2022 Community Health Needs Assessment

110 North Poplar Street
Oxford, Ohio 45056
Butler County

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375 Dixmyth Avenue
Cincinnati, Ohio 45220

EIN: 31-0650283
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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 over 65 years. MHMH has grown along with our community, and continually assesses the needs of our communities as we develop new 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 MHMH communities, 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/Access including psychiatric services
2. Alcohol and Other Drugs, especially opiate use overdoses, smoking/vaping
3. Access to Healthcare (low income, communication, transportation)
4. Food Insecurity /Obesity
5. Healthy behaviors, especially physical activity and healthy eating leading to obesity

Note that these priority health needs align with the 2020-2022 Ohio Department of Health's State Health Improvement Plan's priority topics "Health Behaviors", "Access to Healthcare", "Mental health and addiction" and "Chronic Disease".

The following document is a detailed CHNA for MHMH, a community hospital located in Oxford, Ohio, which opened its doors in 1957. The facility's main campus has grown over the years; the last major expansion/renovation occurred in 2017. However, a major Obstetric update was completed in 2021. In 2015, MHMH affiliated with TriHealth, Inc., which is an integrated health care system, whose mission and vision was similar to MHMH's and whose leadership and resources would help us serve our communities better.

MHMH's main campus, located at 110 North Poplar Street, Oxford, Butler County, Ohio 45056, offers 45 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 Oxford, Hamilton and Camden, Ohio. Through our affiliation with TriHealth, Inc. the resources of Bethesda North, Bethesda Butler, and Good Samaritan Hospitals are also available to our clients.

MHMH has a strong health and wellness commitment to our communities, which we have demonstrated over the years. MHMH provided over 5 million dollars over the last 3 years in financial assistance to those who cannot afford healthcare. We have also provided funding for programs that address our identified health needs that will be discussed later in under progress.

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 2021 Report is available at https://healthcollab.org/wp-content/uploads/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. This CHNA was completed

in 2022; however, all data collection was completed in 2021 with the exception of the Oxford Area meeting and questionnaire that occurred in 2022. 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

We envision a region where everyone has the opportunity to be healthy. To achieve this vision, our region is working on eliminating health disparities by embracing community voice, investing in trusted partnerships, and implementing evidence-based strategies and best practices to achieve equitable health outcomes for all.

To move this vision forward with data-driven action, area Health Systems and hospitals, public health agencies and other health care providers commissioned The Health Collaborative (THC), in partnership with the Greater Dayton Area Hospital Association (GDAHA), to facilitate the 2021 Regional Community Health Needs Assessment (CHNA). This Regional CHNA includes 36 hospitals, 22 health departments, across 26 counties in southwest Ohio and the Greater Dayton Area, southeast Indiana, and northern Kentucky.

Data collection, analysis, and synthesis was conducted by Measurement Resources Company (MRC) and subcontractor Scale Strategic Solutions. A comprehensive, inclusive, and balanced mixed-method approach, and best practices in community engagement, were used in data collection to ensure a representative sample of community members, specifically the voices of marginalized populations and the inclusion of providers across health and social services sectors.

In this Regional CHNA, health encompasses physical, mental, and social conditions. Health care is inclusive of hospitals and emergency rooms, primary care, behavioral health, specialty care (i.e., vision, dental, chiropractic, etc.) and social services that support health or link community members to health care.

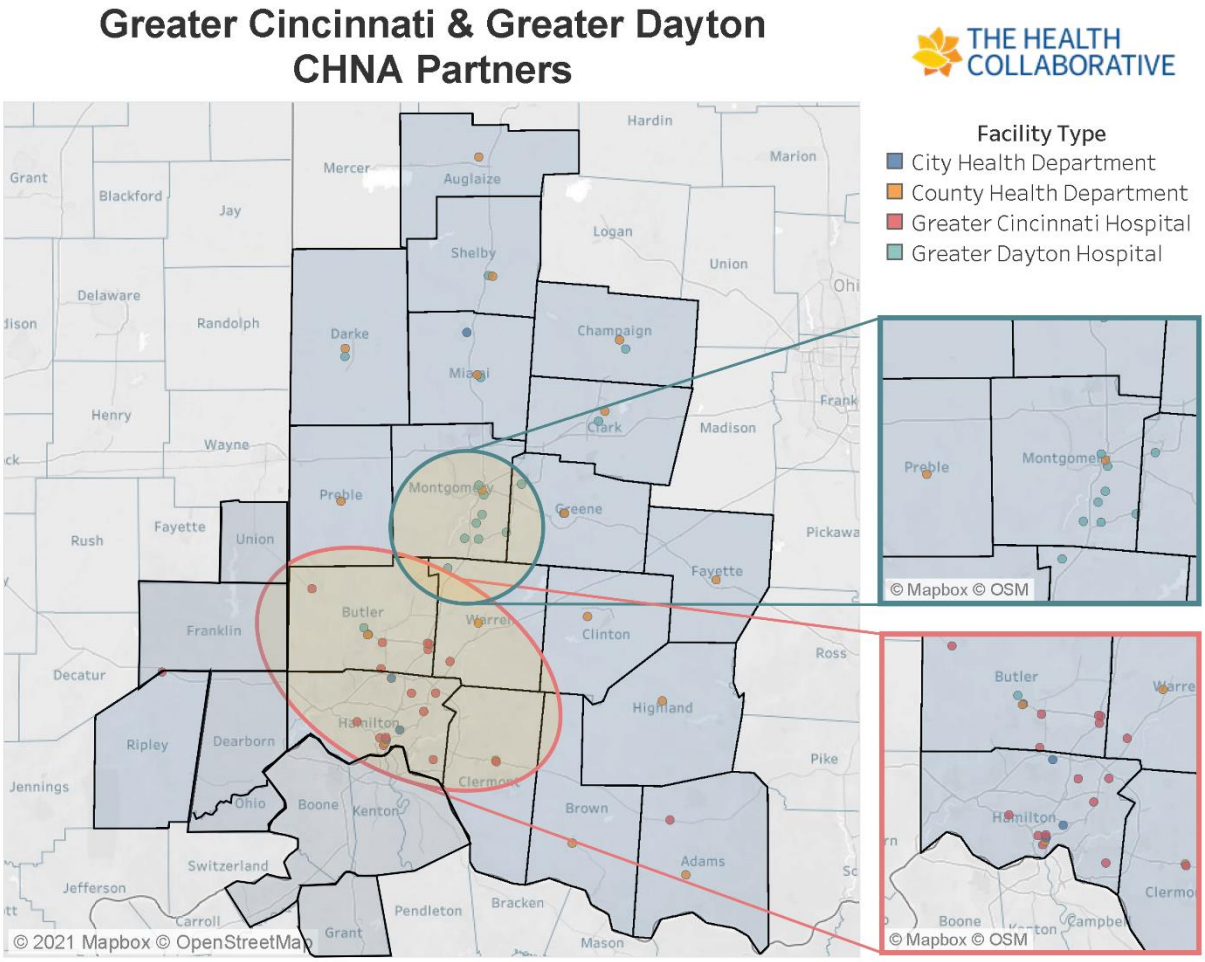
The Regional CHNA was guided by the Advisory Committee. A total of 42 individuals are part of the advisory committee representing hospitals, health departments, and community partners in southwest Ohio and the Greater Dayton Area, southeast Indiana, and northern Kentucky. The advisory committee met monthly from January, 2021 through December, 2021, with THC, GDAHA, MRC and Scale Strategic Solutions to oversee the work and keep THC accountable to the inclusive process.

THC will use the Regional CHNA to inform how they direct energy and resources to equitably meet the healthcare needs of the community. The results will encourage innovative healthcare delivery models designed to unite region-wide efforts in providing high-quality care, increasing access to care, and achieving improved health outcomes for all.

Alignment to the State Health Improvement Plan of Ohio

This Regional CHNA includes a comprehensive data-driven approach to define the current state of health and health equity with the goal of informing a collective and prioritizing an actionable agenda for improving health outcomes across the region over the next three years. Like the Statewide Health Improvement Plan (SHIP) for Ohio, this Regional CHNA explores the priority factors that influence health including perceptions of healthcare quality and access, health behaviors and community conditions (i.e., social determinants of health). Guided by the SHIP, the Regional CHNA focuses on the priority health outcomes related to chronic disease, mental health and addiction, and maternal and infant health. The recommendations put forth in this Needs Assessment support the priorities of the SHIP and provide a framework for working collaboratively in addressing disparities and barriers to a healthier community.

Regional CHNA Geographic Area



Regional CHNA Participating Organizations

HOSPITALS/HEALTH SYSTEMS

Bon Secours Mercy Health
- Bon Secours Mercy Health Anderson Hospital
- Bon Secours Mercy Health Clermont Hospital
- Bon Secours Mercy Health Fairfield Hospital
- Bon Secours Mercy Health Jewish Hospital
- Bon Secours Mercy Health West Hospital

Cincinnati Children's Hospital
- Cincinnati Children's Burnet Campus
- Cincinnati Children's Liberty Campus
- Cincinnati Children's College Hill Campus

The C&F Lindner Center of HOPE

The Christ Hospital, Mt. Auburn

TriHealth
- TriHealth Good Samaritan Hospital
- TriHealth Good Samaritan Evendale Hospital
- TriHealth Bethesda North Hospital
- TriHealth Bethesda Butler Hospital
- TriHealth McCullough Hyde Memorial Hospital

UC Health
- UC Health University of Cincinnati Medical Center
- UC Health West Chester Hospital
- UC Health Drake Center for Post-Acute Care

Greater Dayton Area Hospital Association (GDAHA):

Kettering
- Kettering Medical Center
- Sycamore Medical Center
- Kettering Behavioral Medical Center
- Grandview Medical Center
- Southview Medical Center
- Soin Medical Center
- Greene Memorial Hospital
- Fort Hamilton Hospital

Premier
- Miami Valley Hospital
- Atrium Medical Center
- Upper Valley Medical Center

- Miami Valley Hospital South
- Miami Valley Hospital North

Wilson Memorial Health
Wayne Healthcare
Mercy Health Springfield Regional Medical Center
Mercy Health Urbana Hospital

Adams County Regional Medical Center
Margaret Mary Health

LOCAL HEALTH DEPARTMENTS

City: Cincinnati, Hamilton (City), Norwood, Piqua, Springdale
County: Adams, Auglaize, Brown, Butler, Champaign, Clark, Clermont, Clinton, Darke, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble, Shelby, Warren

COUNTIES

Indiana: Franklin, Dearborn, Ohio, Ripley, Union
Kentucky: Campbell, Boone, Grant, Kenton
Ohio: Adams, Auglaize, Brown, Butler, Champaign, Clark, Clermont, Clinton, Darke, Greene, Hamilton, Highland, Miami, Montgomery, Preble, Shelby, Warren

Notes/Limitations:

- *4 Kentucky counties are managed by 1 NKY Health Department and did not officially participate. These counties are however in the services areas of participating hospitals (Christ, CCHMC) and therefore are included in the county number.*
- *5 Indiana counties do have their own health department/county but did not officially participate. They are included in multiple hospital service areas (GDAHA, MMH, CCHMC, MHMH) and therefore were included in the county number.*
- *5 additional city health departments were engaged, all located within participating counties in Ohio.*

Populations Represented
Hospitals/Health Systems and Local Health Departments represent all populations within their communities, including underserved, low-income and minority populations.

Local Health Departments provide knowledge of and/or expertise in public health.

C & F Lindner Center for HOPE is a nonprofit, mental health center staffed by a diverse team, united in the philosophy that by working together, we can best offer hope for people living with mental illness.

No written comments were received concerning the 2019 CHNA report or Implementation Strategy.

All required sources for community input were obtained.

Regional CHNA Advisory Committee

ADVISORY COMMITTEE		
Participants	**Organization**	**Groups Represented**
Denisha Porter	All in Cincinnati	All-In Cincinnati aims to deepen, amplify, and multiply local and regional efforts to build equitable, thriving neighborhoods. Embracing equity means embracing the idea that a person's opportunities shouldn't be determined by race, ethnicity, gender, nativity, religion, sexual orientation, disability status, zip code or family income.
Kiana Trabue	bi3	Transform the health and well-being of all people in Greater Cincinnati by investing in innovative ideas and supporting Bethesda entities and TriHealth to be market leaders.
Lauren Brinkman	Cincinnati Children's	We're here for every family, every child, every future.
Monica Mitchell	Cincinnati Children's	We're here for every family, every child, every future.
Jeanne Bowman	Champaign Health District	Represents all populations, including the medically underserved, low-income, and minority populations.
Maryse Amin	Cincinnati HD	Represents all populations, including the medically underserved, low-income, and minority populations.
Susan Tilgner	Cincinnati HD	Represents all populations, including the medically underserved, low-income, and minority populations.
Anna Jean Sauter	Clark County Combined Health District	Represents all populations, including the medically underserved, low-income, and minority populations.
Emma Smales	Clark County Combined Health District/Public Health Dayton Montgomery County	Represents all populations, including the medically underserved, low-income, and minority populations.
Dani Isaacsohn	CoHear	We help leaders develop meaningful solutions to difficult problems by organizing and engaging with community members with lived experience.
Jamahal Boyd	Crossroads Center	The Crossroads Center is a full service non-profit behavioral healthcare agency providing services within the Hamilton County and Greater Cincinnati Area.
Lisa Henderson	Greater Dayton Area Hospital Association (GDAHA)	The Greater Dayton Area Hospital Association (GDAHA) ensures that our healthcare community is providing quality medical treatment in the Miami Valley.
Becca Stowe	Hamilton County Public Health	Represents all populations, including the medically underserved, low-income, and minority populations.

Greg Kesterman	Hamilton County Public Health	Represents all populations, including the medically underserved, low-income, and minority populations.
Sarah Mills	HealthCare Access Now (HCAN)	HCAN was started by community leaders in 2009 to improve the overall health status of Greater Cincinnati's most vulnerable residents – those who are likely to have poor health outcomes because they do not have consistent medical care; access to behavioral health care and specialty care; lack support in successfully managing chronic diseases.
Jolene Joseph	Healthcare Connection	Provide quality, culturally sensitive and accessible primary healthcare services focusing on the medically underserved, underinsured and uninsured residing in northern Hamilton County and surrounding areas.
Colleen Desmond	Interact for Health	Interact for Health is improving the health of all people in our region. We serve as a catalyst by promoting health equity through grants, education, research, policy and engagement.
Kelly Adcock	Interact for Health	Interact for Health is improving the health of all people in our region. We serve as a catalyst by promoting health equity through grants, education, research, policy and engagement.
Jonathan Duffy	Kettering Health Network	Represents all populations, including the medically underserved, low-income, and minority populations.
Molly Hallock	Kettering Health Network	Represents all populations, including the medically underserved, low-income, and minority populations.
Jayda Carlton	Mercy Health/Bon Secours	Represents all populations, including the medically underserved, low-income, and minority populations.
Allison Luntz	Mercy Health/Bon Secours	Represents all populations, including the medically underserved, low-income, and minority populations.
Gina Hemenway	Mercy Health	Represents all populations, including the medically underserved, low-income, and minority populations.
Carolyn Young	Mercy Health Springfield	Represents all populations, including the medically underserved, low-income, and minority populations.
Geralyn Litzinger	Margaret Mary Health	Margaret Mary Health is a not-for-profit critical access hospital providing inpatient and outpatient services.
Barbara Marsh	Montgomery/Dayton County Public Health	Represents all populations, including the medically underserved, low-income, and minority populations.
Dawn Ebron	Montgomery/Dayton County Public Health	Represents all populations, including the medically underserved, low-income, and minority populations.
Brian Williamson	Norwood Health Department	Represents all populations, including the medically underserved, low-income, and minority populations.
Sarah Moore	Norwood Health Department	Represents all populations, including the medically underserved, low-income, and minority populations.

Roopsi Narayan	Premier Health	Represents all populations, including the medically underserved, low-income, and minority populations.
Erik Balster	Southwest Association of Ohio Health Commissioners (AOHC)/ Preble County Public Health	Represents all populations, including the medically underserved, low-income, and minority populations.
Ashley Clos	The Christ Hospital	Represents all populations, including the medically underserved, low-income, and minority populations.
Jessica Coyle	The Christ Hospital	Represents all populations, including the medically underserved, low-income, and minority populations.
Shelley Spencer	The Christ Hospital	Represents all populations, including the medically underserved, low-income, and minority populations.
Frank Nation	TriHealth	Represents all populations, including the medically underserved, low-income, and minority populations.
Susan Murray	TriHealth	Represents all populations, including the medically underserved, low-income, and minority populations.
Regan Johnson	University of Cincinnati	Represents all populations, including the medically underserved, low-income, and minority populations.
Dan Maxwell	UC Health	Represents all populations, including the medically underserved, low-income, and minority populations.
Lindsey Cencula	UC Health	Represents all populations, including the medically underserved, low-income, and minority populations.
Laura Nabors	University of Cincinnati	Represents all populations, including the medically underserved, low-income, and minority populations.
Gabe Jones	West Central Association of Ohio Health Commissioners (AOHC)/Champaign County Public Health	Represents all populations, including the medically underserved, low-income, and minority populations.
Bruce Jeffery	YMCA Cradle to Career	Working together, through Collective Impact, we can better support the spirit, mind, and body development of our children.

CORE CIRCLE		
Participants	**Organization**	**Groups Represented**
Lisa Henderson	Greater Dayton Area Hospital Association	The Greater Dayton Area Hospital Association (GDAHA) ensures that our healthcare community is providing quality medical treatment in the Miami Valley.
Erik Balster	Preble County Public Health	Represents all populations, including the medically underserved, low-income, and minority populations.
Lauren Bartoszek	The Health Collaborative	We've imagined a community where good health and quality

		healthcare are a right, not a privilege. Where everyone has the same opportunities, healthcare is designed with intention, and complex problems are solved collaboratively. Together, we're building a healthier Greater Cincinnati through partnerships, data-driven healthcare and innovation, and an unrelenting commitment to improve outcomes.
Ericson Imarenezor	The Health Collaborative	We've imagined a community where good health and quality healthcare are a right, not a privilege. Where everyone has the same opportunities, healthcare is designed with intention, and complex problems are solved collaboratively. Together, we're building a healthier Greater Cincinnati through partnerships, data-driven healthcare and innovation, and an unrelenting commitment to improve outcomes.
Elizabeth Pafford	Measurement Resources Company	Measurement Resources uses data-driven management tools, such as evaluation, organizational development, and performance measurement to help organizations.
Sheri Chaney Jones	Measurement Resources Company	Measurement Resources uses data-driven management tools, such as evaluation, organizational development, and performance measurement to help organizations.
Eliza Gardiner	Measurement Resources Company	Measurement Resources uses data-driven management tools, such as evaluation, organizational development, and performance measurement to help organizations.
Alyssa Petty	Measurement Resources Company	Measurement Resources uses data-driven management tools, such as evaluation, organizational development, and performance measurement to help organizations.
Harley Vossler	Measurement Resources Company	Measurement Resources uses data-driven management tools, such as evaluation, organizational

		development, and performance measurement to help organizations.
Calista Smith	Scale Strategic Solutions	We help organizations and systems execute their visions with data driven management consulting and program evaluation.

Regional CHNA Methodology and Data Collection

Methodology – Regional CNHA

The Regional CHNA methodology and results were generated through an inclusive, comprehensive, and balanced data collection strategy.

Comprehensive Data Collection

The needs assessment utilized a mixed-method approach to data collection including secondary quantitative data and primary quantitative (Regional CHNA community and provider surveys) and qualitative (focus groups and interviews) data.

Secondary data collection, beginning in January of 2021, sought to understand the greatest health conditions of the region, including prevalence and impact on community members. These results informed the creation of survey items that were organized around a set of co-created research questions.

Each data collection strategy adhered to a recruitment plan to ensure a representative sample of community members, voices of marginalized populations, and providers across the health and social services sectors were captured. All results are summarized for the region which includes the Cincinnati Metropolitan Statistical Area (MSA),0F[1] Dayton-Kettering MSA (to include Clark County which is not part of the Dayton MSA but is similar in that it borders the Dayton MSA and is not a rural county),1F[2] and other rural counties in the geographic service area that are predominately rural and not included in other MSAs.2F[3]

Overall, the scope of data collection was robust and informed the results of this Regional CHNA. This includes:

8,321 community surveys available from April, 2021 through June, 2021 in five languages. Within this sample, representation was seen across 26 counties, males, females, ages 18-65+, Black/African American, Multiracial, Asian, American Indian, Alaskan Native, White, and Hispanic/Latino populations.

859 provider surveys, available April, 2021 through May 2021, inclusive of behavioral health, education, emergency medical services, faith-based organizations, federally qualified health centers, justice/corrections, medical care (adult, geriatric, pediatric) oral health, organizations addressing health related social needs and social determinants of health, pharmaceutical, and public health departments.

- Providers also represented administration, direct patient care, academic, support staff, and supervisors/management.
- Providers reported serving a variety of populations including children/youth, people with disabilities, ethnic minorities, people experiencing homelessness, people in the

[1] Includes the following counties: Grant, Butler, Clermont, Hamilton, Warren, Dearborn, Kenton, Boone, Campbell, Brown, Ohio, Union, and Franklin.
[2] Includes the following counties: Clark, Montgomery, Miami, and Greene.
[3] Includes the following counties: Clinton, Highland, Adams, Preble, Shelby, Darke, Auglaize, and Champaign.

justice system, veterans, young adults, low-income populations, and LGBTQ+ populations.

51 focus groups with 234 people were held May, 2021 through July, 2021, representing all three MSAs. Specifically, recruitment for these focus groups were based on advisory committee identification of populations who are traditionally underrepresented, marginalized, or experience greatest health disparities.

- Populations represented in these focus groups include adult men, those experiencing foster care or foster parenting, youth and adults with disabilities, ethnic, cultural and language minorities, first and second-generation immigrants, people experiencing homelessness, those involved in the justice system, low-income families and individuals, parents, veterans, older adults, community members with lived experience of mental health and/or addiction, and first responders.

38 stakeholder interviews were held September 27, 2021 through October 31, 2021 across health and social service providers, specifically with the following being represented: mental health and substance use disorder (SUD), public health, hospital systems, Federally Qualified Health Centers (FQHCs), transportation, housing, food access, healthcare access and policy, school-based health and children's health care, maternal and infant care, LGBTQ+ health care, pharmacy access, and healthcare workforce development.

Appendix A contains a detailed description of each data collection strategy including the sampling or recruitment strategy, and analysis.

Data collection was also comprehensive in that community members, social service providers and healthcare professionals were not only asked "what could be better," but also "what is working." As a result, this Regional CHNA includes a collection of assets and recommended policy and practice initiatives identified by the community that directly tie to system barriers. The symbol (to the left) can be found throughout this report. This symbol identifies a policy or practice that addresses the health need discussed in that section. No data information gaps were identified while conducting the CHNA.

Co-Created Research Questions

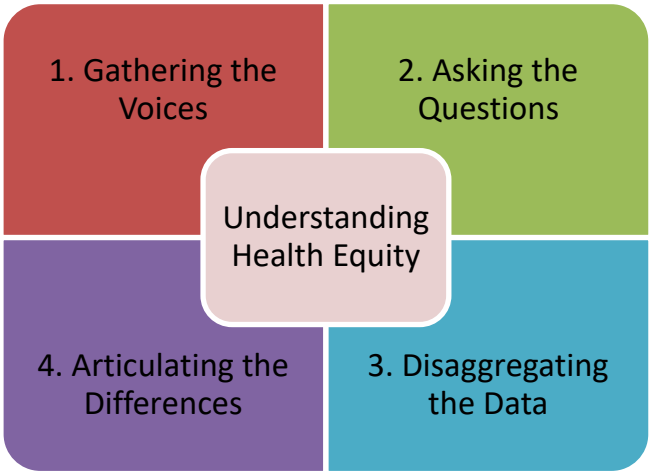
To create the guiding research questions, the healthcare providers participated in a group process, facilitated by MRC, to identify the emerging curiosities related to community health. The exercise focused on moving beyond what is known through secondary data and asking questions that can lead to action. The following research questions were co-created by the advisory committee.

1. What are the greatest health needs in the community?
2. How do the greatest health needs differ across communities and community members?
3. What Social Determinants of Health (SDOH) drive these greatest health needs among different communities and community members?
4. What are the systemic barriers of these greatest health needs among different communities and community members?
5. What are the structural barriers providers face in meeting the needs of the community?
6. What specific action steps can be taken by various partners to address the root causes and achieve more equitable health outcomes?
    a. What community-based expertise should be leveraged?
    b. What best practices are being implemented?

To answer these research questions, a framework was developed for centering equity and a comprehensive understanding of the drivers of health conditions. From this framework, MRC and the Advisory Committee co-created a mixed-method data collection strategy.

Equity-Centered Framework

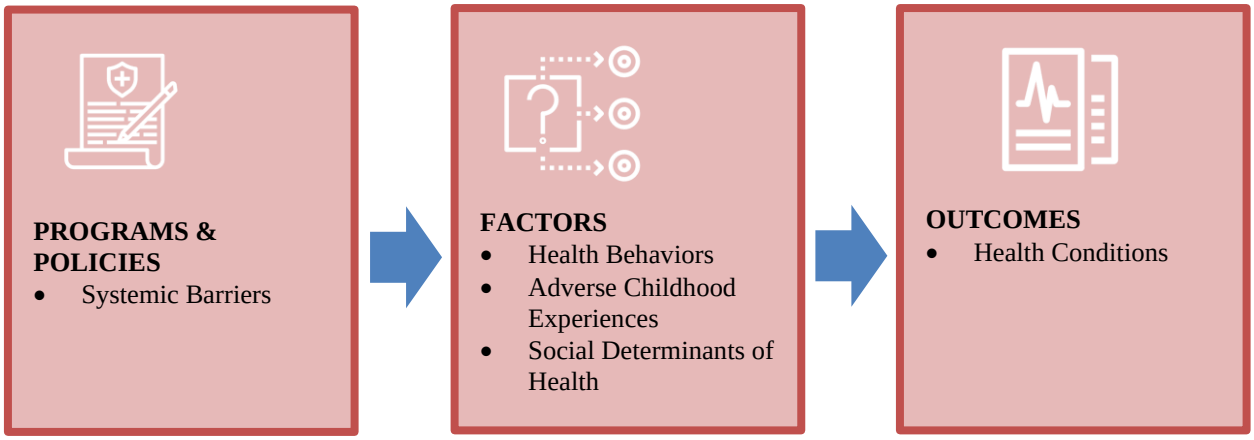
Health equity means everyone has a fair and just opportunity to be as healthy as possible.78F[i] To achieve an understanding of health equity, each data collection strategy included mechanisms to:



1. Hear the voices of community members and be intentional about engaging community members who are historically underrepresented in community data.
2. Ask questions about health experiences, outcomes, barriers, and solutions.
3. Disaggregate the data by region, age, race, and gender and other characteristics with sufficient sample sizes.
4. Use the data to clearly identify the unique experiences of community members.

Comprehensive Drivers of Health Outcomes

The following framework helps us understand the drivers of health outcomes and provides the basis for organizing the health needs assessment. In summary, community members experience health conditions because of the risk and protective factors that are present in their life. Those factors are driven by the programs and policies that govern society.



Programs and Policies

- **Systemic Barriers**
  The governing policies rooted in structural bias perpetuate health disparity and unhealthy behaviors (i.e., not seeking services, self-medicating, etc.). In this Needs Assessment, systemic barriers were assessed from the gender and race lens, perceptions related to stigma, and barriers specific to health care (i.e., workforce shortage, cost reimbursement, etc.).

Factors

- **Health Behaviors**
  Health behaviors are actions of community members that impact health. Health behaviors can improve health or put health at risk. Behaviors include diet and nutrition, exercise, sleep, substance use, etc. In this Needs Assessment,

the literature around each of the health behaviors are explored to determine their impact on health outcomes and disparities in health conditions.

- **Adverse Childhood Experiences Framework**
  Adverse childhood experiences (ACEs) are also a significant risk factor that can lead to poor health, chronic disease and early death. ACEs are traumatic events experienced as a child including abuse, neglect, violence, incarceration of relatives, parental divorce, etc. Exposure to trauma from an early age can disrupt the development of a young person's brain, ultimately leading to higher rates of chronic risk behavior, disease, mental illness, and early death if appropriate interventions and protective factors are not present. As a child's ACEs increase, so does their likelihood of chronic disease and early death.79F[ii] Secondary data and literature were used to inform the discussion of ACEs and ACEs-related disparities.

Social Determinants of Health Framework

- **Social Determinants of Health (SDOH)** are the structural and social conditions in the environment that affect a wide range of health, functioning, and quality-of-life outcomes and risks.80F[iii] The Healthy People 2030 SDOH 81F[iv] framework provided guidance for this Regional CHNA in identifying the community conditions that impact the health of community members. These community conditions include (not in rank order):
  - Economic stability
  - Neighborhood and built environment
  - Education access and quality
  - Social and community context
  - Healthcare access and quality

  SDOH are explored in all data collection strategies to understand their relationship to the region's greatest health needs and disparities in health conditions.

Outcomes

- **Health Conditions**
  The health conditions of our communities are driven by factors within and outside an individual's control. A study from the University of Wisconsin Population Health Institute showed that about 80% of people's health is the result of physical, environmental and behavioral factors.82F[v] In this Regional CHNA, health factors were explored to understand what impacts the most prevalent health conditions in the region.

Summary of Health Needs for Regional CHNA

To summarize the results of the Regional CHNA, the lists below highlight main takeaways to consider in the prioritization process – the significant health needs.

Most Significant Health Conditions	Health Conditions Most Untreated	Health Conditions Most Impacted By SDOH
• Cardiovascular Conditions (Hypertension) • Mental Health (Depression and Anxiety) • Arthritis • Lung/Respiratory Health • Dental • Maternal health concerns • Prevention- related health needs	• Vision • Dental • Allergy • Mental Health (Depression and Anxiety) • Arthritis • Cardiovascular Conditions (Hypertension) • Maternal health concerns	• Cardiovascular Conditions (Hypertension) • Mental Health (Depression and Anxiety) • Vision • Lung/Respiratory Health • Diabetes

SDOH Factors Impacting Health in the Region

- Economic stability *(Stable housing, food security, paying bills)*
- Neighborhood and Built Environment *(Access to reasonable transportation, parks/outdoor activities, stable phone, and internet)*
- Education Access and Quality *(Perception of quality of schools and childcare that are available)*
- Social and Community Connectedness *(Having someone to talk to and feeling connected to the community)*
- Healthcare Access and Quality *(Perception of quality of health care available, cultural relevancy of health care, ease of finding desired health care, ease of navigating healthcare costs)*

Structural Barriers in the Region's Healthcare System

- Competition across healthcare organizations/systems
- Workloads and caseloads are high
- Lack of effective clinical-community linkages
- Language barriers and cultural differences
- High cost of services
- Limited workforce
- Inflexible and restricted funding structures and/or investment in community
- Lack of culturally relevant communication strategies and services across providers
- Limited implementation of DEI practices within organizations
- Community member distrust in the healthcare ecosystem (providers, insurers, pharmacies, etc.)
- Limited implementation of best practices of trauma-informed care

Systemic Barriers

- Structural racism
- High-Cost healthcare system
- Structural divide between healthcare system, holistic wellness providers, and social service providers

Address Health Needs

- Increase access to services in order to improve equitable outcomes for the region's top health needs: behavioral health, cardiovascular disease, dental, and vision.
- Address access to and use of resources for food security and housing with a focus on the development and strengthening of partnerships between providers and community-based organizations.
- Strengthen workforce pipeline and diversity, including cultural competence, within the healthcare ecosystem.

Prioritization of Health Needs for Regional CHNA

The health needs of this region were identified (Table 1) through a series of robust quantitative and qualitative data collection methods across community members, healthcare and social service providers, subject matter experts in hospitals, health departments, community-based organizations, and through review of secondary data and an extensive literature review.

Table 1. Prioritized Significant Health Needs for the Greater Cincinnati/Greater Dayton Regional CHNA

Most Significant Health Conditions (Prioritized)	Health Conditions Most Untreated (Ranked)	Health Conditions Most Impacted By SDOH
1. Cardiovascular Conditions (Hypertension) 2. Mental Health (Depression and Anxiety) 3. Arthritis 4. Lung/Respiratory Health 5. Dental 6. Maternal health concerns 7. Prevention-related needs	• Vision • Dental • Allergy • Mental Health (Depression and Anxiety) • Arthritis • Cardiovascular Conditions (Hypertension) • Maternal health concerns	• Cardiovascular Conditions (Hypertension) • Mental Health (Depression and Anxiety) • Vision • Lung/Respiratory Health • Diabetes

SDOH Factors Impacting Health in the Region

- Economic stability *(Stable housing, food security, paying bills)*
- Neighborhood and Built Environment *(Access to reasonable transportation, parks/outdoor activities, stable phone, and internet)*
- Education Access and Quality *(Perception of quality of schools and childcare that are available)*
- Social and Community Connectedness *(Having someone to talk to and feeling connected to the community)*
- Healthcare Access and Quality *(Perception of quality of health care available, cultural relevancy of health care, ease of finding desired health care, ease of navigating healthcare costs)*

Structural Barriers in the Region's Healthcare System

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- High cost of services
- Limited workforce
- Inflexible and restricted funding structures and/or investment in community
- Lack of culturally relevant communication strategies and services across providers
- Limited implementation of DEI practices within organizations
- Community member distrust in the healthcare ecosystem (i.e., providers, insurers, pharmacies, etc.)
- Limited implementation of best practices of trauma-informed care

Systemic Barriers

- Structural racism, including workforce diversity and cultural competence of healthcare delivery
- High-Cost healthcare system
- Structural divide between healthcare system, holistic wellness providers, and social service providers

A total of 25 one-on-one stakeholder meetings were conducted from September 27, 2021 to October 31, 2021 by The Health Collaborative to review results of the robust data collection process and prioritize the significant health needs using a list of data-driven, actionable recommended priorities. 70F[4] Prioritization of these needs began with a list of recommended priorities that were data driven and action focused. Using a set of five criteria, the top priorities were finalized.

The criteria for prioritization included:

1. Burden and Severity: Are the health conditions the greatest burden for our region, across prevalence, those most often gone untreated, and those that were most impacted by social determinants of health? Would addressing this have an impact on the greatest number of community members?
2. Equity: Do the health conditions/social determinants of health have extreme health disparities across prevalence and qualitative data for our community members? Would addressing this priority significantly address health disparities?
3. Value to Stakeholders: Are the health conditions, social determinants of health, and/or systemic root causes important to address across stakeholders? Would addressing this be a high priority for stakeholders/ organizations for the community members they serve?
4. Capacity and Feasibility: Does our region have the ability to address the need, through partnerships, resources, community will, and funding opportunities?
5. Alignment: The level of alignment of the recommended priority. Does the priority align with:
    a. internal strategic plans at stakeholder organizations?
    b. the Ohio State Health Assessment (SHA) and Ohio State Health Improvement Plan (SHIP)?
    c. national goals through Healthy People 2030?

Each meeting was documented with qualitative data of comments, feedback, concerns, and ideas for prioritizing needs for the region. Additionally, quantitative data was collected on the recommended priorities list by asking each stakeholder to name their top three priorities using a series of strategic questions.

Strategic Questions:

1. Based on your subject matter expertise, what should the top three priorities be for the region?
2. Based on your expertise within your organization, and as a representative of your organization, what should the top three priorities be for the region?
3. To move the needle on advancing health and reducing health disparities for our community, what should the top three priorities be for the region?

The list of data-driven, actionable recommended priorities discussed at each stakeholder meeting includes:

Based on the themes that emerged from multiple data collection strategies, the following broad recommendations were proposed to guide THC in the setting of regional health priorities.

Research demonstrates that community members experiencing lower economic stability, and access to quality health care are at greater risk of heart disease, diabetes, obesity, disability, lung disease, maternal complications, mental health, arthritis, vision concerns, dental concerns and allergies. To address these health concerns, the community will need to address housing stability, food security, healthcare affordability, and improving patient-provider relationships.

[4] THC and the CHNA Advisory Team reviewed the Regional CHNA Report and data-driven recommendations (Section 5) drafted by MRC. From the report and data-driven recommendations, THC and the Advisory Committee completed the prioritization methodology outlined in the chapter.

Recommendation 1: Improve healthcare access and quality:
The health of the community hinges on access to quality health care. To address the healthcare access and quality needs defined by the community across the region, The Health Collaborative may consider the following priorities:

- Strengthen collaboration with community partners who serve priority populations (i.e., increase in resources provided to community-based organization (CBOs), consulting with CBOs as community health experts, and committing to more long-term partnerships that CBOs can count on.)
- Increase workforce diversity across health fields and at every level
- Improve patient-provider interactions to increase trust and transparency
- Increase transparency of costs of health care and financial assistance polices

Recommendation 2: Improve economic stability through collaboration and coordination:
Economic stability (i.e., having enough food, money to pay bills, and a safe place to live) is a key predictor of several health needs. One's economics is also correlated with one experiencing structural barriers (i.e., high-cost healthcare system) and access barriers (i.e., lack of insurance, unable to afford medications or a doctor's visit, etc.). Therefore, a regional approach to improve health will be limited if the economic factors are not addressed. These factors include:

- Safe and stable housing
- Food security
- Health care affordability

Potential priorities for THC may be:

- Increase collaboration with local food security and housing stability efforts.
- Improve communication, referral and data sharing with partners who are addressing healthcare affordability (i.e., including bringing community health workers and social workers on-site (in ERs, clinics, offices, etc.).

Recommendation 3: Adapt metrics to monitor diversity, equity and inclusion (DEI) across all priorities:
The above recommendations are inclusive of DEI best practices for service providing organizations. The Health Collaborative leadership are also committed to DEI, which is another necessary component of successful DEI strategies. To ensure implementation of strategies that support DEI, THC should take the time to establish metrics for all priorities that will allow the region to track progress towards DEI goals.

Most Prevalent Health Conditions in the Region

Greatest health needs across the region were identified utilizing multiple data sources, including self-report Regional CHNA community survey results, hospitals' utilization data (see Appendix A for details), and county-level Center for Disease Control (CDC) leading cause of death data. In review of these varying data sources, the most prevalent health conditions across the region include:

1. **Cardiovascular-related conditions (i.e., high blood pressure and/or high cholesterol)**

Approximately three in ten residents from the Regional CHNA community survey report needing treatment for high blood pressure and/or high cholesterol. As cardiovascular-related conditions, including high blood pressure/high cholesterol are the leading health needs among residents and are major risk factors for heart disease,3F[5] it is of no surprise that Diseases of the Heart, particularly Major Cardiovascular Disease, was the leading cause of death in 2019, with an average age-adjusted rate of 251 per 100,000 individuals.4F[6] Nationally, heart disease is the leading cause of death.83F[vi] Further, among emergency room and inpatient hospital visits in the region from January 2019 through June 2020, seven percent (or 72,889) of the visits were due to primary diagnoses of the circulatory system (after removing visits due to symptoms, signs, and abnormal clinical and laboratory findings).

[5] https://www.cdc.gov/heartdisease/risk_factors.htm

[6] Age-adjusted rates were obtained from CDC Wonder, Underlying Cause of Death (https://wonder.cdc.gov/wonder/help/DataExport.html#Excel) and averaged across all counties within the region (with exception of Ohio and Union Counties due to limited data), ranging from 189.8 in Ripley County to 325.4 in Adams County.

2. Mental health-related conditions (i.e., depression and anxiety disorders)

Across the region, approximately two in ten residents from the Regional CHNA community survey report needing treatment to support their mental health (i.e., depression, anxiety, etc.). This is consistent with national rates.84F[vii] Further, among emergency room and inpatient hospital visits in the region from January 2019 through June 2020, three percent (or 22,112) of the visits were due to primary diagnoses of mood/affective and anxiety/stress-related disorders (after removing visits due to symptoms, signs, and abnormal clinical and laboratory findings).

3. Arthritis or osteoporosis

Across the region, approximately one in ten residents from the Regional CHNA community survey report needing treatment for arthritis or osteoporosis. This is slightly lower than national trends with an estimated two in ten U.S. residents having been diagnosed with arthritis.85F[viii] Further, among emergency room and inpatient hospital visits in the region from January 2019 through June 2020, one percent (or 10,498) of the visits were due to primary diagnoses of osteoarthritis and osteoporosis (after removing visits due to symptoms, signs, and abnormal clinical and laboratory findings).

4. Lung/respiratory-related conditions, including asthma

Across the region, approximately one in ten residents from the Regional CHNA community survey report they needed treatment for lung health conditions (including asthma, COPD, emphysema, chronic bronchitis) and, similarly, for COVID-19. This is higher than national trends. Across the U.S., approximately 8% of adults have asthma and 4.6% have chronic obstructive pulmonary disease (COPD). In terms of the Regional CHNA community survey, need for treatment prevalence for lung-related conditions ranked fifth in terms of the conditions surveyed, however, hospital data reveals that it is among the leading reasons (among the priority health conditions) why people visit the ER or are hospitalized as inpatient. From January 2019 through June 2020, 11 percent (or 111,301) of the visits were due to primary diagnoses of diseases of the respiratory system5F[7] (after removing visits due to symptoms, signs, and abnormal clinical and laboratory findings).

5. Oral/Dental disease

Across all communities, there is a need for access to dental services. Because dental services are not under the system's 'healthcare' umbrella, dental care often requires supplemental insurance. In focus groups, dental services were identified as a need across many community members.

6. Maternal health complications

Maternal health complications were a priority health area for women. Across the region, less than one in ten residents reported they needed treatment for maternal health complications (a lower rate relative to other conditions is to be expected given this can only apply to pregnant women). Further, among emergency room and inpatient hospital visits in the region from January 2019 through June 2020, three percent (or 30,363) of the visits were due to primary diagnoses of pregnancy, childbirth, and the certain conditions originating in the perinatal period.

[7] Based on ICD10 codes provided in the hospital data, we were unable to determine if this accounts for COVID-19.

7. Prevention services

While community members reported needing treatment for the above specific conditions, when asked in focus groups and interviews, community members and providers alike identified the need for prevention services in the region. Prevention services are needed across the life span, with community members highlighting the need for more mental health and addiction prevention programs for youth, adults, and older adults (e.g., mindfulness); preventative reproductive health care for youth and adults; nutritional education; programs that promote social connectivity; and programs that promote exercise and coping with stress.

Regional CHNA Unmet Health Needs

Regional Approach – Insights into What Is an Underserved Population

Demographics

There are a myriad of factors that can explain why individuals have unmet health needs (defined as needing treatment for a condition and not receiving it), ranging from individual factors (e.g., choosing not to seek out health care due to the assumption symptoms will improve on their own), family/personal responsibilities (e.g., prioritizing caregiving responsibilities over one's own health needs), and system-level factors (e.g., lack of availability or accessibility to care). Regardless of the reason why individuals have unmet needs, understanding for whom unmet health needs are most prevalent is critical to inform targeted interventions and/or outreach efforts to ensure residents throughout the region understand when, where, and how to get treatment. The following lists for whom unmet needs are most common and the following sections will provide greater context behind the reasons why treatment is not sought.

- Males. Among the greatest unmet needs across the regions, males, relative to females, are significantly more likely to have unmet health needs for vision concerns (1.2 times as likely),7F[8] dental concerns (1.3 times as likely),8F[9] and mental health (2.2 times as likely).9F[10]
- Black, Multiracial, Asian, and American Indian/Alaskan Native. Among the greatest unmet needs across the regions, Black/African American individuals, relative to White individuals, are significantly more likely to have unmet health needs for dental (1.3 times as likely)10F[11] and allergy-related concerns (1.6 times as likely),11F[12] as well as mental health (1.6 times as likely).12F[13] Multiracial individuals were also significantly more likely to have unmet dental needs (1.5 times as likely) relative to White individuals.13F[14] Finally, individuals identifying as Asian, American Indian/Alaskan Native, Native Hawaiian or Pacific Islander or another race (that is not Black, White or multiracial) relative to those identifying as White, are significantly more likely to have unmet mental health (1.8 times as likely)14F[15] and allergy needs (1.7 times as likely).15F[16]

[8] The odds of having an unmet vision need for males is 1.2 times as large as it is for females ($b = .15$, $p < .05$).
[9] The odds of having an unmet dental need for males is 1.3 times as large as it is for females ($b = .24$, $p < .05$).
[10] The odds of having an unmet mental health need for males is 2.2 times as large as it is for females ($b = .80$, $p < .05$).
[11] The odds of having an unmet dental need for Black/African American individuals is 1.3 times as large as it is for White individuals ($b = .29$, $p < .05$).
[12] The odds of having an unmet allergy need for Black/African American individuals is 1.6 times as large as it is for White individuals ($b = .45$, $p < .001$).
[13] Greater unmet mental health needs for Black/African American individuals mainly derived from qualitative data collection. The logistic regression results were not statistically significant at $p < .05$, though the effect size, odds ratio, for having an unmet mental health need was rather sizeable for Black individuals relative to White individuals (odds were 1.6 times as large; $b = .47$, $p = .059$).
[14] The odds of having an unmet dental need for Multiracial individuals is 1.5 times as large as it is for White individuals ($b = .43$, $p < .05$).
[15] The odds of having an unmet mental health need for individuals identifying as Asian, American Indian/Alaskan Native, Native Hawaiian or Pacific Islander, or identified as another race that is not Black, White or multiracial is 1.8 times as large as it is for White individuals ($b = .57$, $p < .05$).
[16] The odds of having an unmet allergy need for individuals identifying as Asian, American Indian/Alaskan Native, Native Hawaiian or Pacific Islander, or identified as another race that is not Black, White or multiracial is 1.7 times as large as it is for White individuals ($b = .51$, $p < .001$).

- Younger Individuals. Among the greatest unmet health needs throughout the region, younger individuals16F[17] are significantly more likely to experience unmet needs among nearly all the conditions, including dental,17F[18] allergy,18F[19] mental health,19F[20] arthritis/osteoporosis,20F[21] and cardiovascular-related conditions.21F[22] Thus, though younger individuals are less likely to need treatment for these conditions, when they do need treatment, they are also less likely to get it. (See footnotes for effect sizes.)
- LGBTQ+ Individuals. The exposure to chronic and pervasive stress, in line with the minority stress model,86F[ix] creates results in health disparities among LGBTQ+ individuals when compared to heterosexual, cisgender individuals (Caceres 2020).87F[x] The health disparity among LGBTQ+ individuals has primarily been studied in relationship to cardiovascular disease and mental health, with research concluding that rates of occurrence are higher in both cases (Gonzales 2017; Merschel 2020).88F[xi] Certain health conditions are found to be more prevalent among LGBTQ+ adults including high blood pressure and obesity.89F[xii] Because LGBTQ+ individuals report high levels of discrimination when accessing health care (between 50-70% depending on sexual orientation and gender identity), they are more apt to "delay primary or preventative care" and display mistrust in health care.90F[xiii]
- Maternal Age Women. Unmet needs for maternal age women highlight racial and ethnic discrepancies in health care. In Dayton and Cincinnati MSAs, individuals who are Hispanic as well as individuals who are Black have lower rates of receiving prenatal care during the first trimester, with first trimester prenatal care rates up to 19% lower for these individuals relative to other populations in these regions.22F[23] Overall, rates of pre-pregnancy obesity, as well as chronic illness during pregnancy including diabetes and hypertension, have all increased by an average of two percent (Cradle Cincinnati 2020). Other conditions such as drug exposure, postpartum depression, unintentional pregnancies, and those with an underweight pre-pregnancy body mass index have all decreased in recent years (Cradle Cincinnati 2020).
- Veterans and Active Military. Active military, relative to non-active military, are significantly more likely to have unmet mental health (2.5 times as likely),23F[24] arthritis/osteoporosis (2.8 times as likely),24F[25] and cardiovascular-related needs (2.7 times as likely).25F[26] Further, veterans, relative to non-veterans, are significantly more likely to have unmet mental health needs (2.3 times as likely).26F[27]

[17] Age is treated as a continuous variable and thus differences in unmet need based on age is interpreted as each additional year younger.

[18] For each additional year increase in age, the odds of having an unmet dental need are .7% less ($b = .007$, $p < .05$). Thus, the odds of having an unmet need for an individual aged 55 are .7% less relative to an individual aged 54; the odds of having an unmet need for an individual aged 55 are 6.4% less than an individual aged 45.

[19] For each additional year increase in age, the odds of having an unmet allergy need are 1.6% less ($b = -.02$, $p < .001$).

[20] For each additional year increase in age, the odds of having an unmet mental health need are 3.0% less ($b = -.03$, $p < .001$).

[21] For each additional year increase in age, the odds of having an unmet arthritis/osteoporosis need are 4.5% less ($b = -.05$, $p < .001$).

[22] For each additional year increase in age, the odds of having an unmet cardiovascular need are 7.4% less ($b = -.08$, $p < .001$).

[23] https://wonder.cdc.gov/wonder/help/DataExport.html#Excel; estimates are limited to counties with sufficient data needed for CDC to calculate reliable estimates. These counties include: Boone, Kenton, Butler, Clermont, Hamilton, Warren, Clark, Greene, Miami, and Montgomery.

[24] The odds of having an unmet mental health need for active military is 2.5 times as large as it is for non-active military ($b = .90$, $p < .01$).

[25] The odds of having an unmet arthritis/osteoporosis need for active military is 2.8 times as large as it is for non-active military ($b = 1.01$, $p < .05$).

[26] The odds of having an unmet cardiovascular need for active military is 2.7 times as large as it is for non-active military ($b = .98$, $p < .01$).

[27] The odds of having an unmet mental health need for veterans is 2.3 times as large as it is for non-veterans ($b = .82$, $p < .001$).

- Individuals with Disabilities. Individuals with disabilities, relative to those without disabilities, are significantly more likely to have unmet vision (1.7 times as likely),27F[28] dental (1.7 times as likely),28F[29] and allergy needs (1.4 times as likely).29F[30]
- Caregivers of Individuals with Disabilities. Individuals caring for others with a disability are significantly more likely to have unmet needs for nearly all of the greatest unmet needs in the region (except cardiovascular-related), including mental health (1.5 times as likely),30F[31] dental (1.7 times as likely),31F[32] vision (1.5 times as likely),32F[33] allergy (1.2 times as likely),33F[34] and arthritis/osteoporosis (2.1 times as likely).34F[35]
- Individuals without Private Insurance. Individuals without private insurance (those not insured and those publicly insured) are significantly more likely to have unmet mental health (.6 times as likely),35F[36] dental (.7 times as likely),36F[37] and cardiovascular-related needs (.6 times as likely),37F[38] relative to privately insured individuals.
- Individuals with Lower Educational Attainment. Individuals with lower educational attainment are significantly more likely to have unmet vision,38F[39] dental,39F[40] and cardiovascular needs.40F[41]
- Women with past traumas of physical abuse and/or sex trafficking identified a need for chiropractic care but the cost can be too high, the care is not often covered by insurance, and/or the service is not accessible from shelters or group homes.
- Incarcerated community members and community members transitioning back into the community identified a need for greater access to longer term mental health services, particularly coordination of services.
- Community members in addiction recovery reported needing dental repair and/or dentures.
- Older adults and youth need prevention services in both mental health and addiction.

[28] The odds of having an unmet vision need for individuals with disabilities is 1.7 times as large as it is for those without disabilities ($b = .52$, $p < .001$).
[29] The odds of having an unmet dental need for individuals with disabilities is 1.7 times as large as it is for those without disabilities ($b = .53$, $p < .001$).
[30] The odds of having an unmet allergy need for individuals with disabilities is 1.4 times as large as it is for those without disabilities ($b = .30$, $p < .001$).
[31] The odds of having an unmet mental health need for caregivers of individuals with disabilities is 1.5 times as large as it is for those who are not caregivers ($b = .40$, $p < .01$).
[32] The odds of having an unmet dental need for caregivers of individuals with disabilities is 1.7 times as large as it is for those who are not caregivers ($b = .53$, $p < .001$).
[33] The odds of having an unmet vision need for caregivers of individuals with disabilities is 1.5 times as large as it is for those who are not caregivers ($b = .44$, $p < .001$).
[34] The odds of having an unmet allergy need for caregivers of individuals with disabilities is 1.2 times as large as it is for those who are not caregivers ($b = .18$, $p < .05$).
[35] The odds of having an unmet arthritis/osteoporosis need for caregivers of individuals with disabilities is 2.1 times as large as it is for those who are not caregivers ($b = .74$, $p < .001$).
[36] The odds of having an unmet mental health need for privately insured is .6 times as large (i.e., less likely) as it is for those who are not privately insured ($b = -.51$, $p < .001$).
[37] The odds of having an unmet dental need for privately insured is .7 times as large (i.e., less likely) as it is for those who are not privately insured ($b = -.34$, $p < .001$).
[38] The odds of having an unmet cardiovascular need for privately insured is .6 times as large (i.e., less likely) as it is for those who are not privately insured ($b = -.51$, $p < .01$).
[39] The odds of having an unmet vision need for those with a college degree and those with a graduate degree are .81, and .76 times as large (i.e., less likely), respectively, as it is for those with only a high school degree ($b = -.22$, $p < .05$; $b = -.28$, $p < .05$, respectively).
[40] The odds of having an unmet dental need for those with a college degree and those with a graduate degree are .71, and .59 times as large (i.e., less likely), respectively, as it is for those with only a high school degree ($b = -.33$, $p < .05$; $b = -.53$, $p < .05$, respectively).
[41] The odds of having an unmet cardiovascular need for those with a graduate degree are .46 times as large (i.e., less likely) as it is for those with only a high school degree ($b = -.77$, $p < .05$).

Themes from qualitative, secondary, and survey data highlight specific populations within the region most likely to have unmet needs. All differences reported below (except for qualitative data summaries) are after accounting for all other demographic variables listed in Table 2.

Table 2. Populations most likely to have unmet needs among the largest unmet health conditions in the regions.

Disparity	Vision	Dental	Allergy-Related	Mental Health	Arthritis/ Osteoporosis	Cardio-vascular	Maternal Complications
Males	X	X		X			
Younger individuals		X	X	X	X	X	
Older individuals	X						
Black individuals		X	X	*			*
Multiracial individuals		X					
Asian, American Indian/Alaskan Native, Native Hawaiian or Pacific Islander or another race that is not White or Black or Multiracial			X	X			
Active military				X	X	X	
Military veterans				X			
Individuals without private insurance		X		X		X	
Individuals with disabilities	X	X	X				
Individuals with lower education	X	X				X	
Individuals caring for a disabled individual	X	X	X	X	X		
LGBTQ+ individuals				*		*	
Cincinnati MSA			X				
Dayton MSA						X	

Data source: Regional CHNA community survey

Note. "X" indicates significant, negative effects (i.e., greater likelihood of having an unmet need relative to the reference, such as males compared to females or Black/African American compared to White) from logistic regression analyses. Each unmet health condition was a separate analysis with the same predictors across all models: gender, age, race, ethnicity, education, military/veteran status, disability status, private insurance, sexual orientation, and caregiver of an individual with a disability. Thus, all negative effects are after controlling for all other variables in the model. "*" indicates an additional theme gathered from interviews/focus groups or secondary data, not effects from regression analyses.

Places with Unmet Needs

Differences between subregions were not very common with respect to unmet health needs (i.e., after accounting for individual demographic differences, there were often not meaningful differences by subregion). However, two themes emerged.

- Relative to Dayton MSA, individuals in Cincinnati MSA are significantly more likely to have unmet allergy needs.41F[42]
- Relative to individuals living in Cincinnati MSA, individuals living in Dayton MSA are significantly more likely to have unmet cardiovascular-related needs.42F[43]

SDOH Driving Health in the Region - Excerpted

Only a part of an individual's health status depends on their genetics and behaviors. Social Determinants of Health (SDOH) are the structural and social conditions that affect a wide range of health, functioning, and quality-of-life outcomes and risks.91F[xiv] In line with Healthy People 2030 SDOH framework, five categories of Social Determinants of Health were identified as key drivers of health in this Region (not in a rank order):

- Economic stability
- Neighborhood and built environment
- Education access and quality
- Social and community connectiveness
- Healthcare access and quality

As a driving factor of health, strategies to improve health at the community level will need to address all SDOH.

Different SDOH impact different health conditions (Table 3a) and SDOH are experienced differently depending on specific people groups (Table 3b) and places (Table 3c) as identified through the community survey ("X") and the Healthy People 2030 Framework ("+").
Methods utilized to assess these themes are further explained in the respective SDOH sections below. It should be noted that the lack of statistical significance in survey analysis does not mean there is not a need for a particular population group; rather such a need was not detected after accounting for all other demographic variables in the models in the context of the survey sample.

Key Takeaways Regional CHNA

- Healthcare access and quality as a SDOH is associated with the largest number of health conditions, using national Healthy People 2030 data. Using Regional CHNA community survey data, economic stability factors are associated with the largest number of health conditions, (Table 3a).
- Regional CHNA community survey data shows that Black community members in the region are significantly more impacted (negatively) in every SDOH when compared to White community members, followed by community members who identify as Asian, American Indian/Alaskan Native, Native Hawaiian or Pacific Islander, or identified as another race and community members with lower levels of education, (Table 3b).
- Regional CHNA community survey data shows that community members in rural counties reported significantly lower perceptions of their neighborhood and built environment. (Table 3c).

Key community need metrics that indicate the largest disparities are shown in the below summary table.

Significant Disparity	Hamilton	Butler	Warren	Clermont

[42] The odds of having an unmet allergy need for individuals living in Cincinnati MSA are 1.7 times as large as it is for those living in Dayton MSA, adjusting for age, sex, race, ethnicity, education level, military status, disability status, and caring for a disabled person. ($b = .29$, $p < .001$).
[43] The odds of having an unmet cardiovascular need for individuals living in Cincinnati MSA are .66 times as large (i.e., less likely) as it is for those living in Dayton MSA, adjusting for age, sex, race, ethnicity, education level, military status, private insurance or lack thereof, caring for a disabled person, and sexual orientation. ($b = -.42$, $p < .05$).

	Variation from Cincinnati MSA OR from County Avg			
Heart Disease Death Rate – all Males[1] Heart Disease Death Rate – Black Males Per 100,000	+16% +69%	+32%	+16%	+19%
Cancer Death Rates – All Males[1] Cancer Death Rates – Black Males Per 100,000	+26% +40%	+16% -	- -	+25% -
Avg Over Dose Death Rates[2] Per 100,000	+27pt	+7.5pts	-	-
Preventable Hospitalizations (Medicare)[4] Per 100,000	-	+8%	-	+7%
Infant Mortality Rate[5] <1, per 1000 births	+18%	-	-	-
Childhood Mortality Rate[6] <18, per 100,000	+24%	-	-	-
% Uninsured Population[12]	8%	-	-	8%

Variances of 15% or greater
All Males = Black, White, non-Hispanic and Latino

1. CDC Wonder, Underlying Cause of Death (https://wonder.cdc.gov/wonder/help/DataExport.html#Excel); Life expectancy by race is from 2021 County Health Rankings data, a different source than the five Mortality Rate plots, therefore an aligned breakdown of race cannot be guaranteed. Available data related to race breakdown was reported.

1., 2., 4., 5., 6. County Health Rankings: 2021 https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/2021- measures

12. County Rankings: https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation

The validation testing affirmed the link between community need, access to care, and preventable hospitalizations. A comparison of CNI scores to hospital utilization showed a strong correlation between high need and high use. Admission rates were more than 60% higher for communities with the highest need (CNI score = 5) compared to communities with the lowest need (CNI score = 1).[44]

Assessing the Health Needs of MHMH'S Community Served

Because the Regional CHNA process included other communities outside of MHMH's community served, and because Butler County is such a diverse county and Oxford a unique college town, MHMH took additional steps to assure we thoroughly assessed the needs of the communities we serve. We held an **Oxford Community Meeting** on May 22, 2022 and sent out questionnaires to those community leaders, physicians and advocates who could not join the May 22 CHNA. Based on the discussion and questionnaire, the top priorities were:

- Alcohol and other drugs - specifically tobacco/smokeless/vaping
- Mental Health - specifically psychiatric care
- Access to Health Care
- Obesity/lack of physical activity and Healthy Eating access
- Public Transportation

Community Served By MHMH

MHMH identifies its "community served" as the residents of 4 counties: In Ohio: Butler and Preble and in Indiana: Franklin and Union. The following zip codes are a breakdown of MHMH Emergency Department visits during 2021

[44] Roth, R., Presken, P., and Pickens G. (2004). "A Standardized National Community Needs Index for the Objective High- Level Assessment of Community Health Care." San Francisco: Catholic Healthcare West. www.dignityhealth.org/stellent/groups/public/@xinternet_con_sys/documents/webcontent/084757.pdf.

which we have used to determine our MHMH service area, as 78.7% of Emergency Department patients reside in these counties:

Butler County: 48.9% (↑1.6%)

- 45056 (Oxford): 32.7%
- 45011 and 45013 (Hamilton): 7.6%
- Other Butler County zips in Service Area: 8.6%

Preble County: 7.7% (↓0.2%)

- 45311 (Camden): 5.5%
- 45320 (Eaton): 1.7%
- Other Preble County zips in Service Area: 0.5%

Franklin County: 8.3% (↓2.2%)

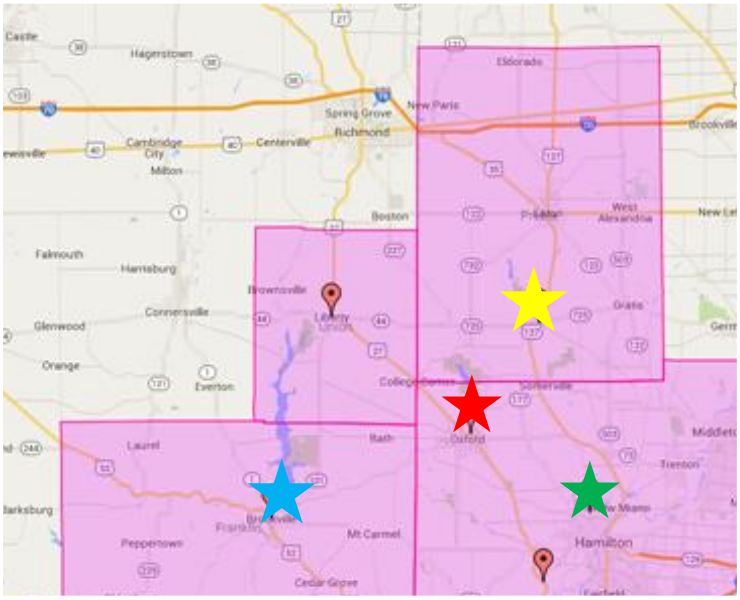
- 47012 (Brookville): 6.8%
- Other Franklin County zips in our service area: 1.5%

Union County: 10.5% (↓2.5 %)

- 47353 (Liberty): 6.2%
- 47003 (West College Corner): 3.1%
- Other Union County zips in our service area: 0.5%

Miscellaneous– outside service area 24.4 % (↓3.2%). Note: Many MU students list their home address, but live in Oxford, so a much greater number than 32.7 % actually come from Oxford.

Map of MHMH Service area



McCullough Hyde Main Campus and Medical Office Building - Oxford

Hamilton Campus

Camden Medical Building

Brookville Medical Building

MHMH's Methodology and Data Collection

MHMH carefully considered the health needs identified in the Regional CHNA for the communities served by MHMH, current data (see below for data sources reviewed) and input from local leaders, physicians and community advocates and determined that an identified need was significant if (i) it was represented by the research as severe within a discrete portion of MHMH's community served, (ii) it was prevalent throughout MHMH's community served regardless of severity, or (iii) its local findings were significant in comparison to state and national averages.

Not only was the information from the Health Collaborative reviewed when looking at those MHMH serves, we reviewed/used the following data sources to help us determine the top needs.

1. **2021 Community Need Index** scores were reviewed for each county and zip codes MHMH served. CNI scores were calculated based on specific barriers to access, shown in Table below:

Barrier	Description	Reason for Inclusion in CNI Score
Income	Percentage of elderly, children, and single parents living in poverty	Patients may be less able to pay for insurance and/or health expenses.
Cultural/ Language	Percentage Caucasian/ non-Caucasian and percentage of adults over the age of 25 with limited English proficiency	Barrier can contribute to increased prevalence of disease and lower recruitment into government health programs. Patients may not understand medical instructions.
Education	Percentage without high school diploma	It is an indicator of poor health and increased likelihood of poverty and lack of insurance. Patients may not recognize early disease symptoms or understand medical information.
Insurance	Percentage uninsured and percentage unemployed	Patients may delay or forego treatment, resulting in hospitalization for chronic conditions.
Housing	Percentage renting houses	Rental housing is more likely to be sub-standard and be located in areas with higher crime rates, lower quality schools, limited healthy food choices, and fewer recreational opportunities. It is associated with transitory lifestyles that may deter health prevention.

   The CNI is an objective and unbiased assessment of community need and socioeconomic barriers to health care. A high CNI score is a warning sign. It announces: 'Look here! People living in this ZIP Code are more likely to have a disadvantage in accessing care, affording care, preventing and managing disease, obtaining an early diagnosis, having access to health information, and understanding medication and doctors' instructions.'

   The CNI is a starting point for looking at geographic areas with a fresh perspective. Hospitals cannot always know about the barriers experienced by people who don't come into the hospital. This is a foundation on which to layer specialized knowledge, local context, and information about emerging trends. Addressing the underlying causes of health inequity and disparity of care can also achieve the Triple Aim of improved care for individuals, improved health of the community, and reduced costs associated with unnecessary hospitalizations and diseases discovered only at a late stage.

2. **2020 US Census Data**
3. **University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2021**
   The County Health Rankings & Roadmaps program compares the health of nearly all counties in the United States to others within its own state, and supports coalitions tackling the social, economic and environmental factors that influence health. The annual Rankings provide a revealing snapshot of how health is influenced by where we live, learn, work and play. As the Rankings provide a starting point for change, the Roadmaps provide guidance and tools to understand the data, and strategies that communities can use to move from education to action. County Health Rankings and Roadmaps is a program of the University of Wisconsin Population Health Institute, funded by the Robert Wood Johnson Foundation, to measure the progress of building a Culture of Health.
4. **Ohio Department of Health Cancer Profiles, 2021**

MHMH received no written comments on the 2019 CHNA or Implementation Strategy.

MHMH's Process for Identifying and Prioritizing Significant Health Needs of MHMH's Community Served

The **Oxford Community Meeting** was held on May 22, 2022 to consider the data and assess the needs of the MHMH community. After review of the data and discussion, meeting participants (see Appendix 4) each identified the top 2 concerns for the community from their perspective. Questionnaires were sent to those community leaders, physicians who practice in the service area, providers of social services, providers of medical services, and advocates who could not join the May 22 Oxford Community Meeting. Questionnaires were distributed and available for completion May 16, 2022 through May 31, 2022. Participants in the local MHMH questionnaire also were given the opportunity to review all the identified needs and then identify the top 2 concerns from their perspective. Participants at the meeting and respondents to the questionnaire were told to consider the following criteria when choosing their top concerns:

1. Does MHMH/the Coalition for a Healthy Community - Oxford Area have the expertise to address the concern?
2. Are there others in our community addressing the concern currently?
3. Where can MHMH/the Coalition have the greatest impact on the health and wellness of the community?

Based on responses from meeting participants and 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:

1. Mental Health/Access including psychiatric services
2. Alcohol and Other Drugs, especially opiate use overdoses, smoking/vaping
3. Access to Healthcare (low income, communication, transportation)
4. Food Insecurity/Obesity
5. Healthy behaviors, especially physical activity and healthy eating leading to obesity

Note that these priority health needs align with the 2020-2022 Ohio Department of Health's State Health Improvement Plan's priority topics "Health Behaviors", "Access to Healthcare", "Mental health and addiction" and "Chronic Disease".

* - Discussion on access to health care and communication:

Health Needs noted at Oxford Community Health Needs Assessment:

Topic	Discussion/Specifics
Access to Health Care	• Communication: Our community is mostly a rural community and in many of our townships (both in Ohio and Indiana) electronic communication is limited or nonexistent, i.e. areas do not have internet access/or have dial up access, cell phones are often unusable (no tower strength), and with our local paper closing, difficult to share any information on programing to address health needs, unable to use telemedicine, etc. • Transportation: No public transportation in our area. This limits access to care. Seniors offered limited transportation to Oxford community weekdays. • Healthcare shortage • Home Health Care is hard to find • Not diverse providers • Uninsured/underinsured • Limited Primary care - no one taking new patients
Alcohol and Drug use	• Increase use of opioids was mentioned by multiple people • Limited treatment options • Alcohol use, especially in MU student Population • Vaping and cigarette use, especially in our youth

Topic	Discussion/Specifics
Mental Health	• Psychiatrist is number 1 need • No community-based providers • Therapists are aging and retiring • No Intensive outpatient close by • Stigma around mental health • Children's services for Mental Health are often full and not accepting patients
Food Insecurity	• Multiple people mentioned food insecurity. We have a food pantry, but transportation once again is a barrier
Affordable Housing	• Mentioned by multiple people. Most rentals are aimed at MU students and rent is high. Seniors and low-income families struggle with housing in the Oxford area. • Safe and Clean housing for low-income
Obesity and Diabetes	• Again multiple people felt that Obesity and Diabetes were not being addressed as well as needed as rates are increasing.
Fall prevention	• Several people mentioned seniors and falls
Dental Access	• For the uninsured
Childcare	• Parenting classes • Childcare for low-income parents • Kinship classes/assistance: More grandparents and other relatives are raising kids without support.

Existing Health Care Facilities And Resources To Address MHMH's Significant Health Care Needs

- Coalition for a Healthy Community – Address alcohol and other drugs in the greater Oxford community, mental health, promote safe activities, and active living/healthy eating (lifestyles that lead to obesity and diabetes)
- McCullough-Hyde Memorial Hospital |TriHealth (MHMH)
    - MHMH's Diabetes Self-Management Program: MHMH provides monthly DSME classes. The class is accredited by the American Diabetes Association and taught by an RN and Dietitian who have special training in diabetes education. While insurances do pay for this class, McCullough-Hyde foundation has a fund specifically to pay for this class and help those living with Diabetes with special needs.
    - TriHealth Hospitals – Bethesda North, Good Samaritan, Bethesda Butler, Arrow Springs, Western Ridge
    - TriHealth Behavioral Health (inpatient services)
- Miami University - Student Wellness and other Miami wellness initiatives for students or open to the public
- TOPP/Oxford Community Choice Pantry
- Oxford College Corner Free Clinic: MHMH is the major supporter of the free clinic that cares for over 300 patients in the MHMH service area. Staffed by volunteer physicians, nurses and front office staff, the Free Clinic has both a chronic illness and gynecological clinics. Besides financial support, the hospital supports the Free clinic by providing space to hold the clinic, credentialing its physicians and the Wellness Director acts as the clinical coordinator for the clinic.
- Primary Health Solutions (a Federally Qualified Health Center-FQHC), Hamilton, Butler Co., OH
- Talawanda School District's free and reduced lunch program and weekend and summer backpack programs
- Provided playgrounds in Brookville (population 2509), Camden (population 1988), Darrtown (516, but Milford Township has 3714), and Oxford (population 22869), and Reily (population 2808) to encourage active, safe play
- Preble County Mental Health and Recovery Services, Eaton, OH

- Gebhard Counseling Solutions, LLC, Eaton, OH, Preble County – Mental health services
- Reid Health, Eaton, Preble Co., OH – Outpatient behavioral health services
- Jefferson House, Eaton, Preble Co., OH – Mental health services
- Butler Behavioral Health, Hamilton, Butler Co., OH
- Community Behavioral Health, Hamilton, Butler Co., OH
- Butler County Mental Health Board, Fairfield, Butler Co., OH
- Centerstone Recovery Center Indiana – Mental illness, chronic addiction, housing
- Brookville Mental Health Center and Recovery Services, Franklin Co., IN
- Green Summit Alcohol Detox, Brookville, Franklin Co., IN
- SIEOC, Brookville, Franklin Co., IN – Community Action Partnership
- Batesville Food Pantry, Franklin Co., IN
- Red Life Church, Brookville, Franklin Co., IN
- CCC Food and Clothing Pantry, Liberty, Union Co., IN
- Gleaners Mobile Food Pantry, W. College Corner, Union Co., IN
- College Corner Food Pantry, W. College Corner, Union Co., IN
- Christian Community Co-op, Liberty, Union Co. IN
- Union County Council – Aging, Inc.
- Neighborhood Health Care – Union County Medical Center (FQHC)

All of the MHMH supported work of the Coalition for a Healthy Community – Oxford Area is shared/offered to be replicated with other communities in our service area.

Progress in Addressing MHMH Community's Significant Health Needs Since the 2019 CHNA

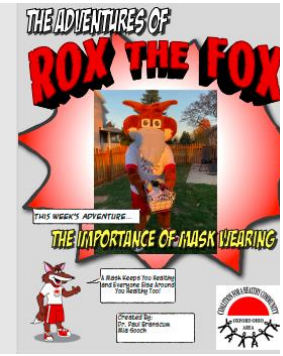
Our partnership with the Coalition for a Healthy Community - Oxford Area (Coalition) continued to address our top needs and to be the conduit for our implementation work. The Coalition is a grassroots organization that started in 1999 to address Alcohol and other Drugs in the greater Oxford Community. The Coalition received an Ohio – Drug Free Communities grant which brought one million dollars to the community to address these needs. The coalition's leadership group includes representatives from: MHMH, Miami University (MU), Talawanda, the City of Oxford (Law enforcement, City Council Member), the religious community, businesses, and citizens. The Coalition created three community workgroups to address the MHMH CHNA top identified health needs.

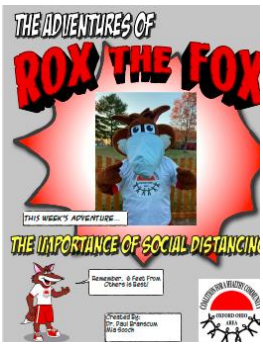
With the onset of the COVID pandemic in March 2020, much of the resources of the hospital were directed towards providing care and helping prevent the continued spread of the disease. Almost all our resources starting in March went to:

- MHMH prepared to care for our community, by educating staff on how to care for COVID patients safely.
- Obtaining needed supplies that were difficult to obtain. Our community came through and sewed masks and Talawanda School District provided us with all their health supplies and different departments at MU also donated supplies.
- Vaccinating our community. MHMH gave over 13,000 vaccines (almost 8000 community vaccines and we supported the Miami University vaccine clinic with over 5000 vaccines) to ages 12+, including boosters. We also supported the Oxford Pediatric Practice in vaccinating children 6-11 years old. Knowing that our marginalized population would have difficulties getting to vaccine centers due to our lack of public transportation, MHMH "went on the road" and offered vaccine clinics at locations where people gathered, including at our African Methodist Episcopal Church, in low-income neighborhoods, uptown at community events and even a bar popular with Miami Students. We partnered with the City of Oxford to provide incentives to those getting vaccines in areas of need.
- Opening and staffing drive through COVID testing

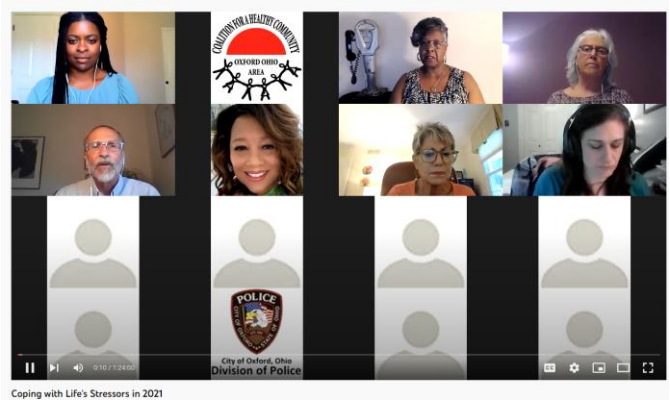
Like the rest of the communities in our nation, Oxford had its challenges during COVID. The Coalition took on the work to address the side effects of COVID in our community. To address the mental health issues that were rising from the "lockdown", these are some of the actions taken:

- Rox (our mascot for healthy choices in the greater Oxford area) teamed up with Oxford Parks and Recreation to make a video to promote safe activity while our Talawanda kids learned remotely.
- Knowing of the isolation due to COVID and racial tension due to the George Floyd killing, our YITS (Youth Initiative team - High School) met virtually and developed 4 different yard signs for hope with phrases like "Kindness is contagious", "You are not alone". The Coalition had 500 signs printed and they "popped up" in the yards of local businesses, churches and neighbors across the greater Oxford area.
- Our BITS (Braves Initiative Team – Middle School) launched a "Talawanda Middle School gives thanks" video program around thanksgiving to allow the still remote learners to share what they are thankful for with others.
- The YITS, BITS and MITs (Miami Initiative Team -College age) launched a video "Stay Healthy and Stay Safe".
- A Rox Comic book was developed on the importance of wearing a mask and social distancing.





- The YITs developed a Self-care challenge on Facebook
- We held 2 virtual mental health town halls, one in partnership with the NAACP to address mental health and racism and one on general mental health with experts to answer questions.



These are just a few of the COVID directed protective actions taken.

The Coalition still continued to address our community's top needs: Mental Health, Alcohol and other drug use and Active Living/Healthy Eating (lifestyles that lead to obesity and diabetes).

The Alcohol and Other Drug Workgroup (AOD) is chaired by Miami University's Student Wellness Director Rebecca Baudry Young. The primary focus of this group is to address the issue of substance use and misuse at the

community level and implement prevention strategies across multiple sectors of the community. Wins from this workgroup include:

A Substance Use Disorder (SUD) Consortium was formed to apply for a Health Resources and Services Administration (HRSA) rural community grant to address SUD. The consortium members are Butler County Mental Health and Addiction Services Board, Epiphany Community Services, The Coalition, McCullough-Hyde Memorial Hospital | TriHealth, Miami University and Talawanda School District. We were awarded this $1 million-dollar, three-year grant in late 2020 to address prevention, treatment, and recovery services for SUD in Oxford and Oxford Township. Through this grant (so far) we have:

- Placed a 0.5 FTE Peer supporter at MHMH. Peer Support is an evidence-based practice for individuals with mental health or addiction conditions. Medicare and Medicaid states that Peer Support is cost effective and cost savings. Peer support is the "process of giving and receiving encouragement and assistance to achieve long-term recovery." Peer supporters "offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities, communities of support, and other people" and can improve people's wellbeing, meaning they have fewer hospital stays, larger support networks, and better self-esteem, confidence and social skills. Research has shown that when people with substance use disorders (SUDs) are hospitalized or visit the emergency department, there is a critical window of opportunity to connect them to recovery-related services and treatment. Once connected to the Peer Support, peer support can continue for up to one year without charge to the client through this grant.
- Brought Butler County Harm Reduction to Oxford on a weekly basis which provides FREE Narcan, HIV testing, Fentanyl Test Strips, Safer Sex Supplies and education on overdose prevention/harm reduction.
- Purchased and placed 1 new permanent medication drop box at Oxford Township Police Department (this means all 3 police departments in our area now have drop boxes).
- Developed and implemented a new Anti-Stigma media campaign – "Oxford Hope".
- Talawanda School District staff trained in "Handle with Care" which is a trauma-informed, cross-systems, collaborative program aimed at ensuring that children who are exposed to adverse events receive appropriate interventions and have opportunities to build resilience through positive relationships with teachers and first responders.

Other work/results due from the AOD workgroup include:

1. According to the Student Drug Use Survey, Talawanda youth report a decrease in 30-day use rates for alcohol, tobacco, marijuana, E-vapor, and prescription drugs.
2. We have collected over 3200 pounds of medication with our Medication Take Back project (since the program's inception)
3. It was identified that one of our neighborhoods had the most calls for OD in our community. The Coalition helped this group form a Residence Council, so they could lead the work in their community.
    - A "cleanup day" was organized, and flowers planted
    - Thanksgiving meal for the neighborhood was served
    - Kids from the neighborhood went to see SANTA
    - New lighting was purchased for the community shelter to address safety concerns
    - A new sign went up in the neighborhood park that states "This is where community is built, and kids play"
    - The local Food pantry started a day a week in the neighborhood with their new food truck for "shopping"

The Mental Health Workgroup is chaired by Dr. Kip Alishio, retired director of Miami's student counseling service. The goal of this group is to increase mental health resources for residents and to reduce the stigma of mental illness. To meet this goal this workgroup has:

1. Continued to update the Mental Health Resource List annually. This list is widely used throughout the community by physician offices, police department, faith communities, schools, and others.
2. Offered a Mental Health First Aid (MHFA) (virtually during COVID). We currently have 785 people trained in MHFA. This has increased more than 185 since our 2019 CHNA.

3. Supported the Oxford Police Department hiring a mental health team member (their mental health calls increased significantly during COVID).
4. Offered PAX for the community: PAX is an evidence-based universal preventive intervention. This evidence-based practice consists of a set of research-based strategies with origins in behavioral science, neuroscience, and cultural wisdom that operate together to improve children's self-regulation. PAX for the Community gives the skills taught to teachers and uses the same language to help reinforce the messages to kids throughout the community.

Active Living/Healthy Eating (HEAL) is chaired by MHMH's Community Relations Director, Sharon Klein. The goal of this group is to engage community members of all ages to promote healthy lifestyles, especially in the areas of nutrition and exercise. Examples of the work of this group include:

1. Our Thriving Community Grant from Interact for Health was expanded to a 5 year grant (originally it was 3 years). This grant provided funding for much of the HEAL work including:
    - Reily project: Reily (population 2660 per 2020 US Census) reached out and asked for a walking trail. Their kids were riding bikes on US Route 732, which is not safe. A listen session was held, and ideas generated by community members. Work on the park included:
        - 3 revitalized Baseball Fields: With little league fields being taken away due to a school remodeling, more fields were needed. We applied for a Cincinnati Reds Foundation grant to help with the ball fields and were awarded $10,000. The revitalization included new fields, new backstops, and dugouts; new bases and new storage shed for Little League equipment.
        - New walking trail was designed and installed with benches along trail
        - New playground was donated by McCullough-Hyde
        - Reily Trustees voted to make the Reily Park a "smoke free, vape free park" at the request of the Coalition.
    - We continue to offer "Yoga in the Park" each Saturday morning from June – September. During COVID we initially cancelled Yoga in the Park when our infection rate was high but developed a way to restart once our rates dropped below "Red". Since this is an outdoor program, we developed a way to make sure every mat was 6 feet from another mat. The program was needed and well attended even during COVID.
    - Organized community walk challenges on our community trails with incentives to be active, while staying safe (social distancing)
2. Developed a Food Security map to show where you can get free food (food pantries or faith meals), or where to purchase foods.
3. Completed a Community Park survey for safety, signage, etc.

The Coalition for a Healthy Community – Oxford Area work is supported not just by MHMH, but other organizations in our service area. MHMH also shares this work with other communities in our service area. The Coalition has been asked to share how they became successful with other communities (Ross, Ohio, Connersville, Indiana).

Other Community Services that address our CHNA top needs:

- Diabetes Self-Management Education (DSME): MHMH provides monthly DSME classes. These classes resumed in 2021 after vaccines became available. This class is accredited by the American Diabetes Association and taught by an RN and Dietitian who have special training in diabetes education. While insurances do pay for this class, we have a foundation account that will pay for any uninsured or underinsured person to take the class. Diabetes became one of the most often reason for readmission, so more effort has been made to have patient referred to this class.
- Oxford Free Clinic: MHMH is the major supporter of the free clinic that cares for over 300 patients in the MHMH service area. Staffed by volunteer physicians, nurses and front office staff, the Free Clinic has both a chronic illness and gynecological clinics. Besides financial support, the hospital supports the Free clinic by providing space to hold the clinic, credentialing its physicians and the Wellness Director acts as the clinical coordinator for the clinic.

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 the 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.

Measurement Resources – located at 1480 Manning Parkway, Suite A, Powell, Ohio 43065**.** Measurement Resources' team brings together strategic public sector planning experts, social determinants of health researchers, facilitators, and industrial and organizational psychologists. They are experts in gathering and analyzing the most relevant data and information, and coupling that analysis with strategic community engagement initiatives, change management and implementation science. The work requires design thinking, the collection and analysis of secondary data, design and implementation of primary data collection strategies and analysis, and scientific writing.
For more information, please refer to the web site at: https://measurementresourcesco.com/about/team/

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For more information, please refer to the web site at: https://www.scalestrategicsolutions.com/about

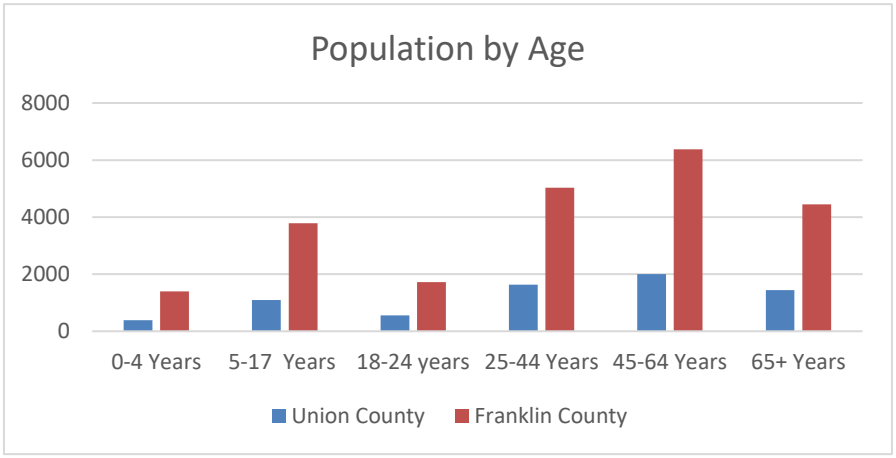
Appendix 1 – Franklin and Union Counties, Indiana

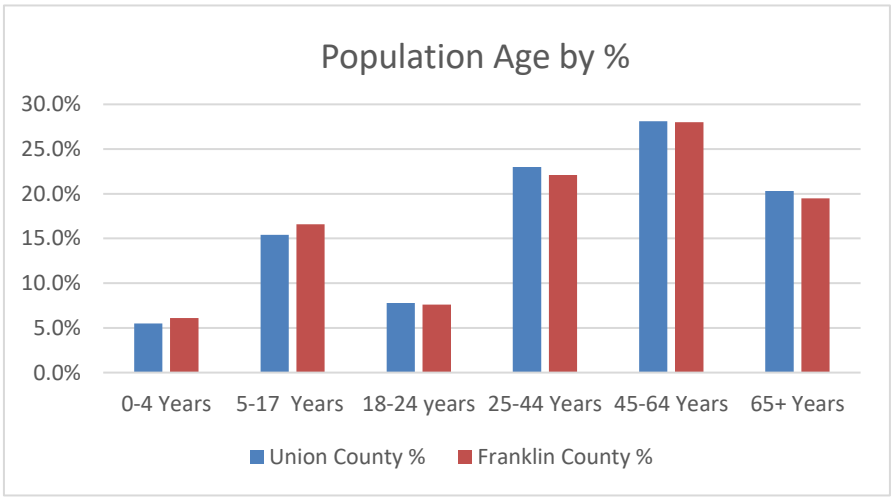
Franklin and Union County Indiana Demographics and Summary Findings:

Franklin County is mostly rural. Alcohol-impaired driving deaths and injury death rates in Franklin County are higher than Indiana averages. Rates of children living in poverty are lower than the U.S. and Indiana rates and decreasing.

Union County is 100% rural. Ratios of primary care and mental health providers are significantly worse than Indiana and U.S. averages. The adult smoking rate in Union is lower than the Indiana average and decreasing. Union County has one ZIP Code that a CNI score of 3.4, indicating the likelihood of health disparities.

Population Charts based on 2020 US Census





Change in Population
2010 vs 2020 US Census

Franklin County - ↓1.1%
Union County - ↓6.2%

THE HEALTH COLLABORATIVE

regional community health needs assessment 2021

Franklin County

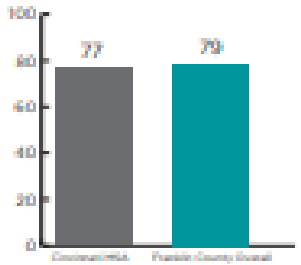
LOCAL HEALTH INDICATORS

SECONDARY DATA 2019 OR PRIOR (PRE-COVID-19)

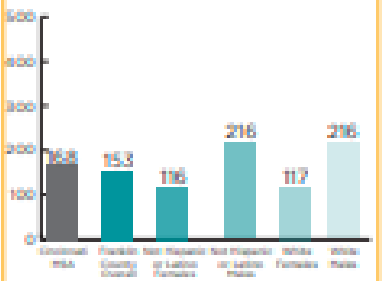
Cause of Death Summary (by Race) Age-adjusted Mortality Rates[1]

Rates per 100,000

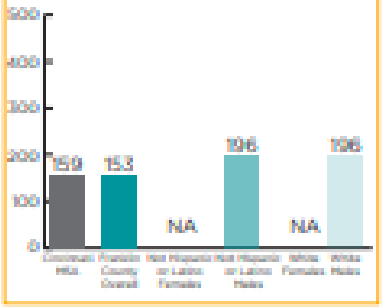
Life Expectancy by Race



Diseases of the Heart



Cancer



Other Causes of Death[2]

	Cincinnati MSA	Franklin County
Drug Overdose Deaths	46.9	30.8
Firearm-related Fatality	12.3	15.0
Suicide	13.8	18.8
Homicide	5.6	NA

Rate per 100,000

Prevalence of Disease[3]

	Cincinnati MSA	Franklin County
Heart Disease *(of population over 18)*	7.3%	7.3%
Frequent Mental Distress *(14 days or more per month of mental distress)*	14.7%	15.5%

Preventable Hospitalization Rate[4]

Cincinnati MSA: **4,748**

Franklin County: **5,171**

per 100,000 Medicare enrollees

Infant Mortality Rate[5]

Under 1

Cincinnati MSA: **7.6**

Franklin County: **NA**

per 1,000 live births

Childhood Mortality Rate[6]

Under 18

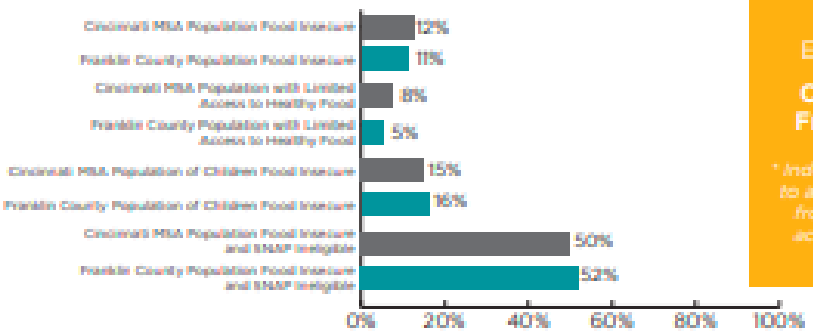
Cincinnati MSA: **58.8**

Franklin County: **NA**

per 100,000

HEALTH-RELATED SOCIAL INDICATORS

Food Security[7]



Food Environment Index*

Cincinnati MSA: 7.7
Franklin County: 8.3

** Index of factors that contribute to a healthy food environment; from 0 (worst) to 10 (best), according to County Health Rankings & Roadmaps.*

Education[8]

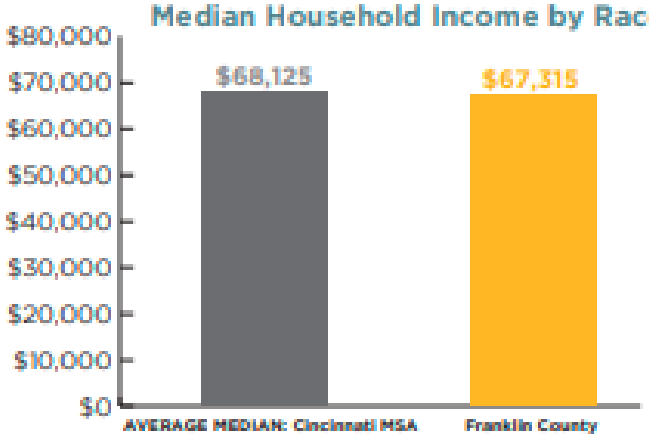
	Cincinnati MSA	Franklin County
High School Graduation Rate	87.4%	97.5%
Some College Experience	69.2%	55.1%

Children in Poverty[11]

Cincinnati MSA	Franklin County
15.3%	13.2%

Percent of Households that are Housing Cost Burdened[9]
26% Cincinnati MSA | 19% Franklin County

Median Household Income by Race[10]



Health Insurance[12]

Percent Uninsured

Cincinnati MSA	Franklin County
6.5%	8.5%

Primary Care, Mental Health, Dental[13]

Rates of providers per 100,000 residents

Primary Care Physicians		Mental Health Providers		Dentists	
Cincinnati MSA	Franklin County	Cincinnati MSA	Franklin County	Cincinnati MSA	Franklin County
83.7	79.2	260.5	35.2	57.9	65.9

HEALTH BEHAVIORS

Frequency of Check-up Over Age 18[14]

(Age-adjusted)

74.4%

% of Adults Reporting No Leisure-time Physical Activity[15]

(Age 20 and Over)

Cincinnati MSA	Franklin County
24.2%	29.6%

Healthy Eating Habits[16]

(Age 20 and Over)

	Cincinnati MSA	Franklin County
Obesity	32.4%	35.6%
Diabetes	11.8%	12.6%

Adult Smoking[17]

(Age-adjusted)

Cincinnati MSA	Franklin County
20.3%	23.8%

Excessive Drinking[18]

(% of Adults Reporting Binge or Heavy Drinking, Age-adjusted)

Cincinnati MSA	Franklin County
19.2%	19.1%

CINCINNATI MSA[19] MET AND UNMET HEALTH NEEDS

Between April 2020 and March 2021, the proportion of met and unmet treatment needs among those who reported needing treatment:

Met Treatment Need

Unmet Treatment Need

Cardiovascular

Maternal Health

Mental Health

Substance Use Disorder

CINCINNATI MSA OTHER UNTREATED HEALTH CONDITIONS

(BETWEEN APRIL 2020-MARCH 2021)

Vision

Unmet Treatment Need: 21.4%

Dental

Unmet Treatment Need: 19.3%

Notes

The regional comparison measures are weighted means, weighted using County population data from the 2019 ACS. Regions were created based off our grouping in the 2020 CHNA full report.

1. CDC Wonder, Underlying Cause of Death (https://wonder.cdc.gov/wonder/help/DataExport.html#Excel); Life expectancy by race is from 2021 County Health Rankings data, a different source than the five Mortality Rate plots, therefore an aligned breakdown of race cannot be guaranteed. Available data related to race breakdown was reported.

1., 2., 3., 4., 5., 6. County Health Rankings: 2021 https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/2021-measures

3. Estimated County-Level Prevalence of Selected Underlying Medical Conditions Associated with Increased Risk for Severe COVID-19 Illness — United States, 2018: https://stacks.cdc.gov/view/cdc/90519

7. 2019 County Rankings: https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation; Feeding America's 2019 County Data: https://www.feedingamerica.org/research/map-the-meal-gap/by-county; Map the Meal Gap: https://map.feedingamerica.org/

8., 10., 11., 12., 13. 2021 County Rankings: https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation

9. 2019 ACS

14., PLACES Map

15., 16., 17., 18. 2021 County Rankings: https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation

19. For list of counties included in this MSA, please see The Health Collaborative's full Community Health Needs Assessment 2021 report.

Research conducted by: Measurement Resources

FRANKLIN COUNTY SURVEY RESPONSES AND DEMOGRAPHICS

n = 453

The following data represents community members' engagement in the survey.

Age

18-24	11.3%	45-64	20.1%
25-34	43.4%	65+	13.4%
35-44	11.8%		

Race

American Indian/ Alaska Native	1.1%	Multi-racial	3.0%
Asian/Pacific Islander	6.0%	Other	0%
Black	3.7%	White	74.6%
Hispanic	1.6%		

Sex

Female	49.2%	Male	50.8%

Insurance

No Private Insurance	49.9%	Private Insurance	50.1%

Gender Identification

Male	47.7%	Agender	0.3%
Female	49.6%	Gender Fluid	0%
Female to Male	0.8%	Two-Spirited	0.8%
Male to Female	0.5%	Other Gender	0.3%

Military Status

Currently Serving	8.3%	No Military	78.5%
Veterans	8.8%	Decline to State	3.4%

Employment

Working Full Time	59.8%	Retired	13.5%
Working Part Time	14.5%	Disabled, Unable to Work	1.0%
Unemployed, Looking for Work	4.2%	Decline to State	1.3%
Unemployed, Not Looking for Work	5.7%		

English Ability

Fluent	94.2%	None	0.3%
Limited	5.5%	Decline to State	0%

Education

Less Than High School	1.6%	Bachelor's Degree	22.6%
Some High School	4.7%	Graduate Degree or Higher	12.5%
Diploma/GED	29.8%	Decline to State	1.0%
Some College/Associates Degree	27.8%		

Household Income

< $25,000	13.8%	$75,000+	29.9%
$25,000 - $34,999	11.7%	Unsure of Income	2.6%
$35,000 - 49,999	14.1%	Decline to State	6.3%
$50,000 - 74,999	21.6%		

Population 22,842
Per 2020 US Census

gs (University of Wisconsin Population nkings & Roadmaps 2022; Data from

Health Outcomes

Indicator/Measure	County	Trend	State
Diabetes (%)	10	-	11
Injury Deaths (rate per 100,000)	85	↑	97
Poor physical health days (last 30 days)	4.3	↑	4.1
Poor mental health days (last 30 days)	5.1	↑	4.8
Health Behaviors			
Adult Obesity ((%)	34	↑	35
Adult Smoking (%)	22	↑	20
Alcohol impaired driving deaths (%)	21	↓	19
Sexually transmitted infections (rate per 100,000)	135.2	↓	526.3
Excessive drinking (%)	20	↑	18
Motor Vehicle crash deaths (rate per 100,000	13	↑	12
Physical inactivity (%)	30	↑	31
Mammography Screening (%)	46	↓	44
Substance Abuse/ Mental Health			
Drug overdoses/mortality rate (per 100,000)	40	↑	28
Suicide (rate per 100,000)	21	↑	15
Access to Clinical Care			
Dentists (ratio)	1420:1	-	1720:1
Diabetic Screening (% HbA1c)	1620:1	↓	1852:1
Mental Health Providers (ratio)	3250:1	-	560:1
Primary Care Physicians	1420:1	↑	1490:1
Uninsured Adults (%)	7	↓	7
Socio-Economic /Demographic			
People in poverty (%)	7.7%	↓	11.6
African-American (%)	0.3	-	9.9
Population that is 65 and older (%)	19.5	↑	16.5
Population that is below 18 years of age (%)	22.8	↓	23.2

Mental Health

Suicide rate increased again (14.8 to 21/100,000), over both U.S. and Indiana averages. Significantly fewer mental health providers

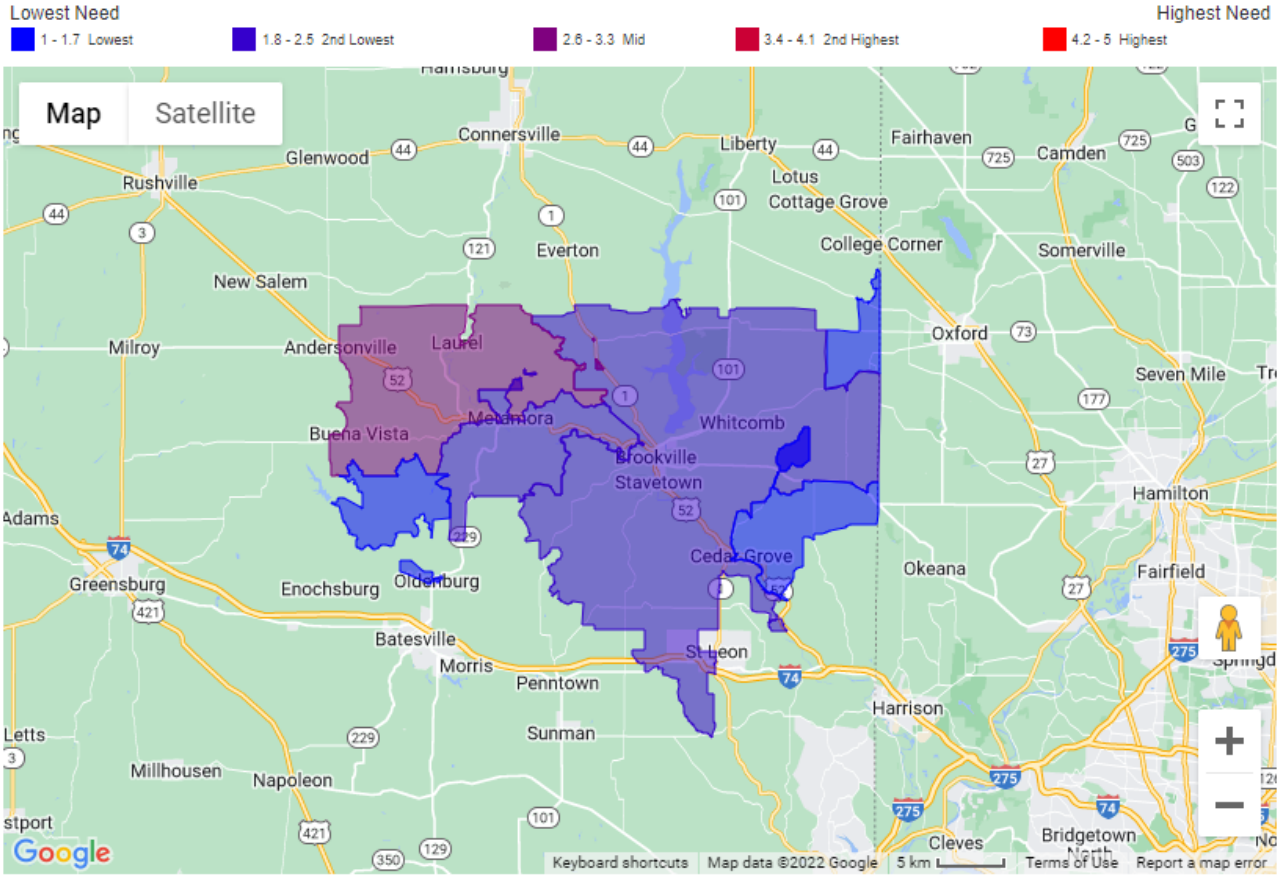
Drug overdose deaths

Rate increased from 28 to 40/100,000

Injury Deaths

Increased from 71 to 85/100,000, however this is below the state average (which also rose significantly)

Franklin County Community Health Index (CNI): A high score (3.4 – 5.0) is an indication for socioeconomic variation, barriers to care, and increased need for health service. None of the county's zip codes exceeded a 3.2 score. All communities in our services area remained the same or dropped in health need risk.



Mean(zipcode): 2 / Mean(person): 2.3 CNI Score Median: 2.2 CNI Score Mode: 1.6

Zip Code	CNI Score	Population	City	County	State
47010	1.6	328	Bath	Franklin	Indiana
47012	2.2	9671	Brookville	Franklin	Indiana
47016	1.6	917	Cedar Grove	Franklin	Indiana
47024	3.2	3083	Laurel	Franklin	Indiana
47030	2.2	1579	Metamora	Franklin	Indiana
47035	1.8	298	New Trenton	Franklin	Indiana
47036	1.6	1002	Oldenburg	Franklin	Indiana

THE HEALTH COLLABORATIVE

regional community health needs assessment 2021

Union County

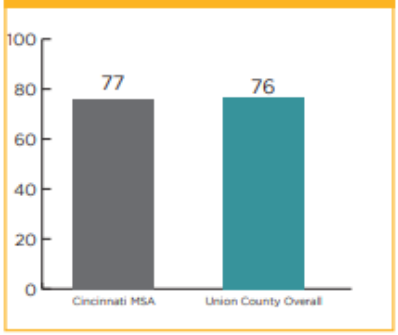
LOCAL HEALTH INDICATORS

SECONDARY DATA 2019 OR PRIOR (PRE-COVID-19)

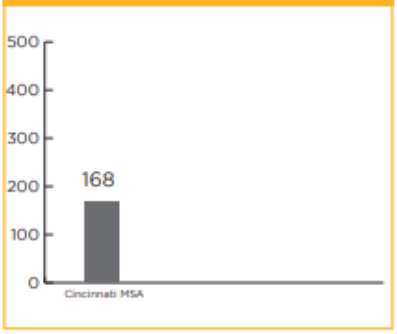
Cause of Death Summary (by Race) Age-adjusted Mortality Rates[1]

Rates per 100,000

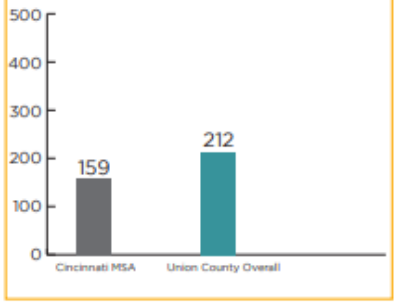
Life Expectancy by Race



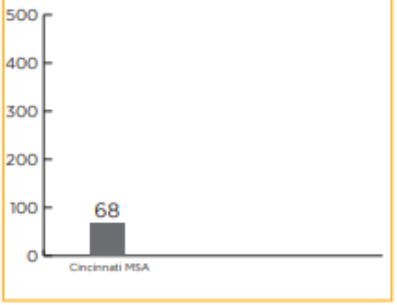
Diseases of the Heart



Cancer



Accidents/Unintentional Injuries



Other Causes of Death[2]

	Cincinnati MSA	Union County
Drug Overdose Deaths	46.9	65.8
Firearm-related Fatality	12.3	NA
Suicide	13.8	NA
Homicide	5.6	NA

Rate per 100,000

Prevalence of Disease[3]

	Cincinnati MSA	Union County
Heart Disease *(of population over 18)*	7.3%	8.5%
Frequent Mental Distress *(14 days or more per month of mental distress)*	14.7%	16.2%

Preventable Hospitalization Rate[4]

Cincinnati MSA: **4,748**

Union County: **4,748**

per 100,000 Medicare enrollees

Infant Mortality Rate[5]

Under 1

Cincinnati MSA: **7.6**

Union County: **NA**

per 1,000 live births

Childhood Mortality Rate[6]

Under 18

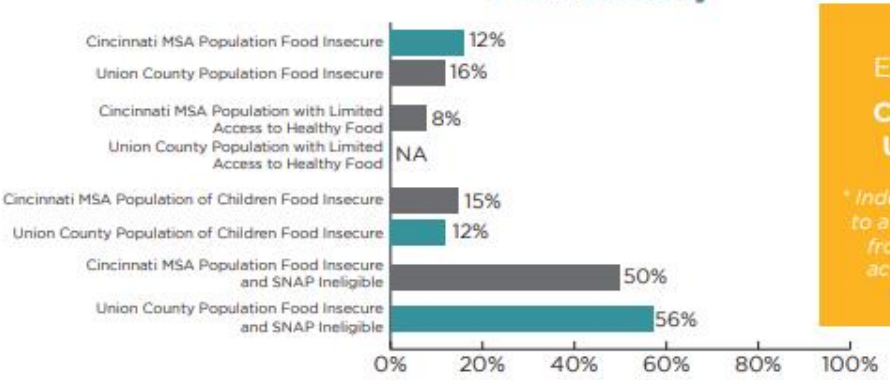
Cincinnati MSA: **58.8**

Union County: **NA**

per 100,000

HEALTH-RELATED SOCIAL INDICATORS

Food Security[7]



Food Environment Index*

Cincinnati MSA: 7.7
Union County: NA

** Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best), according to County Health Rankings & Roadmaps.*

Education[8]

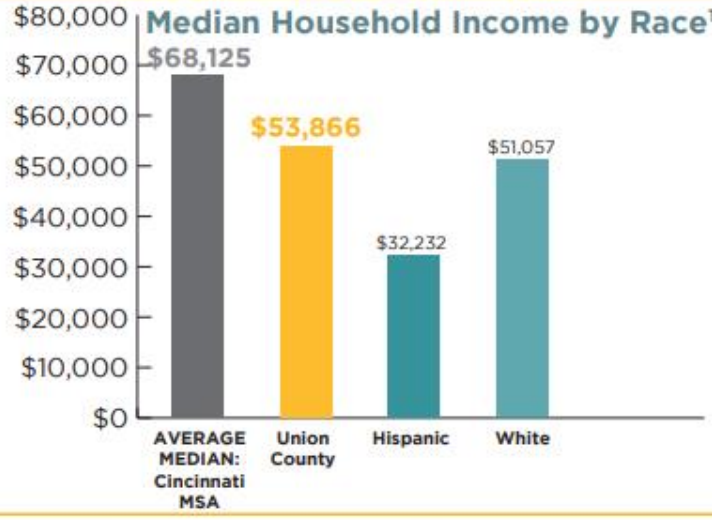
	Cincinnati MSA	Union County
High School Graduation Rate	87.4%	92.5%
Some College Experience	69.2%	49.5%

Children in Poverty[11]

Cincinnati MSA	Union County
15.3%	13.4%

Percent of Households that are Housing Cost Burdened[9]
26% *Cincinnati MSA* | **24%** *Union County*

Median Household Income by Race[10]



Health Insurance[12]

Percent Uninsured

Cincinnati MSA	Union County
6.5%	9.2%

Primary Care, Mental Health, Dental[13]

Rates of providers per 100,000 residents

Primary Care Physicians

Cincinnati MSA	Union County
83.7	14.2

Mental Health Providers

Cincinnati MSA	Union County
260.5	NA

Dentists

Cincinnati MSA	Union County
57.9	NA

HEALTH BEHAVIORS

Frequency of Check-up Over Age 18[14]

(Age-adjusted)

74.1%

% of Adults Reporting No Leisure-time Physical Activity[15]

(Age 20 and Over)

Cincinnati MSA	Union County
24.2%	22.7%

Healthy Eating Habits[16]

(Age 20 and Over)

	Cincinnati MSA	Union County
Obesity	32.4%	28.1%
Diabetes	11.8%	7.5%

Adult Smoking[17]

(Age-adjusted)

Cincinnati MSA	Union County
20.3%	24.6%

Excessive Drinking[18]

(% of Adults Reporting Binge or Heavy Drinking, Age-adjusted)

Cincinnati MSA	Union County
19.2%	17.8%

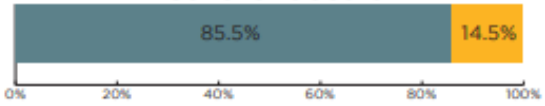
CINCINNATI MSA[19] MET AND UNMET HEALTH NEEDS

Between April 2020 and March 2021, the proportion of met and unmet treatment needs among those who reported needing treatment:

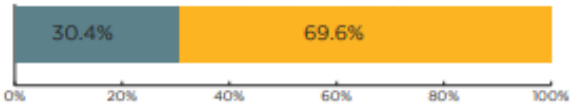
Met Treatment Need

Unmet Treatment Need

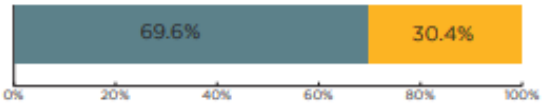
Cardiovascular



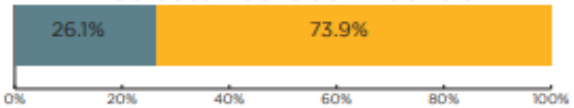
Maternal Health



Mental Health



Substance Use Disorder



CINCINNATI MSA OTHER UNTREATED HEALTH CONDITIONS

(BETWEEN APRIL 2020-MARCH 2021)

Vision

Unmet Treatment Need: **21.4%**

Dental

Unmet Treatment Need: **19.3%**

Notes

The regional comparison measures are weighted means, weighted using County population data from the 2019 ACS. Regions were created based off our grouping in the 2020 CHNA full report.

1. CDC Wonder, Underlying Cause of Death (https://wonder.cdc.gov/wonder/help/DataExport.html#Excel); Life expectancy by race is from 2021 County Health Rankings data, a different source than the five Mortality Rate plots, therefore an aligned breakdown of race cannot be guaranteed. Available data related to race breakdown was reported.

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7. 2019 County Rankings: https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation; Feeding America's 2019 County Data: https://www.feedingamerica.org/research/map-the-meal-gap/by-county; Map the Meal Gap: https://map.feedingamerica.org/

8., 10., 11., 12., 13. 2021 County Rankings: https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation

9. 2019 ACS

14., PLACES Map

15., 16., 17., 18. 2021 County Rankings: https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation

19. For list of counties included in this MSA, please see The Health Collaborative's full Community Health Needs Assessment 2021 report.

Research conducted by: Measurement Resources

UNION COUNTY SURVEY RESPONSES AND DEMOGRAPHICS

n = 87

The following data represents community members' engagement in the survey.

Age

18-24	15.0%	45-64	2.3%
25-34	77.1%	65+	0%
35-44	5.6%		

Race

American Indian/ Alaska Native	18.4%	Multi-racial	5.8%
Asian/Pacific Islander	5.8%	Other	0%
Black	5.8%	White	57.3%
Hispanic	6.9%		

Sex

Female	37.9%	Male	62.1%

Insurance

No Private Insurance	75.9%	Private Insurance	24.1%

Gender Identification

Male	56.2%	Agender	0%
Female	32.9%	Gender Fluid	0%
Female to Male	6.1%	Two-Spirited	1.2%
Male to Female	2.4%	Other Gender	1.2%

Military Status

Currently Serving	17.7%	No Military	59.5%
Veterans	20.3%	Decline to State	2.5%

Employment

Working Full Time	67.1%	Retired	1.2%
Working Part Time	15.9%	Disabled, Unable to Work	2.4%
Unemployed, Looking for Work	11.0%	Decline to State	0%
Unemployed, Not Looking for Work	2.4%		

English Ability

Fluent	73.1%	None	1.3%
Limited	25.6%	Decline to State	0%

Education

Less Than High School	6.2%	Bachelor's Degree	17.3%
Some High School	11.1%	Graduate Degree or Higher	1.2%
Diploma/GED	37.0%	Decline to State	0%
Some College/Associates Degree	27.2%		

Household Income

< $25,000	22.0%	$75,000+	11.0%
$25,000 - $34,999	24.4%	Unsure of Income	1.2%
$35,000 - 49,999	12.2%	Decline to State	0%
$50,000 - 74,999	29.2%		

Union **Population: 7,050** versity of Wisconsin Population
Health igs & Roadmaps 2022; Data from
2019-2020)

Health Outcomes

Indicator/Measure	County	Trend	State
Diabetes (%)	10	↓	11
Injury Deaths (rate per 100,000)	126	↑	85
Low Birthweight (%)	6	-	8
Poor physical health days (last 30 days)	4.4	↑	4.1
Poor mental health days (last 30 days)	5.2	↑	4.8
Health Behaviors			
Adult Obesity (%)	35	↑	35
Adult Smoking	23	↑	20
Alcohol impaired driving deaths (%)	0	-	19
Excessive drinking (%)	18	↑	18
Sexually transmitted infections (rate per 100,000)	269.4	-	526.3
HIV prevalence (rate per 100,000)	U	↑	196
Motor Vehicle crash deaths (rate per 100,000	U		12
Physical inactivity (%)	32	↓	31
Substance Abuse/ Mental Health			
Drug overdoses/mortality rate (per 100,000)	47	↑	28
Access to Clinical Care			
Dentists (rate per 100,000)	U	-	1852:1
Mammogram screening (%)	43	↓	44
Mental Health Providers (ratio)	U	-	560:1
Primary Care Physicians	7050:1	↑	1490:1
Uninsured (%)	10.7	-	10.3
Socio-Economic /Demographic			
Poverty Rate among Children (%)	13.4		15.1
Persons in poverty (%)	10	↓	11.6
African-American (%)	1%		9.9
Population that is 65 and older (%)	19	↑	16.1
Population that is below 18 years of age (%)	20.8%	↓	23.3

Mental Health Worker

Number too small to measure

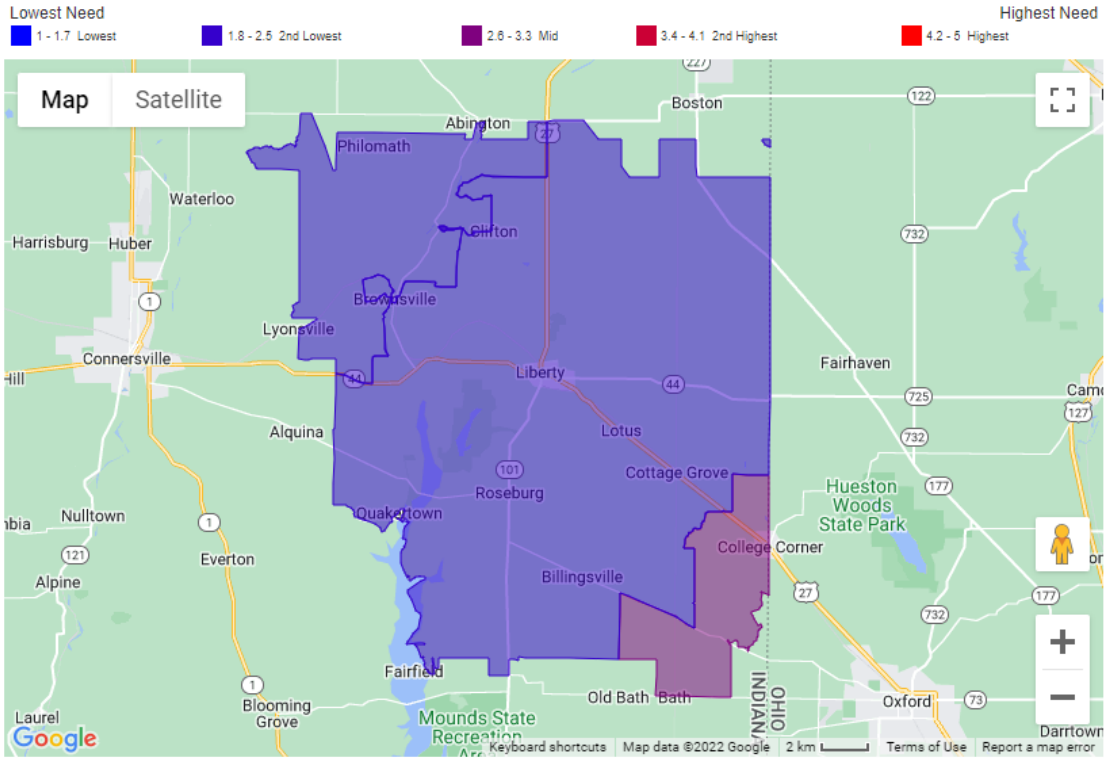
Primary Care Physicians

None

Overdoses mortality rate

Increased from unmeasurable to 40/100,000 (actual # was 10)

Union County Community Health Index (CNI): A high score (3.4 – 5.0) is an indication for socioeconomic variation, barriers to care, and increased need for health service. West College Corner dropped from 3.4 to 2.6 (lowering their risk of need) and Liberty remained the same at 2.4.



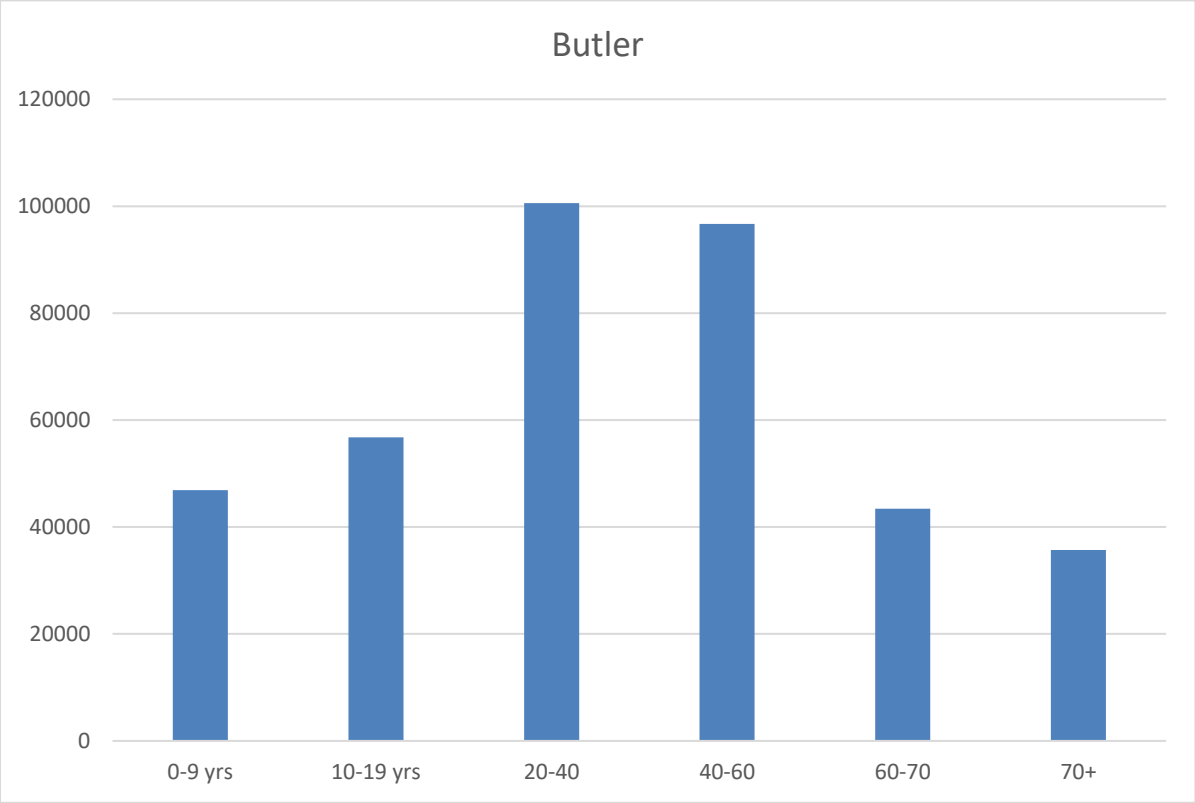
Mean(zipcode): 2.3 / Mean(person): 2.4 CNI Score Median: 2.6 CNI Score Mode: None

Zip Code	CNI Score	Population	City	County	State
47003	2.6	1002	West College Corner	Union	Indiana
47325	1.8	706	Brownsville	Union	Indiana
47353	2.4	5387	Liberty	Union	Indiana

Appendix 2 – Butler County, Ohio

Butler County Ohio Demographics and Summary Findings

Butler County is one of the most populated counties in the region and includes the cities of Hamilton and Middletown, former hubs of industry. The City of Oxford is in Butler County and is home to Miami University. Of all the counties, there are 12 ZIP Codes in the County; 45015 in Hamilton and 45044 in Middletown have elevated CNI scores of 4 or above, indicating the likelihood of health disparities.



From 2020 US Census

THE HEALTH COLLABORATIVE

regional community health needs assessment 2021

Butler County

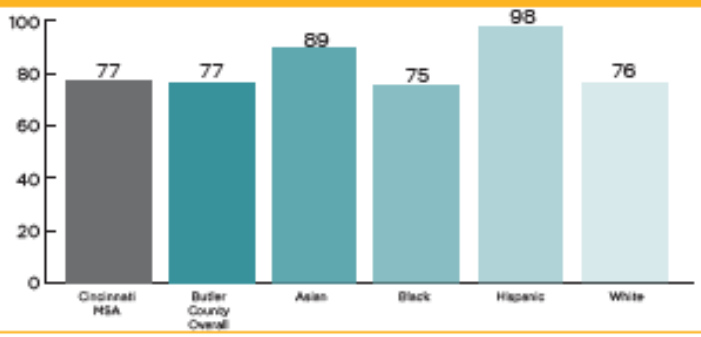
LOCAL HEALTH INDICATORS

SECONDARY DATA 2019 OR PRIOR (PRE-COVID-19)

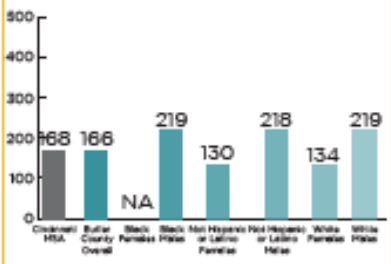
Cause of Death Summary (by Race) Age-adjusted Mortality Rates[1]

Rates per 100,000

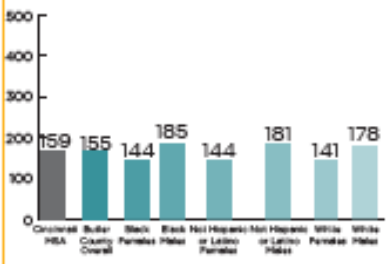
Life Expectancy by Race



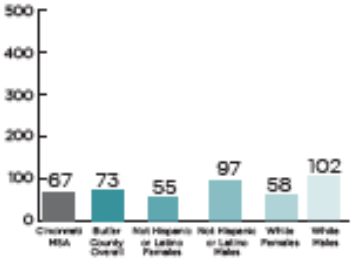
Diseases of the Heart



Cancer



Accidents/Unintentional Injuries



Other Causes of Death[2]

	Cincinnati MSA	Butler County
Drug Overdose Deaths	46.9	54.4
Firearm-related Fatality	12.3	11.4
Suicide	13.8	13.5
Homicide	5.6	4.1

Rate per 100,000

Prevalence of Disease[3]

	Cincinnati MSA	Butler County
Heart Disease *(of population over 18)*	7.3%	6.9%
Frequent Mental Distress *(14 days or more per month of mental distress)*	14.7%	15.1%

Preventable Hospitalization Rate[4]

Cincinnati MSA: **4,748**

Butler County: **5,151**

per 100,000 Medicare enrollees

Infant Mortality Rate[5]

Under 1

Cincinnati MSA: **7.6**

Butler County: **7.5**

per 1,000 live births

Childhood Mortality Rate[6]

Under 18

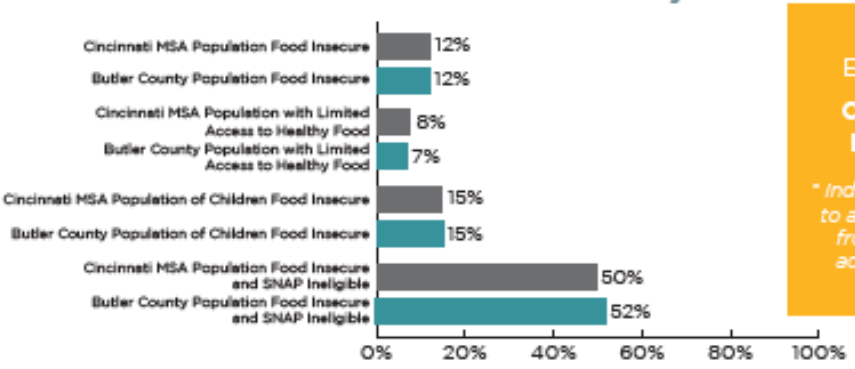
Cincinnati MSA: **58.8**

Butler County: **52.4**

per 100,000

HEALTH-RELATED SOCIAL INDICATORS

Food Security[7]



Food Environment Index*

Cincinnati MSA: 7.7
Butler County: 7.8

** Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best), according to County Health Rankings & Roadmaps.*

Education[8]

	Cincinnati MSA	Butler County
High School Graduation Rate	87.4%	87.2%
Some College Experience	69.2%	64.5%

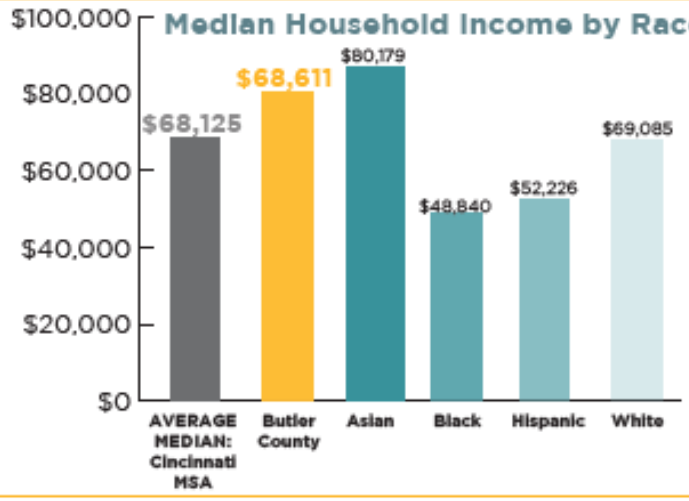
Children in Poverty[11]

Cincinnati MSA	Butler County
15.3%	14.1%

Percent of Households that are Housing Cost Burdened[9]

26% Cincinnati MSA | 25% Butler County

Median Household Income by Race[10]



Health Insurance[12]

Percent Uninsured

Cincinnati MSA	Butler County
6.5%	6.8%

Primary Care, Mental Health, Dental[13]

Rates of providers per 100,000 residents

Primary Care Physicians

Cincinnati MSA	Butler County
83.7	54.1

Mental Health Providers

Cincinnati MSA	Butler County
260.5	240.9

Dentists

Cincinnati MSA	Butler County
57.9	51.9

HEALTH BEHAVIORS

Frequency of Check-up Over Age 18[14]
(Age-adjusted)

77.8%

% of Adults Reporting No Leisure-time Physical Activity[15]
(Age 20 and Over)

Cincinnati MSA	Butler County
24.2%	23.4%

Healthy Eating Habits[16]
(Age 20 and Over)

	Cincinnati MSA	Butler County
Obesity	32.4%	32.3%
Diabetes	11.8%	12.0%

Adult Smoking[17]
(Age-adjusted)

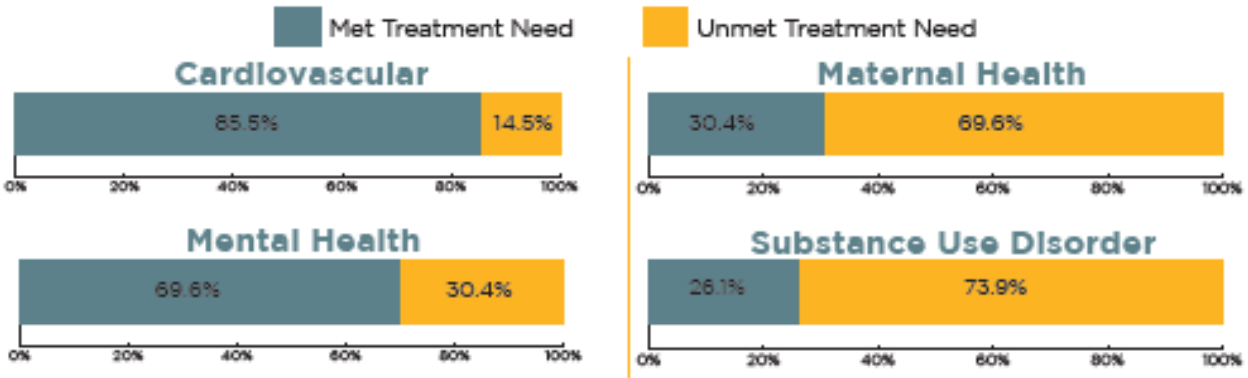
Cincinnati MSA	Butler County
20.3%	21.4%

Excessive Drinking[18]
(% of Adults Reporting Binge or Heavy Drinking, Age-adjusted)

Cincinnati MSA	Butler County
19.2%	19.0%

CINCINNATI MSA[19] MET AND UNMET HEALTH NEEDS

Between April 2020 and March 2021, the proportion of met and unmet treatment needs among those who reported needing treatment:



CINCINNATI MSA OTHER UNTREATED HEALTH CONDITIONS
(BETWEEN APRIL 2020-MARCH 2021)

Vision
Unmet Treatment Need: **21.4%**

Dental
Unmet Treatment Need: **19.3%**

Notes

The regional comparison measures are weighted means, weighted using County population data from the 2019 ACS. Regions were created based off our grouping in the 2020 CHNA full report.

1. CDC Wonder, Underlying Cause of Death (https://wonder.cdc.gov/wonder/help/DataExport.html#Excel); Life expectancy by race is from 2021 County Health Rankings data, a different source than the five Mortality Rate plots, therefore an aligned breakdown of race cannot be guaranteed. Available data related to race breakdown was reported.

1., 2., 3., 4., 5., 6. County Health Rankings: 2021 https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/2021-measures

3. Estimated County-Level Prevalence of Selected Underlying Medical Conditions Associated with Increased Risk for Severe COVID-19 Illness — United States, 2018: https://stacks.cdc.gov/view/cdc/90519

7. 2019 County Rankings: https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation; Feeding America's 2019 County Data: https://www.feedingamerica.org/research/map-the-meal-gap/by-county; Map the Meal Gap: https://map.feedingamerica.org/

8., 10., 11., 12., 13. 2021 County Rankings: https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation

9. 2019 ACS

14., PLACES Map

15., 16., 17., 18. 2021 County Rankings: https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation

19. For list of counties included in this MSA, please see The Health Collaborative's full Community Health Needs Assessment 2021 report.

Research conducted by: Measurement Resources

BUTLER COUNTY SURVEY RESPONSES AND DEMOGRAPHICS

n = 404

The following data represents community members' engagement in the survey.

Age

18-24	8.9%	45-64	42.6%
25-34	23.0%	65+	8.4%
35-44	17.1%		

Race

American Indian/ Alaska Native	4.0%	Multi-racial	4.2%
Asian/Pacific Islander	3.0%	Other	0.7%
Black	6.2%	White	78.9%
Hispanic	3.0%		

Sex

Female	76.5%	Male	23.5%

Insurance

No Private Insurance	24.5%	Private Insurance	75.5%

Gender Identification

Male	22.9%	Agender	0.6%
Female	75.3%	Gender Fluid	0.3%
Female to Male	0.3%	Two-Spirited	0%
Male to Female	0.3%	Other Gender	0.3%

Military Status

Currently Serving	6.6%	No Military	82.9%
Veterans	9.9%	Decline to State	0.6%

Employment

Working Full Time	70.4%	Retired	5.0%
Working Part Time	18.7%	Disabled, Unable to Work	0%
Unemployed, Looking for Work	2.8%	Decline to State	0.3%
Unemployed, Not Looking for Work	2.8%		

English Ability

Fluent	94.5%	None	0.5%
Limited	5.0%	Decline to State	0%

Education

Less Than High School	0.6%	Bachelor's Degree	28.9%
Some High School	3.3%	Graduate Degree or Higher	20.9%
Diploma/GED	13.5%	Decline to State	0%
Some College/Associates Degree	32.8%		

Household Income

< $25,000	3.9%	$75,000+	47.6%
$25,000 - $34,999	10.5%	Unsure of Income	2.2%
$35,000 - 49,999	12.7%	Decline to State	6.6%
$50,000 - 74,999	16.5%		

Population: 390,234
(US Census 2020)

Butler County Health Rankings (University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2022; Data from 2019-2020)			
Indicator/Measure	County	Trend	State
Health Outcomes			
*Cancer mortality, Breast (rate per 100,000)	20.7	↑	21.9
*Cancer mortality, Colon & Rectum (rate per 100,000)	13.6	↓	15.1
*Cancer mortality, Overall (rate per 100,000)	168.2	-	172.3
Diabetes (%)	11	-	10
Infant Mortality (rate per 100.000 live births	7	↓	7
Injury Deaths (rate per 100,000)	100	↑	96
Low birth weight (%)	8	↑	9
Poor physical health days (last 30 days)	4.2	↓	4.2
Poor mental health days (last 30 days)	5.0	-	5.2
Health Behaviors			
Adult Obesity (%)	34	↑	35
Adult Smoking	22	-	22.0
Alcohol impaired driving deaths (%)	30	↓	33
Sexually transmitted Infections (rate per 100,000)	398.8	↑	559.4
HIV Prevalence (rate per 100,000)	139	↑	235
Physical inactivity	28	-	28
Substance Abuse/ Mental Health			
Suicides (per 100,000)	13	-	15
Drug overdose deaths (per 100,000)	49	↑	38
Excessive drinking (%)	19	-	21
Access to Clinical Care			
Dentists (ratio)	1920:1	↑	1570:1
Mammogram Screening (%)	43	↑	45
Mental Health Providers (ratio)	380:1	↑	350:1
Primary Care Physicians	1820:1	-	1990:1
Uninsured Adults (%)	9.0	↑	9.0
Socio-Economic /Demographic			
Children in poverty (%)	12	↓	17
Children eligible for free or reduced lunch (%)	37	-	36
Hispanic (%)	5	↑	4
African-American (%)	9.2	↑	13.1
Population that is 65 and older (%)	15.1	↑	17.5
Population that is below 18 years of age (%)	23.3	↓	22.1

Mammograms Screenings
declined from 69.1% to 43%.
COVID impact

Children in Poverty
Decreased from 18.6% to 12%

Injury Deaths
Increased from 83.9 to 100/100,000

Race
African American increased from 7.8 to 9.2%

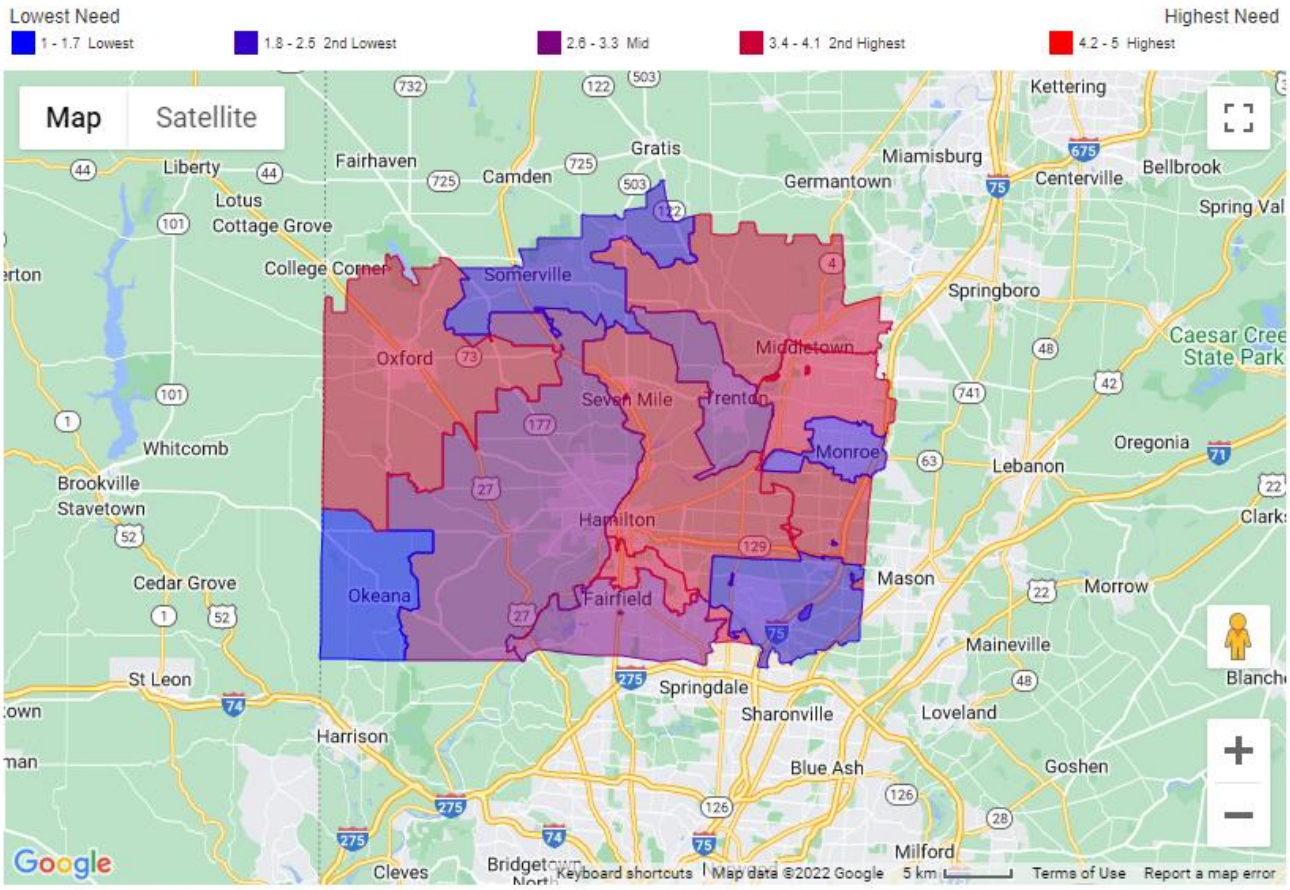
Hispanic increased from 4.4 to 5%

HIV Prevalence
Increased from 107-139/100,000

This is people age 13 and over living with HIV

*Cancer rates based on Butler County Cancer Profile, from the Ohio Department of Health 2021 (2014-2018 data)

Community Health Index (CNI): A high score (3.4 – 5.0) is an indication for socioeconomic variation, barriers to care, and increased need for health service. Oxford rose to 3.4 from 3.0 from 2019-2021.



Mean(zipcode): 2.8 / Mean(person): 3.1 CNI Score Median: 3 CNI Score Mode: 3.4

Zip Code	CNI Score	Population	City	County	State
45011	3.4	76662	Hamilton	Butler	Ohio
45013	2.8	53061	Hamilton	Butler	Ohio
45014	3.2	45176	Fairfield	Butler	Ohio
45015	4	11983	Hamilton	Butler	Ohio
45042	3.4	25568	Middletown	Butler	Ohio
45044	3.8	54340	Middletown	Butler	Ohio
45050	2.2	10910	Monroe	Butler	Ohio
45053	1.4	3174	Okeana	Butler	Ohio
45056	3.4	28096	Oxford	Butler	Ohio
45064	1.8	3244	Somerville	Butler	Ohio
45067	2.8	15640	Trenton	Butler	Ohio
45069	2	52845	West Chester	Butler	Ohio

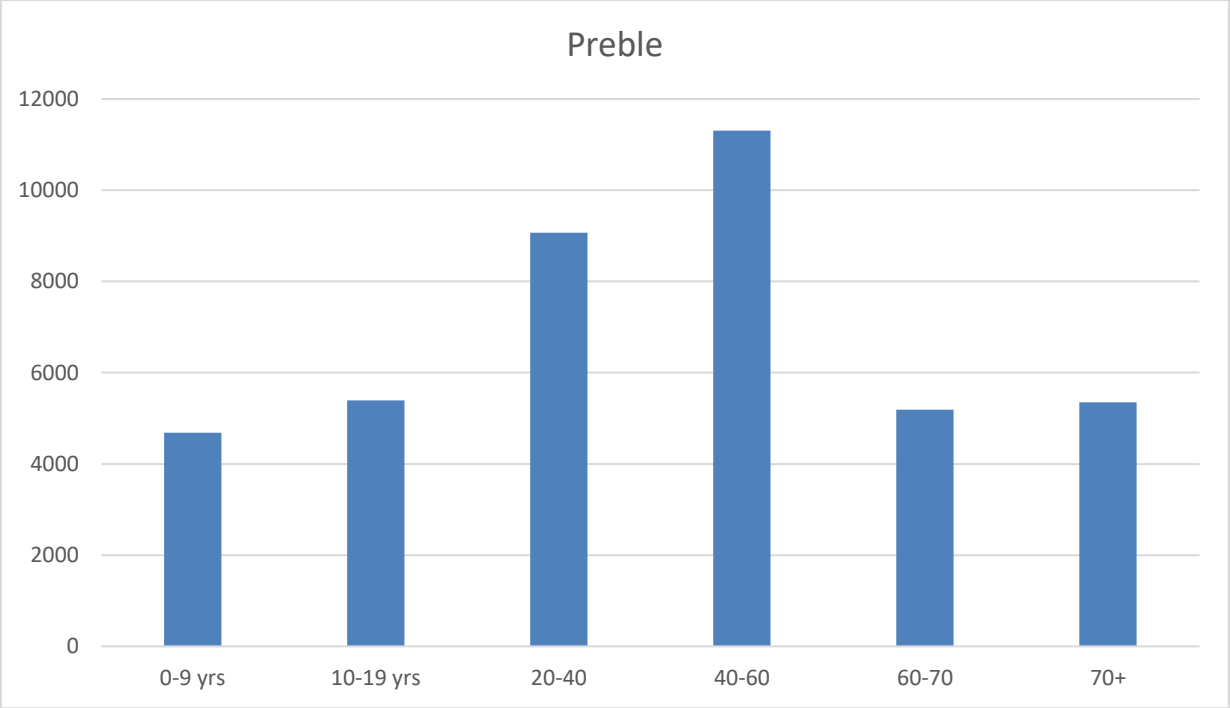
Appendix 3 – Preble County, Ohio

Preble County Ohio Demographics and Summary Findings

More than 69% of Preble County's population is considered rural. The county seat is Eaton. Injury deaths in the County are above the Ohio and U.S. rates and rising. There are fewer mental health providers and higher suicide rates in the County than the Ohio and U.S. rates. There are fewer primary care and dental providers in the County than the Ohio and U.S. ratios.

Population Chart

The following is a population chart from Preble County from 2020 US Census.



THE HEALTH COLLABORATIVE

regional community health needs assessment 2021

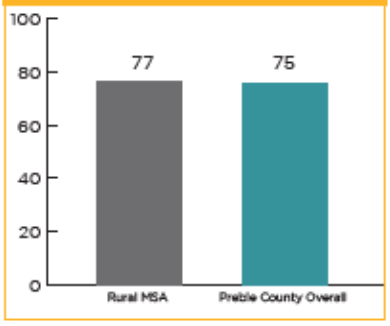
Preble County

LOCAL HEALTH INDICATORS

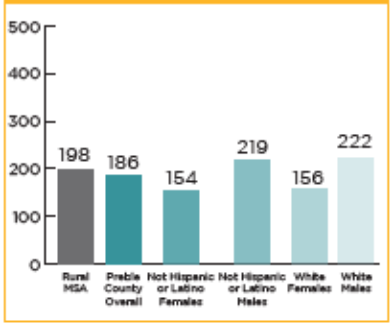
SECONDARY DATA 2019 OR PRIOR (PRE-COVID-19)

Cause of Death Summary (by Race) Age-adjusted Mortality Rates[1]

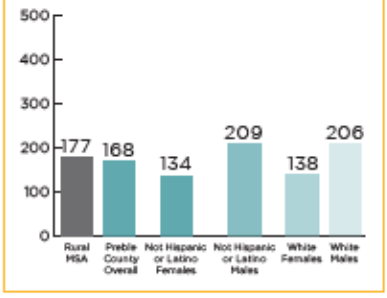
Life Expectancy *in Years*



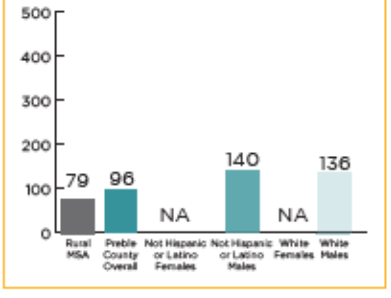
Diseases of the Heart *Rates per 100,000*



Cancer *Rates per 100,000*



Accidents/Unintentional Injuries *Rates per 100,000*



Other Causes of Death[2]

	Rural MSA	Preble County
Drug Overdose Deaths	39.4	46.3
Firearm-related Fatality	10.8	11.2
Suicide	15.9	13.9
Homicide	NA	NA

Rate per 100,000

Prevalence of Disease

	Rural MSA	Preble County
Heart Disease[3] *(population age 18 and over)*	8.7%	8.7%
Frequent Mental Distress[2] *(14 days or more per month of mental distress)*	16.4%	16.2%

Preventable Hospitalization Rate[4]

Rural MSA: **4,834**

Preble County: **4,464**

per 100,000 Medicare enrollees

Infant Mortality Rate[5]

Under 1

Rural MSA: **7.0**

Preble County: **NA**

per 1,000 live births

Childhood Mortality Rate[6]

Under 18

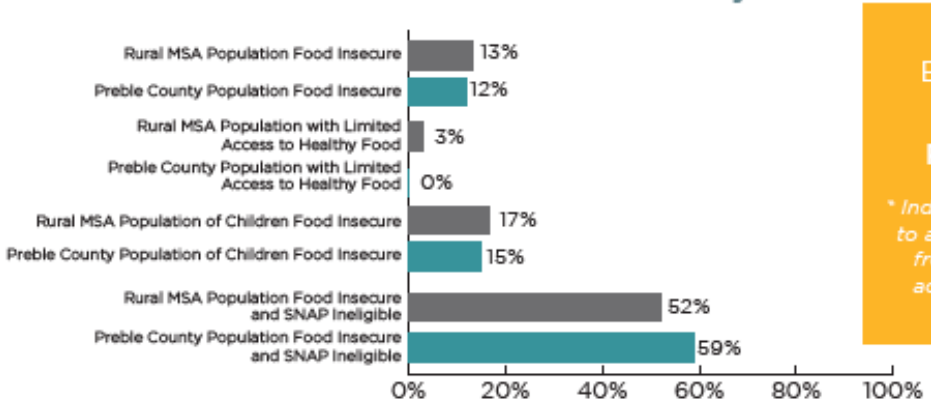
Rural MSA: **57.0**

Preble County: **46.0**

per 100,000

HEALTH-RELATED SOCIAL INDICATORS

Food Security[7]



Food Environment Index*

Rural MSA: 8.0
Preble County: 8.3

** Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best), according to County Health Rankings & Roadmaps.*

Education[8]

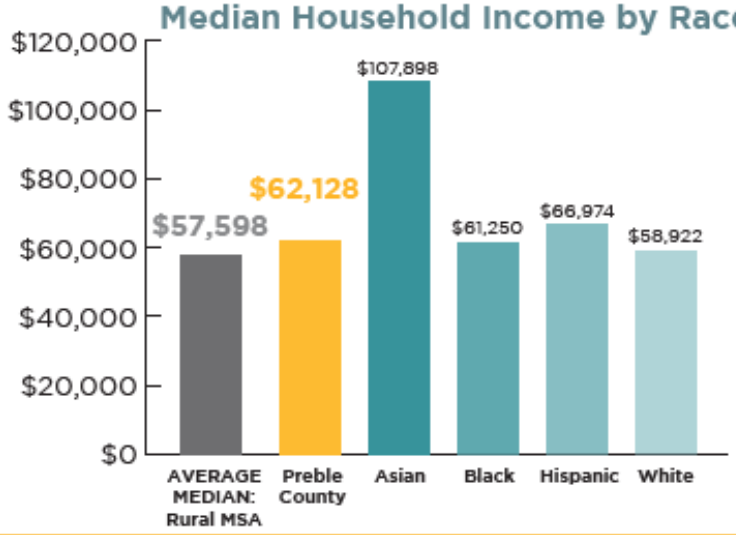
	Rural MSA	Preble County
High School Graduation Rate	90.1%	91.4%
Some College Experience	54.8%	57.7%

Children in Poverty[11]

Rural MSA	Preble County
16.1%	13.3%

Percent of Households that are Housing Cost Burdened[9]
21% *Rural MSA* | **21%** *Preble County*

Median Household Income by Race[10]



Health Insurance[12]

Percent Uninsured

Rural MSA	Preble County
8.0%	8.2%

Primary Care, Mental Health, Dental[13]

Rates of providers per 100,000 residents

Primary Care Physicians

Rural MSA	Preble County
36.5	17.1

Mental Health Providers

Rural MSA	Preble County
104.6	78.3

Dentists

Rural MSA	Preble County
31.1	17.1

HEALTH BEHAVIORS

% of Adults Receiving Yearly Checkup[14]
(Age-adjusted, 18 and Over)

75.8%

% of Adults Reporting No Leisure-time Physical Activity[15]
(Age 20 and Over)

Rural MSA	Preble County
30.6%	25.7%

Healthy Eating Habits[16]
(Age 20 and Over)

	Rural MSA	Preble County
Obesity	35.3%	36.7%
Diabetes	12.1%	10.1%

Adult Smoking[17]
(Age-adjusted)

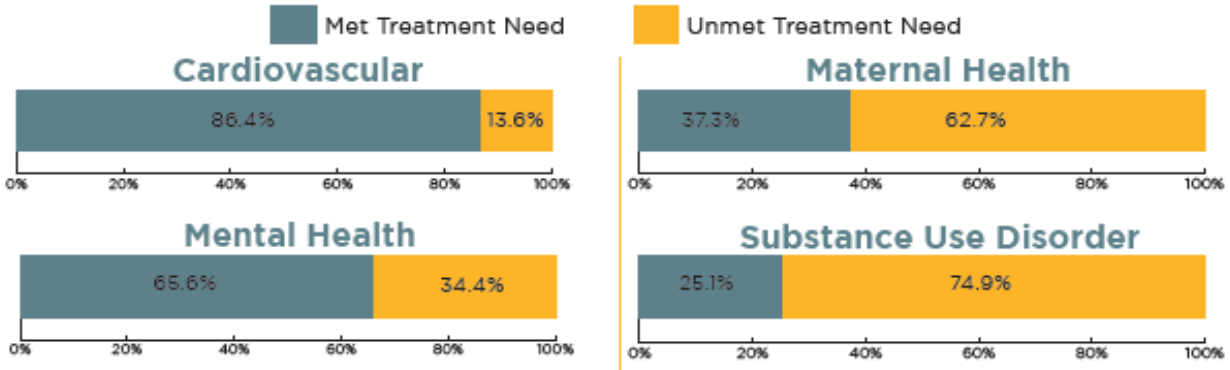
Rural MSA	Preble County
24.7%	24.3%

Excessive Drinking[18]
(% of Adults Reporting Binge or Heavy Drinking, Age-adjusted)

Rural MSA	Preble County
18.5%	19.6%

RURAL MSA[19] MET AND UNMET HEALTH NEEDS

Between April 2020 and March 2021, the proportion of met and unmet treatment needs among those who reported needing treatment:



RURAL MSA OTHER UNTREATED HEALTH CONDITIONS
(BETWEEN APRIL 2020-MARCH 2021)

Vision
Unmet Treatment Need: 22.2%

Dental
Unmet Treatment Need: 16.5%

Notes

The regional comparison measures are weighted means, weighted using County population data from the 2019 ACS. Regions were created based off our grouping in the 2020 CHNA full report.

1. CDC Wonder, Underlying Cause of Death (https://wonder.cdc.gov/wonder/help/DataExport.html#Excel); Life expectancy by race is from 2021 County Health Rankings data, a different source than the five Mortality Rate plots, therefore an aligned breakdown of race cannot be guaranteed. Available data related to race breakdown was reported.

2., 4., 5., 6. County Health Rankings: 2021 https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/2021-measures

3. Estimated County-Level Prevalence of Selected Underlying Medical Conditions Associated with Increased Risk for Severe COVID-19 Illness — United States, 2018: https://stacks.cdc.gov/view/cdc/90519

7. 2019 County Rankings: https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation; Feeding America's 2019 County Data: https://www.feedingamerica.org/research/map-the-meal-gap/by-county; Map the Meal Gap: https://map.feedingamerica.org/

8., 10., 11., 12., 13. 2021 County Rankings: https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation

9. 2019 ACS

14. PLACES Map: https://www.cdc.gov/places/

15., 16., 17., 18. 2021 County Rankings: https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation

19. For list of counties included in this MSA, please see The Health Collaborative's full Community Health Needs Assessment 2021 report.

Research conducted by: Measurement Resources

PREBLE COUNTY SURVEY RESPONSES AND DEMOGRAPHICS

n = 268

The following data represents community members' engagement in the survey.

Age

18-24	6.3%	45-64	45.9%
25-34	14.2%	65+	10.1%
35-44	23.5%		

Race

American Indian/ Alaska Native	0%	Multi-racial	1.5%
Asian/Pacific Islander	0.4%	Other	0%
Black	0%	White	98.1%
Hispanic	0%		

Sex

Female	78.4%	Male	21.6%

Insurance

No Private Insurance	26.1%	Private Insurance	73.9%

Gender Identification

Male	21.3%	Agender	0%
Female	77.5%	Gender Fluid	1.2%
Female to Male	0%	Two-Spirited	0%
Male to Female	0%	Other Gender	0%
		Declined to State	0%

Military Status

Currently Serving	0.8%	No Military	95.1%
Veterans	3.7%	Decline to State	0.4%

Employment

Working Full Time	74.2%	Retired	7.8%
Working Part Time	9.8%	Disabled, Unable to Work	2.5%
Unemployed, Looking for Work	1.6%	Decline to State	1.6%
Unemployed, Not Looking for Work	2.5%		

English Ability

Fluent	100.0%	None	0%
Limited	0%	Decline to State	0%

Education

Less Than High School	0.4%	Bachelor's Degree	21.9%
Some High School	0%	Graduate Degree or Higher	18.6%
Diploma/GED	21.1%	Decline to State	0%
Some College/Associates Degree	38.0%		

Household Income

< $25,000	4.9%	$75,000+	36.9%
$25,000 - $34,999	8.2%	Unsure of Income	4.9%
$35,000 - 49,999	9.8%	Decline to State	11.9%
$50,000 - 74,999	23.4%		

Preble County Health Rankings (University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps 2022; Data from 2019-2020)			
Indicator/Measure	County	Trend	State
Health Outcomes			
*Cancer mortality, Breast (rate per 100,000)	30.2		21.9
*Cancer mortality, Colon & Rectum (rate per 100,000)	16.1	↑	15.1
*Cancer mortality, Overall (rate per 100,000)	192	↑	172.3
Adult Diabetes Prevalence (%)	10	↓	10
Low birth weight (%)	9.0	-	9
Poor physical health days (last 30 days)	4.3	↑	4.2
Poor mental health days (last 30 days)	7.3	↓	5.2
Adult Obesity ((%)	38	↑	35
Adult Smoking (%)	23	↓	22.0
Alcohol impaired driving deaths (%)	18	↓	33
Sexually transmitted infections (rate per 100,000)	251.9	↑	559.4
HIV Prevalence (rate per 100,000)	58	-	235
Excessive drinking (%)	20	↓	21
Motor Vehicle crash deaths (rate per 100,000	23	-	10
Physical inactivity (%)	30	↑	28
Substance Abuse/ Mental Health			
Drug overdose mortality (per 100,000)	38	↑	38
Suicide (rate per 100,000)	15	↓	15
Access to Clinical Care			
Dentists (ratio)	5830:1	-	1570:1
Mammogram Screening (%)	41	↓	45
Mental Health Providers (ratio)	1100:1	↓	350:1
Primary Care Physicians	6810:1	↓	1290:1
Uninsured, under age 65 (%)	8	-	8
Socio-Economic /Demographic Children eligible for free/reduced lunch (%)	51	-	36
African-American (%)	0.7	-	12.7
Population that is 65 and older (%)	20.2	↑	17.9
Population that is below 18 years of age (%)	22.2	-	22.0

Population 40,836

Cancer mortality rates
Are significantly higher than Ohio and overall mortality has ↑from 186.0 to 192.2

Adult Obesity
Has significantly increased from 22.8% to 38%

Adult Smoking
Has significantly decreased from 42.7% to 23%

Children in Poverty
Decreased from 18.6% to 12%

Injury Deaths
Increased from 83.9 to 100/100,000

Drug overdose deaths
30.7 to 38/100,000

Primary Care Provider
Has significantly worsened 4590:1 to 6810:1

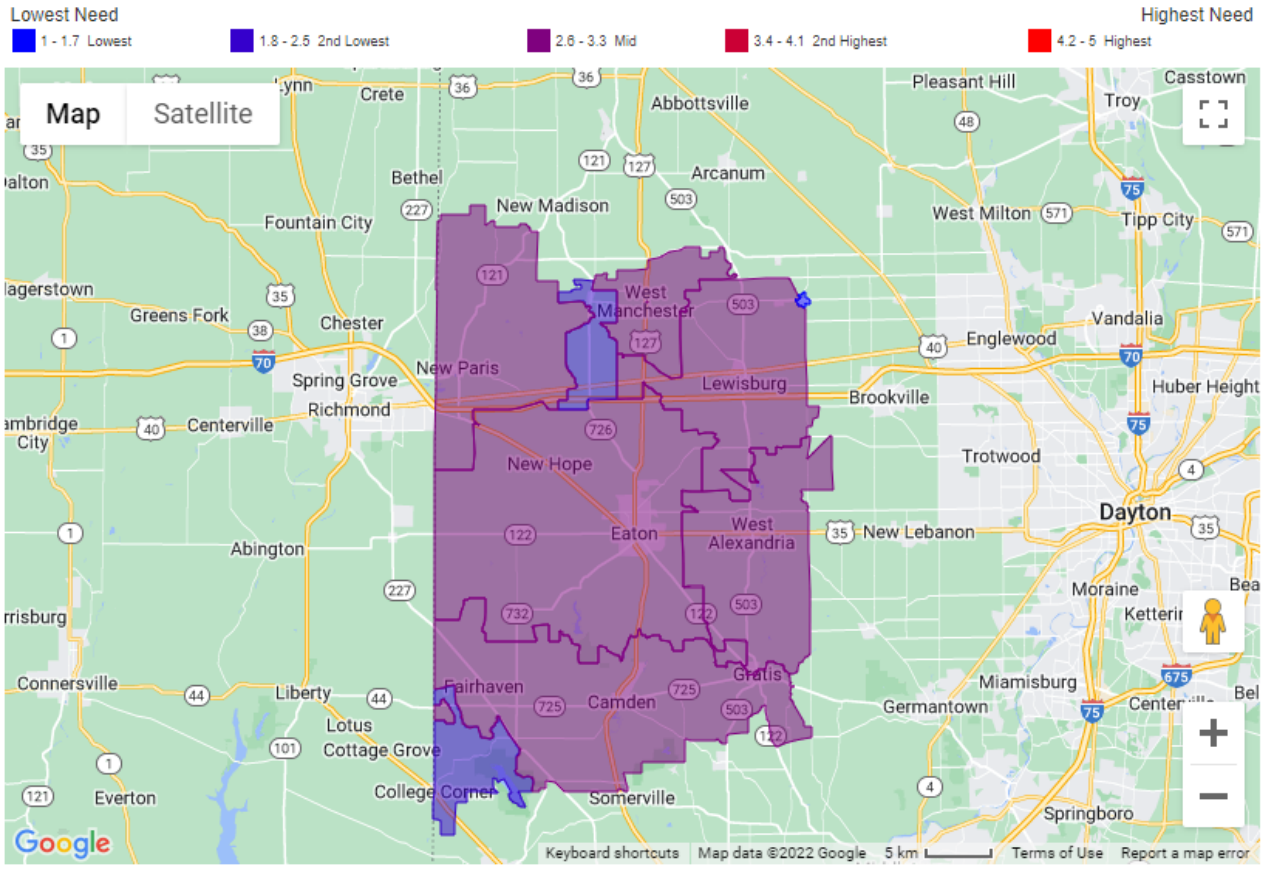
HIV Prevalence
Increased from 107 to139/100,000

This is people age 13 and over living with HIV

Mammograms Screenings
Went from 84% to 41%
Is this due to COVID

*Cancer rates based on Butler County Cancer Profile, from the Ohio Department of Health 2021 (2014-2018 data)

Community Health Index (CNI): A high score (3.4 – 5.0) is an indication for socioeconomic variation, barriers to care, and increased need for health service. None of the county's zip codes exceeds a 2.8 score. 2 zip codes in our service area increased their risk. College Corner from 2.0 to 2.2 and Eaton from 2.4 to 2.8.



Mean(zipcode): 2.5 / Mean(person): 2.7 CNI Score Median: 2.6 CNI Score Mode: 2.6

Zip Code	CNI Score	Population	City	County	State
45003	2.2	782	College Corner	Preble	Ohio
45311	2.6	6099	Camden	Preble	Ohio
45320	2.8	15795	Eaton	Preble	Ohio
45321	2.2	948	Eldorado	Preble	Ohio
45338	2.6	5130	Lewisburg	Preble	Ohio
45347	3.2	4142	New Paris	Preble	Ohio
45378	1.4	311	Verona	Preble	Ohio
45381	2.6	5628	West Alexandria	Preble	Ohio
45382	2.8	1056	West Manchester	Preble	Ohio

Appendix 4 – Participants in the May 22, 2022 MHMH's Oxford Community CHNA Meeting

Name	Affiliation	Populations Represented
Akers, Natalie	Miami University Student/ Community Member	University student population
Alishio, Kip	Psychologist/Coalition Member	All community populations – including underserved, low-income, and minority populations
Beaton, Beth	Community Member	All community populations – including underserved, low-income, and minority populations
Collins, Julian	Interact for Health*	Interact for Health is improving the health of all people in our region. We serve as a catalyst by promoting health equity through grants, education, research, policy and engagement. To amplify the impact of our work, Interact for Health focuses on three strategic priorities: reducing tobacco use, addressing the opioid epidemic and ensuring that children have access to health care through school-based health centers.
Cronk, Lynn	Community Member	All community populations
Crowder, Debbie	Talawanda School District Psychologist/Coalition Member	School aged population
Daggett, Caroline	Miami University Student/Community Member	University student population
Dana, Prue	Community Member/League of Women Voters	The League of Women Voters, a nonpartisan political organization, encourages informed and active participation in government, works to increase understanding of major public policy issues, and influences public policy through education and advocacy.
Dana, Steven	Coalition Member	All community populations– including underserved, low-income, and minority populations
Dun-Roseman, Becca	Miami University Student/Community Member	University student population
Dysart, Logan	Coalition Member/Minister	All community populations– including underserved, low-income, and minority populations
Fuehrer, Ann	Oxford Citizens for Peace and Justice/Former Topps Executive Director	Our mission is to educate and act locally to recruit and organize a citizens' movement with the sustained political power to construct a world of peace with social, economic, and environmental justice.
Jewell, Sebrina	Oxford Seniors/Coalition Member	Senior citizens

Jones, Kenzie	Miami University Student/Community Member	University student population
Keith, Beth	Miami University Rec Center/Coalition Member	University student Population
Klein, Sharon	Facilitator/Coalition Member/MHMH	All community populations
Lacy, Laura	Knolls of Oxford	Senior citizens
Large, Steve	AVP of Miami Health and Wellness/Coalition Member	University Student Affairs: student health service, student wellness (including sexual and interpersonal violence prevention and education), student counseling services and the Healthy Miami Collaborative.
Macechko, Amy	Facilitator/Coalition Member/Talawanda School District	School aged population
Marstan, Jennifer	Oxford Kiwanis President/Coalition Member	Our emphasis on serving children is paramount. Our members assist Kiwanis Service Learning Programs (SLP) K-Kids, Builders Club, Key Club, and Circle K at every school in the Talawanda District and at Miami University. We also support the local Girl Scout, Boy Scout, and Cub Scout organizations.
O'Donnell, Alivia	Miami University Student/Community Member	University student population
Race, Beth	Butler County Educational Services Center	Serve as the central educational and service resource for schools, government agencies, families, children and the community of Butler County, Ohio. Our Services Include: • Educational programs and services, professional development, and multi-faceted family services from prenatal through high school. • Leadership and support for school administration in the form of management and consultation to school districts. • Staffing service: Specially trained professional and technology support for school districts.
Ratterman, Bob	Media/Coalition Member	All community populations– including underserved, low-income, and minority populations
Ratterman, Emilie	Community Member	All community populations– including underserved, low-income, and minority populations
Robinson, Raj	Miami University Student/Community Member	University student population
Rousmaniere, Kate	Oxford Township Trustee	All community populations – including underserved, low-income, and minority populations

Sassor, Marilyn	Oxford College Corner Free Clinic	Our mission is to reach the chronically ill, especially those with congestive heart failure, diabetes, or hypertension, and those who have significant monthly medical costs. We want to enable area residents to follow their prescribed course of treatment.
Schlichter, Marcia	Community Member/Coalition Member	All community populations – including underserved, low-income, and minority populations
Schnabl, Steve	Oxford Seniors	Senior citizens
Skillings, Donna	Community Member	All community populations – including underserved, low-income, and minority populations
Tice, Tim	MHMH Chaplain, local Pastor	All community populations – including underserved, low-income, and minority populations
Wash, Tyler	MHMH Foundation	The McCullough-Hyde Memorial Hospital Foundation provides financial support for quality comprehensive medical services and programs to meet the evolving needs of our diverse community.
White, Nicole	Emergency Department Physician	All community populations – including underserved, low-income, and minority populations

*Knowledge of or expertise in public health
All required sources for community input participated.
Representatives from Butler and Preble Counties, Ohio, participated in the Regional CHNA process.
Representatives from Franklin and Union Counties, Indiana, were invited to the Regional CHNA process but did not participate.

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[iv] ibid

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[vii] National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/mental-illness

[viii] Centers for Disease Control, Arthritis Data and Statistics. https://www.cdc.gov/arthritis/data_statistics/national-statistics.html

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[xiii] American Heart Association. (2020). Cardiovascular health for LGBTQ adults. https://www.heart.org/en/about-us/diversity-inclusion/pride-with-heart/cardiovascular-health-for-lgbtq-adults

[xiv] Healthy People 2030, U.S. Department of Health and Human Services, Offices of Disease Prevention and Health Promotion. Retrieved on 2/19/20 from https://health.gov/healthypeople/objectives-and-data/social-determinants-health