

DELIVERED BY:



2026-2028 WOOD COUNTY IMPLEMENTATION STRATEGY/ COMMUNITY HEALTH IMPROVEMENT PLAN

PUBLISHED NOVEMBER 2025



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A NOTE FROM THE WOOD COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) STEERING COMMITTEE



The Wood County CHNA Steering Committee 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 community's needs and prioritizing those needs for impact. In 2025, the Wood County CHNA Steering Committee partnered with Moxley Public Health and community-based organizations to conduct a comprehensive Community Health Needs Assessment (CHNA) to identify priority health issues and evaluate the overall current health status of the health department and hospitals' service area. These findings were then used to develop an Implementation Strategy (IS)/Improvement Plan (CHIP) to describe the response to the needs identified in the CHNA report.

The 2026-2028 Wood County IS/CHIP would not have been possible without the help of numerous Wood County organizations, acknowledged on the following pages. It is vital that assessments such as this continue, so partners know where to direct resources and how to use them in the most advantageous ways.

The goals of public health can only be accomplished through community members' commitment to themselves and to each other. The Wood County CHNA Steering Committee believes that together, Wood County can be a thriving community of health and well-being at home, work, school, and play.

Importantly, this report could not exist without the contributions of individuals in the community who participated in interviews and completed the community member survey. The Wood County CHNA Steering Committee is grateful for those individuals who are committed to the health of the community, and took the time to share their health concerns, needs, behaviors, praises, and suggestions for future improvement.

Sincerely,

Benjamin Robison
Health Commissioner
Wood County Health Department

Stanley Korducki
President
Wood County Hospital

Alison Avendt
President
Mercy Health—Perrysburg Hospital

ACKNOWLEDGMENTS



This IS/CHIP was made possible thanks to the collaborative efforts of the Wood County CHNA Steering Committee, 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.

The Wood County CHNA Steering Committee would like to recognize the following organizations for their contributions to this report:

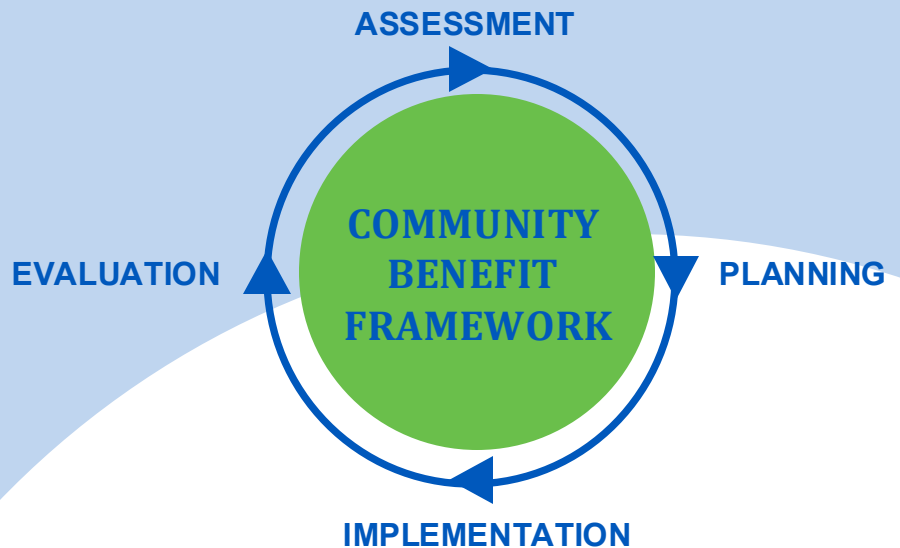
Bowling Green Chamber of Commerce
Bowling Green State University
City of Bowling Green
Great Lakes Community Action Partnership
La Conexión
Mercy Health—Perrysburg Hospital
Middleton Township Emergency Medical
Services (EMS)
National Alliance on Mental Illness (NAMI) -
Wood County
North Baltimore Chamber of Commerce
North Baltimore Local Schools
Ohio State University Extension Office
Perrysburg Chamber of Commerce
Perrysburg Heights Community Center

The Cocoon
Unison Health
Wood County Area Ministries
Wood County Board of County Commissioners
Wood County Board of Developmental Disabilities
Wood County Committee on Aging
Wood County Educational Service Center
Wood County Emergency Management Agency
Wood County Health Department
Wood County Hospital
Wood County Job and Family Services
Wood County Planning Commission
Wood County Safety Council
Wood County Sheriff's Office
Wood County Veterans Service Office



INTRODUCTION

WHAT IS AN IMPLEMENTATION STRATEGY (IS)/ IMPROVEMENT PLAN (CHIP)?



An **Implementation Strategy (IS)/Community Health Improvement Plan (CHIP)** is part of a framework that is used to guide community benefit activities, policy, advocacy, and program-planning efforts. For health departments, the Community Health Improvement Plan (CHIP) fulfills the mandates of the Public Health Accreditation Board (PHAB). For hospitals, the Implementation Strategy describes their plan to respond to the needs identified through the previous Community Health Needs Assessment (CHNA) process. It also fulfills a requirement mandated by the Internal Revenue Service (IRS) in Section 1.501(r)(3).

OVERVIEW OF THE PROCESS



In order to develop an IS/CHIP, the Wood County CHNA Steering Committee followed a process that included the following steps:

STEP 1: Plan and prepare for the IS/CHIP.

STEP 2: Develop goals/objectives and identify indicators to address health needs.

STEP 3: Consider approaches/strategies to address prioritized needs, health disparities, and social determinants of health.

STEP 4: Select approaches with community partners.

STEP 5: Integrate IS/CHIP with community partner, health department, and hospital plans.

STEP 6: Develop a written IS/CHIP.

STEP 7: Adopt the IS/CHIP.

STEP 8: Update and sustain the IS/CHIP.

Within each step of this process, the guidelines and requirements of both the state and federal governments are followed precisely and systematically.

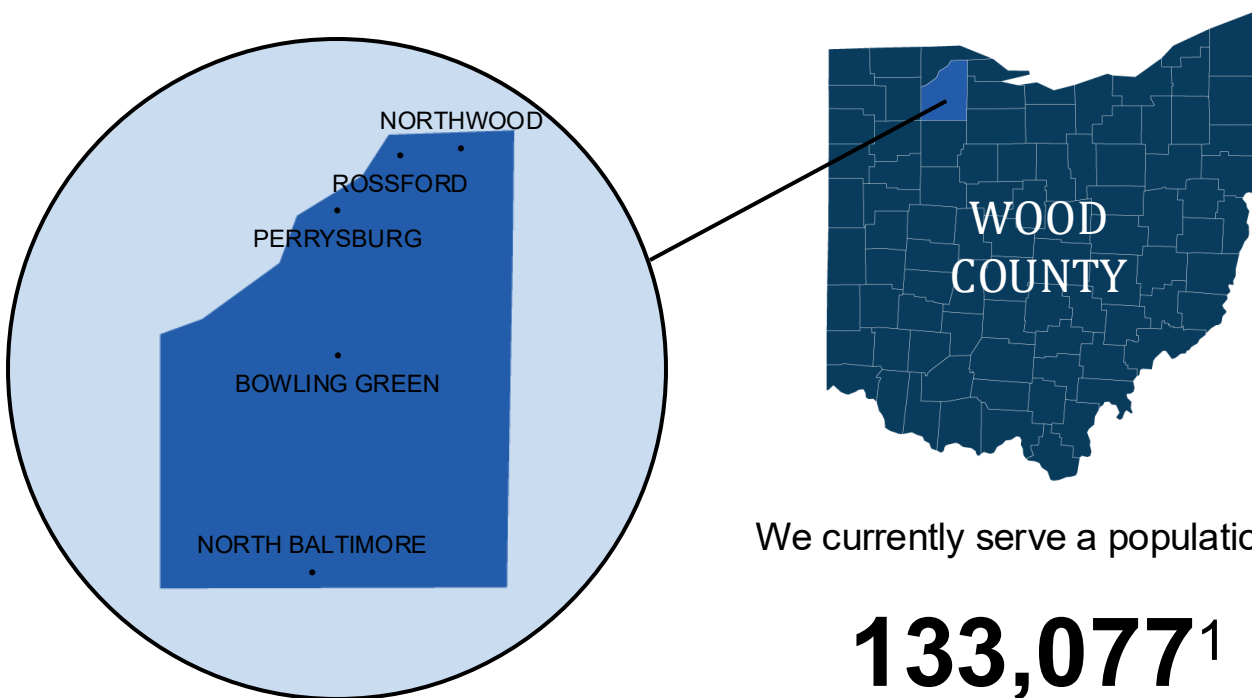
The 2026-2028 Wood County IS/CHIP meets all IRS and Public Health Accreditation Board (PHAB) regulations.



DEFINING THE WOOD COUNTY SERVICE AREA



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



We currently serve a population of

133,077¹

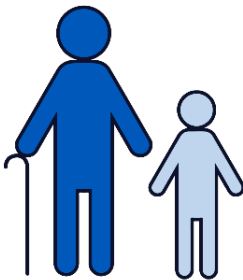
WOOD COUNTY



WOOD COUNTY AT-A-GLANCE



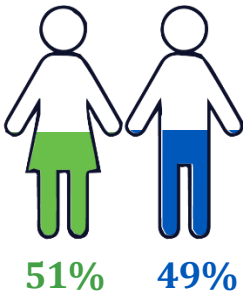
The life expectancy in Wood County of **77.4 years** is **2.2 years longer** than it is for the state of Ohio.²



Youth ages 0-18 and seniors 65+ make up **37% of the population** (vs. **40%** for Ohio).

In the Wood County service area, nearly **1 in 6 residents are ages 65+.**³

51% of both Wood County and Ohio residents are **women.**³



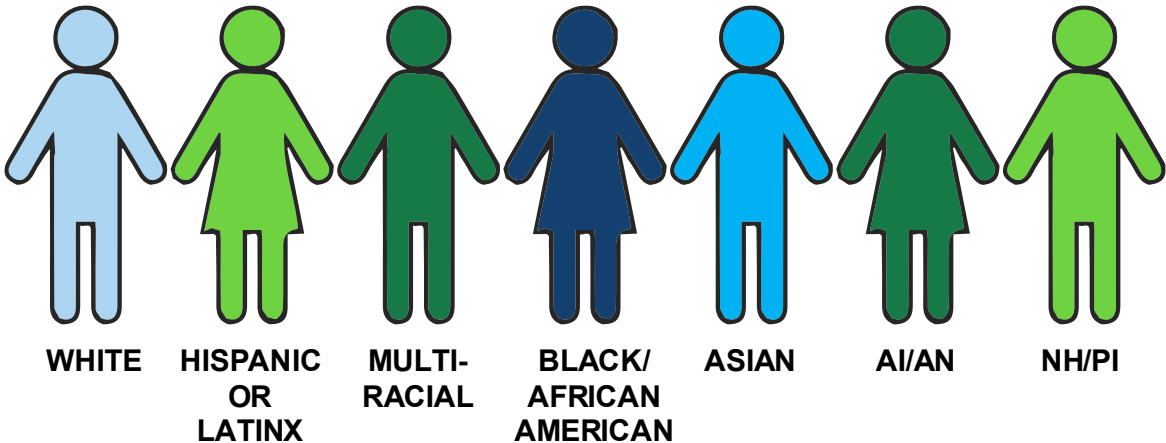
6%

of Wood County residents are **veterans**, vs. 7% for Ohio.⁴

3% of Wood County's population is **foreign-born** (vs. **5%** for Ohio), while **5%** of Wood County residents **do not speak English as their first language** (vs. **8%** for Ohio).⁴



There is a **higher proportion of White residents and Hispanic/Latinx residents** in Wood County than in the state of Ohio.³



	WHITE	HISPANIC OR LATINX	MULTI-RACIAL	BLACK/ AFRICAN AMERICAN	ASIAN	AI/AN	NH/PI
WOOD	86%	6%	3%	2%	2%	0.1%	0.1%
OHIO	77%	5%	4%	12%	2%	0.1%	0%

STEP 1

PLAN AND PREPARE FOR THE IMPLEMENTATION STRATEGY/ IMPROVEMENT PLAN



In this step, the Wood County CHNA Steering Committee:

- ✓ Determined who would participate in the development of the IS/CHIP
- ✓ Engaged board and executive leadership
- ✓ Reviewed the Community Health Needs Assessment



PLAN AND PREPARE

Secondary and primary data were collected to complete the 2025 Wood County Community Health Needs Assessment (available at: <https://woodcountyhealth.org/home/reports-publications/>, <https://www.woodcountyhospital.org/about-us/community-programs> & <https://www.mercy.com/about-us/mission/giving-back/community-health-needs-assessment>). Secondary data were collected from a variety of local, county, and state sources to present community demographics, social determinants of health, healthcare access, birth characteristics, leading causes of death, chronic disease, health behaviors, mental health, substance use, and preventive practices. The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection.

Primary data were collected through key informant interviews with **22** experts from various organizations serving Wood County, and included leaders and representatives of medically underserved, low-income, and minority populations, or local health or other departments or agencies. A community member survey was distributed via a QR code and link, with **589** responses. The survey responses (from community members) were used to prioritize the health needs, answer in-depth questions about the health needs in the county, and identify health disparities present in the community. Finally, there was **1** focus group held in Wood County, representing a total of **8** community members from priority populations. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets potentially available to address needs, and prioritize health needs. More details on methodology can be found in the 2025 Wood County Community Health Needs Assessment.

“

A community health assessment and improvement planning process involves an ongoing collaborative, community-wide effort to identify, analyze, and address health problems.

- Public Health Accreditation Board (PHAB)

”

STEP 2

DEVELOP GOALS AND OBJECTIVES AND IDENTIFY INDICATORS FOR ADDRESSING COMMUNITY HEALTH NEEDS



In this step, the Wood County CHNA Steering Committee:

- ✓ Developed goals for the IS/CHIP based on the findings from the Community Health Needs Assessment
- ✓ Selected indicators to achieve goals

OVERVIEW OF THE PROCESS



Ohio Department of Health (ODH) Framework

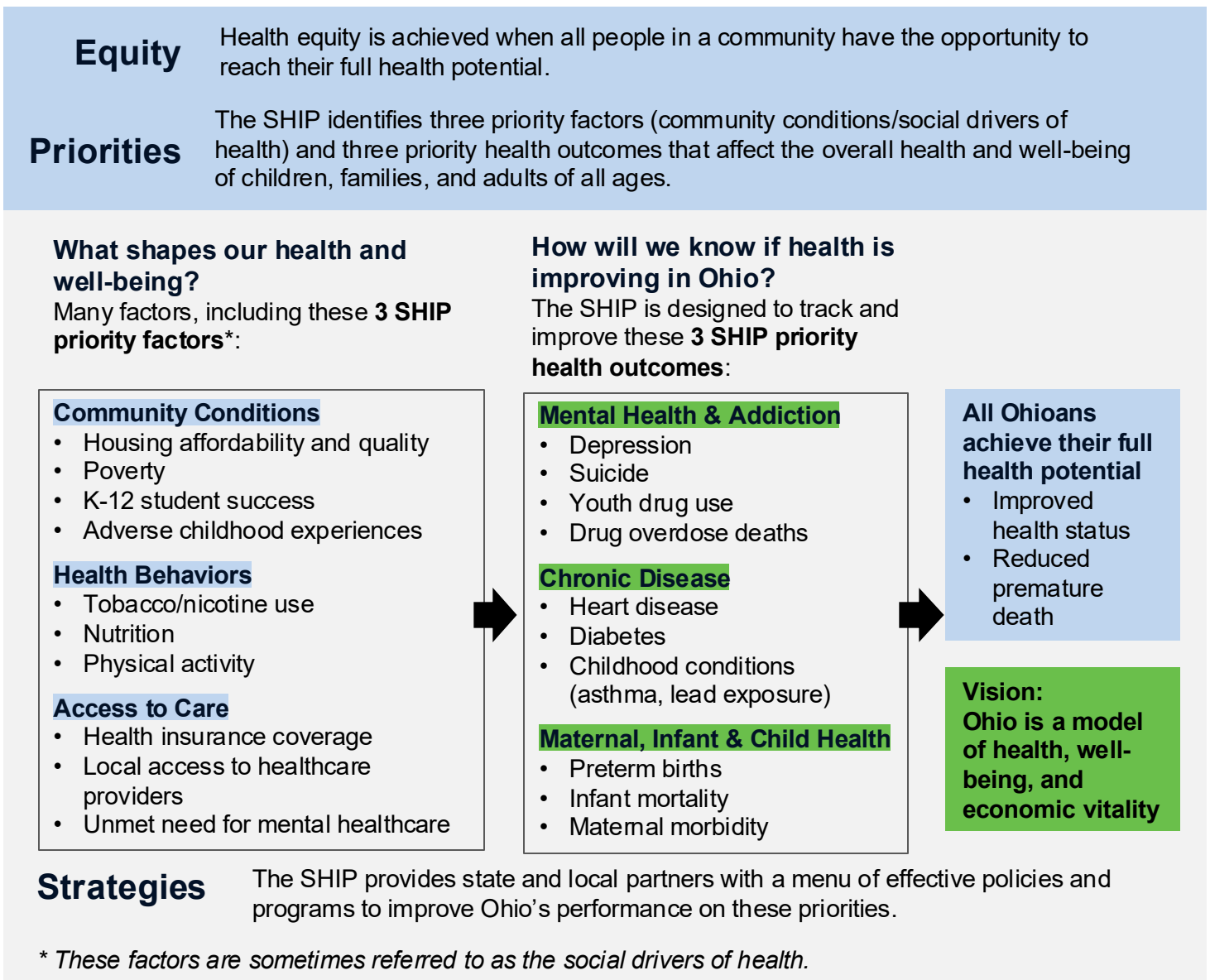
The following image shows the framework from ODH that this report followed while also adhering to federal requirements and the community's needs.

The Wood County CHNA Steering Committee desired to align with the priorities and indicators of ODH. To do this, they used the following guidelines when prioritizing the health needs of their community.

The Steering Committee used the same language as the state of Ohio when assessing the factors and health outcomes of their community in the 2025 Wood County CHNA.

To align with the Ohio Department of Health's initiative to improve health, well-being, and economic vitality, the Wood County CHNA Steering Committee included the state's priority factors and health outcomes when assessing the community.

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



Next, with the data findings from the community health needs assessment process, the Wood County CHNA Steering Committee used the following guidelines/worksheet to choose priority social drivers of health and priority health outcomes (worksheet/guidelines continued to next page).

ALIGNMENT WITH PRIORITIES & INDICATORS

STEP 1: Identify priority social drivers of health and health outcomes.

PRIORITY SOCIAL DRIVERS OF HEALTH	PRIORITY HEALTH OUTCOMES
☒ Community Conditions	☒ Mental Health & Addiction
☒ Health Behaviors	☒ Chronic Disease
☒ Access to Care	☒ Maternal & Infant Health

STEP 2: Check the indicators that are being addressed for each identified priority social driver of health.

PRIORITY SOCIAL DRIVERS OF HEALTH	
COMMUNITY CONDITIONS	
TOPIC	INDICATOR NAME
Housing Affordability & Quality	☒ Affordable & Available Housing
Poverty	☒ Child Poverty
	☒ Adult Poverty
K-12 Student Success	☐ Chronic Absenteeism (K-12 students)
	☐ Kindergarten Readiness
Adverse Childhood Experiences	☒ Adverse Childhood Experiences (ACEs)
	☐ Child Abuse & Neglects
Food Insecurity	☒ Food Insecurity
Environmental Conditions	☐ Air Quality
	☐ Water Quality
HEALTH BEHAVIORS	
TOPIC	INDICATOR NAME
Tobacco & Nicotine Use	☐ Adult Smoking
	☐ Youth All-Tobacco/Nicotine Use
Nutrition	☒ Fruit Consumption
	☒ Vegetable Consumption
Physical Activity	☒ Child Physical Activity
	☒ Adult Physical Activity
ACCESS TO CARE	
TOPIC	INDICATOR NAME
Health Insurance Coverage	☒ Uninsured Adults
	☒ Uninsured Children
Local Access to Healthcare	☐ Primary Care Health Professional Shortage Areas
	☐ Mental Health Professional Shortage Areas
Unmet Need for Mental Healthcare	☒ Youth Depression Treatment Unmet Need
	☒ Adult Mental Healthcare Unmet Need

ALIGNMENT WITH PRIORITIES & INDICATORS (continued)

STEP 3: Check the indicators that are being addressed for each identified priority health outcome.

PRIORITY HEALTH OUTCOMES	
MENTAL HEALTH & ADDICTION	
TOPIC	INDICATOR NAME
Depression	☒ Youth Depression
	☒ Adult Depression
Suicide Deaths	☒ Youth Suicide Deaths
	☒ Adult Suicide Deaths
Youth Drug Use	☒ Youth Alcohol Use
	☒ Youth Marijuana Use
Drug Overdose Deaths	☐ Unintentional Drug Overdose Deaths
CHRONIC DISEASE	
TOPIC	INDICATOR NAME
Heart Disease	☒ Coronary Heart Disease
	☒ Premature Death – Heart Disease
	☒ Hypertension
Diabetes	☒ Diabetes
Harmful Childhood Conditions	☐ Child Asthma Morbidity
	☐ Child Lead Poisoning
MATERNAL & INFANT HEALTH	
TOPIC	INDICATOR NAME
Preterm Births	☒ Preterm Births
Infant Mortality	☒ Infant Mortality
Maternal Morbidity/Mortality	☐ Severe Maternal Morbidity/Mortality

ADDRESSING THE HEALTH NEEDS



The 2025 Community Health Needs Assessment (CHNA) identified the following significant health needs from an extensive review of the primary (community survey, interviews, and focus group) and secondary data (existing data). The significant health needs were ranked as follows through the community member survey (589 responses from community members).

COMMUNITY CONDITIONS RANKING FROM COMMUNITY MEMBER SURVEY	
#1 Access to healthcare	41%
#2 Nutrition & physical health/exercise	37%
#3 Transportation	36%
#4 Income/poverty	35%
#5 Adverse childhood experiences (ACEs)	34%
#6 Food insecurity	34%
#7 Access to childcare	31%
#8 Substance use	30%
#9 Education	25%
#10 Community engagement	25%
#11 Housing & homelessness	21%
#12 Employment/work	21%
#13 Preventive care & practices	20%
#14 Tobacco and nicotine use/smoking/vaping	18%
#15 Environmental conditions	14%
#16 Crime & violence	12%
#17 Internet/Wi-Fi access	10%
#18 Addiction to gambling, gaming, or sports betting	6%

HEALTH OUTCOMES RANKING FROM COMMUNITY MEMBER SURVEY	
#1 Mental health	89%
#2 Chronic diseases	75%
#3 Disabilities	40%
#4 Infectious diseases	33%
#5 Maternal, infant, and child health	22%
#6 Injuries	17%
#7 HIV/AIDS and Sexually Transmitted Infections (STIs)	6%

PRIORITY HEALTH NEEDS FOR WOOD COUNTY



From the significant health needs, the Wood County CHNA Steering Committee chose health needs that considered the health department, hospitals, and community partners' capacity to address community needs, the strength of community partnerships, and those needs that correspond with the health department, hospitals, and community partners' priorities. **The four priority health needs that will be addressed in the 2026-2028 Implementation Strategy (IS)/Improvement Plan (CHIP) are:**

1

COMMUNITY CONDITIONS



- **40%** of community survey respondents said that **transportation is lacking** in Wood County.
- **14%** of Wood County residents experience **food insecurity**.⁵
- **Affordable housing** was the **#1 reported resource needed** in Wood County in the community survey.

2

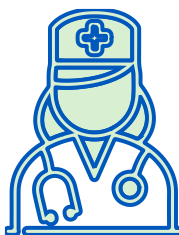
CHRONIC DISEASE



- Heart disease is the **leading cause of death** in Wood County.⁶
- **64%** of community survey respondents reported having **at least one chronic health condition or disability**.

3

ACCESS TO HEALTHCARE



- **18%** of community survey respondents have **delayed or gone without medical care** due to being unable to get an appointment.
- **22%** of Wood County adults **did not have a routine checkup in the prior year**, compared to 23% of Ohio adults.^{7, 8}

4

BEHAVIORAL HEALTH



- **45%** of survey respondents reported **experiencing barriers to accessing needed mental, behavioral health, or substance use counseling**.
- **21%** of both Wood County and Ohio adults report engaging in **binge or heavy drinking**.²
- **34%** of survey respondents said that **Adverse Childhood Experiences (ACEs)** are a **top community concern**.

STEPS 3 & 4

CONSIDER AND SELECT APPROACHES/STRATEGIES TO ADDRESS PRIORITIZED NEEDS, HEALTH DISPARITIES, AND SOCIAL DETERMINANTS OF HEALTH WITH COMMUNITY PARTNERS



In this step, the Wood County CHNA Steering Committee:

- ✓ Selected approaches/ strategies to address the Wood County prioritized health needs, health disparities, and social determinants of health
- ✓ Developed a written IS/CHIP report

#1 Priority Area: COMMUNITY CONDITIONS

Includes transportation, housing, food insecurity, and income/poverty & employment.



STRATEGIES

By 2028, increase accessible transportation service providers, improve walkability, and support Mobile Health Center access throughout Wood County to reduce transportation barriers.

By 2028, support No Wrong Door growth & expansion to all areas and sectors of the county.

By 2028, increase accessible and affordable housing as well as access to existing services throughout Wood County.

By 2028, reduce the number of Wood County households reporting food insecurity by increasing equitable access to affordable, nutritious foods and nutrition-supportive programs.

PARTNERS

Wood County Hospital, Wood County Health Department, Cocoon, Wood County Planning, North Baltimore Area Chamber of Commerce

Wood County Hospital, Wood County Health Department, Community Partners Group

Wood County Housing & Homelessness Coalition, Wood County Planning, Wood County Health Department

Bowling Green Ministerial Association, Wood County Hospital

PRIORITY POPULATIONS

Rural communities, Bowling Green, low-income population, Hispanic/Latinx residents, residents age 65+

25–34-year-olds, Bowling Green, Perrysburg Heights, minority communities, low-income population, residents with a high school degree/equivalent

Low-income population, students, older adults, those with developmental disabilities, women

25–34-year-olds, rural communities, low-income population, older adults



DESIRED OUTCOMES OF STRATEGIES



Transportation



Access to and knowledge of community resources



Access to affordable and available housing



Access to affordable, healthy food



OVERALL IMPACT OF STRATEGIES



Health status



Quality of life



Homelessness and precarious housing



Food insecurity



**ALL WOOD COUNTY SERVICE AREA RESIDENTS
ACHIEVE THEIR FULL HEALTH POTENTIAL**

#2 Priority Area: CHRONIC DISEASE

Includes health behaviors, preventive care, and nutrition & physical health.



STRATEGIES

By April 1, 2026, build a budget that identifies goals to support chronic disease programs across the county.

By January 1, 2027, enhance community-based health screening programs to improve the identification and management of chronic conditions.

By December 1, 2027, identify educational resources, toolkits, and programs to support the prevention and management of chronic disease, including post-screening, future steps, prevention, and connection to healthcare.

PARTNERS

Mercy Health—Perrysburg Hospital, Bowling Green State University, Wood County Hospital, Wood County Health Department

Mercy Health—Perrysburg Hospital, Bowling Green State University, Wood County Hospital, Wood County Health Department, Wood County Committee on Aging

Mercy Health—Perrysburg Hospital, Bowling Green State University, Wood County Hospital, Wood County Health Department, Wood County Committee on Aging

PRIORITY POPULATIONS

People with chronic conditions, those at high risk for developing chronic conditions

People with chronic conditions, those at high risk for developing chronic conditions, residents with transportation challenges

People with chronic conditions, those at high risk for developing chronic conditions, school-age youth, low-income families, older adults



DESIRED OUTCOMES OF STRATEGIES



Education on chronic diseases & risk factors



Chronic disease prevention, screening & management



Nutrition, including fruit & vegetable consumption



Sedentary youth and adults



OVERALL IMPACT OF STRATEGIES



Access to primary care



Quality of life



Physical health



Overweight and obesity



Chronic disease



Premature mortality



**ALL WOOD COUNTY SERVICE AREA RESIDENTS
ACHIEVE THEIR FULL HEALTH POTENTIAL**

#3 Priority Area: ACCESS TO HEALTHCARE

Includes primary, hospital, specialist, dental, vision, insurance coverage, maternal & infant/child health, and barriers to care.



STRATEGIES

By 2028, increase the percentage of residents - regardless of age, income, insurance status, or geographic location – with access to preventive and restorative dental care by 20%.

By 2028, increase the percentage of residents who have a usual source of primary medical care by 20% and establish a medical home, by addressing barriers to care and closing identified service gaps.

PARTNERS

Wood County Health Department, Wood County Hospital, Wood County Veterans Service Office, La Conexión, Penta Dental Program, Owens Dental Program, Wood County Committee on Aging

Wood County Hospital, Wood County Health Department, Wood County Veterans Service Office, La Conexión, Wood County Committee on Aging, Welcome BG

PRIORITY POPULATIONS

Wood County overall, Elderly residents, maternal-child population, veterans, youth, Hispanic/Latinx residents, rural communities, under-/uninsured residents, those with Medicaid

Wood County overall, Elderly residents, maternal-child population, veterans, youth, Hispanic/Latinx residents, rural communities, under-/uninsured residents, those with Medicaid



DESIRED OUTCOMES OF STRATEGIES



Delayed care



Access and utilization of non-emergency healthcare services and existing healthcare resources



Education and access to healthcare resources



OVERALL IMPACT OF STRATEGIES



Access to primary, dental, and preventive care



Quality of life



Physical health



Uninsured residents



Unmet care needs



Premature mortality



**ALL WOOD COUNTY SERVICE AREA RESIDENTS
ACHIEVE THEIR FULL HEALTH POTENTIAL**

Access to Healthcare continued on next page →

#3 Priority Area: ACCESS TO HEALTHCARE

Includes primary, hospital, specialist, dental, vision, insurance coverage, maternal & infant/child health, and barriers to care.



→ Continued from previous page

STRATEGIES

- By 2028, increase the percentage of adults and youth receiving age-appropriate preventive services by 20% to improve health outcomes and reduce disparities across the lifespan.
- Improve access to health insurance by 10% by 2028 through empowering people with knowledge to obtain and utilize insurance options.

PARTNERS

- Wood County Hospital, Wood County Health Department, Wood County Veterans Service Office, La Conexión, Wood County Committee on Aging, Welcome BG, Local Schools, BGSU, Local Libraries, Mercy Health—Mobile Unit
- La Conexión, Wood County Hospital, Wood County Health Department, Wood County Veterans Service Office, Wood County Committee on Aging, United Way, Local Libraries, Community Health Workers, Faith-Based Groups

PRIORITY POPULATIONS

- Wood County overall, rural communities, underserved youth and adults
- Adults age 18+, elderly residents, maternal-child population, veterans, Hispanic/Latinx residents, self-employed residents, those on a fixed income, under-/uninsured residents, those with Medicaid



DESIRED OUTCOMES OF STRATEGIES

- Delayed care
- Access and utilization of non-emergency healthcare services and existing healthcare resources
- Education and access to healthcare resources



OVERALL IMPACT OF STRATEGIES

- Access to primary, dental, and preventive care
- Quality of life
- Physical health
- Uninsured residents
- Unmet care needs
- Premature mortality



ALL WOOD COUNTY SERVICE AREA RESIDENTS
ACHIEVE THEIR FULL HEALTH POTENTIAL

#4 Priority Area: BEHAVIORAL HEALTH

Includes mental health, addiction, substance use disorder, Adverse Childhood Experiences (ACEs), and social wellness.



STRATEGIES

Increase behavioral health service/program knowledge among Wood County residents by 30% by December 2028 through strategic promotion of current behavioral health services throughout the county.

Develop an outreach plan to market current available services to PCPs, Pediatricians, and OB/GYNs in Wood County. Increase referral rates by 10% by the end of 2028.

Promote No Wrong Door Trainings to Case Management, Community Health Workers, and others starting work in the mental health community in Wood County. Increase attendance by 30% by the end of 2028.

PARTNERS

Wood County ADAMHS Board and provider agencies, Wood County Health Department, Wood County Hospital, BGSU

NAMI Wood County

NAMI Wood County, No Wrong Door Committee, Wood County Health Department, Wood County Hospital, Wood County Job & Family Services, CCHIO

PRIORITY POPULATIONS

Those affected by behavioral health conditions in Wood County

Those affected by behavioral health conditions in Wood County, health providers in Wood County

Those affected by behavioral health conditions in Wood County, mental health providers in Wood County, higher education entities in Wood County



DESIRED OUTCOMES OF STRATEGIES



Education and awareness on mental health



Access to mental health and substance abuse care



Mental health stigma



OVERALL IMPACT OF STRATEGIES



Mental health



Quality of life



Substance misuse



Mental health and substance abuse ER visits



Overdose deaths



Death by suicide



**ALL WOOD COUNTY SERVICE AREA RESIDENTS
ACHIEVE THEIR FULL HEALTH POTENTIAL**

CURRENT RESOURCES

ADDRESSING PRIORITY HEALTH NEEDS

WOOD COUNTY



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 Healthcare

Blanchard Valley Health System
CVS Pharmacy
Dental Center of Northwest Ohio
Falcon Health Center
Hospice of Northwest Ohio
Medicare and Medicaid
Mercy Health—Mobile Mammography Van
Mercy Health—Perrysburg Hospital
Mobile Health Center
Planned Parenthood
ProMedica Clinics
ProMedica Hospice
Telehealth Services
The Sight Center
Unison Health
Urgent Care Centers
Women's Care of Wood County
Wood County Board of Developmental Disabilities
Wood County Community Health Center
Wood County Early Intervention
Wood County Health Department
Wood County Hospital

Community & Social Services

Ability Center
Advocates for Basic Legal Equality, Inc. (ABLE)
American Red Cross
Autism Society of Northwest Ohio
Bittersweet Farms
Big Brothers Big Sisters
Bowling Green Chamber of Commerce
Bowling Green, Ohio (BGO) Pride Association
Child Protective Services
Clothesline
Community Christian Legal Service
Deacon's Shop
Emergency Management Agency
Faith-based Organizations/Local Churches

Community & Social Services (cont.)

Family & Youth Advocacy Center
Great Lakes Community Action Partnership (GLCAP)
Help Me Grow
Her Choice
Juvenile Residential Center of Northwest Ohio
La Conexión
Legal Aid Line
Local Police Departments
Not In Our Town Bowling Green
Perrysburg Heights Community Association (PHCA)
Safe Communities
Salvation Army
Shared Bounty
United Way
Welcome Bowling Green (BG)
Wood County Area Ministries
Wood County Child Support Enforcement Agency
Wood County Clerk of Courts
Wood County Committee on Aging
Wood County Family and Children First Council (FCFC)
Wood County Job and Family Services
Wood County Public Library
Wood County Safety Council
Wood County Sheriff's Office
Wood County Veterans Service Office

Education

Bowling Green City Schools
Bowling Green State University (BGSU)
Eastwood Local Schools
Elmwood Local Schools
Head Start
Lake Local Schools
North Baltimore Local Schools
Northwood Local Schools
Otsego Local Schools
Owens Community College
Penta Career Center
Perrysburg Exempted Village Schools

Education (cont.)

Public Libraries
Rossford Exempted Village Schools
Summer STARS Program
The Nest
Wood County Educational Service Center
Wood County Technical Center
Wood Lane School

Employment

Bureau of Workers' Compensation
Ohio Means Jobs—Wood County
Opportunities for Ohioans with Disabilities
Wood County Employment Resource Center
Work Leads to Independence

Food Insecurity

Bowling Green (BG) Christian Food Pantry
Bowling Green State University (BGSU) Student Food Pantry
Brown Bag Food Project
Community Garden
Farmers' Markets
First Christian Church—Bowling Green (BG)
Food Pantries
Islamic Food Bank
Meals on Wheels
Mom's Mobile Mission
Perrysburg Christians United (PCU) Food Pantry
Sharing Kitchen—Fostoria
St. Mark's Lutheran—Bowling Green (BG)
Supplemental Nutrition Assistance Program (SNAP)
Women, Infants, and Children (WIC) Program
Zoar Lutheran Church—Perrysburg

CURRENT RESOURCES (CONTINUED)

ADDRESSING PRIORITY HEALTH NEEDS

WOOD COUNTY



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.

Housing & Homelessness

Community Housing Impact (CHIP)
Department of Housing and Urban
Development (HUD)/Section 8
Housing
First Step
Habitat for Humanity of Wood County
The Cocoon
The Fair Housing Center
Wood County Housing and
Homelessness Coalition

Mental Health & Addiction

Access to Wellness Program
Alcoholics Anonymous (AA)
Arrowhead
Behavioral Connections of Wood
County
Brightview
Children's Resource Center (CRC)
Community Mental Health Providers
Crisis Helplines/Hotlines
Crisis Stabilization Unit (CSU)
Harbor Behavioral Health
Heroin Anonymous
HOPE National Suicide Prevention
Lutheran Social Services
Midwest Recovery Center
Narcotics Anonymous
National Alliance on Mental Illness
(NAMI) Wood County
Narcan distribution

Mental Health & Addiction (cont.)

Ohio Guidestone
The Willow Center
Wood County Addiction Response
Collaborative (ARC)
Wood County Addiction Task Force
Wood County Alcohol, Drug Addiction and
Mental Health Services (ADAMHS) Board
Wood County Crisis Line
Wood County Prevention Coalition
Wood County Suicide Prevention Coalition
Zepf Center

Nutrition & Physical Health

American Cancer Society
American Heart Association
Bike/Walking Trails
Bowling Green Community Center
Bowling Green State University (BGSU)
Recreation Center
City of Bowling Green Parks and Recreation
City of Perrysburg Parks and Recreation
Fitness Made Simple Program
Ohio State University (OSU) Extension
Wood County
Private Gyms
Rossford Recreation Department
Silver Sneakers
Wood County Hospital—Diabetes Education
Program
Wood County Hospital—Medical Nutrition
Therapy (MNT)
Wood County Park District
YMCA

Transportation

Bowling Green State University
(BGSU) Shuttle Service
Bowling Green (BG) Transit
Perrysburg Transit
Ride Right
Taxi Services
Toledo Area Regional Transit
Authority (TARTA)
Uber/Lyft
Wood County Committee on
Aging—Medical Transportation
Wood County Job and Family
Services—Non-Emergency
Transportation (NET) Plus
Ziggy Zooms

STEPS 5-8

INTEGRATE, DEVELOP, ADOPT, AND SUSTAIN IMPLEMENTATION STRATEGY/IMPROVEMENT PLAN



**In this step, the Wood County CHNA
Steering Committee will:**

- Integrate IS/CHIP with community partner, hospital, and health department plans
- Adopt the IS/CHIP
- Update and sustain the IS/CHIP

WOOD COUNTY NEXT STEPS



The Community Health Needs Assessment (CHNA) and this resulting Implementation Strategy (IS)/Improvement Plan (CHIP) identify and address significant community health needs and help guide community benefit activities. This IS/CHIP explains how the Wood County CHNA Steering Committee plans to address the selected priority health needs identified by the CHNA. The IS/CHIP is an evolving and ongoing process. Organizations and individuals interested in contributing to one or more of the strategies are invited to reach out to any of the contacts listed below to learn how to get involved.

This IS/CHIP report was adopted by Wood County Health Department, Wood County Hospital, and Mercy Health—Perrysburg Hospital leadership in November 2025.

This report is widely available to the public on the following websites:

Wood County Health Department: <https://woodcountyhealth.org/home/reports-publications/>

Wood County Hospital: <https://www.woodcountyhospital.org/about-us/community-programs>

Mercy Health—Perrysburg Hospital: <https://www.mercy.com/about-us/mission/giving-back/community-health-needs-assessment>

Written comments on this report are welcomed and can be made by emailing: psnyder@woodcountyohio.gov, laurert@woodcountyhospital.org, or lindsay_chandler@mercy.com.

EVALUATION OF IMPACT

The Wood County CHNA Steering Committee will monitor and evaluate the programs and actions outlined above. We anticipate the actions taken to address significant health needs will improve health knowledge, behaviors, and status, increase access to care, and overall help support good health. The Steering Committee is committed to monitoring key indicators to assess impact. Our reporting process includes the collection and documentation of tracking measures, such as the number of people reached/served and collaborative efforts to address health needs. A review of the impact of the Steering Committee's actions to address these significant health needs will be reported in the next scheduled CHNA.

ADDITIONAL HEALTH NEEDS NOT DIRECTLY ADDRESSED

Since the Wood County CHNA Steering Committee cannot directly address all the health needs present in the community, we will concentrate our resources on those health needs where we can effectively impact our region given our areas of focus and expertise. Taking existing organization and community resources into consideration, the Steering Committee will not directly address the remaining health needs identified in the CHNA, including but not limited to access to childcare, education, tobacco and nicotine use, internet/Wi-Fi access, crime and violence, environmental conditions, injuries, and HIV/AIDS and STIs. We will continue to look for opportunities to address community needs where we can make a meaningful contribution. Community partnerships may support other initiatives that the Steering Committee cannot independently lead in order to address the other health needs identified in the 2025 CHNA.

APPENDIX A

INTERNAL REVENUE SERVICE (IRS) REQUIREMENTS CHECKLIST: IMPLEMENTATION STRATEGY



Meeting the IRS Requirements for the Implementation Strategy

The Internal Revenue Service (IRS) requirements for an Implementation Strategy serve as the official guidance for IRS compliance. The following pages demonstrate how this IS/CHIP meets those IRS requirements.

APPENDIX A:

IRS IMPLEMENTATION STRATEGY

REQUIREMENTS CHECKLIST

INTERNAL REVENUE SERVICE REQUIREMENTS FOR IMPLEMENTATION STRATEGIES				
YES	PAGE #	IRS REQUIREMENTS CHECKLIST	REGULATION SUBSECTION NUMBER	NOTES/ RECOMMENDATIONS
✓	17-27	(2) Description of how the hospital facility plans to address the health needs selected, including: i. Actions the hospital facility intends to take and the anticipated impact of these actions; ii. Resources the hospital facility plans to commit; and iii. Any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need.	(c)(2) (c)(2)(i) (c)(2)(ii) (c)(2)(iii)	
✓	27	(3) Description of why a hospital facility is not addressing a significant health need identified in the CHNA. <i>Note: A “brief explanation” is sufficient. Such reasons may include resource constraints, other organizations are addressing the need, or a relative lack of expertise to effectively address the need.</i>	(c)(3)	
✓	Throughout report	(4) For those hospital facilities that adopted a joint CHNA report, a joint IS may be adopted that meets the requirements above. In addition, the joint IS must: i. Be clearly identified as applying to the hospital facility; ii. Clearly identify the hospital facility's role and responsibilities in taking the actions described in the IS and the resources the hospital facility plans to commit to such actions; and iii. Include a summary or other tool that helps the reader easily locate those portions of the strategy that relate to the hospital facility.	(c)(4) (c)(4)(i) (c)(4)(ii) (c)(4)(iii)	Strategies that hospitals are collaborating on are indicated throughout the report.
✓	3, 27	(5) An authorized body adopts the IS on or before the 15th day of the fifth month after the end of the taxable year in which the CHNA was conducted and completed, regardless of whether the hospital facility began working on the CHNA in a prior taxable year. Exceptions (if applicable): Transition Rule (if applicable):	(c)(5)	

APPENDIX B

PUBLIC HEALTH ACCREDITATION BOARD (PHAB) CHECKLIST: IMPROVEMENT PLAN (CHIP)



Meeting the PHAB Requirements for the CHIP

The PHAB Standards & Measures serve as the official guidance for PHAB national public health department accreditation and include requirements for the completion of Community Health Assessments (CHAs) and CHIPs for local health departments. The following page demonstrates how this IS/CHIP meets the PHAB requirements.

APPENDIX B:

PHAB COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) REQUIREMENTS CHECKLIST

PUBLIC HEALTH ACCREDITATION BOARD (PHAB) REQUIREMENTS FOR CHIPs			
YES	PAGE #	PHAB REQUIREMENTS CHECKLIST	NOTES/ RECOMMENDATIONS
✓	19-23	MEASURE 5.2.1 A: Adopt a community health improvement plan. 1. A community health improvement plan (CHIP), which includes all of the following: a. At least two health priorities. b. Measurable objective(s) for each priority. c. Improvement strategy(ies) or activity(ies) for each priority. i. Each activity or strategy must include a timeframe and a designation of organizations or individuals that have accepted responsibility for implementing it. ii. At least two of the strategies or activities must include a policy recommendation, one of which must be aimed at alleviating causes of health inequities. d. Identification of the assets or resources that will be used to address at least one of the specific priority areas. e. Description of the process used to track the status of the effort or results of the actions taken to implement CHIP strategies or activities.	A detailed work plan (living document) has been developed that includes strategies, SMART objectives, annual activities, indicators, partners, and priority populations.
	19-23		
	19-23		
	24-25		
	27		
		MEASURE 5.2.2 A: Encourage and participate in collaborative implementation and revision of the community health improvement plan. 1. Implementation of a community health improvement plan (CHIP) strategy or activity, including: a. Which CHIP priority the example addresses. (This may be indicated in the Documentation Form.) b. The health department's role in the implementation. c. Results of the strategy or activity. 2. Community health improvement plan (CHIP) strategy or activity that was revised, in collaboration with partners. The CHIP must address the jurisdiction as described in the description of Standard 5.2.	Implementation activities will be monitored and documented over the cycle. Progress will be reported in the next CHA/CHNA report.
		MEASURE 5.2.3 A: Address factors that contribute to specific populations' higher health risks and poorer health outcomes. 1. Implementation of one strategy, in collaboration with stakeholders, partners, or the community, to address factors that contribute to specific populations' higher health risks and poorer health outcomes, or inequities. 2. Efforts taken that contribute to building environmental resiliency.	Implementation activities will be monitored and documented over the cycle. Progress will be reported in the next CHA/CHNA report.

APPENDIX C

REFERENCES

APPENDIX C:

REFERENCES

¹U.S. Census Bureau, Population Estimates Program (PEP), V2024.
<https://www.census.gov/quickfacts/fact/table>

²University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2025.
www.countyhealthrankings.org.

³U.S. Census Bureau, American Community Survey, DP05, 2023 5-year estimate.
<http://data.census.gov>

⁴U.S. Census Bureau, American Community Survey, DP02, 2023 5-year estimate.
<http://data.census.gov>

⁵Feeding America, Map The Meal Gap, 2023. <https://map.feedingamerica.org>

⁶Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

⁷Ohio Behavioral Risk Factor Surveillance System: 2021 Annual Report. Chronic Disease Epidemiology and Evaluation Section, Bureau of Health Improvement and Wellness, Ohio Department of Health, 2024.

⁸PLACES. Centers for Disease Control and Prevention. Accessed June 20, 2025.
<https://www.cdc.gov/places>



WOOD COUNTY
HOSPITAL

Depend on us.



Wood County
Health Department



MERCYHEALTH



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