Community Health Needs Assessment

Greater Cincinnati Tri-State Region

2024 Report

THE HEALTH COLLABORATIVE

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Acknowledgments

The Health Collaborative (THC) contracted with the Health Policy Institute of Ohio (HPIO) to facilitate development of the Regional Community Health Needs Assessment (CHNA). THC and HPIO sincerely thank all partners for contributing their ideas and expertise to this work (Appendix A contains a full list of partner organizations). Facilitating a comprehensive Regional CHNA process and creating a high-quality report was made possible by their generous commitment of their time and expertise.

Overview

Regional vision: Every individual and community in the region should have equitable access and support to achieve their desired health outcomes. Achieving this vision requires that communities have what they need to be healthy and that our policies, systems, and environments advance health for every individual and family. The Regional Community Health Needs Assessment (CHNA) moves towards this vision by assessing the most significant health needs in the region and defining priorities for collective action.

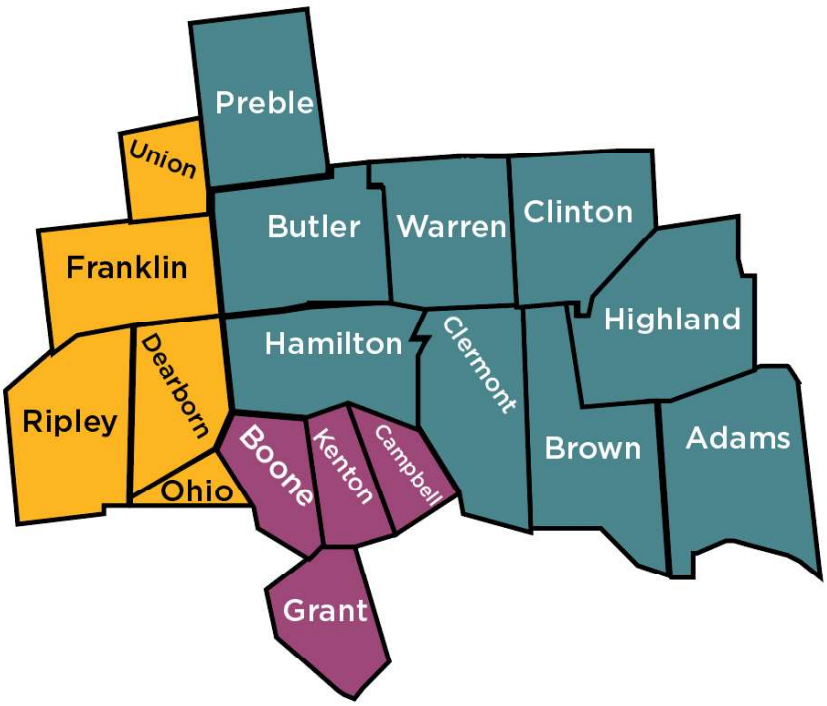
What is the Regional CHNA?

Every three years, the Greater Cincinnati Tri-State Region conducts a Regional CHNA to evaluate the health and well-being of its 18-counties and identify opportunities for collective action. The Regional CHNA is a resource that can be used by partners across sectors, including policymakers, to increase access to data, guide health improvement, and advance equity.

The Regional CHNA informs the 2025-2027 Collective Health Agenda, a Regional Community Health Improvement Plan (CHIP) and roadmap to advance health and equity in the region. It builds upon progress and lessons learned from the **2021 Regional CHNA** and the **2022-2024 Regional CHIP**.

The Regional CHNA report:

- Defines regional health priorities
- Describes the factors that shape the region's health and well-being
- Lists the region's significant health needs
- Describes progress made since the previous Regional CHNA and CHIP



The framework for collective action (figure 1) lays out a comprehensive approach to achieving the region's vision. The approach advances collective action by addressing the factors that shape our health and well-being, measuring if health is improving, and mobilizing community assets and resources.

Figure 1. **Framework for collective action**

How was the Regional CHNA developed?

1. Planned the Regional CHNA approach and methodology based on listening sessions, feedback, and input from the community
2. Formed Regional CHNA Advisory Committee, Special Populations Task Force, and Public Health Task Force
3. Compiled and analyzed primary and secondary data on:
   a. Systems of power, privilege, and oppression
   b. Social determinants of health
   c. Health outcomes and behaviors
4. Launched the Community Partnership Network pilot (see page 47 for details)
5. Hosted a session to review, explore, and interpret the analyzed data
6. Conducted a pre-prioritization survey to identify alignment among partners' priorities
7. Identified 17 significant health needs
8. Prioritized 3 health needs for collective action
9. For each prioritized health need, identified:
   a. Populations who face the greatest barriers
   b. Resources and assets that could be mobilized in the region

The Regional CHNA by the numbers:

- Compiled 49 secondary, quantitative data metrics from 34 different sources
- Analyzed 18 Ohio Hospital Association data metrics
- Reviewed seven other primary and secondary regional data sources such as community surveys, data from 2-1-1 calls, and recent community reports
- Disaggregated 32 metrics by characteristics such as race, ethnicity, age, and income
- Hosted 12 Advisory Committee meetings and six Task Force meetings, which included 45 total partner organizations

For more detail: Appendix A describes the Regional CHNA advisory structure, Appendices C and D describe the data collection and analysis methodology, and Appendix E describes the prioritization process.

Aligning on principles for collective action

The Regional CHNA's conceptual framework (figure 1) outlines three principles for collective action: equity, collaboration, and community voice. The Regional CHNA put these principles into practice by:

Equity

- Identifying opportunities to foster systems, policies, and beliefs that dismantle systems of power, privilege, and oppression
- Disaggregating data by characteristics such as race, ethnicity, age, and income to identify disparities and inequities
- Defining populations who face the greatest barriers for regional priorities with the goal of eliminating disparities across the region

Collaboration

- Building partnerships across health and non-health-specific sectors to lead the Regional CHNA process
- Leaning on alignment and shared decision-making to drive health improvement strategies

Community voice

- Analyzing primary data, including community surveys and focus groups, to center lived experiences and perspectives
- Engaging grassroots organizations and others who work directly with marginalized populations in the advisory structure to guide the Regional CHNA process
- Launching the Community Partnership Network pilot to spark bidirectional communication between Regional CHNA partners and community members

Community Partnership Network

The Health Collaborative launched the Community Partnership Network (CPN) in July 2024 to center equity and community voice in the assessment and planning process, increase bidirectional communication on progress, and minimize the burden of "new" data collection. The CPN leverages existing community meetings, momentum, and assets to strengthen connective tissue and partnership to advance shared goals for community health. Currently in an initial pilot phase, existing community partnerships are co-designing a framework for actionability and sustainability of the CPN.

More information on how collaboration and community voice were used to develop the Regional CHNA is provided in Appendix B.

How can I use the Regional CHNA?

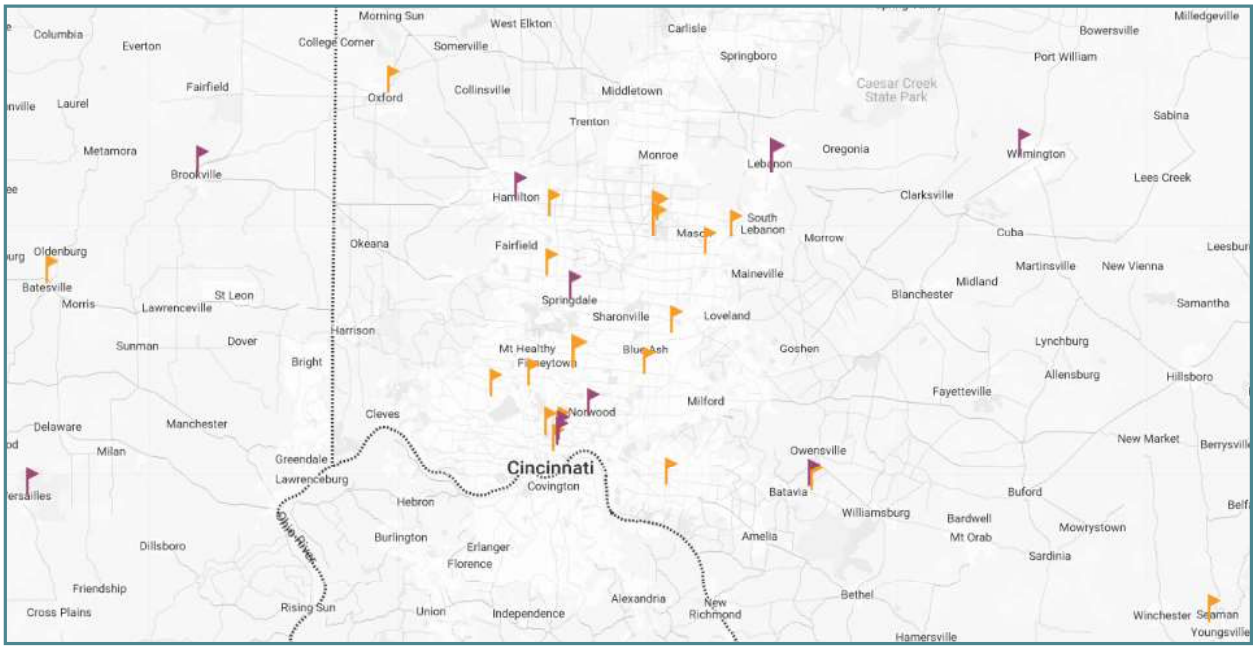
Partners across the region can use the Regional CHNA to:

1. **Share data and information**. Post graphics on social media, share data and information in community presentations, and forward the report to partners and community members.
2. **Align health improvement efforts.** Partner and collaborate across and within sectors to improve outcomes in the region.
3. **Advocate for funding and policy change.** Reference the Regional CHNA in research and grant applications and use it in conversations with state and local policymakers.
4. **Advance equity.** Target resources and tailor evidence-based practices to meet the needs of populations who face the greatest barriers outlined in the Regional CHNA. Measure progress towards eliminating disparities and inequities in health and well-being across the region using the data provided in the Regional CHNA report.
5. **Inform community investment.** Funders can allocate funding and resources and provide technical assistance related to the priorities outlined in the Regional CHNA.

About the region

The region for the CHNA includes 18 counties across Ohio, Indiana, and Kentucky with a variety of health department and hospital partners (displayed in figure 2).

Figure 2. **Greater Cincinnati Tri-State region hospital and health department partners**



Hospitals Local health departments

Regional hospitals, health departments, and other partner organizations are listed in Appendix A.

Population trends and demographics

The region's population grew by 5% between 2008 and 2022 to 2,404,540 people. The region has also become more racially and ethnically diverse, with a 1,062% increase in the Hispanic/Latino population, a 120% increase in the population that is two or more races (non-Hispanic), and 56% increase in the Asian (non-Hispanic) population during that same time. Figure 3 shows an overview of data on the region's demographics.

Figure 3. **CHNA region demographics, 2018-2022**

Total population	**2,404,540**
Age	
0-17	**23%**
18-24	**9%**
25-64	**51%**
65 years and over	**16%**
Race/Ethnicity	
White, non-Hispanic	**79%**
Black/African American, non-Hispanic	**11%**
Asian, non-Hispanic	**3%**
Two or more races, non-Hispanic	**3%**
Hispanic/Latino	**4%**
Household income	
0-$29,999	**19%**
$30,000-$59,999	**21%**
$60,000-$99,999	**23%**
$100,000-$149,999	**18%**
$150,000+	**19%**
Language	
Speaks only English at home	**94%**
Speaks a language other than English at home	**6%**
Immigration status	
U.S. citizen	**97%**
Not a U.S. citizen	**3%**
Other characteristics	
Uninsured	**6%**
Veteran population	**7%**
Population with disabilities	**13%**

Source: U.S. Census Bureau, 2018-2022 American Community Survey 5-year estimates

Regional health priorities

Every neighbor and community in the region deserves dignity, health, and well-being. However, the resources and environments that support health are not equally — or fairly — available to all people. Many groups and communities face barriers to health where they live, work, and play.

To improve health, address community conditions that undermine health, and tackle the systems that prevent some of our neighbors from living long and healthy lives, CHNA partners selected the following three priorities for collective action:

Mental health treatment and prevention

Homelessness prevention and housing stability

Heart disease and stroke prevention and treatment

Regional priorities, informed by data and community voice, were selected by CHNA partners using the following criteria:

1. **Capacity and feasibility:** Does our region have the ability to address this health need?
2. **Connection between factors and outcomes:** To what degree do the prioritized structural/social determinants contribute to prioritized health outcomes?
3. **Equity:** Would addressing this health need significantly address health disparities?
4. **Burden and severity:** Would addressing this health need have an impact on the greatest number of community members?
5. **Ability to track progress:** Are there indicators that can be used to measure progress over time?

More information on how these priorities were selected is available in Appendix E.

Some groups and areas in the region face barriers to health that are rooted in inequities like economic injustice and racism. This can lead to disparities, or systematic differences in outcomes, experienced across populations and communities. Each of the three priority sections that follow include information on **populations who face the greatest barriers** related to that topic.

Each of the three priority sections also contains an inventory of **regional resources and assets** related to that topic. The assets and resources listed are meant to foster connection and guide collaboration across the region, but they are not exhaustive. While this list may serve as a starting point, when embarking on specific efforts across the region, it is important to take stock of local resources and assets that pertain to that effort and geography. If you have recommendations to add, please email **communityhealth@healthcollab.org**.

Priority 1

Mental health treatment and prevention

Mental health treatment and prevention are crucial for our health and the health of our communities. Mental health is closely linked to physical health and can be impacted by factors such as relationships, access to employment and economic opportunities, and the environment in which people live in.[1] Lack of timely and affordable access to mental health services can contribute to poor mental health, while connected, supportive communities with access to quality employment, housing, and education can promote positive mental health.[2]

Key insights on mental health outcomes in the region

Regional data on mental health shows:

- The percentage of adults with depression in the region has risen by 93% over the last 27 years and an estimated 1 in 5 adults (17%) report frequent mental distress.[3]
- The number of deaths due to suicide in the region is approximately 10% higher than the national average and 20% higher than the national Healthy People 2030 benchmark.[4]
- Community members often do not have a way to find needed services and to identify trusted mental health providers.[5]
- Barriers to accessing treatment include stigma, lack of insurance coverage, limited availability of providers, and a lack of culturally responsive mental health services.[6]
- As of 2023, only about 18% of residents in the region had heard about the 988 National Suicide Prevention Lifeline.[7]

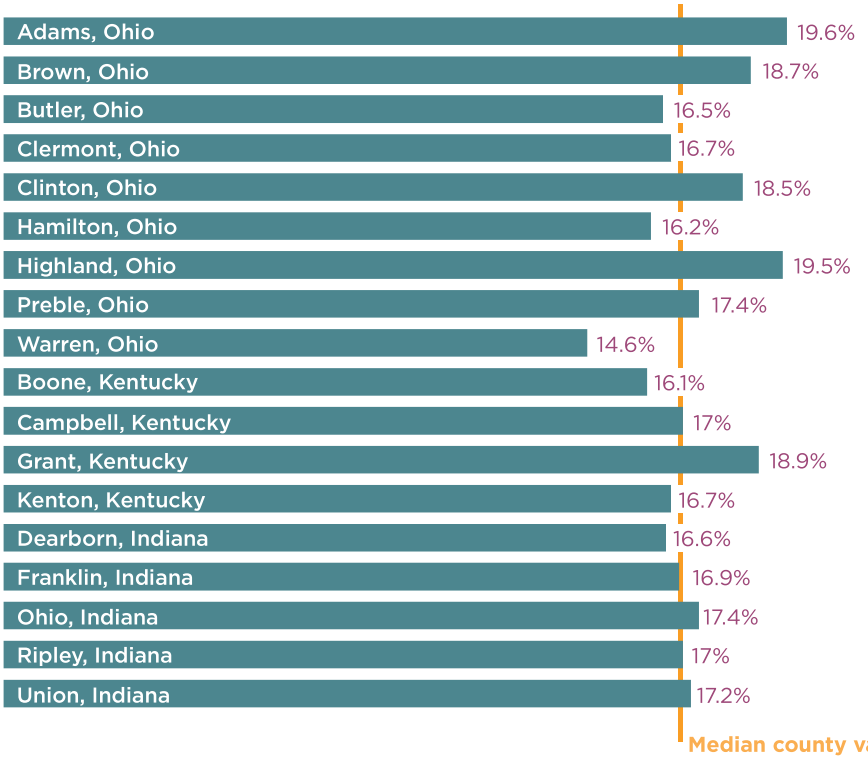
The percentage of adults in the Greater Cincinnati region with depression nearly doubled since 1995 (displayed in figure 4).

Figure 4. **Depression, 1995 and 2022**

Note: The region measured by Interact for Health includes 22 counties across Ohio, Kentucky, and Indiana.
Source: Interact for Health, Our Health, Our Opportunity Report

About 1 in 5 adults (17%) in the region report experiencing 14 or more days of poor mental health per month (exhibited by figure 5).

Figure 5. **Frequent mental distress, by county, 2021**

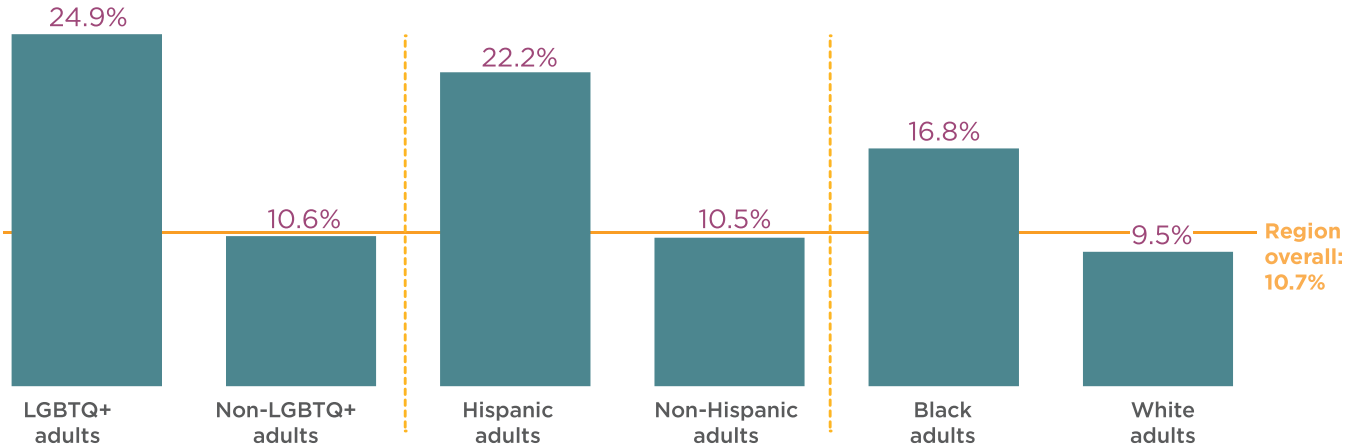


Source: Behavioral Risk Factor Surveillance System, as compiled by County Health Rankings and Roadmaps

There are notable disparities in access to mental health treatment by sexual orientation, gender identity, race, and ethnicity in the region. LGBTQ+ survey respondents reported higher rates of not receiving counseling or therapy when they needed it compared to non-LGBTQ+ residents. Hispanic and Black residents also reported not receiving needed treatment at higher rates than non-Hispanic and white residents, respectively (presented in figure 6).

Figure 6. **Access to mental health treatment, by race, ethnicity, sexual orientation, and gender identity, 2022**

Percent of adults who reported that there was a time in the past 12 months when they thought they needed counseling or therapy but did not get it



Note: The region measured by Interact for Health includes 22 counties across Ohio, Kentucky, and Indiana.
Source: Interact for Health and University of Cincinnati Institute for Policy Research, 2022 Community Health Status Survey

Voices from the community

In focus groups, community members noted difficulty accessing mental health treatment, particularly for marginalized populations.

"For kids not born in [the] U.S., they don't have the support to get to mental health. For one reason is the free mental health services, there are not enough appointments. Most of the professionals that give mental health don't accept anybody without insurance..."

"A lot of times, veterans don't necessarily have access to the mental health services they may need. It's not necessarily because it's not available, it's because of not knowing or not being able to connect."
— 2021 focus group participants

How does the region compare to the nation?

The region performs worse than the U.S. overall on measures of frequent mental distress (i.e., the percent of adults who reported 14 or more days of poor mental health per month) and suicide deaths as displayed in figure 7.

Figure 7. **National benchmarks for mental health***

	Regional value	U.S. overall	Healthy People 2030 benchmark	Region compared to U.S.	Region compared to Healthy People 2030 benchmark
Frequent mental distress (2021)	17.0%**	14.6%	N/A	Worse	N/A
Suicide deaths (2017-2021)	15.5	14 (2021)	12.8	Worse	Worse

*Benchmark comparisons are a calculation of the difference between the regional value, the value for the U.S. overall, and available national Healthy People 2030 benchmarks. In the Regional CHNA report, metrics that have less than 10% difference between the regional and benchmark values are classified as performing the "same." Metrics that have a difference of 10% or greater are classified as "better" or "worse."
Data note: Regional values ** are the median of all available counties.
Sources: Information on regional values can be found in the data appendix spreadsheet. Data for the U.S. overall value for frequent mental distress is from the **CDC BRFSS**. U.S. overall data for suicide deaths is from the **National Institute of Mental Health**.

There is significant alignment between the regional CHNA and **Cincinnati Children's Community Health Needs Assessment**, including in areas such as child and youth mental health and child and youth chronic disease.

Populations who face the greatest barriers to mental health treatment and prevention

The following groups and communities in the region often experience policies, practices, and environments that create barriers to mental health treatment and prevention:

- Appalachian and rural communities
- People of color
- LGBTQ+ residents
- People with disabilities
- People with less educational attainment
- People with lower incomes
- Women/female residents
- Youth and young adults

Regional resources and assets to address mental health

The following resources and assets are available across the region to impact mental health treatment and prevention:

General/prevention

- 1n5
- All-In Cincinnati
- Beech Acres Parenting Center
- Best Point Education & Behavioral Health
- BIPOC Mental and Behavioral Health Provider Directory
- Butler Behavioral Health
- Catholic Charities Southwestern Ohio
- Center for Healing the Hurt
- Centerpoint Health
- Central Clinic Behavioral Health
- Child Focus (Norwood, Eastgate, Mt. Orab)
- Child Mind Institute
- Envision Partnerships
- Federally Qualified Health Centers (FQHCs)
- FindHelpNowKY.org
- Greater Cincinnati Behavioral Health Services
- Greater Cincinnati Foundation
- GreenLight Fund
- Haile Foundation
- Hamilton County Addiction Response Coalition (ARC)
- Hamilton County African American Engagement Workgroup
- HealthSource of Ohio
- HEY! (Hopeful Empowered Youth) Cincinnati
- Hospitals and health systems
- Joe Burrow Foundation
- Lebanon Counseling Center
- Lighthouse Youth Services
- Mental Health America of Northern Kentucky and Southwest Ohio
- Mental Health and Addiction Advocacy Coalition (MHAC)
- Mental Health and Addiction Services Recovery Boards
- Middletown Counseling Center
- Millstone Fund
- MindPeace
- Modern Psychiatry and Wellness
- NAMI Southwest Ohio
- NeighborHub Health
- NewPath Child and Family Solutions
- Preston Brown Foundation
- PreventionFIRST!
- Public Health Departments
- State departments of mental and behavioral health
- Talbert House
- Tristate Trauma Network
- UMADOP of Cincinnati
- Urban League Greater Southwestern Ohio
- Hotlines:
  - 2-1-1 resource hotline
  - Central Clinic/ Connections (513) 558-8888
  - Consumer Warmline (513) 931-WARM
  - Mental Health Hotline (513) 281-CARE

Crisis

- Central Clinic (Mental Health Access Point – MHAP)
- Charlie Health
- Freestanding Inpatient Psychiatric Units
- Georgetown Behavioral Hospital
- Mercy Health — Clermont Clinic
- Mobile Response and Stabilization Services (MRSS) Ohio
- Psychiatric Emergency Services (PES) at UC Health
- Suicide prevention coalitions
- Summit Behavioral Healthcare
- SUN Behavioral Health
- Women Helping Women
- Hotlines:
  - 9-8-8
  - Mobile Crisis Team (Mental Health Crisis) (513) 574-5098
  - Substance Abuse Crisis Response AIM (513) 620-RING (7464)
  - Veterans Hotline (513) 281-VETS (8387)

Additional information

- **Mental Health Data and Statistics, Centers for Disease Control and Prevention**. A list of data resources that provide up-to-date statistics on mental health.
- **Trends in State Mental Health Policy, National Alliance on Mental Illness**. A report on mental health challenges and various policy options for prevention in the United States.

Priority 2

Homelessness prevention and housing stability

Safe and stable housing is vital for our health and well-being. This includes affordable rent, adequate space for household members, and avoiding frequent moves within short periods. High housing costs can limit financial resources for basic needs like child care, nutritious food, and health care.[8] Additionally, poor-quality housing can cause chronic stress, leading to health issues such as high blood pressure and worse mental health.[9]

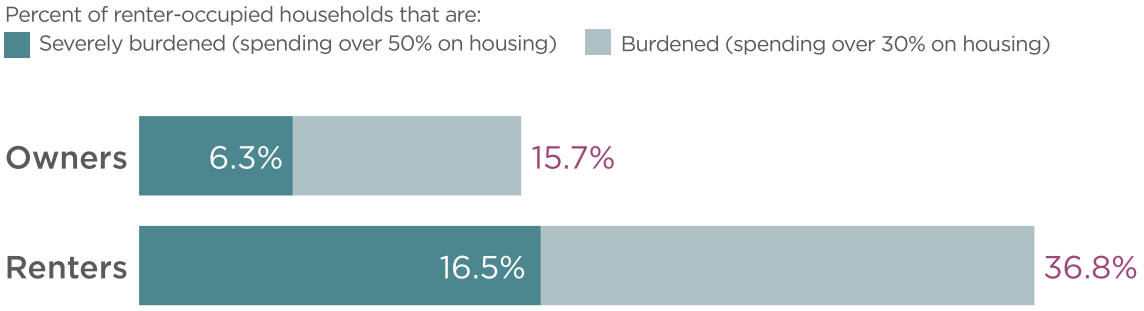
Key insights on housing and homelessness in the region

Regional data on housing and homelessness finds:

- Housing cost burden (spending 30% or more of income on housing costs) in the region is approximately 45% higher than the Healthy People 2030 benchmark.[10]
- There are stark disparities in housing outcomes across the region. For example, Black residents and residents with low incomes are more likely to face challenges with housing stability such as homelessness, eviction, and housing cost burden.[11]
- There is a need for homelessness and housing support services, particularly for Black residents, men, and people who have been incarcerated.[12]
- Gentrification has increased housing costs and displaced those seeking affordable housing.[13]
- Households under 150% of the federal poverty level (FPL) were less likely to experience housing stability than households above 150% FPL.[14]

Sixteen percent of homeowners and 37% of renters in the region are housing cost burdened. Of those who are housing cost burdened, approximately 6% of homeowners are estimated to be housing cost burdened and 17% of renters are severely housing cost burdened (spending over 50% of their income on housing) (displayed in figure 8). Sixty percent of households in the region making less than $50,000 annually are housing cost burdened.[15]

Figure 8. **Housing cost burden, by severity and household type, 2018-2022**

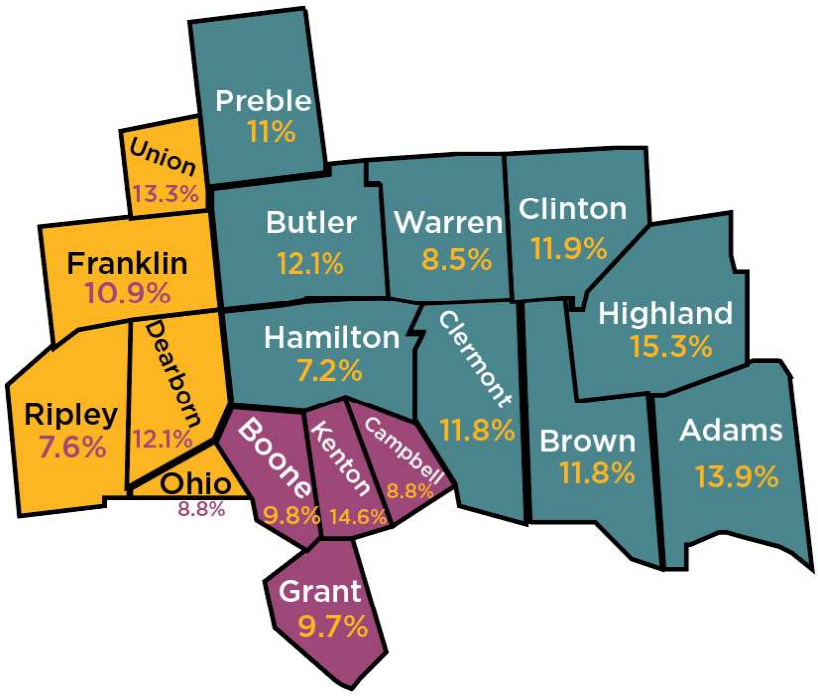


Data note: Regional values are the median of all available counties.
Source: U.S. Census Bureau, American Community Survey 5-year estimates, as compiled by PolicyMap

Approximately 11% of households in the region have one or more of the following problems: overcrowding, high housing costs, or lack of kitchen and/or plumbing facilities (highlighted in figure 9). Households in Highland County, Ohio were 30% more likely to experience these problems than the region overall.

Figure 9. **Percent of homes with severe housing problems, by county, 2016-2020**

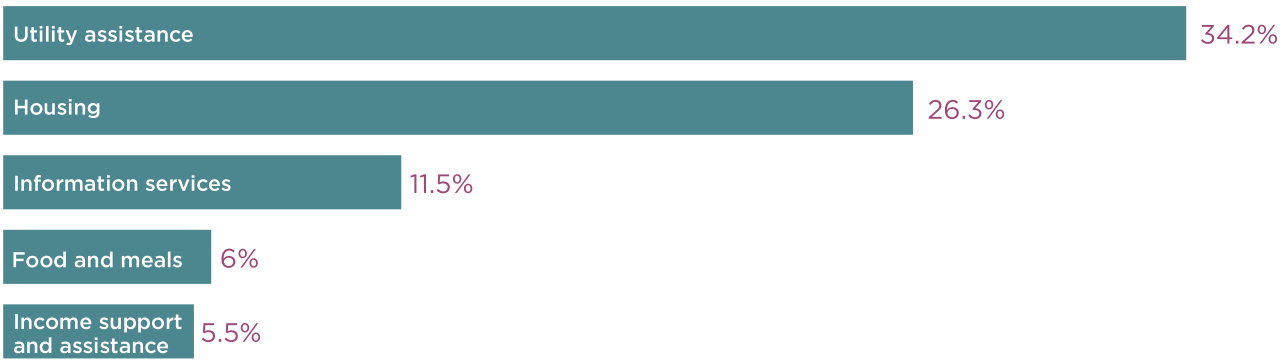
Percent of households who had at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities



Source: Comprehensive Housing Affordability Strategy (CHAS) data, as compiled by County Health Rankings and Roadmaps

While there is a relatively low cost of living in Cincinnati (4% lower than the national average)[16], figure 10 shows that utility assistance and housing are the top two most frequent categories of need in 2-1-1 calls for assistance, making up 35% and 26% of requests respectively in 2023.[17]

Figure 10. **Top categories of need in 2-1-1 calls, 2023**



Source: United Way of Greater Cincinnati and Indiana Family and Social Services Administration

Voices from the community

Regardless of race, over 70% of respondents to one survey of Greater Cincinnati area residents expressed dissatisfaction with affordable housing options.[18]

"They are moving people out of their homes and communities, who cannot afford the replacements."

"Rent is more expensive than mortgages, and homeownership is nearly unattainable for the middle class."

— **2024 Inclusion Survey via State of Black Cincinnati report**

How does the region compare to the nation?

Although the region performs better than the nation overall on metrics related to severe housing problems and housing cost burden, significant issues remain (highlighted in figure 11). For example, housing cost burden in the region is 45% higher than the Healthy People 2030 benchmark.

Figure 11. **National benchmarks for housing and homelessness***

	Regional value	U.S. overall	Healthy People 2030 benchmark	Region compared to U.S.	Region compared to Healthy People 2030 benchmark
Severe housing problems (2016-2020)	11.4%**	16.7%	N/A	Better	N/A
Housing cost burden (2018-2022)	36.8%**	46.5%	25.5%	Better	Worse

*Benchmark comparisons are a calculation of the difference between the regional value, the value for the U.S. overall, and available national Healthy People 2030 benchmarks. In the Regional CHNA report, metrics that have less than 10% difference between the regional and benchmark values are classified as performing the "same." Metrics that have a difference of 10% or greater are classified as "better" or "worse."
Data note: Regional values ** are the median of all available counties.
Sources: Information on regional values can be found in the data appendix spreadsheet. Data for the U.S. overall value for severe housing problems and housing cost burden is from the U.S. Department of Housing and Urban Development "**Comprehensive Housing Affordability Strategy**."

Populations who face the greatest barriers to homelessness prevention and housing stability

The following groups and communities in the region often experience policies, practices, and environments that create barriers to homelessness prevention and housing stability:

- Appalachian communities
- Older adults
- Families with children
- Immigrants and refugees
- People of color
- People who were formerly incarcerated
- People with lower incomes
- Women/female residents

Regional resources and assets to address housing and homelessness

The following resources and assets are available across the region to impact homelessness prevention and housing stability:

Housing stability

- Adams County Economic and Community Development
- Brighton Center
- Caracole
- Cincinnati-Hamilton County Community Action Agency
- Community Development Corporations
- Community Matters
- Council on Aging
- County Departments of Job and Family Services
- Habitat for Humanity
- Housing Opportunities Made Equal (HOME)
- Independence Alliance
- Local Metropolitan Housing Authorities
- Northern Kentucky Community Action Commission (NKCAC)
- Ohio Valley Residential Services
- People Working Cooperatively
- People Working Cooperatively
- Seven Hills Neighborhood Houses
- Shelterhouse
- Talbert House
- The Community Builders
- Warren County Community Services
- Women Helping Women
- Working In Neighborhoods

Homelessness prevention

- Adams County Shelter for the Homeless
- Bethany House
- Central Access Point (CAP) Helpline (513-381-SAFE)
- City Gospel Mission
- Clermont County Community Services
- Emergency Shelter of Northern Kentucky
- Family Promise of Buttler and Warren Counties
- Greater Cincinnati Homeless Coalition
- Healthcare for the Homeless
- Highland County Homeless Shelter
- Homeless Coalition of Southern Indiana
- County Departments of Job and Family Services
- New Life Mission
- Shelterhouse
- St. Vincent de Paul
- Strategies to End Homelessness
- Talbert House
- Tender Mercies
- Welcome House
- Wilmington Hope House
- Women Helping Women
- Working In Neighborhoods
- YWCA Greater Cincinnati

Shared

- 2-1-1 resource hotline
- Coalition on Homelessness and Housing in Ohio
- Federally Qualified Health Centers (FQHCs)
- Greater Cincinnati Foundation
- Hospitals and health systems
- Legal Aid
- LISC Greater Cincinnati
- Public Health Departments
- United Way of Greater Cincinnati

Additional information

- **The Gap: A Shortage of Affordable Homes**, **National Low Income Housing Coalition**. A report that includes data measuring the availability of rental housing units available to extremely low-income householders and other income groups. Data is available at the state and metropolitan statistical area (major cities and their surrounding communities) levels.
- **Out of Reach: The High Cost of Housing**, **National Low Income Housing Coalition**. A report that calls attention to the disparity between wages and the cost of rental housing in the United States. Data is available at the state, metropolitan statistical area (major cities and their surrounding communities), and county levels.
- **Cincinnati Housing Stakeholders, LISC Greater Cincinnati**. An inventory of key actors organized by the role they play in Cincinnati's housing ecosystem.

Priority 3

Heart disease and stroke prevention and treatment

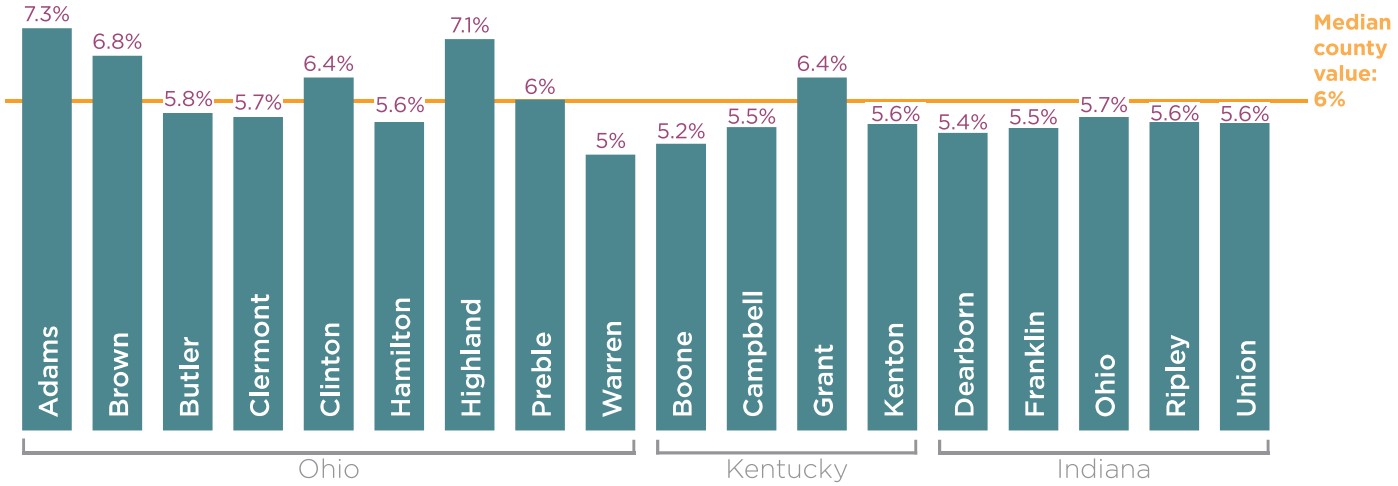
Chronic high blood pressure, also known as hypertension, can lead to other heart conditions such as heart disease and stroke. Heart disease and stroke are serious health conditions that both result from and can worsen our overall health and well-being. They are linked to factors such as inadequate housing and mental health challenges.[19] These conditions rank among the leading causes of death and the most frequent diagnoses in emergency departments in the region.

Key insights on heart disease and stroke in the region

- Of the leading causes of death in the region, heart disease is ranked first, and stroke is ranked fifth. [20]
- Of the top emergency room diagnoses in the region, heart disease is ranked second, heart attack is ranked fifth, and stroke is ranked sixth. [21]
- The rate for heart disease deaths in the region is more than double the benchmark set by Healthy People 2030, and the region's rate for stroke and cerebrovascular disease (conditions that affect the blood flow to your brain, including stroke, brain bleed and carotid artery disease)[22] death is over 75% greater than the benchmark.
- Roughly 33% of adults in the region report being told by a doctor or nurse that they had high blood pressure. There are also sizeable racial disparities in hypertension.[23]

In the region, approximately 6% of adults in 2021 had heart disease and an estimated 3% have had a stroke. The rate of heart disease varied across the region (as shown in figure 12), with Adams County, Ohio having a rate over 25% higher than the region overall.

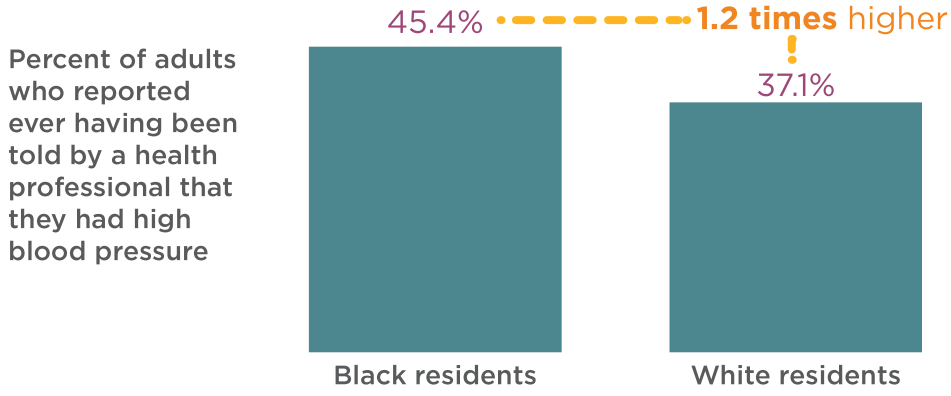
Figure 12. **Heart disease prevalence, by county, 2021**



Source: Behavioral Risk Factor Surveillance System, as compiled by CDC PLACES

Forty-five percent of Black/African American residents in the Greater Cincinnati area report having been diagnosed with high blood pressure (i.e., hypertension) by a healthcare provider, compared to 37% of white residents (displayed in figure 13).

Figure 13. **High blood pressure, by race, 2022**

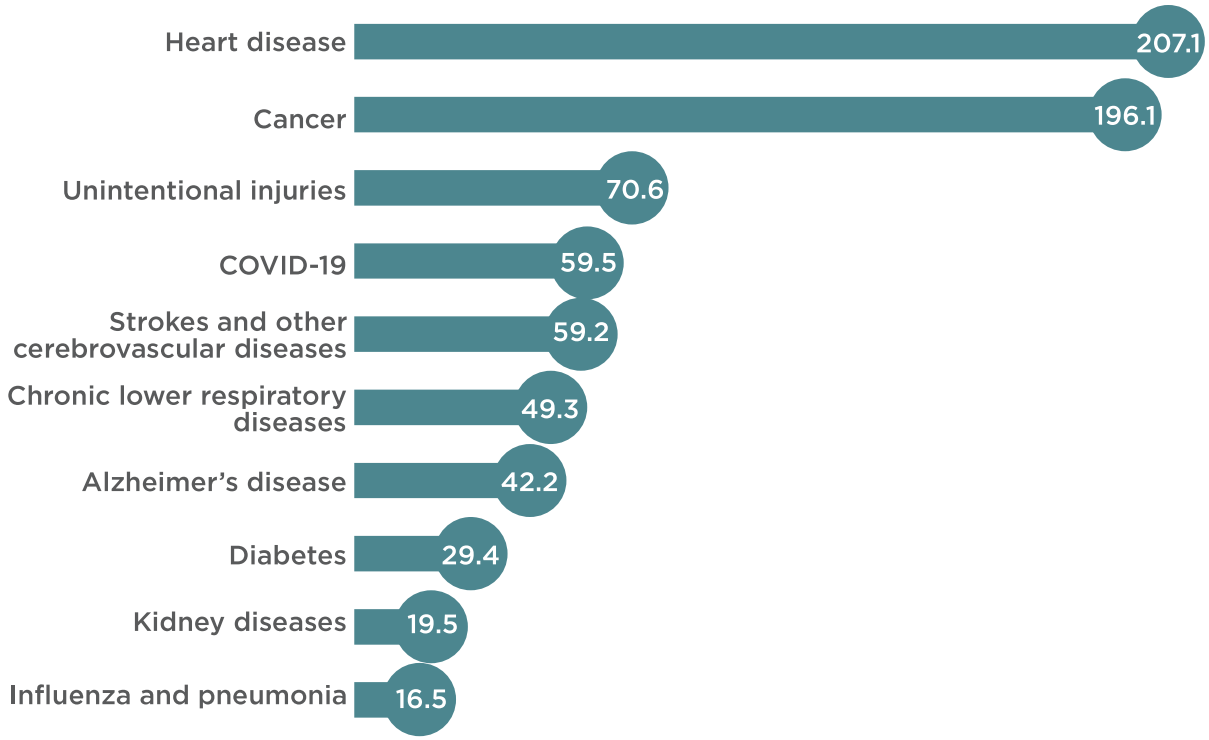


Note: The region measured by Interact for Health includes 22 counties across Ohio, Kentucky, and Indiana.
Source: Interact for Health and University of Cincinnati Institute for Policy Research, 2022 Community Health Status Survey

Figure 14 lists the leading causes of death in the region. Heart disease and stroke were among the leading causes of death from 2018 to 2022.

Figure 14. **Leading causes of death in the region, 2018-2022**

Number of deaths per 100,000 population among the leading causes of death in the region (2018-2022)



Note: Unintentional injuries include overdose deaths and motor vehicle accidents.
Source: Centers for Disease Control and Prevention, Wide-ranging Online Data for Epidemiologic Research (WONDER)

Voices from the community

A focus group participant mentioned being concerned about current health issues leading to heart disease.

"[I am a] diabetic, [and I] have to make sure I have insulin and have a healthy diet and that could lead to heart problems, so I need to make sure I take care of that."
— **2021 focus group participant**

How does the region compare to the nation?

The region has similar estimated rates of hypertension and stroke compared to the nation but an estimated 50% higher rate of heart disease than the U.S. overall (displayed in figure 15). When looking at rates of death, the region's stroke and cerebrovascular disease death rate is approximately 25% greater than the nation's, and the region's heart disease death rate is more than double the Healthy People 2030 target.

Figure 15. **National benchmarks for heart disease and stroke***

	Regional value	U.S. overall	Healthy People 2030 benchmark	Region compared to U.S.	Region compared to Healthy People 2030 benchmark
Heart disease prevalence (2021)	**5.7%****	**3.8%**	**N/A**	**Worse**	**N/A**
Hypertension prevalence (2021)	**32.6%****	**32.4%**	**N/A**	**Same**	**N/A**
Stroke prevalence (2021)	**2.8%****	**3%**	**N/A**	**Same**	**N/A**
Heart disease deaths (2018-2022)	**207.1** per 100,000 population	**206.6** per 100,000 population	**71.1** per 100,000 population (age-adjusted)	**Same**	**Worse**
Stroke and cerebrovascular disease deaths (2018-2022)	**59.2** per 100,000 population	**47.7** per 100,000 population	**33.4** per 100,000 population (age-adjusted)	**Worse**	**Worse**

*Benchmark comparisons are a calculation of the difference between the regional value, the value for the U.S. overall, and available national Healthy People 2030 benchmarks. In the Regional CHNA report, metrics that have less than 10% difference between the regional and benchmark values are classified as performing the "same." Metrics that have a difference of 10% or greater are classified as "better" or "worse."
Data note: Regional values ** are the median of all available counties.
Sources: Information on regional values can be found in the data appendix spreadsheet. Data for the U.S. overall value for heart disease prevalence, hypertension prevalence, and stroke prevalence is from the **CDC BRFSS**. U.S. overall data for heart disease deaths and stroke and cerebrovascular disease deaths is from **CDC WONDER**.

Populations who face the greatest barriers to heart disease and stroke prevention

The following groups and communities in the region often experience policies, practices, and environments that create barriers to heart disease and stroke prevention:

- Appalachian and rural communities
- Black residents
- Older adults
- People with less educational attainment
- People with lower incomes

Regional resources and assets to address heart disease and stroke

The following resources and assets are available across the region to impact heart disease and stroke prevention and treatment:

Regionally based

- American Heart Association (AHA) Greater Cincinnati
- Christ Hospital Preventive Cardiology Program
- Federally Qualified Health Centers (FQHCs)
- HealthPath Foundation
- Heart to Heart Home Healthcare
- Hospice of Cincinnati Cardiac Care Program
- Hospitals and health systems
- Mercy Health – The Heart Institute
- Premier Health HeartWorks
- ProjectADAM
- Public Health Departments
- St. Vincent DePaul Charitable Pharmacy
- The Center for Closing the Health Gap
- TriHealth Heart and Vascular Institute
- University of Cincinnati Heart, Lung and Vascular Institute
- WiseWoman
- Women's Heart Center at The Christ Hospital

State based

- American Heart Association chapters
- Cardi-OH
- State departments of health

Additional information

- **Strategic Plan and Map 2024-2028**, **Kentucky Heart Disease and Stroke Prevention Task Force.** This strategic plan outlines the vision, mission, values, goals, and desired outcomes of the Task Force.
- **Cardi-OH**. A statewide collaborative of healthcare professionals focused on improving health outcomes while eliminating disparities. It offers tools such as monthly newsletters, clinical tips, podcasts, and virtual clinics.

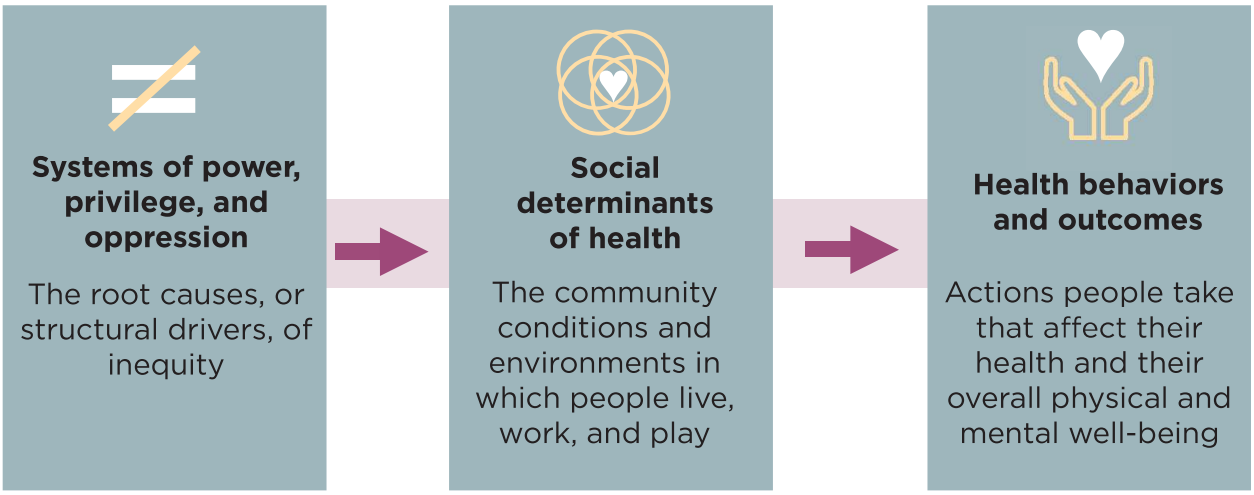
What shapes the region's health and well-being?

Many factors lie at the root of the three regional priorities — and our overall health and well-being. One of the biggest factors is related to the conditions of our communities.[24] Also called the social determinants of health, community conditions—like educational opportunities and housing — support our ability to be healthy and make healthy choices.

Those conditions are shaped by systems of power, privilege, and oppression that can unfairly distribute resources and opportunities across groups and communities (as displayed in figure 16).

The assessment process for the Regional CHNA was organized and based on these domains using the National Association of County and City Health Officials' (NACCHO) **Mobilizing for Action through Planning and Partnerships (MAPP 2.0)** framework. The following sections outline key findings from each of these domains.

Figure 16. **Regional CHNA domains: The root causes of health outcomes and inequities**



Source: Adapted from the NACCHO "Health Equity Action Spectrum"

Systems of power, privilege, and oppression

At the foundation of our health and well-being are systems, such as policies, laws, institutions, and values that shape the communities in which we live. When rooted in inequity, these structures can create persistent hierarchies of privilege and oppression. For example, discriminatory policies and practices, like redlining and housing discrimination, have shaped where people of color live and whether they have access to safe neighborhoods free from harmful conditions.

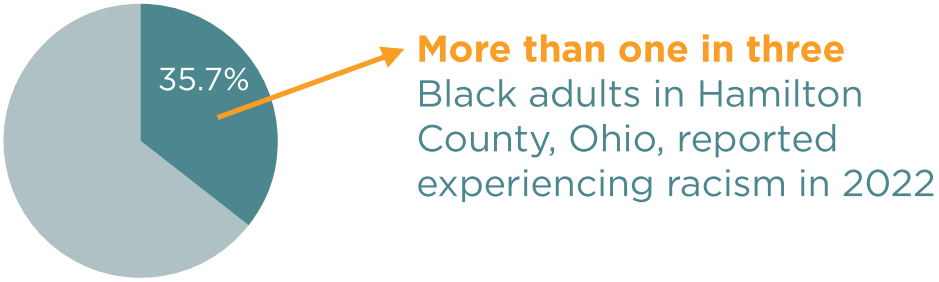
Systems of power, privilege, and oppression measures[25]

Racism and discrimination

As displayed in figure 17, more than a third of Black adults in Hamilton County, Ohio reported experiencing racism in 2022. Racism unfairly and unequally distributes resources, power, and opportunity, resulting in disparities experienced by Black residents and people of color.

Figure 17. **Experiences of racism, by black adults, 2022**

Percent of adults who were treated worse, in general, than other races in the past year

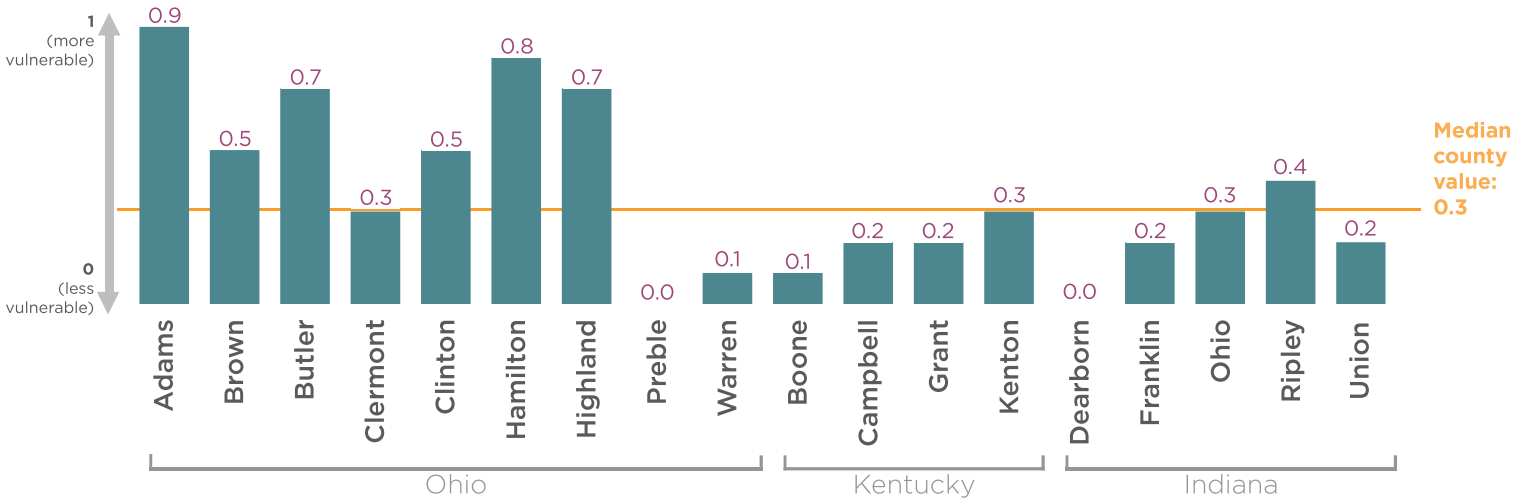


Source: Analysis by HPIO of Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, data provided by the Ohio Department of Health upon request

Underinvestment and unequal access to resources needed for health

Communities near urban centers and in the most rural areas of the region are less likely to have adequate access to the resources needed for health, like stable housing and employment opportunities, increasing their vulnerability to health and economic challenges (highlighted by figure 18).

Figure 18. **Social vulnerability, by county, 2022**



Source: Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry, Social Vulnerability Index

Systems of power, privilege, and oppression unfairly distribute resources and opportunity based on factors such as race, ethnicity, income, sexual orientation, sex and gender identity, age, and geography. As a result, this creates higher risk of exposure to unhealthy environments and poor health outcomes for marginalized communities.

Systems of power, privilege, and oppression: Other findings

- Black residents in the region face inequities in financial discrimination, incarceration, housing discrimination, and health insurance coverage, among others, driven by systems, institutions, and policies.[26]
- Communities in rural areas and with low incomes have fewer systems and supports that create a foundation for good health, like transportation and living-wage jobs.[27]
- LGBTQ+ residents, despite having higher rates of mental health challenges, face greater barriers to accessing mental health care than others in the region.[28]

Social determinants of health

Power, privilege, and inequality play a large role in shaping our health and the factors that affect it, like education, access to healthcare, financial stability, community environment, and social relationships. These factors, called the social determinants of health, influence the conditions we experience throughout life, where we're born, live, learn, work, play, worship, and age, which in turn impact our quality of life and overall well-being.

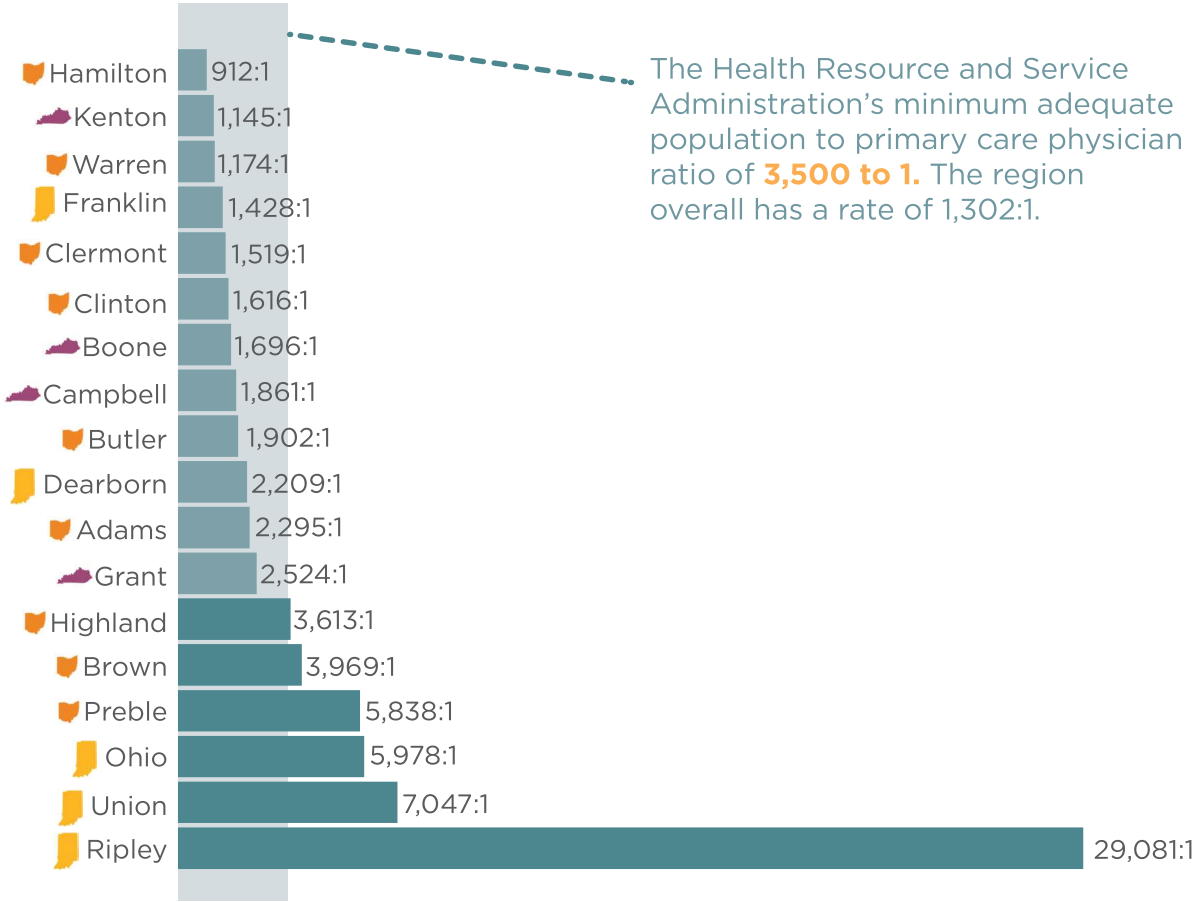
Social determinants of health measures[29]

Access to affordable, timely, and quality health care

The region has one primary care physician for every 1,302 residents (highlighted in figure 19). While the region falls within the Health Resource and Service Administration's minimum adequate population to primary care physician ratio of 3,500 to 1, several counties are well above this ratio.[30]

Figure 19. **Primary care physicians, by county, 2021**

Ratio of population to primary care physicians



Source: Area Health Resource File/American Medical Association, as compiled by County Health Rankings and Roadmaps

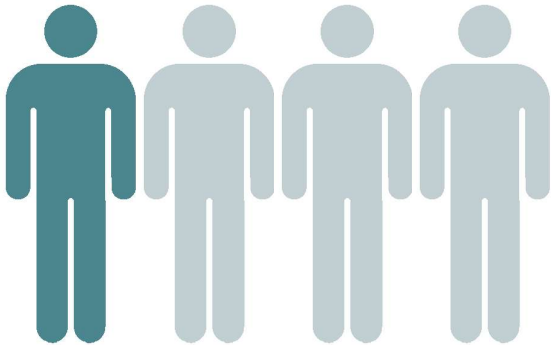
Poverty and economic stability

In the region, an estimated one in four people are employed, but cannot afford to meet their basic needs, including housing, food, child care, health care, transportation, and basic technology (exhibited in figure 20).

Figure 20. **ALICE households, 2022**

Percent of households who were below the ALICE (asset limited, income constrained, and employed) threshold. This includes households earning incomes below and above the federal poverty level, but not enough to afford the basics where they live.

Regionally, approximately **one in four** (36.8%) community members are not able to afford basic needs.



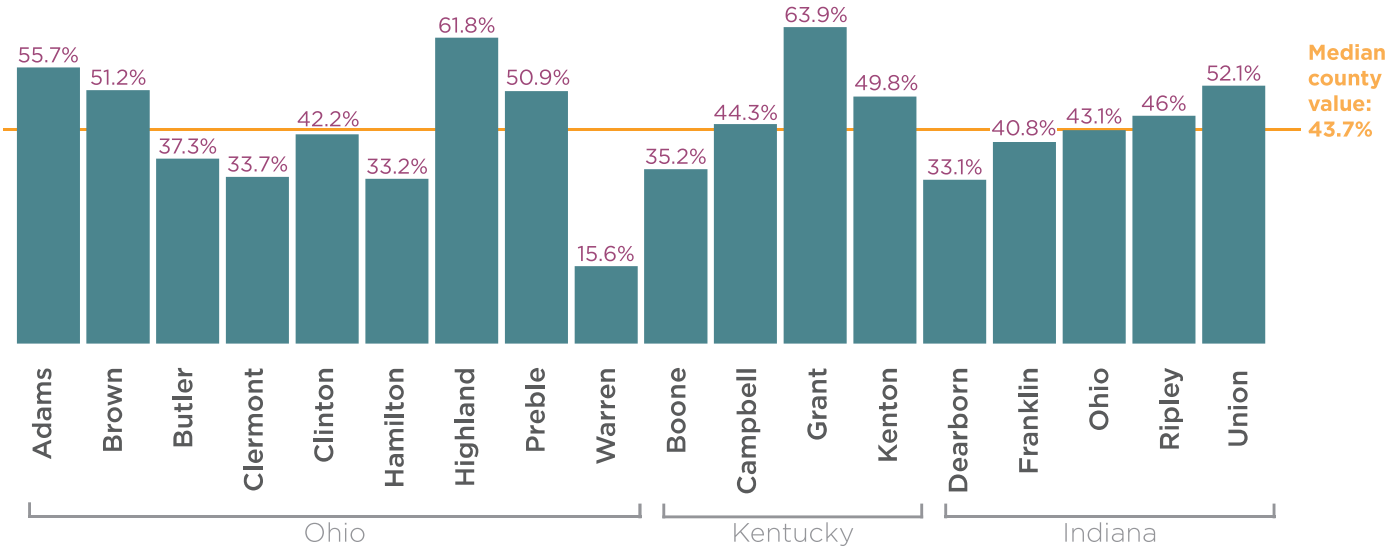
Source: ALICE Threshold and U.S. Census Bureau, American Community Survey as compiled by United for ALICE

Food access and insecurity

In 2019-2020, approximately 44% of children in the region were eligible for free- or reduced-price lunch, meaning that their families are not earning enough to afford school lunch at full price (shown in figure 21). Additionally, 8% of people in the region were estimated to have limited access to healthy food.[31]

Figure 21. **Children eligible for free or reduced-price lunch, by county, 2019-2020 school year**

Percent of children enrolled in public schools that were eligible for free or reduced price lunch



Source: National Center for Education Statistics, as compiled by County Health Rankings and Roadmaps

Social determinants of health: Other findings

- In eight counties in the region, nearly one in three adults reported delaying or avoiding medical care due to cost, lack of transportation, or limited provider availability.[32]
- Rural areas often lack access to living-wage jobs.[33]
- Nearly one in six children live below the FPL.[34]
- LGBTQ+ residents are 1.7 times more likely than non-LGBTQ+ residents to have incomes below the FPL.[35]
- Many people who are food insecure are likely not eligible for the Supplemental Nutrition Assistance Program (SNAP).[36]

Health behaviors and outcomes

Systems of power, privilege, and oppression and the social determinants of health impact health outcomes and behaviors within our communities. Health outcomes reflect the physical and mental well-being of community members, while health behaviors are actions that can affect our health, such as physical activity, smoking, and substance use. Our health behaviors are either supported, or inhibited, by the environments in which we live and the systems that shape them, including access to parks, green space, and healthy foods.

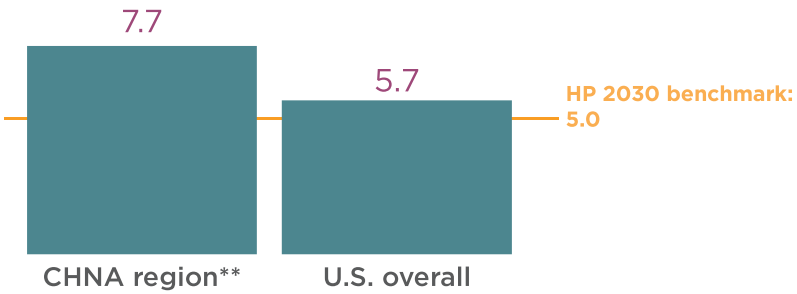
Health behaviors and outcomes measures[37]

Maternal and infant health

The infant mortality rate in the CHNA region is estimated to be higher than the rest of the country and the national target established by Healthy People 2030 (displayed in figure 22).

Figure 22. **Infant mortality, 2015-2021**

Number of infant deaths per 1,000 live births



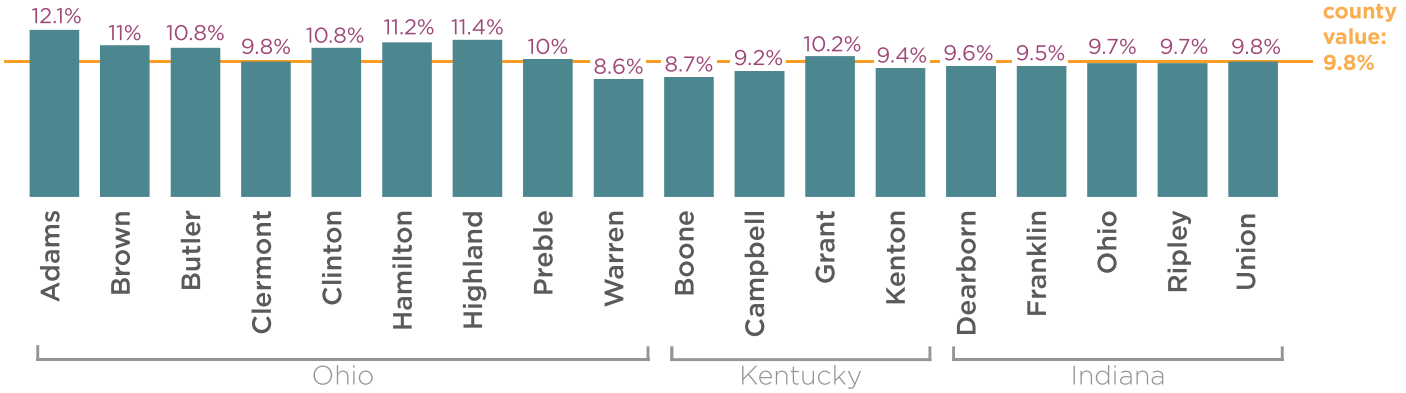
** The median of all available counties
Source: CDC WONDER and National Center for Health Statistics, as compiled by County Health Rankings and Roadmaps

Diabetes

Diabetes is the eighth leading cause of death in the region, and approximately 10% of adults have been diagnosed with diabetes. Figure 23 shows that people in Ohio counties across the region generally have higher rates of diabetes than people in Indiana or Kentucky counties.

Figure 23. **Diabetes, by county, 2021**

Percent of adults, ages 20 and older, who were diagnosed with diabetes



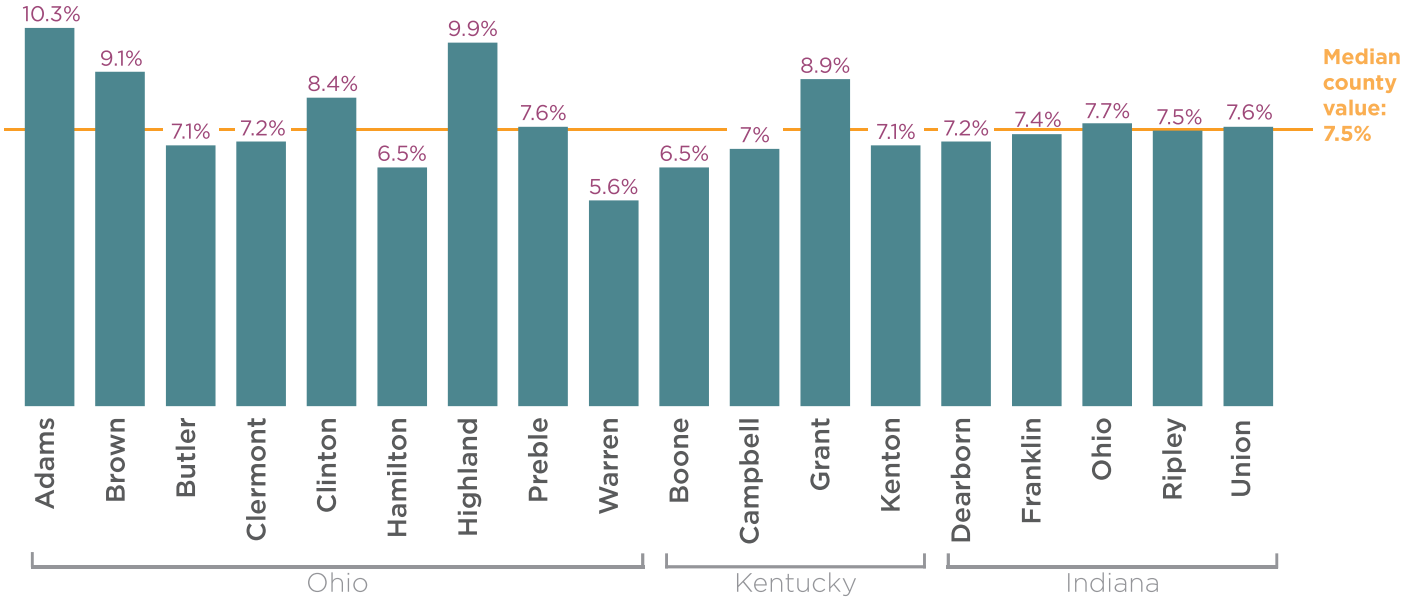
Source: Behavioral Risk Factor Surveillance System, as compiled by County Health Rankings and Roadmaps

Respiratory health

An estimated 8% of adults in the CHNA region have chronic lung disease, which includes COPD, emphysema, and chronic bronchitis (shown in figure 24).

Figure 24. **Chronic lung disease, by county, 2021**

Percent of adults who reported ever having been told by a health professional that they had COPD, emphysema or chronic bronchitis



Source: Behavioral Risk Factor Surveillance System, as compiled by CDC PLACES

Health behaviors and outcomes: Other findings

- Cancer is the second leading cause of death in the region and the colorectal screening rate is low".[38]
- Unintentional injuries, including drug overdose, are the third leading cause of death in the region. "Deaths of despair," which include alcohol-related liver disease, homicide, overdose, and suicide have tripled in the region in the past two decades, driven mostly by increases in overdose.[39]
- There are large disparities in maternal and infant health, such as timely prenatal care, maternal morbidity, gestational diabetes, gestational depression, and pre-eclampsia hospital encounters, across geography, race/ethnicity, and insurance status.[40]

Additional information

Guides to access additional resources, programs, and services in the region:

- **2-1-1 Resources, United Way Greater Cincinnati**
- **Community Characteristics & Resources, HealthSource of Ohio**
- **Homeless & Low-Income Resource Guide, Cincinnati VA Medical Center**
- **Member Directory, Human Services Chamber of Hamilton County**
- **Resource Guide: Brown and Adams County, YWCA Greater Cincinnati**

Significant health needs in the region

The health needs of the region were identified through a robust review of primary and secondary data. Significant health needs are those that rose to the top based on review of the data when looking at prevalence, unmet need, impact, and inequity (listed in figure 25). Appendix E includes more detail on how significant health needs were identified and used in the prioritization process.

Figure 25. **Significant health needs in the region**

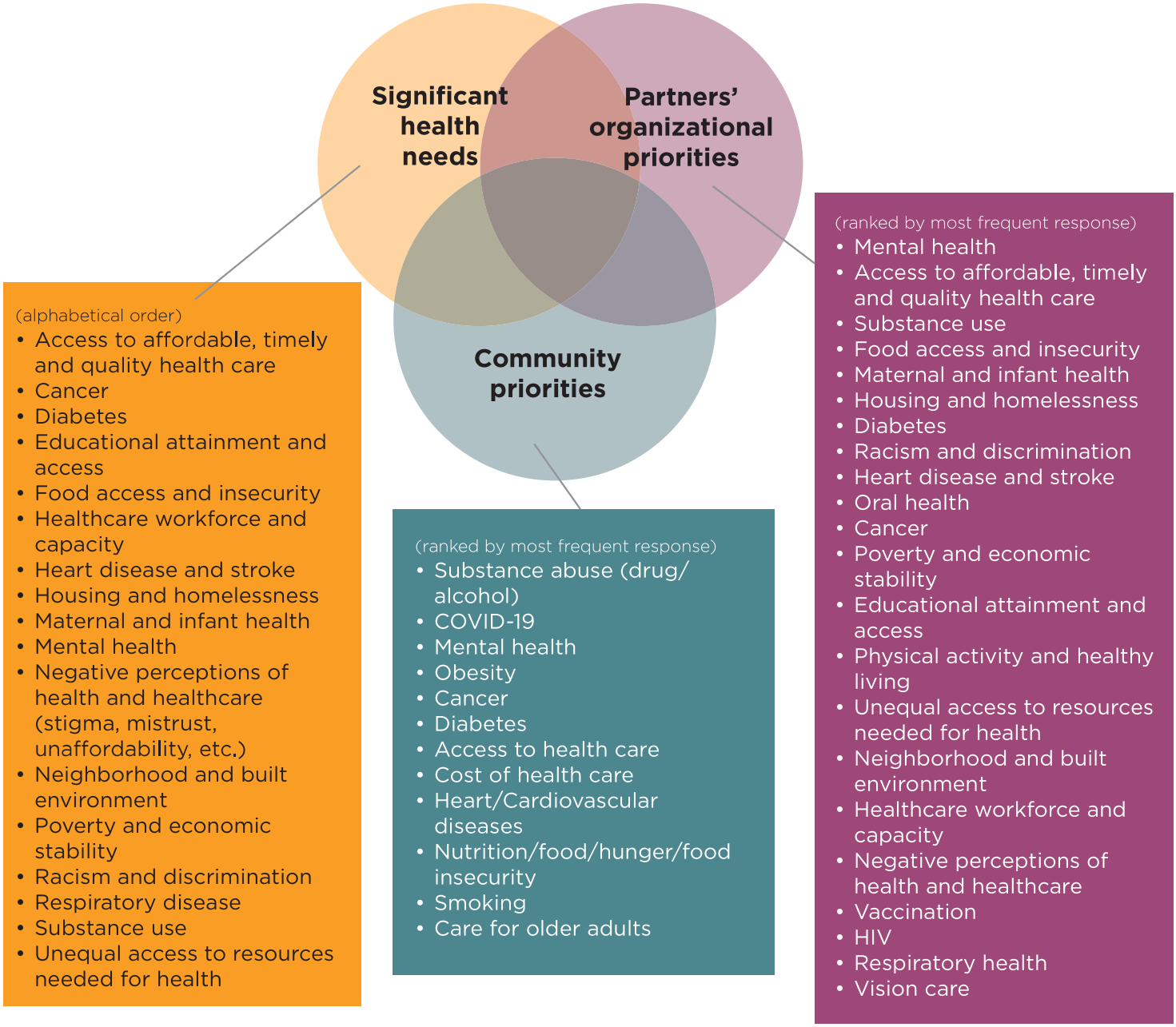
	Healthy People 2030	Ohio SHIP	Kentucky SHIP	Indiana SHIP
Systems of power, privilege, and oppression				
Negative perceptions of health and healthcare (stigma, mistrust, unaffordability, etc.)		■	■	■
Racism and discrimination		■		
Unequal access to resources needed for health	■	■	■	
Social determinants of health				
Access to affordable, timely and quality health care	■	■	■	■
Educational attainment and access	■	■	■	■
Food access and insecurity	■	■	■	■
Healthcare workforce and capacity	■	■	■	■
Housing and homelessness	■	■	■	■
Neighborhood and built environment	■	■		■
Poverty and economic stability	■	■	■	■
Health behaviors and outcomes				
Cancer	■	■	■	■
Diabetes	■	■	■	■
Heart disease and stroke	■	■	■	■
Maternal and infant health	■	■	■	■
Mental health	■	■	■	■
Respiratory disease	■	■	■	■
Substance use	■	■	■	■

Note: Icons indicate alignment with State Health Improvement Plans (SHIPs) and Healthy People 2030

Alignment with community priorities

There is meaningful alignment between the region's significant health needs, the priorities of community members, and the organizational priorities of Regional CHNA partners. Many people and groups across the region are already taking action to address these challenges and improve health. Figure 26 demonstrates how the region's significant health needs, partner priorities, and community priorities are aligned.

Figure 26. **Alignment between significant health needs and partners' and community priorities**



Source: Significant health needs: As defined during the Regional CHNA process; Partners' organizational priorities: "2024 Regional CHNA Pre-Prioritization Survey" administered to Regional CHNA Advisory Committee, Task Forces, and community partners online from September 3 to October 15, 2024; Community priorities: Interact for Health and University of Cincinnati Institute for Policy Research, 2022 Community Health Status Survey

Progress made in previous cycle

Introduction and context

During the 2021 Regional CHNA, three regional priorities and goals were defined and included a focus on access to care for top needs, workforce diversity, and access to resources for food and housing. Specific goals can be found in the Regional Community Health Improvement Plan (CHIP). The information below provides an overview of key initiatives taking place within these three priority areas that are seeking to advance the goals. Within the Regional CHIP, strategies were developed by a cross-sector partnership of stakeholders with suggested timelines and leadership for implementation.

Although The Health Collaborative (THC) oversees the Regional CHNA, we are only part of the ecosystem needed to address problems in our community like healthcare workforce diversity and cardiovascular disease. THC is a unique organization that sits at the intersection of many stakeholders, and therefore cross-cutting strategies and some featured strategies identified within the Regional CHIP sit squarely in our sphere of implementation, and those are documented below. With that in mind, readers are encouraged to review the CHIPs and strategic plans of our partners in this process for more detailed information on specific initiatives different sectors have implemented, all in alignment to our regional goals.

Progress in this document is organized by the three priority areas and includes a summary of reflections and lessons from the COVID-19 pandemic. Community outcomes are provided in Appendix H.

Note: *The regional CHIP was the first of its kind for our community, and therefore progress on these measures, including processes and frameworks for evaluating progress, are still in development. Each measure was identified as a key indicator to monitor over time, however there is not yet a centralized place to track these metrics.*

Goal 1 **Everyone in the region has access to health care when they need it, specifically for the region's top needs: behavioral health, oral health, vision care, and cardiovascular care**

Cross Cutting Strategy 1.0.1: Coordinate, strengthen, and expand behavioral health services in the region.

The Health Collaborative convenes a regional Behavioral Health Continuity of Care committee of hospitals, community mental health providers, freestanding inpatient hospitals, and mental health and recovery boards. While originating from COVID, this group has found value in meeting to address communication and care transitions for the last several years. The establishment of access to health services as a regional priority further amplified the need for cross-sector collaboration among providers

in our region. To date, THC has launched the Behavioral Health Provider Directory, where providers from across hospitals and community mental health organizations can access critical contact information for each other regarding admissions or discharges for shared patients. Through this directory, THC maintains a listing of contacts at each organization to facilitate real-time and direct communication across organizations for patient care. We do this as a service to our members in recognition of the multi-stakeholder partnership that is needed to provide coordinated and efficient care across the continuum. It provides an up-to-date listing of our network of behavioral health providers throughout the region.

Additional momentum is growing for addressing mental and behavioral health in our region with the **creation of several key initiatives among partners**, outlined below.

- **HEY! Cincinnati** is a diverse coalition of community groups, healthcare providers, educators, policymakers, families, and young people themselves, working collaboratively to create a community that supports the well-being of all youth from ages 0-24 in Greater Cincinnati, especially those facing the greatest barriers and disparities. Developed with the Youth Fellowship, HEY! ensures this collaborative effort feels accessible and relevant to youth in our community.
- **Mental Health and Addiction Advocacy (MHAC) Behavioral Health Workforce Coalition** is a coalition led by the Southwest Regions MHAC, a statewide organization that unifies diverse local voices to advocate for the goals of increasing awareness of issues and advancing policies for Ohioans affected by mental illnesses and addiction disorders.
- **New Crisis Center** will open in 2025. The Hamilton County Crisis Center will be a centralized location providing addiction and mental health crisis and stabilization services and treatment services. The facility will also include a primary care clinic to address the overall health care needs of the clients. Several existing programs will be moving to this new location, and new programs will be established.

Featured Strategy: 1.2.1 Support ongoing efforts to reduce hypertension and stroke in the region through preventive services.

Like many other conditions, heart disease is often best treated as early as possible through preventive measures. These efforts at education and self-care can help avoid more deadly progressions of heart disease. In our community, many healthcare institutions and community-based organizations are stepping up to address hypertension and cardiovascular diseases among many populations. To assist in the opportunity for collaboration on this health outcome, THC has partnered with the Cincinnati Health Department to research and review local efforts to address heart disease and present a potential opportunity for a Cardiovascular Collaborative. With funding from the city of Cincinnati, this planning period includes extensive listening sessions with key stakeholders across healthcare and community, learning from other communities who are doing this work well, and better understanding data at the neighborhood level to create strategies for intervention and community engagement. This project, called HEAL (Health Equity and Attainable Life Expectancy) showcases a cross-sector partnership to address a critical healthcare challenge that is faced by our entire region, where solutions span sector.

Goal 2: The health care education pipeline and workforce are strong, reflect the diversity of our region, and deliver equitable care to everyone

Priority 2.1: Expand and diversify the healthcare workforce pipeline through education and hiring opportunities.
Highlighted Program: The Health Collaborative, in partnership with Cincinnati State, developed a program to support and grow medical assistants, with a focus on diversity within the cohorts.
- Medical Assistant Apprenticeship Program with diversity in each of the 10 cohorts ranging from 25-60%.
- Cohort 11 launched in January 2025.

Other key activities related to this priority include the following, and more information can be found on **The Health Collaborative's website for Workforce Innovation**.

Convening

The Health Collaborative convenes over 50 affinity groups throughout the year. Through our Workforce Innovation team, the following key stakeholders are brough together to discuss challenges and opportunities for collective action and collaboration.
- Workforce Advisory Council
- Ohio Healthcare Education and Workforce Leaders
- Ohio Healthcare Workforce Collaborative
- Ohio Healthcare Industry Sector Partnership Leaders
- Regional Career Exploration Collaboration
- Hospital Chief Nursing Officers
- Hospital Chief Human Resources Officers

The Health Collaborative also hosts Healthcare SuccessBound, an annual event hosted in partnership with TechPrep.

Advocating for Systems Change

Workforce Innovation at The Health Collaborative has been collaborating with organizations state-wide to "uncrimp" Ohio's nursing pipeline over the past year by obtaining:
- Approval of Ohio's first-ever Industry Transfer Assurance Guide (ITAG) for individuals with active LPN credentials, guaranteeing them college credit at Ohio-funded state colleges and universities.
- Ohio legislative support for changing LPN instructor requirements (Ohio House Bill 583)
- Ohio Department of Health support implementing STNA rule changes for instructor requirements, program delivery, passing test score, and more.

To ensure the quality and availability of healthcare to people in Southwest Ohio, and across the CHNA region, Workforce Innovation continues to lead and support collaboration with regional partners. We remain committed and steadfast to

advocating for smart regulations, sharing innovative practices, and pursuing resources to reduce the nursing shortage.

Career Exploration

The Health Collaborative offers numerous options for students and job seekers to explore healthcare careers and for employers to engage in initiatives to build their future workforce.

- TapHealth Programs (TapMD, Tap Remote)
- You Belong in Healthcare TAP Event
- Tap Health Summer Academy
- HealthFORCE annual event — the region's largest healthcare career expo to give high school students an opportunity to explore a range of careers in healthcare!

Launch of HealthFORCE Boost! — a new event of HealthFORCE specifically designed for adult job seekers. This new healthcare careers fair & hiring event allows adult job seekers to explore numerous job opportunities, college and training programs, and resources. In 2024, **this event saw**:

- 5 healthcare industry panelists
- 858 high school students from 26 regional high schools
- Over 50 high school educators
- 120 healthcare employer exhibitors & volunteers with 45 tables

Workforce Innovation is dedicated to being a good partner and representing our members' interests throughout Greater Cincinnati. To achieve this, we actively participate in many healthcare and workforce advisory councils, boards, committees, and planning groups, including the following:

- Catholic Inner-City Schools Education (CISE) Business Advisory Council
- Cincinnati Public School's Healthcare Advisory Groups and Business Advisory Council
- Cincinnati State's Nursing Advisory Council
- Cincinnati & Hamilton County Public Library's Community Advisory Council
- Great Oaks' Healthcare Advisory Council
- Greater Cincinnati Business Advisory Council
- Mental Health and Addiction Advocacy Coalition
- NKY Works (formerly GROW NKY)
- Northern Kentucky College & Career Counselor Network
- Ohio Workforce Council's Leadership Committee
- River City School District Network
- Scarlet Oaks Healthcare Advisory Council
- Sinclair Community College's Strategic Planning Group
- SW Ohio Tech Prep's Strategic Planning Group
- The Talent Collaborative's Steering Committee and Founding Member
- UC's Allied Health Colleges Diversity Liaison Committee
- Warren County's Workforce Strategic Planning
- Workforce Council of SW Ohio Board of Directors

Priority 2.2: Track and consistently publish ongoing workforce data and statistics in a regional dashboard, including class sizes, vacancy rates, and diversity percentages at a regional level, publishing these results annually.
Published in 2023, this dashboard houses key data from JobsEQ across 10 key positions, including diversity data. All detailed information can be found on The Health Collaborative's jobs dashboard located here: **https://workforce.healthcollab.org/data/**. The most recent available data is from 2023 and was updated in February 2025.

Other Key Activities:

- **Increasing participation and diversity in healthcare pipeline**: Tap Health programs saw an overall increase in student participation and an increase in students from a variety of backgrounds (i.e., diversity in students participating) over the last 3 years. For information about our most recent TAP Health Summer Academy, including photos and interesting statistics, please click here: **https://taphealth.healthcollab.org/wp-content/uploads/2024/11/THSA-WRAP-UP-PRESENTATION-1.pdf**
- **Increasing Diversity in Supply Chain**: The Health Collaborative and Cincinnati Children's Hospital began to partner on an event in 2023 and 2024 to connect local and underrepresented suppliers to healthcare leaders and professionals in the region. This event and program is called **DirectConnect**, an event providing opportunities to share knowledge and connect with suppliers while hearing from local healthcare leaders about ways that diverse-owned businesses can set themselves up for success. There is also exposure for suppliers to community resources in the areas of funding, certifications, business advisors, and more. In 2024, over 150 people attended the event and there were 20 exhibitors at the vendor fair.
- **Strengthening culturally competent care:**
  - The Health Collaborative and Greater Dayton Area Hospital Association have joined efforts to complete an **Anti-Human Trafficking Toolkit** to be utilized in a hospital setting. The Health Collaborative attended the Southwest Ohio Human Trafficking Conference, where they were featured as a panelist in a multi-professional discussion about all things human trafficking. We are grateful to be a part of work that helps professionals across the state unite to combat trafficking and to serve survivors.
  - The Emergency Preparedness and Response team at The Health Collaborative leads and manages the TriState Disaster Preparedness Coalition (TSDPC). TSDPC's mission is to promote and enhance healthcare entities' emergency preparedness and response capabilities, which includes prioritizing plan equity and inclusion in regional and local preparedness plan development. In 2024, the TSDPC **launched a new Health Equity in Emergency Preparedness (HEEP) Taskforce** to center the voices of those living with disabilities, or those working with people with disabilities, to create more equitable strategies for assisting people in times of emergencies.

Goal 3

Everyone in the region has access to healthy, affordable food and quality, affordable housing

Cross Cutting Strategies:
3.0.1 Improve coordination between health care systems and social service agencies by establishing a shared mechanism to screen, refer, and follow up on patients' health related social needs (e.g. housing, legal issues, food insecurity).
The Health Collaborative served as a bridge organization for clinical teams and community navigators during a large federal funding opportunity called Accountable Health Communities (AHC). The Health Collaborative administered and monitored this pilot program from 2017-2023. The **AHC Model** addressed a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs (HRSNs) of Medicare and Medicaid beneficiaries' through screening, referral, and community navigation services will impact health care costs and reduce health care utilization.

In 2022, THC wrote for an extension to our funding to support another 12 months of work with our partners at hospital sites, federally qualified health centers, community pathways hub, and health plans. A critical policy change was enacted at the federal level in 2023, requiring all hospitals to screen all patients who were admitted for HRSNs, following the standards of the AHC model. These HRSNs include food, housing, interpersonal violence, utilities, and transportation. During our grant extension period (2022-2023), The Health Collaborative began to bring together key hospital partners to build a sustainability plan for this work after the grant period. As a result of that funding, The Health Collaborative has a unique view of the challenges and opportunities our region faces when seeking to better connect patients in medial settings to resources to meet their needs in social settings, and we are dedicated to continuing to support stakeholders in this endeavor.

Over the last three years (2022-2024) The Health Collaborative has continued to support hospital members and community partners in this space, convening hospitals around alignment and opportunities for collaboration on the operationalizing of the screening requirements, and ensuring key community partners in care coordination (e.g., Council on Aging, United Way, Healthcare Access Now) are informed about the developments in federal requirements for hospitals. In the last year alone, we have brought together hospital leadership to discuss and collaborate more than 10 times and care coordination partners over 20 times. We also recently received funding as a subgrantee to Xavier University to assist in the development of a pilot program utilizing students to serve as navigators, and AmeriCorps members, for connecting patients to resources. This planning grant comes from ServeOhio and is in partnership with TriHealth and CareSource.

3.0.2 Increase the number of Community Health Workers to connect individuals to resources and programs addressing food and housing needs.
To accurately track the number of CHWs in our region, a data source is required. Over the last 3 years, THC has explored possible data sources to document progress on this strategy. This research as returned the following results as possible data sources:

- JobsEQ data source
- Local Hospital employees
- The community pathways HUB Healthcare Access Now (HCAN)
- Community Based Organizations employees

While there are possible sources for this data, there is no clear alignment of definitions of the CHW role across these institutions, or clear data sharing agreements to aggregate the information. There are standard definitions for CHWs through the credentialing and licensing of CHWs at the Board of Nursing for the state of Ohio. Moreover, THC continues to learn from the recently established CHW Center for Excellence in Columbus, Ohio.

Reflections on the COVID-19 Pandemic

The COVID-19 pandemic was a generational event that impacted our state, our country, and the world in profound ways. The Health Collaborative is proud to have worked and be part of the solution that helped put an end to the pandemic for Ohioans. During the efforts to put together a comprehensive post-pandemic playbook, we realized that crisis response is far more than the medical and logistical plan, but also the human factor that unites us, builds trust, and strengthens our communities during the most challenging of times. Reflections from community members across sector showcase that the best problems are solved together through **humility**, **trust,** and **empowerment**.

Humility

The weight of expectation is a heavy burden for healthcare professionals. But the willingness to encourage, accept, and implement ideas from a wide array of subject matter experts guided our response and now provides a standard to move the needle in times of crisis. How we each come to the table provides the capability of collaboration. Organizations, coalitions, and committees from across the state came humbly and openly together and thus tackled the COVID-19 pandemic collaboratively.

Trust

Because so many came to the table humbly and openly, trust was quickly built amongst members of the Collaborative. The experts associated with the pandemic response expended an immeasurable amount of time and effort to work through the unprecedented challenge. The trust amongst all parties, the idea that everyone could be counted on to do their part, pulled everyone onward and forward. As a result, mutual solidarity was evident to the communities we serve, and the public was able to trust what they were being told.

Empowerment

With trust and solidarity, we could focus on ensuring that our communities could feel supported and informed. There was a strong focus on making sure those

that were underrepresented and vulnerable to COVID-19 exposure and illness received particular care and attention. Communities of color, older adults, and people experiencing homelessness all had advocates that kept them included in the response. The result was empowerment through critical data, information, and knowledge. The Health Collaborative made it a mission to collect and share high quality data with the understanding that letting our communities make informed decisions would empower them and include them in the response efforts, bringing us closer together at a time when it was desperately needed.

The Health Collaborative spearheaded response efforts to align the COVID-19 response and collected invaluable data that will allow us to better understand and respond to extreme public health events going forward. We also learned and experienced the innate human factors that allowed us to come together, to move in coordination, and solve problems that were truly only ever going to be best solved together. As we heed the words of those that were leading the way, we know now that it is the spirit, the resolve, and the determination of humans that rise to the level of equal importance as the data we so diligently collected and of the future preparedness plans that we have cultivated, and of the scientific advances that we have made.

For more information on reflections, lessons, and key learnings of COVID, please see the following resources:

- **Learning From COVID-19 To Overcome System Hesitancies In Public Health Preparedness And Response**
- **A regional learning health system of congregate care facilities for COVID-19 response**

Regional CHNA report authorship

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