HAMILTON COUNTY

Community Health Improvement Plan 2020-2023

HAMILTON COUNTY PUBLIC HEALTH

PREVENT. PROMOTE. PROTECT.

ACCREDITED HEALTH DEPARTMENT • PUBLIC HEALTH ACCREDITATION BOARD • PHAB Advancing public health performance

JULY 2020

MISSION

Hamilton County Public Health educates, serves and protects our community for a healthier future.

VISION

Healthy choices. Healthy lives. Healthy communities.

HAMILTON COUNTY PUBLIC HEALTH (HCPH)

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EXECUTIVE SUMMARY

Every three years, Hamilton County Public Health collaborates with the local hospital systems, public health agencies, and community partners in a health assessment and planning process for the purpose of improving the health, safety, and vitality for everyone in Hamilton County.

The 2020-2023 Hamilton County Public Health Community Health Improvement Plan has been created to address priority issues identified in the Community Health Needs Assessment for Hamilton County (2019), as well as alignment to the Ohio State Health Improvement Plan (2020-2022), and Hamilton County Public Health Strategic Plan (2017-2022). Goals, objectives, and strategies are outlined within this document. The purpose of this plan is to set priorities, coordinate and align resources, and establish accountability to ensure that measurable health improvements are made.

The following priority health issues will be addressed as part of the community health improvement plan in order to impact the priority health outcomes of obesity, heart disease, infant mortality, pre-term births, low birth-weight births, overdose deaths, sexually transmitted infections, and other infectious diseases:

- Chronic Disease and Obesity
- Maternal, Infant, and Child Health
- Mental Health and Addiction
- HIV and Sexually Transmitted Infections
- Oral Health

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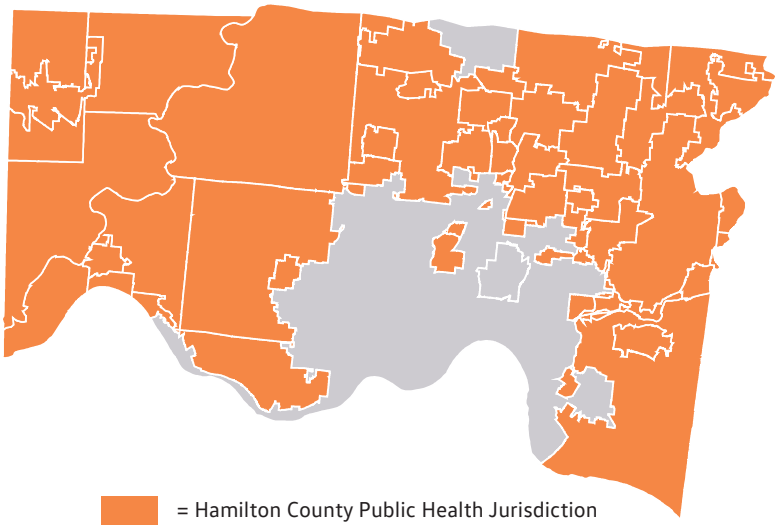
BACKGROUND

Hamilton County Public Health is a local health department in Southwest Ohio that was established in 1919. HCPH serves more than 475,000 people living outside of the cities of Cincinnati, Norwood, and Springdale, shown in Figure 1. Through its 100 member team, it addresses the well-being of Hamilton County residents through a community-focused approach, the monitoring of health and disease trends, health care coordination, inspections, education, and by helping communities to cope with disease prevention and emergencies. In March 2017, Hamilton County Public Health was the first health department in Southwest Ohio to become a nationally accredited health department by the Public Health Accreditation Board.

Figure 1: Hamilton County Public Health Jurisdictions



	Hamilton County Public Health Jurisdictions	Hamilton County	Ohio
Per Capita Income	$12,803 - $116,558	$34,125	$30,304
Poverty	1.7% - 48.4%	16.2%	14.5%
Child Poverty	0% - 63.6%	23.6%	20.8%
Educational Attainment			
Less than High School Graduate	0.5% - 23.9%	9.0%	9.9%
High School Graduate (Or Equivalent)	1.6% - 53.2%	26.4%	33.3%
Bachelor's Degree or Higher	4.5% - 88.2%	37.1%	27.8%
Uninsured	0.9% - 18.2%	8.1%	9.0%
Unemployed	1.6% - 24.6%	8.0%	7.0%
Average Life Expectancy	52-86 Years	76 Years	76 Years

Sources: 2014-2018 American Community Survey 5-Year Estimates; Ohio Department of Health Bureau of Vital Statistics 2014-2018 Mortality Data Sets

The demographics of the communities served by Hamilton County Public Health are varied. Populations range from small villages with 745 residents to large townships with over 50,000 residents. More importantly, there are wide-ranging difference in health indicators, as shown in Table 1. Place Matters. Health is influenced not only by the choices we make, but also by where we live, learn, work and play. This understanding informed the approach used by Hamilton County Public Health as it developed the Community Health Improvement Plan.

PUBLIC HEALTH ACCREDITATION BOARD STANDARDS AND REQUIREMENTS

The 2020-2023 HCPH Community Health Improvement Plan was developed through a process that meets all Public Health Accreditation Board (PHAB) Standards for public health department accreditation and reaccreditation.

Standard 5.2: Conduct a comprehensive planning process resulting in a community health improvement plan

Requirements:

- Community priorities for action.
- The desired measurable outcomes or indicators of the health improvement effort and priorities for action.
- Consideration of addressing social determinants of health, causes of higher health risks, and poorer health outcomes, and health inequities.
- Plans for policy and systems-level changes needed to alleviate the identified causes of health inequity. Policy changes may address social and economic conditions that influence health equity including housing, transportation, education, job availability, neighborhood safety, access to recreational opportunities, and zoning.
- Designation of individuals and organizations that have accepted responsibility for implementing strategies outlined in the community health improvement plan.
- Consideration of national and state health improvement priorities.

COMMUNITY HEALTH IMPROVEMENT PLAN TIMELINE

AUGUST 2019 - DECEMBER 2019

Several plans and data sources were carefully reviewed to help with determining the five priority health focus areas including:

- 2017-2022 Hamilton County Public Health Strategic Plan
- Ohio 2020-2022 State Health Improvement Plan Framework
- Community Health Needs Assessment (2019) for Hamilton County
- Primary and secondary data sources (i.e. vital statistics, surveys)

SEPTEMBER 2019 - DECEMBER 2019

An assessment of agency programs and services was conducted to determine internal assets and opportunities relating to the five priority health focus areas. Information collected included:

- Division and/or program name
- Brief description of the strategy
- Performance metrics and data collected
- Cross-cutting community conditions addressed by the strategy
- How the strategy is funded
- Primary staff contact

JANUARY 2020 - MARCH 2020

Sub-committees were formed around the five priority health focus areas to develop goals, objectives, and strategies that align with the Ohio State Health Improvement Plan Framework, Hamilton County Public Health Strategic Plan, and various health initiatives. Feedback received from partner agencies was incorporated into the CHIP.

MARCH 2020 - JUNE 2020

CHIP goals, objectives, and strategies were presented to the following groups for approval:

- Community Health Improvement Plan Workgroup - 3/30/2020
- Performance Management Council - 4/28/2020
- Hamilton County Public Health Board of Health - 5/11/2020
- Public Health Advisory Council - 6/19/2020

JULY 2020

Implementation of the 2020-2023 CHIP began.

COMMUNITY HEALTH NEEDS ASSESSMENT

As part of the Patient Protection and Affordable Care Act (2010), non-profit hospitals were required to file a community health needs assessment (CHNA) with the Internal Revenue Service every three years to determine how best to distribute community benefit dollars and meet the needs of the communities they serve. Additionally, Ohio Revised Code (ORC) 3701.981 (2016) enacted by the 131st General Assembly requires each board of health and tax-exempt hospital in Ohio to complete assessments and plans on a three-year interval beginning January 1, 2020. While the ORC did not require alignment of efforts until 2020, local hospitals in the Greater Cincinnati Area joined Hamilton County Public Health and other local health departments and community-serving organizations to identify the region's most pressing health needs beginning in 2012. This coordinated approach to the CHNA provided efficient collection of county-level health data and leveraged resources as hospital systems and health departments consider the needs of the communities they serve.

Collaboration further expanded to include the Greater Dayton Area Hospital Association and local health departments with the 2019 CHNA, providing a more robust portrait of the Southwest Ohio region's health status. Among the priorities identified for Hamilton County were:

- Chronic Disease & Obesity
- Substance Abuse & Addiction
- Infant Mortality
- Sexually Transmitted Infections & HIV
- Access to Care

As a supplement to the CHNA, Hamilton County Public Health continued to monitor and review data related to the community conditions that drive health inequities in Hamilton County. Among the indicators were:

- Population Characteristics
- Poverty
- Educational Attainment
- Unemployment Status
- Uninsured Status
- Concentrated Disadvantage
- Racial Residential Segregation
- Life Expectancy

To further drill down data to the local level, community-specific community health assessments (CHAs) continue to be developed through the agency's WeTHRIVE![SM] initiative and presented to communities that are made up of various data points that address:

- Social & Community Context
- Educational Attainment
- Economic Stability
- Neighborhood & Build Environment
- Health Care
- Health Outcomes

A community environmental asset and opportunity audit is conducted to highlight existing strengths, as well as areas for potential intervention. Community input is crucial to the assessment process. A one-question survey is administered through multiple mediums to gather an understanding of what the community sees as the biggest obstacles to creating a healthy community. The survey asks: "In your opinion, what are the most important issues that affect the health, safety, and well-being of the community?" All data is compiled an analyzed. Recommendations are made based on findings and linked back to evidence-based and culturally appropriate strategies to address the areas identified for improvement.

PRIORITY AREA ALIGNMENT

In addition to the Community Health Needs Assessment, Hamilton County Public Health's Community Health Improvement Plan is aligned to the Ohio State Health Improvement Plan and the Hamilton County Public Health Strategic Plan.

STATE HEALTH IMPROVEMENT PLAN

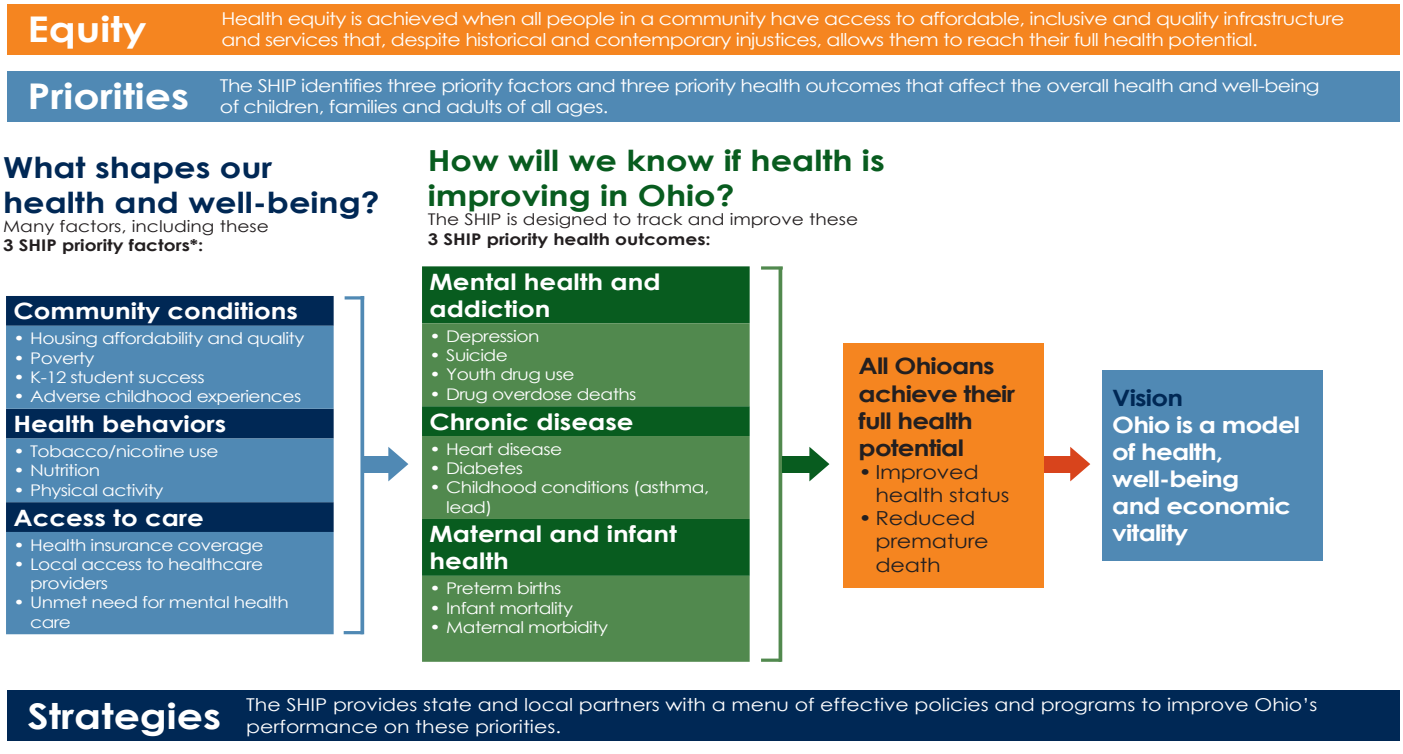
The State of Ohio released its 2020-2022 State Health Improvement Plan (SHIP) in April 2020. The SHIP drives a more efficient and effective allocation of resources towards measurable improvements on overall health and well-being by focusing on three priority health areas and three priority factors that impact health.

The three priority health areas include:

- Mental health and addiction: Includes depression, suicide, youth drug use, and drug overdose deaths.
- Chronic disease: Includes conditions such as diabetes, heart disease, childhood conditions (such as asthma, lead).
- Maternal and infant health: Includes pre-term birth, infant mortality, and maternal morbidity.

The three priority factors that impact health include:

- Community conditions (e.g. housing affordabilty and quality, adverse childhood experiences)
- Health behaviors (e.g. tobacco/nicotine use, nutrition, physical activity)
- Access to care (e.g. health insurance coverage, local access to healthcare providers, unmet need for mental health care)



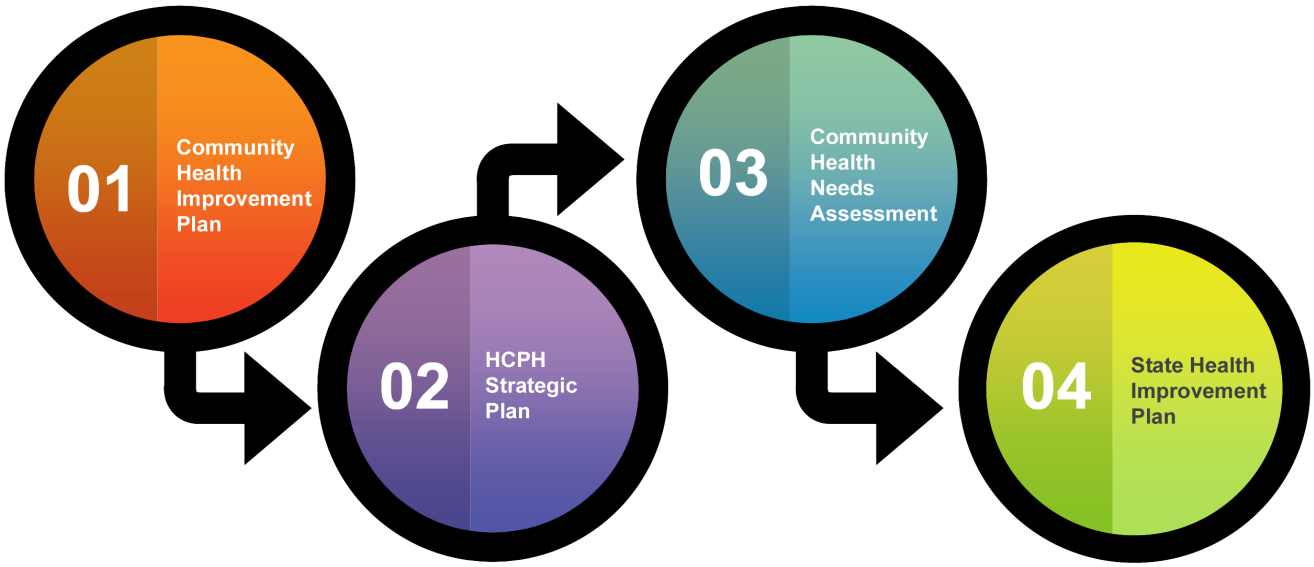
* These factors are sometimes referred to as the social determinants of health or the social drivers of health

HAMILTON COUNTY PUBLIC HEALTH STRATEGIC PLAN

In 2016, Hamilton County Public Health engaged the Board of Health, management, staff, and community stakeholders in a strategic planning process to address internal and external issues and influences on the ability to provide quality programs and service delivery to address health outcomes for citizens and communities within Hamilton County Public Health's service area over the next five years.

The 2017-2022 Hamilton County Public Health Strategic Plan identified the following priorities:

- Mental health
- Substance abuse
- Obesity
- Dental health
- Administration (workforce development, work space, IT, communication, funding)
- Accreditation



01 COMMUNITY HEALTH IMPROVEMENT PLAN

Chronic Disease & Obesity
Maternal, Infant, & Child Health
Mental Health & Addiction
HIV & Sexually Transmitted Infections
Oral Health

02 HCPH STRATEGIC PLAN

Obesity
Mental Health
Substance Abuse
Oral Health

03 COMMUNITY HEALTH NEEDS ASSESSMENT

Chronic Disease
Maternal, Infant, & Child Health
Mental Health & Addiction
HIV & Sexually Transmitted Infections

04 STATE HEALTH IMPROVEMENT PLAN

Mental Health & Addiction
Chronic Disease
Maternal & Infant Health

COMMUNITY CONDITIONS THAT IMPACT HEALTH

One of the fundamental principles of public health is that all people have a right to good health. Differences in health status - often called health inequities - are differences that are avoidable and oftentimes unfair. These inequities are, in large part, driven by determinants such as social, economic, and environmental conditions. Hamilton County Public Health recognizes that there are many cross-cutting community conditions that impact health status and drive unsustainable health care spending that will be considered throughout implementation of the Community Health Improvement Plan. These community conditions are:

- Educational attainment
- Access to health care and social services
- Economic vitality
- Housing affordability and quality
- Transportation
- Violence-free communities
- Environmental quality
- Social connectedness
- Neighborhood and built environment

EDUCATIONAL ATTAINMENT

Educational attainment refers to the highest level of education that an individual has completed. Education attainment has an influence on the health of an individual. Higher educational attainment, such as a bachelor's degree or higher, is often associated with better health. Increasing the educational attainment of an individual can have lasting impacts on the health of an individual over the course of his or her lifetime.

ACCESS TO HEALTH CARE AND SOCIAL SERVICES

Access to comprehensive, quality health care and social services is important for the achievement of health equity and increasing the quality of life for everyone. Quality is the degree to which health services for people increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

ECONOMIC VITALITY

Economic vitality refers to the state of being economically strong and active; which can refer to individuals, communities, cultural groups, society, etc. Factors such as employment status, housing stability, income, and food security play a role in economic vitality.

HOUSING AFFORDABILITY AND QUALITY

This refers to housing which is deemed affordable to show with a medium income as rated by county, state, region, or municipality by a recognized Housing Affordability Index. Families who pay more than 30 percent of their income for housing are considered cost burdened and may have difficulty affording necessities such as food, clothing, transportation, and medical care.

TRANSPORTATION

Transportation is a basic but necessary step for ongoing health care and medication access, especially among individuals with chronic diseases. Transportation barriers lead to rescheduled or missed appointments, delayed care, and missed or delayed medication use, which may lead to poorer management of chronic illness and poorer health outcomes.

VIOLENCE-FREE COMMUNITIES

Violence in our homes, schools, communities, and the media is unacceptable and preventable. Successful violence prevention requires the strengthening of factors that protect and support individuals, families, and communities and reduce risk factors that threaten their well-being.

ENVIRONMENTAL QUALITY

Polluted air, contaminated water, and extreme heat are three environmental conditions that can negatively impact population health. Identifying how environmental exposures vary by population and geographic location can improve our understanding of health disparities.

SOCIAL CONNECTEDNESS

Social connectedness improves physical health and mental and emotional well-being. Research indicates that lack of social connectedness contributes to disease and death beyond traditional risk factors such as smoking, blood pressure, and physical activity. Factors such as civic participation, discrimination, racism, incarceration, and community pride can impact a person's level of social connectedness.

NEIGHBORHOOD AND BUILT ENVIRONMENT

The built environment is the man-made space where people live, work and play on a day-to-day basis, which includes buildings and spaces that are created and modified. The way a community is built can affect the health of its residents. It can improve access to foods that support healthy eating; build sidewalks to support active living; and provide public transportation to support improved access to health care and social services.

GOALS, OBJECTIVES, AND STRATEGIES

The goals, objectives, and strategies to address the identified priority health focus areas are outlined in this section. Each of the priority health focus areas has at a minimum one goal and one objective with several accompanying strategies. Goals in this plan reflect what we intend to happen as a result of our collaborative efforts. The objectives are more specific, measurable, easy to put into action, and have a three-year time frame to complete. The strategies outline the actions we will take to achieve our goals and objectives. The ways in which the strategies are carried out may vary by community and/or priority population based on need and cultural appropriateness.

SUMMARY OF GOALS

PRIORITY AREA 1: Chronic Disease and Obesity

GOAL 1: More people in Hamilton County will have access to healthy foods and safe opportunities for physical activity.

GOAL 2: Fewer people in Hamilton County will report using tobacco products.

PRIORITY AREA 2: Maternal, Infant, and Child Health

GOAL 1: More babies in Hamilton County will celebrate their first birthday.

PRIORITY AREA 3: Mental Health and Addiction

GOAL 1: Fewer Hamilton County residents will die of opiate-related overdose deaths.

GOAL 2: Fewer people who inject drugs will contract an infectious disease in Hamilton County.

PRIORITY AREA 4: HIV and Sexually Transmitted Infections

GOAL 1: Prevent HIV and Syphilis infection and related illnesses among Hamilton County residents.

PRIORITY AREA 5: Oral Health

GOAL 1: Hamilton County residents will have improved access to oral health care.

WHY IS THIS IMPORTANT?

Chronic Disease and Obesity

Chronic diseases are the leading cause of death and disability. Health behaviors, such as poor nutrition, physical inactivity, and tobacco use are linked to chronic conditions, premature death, and disability. Chronic diseases and their outcomes disproportionately impact racial and ethnic populations. Attention to improving access to quality nutrition, opportunities for physical activity, and smoke-free environments are critical steps in reducing health disparities.

Maternal, Infant, and Child Health

Infant mortality is the death of baby before his or her first birthday. It is often considered to be one of the most important indicators of the overall health and well-being of a community. Infant mortality is often associated with other factors such as maternal health, access to and quality of health care, social and economic conditions, and public health practices.

Mental Health and Addiction

Mental health disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. Additionally, substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative and significantly contribute to costly social, physical, mental, and public health problems.

HIV and Sexually Transmitted Infections

Sexually transmitted infections (STIs) are very common among people who are sexually active. Anyone who has sex is at risk, including people with Human Immunodeficiency Virus (HIV). STIs spread from person-to-person through sexual activity, including anal, vaginal, or oral sex. HIV is an STI. Other types of STIs include Syphilis, Chlamydia, and Gonorrhea. Many STIs do not have symptoms, but when left undetected and untreated they can lead to serious health consequences.

Oral Health

Oral (dental) health is essential to general health and quality of life. Some individuals do not have access to preventive programs and dental treatment options which leads to higher rates of oral diseases. A person's ability to access oral health care is associated with factors such as education level, income, race, and ethnicity.

WORK PLANS

Work plans were created for each of the five priority health focus areas. The work plans allow the tracking of activities and milestones towards the accomplishment of the goals established in the prior section. For detailed work plans, please see page xii of the Appendix.

PRIORITY AREA 1: CHRONIC DISEASE & OBESITY

Healthy Eating and Active Living	
GOAL: More people in Hamilton County will have access to healthy foods and safe opportunities for physical activity.	
Objectives	1.1 - By June 30, 2023, the Physical Activity module score of the CHANGE Tool for each priority community will increase by 5 percent. *(Baseline: To be determined during year one.)* 1.2 - By June 30, 2023, the Nutrition module score of the CHANGE Tool for each priority community will increase by 5 percent. *(Baseline: To be determined during year one.)* 1.3 - By June 30, 2023, the Chronic Disease Management module score of the CHANGE Tool for each priority community will increase by 5 percent. *(Baseline: To be determined during year one.)*
Strategies	a) Implement place-based healthy eating and active living policy, systems, and environmental change (PSEC) and PSEC-supportive strategies cross multiple sectors (communities, schools, child care) within 2 priority communities. Identify priority communities for engagement based on data. b) Conduct assessments to establish baseline policy and environment scores relating to nutrition, physical activity, and chronic disease management with priority communities, schools, and child care providers. *(CHANGE Tool, School Health Index, NAP-SACC, WellSAT 2.0, menu audits)* c) Develop action plans that include PSEC and PSEC-supportive strategies that enhance the availability and promotion of healthy eating and safe opportunities for physical activity. d) Support priority communities, schools, and child care providers with implementation of PSEC and PSEC-supportive strategies identified within the action plans. e) Promote healthy eating, active living, and chronic disease management strategies through multiple communication venues *(e.g. social media, website, educational materials, etc.)*

Tobacco-Free

GOAL: Fewer people in Hamilton County will report using tobacco products.

Objectives	2.1 - By June 30, 2023, decrease the percentage of youth who report smoking cigarettes to 2.9 percent. *(Baseline: 3.2 percent)* 2.2 - By June 30, 2023, age of first use of cigarettes among youth will increase to 14.4. *(Baseline: 13.6)* 2.3 - By June 30, 2023, decrease the percentage of youth who report vaping to 10.8 percent. *(Baseline: 12.0 percent)* 2.4 - By June 30, 2023, age of first use of e-vapor products among youth will increase to 15.2. *(Baseline: 14.5)* 2.5 - By June 30, 2023, the adult smoking rate will be reduced to 14 percent. *(Baseline: 19 percent)*
Strategies	a) Provide tobacco education (including vaping and e-cigarettes) to youth, parents, community members, and community organizations. b) Conduct tobacco sales to minor compliance checks in retail establishments located within priority communities outlined in the Tobacco Use Prevention & Cessation (TUPC) grant. c) Conduct store audits in retail establishments located within priority communities outlined in the TUPC grant. d) Implement tobacco counter-marketing campaigns within priority communities outlined in the TUPC grant focusing on access and availability of tobacco to youth; adult use related to low availability/ utilization of cessation services; exposure to secondhand smoke. e) Provide training and technical assistance to tobacco cessation providers and/or referral sources within priority communities outlined in the TUPC grant. f) Provide technical assistance to schools for adopting tobacco-free policies that meet or exceed the Ohio Department of Health's (ODH) policy standards. g) Provide technical assistance to child care providers for adopting comprehensive tobacco-free policies. h) Provide technical assistance to communities for adopting comprehensive tobacco-free policies.

PRIORITY AREA 2: MATERNAL, INFANT, & CHILD HEALTH

Infant Vitality

GOAL: More babies in Hamilton County will celebrate their first birthday.

Objectives	1.1 - By June 30, 2023, the pre-term birth rate for Hamilton County will decrease compared to the 2019 pre-term birth rate. *(Baseline: 10.8 percent)* 1.2 - By June 30, 2023, the low birth-weight birth rate for Hamilton County will decrease compared to the 2019 low birth-weight birth rate. *(Baseline: 9.8 percent)* 1.3 - By June 30, 2023, the number of infant sleep-related deaths for Hamilton County will decrease to 13. *(Baseline: 15)*
Strategies	a) Implement multiple methods of outreach to engage pregnant women in ZIP codes that experience the highest racial disparity in birth outcomes. Promote Ohio Equity Institute (OEI) navigation services through social media, events, and partner organizations. b) Identify and screen women to determine eligibility for OEI navigation services. Complete an intake to determine health care, social service, and other resource needs for pregnant women. c) Refer pregnant women to health care, social services, and other resources based on indicated needs. Provide short-term follow up to facilitate referral process, determine if referrals were accessed, and additional needs. d) Collaborate with Cradle Cincinnati's Policy Committee to advocate for, adopt, and/or implement policy or practices that impact social determinants of health and infant vitality in Hamilton County. e) Convene the Fetal & Infant Mortality Review (FIMR) and Child Fatality Review (CFR) Case Review Teams to review fetal and infant deaths and develop actionable recommendations to prevent fetal, infant, and child deaths.

PRIORITY AREA 3: MENTAL HEALTH & ADDICTION

Opiate-Related Overdose

GOAL: Fewer Hamilton County residents will die of opiate-related overdose deaths.

Objectives	1.1 - By June 30, 2023, the prescription and illicit opioid overdose death rate will decrease to 4.1 per 10,000. *(Baseline: 4.2 per 10,000)* 1.2 - By June 30, 2023, the rate of clients referred to a treatment facility from the Syringe Services Program will increase to 5.5 per 100,000. *(Baseline: 5.0 per 100,000)*
Strategies	a) Implement innovative county-wide surveillance sysetm for physical and behavioral health data related to opioid use disorders, clinical intervention, and treatment. b) Engage primary care providers to improve their use of existing prescription drug monitoring program (PDMP) data through education, training, and hospital peer review of opioid prescriptions. c) Develop and operate a data surveillance dashboard for Hamilton County that can be used as a template for other counties to improve integration of state and local prevention and response efforts. d) Create linkages to care through peer support specialist engagement at key community access points; enhanced promotion of treatment access through Findlocaltreatment.com; and conduct focus groups of individuals impacted by substance use (family, friends, individuals in recovery). e) Assist health systems and providers by refining academic detailing to better incorporate lessons learned from the opioid epidemic into their daily practices and assist with adopting protocols for opioid overdose interventions in the emergency department, including Naloxone distriubtion for at-risk patients. f) Support proactive interventions with youth with high Adverse Childhood Experiences (ACEs) through a school-based partnership to provide training. g) Empower individuals to make safer choices by building awareness of responsible use of prescription drugs and alternative pain management practices, address stigma, and provide risk-reduction messaging for illicit users and vulnerable populations. h) Review all opiate-related deaths to identify areas of opportunity for early intervention, education, and/or policy recommendations. Augment information available to the Overdose Fatality Review (OFR) Case Review Team by interviewing families of decendents. i) Implement a comprehensive Naloxone Distribution program.

People Who Inject Drugs (PWID)

GOAL: Fewer people who inject drugs will contract an infectious disease in Hamilton County.

Objectives	2.1 - By June 30, 2023, the Hepatitis C rate will not be higher than the baseline based on statistical testing. *(Baseline: 16 per 100,000)* 2.2 - By June 30, 2023, the rate of new HIV infections who are also people who inject drugs among all Hamilton County residents will not be greater than the baseline based on statistical testing. *(Baseline: 6.9 per 100,000)*
Strategies	a) Provide provisions of sterile injection equipment and disposal of potentially infectious sharps for individuals utilizing the syringe services program. b) Provide Hepatitis C and HIV testing services for individuals who are exchanging sharps. c) Refer clients to treatment, medical, or other services.

PRIORITY AREA 4: HIV & SEXUALLY TRANSMITTED INFECTIONS

HIV and Syphilis

GOAL: Prevent HIV and Syphilis infection and related illnesses among Hamilton County residents.

Objectives	1.1 - By June 30, 2023, the number of new HIV diagnoses will decrease to 1.9 per 10,000. *(Baseline: 2.3 per 10,000)* 2.2 - By June 30, 2023, the number of new Syphilis diagnoses will decrease to 3.7 per 10,000. *(Baseline: 4.1 per 10,000)*
Strategies	a) Identify persons with an HIV infection by providing risk screening, testing, rapid point-of-care, risk reduction counseling, education, and referrals to all individuals assessed and/or tested. Provide comprehensive prevention for those at-risk for HIV. b) Comprehensive prevention for People Living with HIV (PLWHA) through the provision of confidential services; partner notification and testing; education and counseling related to health risk and risk reduction; provide rapid linkage and/or established care within 30 days of HIV diagnosis; referral to providers who conduct early ART; linkage to care; re-engagement services; and provide short-term health navigations for those living with a positive HIV result. c) Comprehensive prevention for people diagnosed with a reportable sexually transmitted infection (STI) through the provision of confidential services; partner notification and testing; education and counseling related to health risk and risk reduction; same-day syphilis treatment (or start within 14 days of diagnosis); provider education; and provide short-term health navigation for those living with a positive STI result. d) Community-level interventions, such as social marketing and health promotion messaging; community engagement and mobilization activities to recruit, engage, and build capacity in priority and provider populations; condom distribution; and syringe distribution to reduce disease transmission in partnership with the syringe services program.

PRIORITY AREA 5: ORAL HEALTH

Oral Health

GOAL: More Hamilton County residents will have access to comprehensive oral health care.

Objectives	1.1 - By June 30, 2023, the number of individual dentists treating Medicaid patients will increase by 8 percent. *(Baseline: 172 dentists)* 1.2 - By June 30, 2023, oral health emergency department encounters reported by the Ohio Hospital Association will decrease by 8 percent. *(Baseline: 11,386 encounters)*
Strategies	a) Engage oral health professionals, encouraging Medicaid inclusion. Provide education regarding FQHC's and FQHC lookalikes, efforts to increase Medicaid reimbursement rates, and oral health disparities, access to care issues, emergency department (ED) over usage, and the problems arising from the Medical/Oral Health divide affecting communities, especially disparate communities and residents with special needs. b) Advocate for oral health policy change. Provide input to the Ohio Department of Medicaid to foster improved quality of care, increased access, and system accountability. Engage Medicaid Legislative Oversight Committee for state-level Medicaid Oral Health policy change to increase reimbursements, simplify credentialing, streamlined billing/payment processing, and improved efficiency for small provider oral health-Medicaid partnerships. Advocate for oral health inclusion into Medicare Advantage. c) Engage healthcare systems to introduce or expand dental residency programs; assess current status of dental FQHC's; encourage integration of oral health services into medical treatment planning, especially in Women's Services, ED's, Orthopedics, Cardiology, and Oncology. d) Develop pilot program that incorporates creativity and innovation in oral health. Research existing county initiatives (e.g. HCDC) and other innovations in dental/medical products and devices that include dentures and new technology (3-D printing) to provide affordable denture fabrication in line with Medicaid denture reimbursements. Engage all payers (Medicaid, private insurers, Medicare) to ensure reimbursements are attractive enough to alleviate ED encounters (e.g. payment at incentivized rates for safety-net clinics, FQHC's, and private dental practices. e) Support and promote: *OPTIONS, Cincy Care to Share, Give Kids a Smile, Leave No Vet Behind*. Create professional association-sponsored volunteer oral health programs for individuals with a lower income, experiencing a disability, or with limited access to oral health care services. Design promotional programs with consistent, diverse, and universally recognizable oral health messaging. Ensure all educational materials are designed to improve oral health literacy for multiple audiences.

NEXT STEPS

IMPLEMENTATION

Hamilton County Public Health, with the support of its partners, will begin implementation of strategies beginning July 1, 2020*.

PERFORMANCE MANAGEMENT

Ongoing data collection will occur throughout the duration of the Community Health Improvement Plan. The Community Health Improvement Plan Quality Improvement Workgroup, Performance Management Council, and Hamilton County Public Health Board of Health will monitor progress of all goals, objectives, and strategies on a quarterly basis. Process improvements will be identified as needed.

COMMUNICATION TO STAKEHOLDERS

A Community Health Improvement Plan progress report will be provided to the Public Health Advisory Council members on a bi-annual basis at a minimum. Additionally, the Public Health Advisory Council will meet each year to review progress and provide feedback. Progress reports will be available on the Hamilton County Public Health website (hcph.org) for stakeholders and the general public to access.

*A STATEMENT ABOUT COVID-19

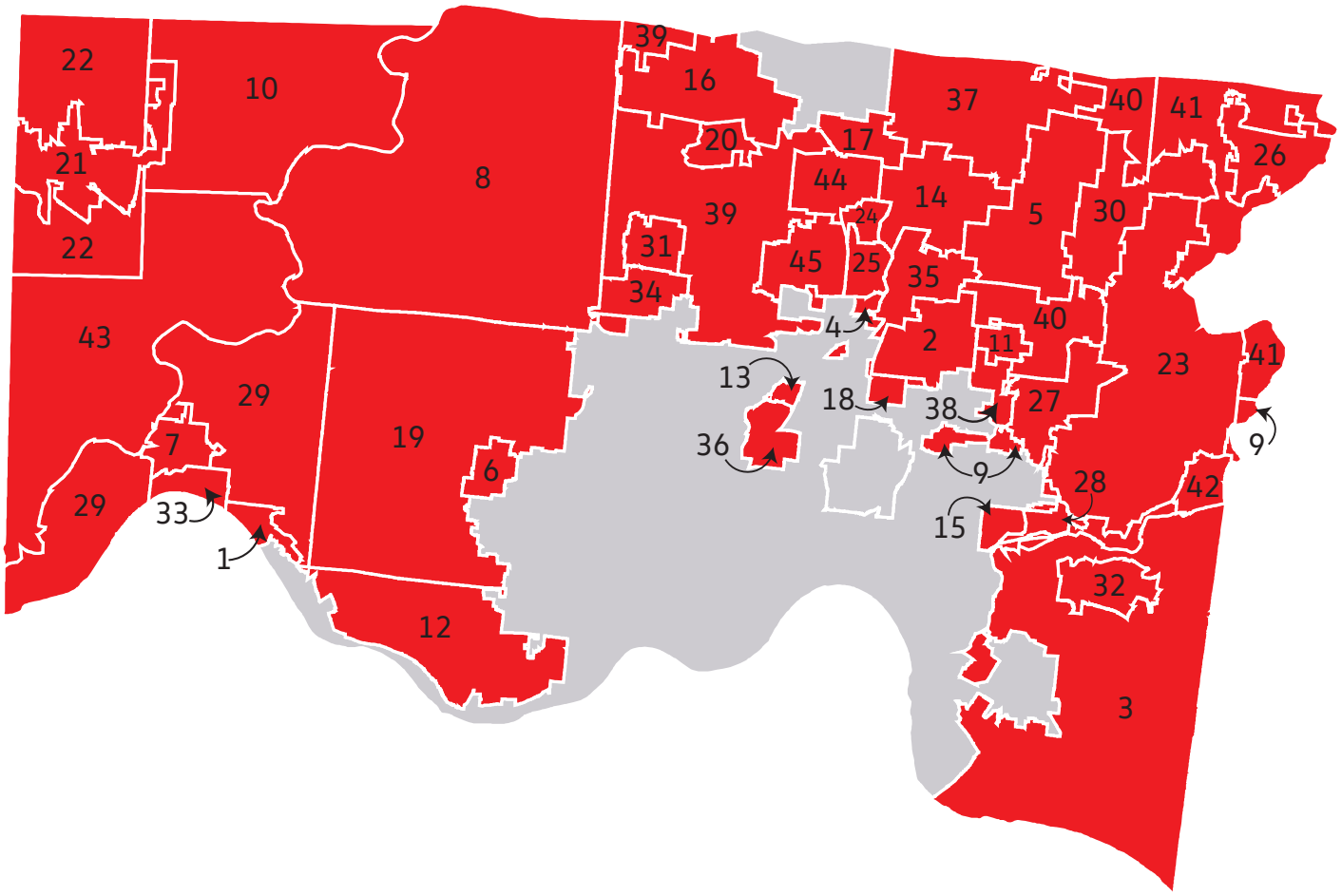
On March 9, 2020, Governor Mike DeWine signed Executive Order 2020-01D, declaring a state of emergency in Ohio to protect the well-being of residents from the dangerous effects of COVID-19. The emergency declaration, coupled with the need for public health emergency response and recovery, may delay progress over the duration of this plan. Hamilton County Public Health and its partners will make every effort to implement strategies outlined within the 2020-2023 Community Health Improvement Plan. Progress will be closely monitored to determine if priority areas and benchmarks need to shift as we work to protect Hamilton County residents during the COVID-19 pandemic.

APPENDICES

HEALTH JURISDICTIONS

WHO WE SERVE

Within Hamilton County, there are 45 communities comprised of cities, villages, and townships that Hamilton County Public Health Provides services to. Below is a map that illustrates the location of each community within Hamilton County Public Health's jurisdiction.



1. Addyston
2. Amberley Village
3. Anderson Township
4. Arlington Heights
5. Blue Ash
6. Cheviot
7. Cleves
8. Colerain Township
9. Columbia Township
10. Crosby Township
11. Deer Park
12. Delhi Township
13. Elmwood Place
14. Evendale
15. Fairfax
16. Forest Park
17. Glendale
18. Golf Manor
19. Green Township
20. Greenhills
21. Harrison
22. Harrison Township
23. Indian Hill
24. Lincoln Heights
25. Lockland
26. Loveland
27. Madeira
28. Mariemont
29. Miami Township
30. Montgomery
31. Mount Healthy
32. Newtown
33. North Bend
34. North College Hill
35. Reading
36. Saint Bernard
37. Sharonville
38. Silverton
39. Springfield Township
40. Sycamore Township
41. Symmes Township
42. Terrace Park
43. Whitewater Township
44. Woodlawn
45. Wyoming

ACRONYMS

Below is a list of acronyms used in the Community Health Improvement Plan to abbreviate commonly used words and phrases:

ACES	Adverse Childhood Experiences
CDC	Centers for Disease Control and Prevention
CFR	Child Fatality Review
CHA	Community Health Assessment
CHANGE	Community Health Assessment aNd Group Evaluation
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
ED	Emergency Department
FIMR	Fetal-Infant Mortality Review
FQHC	Federally Qualified Health Center
HCPH	Hamilton County Public Health
HIV	Human Immunodeficiency Virus
MCH	Maternal and Child Health
NAP-SACC	Nutrition and Physical Activity Self-Assessment for Child Care
OARRS	Ohio Automated Rx Reporting System
OD	Overdose
OD2A	Overdose Data to Action
ODH	Ohio Department of Health
ODOT	Ohio Department of Transportation
ODRS	Ohio Disease Reporting System
OEI	Ohio Equity Institute
OFR	Overdose Fatality Review
PHAB	Public Health Accreditation Board
PMC	Performance Management Council
PSEC	Policy, Systems, and Environmental Change
PWID	People Who Inject Drugs
QI	Quality Improvement
SDOH	Social Determinants of Health
SHI	School Health Index
SHIP	State Health Improvement Plan
SRTS	Safe Routes to School
SSP	Syringe Services Program
STI	Sexually Transmitted Infections

MEMBERSHIP

This section provides the organizational make-up of the key coalitions, committees, and stakeholders that will play a vital role in the implementation of the 2020-2023 Hamilton County Public Health Community Health Improvement Plan.

CINCINNATI-HAMILTON COUNTY COMMUNITY ACTION TEAM (CAT)

The CAT team puts into action the recommendations from the Fetal-Infant Mortality Review and Child Fatality Review to improve fetal, infant, and child health outcomes.

- Care Source
- Cincinnati Children's Hospital
- Cincinnati Health Department
- Council on Child Abuse
- Cradle Cincinnati
- Every Child Succeeds
- Hamilton County Educational Service Center
- Hamilton County Public Health
- Health Care Access Now
- Healthy Beginnings
- Interact for Health
- Lighthouse Youth Services
- March of Dimes
- Mercy Health
- Mind Peace
- Perinatal Loss & Grief
- Planned Parenthood of Southwest Ohio
- Talbert House
- The Christ Hospital
- UC Health

CRADLE CINCINNATI POLICY COMMITEE

The Cradle Cincinnati Policy Committee focuses on alleviating stress for African American women of childbearing age - such as housing, education, transportation, and employment - so as to reduce extreme pre-term birth.

- American Heart Association
- Angel Baby Network
- Bethesda Ideas Investments Innovation
- CareSource
- Cincinnati Children's Hospital
- City of Cincinnati City Council
- Community Learning Center
- Cradle Cincinnati
- Every Child Succeeds
- Hamilton County Public Health
- Health Care Access Now
- March of Dimes
- Rosemary's Babies
- Success by 6
- The Health Collaborative
- UC Health
- United Way
- University of Cincinnati

HAMILTON COUNTY ADDICTION RESPONSE COALITION (HC ARC)

The HC ARC provides county-wide leadership and solutions to address the opiate epidemic through four key focus areas of treatment, prevention and public education, harm reduction, and supply control.

- Addiction Services Council
- Anderson Township Fire Department
- Archdiocese of Cincinnati
- Beckett Springs
- Cincinnati Fire Department
- Cincinnati Health Department
- Cincinnati Police Department
- Cincinnati USA Regional Chamber
- City of Cincinnati
- Colerain Township
- Court Clinic
- GLAST
- Greater Cincinnati Behavioral Health
- Hamilton County Administration
- Hamilton County Association of Chiefs of Police
- Hamilton County Commissioners
- Hamilton County Coroner's Office
- Hamilton County Courts
- Hamilton County Fire Chief's Association
- Hamilton County Heroin Task Force
- Hamilton County Job & Family Services
- Hamilton County Mental Health & Recovery Services Board
- Hamilton County Office of Re-Entry
- Hamilton County Prosecutor's Office
- Hamilton County Public Health
- Hamilton County Sheriff
- Interact for Health
- Mental Health & Addiction Advocacy Coalition
- Mercy Health
- Office of Senator Rob Portman
- Office of Senator Sherrod Brown
- Ohio Attorney General's Office
- Omega Mentoring Youth
- PreventionFIRST!
- Springfield Township
- State Representative Brigid Kelly
- Talbert House
- The AMOS Project
- The BrightView Foundation
- The Christ Hospital
- The Health Collaborative
- UC Health
- University of Cincinnati
- Urban Minority Alcoholism & Drug Abuse Outreach Program
- Vice Mayor of Cincinnati, David Mann
- Village of Newtown Police Department

HAMILTON COUNTY CHILD FATALITY REVIEW (CFR)

The CFR team reviews all deaths occurring among residents under the age of 18 in Hamilton County in an effort to identify opportunities for early intervention, education, and/or policy changes.

- Cincinnati Children's Hospital
- Cincinnati Fire Department
- Cincinnati Health Department
- Cincinnati Police Department
- Hamilton County Coroner's Office
- Hamilton County Job & Family Services
- Hamilton County Juvenile Court
- Hamilton County Mental Health & Recovery Services Board
- Hamilton County Prosecutor's Office
- Hamilton County Public Health
- University of Cincinnati Hospital

HAMILTON COUNTY FETAL-INFANT MORTALITY REVIEW (FIMR)

The FIMR team reviews all fetal and infant deaths in Hamilton County in an effort to identify opportunities for early intervention, education, and/or policy changes.

- Cincinnati Children's Hospital
- Cincinnati Health Department
- Cradle Cincinnati
- Good Samaritan Hospital
- Hamilton County Job & Family Services
- Hamilton County Public Health
- Hamilton County Women, Infants & Children (WIC)
- Lincoln Heights Health Center
- March of Dimes
- Mercy Health
- The Alana Marie Project
- The Christ Hospital
- UC Health

HAMILTON COUNTY ORAL HEALTH COALITION

The Hamilton County Oral Health Coalition engages dental, healthcare, and other communities in addressing pressing oral health needs among Hamilton County residents.

- African American Chamber
- American Dental Association
- Bootsy Collins Foundation
- Cincinnati Dental Society
- Cincinnati Health Department
- Hamilton County Board of County Commissioners
- Hamilton County Job & Family Services
- Hamilton County Public Health
- Oral Health Ohio
- Private Dentists
- The Good Samaritan Free Health Center
- The Health Collaborative
- The Health Gap
- The Healthcare Connection
- UC Health
- United Way

HAMILTON COUNTY OVERDOSE FATALITY REVIEW (OFR)

The OFR team reviews all overdose-related deaths in Hamilton County in an effort to identify opportunities for early intervention, education, and/or policy changes.

- Addiction Services Council
- Cincinnati Fire Department
- Cincinnati Health Department
- Colerain Township Fire Department
- Delhi Township Fire Department
- Drug and Poison Information Center
- Green Township Fire Department
- Hamilton County Coroner's Office
- Hamilton County Heroin Coalition
- Hamilton County Heroin Task Force
- Hamilton County Job & Family Services
- Hamilton County Mental Health & Recovery Services Board
- Hamilton County Prosecutor's Office
- Hamilton County Public Health
- Interact for Health
- Mercy Health
- Sunrise Treatment Center
- The Health Collaborative
- UC College of Medicine

HAMILTON COUNTY PUBLIC HEALTH PERFORMANCE MANAGEMENT COUNCIL (PMC)

The PMC reviews, approves, and monitors all Quality Improvement (QI) Workgroup plans and progress. The PMC is made up of senior management and two members from each of the five QI Workgroups.

- Greg Kesterman, Chair - Health Commissioner
- Rebecca Stowe, Co-Chair - Performance Management & Grants Coordinator
- Dr. Jennifer Mooney - Assistant Health Commissioner
- Greg Varner - Finance Officer
- Whitnéy Remy - Community Health Improvement Plan QI Workgroup, *Chair*
- Mary Ellen Knaebel - Community Health Improvement Plan QI Workgroup, *QI Chair*
- Anne Arble - Customer Feedback QI Workgroup, *Chair*
- Andrea Liptak - Customer Feedback QI Workgroup, *Co-Chair*
- Kim Chelf - Health Equity QI Workgroup, *Chair*
- Denise Comeau - Health Equity QI Workgroup, *QI Chair*
- Lisa Humble - Program Implementation Plan QI Workgroup, *Chair*
- John Sherrard - Program Implementation Plan QI Workgroup
- Stephanie Taylor - Workforce Development QI Workgroup, *Chair*
- Erica Foley - Workforce Development QI Workgroup

HAMILTON COUNTY PUBLIC HEALTH PUBLIC HEALTH ADVISORY COUNCIL (PHAC)

The PHAC is a group of partner organizations that reviews, advises, and holds Hamilton County Public Health accountable for its Community Health Improvement Plan. This group also helps to align and leverage resources in an effort to maximize collective impact.

- Cincinnati Children's Hospital
- Cradle Cincinnati
- Hamilton County Administration
- Hamilton County Developmental Disabilities Services
- Hamilton County Educational Services Center
- Hamilton County Emergency Management & Homeland Security
- Hamilton County Environmental Services
- Hamilton County Job & Family Services
- Hamilton County Mental Health & Recovery Services Board
- Hamilton County Planning + Development
- Interact for Health
- Lincoln Heights Missionary Baptist Church
- Mercy Health
- Northern Kentucky Health Department
- PreventionFIRST!
- The Christ Hospital
- The Health Collaborative
- The HealthCare Connection
- TriHealth
- UC Health
- United Way of Greater Cincinnati

HARM REDUCTION STEERING COMMITTEE

The Harm Reduction Steering Committee provides support and leadership for Hamilton County Public Health's harm reduction services, including the syringe services program and Narcan distribution.

- Anderson Township Fire Department
- Butler County General Health District
- Caracole
- Cincinnati Health Department
- Clermont County Public Health
- Hamilton County Addiction Recovery Coalition
- Hamilton County Public Health
- Interact for Health
- Mercy Health
- Middletown City Health Department
- QRT National
- Talbert House
- The Health Collaborative
- UC Early Intervention Program
- UC Health

HEALTHCARE RESPONSE COMMITTEE

The Healthcare Response Committee focuses on improving coordination and collaboration among various systems in an effort to provide comprehensive healthcare and treatment for individuals with substance use disorders.

- Addiction Services Council
- BrightView
- Cincinnati Children's Hospital
- Cincinnati Health Department
- City Gospel Mission
- Clean Slate
- DeCoach
- Hamilton County Addiction Recovery Coalition
- Hamilton County Coroner's Office
- Hamilton County Job & Family Services
- Hamilton County Public Health
- Hamilton County Quick Response Team
- Joseph House
- Mercy Health
- Northern Kentucky Health Department
- PreventionFIRST!
- Sunrise Treatment Center
- Talbert House
- The Christ Hospital
- The Health Collaborative
- TriHealth
- UC Early Intervention Program
- UC Health
- Urban Minority Alcoholism & Drug Abuse Outreach Program

WeTHRIVE! IMPLEMENTATION TEAM

The WeTHRIVE! Implementation focuses on aligning local health and safety initiatives, leveraging resources and expertise, and maximizing collective impact of policy, systems, environmental change strategies within Hamilton County.

- 1N5
- American Lung Association
- Breast & Cervical Cancer Project - Premier Health
- Cancer Justice Network
- Cincinnati Children's Hospital
- Cincinnati Health Department
- Council on Aging of Southwest Ohio
- FarmChef
- Freestore Foodbank
- Greater Cincinnati Behavioral Health Services
- Greater Cincinnati Regional Food Policy Council of Green Umbrella
- Habitat for Humanity
- Hamilton Co. Department of Environmental Services
- Hamilton Co. Developmental Disabilities Services
- Hamilton Co. Educational Services Center
- Hamilton Co. Emergency Management and Homeland Security Administration
- Hamilton Co. Planning + Development
- Hamilton Co. Public Health
- Hamilton Co. Recycling and Solid Waste
- Hamilton Co. Soil and Water Conservation District
- HealthSource of Ohio
- Holistically Empowering All Teens
- Interact for Health
- LaSoupe
- Living Arrangements for the Developmentally Disabled
- Mercy Health
- MindPeace
- Mission2Move
- National Alliance on Mental Illness (NAMI) of Southwest Ohio
- Ohio State University Cooperative Extension
- Our Harvest
- People Working Cooperatively
- PreventionFIRST!
- Produce Perks Midwest
- Public Library of Cincinnati & Hamilton County
- Special Olympics Hamilton County
- Talbert House
- The Christ Hospital
- The Health Collaborative: Gen-H
- TriHealth
- UC Center for Community Engagement
- United Way Success by 6
- YMCA of Greater Cincinnati

BASELINE DATA

Baseline data was collected from the most recent finalized datasets available prior to the start of the Community Health Improvement Plan. The baseline is the rate/percent/number used to measure the improvement in the five priority health areas. Baseline data are used to create targets, or the expected outcome at the end of the Community Health Improvement Plan. The following are baseline data and targets for each of the objectives within the five health priority areas.

PRIORITY AREA 1: CHRONIC DISEASE & OBESITY

	Baseline	Target
More people in Hamilton County will have access to healthy foods and safe opportunities for physical activity.		
1.1 The Physical Activity module score of the CHANGE Tool for each priority community will increase by 5 percent	**To Be Determined**	5% increase over baseline
1.2 The Nutrition module score of the CHANGE Tool for each priority community will increase by 5 percent	**To Be Determined**	5% increase over baseline
1.3 The Chronic Disease Management module score of the CHANGE Tool for each priority community will increase by 5 percent	**To Be Determined**	5% increase over baseline

Source: CHANGE Tool Module Scores for each priority community completed during year one.

Target Setting Method(s): Projection/Trend Analysis

	Baseline	Target
Fewer people in Hamilton County will report using tobacco products.		
2.1 Decrease the percent of youth who reported smoking cigarettes	**3.2%**	2.9%
2.2 The age of first use of cigarettes among youth will increase	**13.6**	14.4
2.3 Decrease the percent of youth who reported vaping	**12.0%**	10.8%
2.4 The age of first use of e-vapor products among youth will increase	**14.5**	15.2
2.5 The adult smoking rate will be reduced	**19.0%**	14.0%

Source: Robert Wood Johnson Foundation County Health Rankings, 2017
PreventionFIRST! Student Drug Use Survey, 2018

Target Setting Method(s): ~10 percent improvement over baseline (2.1, 2.3); ~5 percent improvement over baseline (2.4); Retention of 2018 CHIP Target (2.2, 2.5)

PRIORITY AREA 2: MATERNAL, INFANT, & CHILD HEALTH

	Baseline	Target
More babies in Hamilton County will celebrate their first birthday.		
1.1 The pre-term birth rate for Hamilton County will decrease compared to the 2019 pre-term birth rate.	**10.8%**	<10.8%
1.2 The low birth-weight birth rate for Hamilton County will decrease compared to the 2019 low birth-weight birth rate.	**9.8%**	<9.8%
1.3 The number of infant sleep-related deaths for Hamilton County will decrease.	**15**	13

Source: Ohio Department of Health Secure Data Warehouse Birth Statistical File, 2019
Hamilton County Child Fatality Review, 2019

Target Setting Method(s): Projection/Trend Analysis

PRIORITY AREA 3: MENTAL HEALTH & ADDICTION

	Baseline	Target
Fewer Hamilton County residents will die of opiate-related overdose deaths.		
1.1 The prescription and illicit opioid overdose death rate will decrease.	**4.2 per 10,000**	4.1 per 10,000
1.2 The rate of clients referred to a treatment facility from the Syringe Services Program will increase.	**5.5 per 100,000**	5.0 per 100,000

Source: Ohio Department of Health Secure Data Warehouse Vital Statistics File, 2019; Hamilton County Public Health Syringe Services Program, 2019

Target Setting Method(s): 1 percent decrease (1.1); 10 percent improvement (1.2)

	Baseline	Target
Fewer People Who Inject Drugs will contract an infectious disease in Hamilton County		
2.1 The Hepatitis C incidence rate will not be higher than the baseline based on statistical testing.	**16 per 100,000**	≤16 per 100,000
2.2 The rate of new HIV infections who are also People Who Inject Drugs among all Hamilton County residents will not be higher than the baseline based on statistical testing.	**6.9 per 100,000**	≤6.9 per 100,000

Source: Ohio Department of Health Disease Reporting System, 2019; Hamilton County Communicable Disease Surveillance, 2019

Target Setting Method(s): 1 percent decrease (1.1); 10 percent improvement (1.2)

PRIORITY AREA 4: HIV & SEXUALLY TRANSMITTED INFECTIONS

	Baseline	Target
Prevent HIV and Syphilis Infection and related illness among Hamilton County Residents		
1.1 The number of new HIV diagnoses will decrease.	**2.3 per 10,000**	1.9 per 10,000
1.2 The number of new Syphilis diagnoses will decrease.	**4.1 per 10,000**	3.7 per 10,000

Source: Hamilton County Public Health Communicable Disease Surveillance System, 2019

Target Setting Method(s): 15 percent improvement (1.1); 10 percent improvement (1.2)

PRIORITY AREA 5: ORAL HEALTH

	Baseline	Target
Hamilton County residents will have improved to oral health care.		
1.1 The number of individual dentists treating Medicaid patients will increase.	**172 dentists**	185 dentists
1.2 Oral health emergency department encounters reported by the Ohio Hospital Association will decrease.	**11,386 encounters**	10,476 encounters

Source: Ohio Hospital Association Claims Data, 2018

Target Setting Method(s): Projection/Trend Analysis (~8 percent improvement)

WORK PLANS

PRIORITY AREA 1: CHRONIC DISEASE & OBESITY

Goal 1: More people in Hamilton County will have access to healthy foods and safe opportunities for physical activity.

Objectives:

1.1 - By June 30, 2023, the Physical Activity module score of the CHANGE Tool for each priority community will increase by 5 percent. *(Baseline: To be determined during year one)*

1.2 - By June 30, 2023, the Nutrition module score of the CHANGE Tool for each priority community will increase by 5 percent. *(Baseline: To be determined during year one)*

1.3 - By June 30, 2023, the Chronic Dis module score of the CHANGE Tool for each priority community will increase by 5 percent. *(Baseline: To be determined during year one)*

Strategies	Lead Agency/Staff	Partners/Resources
a) Implement place-based healthy eating and active living policy, systems, and environmental change (PSEC) and PSEC-supportive strategies across multiple sectors (communities, schools, child care) within 2 priority communities. Identify priority communities for engagement based on data.	HCPH - Health Promotion and Education (HPE) Division; Epidemiology Division	• WeTHRIVE! Implementation Team • WeTHRIVE! communities, schools, child care
b) Conduct assessments to establish baseline policy and environment scores relating to nutrition, physical activity, and chronic disease management with priority communities, schools, and child care providers. *(CHANGE Tool, School Health Index, NAP-SACC, WellSAT 2.0, menu audits)*	HCPH - HPE Division	• WeTHRIVE! Implementation Team • WeTHRIVE! communities, schools, child care
c) Develop action plans that include PSEC and PSEC-supportive strategies that enhance the availability and promotion of healthy eating and safe opportunities for physical activity. *(Gardens, menu enhancements, SNAP infrastructure/EBT acceptance, farmers' markets, healthy celebrations, Safe Routes to School, shared use agreements, sidewalk maintenance & connectivity, complete streets, etc.)*	HCPH - HPE Division	• WeTHRIVE! Implementation Team • WeTHRIVE! communities, schools, child care
d) Support priority communities, schools, and child care providers with implementation of PSEC and PSEC-supportive strategies identified within the action plans.	HCPH - HPE Division	• WeTHRIVE! Implementation Team • WeTHRIVE! communities, schools, child care
e) Promote healthy eating, active living, and chronic disease management strategies through multiple communication venues *(e.g. social media, website, educational materials)*	HCPH - HPE Division	• WeTHRIVE! Implementation Team • WeTHRIVE! communities, schools, child care

Output/Outcome Indicators:

- # of assessments completed (CHANGE Tool, School Health Index, NAP-SACC, menu audits)
- # of healthy eating and active living policies adopted (by sector)
- # of healthy eating and active living environmental change strategies implemented (by sector)
- # of healthy eating and active living PSEC-supportive strategies implemented (by sector)
- # of communication venues used
- # of posts/engagements/media impressions
- Assessment scores
- Baseline assessment scores are established by sector (community-at-large, schools, child care
- Increased access to healthy foods and safe opportunities for physical activity
- Increased awareness of healthy eating and active living strategies and resources

Monitoring/Evaluation Approach:

- CHANGE Tool Assessment - Nutrition, Physical Activity, & Chronic Disease Management modules
- School Health Index (SHI); WellSAT 2.0
- NAP-SACC; menu audits
- Photo-documentation and direct observation
- Other evaluation & surveillance tools to be determined

Goal 2: Fewer people in Hamilton County will report using tobacco products.

Objectives:

2.1 - By June 30, 2023, decrease the percentage of youth who report smoking cigarettes to 2.9. *(Baseline: 3.2 percent)*
2.2 - By June 30, 2023, the age of first use of cigarettes among youth will increase to 14.4. *(Baseline: 13.6)*
2.3 - By June 30, 2023, decrease the percentage of youth who report vaping to 10.8. *(Baseline: 12.0 percent)*
2.4 - By June 30, 2023, the age of first use of e-vapor products among youth will increase to 15.2. *(Baseline: 14.5)*
2.5 - By June 30, 2023, the adult smoking rate will be reduced to 14 percent. *(Baseline: 19 percent)*

Strategies	Lead Agency/Staff	Partners/Resources
a) Provide tobacco education (including vaping and e-cigarettes) to youth, parents, community members, and community organizations.	HCPH - HPE Division	• ODH Tobacco Prevention & Cessation grant • Hamilton County School Districts
b) Conduct tobacco sales to minor compliance checks in retail establishments located within priority communities outlined in the Tobacco Prevention & Cessation grant.	HCPH - HPE Division	• ODH Tobacco Prevention & Cessation grant • Hamilton County Sheriff's Office
c) Conduct store audits in retail establishments located within priority communities outlined in the Tobacco Prevention & Cessation grant.	HCPH - HPE Division	• ODH Tobacco Prevention & Cessation grant
d) Implement tobacco counter-marketing campaigns within priority communities outlined in the Tobacco Prevention & Cessation grant focusing on access & availability of tobacco to youth; adult use related to low availability & utilization of cessation services; and exposure to secondhand smoke.	HCPH - HPE Division; Public Information Officer	• ODH Tobacco Prevention & Cessation grant
e) Provide training and technical assistance to tobacco cessation providers and/or referral sources within priority communities outlined in the Tobacco Prevention & Cessation grant.	HCPH - HPE Division	• ODH Tobacco Prevention & Cessation grant
f) Provide technical assistance to schools for adopting tobacco-free policies that meet or exceed ODH's policy standards.	HCPH - HPE Division	• ODH Tobacco Prevention & Cessation grant • Hamilton County School Districts
g) Provide technical assistance to child care providers for adopting comprehensive tobacco-free policies.	HCPH - HPE Division	• WeTHRIVE! child care providers • Child care providers
h) Provide technical assistance to communities for adopting comprehensive tobacco-free policies.	HCPH - HPE Division	• HCPH health jurisdictions • WeTHRIVE! communities • ODH Tobacco Prevention & Cessation grant

Output/Outcome Indicators:

- # of trainings provided; # of individuals reached
- # of compliance checks completed; # of tobacco sales to minors
- # of tobacco counter-marketing campaigns implemented; # of media impressions/engagements
- # of school districts with 100 percent tobacco-free school campus policy
- # of tobacco-free policies adopted by communities
- # of tobacco-free policies adopted by child care providers
- # of tobacco cessation providers trained
- # of tobacco cessation referral sources trained
- # of peer facilitators trained
- Increased access to tobacco-free environments
- Decrease in the percent of adults who smoke
- Decrease in the percent of youth who smoke and/or vape
- Increase in tobacco cessation resources
- Increased awareness of the dangers of tobacco use, available cessation services, and youth access to tobacco

Monitoring/Evaluation Approach:

- ODH's 100 Percent Smoke-/Tobacco-Free policy scoring rubric
- CHANGE Tool Assessment - Tobacco module
- School Health Index (SHI); WellSAT 2.0
- Photo-documentation and direct observation
- PreventionFIRST! Student Drug Use Survey
- Other evaluation & surveillance tools to be determined

PRIORITY AREA 2: MATERNAL, INFANT, & CHILD HEALTH

Goal 1: More babies in Hamilton County will celebrate their first birthday.

Objectives:

1.1 - By June 30, 2023, the pre-term birth rate for Hamilton County will decrease compared to the 2019 pre-term birth rate. *(Baseline: 10.8 percent)*

1.2 - By June 30, 2023, the low birth-weight birth rate for Hamilton County will decrease compared to the 2019 low birth-weight birth rate. *(Baseline: 9.8 percent)*

1.3 - By June 30, 2023, the number of infant sleep-related deaths for Hamilton County will decrease to 13. *(Baseline: 15)*

Strategies	Lead Agency/Staff	Partners/Resources
a) Implement multiple methods of outreach to engage pregnant women in ZIP codes that experience the highest racial disparity in birth outcomes. Promote Ohio Equity Institute (OEI) navigation services through social media, events, and partner organizations.	HCPH - Maternal & Child Health (MCH) Project Coordinator, OEI Navigators, OEI Epidemiologist	• ODH Ohio Equity Institute 2.0 grant • Other partners & resources to be identified
b) Identify and screen women to determine eligibility for OEI navigation services. Complete an intake to determine health care, social service, and other resource needs for pregnant women and their families.	HCPH - MCH Project Coordinator, OEI Navigators, OEI Epidemiologist	• ODH Ohio Equity Institute 2.0 grant • UC Health • Other partners & resources to be identified
c) Refer pregnant women to health care, social services, and other resources based on indicated needs. Provide short-term follow up to facilitate referral process, determine if referrals were accessed, and additional needs.	HCPH - MCH Project Coordinator, OEI Navigators, OEI Epidemiologist	• ODH Ohio Equity Institute 2.0 grant • UC Health • Other partners & resources to be identified
d) Collaborate with Cradle Cincinnati's Policy Committee to advocate for, adopt, and/or implement policy or practices that impact social determinants of health and infant vitality in Hamilton County.	HCPH - MCH Project Coordinator, OEI Navigators, OEI Epidemiologist	• Cradle Cincinnati Policy Committee
e) Convene the Fetal & Infant Mortality Review (FIMR) and Child Fatality Review (CFR) Case Review Teams to review fetal and infant deaths and develop actionable recommendations to prevent fetal, infant, and child deaths.	HCPH - FIMR/CFR Coordinator, FIMR Maternal Interviewers, Public Health Nurse	• ODH Ohio Equity Institute 2.0 grant • Cincinnati Children's Perinatal Institute • FIMR and CFR Case Review Teams • Cincinnati-Hamilton County Community Action Team

Output/Outcome Indicators:

- # of outreach methods used; # of hours spent on outreach
- # of individuals reached through outreach methods
- # of events held; # of participants
- # of eligible women identified; # of ineligible women identified
- # of completed screenings
- # of referrals offered (by type); % of referrals utilized
- # of policies or practices identified by the Policy Committee
- # of policies or practices adopted as a result of advocacy efforts of the Policy Committee
- # of fetal and infant deaths reviewed by FIMR
- # of sleep-related deaths reviewed by CFR
- # of recommendations presented to the Hamilton County-Cincinnati Community Action Team
- ZIP codes with the highest racial disparity in birth outcomes are prioritized for outreach
- Established partnerships to improve efficiency and effectiveness in identification of pregnant women
- Increased awareness of OEI navigation services
- Pregnant women a greatest risk for a poor birth outcome are connected to needed services and resources
- Increased access to health care, social services, and other identified needs
- Improved understanding of the social determinants of health that impact pregnant women in Hamilton County
- Identification of recurring contributing factors and/or protective factors related to fetal, infant, and/or child loss events
- Development of actionable recommendations to promote reduction of fetal, infant, and child deaths

Monitoring/Evaluation Approach:

- REDCap - screening and recruitment source data (OEI)
- Intake Status Tracker (OEI)
- Time Management System Report (OEI)
- Maternal Survey and Maternal Interviews (FIMR)
- Vital Statistics (Birth/Death Records)
- Case Review Data (FIMR/CFR)
- Annual Reporting

Goal 1: Fewer Hamilton County residents will die of opiate-related overdose deaths,

Objectives:

1.1 - By June 30, 2023, the prescription and illicit opioid overdose death rate will decrease to 4.1 per 10,000. *(Baseline: 4.2 per 10,000)*

1.2 - By June 30, 2023, the rate of clients referred to a treatment facility from the Syringe Services Program will increase to 5.5 per 100,000. *(Baseline: 5.0 per 100,000)*

Strategies	Lead Agency/Staff	Partners/Resources
a) Implement innovative county-wide surveillance system for physical and behavioral health data related to opioid use disorders, clinical intervention, and treatment	HCPH - Medical Director for Addiction Services, Community Coord., Epidemiology Division	• Centers for Disease Control (CDC) Overdose Data to Action (OD2A) grant • Systems Integration Collaborative • Syringe Services Program
b) Engage primary care providers to improve their use of existing prescription drug monitoring program (PDMP) data through education, training, and hospital peer review.	HCPH - Sr. Health Counselor	• CDC OD2A grant • Ohio Board of Pharmacy
c) Develop and operate a data surveillance dashboard for Hamilton County that can be used as a template for other counties to improve integration of state and local prevention and response efforts.	HCPH - Epidemiology Division, Sr. Community Coordinator, Medical Director for Addiction Services	• CDC OD2A grant-funded entities in Ohio - ODH, Cuyahoga County, and Franklin County • Quick Response Teams • Systems Integration Collaborative
d) Create linkages to care through peer support specialist engagement at key community access points; enhanced promotion of treatment access through FindLocalTreatment.com; and conduct focus groups of individuals impacted by substance use (family, friends, individuals in recovery).	HCPH - Harm Reduction Director, Sr. Health Counselor, Epidemiology Director, Community Coordinator	• Ohio Department of Mental Health and Addiction Services • HCPH Customer Service and IT staff • Vesta • Cincinnati Health Department • FindLocalTreatment.com
e) Assist health systems and providers by refining academic detailing to better incorporate lessons learned from the opioid epidemic into daily practice and assist with adopting protocols for opioid overdose interventions in the emergency department, including Naloxone distribution for at-risk patients.	HCPH - Harm Reduction Director, Sr. Health Counselor, Medical Director for Addiction Services	• CDC OD2A grant • Healthcare Response Committee • Hospital systems
f) Support proactive interventions with youth with high Adverse Childhood Experiences (ACEs) through a school-based partnership to provide training.	HCPH - Harm Reduction Director, Community Coordinator	• CDC OD2A grant • Opioid/ACEs Narrative Shift grant • Hamilton County Educational Service Center • Police and First Responders • Local school districts
g) Empower individuals to make safe choices by building awareness of responsible use of prescription drugs and alternative pain management practices, address stigma, and provide risk-reduction messaging for illicit users and vulnerable populations.	HCPH - Community Coordinator, Harm Reduction Specialist, Epidemiologist	• CDC OD2A grant • ODH's Take Charge Ohio campaign • Syringe Services Program
h) Review all opiate-related deaths to identify areas of opportunity for early intervention, education, and/or policy recommendations. Augment information available to the Overdose Fatality Review (OFR) Case Review Team by interviewing families of decedents.	HCPH Sr. Health Counselor, Harm Reduction Director	• Hamilton County Coroner's Office • OFR Case Review Team • CDC OD2A grant
i) Implement a comprehensive Naloxone Distribution program.	HCPH - Harm Reduction Director, Sr. Community Coordinator, Epidemiologist	• ODH Integrated Naloxone Access and Infrastructure grant • Syringe Services Program • Hamilton County Sheriff's Office

Output/Outcome Indicators:

- # of organizations participating in system coordination pilot projects
- # of organizations providing data; # of organizations utilizing data
- # of hospitals with Quality Improvement (QI) Peer Review process
- # of trainings with primary care physicians regarding prescriptions drug prescribing practices
- Data surveillance dashboard developed; # of dashboard views
- # of contacts with FindLocalTreatment.com
- # of referrals made; # of referrals completed
- # of families who have experienced a loss engaged
- # of Academic Detailing Education of providers
- # of emergency departments with post-overdose protocol
- # of youth served by ACEs/trauma intervention
- # of people reporting increased awareness of responsible prescription drug use and alternative pain management practices
- # of Naloxone kits distributed
- # of policies, procedures, and/or protocols developed for Naloxone distribution
- # of Naloxone access points per geographic area
- Decrease in opioid prescribing rates
- Increase in referrals for evidence-based treatment
- Increase in completion of evidence-based treatment
- Increase in treatment referrals post-overdose
- Decrease in opioid use among youth
- Increased awareness of responsible prescription drug use and alternative pain management practices
- Decrease stigma for seeking addiction services

Monitoring/Evaluation Approach:

- REDCap
- Ohio Automated Rx Reporting System (OARRS)
- EpiCenter Surveillance Tool
- Use of emergency services (i.e. 911 dispatch data)

Goal 2: Fewer People Who Inject Drugs will contract an infectious disease in Hamilton County.

Objectives:

1.1 - By June 30, 2023, the Hepatitis C incidence rate will not be higher than the baseline based on statistical testing. *(Baseline: 16 per 100,000)*

1.2 - By June 30, 2023, the rate of new HIV infections who are also People Who Inject Drugs among all Hamilton County residents will not be greater than the baseline based on statistical testing. *(Baseline: 6.9 per 100,000)*

Strategies	Lead Agency/Staff	Partners/Resources
a) Provide provisions of sterile injection equipment and disposal of potentially infectious sharps for individuals utilizing the syringe services program.	HCPH - Harm Reduction Division, Syringe Services Program Staff	• ODH HIV grant • Caracole • University of Cincinnati (UC) Early Intervention Program team • Interact for Health • Harm Reduction Steering Committee
b) Provide Hepatitis C and HIV testing services for individuals who are exchanging sharps.	HCPH - Harm Reduction Program, Syringe Services Program Staff	• ODH HIV grant • Caracole • UC Early Intervention Program team • Interact for Health • Harm Reduction Steering Committee
c) Refer clients to treatment, medical, or other services	HCPH - Harm Reduction Program, Syringe Services Program Staff	• ODH HIV grant • Caracole • UC Early Intervention Program team • Interact for Health • Harm Reduction Steering Committee

Output/Outcome Indicators:

- # of clients
- # of new clients
- # of syringes exchanged
- # of Naloxone kits distributed
- # of Hepatitis C tests administered
- # of HIV tests administered
- # of pregnancy tests distributed
- # of treatment referrals
- # of medical referrals
- # of other referrals
- Decreased HIV incidence rate among People Who Inject Drugs (PWID)
- Decreased Hepatitis C rate among PWID

Monitoring/Evaluation Approach:

- Ohio Disease Reporting System (ODRS) HIV and Hepatitis C data
- REDCap - Syringe Services Program data
- Output indicator tracking

PRIORITY AREA 4: HIV & SEXUALLY TRANSMITTED INFECTIONS

Goal 1: Prevent HIV and Syphilis infection and related illness among Hamilton County residents.

Objectives:

1.1 - By June 30, 2023, the number of new HIV diagnoses will decrease to 1.9 per 10,000. *(Baseline: 2.3 per 10,000)*
1.2 - By June 30, 2023, the number of new Syphilis diagnoses will decrease 3.7 per 10,000. *(Baseline: 4.1 per 10,000)*

Strategies	Lead Agency/Staff	Partners/Resources
a) Identify persons with an HIV infection by providing risk screening, testing, rapid point-of-care, risk reduction counseling, education, and referrals to all individuals assessed and/or tested. Provide comprehensive prevention for those at-risk for HIV.	HCPH - HIV/STI Coordinator, Disease Investigation Specialists (DIS)/ Linkage to Care (LTC), HIV Tester	• ODH HIV and STI grants • University of Cincinnati (UC) Early Intervention Program • Local infectious disease centers: TriHealth, UC, Mercy, Christ Hospital, IV Charis, MATEC, Planned Parenthood of Southwest Ohio (PPSWO), Caracole
b) Comprehensive prevention for People Living with HIV (PLWHA) through the provision of confidential services; partner notification and testing; education and counseling related to health risk and risk reduction; provide rapid linkage and/or established care within 30 days of HIV diagnosis; referral to providers who conduct early ART; linkage to care; re-engagement services; and provide short-term health navigation for those living with a positive HIV result.	HCPH - HIV/STI Coordinator, DIS/LTC, HIV Tester	• ODH HIV and STI grants • UC Early Intervention Program • Local infectious disease centers: TriHealth, UC, Mercy, Christ Hospital, IV Charis, MATEC, PPSWO, Caracole • Infectious disease physicians from UC, TriHealth, and Mercy
c) Comprehensive prevention for people diagnosed with a reportable sexually transmitted infection (STI) through the provision of confidential services; partner notification and testing; education and counseling related to health risk and risk reduction; same-day syphilis treatment (or start treatment within 14 days of diagnosis); provider education; and provide short-term health navigation for those living with a positive STI result.	HCPH - HIV/STI Coordinator, DIS	• ODH HIV and STI grants • UC Early Intervention Program • Local infectious disease centers: TriHealth, UC, Mercy, Christ Hospital, IV Charis, MATEC, PPSWO, Caracole
d) Community-level interventions, such as social marketing and health promotion messaging; community engagement and mobilization activities to recruit, engage, and build capacity in priority and provider populations; condom distribution; and syringe distribution to reduce disease transmission in partnership with the syringe services program.	HCPH - HIV/STI Coordinator, DIS/LTC, HIV Tester, Public Information Officer	• ODH HIV and STI grants • UC Early Intervention Program • Local infectious disease centers: TriHealth, UC, Mercy, Christ Hospital, IV Charis, MATEC, PPSWO, Caracole • HCPH Harm Reduction Division/Syringe Services Program

Output/Outcome Indicators:

- # of individuals screened
- # of individuals tested
- # of testing sites
- # of referrals to treatment
- # of clients utilizing harm reduction services
- # of harm reduction supplies dispensed
- % of individuals identified as HIV+
- # of individuals engaged/re-engaged in care
- # of PLWHA engaged in HIV case management
- % of contacts notified of potential exposure
- % of notified HIV partners that are tested
- % of early syphilis contacts treated within 30 days
- # of provider trainings conducted
- # of condoms distributed
- # of condom distribution locations
- # of community outreach events
- # of social marketing campaigns, media impressions, and engagements
- Increased availability of testing in priority populations
- Improved STI awareness
- Decreased community viral load
- Decreased disease transmission among needle-sharing and sexual partners

Monitoring/Evaluation Approach:

- Ohio Disease Reporting System (ODRS) performance measures
- eHARS data
- HIV Quarterly Surveillance Report
- Syphilis Quarterly Surveillance Report

PRIORITY AREA 5: ORAL HEALTH

Goal 1: Hamilton County residents will have improved access to oral health.

Objectives:

1.1 - By June 30, 2023, the number of individual dentists treatment Medicaid patients will increase by 8 percent. *(Baseline: 172 dentists)*

1.2 - By June 30, 2023, oral health emergency department encounters reported by the Ohio Hospital Association will decrease by 8 percent. *(Baseline: 11,386 encounters)*

Strategies	Lead Agency/Staff	Partners/Resources
a) Engage oral health professionals, encouraging Medicaid inclusion. Provide education regarding FQHC's and FQHC lookalikes, efforts to increase Medicaid reimbursement rates, and oral health disparities, access to care issues, emergency department (ED) over usage, and the problems arising from the Medical/Oral Health divide affecting communities, especially disparate communities and residents with special needs.	Oral Health Coalition, Oral Health Coalition Director, HCPH, Board of County Commissioners	• Oral Health Professionals • Oral Health Ohio • The Health Collaborative • Cincinnati Dental Society (CDS), Ohio Dental Association (ODA), American Dental Association (ADA) • Oral Health Institutions of Graduate Ed. • Dental Residency Participants
b) Advocate for oral health policy change. Provide input to the Ohio Department of Medicaid to foster improved quality of care, increased access, and system accountability. Engage Medicaid Legislative Oversight Committee for state-level Medicaid Oral Health policy change to increase reimbursements, simplify credentialing, streamline billing/payment processing, and improved efficiency for small provider Oral Health-Medicaid partnerships. Advocate for oral health inclusion into Medicare Advantage.	Oral Health Coalition, Oral Health Coalition Director, HCPH, Board of County Commissioners	• Ohio Department of Medicaid • Oral Health Ohio • The Health Collaborative • Managed Care Organizations • Oral Health Professionals • CDS, ODA, ADA Foundation • Local Delegation of Ohio State Senators and Ohio House of Representatives • The Health Gap
c) Engage health care systems to introduce or expand dental residency programs; assess current status of dental FQHC's; encourage integration of oral health services into medical treatment planning, especially in Women's Services, ED's, Orthopedics, Cardiology, and Oncology.	Oral Health Coalition, Oral Health Coalition Director, HCPH, Board of County Commissioners	• Healthcare Systems and Oral Health FQHC's • Dental Residency Participants • Oral Health Ohio The Health Collaborative • Oral Health Institutions of Graduate Ed. • CDS, ODA, ADA • Children's Oral Health Network
d) Develop a pilot program that incorporates creativity and innovation in oral health. Research existing county initiatives (e.g. HCDC) and other innovations in dental/medical products and devices that include dentures and new technology (3-D printing) to provide affordable denture fabrication in line with Medicaid denture reimbursements. Engage all payers (Medicaid, private insurers, Medicare) to ensure reimbursements are attractive enough to alleviate ED encounters (e.g. payment at incentivized rates for safety-net clinics, FQHC's, and private dental practices.	Oral Health Coalition, Oral Health Coalition Director, HCPH, Board of County Commissioners	• Local Delegation of Ohio State Senators and Ohio House of Representatives • HCDC Office of Innovation and Creativity • Ohio Department of Development • Oral Health FQHC's • Safety-Net Oral Health Providers • Public and Private Oral Health Funding Sources • CDS Oral Health Foundation
e) Support and promote: *OPTIONS, Cincy Care to Share, Give Kids a Smile, Leave No Vet Behind*. Create professional association-sponsored volunteer oral health programs for individuals with a lower income, experiencing a disability, or with limited access to oral health care services. Design promotional programs with consistent, diverse, and universally recognizable oral health messaging. Ensure all educational materials are designed to improve oral health literacy for multiple audiences.	Oral Health Coalition, Oral Health Coalition Director, HCPH, Board of County Commissioners	• ODA • CDS Oral Health Foundation • ADA Foundation • Oral Health Ohio • Oral Health Institutions of Graduate Ed. • Oral Health Professionals

Output/Outcome Indicators:

- # of oral health providers receiving introductory letter
- # of meetings/trainings with oral health providers
- # of health professionals receiving education
- # of meetings with Ohio Department of Medicaid
- # of meetings with the Medicaid Oversight Committee
- # of advocacy strategies implemented
- # of health care systems engaged
- # of dental FQHC's assessed
- # of new FQHC oral health providers
- # of new residency dentists
- # of oral health professionals working in OBGYN settings
- # of oral health professionals working in Oncology Departments
- # of oral health professionals working in Orthopedic Departments
- # of oral health professionals working in Cardiology Departments
- # of innovations in dentistry identified through research
- # of payers engaged to plan the pilot (by sector)
- # of new private and public safety-net organizations
- # of new private and public safety-net organizations oral health providers
- # of dental offices performing medical screenings according to best practice protocols
- # of medical practices performing dental screenings according to best practice protocols
- Increase the number of oral health professionals accepting Medicaid patients
- Decrease in the number of oral health emergency department encounters
- Emergency Departments develop and sharpen oral health diversion plans and best practice referral pathways
- Increase in individuals who report a 'dental visit in the last year'
- Oral health is included in the Medicaid Pay-for-Performance (P4P) Program
- Improvements realized in reimbursements, credentialing, and streamlined billing and payment processing in the State of Ohio Oral Health Medicaid System
- Oral health services are integrated into medical treatment planning
- Operational denture lab sustainable by Medicaid reimbursements functioning in Hamilton County

Monitoring/Evaluation Approach:

- Annually track/review: Ohio Medicaid Reimbursement Rates; Oral Health Medicaid codes; Denture ICD-10 codes approved by Medicaid; emergency department encounter numbers submitted to the Ohio Hospital Association
- Surveys
- Other local oral health evaluation and surveillance tools to be determined

LOGIC MODELS

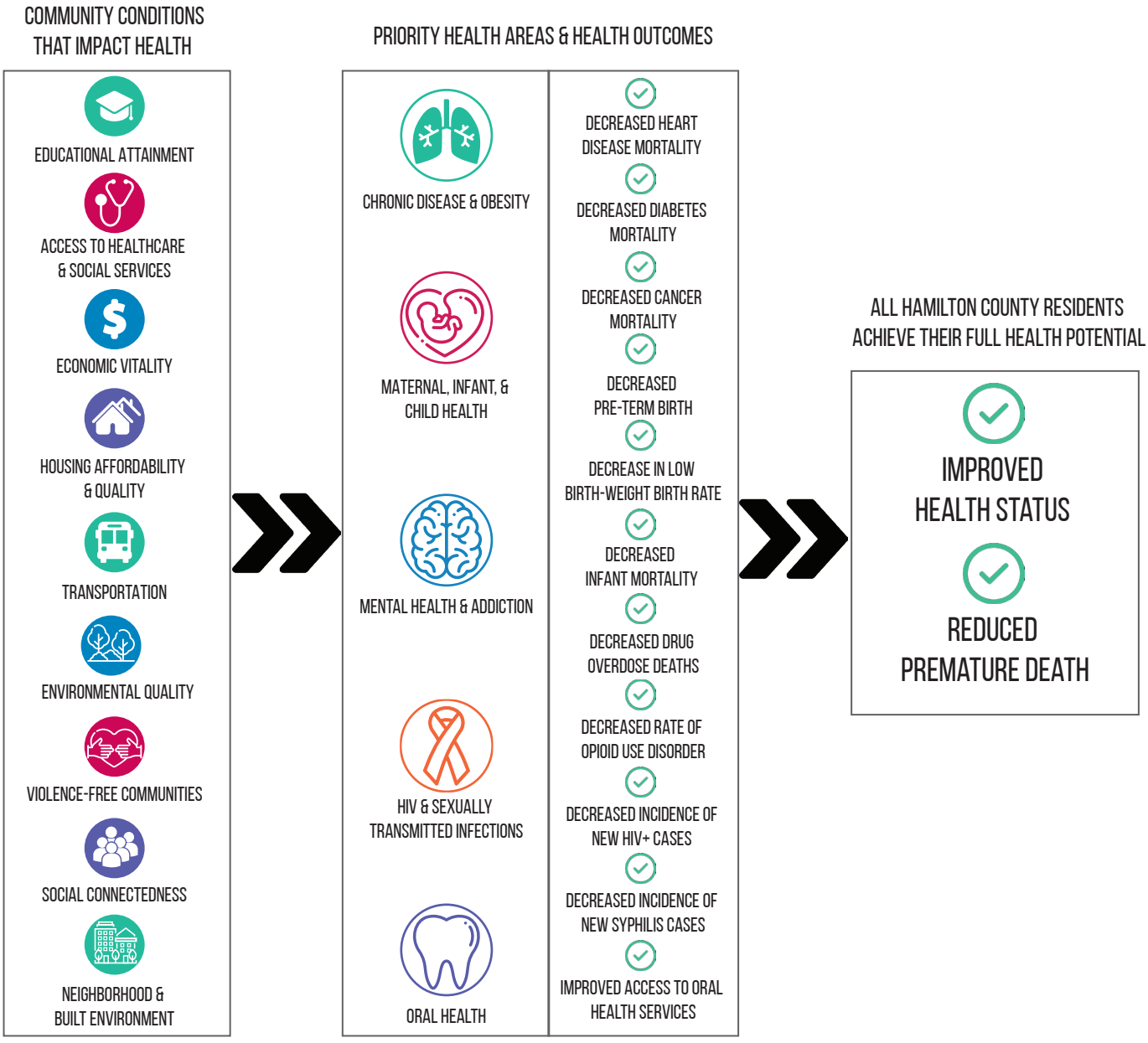
Logic models provide a visual representation between the strategies outlined for each priority health area and the intended effects. The logic models outlined in this section provide the framework Hamilton County Public Health will use to evaluate effectiveness and document accomplishments towards improving health status and reducing premature death among Hamilton County residents.

2020-2023 COMMUNITY HEALTH IMPROVEMENT PLAN FRAMEWORK

To ensure all Hamilton County residents achieve their full health potential, Community Health Improvement Plan (CHIP) strategies will be implemented in communities and among populations where there is greatest need coupled with efforts to address discrimination, racism, and stigmatization.

The CHIP identifies nine community conditions and five priority health areas that affect the health and well-being of Hamilton County residents.

HAMILTON COUNTY 2020-2023 COMMUNITY HEALTH IMPROVEMENT PLAN FRAMEWORK



PRIORITY 1: CHRONIC DISEASE & OBESITY

STRATEGIES	ACTIVITIES	OUTPUTS	SHORT/INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES
Place-based approach to healthy eating and active living	Targeted outreach/engagement of 2 priority communities to work on multi-sectoral healthy eating and active living (HE/AL) policies, systems, and environmental change (PSEC) and PSEC-supportive strategies. Conduct assessments to establish baseline policy and environment scores relating to nutrition, physical activity, and chronic disease management. Develop action plan that includes PSEC and PSEC-supportive strategies to improve access to healthy foods and safe opportunities for physical activity. Implement PSEC and PSEC-supportive strategies relating to HE/AL in communities, schools, and child care settings. Promote HE/AL strategies throug multiple communication venues.	Priority communities identified based on data # of assessments completed (by sector) # of menu audits completed in child care # of HE/AL policy strategies implemented (by sector) # of HE/AL environmental change strategies implemented (by sector) # of HE/AL PSEC-supportive strategies implemented (by sector) # of communication venues used # of posts/engagements/media impressions Assessment score data	Baseline assessment scores are established by sector Increased access to healthy foods Increased access to safe opportunities for physical activity Increased awareness of healthy eating and active living strategies and resources	Decrease in the percent of children who are overweight or obese Decrease in the percent of adults who are overweight or obese Decreased heart disease mortality rate Decreased diabetes mortality rate Decreased chronic obstructive pulmonary disease (COPD) mortality rate Decreased cancer mortality rate
Tobacco-free living (including vaping and e-cigarettes)	Provide tobacco education (including vaping and e-cigarettes) to youth, parents, community members, and community organizations. Conduct tobacco sales to minor compliance checks in retail establishments located within priority communities outlined in the Tobacco Prevention & Cessation (TPC) grant. Conduct store audits in retail establishments within priority communities outlined in the TPC grant. Implement tobacco counter-marketing campaigns within priority communities outlined in the TPC grant Provide training & technical assistance (TA) to tobacco cessation providers and referral sources within priority communities outlined in the TPC grant. Provide TA to schools for adopting tobacco-free policies that meet or exceed ODH's policy standards. Provide TA to child care providers for adopting comprehensive tobacco-free policies. Provide TA to communities for adopting comprehensive tobacco-free policies.	# of trainings provided # of individuals reached # of compliance checks completed # of tobacco sales to minors # of tobacco counter-marketing campaigns implemented # of media impressions/engagements # of school districts with 100% tobacco-free school campus policy # of tobacco-free policies adopted by communities # of tobacco-free policies adopted by child care providers # of tobacco cessation providers trained # of tobacco cessation referral sources trained # of peer facilitators trained	Increased access to tobacco-free environments Decrease in the percent of adults who smoke Decrease in the percent of youth who smoke and/or vape Increase in tobacco cessation resources Increased awareness of the dangers of tobacco use, available cessation services, and youth access to tobacco	

PRIORITY 2: MATERNAL, INFANT, & CHILD HEALTH

STRATEGIES	ACTIVITIES	OUTPUTS	SHORT/INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES
Outreach	Update hotspot ZIP codes to determine priority communities. Implement multipe outreach methods to engage pregnant women. Meet w/partner agencies to increase awareness of Ohio Equity Institute (OEI) navigation services. Host and/or attend events to reach pregnant women in priority ZIP codes. Promote OEI navigation services utilizing multiple communication venues.	Priority ZIP codes determined # of outreach methods used # of hours spent on outreach # of individuals reached through outreach # of community partners # of events held # of participants	ZIP codes with the highest racial disparity in birth outcomes will be prioritized for outreach Partnerships established with community organizations to more efficiently and effectively identify pregnant women who are not already connected to services Increased awareness of OEI navigation services	More babies will celebrate their first birthday Decrease in pre-term birth rate Decreased in low birth weight birth rate Decrease in sleep-related deaths Decrease in infant mortality rate Decrease in the black infant mortality rate Decrease in black-white mortality ratio Decrease in the fetal mortality rate Improved quality of reproductive health care provided to women before, during, and after pregnancy
Identify and screen	Conduct an assessment with each woman to determine eligibility for OEI navigation services. Complete an intake with pregant women who screen eligible for OEI navigation services. Identify health care, social service, and other needs for pregnant women.	# of eligible women identified # of ineligible women identified # of completed screenings # of needs identified for pregant women Demographics of clients	Pregnant women at greatest risk for a poor birth outcome will be identified and connected to needed services and resources Data compiled during intake will inform future interventions & resources needed	
Refer and serve	Refer pregnant women to health care, social service, and/or other services based on indicated needs Follow up w/identified women at least 3x within 21 days of connection to facilitate referral process, referral utilization, and additional support needed. Document feedback from pregnant women about their experiences w/the resource/referral source Meet with agencies to share feedback & experiences of pregnant women referred to their agency	# of referrals offered for (in)eligible women (by type) % of referrals utilized # of contacts per woman # of needs met by a referral Average # of contacts made per woman Average # of referrals per woman # of meetings with partner agencies	Pregnant women at greatest risk for a poor birth outcome will receive resources and services that they need Peer-to-peer support Increased access to health care, social service, and other identified needs Quality improvement of services and resources based on client feedback	
Advocate for policy change that impacts social determinants of health (SDOH)	Collect data from SDOH Assessment Tool, client follow ups, field observation forms, etc. Review & update SDOH data indicators contributing-to poor birth outcomes. Conduct root cause analysis of SDOH contributors to poor birth outcomes. Collaborate w/the Cradle Cinti. Policy Committee to advocate for, adopt, and/or implement police and/or practice changes that impact SDOH & infant vitality.	List of SDOH indicators Root cause analysis findings identified # of SDOH policies or practices identified as a need by the Cradle Cincinnati Policy Committee # of SDOH policies or practices adopted as a result of advocacy efforts of the Cradle Cincinnati Policy Commitee	Improved understanding of the SDOH that are impacting pregnant women in Hamilton County Increase in political will to address SDOH contributors that affect poor birth outcomes	
Fetal & Infant Mortality Review (FIMR) and Child Fatality Review (CFR)	Reach out to families who have experienced a fetal or infant loss for an interview. Conduct interviews. Provide families w/resources for bereavement and/or other identified needs. Convene the FIMR Case Review Team (CRT) to review fetal & infant deaths; CFR CRT to review sleep-related, SUID, & other deaths among children <1 y/o. Present recommendations to the Hamilton Co.-Cinti. Community Action Team (CAT) for implementation.	# of fetal & infant deaths reviewed by FIMR Case Review Team # of maternal interviews # of sleep-related & SUID deaths reviewed by CFR Case Review Team # of other infant-related deaths reviewed by CFR Case Review Team # of recommendations presented to CAT # of recommendations implemented by CAT	Stories of families who have experienced a fetal or infant loss will be heard & shared Better understanding of circumstances leading up to a fetal or infant loss Identification of reoccurring contributing factors and/or protective factors related to fetal, infant, and/or child loss events Development of actionable recommendations to promote reduction of fetal, infant, and child deaths	

PRIORITY 3: MENTAL HEALTH & ADDICTION

STRATEGIES	ACTIVITIES	OUTPUTS	SHORT/INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES
Implement innovative county-wide surveillance	Expand the Systems Integration Collaborative (SIC) to include FQHCs, first responders, and organizations serving people experiencing homelessness. Establish a central database for all Quick Response Teams (QRTs).	# of organizations participating in the SIC # of SIC organizations providing data # of SIC organizations utilizing data	The majority of hospital systems, treatment providers, healthy systems, public safety organizations and others will participate the SIC and either provide or utilize surveillance data.	Decreased rate of opioid misuse and opioid use disorder Decreased rate of opioid use disorder Decreased drug overdose death rate, including prescription and illicit opioid overdose death rate Increased provision of evidence-based treatment for opioid use disorder Decreased rate of ED visits due to misuse or opioid use disorder
Prescription Drug Monitoring Program (PDMP) improvements	Engage primary care providers (PCPs) to improve their use of existing PDMP data through education, training, and hospital peer review of opioid prescriptions.	# of hospitals with Quality Improvement Peer Review process # of trainings with PCPs regarding prescription drug prescribing practices	Increased data-driven prevention and response activities between state and local efforts Decrease in high-risk prescribing practices	
Integration of state and local prevention efforts	Develop and operate a surveillance dashboard to improve integration of state and local prevention efforts Host quarterly roundtables with ODH, Cuyahoga, and Franklin Counties	Data surveillance dashboard developed # of dashboard views # of quarterly implementation roundtables	Organizations across the 3 metro areas will utilize the dashboard to plan services and interventions Increased state involvement in local prevention efforts Increased local preparedness & response	
Linkage to care	Peer Support Specialist (PSS) at key community access points Promote & expand usage of FindLocalTreatment.com (FLT) Establish a family advisory group for families who have experienced a loss	# of PSS hired, trained & placed at key community access points # of referrals made to recovery or other behavioral health services by PSS # of referrals completed # of providers w/verified infomation in FLT # of people who report using FLT # of people engaged in advisory group	Increase in referrals for evidence-based treatment Increase in completion of evidence-based treatment	
Health system support through Academic Detailing, ED interventions, Naloxone provisions, & technical assistance (TA)	Academic Detailing, training, & awareness activities Education for non-prescribing clinicians regarding non-opioid pain treatment modalities Prescriber education on community recovery resources and supports Develop ED protocol for post-overdose (OD)	# of trainings conducted # of TA sessions provided # of EDs w/post-OD protocol # of EDs hosting Naloxone Coordinators # of people served in EDs # of Naloxone doses distributed in EDs	Decrease in high-risk opioid prescribing rates Increase in treatment referrals post-OD Increase in treatment completion post-OD Increase in non-opioid medications and non-pharmocologic treatments for pain by patients	
Partner with public safety and first responders to provide training and services to youth with high Adverse Childhood Experiences	Develop training protocols Engage School Resource Officers with youth with high Adverse Childhood Experiences (ACEs) Refer youth to needed services	# of first responders trained # of first responder agencies with protocols for referrals for youth with ACEs # of schools participating # of trainings completed # of youth referredto the Mayerson Center by first responders and school staff # of youth served after referrals	Improved coordination of public health and public safety efforts Use of shared data to inform collaborative public health/public safety prevention and response activities Increased opportunities/rocess to link individuals to care Improved utilization of evidence-based approaches to prevention, intervention, and referral to treatment Decreased opioid use among youth	

PRIORITY 3: MENTAL HEALTH & ADDICTION (CONTINUED)

STRATEGIES	ACTIVITIES	OUTPUTS	SHORT/INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES
Empower individuals to make safer choices	Promote Take Charge Ohio awareness campaign Promote stigma reduction Partner with the syringe services program to offer comprehensive syringe services and linkage to care	# of people who report increased awareness	Increased awareness Decreased stigma for seeking addiction services Decreased initiation of opioid use/misuse Increased fidelity to opioid prescription/ medication protocol Increased use of non-opioid medications and non-pharmacologic treatment among patients	Decreased rate of opioid misuse and opioid use disorder Decreased rate of opioid use disorder Decreased drug overdose death rate, including prescription and illicit opioid overdose death rate Increased provision of evidence-based treatment for opioid use disorder Decreased rate of ED visits due to misuse or opioid use disorder
Opiate-related overdose death review	Convene the Overdose Fatality Review (OFR) Case Review Team to review all opiate-related deaths Implement protocol involving families/close contacts of decedents Support the Coroner's Office in providing data for OFR case review	Protocol developed # of OFR cases reviewed # of OFR cases' families contacted # of OFR interviews completed # of OFR cases with Coroner's Office data collected OFR recommendations	Engagement of family members leads to better understanding of determinants of overdose and improved treatment protocols Obtain access to Hamilton County Coroner's Office data for OFR case review	
Comprehensive Naloxone Distribution Program	Develop policies and procedures regarding Naloxone training, storage, inventory, dispensing, etc. for: - Syringe Services Program - Justice Center - Community Distribution - "Leave Behind Program" Provide Naloxone training Distribute Naloxone kits	Policies and procedures developed # of individuals trained to administer Naloxone # of Naloxone kits distributed # of known overdoses reversed # of Naloxone access points per geographic region	Have a more comprehensive and refined Naloxone program and processes Increased number of individuals in the target population that received a Naloxone kit	
Syringe Services Program (SSP)	Provide provisions of sterile injection equipment and disposal of potentially infectious sharps for individuals utilizing the Syringe Services Program Provide Hepatitis C and HIV testing services for individuals who are exchanging sharps Make referrals to treatment, medical, or other services	# of clients # of new clients # of syringes exchanged # of Hepatitis C tests administered # of HIV tests administered # of Fentanyl test strips distributed # of pregnancy tests distributed #of referrals to treatment, medical, or other services	Fewer people who inject drugs will contract an infectious disease Increased access to safe injection equipment Increased ability to make safer choices	Decreased HIV incidence rates among people who inject drugs Decreased Hepatitis C rate among people who inject drugs

PRIORITY 4: HIV & SEXUALLY TRANSMITTED INFECTIONS

STRATEGIES	ACTIVITIES	OUTPUTS	SHORT/INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES
Identification of persons with an HIV infection and comprehensive prevention for those at-risk for HIV infection	Conduct initial, basic screening following ODH protocols prior to administering an HIV test Provide risk reduction counseling, education, and referrals to all individuals being assessed and/or tested Continue to operate the Syringe ServicesProgram (SSP) services and expand based on resource availability and community need Distribute harm reduction kits outside of SSP sites Conduct rapid point-of-care to individuals following basic screening Provide testing at community locations and in agencies/facilities to reach priority populations Assess, educate, and actively refer at-risk individuals to pre-exposure prophylaxis (PrEP)/post-exposure prophylaxis (PEP) through OHIV.org	# of individuals screened # of individualized risk-reduction plan based on client assessment # of clients utilizing harm reduction services # of established SSP sites # of site offering expanded hours/services # of individuals tested # of testing sites % of individuals identified as HIV+ # of at-risk individuals linked to PrEP/PEP	Increased harm reduction/disease prevention services Decreased disease transmission among needle-sharing and sexual partners Increase in individuals accessing PrEP/PEP Increased availability of testing in priority populations HIV+ individuals become aware of their status	Decreased incidence of new HIV+ cases Decreased incidence of new Syphilis cases
Comprehensive prevention for People Living with HIV (PLWH)	Provide confidential services to help individuals newly diagnosed with HIV and/or are living with HIV identify their sexual and drug injection partners Notification of partners of past or ongoing exposure to HIV to facilitate partners' access to testing Provide education and counseling related to sexual health risk and risk reduction Provide rapid linkage and/or established care within 30 days of HIV diagnosis among men that have sex with med (MSM), pregnant females, and youth/adolescent populations Conduct provider education and disseminate CDC-recommended screening, dianosis, and treatment guidelines to facilities that provide services in high priority populations Refer HIV+ individuals to providers who conduct early anti-retroviral (ART) initiation Refer and link PLHW to HIV case management to support medication adherence Provide short-term health navigation for those with a positive HIV result	# of individuals tested # of individuals engaged/re-engaged in care % of contacts notified of potential exposure % of notified HIV partners that are tested # of referrals to treatment # of provider trainings conducted # of provider materials disseminated # of referrals made to providers conducting early ART initiation # of PLWH engaged in HIV case management	Individuals at-risk for HIV identified Decreased community viral load HIV+ individuals will be engaged/ re-engaged in care Improved long-term outcomes for HIV+ individuals Notified partners become aware of potential risk of infection and are treated Improved HIV awareness	

PRIORITY 4: HIV & SEXUALLY TRANSMITTED INFECTIONS (CONTINUED)

STRATEGIES	ACTIVITIES	OUTPUTS	SHORT/INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES
Comprehensive prevention for people diagnosed with a reportable sexually transmitted infection (STI)	Provide confidential services to help individuals newly diagnosed with syphilis identify their sexual partners Notification of partners of past or ongoing exposure to syphilis to facilitate partners' access to testing Provide education and counseling related to sexual health risk and risk reduction Provide same day syphilis treatment (or start treatment within 14 days of diagnosis) among MSM, pregnant females, and youth/adolescents diagnosed with primary or secondary syphilis Conduct provider education and disseminate CDC-recommended screening, diagnosis, and treatment guidelines to facilities that provide services in high priority populations Provide short-term health navigation for those with a positive syphilis result	# of individuals tested # of individuals engaged/re-engaged in care % of contacts notified of potential exposure % of notified partners that are tested % of early syphilis contacts within 14 days # of referrals to treatment # of provider trainings conducted # of provider materials disseminated	Individuals at-risk for syphilis identified Decreased community viral load Decrease the number of individuals with infectious syphilis Notified partners become aware of potential risk of infection and are treated Improved syphilis awareness	Decreased incidence of new HIV+ cases Decreased incidence of new Syphilis cases
Community-level intervention	Provide condoms to community partners for distribution to persons living with, or at-risk for, STI and/or HIV infections Engage the priority population to develop and/or review marketing and education materials to ensure cultural appropriateness Conduct outreach to priority populations Participate in community events targeted to at-risk populations Conduct social marketing campaigns focused on priority populations Support People Who Inject Drugs (PWID) empowerment and advocacy group	# of condoms distributed # of condom distribution location # of provider/medical facilities distributing condoms # of community events # of campaigns # of impressions # of engagements # of participants	Increased condom availability Culturally appropriate health promotion materials Improved STI awareness and education Increased testing in targeted populations Peer-to-peer support Advocacy for policies that better serve PWID needs	

PRIORITY 5: ORAL HEALTH

STRATEGIES	ACTIVITIES	OUTPUTS	SHORT/INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES
Engage oral health professionals	Provide introductory letter to oral health professionals to introduce the Oral Health Coalition and disclose intent to have ongoing dialogue Provide education regarding FQHC's and FQHC lookalikes, efforts to increase Medicaid reimbursement rates, and oral health disparities, access to care issues, emergency department over usage, and the problems arising from the Medical/ Oral Health divide affecting communities, especially disparate communities and residents with special needs. Utilize promotional programs to inform oral health professionals and medical providers about integrative medicine	# of oral health providers receiving introductory letter # of meetings/trainings with oral health providers # of health professionals receiving education	Increase in the number of oral health professionals accepting Medicaid patients Decrease in the number of oral health emergency department encounters Emergency Departments develop and sharpen oral health diversion plans and best practice referral pathways Increase in individuals who report a 'dental visit in the last year'	Improved access to oral health services
Oral health policy change	Engage the Ohio Department of Medicaid – provide input to enrich both patient and provider experiences while fostering improved quality of care, increased access, and system accountability Engage Medicaid Oversight Committee for Medical Oral Health policy change at the state level to increase reimbursements; simplify credentialing; streamlined billing/payment processing; improved efficiency for small-provider Oral Health-Medicaid partnerships; expanding preventative Medicaid services to alleviate community reliance on emergency departments Advocate for Oral Health inclusion into Medicare Advantage	# of meetings with Ohio Department of Medicaid # of meetings with the Medicaid Oversight Committee # of advocacy strategies implemented	Oral health is included in the Medicaid Pay-for-Performance (P4P) Program Improvements realized in reimbursements, credentialing, and streamlined billing and payment processing in the State of Ohio Oral Health Medicaid System	
Healthcare system engagement	Provide introductory letter to health care systems that includes a copy of the Oral Health Coalition Strategic Plan. Initiate conversations with the hospital systems to learn the history of their Residency Programs, current status, and plans for future growth Introduce or expand Dental Residency Programs to health care systems Assess current status of each Dental FQHC (e.g. services offered, number of providers, etc.) and inquire about future plans for growth Encourage health care systems to have oral health professionals integrate oral health services into medical treatment planning, especially in Women's Services, emergency departments, Orthopedics, Cardiology, and Oncology.	# of health care systems receiving introductory letter # of health care systems engaged # of dental FQHC's assessed # of new FQHC oral health providers # of new residency dentists # of OBGYN practices that employ oral health professionals # of Oncology departments that employ oral health professionals # of Orthopedic and Cardiology departments that integrate oral health services	Oral health services are integrated into medical treatment planning	

PRIORITY 5: ORAL HEALTH (CONTINUED)

STRATEGIES	ACTIVITIES	OUTPUTS	SHORT/INTERMEDIATE OUTCOMES	LONG-TERM OUTCOMES
Develop pilot program captivating creativity and innovation in health	Research HCDC model Research innovations in dentistry with an emphasis on dentures Establish pilot program engaging all payers (Medicaid, private insurers, Medicare) to ensure reimbursements are attractive enough to alleviate emergency department encounters (e.g. payment at incentivized rates for safety-net clinics, FQHC's, and private dental practices) Implement pilot program	# of innovations in dentistry identified through research # of payers engage to plan the pilot (by sector) # of new private and public safety-net organizations # of new private and public safety-net organization oral health providers	Operational denture lab sustainable by Medicaid reimbursements functioning in Hamilton County	Improved access to oral health services
Oral health promotional programs	Support and promote OPTIONS, Cincy Care to Share, Give Kids a Smile, Leave No Vet Behind. Work with Cincinnati Dental Society to establish new oral health programs for individuals with a lower income, experiencing a disability, or with limited access to oral health care services. Design and launch an Oral Health Promotional Programs to include consistent, diverse, and universally recognizable oral health messaging Utilize promotional programs to inform oral health professionals and medical providers about integrative medicine Ensure all educational and promotional materials are designed to improve oral health literacy for communities, oral health providers, and the medical community.	# of media impressions # of dental offices performing medical screenings according to best practice protocols # of medical practices performing dental screenings according to best practice protocols	Community literacy regarding oral health preventative practices and available community resources will improve Increase in individuals who report a 'dental visit in the last year'	

RESOURCES

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WEBSITE LINKS

- Cradle Cincinnati – cradlecincinnati.org
- Hamilton County Addiction Response Coalition – https://www.hamiltoncountyohio.gov/government/open_hamilton_county/projects/addiction_response_coalition
- Hamilton County Oral Health Coalition – https://www.hamiltoncountyohio.gov/government/board_of_county_commissioners/boards_and_commissions/oral_health_coalition
- Interact for Health – interactforhealth.org
- Ohio Department of Mental Health and Addiction Services – mha.ohio.gov
- PreventionFIRST! – prevention-first.org
- Public Health Accreditation Board – phaboard.org
- WeTHRIVE! – watchusthrive.org

THANK YOU!!

Hamilton County Public Health Board of Health
HCPH Performance Management Council
HCPH Public Health Advisory Council
HCPH Community Health Improvement Plan Workgroup
Other HCPH Staff who contributed to the development of the CHIP

A special thank you for the support and work that you do.
Your efforts contribute greatly to the improvement of the health of Hamilton County residents.

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