations under 501(c)(3) status must adhere to new 501(r) regulations, one of which is conducting a Community Health Needs Assessment (CHNA) and Implementation Strategy every three years.

THE 2024 HANCOCK COUNTY CHA MEETS ALL OHIO DEPARTMENT OF HEALTH AND FEDERAL REGULATIONS.

OVERVIEW
OF THE PROCESS (CONTINUED)

Ohio Department of Health (ODH) Requirements

The following image shows the framework from ODH that this report followed while also adhering to federal requirements and the community's needs.

Be Healthy Now Hancock County (BHNHC) desired to align with the priorities and indicators of the Ohio Department of Health (ODH). To do this, they used the following guidelines when prioritizing the health needs of their community.

First, BHNHC used the same language as the state of Ohio when assessing the factors and health outcomes of their community in the 2024 Hancock County Community Health Assessment (CHA).

Figure 1: Ohio State Health Improvement Plan (SHIP) Framework

Equity Health equity is achieved when all people in a community have access to affordable, inclusive, and quality infrastructure and services that, despite historical and contemporary injustices, allow them to reach their full health potential.

Priorities The SHIP identifies three priority factors (community conditions/social determinants or drivers of health) and three priority health outcomes that affect the overall health and well-being of children, families, and adults of all ages.

What shapes our health and well-being?
Many factors, including these **3 SHIP priority factors***:

Community Conditions
- Housing affordability and quality
- Poverty
- K-12 student success
- Adverse childhood experiences

Health Behaviors
- Tobacco/nicotine use
- Nutrition
- Physical activity

Access to Care
- Health insurance coverage
- Local access to healthcare providers
- Unmet need for mental healthcare

How will we know if health is improving in Ohio?
The SHIP is designed to track and improve these **3 SHIP priority health outcomes**:

Mental Health & Addiction
- Depression
- Suicide
- Youth drug use
- Drug overdose deaths

Chronic Disease
- Heart disease
- Diabetes
- Childhood conditions (asthma, lead exposure)

Maternal, Infant & Child Health
- Preterm births
- Infant mortality
- Maternal morbidity

All Ohioans achieve their full health potential
- Improved health status
- Reduced premature death

Vision: Ohio is a model of health, well-being, and economic vitality

Strategies The SHIP provides state and local partners with a menu of effective policies and programs to improve Ohio's performance on these priorities.

** These factors are sometimes referred to as the social determinants of health or the social drivers of health.*

STEP 1

PLAN AND PREPARE FOR THE ASSESSMENT

IN THIS STEP, BE HEALTHY NOW HANCOCK COUNTY (BHNHC):

- ✓ DETERMINED WHO IN THE COUNTY WOULD PARTICIPATE IN THE NEEDS ASSESSMENT PROCESS
- ✓ PLANNED FOR COMMUNITY ENGAGEMENT
- ✓ ENGAGED COUNTY LEADERSHIP
- ✓ DETERMINED HOW THE COMMUNITY HEALTH ASSESSMENT WOULD BE CONDUCTED
- ✓ DEVELOPED A PRELIMINARY TIMELINE

PLAN AND PREPARE

Be Healthy Now Hancock County (BHNHC) began planning for the 2024 Community Health Assessment (CHA) in 2023. They involved the health department and County leadership, and kept partnership members informed of the assessment activities, allocated funds to the process, and most importantly, engaged the community through various established relationships with leaders of organizations and priority populations, in collaboration with Moxley Public Health.

The assessment team worked together to formulate the multistep process of planning and conducting a CHA. They then formed a timeline for the process.

> ***Community Health Assessments (CHAs) 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.***
>
> \- Catholic Health Association

PREVIOUS COMMUNITY HEALTH ASSESSMENT (CHA) & COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

PREVIOUS CHA (2021)

In 2021, Be Healthy Now Hancock County (BHNHC) conducted the previous CHA. Significant health needs were identified from issues supported by primary and secondary data sources gathered for the CHA. The CHIP associated with the 2021 Hancock County CHA addressed behavioral health, access to care, and community education.

The previous CHA and CHIP were made available to the public on the following websites:

Hancock Public Health: https://www.hancockph.com/reports-and-data
Blanchard Valley Health System: https://www.bvhealthsystem.org/about-bvhs/community-benefit
(Written comments on this report were solicited on the websites where the report was posted.)

HANCOCK COUNTY 2023-2025 PRIORITY HEALTH NEEDS

BHNHC developed the Hancock County 2023-2025 CHIP by reviewing the 2021 CHA. The partnership reviewed and discussed the priority areas and agreed that the following priority health issues could be positively impacted by strategies and activities conducted by BHNHC and their partners:

1. Health Behaviors
2. Access to Care
3. Mental Health & Addiction

IMPACT/PROCESS EVALUATION OF 2021-2023 STRATEGIES

In collaboration with community partners, BHNHC developed and approved a CHIP report for 2023-2025 to address the significant youth health needs that were identified in the 2021 CHA. BHNHC chose to address: health behaviors, access to care, mental health & addiction. **Appendix A** describes the evaluation of the strategies that were planned in the 2023-2025 CHIP.

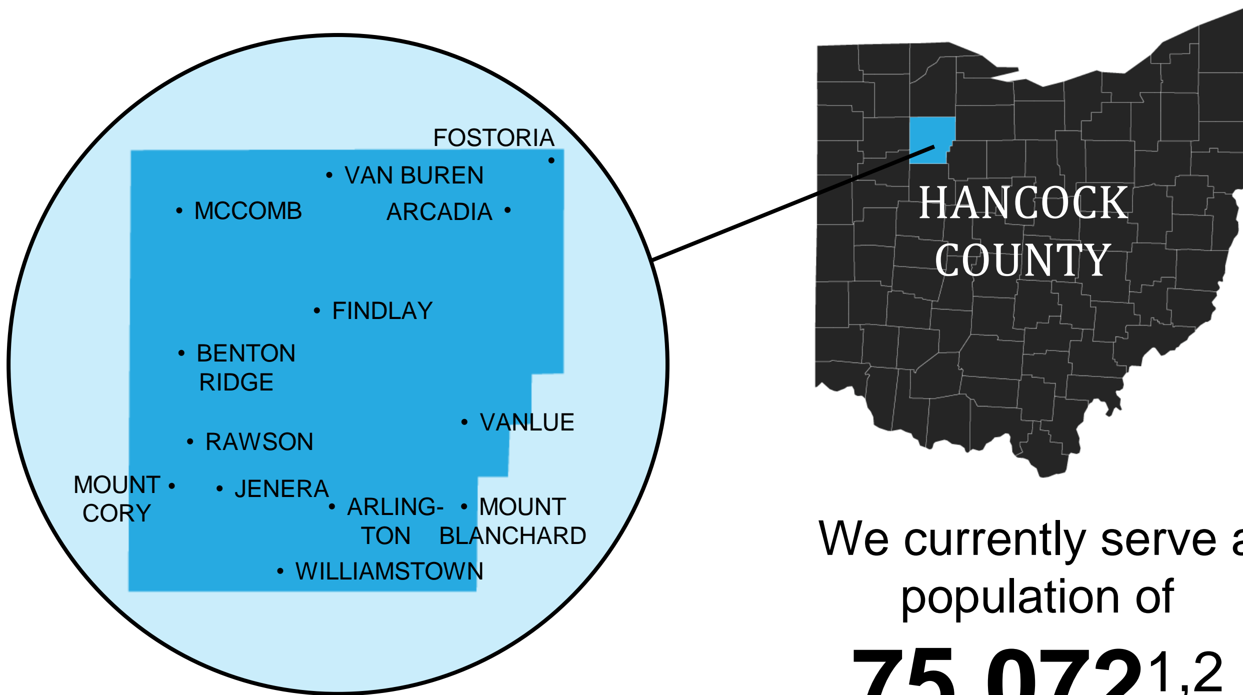
STEP 2
DEFINE THE HANCOCK COUNTY SERVICE AREA

IN THIS STEP, BE HEALTHY NOW HANCOCK COUNTY (BHNHC):

- ✓ DESCRIBED THE HANCOCK COUNTY SERVICE AREA
- ✓ DETERMINED THE PURPOSE OF THE NEEDS ASSESSMENT

DEFINING THE HANCOCK COUNTY
SERVICE AREA

For the purposes of this report, Hancock County defines their primary service area as being made up of Hancock County, Ohio.



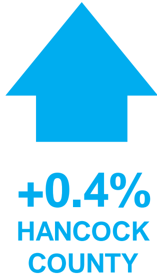
We currently serve a population of

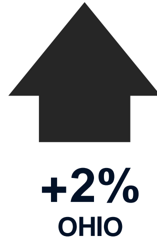
75,072[1,2]

HANCOCK COUNTY SERVICE AREA			
GEOGRAPHIC AREA	ZIP CODE	GEOGRAPHIC AREA	ZIP CODE
Arcadia	44804	McComb	45858
Arlington	45814	Mount Blanchard	45867
Benton Ridge	45816	Mount Cory	45868
Rawson	45881	Van Buren	45889
Findlay	45840	Vanlue	45890
Jenera	45841	Williamstown	45897

HANCOCK COUNTY
AT-A-GLANCE

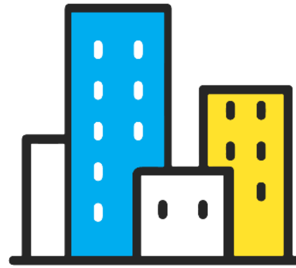
Hancock County's population is **75,072.**
The populations of both Hancock County and Ohio **increased slightly** from 2010 to 2022[1, 2]





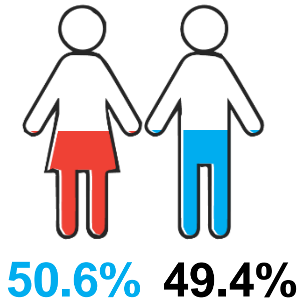
+0.4%
HANCOCK COUNTY

+2%
OHIO



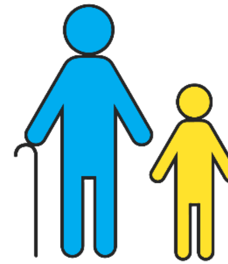
Hancock County is ranked **13th of 88** ranked counties in Ohio, according to social and economic factors (with 1 being the best), placing it in the **top 15%** of the state's counties[3]

The % of males and females is **approximately equal** (with females being slightly higher)[2]



50.6% 49.4%

8%
of Hancock County residents are **veterans**, slightly higher than the state rate[4]

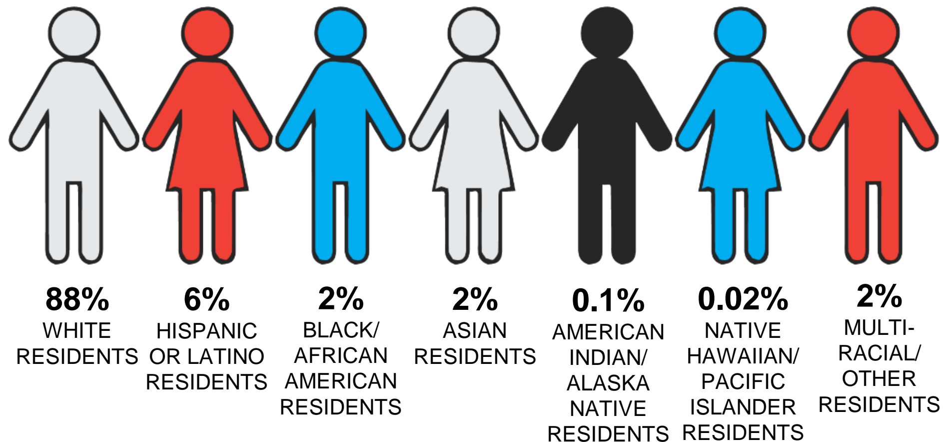


Youth ages 0-19 and seniors 65+ make up
40% of the population

In the Hancock County service area, nearly **1 in 5 residents are age 65+**[2]

95% of the population in the Hancock County service area **speaks only English. 3% are foreign-born**[4]

The **majority (88%)** of the population in Hancock County identifies as **White** as their only race, while there are also significant Hispanic or Latino, Black/African American, and Asian populations[2]



88% WHITE RESIDENTS	**6%** HISPANIC OR LATINO RESIDENTS	**2%** BLACK/ AFRICAN AMERICAN RESIDENTS	**2%** ASIAN RESIDENTS	**0.1%** AMERICAN INDIAN/ ALASKA NATIVE RESIDENTS	**0.02%** NATIVE HAWAIIAN/ PACIFIC ISLANDER RESIDENTS	**2%** MULTI-RACIAL/ OTHER RESIDENTS

The life expectancy in Hancock County of **76.9 years is 1.3 years longer** than it is for the state of Ohio[5]

1 in 256
Hancock County residents will **die prematurely**, which is lower than the Ohio state rate[5]

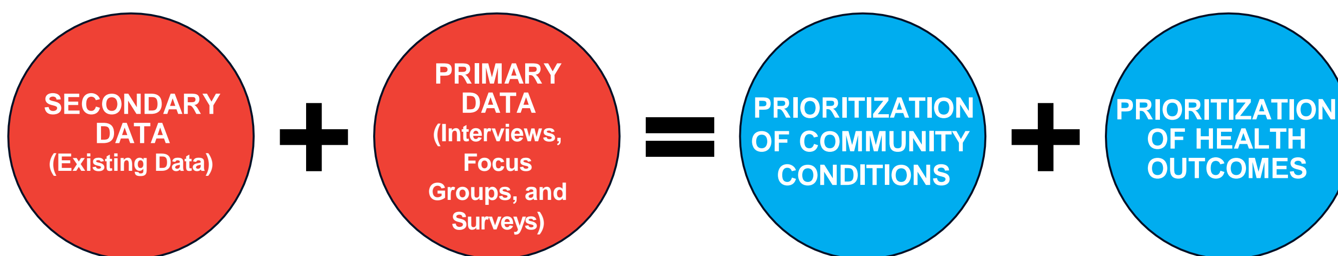
STEPS 3, 4 & 5

IDENTIFY, UNDERSTAND, AND INTERPRET THE DATA AND PRIORITIZE HEALTH NEEDS

IN THIS STEP, BE HEALTHY NOW HANCOCK COUNTY (BHNHC):

- ✓ REVIEWED SECONDARY DATA FOR INITIAL PRIORITY HEALTH NEEDS
- ✓ COLLECTED PRIMARY DATA THROUGH INTERVIEWS, FOCUS GROUPS, AND A COMMUNITY MEMBER SURVEY
- ✓ COLLECTED COMMUNITY INPUT AND FEEDBACK
- ✓ REVIEWED PRIOR ASSESSMENTS AND REPORTS
- ✓ ANALYZED AND INTERPRETED THE DATA
- ✓ IDENTIFIED DISPARITIES AND CURRENT ASSETS
- ✓ IDENTIFIED BARRIERS OR SOCIAL DETERMINANTS OF HEALTH
- ✓ IDENTIFIED AND UNDERSTOOD CAUSAL FACTORS
- ✓ ESTABLISHED CRITERIA FOR SETTING PRIORITIES
- ✓ VALIDATED PRIORITIES
- ✓ IDENTIFIED AVAILABLE RESOURCES
- ✓ DETERMINED RESOURCE OPPORTUNITIES

UNDERSTANDING
PRIORITIZATION OF HEALTH NEEDS



COMMUNITY CONDITIONS (OR SOCIAL DETERMINANTS OF HEALTH OR BARRIERS TO HEALTH) are components of someone's environment, policies, behaviors, and health care that affect the health outcomes of residents of a community. (Examples include housing, crime/violence, access to healthcare, transportation, access to childcare, nutrition and access to healthy foods, economic stability, etc.).

HEALTH OUTCOMES are health results, diseases or changes in the human body. (Examples include chronic diseases, mental health, suicide, injury, and maternal/infant health).

In order to align with the Ohio Department of Health's initiative to improve health, well-being, and economic vitality, Be Healthy Now Hancock County (BHNHC) included the state's priority conditions (social determinants of health) and health outcomes when assessing the community.

PRIMARY & SECONDARY DATA
DATA COLLECTION

ASSESSING HEALTH NEEDS THROUGH COMMUNITY DATA COLLECTION

Initially, health needs were assessed through a review of the secondary (existing) health data collected and analyzed prior to conducting the interviews, focus groups and survey (primary data collection). Priority health needs were identified using the following criteria.

Criteria for Identification of Priority Health Needs:

1. The size of the problem (relative proportion of population afflicted by the problem).
2. The ranking of the problem using data from the community survey, focus groups, and interviews with residents.

To determine the size or seriousness of the problem, the health need indicators of Hancock County service area identified in the secondary data were measured against benchmark data, specifically County rates, state rates, national rates and/or Healthy People 2030 objectives (Healthy People 2030 benchmark data can be seen in **Appendix B**).

The health needs were further assessed through the primary data collection – key informant interviews, focus groups, and a community member survey. The information and data from both the secondary and primary data collection informs this CHA report and the decisions on health needs that the community will address in its Improvement Plan (CHIP).

The data collection process was designed to comprehensively identify the priority issues in the community that affect health, solicit information on disparities among subpopulations, ascertain community assets to address needs, and uncover gaps in resources.

REVIEW OF HANCOCK COUNTY CHA DATA

In order to build upon the work that was initiated previously, the prior 2021 CHA was reviewed. When making final decisions for the 2026-2028 Improvement Plan (CHIP), previous efforts will be assessed and analyzed.

SECONDARY DATA DEFINITIONS

Behavioral Risk Factor Surveillance System (BRFSS) Region 2: Hancock County is part of BRFSS Region 2, which also includes Allen, Auglaize, Hardin, Mercer, Putnam, and Van Wert Counties.

HIV Planning Region 10: Hancock County is part of HIV Planning Region 10, which also includes Allen, Auglaize, Champaign, Hardin, Logan, Mercer, Paulding, Putnam, Shelby and Van Wert Counties.

National Survey on Drug Use and Health (NSDUH) Region: Hancock County is part of an NSDUH Region that also includes Defiance, Fulton, Henry, Mercer, Paulding, Putnam, Van Wert, and Williams Counties.

When data is only available at the regional level, this will be indicated in the report.

2024 HEALTH NEEDS TO BE ASSESSED:

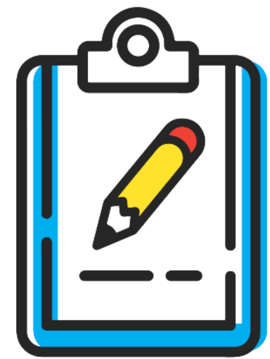
- Access to healthcare (primary, dental/oral, and mental)
- Chronic diseases (asthma, cancer, diabetes, heart disease, stroke, etc.)
- Community conditions (housing, education, income/poverty, internet access, transportation, adverse childhood experiences, crime and violence, access to childcare, food insecurity, etc.)
- Environmental conditions (air and water quality, vector-borne diseases, etc.)
- HIV/AIDS and Sexually Transmitted Infections (STIs)
- Injury
- Leading causes of death
- Maternal, infant, and child health (infant mortality, maternal morbidity and mortality, etc.)
- Mental health (depression and suicide, etc.)
- Nutrition and physical health (overweight and obesity population, etc.)
- Preventive care and practices (vaccines/immunizations, screenings, mammograms/pap smears, etc.)
- Substance use (alcohol and drugs, etc.)
- Tobacco and nicotine use

The secondary and primary data collection will ultimately inform the decisions on health needs that the county will address in the Improvement Plan (CHIP).

Secondary data was collected for the Community Health Needs Assessment (CHNA) in Fall 2024. The most up-to-date data available at the time was collected and included in the CHNA report. Please refer to individual sources in the References section for more information on years and methodology.

PRIMARY DATA COLLECTION

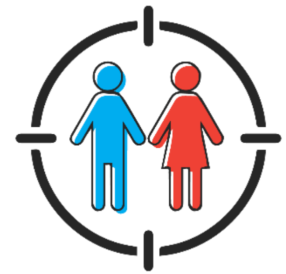
KEY INFORMANT INTERVIEWS



Key informant interviews were used to gather information and opinions from persons who represent the broad interests of the community. We spoke with **29 experts** from various organizations serving the community, including leaders and representatives of medically underserved, low-income, minority populations, and leaders from local health or other departments or agencies (a complete list of participants can be seen in **Appendix C**). The interview questions asked can be seen below.

KEY INFORMANT INTERVIEW QUESTIONS:
Broad questions asked at the beginning of the interview:
What are some of the major health issues affecting individuals in the community?
What are the most important socioeconomic, behavioral, or environmental factors that impact health in the area?
Who are some of the populations in the area that are not regularly accessing health care and social services? Why?
Questions asked for each health need:
What are the issues/challenges/barriers faced for the health need?
Are there specific sub-populations and areas in the community that are most affected by this need?
Where do community residents go to receive help or obtain information for this health need? (resources, programs, and/or community efforts)

PRIMARY DATA COLLECTION
FOCUS GROUPS



Focus groups were used to gather information and opinions from specific sub-populations in the community who are most affected by health needs. We conducted **10 focus groups** with a total of **89 people** in the community. Focus groups included leaders and representatives of medically underserved, low-income, minority populations, and leaders from local health or other departments or agencies (a complete list of groups represented and focus group details can be seen in **Appendix D**). The focus group questions asked can be seen below.

FOCUS GROUP QUESTIONS:
What are your biggest health concerns/issues in our community?
How do these health concerns/issues impact our community?
What are some populations/groups in our community that face barriers to accessing health and social services?
What existing resources/services do you use in our community to address your health needs? How do you access information about health and health and social services? Does this information meet your needs?
What resources do you think are lacking in our community? What health information is lacking in our community? How could this information best reach you and our community?
Do you have any ideas for how to improve health/address health issues in our community?
Do you have any other feedback/thoughts to share with us?

THINGS PEOPLE LOVE ABOUT THE COMMUNITY
FROM KEY INFORMANT INTERVIEWS & FOCUS GROUPS

"There is a strong sense of community. People always try to fill service gaps."

- Community Member Interview

"I love the people, but also the opportunities and programs we have that allow us to be out and engaged in the community."

- Community Member Interview

"[There is a] small town feel and tight-knit community."

- Community Member Interview

"It's a great place to live and raise a family."

- Community Member Interview

"This community is awesome...if there is a need out there, somebody is willing to pitch in and help out."

- Community Member Interview

"[There is a] dedication to small/local businesses."

- Community Member Focus Group

"[We have a] great farmers market."

- Community Member Focus Group

"The community is safe [and] people are friendly."

- Community Member Focus Group

"[I love] the support of and presence of the arts."

- Community Member Focus Group

"We're a very collaborative community. [Sometimes] we have a client who we can't help, but we can connect them to someone else. And that is a remarkable ability to have in a community."

- Community Member Interview

"I love it a lot. [We are] very, very committed [to providing a] network of social services and organizations that want to see the lives of those less fortunate improve and community conditions improve."

- Community Member Interview

TOP PRIORITY HEALTH NEEDS

FROM KEY INFORMANT INTERVIEWS & FOCUS GROUPS

FROM INTERVIEWS:

Major health issues impacting community:

1. Mental/behavioral health
2. Substance use
3. Obesity
4. Diabetes
5. Physical exercise/health

Socioeconomic, behavioral, and/or environmental factors impacting community:

1. Lack of transportation
2. Unmet mental health care needs
3. Poverty/low incomes
4. Housing issues
5. Lack of education

FROM FOCUS GROUPS:

Major health issues impacting community:

1. Mental/behavioral health
2. Transportation
3. Barriers to accessing community resources
4. Housing insecurity
5. Access to healthcare
6. General safety concerns

How health concerns are impacting community:

1. Mental health issues
2. Housing insecurity
3. People do not receive services when needed
4. Lack of education
5. School system concerns

"When you talk with people about their big concerns, people are going to bring up mental health and addiction."

- Community Member Interview

"The people that aren't accessing services are people that struggle with transportation, people that struggle with asking for help."

- Community Member Interview

"There is a lack of access to dental care especially for low-income residents."

- Community Member Focus Group

"Nobody talks about mental health, so it makes people uncomfortable to come forward and say they need help."

- Community Member Focus Group

"I feel that this community can do a better job in public health education. I found it surprising that the absence of basic hygiene care is sometimes an issue in school. I think the community could do better to prevent outbreaks of influenza, respiratory viruses, and other infectious diseases."

- Community Member Focus Group

TOP PRIORITY GROUPS & RESOURCES

FROM KEY INFORMANT INTERVIEWS & FOCUS GROUPS

FROM INTERVIEWS:

Sub-populations in the area that face barriers to accessing healthcare and social services:
1. Low-income population
2. Immigrant population
3. Elderly/aging population
4. Those with mental health issues
5. Unhoused population

FROM FOCUS GROUPS:

Sub-populations in the area that face barriers to accessing healthcare and social services:
1. Immigrant population
2. Those without transportation
3. Low-income population
4. Elderly/aging population
5. Uninsured population

Resources people use in the community to address their health needs:
1. 50 North
2. Blanchard Valley Hospital
3. The Family Center
4. Spectrum of Findlay
5. Primary care physicians

Resources that are lacking in the community:
1. Transportation
2. Translation services
3. More physical and mental healthcare providers
4. Better information on available resources

"We don't have acute behavioral health crisis facilities, and that's just the reality."

- Community Member Interview

"This community is safe and friendly, but it could be a better place for foreign-born residents. My children received negative comments in school for being Asian. Such experiences matter and influence children's education."

- Community Member Focus Group

"[There is a] digital divide for utilizing services [within our aging population]."

- Community Member Interview

"Stable therapists and case managers [are needed] to provide continuity of services. People/families struggling don't want to repeatedly get new providers and share their story over and over again."

- Community Member Focus Group

"Overall cost of living is a challenge... so housing and keeping people stable and healthy becomes a challenge."

- Community Member Interview

"There is a growing immigrant community here and it would be helpful to have websites or handouts translated into Spanish [and other languages]. In addition, having bilingual staff at medical centers or public spaces would be helpful."

- Community Member Focus Group

TOP FINDINGS FROM

HANCOCK COUNTY FOCUS GROUPS

50+ POPULATION:

- **Health issues** include poor care in nursing homes, insufficient mental health resources, and inadequate attention from healthcare providers. These issues lead to caregiver frustration and financial stress, unequal access to services for veterans, and healthcare access and barriers for the Hispanic community due to language and cultural differences.
- **Access barriers** include limited providers accepting Medicaid, transportation issues, financial constraints, and a lack of mental health professionals. Immigrants, veterans, and people with disabilities face significant access challenges.
- **Existing resources** include local services like 50 North, Hancock Area Transportation Service (HATS), food pantries, and church programs. However, newcomers often struggle to find these resources, and better outreach is needed.
- **Resource gaps** exist, including a lack of coordination to connect people to resources, limited affordable healthcare options (e.g. in-home and mental health providers), and a shortage of childcare and adult day program services.
- **Improvement suggestions** include improved communication about resources, more community events, expanded adult daycare, in-person assistance with technology, and a centralized resource guide.
- **Other feedback** relates to technology challenges that persist, particularly for older adults. More paper resources and personal support are needed, along with better orientation for newcomers to the community.

YOUNG ADULTS (UNIVERSITY STUDENTS AGES 18-25):

- **Health issues** include the growing immigrant population experiencing healthcare barriers, stress, housing struggles, and affordability challenges. There is also a need for more childcare, and mental health concerns such as depression are prominent. Other issues include the cycle of poverty, limited transportation affecting healthcare access, and a lack of career opportunities, with some feeling that Findlay cannot meet all their healthcare needs. Many graduates are forced to seek opportunities elsewhere due to a lack of local career and healthcare options. The community also struggles with the cost-effectiveness of healthcare, and young adults face challenges in transitioning from college to the workforce, navigating the healthcare system, and finding a primary care provider after losing insurance at 26.
- **Access barriers** are faced by immigrants due to lack of translators or overwhelmed social service workers, making it harder for them to access or understand services. Additionally, lower-income residents and those without transportation face growing difficulties in meeting their healthcare and social service needs.
- **Existing resources** are present in the community, but some students rely on urgent care or their primary care providers from their hometowns since they struggle to find local providers and lack knowledge about how to do so.
- **Resource gaps** include bilingual resources, including written materials and translators, free or low-cost English classes, education, and transportation options. More support is still needed for referrals and access to services.
- **Improvement suggestions** were provided, including that community resource fairs could be held on campus to increase accessibility, especially for those with transportation issues. Virtual healthcare opportunities could help people connect with providers and assess their comfort with them. Building stronger connections between the campus and the community would raise awareness of available healthcare services and career opportunities for students.

LGBTQ+ POPULATION:

- **Health issues** include a lack of accessible mental healthcare, particularly for LGBTQ+ individuals, with many needing to travel for access. There is also a mistrust of local providers, with reports of judgment or unsafe environments, and Medicaid acceptance and the affordability of medical and dental services are barriers. Housing, and access to basic services are additional health issues. These issues can lead to LGBTQ+ people leaving the community due to safety concerns or lack of resources, mental health stigma, higher rates of self-harm, fear of judgment, and not seeking care.
- **Access barriers** to health services are faced by people with disabilities, low-income individuals, and queer/trans youth. Lack of transportation, provider knowledge gaps, and a shortage of caseworkers hinder access. People who earn too much to qualify for assistance but can't afford services also struggle to find care.
- **Existing resources** include Spectrum of Findlay and local family doctors. Other organizations like CHOPIN Hall and Associated Charities are available, but these services often have high barriers. The Free Store at Connections Church was helpful before it closed. Many participants noted that services in surrounding counties are easier to access.
- **Resource gaps** include mental health services, better housing options, transportation, childcare, affordable youth activities, support for foster/adoptive families, and walkability, particularly for marginalized groups.
- **Improvement suggestions** include hosting community days to offer services like name change clinics, food, and medical assistance. Creating a centralized social services network would help coordinate resources better. Increased support for families, including affordable childcare and transportation, would reduce barriers to accessing healthcare.

TOP FINDINGS FROM
HANCOCK COUNTY FOCUS GROUPS

MENTAL HEALTH AND SUBSTANCE USE:

- **Health issues** include housing, poverty, affordable childcare, and transportation. These factors make it harder for individuals to access healthcare, as high housing and childcare costs can prevent people from working and seeking care, while lack of affordable transportation limits access to medical appointments. There is a cyclical impact, particularly for low-income individuals.
- **Access barriers** are faced by the Haitian community, people recently released from jail, and underrepresented minorities.
- **Existing resources** that participants rely on are FOCUS, the Financial Opportunity Center, Family Resource Center, Alcoholics Anonymous, therapy offices, and the Family Center.
- **Resource gaps** exist for transportation, affordable housing, and accessible inpatient and stabilization centers. These services are essential for addressing immediate healthcare needs and helping individuals maintain stability.
- **Improvement suggestions** were around expanding public transportation, increasing low-barrier housing, and making community resources more accessible and well-known.
- **Other feedback** included a need for more affordable and accessible services, noting that many people are unaware of the resources available to them. There is a desire for a more navigable system.

UNHOUSED POPULATION:

- **Health issues** include housing insecurity due to a lack of affordable housing and "slumlords" who neglect properties, leading to poor health. Many residents also face difficulty accessing healthcare due to lack of Medicaid acceptance. Mental health services are limited, and there is a lack of detox centers for individuals with substance use disorders. Transportation is a barrier, particularly for low-income people traveling for medical care. These issues worsen mental health problems, and limit access to economic opportunities.
- **Access barriers** are faced by older adults, low-income people, unhoused people, and those with substance use or mental health disorders.
- **Existing resources** include food assistance (e.g. CHOPIN Hall, Salvation Army), housing support (e.g. Hope House, Hancock Metropolitan Housing Authority), and support services (e.g. Family Resource Center, Hancock County Job & Family Services); however, there are barriers to accessing them.
- **Resource gaps** include a lack of dental providers who accept Medicaid, adequate mental health services, support for parents, and transportation. There is also a need for more education on issues like Sexually Transmitted Infections (STIs), HIV, substance use, housing insecurity, and mental health.
- **Improvement suggestions** include increasing the number of Medicaid-accepting dentists, creating platforms for community advocacy, creating educational health campaigns, and improving tenant-landlord relationships. More affordable housing and transportation options are needed.
- **Other feedback** was shared about the need for Findlay to grow inclusively and address the needs of all residents, particularly the low-income population.

IMMIGRANT POPULATION/ENGLISH AS A SECOND LANGUAGE (ESL) POPULATION:

- **Two focus groups** were held with this population, during which participants filled out a shortened version of the community survey.
- **Health issues** include access to healthcare, housing, childcare, food insecurity, and transportation
- Participants experience a variety of **barriers to accessing healthcare**, including not being able to get an appointment fast enough, not having time to seek care, not being able to pay for care, not having medical insurance, and the care provider not speaking the individual's native language.
- Participants would like to **receive information about** how to eat healthy when you have limited income, stress management, where to access healthcare, time management, where to go to exercise, and how to keep their children healthy.
- Participants **need help with** accessing dental care, affordable food, affordable housing, healthcare, eye exams, and transportation.

TOP FINDINGS FROM
HANCOCK COUNTY FOCUS GROUPS

JAPANESE:

- **Health issues** include school safety (school lockdowns contribute to anxiety due to lack of clear communication); water quality; expired food items in stores; accessibility of primary care (particularly for non-native speakers of English, as appointment scheduling can be difficult, and many end up using urgent care services); and lack of multi-lingual public health education (e.g. on basic hygiene practices and preventing the spread of infectious diseases).
- **Access barriers** exist for people without cars, as the community is not designed for those relying on public transportation. Foreign-born residents, especially non-native English speakers, experience barriers in integration, with negative experiences in schools affecting children's education, and a need for better information sharing.
- **Existing resources** include urgent care (used due to lack of primary care), library literacy and other programs, hospital language services, school iPads, and the Mazza Museum.
- **Resource gaps** include poor Wi-Fi access in schools, translation services, a Japanese-English speaking school liaison, and more effective recycling programs.
- **Improvement suggestions** include a greater focus on public health education (e.g. promoting healthier school lunches); more information on health programs (e.g. walking in the park), particularly in other languages.
- **Other feedback** was given about the need for better communication during school lockdowns. While Findlay has developed strong resources, like International Friends in Christ (IFC) and Mission Possible, the community could benefit from better language and technology support. Participants suggested sharing accurate information about newcomers to reduce discrimination, as well as public health education on disease prevention and healthy eating.

RURAL POPULATION:

- **Health issues** include childcare accessibility and affordability, a lack of Neonatal Intensive Care Unit (NICU) services, mental health challenges and stigma, long wait times, lack of Medicaid acceptance, and a lack of dental care. These concerns affect those with limited income, lack of transportation, and inadequate insurance.
- **Access barriers** are faced by low-income individuals, unhoused individuals, those in rural communities, and people who are uninsured or underinsured (especially those on Medicaid). There are also challenges for newcomers (Haitian, Hispanic), individuals facing fertility issues, and those needing specialty care locally.
- **Existing resources** accessed include insurance and Medicare, local doctors, mobile dentists and mobile clinics, and some mental health services (often outside the community); there are issues finding a good match with providers.
- **Resource gaps** include a lack of dental care, allergy and genetic testing, and specialists. The community also needs more nutrition education, better access to high-quality food, and services for individuals with disabilities. Other shortages include transportation, and childcare. There's also a need for a larger healthcare provider workforce, having all healthcare in one place, better options for disabilities and specialized care, and school social workers.
- **Improvement suggestions** offered were creating welcome packets for new residents with medical information, sharing an online and print community newsletter, expanding mobile services, making people more aware of local resources like Hancock Helps, increasing healthy food access and recipe sharing, and improving access to libraries.
- **Other feedback** provided included the importance of offering home economics classes (year-round), creating school and community hubs for basic hygiene products and food, and expanding daycare options for all ages.

PARENTS/GRANDPARENTS RAISING GRANDCHILDREN:

- **Health issues** include access to care (e.g. high costs, long wait times for appointments, limited local specialty, pediatric, dental, and vision care, lack of autism providers, and Medicaid gaps); transportation and travel barriers for healthcare; public health education, especially for vulnerable populations, barriers to services for children with disabilities (e.g. delayed diagnoses and lack of school support); high daycare costs; and lack of immigrant support.
- **Access barriers** exist for parents and caregivers (particularly working parents, single mothers, and kinship families, who struggle with finding affordable daycare and healthcare), children and youth (particularly those with mental health issues and disabilities), and immigrants (language barriers and lack of community integration).
- **Existing resources** include the LOFT (FOCUS Recovery and Wellness), McComb daycare, and National Alliance on Mental Illness (NAMI). However, many people struggle to access services due to lack of knowledge or eligibility.
- **Resource barriers** include healthcare services (e.g. pediatric specialists, youth mental health providers, dental and vision providers accepting Medicaid), affordable and accessible childcare (especially in rural areas), support for Kinship families (need insurance support), and translation/interpretation services.
- **Improvement suggestions** were provided on support and advocacy, including expanding mentorship and training programs to help families navigate systems like Individual Educational Plans (IEPs). Participants would also like to have improved navigation supports for healthcare and family assistance resources.

PRIMARY DATA COLLECTION
COMMUNITY MEMBER SURVEY

Each key informant interview and focus group participant was asked to complete an online survey to assess and prioritize the health needs identified by secondary data collection. Additionally, the health department and community partners shared the survey link with clients, patients, and others who live and/or work in the community. This resulted in **1,071 responses** to the community member survey (1,058 English responses and 13 Spanish responses). The results of how the health needs were ranked in the survey are found in the tables below, separated by community conditions (including social determinants of health, health behaviors, and access to care) and health outcomes. This health need ranking was used to order the health needs in the following community conditions and health outcomes sections of this report (note that not every health need has its own section and some health needs have been combined to form larger categories, such as access to healthcare and mental health). More details about the survey, questions, and demographics can be found in **Appendix E**.

COMMUNITY CONDITIONS RANKING FROM COMMUNITY MEMBER SURVEY	
#1 Housing and homelessness	48%
#2 Access to healthcare	38%
#3 Transportation	30%
#4 Income/poverty and employment	29%
#5 Access to childcare	29%
#6 Food insecurity	27%
#7 Nutrition and physical health/ exercise (includes overweight and obesity)	20%
#8 Crime and violence	18%
#9 Adverse childhood experiences (ACEs)	15%
#10 Tobacco and nicotine use	10%
#11 Education	8%
#12 Preventive care and practices	6%
#13 Environmental conditions	5%
#14 Internet/Wi-Fi access	4%

HEALTH OUTCOMES RANKING FROM COMMUNITY MEMBER SURVEY	
#1 Mental health	77%
#2 Substance use (alcohol and drugs)	64%
#3 Cancer	40%
#4 Diabetes	33%
#5 Dementia	25%
#6 Heart disease and stroke	24%
#7 Maternal, infant, and child health	8%
#8 Injuries	6%
#9 HIV/AIDS and Sexually Transmitted Infections (STIs)	4%
#10 Parkinson's disease	3%
#11 Chronic Obstructive Pulmonary Disease (COPD)	2%
#12 Kidney disease	1%
#13 Chronic Liver Disease/Cirrhosis	1%

PRIMARY DATA COLLECTION

SHORTENED COMMUNITY MEMBER SURVEY

A shortened version of the online community member survey was developed to assess and prioritize the health needs identified by secondary data collection, with a particular focus on reaching immigrant and English as a Second Language (ESL) residents; the survey was made available in English, Spanish, and Haitian Creole. It was reviewed to ensure it was accessible for people with different literacy levels, and was kept to a five-minute completion time so that it could be easily shared and completed at community events such as health fairs and vaccination clinics. This version of the survey was also used to collect data for the two immigrant and ESL focus groups. There were **51 responses** to the shortened community member survey. The results of how the health needs were ranked in the survey are found in the tables below. More details about the survey, questions, and demographics can be found in **Appendix E**.

HEALTH NEEDS RANKING FROM SHORTENED COMMUNITY MEMBER SURVEY	
#1 Need for childcare	**41%**
#2 Need for healthcare (e.g. doctors, hospitals, specialists, mental healthcare, dental/oral care, vision care, medical appointments, health insurance coverage, health literacy, etc.)	**41%**
#3 Transportation (e.g. public transit, cars, cycling, walking)	**41%**
#4 Help to find or pay for food	**34%**
#5 Help with finding housing or to pay for housing	**31%**
#6 Income/poverty and employment	**17%**
#7 Mental health (e.g. depression, anxiety, suicide, etc.)	**17%**
#8 Education (e.g. school for children, school for adults, etc.)	**14%**
#9 Need for internet/Wi-Fi	**14%**
#10 Serious and life-long diseases (e.g. cancer, heart disease, diabetes, etc.)	**7%**
#11 Help because of drugs and/or alcohol	**7%**
#12 Tobacco and nicotine use/smoking/vaping	**7%**
#13 Crime and violence (e.g. abuse from spouse, sexual abuse, abuse of children)	**3%**
#14 Environmental conditions (e.g. air and water quality, vector-borne diseases, etc.)	**3%**
#15 Maternal, infant and child health (e.g. pre-term births, infant mortality, maternal morbidity and mortality)	**3%**
#16 Help with men and women health problems	**3%**
#17 Bad things that happen in childhood (e.g. abuse of children, mental health, family issues, trauma, etc.)	**0%**
#18 HIV/AIDS and Sexually Transmitted Infections (STIs)	**0%**
#19 Injuries (workplace injuries, car accidents, falls, etc.)	**0%**
#20 Nutrition and physical health/exercise (includes overweight and obesity)	**0%**

HEALTH NEEDS
COMMUNITY CONDITIONS

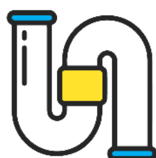
HEALTH NEEDS: COMMUNITY CONDITIONS

The following pages rank the community conditions category of health needs, which include the social determinants of health, health behaviors, and access to care. They are ranked and ordered according to the overall Hancock County ranking from the community member survey as seen on page 25. Each health need section includes a combination of different data sources collected from our community: secondary (existing) data, and primary (new) data – from the community member survey, key informant interviews with community leaders, and focus groups with community members. Priority populations who are most affected by each health need and experience health disparities are also shown. Finally, where applicable, Healthy People 2030 Goals are highlighted, including the performance of Hancock County and the state compared to the benchmark goal.

#1 Health Need: HOUSING

Housing is a concern in terms of quality and affordability, which was negatively impacted by the COVID-19 pandemic. **48%** of community survey respondents ranked **housing and homelessness** as a priority health need, while **69%** of community member survey respondents report **affordable housing** as a resource that is lacking in the community. **Affordable housing was the #1 reported resource needed in Hancock County**

IN OUR COMMUNITY



According to the 2022 Northwest Ohio Regional Housing Needs Assessment, 20% of all renters in Hancock County report severe housing problems (which includes incomplete kitchen and plumbing facilities, severe overcrowding and severe rent burden). This is compared to an average of 25% statewide[6]

Freddie Mac estimates that the vacancy rate should be 13% in a well-functioning housing market. There was only a **7% vacancy rate** in Hancock County in 2022, although this increased from 5% in 2017[7]

21% of all Hancock County households are "cost burdened" (spend 30% or more of their income on housing), vs. 26% for Ohio. **Williamstown** (42%), **Rawson** (23%), **Findlay** (23%), and **McComb** (22%) have the highest proportion of cost-burdened households in the county[7]

The number of **affordable and available units per 100 very-low-income renters** (<50% of area median income) in Hancock County was **only 32**, vs. 44 for Ohio. This puts renters at risk for rent burden, eviction, and housing insecurity[6]

COMMUNITY FEEDBACK

"Findlay has a lot to offer people, but the low-income individuals that these resources serve do not have enough affordable housing in the city to live here. Some of the low-income housing that is available is not safe/healthy."

- Community Member Focus Group

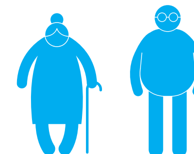
"The high-end buildings are what seem to be being built as opposed to the things that are more affordable for the lower income people in town."

- Community Member Interview

Year	%
2021	55%
2022	55%

The Coalition on Homelessness and Housing in Ohio reported that from 2022 to 2023, the proportion of unhoused individuals in **emergency shelters** in the continuum of care **stayed the same at 55%**[6]

In 2023, Findlay Unhoused Coalition estimated that **150-160 people were unhoused** in Hancock County[8]



Data shows that **13% of Hancock County and Ohio households are seniors who live alone**. Seniors living alone may be isolated and lack adequate support systems[9]

#1 Health Need: HOUSING

COMMUNITY FEEDBACK

"We have a high occupancy rate in Findlay. There's no housing available, whether it's good housing, bad housing, or affordable housing. That's the issue."

- Community Member Interview

"There needs to be more of a focus on the development of affordable housing."

- Community Member Focus Group

"It's expensive to rent even a small apartment now."

- Community Member Interview

"We don't just need affordable housing, but housing that is NOT deplorable. Yes, they technically have a roof over their head, but they are not living in good conditions."

- Community Member Focus Group

Top issues/barriers for housing (reported in interviews and focus groups):

1. Not enough homes (in general)
2. Not enough affordable housing
3. Not enough quality low-income housing
4. Hard to access housing resources

Sub-populations most affected by housing (reported in interviews and focus groups):

1. Low-income population
2. Immigrant population
3. Those with a criminal history

Top resources, services, programs, and/or community efforts for housing:

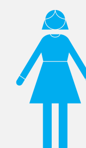
1. Hope House
2. Habitat for Humanity of Findlay/Hancock County
3. City Mission of Findlay

PRIORITY POPULATIONS

HOUSING

While housing is a major issue for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

According to the Ohio Balance of State Continuum of Care, nearly 23% of the unhoused population lives with **mental illness**, 28% were **survivors of domestic violence**, 9% had **chronic substance use challenges**, 4% were **veterans**, and 9% were **young adults** (ages 18-24)[10]



Women who responded to the community survey were significantly more likely than men to report housing and homelessness as a priority need

Residents in **Findlay (45840)** ranked housing and homelessness as a top concern in the community survey, significantly more than residents in other areas of Hancock County

In the community survey, 81% of residents with a household income of **$20,000-$34,999** felt that affordable housing resources were lacking

In the community survey, residents who are currently **employed part-time** were significantly less likely to say they have a steady place to live

According to community survey responses, 100% of **Asian** residents felt that affordable housing resources were lacking, as well as 86% of **Black or African American** residents

Immigrant and English as a Second Language (ESL) respondents to the shortened community member survey were more likely than the general population to lack secure housing and be temporarily staying with others

Housing insecurity issues were mentioned in 70% of focus groups with priority populations (including **young adults, LGBTQ+, mental health, unhoused, immigrant, and rural** populations)

#2 Health Need: ACCESS TO HEALTHCARE

According to the Health Resources & Service Administration, Hancock County has **less access to primary care and dental care providers** than Ohio overall, based on the ratios of population to providers.[5] **38%** of community survey respondents chose access to healthcare as a **priority health need**

IN OUR COMMUNITY

14% of community survey respondents say that **primary healthcare access is lacking** in the community

HANCOCK COUNTY	OHIO
*1,910:1[5]	*1,330:1[5]

*residents : primary care providers

23% of community survey respondents say that **dental healthcare access is lacking** in the community

HANCOCK COUNTY	OHIO
**2,080:1[5]	**1,530:1[5]

**residents : dental care providers

17% of community survey respondents say that **specialist healthcare access is lacking** in the community, while **7%** say that **vision healthcare access is lacking**

BARRIERS TO CARE

20% of community survey respondents **could not obtain a necessary prescription** in the past year

20% of community survey respondents have **delayed or gone without medical care** due to being unable to get an appointment

9% of survey respondents lack health insurance because it **costs too much**

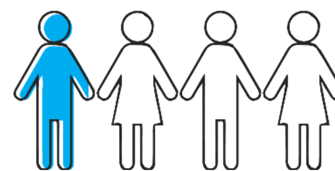
More Hancock County **(19%)** than Ohio (17%) 3rd grade children had **untreated cavities**[12]

17% of community survey respondents' usual source of care is an **urgent care clinic**

54% of Hancock County 3rd graders have a history of **tooth decay**, vs. 51% for Ohio[12]

1 in 10

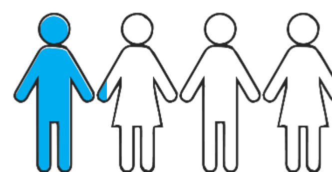
community survey respondents **do not have a usual primary care provider** (PCP)



Nearly 1 in 4 (23%)

BRFSS*** Region 2 (Hancock County area) and Ohio residents **did not have a routine checkup** in the prior year[11]

****Behavioral Risk Factor Surveillance System; BRFSS Region 2 contains Hancock County.*



More than 1 in 4 (27%)

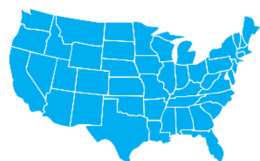
survey respondents **have not been to the dentist in over a year. 15%** reported needing dental care in the last year but not receiving it

COMMUNITY FEEDBACK

"There is a lack of access to primary care services, and as a result, there is an overuse of urgent care."

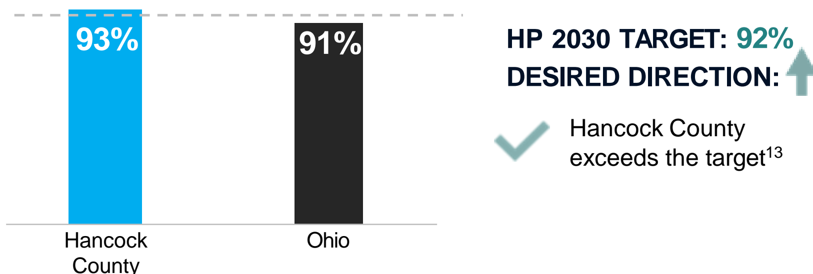
- Community Member Focus Group

#2 Health Need: ACCESS TO HEALTHCARE



HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

HEALTH INSURANCE COVERAGE (ADULTS)



HP 2030 TARGET: 92%
DESIRED DIRECTION: ↑

Hancock County exceeds the target[13]

COMMUNITY FEEDBACK

"If you don't have [a primary care provider], it feels impossible to get established."

- Community Member Interview

"People have to pick between care or paying their bills. It is expensive."

- Community Member Interview

"There's no access to dental care and very limited access to vision care for people that have Medicaid or can't afford it."

- Community Member Interview

"Healthcare in general does not feel safe. People feel judged by providers."

- Community Member Interview

"Primary care doctors are not easily accessible. We have to call to make an appointment, a barrier to non-native English speakers, and it takes a long time. That is why I end up going to urgent care."

- Community Member Focus Group

PRIORITY POPULATIONS

ACCESS TO HEALTHCARE

While **access to healthcare** is a major issue for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

7% of adults (19-64) in Hancock County **do not have health insurance** (vs. Ohio 9%). According to U.S. Census data, this is **highest** in **Willamstown** (23%), **Vanlue** (17%), **Jenera** (15%) **and Rawson** (15%)[13]

According to the community survey, 14% of **Findlay (45840)** residents report not having a checkup in the past year, more than other areas

According to the community survey, individuals **ages 35-44** were more likely than other age groups to indicate access to primary healthcare services as a top concern (42%)

Community survey respondents in **Findlay (45840)** (20%) were more likely to visit urgent care clinics for routine care than those in **McComb (45858)** (11%)

97% of Hancock County's **low-income population** remain unserved by a health center[14]

Of all age groups surveyed, **adults 25-34** (7%) were most likely to report having no insurance due to being ineligible or not qualifying

Community survey respondents who **worry about losing their housing** were significantly less likely to have a primary care provider and to have gotten a check-up in the past year

Healthcare access barriers were mentioned in 100% of focus groups with **priority populations**

Top issues/barriers for access to healthcare (reported in interviews and focus groups):

1. Lack of dental providers
2. Low access to providers
3. Provides not accepting certain insurances

Sub-populations most affected by access to healthcare (reported in interviews and focus groups):

1. Low-income population
2. Elderly population

Top resources, services, programs, and/or community efforts for access to healthcare:

1. Hancock Public Health
2. Hancock Public Health Mobile Health Clinic
2. Caughman Clinic

#3 Health Need: TRANSPORTATION

Transportation has a major influence on health and access to services (for example, attending routine and urgent appointments, as well as running essential errands that support daily life). **30% of community survey respondents reported transportation as a top health need in Hancock County**

IN OUR COMMUNITY

39% of community survey respondents **say that transportation is lacking** in Hancock County. **6%** of respondents say that **lack of transportation prevented their access to one or more essential services** in the past year

When analyzing Hancock County, according to *Walkscore.com*, all areas were 'Car Dependent' (with a few amenities within walking distance) with the exception of Findlay, which was classified as 'Very Walkable'. The walkscores for the most populous communities in Hancock County are displayed above.

COMMUNITY FEEDBACK

"The demand for transportation services far exceeds the resources that we have to provide those services."

- Community Member Interview

According to the **American Community Survey**:[16]

83% of all workers in Hancock County **drive alone to work**, compared to 78% for Ohio[16]

0.3% of Hancock County residents **use public transportation to get to work** (1% for Ohio) and 2**% of both Hancock County and Ohio residents walk or bike to work**[16]

Hancock County workers spend an average of **18 minutes per day commuting** to work, vs. 24 minutes for Ohio workers[16]

Top issues/barriers for transportation (reported in interviews and focus groups):

1. Lack of public transportation
2. Area is not walkable
3. Poor infrastructure

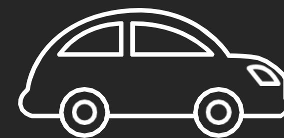
Sub-populations most affected by transportation (reported in interviews and focus groups):

1. Low-income population
2. Elderly population
3. Those without a driver's license

Top resources, services, programs and/or community efforts for transportation:

1. Hancock Area Transportation Service (HATS)/ Hancock Hardin Wyandot Putnam (HHWP) Community Action Commission
2. Local taxi service
3. City of Findlay

#3 Health Need: TRANSPORTATION



COMMUNITY FEEDBACK

"Findlay is the largest city in Ohio that does not have [consistent] public transportation. We have transportation routes, such as Hancock Area Transportation Service (HATS), which is excellent, but it only runs Monday through Friday. During these hours, you must call ahead and schedule, and you still may not get the ride you need."

- Community Member Interview

"You really have to have a car or some kind of transportation to get from one side of the county to the other."

- Community Member Interview

"We don't really have much of a public transportation system."

- Community Member Interview

"We have to travel (sometimes far distances) for services because we have no access to certain services within our community."

- Community Member Focus Group

"If one child needs to go to doctor, parents either need to find childcare for the other kids or find transportation to take the whole family with them. Parents end up not taking their kids to the doctor as often as necessary because of these barriers."

- Community Member Focus Group

PRIORITY POPULATIONS TRANSPORTATION

While **transportation** is a major issue for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Residents of rural areas have less access to public transit and must travel farther to access essential services[15]

According to the community survey, 40% of **Findlay (45840)** and **Van Buren (45889)** residents feel that transportation is a lacking community resource, more than other areas

83% of community members with a **learning disability** and 80% of those who are **blind or visually impaired** surveyed ranked transportation as a top concern

In the community survey, 9% of residents reported **relying on family members for transportation** to medical appointments, 9% for food shopping, and 6% for work

Community survey respondents who **worry about losing their housing** were significantly more likely to say that lack of transportation kept them from accessing needed resources in the community

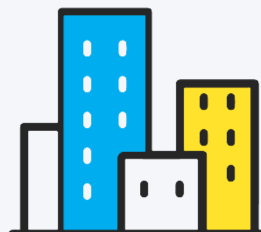
The **immigrant population and English as a Second Language (ESL) population** who filled out the shortened community member survey were more likely than the general population to select transportation as a priority health need (41% vs. 30%)

Transportation barriers were mentioned in 100% of focus groups with **priority populations**

#4 Health Need: INCOME/POVERTY & EMPLOYMENT

Economic stability includes **income**, **employment**, **education,** and many of the most important social factors that impact the community's health…

29% of community survey respondents reported **income/poverty and employment** as top health needs in Hancock County



Hancock County is ranked **13th out of 88 counties** in Ohio for social and economic factors (the lower a ranking is, the better), placing it in the **top 15%** of the state's counties[5]

IN OUR COMMUNITY

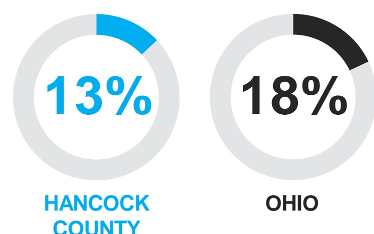
Hancock County's median household income is **higher** than the state average[5]

HANCOCK: $72,700

OHIO: $65,800

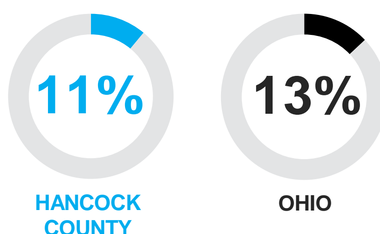
3% of Hancock County residents age 16+ are **unemployed but seeking work**, vs. 4% for Ohio[5]

CHILD POVERTY RATE[17]



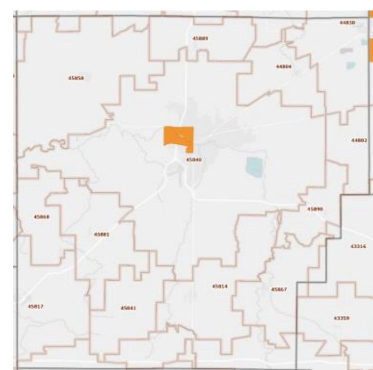
Hancock County has a lower child poverty rate than Ohio. The highest child poverty rates are found in **Rawson** (34%) and **Williamstown** (27%), and **Findlay** (13%)[17]

ADULT POVERTY RATE[17]



Hancock County has a lower adult (age 18-64) poverty rate than Ohio. The highest adult poverty rates are found in **Williamstown** (53%)**, Rawson** (18%), and **Findlay** (12%)[17]

The map below shows areas of Hancock County where more than **20% of the population lives in poverty** (the 45840 ZIP Code in the central-western portion of Findlay, highlighted in orange)[18]



COMMUNITY FEEDBACK

"With high childcare costs, it's more expensive to actually go to work than it is to stay home and be subsidized."

- Community Member Interview

"It is too hard to balance living in poverty with age, working ability, health, and lack of support."

- Community Member Focus Group

#4 Health Need: INCOME/POVERTY & EMPLOYMENT

9% of low-income Hancock County adults utilize food stamps vs. 12% for Ohio[19]

According to the U.S. Census Bureau

2% of Hancock County residents receive public assistance vs. 3% for Ohio[19]

4% of Hancock County residents receive Supplemental Security Income (SSI) vs. 6% for Ohio[19]

COMMUNITY FEEDBACK

"You have incomes that aren't keeping up with inflation, and there is no better area to show it than the cost of food. I know my grocery bill is a lot more than it was just a couple years ago."

- Community Member Interview

"The cost of living here is very difficult for families, especially if they are only making $10-12 an hour."

- Community Member Interview

Top issues/barriers for income/poverty and employment (reported in interviews and focus groups):

1. Transportation
2. Increased poverty in the area
3. Labor shortage
4. Cost of childcare

Sub-populations most affected by income/poverty and employment (reported in interviews and focus groups):

1. Low-income population
2. Immigrant population

Top resources, services, programs, and/or community efforts for income/poverty and employment:

1. Hancock Hardin Wyandot Putnam (HHWP) Community Action Commission
2. Hancock County Job & Family Services
3. Hancock Area Transportation Service (HATS)
4. Christian Clearing House

PRIORITY POPULATIONS

INCOME/POVERTY & EMPLOYMENT

While **income/poverty and employment** are major issues for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

According to the community survey, there are significantly more unemployed residents **ages 25-34** (5%) than all other ages

Arlington (45814) residents (56%) were more likely than residents of other geographical areas to select employment as one of their top concerns on the community survey

13% of Hancock County **children**, 11% of **adults**, and 6% of **seniors** live in poverty[17]

In Hancock County, **Rawson** has the highest child poverty rate (34%), **Williamstown** has the highest adult poverty rate (53%), and **Van Buren** has the highest senior poverty rate (12%)[17]

14% of Hancock County **65+ year-old** community survey respondents earn a relatively low household income of $20,000-34,000 per year, a significantly higher percentage than 35-64 year-olds

In the community member survey, those with a **trade school or vocational certificate** (38%) were more likely to rank employment as a top concern than those with higher levels of education

According to research, there is an income disparity in Hancock County for **Black and Hispanic residents** ($59K and $52K median income) compared to White and Asian residents ($68K and $84K median income)[5]

Research suggests that people with **disabilities** may experience additional challenges obtaining and maintaining employment[5]

Immigrant and English as a Second Language (ESL) respondents to the shortened community member survey were more likely than the general population to be low-income

#5 Health Need: ACCESS TO CHILDCARE

IN OUR COMMUNITY

The average two-child Hancock County household spends 27% of its income on childcare, compared to the state average of 29%[5]

CHILDCARE AVAILABILITY

Hancock County has **8 daycare centers per 1,000 children under 5 years old**, the same as the Ohio rate[5]

COMMUNITY FEEDBACK

"The challenge is that daycares cannot keep employees or find people to work. A lot of them aren't in the position to have health insurance benefits."

- Community Member Interview

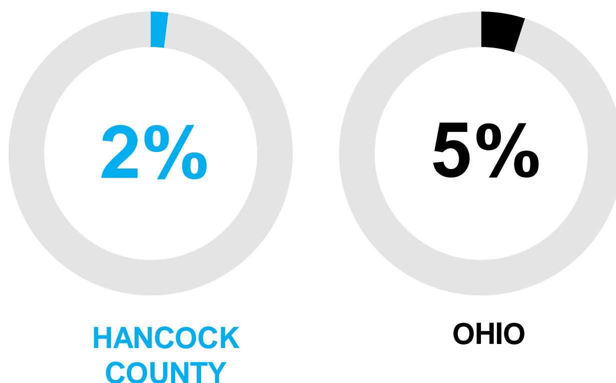
"There needs to be more spots and enough daycares to serve the number of children we have."

- Community Member Interview

"Childcare is too expensive for people to be able to work."

- Community Member Interview

CHILDREN IN PUBLICLY FUNDED CHILDCARE



HANCOCK COUNTY

OHIO

2% of Hancock County children are in publicly funded childcare, **below** the state average of 5%[20]

43% of Hancock County community members surveyed reported that **access to childcare is lacking** in the community

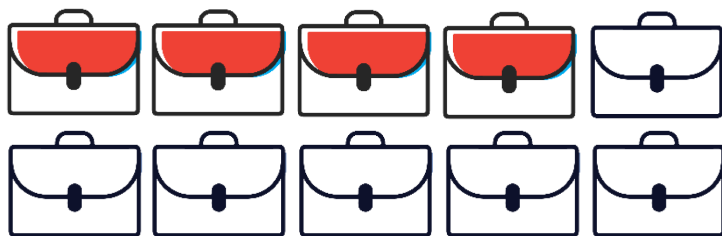
#5 Health Need: ACCESS TO CHILDCARE

According to the 2022 Ohio Childcare Resource & Referral Association Annual Report, the average cost of childcare in Ohio ranges from **$5,564** per year (for school-aged children cared for outside of school hours) to **$11,438** per year (for infants under one year of age)[21]

IN OUR COMMUNITY

29% of Hancock County community members surveyed reported that **access to childcare** is an issue of concern in their community

80% of Ohioans surveyed say that quality childcare is expensive locally[22]



According to the 2023 Groundwork Ohio statewide survey, **40% of working parents** stated that they have had to **cut back on working hours to care for their children[22]**

COMMUNITY FEEDBACK

"Most daycares are open for normal business hours, but people working second or third shift struggle to find childcare, especially if they're a single parent family."

- Community Member Interview

"There are so many stringent regulations about in-home daycares now and for getting daycare licenses; there just are not enough options."

- Community Member Interview

PRIORITY POPULATIONS

ACCESS TO CHILDCARE

While **access to childcare** is a major issue for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

38% of **Black/African American** and 35% of **Hispanic/Latino/a** residents who responded to the community survey rated access to childcare as a top concern

Lower-income residents may have challenges affording childcare. Childcare was identified as an economic issue in the 2022 Ohio Childcare Resource & Referral Association Annual Report)[22]

According to the community survey, Hancock County residents **ages 25-44** (50%) were significantly more likely to report childcare as a top health concern than residents of other ages

The **immigrant population and English as a Second Language (ESL) population** who filled out the shortened community member survey were more likely than the general population to select childcare as a priority health need (41% vs. 29%)

Childcare access barriers were mentioned in 90% of focus groups with **priority populations**

Top issues/barriers for access to childcare (reported in interviews and focus groups):

1. Affordability
2. Lack of spots/availability
3. Not enough childcare facilities

Sub-populations most affected by access to childcare (reported in interviews and focus groups):

1. Low-income population
2. Immigrant population

Top resources, services, programs and/or community efforts for access to childcare:

1. Findlay YMCA
2. Hancock County Job & Family Services
3. Hancock Hardin Wyandot Putnam (HHWP) Community Action Commission

#6 Health Need: FOOD INSECURITY

According to *Feeding America*, 13% of Hancock County residents experienced food insecurity (vs. 14% for Ohio)[23]

When asked what resources were lacking in the community of Hancock County survey, **31%** of respondents answered **affordable food,** while **27%** of survey respondents ranked **access to healthy food** as a top health concern

IN OUR COMMUNITY

Black people experience the highest food insecurity rate in Hancock County (27%), compared to the overall population rate for the county of 11%. This is lower than the Ohio rate for that population (25%)[23]

When asked in the community member survey if they or their families worry that food will run out and that they won't be able to get more, **11% of respondents reported 'yes'**

Williamstown (42%), Benton Ridge (13%), and Findlay (10%) have the highest overall proportion of households receiving food stamps. The highest proportion of single moms with children receiving food stamps was found in **Rawson (72%), Benton Ridge (43%), McComb (38%) and Findlay (37%). Benton Ridge (12%), Findlay (9%), and Mount Cory (8%)** have the highest proportion of older adults (60+) who receive food stamps[24]

The percentage of students in Hancock County who are eligible for the **National School Lunch Program** (NSLP) Free & Reduced Price Meals is **highest at Northview Elementary (67%), Bigelow Hill Elementary (57%), and Whittier Primary (50%)**[25]

COMMUNITY FEEDBACK

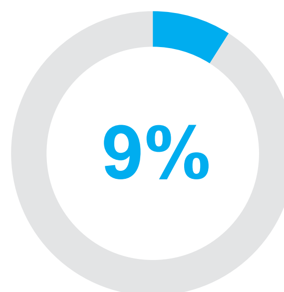
"We have food pantries, but pride often keeps people from using services."

- Community Member Interview

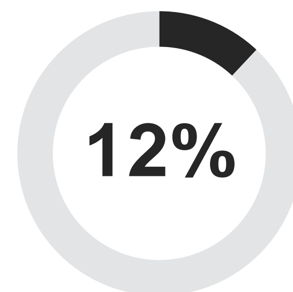
"Freshness is an issue. I find items that are being sold even after the expiration date. I wish other stores would come to Findlay in the future."

- Community Member Focus Group

A **lower rate** of Hancock County than Ohio households access **SNAP* benefits**[24]



HANCOCK COUNTY



OHIO

8.2/10

Hancock County's **food environment rating** out of 10 (0 being worst and 10 being best) is **8.2/10**, vs. **7.0/10** for Ohio[5]

**Supplemental Nutrition Assistance Program*

#6 Health Need: FOOD INSECURITY

COMMUNITY FEEDBACK

“During the summer, the farmers’ market is here. They accept SNAP and have a program for kids to earn coins and purchase produce. The problem is you have to know about the program to use it."

- Community Member Interview

"In our community, there's always a concern about ensuring students have access to food during the day. During the summer there is a concern as well, especially in our low-income populations."

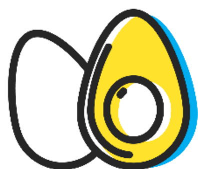
- Community Member Interview

“We need more resources to support people who are unable to eat."

- Community Member Focus Group

“We need more access to stores with quality food. They should try different timings for food distribution so that more people are able to get access.”

- Community Member Focus Group



PRIORITY POPULATIONS

FOOD INSECURITY

While **food insecurity** is a major issue for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Data shows that food insecurity for **Black or Latino** individuals is higher than White individuals in 99% of American counties. 9 out of 10 high food insecurity counties are **rural**. 1 in 3 people facing hunger are **unlikely to qualify for the Supplemental Nutrition Assistance Program (SNAP)**[23]

Research says that 68% of food insecure children in Hancock County (10% of children) **qualify for SNAP benefits but may not be receiving them (likely due to lack of access or caregivers not meeting work requirements)**[23]

According to the community survey, 47% of **Fostoria (44830)** respondents feel that access to healthy foods needs to be addressed in Hancock County, more than other areas

In the community survey, Hancock County residents **ages 45-54** (34%) ranked access to healthy foods as more of a health concern in the community than those ages 24-34

Community survey respondents who **live within walking distance of the University of Findlay** (area with high levels of health disparities) were significantly more likely to say that they worry about running out of food and not being able to get more

Community survey respondents **45-54 years old** felt that affordable food (36%) was lacking more in the community than those who were 65+ years old

Immigrant and English as a Second Language (ESL) respondents to the shortened community member survey were more likely than the general population to select food insecurity as a priority (34% vs. 27%)

Top issues/barriers for food insecurity (reported in interviews and focus groups):

1. Healthy food is expensive
2. Food deserts
3. Lack of transportation

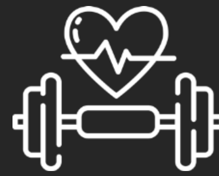
Sub-populations most affected by food insecurity (reported in interviews and focus groups):

1. Low-income population
2. Families with young children

Top resources, services, programs and/or community efforts for food insecurity:

1. Food pantries
2. Supplemental Nutrition Assistance Program (SNAP)
3. Farmers’ markets

#7 Health Need: NUTRITION & PHYSICAL HEALTH

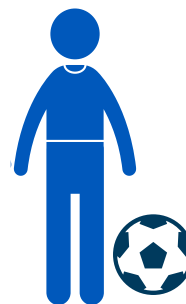


IN OUR COMMUNITY

52% of community survey respondents rated their physical health as **"good"**, while **27%** rated it as **"average"**

37% of community survey respondents **feel that having a busy schedule limits them** from having time to cook healthy food and exercise

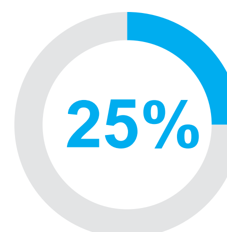
37% of Hancock County residents are obese, lower than the state rate of 38%[5]



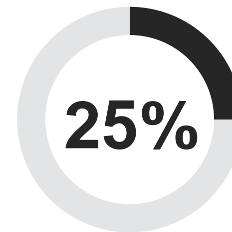
18% of Hancock County and Ohio youth in grades 7-12 are **obese**. **35%** of Hancock County youth are **physically active** for at least 60 minutes per day, vs. 33% for Ohio[26]

19% of community survey respondents **say that recreational spaces are lacking** in Hancock County

3% of community survey respondents say that reliable **transportation has kept them from buying food/groceries** in the past year, while another **2%** say that it has **kept them from physical activity**



HANCOCK COUNTY



OHIO

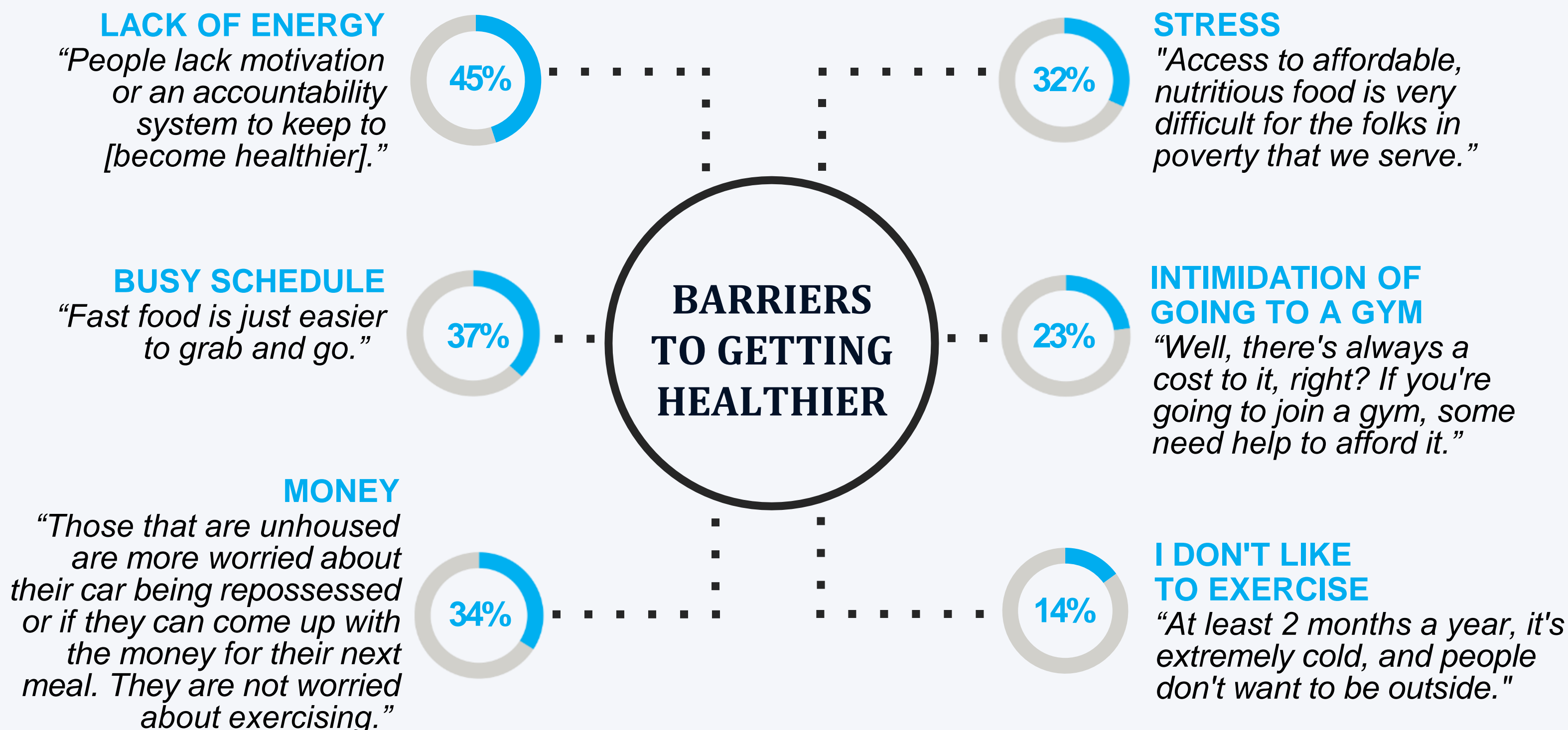
According to the 2024 County Health Rankings program, 25% of both **Hancock County and Ohio adults are sedentary** (did not participate in leisure time physical activity in the past month)[5]

Of adults in BRFSS* Region 2, **20% consume no vegetables per day**, the same as Ohio, while **45% consume no fruit per day** (vs. 43% for Ohio)[11]

In Ohio, **11%** of youth in grades 7-12 **consume no fruits or vegetables daily**. The rate is slightly **lower** in Hancock County at **10%**[26]

**Behavioral Risk Factor Surveillance System; BRFSS Region 2 contains Hancock County.*

#7 Health Need: NUTRITION & PHYSICAL HEALTH



Reported in community member survey, quotes from key informant interviews.

COMMUNITY FEEDBACK

"There's a lack of healthy eating which leads to obesity and chronic health conditions."

- Community Member Interview

"Not all of our neighborhoods have sidewalks that are in good condition, which can prevent people from being active."

- Community Member Interview

"The YMCA goes to different villages, but a challenge or barrier is the cost involved, and that other resources and funding are only sometimes available."

- Community Member Interview

Top issues/ barriers for nutrition & physical health (reported in interviews and focus groups):

1. Unhealthy food is cheap/healthy food is expensive
2. High cost of living in the community
3. Unaffordability of gym memberships

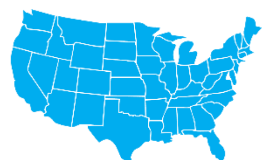
Sub-populations most affected by nutrition & physical health (reported in interviews and focus groups):

1. Low-income population
2. Families with young children
3. Youth

Top resources, services, programs, and/or community efforts for nutrition & physical health:

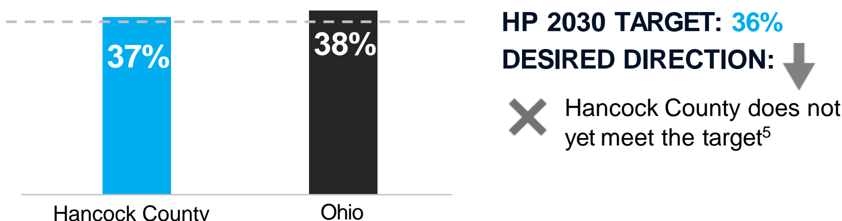
1. Food pantries
2. Findlay YMCA
3. Supplemental Nutrition Assistance Program (SNAP)
4. Farmers' markets
5. Women, Infants, and Children (WIC)

#7 Health Need: NUTRITION & PHYSICAL HEALTH



HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

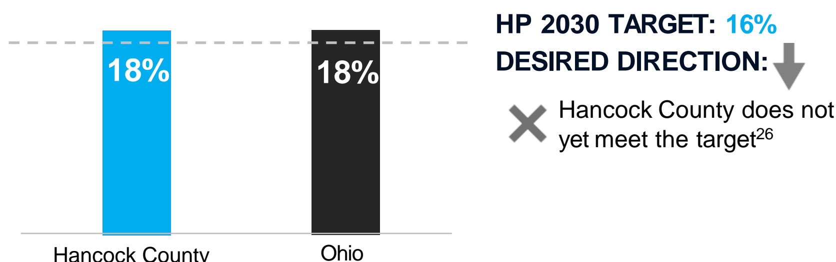
ADULT OBESITY



HP 2030 TARGET: 36%
DESIRED DIRECTION: ↓

✕ Hancock County does not yet meet the target[5]

CHILDREN & TEEN OBESITY



HP 2030 TARGET: 16%
DESIRED DIRECTION: ↓

✕ Hancock County does not yet meet the target[26]

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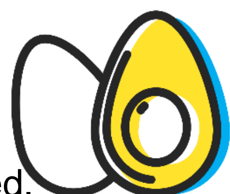
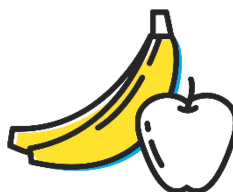
th need.





PRIORITY POPULATIONS

NUTRITION & PHYSICAL HEALTH

While **nutrition and physical health** are major issues for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

According to data, **teen girls** are much more likely than boys to report trying to lose weight, regardless of BMI[26]

50% of **Arlington (45814)** survey respondents feel that their busy schedule impacts their ability to get healthier and in better shape, more than respondents from other areas

According to research, **lower income individuals, males, and older adults** are more likely to be overweight or obese, not exercise, and not eat enough fruits and vegetables[11]

39% of **Bluffton (45817)** community survey respondents indicated not enjoying exercise as a barrier to getting in shape, more than respondents from other areas

22% of survey respondents **ages 24-34** feel that the convenience of eating out being easier holds them back from getting healthier and in better shape, followed by 21% of those **ages 45-54**

48% of female community survey respondents say that lack of energy keeps them from getting healthier and in better shape, significantly more than males (35%)

57% of community survey respondents with household incomes **under $20,000** believe that **money** keeps them from getting healthier and in better shape, followed by 56% for household incomes of **$20,000-$34,000**

Survey respondents **who live within walking distance of the University of Findlay** (area with high levels of health disparities) were significantly more likely to say that stress prevents them from getting healthier and in better shape

#8 Health Need: CRIME & VIOLENCE

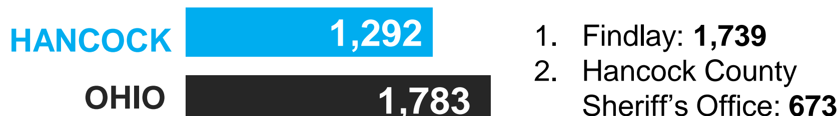
Trigger Warning: The following page discusses violence, which may be disturbing for some people and trigger unpleasant memories or thoughts. You can call the 988 Suicide & Crisis Lifeline at 988 for 24-hour, confidential support

18% of community survey respondents feel that crime and violence is a top issue of concern in the community

IN OUR COMMUNITY

Hancock County's 2022 property and violent crime rates are lower than the state of Ohio overall. Both property and violent crime rates declined between 2018 and 2022[27]

PROPERTY CRIME RATES PER 100,000[27]



1. Findlay: **1,739**
2. Hancock County Sheriff's Office: **673**

VIOLENT CRIME RATES PER 100,000[27]

1. Findlay: **157**
2. Hancock County Sheriff's Office: **90**

COMMUNITY FEEDBACK

"I think because we are a small town, people don't expect crime to happen, but that is not the case."

\- Community Member Interview

"We do have crime issues; I think a lot of the problems are surrounding drug use."

\- Community Member Interview

"I believe our biggest (crime-related) issue is drugs, particularly fentanyl."

\- Community Member Interview

"Most crimes stem from a lack of community resources."

\- Community Member Interview

PRIORITY POPULATIONS CRIME & VIOLENCE

While **crime and violence** are major issues for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

According to the community survey, 25% of respondents with household incomes of **$20,000-$34,000** ranked crime and violence as a top concern, significantly more than those with incomes of **$75,000-$99,999** (13%)

Both property crime and violent crime rates are highest in **Findlay** compared to the rest of Hancock County[27]

Community survey respondents **who live within walking distance of the University of Findlay** (area with high levels of health disparities) were significantly more likely to rate crime and violence as a priority need

Top issues/barriers for crime and violence (reported in interviews and focus groups):

1. Crime/violence due to drugs
2. Petty theft
3. Shootings/gun violence
3. Domestic violence

Sub-populations most affected by crime and violence (reported in interviews and focus groups):

1. People who use substances
2. Low-income population

Top resources, services, programs and/or community efforts for crime and violence:

1. Local law enforcement
2. Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board

#9 Health Need: ADVERSE CHILDHOOD EXPERIENCES

Trigger Warning: The following page discusses trauma and abuse, which may be disturbing for some people and trigger unpleasant memories or thoughts. You can call the 988 Suicide & Crisis Lifeline at 988 for 24-hour, confidential support

Adverse childhood experiences (ACEs), including abuse, neglect, mental illness, substance use, divorce/separation, witnessing violence, and having an incarcerated relative can have lifelong impacts[28]

5 of the top 10 leading causes of death in the U.S. are associated with ACEs[29]

IN OUR COMMUNITY

15% of survey respondents said that **ACEs** are a top concern in the community

Hancock	19.7
Ohio	77.6

Hancock County has a lower rate of substantiated child abuse reports per 1,000 children than the state of Ohio[30]

According to the OHYES! Survey, the most commonly reported types of ACEs in Hancock County are:[26]

- Emotional abuse (55%)
- Physical abuse (25%)
- Household substance use (22%)
- Household mental illness (21%)
- Witnessed domestic violence (17%)
- Incarcerated household member (16%)

Research shows that **youth with the most assets are more likely to**:[29]

- do well in school
- be civically engaged
- value diversity

Research shows that **youth with the most assets are less likely to engage in**:[29]

- alcohol use
- violence
- sexual activity

**Ohio Healthy Youth Environmental Survey (OHYES!)*

Two-thirds (67%) of Hancock County children have experienced at least one ACE[26]

COMMUNITY FEEDBACK

"When unstable parents have custody but are not necessarily 'fit to parent', the children are the ones who are affected."

- Community Member Focus Group

"It's hard for community residents to realize that what happened to them [in their childhood] was unhealthy."

- Community Member Interview

PRIORITY POPULATIONS ADVERSE CHILDHOOD EXPERIENCES

While **adverse childhood experiences are** a major issue for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Girls were more likely than boys to report adverse events at the Ohio state level[26]

Children with the following risk factors are more likely to be impacted by ACEs:[31]

- Lower income
- Precarious housing
- Parents have mental health and/or substance use challenges
- Witnessing violence/incarceration
- Parents are divorced/separated
- Lack of connection to trusted adults

Significantly more residents **ages 45-54** (36%) than residents from other age groups ranked ACEs as a top health concern in the community survey

Top issues/barriers for ACEs (reported in interviews and focus groups):

1. Abuse and neglect
2. Sexual abuse/assault
3. Lack of services/resources
4. Lack of education

Sub-populations most affected by ACEs (reported in interviews and focus groups):

1. Children of parents in poverty
2. Those with mental health concerns

Top resources, services, programs and/or community efforts for ACEs:

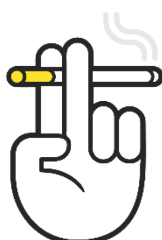
1. Family Resource Center
2. Hancock County Job & Family Services
3. Local court system

#10 Health Need: TOBACCO & NICOTINE USE

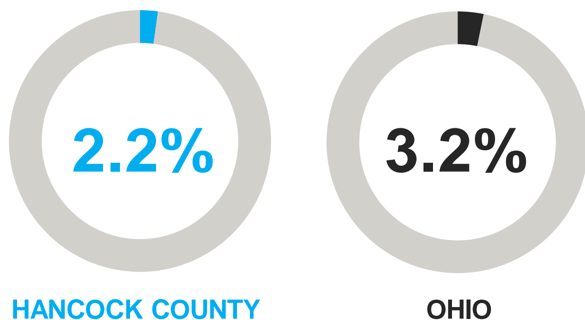
10% of community survey respondents indicated that tobacco and nicotine use were top concerns in Hancock County

IN OUR COMMUNITY

The leading chronic disease causes of death in Hancock County are:[32]
#1 Heart disease
#2 Cancer
#3 COVID-19
#4 Chronic lower respiratory disease
Smoking is a risk factor for all these chronic diseases



2023 rates of current cigarette smoking are **slightly lower** for Hancock County teens than Ohio teens, **declining** from 4% in 2018[26]



In the 2023 OHYES! survey, **15% of Hancock County youth said they vaped in the past 30 days**, compared to 17% for Ohio. This **increased** from 11% in 2018[26]

19% of Hancock County and Ohio adults are current smokers, while **3%** of BRFSS Region 2* vs. **6%** of state adults **use e-cigarettes**[5,33]

In the community survey…

- **5%** of respondents reported **smoking cigarettes** daily or almost every day in the past 30 days
- **4%** reported **vaping or using e-cigarettes** daily or almost every day in the last 30 days
- **3%** reported using **another nicotine or tobacco product** daily or almost every day in the last 30 days

22% of Hancock County and Ohio **teens do not view tobacco use as a moderate or great risk**, compared to 36% for Ohio. **They are less likely to view vaping as a risk** (28% of Hancock County and Ohio teens do not view vaping as a moderate or great risk)[26]

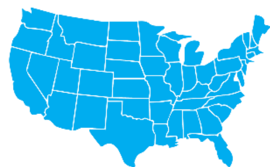
**Behavioral Risk Factor Surveillance System; BRFSS Region 2 contains Hancock County.*

COMMUNITY FEEDBACK

"I see many kids vaping, and vapes with marijuana have become more common."

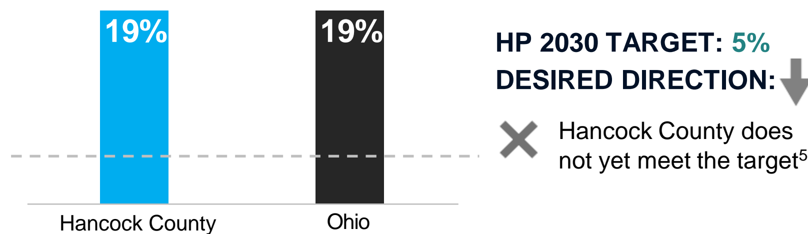
- Community Member Interview

#10 Health Need: TOBACCO & NICOTINE USE



HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

ADULT CIGARETTE SMOKING



HP 2030 TARGET: 5%
DESIRED DIRECTION: ↓

✕ Hancock County does not yet meet the target[5]

Top issues/barriers for tobacco & nicotine use (reported in interviews and focus groups):
1. Vaping
2. Smoking
3. Marketing to youth

Sub-populations most affected by tobacco & nicotine use (reported in interviews and focus groups):
1. Youth

Top resources, services, programs, and/or community efforts for tobacco & nicotine use:
1. School programs
2. Hancock Public Health

COMMUNITY FEEDBACK

"We're finding out that young people from middle school and high school are vaping. They're using it very heavily, so much that they have to wake up in the middle of the night and take a hit off of their vape."

- Community Member Interview

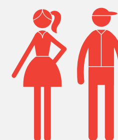
PRIORITY POPULATIONS TOBACCO & NICOTINE USE

While **tobacco and nicotine use** are major issues for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

In the community survey, residents with a **high school degree or equivalent** were significantly more likely to rank tobacco and nicotine use as a top concern (14%)

According to Ohio data, the smoking rate is highest in **multi-racial people, women, people ages 35-44, LQBTQ+ people, people with disabilities**, and **lower income and less educated people**[34, 35]

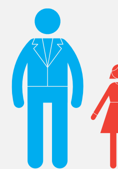
At the Ohio level, vaping rates are highest in **people ages 18-24, men, Hispanic people, people with disabilities**, and **lower income and less educated people**[34, 35]



Youth are more likely to vape/use e-cigarettes than smoke tobacco[34,35]

People with **mental health issues** are more likely to smoke[34, 35]

According to the community survey, 27% of residents **ages 18-24** vaped or used e-cigarettes **daily or almost every day** for the past 30 days, more than other age groups



Significantly more **male** residents than female residents ranked "tobacco and nicotine use" as a top health concern in the community survey

Community survey respondents who **worry about losing their housing** were significantly more likely to say that they smoke daily or almost daily

#11 Health Need: EDUCATION

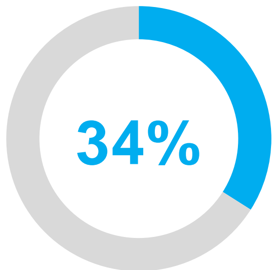
Educational attainment is a key driver of health. **8%** of community survey respondents reported it as a **priority health need**

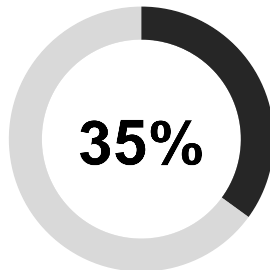
IN OUR COMMUNITY

According to County Health Rankings data from 2022, **6% of Hancock County residents did not have a high school degree or equivalent, vs. 9% for Ohio**[5]

69% of Hancock County residents have at least some college education (vs. 66% for the state of Ohio)[5]

KINDERGARTEN READINESS[36]





The average **Kindergarten readiness** rate for Hancock County schools (34%) was **slightly lower** than Ohio (35%) for 2022-2023. Readiness rates are lowest in **Findlay City Schools** (23%) and **McComb Local School District** (26%)[36]

37% of 3- and 4-year-olds in Hancock County were enrolled in preschool according to a 2022 U.S. Census Bureau report. This is lower than the overall Ohio rate of 43%[37]

Preschool enrollment can improve short- and long-term socioeconomic and health outcomes, particularly for disadvantaged children[38]

Riverdale Local School District (91%), **Arlington Local School District** (95%), and **Findlay City Schools** (95%) have the **lowest 4-year high school graduation rates** in Hancock County for 2022, although these rates are still above the Ohio state average (87%)[39]

COMMUNITY FEEDBACK

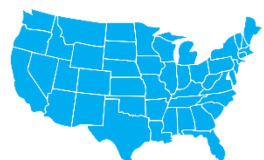
"Children coming into school can be impacted by any kind of lack of equilibrium in the home, including mental health and substance use challenges. This impacts how they are able to show up at school."

\- Community Member Interview

"Safety is a concern of mine. There are lockdowns in school, but I never hear an explanation of why. The lack of information raises my anxiety."

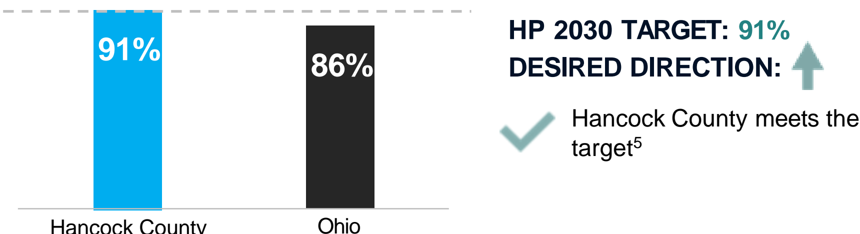
\- Community Member Focus Group

#11 Health Need: EDUCATION



HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

HIGH SCHOOL GRADUATION RATE



HP 2030 TARGET: 91%
DESIRED DIRECTION: ↑

Hancock County meets the target[5]

In 2022-2023, **Findlay City Schools** (18%), **Cory-Rawson Local School District** (17%), **Riverdale Local School District** (16%), and **Arlington Local School District** (15%) had the highest high school chronic absenteeism rates in Hancock County[40]

These are all **lower** than the overall rate for chronic absenteeism for 2022-2023 in Ohio was 27%[40]

COMMUNITY FEEDBACK

"Here in our Head Start program, following COVID-19, I believe we're seeing socialization and behavioral challenges to a greater degree in the children that we serve."

- Community Member Interview

"Students with language barriers are often unable to access services because they can't understand the forms."

- Community Member Interview

"We need to improve the lunch options that children are provided with in schools."

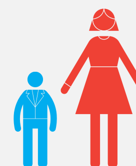
- Community Member Interview

PRIORITY POPULATIONS EDUCATION

While **education** is a major issue for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

11% of community members surveyed reported having a **high school degree or less**

According to research, **children who are lower income** and/or **attending schools in rural areas** may have less access to quality education[40]



According to the community survey, **males** were less likely (6%) to have an associate degree than females (19%)

The Hancock County community survey found that those **ages 55-64** were less likely to have completed higher education compared to those ages 35-44

Community survey respondents who **worry about losing their housing** were significantly less likely to have completed post-secondary education

Immigrant and English as a Second Language (ESL) respondents to the shortened community member survey were more likely than the general population to select education as a priority (14% vs. 8%)

Top issues/barriers for education (reported in interviews and focus groups):

1. Language barriers
2. Lack of preschool resources

Sub-populations most affected by education (reported in interviews and focus groups):

1. Children of working parents

Top resources, services, programs, and/or community efforts for education:

1. Hancock County school districts
2. Findlay YMCA

#12 Health Need: PREVENTIVE CARE & PRACTICES

Access to preventive care has been found to significantly increase life expectancy, and can help prevent and manage chronic conditions, which are the most common negative health outcomes in the county[5]

IN OUR COMMUNITY

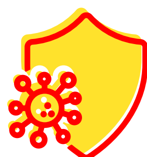
6% of community survey respondents said that addressing **preventive care and practices** in Hancock County is a top concern

Childhood immunization rates entering kindergarten in Ohio **slightly lag behind** U.S. rates and Healthy People 2020 goals for all required vaccines, ranging from 89% for chickenpox to 93% for Hepatitis B[41]

54%

Just over half (54%) of Hancock County Medicare enrollees received a flu vaccine in 2021[5]

12% of community survey respondents have **NEVER** had a flu shot, while only **52%** say they have had one in the past year



21% of community survey respondents have **NEVER** had a COVID-19 vaccine, while only **23%** say they have had one in the past year

1 in 3 (33%) Hancock County women ages 50-74 have not had a mammogram in the past two years[42]

More than 1 in 3 (36%) Hancock County adults ages 50–75 do not meet colorectal screening guidelines[42]

More than 1 in 7 (15%) Hancock County women ages 21–65 have not had a pap test in the past three years[42]

COMMUNITY FEEDBACK

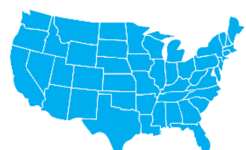
"There is a decrease in the uptake of vaccinations for everyone. People fear them, and then we see an increase in diseases that we previously had controlled."

\- Community Member Interview

"People with insurance don't have an issue, but those who don't have insurance lack access to screenings and vaccinations."

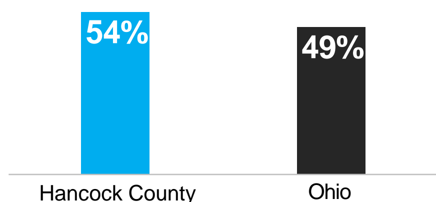
\- Community Member Interview

#12 Health Need: PREVENTIVE CARE & PRACTICES



HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

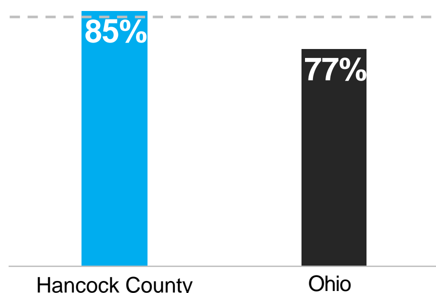
MEDICARE ENROLLEE ANNUAL FLU VACCINATION



HP 2030 TARGET: 70%
DESIRED DIRECTION: ↑

✕ Hancock County does not yet meet the target[5]

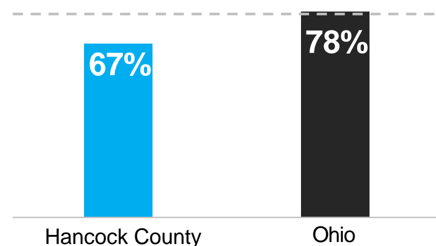
WOMEN 21-65 WITH PAP SMEAR IN PAST 3 YEARS



HP 2030 TARGET: 84%
DESIRED DIRECTION: ↑

✓ Hancock County exceeds the target[42]

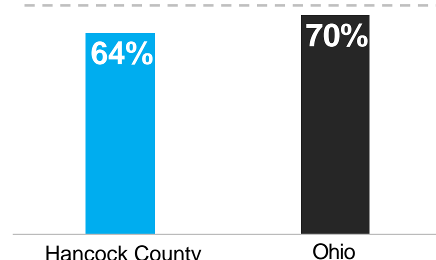
WOMEN 50-74 WITH MAMMOGRAM IN PAST 2 YEARS



HP 2030 TARGET: 77%
DESIRED DIRECTION: ↑

✕ Hancock County does not yet meet the target[42]

ADULTS 50-75 WHO MEET COLORECTAL SCREENING GUIDELINES



HP 2030 TARGET: 74%
DESIRED DIRECTION: ↑

✕ Hancock County does not yet meet the target[42]

PRIORITY POPULATIONS PREVENTIVE CARE & PRACTICES

While **preventive care** is a major issue for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Data shows that Ohioans are less likely to engage in preventive care the **less educated they are, the less money they have, the younger they are, and if they are men**[43]

According to the community survey, residents **ages 35-44 and 55-64** (8%) were more likely to rank preventive practices as a top concern

Findlay (45840) community survey respondents reported that they are less likely to get an annual or routine check-up with a provider than residents of other areas

Survey respondents **who live within walking distance of the University of Findlay** (area with high levels of health disparities) were significantly more likely to say they did not get a flu and/or COVID-19 vaccine in the past year

Top issues/barriers for preventive care & practices (reported in interviews and focus groups):

1. Lack of awareness/education/utilization of services
2. Expensive
3. Lack of health insurance coverage

Sub-populations most affected by preventive care & practices (reported in interviews and focus groups):

1. Low-income population
2. Immigrant population

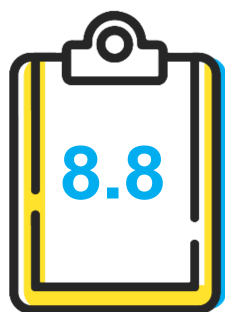
Top resources, services, programs and/or community efforts for preventive care & practices:

1. Hancock Public Health (and Mobile Health Clinic)
2. Blanchard Valley Hospital
3. Caughman Clinic

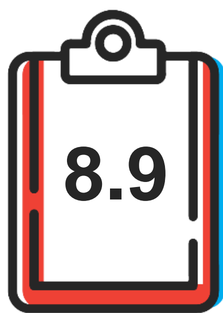
#13 Health Need: ENVIRONMENTAL CONDITIONS

5% of Hancock County community survey respondents reported environmental conditions as a top health need for the community

IN OUR COMMUNITY



HANCOCK COUNTY



OHIO

In 2019, **Hancock County had a similar air quality** measurement (based on number of micrograms of particulate matter per cubic meter of air) to Ohio overall[5]

In 2023, 6% of mosquitos trapped and tested in Hancock County were positive for West Nile Virus, while **no cases were identified in residents. There were 2 cases of diagnosed Lyme disease that year** (although these individuals may have been infected outside of the county)[44]

In 2022, **at least one community water system** in Hancock County, Ohio **reported a health-based drinking water violation**[5]

COMMUNITY FEEDBACK

"When announcements related to environmental issues are made, they are only in English, posing a barrier for immigrant populations."

\- Community Member Interview

"Clean and safe drinking water is a challenge. Some people cannot afford it."

\- Community Member Interview

PRIORITY POPULATIONS ENVIRONMENTAL CONDITIONS

While **environmental conditions** are a major issue for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Children, particularly young children, are more vulnerable to air pollution than adults, including long-term physical, cognitive, and behavioral health effects[5]

9% of Hancock County residents **ages 65+** who responded to the community survey ranked air and water quality as a top concern

Top issues/barriers for environmental conditions (reported in interviews and focus groups):

1. Water quality
2. Air quality
3. Flooding

Sub-populations most affected by environmental conditions (reported in interviews and focus groups):

1. Immigrant population
2. Rural population

Top resources, services, programs, and/or community efforts for environmental conditions:

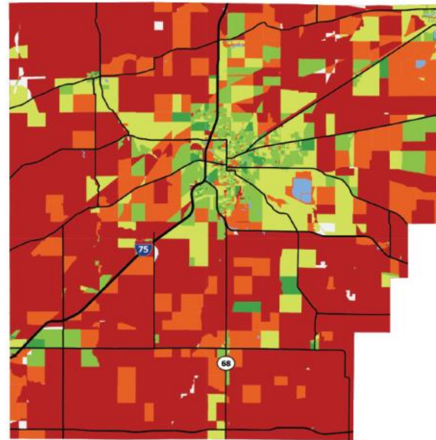
1. Blanchard River Watershed Partnership

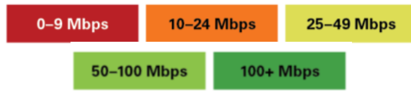
#14 Health Need: INTERNET ACCESS

Ohio ranks 38th out of 50 U.S. States in BroadbandNow's 2024 rankings of internet coverage, speed, and availability (with 1 being better coverage)[45] **4%** of community survey respondents rated internet access as a **priority health need**

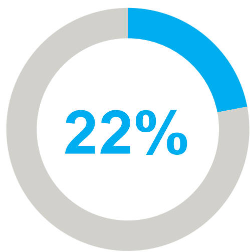
IN OUR COMMUNITY

The map to the right shows **broadband internet access** across Hancock County (**red** areas have the least access to internet while **green** areas have the most access)[46]

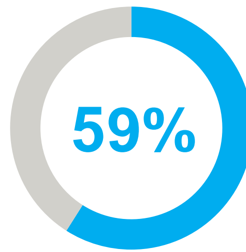




*megabits per second



of households in Hancock County lack access to broadband internet (25/3 mbps (megabits per second) – standard internet speed)[47]



of households in Hancock County without access to broadband internet have low internet speeds (10/1 mbps or less)[47]

COMMUNITY FEEDBACK

"The challenge is more about not being able to pay the monthly fee for internet access."

- Community Member Interview

"Most students depend on cellphones to do their schoolwork."

- Community Member Interview

"The translation system is getting better in schools and the hospital, but the lack of Wi-Fi reception sometimes prevents us from using it effectively."

- Community Member Focus Group

PRIORITY POPULATIONS

INTERNET ACCESS

While **internet access** is a major issue for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Lower income people have a lower likelihood of having internet access, according to research[45]

According to the community survey, 5% of residents **ages 35-44 and 65+** ranked internet as a top concern in Hancock County, more than other age groups

Community survey respondents who **worry about losing their housing** were significantly more likely to rate internet access as a top health need

Top issues/barriers to internet access (reported in interviews and focus groups):

1. Spotty internet coverage
2. Using phone data instead of Wi-Fi
3. Lack of access

Sub-populations most affected by internet access (reported in interviews and focus groups):

1. Rural population
2. Low-income population
3. Students

Top resources, services, programs, and/or community efforts for internet access:

1. Schools
2. Public access points/hotspots

HEALTH NEEDS

HEALTH OUTCOMES

HEALTH NEEDS: HEALTH OUTCOMES

The following pages rank the health outcomes category of health needs. They are ranked and ordered according to the overall Hancock County ranking from the community member survey as seen on page 25 (note that not every health need has its own section and some health needs have been combined to form larger categories, such as chronic diseases). Each health need section includes a combination of different data sources collected from our community: secondary (existing) data, and primary (new) data – from the community member survey, key informant interviews with community leaders, and focus groups with community members. Priority populations who are most affected by each health need and experience health disparities are also shown. Finally, where applicable, Healthy People 2030 Goals are highlighted, including the performance of Hancock County and the state compared to the benchmark goal.

#1 Health Need: MENTAL HEALTH

Trigger Warning: The following pages discuss suicide, which may be disturbing for some people and trigger unpleasant memories or thoughts. You can call the 988 Suicide & Crisis Lifeline at 988 for 24-hour, confidential support

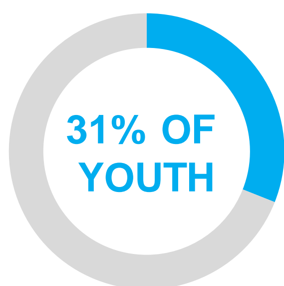
Mental health and access to mental healthcare was the **#1 ranked health outcome** reported in the community member survey (77%).

36% of survey respondents say that **mental healthcare access is lacking** in the community. **13%** said they **could not get needed mental health or substance use counseling** in the past year

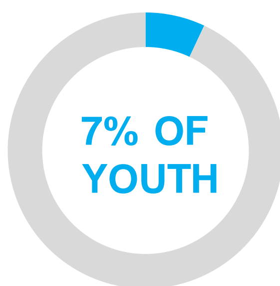
OVER 20%

of Hancock County survey respondents rate their **access to mental or behavioral health services** as **LOW** or **VERY LOW**, with another 39% rating it as **NEUTRAL.** The most common barriers are not being able to get an appointment and not knowing where to get services

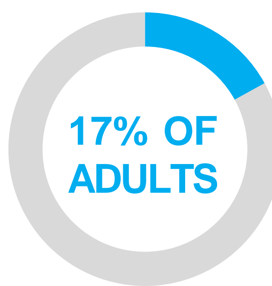
IN OUR COMMUNITY



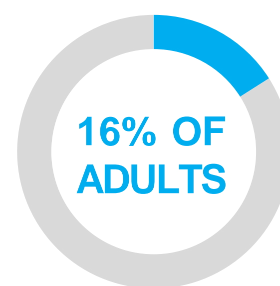
in Hancock County experienced **poor mental health** (felt sad or hopeless almost every day for two weeks or more in a row during the past 12 months), vs. 28% for Ohio[26]



in Hancock County **attempted suicide** in the past year, compared to 6% for Ohio[26]



in BRFSS* Region 2 have been diagnosed with **depression** by a mental health professional, compared to 22% for Ohio[11]



in Hancock County experienced **frequent mental distress** (2+ weeks/month in the past month), compared to 17% for Ohio[5]

HANCOCK COUNTY	OHIO
**460:1	**310:1

The 2024 County Health Rankings found that Hancock County has **fewer mental health providers** relative to its population when comparing the ratio to Ohio[5]

Hancock County and Ohio's overall suicide rate is **14 per 100,000, and 19 per 100,000 for adults 18+.** The youth suicide rate for Hancock County was suppressed due to low counts, while it is 5 per 100,000 for Ohio[32, 48]

**Behavioral Risk Factor Surveillance System; BRFSS Region 2 contains Hancock County.*
***residents : mental health providers.*

45% of community survey residents somewhat or strongly agree that **Hancock County is a place that welcomes and embraces diversity in general.** This proportion is slightly lower for welcoming and embracing ethnically diverse people (44%) and welcoming and embracing LGBTQ+ people (41%)

Hancock County adults report **4.9 mentally unhealthy days per month**, compared to 5.5 for Ohio[5]

Only **19%** of respondents to the 2024 community member survey requiring mental or behavioral health services **received all the care they needed**

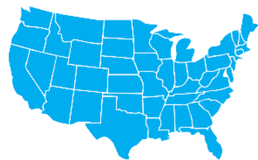
28% of community member survey respondents bought **lottery tickets** in the past year, **8%** gambled at the **casino**, and **4%** participated in **sports betting and bingo** respectively. Gambling may have an impact on mental health[5]

COMMUNITY FEEDBACK

"Mental health is an issue because our mental health hospital is not large enough. Those who suffer may end up in trouble and in our local jails."

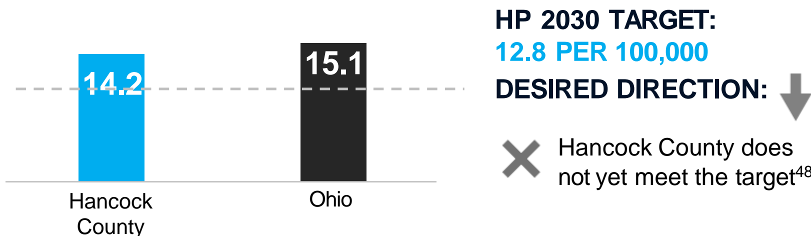
\- Community Member Interview

#1 Health Need: MENTAL HEALTH



HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

SUICIDE RATE



HP 2030 TARGET:
12.8 PER 100,000
DESIRED DIRECTION:

Hancock County does not yet meet the target[48]

COMMUNITY FEEDBACK

"Inpatient pediatric [mental health care] is a sinkhole. We cannot keep a child in the emergency room for days on end."

- Community Member Interview

"The issue with mental health is that we don't have enough counselors."

- Community Member Interview

"The problem is that mental health and addiction is not like a broken leg. Break a leg, you get a cast for six weeks and it's healed, but it's not the same for mental health. Individuals can get help for their struggles, but they live in a community where they need support from the rest of the community to sustain their highest level of recovery and functioning."

- Community Member Interview

"The mental health agencies here are not enough. We have to go out of the county for good mental healthcare/counselling/ therapists/psychiatrists (sometimes almost 2 hours away to Columbus). There are even fewer queer-affirming options."

- Community Member Focus Group

"Mental health services should be provided on a sliding fee scale. There is too much turnover for mental health providers and case managers, leading to a lack of services and long wait times."

- Community Member Focus Group

PRIORITY POPULATIONS

MENTAL HEALTH

While **mental health** is a major issue for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Residents of **McComb (45858)** were more likely to say that they did not know how to find mental/behavioral health services in the community survey than residents of other geographical areas

Only 19% of **Van Buren (45889)** residents rated their overall mental health as excellent on the community survey. This was significantly less than **Rawson (45841)** residents (83%)

Mental health was ranked as a top health outcome to address in **Rawson (45841), Findlay (45840), and Bluffton (45817)** in the community survey

Lower income residents are more likely to have mental health challenges[33]

25-44 year-olds were most likely to rank mental health as a top concern in the community survey

Mental health was a top concern in 70% of focus groups with **priority populations**

Top issues/barriers for mental health (reported in interviews and focus groups):

1. High prevalence of mental health issues
2. Stigma
2. Lack of providers
2. Depression

Sub-populations most affected by mental health (reported in interviews and focus groups):

1. Low-income population
2. Youth
3. Immigrant population
3. Students

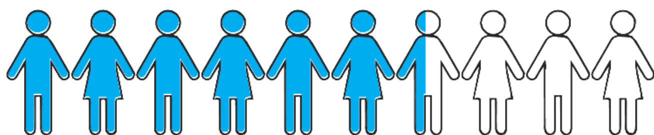
Top resources, services, programs and/or community efforts for mental health:

1. Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board
2. FOCUS Recovery and Wellness
2. Hancock Helps

#2 Health Need: SUBSTANCE USE

Trigger Warning: The following pages discuss problematic substance use and overdose, which may be disturbing for some people and trigger unpleasant memories or thoughts. You can call the 988 Suicide & Crisis Lifeline at 988 for 24-hour, confidential support

IN OUR COMMUNITY



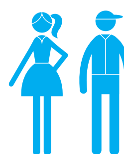
In the community member survey, **nearly two-thirds (64%)** of Hancock County respondents reported **substance use** as a top health concern. **16%** say that substance use disorder services are **lacking** in the community

18% of adults in Hancock County report **binge or heavy drinking in the past month**, vs. 20% for the state of Ohio[5]

ACCORDING TO THE OHIO HEALTHY YOUTH ENVIRONMENTS SURVEY (OHYES!):

7%	of Hancock County teens have **used alcohol in the past month**, vs. 9% for Ohio[26]
29%	of Hancock County and Ohio teens have **ever drank more than a few sips of alcohol**[26]
49%	of Hancock County teens who have used alcohol in the past month have **binge drank**, vs. 56% for Ohio[26]
33%	of Hancock County and Ohio teens perceive **binge drinking once or twice a week as a great risk**[26]

10% of Hancock County youth surveyed have **used marijuana at least once**, compared to 14% for Ohio youth. **4%** of Hancock County youth have used the substance in the **past 30** days, compared to 6% for Ohio youth[26]



36% of Hancock County youth perceive **using marijuana once or twice per week to have great risk**, compared to 31% for Ohio youth[26]

In the community survey, 3**%** of Hancock County residents ages 18+ said they have **used marijuana one or more times** in the past 30 days

49% of **motor vehicle crash deaths** in Hancock County involve **alcohol**, compared to 32% for Ohio[5]

2% of community survey respondents **gambled while drunk or high** in the past year

2% of community survey respondents reported that in the past 6 months they **used prescription medication that was not prescribed for them or used prescriptions in excess** in order to feel good, high, more active, or more alert

COMMUNITY FEEDBACK

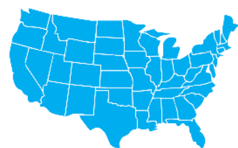
"We do have a drug problem...and we don't have a lot of treatment available for juveniles. We don't have intensive outpatient care for [youth]. Seeing somebody every two to four weeks is not good enough for [them]. So, we lack good comprehensive care for juveniles in addiction."

\- Community Member Interview

"If there is not support for mental health, then substance use will grow/remain an issue."

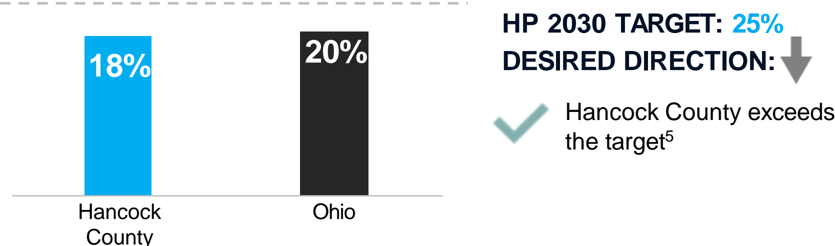
\- Community Member Focus Group

#2 Health Need: SUBSTANCE USE



HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

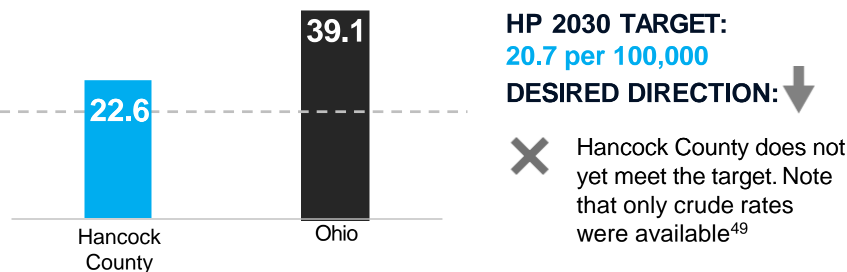
ADULT BINGE OR HEAVY DRINKING



HP 2030 TARGET: 25%
DESIRED DIRECTION: ↓

✓ Hancock County exceeds the target[5]

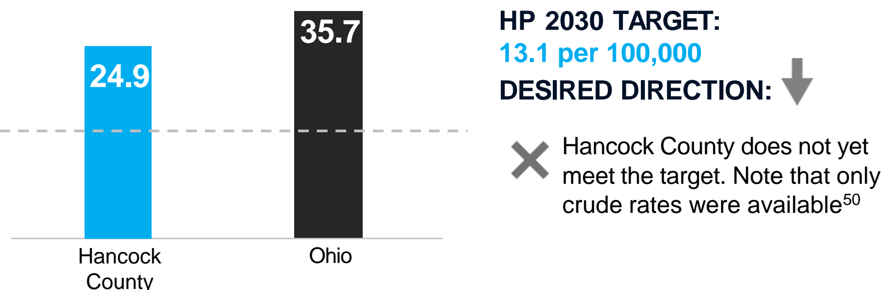
UNINTENTIONAL DRUG OVERDOSE DEATHS PER 100,000



HP 2030 TARGET: 20.7 per 100,000
DESIRED DIRECTION: ↓

✗ Hancock County does not yet meet the target. Note that only crude rates were available[49]

OPIOID OVERDOSE DEATHS PER 100,000



HP 2030 TARGET: 13.1 per 100,000
DESIRED DIRECTION: ↓

✗ Hancock County does not yet meet the target. Note that only crude rates were available[50]

COMMUNITY FEEDBACK

"One of the issues we have is we don't really have local facilities for long-term inpatient treatment."

- Community Member Interview

"Fentanyl, in particular, is a nationwide epidemic. Just the fact that it's out there and people are overdosing on it because they don't know what they're taking."

- Community Member Interview

PRIORITY POPULATIONS

SUBSTANCE USE

While **substance use** is a major issue for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

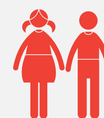
In the community survey, most **Findlay (45840)** residents (65%) rated substance use in their top community concerns

According to research, **boys** were more likely than girls to try drinking alcohol at a younger age[26]

State binge drinking rates are highest among **men**, **adults ages 25-39**, **White people**, and **higher income households**[11]

According to the community survey, almost three-quarters (73%) of Hancock County residents **ages 45-54** feel substance use is a top health concern in the community

12% of the **unhoused** population in the Balance of State Continuum of Care have chronic substance use challenges[10]



Youth are more impacted by substance use due to their developing brains[26]

Top issues/barriers for substance use (reported in interviews and focus groups):

1. High usage of drugs/alcohol
2. High drug use in youth
3. Fentanyl

Sub-populations most affected by substance use (reported in interviews and focus groups):

1. Youth
2. Adults
3. Low-income population

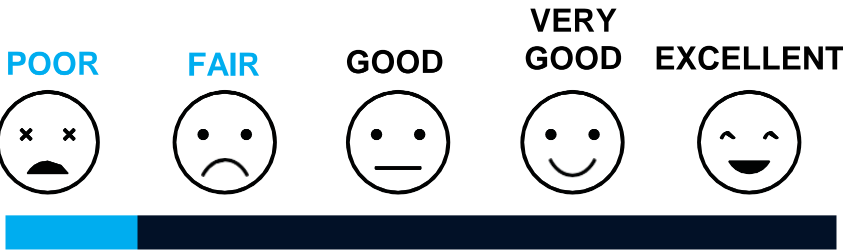
Top resources, services, programs, and/or community efforts for substance use:

1. Hancock Public Health
2. Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board
3. School-based Education Services - Family Resource Center

#3 Health Need: CHRONIC DISEASES

The most prevalent chronic conditions in Hancock County are **hypertension, high cholesterol, diabetes, asthma, cancer, heart disease,** and **COPD**[11]

IN OUR COMMUNITY



15% of Hancock County adults rate their health as **fair or poor** (vs. 16% of Ohio), while the other 85% rank it as excellent, very good, or good[5]

COMMUNITY FEEDBACK

"Chronic diseases are on the rise everywhere, and we have a lot of fast food, which is highly related to the prevalence."

\- Community Member Interview

"The cost of insulin has skyrocketed."

\- Community Member Interview

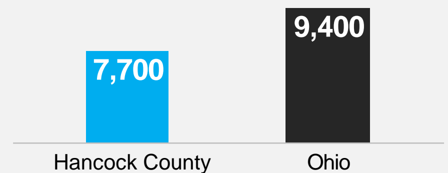
"We could do better in public health education (disease prevention, healthy food)."

\- Community Member Focus Group

13% of Hancock County adults identify as having a disability, vs. 14% for Ohio[51]

16% of community survey respondents chose **chronic diseases** as a top community health need

8% of those surveyed felt that a **lack of provider awareness and/or education about their health condition** was a barrier to accessing healthcare



There were **7,700 (age-adjusted) years of potential life lost** among Hancock County residents under age 75, vs. 9,400 for Ohio[5]

Top issues/barriers for chronic diseases (reported in interviews and focus groups):

1. Poor diet/obesity
2. Lack of physical activity
3. Lack of motivation (to stay/become healthy)

Sub-populations most affected by chronic diseases (reported in interviews and focus groups):

1. Elderly population
2. Low-income population

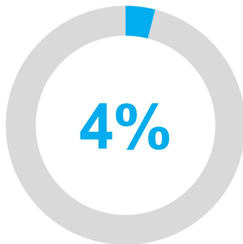
Top resources, services, programs and/or community efforts for chronic diseases:

1. Blanchard Valley Hospital
2. Local healthcare providers
3. Hancock Public Health

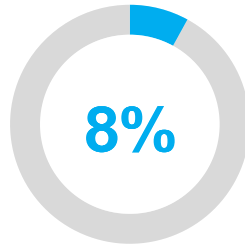
#3 Health Need: CHRONIC DISEASES

Heart disease is the **leading cause of death** in Hancock County.[32] **24%** of community survey respondents rated it as a **top need**

HEART DISEASE & STROKE

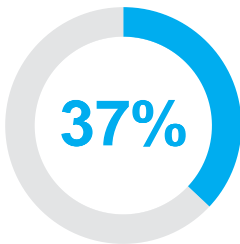


of both BRFSS Region 2* and Ohio adults reported that they have had a **stroke**[11]

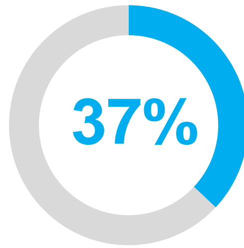


of BRFSS Region 2* and Ohio adults reported having had a **heart attack, angina, or coronary heart disease**[11]

HYPERTENSION & HIGH CHOLESTEROL



of BRFSS Region 2* adults have **hypertension**, vs. 36% for Ohio[11]



of BRFSS Region 2* adults have **high cholesterol**, compared to 36% for Ohio[11]

25% of community survey respondents rated **dementia** as a top health need

DIABETES

33% of community survey respondents rated diabetes as a **top need**

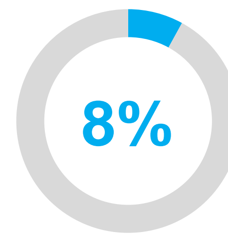
13% of BRFSS* Region 2 and Ohio adults have diabetes[11]

9% of BRFSS Region 2* adults have prediabetes, compared to 10% of Ohio adults[11]

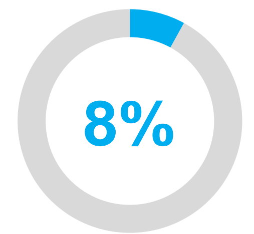
Of those with prediabetes, 20% will go on to develop diabetes within five years without lifestyle modification[11]

Diabetes prevalence rises with age and is also highly impacted by income and level of education[11]

ASTHMA & COPD



of BRFSS Region 2* has **asthma**, vs. 10% for Ohio[11]



of BRFSS* Region 2 adults have **COPD**, vs. 9% for Ohio[11]

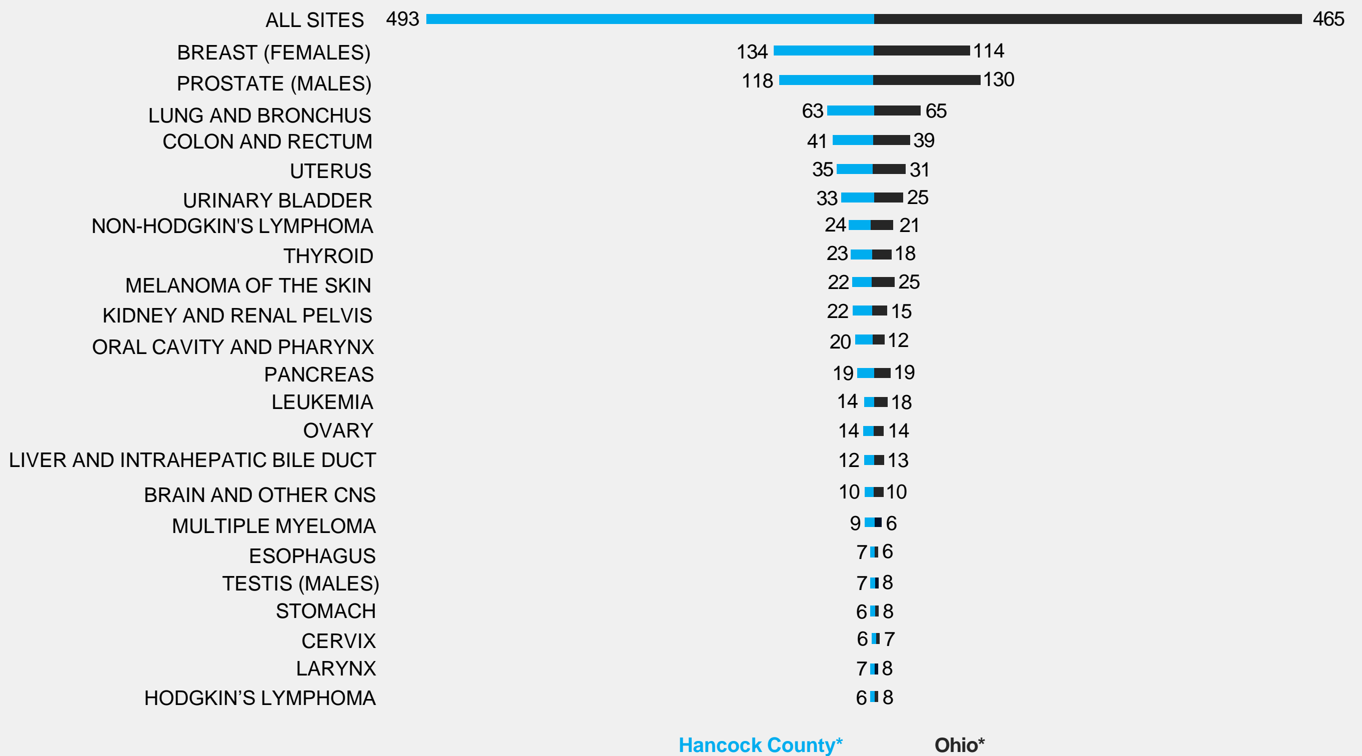
Many hospital admissions due to chronic obstructive pulmonary disease (COPD) and asthma in Hancock County **may be preventable** each year through access to primary care[11]

**Behavioral Risk Factor Surveillance System; BRFSS Region 2 contains Hancock County.*

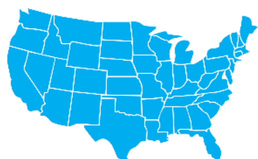
#3 Health Need: CHRONIC DISEASES

According to the Ohio Health Data Warehouse, cancer is the **second leading cause of death** in Hancock County. Hancock County has a **lower overall incidence of cancer** per 100,000 than Ohio[52] **40%** of community survey respondents chose cancer as a **top community health need**

Bladder, non-Hodgkin's lymphoma, thyroid, multiple myeloma, and esophagus cancers had higher incidence rates in Hancock County than Ohio[52]



Age-adjusted rates per 100,000, 2016-2020 average.



HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

Hancock County does not yet meet the Healthy People 2030 target for prostate, lung, colorectal, and overall cancer mortality rates, while it does meet the target for breast cancer mortality[32]

#3 Health Need: CHRONIC DISEASES

PRIORITY POPULATIONS

CHRONIC DISEASES

While **chronic diseases** are a major issue for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

- Survey respondents **ages 65+** were more likely to rank chronic diseases (such as cancer, dementia, heart disease, kidney disease, and Parkinson's disease) among their top health concerns than residents ages 25-44. 51% of those surveyed ages 65+ chose cancer as a top community health need
- **Fostoria (44830)** survey respondents (33%) were more likely to rate chronic diseases as top concerns to address in the community than McComb (45858) respondents (30%) and Findlay (45840) respondents (15%)
- **Male** residents (18%) were more likely to rank chronic diseases as top concerns to address than female residents (16%) in the community survey
- **Hispanic and White/Caucasian** (17% respectively) and **Black or African American** (13%) community survey respondents were most likely to rank chronic diseases as a top concern
- **42%** of survey respondents **ages 55-64** chose diabetes as a top community health need, more than other age groups
- **Lower-income** people are at a higher risk of developing many chronic conditions[33]
- Chronic conditions are more common in **older adults**[33]
- People with **high exposure to air pollution**[33]
- People who **smoke**[33]
- People with **challenges with physical activity and nutrition**[33]

#4 Health Need: MATERNAL, INFANT & CHILD HEALTH

8% of community survey respondents say that addressing **maternal and child health** in the community is a top concern. **4%** say that these **services are lacking** in the community

IN OUR COMMUNITY

8% Hancock County has a **low birth weight rate** of 8%, vs. 9% for Ohio[53]

Hancock County's **teenage birth rate** for ages 15-19 (16 per 1,000 females) is lower than that of Ohio's (18 per 1,000 females)[5]

According to health department data, **1%** of Hancock County and 2% of Ohio children under 6 tested had **elevated blood lead levels** in 2023. Within the county, **15 ZIP Codes** were identified as high risk for elevated blood lead levels[53]

Severe maternal morbidities (SMM) are unexpected outcomes of childbirth that result in significant health consequences. In Ohio, **59% of all SMM from 2016 to 2019 were blood transfusions.** The rate of SMM in Ohio is 71 per 10,000 deliveries[54]

The pregnancy-related maternal mortality rate in Ohio is 15 per 100,000 live births. The leading causes are:[55]
#1 Mental health conditions (47%)
#2 Infections (11%)
#3 Cardiovascular conditions (8%)
#4 Embolisms (8%)
#5 Hemorrhage (6%)
More than half (57%) of these deaths may be preventable[55]

COMMUNITY FEEDBACK

"We've had women come who are 8 months pregnant, who have had no prenatal care, and are just now trying to determine what they need. The education on that kind of stuff is pretty lacking."

- Community Member Interview

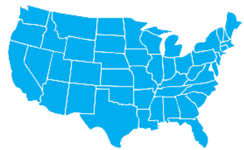
"I see a lot of the immigrant population who are not seeking prenatal care because they don't have health insurance."

- Community Member Interview

"There is a lack of support for people with fertility issues and infant childcare."

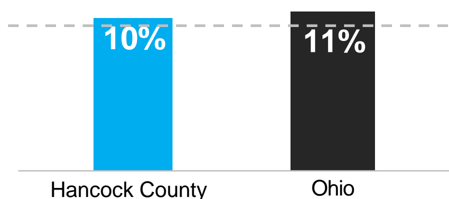
- Community Member Focus Group

#4 Health Need:
MATERNAL, INFANT & CHILD HEALTH



HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

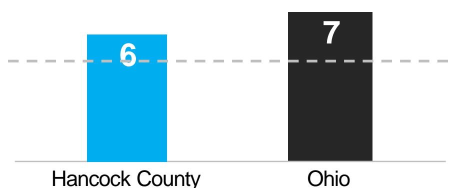
PRETERM BIRTH RATE



HP 2030 TARGET: 9%
DESIRED DIRECTION: ↓

✕ Hancock County does not yet meet the target[53]

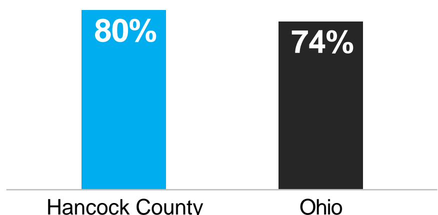
INFANT MORTALITY RATE PER 1,000



HP 2030 TARGET: 5 PER 1,000
DESIRED DIRECTION: ↓

✕ Hancock County does not yet meet the target[56]

ON-TIME PRENATAL CARE



HP 2030 TARGET: 95%
DESIRED DIRECTION: ↑

✕ Hancock County does not yet meet the target[53]

COMMUNITY FEEDBACK

"The health department offers pack and plays, car seats for kids, and car seat education. We're extremely proud of that program, and love seeing the success that it's having."

\- Community Member Interview

"People have to go outside of our area for care. We don't have anything maternal...I've actually seen more home births this year than I ever have."

\- Community Member Interview

PRIORITY POPULATIONS
MATERNAL, INFANT & CHILD HEALTH

While **maternal, infant & child health** are major issues for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

8% of community survey respondents in **Findlay (45840)** ranked maternal and child health as a top concern in Hancock County, higher than other geographical areas

In Ohio, as in the nation, rates of severe maternal morbidity (SMM) and mortality are much higher among **non-Hispanic Black women** compared to white women[55]

Research data shows that the SMM rate for **Asian women in rural Ohio counties** was 2.6 times greater than Asian women in suburban Ohio counties[54]

Top issues/barriers for maternal, infant, and child health (reported in interviews and focus groups):

1. Cultural barriers
2. Lack of access to reproductive care
3. Lack of education

Sub-populations most affected by maternal, infant, and child health (reported in interviews and focus groups):

1. Low-income population
2. Immigrant/undocumented population

Top resources, services, programs and/or community efforts for maternal, infant, and child health:

1. FOCUS moms' program
2. Women's Resource Center of Hancock County
3. Women, Infants, and Children (WIC)

#5 Health Need: INJURIES

Hancock County's unintentional injury death rate* (60 per 100,000 population) is **lower** than that of Ohio (77 per 100,000).[3] **26%** of community survey respondents chose injuries as a **top community health need**

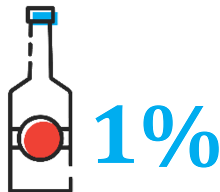
IN OUR COMMUNITY

28% of both BRFSS Region 2** and Ohio adults ages 65+ **fell one or more times** in the past year[33]

The **unintentional fall injury rate*** for those age 65+ in Hancock County (43 per 100,000) is **lower** than it is for Ohio (79 per 100,000)[32]

91%

of BRFSS Region 2** adults **always wear a seatbelt** in the car, vs. 93% for Ohio[33]



1%

of BRFSS Region 2** adults say that in the past 30 days, **they've driven when they had too much to drink**, vs. 3% for Ohio[33]

PRIORITY POPULATIONS INJURIES

While **injuries** are a major issue for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Individuals who work in jobs with a higher risk of occupational injury, such as **manufacturing, construction, agriculture, transportation, trades,** and **frontline workers**[33]

Older residents are at a higher risk of falling and sustaining injuries from falling[32]

Top issues/barriers for injuries (reported in interviews and focus groups):

1. Motor vehicle accidents
2. Workplace injuries

Sub-populations most affected by injuries (reported in interviews and focus groups):

1. Elderly population

*Crude rates per 100,000, 2018-2022 average (only crude rates are available starting in 2021).
**Behavioral Risk Factor Surveillance System; BRFSS Region 2 contains Hancock County.

COMMUNITY FEEDBACK

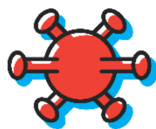
"I do juvenile traffic once a week, so I know that we have kids driving sometimes too fast, and having car accidents."

- Community Member Interview

"For workplace injuries, how easy the reporting process is plays a role in whether or not people will report."

- Community Member Interview

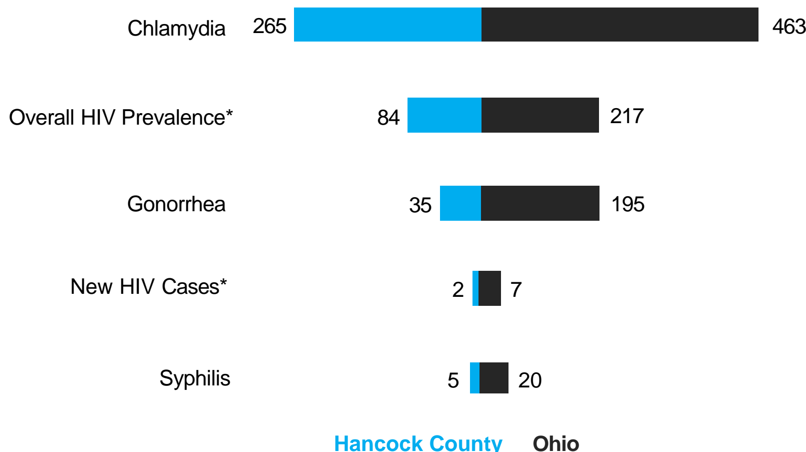
#6 Health Need: HIV & STIs

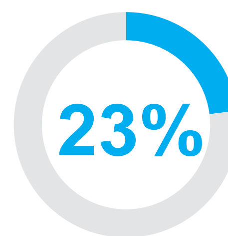


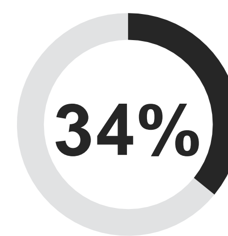
The COVID-19 pandemic may have impacted the testing and diagnosis rates for HIV & Sexually Transmitted Infections (STIs)[57]

IN OUR COMMUNITY

Hancock County has **much lower** rates of STI cases and HIV per 100,000 people than Ohio as a whole[57, 58]







BRFSS REGION 2**[33]

OHIO[33]

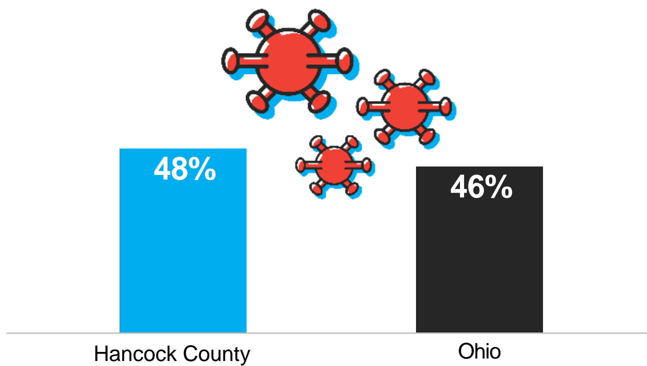
A **lower proportion** of adults in Hancock County's BRFSS** region have ever been **tested for HIV**, compared to the state[33]

*HIV rates are for HIV Planning Region 10.

**Behavioral Risk Factor Surveillance System; BRFSS Region 2 contains Hancock County.

#6 Health Need: HIV & STIs

4% of community survey respondents say that addressing **HIV/AIDS and Sexually Transmitted Infections (STIs)** in the community is a top concern



According to state data, **just under half (48%)** of individuals living with HIV in Ohio's HIV Planning Region 10 (that includes Hancock County) have progressed to an **AIDS diagnosis**, compared to 46% for Ohio overall[58]

COMMUNITY FEEDBACK

"I'm concerned that with some of the stigma around birth control that has popped up, you're going to have folks that are less likely to have access to contraceptives."

- Community Member Interview

"With HIV/AIDS, the issue is access to care in our community, stigma, and shame. People do not want to talk about it."

- Community Member Interview

PRIORITY POPULATIONS

HIV & STIs

While **HIV and STIs** are a major issue for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Women have higher rates of chlamydia, particularly those ages 20-24[57]

Men have higher rates of syphilis and gonorrhea[57]

Top issues/barriers for HIV & STIs (reported in interviews and focus groups):

1. Stigma
2. Lack of affordability of care
3. Lack of access to care

Sub-populations most affected by HIV & STIs (reported in interviews and focus groups):

1. Low-income population
2. People who use drugs/inject drugs
3. LGBTQ+ population

Top resources, services, programs and/or community efforts for HIV & STIs:

1. Hancock Public Health
2. Primary care
3. Hancock Helps
4. School education

LEADING CAUSES
OF DEATH

Cause	HANCOCK COUNTY*	OHIO*
ALL CAUSES	1,148	1,156
HEART DISEASE	214	255
CANCER	207	213
COVID-19	129	117
UNINTENTIONAL INJURIES	60	77
CHRONIC LOWER RESPIRATORY DISEASE	60	60
STROKE	54	59
ALZHEIMER'S DISEASE	44	45
DIABETES	41	36
KIDNEY DISEASE	27	19
PARKINSON'S DISEASE	16	13
LIVER DISEASE	15	15
SUICIDE	14	14
INFLUENZA/PNEUMONIA	13	17
HYPERTENSION AND HYPERTENSIVE RENAL DISEASE	13	13
SEPTICEMIA	11	13

The top two leading causes of death in Hancock County are heart disease and cancer. Hancock County has a slightly lower all-cause crude mortality rate per 100,000 than Ohio. All rates for specific cause are the same or lower for Hancock County than Ohio, except for COVID-19, diabetes, kidney disease, and Parkinson's disease[32, 48]

**Crude rates per 100,000, 2018-2022 average (only crude rates are available starting in 2021).*

IDEAS FOR CHANGE
FROM OUR COMMUNITY

These are ***ideas*** that we heard from community leaders and community members for potential suggestions to support community health.

ACCESS TO HEALTHCARE

- Increase the number of local healthcare providers accepting Medicaid and marketplace insurance.
- Improve cultural training for healthcare providers.
- Increase the number of healthcare providers specializing in care for the LGBTQ+ population.
- Increase access to affordable dental and vision care.
- Increase the number of local primary care providers.
- Make it easier for non-native English speakers to make medical appointments and file insurance claims.
- Increase access to local medical specialists.
- Advocate for more affordable healthcare and insurance.
- Improve the availability of local prenatal care.
- Improve geriatric care.
- Improve public health education throughout the community.
- Improve quality of care by reducing medical staff turnover and preventing burnout.
- Create an easily-accessible resource enabling patients to determine which types of insurance local healthcare providers accept.
- Expand the mobile health services available to the community.
- Make translation services more readily-available at healthcare centers.
- Increase access to reproductive care by re-establishing a Planned Parenthood chapter in the community
- Work to rebuild trust in the healthcare industry to encourage community members to receive care.
- Publish easy-to-understand healthcare information in multiple languages.

ADVERSE CHILDHOOD EXPERIENCES (ACEs)

- Provide parents/guardians with resources related to parenting and childcare.
- Improve processes that allow parents to regain custody of their children (when this is in the child's best-interest).
- Expand the reach of the Dual Status Youth Program.
- Improve education, services, and resources pertaining to adverse childhood experiences (ACEs).
- Increase screening for ACEs.

CHRONIC DISEASES

- Improve education about chronic diseases and their management.
- Increase education for parents about childhood medical conditions.
- Promote self-management amongst patients with chronic diseases.
- Improve accessibility of preventive screenings.

CRIME AND/OR VIOLENCE

- Improve general community safety, and create safe gathering places.
- Increase funding for law enforcement, and hire more officers.
- Improve enforcement of drug-crime laws.

EDUCATION

- Reduce bullying by improving cultural awareness.
- Bolster in-school translation services.
- Hire school counselors who speak common non-English languages.
- Re-examine school attendance policies to ensure they are not unduly strict.
- Expand student access to Individual Education Plans (IEPs).
- Notify parents/guardians about in-progress school lockdowns.
- Improve in-school education about healthy interpersonal relationships.
- Expand the availability of local English as a second language (ESL) classes.
- Improve assistance for ESL parents with filling out required school forms.
- Improve in-school support systems for children who may be struggling in their home lives.
- Improve the in-school mental health support available to children.

IDEAS FOR CHANGE

FROM OUR COMMUNITY

These are ***ideas*** that we heard from community leaders and community members for potential suggestions to support community health.

ENVIRONMENTAL CONDITIONS

- Improve water quality and affordability.
- Implement recycling systems at more workplaces.
- Share announcements related to environmental exposures in non-English languages.

FOOD INSECURITY

- Improve access to healthy foods.
- Improve the quality and freshness of foods sold in stores.
- Expand food access for students during school breaks (i.e. summer vacation).
- Provide cooking tips in non-English languages.
- Improve food access by increasing knowledge about available resources, and reducing the barriers to access them.

HIV/STIs & INFECTIOUS DISEASES

- Improve infectious disease education and prevention measures.
- Reduce stigma by having open conversations about HIV/STIs.
- Improve access to contraceptives.
- Improve the affordability of testing and treatment for HIV/STIs.

HOUSING

- Build more affordable housing.
- Increase the availability of entry-level housing.
- Improve the quality of low-income housing.
- Increase the safety of existing shelters.
- Create more shelters in the community.
- Create a shelter that is accepting of the LGBTQ+ community.
- Continuously update websites that support residents with finding housing options.
- Learn about how to best serve the unhoused population.
- Expand housing development to areas in Hancock County outside of Findlay.

INCOME/POVERTY & EMPLOYMENT

- Develop more programs to help those in poverty and increase access to existing resources.
- Improve employment opportunities for English as a second language (ESL) workers.
- Increase support for immigrant workers with filing work paperwork/permits.

INTERNET/WI-FI ACCESS

- Improve internet/Wi-Fi access, especially in hospitals and schools
- Expand broadband internet access to rural areas.
- Improve the affordability of internet and cellular services.

MATERNAL/INFANT/CHILD HEALTH

- Offer school-based Occupational Therapy/Physical Therapy (OT/PT) for students.
- Open a Neonatal Intensive Care Unit (NICU) department at the local hospital.
- Increase access to prenatal care, especially for those who are uninsured.
- Increase access to education and resources related to prenatal and postpartum care.
- Reduce cultural barriers related to maternal healthcare.
- Increase resources for pregnant women who are unhoused and/or struggling with addiction.

MENTAL HEALTH

- Bring more therapists and case managers to the area to help reduce wait times.
- Support therapists to stay in the area to improve the stability of care for patients and reduce turnover.
- Increase mental health treatment options and services available.
- Increase providers that specialize in care for the LGBTQ+ and youth populations.
- Increase conversation around mental health in the community to reduce the stigma.
- Change the fee for mental health services to be a sliding scale system.
- Expand services to include inpatient care, specifically for pediatric care.
- Expand services for immigrants, especially services available in their native language.

IDEAS FOR CHANGE
FROM OUR COMMUNITY

These are ***ideas*** that we heard from community leaders and community members for potential suggestions to support community health.

NUTRITION/PHYSICAL HEALTH

- Expand local access to stores that offer healthier options (e.g. Trader Joe's, Whole Foods).
- Facilitate access to nutrition education.
- Improve in-school lunch options for children.
- Build more local parks and playgrounds.
- Improve the affordability of recreational activities/centers.

PEOPLE WITH DISABILITIES

- Improve access to child autism care and treatment.
- Increase the services available for those with intellectual and developmental disabilities.
- Improve the accessibility of public buildings and housing.
- Improve support networks for family members of people with disabilities.

SUBSTANCE USE

- Expand the availability of inpatient and outpatient substance use disorder treatment services, especially for youth.
- Hire professionals trained to treat youth with substance use disorders.
- Improve community education about substance use.

TOBACCO/NICOTINE USE

- Expand tobacco, nicotine, and vaping education for youth.

TRANSPORTATION

- Improve community sidewalks and walkability.
- Improve the safety of area roads.
- Make local public transportation system more accessible by expanding hours.

OTHER OPPORTUNITES

- Foster a stronger relationship between post-secondary institutions and the community.
- Increase opportunities for community engagement.
- Hold more focus groups to collect community feedback.
- Establish more community support groups.
- Improve social services available, and establish a network of social workers in the community.
- Make community resources more accessible.
- Improve accessibility of Hancock Helps website.

CURRENT RESOURCES
ADDRESSING PRIORITY HEALTH NEEDS

Information was gathered on assets and resources that currently exist in the community. This was done using feedback from the community and an overall assessment of the service area. While this list strives to be comprehensive, it may not be complete.

Access to Childcare

Almost Home, Inc.
Almost Home Infant Care & Preschool
Around the Clock, Inc.
Around the Clock II
Bethel Christian Preschool
Bluffton Child Development Center
Children's Corner South
Christine Warner (Our Turn to Serve, Family Childcare Home)
Findlay YMCA After-Before-School Services
Findlay YMCA Child Development Center
First Presbyterian Church Nursery School
Immanuel Lutheran Preschool
Joylynn Baxter (Family Childcare Home)
Kim A. Rice (Family Childcare Home)
Little Panthers Learning Center, LLC
Marilyn's Lifelong Educational Center
McComb ESC Preschool
Nicole L. Trinko (Family Childcare Home)
Ohio Department of Education Licensed Preschool
Owens Community College Early Learning Center
Riverdale School
Sarah E. Wallen (Family Childcare Home)
Shining Stars Christian Preschool
Something Special Learning Center
The Fostoria Early Childhood Center
TLC Preschool and Childcare
Trinity Lutheran Child Development Center
Winfield Child Development Center Head Start
Wesley Center
YMCA Early Learning Center at Cory-Rawson

Access to Healthcare/Public Health

Allergy & Immunology Specialists of Northwest Ohio
Be Healthy Now Hancock County (BHNHC)
Blanchard Valley Health System
Blanchard Valley Pediatrics
Bridge Home Health & Hospice
Cancer Patient Services
Caughman Clinic
Center for Safe and Healthy Children
Century Health
Dental Center of North West Ohio
EasternWoods Outpatient Center
Findlay Ear, Nose & Throat Association, Inc.
Greater Midwest Urgent Cares, Findlay Urgent Care
Hancock Public Health
Hancock Public Health Mobile Health Clinic
Help Me Grow
Northwest Ohio Medical Center
Opti-Health Physical Therapy
Oral and Facial Surgery Inc; Dr. Bradley A. Gregory
Physicians Plus Urgent Care
Poison Control
Psychiatric Center of Northwest Ohio
Right at Home
Special Kids Therapy
Terra Nova Medical Clinic

Community & Social Services

50 North
Alzheimer's Association
American Cancer Society
Associated Charities
Children's Mentoring Connection
CHOPIN Hall - Christians Helping Other People in Need
Christian Clearing House
Church of the Living God
City of Findlay
City of Findlay Parks & Recreation
Family Resource Center of Northwest Ohio, Inc.
Findlay YMCA

Community & Social Services (cont.)

Findlay-Hancock County Community Foundation
First Call For Help
Friends of Findlay
Hancock County Adult Protective Services
Hancock County Agency On Aging (OhioHOPES)
Hancock County Children's Protective Services
Hancock County Christian Clearing House
Hancock County Family & Children First Council
Hancock County Veteran Services
Hancock County Women, Infants, Children (WIC) Program - The Family Center
Hancock Hardin Wyandot Putnam (HHWP) Community Action Commission
Hancock Helps
Hancock Youth Leadership
Immigration Task Force
LGBTQ+ Spectrum of Findlay
Lions Club
Lutheran Social Services - St. John's Lutheran Church
Mission Possible
No Wrong Door
Office of Service & Community Engagement
OhioKAN: Resources For Kinship & Adoptive Caregivers
Open Arms Domestic Violence and Rape Crisis Services
Parent Advisory Group
Red Cross
Salvation Army of Findlay
The Family Center
The First Step
United Way of Hancock County
Women's Resource Center

CURRENT RESOURCES
ADDRESSING PRIORITY HEALTH NEEDS

Information was gathered on assets and resources that currently exist in the community. This was done using feedback from the community and an overall assessment of the service area. While this list strives to be comprehensive, it may not be complete.

Disabilities & Support Services
Blanchard Valley Center
Fox Run Manor
Grace Speaks
Hancock County Society for the Handicapped
Hancock County Board of Developmental Disabilities
Heartstring Melodies, LLC
Miracle League of Findlay
The Center for Autism & Dyslexia

Education & Literacy
Arcadia Local School District
Arlington Local School District
Black Heritage Library & Multicultural Center
Bluffton University
Cory-Rawson Local School District
Findlay City Schools
Findlay Hancock County Public Library
Liberty-Benton Local School District
McComb Local School District
Owens Community College
Riverdale Local School District
Speak Easy Program
Sylvan Learning Centers
The Ohio State University Extension Office
University of Findlay
University of Findlay's Mazza Museum
Van Buren Local School District
Vanlue Local School District

Environmental Conditions
Blanchard River Watershed Partnership

Food Insecurity
Catalyst Church
CHOPIN Hall - Christians Helping Other People In Need
Findlay City Mission
Findlay YMCA - Feed-a-Child
First Lutheran Church
First Presbyterian Church

Food Insecurity (cont.)
Howard UMC
Little Free Pantry
Lutheran Social Services
Maranatha Bible Church
Salvation Army
St. Andrew's United Methodist Church
St. Paul's United Methodist Church
West Ohio Food Bank

Housing
Blanchard Valley Center
Findlay City Mission
Habitat for Humanity of Findlay/Hancock County
Hancock Metropolitan Housing Authority
Home Energy Assistance Program (HEAP)
Hope House
Provision Living at Findlay
Rapid Rehousing

Income & Employment
Careers4You Training Center
Financial Opportunity Center (FOC)
Findlay Hancock County Chamber of Commerce
Hancock County Child Support Enforcement Agency
Hancock County Educational Service Center
Hancock County Social Security Administration
Hancock County Job & Family Services
Job Solutions
Kan-Du Group
Legal Aid of Western Ohio
Microenterprise Loan Program
Millstream Career Center
Ohio Means Jobs Hancock County
Opportunities for Ohioans with Disabilities
Raise the Bar Hancock County

Legal & Law Enforcement
Crime Prevention Association of Findlay/Hancock County
Dual Status Youth
Hancock County Domestic Relations Court
Hancock County Probate/Juvenile Court
Hancock County Prosecutor's Office
Hancock County Sherrif's Office
Legal Aid of Western Ohio
Pre-Trial Diversion Program

Mental Health & Addiction
Alcoholics Anonymous and Alcoholics Anonymous Teen
Bereavement Services
Findlay Recovery Center
Findlay Treatment Services
FOCUS Recovery & Wellness Community/Peer Advisory Partnership
Hancock County Board of Alcohol, Drug Addiction, and Mental Health Service
Hancock County Coalition on Addiction
Hancock County Crisis Hotline
Maternal Opiate Medical Support (MOMS)
Mind Body Health Associates
National Alliance on Mental Illness (NAMI) Hancock County
Ohio Guidestone Behavioral Health Services
Orchard Hall
Pioneer Club - Narcotics Anonymous, Alcoholics Anonymous
ProMedica Physicians Behavioral Health
The Lavender Hour

Transportation
Accurate Cab
Department of Motor Vehicles
Go Ohio - Carpooling
Hancock Area Transportation Services (HATS)
T&H Lift
USA Cab Company

STEP 6

DOCUMENT, ADOPT/POST AND COMMUNICATE RESULTS

IN THIS STEP, BE HEALTHY NOW HANCOCK COUNTY (BHNHC):

- WROTE AN EASILY UNDERSTANDABLE COMMUNITY HEALTH ASSESSMENT (CHA) REPORT
- ADOPTED AND APPROVED CHA REPORT
- DISSEMINATED THE RESULTS SO THAT IT WAS WIDELY AVAILABLE TO THE PUBLIC

DOCUMENT, ADOPT/POST AND COMMUNICATE RESULTS

Be Healthy Now Hancock County (BHNHC) worked with Moxley Public Health to pool expertise and resources to conduct the 2024 Community Health Assessment (CHA). By gathering secondary (existing) data and conducting new primary research as a team (through interviews with community leaders, focus groups with subpopulations and priority groups, and a community member survey), the stakeholders will be able to understand the community's perception of health needs. Additionally, the community partners will be able to prioritize health needs with an understanding of how each need compares against benchmarks and is ranked in importance by Hancock County residents.

The 2024 Hancock County CHA, which builds upon the prior assessment completed in 2021, meets all Public Health Accreditation Board (PHAB) and Ohio state requirements.

REPORT ADOPTION, AVAILABILITY AND COMMENTS

This CHA report was adopted by BHNHC leadership in February 2025. It is widely available to the public on the following websites:

Hancock Public Health: https://www.hancockph.com/reports-and-data
Blanchard Valley Health System: https://www.bvhealthsystem.org/about-bvhs/community-benefit

Written comments on this report are welcomed and can be made by visiting the Hancock Public Health website at https://www.hancockph.com/.

CONCLUSION & NEXT STEPS

THE NEXT STEPS WILL BE:

- DEVELOP IMPROVEMENT PLAN (CHIP) FOR 2026-2028
- SELECT PRIORITY HEALTH NEEDS
- CHOOSE INDICATORS TO VIEW FOR IMPACT CHANGE FOR 2026-2028 PRIORITY HEALTH NEEDS
- DEVELOP SMART OBJECTIVES FOR IMPROVEMENT PLAN (CHIP)
- SELECT EVIDENCE-BASED AND PROMISING STRATEGIES TO ADDRESS PRIORITY HEALTH NEEDS

CONCLUSION

NEXT STEPS FOR HANCOCK COUNTY

- Monitor community comments on the CHA report (ongoing) to the provided contacts at Be Healthy Now Hancock County (BHNHC).

- Select a final list of priority health needs to address using a set of criteria that is recommended by Moxley Public Health and approved by BHNHC. (The identification process to decide the priority health needs that are going to be addressed will be transparent to the public. The information on why certain needs were identified as priorities and why other needs will not be addressed will also be public knowledge).

- Community partners (including BHNHC and many other organizations throughout the county) will select strategies to address priority health needs and priority populations. (We will use, but not be limited by, information from community members and stakeholders and evidence-based strategies recommended by the Ohio Department of Health).

- The 2026-2028 Improvement Plan (CHIP) (that includes indicators and SMART objectives to successfully monitor and evaluate the improvement plan) will be adopted and approved by BHNHC, reviewed by the public, and then the final draft will be publicly posted and made widely available to the community.

APPENDIX A

IMPACT AND PROCESS EVALUATION

IMPACT AND PROCESS EVALUATION

The following tables indicate the priority health needs selected from the 2021 Community Health Assessment (CHA) and the impact of Hancock County's 2023-2025 Community Health Improvement Plan (CHIP) on the previous priority health needs. The tables that follow are not exhaustive of these activities but highlight what has been achieved in the county since the previous CHA. The impact data (indicators of each priority health need to show if it is getting better or worse) and process data (to show whether the strategies are happening or not) will be reported and measured in an evaluation plan. That data will be reported annually and in the next CHA.

APPENDIX A:

IMPACT AND PROCESS EVALUATION OF PREVIOUS COMMUNITY HEALTH IMPROVEMENT PLAN (2023-2025)

Last updated 12/02/2024

ROADMAP TO A HEALTHIER HANCOCK COUNTY

2023-2025 Hancock County Community Health Improvement Plan

WHAT ARE THE 2023-2025 PRIORITIES, AND WHAT ARE THE STRATEGIES ASSOCIATED WITH THEM?

PRIORITY: MENTAL HEALTH & ADDICTION

STRATEGIES:

- *Medication-Assisted Treatment (MAT) Access Enhancement*
- *Development of Suicide and Overdose Fatality Review Team*
- *Expansion of Harm Reduction Services*
- *Implementation of Youth Thrive Framework*
- *Development of Health and Human Services Workforce Development Committee*

LEAD AGENCIES FOR THIS PRIORITY: Hancock County Family and Children First Council; adamhs (your path to health); Blanchard Valley Health System; Hancock Public Health

PRIORITY: ACCESS TO CARE

STRATEGIES:

- *Increase deployment of Mobile Health Clinic*
- *Increased awareness and use of non-emergency medical transportation (NEMT)*

LEAD AGENCIES FOR THIS PRIORITY: HHWP Community Action Commission; Hancock Public Health

PRIORITY: HEALTH BEHAVIORS

STRATEGIES:

- *Diabetes Prevention Programs*
- *Increase access and affordability of tobacco cessation therapy*
- *Expansion of CATCH My Breath Prevention Programs*
- *Healthy Foods Initiatives in Food Banks*

LEAD AGENCIES FOR THIS PRIORITY: Blanchard Valley Health System; West Ohio Food Bank; Hancock Public Health

**Graphics taken from Roadmap to a Healthier Hancock County Progress Report, published 2024.*

APPENDIX A:

IMPACT AND PROCESS EVALUATION OF PREVIOUS COMMUNITY HEALTH IMPROVEMENT PLAN (2023-2025)

Last updated 12/02/2024

ROADMAP TO A HEALTHIER HANCOCK COUNTY

2023-2025 Hancock County Community Health Improvement Plan

2023 PROGRESS

PRIORITY: MENTAL HEALTH & ADDICTION

PROGRESS:

- ✔ *Implemented Youth Thrive Framework*
- ✔ *Establishment of Suicide and Overdose Fatality Review (SOFR) team*
  - *Including quarterly reviews of cases, compiled in an annual report.*
- ✔ *Expanded Harm Reduction Services*
  - *Received NASTAD grant*
  - *Opened second SafeWorks location*
  - *Placed 22 NaloxBoxes throughout the county (3 outdoor, 19 indoor, adding to the 16 indoor boxes placed in 2022)*
- ✔ *Medication Assisted Treatment (MAT) services developed and implemented at Blanchard Valley Health System.*
- ✔ *Partnership formed with Raise the Bar to support Health and Human Services workforce recruitment and retention.*

PRIORITY: ACCESS TO CARE

PROGRESS:

- ✔ *Gathered baseline data on current use of non-emergency medical transportation (NEMT) for Medicaid and Medicare patients.*
- ✔ *Promoted and raised awareness of NEMT use and availability.*
- ✔ *Identified list of community partners and locations that could benefit from Mobile Health Clinic (MHC) visits*
- ✔ *Deployed MHC to provide screenings and connect patients with providers and other healthcare resources.*

PRIORITY: HEALTH BEHAVIORS

PROGRESS:

- ✔ *Dexcom diabetes study began at Hancock Public Health (HPH).*
  - *Enlisted trained Medical Reserve Corps (MRC) volunteers to aid in program expansion (estimated $22,000 economic impact)*
  - *Enrolled 300 individuals in the study.*
- ✔ *Increased number of school staff trained in CATCH curriculum.*
  - *Including School Resource Officers and School Nurses*
- ✔ *Began analysis of food relief agencies*
  - *Including number of agencies and their locations, demographic data of those utilizing services, and any identifying barriers among food insecure individuals.*

**Graphics taken from Roadmap to a Healthier Hancock County Progress Report, published 2024.*

APPENDIX A:

IMPACT AND PROCESS EVALUATION OF PREVIOUS COMMUNITY HEALTH IMPROVEMENT PLAN (2023-2025)

Last updated 12/02/2024

ROADMAP TO A HEALTHIER HANCOCK COUNTY

2023-2025 Hancock County Community Health Improvement Plan

2024 PROGRESS

PRIORITY: MENTAL HEALTH & ADDICTION

PROGRESS:

- *Provided Youth Thrive training to 32 community members/service providers.*
- *Implemented Suicide and Overdose Survivor Support (SOSS)*
    - *Conducting on-site outreach for individuals affected by suicide and overdose deaths and non-fatal overdoses.*
- *Expanded Harm Reduction Services*
    - *Placed 3 Harm Reduction Vending Machines, containing feminine hygiene products, fentanyl and xylazine test strips, small sharps containers, first aid kits, and more.*
    - *Trained one employee in the Grief Recovery Method*
    - *Placed 13 NaloxBoxes throughout the county (4 outdoor, 9 indoor)*
- *Began partnership with local justice center to increase medication assisted treatment (MAT) for inmates.*
- *Efforts made to increase the Health and Human Services workforce*
    - *Millstream Career Center to begin offering courses in Mental Health for Health Professions Students*

PRIORITY: ACCESS TO CARE

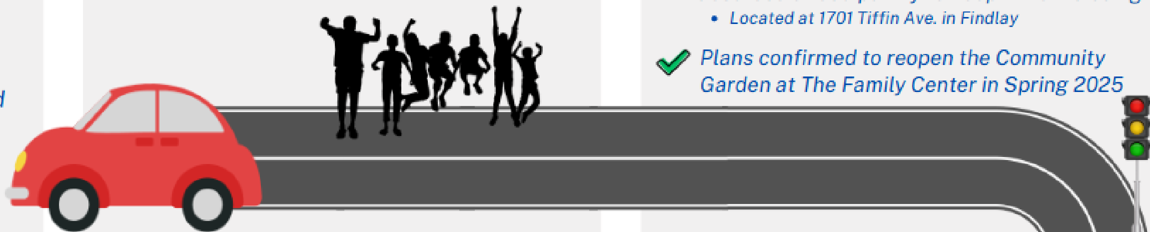
PROGRESS:

- *Collaborated with local transportation providers to increase awareness of non-emergency medical transportation (NEMT) for Medicaid and Medicare patients.*
    - *Usage of Medicaid transportation benefit by county residents continues to increase each year.*
- *Increased number of Mobile Health Clinic (MHC) visits and events*
    - *58 health/resource fairs attended in 2024*
    - *Offered vaccinations at 28 of these events*

PRIORITY: HEALTH BEHAVIORS

PROGRESS:

- *Ongoing efforts to promote healthy lifestyles and diabetes education at community events.*
- *Partnership formed between Hancock Public Health and Blanchard Valley Health system*
    - *Dexcom diabetes study transitioned to BVHS, allowing for further expansion.*
    - *Continuing to see a trend of improvements in diabetes risk factors.*
- *Increased screenings at events attended by HPH Mobile Health Clinic*
    - *Total of 69 individuals provided with diabetes education and referral information in 2024.*
- *Evaluated and implemented evidence-based practices into BVHS smoking cessation program.*
- *St. John's Evangelical Lutheran Church absorbed a food pantry to keep it from closing*
    - *Located at 1701 Tiffin Ave. in Findlay*
- *Plans confirmed to reopen the Community Garden at The Family Center in Spring 2025*



**Graphics taken from Roadmap to a Healthier Hancock County Progress Report, published 2024.*

APPENDIX B
BENCHMARK COMPARISONS

BENCHMARK COMPARISONS

The following table compares County rates of the identified health needs to national goals called **Healthy People 2030 Objectives**. These benchmarks show how the county compares to national goals for the same health need. This appendix is useful for monitoring and evaluation purposes in order to track the impact of our Improvement Plan (CHIP) to address priority health needs.

APPENDIX B:

HEALTHY PEOPLE OBJECTIVES & BENCHMARK COMPARISONS

Where data were available, Hancock County health and social indicators were compared to the Healthy People 2030 objectives. The **black** indicators are Healthy People 2030 objectives that did not meet established benchmarks, and the **blue** items met or exceeded the objectives. Certain indicators were not reported, marked as N/R. Healthy People Objectives are released by the U.S. Department of Health and Human Services every decade to identify science-based objectives with targets to monitor progress, motivate and focus action. Hancock County rates marked with an asterisk (*) are crude rates.

BENCHMARK COMPARISONS			
INDICATORS	**DESIRED DIRECTION**	**HANCOCK COUNTY**	**HEALTHY PEOPLE 2030 OBJECTIVES**
High school graduation rate[5]	↑	**91.0%**	**90.7%**
Child health insurance rate[13]	↑	**97.6%**	**92.1%**
Adult health insurance rate[13]	↑	**92.8%**	**92.1%**
Ischemic heart disease deaths[32]	↓	**122.9***	**71.1 per 100,000 persons**
Cancer deaths[32]	↓	**160.9***	**122.7 per 100,000 persons**
Colon/rectum cancer deaths[32]	↓	**17.1***	**8.9 per 100,000 persons**
Lung cancer deaths[32]	↓	**34.8***	**25.1 per 100,000 persons**
Female breast cancer deaths[32]	↓	**15.0***	**15.3 per 100,000 persons**
Prostate cancer deaths[32]	↓	**23.2***	**16.9 per 100,000 persons**
Stroke deaths[32]	↓	**50.4***	**33.4 per 100,000 persons**
Unintentional injury deaths[32]	↓	**57.0***	**43.2 per 100,000 persons**
Suicides[48]	↓	**14.2**	**12.8 per 100,000 persons**
Liver disease (cirrhosis) deaths[32]	↓	**14.6***	**10.9 per 100,000 persons**
Unintentional fall deaths, adults 65+[32]	↓	**42.9***	**63.4 per 100,000 persons ages 65+**
Unintentional drug-overdose deaths[49]	↓	**22.6***	**20.7 per 100,000 persons**
Overdose deaths involving opioids[50]	↓	**24.9***	**13.1 per 100,000 persons**
On-time (first trimester) prenatal care (HP2020 Goal)[53]	↑	**80.0%**	**84.8% (HP2020 Goal)**
Preterm births, babies born before 37 weeks of gestation (%)[53]	↓	**10.2%**	**9.0%**
Infant death rate[56]	↓	**5.7**	**5.0 per 1,000 live births**
Adults, ages 20+, obese[5]	↓	**37.0%**	**36.0%, adults ages 20+**
Students, grades 7th to 12th, obese[26]	↓	**17.7%**	**15.5%, children & youth, 2-19**
Adults engaging in binge drinking[11]	↓	**18.5%**	**25.4%**
Cigarette smoking by adults[5]	↓	**19.0%**	**5.0%**
Pap smears, ages 21-65, screened in the past 3 years[42]	↑	**84.8%**	**84.3%**
Mammograms, ages 50-74, screened in the past 2 years[42]	↑	**66.5%**	**77.1%**
Colorectal cancer screenings, ages 50-75, per guidelines[42]	↑	**64.2%**	**74.4%**
Medicare enrollee annual influenza vaccinations[5]	↑	**54.0%**	**70.0%, all adults**
Food insecure households[23]	↓	**13.3%**	**6.0%**
Suicide attempts by adolescents in past year[26]	↓	**7.3%**	**1.8%**

APPENDIX C

KEY INFORMANT INTERVIEW PARTICIPANTS

KEY INFORMANT INTERVIEW PARTICIPANTS

Listed on the following page are the names of **29** leaders, representatives, and members of the Hancock County community who were consulted for their expertise on the needs of the community. The following individuals were identified by the Community Health Assessment (CHA) team as leaders based on their professional expertise and knowledge of various target groups throughout the Hancock County community.

APPENDIX C:
KEY INFORMANT INTERVIEW PARTICIPANTS

INTERVIEW PARTICIPANTS		
NAME(S)	**ROLE**	**ORGANIZATION**
1. Judge Kristen Johnson	Judge	Hancock County Probate/Juvenile Court
2. Laura Reinhart	Certified Nurse Practitioner, Mobile Health Clinic	Hancock Public Health
3. Kimberly Bash	Chief Community Engagement Officer	The Findlay-Hancock County Community Foundation
4. Kathryn Bausman 5. Tyler Layton	Executive Director Student	City Mission of Findlay
6. Brooke Nissin	Executive Director	FOCUS Recovery & Wellness Center
7. Jessi Smith	OhioKAN Navigator	LGBTQ+ Spectrum of Findlay
8. Chief James Mathias	Police Chief	City of Findlay
9. Peggy Grandbois	Coordinator	Family & Children First Council
10. Tricia Valasek	Executive Director	Raise the Bar
11. Sheriff Michael Heldman	Sheriff	Hancock County
12. Kristy Szkudlarek	Social Media Coordinator	Findlay Hancock County Public Library (Speak Easy Program, Read for Life Program)
13. Stacy Shaw	Chair Executive Director	Hancock County Community Partnership Children's Mentoring Connection
14. Carolyn Copus	Executive Director	50 North

APPENDIX C:
KEY INFORMANT INTERVIEW PARTICIPANTS

INTERVIEW PARTICIPANTS		
NAME(S)	**ROLE**	**ORGANIZATION**
15. Dionne Neubauer	Director	Findlay Hancock County Chamber of Commerce
16. Myron Lewis	CEO	Blanchard Valley Hospital
17. Stephanie Renn 18. Krista Miller	Director of Elementary Instruction Assistant Superintendent	Findlay City Schools
19. Christina Muryn 20. Robert Martin	Mayor Director Of Emergency Services	City of Findlay
21. Precia Stuby	Executive Director	Hancock County Alcohol, Drug Addiction and Mental Health Services (ADAMHS)
22. Rene Gabriel 23. Hachemy Gabriel	Public Relations Coordinator	Mission Possible
24. Josh Anderson	President/CEO	Hancock Hardin Wyandot Putnam (HHWP) Community Action Commission
25. Pastor Juan Salinas	Pastor	Church of the Living God
26. Nichole Coleman	County Veterans Service Officer, Executive Director	Hancock County Veteran Services
27. Jeff Young	Superintendent	Hancock County Educational Service Center
28. Kegan Wise	Industrial Engineering Manager	Whirlpool
29. Debra Parker	Chair Dean	Hancock County Coalition on Addiction University of Findlay College of Pharmacy

APPENDIX D

FOCUS GROUP PARTICIPANTS

FOCUS GROUP PARTICIPANTS

Listed on the following page are the details of the **10 focus groups** conducted with **89 community members**, including the number of participants, format, and groups represented.

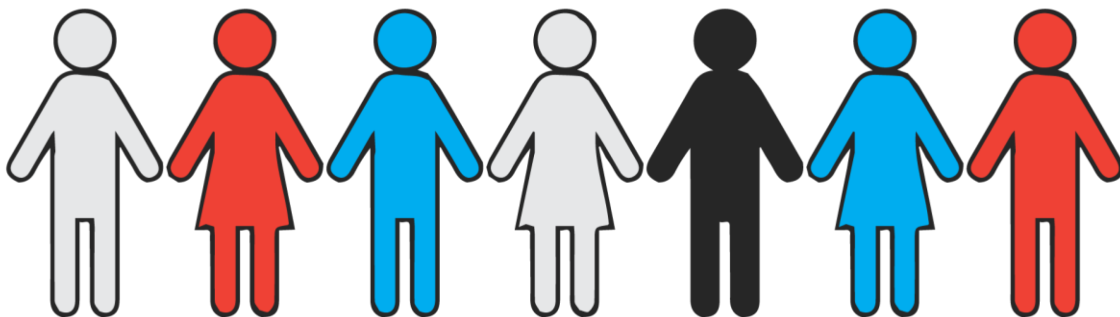
APPENDIX D:
FOCUS GROUP PARTICIPANTS

FOCUS GROUP PARTICIPANTS			
GROUP REPRESENTED	**FORMAT**	**PARTICIPATING ORGANIZATION(S)**	**# OF PARTICIPANTS**
1. 50+ Population	In-Person	50 North, Hancock Public Health	12
2. Young Adults (University Students Ages 18-25)	In-Person	United Way, Hancock Public Health	9
3. LGBTQ+ Population	In-Person	LGBTQ+ Spectrum of Findlay, Hancock Public Health	6
4. Mental Health and Substance Use (Recovery Peers – People with Lived Experience)	In-Person	FOCUS Recovery & Wellness Community/Peer Advisory Partnership, Hancock Public Health	11
5. Unhoused Population	In-Person	Hope House, Hancock Public Health	5
6. Immigrant Population/ English as a Second Language (ESL) Population – Focus Group #1	In-Person	Findlay Hancock County Public Library, Hancock Public Health	9 (completed shortened survey)
7. Immigrant Population/ English as a Second Language (ESL) Population – Focus Group #2	In-Person	Findlay Hancock County Public Library, Hancock Public Health	18 (completed shortened survey)
8. Japanese (Women)	In-Person	Findlay City Schools, Friends of Findlay, University of Findlay, Hancock Public Health	7
9. Rural Population	In-Person	The Findlay-Hancock County Community Foundation, Hancock Public Health	8
10. Parents/Grandparents Raising Grandchildren	In-Person	Family Resource Center, Parent Advisory Group Hancock Public Health	4
TOTAL			**89**

APPENDIX D:
FOCUS GROUP DEMOGRAPHICS

Note: 65% of focus group participants responded to some or all of the optional demographic questions. Focus groups were meant to hear specifically from priority populations in the community most affected by health disparities, not necessarily to represent the overall demographics of the community.

- Participants were mainly from **Findlay/Houcktown (45840) – 69%**, with representation from Jenera (45841), McComb/Deweyville (45858), and other areas.
- **65+ was the most represented age group (33%)**, followed by 35-44, 25-34, and 18-24 (all with 15%). With the exception of those under 18, all age groups had some representation.
- **85% of participants were women**.
- **Most participants (93%) were straight.**
- **73% of participants were White**, while there was representation from Asian (21%) and Hispanic (6%) residents.
- **Participants mainly spoke English** as a primary language (75%), while others spoke Japanese and Spanish.
- **56% of participants had no children** in their home, while 32% had 1 or 2 children in their home.
- **47% of participants had a Bachelor's degree**, while 18% had a Graduate degree, 15% had a high school degree or equivalent, and 12% had an Associate's degree.
- **32% were employed**, while 68% were unemployed.
- **Education, law and social, community and government services,** followed by business, finance, and administration were the most common occupational categories represented.
- Participants were generally **lower to middle income**, with 35% having a household income under $50,000 per year. All income categories were represented.
- 6% of participants **identified as having a disability**.
- 92% of participants **have a steady place to live**.



APPENDIX E
COMMUNITY MEMBER SURVEY

COMMUNITY MEMBER SURVEY

On the following pages are the questions and demographics from the community member survey that was distributed to the Hancock County community to get their perspectives and experiences on the health assets and needs of the community they call home. **1,071 responses** (1,058 English responses and 13 Spanish responses) were received. This section also contains the questions and demographics from the shortened version of the community member survey, with **51 responses**.

APPENDIX E:
COMMUNITY MEMBER SURVEY

Welcome!

Hancock County is conducting a Community Health Assessment (CHA) to identify and assess the health needs of the community. We are asking community members (those who live and/or work in Hancock County) to complete this short, **20-minute** survey. This information will help guide us as we consider services, programs, and policies that will benefit the community.

Be assured that this process is completely anonymous - we cannot access your name or any other identifying information. Your individual responses will be kept strictly confidential and the information will only be presented in aggregate (as a group). Your participation in this survey is entirely voluntary and you are free to leave any of the questions unanswered/skip questions you prefer not to answer (so only answer the questions you want to answer!). Thank you for helping us to better serve our community!

1. Where do you live or reside in Hancock County? (choose one)

- 45840
- 44830
- 45810
- 45817
- 45872
- 45843
- 45858
- 45814
- 45889
- 44817
- 45881
- 45841
- 44804
- 45867
- 44802
- 45868
- 45890
- 45816
- 45839
- 45897
- Prefer not to answer
- None of the above, I live primarily at the following ZIP code:

2. Where do you work? (choose one)

- 45840
- 44830
- 45810
- 45817
- 45872
- 45843
- 45858
- 45814
- 45889
- 44817
- 45881
- 45841
- 44804
- 45867
- 44802
- 45868
- 45890
- 45816
- 45839
- 45897
- I am not currently employed
- Prefer not to answer
- None of the above, I live primarily at the following ZIP code:

3. Do you live within walking distance (10-15 minutes) of the University of Findlay?

- Yes
- No
- Don't know
- Prefer not to answer

4. Which of the following best describes your age?

- Under 18
- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65+
- Prefer not to answer

5. What is your gender identity?

- Male
- Female
- Transgender
- Non-binary
- Prefer not to answer
- Transgender/ Trans woman (person who identifies as a woman)
- Transgender/ Trans man (person who identifies as a man)
- Prefer not to answer
- Not Listed (feel free to specify)

6. What is your sexual orientation?

- Heterosexual or straight
- Bisexual
- Gay
- Lesbian
- Asexual
- Not Listed (feel free to specify)
- Prefer not to answer

7. What is your race and/or ethnicity? (Select all that apply)

- Asian
- Black or African American
- Hispanic/Latino/a
- White/Caucasian
- Multiracial/More than one race
- Native American/Alaska Native
- Native Hawaiian/Pacific Islander
- Prefer not to answer
- Not Listed (feel free to specify)

8. Which is your primary language spoken at home?

- English
- Spanish
- Prefer not to answer
- Not Listed (feel free to specify)

9. How many children, ages 0-18, live in your household?

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- Prefer not to answer
- Not Listed (feel free to specify)

APPENDIX E:
COMMUNITY MEMBER SURVEY

10. What is the highest level of education you have completed?
- Less than a High School diploma
- High School degree or equivalent
- Some college but no degree
- Associate's degree (e.g. AA, AS)
- Bachelor's degree (e.g. BA, BS)
- Graduate degree (e.g. MA, MS, PhD, EdD, MD)

11. Are you currently employed?
- Yes, part-time (less than 30 hours per week)
- Yes, full-time (30 hours per week or more)
- Not employed - but looking for work
- Not employed - not actively looking for work
- Student
- Retired
- Disabled

12. What is your annual household income?
- Less than $20,000
- $20,000-$34,999
- $35,000-$49,999
- $50,000-$74,999
- $75,000-$99,999
- Over $100,000

13. Do you have any of the following disabilities or chronic conditions? (select all that apply)
- Attention deficit
- Autism
- Blind or visually impaired
- Deaf or hard of hearing
- Health-related disability
- Learning Disability
- Mental health condition
- Mobility-related disability
- Speech-related disability
- None
- Not Listed (feel free to specify or tell us more)

14. What is your current living situation?
- I have a steady place to live
- I have a place to live today, but I am worried about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others)
- I am staying in a shelter
- I am living outside
- I am living in a car
- I am living elsewhere

15. Have you experienced any of the following types of abuse in the past year?
- Verbal/Emotional (hurtful words, insults, etc.)
- Mental/psychological (negatively affecting someone's mental health, manipulation, etc.)
- Cultural/Identity (discrimination based on race, culture, religion, sexual orientation, gender identity, disability, class, age, etc.)
- Financial/Economic (using money/finances to control someone)
- Physical violence (punching, hitting, slapping, kicking, strangling, or physically restraining someone against their will, use of weapons, etc.)
- Sexual (rape or other forced sexual acts, unwanted touching, etc.)
- Elder (an intentional act or failure to act that causes or creates a risk of harm to an older adult)
- Not Listed (feel free to specify)

16. While it can be hard to choose, do your best to select what you feel are the TOP 3 COMMUNITY CONDITIONS/SOCIAL DETERMINANTS OF HEALTH of concern in your community? (please check your top 3)
- Access to childcare
- Access to healthcare (e.g. doctors, hospitals, specialists, mental healthcare, dental/oral care, vision care, medical appointments, health insurance coverage, health literacy, etc.)
- Adverse childhood experiences (e.g. child abuse, mental health, family issues, trauma, etc.)
- Crime and violence
- Education (e.g. early childhood education, elementary school, post-secondary education, etc.)
- Environmental conditions (e.g. air and water quality, vector-borne diseases, etc.)
- Food insecurity (e.g. not being able to access and/or afford healthy food)
- Housing and homelessness
- Income/poverty and employment
- Internet/Wi-Fi access
- Nutrition and physical health/exercise (includes overweight and obesity)
- Preventive care and practices (e.g. screenings, mammograms, pap tests, vaccinations)
- Tobacco and nicotine use/smoking/vaping
- Transportation (e.g. public transit, cars, cycling, walking)
- Not Listed (feel free to specify)

17. While it can be hard to choose, do your best to select what you feel are the TOP 3 HEALTH OUTCOMES (e.g. impacts, diseases, conditions, etc.) of concern in your community? (please check your top 3)
- Cancer
- Chronic Liver Disease/Cirrhosis
- Chronic Obstructive Pulmonary Disease (COPD)
- Dementia (e.g. Alzheimer's and other worsening confusion and cognitive decline)
- Diabetes
- HIV/AIDS and Sexually Transmitted Infections (STIs)
- Heart disease and stroke
- Injuries (workplace injuries, car accidents, falls, etc.)
- Kidney disease
- Maternal, infant and child health (e.g. pre-term births, infant mortality, maternal morbidity and mortality)
- Mental health (e.g. depression, anxiety, suicide, etc.)
- Parkinson's disease
- Substance misuse/substance use disorder (alcohol and drugs)
- Not Listed (feel free to specify)

18. If you do NOT currently have healthcare coverage or insurance, what are the main reasons why? (Select all that apply)
- I am waiting to get coverage through my job
- I don't think I need health insurance
- I haven't had time to deal with it
- It costs too much
- I am not eligible or do not qualify
- It is too confusing to sign up
- Does not apply - I have health coverage/insurance

COMMUNITY MEMBER SURVEY

19. During the most recent time you or a member of your household delayed or went without needed healthcare, what were the main reasons? (Select all that apply)
- Could not get an appointment quickly enough/too long of a wait for an appointment
- Could not get an appointment that was convenient with my work hours or child's school
- schedule
- Distrust/fear of discrimination
- Insurance did not cover the cost of the procedure or care
- Lack of provider awareness and/or education about my health condition
- Lack of transportation to the appointment
- Language barriers
- No insurance and could not afford care
- Insurance did not cover the cost of the procedure or care
- Not knowing where to go or how to find a doctor
- Technology barriers with virtual visits/telehealth services
- Not having a provider who understands and/or respects my cultural or religious beliefs
- The appointment was too far away and outside of Hancock County
- No barriers and did not delay health care - received all the care that was needed
- Not Listed (feel free to specify)

20. Where do you and your family members go most often to receive routine healthcare services (physical exams, check-ups, immunizations, treatment for chronic diseases)? (Select all that apply)
- Doctor's office (primary care physician, family physician, internist, pediatrician, etc.)
- Emergency room department at the hospital
- Urgent care clinic
- I wouldn't go to a doctor unless it was an emergency
- Not sure
- None of the above

21. How long has it been since you have been to the doctor to get a checkup when you were well (not because you were already sick)?
- Within the last year
- 1-2 years ago
- 3-5 years ago
- More than 5 years ago
- I have never been to a doctor for a checkup

22. If you were sick, where would you go first for treatment? Assume that this is not an emergency situation.
- Doctor's office (primary care physician, family physician, internist, pediatrician, etc.)
- Specialist's office (cardiologist, pulmonologist, endocrinologist, etc.)
- Emergency room department at hospital
- Urgent care clinic
- I wouldn't go to a doctor unless it was an emergency
- Not sure
- None of the above

23. How would you rate your current access to mental or behavioral health services?
- Very high access
- High access
- Neutral
- Low access
- Very low access

24. What, if any, are your main barriers to accessing mental or behavioral health services, if needed? (Select all that apply)
- Could not get an appointment quickly enough/ too long of a wait for an appointment
- Distrust/fear of discrimination
- Do not need behavioral or mental health care
- No insurance and it costs too much
- I have insurance but it did not cover the cost of the services
- Not knowing where to go or how to find behavioral or mental health providers
- COVID-19 appointment cancellation, concern of
- Lack of provider awareness and/or education about my health condition
- Lacked transportation to the appointment
- Language barriers
- No barriers – received all the behavioral and mental health care that was needed
- Not having a provider who understands and/or respects my cultural or religious beliefs
- Office hours of provider don't work with my schedule
- Stigma of mental or behavioral health/nervous about admitting that I have a mental or behavioral health concern
- Technology barriers with virtual visits/telehealth services
- Uncomfortable with mental or behavioral health provider

25. If you do want to get healthier and in better shape; what if anything, do you feel is holding you back? (Select all that apply)
- Stress
- Lack of energy
- My busy schedule (I don't have time to cook or exercise)
- Lack of support from friends
- Lack of support from family
- I feel intimidated or awkward going to a gym or fitness center
- Money (gyms and healthy foods are too expensive)
- Lack of gyms or fitness centers to go to near me
- Food and fitness is too confusing
- Convenience (eating out is easier)
- Childcare concerns
- I don't like to cook
- I don't like to exercise
- I don't feel motivated to be healthier
- None of the above. (I'm in good shape or don't want to be in better shape)

26. In the last year, was there a time when you needed prescription medicine but were not able to get it?
- Yes
- No

APPENDIX E:
COMMUNITY MEMBER SURVEY

27. About how long has it been since you have been to the dentist to get a checkup (not for an emergency)?
- Within the last year
- 1-2 years ago
- 3-5 years ago
- More than 5 years ago
- I have never been to the dentist for a checkup

28. In the last year, was there a time when you needed dental care but could not get it?
- Yes
- No

29. In the last year, was there a time when you needed mental health and/or substance use counseling but could not get it?
- Yes
- No

30. Do you have a personal physician/primary care provider?
- Yes
- No

31. How long has it been since you have had a flu shot?
- Within the last year
- 1-2 years
- 3-5 years
- 5 or more years ago
- I have never had a flu shot

32. How long has it been since you have had a COVID-19 shot/vaccine?
- Within the last year
- 1-2 years
- 3-5 years
- 5 or more years ago
- I have never had a COVID-19 shot/vaccine
- Prefer not to answer

33. Overall, my physical health is:
- Good
- Average
- Poor
- Excellent

34. Overall, my mental health is:
- Good
- Average
- Poor
- Excellent

35. In the past 12 months, has lack of reliable transportation kept you from going to (select all that apply):
- Medical Appointments
- Buying food/groceries
- Getting other things for daily living
- Work/meetings
- Childcare
- Physical activity opportunities/the gym
- School (for yourself or another member of your family)
- Not Applicable
- Not Listed (feel free to specify)

36. How do you travel to where you need to go? (select all that apply for each category – work, appointments, food shopping)

	Drive alone	Public transit (e.g. HATS)	Taxi/cab	Ride with others in a carpool or vanpool	Cycle	Walk	Family member takes me	It depends on the day as to what is available	I struggle with finding a way to get here
Work	☐	☐	☐	☐	☐	☐	☐	☐	☐
Appointments (e.g. medical, mental health, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Food shopping	☐	☐	☐	☐	☐	☐	☐	☐	☐

Not Listed (feel free to specify)

37. What resources are lacking within your community? (select all that apply)
- Affordable food
- Affordable housing
- Childcare
- Dental/oral healthcare access
- Hospital/acute and emergency healthcare
- Maternal, infant, and child healthcare (e.g. OB/GYN, midwives, doulas, pediatricians, etc.)
- Mental healthcare access
- Primary healthcare access
- Recreational spaces (e.g. parks, walking paths, community centers, gyms/workout facilities, etc.)
- Specialist healthcare (e.g. oncologist/cancer care, cardiologist/heart care, nephrologist/kidney care, physical therapy, dietitian, etc.)
- Substance use treatment/harm reduction services
- Transportation
- Vision healthcare access
- There is no lack of resources in my community
- I don't know what resources are lacking in my community
- Not Listed (feel free to specify)

38. During the past 30 days (1 month) on how many days did you smoke cigarettes?
- Every day or almost every day
- Some days
- No days
- Not Listed (feel free to specify)

39. During the past 30 days (1 month) on how many days did you vape/use e-cigarettes?
- Every day or almost every day
- Some days
- No days
- Not Listed (feel free to specify)

40. During the past 30 days (1 month) on how many days did you use other nicotine or tobacco products?
- Every day or almost every day
- Some days
- No days
- Not Listed (feel free to specify)

APPENDIX E:
COMMUNITY MEMBER SURVEY

41. How often do you have a drink containing alcohol?
- Never
- Monthly or less
- 2 to 4 times a month
- 2 to 4 times a week
- 4 or more times a week

42. Do you ever have 5 or more drinks containing alcohol at any one time?
- Never
- Monthly or less
- 2 to 4 times a month
- 2 to 4 times a week
- 4 or more times a week

43. How often in the last 30 days (last month) have you used marijuana?
- None
- 1-2 times
- 3-9 times
- 10-19 times
- 20 or more times
- Several times a day
- Not Listed (feel free to specify)

44. How often in the last 30 days (last month) have you used illicit/illegal drugs/substances?
- None
- 1-2 times
- 3-9 times
- 10-19 times
- 20 or more times
- Several times a day
- Not Listed (feel free to specify)

45. In the past 6 months, have you used prescription medication that was not prescribed for you, or took more medicine than was prescribed for you, in order to feel good, high, more active, or more alert?
- Yes
- No
- Prefer not to answer
- Not Listed (feel free to specify)

46. During the past 12 months, have you spent money on any of the following activities? (select all that apply)
- Bingo
- Casino gambling
- Poker or other card games, dice or craps (not a casino)
- Horse/dog racing track
- Fantasy sports/online betting
- Lottery/scratch-offs tickets/office pools, etc.
- Sports betting with a bookie/office sports pool
- Don’t know
- I have not spent money on any of those activities in the past 12 months
- Not listed (feel free to specify)

47. Have you experienced any of the following due to gambling? (select all that apply)
- Gambled while drunk or high
- Someone else expressed a concern
- Gambled with larger amounts of money to get the same excitement
- Lied to family members or others to hide your gambling
- Unable to pay bills
- Don't know
- I have not experienced any of the following while gambling
- Not listed (feel free to specify)

48. Do you or your family worry that your food will run out and that you won't be able to get more?
- Yes
- No
- Prefer not to answer
- Not Listed (feel free to specify)

Please rate your agreement with the following statements:

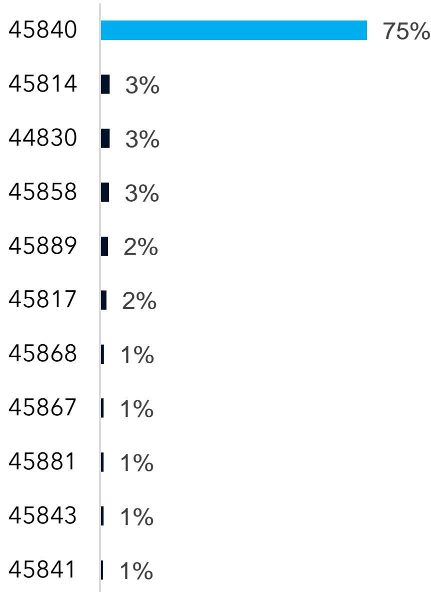
	Strongly agree	Somewhat agree	Neutral	Somewhat disagree	Strongly disagree
Hancock County is a place that welcomes and embraces diversity in general.	○	○	○	○	○
Hancock County is a place that welcomes and embraces racial and ethnically diverse people.	○	○	○	○	○
Hancock County is a place that welcomes and embraces LGBTQ+ people.	○	○	○	○	○

49. Do you have any other feedback or comments to share with us?

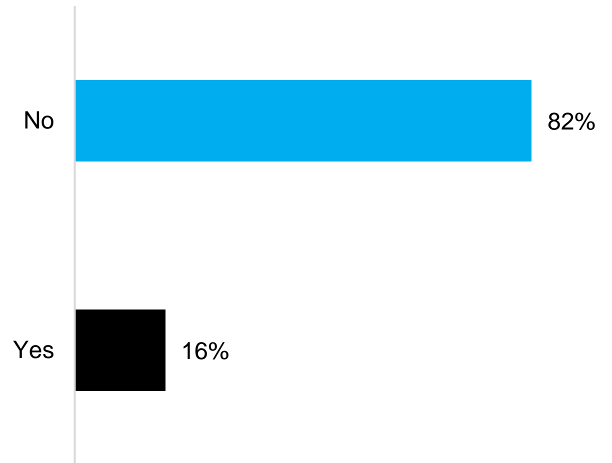
Thank you! Please send this survey to anyone you know who lives and/or works in Hancock County.

APPENDIX E: COMMUNITY MEMBER SURVEY DEMOGRAPHICS

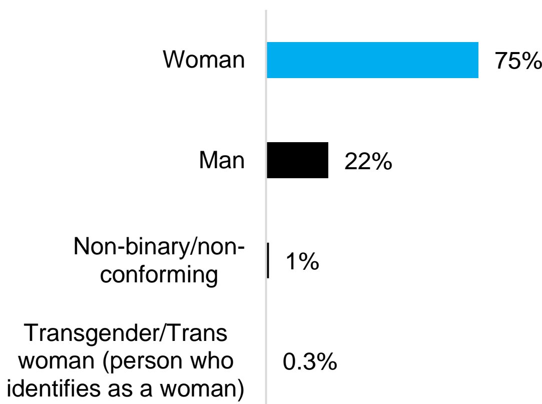
The majority of respondents live in **Findlay (45840)**, consistent with the population of the county



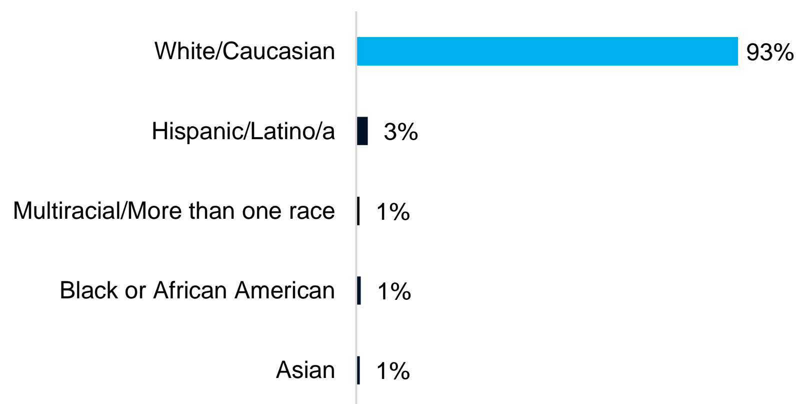
The majority of respondents **do not live within walking distance of the University of Findlay** (an approximation of the 9.01 and 9.02 census tracts, which were found to experience the greatest health disparities in the Hancock County 2021 Health Equity Report); however, a significant proportion (16%) do live in this area



The majority of respondents were **women**

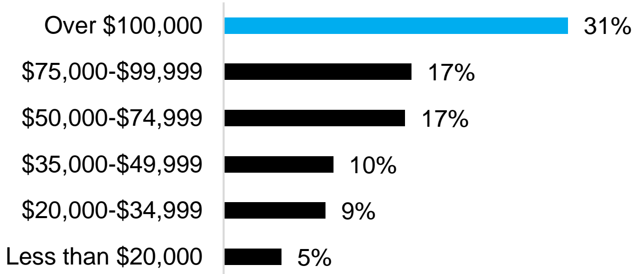


The majority of respondents were **White**, consistent with the composition of the county. Other racial groups were somewhat underrepresented

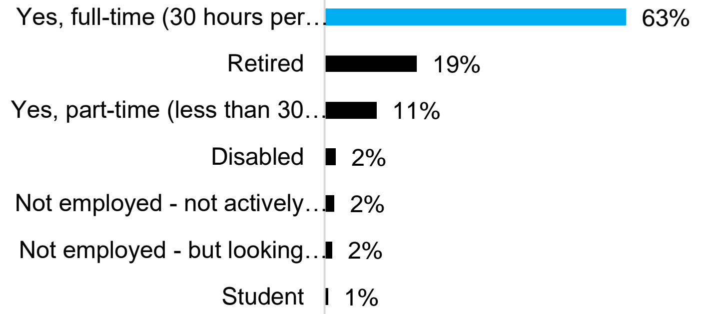


APPENDIX E: COMMUNITY MEMBER SURVEY DEMOGRAPHICS

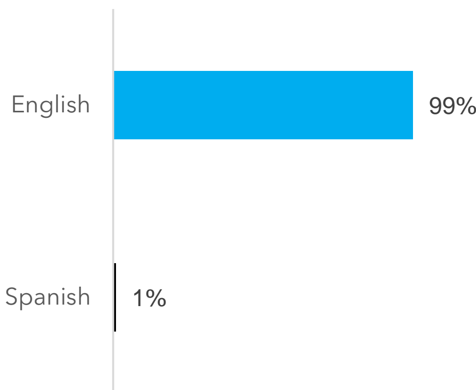
Respondents were generally **higher income**, with nearly one-third having an annual household income of $100,000 or more. This representation is similar to the county as a whole



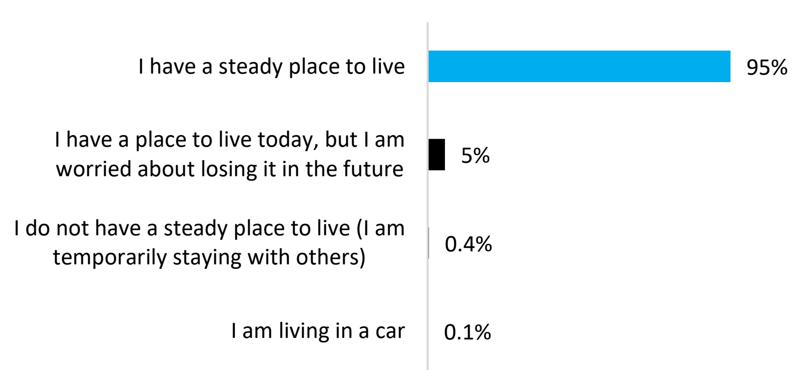
The majority of respondents are **employed full-time**



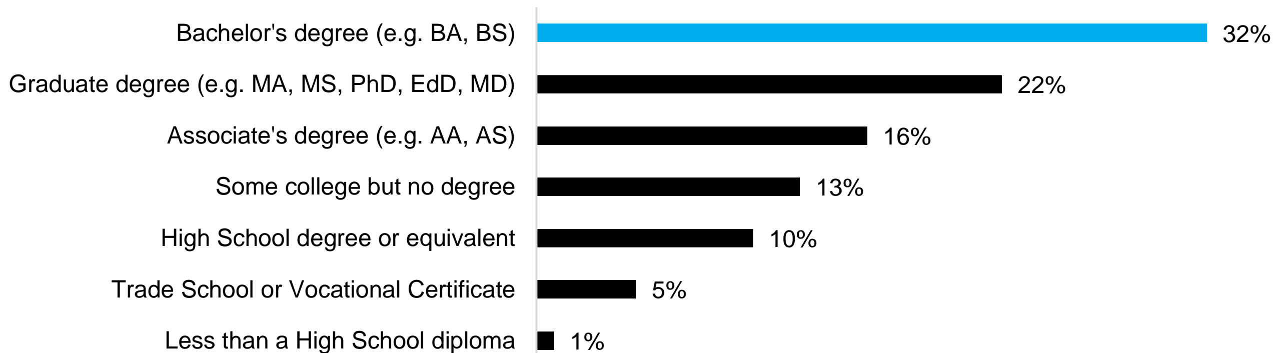
Respondents reported that their primary language spoken at home was **English**



The majority of respondents have a **steady place to live**

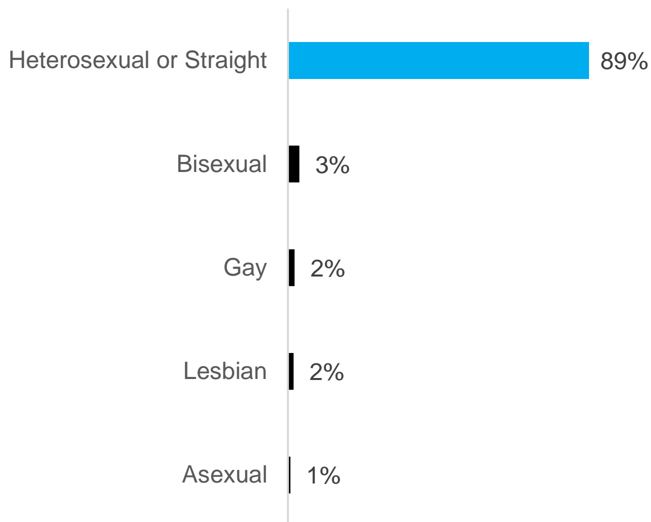


The majority of respondents have some post-secondary education, the most common being a **Bachelor's degree**

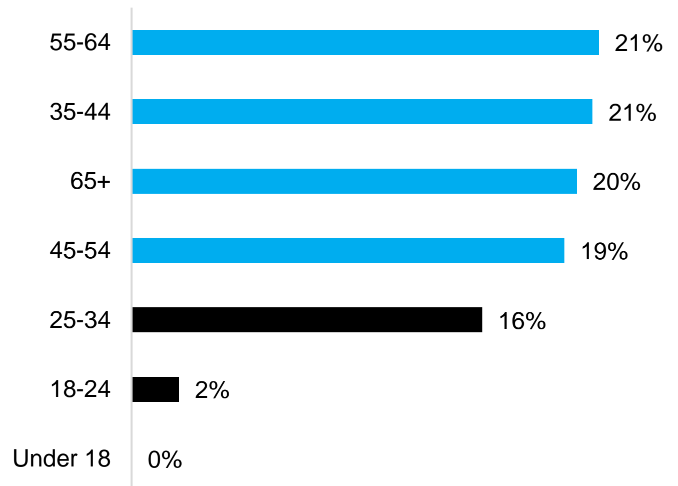


APPENDIX E:
COMMUNITY MEMBER SURVEY DEMOGRAPHICS

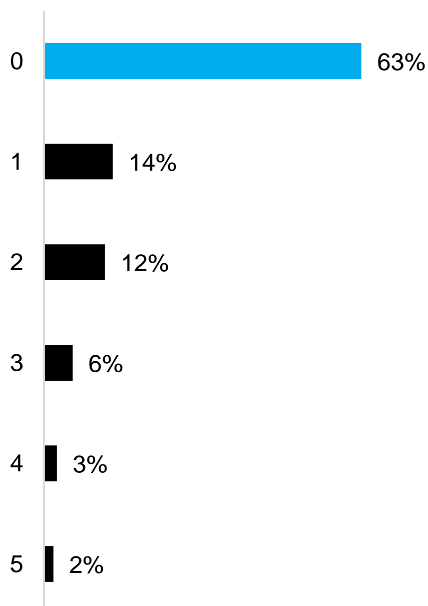
The majority of respondents reported their sexual orientation as **heterosexual or straight**



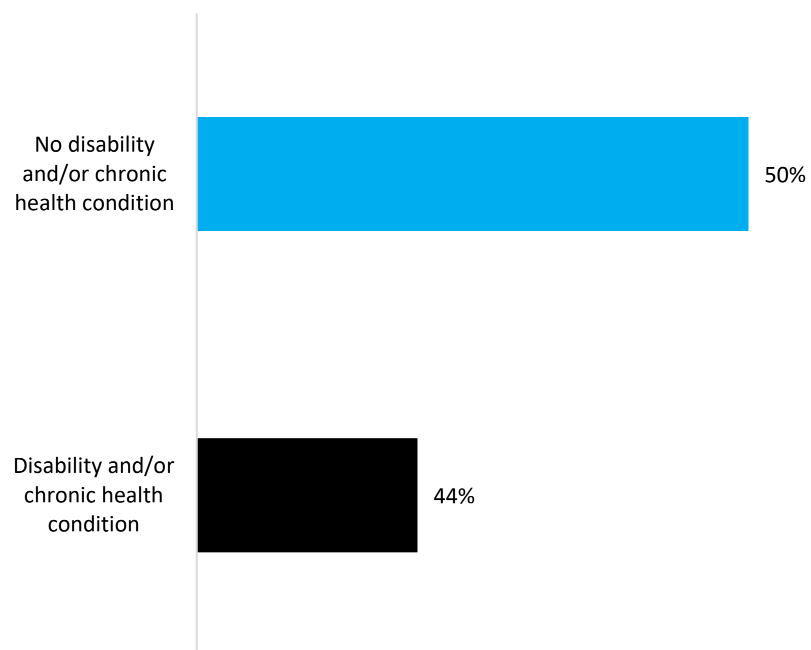
There was **similar representation from all age groups**, with the exception of younger adults ages 18-24



Most respondents reported having **no children at home**



The majority of respondents reported **not having a disability**



APPENDIX E:
SHORTENED COMMUNITY MEMBER SURVEY

Welcome!

Hancock County is asking for a Community Health Assessment (CHA) to identify and assess the health needs of the community. We are asking community members (those who live and/or work in Hancock County) to complete this short, **5-minute** survey. This information will help us bring better programs and services to the community.

This process is completely anonymous - we cannot access your name or any other personal information. Your individual responses will be kept strictly confidential and the information will only be presented as a group. Your participation in this survey is your choice and you are free to skip questions you prefer not to answer (so only answer the questions you want to answer!). Thank you for helping us to better serve our community!

1. Are you currently living in Findlay, Ohio? If not, where? (choose one)
- Yes
- No
- Prefer not to answer
- I don't live in Findlay Ohio, I live in:

2. Do you live within walking distance (10-15 minutes) of the University of Findlay (this is a college in Findlay located at 1000 N Main St, Findlay, Ohio)?
- Yes
- No
- Don't know
- Prefer not to answer

3. How many years old are you?
- Under 18 years
- 18 to 24 years
- 25 to 34 years
- 35 to 44 years
- 45 to 54 years
- 55 to 64 years
- 65+ years
- Prefer not to answer

4. What is your gender identity? (select all that apply)
- Woman
- Man
- Transgender/Trans woman (person who identifies as a woman)
- Transgender/Trans man (person who identifies as a man)
- Non-binary/non-conforming
- Prefer not to answer
- Not Listed (feel free to specify)

5. What is your sexual orientation? (select all that apply)
- Heterosexual or Straight (you are attracted to the opposite gender, for example a man who is attracted to a woman)
- Gay (you are attracted to the same gender, for example a man who is attracted to a man)
- Lesbian (you are attracted to the same gender, for example a woman who is attracted to a woman)
- Bisexual (you are attracted to men and women)
- Asexual (you aren't attracted to anyone)
- Prefer not to answer
- Not Listed (feel free to specify)

6. What is your race and/or ethnicity? (select all that apply)
- Asian
- Black or African American
- Hispanic/Latino/a
- White/Caucasian
- Multiracial/More than one race
- Native American/Alaska Native
- Native Hawaiian/Pacific Islander
- Prefer not to answer
- Not Listed (feel free to specify)

7. What is your country of origin / Where were you born?
- United States
- Prefer not to answer
- Not listed (feel free to specify)

8. What is your native language?
- English
- Español
- Kreyòl
- Prefer not to answer
- Not Listed (feel free to specify)

9. How many children under age 18 live in your household?
- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- Prefer not to answer
- Not Listed (feel free to specify)

10. What is the highest level of education you have completed?
- Grade school
- Some High School (did not complete school)
- High School degree or equivalent
- Some college but no degree
- Trade School or Vocational Certificate
- College graduate or higher education
- Prefer not to answer

11. Do you have a job?
- Yes, I work full-time (30 hours per week or more)
- Yes, I work part-time (less than 30 hours per week)
- No job - but looking for work
- No job - not looking for a job
- Student
- Retired
- Disabled
- Seasonal (I have a job for part of the year, e.g. just the summer)
- Prefer not to answer

APPENDIX E:
SHORTENED COMMUNITY MEMBER SURVEY

12. How much do you get paid per hour?
- Less than $10 per hour
- $10 to $15 per hour
- $15 to $20 per hour
- $20 to $25 per hour
- Prefer not to answer
- Not listed (feel free to specify)

13. How is your housing situation? (select all that apply)
- I have a secure place to live
- I have a place to stay, but it is not permanent
- I do not have a secure place to live (I am temporarily staying with others)
- I am staying in a shelter
- I am staying in a hotel
- I am living outside
- I am living in a car
- I am living elsewhere
- Prefer not to answer
- Not Listed (feel free to specify)

14. Select up to 5 concerns that you see or hear about where you live.
- Need for childcare
- Need for healthcare (e.g. doctors, hospitals, specialists, mental healthcare, dental/oral care, vision care, medical appointments, health insurance coverage, health literacy, etc.)
- Bad things that happen in childhood (e.g. abuse of children, mental health, family issues, trauma, etc.)
- Serious and life-long diseases (e.g. cancer, heart disease, diabetes, etc.)
- Crime and violence (e.g. abuse from spouse, sexual abuse, abuse of children)
- Education (e.g. school for children, school for adults, etc.)
- Environmental conditions (e.g. air and water quality, vector-borne diseases, etc.)
- Help to find or pay for food
- HIV/AIDS and Sexually Transmitted Infections (STIs)
- Help with finding housing or to pay for housing
- Income/poverty and employment
- Injuries (workplace injuries, car accidents, falls, etc.)
- Need for internet/Wi-Fi
- Maternal, infant and child health (e.g. pre-term births, infant mortality, maternal morbidity and mortality)
- Mental health (e.g. depression, anxiety, suicide, etc.)
- Nutrition and physical health/exercise (includes overweight and obesity)
- Help with men and women health problems
- Help because of drugs and/or alcohol
- Tobacco and nicotine use/smoking/vaping
- Transportation (e.g. public transit, cars, cycling, walking)
- Not Listed (feel free to specify)

15. Why don't you have medical insurance? (select all that apply)
- I am waiting to get medical insurance through my job
- I don't think I need medical insurance, I'm healthy
- I haven't had time to deal with it
- I can't pay for it
- I am not eligible or do not qualify
- I don't understand what it is or why I need it
- Does not apply - I have medical insurance
- Not Listed (feel free to specify)

16. Why do you feel you are not able to see a doctor? (select all that apply)
- Could not get an appointment quickly or had to wait too long
- My schedule is not good for the times to see the doctor
- I do not trust the doctor - I am afraid
- I am afraid the doctor will not be good to me because of who I am
- The doctor does not speak my language
- I do not have medical insurance
- I do not have money to pay for the doctor
- I do not know where to go or who to ask to find a doctor
- Technology barriers with virtual visits/telehealth services
- Not having a provider who understands and/or respects my cultural or religious beliefs
- No transportation to the doctor
- The doctor is too far away
- I had no problems going to see my doctor
- I could not find a doctor that takes Medicaid (Molina, Anthem, Caritas, CareSource, Buckeye, Humana, United Healthcare)
- Not Listed (feel free to specify)

17. Where do you and your family go to see the doctor to get medical help? (select all that apply)
- Doctor's office
- Emergency room department at the hospital
- Urgent care clinic
- Health department
- I wouldn't go to a doctor unless it was an emergency
- Not sure
- None of the above
- Not Listed (feel free to specify)

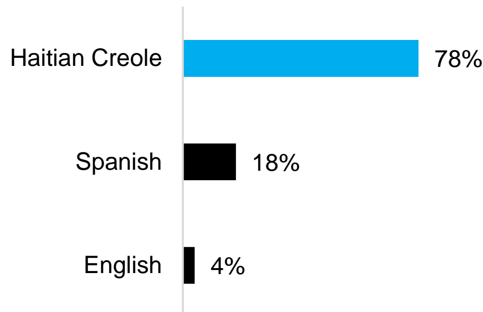
18. Would you like to have information or programs to help you be more healthy? If yes, select which topics you are interested in learning more about (select all that apply)
- Stress management
- Time management
- Where the local fitness gyms are and how to sign up
- How to eat healthy when you have limited income
- How to keep my kids healthy
- Where to go to the doctor
- None of the above
- Not Listed (feel free to specify)

19. What do you need help with? (select all that apply)
- Affordable food
- Affordable housing
- Childcare/school for my children
- Need for better dental/oral health
- Hospital/acute and emergency healthcare
- Maternal, infant, and child healthcare (e.g. OB/GYN, midwives, doulas, pediatricians, etc.)
- Better mental health
- Need for doctor
- Places to take my family (e.g. parks, walking paths, community centers, gyms/workout facilities, etc.)
- Specialist healthcare (e.g. oncologist/cancer care, cardiologist/heart care, nephrologist/kidney care, physical therapy, dietitian, etc.)
- Treatment for alcohol or drug abuse
- Transportation
- Need for eye exam or eye glasses
- I don't need help
- Not Listed (feel free to specify)

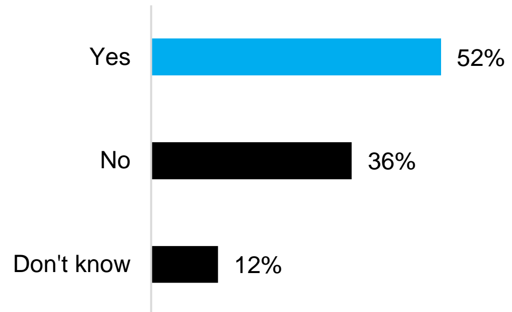
20. Do you have any other feedback or comments to share with us?

APPENDIX E:
SHORTENED COMMUNITY MEMBER SURVEY DEMOGRAPHICS

The majority of respondents completed the survey in **Haitian Creole**

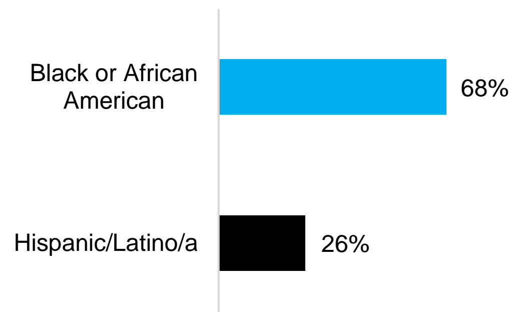


The majority of respondents live **within walking distance of the University of Findlay** (an approximation of the 9.01 and 9.02 census tracts, which were found to experience the greatest health disparities in the Hancock County 2021 Health Equity Report)



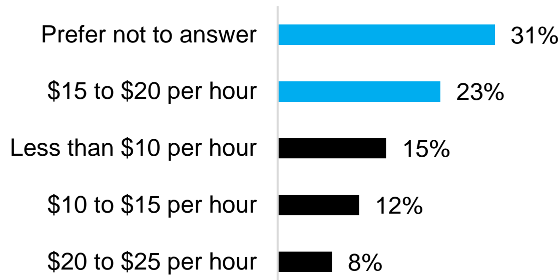
An **equal** number of men and women responded to the survey

The majority of respondents were **Black or African American**, with some Hispanic/Latino/a representation

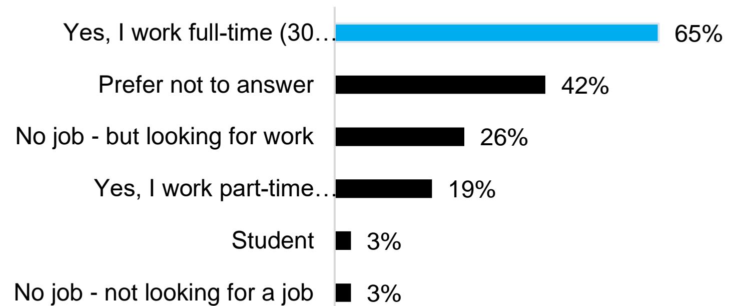


APPENDIX E:
SHORTENED COMMUNITY MEMBER SURVEY DEMOGRAPHICS

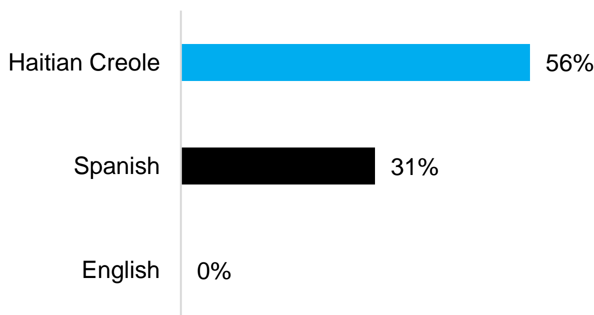
Respondents were generally **lower-income**



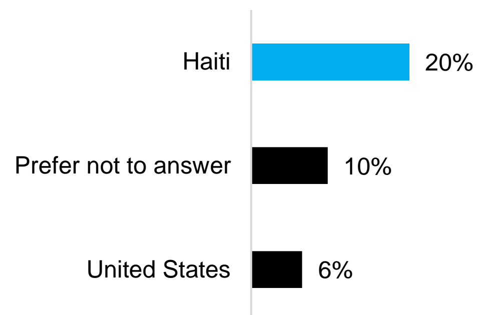
The majority of respondents are **employed full-time**



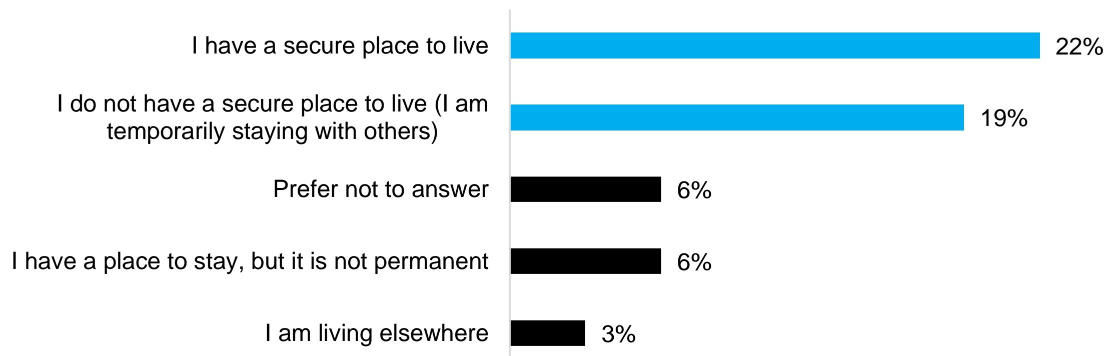
Most respondents reported that their native language was **Haitian Creole**, followed by Spanish



The most common country where participants were born is **Haiti**

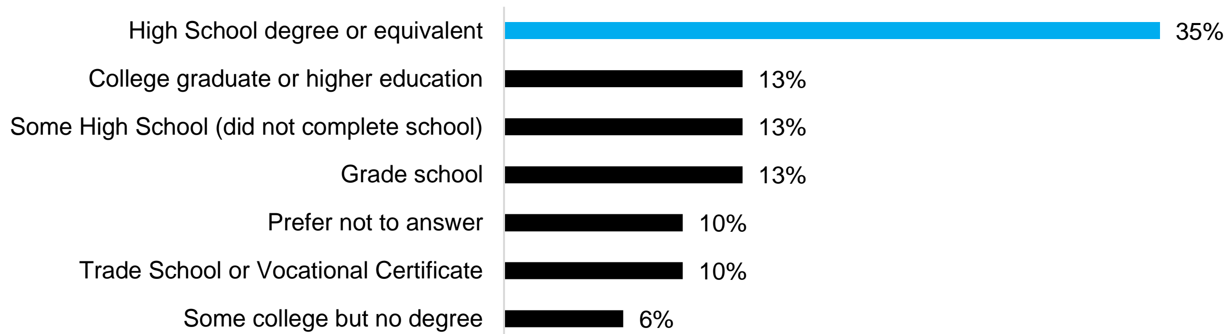


Some respondents have a **steady place to live**; however, there is a significant portion who are temporarily staying with others

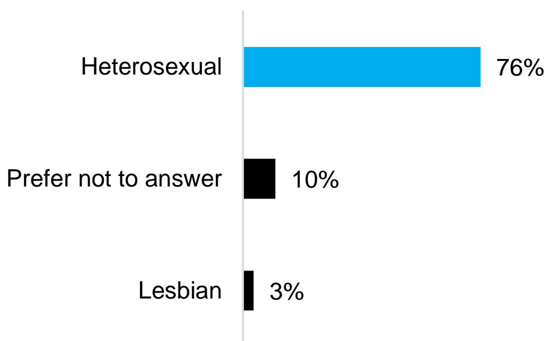


APPENDIX E:
SHORTENED COMMUNITY MEMBER SURVEY DEMOGRAPHICS

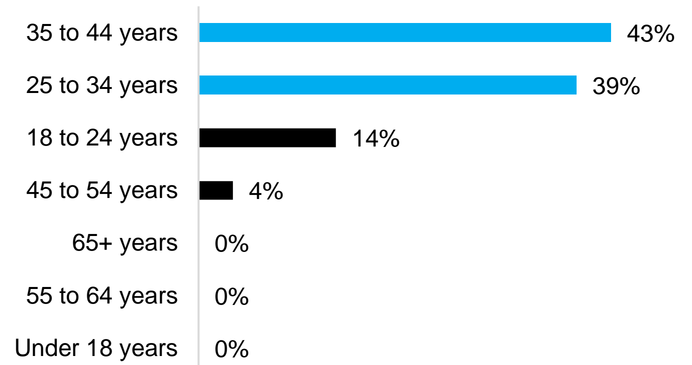
The most common level of education for respondents is a **high school degree or equivalent**



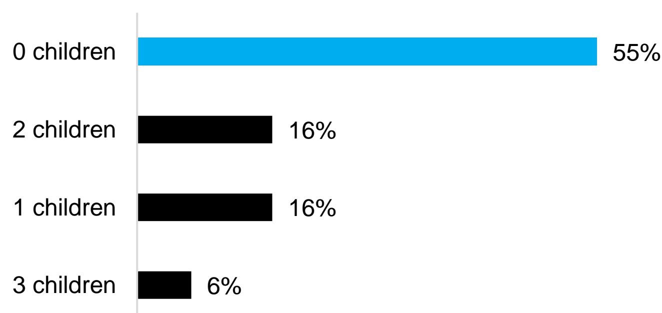
The majority of respondents reported their sexual orientation as **heterosexual or straight**



There was a greater proportion of survey responses from **younger** age groups



Most respondents reported having **no children at home**



APPENDIX F

PUBLIC HEALTH ACCREDITATION BOARD (PHAB) CHECKLIST: COMMUNITY HEALTH ASSESSMENT

MEETING THE PHAB REQUIREMENTS FOR COMMUNITY HEALTH NEEDS ASSESSMENT

The Public Health Accreditation Board (PHAB) Standards & Measures serves as the official guidance for PHAB national public health department accreditation, and includes requirements for the completion of Community Health Assessments (CHAs) for local health departments. The following page demonstrates how this CHA meets the PHAB requirements.

APPENDIX F:

PHAB CHA REQUIREMENTS CHECKLIST

PUBLIC HEALTH ACCREDITATION BOARD REQUIREMENTS FOR COMMUNITY HEALTH ASSESSMENTS			
YES	**PAGE #**	**PHAB REQUIREMENTS CHECKLIST**	**NOTES/ RECOMMENDATIONS**
✓	4	a. A list of participating partners involved in the CHA process. Participation must include: i. At least 2 organizations representing sectors other than governmental public health. ii. At least 2 community members or organizations that represent populations who are disproportionately affected by conditions that contribute to poorer health outcomes.	Integrated throughout the report Community member survey included a question that asked respondents to select their top 5 community health needs and rate the importance of addressing each health need.
✓	5–26	b. The process for how partners collaborated in developing the CHA.	
✓	13, 19-72	c. Comprehensive, broad-based data. Data must include: i. Primary data. ii. Secondary data from two or more different sources.	Primary and secondary data is integrated together throughout the report
✓	13	d. A description of the demographics of the population served by the health department, which must, at minimum, include: i. The percent of the population by race and ethnicity. ii. Languages spoken within the jurisdiction. iii. Other demographic characteristics, as appropriate for the jurisdiction.	
✓	19-72	e. A description of health challenges experienced by the population served by the health department, based on data listed in required element (c) above, which must include an examination of disparities between subpopulations or sub-geographic areas in terms of each of the following: i. Health status ii. Health behaviors.	Integrated throughout the report. Health disparities and potential priority populations are listed clearly for EACH health need.
✓	19-72	f. A description of inequities in the factors that contribute to health challenges (required element e), which must, include social determinants of health or built environment.	Integrated throughout the report. Health disparities and potential priority populations are listed clearly for EACH health need.
✓	71-72	g. Community assets or resources beyond healthcare and the health department that can be mobilized to address health challenges. The CHNA (or CHA) must address the jurisdiction as described in the description of Standard 1.1.	

APPENDIX G

INTERNAL REVENUE SERVICE (IRS) CHECKLIST: COMMUNITY HEALTH NEEDS ASSESSMENT

MEETING THE IRS REQUIREMENTS FOR COMMUNITY HEALTH NEEDS ASSESSMENT

The Internal Revenue Service (IRS) requirements for a Community Health Needs Assessment (CHNA) serve as the official guidance for IRS compliance. The following pages demonstrate how this CHA meets those IRS requirements.

APPENDIX G:

IRS CHNA REQUIREMENTS CHECKLIST

INTERNAL REVENUE SERVICE REQUIREMENTS FOR COMMUNITY HEALTH NEEDS ASSESSMENTS				
YES	**PAGE #**	**IRS REQUIREMENTS CHECKLIST**	**REGULATION SUBSECTION NUMBER**	**NOTES/ RECOMMENDATIONS**
✓	Appendix A (77-80)	**A. Activities Since Previous CHNA(s)** i. Describes the written comments received on the hospital's most recently conducted CHNA and most recently adopted implementation strategy. ii. Describes an evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).	(b)(5)(C) (b)(6)(F)	
✓	3-26	**B. Process and Methods**		
		Background Information		
		i. Identifies any parties with whom the facility collaborated in preparing the CHNA(s).	b)(6)(F)(ii)	
		ii. Identifies any third parties contracted to assist in conducting a CHNA.	(b)(6)(F)(ii)	
		iii. Defines the community it serves, which:		
		a. Must take into account all patients without regard to whether (or how much) they or their insurers pay for care or whether they are eligible for assistance.	(b)(i)	
		b. May take into account all relevant circumstances including the geographic area served by the hospital, target population(s), and principal functions.	(b)(3)	
		c. May not exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital draws its patients.	(b)(6)(i)(A)	
		iv. Describes how the community was determined.	(b)(6)(i)(A)	
		v. Describes demographics and other descriptors of the hospital service area.	(b)(6)(i)(A)	

APPENDIX G:

IRS CHNA REQUIREMENTS CHECKLIST

INTERNAL REVENUE SERVICE REQUIREMENTS FOR COMMUNITY HEALTH NEEDS ASSESSMENTS				
YES	**PAGE #**	**IRS REQUIREMENTS CHECKLIST**	**REGULATION SUBSECTION NUMBER**	**NOTES/ RECOMMENDATIONS**
✓	Methods: 3-26, Appendix B, C, D, E Data: 13, 19-72	*Health Needs Data Collection* i. Describes data and other information used in the assessment:	(b)(6)(ii)	Primary and secondary data is integrated together throughout the report
		a. Cites external source material (rather than describe the method of collecting the data).	(b)(6)(F)(ii)	
		b. Describes methods of collecting and analyzing the data and information.	(b)(6)(ii)	
		i. CHNA describes how it took into account input from persons who represent the broad interests of the community it serves in order to identify and prioritize health needs and identify resources potentially available to address those health needs.	(b)(1)(iii)	
		ii. Describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provide input.	(b)(5)(i)	
		a. At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) or a State Office of Rural Health. b. Members of the following populations, or individuals serving or representing the interests of populations listed below. (Report includes the names of any organizations - names or other identifiers not required.)	(b)(6)(F)(iii) (b)(6)(F)(iii)	
		1. Medically underserved populations 2. Low-income populations 3. Minority populations		
		c. Additional sources (optional) – (e.g. healthcare consumers, advocates, nonprofit and community-based organizations, elected officials, school districts, healthcare providers and community health centers).	(b)(5)(i)(A)	
		iii. Describes how such input was provided (e.g., through focus groups, interviews or surveys).	(b)(5)(i)(B)	
		iv. Describes over what time period such input was provided and between what approximate dates.	(b)(5)(ii)	
		v. Summarizes the nature and extent of the organizations' input.	(b)(6)(F)(iii)	

APPENDIX G:

IRS CHNA REQUIREMENTS CHECKLIST

INTERNAL REVENUE SERVICE REQUIREMENTS FOR COMMUNITY HEALTH NEEDS ASSESSMENTS				
YES	**PAGE #**	**IRS REQUIREMENTS CHECKLIST**	**REGULATION SUBSECTION NUMBER**	**NOTES/ RECOMMENDATIONS**
✓		**C. CHNA Needs Description & Prioritization**		Integrated throughout the report
	5-26	i. Health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities). ii. Prioritized description of significant health needs identified.	(b)(4) (b)(6)(i)(D)	Community member survey included a question that asked respondents to select their top community health needs and rate the importance of addressing each health need.
		iii. Description of process and criteria used to identify certain health needs as significant and prioritizing those significant health needs.	(b)(6)(i)(D)	
	71-72	iv. Description of the resources potentially available to address the significant health needs (such as organizations, facilities, and programs in the community, including those of the hospital facility.	(b)(4) (b)(6)(E)	
✓		**D. Finalizing the CHNA**		Integrated throughout the report The CHA was adopted by Be Healthy Now Hancock County (BHNHC) leadership in January 2025 and made widely available by posting on the health department and hospital websites (report will be made available in other formats such as paper upon request): Hancock Public Health: https://www.hancockph.com/reports-and-data Blanchard Valley Health System: https://www.bvhealthsystem.org/about-bvhs/community-benefit
		i. CHNA is conducted in such taxable year or in either of the two taxable years immediately preceding such taxable year.	(a)1	
		ii. CHNA is a written report that is adopted for the hospital facility by an authorized body of the hospital facility (authorized body defined in §1.501(r)-1(b)(4)).	(b)(iv)	
		iii. Final, complete, and current CHNA report has been made widely available to the public until the subsequent two CHNAs are made widely available to the public. “Widely available on a web site” is defined in §1.501(r)- 1(b)(29).	(b)(7)(i)(A)	
		a. May not be a copy marked “Draft.”	(b)(7)(ii)	
		b. Posted conspicuously on website (either the hospital facility’s website or a conspicuously located link to a website established by another entity).	(b)(7)(i)(A)	
		c. Instructions for accessing CHNA report are clear.	(b)(7)(i)(A)	
		d. Individuals with Internet access can access and print reports without special software, without payment of a fee, and without creating an account.	(b)(7)(i)(A)	
		e. Individuals requesting a copy of the report(s) are provided the URL.	(b)(7)(i)(A)	
		f. Makes a paper copy available for public inspection upon request and without charge at the hospital facility.	(b)(7)(i)(B)	

APPENDIX H

REFERENCES

APPENDIX H: REFERENCES

The following reference list provides the sources for the secondary data that was collected for the Community Health Assessment (CHA) in Fall 2024. The most up-to-date data available at the time was collected and included in the CHA report. Please refer to individual sources for more information on years and methodology.

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APPENDIX H:
REFERENCES

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