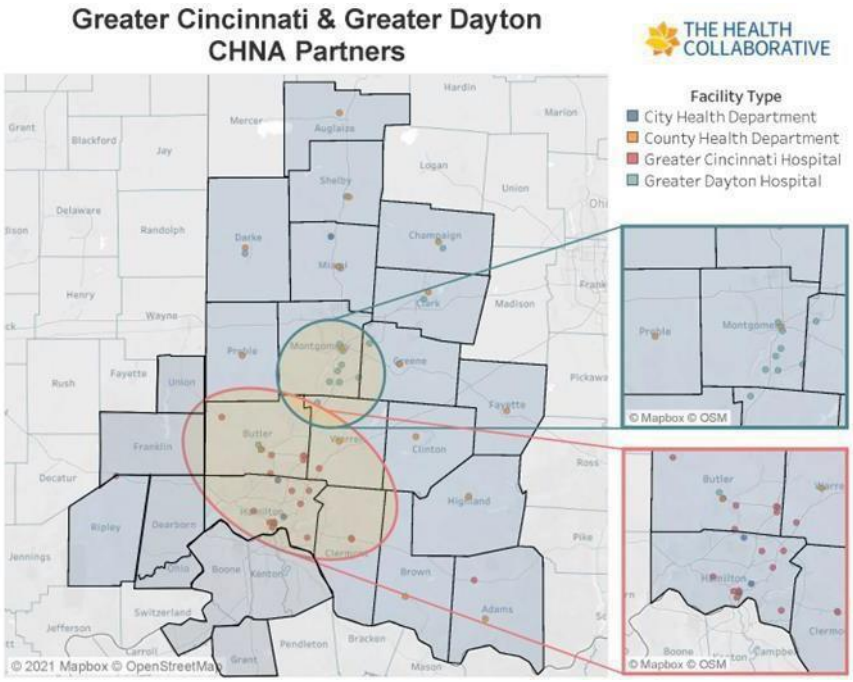
McCullough-Hyde
Memorial Hospital | TriHealth

2025 Community Health Needs Assessment

110 North Poplar Street
Oxford, Ohio 45056
Butler County



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Introduction

McCullough-Hyde Memorial Hospital | TriHealth's (MHMH) long standing commitment to Oxford and its community served (Preble and Butler County of Ohio, and Franklin and Union Counties of Indiana) spans almost 70 years. MHMH has grown along with our community, continually assesses the needs of our communities as we develop innovative programs and services. Over the last year, we have completed a comprehensive Community Health Needs Assessment (CHNA). Our CHNA included input from a wide variety of sources, including, but not limited to customers, community leaders, physicians, county health departments and a paid external consultant.

Through our CHNA, MHMH has identified the greatest health needs in our community, which will allow MHMH to direct our resources appropriately toward education, prevention programs, and wellness opportunities. The significant health needs of the MHMH community served are in order of priority:

1. Mental Health
2. Substance Use including drugs and/or alcohol
3. Healthy Behaviors including access to healthcare, food, transportation, housing and physical activity
4. Chronic conditions including hypertension and stroke

The following document is a detailed CHNA for MHMH, a community hospital located at 110 North Poplar Street, Oxford, Butler County, Ohio 45056. The McCullough and Hyde families opened McCullough-Hyde Memorial Hospital's doors in 1957. The facility's main campus has grown over the years. The last major expansion/renovation occurred in 2017. With a major Obstetric update completed in 2021. MHMH is affiliated with TriHealth, Inc., which is an integrated health care system, whose mission, vision, leadership, and resources help us serve our communities. Through our affiliation with TriHealth, Inc. the resources of Good Samaritan Hospital, Bethesda North Hospital, and Bethesda Butler Hospital are also available to our patients.

MHMH's main campus offers forty-five acute inpatient beds, including intensive care, medical-surgical and obstetrics. MHMH also offers an array of outpatient medical and surgical services, including emergency 24/7, outpatient surgery, oncology/infusion center, physical therapy and diagnostic services which include laboratory and imaging services. MHMH houses numerous specialists to care for a multitude of needs and offers services at our regional campuses located in Camden, Oxford and Hamilton in Ohio and Brookville and West College Corner in Indiana.

MHMH recognizes that a CHNA is required to meet current government regulations for 501(c)(3) tax exempt hospitals and this assessment is intended to fulfill this purpose. We also recognize the importance of this assessment in helping to meet the needs of our communities.

MHMH participated in the broader Regional CHNA process to assess the region's community health needs. The Regional Community Health Needs Assessment 2025 Report is available at https://healthcollab.org/wp-content/uploards/2022/02/2021-Regional-Community-Health-Needs-Assessment-cobranded.pdf. MHMH carefully considered the health needs identified in the Regional CHNA for the communities served by MHMH. In addition to the Regional CHNA process, current data and input from local leaders, physicians and community advocates were solicited to determine the significant health needs for the MHMH community served through community roundtable meetings and surveys conducted in 2024. This MHMH CHNA was completed in 2025; however, all other data collection was completed in 2021 and 2024. The MHMH CHNA is the foundation for our implementation plan as

required by the applicable regulations. The question of how the hospital can best use its limited resources to assist communities is addressed in our implementation plan. MHMH has taken a leadership role in both the CHNA and in our communities' plans to address the needs identified.

Please contact Frank Nation, VP Mission and Culture, at 513-569-6248, or at *Frank_Nation@trihealth.com* to obtain a hard copy of the CHNA report at no charge. Written comments regarding this CHNA report and related implementation strategy may be submitted to *Frank_Nation@trihealth.com*.

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Summary of Regional Approach and Health Findings Introduction

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 and systems 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 and 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

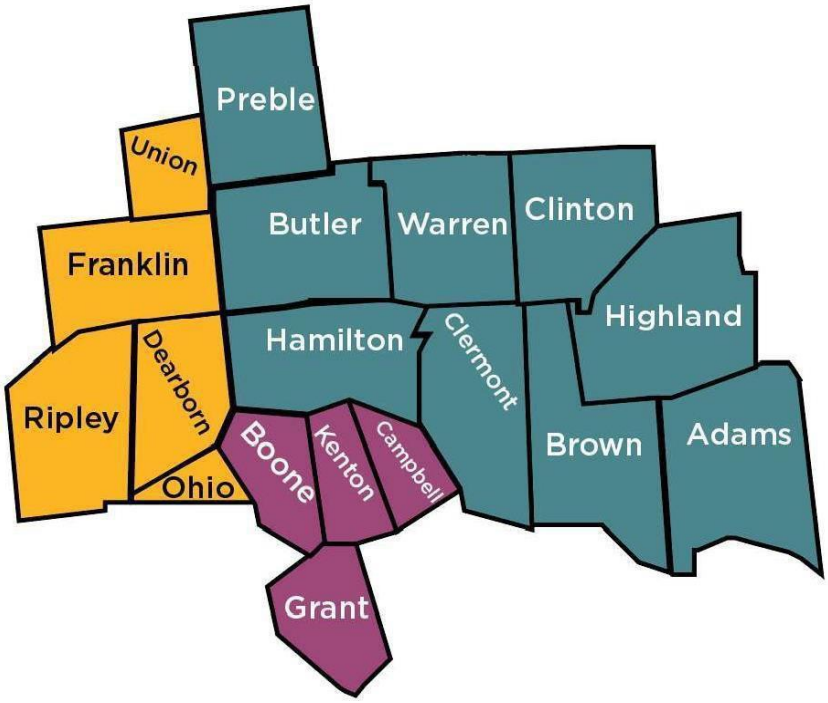
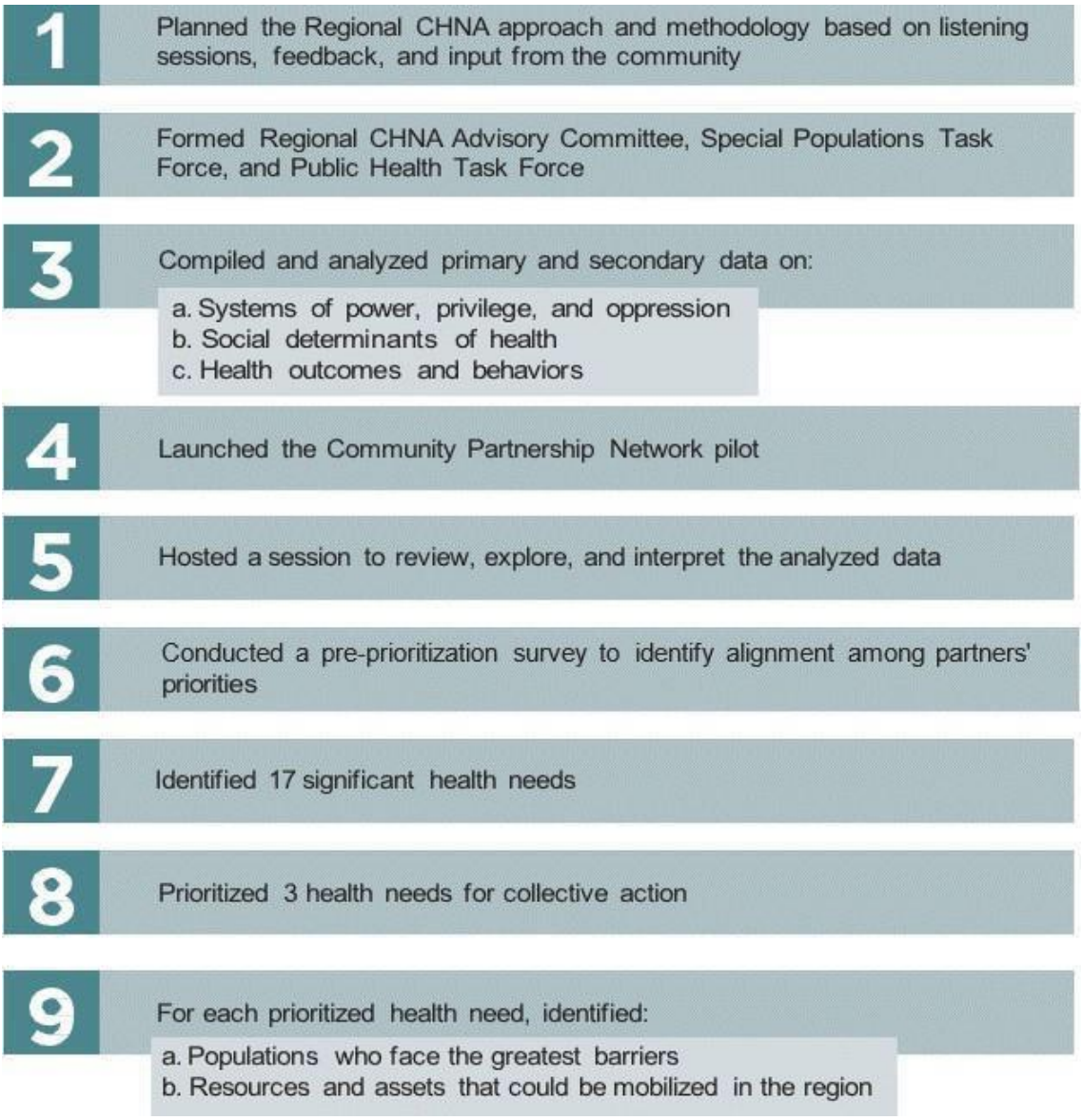


Figure 1. **Framework for collective action**

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.

How was the Regional CHNA developed?



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 Community Engagement approach. Appendix B describes the Regional CHNA advisory structure. Appendix C describes the data collection and analysis methodology, and Appendix D 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 priority populations 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 CHNA process
- Leaning on alignment and shared decision-making to drive health improvement strategies

Community voice

- Analyzing primary data, including community surveys, to center lived experiences and perspectives
- Engaging grassroots organizations and others who work directly with priority populations in the advisory structure to guide the CHNA process
- Launching the Community Partnership Network to facilitate bidirectional communication between 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:

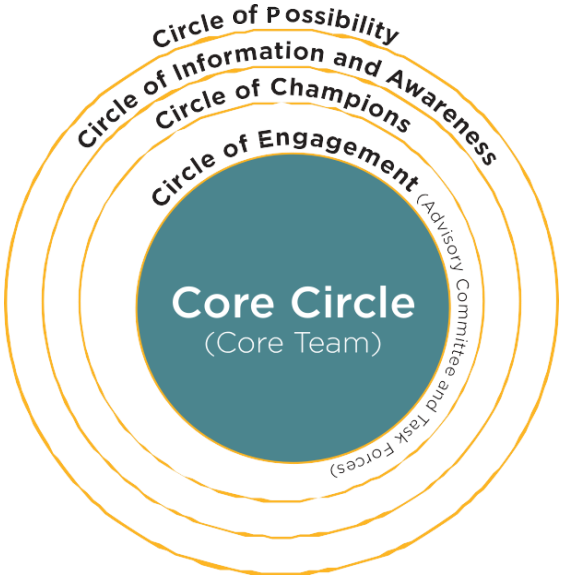
1. **Share data and information.** Post graphics on social media, share data and information in community presentations, and forward the report to partners and community members.
2. **Align health improvement efforts.** Partner and collaborate across and within sectors to improve outcomes in the region.

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 priority populations 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.

Regional CHNA Methodology

Collaborative Advisory / Work Structure

The advisory structure for the Regional Community Health Needs Assessment (CHNA) was built using the Mobilizing Action through Planning and Partnerships 2.0 (MAPP) Circle of Involvement Framework. This includes the:



See Appendix B for membership.

Community Engagement

Building the assessment and telling the community story

To minimize the burden on community members who report being over-surveyed and assessed, the Advisory Committee decided to leverage recent, existing sources of primary and secondary community data, rather than collecting new primary data. Advisory Committee and Task Force members were invited to share any data they have collected to be included in the Regional CHNA, with a focus on sources that filled data gaps (described in Appendix C). Seven additional sources of community data were identified and included in the Regional CHNA.

Data Collection and Analysis

The Health Collaborative contracted with the Health Policy Institute of Ohio (HPIO) to develop the Regional Community Health Needs Assessment (CHNA). The analysis was guided by a set of research questions, and consisted of:

- Secondary, quantitative data compilation and analysis
- Additional primary and secondary community data analysis

Research Questions

The Health Collaborative and HPIO developed the following research questions, based on Public Health Accreditation Board (PHAB) and Internal Revenue Service (IRS) requirements, to guide development of this Community Health Needs Assessment:

1. What are the most significant health needs in the region?
2. What populations are experiencing inequities and disparities across health, socio- economic, environmental, and quality-of-life outcomes?
3. What are the systems and structures that drive the identified health needs?
4. What strengths and resources does the region have that can address the region's most significant health needs? What resources and assets exist to support communities experiencing inequities and disparities?
5. What progress have partners made on the priorities identified in the last CHNA?

Secondary, quantitative data analysis methodology

How were metrics selected?

HPIO reviewed a wide range of publicly available data sources, including national- and state-based population health surveys, vital statistics, and administrative data from state and federal agencies, among other sources. Using these sources, HPIO compiled a list of 264 metrics for consideration in the Regional CHNA. From this inventory of metrics, The Health Collaborative and HPIO recommended 67 secondary, quantitative metrics using the following criteria approved by the Advisory Committee.

Metric selection criteria

Goal: Identify the **most important** metrics needed to describe the region's significant health needs, including social and structural drivers of health

- **Data availability** — Data available at the county-level that can be assessed for long- term trend (change over time), compared to performance of the U.S. or the state overall, and can be disaggregated to look at disparities and inequities (e.g., by race, ethnicity, household income)
- **Source integrity** — Metrics are recognized as valid and reliable, and data is gathered from reputable sources
- **Face value** — Metrics are easily understood by the public
- **Alignment** — Metrics align with relevant state and local plans
- **Data quality and recency** — Data for the metric is complete, accurate, and most- recent data is from the past three years

See Appendix C for more information

Regional Priorities

Coming to consensus around shared regional priorities

Throughout the Regional CHNA process, THC emphasized the shared values and principles of collective action for the Advisory Committee and Task Force members. This invited alignment from partners on the significant health needs, potential priorities, and final priorities is described in Appendix D.

To inform the prioritization process, HPIO developed a pre-prioritization survey to be completed by hospitals, local health departments, and other community partners. Of the forty-seven partners who responded, the largest proportion represented community- based organizations (28%), highlighting the inclusion of community voices through the prioritization process.

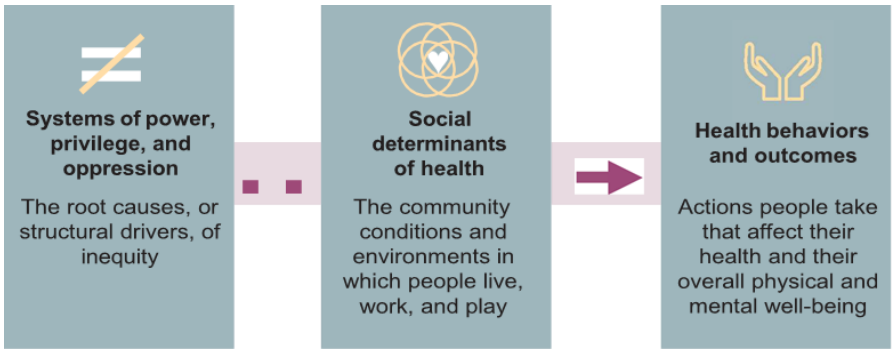
What Shapes the Region's Health and Well-Being?

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.

Regional CHNA domains: The root causes of health outcomes and inequities



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

Significant Health Needs in the Region

The health needs of the region were identified through a robust review of primary and secondary data with community and stakeholder input. 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. Appendix D includes more detail on how significant health needs were identified and used in the prioritization process.

Significant health needs in the region

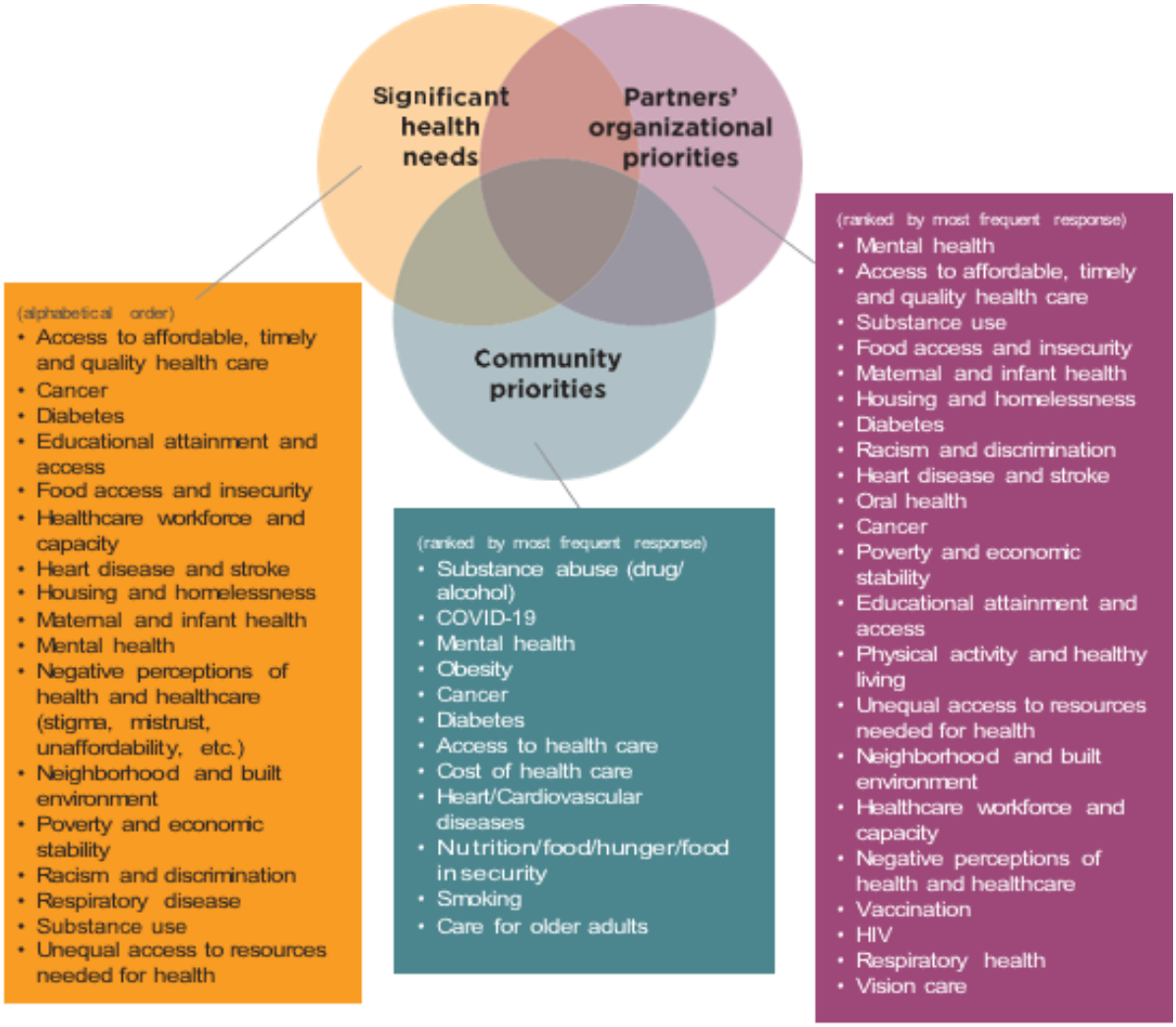
	Healthy People 2030	Ohio SHIP	Kentucky SHIP	Indiana SHIP
Systems of power, privilege, and oppression				
Negative perceptions of health and healthcare (stigma, mistrust, unaffordability, etc.)		✓	✓	✓
Racism and discrimination		✓		
Unequal access to resources needed for health	✓	✓	✓	
Social determinants 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. How the region's significant health needs, partner priorities, and community priorities are aligned is demonstrated below.

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

Regional Health Priorities

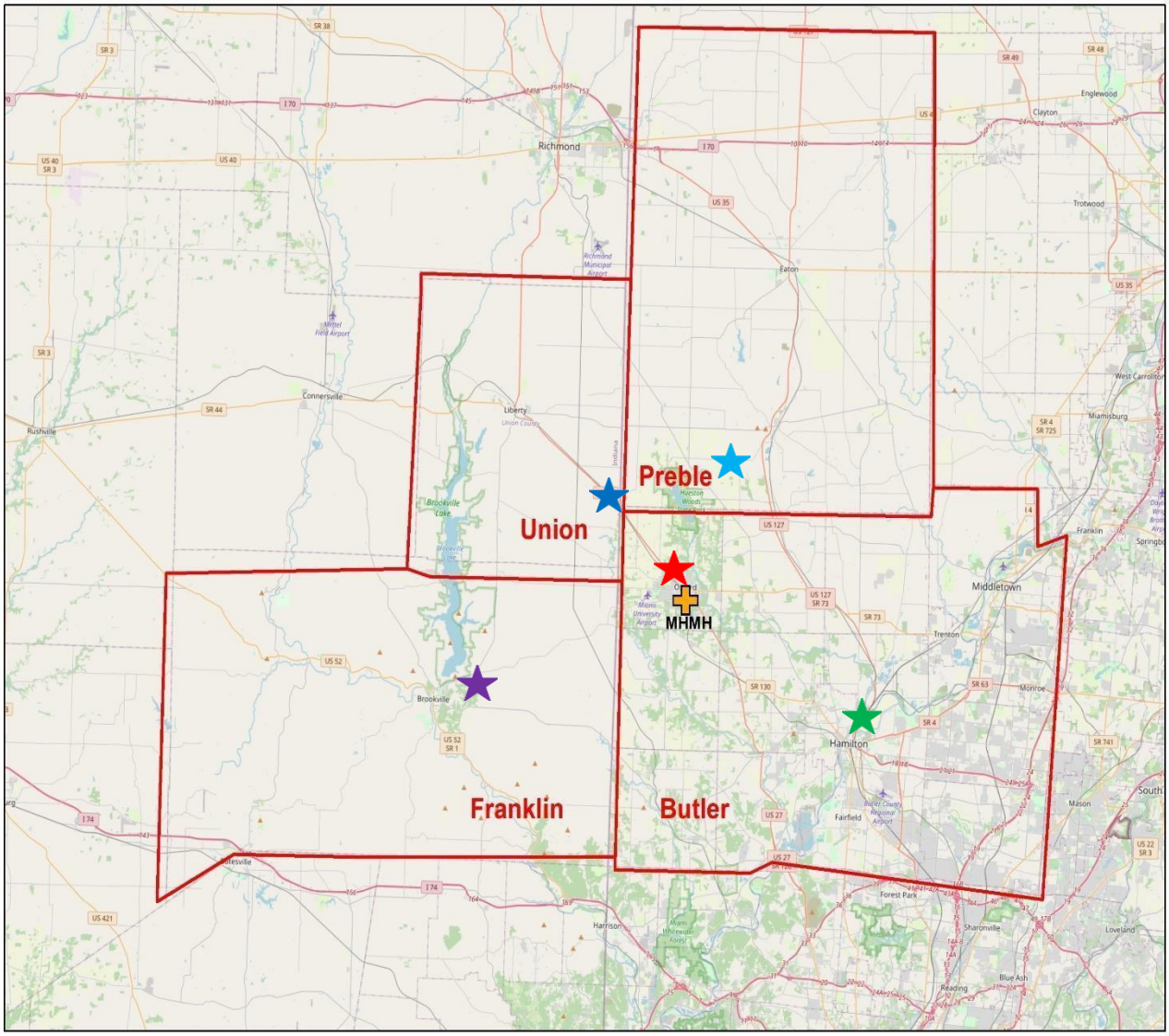
To improve health, address community conditions that undermine health, and tackle the systems that prevent some of our neighbors from living long and healthy lives, CHNA partners selected the following three priorities for collective action:

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?

McCullough-Hyde Memorial Hospital's Service Area

McCullough-Hyde Memorial Hospital defines its service area to be Butler and Preble counties in Ohio, and Franklin and Union counites in Indiana as determined by the county of origin for inpatients. MHMH gets more than 92% of its inpatients from a four-county region.



- Brookville, Indiana Services: Primary, Pediatric, and Obstetric Care
- West College Corner, IN Services: Primary Care
- Camden, Ohio Services: Outpatient Imaging and Laboratory
- Oxford, Ohio Services: Primary, Pediatric, Obstetric, Specialty Care, and Physical Therapy
- Hamilton, Ohio Services: Physical Therapy

Service Area Demographics

Demographic	Franklin	Union	Butler	Preble
2024 Population	17,064	6,950	386,704	39,584
2029 Projection	17,353	6,841	392,395	39,257
Population by Race				
White	96.0%	95.0%	74.0%	94.5%
African American	0.2%	0.5%	9.8%	0.5%
All Other Races	3.8%	4.5%	16.2%	5.0%
Hispanic (Any Race)	1.0%	1.2%	7.2%	1.3%
Population by Gender				
Female	49.6%	50.1%	50.8%	50.5%
Male	50.4%	49.9%	49.2%	49.5%
Population by Age	**Franklin**	**Union**	**Butler**	**Preble**
<5	6.2%	5.6%	5.8%	5.4%
5-17	16.2%	15.8%	16.6%	16.0%
18-24	9.0%	8.9%	11.1%	9.1%
25-44	20.9%	21.8%	24.8%	21.2%
45-64	26.6%	25.7%	24.5%	25.6%
65+	21.2%	22.1%	17.3%	22.7%
Median Age	43.4	43	39.3	42.8
Household Income				
Household Income Below 50k	33.3%	32.1%	34.0%	34.5%
Household Income Below 25k	12.8%	8.0%	15.1%	13.7%

Source: Sg2 Feb 2025

Life Expectancy

County	Overall	Asian	Black	Hispanic	White
Franklin (IN)	76.2	-	-	-	-
Union (IN)	75.5	-	-	-	-
Butler	76.4	86.7	74.6	97.8	76.1
Preble	75.7	-	-	-	-
4 County Average	75.9	86.7	74.6	97.8	76.1
Ohio Average	76.4	88.3	73.8	89.1	76.7
Indiana Average	75.6	87.6	71.1	85.7	75.8

Source: https://www.countyhealthrankings.org/health-data/ohio/data-and-resources

Community Health Needs Identified by McCullough-Hyde Memorial Hospital

Community Health Issues and Disparities

1. Mental Health
2. Substance Use including drugs and/or alcohol
3. Healthy Behaviors including access to healthcare, healthy eating, physical activity, housing, transportation, and other resources
4. Chronic conditions including heart disease, hypertension and stroke

The Community Needs priorities identified in the Regional CHNA, summarized on page 10, were titrated to the hospital service area and hospital scope, with TWO of the three regional priorities identified by McCullough-Hyde Memorial Hospital as key community needs. In addition, McCullough-Hyde Memorial Hospital identified several health issues that are specific to its four-county service area.

Regional (18-County) Priority 1: Mental Health treatment and prevention

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

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 93% over the last 27 years and nearly 1 in 5 adults report frequent mental distress.[1]
- The number of deaths due to suicide in the region is 10% higher than the national average and 20% higher than the national Healthy People 2030 benchmark.[2]
- Community members often do not have a way to find needed services and to identify trusted mental health providers.[3]
- Barriers to accessing treatment include stigma, lack of insurance coverage, limited availability of providers, and a lack of culturally responsive mental health services.[4]
- As of 2023, only about 18% of residents in the region had heard about the 988 National Suicide Prevention Lifeline.[5]

[1] "About Mental Health." Centers for Disease Control and Prevention, Accessed December 13, 2024. https://www.cdc.gov/ mental-health/about/index.html

[2] "About Mental Health." Centers for Disease Control and Prevention, Accessed December 13, 2024. https://www.cdc.gov/ mental-health/about/index.html

[3] "2021CHNA focus group results." The Health Collaborative and Measurement Resources Company, 2021.

[4] Ibid.

[5] Our Health, Our Opportunity. Cincinnati, OH: Interact for Health, September 2024. https://www.ourhealthouropportunity. org/. Residents surveyed

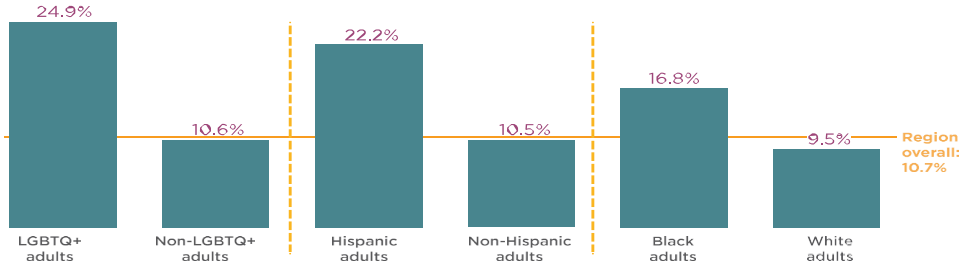
The percentage of adults in the Greater Cincinnati region with depression nearly doubled between 1995 and 2022.

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

There are notable disparities in access to mental health treatment by sexual orientation, gender identity, race, and ethnicity in the region.

Access to Mental Health Treatment, By Race, Ethnicity, Sexual Orientation, and Gender Identity, 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

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.

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 c2021)	17.0%**	14.6%	N/A	Worse	N/A
Suicide deaths c201?-2021)	15.5	14 (2021)	12.8	Worse	Worse

were in the region covered by Interact for Health which serves 20 counties across Ohio, Kentucky, and Indiana.

*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: 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**

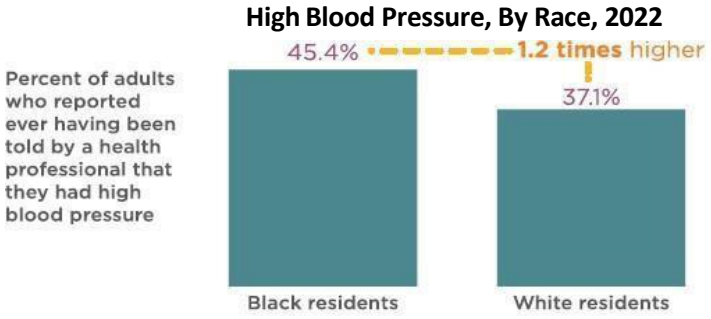
Regional (18-County) Priority 2: Heart Disease and Stroke prevention and treatment

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

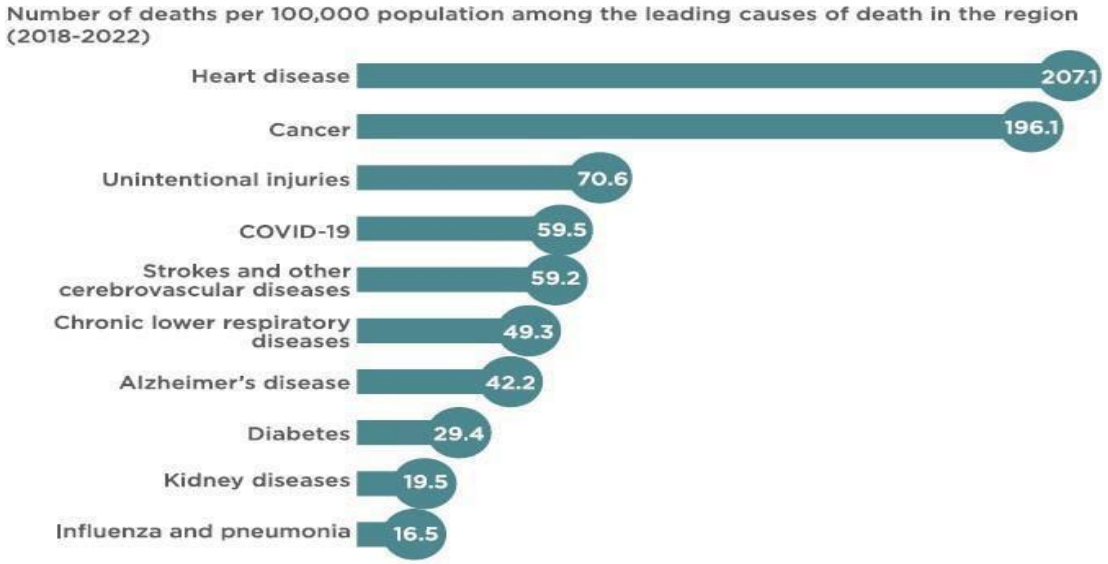
Forty-five percent of African American residents in the Greater Cincinnati area report having been diagnosed with high blood pressure (i.e., hypertension) by a healthcare provider, compared to 37% of white residents.



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

Heart disease and stroke related to hypertension were among the leading causes of death in the region from 2018 to 2022.

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)

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. 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.

National Benchmarks for Heart Disease and Stroke*

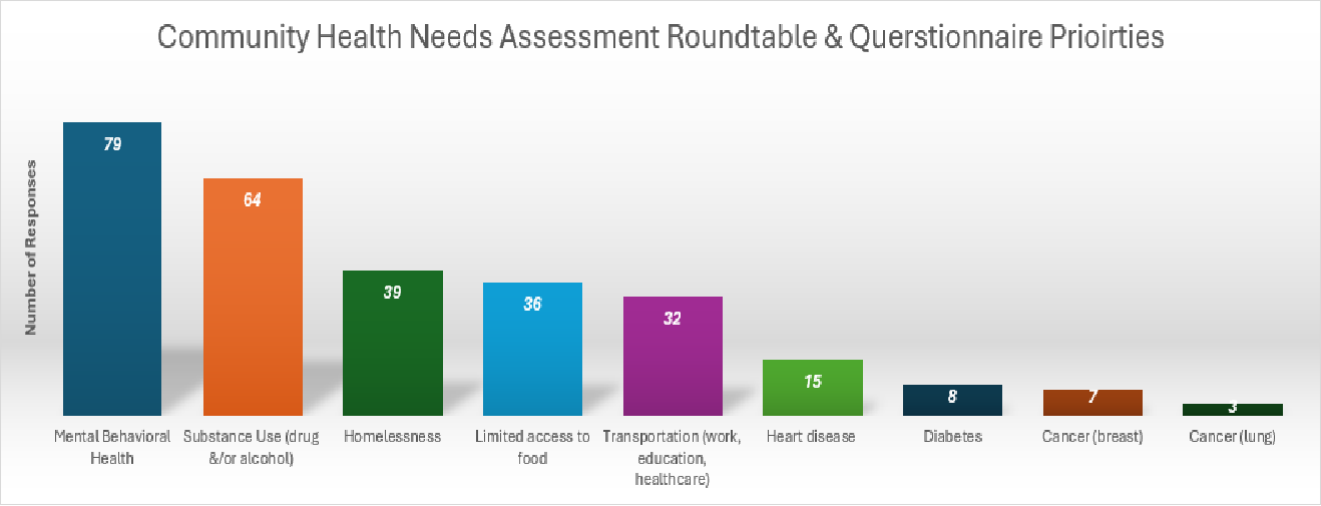
	Regional value	U.S. overall	Healthy People 2030 benchmark	Region compared to U.S.	Region compared to Healthy People 2030 benchmark
Heart disease prevalence (2021)	5.7%**	3.8%	N/A	Worse	N/A
Hypertension prevalence (2021)	32.6%**	32.4%	N/A	Same	N/A
Stroke prevalence (2021)	2.8%**	3%	N/A	Same	N/A
Heart 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**.

McCullough-Hyde Memorial Hospital Service Area Additional Health Needs

Alongside the two community health needs highlighted by the regional CHNA that are also significant in McCullough-Hyde Memorial Hospital's service area, MHMH analyzed data and current collaborative efforts addressing health disparities to pinpoint additional high-priority community health needs relevant to its four-county service area.

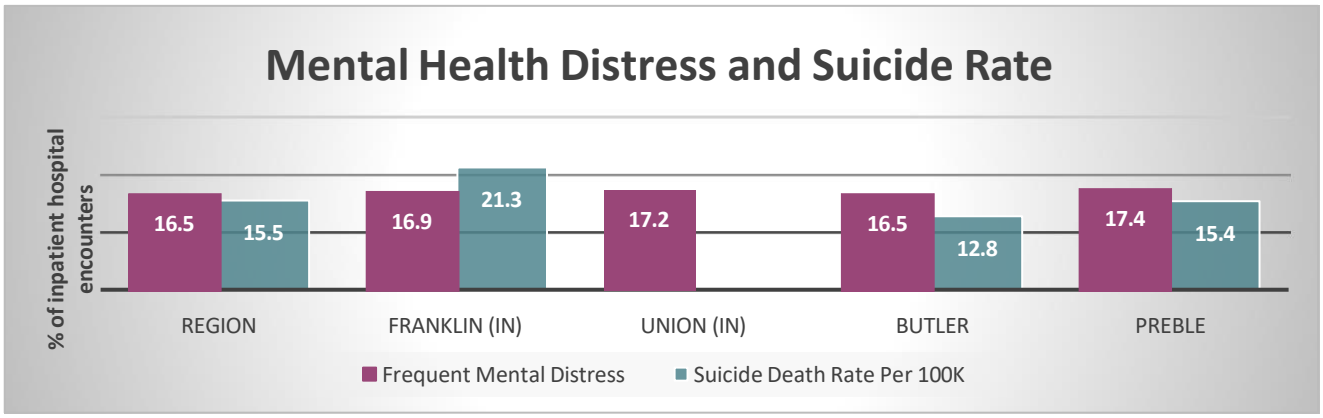
Based on responses from Community Roundtable Meeting hosted in each county questionnaire respondents, considering the criteria enumerated above and additional factors and health indicators, including environmental and population issues, the following health needs are significant for the service area of MHMH in prioritized order:



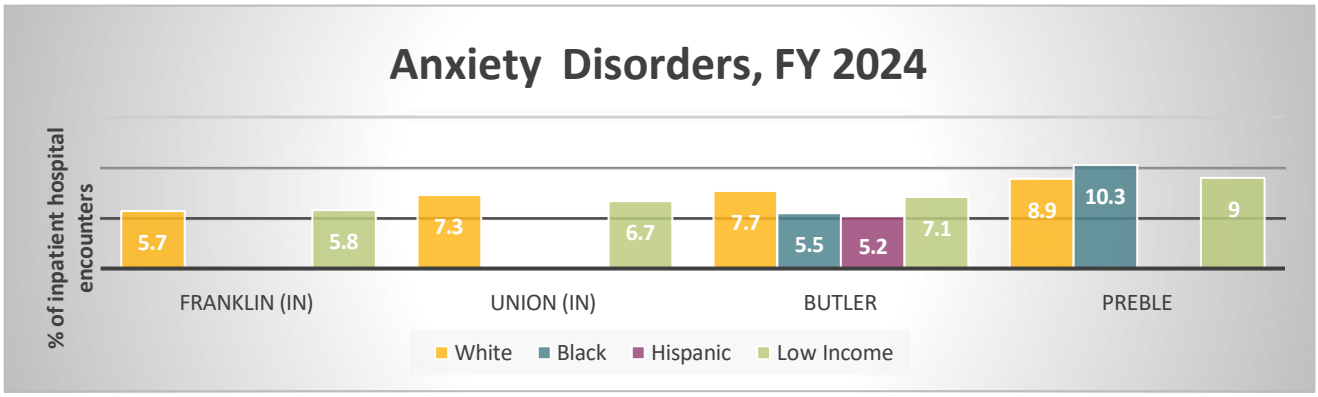
Source: Four County Community Roundtable Survey, 2024

Service Area Health Need: Mental Health

Reinforcing the regional priority, although the overall service area does not indicate significantly high mental health issues, low-income White and Black patients experience anxiety at a much higher rate than those with commercial or Medicare insurance.



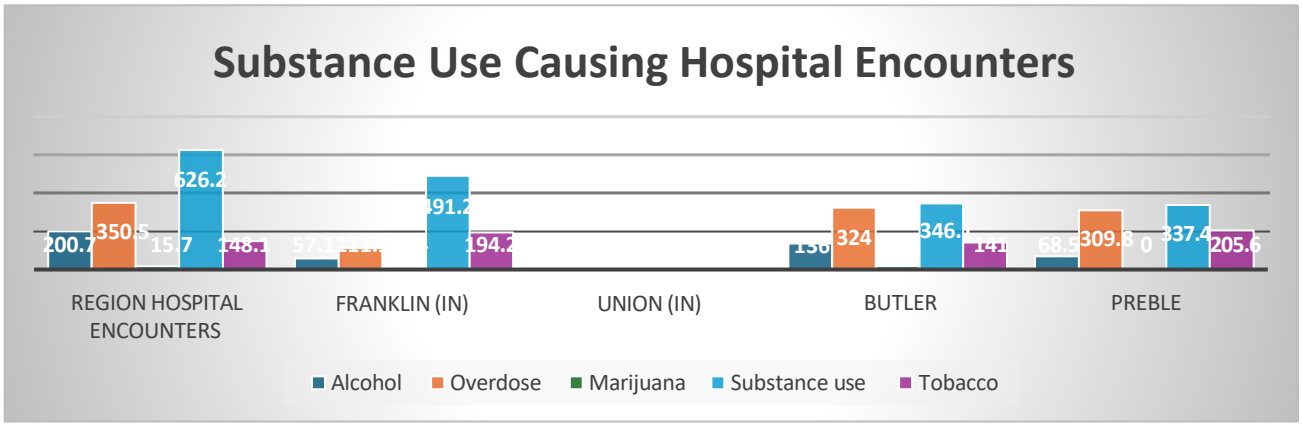
Source: County Health Rankings, 2021



Source: Medicaid & Self Pay Patients 18+ years old

Service Area Health Need: Substance Use including drugs and/or alcohol

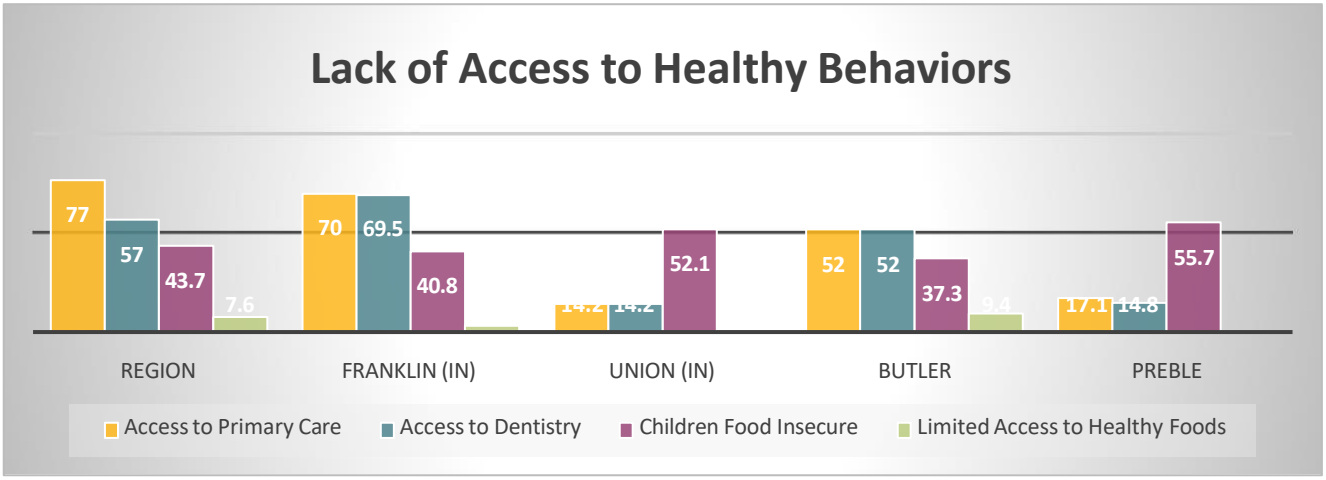
Most of the service area experiences a high incidence of substance use. Low-income patients are hospitalized for substance use at a higher rate than those with commercial or Medicare insurance.



Source: Ohio Hospital Association Data Tables, 2024 by the Health Collaborative

Service Area Health Need: Healthy Behaviors including access to healthcare, food, physical activity and other resources

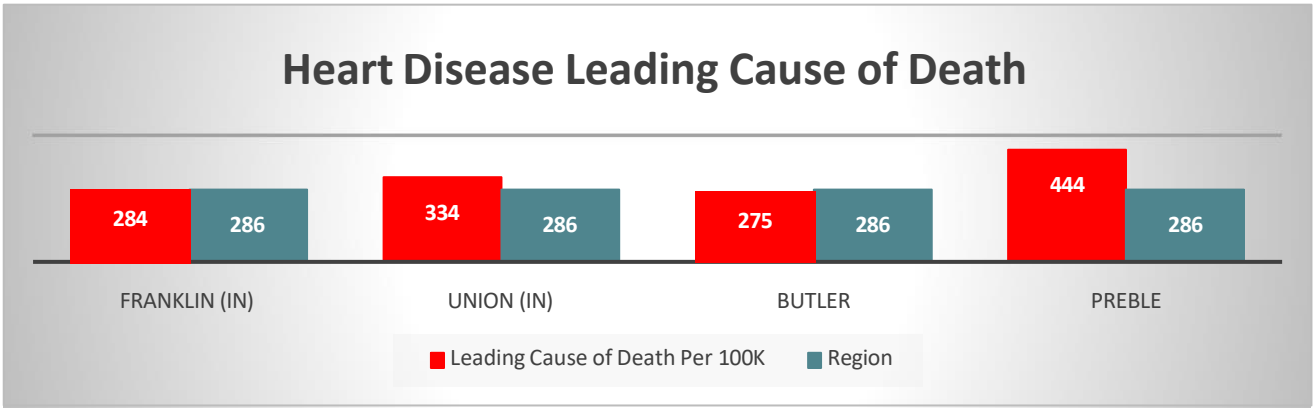
The rural service area faces significant health challenges due to limited access to essential resources, including access to healthcare, healthy eating, physical activity, housing, transportation and other resources. This lack of access contributes to poorer health outcomes and highlights the urgent need for targeted interventions to promote healthy behaviors within the community. Addressing these gaps is crucial for improving overall health and well-being in the region.



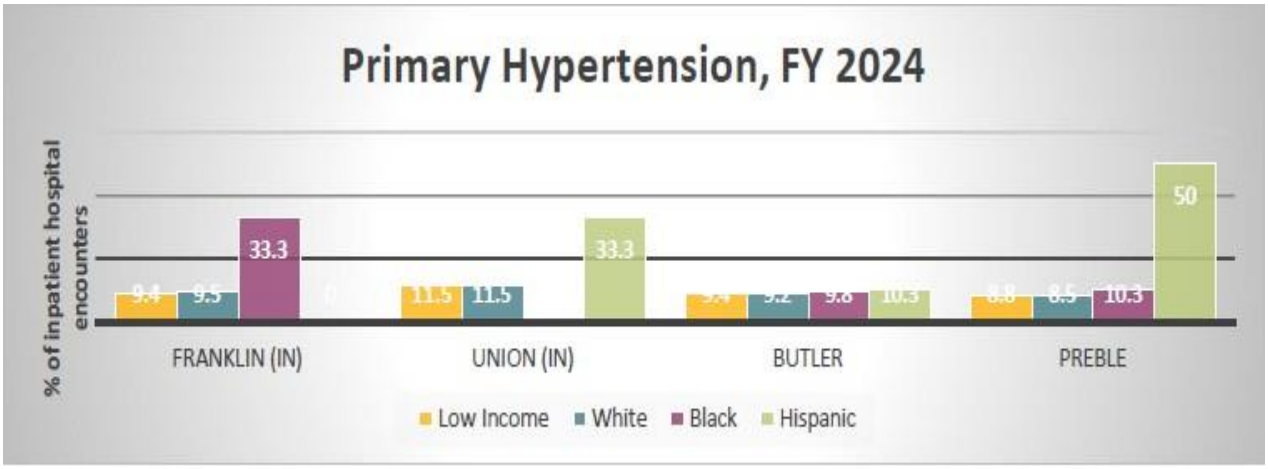
Source: County Health Rankings, 2021

Service Area Health Need: Chronic Conditions including heart disease

Low income Black and Hispanic populations experience a significantly higher incidence of hypertension.



Source: CDC, Wide-ranging Online Data for Epidemiologic Research (WONDER), 2023



Source: Medicaid & Self Pay Patients 18+ years old

In summary the four community health needs identified by McCullough Memorial Hospital to be prioritized for action plans were derived from:

1. The Regional Community Health Needs Assessment (CHNA)
2. McCullough-Hyde Memorial Hospital's ongoing community benefit initiatives and insights into the population
3. Identification of underlying health conditions among the low-income population (using Medicaid and self-pay as a surrogate) that are acute enough to result in inpatient hospitalization.

Before the prioritization work by McCullough-Hyde Memorial Hospital, the following health conditions were recognized:

1. Mental Health (Anxiety and Depression) affecting all populations.
2. Substance Use including Drugs and/or Alcohol.
3. Healthy Behaviors encompassing access to healthcare, healthy eating, transportation, housing, physical activity and other resources
4. Chronic Conditions including heart disease, hypertension and stroke

Progress Made Since 2022 CHNA

Since the 2022 Community Health Needs Assessment (CHNA), McCullough-Hyde Memorial Hospital, in collaboration with the McCullough-Hyde Foundation and the Coalition for a Healthy Community - Oxford Area has continued its efforts to tackle key health concerns, particularly regarding mental health, food insecurity, healthy behaviors, alcohol and drug use. Coalition leadership comprises various stakeholders, including representatives from MHMH, Miami University, Talawanda School District, local law enforcement, city council, the faith-based community, businesses, and citizens. The Coalition has formed three workgroups to specifically address the health needs identified in the CHNA. In 2023, the McCullough-Hyde Foundation created a Community Granting Program, a philanthropic program that makes investments that address significant health needs of local communities as identified in the CHNA. Through strategic partnerships, more than **$2.3 million** in grants and funding were secured locally to support the CHNA.

Health Need: Mental Health and Substance Use		
Anticipated Impact (Goal)	To deliver exceptional, accessible care to our local community while fostering seamless connections between patients and the wider TriHealth system. We aim to strengthen our call to action and community partnerships, ensuring that individuals receive the appropriate care for mental health and substance use disorders in the right setting and at the right time through comprehensive education and support.	
Strategy or Program	**Summary Description**	**Progress Made**
MHMH Specialty Referral Coordinator	• Offer support to patients and community members regardless of their ability to pay in a structured setting.	• Non-certified community resource navigator who supports McCullough-Hyde Memorial Hospital emergency department, obstetrics, and inpatient services to provide mental health, addiction treatment options, and other community resources with a goal to make resource connections within 48-hours post discharge. • Creating Community Resource Guide for all 4 counties that provides information on resources for 24-Hour Help and

Health Need: Mental Health and Substance Use		
		Information, Addiction Recovery Services, Community Programs, Mental Health Resources, Domestic Violence Resources, Education Support, Employment Support, Family Support, Food Resources, Health Care & Medical Insurance, Housing, Legal Resources, Mediation Assistance, Mobile Crisis, Senior Resources, Social Security, Transportation, Veteran's Resources, Vision and Dental Resources. ● FY2024: Engaged with twenty-nine patients since December of 2024
Addiction Services Peer Support	● Peer support provides an evidence-based practice for individual with mental health or addiction conditions.	● Maintained services for Peer Support
Oxford Coalition for a Healthy Community Mental Health Workgroup and Amplifying Community Voices Workgroup	● Miami University Psychology Clinic ● Mental Health Resource Guide ● Law Enforcement Social Services Liaison ● Oxford SSP ● Harm Reduction Collaborative/Wellness Wednesdays ● Crisis Intervention Training ● Screening, Brief Intervention and Referral to Treatment (SBIRT) Training ● Mental Health First Aid Courses ● Tobacco Prevention and Evaluation ● PAX Good Behavior Game Harm ● K-12 Social Emotional Learning Initiative Teams ● Addiction Services Peer Support ● Butler County Harm Reduction ● Medication Take Back Days	● Miami University Psychology Clinic provides services to adults or children regardless of the ability to pay. They use screenings and provide mental health counseling options. Engaged 16 assessment clients and 16 therapy clients funded by Hope Grant. ● Mental Health Resource Guide annually updated. ● OPD Social Services Liaison 236 connections from 2022 through 20224 ● Oxford SSP has made 1291 engaged 1291 times from 2022 through 2024 ● Harm Reduction Wellness Wednesdays has engaged 349 individuals from September 2022 through August 2024 ● Number of trainings completed. 1. SBIRT individual trainings at the TDS = 7

Health Need: Mental Health and Substance Use		
		2. SBIRT screenings at MU average 10,000 annually 3. MHFA law enforcement = 26 4. PAX school assemblies = 3 5. PAX Tool Training groups = 6 6. PAX Next Steps staff training = 20 7. Good Behavior Game staff training = 39 8. Vaping Prevention = All 5th graders and health education classes at THS 9. Calm Classroom = TSD 10. Second Step curriculum = K through 5th grade 11. Created video for adult caregivers on how to talk to youth about vaping. • Offer weekly harm reduction education on overdose and free supplies including Narcan, Fentanyl test strips, HIV test, safer sex supplies. • Collected over 26.6 months 46 pounds a month for a total of 101 boxes of medication from January 2023 through February 2025
Medication Take Back	• Purchased and installed medication take back bin for the hospital main lobby.	• Installed Medication Take Back bin in the hospital main lobby.
McCullough-Hyde Foundation	• Community Grants and McCullough-Hyde Women's Giving Circle grants support education, prevention programs, awareness efforts, wellness opportunities and direct care focused on the CHNA. Organizations throughout Butler County (OH), Franklin County (IN), Preble County (OH) or Union County (IN) are eligible to receive a Community Grant.	• 17 community grants totaling $65,200 were awarded to organizations addressing mental health and substance use. • 4 McCullough-Hyde Women's Giving Circle grants totaling $17,200 were awarded to organizations addressing mental health and substance use, specific to women and children. • The Hope Cooperative secured a $2 million federal grant to support mental and behavioral

Health Need: Mental Health and Substance Use		
	• The Hope Cooperative and its members (McCullough-Hyde Foundation, McCullough-Hyde Memorial Hospital, Miami University, Coalition for a Healthy Community-Oxford Area, Talawanda School District, Butler County Mental Health and Addition Recovery Services Board, and Epiphany Community Services) collaboratively secures funding to support the joint mission of "increasing access to, and utilization of, comprehensive health care services and promoting community health and wellness in the youth, college-age, and adult populations located in the rural Oxford area of Ohio."	health by improving rural behavioral health care service delivery.

Health Need: Access to Health Care		
Anticipated Impact (Goal)	To provide best-in-class, convenient care to its local population and seamlessly connect patients and the community to the broader TriHealth system through its call to action and community partnerships, as well as educate, those in our community who need the right care, in the right setting, at the right time by promoting access to care through telehealth.	
Strategy or Program	**Summary Description**	**Progress Made**
Telehealth Promotion	• Educational campaign on telehealth / hotspots and library offerings • Continue Togetherall Programming for Miami University	• Sent mailers, posted on social media, created 2 billboards to be shared in rural demographic to promote telehealth services and use • BeWell Miami implemented
No Wrong door	• Convene local service providers to discuss program offerings and target populations. • Attend Needs Awareness	• Continues to be in progress • Hospital participates in a monthly meeting for needs awareness

Health Need: Access to Health Care		
	Committee Meetings	
Transportation	• Identifying trends and needs specific to rural community	• Survey sent out. Evaluation in progress.
Private Practice	• Conducted a focus group with private practitioners	• Survey completed with focus group. Identified a need for education on billing and coding. Implemented an education session offered one on one and with Miami University Social Work students interested in private practice.

Oxford Free Clinic	• Cares for over 300 patients in the MHMH services area	• MHMH supports the free clinic through:
		  ◦ Volunteer staff
		  ◦ Financial support
		  ◦ Physician Credentialing
		  ◦ Clinical Coordinator support
		• Impact
		  ◦ 107 unduplicated patient visits
		  ◦ 1000 prescriptions provided.
		  ◦ 2 patients enrolled in pharmacy assistance.
		  ◦ 68% chronically ill patients stabilized and amended their health.
		  ◦ 100% of diagnosed diabetes patients were referred to diabetes education classes

McCullough-Hyde Foundation	• Community Grants and McCullough-Hyde Women's Giving Circle grants support education, prevention programs, awareness efforts, wellness opportunities and direct care focused on the CHNA. Organizations throughout Butler County (OH), Franklin County (IN), Preble County (OH) or Union County (IN) are eligible to receive a Community Grant.	• 17 community grants totaling $244,800 were awarded to organizations addressing access to health care. • 3 McCullough-Hyde Women's Giving Circle grants totaling $21,000 were awarded to organizations addressing access to health care, specific to women and children.

Health Need: Healthy Behaviors and Food Insecurity/Obesity		
Anticipated Impact (Goal)	To provide best-in-class, convenient care to its local population and seamlessly connect patients and the community to the broader TriHealth system through its call to action and community partnerships, as well as educate, those in our community who need the right care, in the right setting, at the right time regarding healthy behaviors and access to food to improve health outcomes.	
Strategy or Program	**Summary Description**	**Progress Made**
Oxford Coalition for a Healthy Community Healthy Eating Active Living (HEAL) Workgroup	• Community Programs • Resource Maps	• Annual Fresh Air Fair • Yoga in the Park Saturday mornings June through October • Assisted community in building a raised garden for vegetables to be shared by the park. • Updated monthly free food security map • Created indoor/outdoor playground map
Education Classes	• Evidence based education and support for chronic illness	• Outpatient Diabetes Self-Management Education Classes is accredited by the American Diabetes Association and taught by Dietitian and RN who have special training. Seventy referrals with at 72% attendance rate. Patients that attend class from July 2024 through February 2025 had a decrease in A1C by 50% • Cardiac Rehabilitation Classes engaged 4,370 patients from 2022 through 2024 • Lactation Classes started March 2025
Food Pantries	• Established additional food pantries for MHMH patients that have been assed as food insecure.	• Miami Cares Food Pantry (Student Success Office) estimate served annually 500 students • MHMH free food pantry now serving patients who report food insecurity issues during their Social Determinants of Health intake conversation.

Health Need: Healthy Behaviors and Food Insecurity/Obesity		
McCullough-Hyde Foundation	• Community Grants and McCullough-Hyde Women's Giving Circle grants support education, prevention programs, awareness efforts, wellness opportunities and direct care focused on the CHNA. Organizations throughout Butler County (OH), Franklin County (IN), Preble County (OH) or Union County (IN) are eligible to receive a Community Grant.	• 13 community grants totaling $88,300 were awarded to organizations addressing food insecurity. • 2 McCullough-Hyde Women's Giving Circle grants totaling $22,000 were awarded to organizations addressing food insecurity, specific to women and children. • 34 community grants totaling $189,670 were awarded to organizations addressing healthy behaviors. • 3 McCullough-Hyde Women's Giving Circle grants totaling $17,800 were awarded to organizations addressing healthy behaviors, specific to women and children.

Appendices

Appendix A. Community engagement

Development of the Greater Cincinnati Tri-State Region Community Health Needs Assessment (CHNA) was informed by the Advisory Committee and Public Health and Special Populations Task Forces (Appendix B) contains a list of Advisory Committee and Task Force member organizations. Advisory Group and Task Force members were engaged in the process because of their close ties to the communities they live in and serve. They were a valuable source of data and information throughout the assessment process.

Community engagement was brought to the forefront of the Regional CHNA process by building the assessment and telling the community story, coming to consensus around shared regional priorities, and launching a Community Partnership Network to build infrastructure for ongoing, bi-directional communication.

The Health Policy Institute of Ohio (HPIO) and The Health Collaborative (THC) provided regular updates to both the Advisory Committee and Task Forces, including monthly meetings with the Advisory Committee and six meetings with the Task Forces.

Defining community engagement

For the regional CHNA, engagement with community began with clearly defining the community and then establishing intentional, thoughtful, and co-created ways to engage with partners and build trust. Facilitated by THC, community is defined as the 18-county region of southwest Ohio, Northern Kentucky, and Southeast Indiana, and inclusive of health systems and hospitals, public health departments that serve those jurisdictions, and all community-based organizations serving community members. Through specific activities built for a variety of audiences within this community, THC engages partners throughout all phases of the Collective Health Agenda cycle (including the regional CHNA) with convening, stakeholder listening sessions, one- on-one meetings, and in alignment with principles of community based participatory research.

Building the assessment and telling the community story

To minimize the burden on community members who report being over-surveyed and assessed, the Advisory Committee decided to leverage recent, existing sources of primary and secondary community data, rather than collecting new primary data. Advisory Committee and Task Force members were invited to share any data they have collected to be included in the Regional CHNA, with a focus on sources that filled data gaps (described in Appendix C). Seven additional sources of community data were identified and included in the Regional CHNA.

Coming to consensus around shared regional priorities

Throughout the Regional CHNA process, THC emphasized the shared values and principles of collective action for the Advisory Committee and Task Force members. This invited alignment from partners on the significant health needs, potential priorities, and final priorities described in Appendix D.

To inform the prioritization process, HPIO developed a pre-prioritization survey to be completed by hospitals, local health departments, and other community partners. Of the 47 partners who responded, the largest proportion represented community- based organizations (28%), highlighting the inclusion of community voices through the prioritization process.

More information on the results of the pre-prioritization survey can be found in Appendix D.

Launching a Community Partnership Network

The Health Collaborative developed the Community Partnership Network (CPN) to build ongoing community engagement into the work of the Regional CHNA and Collective Health Agenda. The CPN was created based on feedback THC received from partners that the Regional CHNA process for the last several cycles felt very circular, asking the same questions repeatedly to the same communities, with little to no action on issues that arise. Communities and organizations across the region and across sectors expressed concern around the repeated data collection processes, citing the burden it has on community members to discuss problems without seeing any solutions or actions to address community needs.

The CPN will create an opportunity for more regular community engagement, to center community voice and equity in the Regional CHNA, provide space for bidirectional communication between health

systems and the community, and reduce "new" data collection (e.g., focus groups and community health needs surveys). The purpose of the CPN is to leverage existing community meetings, momentum, and assets to strengthen connections between partners, including the community, and advance shared goals for community health.

The following community-based organizations have agreed to participate in the CPN:

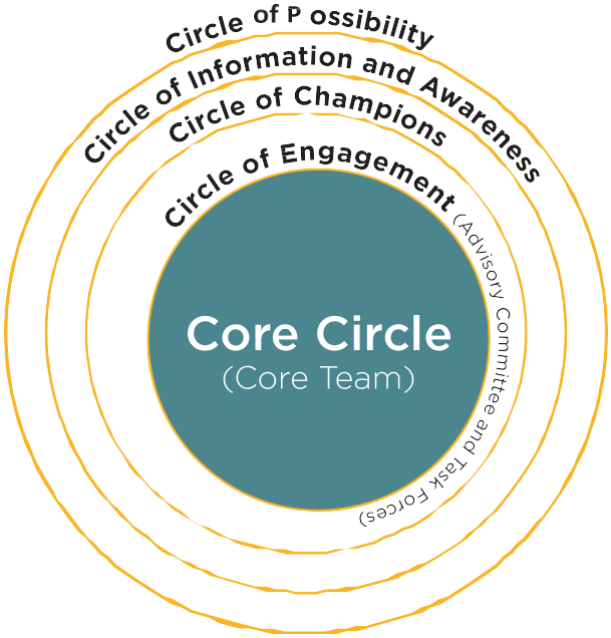
- Cincinnati Compass
- Clermont County Healthy Partners (through the health department)
- Hamilton County Suicide Prevention Coalition
- Black Women Cultivating Change
- Hamilton County Human Services Chamber (HSC)
- Center for Closing the Health Gap

The CPN has met these milestones:

- Attended five meetings to date with CPN partners, with a goal of six meetings. These meetings have included five preparatory meetings and one follow-up.
- Contracted with academic experts to create an infrastructure for THC in partnership with CPN pilot partners.
- Created and co-designed drafts for key CPN infrastructure.

Appendix B. Regional CHNA advisory structure

The advisory structure for the Regional Community Health Needs Assessment (CHNA) was built using the Mobilizing Action through Planning and Partnerships 2.0 (MAPP) Circle of Involvement Framework. This includes the:



Core Circle

The Core Circle (Core Team) met regularly, hosted and facilitated meetings, were responsible for deliverables, and managed day-to-day operations of the project.

Core Team
The Health Collaborative
Butler County General Health District
Health Policy Institute of Ohio

Circle of Engagement

The Circle of Engagement (Advisory Committee and Task Forces) kept the Core Circle accountable for progress, provided expertise on each step of the Regional CHNA including data collection and analysis, reviewed results and report drafts, and approved the final Regional CHNA report. Across the 45 participating organizations in the Advisory Committee and Task Forces, diverse populations were represented that include medically underserved people, Black and African American residents, immigrants and refugees, mothers and babies, Hispanic/Latino residents, people experiencing homelessness, people experiencing mental health challenges, people experiencing food insecurity, people with disabilities, and other marginalized populations.

Advisory Committee
Hospitals and health systems
Adams County Regional Medical Center (ACRMC)
Christ Hospital
Cincinnati Children's Hospital Medical Center
Lindner Center of Hope
Margaret Mary Health
Mercy Health Cincinnati
TriHealth
UC Health
Public health
Butler County General Health District and Southwest Association of Ohio Health Commissioners
Cincinnati Health Department
Clermont County Public Health
Hamilton County Public Health
Community-based organizations
Center for Closing the Health Gap

Hamilton County Human Services Chamber
United Way of Greater Cincinnati
Urban League of Greater Southwestern Ohio
Philanthropy
bi3
Interact for Health
Federally Qualified Health Centers
The HealthCare Connection
HealthSource of Ohio
Payor
CareSource

Task Forces
Public Health Task Force:
Butler County General Health District, Ohio
Cincinnati Health Department, Ohio
Norwood City Board of Health, Ohio
City of Springdale Health Department, Ohio
Clermont County Public Health, Ohio
Clinton County Health District, Ohio
Franklin County Health Department, Indiana
Hamilton County Public Health, Ohio
Ripley County Health Department, Indiana
Warren County Health District, Ohio
Special Populations Task Force:
All-In Cincinnati
Black Women Cultivating Change
Cincinnati Compass
Clermont County Board of Developmental Disabilities
Community Builders
Cradle Cincinnati
Foodbank of Dayton
Freestore Foodbank
Greater Cincinnati Behavioral Health Services

Greater Cincinnati Regional Food Policy Council
Healthcare Access Now
Housing Opportunities Made Equal (HOME)
NAMI Southwest Ohio
Refugee Connect
Santa Maria Community Services
Shared Harvest Food Bank
Su Casa
United Way of Greater Cincinnati

Circles of Champions, Information and Awareness, and Possibility

The Circle of Champions and the Circle of Information and Awareness provided high-level review and oversight of the work on behalf of their organizations.

Finally, the Circle of Possibility represents all the community organizations and community members who can be included in actionable strategies for implementation of the Collective Health Agenda and Community Health Improvement Plans.

Appendix C. Data collection and analysis methodology

The Health Collaborative contracted with the Health Policy Institute of Ohio (HPIO) to develop the Regional Community Health Needs Assessment (CHNA). The analysis was guided by a set of research questions, and consisted of:

- Secondary, quantitative data compilation and analysis
- Additional primary and secondary community data analysis

Research questions

The Health Collaborative and HPIO developed the following research questions, based on Public Health Accreditation Board (PHAB) and Internal Revenue Service (IRS) requirements, to guide development of this Community Health Needs Assessment:

1. What are the most significant health needs in the region?
2. What populations are experiencing inequities and disparities across health, socio-economic, environmental and quality-of-life outcomes?
3. What are the systems and structures that drive the identified health needs?
4. What strengths and resources does the region have that can address the region's most significant health needs? What resources and assets exist to support communities experiencing inequities and disparities?
5. What progress have partners made on the priorities identified in the last CHNA?

Secondary, quantitative data analysis methodology

How were metrics selected?

HPIO reviewed a wide range of publicly available data sources, including national- and state-based population health surveys, vital statistics, and administrative data from state and federal agencies, among other sources. Using these sources, HPIO compiled a list of 264 metrics for consideration in the Regional CHNA. From this inventory of metrics, The Health Collaborative and HPIO recommended 67 secondary, quantitative metrics using the following criteria approved by the Advisory Committee.

Metric selection criteria

Goal: Identify the **most important** metrics needed to describe the region's significant health needs, including social and structural drivers of health

- **Data availability** — Data available at the county-level that can be assessed for long- term trend (change over time), compared to performance of the U.S. or the state overall, and can be disaggregated to look at disparities and inequities (e.g., by race, ethnicity, household income)
- **Source integrity** — Metrics are recognized as valid and reliable, and data is gathered from reputable sources
- **Face value** — Metrics are easily understood by the public
- **Alignment** — Metrics align with relevant state and local plans
- **Data quality and recency** — Data for the metric is complete, accurate, and most- recent data is from the past three years

Figure C.1. displays how the 67 metrics are organized in the Regional CHNA. These metrics were

organized based on the domains in the Mobilizing for Action through Planning and Partnership (MAPP 2.0) **framework.**

Figure C.1. **Regional CHNA metric information**

Domain	Total metrics	Metric disaggregated (i.e., broken out by race, ethnicity, age, income or other factor)
Demographics	3	3
Systems of power, privilege, and oppression	3	1
Social determinants of health	26*	10
Health behaviors and outcomes	35*	18
Total	**67**	**32**

*These domains each include a metric that has one or more additional, underlying metrics. These metrics were only counted once for the purpose of these totals.

Data years vary by metric based on the data source. HPIO compiled the most recent year of available data for the Regional CHNA.

Quantitative data analysis methodology

The use of rates, percentages and numbers. To demonstrate the frequency of an event, incident or condition, the Regional CHNA report often uses rates, which are calculated as the "number of incidences, per population." Rates provide standardized measurement for comparison across different groups (e.g., white, compared to Black) or different geographic locations (e.g., Hamilton County as compared to Franklin County). Percentages are often used to represent parts of a whole or express proportions, and are helpful for understanding relative values, or changes over time (e.g., 25% of the total population was impacted). Numbers, which describe absolute values or quantities, are useful for planning purposes but have limitations when comparing across groups of different sizes.

Regional values. Regional data values in this report were calculated one of two ways. If the data source provided a numerator and denominator for all 18 counties in the region, a true regional value was calculated. When a data source did not provide numerators and denominators and/or up to one-third of available counties were missing from the data source, a median value was calculated for the region to serve as the regional value. The median county value in the region was used as a proxy measure for the region overall value when a regional overall value could not be calculated. These are noted in the tables and graphics where they occur.

Benchmark analysis. Benchmarks, including national data and Healthy People 2030 targets, were identified for all potential priorities (described in Appendix D). The regional value for each potential priority was then compared to the value of the U.S. overall and to applicable national Healthy People 2030 targets, when available. For the Regional CHNA's three priority areas, benchmarks were analyzed to determine if the region performs better, worse, or the same as the rest of the nation and the Healthy

People 2030 benchmarks. Metrics that had less than 10% difference between the regional and benchmark values were classified as performing the "same." Metrics that had a difference of 10% or greater were classified as "better" or "worse."

Analysis of populations who face the greatest barriers. The magnitude of disparities across population characteristics such as race and ethnicity, age, and county type were assessed for 12 metrics related to the Regional CHNA's three priorities using disparity ratios. Disparity ratios were calculated by dividing the outcome of each comparison group by the outcome of the rest of the region. The prevalence estimates for each disaggregated metric were calculated for each comparison group. The prevalence for the rest of the region is then re-calculated for each additional breakout group.

When data availability limited the ability to calculate the magnitude of difference between a group and the rest of the region, a median regional value was used. The following measures had missing counties:

- Suicide deaths
- Mental health providers
- Mental health-related hospital encounters
- Depression-related hospital encounters
- Suicide attempt-related hospital encounters

To analyze potential disparities in rural areas, the USDA **Economic Research Service (ERS)** Metropolitan (Metro) and Nonmetropolitan (non-Metro) county type classification was used.

To analyze potential disparities in Appalachian areas, the **Appalachian Regional Commission's** county type classification was used.

When possible, race and ethnicity data were disaggregated, or separated, into the following groups: white (non-Hispanic), Black (non-Hispanic), Asian and/or Pacific Islander (non-Hispanic), Other (non-Hispanic), and Hispanic. When data was not available to classify based on these groups, different racial and ethnic classifications were used based on the data source and data availability.

Once disparity ratios were calculated, any ratio that was at least 10% worse than the rest of the region was elevated as a population who faces the greatest barriers. Because this analysis was limited to metrics with available disaggregated data, the Advisory Committee and Task Forces were consulted to identify other groups experiencing disparities and inequities that were not identifiable in the analyzed data.

Ohio Hospital Association (OHA) data analysis. The Health Collaborative and HPIO analyzed 18 Ohio Hospital Association data metrics on hospital encounters in the region. The methodology used for that data set is available in Appendix D.

Supplemental primary and secondary community data analysis methodology

In analyzing the secondary quantitative data described above, the following gaps emerged:

- Lack of data for smaller counties, including rural and Appalachian communities

- Lack of data for specific groups, including certain racial and ethnic populations and members of the LGBTQ+ community
- Lack of data on certain social and systemic drivers of health

Seven additional sources of primary and secondary data were identified by THC, HPIO, the Advisory Committee and Task Forces to fill those data gaps and center community voices and perspectives.

HPIO analyzed the seven sources listed below, which include surveys, focus groups and reports. Key findings from the sources were then themed based on the domains in the MAPP 2.0 **framework.**

The seven sources focused on the Greater Cincinnati Tri-State region, with variation in area of focus, as noted below. Some of these sources included secondary data.

Analysis of this data was limited to available information and not based on the underlying data source.

Sources analyzed include:

- **2-1-1 data.** United Way of Greater Cincinnati and Indiana Family and Social Services Administration, 2024. Area of focus: counties in the greater Cincinnati region, including Ohio, Kentucky and Indiana
- **State of Black Cincinnati report.** Urban League of Greater Southwestern Ohio, 2024. Area of focus: Cincinnati
- **Our Health, Our Opportunity report.** Interact for Health, 2024. Area of focus: Greater Cincinnati region
- **Community Health Status Survey.** Interact for Health and the University of Cincinnati Institute for Policy Research, 2022. Area of focus: 22 counties in the Greater Cincinnati region
- **2021 CHNA provider survey results.** The Health Collaborative and Measurement Resources Company, 2021. Area of focus: 26 counties in the Greater Cincinnati region
- **2021 CHNA focus group results.** The Health Collaborative and Measurement Resources Company, 2021. Area of focus: 26 counties in the Greater Cincinnati region
- **OHA Metrics/Analysis.** The Health Collaborative analyzed 18 Ohio Hospital Association (OHA) data metrics on hospital encounters in the region. The methodology used for that data analysis is included below.

Figure C.2. **Source and theme matrix**

The table below summarizes which sources had key themes in each domain of the Regional CHNA.

	Community strengths and organizational capacities	Systems of power, privilege and oppression	Social determinants of health	Health behaviors and outcomes
2-1-1 data		✓	✓	
State of Black Cincinnati report	✓	✓	✓	✓
Our Health, Our Opportunity report	✓	✓	✓	✓
Community Health Status Survey	✓		✓	✓
2021 CHNA provider survey			✓	
2021 CHNA focus groups			✓	

Limitations of the assessment

The Regional CHNA includes data from a variety of data sources, including publicly available and requested data. It includes survey results, birth records, and administrative data. While care was taken to compile data from credible sources, each source has its own set of limitations, such as self-reported conditions and potential changes in methodology from year to year.

There are several limitations that emerged:

- **Population focus.** The Regional CHNA is focused on adults, ages 18 and over, and families living in the Greater Cincinnati Tri-State Region. Other partners in the region are assessing the health and well-being of children. Only one metric is child- specific (child poverty).
- **County-level data.** HPIO's main level of analysis for secondary, quantitative data analysis for the Regional CHNA was at the county-level. When metrics are disaggregated by county, the sample sizes of the populations can become too small, creating data reliability and suppression issues. In these cases, data values for certain counties could not be reported.
- **Disaggregated data.** Very few data sources allowed for disaggregation of data by county and other demographic categories, such as income, age, or race and ethnicity. In addition, not all sources use mutually exclusive racial and ethnic categories (e.g., Black non-Hispanic and Hispanic, all races) for the disaggregation of data by race and ethnicity. When metrics could be disaggregated by county and another demographic characteristic, the sample sizes of the population groups often became too small, creating data reliability and suppression issues. In these cases, data values could not be reported. Many data sources often have limited categories for disaggregation and lack the necessary information to break data down by groups such as LGBTQ+ individuals or veterans.

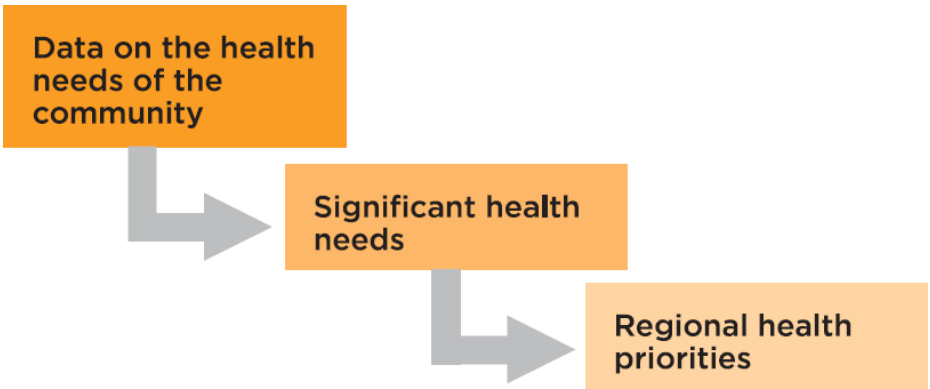
- **Data years.** HPIO provided the most recent year of data for which data was available for the most counties in the region. For data points in the Additional Primary and Secondary Community Data Analysis, consult those sources for more information on their methodology.
- **Access to underlying data for supplemental data analysis.** For the supplemental primary and secondary data analysis (described on pages 51 and 52), HPIO was provided with final reports or summary documents often without access to the underlying data (e.g., sample sizes or raw data values to conduct additional data analysis). Data from those sources are presented as is from the source. For further information on the methodology used by those reports and summaries, please consult the sources listed in figure C2 above.

Appendix D. Prioritization process for the Regional CHNA

The Internal Revenue Service (IRS) requires nonprofit hospitals and health systems, as part of the Regional Community Health Needs Assessment (CHNA), to assess the health needs of their communities, identify the significant health needs of their communities, and prioritize those health needs. Similarly, Public Health Accreditation Board (PHAB) standards require local public health departments to create Community Health Assessments (CHAs) that evaluate their communities' health status and needs.

Figure D.1 describes the Regional CHNA prioritization process. Regional CHNA partners began by analyzing data on the health needs of the community, then identified a list of significant health needs based on that data, and finally prioritized a set of those significant health needs for collective action. The following sections describe this process in more detail.

Figure D.1. **Regional CHNA prioritization process**



Data on the health needs of the community

The health needs of the region were identified through a robust review of primary and secondary data. This included 49 secondary, quantitative data metrics, 18 Ohio Hospital Association data metrics, review of seven additional primary and secondary data sources, and primary data from Advisory Committee and Task Force partners (Appendix C provides details on the data analysis methodology). Data was reviewed by Regional CHNA Advisory Committee and Task Force members during a meaning- making session on August 22, 2024.

Significant Health Needs

To identify significant health needs, the Health Policy Institute of Ohio (HPIO) applied a set of criteria to the health needs that emerged through the data review.

Those criteria were:

- **Prevalence:** Which needs are the most widespread?
- **Unmet need**: Which needs are most unmet and/or untreated?
- **Impact**: Which needs have the greatest impact on health?
- **Inequity**: Which needs are most disparate across populations in the region?

Based on those criteria, the following significant health needs were identified (displayed in figure D.2). Significant health needs were reviewed by Regional CHNA Advisory Committee and Task Force members during a meeting on October 24, 2024.

Figure D.2. **Significant health needs**

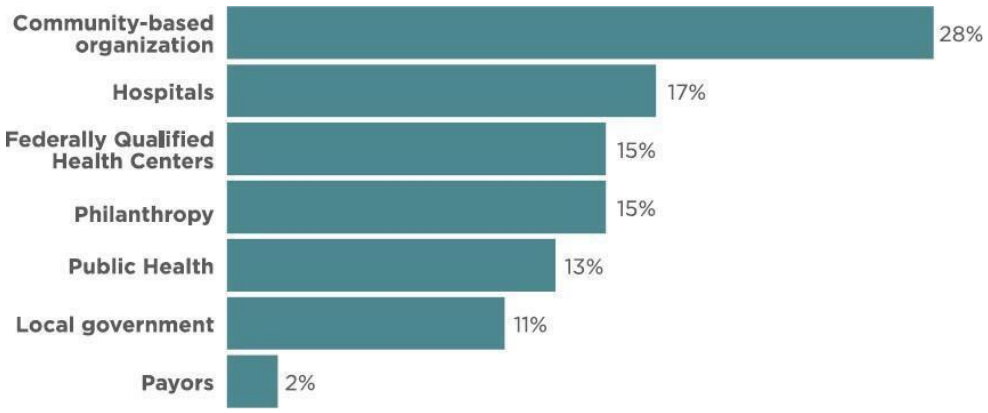
Systems of power, privilege and oppression
Negative perceptions of health and healthcare (stigma, mistrust, unaffordability, etc.)
Racism and discrimination
Unequal access to resources needed for health
Social determinants of health
Access to affordable, timely and quality health care
Educational attainment 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

Regional health priorities

To inform prioritization, HPIO administered a "2024 Regional CHNA Pre-Prioritization Survey" to

Regional CHNA Advisory Committee members, Task Forces, and community partners online from September 3 to October 15, 2024. The survey gathered information on partners' and the community's priorities and their view of the most pressing health issues in the region. There were 47 responses, with the highest proportion (28%) from community-based organizations, followed by hospitals (17%) (exhibited in figure D.3).

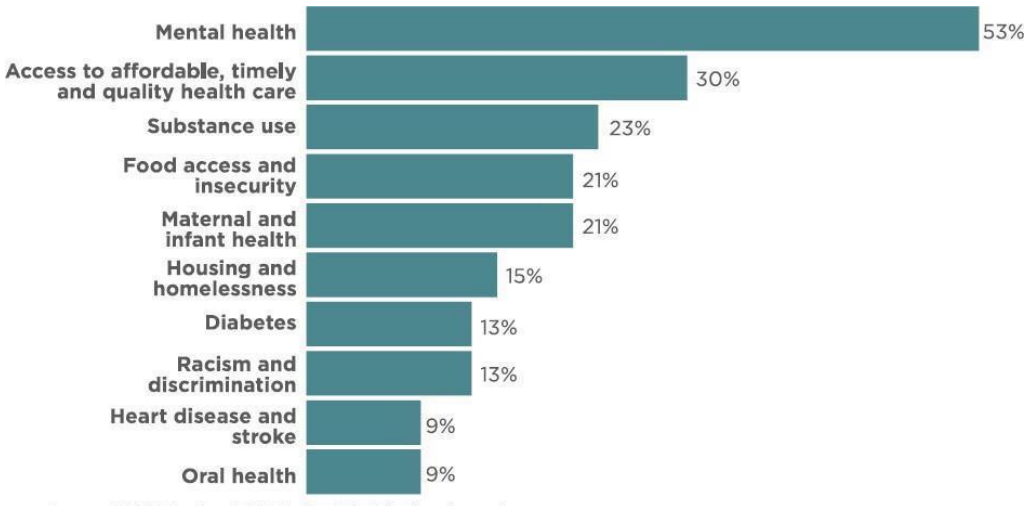
Figure D.3. **Responses to: "What sector does your organization represent?"**



Source: "2024 Regional CHNA Pre-Prioritization Survey"

Question 3 of the survey (shown in figure D.4) explored partners' and community priorities and was used to narrow down the full list of significant health needs to create a list of potential priorities for consideration by Regional CHNA partners. HPIO cross-walked the two lists and identified ten potential priorities (shown in figure D.5) that Regional CHNA Advisory Committee and Task Force members discussed during a meeting on Oct. 24, 2024.

Figure D.4. Responses to: "What are the 1-3 health issues that your organization is most focused on addressing in the region?" (top ten responses)



Source: "2024 Regional CHNA Pre-Prioritization Survey"

Figure D.5. **Potential priorities for discussion**

- **Mental health** service navigation
- **Access** to quality, affordable healthcare
- **Substance use** prevention and treatment
- Access to **healthy and nutritious food**
- **Maternal and infant health** equity
- **Homelessness** prevention and **housing** stability
- **Diabetes** management and prevention
- Collaborative efforts to dismantle **racism and reduce discrimination**
- **Heart disease and stroke** prevention and treatment
- Collaboratively **address data gaps** for underrepresented populations

The Advisory Committee and Task Force members then discussed the data behind each of these potential priorities, including national benchmarks, and applied the following criteria to select the final list of regional health priorities:

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?

Regional CHNA Advisory Committee and Task Force members were then given the opportunity to vote for regional priorities, using the above criteria, on an online survey that was open from Oct. 24 to Nov. 1, 2024. There were 24 total responses; most respondents selected mental health treatment and prevention (75%), followed by homelessness prevention and housing stability (42%), and heart disease and stroke prevention and treatment (33%) as the needs that were most aligned with the prioritization criteria to be prioritized in the Regional CHNA.

Appendix E. Local CHNA roundtable and questionnaire participants

The local Core Circle (Core Team) met regularly, hosted and facilitated meetings, were responsible for deliverables, and managed day-to-day operations and implementation of the project.

Core team
Butler County Mental Health Department
Coalition for Healthy Living Oxford Area
Epiphany Community Services
Harm Reduction Collaborative
McCullough-Hyde Foundation
McCullough-Hyde Memorial Hospital
Miami University
Talawanda School District
Public health
Butler County Health Department
Franklin County Health Department
Oxford College Corner Free Clinic
Preble County Emergency Management
Preble County Public Health
Union County Health Department
Community-based organizations
Big Brothers Big Sisters of Butler County
Butler County Education Services Center (BCESC)
College Corner Fire Department
College Corner Food Pantry
Community Adult Day Services
Community Care in Union County
Council on Aging of Southwest Ohio
Dream Chasers
Fairfield Prevention Coalition
Family Promise of Butler County
Feed the Hungry Project
Focus on Youth
Franklin County Coalitions

Franklin County Community School District
Franklin County Library
Friends of Neighbors in Need
Girls Inc of Butler County
H.O.P.E. – full Pastures Therapeutic Farm
Hideaway Trails for Hope Ranch
Home Is The Foundation (HIT)
Inspiration Studios
Interfaith Center at Miami University
Oxford Community Arts Center
Open Hands Food Pantry
Oxford Area PFLAG
Oxford Area Solutions for Housing (OASH)
Oxford City Council
Oxford Free Press
Oxford Police Department
Oxford Reach Out and Read
Oxford SAY Soccer
Oxford Senior Center
Oxford Township Police Department
PARACHUTE: Butler County CASA
Play the Park
Preble County Council on Aging
Preble County Economic Development
Preble County Senior Center
Preble Shawnee Local Schools
Safe Passage
Serve City
Talawanda Pantry Oxford and Social Services (TOPSS)
The Haven
Thread Up Oxford
Three Valley Trust Conservation
Triangle Therapy Association
Union County College Corner Joint School District

Union County Public Library
Union County Youth League
Whitewater Publications
Whitewater Valley REMC
Women Helping Women
YWCA Hamilton
Philanthropy
Franklin County Community Foundation
Interact for Health
McCullough-Hyde Foundation
Oxford Community Foundation
Union County Foundation
Federally Qualified Health Centers
The Neighborhood Clinic

Appendix F. Service Area Demographics

Service Area Demographics

Demographic	Franklin	Union	Butler	Preble
2024 Population	17,064	6,950	386,704	39,584
2029 Projection	17,353	6,841	392,395	39,257
Population by Race				
White	96.0%	95.0%	74.0%	94.5%
African American	0.2%	0.5%	9.8%	0.5%
All Other Races	3.8%	4.5%	16.2%	5.0%
Hispanic (Any Race)	1.0%	1.2%	7.2%	1.3%
Population by Gender				
Female	49.6%	50.1%	50.8%	50.5%
Male	50.4%	49.9%	49.2%	49.5%
Population by Age	**Franklin**	**Union**	**Butler**	**Preble**
<5	6.2%	5.6%	5.8%	5.4%
5-17	16.2%	15.8%	16.6%	16.0%
18-24	9.0%	8.9%	11.1%	9.1%
25-44	20.9%	21.8%	24.8%	21.2%
45-64	26.6%	25.7%	24.5%	25.6%
65+	21.2%	22.1%	17.3%	22.7%
Median Age	43.4	43	39.3	42.8
Household Income				
Household Income Below 50k	33.3%	32.1%	34.0%	34.5%
Household Income Below 25k	12.8%	8.0%	15.1%	13.7%

Source: Sg2 Feb 2025

Life Expectancy

County	Overall	Asian	Black	Hispanic	White
Franklin (IN)	76.2	-	-	-	-
Union (IN)	75.5	-	-	-	-
Butler	76.4	86.7	74.6	97.8	76.1
Preble	75.7	-	-	-	-
4 County Average	75.9	86.7	74.6	97.8	76.1
Ohio Average	76.4	88.3	73.8	89.1	76.7
Indiana Average	75.6	87.6	71.1	85.7	75.8

Source: https://www.countyhealthrankings.org/health-data/ohio/data-and-resources

Franklin County: 2024 County Profile

THE HEALTH COLLABORATIVE

DEMOGRAPHICS

Age (Years)	Region (%)	Franklin (%)
0-17	23.2	22.8
18-24	9.3	7.9
25-64	51.4	50.0
65+	16.1	19.2

Source: U.S. Census Bureau, 2022

Race	Region (%)	Franklin (%)
White, non-Hispanic	78.9	96.2
Black/African American, non-Hispanic	11.2	0.1
Asian, non-Hispanic	2.7	0.6
Hispanic/Latino	3.5	1.3
Native Hawaiian and Other Pacific Islander, non-Hispanic	0.0	0.0

Source: U.S. Census Bureau, 2022

Population Estimates

	Region	Franklin
Total Population	2,404,540	22,889

1.2% of Franklin County's Population is foreign Born

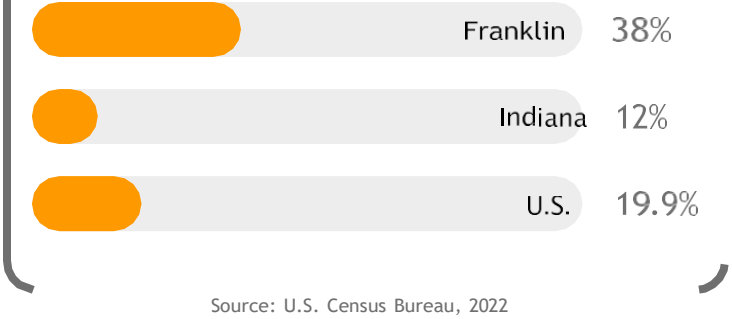
Population with disabilities

Region 12.9%

Franklin 13.6%

Source: U.S. Census Bureau, 2022

% of Rural



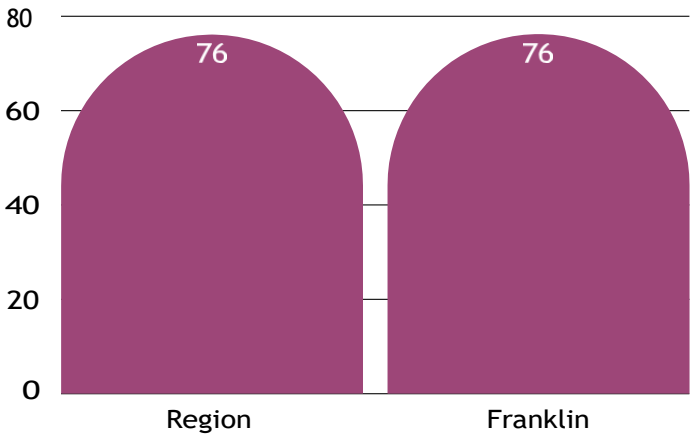
Source: U.S. Census Bureau, 2022

Franklin County: 2024 County Profile

THE HEALTH COLLABORATIVE

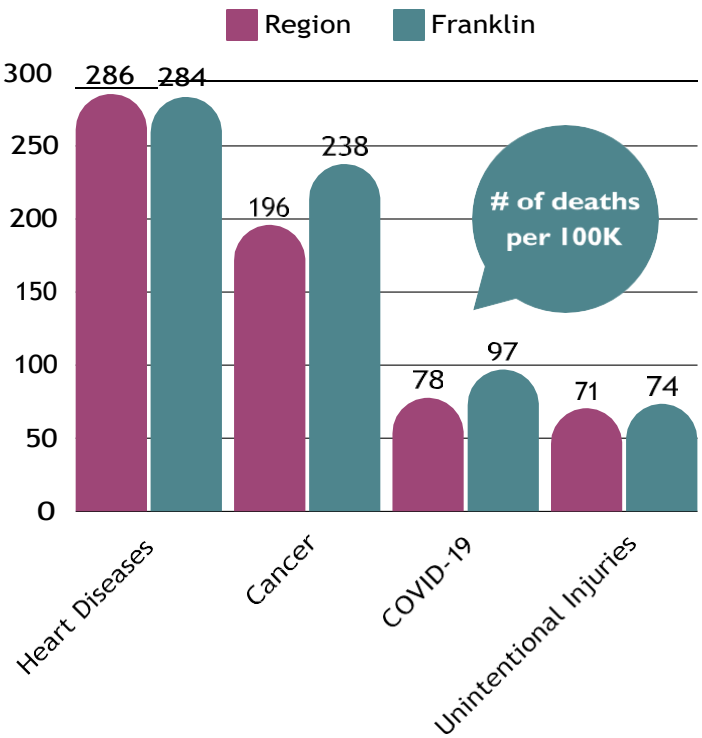
HEALTHY BEHAVIORS AND OUTCOMES

Life Expectancy



Source: County Health Rankings, 2021

Leading Causes of Death



Source: CDC, Wide-ranging Online Data for Epidemiologic Research (WONDER), 2023

TOP 5 HOSPITAL ADMISSIONS VIA EMERGENCY DEPARTMENT

1. Other Sepsis
2. Acute myocardial infarction
3. Cerebral infarction
4. Atrial fibrillation and flutter
5. Acute kidney failure

3 out of the Top 5 are Heart Related

Source: Analysis of OHA Data Tables (August 2024) by the Health Collaborative

INFANT HEALTH

Infant Mortality

No Infant Mortality Data Available for Franklin County

No Timely Prenatal Care Data Available for Franklin County

Source: County Health Rankings, 2021

Timely Prenatal Care: Hamilton County

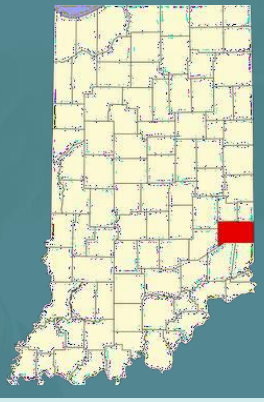
Preterm Birth: Hamilton County

No Preterm Birth Data Available for Franklin County

Source: CDC, Wide-ranging Online Data for Epidemiologic Research (WONDER), 2023

Franklin County: 2024 County Profile

THE HEALTH COLLABORATIVE



HEALTHY BEHAVIORS AND OUTCOMES

Conditions & Diseases (%)

	Region	Franklin
Hypertension (% 18+)	32.6	30.5
Diabetes (% 20+)	9.8	9.5
Chronic lung disease (% 18+)	7.5	7.4
Heart Disease (% 18+)	5.7	5.5
Stroke (% 18+)	2.8	2.8

Source: County Health Rankings, 2021

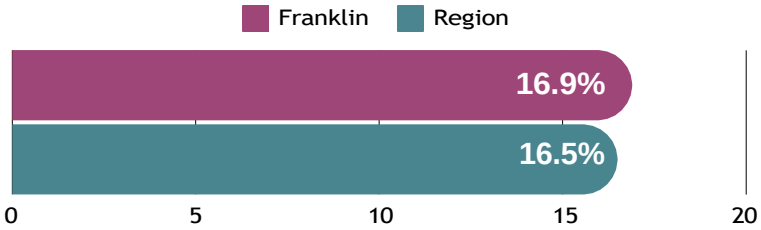
Franklin County is seeing a rate of Hypertension 6.4% lower than the region

Similarly, the rate of Diabetes is 3.1% lower than the region

Source: BRFSS, 2023
Source: County Health Rankings, 2021
Source: PolicyMap, 2019

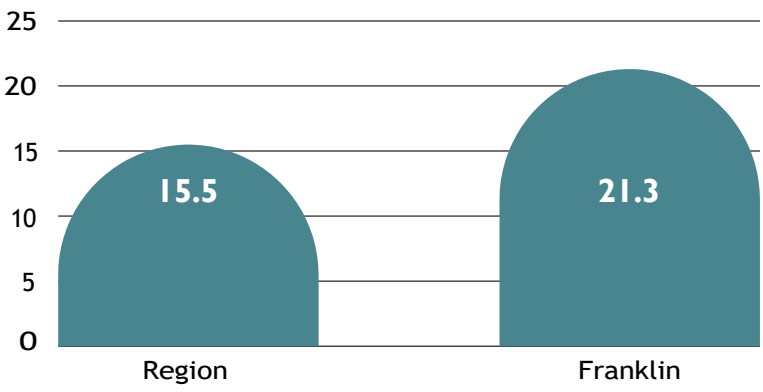
MENTAL HEALTH AND WELL BEING

Frequent Mental Distress



Source: County Health Rankings, 2021

Suicide Death
Rate Per 100K



Source: County Health Rankings, 2021

Did You Know?

Per 100,000 hospital encounters, Franklin County has ...

1. More than 1,700 mental health-related hospital encounters.
2. More than 490 substance use disorder-related hospital encounters.
3. More than 250 depression-related hospital encounters.
4. More than 110 overdose-related hospital encounters.

Source: Analysis of OHA Data Tables (August 2024) by the Health Collaborative

Franklin County: 2024 County Profile

THE HEALTH COLLABORATIVE

SOCIAL DETERMINANTS OF HEALTH

Healthcare Access

	Region	Franklin
Primary Care Doctors Per 100,000 Residents	77	70.0
Mental Health Providers Per 100,000 Residents	301	30.4
Dentists Per 100,000 Residents	57	69.5

Source: County Health Rankings, 2021

Franklin County has 9.1 percent fewer primary care physicians per 100,000 residents than the region.

Franklin County has 21.9 percent more dentists per 100,000 residents than the region.

PERCENT UNINSURED:
Region: 6.9%
Franklin County: 7.9%

Cancer Screening Rates

	Region (%)	Franklin (%)
Mammography (age 50-74)	44.5	46.0
Colorectal cancer (age 50-75)	71.3	69.1
Cervical cancer (age 21-65)	81.2	80.9

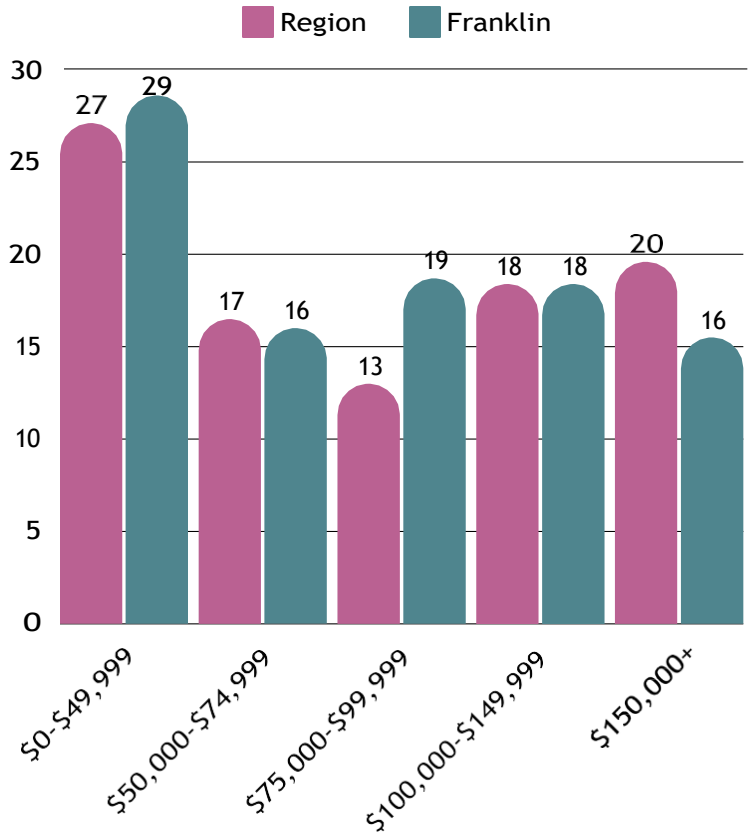
Source: BRFSS, 2023
Source: County Health Rankings, 2021

The High School Graduation Rate for the region is **88.6%.**

The High School Graduation Rate for Franklin County is **97.5%.**

Source: County Health Rankings, 2021

Household Income



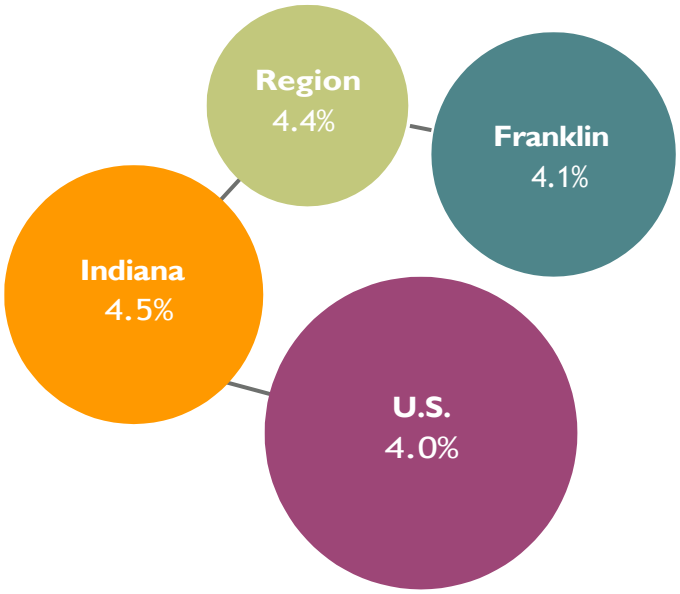
Source: U.S. Census Bureau, 2022

Franklin County: 2024 County Profile

THE HEALTH COLLABORATIVE

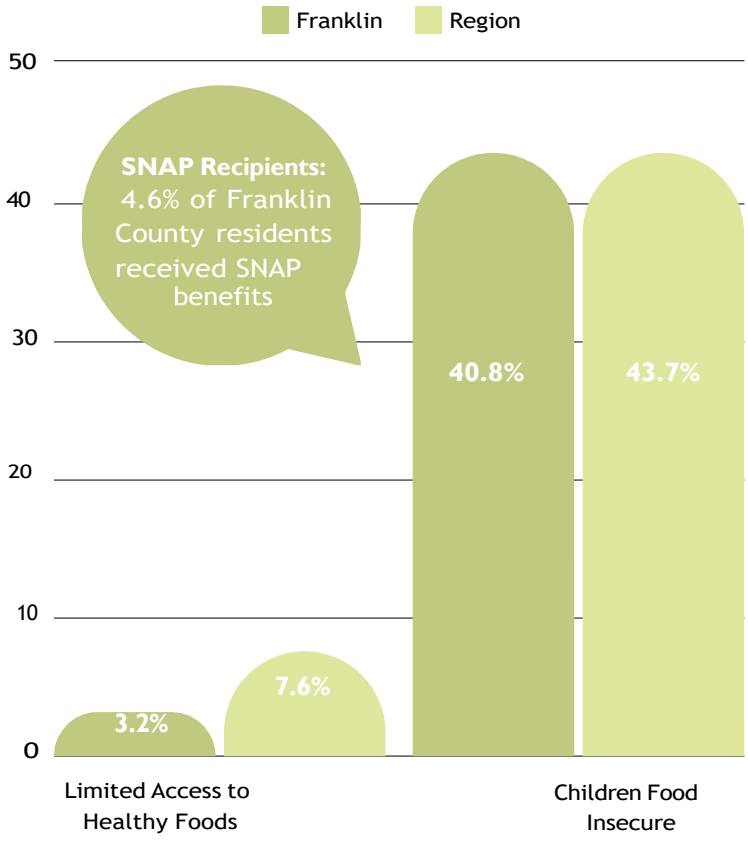
SOCIAL DETERMINANTS OF HEALTH

Unemployment Rate (%)



Source: Bureau of Labor Statistics, via FRED (February 2025)

Food Access and Insecurity



Source: County Health Rankings, 2021

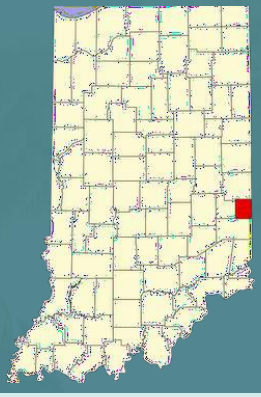
SYSTEMS OF POWER, PRIVILEGE AND OPPRESSION

	Region	Franklin
Income Inequality	4.3	3.9
Social Vulnerability Index	0.3	0.2

Source: County Health Rankings, 2021
Source: CDC Social Vulnerability Index

Union County: 2024 County Profile

THE HEALTH COLLABORATIVE



DEMOGRAPHICS

Age (Years)	Region (%)	Union (%)
0-17	23.2	20.6
18-24	9.3	7.8
25-64	51.4	51.3
65+	16.1	20.2

Source: U.S. Census Bureau, 2022

Race	Region (%)	Union (%)
White, non-Hispanic	78.9	94.4
Black/African American, non-Hispanic	11.2	0.4
Asian, non-Hispanic	2.7	0.7
Hispanic/Latino	3.5	2.3
Native Hawaiian and Other Pacific Islander, non-Hispanic	0.0	0.0

Source: U.S. Census Bureau, 2022

Population Estimates

	Region	Union
Total Population	2,404,540	7,018

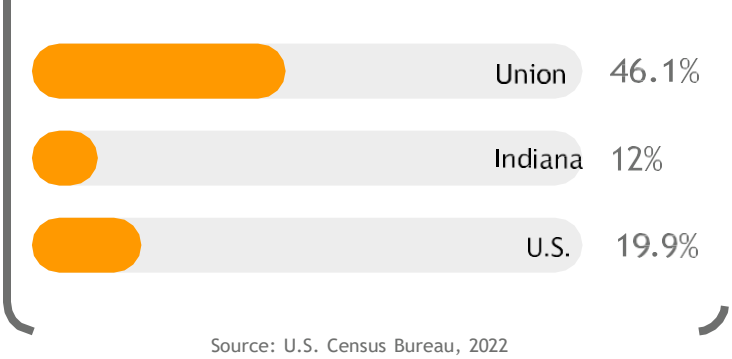
0.9% of Union County's Population is foreign Born

Population with disabilities

- Region 12.9%
- Union 14.4%

Source: U.S. Census Bureau, 2022

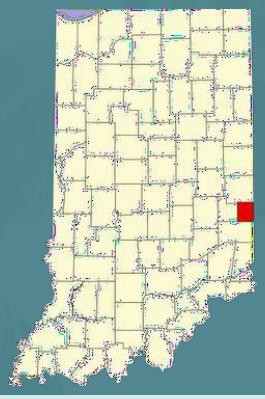
% of Rural



Source: U.S. Census Bureau, 2022

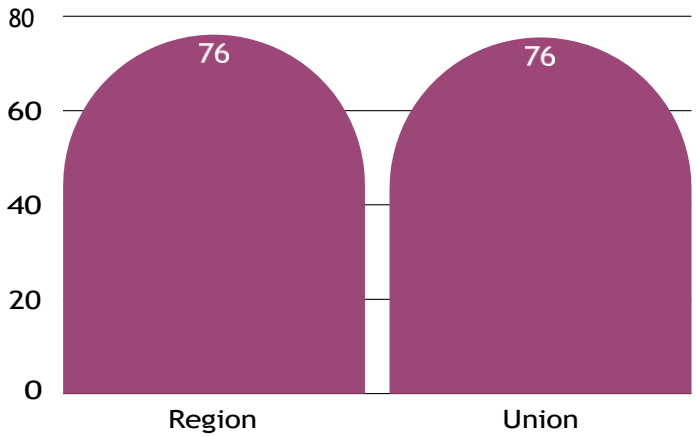
Union County: 2024 County Profile

THE HEALTH COLLABORATIVE



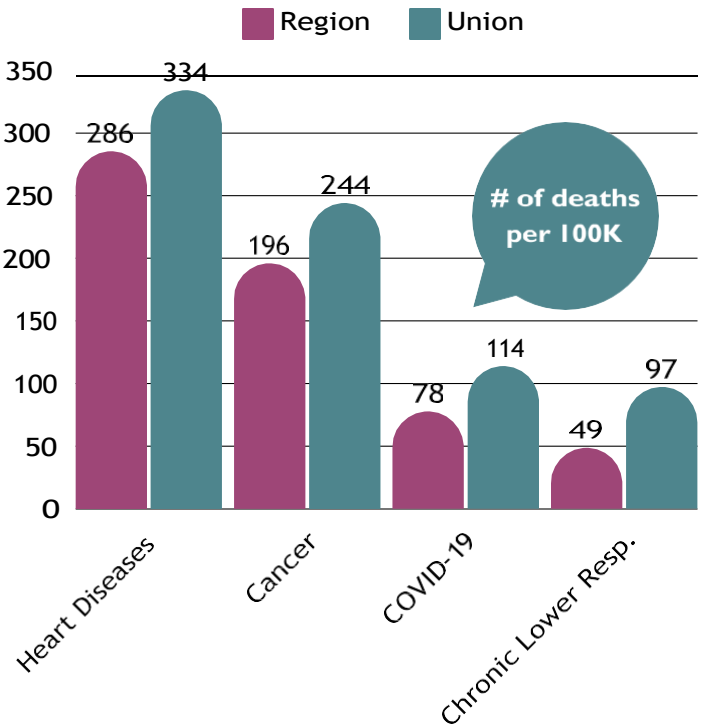
HEALTHY BEHAVIORS AND OUTCOMES

Life Expectancy



Source: County Health Rankings, 2021

Leading Causes of Death



Source: CDC, Wide-ranging Online Data for Epidemiologic Research (WONDER), 2023

TOP 5 HOSPITAL ADMISSIONS VIA EMERGENCY DEPARTMENT

1. Acute kidney failure
2. Complications of internal orthopedic prosth dev/grft
3. Hypertensive heart and chronic kidney disease
4. Other sepsis
5. Cerebral infarction

2 out of the Top 5 are Heart Related

Source: Analysis of OHA Data Tables (August 2024) by the Health Collaborative

INFANT HEALTH

Infant Mortality

No Infant Mortality Data Available for Union County

No Timely Prenatal Care Data Available for Union County

Source: County Health Rankings, 2021

Timely Prenatal Care: Hamilton County

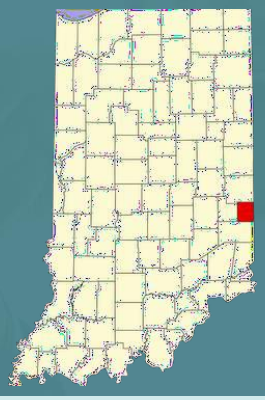
Preterm Birth: Hamilton County

No Preterm Birth Data Available for Union County

Source: CDC, Wide-ranging Online Data for Epidemiologic Research (WONDER), 2023

Union County: 2024 County Profile

THE HEALTH COLLABORATIVE



HEALTHY BEHAVIORS AND OUTCOMES

Conditions & Diseases (%)

	Region	Union
Hypertension (% 18+)	32.6	31.4
Diabetes (% 20+)	9.8	9.8
Chronic lung disease (% 18+)	7.5	7.6
Heart Disease (% 18+)	5.7	5.6
Stroke (% 18+)	2.8	2.8

Source: County Health Rankings, 2021

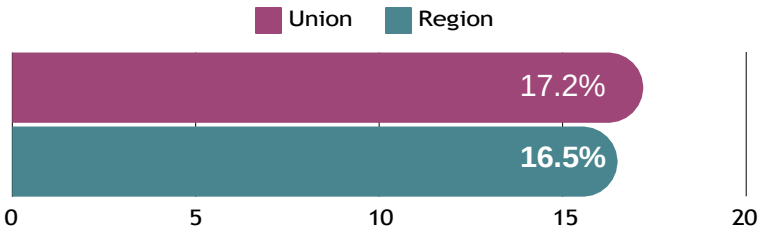
Union County is seeing a rate of Hypertension 3.7% lower than the region

However, the rate of Diabetes is exactly the same as the region

Source: BRFSS, 2023
Source: County Health Rankings, 2021
Source: PolicyMap, 2019

MENTAL HEALTH AND WELL BEING

Frequent Mental Distress



Source: County Health Rankings, 2021

Suicide Death

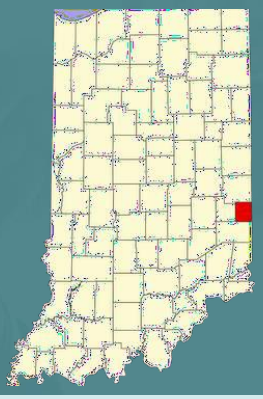
Rate Per 100K

No Suicide Data Available for Union County

Source: County Health Rankings, 2021

Union County: 2024 County Profile

THE HEALTH COLLABORATIVE



SOCIAL DETERMINANTS OF HEALTH

Healthcare Access

	Region	Union
Primary Care Doctors Per 100,000 Residents	77	14.2
Mental Health Providers Per 100,000 Residents	301	14.4
Dentists Per 100,000 Residents	57	14.2

Source: County Health Rankings, 2021

Union County has 81.6 percent fewer primary care physicians per 100,000 residents than the region.

Union County has 75.1 percent more dentists per 100,000 residents than the region.

PERCENT UNINSURED:
Region: 6.9%
Union County: 9.9%

Cancer Screening Rates

	Region (%)	Union (%)
Mammography (age 50-74)	44.5	39.0
Colorectal cancer (age 50-75)	71.3	70.2
Cervical cancer (age 21-65)	81.2	81.1

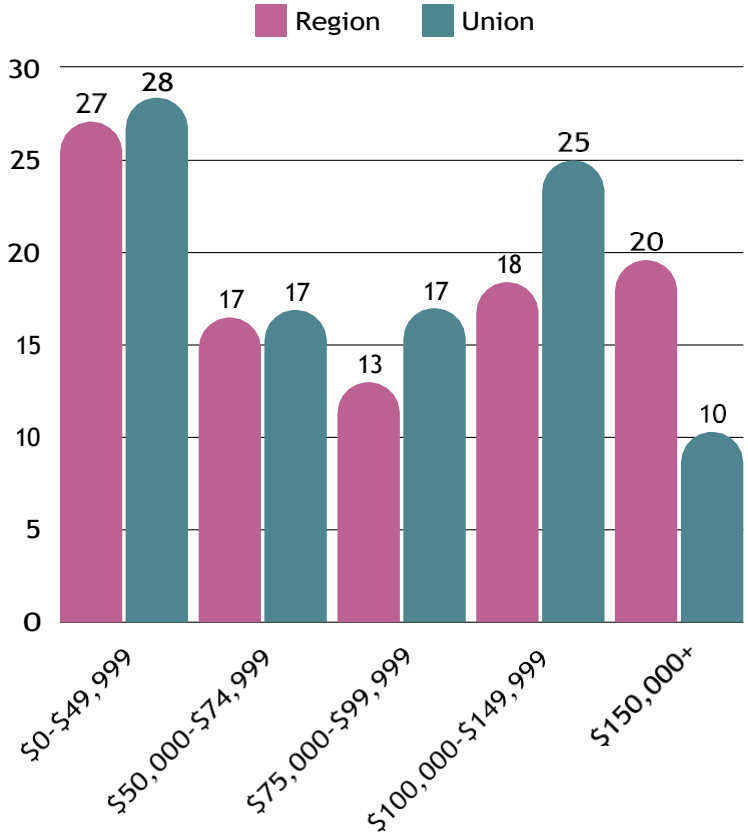
Source: BRFSS, 2023
Source: County Health Rankings, 2021

The High School Graduation Rate for the region is **88.6%.**

The High School Graduation Rate for Union County is **97.5%.**

Source: County Health Rankings, 2021

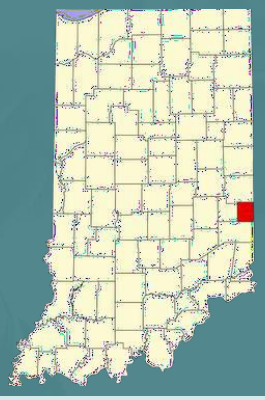
Household Income



Source: U.S. Census Bureau, 2022

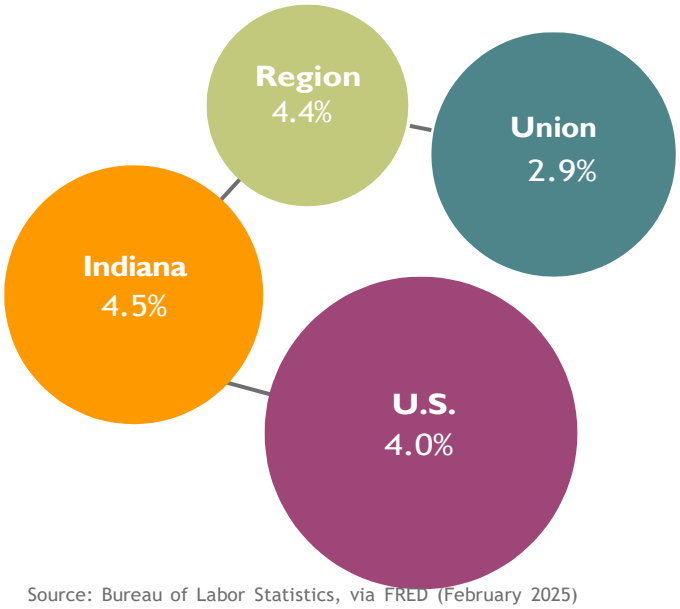
Union County: 2024 County Profile

THE HEALTH COLLABORATIVE



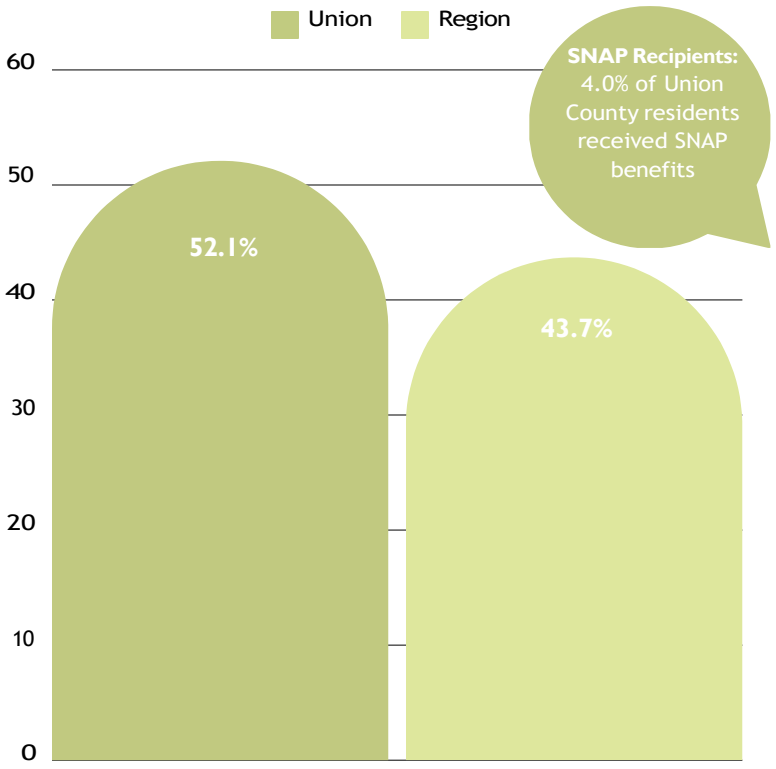
SOCIAL DETERMINANTS OF HEALTH

Unemployment Rate (%)



Source: Bureau of Labor Statistics, via FRED (February 2025)

Food Access and Insecurity



Source: County Health Rankings, 2021

SYSTEMS OF POWER, PRIVILEGE AND OPPRESSION

	Region	Union
Income Inequality	4.3	3.5
Social Vulnerability Index	0.3	0.2

Source: County Health Rankings, 2021
Source: CDC Social Vulnerability Index

Butler County: 2024 County Profile

THE HEALTH COLLABORATIVE

DEMOGRAPHICS

Age (Years)	Region (%)	Butler (%)
0-17	23.2	23.3
18-24	9.3	12.3
25-64	51.4	52.1
65+	16.1	17.4

Source: U.S. Census Bureau, 2022

Race	Region (%)	Butler (%)
White, non-Hispanic	78.9	77.9
Black/African American, non-Hispanic	11.2	8.2
Asian, non-Hispanic	2.7	4.0
Hispanic/Latino	3.5	5.2
Native Hawaiian and Other Pacific Islander, non-Hispanic	0.0	0.1

Source: U.S. Census Bureau, 2022

Population Estimates

	Region	Butler
Total Population	2,404,540	387,619

8.1% of Butler County's Population is foreign Born

Population with disabilities

Region	12.9%
Butler	12.1%

Source: U.S. Census Bureau, 2022

% of Rural

Butler County	9.7%
Ohio	23.8%
U.S.	19.9%

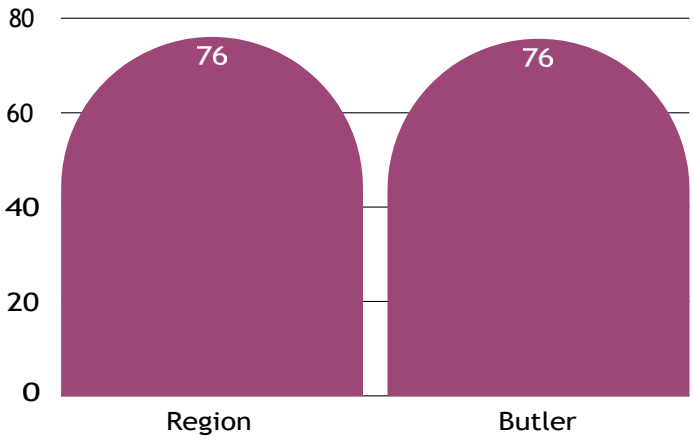
Source: U.S. Census Bureau, 2022

Butler County: 2024 County Profile

THE HEALTH COLLABORATIVE

HEALTHY BEHAVIORS AND OUTCOMES

Life Expectancy



Source: County Health Rankings, 2021

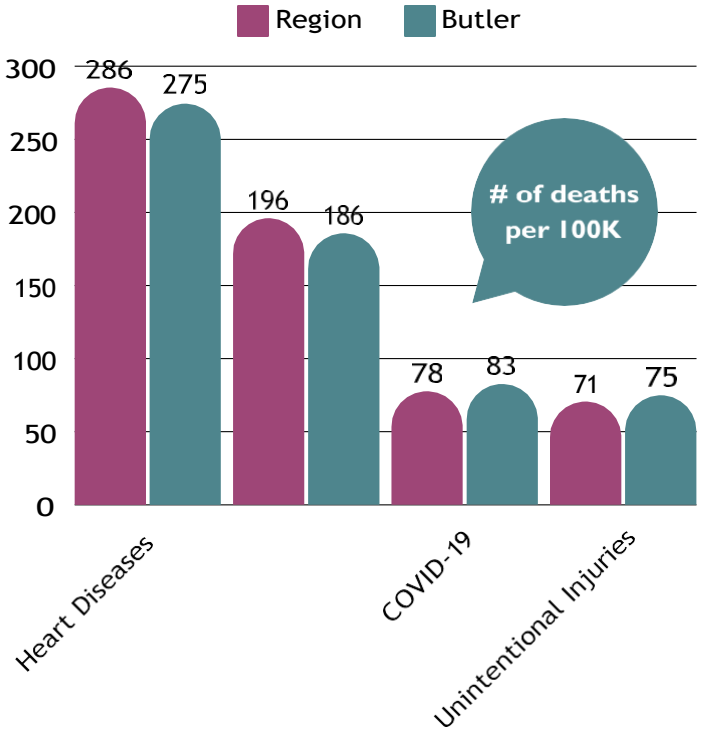
TOP 5 HOSPITAL ADMISSIONS VIA EMERGENCY DEPARTMENT

1. Other sepsis
2. Atrial fibrillation and flutter
3. Hypertensive heart and chronic kidney disease
4. Acute myocardial infarction
5. Hypertensive heart disease

4 out of the Top 5 are Heart Related

Source: Analysis of OHA Data Tables (August 2024) by the Health Collaborative

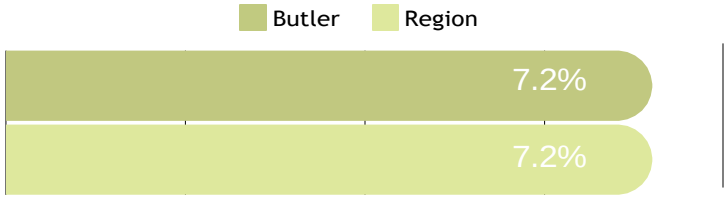
Leading Causes of Death



Source: CDC, Wide-ranging Online Data for Epidemiologic Research (WONDER), 2023

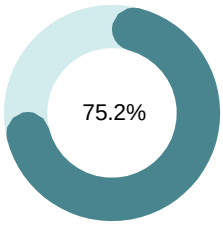
INFANT HEALTH

Infant Mortality

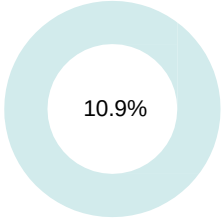


Source: County Health Rankings, 2021

Timely Prenatal Care: Butler County



Preterm Birth: Butler County



Source: CDC, Wide-ranging Online Data for Epidemiologic Research (WONDER), 2023

Butler County: 2024 County Profile

THE HEALTH COLLABORATIVE

HEALTHY BEHAVIORS AND OUTCOMES

Conditions & Diseases (%)

	Region	Butler
Hypertension (% 18+)	32.6	32.8
Heart Disease (% 18+)	5.7	5.8
Diabetes (% 20+)	9.8	10.8
Stroke (% 18+)	2.8	2.8
Chronic lung disease (% 18+)	7.5	7.1

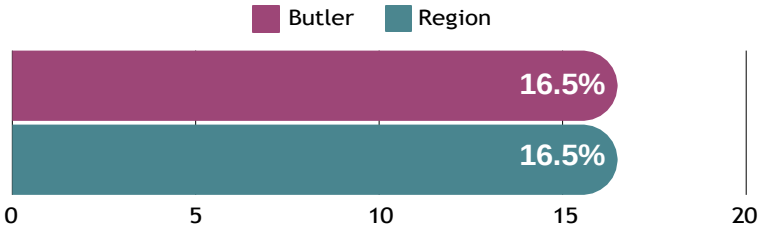
Butler County is seeing a rate of Hypertension 0.6% higher than the region

Similarly, the rate of Heart Disease is 1.7% higher than the region

Source: BRFSS, 2023
Source: County Health Rankings, 2021
Source: PolicyMap, 2019

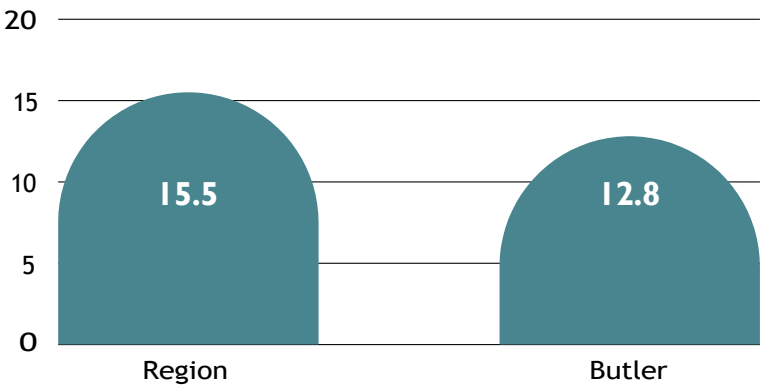
MENTAL HEALTH AND WELL BEING

Frequent Mental Distress



Source: County Health Rankings, 2021

Suicide Death
Rate Per 100K



Source: County Health Rankings, 2021

Did You Know?

Per 100,000 residents, Butler County has ...

1. More than 3,300 mental health-related hospital encounters.
2. More than 450 depression-related hospital encounters.
3. More than 300 overdose-related hospital encounters.
4. More than 300 substance use disorder-related hospital encounters

Source: Analysis of OHA Data Tables (August 2024) by the Health Collaborative

Butler County: 2024 County Profile

THE HEALTH COLLABORATIVE

SOCIAL DETERMINANTS OF HEALTH

Healthcare Access

	Region	Butler
Primary Care Doctors Per 100,000 Residents	77	52
Mental Health Providers Per 100,000 Residents	301	282
Dentists Per 100,000 Residents	57	52

Source: County Health Rankings, 2021

Butler County has 32 percent fewer primary care physicians per 100,000 residents than the region.

Butler County has 9 percent fewer dentists per 100,000 residents than the region.

PERCENT UNINSURED:
Region:6.9%
Butler County: 9.1%

Cancer Screening Rates

	Region (%)	Butler (%)
Mammography (age 50-74)	44.5	45.0
Colorectal cancer (age 50-75)	71.3	72.3
Cervical cancer (age 21-65)	81.2	80.5

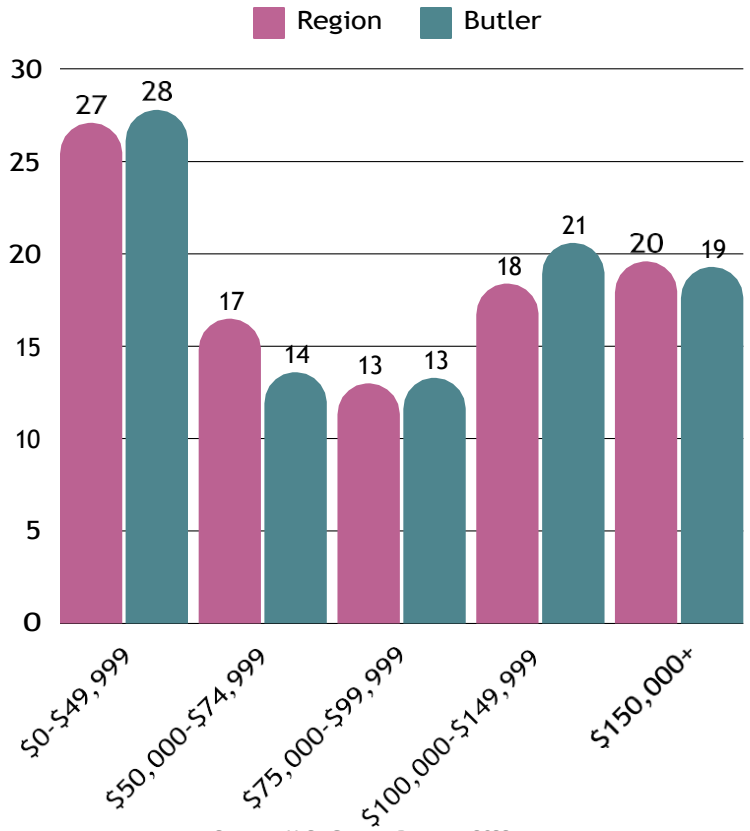
Source: BRFSS, 2023
Source: County Health Rankings, 2021

The High School Graduation Rate for the region is **88.6%.**

The High School Graduation Rate for Butler County is **88.2%.**

Source: County Health Rankings, 2021

Household Income



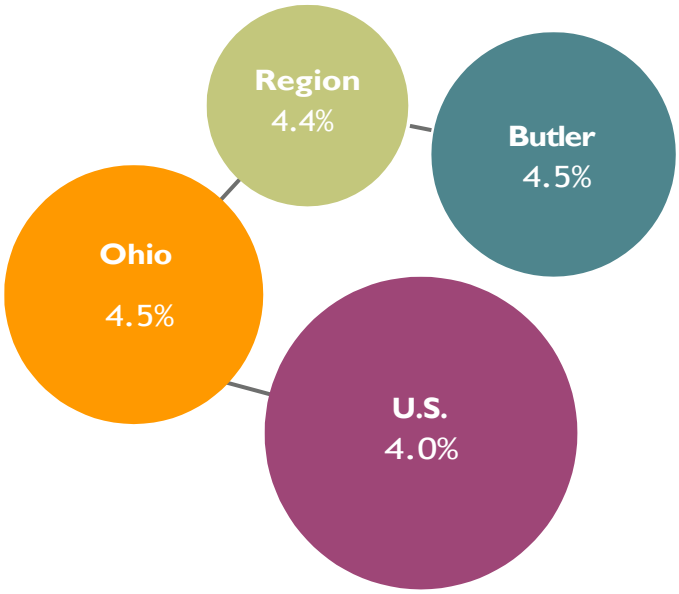
Source: U.S. Census Bureau, 2022

Butler County: 2024 County Profile

THE HEALTH COLLABORATIVE

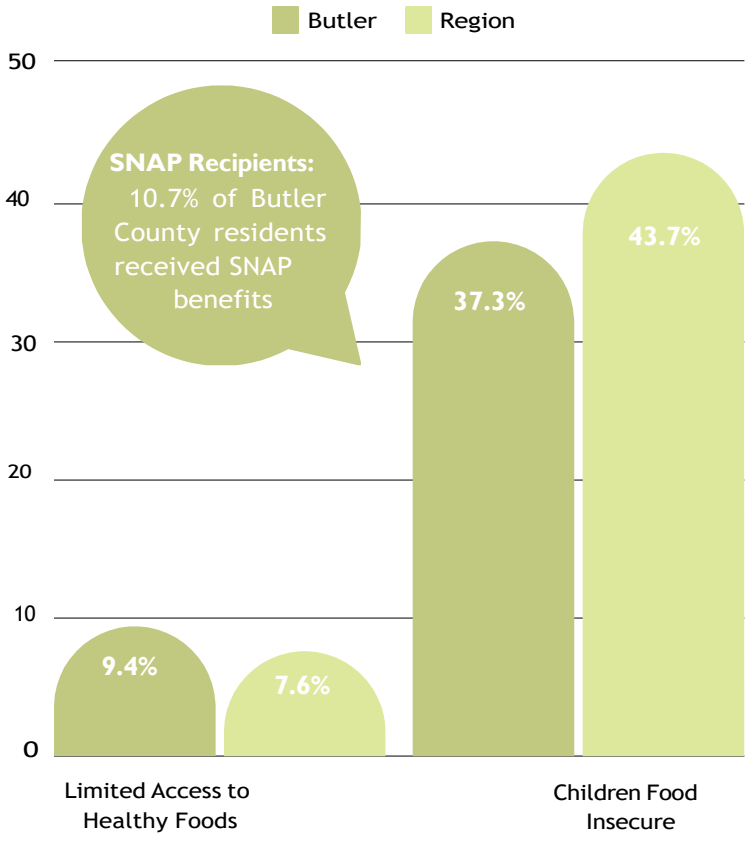
SOCIAL DETERMINANTS OF HEALTH

Unemployment Rate (%)



Source: Bureau of Labor Statistics, via FRED (February 2025)

Food Access and Insecurity



Source: County Health Rankings, 2021

SYSTEMS OF POWER, PRIVILEGE AND OPPRESSION

	Region	Butler
Income Inequality	4.3	4.5
Social Vulnerability Index	0.3	0.7

Source: County Health Rankings, 2021
Source: CDC Social Vulnerability Index

Preble County: 2024 County Profile

THE HEALTH COLLABORATIVE

DEMOGRAPHICS

Age (Years)	Region (%)	Preble (%)
0-17	23.2	22.1
18-24	9.3	7.6
25-64	51.4	50.7
65+	16.1	19.6

Source: U.S. Census Bureau, 2022

Race	Region (%)	Preble (%)
White, non-Hispanic	78.9	95.5
Black/African American, non-Hispanic	11.2	0.7
Asian, non-Hispanic	2.7	0.2
Hispanic/Latino	3.5	1.1
Native Hawaiian and Other Pacific Islander, non-Hispanic	0.0	0.0

Source: U.S. Census Bureau, 2022

Population Estimates

	Region	Preble
Total Population	2,404,540	40,871

0.5% of Preble County's Population is foreign Born

Population with disabilities

Region	12.9%
Preble	15.0%

Source: U.S. Census Bureau, 2022

% of Rural

Preble	32.8%
Ohio	23.8%
U.S.	19.9%

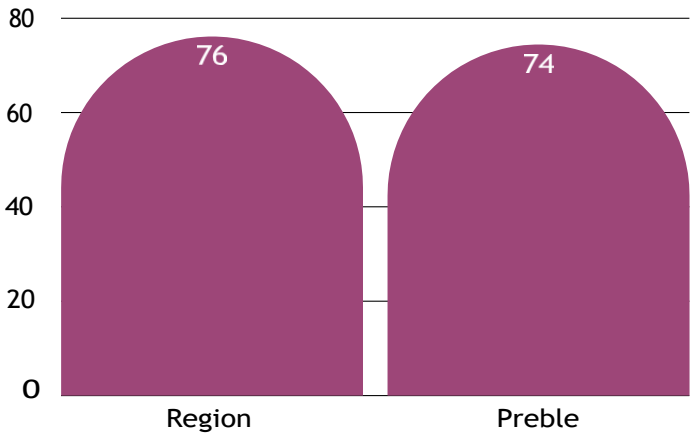
Source: U.S. Census Bureau, 2022

Preble County: 2024 County Profile

THE HEALTH COLLABORATIVE

HEALTHY BEHAVIORS AND OUTCOMES

Life Expectancy



Source: County Health Rankings, 2021

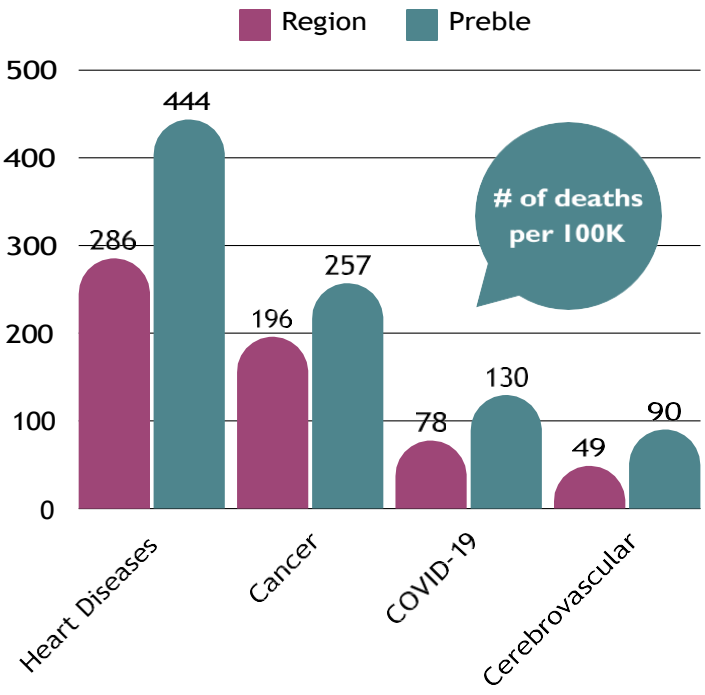
TOP 5 HOSPITAL ADMISSIONS VIA EMERGENCY DEPARTMENT

1. Other Sepsis
2. Acute kidney failure
3. Type 2 diabetes mellitus
4. Chronic ischemic heart disease
5. Hypertensive heart and chronic kidney disease

2 out of the Top 5 are Heart Related

Source: Analysis of OHA Data Tables (August 2024) by the Health Collaborative

Leading Causes of Death



Source: CDC, Wide-ranging Online Data for Epidemiologic Research (WONDER), 2023

INFANT HEALTH

Infant Mortality

No Infant Mortality Data Available for Preble County

No Timely Prenatal Care Data Available for Preble County

Source: County Health Rankings, 2021

Timely Prenatal Care: Hamilton County

Preterm Birth: Hamilton County

No Preterm Birth Data Available for Preble County

Source: CDC, Wide-ranging Online Data for Epidemiologic Research (WONDER), 2023

Preble County: 2024 County Profile

THE HEALTH COLLABORATIVE

HEALTHY BEHAVIORS AND OUTCOMES

Conditions & Diseases (%)

	Region	Preble
Hypertension (% 18+)	32.6	32.2
Diabetes (% 20+)	9.8	10.0
Chronic lung disease (% 18+)	7.5	7.6
Heart Disease (% 18+)	5.7	6.0
Stroke (% 18+)	2.8	2.8

Source: County Health Rankings, 2021

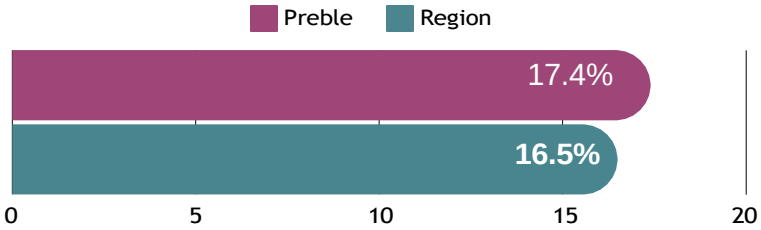
Preble County is seeing a rate of Hypertension 1.2% lower than the region

However, the rate of Diabetes is 2.0% higher than the region

Source: BRFSS, 2023
Source: County Health Rankings, 2021
Source: PolicyMap, 2019

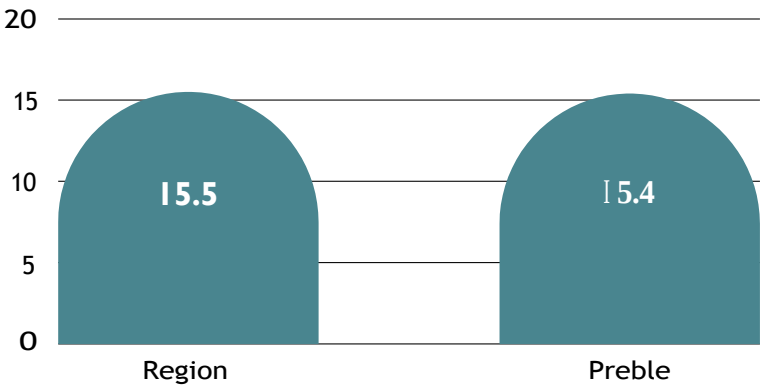
MENTAL HEALTH AND WELL BEING

Frequent Mental Distress



Source: County Health Rankings, 2021

Suicide Death
Rate Per 100K



Source: County Health Rankings, 2021

Did You Know?

Per 100,000 residents, Preble County has ...

1. More than 2,300 mental health-related hospital encounters.
2. More than 350 depression-related hospital encounters.
3. More than 330 substance use disorder-related hospital encounters.
4. More than 300 overdose-related hospital encounters.

Source: Analysis of OHA Data Tables (August 2024) by the Health Collaborative

Preble County: 2024 County Profile

THE HEALTH COLLABORATIVE

SOCIAL DETERMINANTS OF HEALTH

Healthcare Access

	Region	Preble
Primary Care Doctors Per 100,000 Residents	77	17.1
Mental Health Providers Per 100,000 Residents	301	93.6
Dentists Per 100,000 Residents	57	14.8

Source: County Health Rankings, 2021

Preble County has 77.8 percent fewer primary care physicians per 100,000 residents than the region.

Preble County has 74.0 percent fewer dentists per 100,000 residents than the region.

PERCENT UNINSURED:
Region: 6.9%
Preble County: 7.2%

Cancer Screening Rates

	Region (%)	Preble (%)
Mammography (age 50-74)	44.5	42.0
Colorectal cancer (age 50-75)	71.3	71.4
Cervical cancer (age 21-65)	81.2	81.8

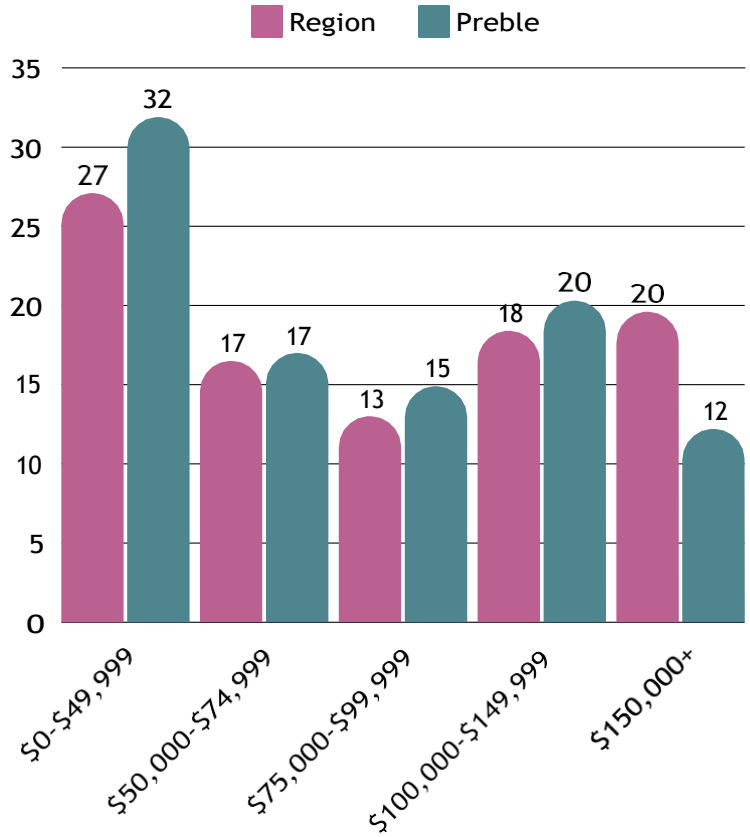
Source: BRFSS, 2023
Source: County Health Rankings, 2021

The High School Graduation Rate for the region is **88.6%.**

The High School Graduation Rate for Preble County is **95.0%.**

Source: County Health Rankings, 2021

Household Income



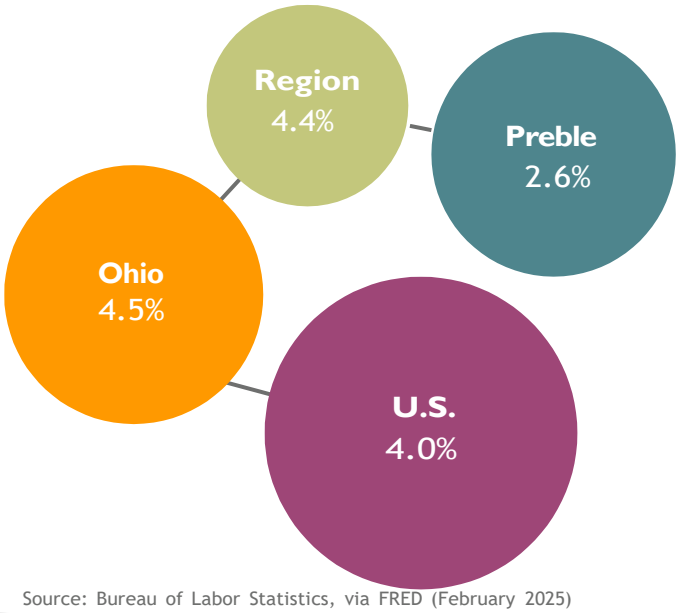
Source: U.S. Census Bureau, 2022

Preble County: 2024 County Profile

THE HEALTH COLLABORATIVE

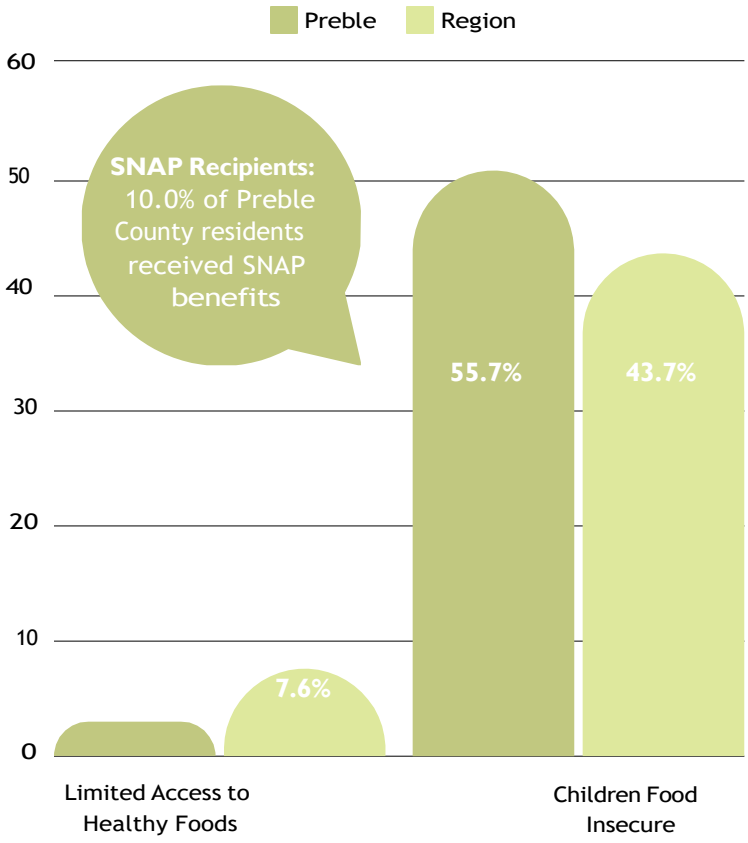
SOCIAL DETERMINANTS OF HEALTH

Unemployment Rate (%)



Source: Bureau of Labor Statistics, via FRED (February 2025)

Food Access and Insecurity



Source: County Health Rankings, 2021

SYSTEMS OF POWER, PRIVILEGE AND OPPRESSION

	Region	Preble
Income Inequality	4.3	3.9
Social Vulnerability Index	0.3	0.0

Source: County Health Rankings, 2021
Source: CDC Social Vulnerability Index

Contracted Consultants

Bricker & Eckler LLP/INCompliance Consulting, Jim Flynn and Christine Kenney – located at 100 South Third Street, Columbus, Ohio 43215. Bricker & Eckler LLP / INCompliance Consulting was contracted to review this CHNA report. Jim Flynn is managing partner with Bricker & Eckler's healthcare group, where he has practiced for 31 years. His general healthcare practice focuses on health planning matters, certificates of need, nonprofit and tax-exempt healthcare providers, and federal and state regulatory issues. Mr. Flynn has provided consultation to healthcare providers, including nonprofit and tax-exempt healthcare providers as well as public hospitals, on community health needs assessments. Christine Kenney is the director of regulatory services with INCompliance Consulting, an affiliate of Bricker & Eckler LLP. Ms. Kenney has more than 42 years of experience in healthcare planning and policy development, federal and state regulations, certificate of need regulations, and Medicare and Medicaid certification. She has been conducting CHNAs since 2012, providing expert testimony on community needs and offering presentations and educational sessions regarding CHNAs.