

Clermont County Community Health Improvement Plan

Framework and Methodology

2026-2028

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Clermont Partnership for Health

The Clermont Partnership for Health (CPH), established in October 2023, is a collaborative effort among community organizations, healthcare providers, local government agencies, businesses, schools, and other key partners in Clermont County, Ohio. Through cross-sector collaboration, the partnership is committed to advancing health equity by identifying key health priorities in Clermont County and coordinating action to improve population health.

Guiding Principles

The guiding principles for this Community Health Improvement Plan (CHIP) and Community Health Assessment (CHA) process were embodied by the vision, mission, and values of the CPH:

Vision: A thriving, vibrant, healthy community to live, play, work, learn, and grow!

Mission: Improve population health and advance health equity in Clermont County by identifying key health priorities and coordinating strategic action through cross-sector collaboration.

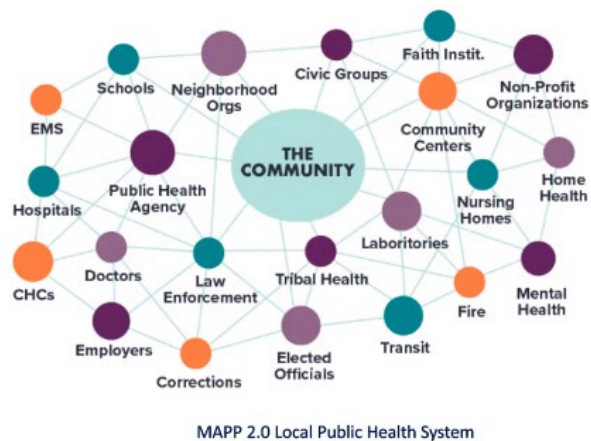
Values: Collaboration, relationship-building, equity, innovation, compassion, inclusion, and respect.

Partners Involved

Various sectors and partners are involved in the CHA and CHIP process with Clermont County Public Health (CCPH) within the CPH because community health is influenced by many factors beyond healthcare alone.

- **Healthcare providers and hospitals** contribute clinical expertise, data, and resources to address disease prevention and treatment.
- **Schools and educational institutions** help influence youth health, health literacy, and long-term behaviors.
- **Local government agencies** (e.g., housing, transportation, planning) shape policies and environments that affect social determinants of health.

Figure 1: National Association of County & City Health Officials Local Public Health System Diagram



- **Community-based and faith-based organizations** provide trusted connections to residents and help reach vulnerable populations.
- **Businesses and employers** impact workplace wellness, economic stability, and access to health benefits.
- **Law enforcement and emergency services** contribute to injury prevention and public safety efforts.
- **Residents and community leaders** ensure that priorities reflect real community needs and lived experiences.

Because health outcomes are shaped by social, economic, environmental, and behavioral factors, a collaborative, cross-sector approach in the CHIP process leads to more comprehensive strategies, shared accountability, stronger community buy-in, and more sustainable improvements in population health.

The complete list of partners involved in this initiative can be found in the appendix section of this document.

Roles And Responsibilities

Clermont Partnership for Health: The partnership supporting the CHA and CHIP is structured across multiple levels of engagement to support shared leadership, flexibility, and broad participation. Organizations can determine their level of involvement by completing the Partnership Membership Form, which allows them to identify their preferred role and designate a representative to participate in CHA/CHIP-related activities.

Core Support team, comprised of CCPH staff, the core support team provides overall leadership, coordination, and facilitation of the CHA/CHIP process using the Mobilizing for Action through Planning and Partnerships (MAPP) framework. The team ensures alignment with public health best practices, guiding principles, and accreditation standards. Key responsibilities include:

- Facilitate meetings and quarterly touchpoints
- Facilitate the creation of CHA/CHIP
- Oversee overall CHA/CHIP implementation and progress
- Maintain centralized tracking of all action items and indicators
- Co-lead CPH meetings

Steering committee provides strategic guidance and shared decision-making throughout the CHA/CHIP process. Members actively participate or designate a representative to attend

partnership meetings, priority subcommittee meetings, and special meetings as needed. Key responsibilities include:

- Bringing knowledge of specific community health issues while maintaining a shared investment in the overall health of Clermont County
- Participating in decision-making related to priority identification, strategy development, and implementation
- Assisting with engaging community members and additional partners in specific tasks and activities
- Serving as champions of the CHA/CHIP process by sharing information, discussing findings, and promoting collective action within their organizations, networks, and communities

Priority area leads support implementation and continuous improvement within specific CHIP focus areas. These individuals bring subject matter expertise related to the creation of related CHA/CHIP content and facilitate coordination among partners working within each priority area. Key responsibilities include:

- Champion integration of CHIP strategies into daily work, partner activities, and coalition efforts
- Identify barriers and opportunities within their priority area
- Recommend adjustments to strategies based on data, trends, and emerging issues
- Collaborate with the CPH core team and other priority leads to ensure alignment
- Co-lead CPH meetings and contribute to strategic discussions

Lead organizations and key partners by priority area:

Youth Mental Health is led by a representative of the Mental Health & Recovery Board who leads the Clermont County Suicide Prevention Coalition and the Clermont County Early Childhood Coordinating Committee.

Adult Substance Misuse is led by a representative of the Mental Health & Recovery Board who leads the Clermont Addiction Recovery Partnership.

Housing is led by the Clermont County Homeless & Housing Coalition.

Broad Community members: Includes community partners and residents who wish to stay informed and involved in a more general capacity. Participation includes:

- Receiving updates and newsletters about partnership activities
- Attending open forums or input sessions
- Volunteering for specific projects or events, as needed

Executive Summary

The CHIP is a shared roadmap that helps communities work together to improve priority health needs and advance health equity. It builds on the CHA and creates a clear path from assessment to planning to coordinated action to address community health priorities.

The CHIP is for everyone involved in improving community health—including residents, community organizations, health departments, local leaders, governing bodies, elected officials, and funders. Its success depends on broad community partnership and input.

Based on community and CPH members' input, the top health issues facing Clermont County are:

- Youth Mental Health
- Adult Substance Misuse
- Housing

The CHIP was created following the frameworks as explained throughout the document and within the appendices. MAPP, by the National Association of County and City Health Officials (NACCHO), was utilized to guide the steps in creating the CHIP. MAPP is a step-by-step community planning process that helps a community understand its health needs and decide what to work on together to improve health.

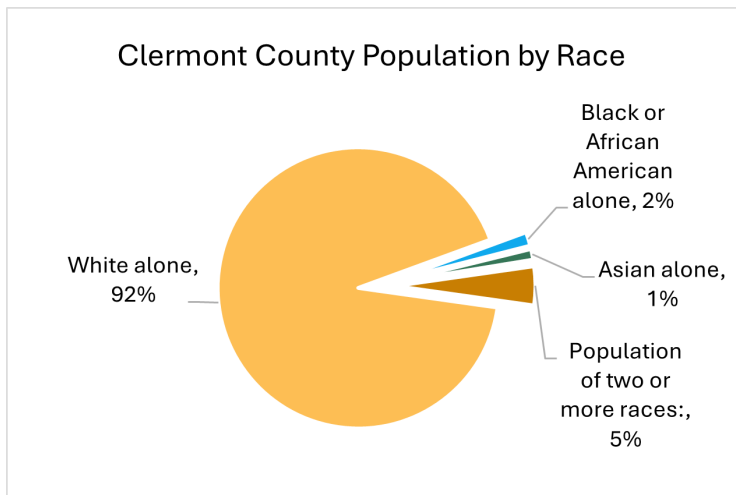
CCPH facilitates the process for creating and implementing the CHIP with the CPH. In 2025, CCPH contracted with The Health Collaborative (THC) to facilitate the activities to complete the CHIP process. In its role as a consultant to CCPH, THC applied an approach grounded in its mission to foster partnerships, activate data, and mobilize coalitions. This approach guided the facilitation of CHIP development activities and ensured alignment with community priorities, data-informed decision-making, and collaborative action. The following elements describe the framework used to support CCPH and CPH in the development of the CHIP.

- Authentically engage partners:** understand partner priorities and unique challenges.
- Utilize data:** review qualitative and quantitative data for problem identification and incorporate partner insight to understand root causes.
- Adapt evidence:** identify proven strategies and emerging best practices and tailor them to fit this community process and need.
- Convene with purpose:** facilitate structured, action-oriented discussions that maximize partner contributions, respect constraints, and drive solutions.

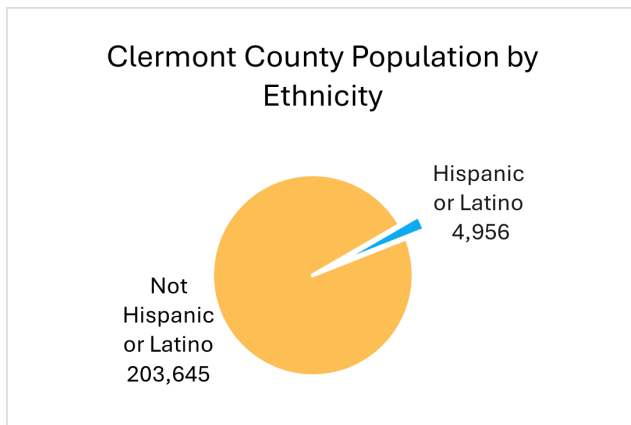
Community Description & Context

Clermont County is in Southwest Ohio and has an estimated population of 208,601, according to the 2020 United States Census. Covering 452 square miles, Clermont County is the 42nd largest county in Ohio by area. Located in the southwest portion of the state along the Ohio River, Clermont County is bordered by Brown, Clinton, Hamilton, and Warren counties in Ohio, and Bracken, Campbell, and Pendleton counties in Kentucky. Clermont County is the westernmost county in Ohio, designated as part of the Appalachian region, and consists of 14 townships and nine villages. The most densely populated areas are largely suburban neighborhoods on the western side of the county bordering Hamilton County, which contains the City of Cincinnati. Agricultural and small residential areas are in the eastern and southern portions of the county. The community encompasses both suburban and rural areas. Residents reflect diverse ages, backgrounds, and socioeconomic conditions that shape health needs and outcomes.

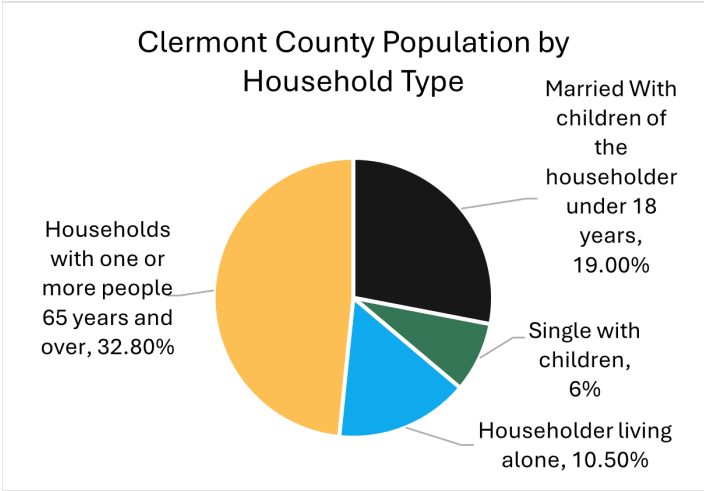
Figure 2: Clermont County Census Data, 2020



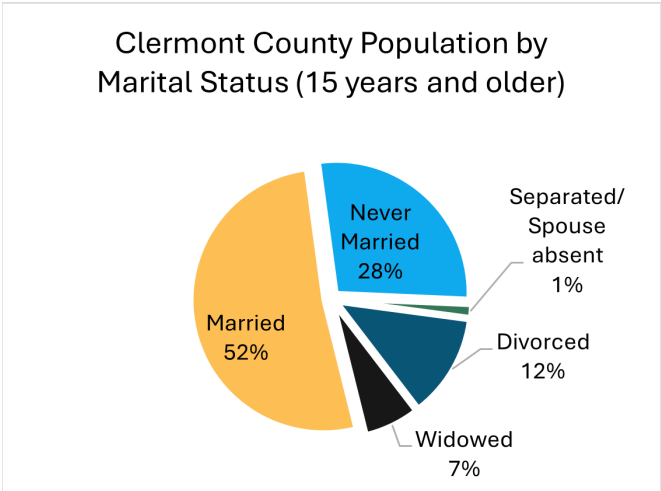
Source: American Community Survey, 2020



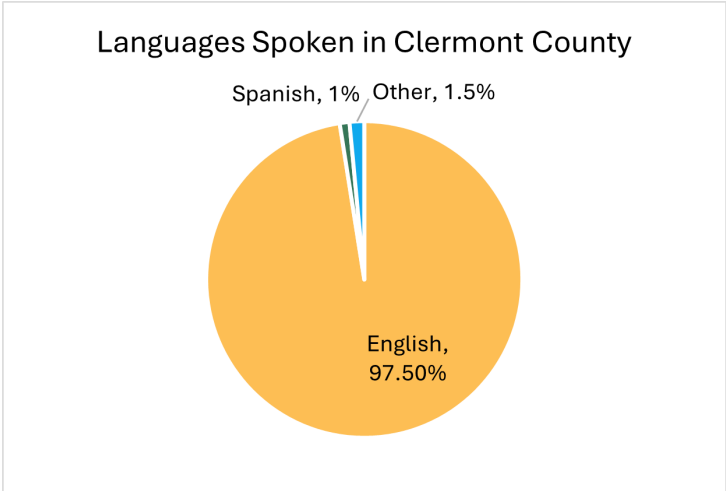
Source: American Community Survey, 2020



Source: American Community Survey, 2021

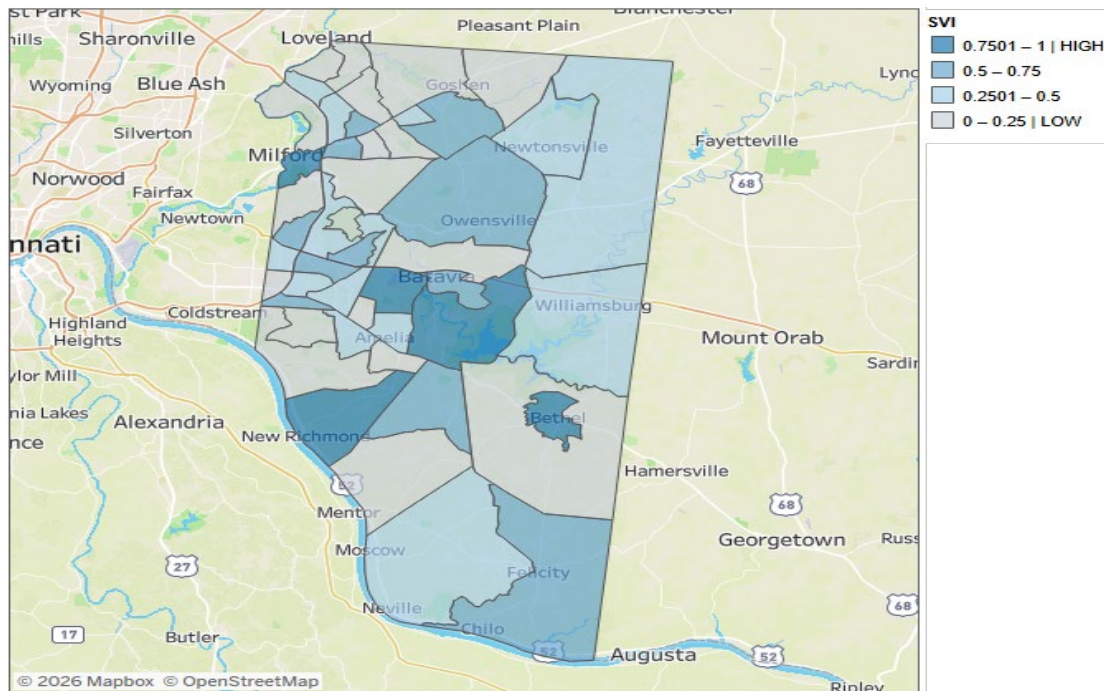


Source: American Community Survey, 2021



Source: American Community Survey, 2024, Table DP02

Figure 3: Clermont County Social Vulnerability Index Map, 2026



Source: Ohio Department of Health, Health Improvement Zones

Social and economic factors such as income, education, housing, transportation, and the built environment significantly influence community health. While Clermont County benefits from existing health care providers, community organizations, and public health programs, barriers, including cost, access, and transportation, affect equitable access to care.

Priority health concerns identified through community assessment include youth mental health, adult substance misuse, and housing, alongside notable community strengths such as strong partnerships, engaged partners, and existing prevention efforts. This CHIP builds on these assets to address health disparities, improve outcomes, and promote health equity for all residents.

Timeframe & Timelines

Month / Timeframe	Activity Summary
January 2025	Regional Community Health Needs Assessment (CHNA) was published, providing foundational data for CHIP development
March 2025	Regional priority areas and Clermont County–specific data were reviewed with CPH partners
May 2025	Community Partner Assessment (CPA) was conducted to identify organizational capacity, gaps, and collaboration opportunities
May–June 2025	CPH Core team developed assessments and analytic tools to support data synthesis and issue identification
June–July 2025	Assessment findings were reviewed and synthesized into Issue Profiles to support community priority-setting
July 2025	CPH contracted with THC to facilitate a structured CHIP development process
August 2025	CPH partners reviewed Issue Profiles, selected three CHIP priority areas, and initiated root cause analysis
September 2025	Root cause analysis continued; initial strategies and activities were discussed and refined
October 2025	Final facilitated CPH meeting held to refine strategies, activities, and assign priority leads
November 2025 – February 2026	Strategies and activities were reviewed, consolidated, and finalized for inclusion in the CHIP



Relationship with Community Health Assessment

The CHA is a broad, systematic process used by public health departments and partners to identify health status, needs, strengths, and social determinants of health in a community. Briefly, under the MAPP framework, the CHA directly informs and drives the development of the CHIP in the following way:

1. Translating Assessment Findings into Priorities

The Regional CHNA and the Clermont County supplemental assessments synthesize data from three MAPP assessments—the Community Partner Assessment, Community Status Assessment, and Community Context Assessment—and are collectively referred to as the CHA throughout this document. Together, these efforts expanded on the regional data by incorporating local population characteristics, system capacity, and partnership insights. Using the MAPP framework, CPH partners reviewed and synthesized these findings to identify the most significant health issues, disparities, and contributing factors, ensuring that CHIP strategies are targeted, relevant, and responsive to the community's unique needs.

2. Community-Driven Priority Setting

Using the CHA results, members of CPH collectively reviewed and prioritized health needs through the lens of the diverse populations they serve. Drawing on their direct experience with different communities, partners applied shared criteria such as magnitude, severity, feasibility, and equity to ensure that priority selection reflected real community needs and lived experiences. This collaborative, representative approach ensured that the CHIP was shaped by a broad cross-section of voices and perspectives, resulting in shared community priorities rather than individual organizational agendas.

3. Strategy Selection and Action Planning

For each priority area identified in the CHA, evidence-based strategies and interventions are selected. Roles and responsibilities are assigned across partners, aligning hospital implementation strategies and public health actions within a single coordinated plan.

4. Development of Goals, Objectives, and Measures

The CHA data establish baselines that are used to define measurable goals and objectives in the CHIP. Performance indicators are selected to monitor progress and guide continuous improvement.

5. Ongoing Monitoring and Improvement

The CHIP is implemented and monitored using the CHA findings as a reference point.

MAPP emphasizes continuous reassessment, allowing communities to adjust strategies as conditions and data change.

In summary, the CHA provides the evidence and community voice that shape priorities, strategies, and measurable actions in the CHIP, making the CHIP the action-oriented product of the MAPP assessment process.

CHA Key Findings and Priority Health Issues

Consistent with the MAPP framework, issue profiles are developed to synthesize extensive assessment data into clear, decision-ready summaries of the community's most significant health concerns. Topics for issue profiles were selected by reviewing results from the four MAPP assessments, identifying key community health concerns, and prioritizing issues based on impact, community need, and feasibility. When multiple data sources consistently point to the same concern—such as rising behavioral health needs, housing instability, or chronic disease burden—that issue is elevated for deeper analysis. This triangulated approach ensures that priority issues reflect both statistical evidence and lived community experience, strengthening the validity and relevance of subsequent strategic planning.

Each issue profile summarizes the scope and magnitude of the problem, its impact on community health, affected populations and disparities, contributing factors, potential root causes, existing community assets, and evidence-informed strategies. Profiles also consider policy, systems, environmental conditions, and structural determinants of health that influence health and equity. These summaries are shared through CPH, communicated to the broader community, and presented to CCPH's Board of Health to support informed decision-making.

Issue profiles were developed for the following priority topics: adult substance misuse, adult suicide, cardiovascular health, housing, transportation, youth mental health, and youth substance misuse. Each profile includes an overview of the issue, its relevance to the community, key data including population-specific indicators, potential strategies, and alignment with previous Clermont County CHIP, regional CHNA, Ohio State Health Improvement Plan (SHIP), and Healthy People 2030.

The following section summarizes the selected issue profiles prioritized for the CHIP. Each profile illustrates how assessment findings were translated into actionable priorities through community engagement and data-informed decision-making.

The Youth Mental Health issue profile highlights data from the most recent 2024 Parents' Resource Institute for Drug Education (PRIDE) survey, in which 3,978 students throughout Clermont County completed the survey. Of those students, 35.7% responded that they had experienced anxiety in the past 30 days, underscoring the growing mental health needs of

youth. Proposed strategies focused on reducing stigma, increasing access to mental health services, and strengthening the integration of mental health education within schools for students and caregivers.

The Adult Substance Misuse issue profile highlights data from CCPH's 2024 Overdose Fatality Review. A key finding is that of a 56.25% decrease in accidental drug overdose deaths that occurred in the county from 2023 to 2024. The findings further identify adults aged 35–44 years as one of the most significantly impacted populations. Strategies emphasize targeted intervention activities, recovery resource coordination, and stigma reduction.

The Housing issue profile highlights data from the 2025 Comprehensive Housing Study, 2024 CCPH and Clermont Homeless Coalition, and the 2024 Housing Needs Assessment: Change in Median Gross Rent. Findings indicate that housing instability is a growing concern in Clermont County, with 44% of renters and 21% of homeowners classified as housing cost-burdened. In 2022, the eviction filing rate was 6.9%, exceeding Ohio's overall rate of 6.43% and placing Clermont County among the top ten counties statewide for evictions. Homelessness has also increased, with 60 individuals identified in the 2024 Point-in-Time count, including 33 unsheltered individuals, highlighting that the current hotel-based shelter model is insufficient to meet community needs.

Further, the issue profile identifies low-income households, rural residents, and individuals experiencing homelessness as disproportionately impacted subpopulations, particularly among the 35% of households earning less than \$50,000 annually. Proposed strategies focus on improving housing affordability and stability through expanded housing options, supportive services, voucher programs, and increased shelter capacity.

Following the prioritization of the three issue profiles, CPH conducted a deeper root cause analysis to further inform CHIP strategy development. This analysis applied the 5 Whys methodology using a logic model lens, including Levels of Impact—Social Determinants and Social Needs (de Beaumont) and the Social Ecological Model. While root cause analysis is often conducted earlier in the CHA process, extending this step strengthened alignment between identified priorities, underlying drivers of health inequities, and actionable, equity-centered CHIP strategies in Clermont County.

The findings of the Root Cause Analysis included the following:

Youth Mental Health

Home/family:

- Economic instability

- Lack of parental/familial emotional and social support due to limited knowledge, time/priorities, and clarity of roles (i.e., expecting schools to teach emotional and social skills)

School:

- Pressure to do really well to gain recognition (social recognition, scholarships, etc.) or pressure from family to do well
 - Or the opposite - no/low expectations due to the school staff-to-student ratio (teachers unable to monitor as well), lack of parental involvement, etc.
- Understaffed schools due to funding, causing students not to get the resources they need to thrive

Social:

- Changing culture causes more digital experiences and fewer real-world connections

Healthcare:

- Access to healthcare is diminished due to healthcare facilities not being prioritized in areas that need it most, and a lack of healthcare staff to handle the demands adequately

Adult Substance Misuse

Healthcare:

- Recovery treatment barriers
- Lack of access to care
- Inadequate addiction treatment leads to poor outcomes
- Inadequate harm reduction strategies to serve the population

Environmental:

- Availability of legal substances
- Normalization of substance use among family and peers
- Trauma and Adverse Childhood Experiences (ACEs)
- Life Stressors
- Economic stress and instability
- Lack of mental health/wellness prioritization in the workplace

Mental and Physical Health:

- Mental health disorders exacerbating drug use

- Biological and genetic factors
- Physical health (i.e., chronic pain)

Housing

Structural Inequities:

- Gentrification
- Allocation of funding to those who need it

Personal or family circumstances:

- Deficient life skills due to insufficient education and resource coordination
- Multigenerational stigma
- Lifestyle choices that lead to chronic conditions or poor physical health

Foreclosures and evictions:

- Wages do not meet cost-of-living needs due to a variety of factors

Built environment:

- No economic incentive for developers to build for the low-income population or landlords to upkeep current properties
- Poor housing conditions due to lack of regulation/enforcement
- Rapid growth within the county, but not planning accordingly for the population's needs

Policy & System:

- Insufficient funding/allocation of resources for affordable housing
- Insufficient coordination and collaboration among agencies
- Belief by policymakers that housing is not a fundamental right
- Lack of collective advocacy

Together, the development, validation, prioritization, and root cause analysis of the issue profiles established a strong foundation for the next phase of the MAPP framework by clarifying priority issues and their underlying drivers.

These findings informed subsequent CHIP development steps, including identification of desired results, performance indicators, strategies, and SMARTIE (Specific, Measurable, Attainable, Realistic/ Relevant, Time-Based/ Bound, Inclusive, and Equitable)-aligned activities. The process ensures that CHIP strategies address upstream determinants of health, align with community capacity, and support measurable and sustainable improvements.

While not all issue profiles were prioritized for inclusion in the CHIP, the additional profiles remain valuable resources for CPH and community partners. They provide data, context, and evidence-informed considerations to support ongoing planning, program development, policy decisions, and collaboration beyond the CHIP cycle.

Data findings from the issue profiles and root cause analysis inform the development or revision of policies, processes, programs, or interventions designed to improve population health.

CHIP Development Process

The CHIP development was created following MAPP Phase III: Continuously Improve the Community. CHIP development activities were structured into three (3) distinct stages, each facilitated through three (3) in-person meetings with CPH members.

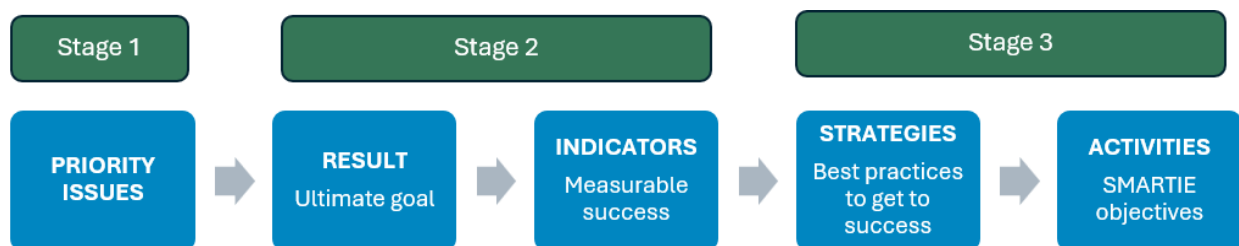
CCPH established a high-level project plan to guide the development of the CHIP. THC, serving as the external consultant and facilitator, completed the agreed-upon scope of work in partnership with CCPH and CPH as outlined in the project plan.

The phases described below align with the MAPP 2.0 framework, specifically Phase II, Step 5, and Phase III, Steps 1, 6, and a portion of Step 7, ensuring a structured, data-informed, and collaborative approach to CHIP development.

Project Plan and Stages Overview

Each stage included facilitation and methodologies that align with public health and healthcare best practices. Below is a description of frameworks and methodologies used in each stage, and a full list can be found in the appendix.

Figure 4: Visual of the Project Plan and Stage



Stage 1: Setting priority issues

Because the CHNA was conducted at the regional level, CPH identified the need to further review and validate priorities locally with community partners using issue profiles developed by

the CPH core team. Priority issues were reviewed through a series of steps from the NACCHO Prioritization Techniques resource, including **data review, criteria review, individual forced ranking, and group voting.**

1. **Issue Identification:** All potential priority areas were first identified by triangulating data from multiple sources (Appendix: Detailed Data Tables), resulting in the development of issue profiles.
2. **Individual Prioritization:** Participants then individually ranked the issue profiles from highest to lowest priority using five criteria: magnitude, inequity, impact on health, capacity/feasibility, and alignment. (See Table 1 for detailed criteria definitions.)
3. **Group Discussion:** Participants engaged in facilitated group discussions to share their rankings and consider perspectives from other participants.
4. **Final Selection:** The group then voted to select the top three priorities, with one vote per participating organization. Voting was conducted using the Mentimeter tool.

Table 1. Criteria for Prioritization

Magnitude	(Mortality, prevalence): most widespread	High to low	<i>Heart disease is the leading cause of death consistently</i>
Inequity	(Disparities): most disparate across populations	Large to small	<i>Infant mortality is significantly higher among black babies than white babies</i>
Impact on Health	(Premature death, Quality of life, economic burden): greatest impact on health, urgency	Great or small	<i>Housing insecurity has a great impact on other areas of our community (social services, healthcare, public health, economy)</i>
Capacity	(Feasibility) confidence and efficacy in the ability to address the issue; availability of solutions	High to low	<i>Our community has available resources to dedicate to addressing food insecurity</i>
Alignment	(Already prioritized): momentum across partners and community, existing partnerships	Aligned to misaligned	<i>Mental health aligns with the Ohio SHIP and with several other partners in our community.</i>

Stage 2: Goal Setting and Identification of Indicators

To create goals for the identified three (3) priority areas, the **Targeted Universalism** approach was used. This approach allows for visionary thinking to create a universally recognized and aligned goal, while still allowing for more sector-specific, targeted strategies to be put into place for subpopulations.

After a universal goal was written for each priority area, the group was challenged to ask the question, "Why are we not meeting that goal?" and then use **the 5 Whys method to conduct a root cause analysis** for each priority issue. This exercise was completed over two working sessions and resulted in a more shared understanding of the problem.

Once some key root causes were established, the group then participated in a discussion to align on measures of progress. Specifically, CCPH and THC used existing data sources, sets, and frameworks to identify possible measures to bring to the group. Data sources for the CHIP are selected based on their relevance, reliability, and ability to reflect the health status and needs of the population. Both primary data (such as surveys, focus groups, and community input) and secondary data (including public health surveillance systems and existing reports) are utilized to measure population-level impact and track progress over time. An inclusive view of the population impact indicators being monitored for each priority area can be found in the appendix. The resources used included **Healthy People 2030** targets, the **Regional CHNA** data appendix and priority measures, and existing data being collected in the jurisdiction, such as the PRIDE survey data, eviction data, and overdose fatality data. Then, the group was asked to add any measures or data sources to the list of potential measures, using their expertise, experience, and organizational perspective. Finally, facilitation then asked participants to review current data across 19 potential measures and vote on one of the top 1-3 measures that should be tracked for each priority area across the entire jurisdiction (county).

Stage 3: Best Practices, Strategies, and Objectives

During this stage of CHIP development, the group outlined strategies that could be used to address the root cause identified in Stage 2 and that would have a meaningful impact on universal goals. First, a discussion and presentation on strategy was held to encourage and increase alignment on strategy development. In alignment with the Targeted Universalism design approach, **strategy** was defined as "the intelligent and intentional allocation of resources through a unique system of activities to achieve a goal." For the group to discern between a **broad "strategy" and specific "strategies"**, the following definitions were used:

- *Strategy: the intelligent and intentional allocation of resources through a unique system of activities to achieve a goal (the bigger, full plan)*

- *Strategies: specific types of approaches and best practices that are known to work in addressing the problem.*

During this stage, CPH determined that, while housing remains a critical and cross-cutting community issue, it would be tabled as a primary CHIP priority area for direct implementation. This decision reflected the presence of a newly established housing-focused coalition and ongoing initiatives already actively addressing housing affordability, homelessness, and shelter capacity within the community. The CHIP strategies and activities related to this priority will be to support the efforts of the Clermont County Homeless Coalition and will be further defined in future updates.

Consistent with guidance from NACCHO, which emphasizes that the CHIP should align with, reinforce, and not duplicate existing partnership-led efforts, the CHIP defines a complementary role for CPH and its partners. Rather than creating a parallel action plan, the partnership committed to supporting and strengthening existing housing initiatives through coordination, alignment, and shared accountability.

As part of this approach, CPH will support Phase II resource dissemination activities related to housing by elevating and communicating existing resources, housing-related data, findings, and community needs to partners, decision-makers, and the broader community. Through this supportive role, the CHIP functions as a strategic backbone, reinforcing shared goals, promoting data-informed decision-making, and ensuring that housing-related efforts remain visible, aligned, and accountable within the broader community health improvement framework.

To compile a list of possible strategies/best practices for the remaining priorities, the Levels of Prevention/Impact were used. Specifically, participants were asked to develop one or two strategies that could impact each priority issue across three levels identified by the de Beaumont Foundation: **Upstream, Midstream, and Downstream**. In public health, these terms can also be synonymous with primary, secondary, tertiary prevention, or prevention, intervention, and treatment. Ideally, these strategies support the "targeted" part of Targeted Universalism, whereby strategies can support those populations and places that have different outcomes to the universal goal. With the establishment of strategies, participants were then asked to develop different types of activities that could be done to achieve the universal goal. To help participants consider different types and levels of activities, the **Social Ecological Model** was introduced. This model allows participants to think through how work can support individuals, communities, families, organizations, and policy. Finally, as the group determined activities to complete across sectors, CCPH, with help from key partners, developed SMARTIE objectives to help support progress and monitoring for all activities related to the three priority issues. These objectives – including owners and timelines – will help support implementation and monitoring of the CHIP.

Concurrently with the discussion of strategies and activities, CPH identified established assets and resources within the county that are already pursuing progress in the priority areas. A significant asset identified is the strong network of cross-sector community partnerships dedicated to addressing youth mental health, adult substance misuse, and housing. Through sustained collaboration, shared data review, coordinated planning, and aligned resources, partners implement evidence-based prevention, early intervention, treatment, harm reduction, recovery, and mental health promotion strategies to improve health and well-being outcomes for both adults and young people.

Clermont County has established evidence-informed strategies and best practices currently in place to address the identified priority needs. One available asset in Clermont is the Clermont County Crisis Hotline, which provides free and confidential services, including suicide prevention, crisis intervention, and referral information for residents of all ages. A CHIP strategy to address adult substance misuse is to increase awareness of the hotline to expand its reach.

An additional key community asset supporting access to care is the Clermont County Senior Services transportation assistance program. This program plays a vital role in helping older adults remain independent in their homes by ensuring reliable transportation to medical appointments, pharmacy visits, grocery shopping, and other essential services. By reducing transportation barriers, the program strengthens access to healthcare and supports overall health maintenance for the older adult population.

Engagement Methods

The development of the CHIP was guided by a comprehensive and inclusive engagement approach designed to ensure that community voices, partner expertise, and data-driven insights informed all stages of the process. Engagement activities were intentionally structured to reduce participation barriers and elevate voices from populations disproportionately impacted by health inequities, promote shared ownership, transparency, and recognize that sustainable health improvement requires collaboration across sectors and active participation from community members.

Partner engagement:

The CPH core team actively engaged partner organizations around key outcomes and activities, fostering collaboration and alignment across priority areas. The CPH Steering Committee played an integral role in the CHIP process and was involved in decision-making at each major phase, including priority identification, strategy development, and action planning.

As priorities were identified, priority area leads were selected to reflect and represent key populations and community perspectives relevant to each focus area. These leads contributed

subject matter expertise, community insight, and implementation capacity to support equitable and effective planning.

Broad community members included community partners and residents who chose to remain informed and engaged in a general capacity. These individuals received regular updates and opportunities to provide input, ensuring that the CHIP reflected community perspectives while maintaining an inclusive and accessible engagement structure.

Community engagement:

Community engagement was a foundational component of the CHIP process. Engagement began with clearly defining the community and establishing intentional, accessible, and ongoing opportunities for community members and partners to share input and inform decision-making. For this CHIP, the community was defined as individuals who live, work, learn, and receive services in Clermont County, including residents, community-based organizations, service providers, and cross-sector partners.

To support continuous community input, CCPH hosted a CHA/CHIP feedback survey on the CCPH website, which was regularly promoted by CPH partners. The survey remained available throughout the planning process and served as an ongoing mechanism to collect community perspectives related to health needs, barriers, priorities, and lived experiences. This approach allowed residents and partners to engage at their own pace and ensured that input was gathered from a broad and diverse cross-section of the community.

Survey data were regularly compiled, analyzed, and synthesized by the CPH Core team and shared with community partners and the CPH Steering committee. Findings were presented alongside other quantitative and qualitative data sources to support informed discussion, priority setting, and strategy development. This iterative feedback loop ensured that community input directly informed key decisions throughout the CHIP process.

In addition to the CHA/CHIP survey, CCPH engaged partners through meetings, collaborative discussions, and structured review of findings, reinforcing a participatory and data-informed approach. By embedding ongoing community input into each phase of planning, CCPH strengthened transparency, built trust with partners, and ensured that the CHIP reflects community-identified needs and priorities.

Future direction and ongoing engagement:

To sustain momentum and ensure accountability, a structured approach to ongoing engagement and monitoring will guide implementation of the CHIP. Engagement will continue beyond the planning phase through regularly scheduled touchpoints designed to assess progress, respond to emerging needs, and maintain alignment among partners.

Collaboration with community partners in Clermont County occurs on a routine and ongoing basis through well-established coalitions, workgroups, and cross-sector partnerships that are actively engaged in addressing community health priorities. These existing collaborations provide regular opportunities for information sharing, coordination, and collective problem-solving beyond formal CHIP meetings.

Given the strength and maturity of these partnerships, the CHIP engagement cadence is intentionally designed to complement—not duplicate—ongoing coalition activities. CPH meetings allow partners to step back from operational discussions and engage in a focused, strategic review of CHIP action items, progress toward outcomes, contributing factors, and emerging trends. These meetings support data-informed adjustments and alignment with broader community efforts.



Between meetings, email touchpoints ensure continued communication, timely updates on action items, and resolution of immediate questions or challenges. This approach maintains alignment across partners while respecting existing collaboration structures and minimizing participant burden.

Media package:

CPH will use a coordinated media and communication approach to support transparency, community awareness, and ongoing engagement throughout the CHIP implementation. Public-facing materials and partner-ready messaging will be used to share information about CHIP priorities, promote opportunities for community input, and encourage participation in the CHA/CHIP survey hosted on the CCPH website.

Media tools will support continuous engagement by directing residents and partners to the survey and other engagement opportunities. Community input collected through these channels will be analyzed and shared with partners and the CPH Steering Committee to inform discussion, priority setting, and decision-making.

Priority Areas, Goals & Strategies

CHIP priorities identified are Youth Mental Health, Adult Substance Misuse, and Housing. These priorities, goals, strategies, and activities are available via an online "Community Health

Improvement Scorecard." It's an easy way to learn about Clermont County's current health priorities and what our community leaders, partners, and residents are working on together to improve the health of our community. This scorecard is a living document that will change as the community priorities, progress, and landscape change. This tool makes it easy to see and get up-to-date information about:

- Results we hope to see as our health improves
- Data that concerns us and the story behind the data that helps us understand why things are getting better or worse
- Partners and programs working together to make things better
- Ways we are measuring success and describing how we are making a difference

Reviewers can click anywhere on the scorecard to learn more about the programs and partners who are working together to improve health in Clermont County. Use the + icons to expand items and the note icon to read more.

www.clermonthhealthohio.gov/cph

Key Social, Economic, and Environmental Conditions

CHIP prioritizes several pressing social and economic challenges that significantly affect overall well-being. Youth mental health has emerged as a critical concern, with increasing rates of stress, anxiety, and depression linked to academic pressure, social isolation, and limited access to behavioral health services. Adult substance misuse continues to strain families, healthcare systems, and public safety, often intersecting with mental health needs and economic instability. Housing insecurity, including affordability challenges and unstable living conditions, undermines physical and mental health and disproportionately impacts low-income households and vulnerable populations. Additionally, limited and unreliable transportation options create barriers to employment, healthcare access, education, and social connection. Addressing these priority areas through coordinated, community-driven strategies is essential to improving health outcomes and advancing equity across the community.

Health Equity Context

Youth mental health inequities in the community disproportionately affect older adolescents, particularly 11th- and 12th-grade youth, those living in low-income households, and youth who have experienced multiple ACEs. These populations are more likely to face barriers that negatively influence mental well-being, including economic instability, limited social support, and reduced community connectedness. System-level challenges such as inadequate availability

and capacity for mental health services further exacerbate these inequities, resulting in delayed or unmet care for youth who are already at heightened risk.

Adult substance misuse also reflects significant health equity concerns, especially among working-aged adults (approximate ages 30–50), single or unmarried men, and adults living with mental health conditions or disabilities. Individuals with a history of incarceration and those residing in rural areas of the county experience additional risk due to compounded barriers. Systemic factors contributing to adult substance misuse include limited access to addiction treatment and integrated medical care, widespread availability of substances, and normalization of substance use within families and communities. These structural conditions increase exposure while simultaneously restricting pathways to prevention, treatment, and recovery.

Housing instability intersects both mental health and substance misuse inequities and disproportionately impacts renters, low-income households, and adults with mental health conditions, disabilities, or prior criminal charges. Structural drivers such as economic inequity, inequitable allocation of funding, gentrification, and rapid population growth have reduced the availability of affordable and stable housing. These challenges are compounded by multigenerational stigma, limited financial education, and insufficient regulation and enforcement of housing laws. Together, these systemic factors create persistent barriers to housing stability, reinforcing broader health inequities across the community.

Through the CHA and prioritization process, transportation was identified as a significant community need due to its influence on access to services, employment, education, and social connections. While transportation emerged as an important concern, CPH determined that transportation barriers function most effectively as a cross-cutting determinant of health rather than a standalone priority area. As a result, CPH committed to intentionally identifying and addressing transportation-related barriers within the action plans for each selected priority area. By embedding transportation considerations across all CHIP priorities, CPH ensures that strategies address not only individual behaviors but also the structural and systemic conditions that shape access, equity, and outcomes.

Strategies & Evidence-Based Interventions

The strategies and activities to improve community health were developed through a collaborative process that integrates community strengths, data analysis, and community voice to achieve sustainable improvements in health and equity. CPH used CHA data and other relevant sources to identify populations experiencing higher health risks and poorer health

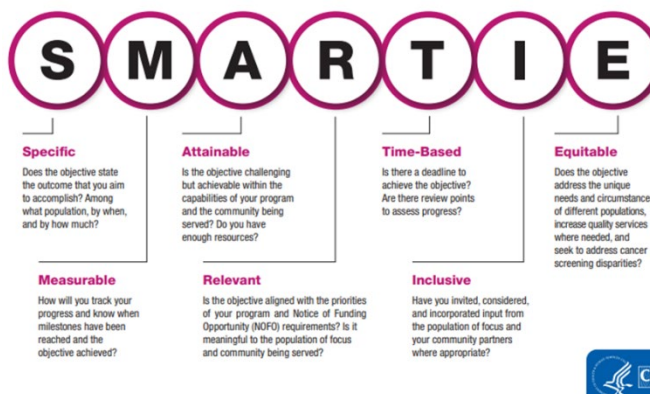
outcomes and to assess the underlying factors contributing to these disparities, including social, economic, environmental, and systemic influences.

Where disparities were identified, CPH developed population-specific strategies and interventions designed to address root causes and reduce barriers to health. These strategies focus on improving equitable access to services, resources, and opportunities and strengthening protective factors for populations disproportionately impacted by health inequities.

Strategies and interventions are informed by evidence-based and promising practices to ensure effectiveness and accountability. CPH identified interventions through review of public health research, best practice guidance, community expertise, and partner experience, ensuring alignment with identified community needs and contributing factors to health disparities.

Evidence-based and promising practices supporting CHIP priorities are documented and monitored within the Clear Impact performance management system under the "What Works" section, which identifies the rationale for selected approaches and supports evaluation of their effectiveness.

All strategies and activities were developed using SMARTIE objectives, ensuring that implementation efforts are clearly defined, measurable, population-focused, and designed to improve outcomes for those experiencing the greatest health risks. The specific SMARTIE objectives will be refined throughout the CHIP process and can be found under each priority area within the CHIP dashboard.



Implementation Plan

CPH has established a structured process to implement, monitor, track, and evaluate progress on CHIP strategies and activities. This process defines leadership roles, performance monitoring methods, reporting expectations, and evaluation procedures to ensure accountability, continuous improvement, and measurable impact. CPH, with the support of its partners, will begin the implementation of the CHIP strategies.

Implementation Structure and Leadership

To ensure coordinated implementation, accountability, and sustained progress, priority leads have been formally designated for each CHIP focus area. These leaders provide subject matter expertise, facilitate cross-sector collaboration, and oversee implementation activities.

As previously identified, the roles and responsibilities of the priority leads were clearly established to ensure accountability and coordinated progress across CHIP priority areas. In practice, priority leads play a central role in tracking and advancing implementation efforts within their designated focus areas. They monitor the execution of CHIP strategies and action steps, while also working to integrate CHIP objectives into the activities of partner organizations and coalitions.

Priority leads regularly report progress and performance data to the CPH Core team, including activities completed, milestones achieved within established timelines, barriers encountered, resource needs, and any implementation gaps. They also highlight adjustments made or needed to action plans and outline upcoming steps to maintain forward momentum. In addition, priority leads collaborate closely with the CPH Core team and fellow priority leads to promote cross-sector alignment and coordinated impact. They support continuous improvement efforts by co-facilitating review meetings and participating in evaluation discussions to ensure strategies remain responsive and effective.

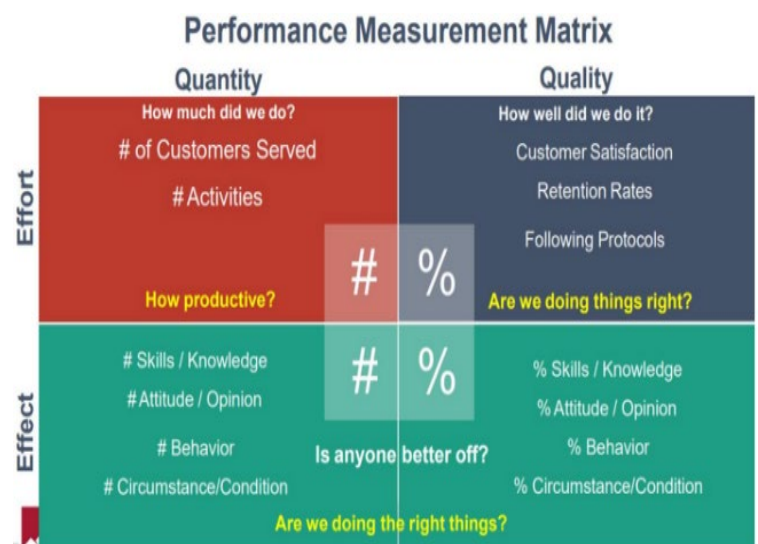
All CHIP partners share responsibility for implementing strategies, reporting progress, and participating in evaluation and continuous improvement activities.

Performance Monitoring & System

CPH tracks CHIP implementation using Clear Impact, a performance management platform based on Results-Based Accountability (RBA). The system provides a standardized framework to document, monitor, and evaluate implementation activities and outcomes. Information entered in Clear Impact includes:

- **Results:** Long-term community outcomes the CHIP seeks to achieve
- **Indicators:** Population-based measures used to track progress toward results, including baseline data and targets

Figure 3: Results-Based Accountability Framework



- **Story Behind the Curve:** Narrative explaining trends, contributing factors, and barriers
- **Data Sources:** Data used to monitor performance and identify disparities among subpopulations
- **Partners:** Organizations responsible for implementation
- **Strategies:** Evidence-based or promising approaches to achieve results
- **Action Plans:** Coordinated approaches for implementing strategies
- **Activities:** SMARTIE objectives defining specific implementation steps, timelines, and responsible parties

Progress is tracked using both outcome indicators (population-based) and process (performance metrics). Population-based indicators were selected using the RBA matrix within Clear Impact, which evaluates measures based on quantity and quality as well as effort and effect. The CPH Core team reviewed historical CHA and CHIP measures and worked with partners to select indicators that demonstrate meaningful change in priority areas.

Performance metrics for each activity are measured based on the SMARTIE goals that are established and the desired impact of that activity. Process measures track whether planned activities are being completed as intended and within the established timeframe. These metrics focus on accountability and fidelity to the plan. These metrics evaluate improvements in infrastructure, collaboration, and sustainability. Performance measures also review the impact on population-level data to determine progress and to identify disparity changes to inform targeted interventions.

Health equity is integrated throughout CHIP monitoring to ensure disparities are identified and addressed. This includes the use of disaggregated data, root-cause analysis to understand drivers of inequities, development of equity-focused strategies, and public reporting of progress.

This system enables CPH to track progress, assess performance, and identify opportunities for improvement. CPH follows a defined schedule to track implementation progress.

Quarterly Monitoring Meetings

CPH Core team conducts quarterly monitoring meetings with priority leads and partners to:

- Review progress on strategies, activities, and performance indicators
- Monitor completion of action steps
- Identify implementation barriers and resource needs
- Address emerging community conditions and
- Ensure coordination among partners

Biannual Comprehensive Review

Twice each year, the CPH Core team convenes comprehensive CHIP review meetings to evaluate overall progress and guide continuous improvement. These reviews include:

- Assessment of progress toward CHIP goals and objectives;
- Review of process and outcome performance measures;
- Analysis of disparities, contributing factors, and trends;
- Review of supplemental or alternative data sources; and
- Identification of modifications to strategies or performance targets.

Meeting documentation is maintained to demonstrate monitoring activities, partner engagement, and responsiveness.

Organizational Alignment and Integration

Population health targets are most effective when they are grounded in a comprehensive evaluation of local data trends and aligned with broader regional, state, and national benchmarks. Establishing these targets begins with a systematic review of local population health data, including epidemiologic indicators, demographic trends, social determinants of health, and health outcomes. Examining multi-year local data allows communities to identify priority health issues, emerging trends, and persistent disparities among subpopulations.

Local data trends are then compared to regional, state, and national targets such as Healthy People objectives or state health improvement goals to provide context for local performance. This comparison helps determine whether local outcomes lag behind, align with, or exceed broader benchmarks. Where gaps exist, targets can be set to achieve incremental improvement over a defined period, taking into account the community's baseline data, capacity, and available resources. Aligning local targets with higher-level benchmarks also ensures consistency with statewide and national public health priorities while maintaining local relevance.

Youth Mental Health Alignment and Targets

- **Regional CHNA**
 - Mental health was identified as a significant health need within health behaviors and outcomes in the region.
- **Ohio State Health Improvement Plan**

- One objective focuses on lowering the percentage of youth suffering from depression.
 - <https://dam.assets.ohio.gov/image/upload/odh.ohio.gov/SHIP/2020-2022/2020-2022-SHIP.pdf>
- **Healthy People 2030**
 - Objectives for adolescents under Healthy People 2030 include increasing the proportion of young people receiving treatment for depression, trauma symptoms, and serious emotional disturbances.
 - <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/mental-health-and-mental-disorders>

Adult Substance Misuse Alignment and Targets

- **Regional CHNA**
 - Substance use was included within health behaviors and outcomes and was found to be a significant health need in the region.
- **Ohio State Health Improvement Plan**
 - Strategies in Ohio to reduce drug overdose deaths include overdose prevention and reversal programs, as well as access to addiction treatment.
 - <https://dam.assets.ohio.gov/image/upload/odh.ohio.gov/SHIP/2020-2022/2020-2022-SHIP.pdf>
- **Healthy People 2030**
 - Objectives for Healthy People 2030 target drug and alcohol use, addiction, injury prevention, infectious disease, and more.
 - <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use>

Additionally, CHIP strategies are formally integrated into the CCPH’s approved Strategic Plan to ensure organizational alignment, sustainability, and accountability. Implementation progress is monitored through established performance measures and aligned with agency performance management processes.

How the results will be reviewed and used

Ongoing data collection and monitoring are essential to improving local outcomes over time. Community health and improvement plan data follow the continuous quality improvement methodology. By establishing measurable indicators and tracking the progress of activities at regular intervals, communities can assess whether implemented strategies are producing the desired impact. Continuous evaluation allows for course correction, resource reallocation, and refinement of interventions as needed. As local systems, partnerships, and policies evolve, improvements in local data can be documented and used to update targets, demonstrate

accountability, and sustain momentum. The updates to the indicators and the reevaluation of upcoming targets are reviewed as new data is published. Each indicator explains where the data is sourced and the frequency of expected updates.

Progress tracking for strategies and activities occurs through regular data collection and reporting cycles. Quantitative indicators—such as service utilization, participation rates, and policy adoption are monitored using program data and partner reports. Qualitative information, including stakeholder feedback and community input, is also incorporated to provide context and insight into implementation challenges and successes.

Implementation partners submit periodic status updates that document activities completed, milestones achieved, barriers encountered, and adjustments made. These updates are reviewed by the CHIP Core team and CHIP priority leads during scheduled meetings to assess whether strategies are being implemented as planned and to determine if timelines or approaches need modification. This is additionally a time to discuss if there are community health concerns that are trending and could be considered for prioritization. This review process supports shared accountability and strengthens collaboration among partners.

Communication & Use of the CHIP

The CHIP is intended to be a living, actionable document that guides decision-making, collaboration, and communication across Clermont County. It serves as a shared framework to align programs, policies, funding decisions, and partnerships around community-identified priorities and strategies, ensuring coordinated and equitable action.

How CHIP Will Guide Action and Partner Use

The CHIP serves as a shared roadmap for advancing health and equity across Clermont County and is intended to be a practical tool that community partners can use to guide planning, coordination, and collective action in support of community-identified priorities. The CHIP guides the planning and implementation of programs and initiatives across sectors by helping partners align existing and future efforts with shared community goals, ensuring that activities are responsive to documented community needs, consistent across sectors, and not duplicative.

The CHIP also informs policy discussions, funding decisions, and grant applications by providing a credible, data-informed foundation that reflects community needs and cross-sector collaboration. By referencing the CHIP, partners can strengthen needs statements, justify proposed interventions, and demonstrate shared accountability for improving community health outcomes.

In addition, the CHIP supports collective action by providing a common framework through which partners can coordinate activities, leverage resources, and contribute expertise across organizations and sectors. By using the CHIP as a guiding framework, partners help advance coordinated, equitable, and sustainable efforts to improve health outcomes and address underlying social and structural determinants of health throughout the community.

Communication Strategy

The CPH Core team will lead a coordinated communication approach to ensure the CHIP remains visible, accessible, and responsive to the community. The Core team will continuously create, implement, evaluate, and improve a media package campaign that communicates CHIP priorities, strategies, and activities using multiple modes of communication. Community voice and public health best practices will be incorporated to help shape the final content of the information provided to the public.

Communication methods may include, but are not limited to, social media posts, public service announcements, posters, video messaging, and other digital or print materials. All messaging will include a clear call to action and explain why the action is important. The Core team will ensure that communication reflects cultural humility and linguistic appropriateness to reach diverse populations across Clermont County effectively.

Communication Content and Timeline

CHIP-related communication will focus on clear, accessible themes, including:

- What is the CHA, and how is community input used?
- What is the CHIP, and how does it translate data into action?
- The role of community partnerships and how individuals and organizations can get involved
- Updates on priority areas, including why they matter and what actions can be taken

The communication and engagement plan includes a phased approach:

- January- February 2026: Core team reviews example and begins drafting communication content
- February 2026: Development of "What is the CHA?" and "What is the CHIP?" messaging; drafting and approval of media kit materials
- May 2026: Release of introductory CHA and CHIP educational posts
- May 2026: Initiation of broader community outreach
- Ongoing: Collection of community feedback and sharing of progress updates

Communication Channels and Partner Amplification

CHIP information will be shared through multiple channels, including:

- Social media platforms
- CCPH communications and partner outreach
- Quarterly communication letters
- Partner networks, consistent with the CPH Charter, which encourages partners to share CHA/CHIP information with the populations they serve

A CHIP media package will support consistent and coordinated messaging and may include:

- Guidance for partners on using and adapting materials (e.g., sharing CCPH posts or co-branding content with partner logos)
- Options for incorporating partner logos to support co-branded communications
- One-page summaries and updated profiles highlighting priority areas, strategies, and key activities
- Sample communication materials tailored to focus areas such as WIC and injury prevention

Evaluation and Continuous Improvement of Communication

In alignment with best practice guidance from the Public Health Accreditation Board (PHAB) Measure 3.2.2, the core team will regularly evaluate communication efforts to assess whether evidence-based or promising practices are appropriately tailored to community needs. Evaluation will consider whether community voice was meaningfully incorporated, whether messaging was culturally and linguistically appropriate, and whether communication efforts contributed to increased awareness, engagement, or behavior change.

Evaluation methods may include review of website traffic, social media analytics, survey responses, qualitative feedback from comments or community conversations, and other engagement metrics. Findings will be used to refine messaging, communication methods, and outreach strategies over time.

Sustainability & Updating the CHIP

Sustaining progress on community health priorities in Clermont County depends on the continued commitment, collaboration, and leadership of local partners and community members. The CHIP was developed as a shared, living roadmap that reflects the strengths of existing relationships and the collective responsibility to improve health and advance equity across the county.

Long-term sustainability will be supported by integrating CHIP priorities into the ongoing work of CCPH, partner organizations, and established coalitions. Many partners are already engaged in activities that align with CHIP goals, and continued implementation will build on this foundation by embedding CHIP strategies into organizational plans, programs, and funding efforts. Using the CHIP to guide alignment and grant applications helps reinforce shared ownership and ensures that efforts remain focused on community-identified needs.

The CHIP will be reviewed and updated through engagement structures that are familiar to Clermont County partners. Biannual CHIP meetings will provide space for partners to step back from day-to-day operations to reflect on progress, assess outcomes, and discuss what is working and what may need to change. Between these meetings, ongoing communication and quarterly touchpoints will allow partners to stay connected, address challenges, and maintain alignment.

New data and community input will continue to shape the CHIP over time. Updates from the CHA, ongoing community feedback, and partner insights will be reviewed and shared to inform adjustments to strategies and action steps. This ensures that the CHIP remains responsive to changing conditions, emerging trends, and the lived experiences of Clermont County residents.

By maintaining strong partnerships, valuing community voice, and committing to continuous learning, Clermont County partners and community members will collectively sustain and strengthen the CHIP as a tool for long-term, meaningful improvement in community health.

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Appendices

Partner list

The partnership includes representation from various sectors of the community and organizations representing those populations who are disproportionately affected by conditions that place individuals at risk for poorer health outcomes. Individuals who work closely with people with lived experience were encouraged to engage directly with community members to gather their input and ensure that community feedback informed the creation, implementation, and evaluation of the CHP.

Figure 7: Sectors of Clermont Partnership for Health

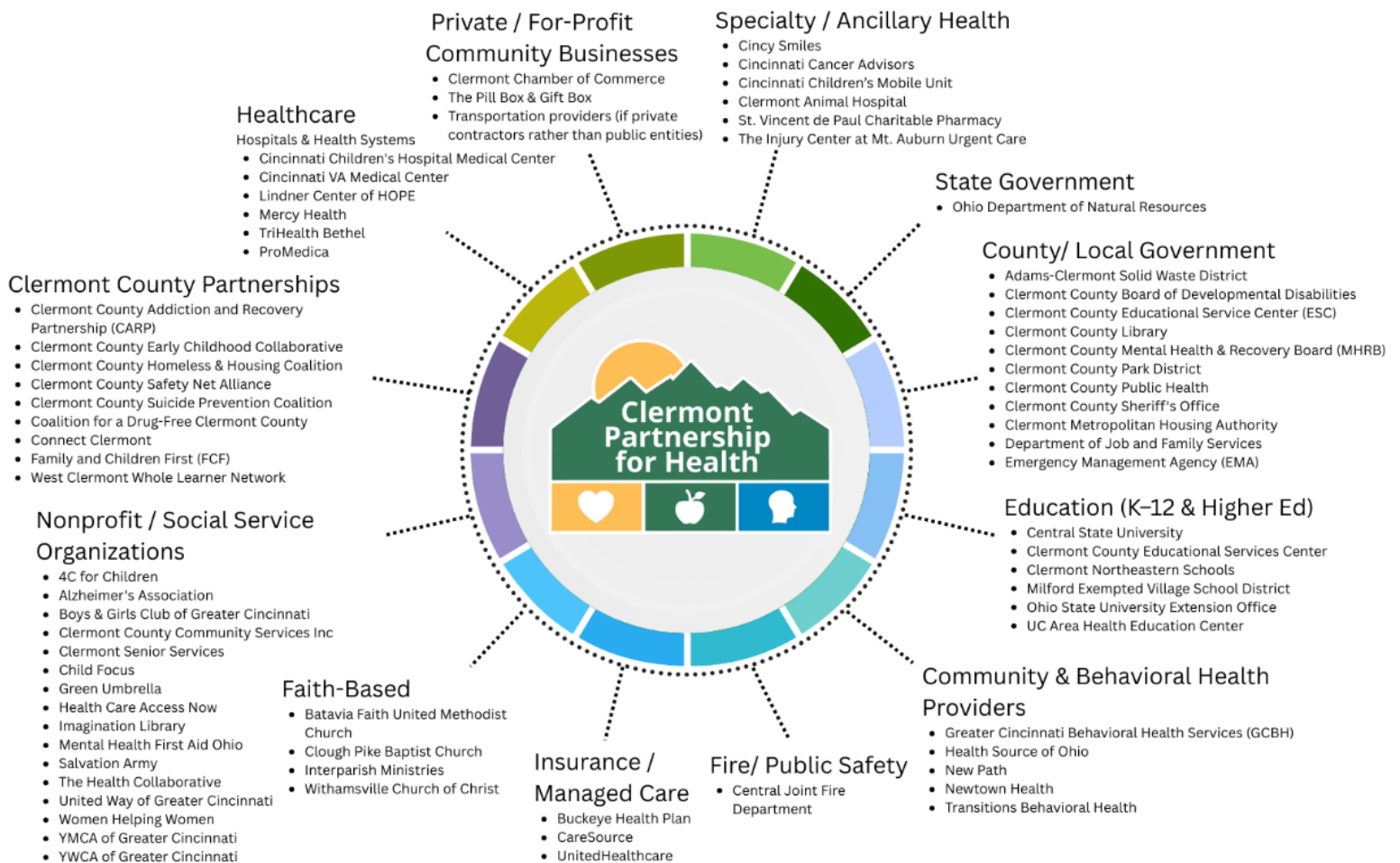


Table 2: List of Partners in the Clermont Partnership for Health

4C for Children
Adams-Clermont Solid Waste District
Alzheimer's Association
Batavia Faith & Summerside UMC
Boys & Girls Club of Greater Cincinnati
Buckeye Health
CareSource
Cincinnati Children's Hospital Medical Center
Central Joint Fire Department
Central State University
Child Focus
Cincinnati Cancer Advisor
Cincinnati Children's Mobile Unit
Cincinnati VA Medical Center
Cincy Smiles
Clermont Animal Hospital
Clermont Chamber of Commerce
Clermont County Board of Developmental Disabilities
Clermont County Community Services Inc
Clermont County Educational Service Center (ESC)
Clermont County Library
Clermont County Mental Health & Recovery Board (MHRB)
Clermont County Mental Health & Recovery Board (MHRB)/Early Childhood Collaboration
Clermont County Park District
Clermont County Public Health (CCPH)
Clermont County Sheriff's Office
Clermont Family Young Men's Christian Association (YMCA)
Clermont Transportation Connection (CTC)
Clermont Metropolitan Housing Authority
Clermont Northeastern Schools
Clermont Senior Services
Clough Pike Baptist Church
Coalition for a Drug-Free Clermont County
Department of Job and Family Services
Emergency Management Agency (EMA)
Family and Children First (FCF)
Greater Cincinnati Behavioral Health Services (GCBH)
Green Umbrella
Health Care Access Now
Health Source of Ohio

Inter Parish Ministries (IPM) Food Pantry
Lindner Center of Hope
Mental Health First Aid Statewide
Mercy Health
Mercy Health Partnership Program Community Health
Milford Exempted Village School District
New Path
Newtown Health
Ohio Department of Natural Resources
OSU Ext Office
ProMedica
Salvation Army
St. Vincent de Paul Charitable Pharmacy
The Health Collaborative (THC)
The Injury Center at Mt. Auburn Urgent Care
The Pill Box & Gift Box
Transitions Behavioral Health
TriHealth Bethel
UC Area Health Education Center
United Health Care
United Way Greater Cincinnati (UWGC)
Withamsville Church of Christ
Women Helping Women
Young Women's Christian Association (YWCA) Greater Cincinnati, Clermont, Brown, and Adams Counties

Logic models & Framework to Complete CHIP

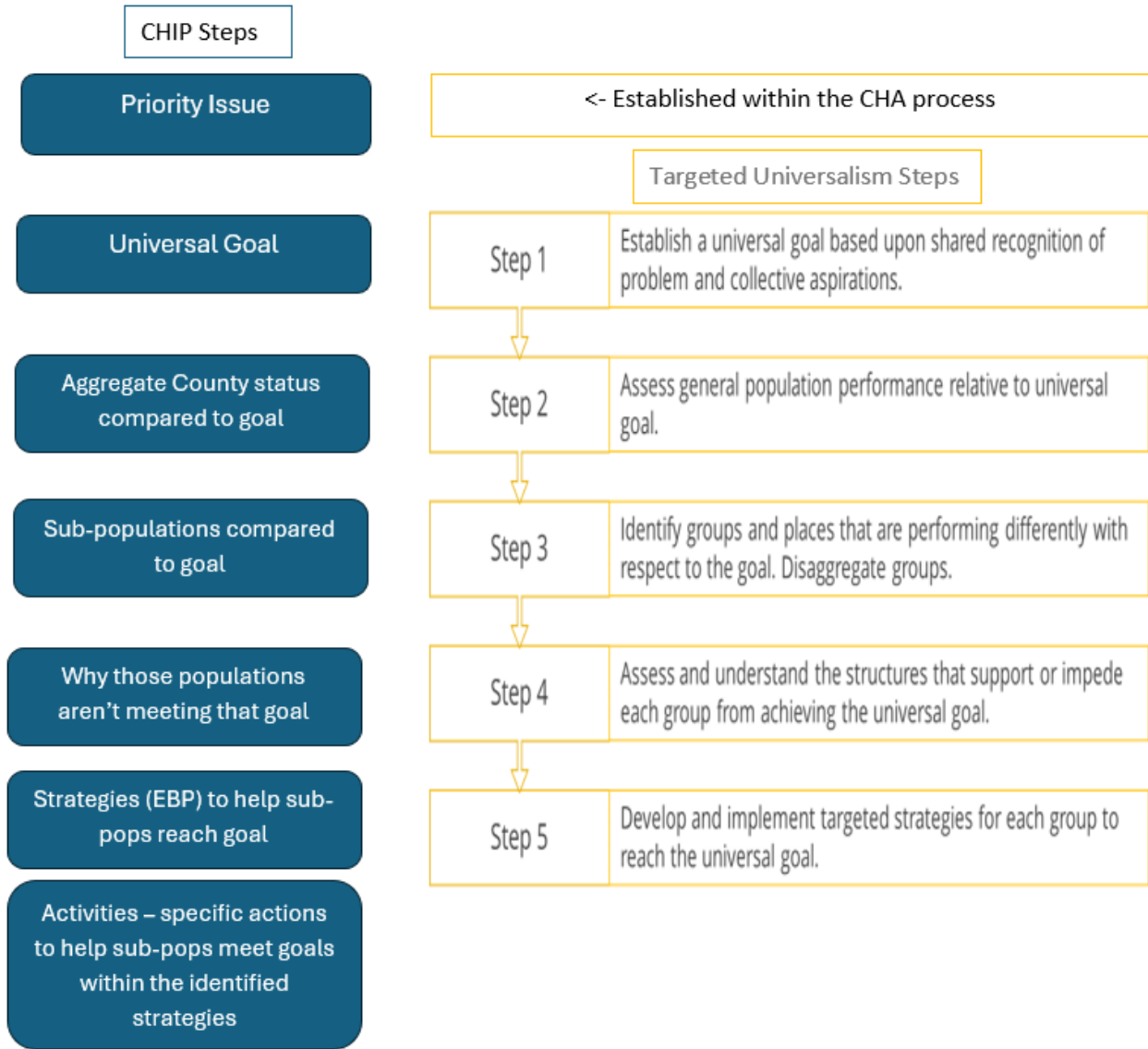
MAPP Phase III: Continuously Improve the Community

This phase centers on developing the CHIP by prioritizing issues and applying and evaluating strategies by community partners. The activities related to each of these steps is documented throughout this document. The core group can access each of the step processes and documents within the CCPH SharePoint Clermont County CHA & CHIP Collaboration Hub page.

1. Prioritize Issues for the CHIP
 - Using findings from the three assessments in Phase II and the issue profiles, identify three to five priority issues for the CHIP.
2. Do a Power Analysis of Each Issue
 - Do a power analysis to assess how each priority issue is influenced by people and institutions, including the factors that caused or led to the issue.
3. Set Up Priority Issue Subcommittees
 - For each priority issue, create a subcommittee to develop the action plan and assign the implementation process for selected strategies.
4. Create Community Partner Profiles
 - Distribute and analyze "partner profile" worksheets for each partner selected to be on the priority issue subcommittee to further understand their values, mission, available resources, and programmatic efforts related to the priority issue.
5. Develop Shared Goals and Long-Term Measures
 - Develop broad goal statements for each priority issue and identify how to measure progress.
6. Select CHIP Strategies
 - Using selected goals, identify strategies along the health equity action spectrum to achieve the desired outcome.

Targeted Universalism Steps and the Alignment with CHIP Steps

Figure 8: Targeted Universalism Steps and the Alignment with CHIP Steps

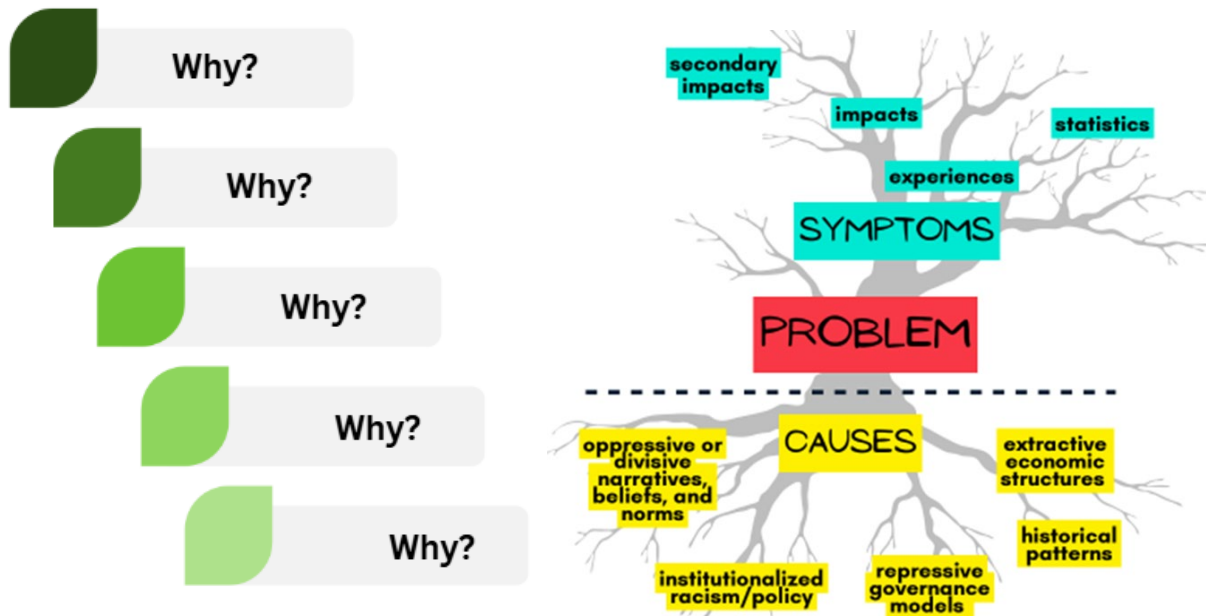


5 Whys

The 5 Whys is a root cause analysis technique that digs beneath surface-level symptoms by asking "Why?" repeatedly, typically five times, until the fundamental, actionable cause of a problem is identified. Health issues are rarely caused by a single factor. The 5 Whys reveals how multiple systems—healthcare, education, housing, transportation, and economic development—interact.

A root cause tree is a visual or conceptual tool used to explore the underlying causes of a problem by linking symptoms, the problem itself, and its root causes in a structured hierarchy. At the top of the tree are the observable symptoms, which are the immediate signs or effects of an issue. These symptoms lead to the identification of the problem, a more defined statement of what is going wrong. Beneath the problem are the causes, which are the factors contributing to the problem, often organized in multiple layers to reflect direct and indirect influences. The 5 Whys methodology complements a root cause tree by prompting repeated questioning—"Why does this happen?"—to dig deeper at each level of the tree until the true root cause is identified. By connecting symptoms to the problem and then tracing through successive causes, the root cause tree, combined with the 5 Whys, helps teams move beyond superficial fixes, enabling targeted interventions that address the foundational issues rather than just mitigating immediate effects. This broader perspective supports more comprehensive and collaborative solutions within a Community Health Improvement Plan.

Figure 9: 5 Whys Root Cause Analysis Visual and Root Cause Tree



Levels of Impact- Social Determinants and Social Needs: Moving Beyond Midstream by de Beaumont

Levels of Impact: Social Determinants and Social Needs – Moving Beyond Midstream, developed by the de Beaumont Foundation, provides a framework for understanding how interventions can address health at different levels. The model distinguishes between social needs and social determinants of health (SDOH) and emphasizes the importance of targeting

Figure 10: Levels of Impact- Social Determinants and Social Needs: Moving Beyond Midstream by de Beaumont



Graphic adapted from de Beaumont Foundation and Trust for America's Health. (January 2019) "Social Determinants and Social Needs: Moving Beyond Midstream"

upstream causes, rather than focusing solely on immediate or midstream solutions.

Downstream interventions address individual-level social needs, such as providing food, rental assistance, or transportation for healthcare appointments, which help people in the short term but do not change underlying conditions. Midstream strategies focus on improving systems and services within communities, like developing referral networks, expanding community health worker programs, or increasing access to primary care, which improve coordination but still

may not address root causes. Upstream interventions target structural and environmental factors, such as policies for affordable housing, transportation infrastructure, living wages, or zoning reforms, aiming to change the conditions that influence health outcomes across populations. The central message of the framework is that sustainable health improvement requires moving beyond midstream approaches to incorporate upstream strategies that address the social determinants shaping health inequities.

This framework encourages communities not to focus solely on addressing individual social needs or improving services, but to also invest in upstream, structural strategies that change the conditions driving poor health outcomes.

Levels of Influence- Social Ecological Model

The Social-Ecological Model (SEM) is a framework showing human development and behavior are shaped by interconnected levels: the individual, their relationships (family/friends), community settings (schools, workplaces), and broader societal/policy factors (culture, laws). Developed by Urie Bronfenbrenner, it emphasizes that effective health and social interventions must address multiple levels, not just individual choices, by understanding the complex interplay between personal traits and environmental influences.

Figure 11: Levels of Influence- Social Ecological Model



MAPP Crosswalk to PHAB standards

STEP	DESCRIPTION	Suggested Frequency to Revisit or Update			PHAB
		Annual/ Ongoing	3 years	5 years	Domain/ Measure
Phase I: Build the Community Health Improvement Foundation. This phase unites many partner organizations and people to plan for MAPP.		Estimated Timeline: 9 months			
1. Do a Stakeholder and Power Analysis	Identify people and groups who have an effect on MAPP, and whom MAPP will affect, and analyze those impacts.	X			4.1.3 1; 5.1.1 1; 5.1.2 1
2. Establish or Revisit CHI Leadership Structures	Develop a diverse core group and a steering committee of community members and partner organizations to direct the process.	X			1.1.1 a; 4.1.2; 7.1.1 a
3. Engage and Orient the Steering Committee	Onboard the Steering Committee to MAPP to establish a baseline understanding of foundational concepts for CHI, health equity, and community engagement.	X			
4. Establish Administrative Structures for MAPP	Decide who will provide administrative support for MAPP and how to formalize partnerships and organizational commitments to MAPP.			X	4.1.2
5. Develop the Community Vision	Collectively define "the community" and a vision for a healthy future.			X	

6. Do the Starting Point Assessment	Reflect on the past cycle, identify resources available for the current cycle, and create goals for the current cycle.			X	
7. Identify CHI Infrastructure Priorities and Develop Workgroups	Establish two to four workgroups to strengthen the CHI infrastructure during the current CHI cycle.	X			
8. Develop the Workplan and Budget	Outline milestones and goals for MAPP.			X	
Phase II: Tell the Community Story This phase includes the preparation, application, and analysis of the three assessments.		Estimated Timeline: 9 months			
1. Form the Assessment Design Team	Recruit a team that represents the community to coordinate the design, application, and interpretation of the assessments.	X			5.2.1 1
2. Design the Assessment Process	Design the process for the assessments, specifically thinking about the order in which the assessments will be done.	X			1.1.1 b
3. Do the Three Assessments	Do the Community Partner Assessment (CPA), Community Status Assessment (CSA), and Community Context Assessment (CCA) to understand the status of health in your community.		X		1.1.1 c,d; 1.3.1; 7.1.1 b, c; 7.2.2
4. Triangulate Data, Identify Themes, and	Develop a thorough understanding of the community through data triangulation, identifying cross-cutting		X		1.1.1 e, f; 1.3.1;

Develop Issue Statements	themes that will be used to develop issue statements that reflect the issues faced by the community.				5.1.1 1; 7.1.1 d
5. Develop Issue Profiles through Root Cause Analysis	Discuss the findings and develop "issue profiles" of the issues identified in the previous step, including descriptions/contributors of the problem, priority community indicators that tie together "upstream and downstream" metrics, and assets to address the issues.		X		1.1.1 e, f; 1.2.1; 1.3.1; 1.3.3 1; 5.1.1 1; 5.2.1 c; 7.1.1 d
6. Share CH[N]A Findings	Use the data across the three assessments and issue profiles to develop and share CH[N]A findings with the community.		X		5.1.1 1
Phase III: Continuously Improve the Community This phase centers on developing the CHIP by prioritizing issues and applying and evaluating strategies by community partners.		Estimated Timeline: 6 months			
1. Prioritize Issues for the CHIP	Using findings from the three assessments in Phase II and the issue profiles, identify three to five priority issues for the CHIP.			X	1.1.2 1; 5.2.1 d; 5.2.2 a
2. Do a Power Analysis of Each Issue	Do a power analysis to assess how each priority issue is influenced by people and institutions, including the factors that caused or led to the issue.	X			4.1.3
3. Set Up Priority Issue Subcommittees	For each priority issue, create a subcommittee to develop the action plan and assign the implementation process for selected strategies.	X			4.1.1; 5.2.1 a

4. Create Community Partner Profiles	Distribute and analyze "partner profile" worksheets for each partner selected to be on the priority issue subcommittee to further understand their values, mission, available resources, and programmatic efforts related to the priority issue.	X			4.1.1; 5.1.2 1; 5.2.2 d
5. Develop Shared Goals and Long-Term Measures	Develop broad goal statements for each priority issue and identify how to measure progress.			X	5.1.2 1; 5.2.1 b; 5.2.2 d
6. Select CHIP Strategies	Using selected goals, identify strategies along the health equity action spectrum to achieve the desired outcome.	X			1.3.2; 4.1.2; 5.1. 1 ; 5.2.3; 7.1.2; 7.2.1; 7.2.2
7. Develop Continuous Quality Improvement Action Planning Cycles	Develop an action plan including objectives, measures, timelines, and a plan-do-study-act cycle that details the needed milestones and responsibilities of the MAPP team and subcommittee members.	X			4.1.2 ; 5.1.1; 5.2.3; 7.1.2; 7.2.1
8. Monitor and Evaluate the CHIP	Plan ongoing monitoring of CHIP priorities through data collection and activity performance to observe measurable progress on goals and strategies over time.	X			1.1.2; 1.3.1; 1.3.2 5.2.2 ; 5.2.3; 7.1.2; 7.2.1

Detailed Data Tables

The data tables below are used to systematically monitor progress across the identified community health improvement priority areas. These include metrics that identify population (Indicator [big I]) and sub-population (indicator [little i]). They provide measurable indicators, trend data, and benchmarks that help assess outcomes, identify disparities, and guide data-driven decision-making. By regularly reviewing these tables, partners can track performance, evaluate the impact of interventions, and adjust strategies as needed to improve community health.

Indicator (big I): the data point and measures at the county level; an aggregate value across all populations; there is only one of these.

indicator (little i): the data point and measure at the sub-population level; disaggregated values of the Indicators; there is more than one of these.

Housing

Metric and Year	Description	Source	Clermont Data		Disaggregated Data (yes/ no)
Severe housing problems. Percent of households that had at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities (2016-2020).	Percent of households that had at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	Comprehensive Housing Affordability Strategy (CHAS) data, as compiled by County Health Rankings and Roadmaps.	11.8%		No
Housing cost burden. Percent of all homeowners or renters who are burdened or severely burdened by housing costs (2018-2022).	Percent of all homeowners or renters who are burdened or severely burdened by housing costs. This means that homeowners are spending 30% or more (burdened) or 50% or more (severely burdened) of their household income on selected monthly owner costs, including mortgage principal payments, interest payments, real estate taxes, property insurance, homeowner fees, condo or coop fees, and utilities (not	U.S. Census Bureau, American Community Survey 5-year estimates, as compiled by Policy Map.	30% owner cost burden	17.1%	Yes
			50% owner cost burden	7.1%	Yes

Housing

	<p>including telephone or cable television). For renters, this means that they are spending 30% or more (burdened) or 50% or more (severely burdened) on gross rent, which includes contract rent and the estimated average monthly cost of utilities (electricity, gas, water and sewer) and fuels (oil, coal, kerosene, wood, etc.) if these are paid by the renter (or paid for the renter by someone else).</p>		<p>30% renter cost burden</p>	<p>37.5 %</p>	<p>Yes</p>
			<p>50% renter cost burden</p>	<p>17.4 %</p>	<p>Yes</p>
<p>ALICE households: Percent of households that were below the ALICE (asset-limited, income-constrained, and employed) threshold (2022).</p>	<p>Percent of households that were below the ALICE (asset-limited, income-constrained, and employed) threshold. This includes households earning incomes below the federal poverty level and households that earn more than the federal poverty level, but</p>	<p>ALICE Threshold and U.S. Census Bureau, American Community Survey, as compiled by United for ALICE.</p>	<p>33.9%</p>	<p>Yes</p>	

Housing

	not enough to afford the basics where they live.			
United Way: Calls to 211 for housing needs (2022).	Calls to 211 for housing needs in one calendar year (2022).		1,067	Yes
Homeownership	Rate, 2017-2021. The proportion of households that are owners is termed the homeownership rate. It is computed by dividing the number of households that are owned by the total number of occupied households.	Source: 2017–2021 American Community Survey (ACS) Five-Year Estimates, Table B25003; 2021 Current Population Survey/Housing Vacancy Survey (CPS/HVS), U.S. Census Bureau <i>Taken from</i> https://ohiohome.org/research/homeownership-23.aspx	73.2%	
Median household rent reflects the relative affluence and prosperity of an area. Areas with higher median household rents are likely to have more educated residents and lower	There are 410 Census Tract values. The lowest value is \$387, and the highest value is \$2,667. Half of the values are between \$890 and \$1,287. The middle (median) value is \$1,056.	Southwest Ohio Datahub: Indicators: Median Household Gross Rent.	\$1,056	Yes – Census tract

Housing

<p>unemployment rates (2019-2023).</p>				
<p>Prevalence of Severe Rent Burden by County.</p>	<p>Rate, 2017-2021. Severe rent burden is defined as a renter household spending at least 50 percent of household income on gross rent or having no income.</p>	<p>https://ohiohome.org/research/rentalhousing-23.aspx#severe Ohio Housing Finance Agency: FY 2024 Housing Needs Assessment.</p>	<p>4,134; Rate 20.0% (2017-2021)</p>	<p>No Table 2.23 - Top 25 School Districts by Prevalence of Severe Rent Burden - Goshen Local School District (Clermont) 312 (32.8%)</p>
<p>Students Experiencing Homelessness by County. Percent of students that are enrolled that are experiencing homelessness (2021-2022).</p>	<p>Percent of students that are enrolled that are experiencing homelessness.</p>	<p>https://ohiohome.org/research/housinginsecurity-23.aspx Ohio Housing Finance Agency: FY 2024 Housing Needs Assessment. Ohio Department of Education (public data request, based on 2021–2022 school year data)</p>	<p>98; 0.35% enrollment (2021-2022 school year)</p>	<p>No</p>

Housing

<p>Point in Time Count. Provides a Snapshot of Homelessness (2025).</p>	<p>Number of individuals experiencing homelessness in the county.</p>	<p>Coalition on Homelessness and Housing in Ohio https://cohhio.org/boscoc/hicpit/</p>	<p>7 Unsheltered; 31 Sheltered (Point in Time Date 1/28/25)</p>	<p>No</p>
<p>Eviction Filing Rate. The rate in which evictions were filed in Clermont County (total count also available) (2022).</p>	<p>The rate in which evictions were filed in Clermont County (total count also available). Caseload statistical reports are submitted to the Supreme Court of Ohio's Case Management Section.</p>	<p>https://ohiohome.org/research/housinginsecurity-23.aspx Ohio Housing Finance Agency: FY 2024 Housing Needs Assessment. State of Ohio Court Statistics; 2017-2021 American Community Survey Five-Year Estimates, Table B25003</p>	<p>1,434; Rate 6.9%</p>	<p>No</p>

Youth Mental Health

Metrics	Description	Source	Clermont Data	Disaggregated Data (yes/ no)
<p>Depressive symptoms. Percent of students who responded to how often they exhibit depression symptoms (2024).</p>	<p>Percentage of students who responded "often/a lot" to the question "during the past 30 days, about how often did you feel depressed, sad, or hopeless?"</p>	<p>Parents' Resource Institute for Drug Education (PRIDE) Survey 2024</p>	<p>18.2%</p>	<p>Yes- by grade. Some additional demographics are available with multiple years of aggregation.</p>
<p>Suicide ideation. Percent of students who have thought about attempting suicide (2024).</p>	<p>Percentage of students who responded "often/a lot" to the question "Have you ever thought about attempting suicide?"</p>	<p>Pride Survey 2024</p>	<p>7.5%</p>	<p>Yes- by grade. Some additional demographics are available with multiple years of aggregation.</p>
<p>Anxiety prevalence. Percent of students who feel nervous or anxious (2024).</p>	<p>Percentage of students who responded "often/a lot" to the question "during the past 30 days, about how often did you feel nervous or anxious?"</p>	<p>Pride Survey 2024</p>	<p>35.6%</p>	<p>Yes- by grade. Some additional demographics are available with multiple</p>

Youth Mental Health

				years of aggregation.
Social connectedness. Percent of students who feel the desire to be alone all of the time (2024).	Percentage of students who responded "often/a lot" to the question "during the past 30 days, about how often did you feel a desire to be alone all the time (avoiding people and activities)."	Pride Survey 2024	23.3%	Yes- by grade. Some additional demographics are available with multiple years of aggregation.

Adult Substance Misuse

Metric and Year	Description	Source	Clermont Data	Disaggregated Data (yes/ no)
<p>Frequent mental distress. Percent of adults who reported 14 or more days of poor mental health per month (2021).</p>	<p>Percent of adults who reported experiencing 14 or more days of poor mental health per month (age-adjusted).</p>	<p>Behavioral Risk Factor Surveillance System, as compiled by County Health Rankings and Roadmaps.</p>	<p>16.7</p>	<p>No</p>
<p>Substance use disorder-related hospital encounters. Number of hospital encounters with a primary or secondary diagnosis for a substance use disorder, per 100,000 hospital encounters (2023).</p>	<p>Number of hospital encounters with a primary or secondary diagnosis for a substance use disorder, per 100,000 hospital encounters. Substance use disorder diagnoses are identified by ICD-10 codes F10 through F19.</p>	<p>Analysis of Ohio Hospital Association Data Tables (August 2024) by the Health Collaborative.</p>	<p>397</p>	<p>Yes</p>
<p>Mental health-related hospital encounters. Number of hospital encounters with a primary or admission diagnosis for mental health, per 100,000 hospital encounters (2023).</p>	<p>Number of hospital encounters with a primary or admission diagnosis for mental health, per 100,000 hospital encounters. Mental health diagnoses are identified by ICD-10 codes F01 through F99.</p>	<p>Analysis of Ohio Hospital Association Data Tables (August 2024) by the Health Collaborative.</p>	<p>3201.7</p>	<p>Yes</p>

Adult Substance Misuse

<p>Overdose-related hospital encounters. Number of hospital encounters, for people ages 11 and older, with any diagnosis for non-fatal drug overdose, per 100,000 hospital encounters (2023).</p>	<p>Number of hospital encounters, for people ages 11 and older, with a diagnosis for non-fatal drug overdose, per 100,000 hospital encounters. Overdose-related hospital encounters are identified by ICD-10 codes from Ohio Administrative Code Rule 3701-3-16, Appendix A.</p>	<p>Analysis of Ohio Hospital Association Data Tables (August 2024) by the Health Collaborative.</p>	<p>288.2</p>	<p>Yes</p>
<p>Unintentional drug overdose deaths. Detailed reports that investigate the contributing factors of the overdose fatality (2023).</p>	<p>The State Unintentional Drug Overdose Reporting System (SUDORS) was developed by the Centers for Disease Control and Prevention (CDC) for participating states to collect in-depth information on unintentional drug overdose deaths. This detailed data is compiled using coroner and medical examiner reports involving fatal drug overdoses. The goal of collecting this data is better to comprehend key elements of unintentional drug overdose deaths to help inform public health efforts in prevention and response.</p>	<p>Ohio State Unintentional Drug Overdose Reporting System Data.</p>	<p>56</p>	<p>Yes- by gender (% and number) and race (%).</p>
<p>Overdose Fatality Review. A detailed report examining the demographics of the decedents (2024).</p>	<p>Number of decedents whose death was classified as an accidental drug overdose and occurred in Clermont County.</p>	<p>Clermont County Public Health Overdose Fatality Review. https://ccphohio.org/fatality-reviews/</p>	<p>21</p>	<p>Yes- by multiple demographics.</p>

Adult Substance Misuse

<p>911 call data. Total count review of calls made to 911 related to unintentional drug overdose (2024).</p>	<p>911 calls for unintentional drug overdoses as reported to CCPH by the Department of Public Safety.</p>	<p>Clermont County Public Health Overdose Fatality Review. https://ccphohio.org/fatality-reviews/</p>	<p>116</p>	<p>The public report is not disaggregated by geography, gender, or age, but data is available.</p>
<p>Emergency department visits for unintentional drug overdose. Information regarding emergency department visits for unintentional drug overdose (2024).</p>	<p>Information regarding emergency department visits for unintentional drug overdose can be downloaded from EpiCenter.</p>	<p>EpiCenter & Fatality Review. https://ccphohio.org/fatality-reviews/</p>	<p>213</p>	<p>The public report is not disaggregated by geography, gender, or age, but data is available.</p>
<p>Naloxone dose administration by EMS. Reported administration of Naloxone in Ohio and the frequency at which the services are provided (2025).</p>	<p>The purpose of EMS Incident Reporting System (EMSIRS) is to collect information regarding the delivery of emergency medical services in Ohio and the frequency at which the services are provided. Information collected will be used as a guide to determine the impact of training and the areas that need to be focused on for training.</p>	<p>Ohio EMS. https://ems.ohio.gov/ems-trauma-data/naloxone-watch</p>	<p>Data updated and posted quarterly – most updated is from 9/8/25, 119 total administrations.</p>	<p>Yes- quarterly by zip code.</p>

Issue Profiles

Cardiovascular Health

CARDIOVASCULAR HEALTH

Heart disease is among the top leading causes of death in older adults living in Clermont County and can be caused by certain health behaviors or lack of healthcare access in the county.



DESCRIPTION OF ISSUE

Heart disease is a health outcome and is a priority area identified by the Ohio Department of Health. Heart disease mortality has been increasing in Clermont County, and it is vital to provide residents with education on health behaviors, as well as access to beneficial resources. Health behaviors, such as physical activity, nutrition, substance use, and weight, can have a significant impact on cardiovascular health.

COMMUNITY INDICATORS

#1 LEADING CAUSE OF DEATH IN CLERMONT COUNTY IN 2022

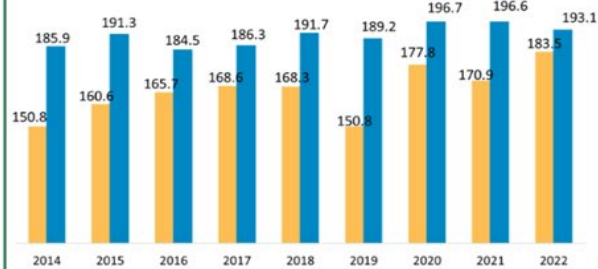
Source: 2014 - 2022 Ohio Mortality Data (secondary source).



There is a barrier for people to get more physically active due to a lack of sidewalks where people can safely walk or run on...

- Clermont County Resident

AGE ADJUSTED RATE OF DEATH DUE TO DISEASE OF THE HEART IN CLERMONT COUNTY COMPARED TO OHIO



Source: 2014 - 2022 Ohio Mortality Data (secondary source).



POTENTIAL SOLUTIONS

PHYSICAL ACTIVITY HEALTH PROMOTION

Lack of physical activity can be a risk factor for heart disease. Increasing access to safe walking paths, exercise equipment, and other methods of physical activity is important in mitigating risk.

HEALTH BEHAVIOR EDUCATION

Educating the community on how health behavior can directly correlate with cardiovascular health can help them understand the impact of actions and ways to make lifestyle changes.

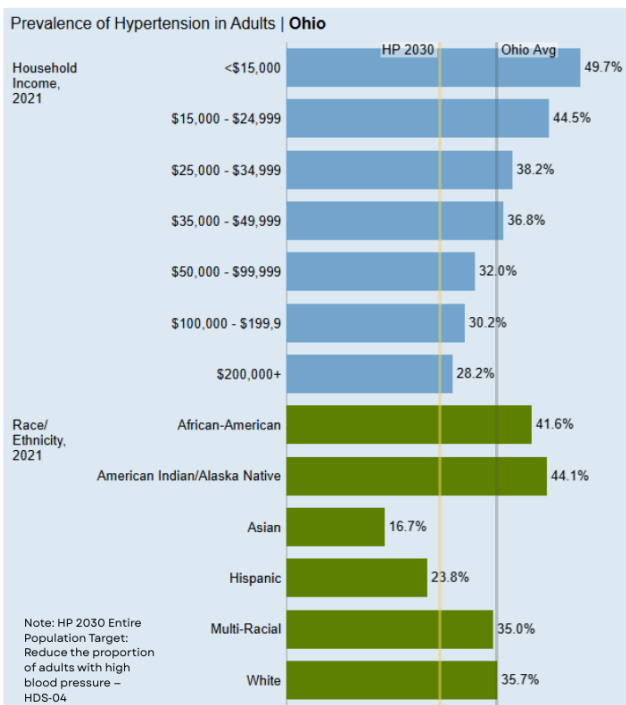
IMPROVED ACCESS TO CARE

Increasing access to care is vital as it can help increase preventive measures and provide people with necessary health actions and education.

ALIGNMENT

- **Regional CHNA**
 - Heart disease and stroke were included within health behaviors and outcomes and found as a significant health need in the region.
 - <https://ccphohio.org/cph/>
- **Ohio State Health Improvement Plan**
 - Ohio identifies heart disease as a key health objective and provides strategies for improving health outcomes, including increasing physical activity, promoting healthy nutrition, and reducing disparities.
 - <https://dam.assets.ohio.gov/image/upload/odh.ohio.gov/SHIP/2020-2022/2020-2022-SHIP.pdf>
- **Healthy People 2030**
 - Objectives for Healthy People 2030 to improve cardiovascular health outcomes include reducing cardiovascular-related deaths, enhancing overall health outcomes, improving emergency preparedness, hospital and emergency services, and promoting preventive care.
 - <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/heart-disease-and-stroke>

POPULATION SPECIFIC INFORMATION



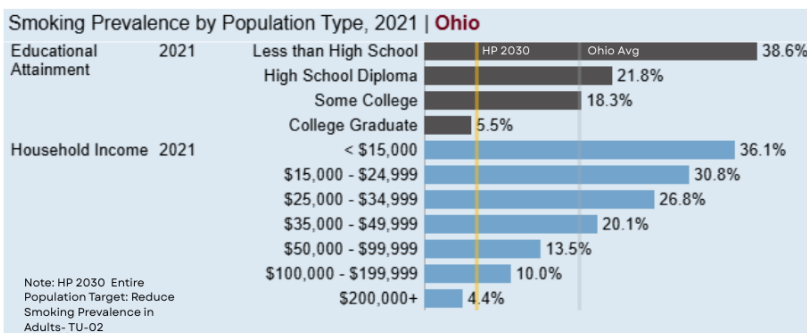
Due to data limitations, population-specific information for Clermont was not available. Below are two tables from the Ohio Department of Health, which contain 2021 Ohio population data regarding the Prevalence of Hypertension in Adults and the prevalence of smoking by Population Type. Smoking prevalence is a health behavior associated with a higher risk of cardiovascular disease.

Prevalence of Hypertension in Adults, Ohio 2021

Among Race/Ethnicity in 2021, American Indians/Alaska Natives had the highest prevalence of hypertension (44.1%), followed by African Americans (41.6%) and Whites (35.7%).

Smoking Prevalence by Population Type, Ohio 2021

When considering educational attainment, those with Less than a High School Diploma had the highest smoking prevalence (38.6%), while those who were college graduates had the lowest prevalence of smoking (5.5%).



Among various household income levels, the highest prevalence of both smoking and hypertension was observed in individuals earning less than \$15,000. In contrast, households with incomes exceeding \$200,000 exhibited the lowest prevalence rates for both conditions. Notably, there was a clear trend showing that the prevalence of these issues decreased as household income increased.

Source: Ohio Department of Health State Health Assessment 2019 (secondary source).

YOUTH SUBSTANCE MISUSE

Youth in Clermont County are at risk for increased alcohol and drug use due to influence on social media, loosening laws surrounding marijuana use (making it more accessible), and alcohol companies releasing advertisements that target the youth demographic.



DESCRIPTION OF ISSUE

Recognizing substance misuse among the youth population could allow for better early intervention strategies to be implemented to reduce the risk of progressing into lifelong health issues or becoming adults with substance use disorders.

COMMUNITY INDICATOR



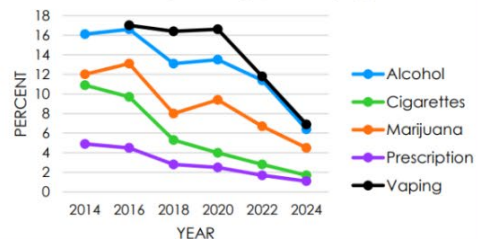
Most kids are **NOT** using alcohol, tobacco, or other drugs.



Past 30-Day use of Alcohol decreased from 11.4% in 2022 to 6.4% in 2024.

Past 30-Day use Electronic- Vapor Products is at the lowest level ever recorded, dropping 4.9% from 2022 to 2024.

30-Day Use of Alcohol, Cigarettes, Marijuana, Prescription Drugs, and Vaping



Source: Prevention First (2024). Student Survey Alcohol & Drug Misuse by Youth in Clermont County. (primary source).

COMMUNITY INDICATOR

Youth is the primary demographic that community partners focus on, accounting for 42%.

In recent years, laws surrounding marijuana have become more relaxed, leading to increased accessibility across all demographics and reducing the associated risks of consequences.

POTENTIAL SOLUTIONS



EDUCATION

Continue school-based prevention programs and education on the risk of using marijuana as an adolescent.



FAMILY/COMMUNITY SUPPORT

Support from family and the community can play a vital role in assisting individuals in overcoming substance use disorders.



SAFE USE PROGRAMS

Continue to operate and promote safe use programs, which can provide crucial resources for individuals who find it challenging to quit. These initiatives not only guarantee safe usage but also create a supportive atmosphere for those ready to make meaningful changes in their lives.



ALIGNMENT

- **Prior Year Clermont CHIP:**
 - Youth Alcohol & Substance Use was a priority topic from the previous CHIP.
 - <https://ccphohio.org/cph/>
- **Regional CHNA:**
 - Improving the incident rate for youth drug use is a long-term regional goal.
 - <https://ccphohio.org/cph/>
- **Ohio State Health Improvement Plan (SHIP):**
 - Youth drug use is part of Mental health and an additional priority health outcome for the Ohio SHIP.
 - <https://dam.assets.ohio.gov/image/upload/odh.ohio.gov/SHIP/2020-2022/2020-2022-SHIP.pdf>
- **Healthy People 2030:**
 - Objectives for Healthy People 2030 to improve substance use in adolescents include reducing the proportion who drank or used drugs in the past month and increasing the proportion who think substance abuse is risky
 - <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use>

POPULATION SPECIFIC INFORMATION

Prevention First 2024 Student Survey One-Pager:

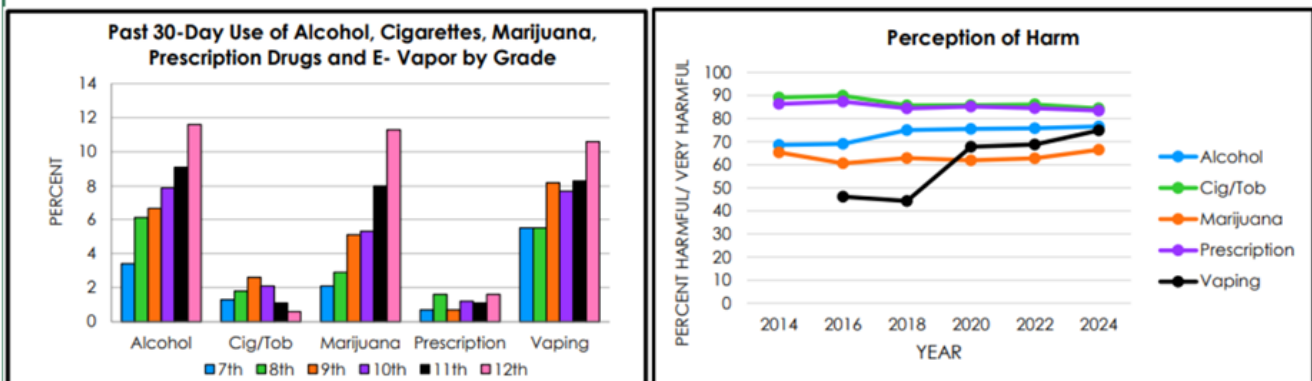
4 Key Measures of Substance Use/Misuse for Clermont County

Measure	Alcohol	Tobacco	Marijuana	Prescription Drugs ¹	Vaping
Past 30-Day Use	6.4%	1.7%	4.5%	1.1%	6.9%
Perception of Harm ²	76.6%	84.4%	66.5%	83.5%	74.9%
Parental Disapproval ³	87.8%	93.2%	90.5%	94.6%	92.0%
Friend Disapproval ³	73.2%	82.5%	79.2%	89.0%	77.9%

¹Non-medical use ²Percent responding harmful or very harmful ³Percent responding that parent or friend feels behavior is wrong or very wrong

PRIDE survey:

- Over one-third of students reported experiencing anxiety all or most of the time. Furthermore, 7.5% indicated that they frequently or often have thoughts of suicide.
- Percentage of students feeling emotions all or most of the time:
 - Anxiety 35.7%
 - Depression 18.2%
 - Isolation 23.3%



Source: Prevention First (2024). Student Survey Alcohol & Drug Misuse by Youth in Clermont County. (primary source).

TRANSPORTATION

Residents in the rural regions of Clermont County often face limited transportation options owing to fewer public transit services. This situation can lead to reduced access to healthcare, food resources, and other essential human needs.



DESCRIPTION OF ISSUE

Community members with limited transportation options face the risk of poorer health outcomes, as they may struggle to attend routine healthcare appointments or delay accessing emergency care. Additionally, restricted transportation can hinder access to fresh food sources and affect employment opportunities, ultimately impacting their overall health and well-being.

COMMUNITY INDICATOR

“
Transportation for some patients/residents is a problem.
”

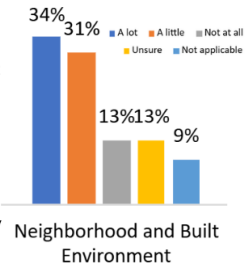
-Clermont County resident

“
Housing development needs to align with local job centers and transportation access.
”

-Respondent to Comprehensive Housing Study Stakeholder Interview

34% of community partners focus a lot on neighborhood and built environment, while 31% reported a little focus on that area.

Source: Clermont Partnership for Health (2025). Clermont County Partnership Survey (primary source).



SENIOR SERVICES

The 2019 Senior Services Needs Assessment revealed several gaps in transportation services, including:

- Availability for personal trips
- Same-day ride options
- Evening and weekend service
- Ambulette services
- Emergency trip provisions

Additional feedback highlighted positive aspects such as:

- Ease of use
- Punctuality
- Friendly staff
- Clean vehicles

Source: Clermont Senior Services (2019). Senior Services Needs Assessment (primary source).



POTENTIAL SOLUTIONS

PUBLIC TRANSIT

A stronger public transportation network that extends to rural regions of the county, offering residents access to essential services such as healthcare and food locations.

TRANSPORTATION SERVICES

Partner with Medicaid or local providers to offer free or low-cost transportation for medical appointments. Enhancing collaboration among community-based organizations can also aid in facilitating transportation for residents to access essential appointments.

INFRASTRUCTURE CONSIDERATIONS

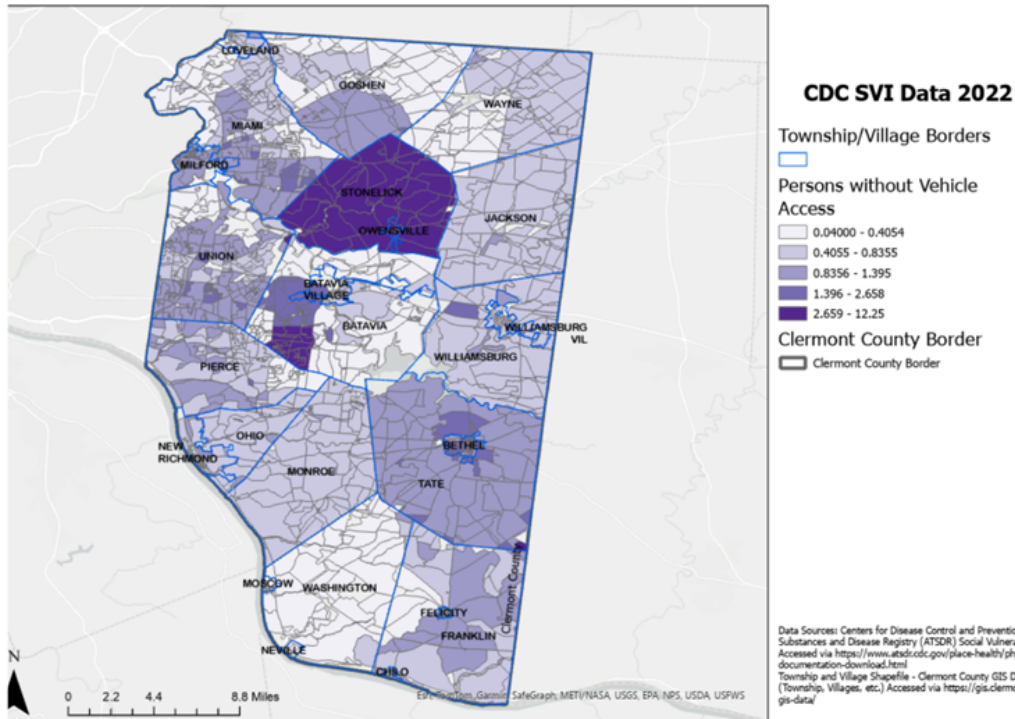
When planning new community spaces and neighborhoods, it's essential to integrate walkable options and ensure that food and healthcare services are conveniently located nearby.

ALIGNMENT

- **Prior Year Clermont CHIP:**
 - The CCPH CHIP identifies transportation as a barrier to accessing care across various focus areas.
 - <https://ccphohio.org/cph/>
- **Regional CHNA:**
 - The regional CHNA emphasizes transportation as a social determinant of health (SDOH) that significantly affects health outcomes.
 - <https://ccphohio.org/cph/>
- **Ohio State Health Improvement Plan (SHIP):**
 - Transportation is frequently referenced throughout the Ohio SHIP as a crucial factor in enhancing physical activity, local access to healthcare providers, and addressing preterm birth and infant mortality.
 - <https://dam.assets.ohio.gov/image/upload/odh.ohio.gov/SHIP/2020-2022/2020-2022-SHIP.pdf>
- **Healthy People 2030:**
 - “Mass transit options, like buses and trains, produce far less air pollution than cars – and people who walk and bike places get more physical activity.”
 - <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/transportation>

POPULATION SPECIFIC INFORMATION

GIS Map Persons without vehicles



Source: Clermont County Public Health. (2024). Clermont County GIS Maps. [image] (primary source).

ADULT SUICIDE

In 2022, suicide ranked as the fifth leading cause of death among working-aged individuals in Ohio. The risk of suicide is closely linked to local economic and social conditions, serving as a vital indicator of community health. By tackling the factors that contribute to suicidality, we can enhance the overall well-being of the community.



DESCRIPTION OF ISSUE

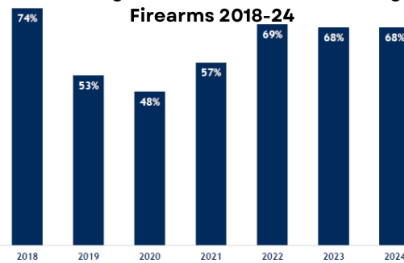
From 2014 to 2024, Clermont County experienced an average of 30 suicide deaths annually among its residents. The Clermont CHIP has recognized suicide as one of the five key health issues within the county. Notably, 35% of the partners in the Community Partner Assessment identified individuals facing mental health challenges as a prioritized population. In Clermont County, groups that are disproportionately affected include veterans, men, middle-aged and working-age adults, older adults, and those living in rural areas.

LETHAL MEANS SAFETY

In 2024, firearms accounted for 68% of deaths in Ohio, consistently ranking as the leading method nearly every year over the past decade. Ensuring safety around lethal means is crucial in efforts to prevent suicide deaths.

Source: Ohio Department of Health (2024). Data Catalog-Clermont Mortality Data (secondary source).

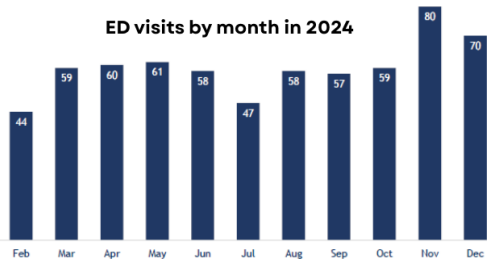
Percentage of Suicide Deaths Involving Firearms 2018-24



HOSPITAL VISITS

In 2024, there were 716 visits to emergency departments for self-harm, suicidal ideation, and suicide attempts from Clermont County residents.

ED visits by month in 2024



Source: Clermont County Public Health (2024). Suicide Fatality Review Report-2024 (primary source).

POTENTIAL SOLUTIONS



Break mental health stigma by increasing awareness

- Promote 988/528-SAVE hotline.
- Outreach to working-aged men and veteran populations, including peer mentorship programs.
- Provide lethal means safety and safe storage education.



Increase access to quality medical care

Coordination between hospitals and Clermont County behavioral health services to ensure follow-up/referral following emergency department visit



Support upstream prevention

- Increase access to affordable housing and provide sustainable housing solutions.
- Generational/family support, preventing adverse childhood experiences (ACEs), preventing events that cause PTSD, and improving the quality of care for those with PTSD.
- Building community support networks.



ALIGNMENT

- **Clermont CHIP**
 - Suicide deaths have been recognized as a major concern for Clermont County.
 - <https://ccphohio.org/wp-content/uploads/sites/21/2021/06/2021-2023-chip-report.pdf>
- **Regional CHNA**
 - One of the top three priorities for enhancing health is mental health treatment and prevention, aimed at addressing community conditions that negatively impact health and tackling the systems that hinder some neighbors from achieving long and healthy lives.
 - https://ccphohio.org/wp-content/uploads/sites/21/2025/05/2024-regional-chna_execsummary_final.pdf
- **Ohio State Health Improvement Plan**
 - Mental health and addiction are among the three priority health outcomes identified in SHIP.
 - Improvement in health across Ohio is expected to lead to fewer suicide deaths, the elimination of disparities in the suicide rate, and accessible support for all Ohioans in crisis.
 - <https://dam.assets.ohio.gov/image/upload/odh.ohio.gov/SHIP/2020-2022/2020-2022-SHIP.pdf>
- **Healthy People 2030 Objectives include:**
 - Increase the proportion of individuals with substance use and mental health disorders who receive treatment.
 - Enhance the proportion of primary care visits where adolescents and adults are screened for depression.
 - Boost the percentage of adults with depression who obtain treatment.
 - Elevate the proportion of adults with serious mental illness who receive treatment.
 - Increase the number of homeless adults with mental health issues accessing mental health services.
 - Aim to reduce the suicide rate.
 - Decrease emergency department visits due to nonfatal intentional self-harm injuries.
 - <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/mental-health-and-mental-disorders>

POPULATION-SPECIFIC INFORMATION

- Between 2014 and 2023, 16% of all suicide deaths occurred among veterans, who represent approximately 8% of the adult population in the county.
- During the same period, around 75% of all suicide fatalities involved men.
- Over half of all suicide deaths were among working-aged adults aged 30-59 from 2014 to 2023.
- Only 16% of individuals who died by suicide held a bachelor's degree, compared to about 30% of the adult population in the county.
- In 2024, among individuals who visited an emergency department:
 - 44% were within the 15-29 age group.
 - 54% were female.

Source: Ohio Department of Health (2024). Data Catalog-Clermont Mortality Data. (secondary source).
Clermont County Public Health (2024). Suicide Fatality Review (SFR) Report-2024 (primary source).

YOUTH MENTAL HEALTH

Youth in Clermont County face mental health challenges that are exacerbated by stigma, limited mental health education in schools, disparities, and access to healthcare, which can lead to youth not receiving support for mental health issues.



WHY IS THIS IMPORTANT?

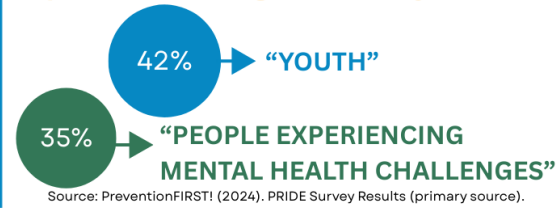
Mental health influences every facet of our lives, from physical well-being to relationships, stability, academic success, and beyond. The PRIDE Survey reveals that nearly half of the students in Clermont County feel stressed often or a lot. Early interventions are crucial for raising awareness about youth mental health and equipping them with the necessary resources and support.

COMMUNITY INDICATORS

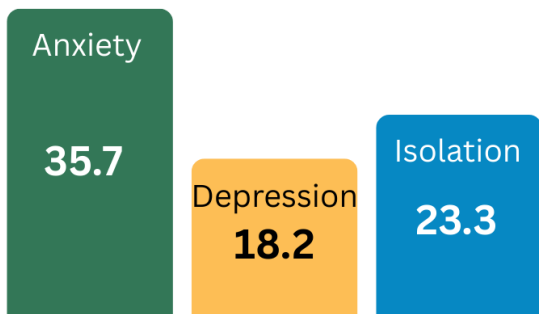
“Participants also elevated continuing integration into school-based services and addressing mental health stigma as ways to address needs over the next five years.”

- Cincinnati Children’s Hospital Medical Center
Community Health Needs Assessment

Percentage of Identified Priority Populations among Community Partners



PERCENTAGE OF STUDENTS GRADES 9 TO 12 WHO FEEL ANXIOUS, DEPRESSED, AND ISOLATED ALL OR MOST OF TIME



POTENTIAL SOLUTIONS

FULLY INTEGRATE EDUCATION ON MENTAL HEALTH IN SCHOOLS FOR STUDENTS AND GUARDIANS

Enhancing education on mental health within schools can be an excellent way to engage young people. It helps them learn about available resources and how to manage their mental well-being. Additionally, educating guardians can empower them to recognize their child's mental health needs.

REDUCING STIGMA WITHIN COMMUNITY

Reducing stigma creates an environment where individuals can feel at ease and secure when discussing mental health and seeking support.

INCREASED ACCESS TO MENTAL HEALTH SERVICES

Ensuring that resources are readily available and accessible during times of need will enhance the response to and support for mental health requirements.

ALIGNMENT

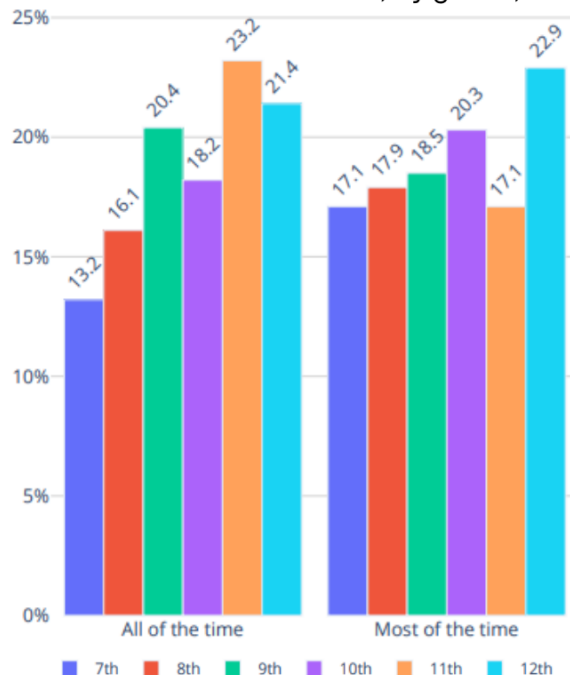
- **Prior Year Clermont CHIP**
 - A priority of the CHIP is mental health, aiming to reduce the number of students experiencing high levels of stress.
 - <https://ccphohio.org/cph/>
- **Regional CHNA**
 - Mental health was identified as a significant health need within health behaviors and outcomes in the region.
 - <https://ccphohio.org/cph/>
- **Ohio State Health Improvement Plan**
 - One objective in Ohio focuses on lowering the percentage of youth suffering from depression.
 - <https://dam.assets.ohio.gov/image/upload/odh.ohio.gov/SHIP/2020-2022/2020-2022-SHIP.pdf>
- **Healthy People 2030**
 - Objectives for adolescents under Healthy People 2030 include increasing the proportion of young people receiving treatment for depression, trauma symptoms, and serious emotional disturbances.
 - <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/mental-health-and-mental-disorders>

POPULATION SPECIFIC INFORMATION

Among students who reported feeling anxious **all of the time**, 11th graders had the highest percentage (23.2%), followed by 12th graders (21.4%), 9th graders (20.4%), and 10th graders (18.2%).

Among students who reported feeling anxious **most of the time**, 12th graders had the highest percentage (22.9%), followed by 10th graders (20.3%), 9th graders (18.5%), and 11th graders (17.1%).

During the past 30 days, about how often did you feel nervous or anxious, by grade, %



Source: PreventionFIRST! (2024). PRIDE Survey Results (primary source).
The figure displayed here is a cropped section of the full results to highlight the relevant results.

ADULT SUBSTANCE MISUSE

Residents throughout Clermont County have limited access to addiction treatment due to limited funding, policies, and stigma that restrict the reach of programs that would provide them with safe use supplies and connect them with valuable resources from community partners.



WHY IS THIS IMPORTANT?

Adult substance misuse is stigmatized in Clermont County. Intervention resources and those needing them face barriers within the community, whether it is community outreach or access to care. Increasing awareness of substance use disorders could help combat stigma and bring more support to available resources and those needing them.

COMMUNITY INDICATORS



CARP ranked as the fifth most recognized collaboration among partners, accounting for 19%.

Source: Clermont Partnership for Health (2025). Clermont Partner Assessment. (primary source).

Percentage Reduction in Accidental Drug-Related Overdose Deaths in Clermont County from 2023 to 2024.

-56.25%

Source: Clermont County Public Health (2025). Overdose Fatality Review 2024. (primary source).

COMMUNITY QUOTE

“Stigma surrounding substance use/mental health in this region leads a lot of people in this community to ignore treatment options and harm reduction out of fear of judgement and shame.”

- Clermont County Resident

POTENTIAL SOLUTIONS



INTERVENTION ACTIVITIES

Interventions can serve as a crucial turning point in an individual's recovery journey. It is essential to offer the community events that involve local partners, creating opportunities for individuals to realize they are not alone and that support is available.



RECOVERY RESOURCE SHARING

Within Clermont County, a variety of recovery resources are available, yet not everyone is aware of them. Besides resource events, it would be beneficial for partners to share information regarding additional resources that may better align with an individual's specific needs or desires.



COMBATING STIGMA

Engaging with the community by providing substance misuse education to those affected can play a vital role in dismantling stigma. This ongoing outreach not only raises awareness but also encourages individuals seeking assistance to initiate important conversations.



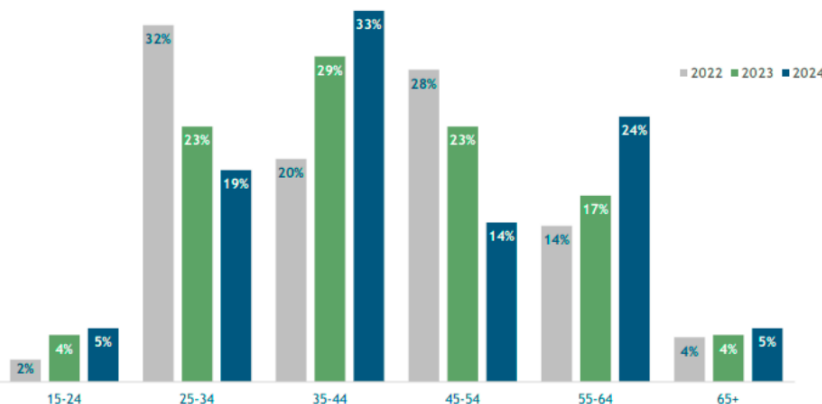
ALIGNMENT

- **Prior Year Clermont CHIP**
 - One of the CHIP priorities includes decreasing the number of unintentional drug overdose deaths.
 - <https://ccphohio.org/cph/>
- **Regional CHNA**
 - Substance use was included within health behaviors and outcomes and was found to be a significant health need in the region.
 - <https://ccphohio.org/cph/>
- **Ohio State Health Improvement Plan**
 - Strategies in Ohio to reduce drug overdose deaths include overdose prevention and reversal programs, as well as access to addiction treatment.
 - <https://dam.assets.ohio.gov/image/upload/odh.ohio.gov/SHIP/2020-2022/2020-2022-SHIP.pdf>
- **Healthy People 2030**
 - Objectives for Healthy People 2030 target drug and alcohol use, addiction, injury prevention, infectious disease, and more.
 - <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use>

POPULATION SPECIFIC INFORMATION

In Clermont County, the age group that experienced the highest percentage of overdoses was 35-44 years old, accounting for 33%. This same age group also had the greatest number of overdoses in 2023, totaling 29%. Furthermore, the zip code with the most injuries in Clermont County was 45103, which is centrally located and encompasses the Village of Batavia.

In 2024, a third of all overdose related deaths were aged **35 - 44**.



Zip code distribution of injuries from highest to lowest

lowest

45140

45245

45103

45122

45157

45244

45106

45255

45102

Source: Clermont County Public Health (2025). Overdose Fatality Review 2024. (primary source).

HOUSING

Housing is a social determinant of health that affects the overall physical and mental health of a community. The cost of housing has increased over the past decade, making both renting and owning a home more unaffordable for many in Clermont County.



DESCRIPTION OF ISSUE

People with unstable or no housing were among the top 3 priority populations identified by CPH partners in the Community Partner Assessment. Two themes identified in the Community Context Assessment included Neighborhood Walkability & Transportation and Increasing Economic Pressure, both of which intersect with housing. There was a call from the community for zoning and infrastructure planning to develop safe, walkable neighborhoods with increased transportation options, aiming to improve health, safety, and access to care and employment. Affordable housing was identified as a need within the community. Housing intersects with mental and physical health. Improving the overall health of a community involves providing affordable housing in safe neighborhoods, along with access to healthy food and opportunities for physical activity.

HOUSING COST

- **Housing Cost Burden:** Approximately 44% of households who rent and 21% of homeowners with a mortgage are classified as housing cost-burdened, meaning they allocate 30% or more of their monthly income to housing.
- **Eviction Rates:** In 2022, the eviction filing rate stood at 6.9%, which is greater than Ohio's overall rate of 6.43%, positioning Clermont among the top ten counties in the state for evictions.
- Home prices in Clermont County have consistently risen from 2010 to 2024, reflecting a 41.5% increase at an annualized rate of 9.9%. The median sale price for houses constructed after 2010 is \$340,751.
- Between the periods of 2012-2016 and 2017-2021, the Adjusted Median Gross Rent experienced a change of +5.85%, surpassing Ohio's overall increase of +2.97%.

Source: Clermont County Ohio (2025). Comprehensive Housing Study. (primary source).
Ohio Finance Agency (2024). 2024 Housing Needs Assessment-Change in Median Gross Rent. (secondary source).
US Census Bureau (2023). DP04: Selected Housing Characteristics - Census Bureau. (secondary source).

HOMELESSNESS

- During the 2024 Point-in-Time count, 60 individuals experiencing homelessness were identified in Clermont County.
 - Among them, 33 were unsheltered, marking the highest count since at least 2015.
- Currently, there are no homeless shelters operating in Clermont County.
- The Clermont Metropolitan Housing Authority's voucher and asset management programs are either at or near capacity, with many individuals on the waiting list.
- Vacancy rates for multi-family rental housing continue to remain low.
 - 58% of rental units are priced at \$1,000 or more per month.

Source: Clermont County Ohio (2025). Comprehensive Housing Study. (primary source).
Clermont Partnership for Health (2024). Homelessness and Housing in Clermont County. (primary source).



POTENTIAL SOLUTIONS



Make renting more affordable and accessible

- Support policies that promote rent stability and affordability by limiting excessive rent increases. Advocate for regulations that align rental costs with local income levels to help ensure long-term housing security for residents.
- Encourage mixed-income neighborhoods. Foster diversity in housing options, including apartments, townhomes, and single-family homes.



Expand housing for middle-income families

- Create and promote housing options that are accessible to individuals who earn too much for low-income programs yet still find current market rates unaffordable.
- Foster the construction of ranch-style homes and age-friendly housing that are simpler to maintain.



Expand services for low-income individuals and those experiencing homelessness

- Reopen the homeless shelter in Clermont County.
- Enhance permanent supportive housing options for individuals in addiction recovery.
- Broaden the voucher and asset management program.

ALIGNMENT

- **Clermont CHIP**
 - Stable housing plays a crucial role in enhancing outcomes related to mental health, suicide rates, and drug overdose fatalities.
 - <https://ccphohio.org/wp-content/uploads/sites/21/2021/06/2021-2023-chip-report.pdf>
- **Regional CHNA**
 - Preventing homelessness and ensuring housing stability are among the top three priorities for improving health, addressing community conditions that jeopardize well-being, and tackling the systems that hinder some of our neighbors from leading long and healthy lives.
 - https://ccphohio.org/wp-content/uploads/sites/21/2025/05/2024-regional-chna_execsummary_final.pdf
- **Ohio State Health Improvement Plan**
 - Community conditions, which encompass housing affordability and quality, are identified as one of the three priority factors in the SHIP.
 - “The absence of well-maintained and affordable housing contributes to various physical and mental health issues, including chronic stress and exposure to harmful substances like lead and mold. Elevated housing costs hinder low-income families from affording other essential needs, such as food and medical care, which negatively impacts their health.”
 - <https://dam.assets.ohio.gov/image/upload/odh.ohio.gov/SHIP/2020-2022/2020-2022-SHIP.pdf>
- **Healthy People 2030**
 - Goal: Reduce the percentage of families spending over 30 percent of their income on housing – SDOH-04
 - <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04>

POPULATION-SPECIFIC INFORMATION

- 35% of households in Clermont County earn less than \$50,000 annually.
- In 2020, 9.2% of residents lived at or below 100% of the federal poverty line, which was \$12,760.
- Rural areas of the county have a higher number of individuals living below 150% of the poverty level compared to suburban regions.

Source: Clermont Partnership for Health (2024). Homelessness and Housing in Clermont County. (primary source). ODH (accessed July 29, 2025). Ohio State Health Assessment-Demographic Characteristics. (secondary source).

Priority Profiles

Youth Mental Health

YOUTH MENTAL HEALTH

Youth in Clermont County face mental health challenges that are exacerbated by stigma, limited mental health education in schools, disparities, and access to healthcare, which can lead to youth not receiving support for mental health issues.



WHAT WORKS

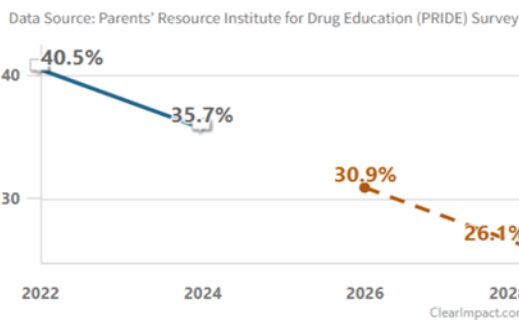
Mental health education: Enhancing education on mental health within schools can be an excellent way to engage young people. It helps them learn about available resources and how to manage their mental well-being. Additionally, educating guardians can empower them to recognize their child's mental health needs.

Reducing stigma: Reducing stigma creates an environment where individuals can feel at ease and secure when discussing mental health and seeking support.

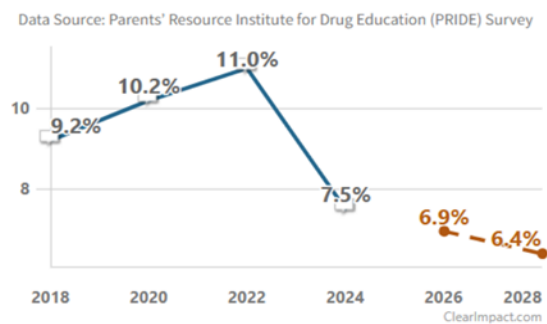
Increased access to mental health services: Ensuring that resources are readily available and accessible during times of need will enhance the response to and support for mental health requirements.

COMMUNITY INDICATORS

1) THERE WAS A 4.8% DECREASED IN ANXIETY AMONG 7TH THROUGH 12TH GRADERS IN CLERMONT COUNTY FROM 2022 TO 2024.



2) THERE WAS A 3.5% DECREASED IN SUICIDAL IDEATION AMONG 7TH THROUGH 12TH GRADERS IN CLERMONT COUNTY FROM 2022 TO 2024.



STRATEGIES



RESOURCE NAVIGATION, CONSOLIDATION, AND PROMOTION

Determine current resources, identify gaps, and develop and disseminate needed resources/guides for caregivers.



INCREASE COPING SKILLS IN YOUTH

Develop educational materials and/or activities to promote coping and life skills in youth in Clermont County.



ENGAGING NON-TRADITIONAL PARTNERS AND COMMUNITY MEMBERS; DATA TO ACTION IMPROVEMENTS

Inviting non-traditional partners to the table and in data sharing. Implementing policy within partnership groups to auto release data that is collected.

ALIGNMENT

- **Prior Year Clermont CHIP**
 - A priority of the CHIP is mental health, aiming to reduce the number of students experiencing high levels of stress.
 - <https://clermonthealthohio.gov/cph>
- **Regional CHNA**
 - Mental health was identified as a significant health need within health behaviors and outcomes in the region.
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- **Healthy People 2030**
 - Objectives for adolescents under Healthy People 2030 include increasing the proportion of young people receiving treatment for depression, trauma symptoms, and serious emotional disturbances.
 - <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/mental-health-and-mental-disorders>

POPULATION SPECIFIC INFORMATION

35.7% of all 7th-12th graders in Clermont County responded, “A Lot” or “Often” when asked how often they felt nervous or anxious in the past 30 days.

7.5% of all 7th-12th graders in Clermont County responded, “A Lot” or “Often” when asked, “Have you ever thought about attempting suicide?”

ADULT SUBSTANCE MISUSE

Residents throughout Clermont County have limited access to addiction treatment due to limited funding, policies, and stigma that restrict the reach of programs that would provide them with safe use supplies and connect them with valuable resources from community partners.



WHAT WORKS

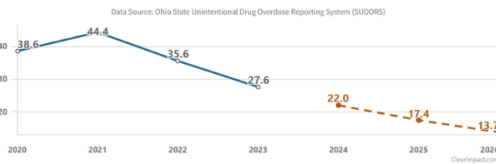
Intervention activities: Interventions can serve as a crucial turning point in an individual’s recovery journey. It is essential to offer the community events that involve local partners, creating opportunities for individuals to realize they are not alone and that support is available.

Recovery resource sharing: Within Clermont County, a variety of recovery resources are available, yet not everyone is aware of them. Besides resource events, it is beneficial for partners to share information regarding additional resources that may better align with an individual's specific needs or desires.

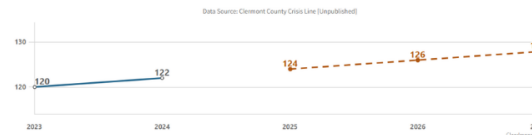
Combating stigma: Engaging with the community by providing substance misuse education to those affected can play a vital role in dismantling stigma. This ongoing outreach not only raises awareness but also encourages individuals seeking assistance to initiate important conversations.

COMMUNITY INDICATORS

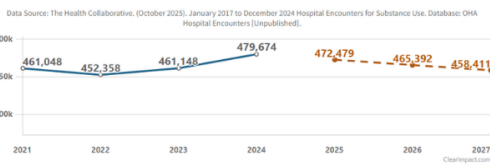
1) THERE WAS A 22% DECREASE IN THE RATE OF OVERDOSE DEATHS AMONG CLERMONT COUNTY RESIDENTS WHO DIED IN OHIO FROM 2022 TO 2023.



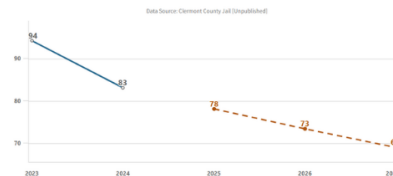
2) THE NUMBER OF CALLS TO THE CLERMONT COUNTY CRISIS LINE FOR SUBSTANCE ABUSE/ADDICTION INCREASED SLIGHTLY FROM 120 IN 2023 TO 122 IN 2024.






3) THERE WAS A 6% INCREASE IN HOSPITAL ENCOUNTERS FOR SUBSTANCE USE AMONG CLERMONT COUNTY RESIDENTS FROM 2022 TO 2024.



4) THE AVERAGE MONTHLY NUMBER OF INDIVIDUALS WITH DRUG CHARGES IN CLERMONT COUNTY JAIL DECREASED BY 11.7% FROM 2023 TO 2024.



STRATEGIES & ACTIVITIES

- 
ENHANCING LIFE AND COPING SKILLS
 - Create a media toolkit that can be shared and utilized to educate on enhancing life and coping skills in adulthood.
 - Implement art therapy programming in recovery spaces throughout the county.
- 
RECOVERY RESOURCE SHARING
 - Create a joint media campaign and toolkit that can be shared and utilized to educate about the crisis line.
- 
PROMOTION OF SAFE STORAGE
 - Create an advocacy toolkit promoting safe storage. Partners and community members will be encouraged to utilize the advocacy toolkit where applicable.

ALIGNMENT

- **Prior Year Clermont CHIP**
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 - Substance use was included within health behaviors and outcomes and was found to be a significant health need in the region.
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 - <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use>

POPULATION SPECIFIC INFORMATION

