SOCIAL DETERMINANTS OF HEALTH ACCELERATOR PLAN

HAMILTON COUNTY GENERAL HEALTH DISTRICT

DBA HAMILTON COUNTY PUBLIC HEALTH

AUGUST 2023

HAMILTON COUNTY PUBLIC HEALTH

PREVENT. PROMOTE. PROTECT.

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BACKGROUND

COMMUNITY BACKGROUND

Hamilton County Public Health (HCPH) identified ten high concentrated disadvantage communities within Hamilton County Ohio as the priority communities for the Social Determinants of Health (SDOH) Accelerator Plan. The communities identified include:

Jurisdiction	Population
Addyston	790
Arlington Heights	986
Cheviot	8,683
Elmwood Place	2,215
Golf Manor	3,782
Lincoln Heights	3,153
Lockland	3,495
Mt Healthy	6,976
North College Hill	9,605
Woodlawn	3,844

US Census Data, American Fact Finder 2021

TABLE 1: HCPH PRIORITY COMMUNITIES FOR SDOH ACCELERATOR PLAN; U.S. CENSUS DATA, AMERICAN FACT FINDER 2021

The 10 communities identified by HCPH are the highest need within Hamilton County and while they are varied and diverse communities, many are in close proximity to one another and have overlapping resources.

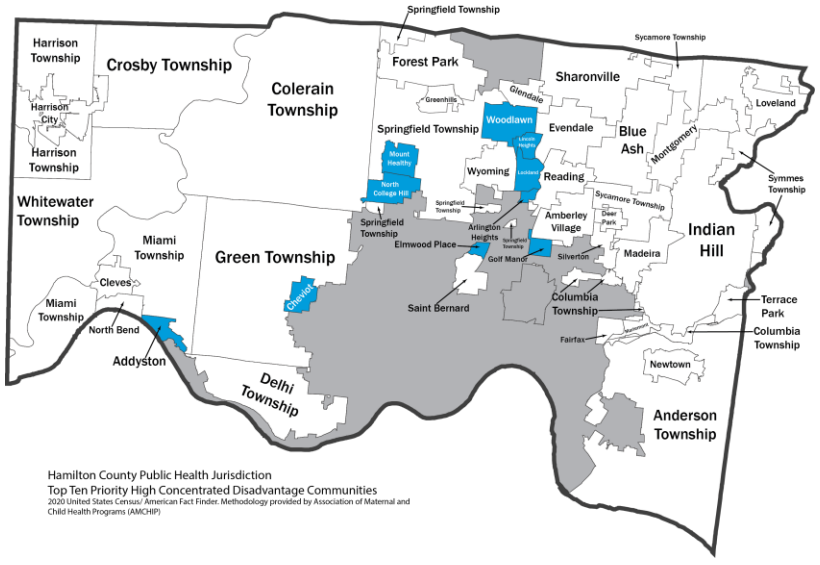

FIGURE 1: HCPH PRIORITY COMMUNITIES FOR SDOH ACCELERATOR PLAN

All communities identified to be included in the SDOH Accelerator Plan are also WeTHRIVE![sm] Communities. HCPH's WeTHRIVE! initiative was created in 2009, to partner with communities, schools, and childcare providers to identify the unique needs within their community or school to ensure that all individuals of can thrive and address priorities that threaten or limit optimal health. WeTHRIVE! is a community-driven initiative of HCPH, where public health works in partnership with local communities and schools. WeTHRIVE! success has been built on learning to tap into the collective intelligence of the community. WeTHRIVE! communities adopt a resolution in support of the initiative, establish teams with diverse representation, conduct assessments, select at least one focus area, develop action plans to address the needs identified, and participate in quarterly WeTHRIVE! Learning Collaborative meetings. HCPH staff provide technical assistance and support for WeTHRIVE! communities, schools, and childcare providers throughout the process. Community engagement, assessment, action planning, implementation, capacity-building, and evaluation are key pillars of the initiative. WeTHRIVE! initiative was selected by the National Association of City and County Health Officials as a Model Practice in 2017 for its innovative approach to addressing health, safety, and vitality throughout Hamilton County. The SDOH Accelerator Plan funding allows HCPH to expand the WeTHRIVE! Implementation Team and to identify community specific strategies to address SDOH factors impacting or limiting optimal health within high concentrated disadvantage communities within Hamilton County.

COMMUNITY HEALTH ISSUES

The 2021 Community Health Needs Assessment (CHNA) for Hamilton County, Ohio utilized a mixed-method approach to data collection including secondary quantitative data and primary quantitative and qualitative data. The framework for the development of the regional CHNA looked at the role programs and policies (systematic barriers) play in impacting factors (health behaviors, adverse childhood experiences, SDOH) that drive health outcomes (Figure 1). Utilizing this framework allowed the team developing the regional CHNA to understand the relationships between SDOH factors and the region's greatest health needs and disparities in health conditions. For the first time the regional CHNA provides data to support the direct connection between SDOH and chronic disease health outcomes, providing HCPH a framework for improving chronic disease health outcomes by addressing SDOH factors. A summary of results from the Regional CHNA can be found in the table below (Table 1). The results highlight the need to address SDOH areas that impact health, specifically chronic diseases within the region. Health conditions and SDOH factors impacting health that were identified as top concerns for the Tri-State Region mirror the health conditions and SDOH factors impacting health within Hamilton County.

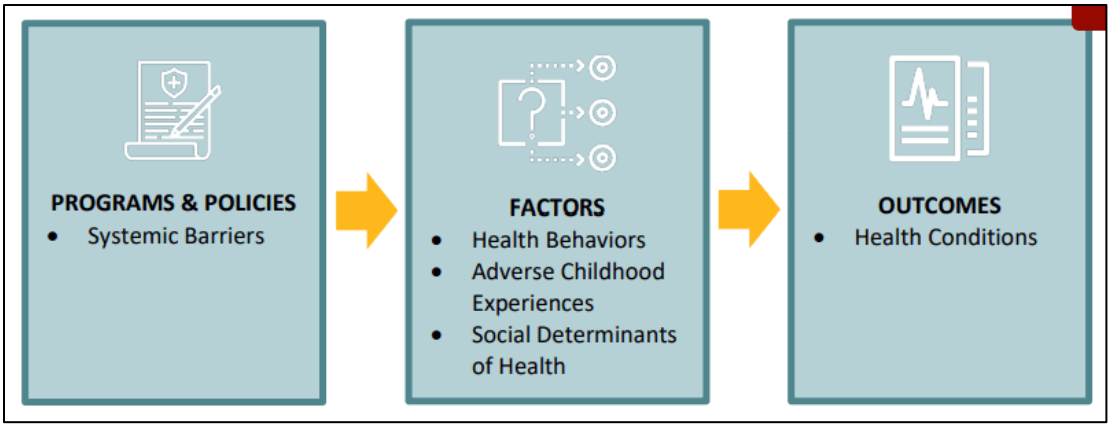

FIGURE 2 FRAMEWORK UTILIZED TO DEVELOP 2021 REGIONAL CHNA

Most Prevalent Health Conditions (Ranked)	Health Condition Most Untreated (Ranked)	Health Conditions Most Impacted by SDOH
1. Cardiovascular Conditions (Hypertension) 2. Mental Health (depression and anxiety) 3. Arthritis 4. Lung/Respiratory Health 5. Dental 6. Maternal health concerns **7.** Prevention-related health needs	1. Vision 2. Dental 3. Allergy 4. Mental Health (Depression and Anxiety) 5. Arthritis 6. Cardiovascular Conditions (Hypertension) 7. Maternal Health Concerns	• Cardiovascular Conditions (Hypertension) • Mental Health (Depression and Anxiety) • Vision • Lung/Respiratory Health • Diabetes
SDOH Factors Impacting Health in the Region		
• Economic stability (Stable housing, food security, paying bills) • Neighborhood and Built Environment (Access to reasonable transportation, parks/outdoor activities, stable phone, and internet) • Education Access and Quality (Perception of quality schools and childcare that are available) • Social and Community Connectedness (having someone to talk to and feeling connected to the community) • Healthcare Access and Quality (Perception of quality health care available, cultural relevancy of health care, ease of finding desired health care, ease of navigating healthcare costs)		

TABLE 2: SUMMARY OF RESULTS FROM REGIONAL CHNA

Understanding the leading cause of death for all Hamilton County residents helps to ensure HCPH can identify the contributing SDOH factors, as well as strategies to address the identified SDOH factors that are meaningful and impactful for all residents. Targeting strategies to address SDOH factors based on the composition of the high concentrated disadvantage communities will have a significant impact on the health outcomes on those populations.

Age-Adjusted Mortality Rate High Concentrated Disadvantage Communities and Hamilton County 2016-2020		
	High Concentrated Disadvantage Communities	Hamilton County
Age-Adjusted Overall Mortality Rate	1,146.8 per 100,000	876.1 per 100,000
Age-Adjusted Cancer Mortality Rate	218.6 per 100,000	170.4 per 100,000
Age-Adjusted COPD Mortality Rate	50.1 per 100,000	36.9 per 100,000
Age-Adjusted Heart Disease Mortality Rate	240.0 per 100,000	180.2 per 100,000
Age-Adjusted Diabetes Mortality Rate	38.1 per 100,000	24.5 per 100,000

TABLE 3: AGE-ADJUSTED MORTALITY RATES 2016-2020 HIGH CONCENTRATED DISADVANTAGE COMMUNITIES AND HAMILTON COUNTY

Leading Cause of Death High Concentrated Disadvantage Communities 2016-2020	
Cancer	15.1%
Heart Disease	13.0%
Cerebrovascular Diseases	8.4%
Assaults (Homicides)	6.2%
Alzheimer's	5.9%

TABLE 4: LEADING CAUSE OF DEATH IN HIGH CONCENTRATED DISADVANTAGE COMMUNITIES

SELECTED POPULATIONS

High Concentrated Disadvantage

Health equity and the health status of a person are influenced by many factors. One way to look at how several factors influence the health of a person and community is to look at the level of concentrated disadvantage. Concentrated disadvantage is an effective measure that considers aspects of poverty. It is an indicator that measures a community's level of economic disadvantage. HCPH has identified high concentrated disadvantage communities within HCPH's jurisdiction as the target population for this grant proposal. Priority high concentrated disadvantage communities include Lincoln Heights, Lockland, North College Hill, Addyston, Cheviot, Mt. Healthy, Elmwood Place, Woodlawn, Arlington Heights, and Golf Manor.

Concentrated disadvantage is a metric that was developed by the Association of Maternal and Child Health Programs (AMCHIP). It is the proportion of households located in census tracts with a high level of concentrated disadvantage, calculated using five census variables from the American Community Survey (ACS): 1) Percent of individuals below the poverty line, 2) Percent of individuals on public assistance, 3) Percent female-headed households, 4) Percent unemployed, 5) Percent less than age 18. Female-headed household is a metric utilized for concentrated disadvantage as women have lower incomes and higher living expenses. While the poverty rate for women has declined in recent years, more women still live in poverty than men. Based on the ACS, median income for households maintained by women ($38,005) was lower than that for married-couple family households ($113,051) and those maintained by men ($54,993) in 2021. The poverty rate for families with a female headed household (23.6 percent) was higher than that for married-couple families (5.6 percent) in 2021.

The ten communities identified by HCPH are diverse and have varying needs. Demographic information for each of the identified communities can be found below.

Jurisdiction: Addyston	
Total Population (2021)	790
non-Hispanic White (2021)	72%
non-Hispanic Black (2021)	13%
Hispanic (2021)	6%
Total Population Living in Poverty (2020)	27%
Children Living in Poverty (2020)	44%
Unemployed (16 and older) (2020)	2%
Resident with Housing Cost Burden (2020)	21%
Average Household Income (2020)	$63,313
Households with Internet Access (2021)	85%
Total Population Uninsured (2021)	5%
Children Uninsured (2021)	0%

Jurisdiction: Arlington Heights	
Total Population (2021)	986
non-Hispanic White (2021)	62%
non-Hispanic Black (2021)	28%
Hispanic (2021)	3%

Total Population Living in Poverty (2020)	15%
Children Living in Poverty (2020)	20%
Unemployed (16 and older) (2020)	10%
Resident with Housing Cost Burden (2020)	25%
Average Household Income (2020)	$42,443
Households with Internet Access (2021)	87%
Total Population Uninsured (2021)	11%
Children Uninsured (2021)	1%

Jurisdiction: Cheviot	
Total Population 2021)	8,683
non-Hispanic White (2021)	71%
non-Hispanic Black (2021)	20%
Hispanic (2021)	4%
Total Population Living in Poverty (2020)	20%
Children Living in Poverty (2020)	24%
Unemployed (16 and older) (2020)	12%
Resident with Housing Cost Burden (2020)	37%
Average Household Income (2020)	$45,428
Households with Internet Access (2021)	85%
Total Population Uninsured (2021)	10%
Children Uninsured (2021)	8%

Jurisdiction: Elmwood Place	
Total Population (2021)	2,215
non-Hispanic White (2021)	76%
non-Hispanic Black (2021)	17%
Hispanic (2021)	1%
Total Population Living in Poverty (2020)	24%
Children Living in Poverty (2020)	13%
Unemployed (16 and older) (2020)	6%
Resident with Housing Cost Burden (2020)	38%

Average Household Income (2020)	$37,552
Households with Internet Access (2021)	64%
Total Population Uninsured (2021)	14%
Children Uninsured (2021)	21%

Jurisdiction: Golf Manor	
Total Population (2021)	3,782
non-Hispanic White (2021)	31%
non-Hispanic Black (2021)	56%
Hispanic (2021)	3%
Total Population Living in Poverty (2020)	18%
Children Living in Poverty (2020)	9%
Unemployed (16 and older) (2020)	3%
Resident with Housing Cost Burden (2020)	40%
Average Household Income (2020)	$39,360
Households with Internet Access (2021)	79%
Total Population Uninsured (2021)	4%
Children Uninsured (2021)	3%

Jurisdiction: Lincoln Heights	
Total Population (2021)	3,153
non-Hispanic White (2021)	7%
non-Hispanic Black (2021)	82%
Hispanic (2021)	0%
Total Population Living in Poverty (2020)	64%
Children Living in Poverty (2020)	91%
Unemployed (16 and older) (2020)	26%
Resident with Housing Cost Burden (2020)	43%
Average Household Income (2020)	$12,183
Households with Internet Access (2021)	77%
Total Population Uninsured (2021)	3%
Children Uninsured (2021)	1%

Jurisdiction: Lockland	
Total Population (2021)	3,495
non-Hispanic White (2021)	57%
non-Hispanic Black (2021)	37%
Hispanic (2021)	1%
Total Population Living in Poverty (2020)	32%
Children Living in Poverty (2020)	71%
Unemployed (16 and older) (2020)	6%
Resident with Housing Cost Burden (2020)	37%
Average Household Income (2020)	$37,717
Households with Internet Access (2021)	74%
Total Population Uninsured (2021)	4%
Children Uninsured (2021)	0%

Jurisdiction: Mt. Healthy	
Total Population (2021)	6,976
non-Hispanic White (2021)	53%
non-Hispanic Black (2021)	41%
Hispanic (2021)	2%
Total Population Living in Poverty (2020)	20%
Children Living in Poverty (2020)	39%
Unemployed (16 and older) (2020)	9%
Resident with Housing Cost Burden (2020)	37%
Average Household Income (2020)	$41,389
Households with Internet Access (2021)	77%
Total Population Uninsured (2021)	8%
Children Uninsured (2021)	5%

Jurisdiction: North College Hill	
Total Population (2021)	9,605
non-Hispanic White (2021)	31%

non-Hispanic Black (2021)	61%
Hispanic (2021)	1%
Total Population Living in Poverty (2020)	25%
Children Living in Poverty (2020)	41%
Unemployed (16 and older) (2020)	8%
Resident with Housing Cost Burden (2020)	31%
Average Household Income (2020)	$51,120
Households with Internet Access (2021)	89%
Total Population Uninsured (2021)	7%
Children Uninsured (2021)	6%

Jurisdiction: Woodlawn	
Total Population (2021)	3,844
non-Hispanic White (2021)	30%
non-Hispanic Black (2021)	56%
Hispanic (2021)	4%
Total Population Living in Poverty (2020)	19%
Children Living in Poverty (2020)	27%
Unemployed (16 and older) (2020)	2%
Resident with Housing Cost Burden (2020)	35%
Average Household Income (2020)	$54,345
Households with Internet Access (2021)	87%
Total Population Uninsured (2021)	5%

TABLE 5-14: DEMOGRAPHIC INFORMATION FROM WETHRIVE! COMMUNITY DATA PROFILES

PARTNERSHIPS

LEADERSHIP TEAM

During the first quarter of funding, HCPH convened the Leadership Team identified in the grant application to review grant deliverables and expectation, outlined the Leadership Team's role and goals for next year. During that meeting additional Leadership Team partner agencies were identified as missing from the table. The partners added after the Leadership Team's initial meeting included: All-In Cincinnati, American Heart Association, LISC, United Way of Greater Cincinnati.

During the second quarter, HCPH staff met one-on-one with Leadership Team members to identify strategies that could be implemented at the local level to address the four SDOH buckets within the Accelerator Plan. Along with identifying potential strategies, HCPH worked with Leadership Team members to identify resources within Hamilton County that could support implementation of the strategies as well as success stories from other communities. The Leadership Team reconvened during the third quarter to review and discuss the strategies that were identified during the one-on-one meetings and discussed the collaboration of an SDOH data dashboard that was developed for tracking SDOH indicators. As content area experts, the Leadership Team developed a list of strategies utilized by Blume Community Partners (community engagement contractor), to develop a community survey. The community survey serves as a structure for community engagement events/community conversations. The feedback received from residents during the community engagement process created the final list of strategies included within the SDOH Accelerator Plan as these are the strategies that communities felt would be the most meaningful for them in addressing the SDOH factors that limit optimal health.

INFORMATION ABOUT LEADERSHIP TEAM MEMBERS:

ALL-IN CINCINNATI

All-In Cincinnati is a community-led equity coalition focused on systemic change. They aim to deepen, amplify, and multiply local and regional efforts to build equitable, thriving neighborhoods. All-In Cincinnati adds their experience in community-led coalitions focused on addressing barriers to achieving equity to the Leadership Team.

AMERICAN HEART ASSOCIATION

American Heart Association is working across Hamilton County to ensure that everyone has the opportunity to live longer, healthier lives. American Heart Association has multiple programs and initiatives addressing food insecurity and bring their expertise in addressing that SDOH bucket to the Leadership Team.

BI3

bi3 is Bethesda Inc.'s philanthropic initiative to transform health. The mission and purpose of bi3 is to lead the way to a day when every person has a fair and just opportunity to be as healthy as possible; when a person's health can no longer be predicted by race, ethnicity, ability, or zip code. bi3 leverages its strategic partnership with the TriHealth health system to spark and scale new approaches to healthcare and partners with community-based organizations to fuel new solutions

to deep-seated community health issues. On the Leadership Team, bi3 brings their expertise in addressing health inequities and partnering with communities to address the specific needs of the community.

CINCINNATI HAMILTON COUNTY PUBLIC LIBRARY

The mission of Cincinnati Hamilton County Public Library is to connect people with the world of ideas and information through their 41 branch locations throughout Hamilton County. The Cincinnati Hamilton County Public Library serves as a resource to all Hamilton County residents. Their participation on the Leadership Team will strengthen the existing partnerships with HCPH and expand the library's infrastructure and capacity to provide health-related resources to all residents served. The Cincinnati Hamilton County Public Library will bring their expertise in social and community connectedness to the Leadership Team.

GREATER CINCINNATI REGIONAL FOOD POLICY COUNCIL (GCRFPC)

GCRFP is an initiative of Green Umbrella, the sustainability alliance for the Greater Cincinnati region. Green Umbrella leads collaboration, incubates ideas, and catalyzes solutions that create a resilient region for all. The GCRFPC drives impact toward our vision of a food secure community in our region. On the Leadership Team, GCRFPC brings their expertise and knowledge in addressing nutritional insecurity as a health and equity issue in the communities of highest need and ensure alignment of the SDOH Accelerator Plan with regional and Hamilton County plans (Green Umbrella Strategic Plan).

HAMILTON COUNTY PLANNING AND DEVELOPMENT

Hamilton County Planning and Development ensures safe, responsible development and redevelopment while building partnerships to create and implement visionary plans. The development of the SDOH Accelerator Plan supports and aligns with the mission of Hamilton County Planning and Development by improving the built environment and enhancing social connectedness within Hamilton County specifically within the priority communities identified in this proposal. Hamilton County Planning and Development bring their expertise as it relates to the built environment and knowledge of strategies communities can implement to improve the built environment to the Leadership Team.

INTERACT FOR HEALTH

Interact for Health is an independent foundation that serves 20 counites in Southwest Ohio, Northern Kentucky, and Southeast Indiana including Hamilton County. The mission of Interact for Health is to improve health by promoting health equity in the region through community engagement, grants, research, education, and policy. Interact for Health brings their expertise and knowledge of addressing health equity and reducing tobacco use through policy, systems, and environmental change strategies to the Leadership Team.

LOCAL INITIATIVES SUPPORT CORPORATION (LISC)

In collaboration with local groups, LISC works to identify priorities and challenges for low-income communities, formulate comprehensive strategies to address them and deliver effective support to meet the needs on the ground. LISC works with residents and partners to close systemic gaps and opportunity and advance racial equity so that people and places can thrive. LISC brings their expertise in community engagement and community led efforts to address factors impacting optimal health to the Leadership Team.

THE HEALTHCARE CONNECTION

The HealthCare Connection is a federally qualified health center in Northern Hamilton County that provides comprehensive healthcare services for marginalized and disadvantage residents. Staff at The HealthCare Connection work to address SDOH as a primary approach to achieving health equity and eliminate health disparities among the vulnerable populations served by providing affordable, quality primary medical, dental, and behavioral health services. The HealthCare connection brings their expertise in providing quality care to all individuals while actively addressing the SDOH that impact individuals' ability to receive care to the Leadership Team.

THE HEALTH COLLABORATIVE

The Health Collaborative aims to build a healthier Greater Cincinnati through partnerships, data-driven healthcare, and innovation. They imagine a community where good health and quality healthcare are a right, not a privilege, where everyone has the same opportunities. The Health Collaborative was the lead organization for the development of the 2021 Regional Community Health Needs Assessment and Regional CHIP. The Health Collaborative brings their extensive knowledge around data collection and of addressing SDOH at a community-level to the Leadership Team and will ensure alignment of the SDOH Accelerator Plan to the Regional CHIP.

UNITED WAY OF GREATER CINCINNATI

United Way is dedicated to building long-term solutions and align systems to help families throughout Greater Cincinnati thrive by bringing people and organizations together to solve problems holistically, using family input and data-driven decisions. United Way of Cincinnati brings their extensive experience in working with communities and families to address SDOH utilizing a family/community centered approach to the Leadership Team.

WETHRIVE! TEAMS IN SDOH PRIORITY COMMUNITIES

WeTHRIVE! is a community-driven initiative of HCPH, where public health works in partnership with local communities and schools. WeTHRIVE! success has been built on learning to tap into the collective intelligence of the community. WeTHRIVE! communities adopt a resolution in support of the initiative, establish teams with diverse representation, conduct assessments, select at least one focus area, develop action plans to address the needs identified, and participate in quarterly WeTHRIVE! Learning Collaborative meetings. HCPH staff provide technical assistance and support for WeTHRIVE! communities, schools, and childcare providers throughout the process. Community engagement, assessment, action planning, implementation, capacity-building, and evaluation are key pillars of the initiative.

MULTISECTORAL PARTNERS

The engagement of the Leadership Team and WeTHRIVE! Community teams allowed HCPH the perspective of bringing together both subject matter experts to provide knowledge and expertise around SDOH categories (including resources, success stories, connections to additional local organizations), direct community experience through the lens of the WeTHRIVE! Team representatives, and the community voice that was expressed at listening sessions and community events. Both sectors were able to provide different perspectives and support for the community engagement efforts, knowledge around SDOH categories provided insight into the final development of the accelerator plan.

Throughout this process, it was essential to receive feedback from all multisectoral partners to identify potential missing partners that may contribute to improving SDOH. The Leadership Team was a prime example of identifying additional local organizations. In the first quarter Leadership Team meeting, the group discussed a variety of opportunities to engage community in unique ways and introduced HCPH to Blume Community Partners. Blume Community Partners became a key component of the SDOH community engagement work and development of surveys that aligned to other local work (LISC Social Capital Survey funded by United Way). The connection to Blume Community Partners helped advance connections to other organizations such as LISC and United Way to join the table. Additionally, Leadership Team members recommended Mercy Health, American Heart Association and All-In-Cincinnati to participate to share their knowledge and expertise around SDOH categories. Among Leadership Team organizations, many organizations overlap in their missions to address SDOH. HCPH was fortunate to have long standing relationships with many of the organizations through the WeTHRIVE! Implementation Team that has met quarterly for over a decade as a space to share update from the organizations and strive for awareness, collaboration, and alignment. During the Leadership Team one-on-one meetings in quarter two, HCPH was able to do deeper dives with each individual Leadership Team meeting in a setting that promoted the ability to dive into further detail about their current work and identify areas of overlap and alignment. One such example is the significant amount of work that many Leadership Team representatives and other local organizations are doing in the food access space. Specifically, HCPH learned about aligned initiatives around increasing access to refrigeration and freezers at local food distribution locations. This information was shared back to the group to allow opportunities for sharing resources and alignment.

Furthermore, WeTHRIVE! Teams were often able to help make connections to additional local leaders and community members who were able to provide opportunities for additional community engagement and reach. Throughout the community engagement strategies of SDOH, numerous local existing institutions that sit in the selected communities (VFW, Churches, etc.) were identified as key hubs for the community and will be imperative to engage as the work around SDOH continues beyond the funding.

SHARED MISSION AND GOAL STATEMENT

The mission of the Leadership Team was to create a culture of health, safety and vitality in communities and schools throughout Hamilton County. The vision is to identify strategies that can be implemented at the local level to address social determinants of health while aligning with and supporting county and regional plans.

PROGRAMS AND RESOURCES FOR SDOH

EXISTING RESOURCES AND PROGRAMS

A pivotal component of the development of the SDOH Accelerator plan was for HCPH to take deep dives with representatives of the Leadership Team to elaborate on existing resources, best practice, or innovative programs. These deep dive meetings were conducted between January to March 2023. Information learned during the one-on-one meetings is summarized in the table below, HPCH was made aware of existing resources and programs offered by the Leadership Team members as well as connections to other organizations Leadership Team members work with.

Organization	Deep Dive Highlights: Existing Resources and Programs

American Heart Association	Food Access:
	• Local Grocery Stores
	  ○ Your Store the Queen City
	  ○ Queen Mothers Market
	  ○ Bond Hill Market
	• Implementing nutrition security screenings in clinics and non-clinical spaces and connecting to navigation
	• Produce Perks
	• Establishing EBT within Farmer's Markets
	• SNAP Requirements: Food Delivery
	• Food bank pantry align with healthy nutrition standards
	• Increase capacity of fresh/frozen produce
	  ○ The Free Fridge etc. — ETC Produce & Provisions
	• Increase healthy vending
	• Increase access to nutrition programs (free lunch for all children in state)
	• Increase summer programs for children (Library system)
	• Sugar and sweetened beverages- healthy default beverages
	• Community: retail density
	• Convenience Stores (fresh produce)
	
	Tobacco:
	• Tobacco free venues (Farmers Markets)
	• Tobacco free outdoor spaces
	• Religious based organizations, No Menthol Sundays

Green Umbrella, Food Policy Council	Food Access:
	• Zoning to Promote Growing Food in Yards
	• Farm to School
	• Food Education Programs
	  ○ Growing Our Teachers
	  ○ OSU Extension & EFNEP Education
	• Farmer's Markets
	• Food Recovery Programming

	○ Hamilton R3Sources ○ Last Mile Food Rescue ○ LaSoupe • Local Civic Organizations/Gardening Clubs • Tikkun Farm • Co-op Cincy ○ Our Harvest ○ Queen Mother's Market ▪ Bulk Buying Clubs ○ Growing Black Power ○ Meiser's Grocery Store • Cincinnati & Hamilton County Library ○ After School Meal Program • Produce Perks ○ Prx ○ Nutrition Incentives • Institutions purchasing local food • Local/healthy food guidelines
Hamilton County Planning & Development (HCP&D)	Built Environment: • Legal Aid • Root Ambassadors • HCP&D Funding ○ Community Revitalization Grants ○ CDBG CEDAP (Community and Economic Development Assistance Program) ○ Masters in Public Administration Program Grant Partnership Application • METRO Transit Infrastructure Fund • The State Capital Improvement Program & Local Transportation Improvement Program (SCIP/LTIP)
Bi3	Social Connection: • Interact for Health ○ Advancing Health Justice ○ Mental Health Equity • Lighthouse Youth Services • Best Point • All in Cincinnati- Health Equity Policy Director Built Environment: • Cincinnati Housing Trust
All In Cincinnati	Food Access: • Component of new strategic plan • Cincinnati Childrens & CTST CHW- collect food access data Tobacco: • Tobacco Retail License/Enforcement Built Environment: • Zoning Housing Strategies

	• Funding opportunities to increase black home ownership • Zoning for multi-unit housing Social Connection: • Racial Healing Circles with Hospital Systems • Mental Health Advisory Committee- addressing racial inequity within mental health realm
United Way	Social Connection: • Project Lift- increase capacity and sharing of information with faith-based organizations • 211 Overall: • Social Capital Survey (partnership with LISC) • Black Empowerment Projects • "Community Testing Groups" & Mini Grants

Health Care Connections	Food Access:
	• Expansion of services to include dietician for nutrition and behavior change
	• Outreach & Enrollment Team Screening for Food Access (works on qualifications for SNAP, Medicaid, Health Insurance Marketplace)
	• Valley Interfaith Partnerships (Lincoln Heights & Mt. Healthy)
	• No Kid Hungry Backpack Program (Mt. Healthy)
	• Partnership with Mobile Produce Pop Up at HCC Locations
	• Partnership with fraternity to disseminate food
	• Produce Perks
	  ○ Prx
	• Humana
	  ○ Food Insecurity
	Built Environment:
	• Screening for housing
	• Metro and transportation alignment from patient's perspectives
	
	Overall:
	• Language barriers when referring to services

Cincinnati & Hamilton County Library	Food Access: • OSU EFNEP Cooking Classes • Summer Feeding Program • Resource Navigator Social Connection: • QRT Response • Safe Spaces for Kids • Adaptive spaces to learn and study together • Community event and meeting space • Memory Cafes • COA & ProSeniors- Caregiver workshops for seniors • Youth Librarians • Homework helpers/Tutors

	• Monitor Mentors Restorative Practices Built Environment: • Cincinnati Chapter of National Architects • People Experiencing Homelessness Resource Navigator Tobacco: • Hub for disseminating tobacco information and health fact sheets with UC Health Sciences Library
Health Collaborative	Overall: • Partnership with Council of Aging to address SDOH- screenings and referrals- key partner with United Way
Local Initiatives Support Corporation (LISC)	Built Environment: • Housing Action Plans in partnership with Hamilton County Planning & Development and Blume Community Partners • Access to Home Ownership • Preservation of Affordable Rental Housing • Emergency Housing Support • Policy & Zoning • "Connected Communities" • Housing Our Future o The Affordable Housing Leverage Fund o Housing Opportunities Made Equal of Greater Cincinnati, Inc. (HOME) released the Roadmap for Increasing Black Homeownership o Housing Our Future partners for rental and utility assistance Overall: • Social Capital Survey (United Way)

TABLE 15: LEADESRHIP TEAM

From the high-level list of existing strategies and resources, significant overlap between initiatives were evident and exemplify the regions communication and ability to collaborate. The information provided from the Leadership Team was utilized to develop an initial draft of strategies for each SDOH category to be utilized within the community engagement and community survey components, which both played important roles in the development of the final SDOH accelerator plan.

APPROACH

SDOH PRIORITY AREAS

Within the 2021 CHNA for Southwest Ohio and Hamilton County the following SDOH factors were identified as key factors impacting health within the region:

- Economic Stability (stable house, food security, paying bills)
- Neighborhood and Built Environment
- Education Access and Quality
- Social and Community Connectedness

- Healthcare Access and Quality.

HCPH selected Built Environment, Access to Healthy Food and Social Connectedness to align with the results of the CHNA. Tobacco-Free Environments was also selected due to HCPH experience in working with communities to create tobacco-free environments and as an opportunity to expand the work tobacco prevention work of HCPH.

OUTCOME OBJECTIVES

Please refer to SDOH Priority Area Logic Models (Appendix II) and Implementation Plan.

ACTIVITIES

The goal of HCPH's Accelerator Plan was to develop a list of best practice SDOH strategies aligned with the voices of communities to help prioritize potential strategies that could be implemented through the WeTHRIVE! initiative because of the development of the SDOH Accelerator Plan. HCPH utilized three main methods for identifying and tailoring approaches to the selected priority communities:

- Leadership Team Inventory: Inventory knowledge and expertise around SDOH categories to gain insights around best practices, innovate local strategies and available resources.
- Community Engagement: Work in collaboration with priority community WeTHRIVE! Teams engage the community through community conversations and community events as they are subject matter experts in their own communities.
- Community Survey: Development of the survey with Blume Community Partners to elaborate on conversations and discussions from community engagement opportunities to identify SDOH priorities.

As mentioned in the Leadership Team & Partnerships sections above, an initial component of identifying tailored approaches around SDOH was primarily to engage with the Leadership Team to inventory knowledge and expertise around each SDOH category to learn about best practices, identify innovative local strategies, and identify available resources for implementing SDOH activities. During the first quarter Leadership Team meeting, it was discussed that by initially developing an overarching list of priorities and activities, it may help to foster stronger discussions for the community engagement opportunities and help to develop the best possible community survey. This led to the development of an initial list of strategies around each SDOH category.

Through the recommendation of the Leadership Team, HCPH contracted with Blume Community Partners to support community engagement and to ensure that residents within priority communities were engaged as subject matter experts in their community to share what SDOH strategies would be most meaningful to prioritize for optimal health within their community.

Blume Community Partners worked directly with HCPH staff to design a tailored approach in each of the 10 priority communities. The overarching approach was to utilize the existing WeTHRIVE! team in each community as a starting point for engagement. In the communities where there was an operating WeTHRIVE! Committee, Blume Community Partners and HCPH staff assessed whether we could leverage the existing committee to host a traditional community meeting. The WeTHRIVE! committees in three of the ten communities opted to host an open community meeting during their regularly scheduled WeTHRIVE! meeting. In the remaining communities we worked to identify community events to help meet residents where they already were. It was determined that going to existing community events, many of which embedded community partners were hosting, was more effective than scheduling one more meeting and hoping people would participate. These

"events" spanned the spectrum of Juneteenth celebrations, partnering with the 513 Relief Bus, tabling at food giveaways and joining senior groups.

During the community conversations and community events, the third method for identifying tailored approaches to the selected priority communities was the development of the Healthy & Thriving Communities Survey. Blume Community Partners developed a survey (in English and Spanish) utilizing insights from the Leadership Team's inventory in addition to leveraging metrics from existing community surveys (LISC's social capital survey). The survey provided residents with another opportunity to provide feedback on the four SDOH categories and prioritize the most impactful activities that would help residents within their community live healthy lives. Engagement was completed between May and July of 2023 resulting in a total of 184 survey responses collected from the priority communities.

The results of the Blume Community Partners community engagement were summarized in the Social Determinants of Health Community Engagement Findings + Recommendations (Appendix III). This final report provides community overviews for each priority community, illustrating how the community was engaged and the summary qualitative feedback provided by the community subject matter experts. Overarching summaries and recommendations for each SDOH category were developed looking at all ten priority communities.

The Leadership Team inventory of best practice and innovative strategies was then married with the recommendations and data from the BCP report to develop a list of best practice strategies that impact each SDOH category. This is a cumulative list for all priority communities, but it is imperative to use the priority community specific feedback from the BCP Community Engagement Findings + Recommendations to ensure each community's voice is heard and elevated for their individual needs and feedback.

SDOH IDENTIFIED STRATEGIES (*for additional information, please see logic model in appendix II)*

TABLE 16: BUILT ENVIRONMENT

Priority	Activities
Address Poor Housing Conditions and Increase Affordable Housing Supply	Code Enforcement Programs for Rental and Owner-Occupied Units
	Inclusionary Zoning
	Awareness Campaign for Renter's Rights
	Landlord Registration Project
	Mitigation Fund
Invest in Quality and Safe Community Parks and Greenspaces	Improve Access to Existing Assets
	Renovate and Improve Existing Assets
Implement Traffic Calming Measures to Improve Pedestrian and Bike Safety	Traffic Calming Measures (especially in business and school districts)
	Clear and Well-Maintained Cross Walks around Schools and Community Assets
	Sidewalk and Crosswalk Infrastructure Near Bus Stops & Highly Traveled Pedestrian Routes
	Creation of Active Transportation Plans or Safe Routes to School, School Travel Plans

Identify Opportunities to Promote Connectivity Across Communities to Improve Access to Shared Assets	Complete Street Policies
	Version Zero
	Prioritize facilities that are physically separated from car traffic (trails, shared use paths, protected bike lanes and sidewalks)
	Test ideas with demonstration projects to justify permanent investment
	Optimize multi-modal transportation options. Connect first mile and last mile infrastructure to transit and key destinations
	Improve zoning and other regulations that will encourage walking and biking
	Work with SORTA Metro to Improve Bus Stop Infrastructure at Key Stops & Promote Metro Now
	Promote Community Voice Around Physical and Environmental Impacts of Transportation Infrastructure

TABLE 17: ACCESS TO HEALTHY FOOD

Priority	Activities
EBT/WIC at Food Access Points	Support Farmer's Markets to Incorporate EBT/WIC
	Farmer's Market Nutrition Program
	Utilizing SNAP For Food Delivery
Food Distribution Programs/Access Points	Increase Access of Affordable or No Cost Fresh/Frozen Products
	Innovative Food Delivery/Distribution (Porch Visits, Crockpot Meals, Feeding Programs)
	Food Rescues & Recovery
	Produce Pop-up
	Fresh Produce at Corner Stores
	Produce Prescription (Prx)
	Farm To School & Farm to Early Childhood
	Community Distribution Freestanding Locations
	Farmers Markets
Nutrition Standards	Align Food Distribution Locations with Healthy Nutrition Standards
	Increase Health Vending/Concession Stands
	Sugar Sweetened Beverage and Default Beverage Policies
Nutrition Education	Cooking Education/Programs
	Gardening Education/Programs

TABLE 18: SOCIAL CONNECTION

Priority	Activities
Design the Built Environment to Promote Safe Social Connection	Public Spaces Accessible for All
	Community Gardens
	Farmers Markets
	Parks & Playgrounds
	Plan & Develop Connected Transportation Networks
Create Opportunities and	Establish and Scale Community Connection Programs
	Develop Opportunities for Positive and Constructive Civic Engagement

Spaces for Inclusive Social Connection	Promote Opportunities to Engage with People of Different Backgrounds and Experiences
	Community Art Experiences
	Community Events (Entertainment, Food Events, Block Events, Volunteer Opportunities, Physical Activity Events)
	Neighbor to Neighbor/Know Your Neighbor Programs
	Support Spaces
Support and Connect with Existing Institutions to Increase Awareness and Access to Existing Resources	
Support Community Driven Events, Celebrations and Projects	
Advance Public Education and Awareness Efforts to Introduce and Elevate the Topic of Social Isolation	

TABLE 19: TOBACCO FREE ENVIRONMENTS

Priority	Activities
Adoption of Policies	100% Tobacco-Free Policies (community spaces, events, campuses)
	Tobacco-Free Retail License (eligible communities)
	Implementing alternative to suspension policies/programs within schools or community-based organizations service youth
Cessation Support	Education and promotion of cessation resources
	Developing referral systems to connect individuals who use tobacco to Ohio Quitline or Local Cessation
Education & Awareness	Promotion of No Menthol Sundays
	Education and Awareness of Tobacco Marketing Strategies for Youth and Minority Populations

COMMUNITY & SYSTEMIC BARRIERS ENCOUNTERED

Overall, the collaboration and alignment of the Leadership Team, WeTHRIVE! Initiative and Blume Community Partners allowed for positive engagement in the development of the accelerator plan; however, HCPH acknowledges some community and systemic barriers were identified and encountered.

A primary concern echoed by the Leadership Team, HCPH, and WeTHRIVE! communities was the over surveying of many communities with lack of communication and follow through after providing feedback. This allowed for conversations around alignment among the Leadership Team around surveying methods, questions and trying to minimize duplicative questions that community may be asked, the length of the survey, and compensation for the completion of the survey. Survey respondents who completed the survey were added to a raffle where two participants were selected from each priority community to receive a Kroger gift card for their time in completing the survey. The team also developed a communication plan for disseminating all community engagement feedback. This includes disseminating findings through the Leadership Team, WeTHRIVE! Initiative teams, local administrations of the priority jurisdictions, and to participants who completed the Blume Community Partners online survey and provided their e-mail address.

Another general barrier includes the reach of the community engagement. With all community facing initiatives, getting representative feedback can be challenging. The team put into place several strategies to support the overall reach of the engagement from working with trusted and key community leaders to promote community conversations and survey to providing a raffle opportunity as compensation for their feedback. Overall, from the Blume Community Partners report in Appendix III, demographic information showed a decent distribution of income, age, rental/ownership, and each priority community. The survey demographic data only represents the individuals who completed the online survey which was only a fraction of individuals who the team interacted with and provided qualitative feedback in conversation settings.

ALIGNMENT OF POLICY, SYSTEMS, ENVIRONMENTAL, PROGRAMMATIC & INFRASTRUCTURE ACTIVITIES

Policy: Policies are the foundation of any health improvement effort. They provide the legal and regulatory framework that guides actions and decisions. Effective policies set the stage for positive change by creating a supportive environment. Policies can regulate behaviors, allocate resources, and shape the overall direction of public health initiatives.

Systems: Systems refer to the organizational structures and processes that are in place to implement policies and strategies. Well-functioning health systems ensure that policies are carried out effectively and that resources are allocated appropriately. This includes healthcare delivery systems, data collection and analysis systems, and communication systems.

Environmental: Environmental factors include the physical and social surroundings that influence behaviors and health outcomes. Positive changes in the environment can encourage healthier choices and behaviors, making it easier for individuals to adopt and maintain healthy lifestyles.

Programmatic: Programmatic activities involve specific interventions and initiatives that target individuals or groups to promote health and prevent disease. Effective program design ensures that interventions are tailored to the needs of the population and are delivered in a culturally sensitive and appropriate manner.

Infrastructure: Infrastructure refers to the physical and organizational structures that support health initiatives. A strong infrastructure is essential for the successful implementation of policies, systems, and programs.

These components are interconnected and work together to sustain health improvements and achieve selected outcomes. Here's how they build on each other:

- Policy sets the overarching goals and guidelines for health improvement efforts.
- Systems provide the mechanisms for implementing policies and ensuring coordination and collaboration among different stakeholders.
- Environmental changes support the adoption and maintenance of healthy behaviors by making the healthy choice the easy choice.
- Programmatic activities deliver targeted interventions to specific populations, addressing their unique needs and challenges.
- Infrastructure provides the necessary support and resources for policies, systems, environmental changes, and programmatic activities to be effectively implemented.

By addressing all these components comprehensively and ensuring their alignment, HCPH strives to maximize the chances of sustaining health improvements and achieving desired outcomes over the long term. Each component reinforces and complements the others, creating a synergistic effect that enhances overall health and well-being.

ANTICIPATED REACH OF THE ACTIVITIES

The ten priority communities identified for the SDOH Accelerator Plan equate to a total of 44,417 Hamilton County residents. Total reach will significantly rely on what specific strategy(ies) each community implements as each strategy will have a unique reach.

Jurisdiction	Population
Addyston	790
Arlington Heights	986
Cheviot	8,683
Elmwood Place	2,215
Golf Manor	3,782
Lincoln Heights	3,153
Lockland	3,495
Mt Healthy	6,976
North College Hill	9,605
Woodlawn	3,844
Total	**44,417**

US Census Data, American Fact Finder 2021

TABLE 20: HCPH PRIORITY COMMUNITIES FOR SDOH ACCELERATOR PLAN; U.S. CENSUS DATA, AMERICAN FACT FINDER 2021

ANTICIPATED POLICY, SYSTEMS, ENVIRONMENTAL, PROGRAMMATIC AND INFRASTRUCTURE OUTCOMES

The anticipated outcome from the development of the Accelerator Plan is a menu of strategies that will be shared back with priority communities along with the recommendations and community specific community engagement qualitative feedback for jurisdictions to prioritize and include strategies and resources into their ongoing WeTHRIVE! Action Plans.

Please refer to SDOH Priority Area Logic Models (Appendix II) and Implementation Plan for anticipated outcomes for each of the identified strategies/activities.

EVALUATION OF THE SDOH ACCELERATOR PLAN STRATEGIES

HCPH will work with the priority communities to identify strategies from the SDOH Accelerator Plan that are meaningful to their community and encourage them to incorporate the identified strategies into their WeTHRIVE! Community Action Plan. Evaluation is built into the WeTHRIVE! Community Action Plan and HCPH will provide ongoing technical assistance to communities as they look to evaluate the identified SDOH strategies. HCPH will continue to work with Leadership Team members to

evaluate the impact of implementation of selected strategies within priority communities and Hamilton County.

DATA INTEGRATION

A component of the SDOH funding was to further align existing data to track SDOH outcome indicators through the development of a SDOH Data Dashboard. This data dashboard utilized the collaboration with HCPH and the Health Collaborative, regional Health Information Exchange. HCPH's Epidemiology division worked closely with the Health Collaborative's Data Analysts to identify key health metrics that align to the outcomes of addressing SDOH categories. Please see Appendix V for more information regarding the dashboard and for additional data notes.

TABLE 21: SDOH DATA DASHBOARD METRICS
Race
Gender
Age Range
Ethnicity
Jurisdiction/Township
Hypertension
Hyperlipidemia
Diabetes
Heart Disease-morbidity 1. Ischemic Heart Disease 2. Heart Failure and Non-Ischemic Heart Disease 3. Atrial Fibrillation and Flutter **4.** Acute Myocardial Infarction
Mood Disorders 1. Depression **2.** Bipolar Disorder
Heart Disease-mortality
Malignant Neoplasms
Unintentional Accidents
Cerebrovascular Disease
Alzheimer's Disease
Problems Related to Upbringing 1. Neglect 2. Physical Sex Abuse **3.** Unspecified Sex Abuse
Primary Support Group Problems **1.** Separation and Divorce
Other Psychosocial Problems 1. Imprisonment/Other Incarceration 2. Living Alone 3. Acculturation Difficulty **4.** Exclusion/Rejection

Housing/Economic 1. Discord with Neighbors, Lodgers, and Landlords 2. Extreme Poverty 3. Food Insecurity 4. Homelessness Unspecified 5. Housing Instability 6. Housed with Risk of Homelessness 7. Inadequate Housing 8. Low Income 9. Material Hardship 10. Other Problems Related to Housing/Economic Circumstances 11. Problems Related to Living in a Residential Institution **12.** Unsheltered Homelessness
Education/Literacy Problems 1. Illiteracy **2.** Low Level Literacy

HCPH will continue to identify key data metrics to measure the impact of implemented SDOH Accelerator Plan strategies within priority communities and Hamilton County.

RESPONSIBLE PARTY

HCPH will be lead for implementing the plan identified below and working with WeTHRIVE! Communities. Community Administration and WeTHRIVE! Community Teams will be responsible for implementing identified SDOH strategies within their community with the support from HCPH staff and WeTHRIVE! Implementation Team (SDOH Leadership Team) partners.

IMPLEMENTATION PLAN

HCPH's approach to the SDOH Accelerator plan was to develop a menu of strategies that can be implemented at the community level to address the four SDOH focus areas (Built Environment, Food Insecurity, Social Connectedness and Tobacco Free Environments). The menu of strategies included within the Final Plan were identified based on feedback from partners/experts within the area as well as from the priority communities. The SDOH Accelerator Plan aims to bridge state, regional and county plans for future recommendations at the local level so communities can address their biggest concerns. Budget for implementation of the identified strategies will vary from community to community depending on what they select to implement. HCPH is committed to providing support to communities as they work to implement the strategies outlined within the SDOH Accelerator Plan and will continue to identify local, state, regional and national resources to support implementation.

Activity	Person Responsible	Timeframe	Outcome
Development of Community Specific summary of community engagement results and recommendations	HCPH	September/ October 2023	Administration within priority communities will receive results of

			community engagement conducted
Meeting with Community Administration/ WeTHRIVE! Teams to review community specific results and recommendations	HCPH, Community Administration, WeTHRIVE! Teams	October-December 2023	Meetings within each priority community
Identify recommendation(s) community and/or WeTHRIVE! Team would like to implement	HCPH, Community Administration, WeTHRIVE! Teams	By March 2024	Recommendations to implement identified
Develop action plan for implementation of identified recommendation	HCPH, Community Administration, WeTHRIVE! Teams	By June 2024	Action Plans developed
Identified additional funding and/or resources needed to support implementation as outline within action plan	HCPH, Community Administration, WeTHRIVE! Teams	June 2024	Funding and Resources Identified
Ongoing engagement with partner agencies and Leadership Team members to share what communities have identified and connect communities to available resources	HCPH, Community Administration, WeTHRIVE! Teams, SDOH Leadership Team, WeTHRIVE! Implementation Team	December 2024	Partner meetings; increased knowledge of local resources; connection of communities to resources
Implementation of community specific action plans integrated into the WeTHRIVE! initiative	HCPH, Community Administration, WeTHRIVE! Teams, SDOH Leadership Team, WeTHRIVE! Implementation Team	December 2024	Implementation (outcomes will be identified in community specific plans)

TABLE 22: HCPH IMPLEMENTATION PLAN 2023-2024

SUSTAINABILITY/FUNDING STRATEGY

Sustainability and funding to continue the work of the SDOH Accelerator Plan were at the forefront of many conversations throughout the grant year. The work of the SDOH Accelerator Plan significantly aligns to WeTHRIVE! an Initiative of Hamilton County Public Health. WeTHRIVE! is has been funded out of general funds of Hamilton County Public Health since 2014. The strategies that each priority community may be interested in pursuing can be integrated into the WeTHRIVE! initiative's structure, each WeTHRIVE! team creates a two-year action plan as required for recognition as a WeTHRIVE! community. Additionally, the SDOH Leadership Team will be carried forward into the WeTHRIVE! Implementation Team, quarterly meetings for all WeTHRIVE! partner organizations. While some representatives of the SDOH Leadership Team already participated in

the WeTHRIVE! Implementation Team, HCPH is working with all Leadership Team members to sign letters of support to participate on the WeTHRIVE! Implementation Team.

In addition to integration within the already existing WeTHRIVE! initiative, HCPH continues to strive for additional funding to further the work. This funding includes the Tobacco Use Prevention and Cessation grant from the Ohio Department of Health (ODH). We are hopeful for future funding including Health Eating Active Living (HEAL) funding from ODH and Racial and Ethnic Approaches to Community Health (REACH) from the Centers for Disease Control (CDC).

Lastly, HCPH facilitates are ongoing conversations for alignment with local funding efforts that can support the implementation of SDOH activities. Potential local funding opportunities are highlighted above in the existing resources and programs chart as well as within the Logic Models. HCPH will continue to provide technical assistance and support to WeTHRIVE! communities to identify and secure local funding to support implementation of identified strategies.

SUCCESS STORY

The DP22-2210 Success Story from HCPH will be submitted to the CDC by December 28, 2023.

APPENDICES

I. Summary Of Strategies
II. SDOH Logic Models
III. Blume Community Partner Report
IV. Community Survey Template
V. PDF's of SDOH Dashboard & Data Notes