MERCYHEALTH

2025 Community Health Needs Assessment

Mercy Health — Cincinnati

CINCINNATI, OH

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Adopted by the Mercy Health — Cincinnati Board of Directors, September 30, 2025

As part of Bon Secours Mercy Health, Mercy Health — Cincinnati is honored to uphold nearly two centuries of dedication to the communities we serve. This commitment has continually evolved to address the most pressing needs in each community, as identified through the input of residents, businesses, and other community members.

Every three years, we reaffirm this dedication, in part by conducting a comprehensive Community Health Needs Assessment (CHNA). The most recent assessment, completed by Mercy Health — Cincinnati, incorporates robust quantitative and qualitative data. This process guides our strategic planning, community investment and community benefit initiatives. The following document provides a detailed CHNA specific to Mercy Health — Cincinnati.

Guided by our Mission to extend the compassionate ministry of Jesus, Mercy Health remains steadfast in improving the health and well-being of our communities and bringing good help to those in need — especially people who are poor, underserved and dying.

Mercy Health — Cincinnati has identified the greatest needs within our community by listening to its local voices. Leveraging various engagement strategies, we diligently seek input from our partners and neighbors. This ensures that our outreach, prevention, education and wellness resources are strategically aligned to deliver the greatest impact.

We welcome written comments regarding the health needs identified in this CHNA. Please direct your feedback to Gina Hemenway, Executive Director of Community Health, RAHemenway@mercy.com.

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Mercy Health CHNA Short Link:
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Executive Summary

Market Summary

Operating six hospitals in Hamilton, Butler, Clermont and Warren counties, Mercy Health — Cincinnati serves a broad geography and works alongside community leaders and members to address underlying challenges and barriers to health.

Hospital sites include:

- Mercy Health — Anderson Hospital
- Mercy Health — Clermont Hospital
- Mercy Health — Fairfield Hospital
- Mercy Health — Kings Mills Hospital
- Mercy Health — West Hospital
- The Jewish Hospital — Mercy Health

Outpatient centers complement these facilities, including urgent care locations and physician practices, providing convenient access to health care across the region.

Collaborating Partners

Mercy Health — Cincinnati thanks The Health Collaborative (THC) and the Health Policy Institute of Ohio (HPIO) for their facilitation and development of the Regional Community Health Needs Assessment (CHNA). Mercy Health — Cincinnati endorses the regional process, findings and priorities that serve as the basis for this specific Mercy Health — Cincinnati CHNA.

Additionally, we sincerely thank all partners for contributing their ideas and expertise to this work. Regional hospitals, health departments and community organizations that were part of the Regional CHNA Advisory Committee, the Special Populations Task Force and the Public Health Task Force are listed in Community Input.

Overview

The 2025 Community Health Needs Assessment (CHNA) is a comprehensive, data-driven and actionable review of the health of our region. This CHNA is a summation of work completed through a regional collaboration, facilitated by The Health Collaborative, across 18 counties in Greater Cincinnati, southeast Indiana and northern Kentucky. The Health Policy Institute of Ohio conducted data collection, analysis, and synthesis.

The methodology was informed by feedback from community members through listening sessions and collaboration with various advisory groups, including the Regional CHNA Advisory Committee, the Special Populations Task Force and the Public Health Task Force. These groups incorporated broad representation across hospitals, public health departments, community-based organizations, philanthropy and federally qualified health centers. The collaborative planning process ensures the approach appropriately reflects community priorities and needs.

The Regional CHNA by the numbers:

- Compiled 49 secondary, quantitative data metrics from 34 different sources
- Analyzed 18 Ohio Hospital Association data metrics
- Reviewed 7 other primary and secondary regional data sources, such as community surveys, data from 2-1-1 calls and recent community reports
- Disaggregated 32 metrics by characteristics such as race, ethnicity, age and income
- Hosted 12 Advisory Committee meetings and 6 Task Force meetings, which included 45 total partner organizations

Based on data review, significant health needs rose to the top when looking at prevalence, unmet need, impact and inequity. HPIO administered a "Pre-Prioritization Survey" to Advisory Committee members, Task Forces and community partners to inform prioritization. The survey gathered information on partners' and the community's priorities and their view of the most pressing health issues in the region.

Through a series of stakeholder meetings, the collected data was further refined into a list of potential priorities and voted on by Advisory Committee and Task Force members to produce the final list of regional health priorities.

Prioritized Health Needs

CHNA partners selected the following three priorities for collective action:

- Mental health treatment and prevention
- Homelessness prevention and housing stability
- Heart disease and stroke prevention and treatment

Our Mission

Our mission is to extend the compassionate ministry of Jesus by improving the health and well-being of our communities and bring good help to those in need, especially people who are poor, dying and underserved.

Our Vision

Inspired by God's hope for the world, we will be a ministry where associates want to work, clinicians want to practice, people seek wellness and communities thrive.

Our Values

Human Dignity

We commit to upholding the sacredness of life and being respectful and inclusive of everyone.

Integrity

We commit to acting ethically and modeling right relationships in all of our individual and organizational encounters.

Compassion

We commit to accompanying those we serve with mercy and tenderness, recognizing that "being with" is as important as "doing for."

Stewardship

We commit to promoting the responsible use of all human and financial resources, including Earth itself.

Service

We commit to providing the highest quality in every dimension of our ministry.

Facilities Description

Mercy Health — Cincinnati serves the Greater Cincinnati area through its six hospitals, focusing on communities immediately surrounding its care sites. It strives to ensure all community residents have access to the care they need, when they need it, regardless of financial capacity and social circumstance.

Mercy Health — Anderson Hospital, located in ZIP code 45255, predominantly serves residents of the same and contiguous ZIP code areas, which include Hamilton and Clermont counties and surrounding areas.

Mercy Health — Clermont Hospital, located in ZIP code 45103, primarily serves residents of the same and contiguous ZIP code areas, which include Adams, Brown, Clermont, Hamilton and Highland counties and surrounding areas.

Mercy Health — Fairfield Hospital, located in ZIP code 45104, primarily serves residents of the same and contiguous ZIP code areas, which include portions of Butler and Hamilton counties and surrounding areas.

Mercy Health — Kings Mills Hospital, located in ZIP code 45040, primarily serves residents of the same and contiguous ZIP code areas, which include Warren County and surrounding areas.

Mercy Health — West Hospital, located in ZIP code 45211, primarily serves residents of the same and contiguous ZIP codes, which include Hamilton County and surrounding areas.

The Jewish Hospital — Mercy Health, located in ZIP code 45236, primarily serves residents of the same and contiguous ZIP code areas, which include portions of Hamilton, Warren, Butler, Clermont counties and surrounding areas.

Community Served by Hospital

Mercy Health — Cincinnati participated alongside regional health partners and hospitals to develop the 2025 Community Health Needs Assessment (CHNA). In collaboration with The Health Collaborative, we created a robust portrait of the larger Southwest Ohio region. The regional report covers Greater Cincinnati, including Northern Kentucky and Southeastern Indiana, including 18 counties across Ohio, Indiana and Kentucky, with various health departments and hospital partners.

The region's population grew by 5% between 2008 and 2022 to 2,404,540 people. The area has become more racially and ethnically diverse, with a 1,062% increase in the Hispanic/Latino population, a 120% increase in the population that is two or more races (non-Hispanic) and a 50% increase in the Asian (non-Hispanic) population during that same time.

JOINT CHNA §1.501(r)-3(b)(6)(i)

This is a "joint CHNA report," within the meaning of Treas. Reg. §1.501(r)-3(b)(6)(v), by and for Mercy Health — Cincinnati, including The Jewish Hospital — Mercy Health, Mercy Health — Anderson Hospital, Mercy Health — Clermont Hospital, Mercy Health — Fairfield Hospital, Mercy Health — West Hospital and Mercy Health — Kings Mills Hospital.

This report reflects the hospitals' collaborative efforts to assess the community's health needs. Each hospital included in this joint CHNA report defines its community to be the same as the other included hospitals. The assessment sought and received input from that community.

Process and Methods

Process and Methods to Conduct the Community Health Needs Assessment

The Community Health Needs Assessment (CHNA) was facilitated by collaborating with partners across the Greater Cincinnati Region. Data collection, analysis and synthesis were conducted by Health Policy Institute of Ohio (HPIO) to answer the following research questions, developed in alignment with the requirements of the Public Health Accreditation Board (PHAB) and the Internal Revenue Service (IRS) to guide the CHNA process:

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

Criteria Used in Selecting Data Sources:

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

A comprehensive data analysis was conducted to inform the CHNA, beginning with an in-depth review of 18 metrics from the Ohio Hospital Association. This was supplemented by seven additional primary and secondary data sources, including community surveys, 2-1-1 call data and recent community reports. The secondary data analysis also drew from a broad range of publicly available information, such as national and state population health surveys, vital statistics and administrative data from state and federal agencies, among other relevant sources.

Using these sources, 264 metrics were compiled for consideration in the Regional CHNA. From this inventory of metrics, 67 secondary, quantitative metrics were recommended using the following criteria approved by the Advisory Committee.

How was the Regional CHNA developed?

1. Planned the Regional CHNA approach and methodology based on listening sessions, feedback, and input from the community
2. Formed Regional CHNA Advisory Committee, Special Populations Task Force, and Public Health Task Force
3. Compiled and analyzed primary and secondary data on:
   a. Systems of power, privilege, and oppression
   b. Social determinants of health
   c. Health outcomes and behaviors
4. Launched the Community Partnership Network pilot
5. Hosted a session to review, explore, and interpret the analyzed data
6. Conducted a pre-prioritization survey to identify alignment among partners' priorities
7. Identified 17 significant health needs
8. Prioritized 3 health needs for collective action
9. For each prioritized health need, identified:
   a. Populations who face the greatest barriers
   b. Resources and assets that could be mobilized in the region

External Sources

Thirty-four sources were consulted for the secondary data collection.

Sources included:	
U.S. Census Bureau, ACS	National Center for Health Statistics - Natality and Mortality Files
County Health Rankings	National Center for Education Statistics
Ohio Department of Health Behavioral Risk Factor Surveillance System	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Ohio Hospital Association	ODJFS, SNAP Data Map
Area Health Resource File/American Medical Association	Ohio Pregnancy Assessment Survey
Area Health Resource File/National Provider Identifier	Ohio Medicaid Assessment Survey
CDC PLACES	Strategies to End Homelessness
CDC State cancer profiles	USDA Economic Service, Atlas of Rural and Small-Town America
CDC/ATSDR Social Vulnerability Index	USDA Food Environment Atlas
CDC WONDER	Map the Meal Gap from Feeding America
CMS, Mapping Medicare Disparities	U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics
CMS, National Provider Identification	Center for Research and Data at the Cincinnati Regional Chamber
Comprehensive Housing Affordability Strategy (CHAS) data	National Equity Atlas
County Health Rankings	Policy Map
National Center for Health Statistics - Mortality Files	City Health Dashboard

Community Input

Community input was prioritized at each step of the process, from shaping the assessment to reaching consensus on shared regional priorities. In addition to key representation on the Advisory Committee, the project design intentionally included a Special Populations Task Force and the development of a Community Partnership Network to establish infrastructure for ongoing, two-way communication.

Primary data analysis included community surveys and focus groups conducted between 2021 and 2024, to center lived experiences and perspectives. Of the 47 partners who responded to HPIO's pre-prioritization survey from September 3 to October 15, 2024, the largest proportion represented community-based organizations (28%), highlighting the inclusion of community voices through the prioritization process.

Special Populations Task Force

The Special Populations Task Force met four times from March to November 2024. To guide the CHNA process, they engaged grassroots organizations and others who work directly with marginalized populations. The task force provided input on the design of the conceptual framework, research questions and selection of assessment metrics, with discussions centered around data sources, disaggregation and community representation. The task force also provided feedback on the County Profiles, asset mapping and the alignment of regional and county priorities.

Community Partnership Network

The Community Partnership Network (CPN) was launched in July 2024 to center equity and community voice in the assessment and planning process. It increased bidirectional communication on progress and minimized the "new" data collection burden.

The CPN leveraged existing community meetings, momentum and assets to strengthen connections and partnerships that advance shared goals for community health. Currently in an initial pilot phase, existing community partnerships are co-designing a framework for the actionability and sustainability of the CPN. The following community-based organizations are presently part of the CPN:

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

Data Analysis

The Health Collaborative, Health Policy Institute of Ohio and the Advisory Committee and Task Forces identified seven additional primary and secondary data sources to fill data gaps and center community voices and perspectives. These included surveys, focus groups and reports. These sources focused on the Greater Cincinnati Tri-State region, with varying areas of emphasis. Some sources included secondary data, and analysis was limited to available information rather than the underlying datasets.

Sources analyzed include:

- **2-1-1 data** – United Way of Greater Cincinnati and Indiana Family and Social Services Administration, 2024. *Area of focus: Counties in the Greater Cincinnati region, including Ohio, Kentucky and Indiana*
- **State of Black Cincinnati report** – Urban League of Greater Southwestern Ohio, 2024. *Area of focus: Cincinnati*
- **Our Health, Our Opportunity report** – Interact for Health, 2024. *Area of focus: Greater Cincinnati region*
- **Community Health Status Survey** – Interact for Health and the University of Cincinnati Institute for Policy Research, 2022. *Area of focus: 22 counties in the Greater Cincinnati region*
- **2021 CHNA provider survey results** – The Health Collaborative and Measurement Resources Company, 2021. **Area of focus: 26 counties in the Greater Cincinnati region**
- **2021 CHNA focus group results** – The Health Collaborative and Measurement Resources Company, 2021. *Area of focus: 26 counties in the Greater Cincinnati region*

Collaborating Partners

In addition to the Health Collaborative and Health Policy Institute of Ohio, Mercy Health — Cincinnati partnered with the following organizations as part of the process of conducting the needs assessment:

Advisory Committee
Hospitals and health systems
Adams County Regional Medical Center (ACRMC)
Christ Hospital
Cincinnati Children's Hospital Medical Center
Lindner Center of Hope
Margaret Mary Health
Mercy Health — Cincinnati
TriHealth
UC Health
Public health
Butler County General Health District and Southwest Association of Ohio Health Commissioners
Cincinnati Health Department
Clermont County Public Health
Hamilton County Public Health
Community-based organizations
Center for Closing the Health Gap
Hamilton County Human Services Chamber
United Way of Greater Cincinnati
Urban League of Greater Southwestern Ohio
Philanthropy
bi3
Interact for Health
Federally Qualified Health Centers
The HealthCare Connection
HealthSource of Ohio
Payor
CareSource

Task Forces
Public Health Task Force:
Butler County General Health District
Cincinnati Health Department
Norwood City Board of Health
City of Springdale Health Department
Clermont County Public Health
Clinton County Health District
Franklin County Health Department
Hamilton County Public Health
Ripley County Health Department
Warren County Health District
Ohio Special Populations Task Force:
All-In Cincinnati
Black Women Cultivating Change
Cincinnati Compass
Clermont County Board of Developmental Disabilities
Community Builders
Cradle Cincinnati
Foodbank of Dayton
Freestore Foodbank
Greater Cincinnati Behavioral Health Services
Greater Cincinnati Regional Food Policy Council
Health Care Access Now
Housing Opportunities Made Equal (HOME)
NAMI Southwest Ohio
Refugee Connect
Santa Maria Community Services
Shared Harvest Foodbank
Su Casa Hispanic Center of Cincinnati
United Way of Greater Cincinnati

Information and Data Considered in Identifying Potential Need

Advisory Committee Meeting	Date of data/information
The Advisory Committee, comprised of a variety of stakeholders (refer to the list above)	**The Advisory Committee** was responsible for ensuring progress, providing expertise at each step of the Regional CHNA — including data collection and analysis, reviewing results and report drafts and approving the final report. The committee met 13 times from November 2023 to January 2025. Meeting dates are listed below: November 13, 2023 December 11, 2023 January 25, 2024 February 22, 2024 March 28, 2024 April 25, 2024 May 23, 2024 June 27, 2024 August 22, 2024 September 26, 2024 October 24, 2024 November 21, 2024 December 19, 2024 January 23, 2025
Public health departments	**Date of data/information**
Butler County General Health District (Ohio)	**The Public Health Task Force** aligned with Advisory Committee meetings and gathered input, feedback, comments and concerns on CHNA design, conceptual framework, metrics, Community Partner Network (CPN) and progress, including finalization of regional priorities. The task force met four times from March 2024 to November 2024. Meeting dates are listed below: March 7, 2024 April 8, 2024 August 15, 2024 November 15, 2024
Cincinnati Health Department (Ohio)	
Norwood City Board of Health (Ohio)	
City of Springdale Health Department (Ohio)	
Clermont County Public Health (Ohio)	
Clinton County Health District (Ohio)	
Franklin County Health Department (Indiana)	
Hamilton County Public Health (Ohio)	
Ripley County Health Department (Indiana)	
Warren County Health District (Ohio)	
Hamilton County Public Health	Alignment on data collection processes and methods for 2024 regional reporting. Meeting date: July 30, 2024
Southwest Ohio Association of Health Commissioners (all health commissioners in this region)	Presentation to the Southwest Ohio Association of Health Commissioners on CHNA progress and next steps and gathered feedback on best methods of communication and engagement with public health. Meeting date: June 20, 2024

**Individuals or organizations staffed by fewer than five people may not be named to protect anonymity.*

Significant Community Identified Health Needs

Primary and secondary data were compiled and analyzed on systems of power, privilege and oppression; social determinants of health; and health outcomes and behaviors. Based on data review, significant health needs rose to the top when looking at prevalence, unmet need, impact and inequity.

Capacity and adequacy of service levels

The capacity and adequacy of current services were evaluated based on the region's ability to address prioritized health needs in the next three years, including identifying priorities that can be addressed with existing resources or require additional capacity or infrastructure. This process ensures that the region can feasibly implement strategies to improve health outcomes while considering the availability of resources and the ability to track progress effectively.

Needs Identified as Significant

Systems of power, privilege and oppression
Negative perceptions of health and health care (stigma, mistrust, unaffordability, etc.)
Discrimination
Unequal access to resources needed for health
Social determinants of health
Access to affordable, timely and quality health care
Educational attainment and access
Food access and insecurity
Health care workforce and capacity
Housing and homelessness
Neighborhood and built environment
Poverty and economic stability
Health behaviors and outcomes
Cancer
Diabetes
Heart disease and stroke
Maternal and infant health
Mental health
Respiratory disease
Substance use

Significant health needs were further refined to a list of ten potential priorities based on the results of a pre-prioritization survey that asked community partners to identify one to three health issues their organization was most focused on addressing. HPIO cross-checked the two lists and identified ten potential priorities for continued consideration (listed in no particular order):

1. **Mental health service navigation**

   Mental health was the leading priority in the pre-prioritization survey, with 53% of organizations identifying it as an area of focus. The percentage of adults with depression in the region has risen by 93% over the last 27 years. An estimated 1 in 5 adults (17%) report frequent mental distress.[1]

2. **Access to quality, affordable health care**

   The region has one primary care physician for every 1,302 residents. The region falls within the Health Resource and Service Administration's minimum adequate population with a primary care physician ratio of 3,500 to 1. In addition, several counties are well above this ratio.[2]

   Access to affordable, timely and quality health care was the second-highest priority on the pre-prioritization survey, with 30% of organizations identifying it as an area of focus.

3. **Substance use prevention and treatment**

   In 2023, there were 200.7 alcohol-related hospital encounters per 100,000 hospital encounters, and 350.5 overdose-related encounters among individuals ages 11 and older. Substance use disorder-related hospital encounters were the highest, at 626.2 per 100,000, followed by tobacco use-related encounters at 148.1 and marijuana-related encounters at 15.7 per 100,000 hospital encounters.[3] Twenty-three percent of organizations that responded to the pre-prioritization survey said this was an area of focus for their organization.

4. **Access to healthy and nutritious food**

   In 2019-2020, approximately 44% of children in the region were eligible for free or reduced-price lunch, meaning that their families are not earning enough to afford full-price school lunch. Additionally, 8% of people in the region were estimated to have limited access to healthy food.[4] Twenty-one percent of organizations that responded to the pre-prioritization survey said this was an area of focus for their organization.

5. **Maternal and infant health equity**

   The infant mortality rate in the CHNA region is estimated to be higher than the rest of the country and the national target established by Healthy People 2030.[5] Twenty-one percent of organizations that responded to the pre-prioritization survey said this was an area of focus for their organization.

6. **Homelessness prevention and housing stability**

   Sixteen percent of homeowners and 37% of renters in the region are burdened by housing costs (spending more than 30% of their income on housing). Utility assistance and housing are the top two most frequent categories of need in 2-1-1 calls, making up 35% and 26% of requests, respectively, in 2023.[6]

7. **Diabetes management and prevention**

   Diabetes is the eighth leading cause of death in the region, and approximately 10% of adults have been diagnosed with diabetes.[7] People in Ohio counties across the region generally have higher rates of diabetes than people in Indiana or Kentucky counties.

8. **Collaborative efforts to dismantle racism and reduce discrimination**

   More than a third of Black adults in Hamilton County, Ohio, reported experiencing racism in 2022.[8] Racism unfairly and unequally distributes resources, power and opportunity, resulting in disparities experienced by Black residents and people of color.[9]

9. **Heart disease and stroke prevention and treatment**

   Heart disease and stroke were among the leading causes of death from 2018 to 2022.[10]

10. **Collaboratively address data gaps for underrepresented populations**

    Data gaps were discovered when identifying publicly available data sources and selecting metrics widely recognized as valid, reliable and reputable sources. Strategies are needed to fill these gaps without burdening underrepresented community members who already report being over-surveyed and assessed.

Resources Available

Due to the considerable and complex nature of the community identified significant health needs, several organizations may be available to address one or more of the needs identified in this report. A complete resource list is provided in Appendix A. Some key resources serving across the Greater Cincinnati Region include:

Health Care Facilities & Services
Mercy Health
Christ Hospital
Cincinnati Children's Hospital Medical Center
Lindner Center of Hope
Margaret Mary Health
TriHealth
UC Health
Mercy Health operates clinics, urgent care and medical centers throughout Greater Cincinnati. To find a location near you, visit https://www.mercy.com/
Health Departments
Butler County General Health District and Southwest Association of Ohio Health Commissioners
Cincinnati Health Department
Clermont County Public Health
Hamilton County Public Health
Warren County General Health District
Other Local and National Resources
2-1-1 resource hotline
Housing Opportunities Made Equal
Strategies to End Homelessness
Coalition on Homelessness and Housing in Ohio
Talbert House
Urban League of Greater Southwestern Ohio
Legal Aid

Prioritization of Health Needs

The region's health needs were identified through a robust review of primary and secondary data. This included 49 secondary, quantitative data metrics, 18 Ohio data sources and primary data from Advisory Committee and Task Force partners. Data was reviewed by the Regional CHNA Advisory Committee and Task Force members during a meaning-making session on August 22, 2024.

Significant health needs are those that rose to the top based on review of data when looking at the following criteria:

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

HPIO administered an online "2024 Regional CHNA Pre-Prioritization Survey" from September 3 to October 15, 2024, to advisory committee members, task forces and community partners to inform prioritization. The survey gathered information on priorities and the stakeholders' view of the most pressing health issues in the region. There were 47 responses, with the highest proportion (28%) from community-based organizations, followed by hospitals (17%).

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

- **Capacity and feasibility:** Does our region have the ability to address this health need?
- **Connection between factors and outcomes:** To what degree do the prioritized structural/social determinants contribute to prioritized health outcomes?
- **Equity:** Would addressing this health need significantly address health disparities?
- **Burden and severity:** Would addressing this health need impact the greatest number of community members?
- **Ability to track progress:** Are there indicators that can be used to measure progress over time?

Regional CHNA Advisory Committee and Task Force members were then allowed to vote for regional priorities, using the above criteria, on an online survey open from October 24 to November 1, 2024. There were 24 total responses.

Most respondents selected mental health treatment and prevention (75%), followed by homelessness prevention and housing stability (42%), and heart disease and stroke prevention and treatment (33%) as the needs that were most aligned with the prioritization criteria.

Prioritized Health Needs

Based on all the above information and processes, the prioritized health needs of the community served by Mercy Health — Cincinnati are listed below.

Mental Health Treatment and Prevention

Mental health has bidirectional associations with physical health, interpersonal relationships, socioeconomic factors and the environment in which people live.11 Lack of timely and affordable access to mental health services can contribute to poor mental health, while connected, supportive communities with access to quality employment, housing and education can promote positive mental health.

Key insights on mental health outcomes in the region show:

- The percentage of adults with depression in the region has risen by 93% over the last 27 years. An estimated 1 in 5 adults (17%) report frequent mental distress.[12]
- The number of deaths due to suicide in the region is approximately 10% higher than the national average and 20% higher than the national Healthy People 2030 benchmark.[13]
- Community members often experience barriers in finding needed services and identifying trusted mental health providers.[14]
- Barriers to accessing treatment include stigma, lack of insurance coverage, limited availability of providers and a lack of culturally responsive mental health services.[15]
- As of 2023, only about 18% of residents in the region had heard about the 988 National Suicide Prevention Lifeline.[16]
- The percentage of adults in the Greater Cincinnati region with depression nearly doubled since 1995.[17]

How does the region compare to the nation?

The region performs worse than the U.S. overall on measures of frequent mental distress (i.e., the percent of adults who reported 14 or more days of poor mental health per month) and suicide deaths, as displayed below.

National benchmarks for mental health*

	Regional value	U.S. overall	Healthy People 2030 benchmark	Region compared to U.S.	Region compared to Healthy People 2030 benchmark
Frequent mental distress (2021)	17.0%**	14.6%	N/A	Worse	N/A
Suicide deaths (2017-2021)	15.5	14 (2021)	12.8	Worse	Worse

*Benchmark comparisons are a calculation of the difference between the regional value, the value for the U.S. overall, and available national Healthy People 2030 benchmarks. In the Regional CHNA report, metrics that have less than 10% difference between the regional and benchmark values are classified as performing the "same." Metrics that have a difference of 10% or greater are classified as "better" or "worse."
Data note: Regional values ** are the median of all available counties.
Sources: Information on regional values can be found in the data appendix spreadsheet. Data for the U.S. overall value for frequent mental distress is from the **CDC BRFSS**. U.S. overall data for suicide deaths is from the **National Institute of Mental Health**.

Homelessness Prevention and Housing Stability

Safe and stable housing is vital for our health and well-being. This includes affordable rent, adequate space for household members and avoiding frequent moves within short periods. High housing costs can limit financial resources for basic needs like childcare, nutritious food and health care.[18] Additionally, poor-quality housing can cause chronic stress, leading to health issues such as high blood pressure and worse mental health.[19]

Key insights on housing and homelessness in the region:

- Housing cost burden (spending 30% or more of income on housing costs) in the region is approximately 45% higher than the Healthy People 2030 benchmark.[20]
- There are stark disparities in housing outcomes across the region. For example, Black residents and residents with low incomes are more likely to face challenges with housing stability, such as homelessness, eviction and housing cost burden.[21]
- There is a need for homelessness and housing support services, particularly for Black residents, men and people who have been incarcerated.[22]
- Gentrification has increased housing costs and displaced those seeking affordable housing.[23]
- Households under 150% of the federal poverty level (FPL) were less likely to experience housing stability than households above 150% FPL.[24]

How does the region compare to the nation?

Although the region performs better than the nation overall on metrics related to severe housing problems and housing cost burden, significant issues remain (highlighted below). For example, the housing cost burden in the region is 45% higher than the Healthy People 2030 benchmark.

National benchmarks for housing and homelessness*

	Regional value	U.S. overall	Healthy People 2030 benchmark	Region compared to U.S.	Region compared to Healthy People 2030 benchmark
Severe housing problems (2016-2020)	11.4%**	16.7%	N/A	Better	N/A
Housing cost burden (2018-2022)	36.8%**	46.5%	25.5%	Better	Worse

*Benchmark comparisons are a calculation of the difference between the regional value, the value for the U.S. overall, and available national Healthy People 2030 benchmarks. In the Regional CHNA report, metrics that have less than 10% difference between the regional and benchmark values are classified as performing the "same." Metrics that have a difference of 10% or greater are classified as "better" or "worse."
Data note: Regional values ** are the median of all available counties.
Sources: Information on regional values can be found in the data appendix spreadsheet. Data for the U.S. overall value for severe housing problems and housing cost burden is from the U.S. Department of Housing and Urban Development "**Comprehensive Housing Affordability Strategy**."

Heart Disease and Stroke Prevention and Treatment

Chronic high blood pressure, also known as hypertension, can lead to other heart conditions such as heart disease and stroke. Heart disease and stroke are serious health conditions that both result from and can worsen our overall health and wellbeing. They are linked to factors such as inadequate housing and mental health challenges.[25]

These conditions rank among the leading causes of death and the most frequent diagnoses in emergency departments in the region.

Key insights on heart disease and stroke in the region:

- Of the leading causes of death in the region, heart disease is ranked first, and stroke is ranked fifth.[26]
- Of the top emergency room diagnoses in the region, heart disease is ranked second, heart attack is ranked fifth, and stroke is ranked sixth.[27]
- The rate for heart disease deaths in the region is more than double the benchmark set by Healthy People 2030. The region's rate for stroke and cerebrovascular disease (conditions that affect the blood flow to your brain, including stroke, brain bleed and carotid artery disease)28 death is over 75% greater than the benchmark.
- Roughly 33% of adults in the region report being told by a doctor or nurse that they had high blood pressure. There are also sizeable racial disparities in hypertension.[29]

How does the region compare to the nation?

The region has similar estimated rates of hypertension and stroke compared to the nation, but an estimated 50% higher rate of heart disease than the U.S. overall (displayed below). The region's stroke and cerebrovascular disease death rate is approximately 25% greater than the nation's. The region's heart disease death rate is more than double the Healthy People 2030 target.

National benchmarks for heart disease and stroke*

	Regional value	U.S. overall	Healthy People 2030 benchmark	Region compared to U.S.	Region compared to Healthy People 2030 benchmark
Heart disease prevalence (2021)	5.7%**	3.8%	N/A	Worse	N/A
Hypertension prevalence (2021)	32.6%**	32.4%	N/A	Same	N/A
Stroke prevalence (2021)	2.8%**	3%	N/A	Same	N/A
Heart disease deaths (2018-2022)	207.1 per 100,000 population	206.6 per 100,000 population	71.1 per 100,000 population (age-adjusted)	Same	Worse
Stroke and cerebrovascular disease deaths (2018-2022)	59.2 per 100,000 population	47.7 per 100,000 population	33.4 per 100,000 population (age-adjusted)	Worse	Worse

*Benchmark comparisons are a calculation of the difference between the regional value, the value for the U.S. overall, and available national Healthy People 2030 benchmarks. In the Regional CHNA report, metrics that have less than 10% difference between the regional and benchmark values are classified as performing the "same." Metrics that have a difference of 10% or greater are classified as "better" or "worse."

Data note: Regional values ** are the median of all available counties.

Sources: Information on regional values can be found in the data appendix spreadsheet. Data for the U.S. overall value for heart disease prevalence, hypertension prevalence, and stroke prevalence is from the CDC BRFSS. U.S. overall data for heart disease deaths and stroke and cerebrovascular disease deaths is from CDC WONDER.

Significant Health Needs Not Prioritized

There is meaningful alignment between the region's significant health needs, the priorities of community members and the organizational goals of Regional CHNA partners. Across the region, many individuals and organizations are already taking action to address these challenges and improve health outcomes. This collective effort ensures that the most pressing issues receive continued attention and collaborative support.

While many important needs emerged through this process, not all were included as top priorities. The prioritization focused on those issues with the strongest potential for regional collaboration, alignment with existing initiatives and the ability to make a measurable impact. Some needs — though still significant — were determined to be highly localized, already being addressed through other efforts or beyond the reach of current resources and infrastructure.

Significant Health Needs not prioritized:

- Negative perceptions of health and health care (stigma, mistrust, unaffordability, etc.)
- Discrimination
- Unequal access to resources needed for the social determinants of health
- Access to affordable, timely and quality health care
- Educational attainment and access
- Food access and insecurity
- Health care workforce and capacity
- Neighborhood and built environment
- Poverty and economic stability
- Health behaviors and outcomes
- Cancer
- Diabetes
- Maternal and infant health
- Respiratory disease
- Substance use

Progress and Impact

Workforce Pipeline and Cultural Competency

Strategies	Progress
De Paul Christo Rey Work Study Program	De Paul Christo Rey High School is a uniquely affordable Catholic, college-prep curriculum and innovative work study program that supports students from families with low incomes through high school and college graduation. Mercy Health is a work study program partner and pays an annual fee to host students every school year. These funds are used to defray student tuition. Over the course of the 2023-2025 Community Health Improvement Plan (CHIP), Mercy Health — Cincinnati supported 5 students' placements at site facilities each school year. **DePaul Christo Rey Work Study Program School Year 2023-2024:** 5 students placed at Mercy Health **DePaul Christo Rey Work Study Program School Year 2024-2025:** 5 students placed at Mercy Health
Mercy Neighborhood Ministries Hospital Worker Readiness Program	Mercy Neighborhood Ministries (MNM) promotes the empowerment of individuals through proven programs that educate, foster self-sufficiency and support enhanced quality of life. The MNM workforce development program excels at stabilizing and improving the quality of life for disadvantaged people. In partnership with Mercy Health, the MNM hospital worker readiness program (HWRP) results in a guaranteed interview with an opportunity to be hired within the Mercy Health system. Job opportunities include patient transport, dietary/nutrition, and environmental services. The HWRP provides education and training on professional behaviors in the workforce, various health care-related skills such as safety and infection control, basic computer skills, resume creation, job applications, interviews and ongoing employment coaching after graduation. Over the 2023- 2025 CHIP, Mercy Health — Cincinnati successfully supported the participation, graduation and placement of HWRP participants. **2023:** 32 enrolled participants; 23 graduates; 21 job placements **2024:** 43 enrolled participants; 37 graduates; 23 job placements **2025:** 7 enrolled participants; 7 graduates; 2 job placements

Strategies	Progress
Baby Café	Baby Café is a free, drop-in, informal community-based lactation support group offering ongoing professional lactation care and intervention. Mercy Health — Cincinnati is committed to providing staff and funding to launch two new Baby Cafés. As part of the effort, Mercy Health — Cincinnati focused on increasing the certification and competency of diverse lactation professionals. Over the 2023-2025 CHIP, Mercy Health — Cincinnati supported the launch of one Baby Café and trained numerous staff to obtain CLC certification and enhance cultural competency within lactation services. **2023**: 1 café supported **2024**: 1 café supported (continuation, not a new site) **2025**: Baby Café has been discontinued due to the birthing center closure and the transition of key clinical staff who directly supported this program. Mercy Health — Cincinnati remains committed to building community amongst breastfeeding moms and continues offering bi-weekly breastfeeding support groups at Mercy Health — Anderson Hospital.
Mama Certified	Mama Certified Equity Centered Maternal Care is a national pilot and collaborative project in response to a call from mothers in Hamilton County for a solution that would provide them with the information they need to make informed decisions about where they seek maternal care. As a collective impact approach to maternal and infant health equity, the project aims to provide Black parents-to-be with visibility into the maternal-related efforts of local hospital networks and to promote increased efforts toward maternal equity. This project brings together birthing hospitals in Greater Cincinnati to address maternal equity and improve outcomes for Black and Brown mothers and babies in their care. Mercy Health — Cincinnati is committed to ongoing participation in this important effort. Over the 2023-2025 CHIP, Mercy Health — Cincinnati successfully obtained and maintained certification, including receiving Leader badges for infant and maternal health. **2023**: Obtained successful certification; all Mercy Health — Cincinnati birthing hospitals (3) received Leader badges for infant and maternal health and met 90% or more of the requirements (the highest badge possible). **2024**: Obtained successful certification, maintained Leader badge for infant and maternal health and achieved a Leader badge in the new community category. **2025**: 2025 certification and badging levels to be released in Q1 2026.

Strategies	Progress
Guild Education Program	The Guild Education Program provides tuition assistance/reimbursement to current Mercy Health employees, including full-time, part-time and PRN associates. With over 100 educational offerings included, the program is designed to encourage working adults to grow their careers and attract new talent to the ministry. Personal assistance from live coaches and other support aid associates in finding and completing their desired educational pathway for career growth and development. Available programs include certifications and bootcamps, high school diploma completion, language programs and higher education degree programs ranging from associate to doctoral programs. Bon Secours Mercy Health is committed to this partnership with Guild to provide education benefits to help associates develop in-demand skills and build a career path within the ministry. Over the 2023- 2025 CHIP, Mercy Health — Cincinnati has successfully provided education benefits to associates. **2023**: 553 associates completed a program **2024**: 66 associates completed a program* **2025**: 2 associates completed a program *Decrease due to shift in focus on clinical track programs only.

Food and Housing Security

Strategies	Progress
Social Drivers of Health Screening	Social Drivers of Health (SDOH) Screening is an evidence-based screening incorporated into the clinical workflow. It is based on broad acknowledgment that patients may experience health-related social needs like food insecurity, transportation difficulty or housing instability that directly impact clinical outcomes, utilization patterns and total health care costs. Mercy Health — Cincinnati primary care practices and OB offices routinely screen new and existing patients at annual well visits. Over the 2023 - 2025 CHIP, Mercy Health — Cincinnati has successfully implemented routine screenings. **2023**: 77.2% of eligible patients screened **2024**: 87.3% of eligible patients screened **2025**: 57.75% of eligible patients screened, rolling 12 months 85% patients requesting support received resource referrals

Strategies	Progress
Mercy Serves SDOH Screenings	Mercy Serves AmeriCorps is a diverse, energetic volunteer corps that serves Mercy Health Emergency Departments and supports patients with substance use disorders. In 2023, Mercy Health — Cincinnati expanded the scope of the members' role to include screening, brief intervention of SDOH and referral to community resources for emergency department patients. The program expanded training around social determinants and patient navigation, including Community Health Worker (CHW) curriculum and certification for select members. The Mercy Serves program is generously supported by Mercy Health — Cincinnati, Mercy Health Foundation and federal funding through ServeOhio and the Corporation for National and Community Service. Over the course of the 2023-2025 CHIP, Mercy Serves has successfully implemented SDOH screenings in the Emergency Department setting: **Program Year 22-23** 629 SDOH Screenings **Program Year 23-24** 3,513 SDOH Screenings **Program Year 24-25 YTD (through Q2 of program year)** 1,907 SDOH Screenings
Financial Assistance	Financial assistance for patients facing potential eviction or foreclosure is available to participants actively engaged in Mercy Health Community Health programs. These participants have access to emergency assistance, which can cover eligible housing expenses, including application fees and past-due rent. Similarly, associates of Mercy Health have access to the Caring for Our Own General Hardship Fund to cover housing expenses in times of financial hardship. Over the 2023-2025 CHIP, Mercy Health — Cincinnati has successfully provided financial assistance to those who actively engage in Mercy Health Community Health programs and associates. **2023:** Community Health: 7 program clients assisted with $19,954.28 Caring For Our Own: 37 associates assisted with $55,400 **2024:** Community Health: 16 program clients assisted with $31,305.80 Caring For Our Own: 40 associates assisted with $71,423.37 **2025 YTD (through Q1):** Community Health: 5 program clients assisted with $11,311.90 Caring For Our Own: 6 associates assisted with $2,369

Strategies	Progress
Affordable Housing Trust Fund	The Affordable Housing Leverage Fund (AHLF) is a coordinated suite of financial products that can dramatically increase the production and preservation of affordable units. A diverse portfolio of public and private partners supports it. Bon Secours Mercy Health has committed low-interest, patient loan capital that can be leveraged with other fund investments to advance the community-wide affordable housing effort. Over the 2023-2025 CHIP, Mercy Health — Cincinnati successfully supported the number of affordable units produced and/or preserved. **September 2022-September 2024:** AHLF produced/preserved 1907 housing units, 1529 which were affordable to residents earning 60% or less of Area Median Income (AMI).
Produce Perks Midwest	Mercy Health's partnership with Produce Perks Midwest (PPM) supports healthy food purchases through nutrition (produce) prescriptions, fruit/vegetable vouchers and other incentives to assist families experiencing challenges financially and with nutrition-related illness. Programs provide nutrition education and basic household cooking equipment to support long-term health and wellness. In addition, PPM and Mercy Health are committed to increasing the capacity of the community to support nutrition programming by growing the number of community locations participating in the Supplemental Nutrition Assistance Program (SNAP) and equipped to carry fresh fruits and vegetables. Over the 2023-2025 CHIP, Mercy Health — Cincinnati successfully supported the number of participants enrolled in PPM programming, the number of participating locations and increases in healthy food purchases by SNAP recipients. **2023**: 7917 participants enrolled in PPM programming; 19 participating locations; $127,268 in healthy food purchases by SNAP participants **2024**: 7213 participants enrolled in PPM programming; 17 participating locations; $122,118.46 in healthy food purchases by SNAP participants **2025**: 1182 participants enrolled in PPM programming; 16 participating locations; $22,274.90 in healthy food purchases by SNAP participants

Access to Services

Strategies	Progress
Mercy Health Partnership Program	The Mercy Health Partnership Program consists of Licensed Social Workers and Certified Community Health Workers dedicated to providing education, advocacy, and support to patients from Mercy Health — Cincinnati ambulatory and acute care providers. Program services address barriers to care, including social needs, health care coverage and support with medical bills. For the 2023-2025 CHIP, Mercy Health Partnership Program steadily maintained insurance enrollment for patients who need it. **2023**: 63 patients eligible for insurance enrollment were assisted with enrollment. **2024**: 48 patients eligible for insurance enrollment were assisted with enrollment. **2025 (through Q1)**: 21 patients eligible for insurance enrollment were assisted with enrollment.
Mercy Serves AmeriCorps	Mercy Serves AmeriCorps is a diverse, energetic, volunteer corps serving in Mercy Health Emergency Departments to prevent and reduce substance use disorder. AmeriCorps members provide patient education, substance use risk screening, emotional support and referrals to treatment and social services for emergency department patients. AmeriCorps members work alongside nurses, providers and social workers to ensure patients receive necessary support and resources to make healthy choices and encourage behavior change. The Mercy Serves program is generously supported by Mercy Health — Cincinnati, Mercy Health Foundation and federal funding through ServeOhio and the Corporation for National and Community Service For the 2023-2025 CHIP, Mercy Health — Cincinnati successfully supported 3 Mercy Serves cohorts, with another scheduled to launch in September 2025. **2022-2023 (Year 6)**: 104 patients referred to treatment; 60% of referred patients admitted to treatment. **2023-2024 (Year 7**): 196 patients referred to treatment; 39% of referred patients admitted to treatment. **2024-2025** (Year 8 through Q1): 58 patients referred to treatment; 19% of referred patients admitted to treatment.

Strategies	Progress
Perinatal Outreach Program	Mercy Health Perinatal Outreach Program (POP) is part of Mercy Health's larger response to addressing infant mortality in Greater Cincinnati. POP comprises two certified Community Health Workers (CHWs) and a Program Manager dedicated to providing education, advocacy and support. Its goal is to ensure a healthy pregnancy and birth for at-risk moms and babies, with a particular focus on families who are Black/ African American. The program removes obstacles contributing to high infant mortality rates, pre-term births and racial disparities in maternal and infant health. Support for the program is a collaborative funding of Mercy Health — Cincinnati, Mercy Health Foundation, Cradle Cincinnati and the Ohio Department of Medicaid. For the 2023-2025 CHIP, Mercy Health — Cincinnati successfully supported pregnant women. **2023**: 74 clients enrolled; 100% born >37 weeks. **2024**: 86 new clients enrolled; 88% born >37 weeks. **2025 (through Q1)**: 17 new clients enrolled; 81% born >37 weeks
Prevent Blindness Ohio	Vision screenings are available to Mercy Health patients through a partnership with Prevent Blindness Ohio, a local non-profit committed to reducing unnecessary vision loss and impairment by providing access to donated vision care services for uninsured and underinsured patients. Mercy Health Partnership Program staff are trained to conduct vision screenings and refer eligible participants for services through Prevent Blindness Ohio. For the 2023-2025 CHIP, Mercy Health — Cincinnati consistently supported eligible patients with vision care through Prevent Blindness Ohio. **2023**: 4 referred to appointments through Prevention Blindness Ohio; 4 completed appointments through Prevent Blindness Ohio **2024**: 3 referred to appointments through Prevention Blindness Ohio; 3 completed appointments through Prevent Blindness Ohio **2025 (YTD)**- 0 referred to appointments through Prevention Blindness Ohio; 0 completed appointments through Prevent Blindness Ohio
Mercy Care Clinics	Mercy Health community clinics provide critical primary care access to uninsured and underinsured patients in underserved communities. There are two clinical locations in the Mercy Health — Cincinnati service area, located within Mercy Health — Anderson Hospital and Mercy Health — Clermont Hospital. Over the 2023-2025 CHIP, Mercy Health Care Clinics maintained services and provided steady support for vulnerable patients. **2023**: 746 patients served **2024**: 760 patients served **2025 (through Q1)**: 125 patients served

Strategies	Progress
Mercy Health School-Based Health Centers	Mercy Health School-Based Health Centers provide critical health care access to students and their families by offering a location that is safe, convenient and accessible. These health centers are strategically placed within medical deserts and are open to the community to help support broader primary care needs. The school-based health team works alongside school leadership, community organizations and families to ensure children and adolescents have the resources they need to thrive in the classroom and beyond. Over the course of the 2023-2025 CHIP, Mercy Health School-Based Health Centers maintained service and performance levels. **2022-2023 School Year**: 6,345 clients served; 94% immunization rate **2023-2024 School Year**: 5,508 clients served; 93.47% immunization rate **2024-2025 School Year YTD**: 2,527 clients served; 95% immunization rate
Cincy Smiles - Dental Assistance	Dental Assistance is available to Mercy Health patients through a partnership with Cincy Smiles, a local non-profit committed to ensuring all community members have access to oral health education, disease prevention and discounted treatment services. Patients with low incomes presenting to the Emergency Department with dental needs are scheduled at Cincy Smiles for free services, often for exams, x-rays, fillings and extractions. Mercy Health subsidizes the cost of this care on a case-by-case basis. Referrals made to Cincy Smiles are currently focused on the west side of Cincinnati. Over the course of the 2023-2025 CHIP, Mercy Health — Cincinnati maintained service and performance levels. **2023**: 180 Mercy patients served **2024**: 330 Mercy patients served **2025 YTD**: Data not available at the time of this report.
Mercy Health Financial Assistance	Mercy Health Financial Assistance programs are designed to assist in finding resources that may help pay health care bills. Financial assistance is available for emergency and other medically necessary care to uninsured and underinsured patients whose family income does not exceed four times the Federal Poverty Guidelines. Mercy Health — Cincinnati is committed to providing care to everyone who seeks care, regardless of their ability to pay. A team of financial counselors assists patients in obtaining financial assistance and more sustainable health insurance coverage. Over the course of the 2023-2025 CHIP, Mercy Health — Cincinnati supported patients through Mercy Health financial counselors. **2023**: 13,960 Mercy Health patients supported **2024**: 22,227 Mercy Health patients supported **2025 (through Q1)**: 2,630 Mercy Health patients supported

Strategies	Progress
Charitable Pharmacy	Charitable Pharmacy is prescription assistance provided through a variety of settings. Hospital outpatient pharmacies offer free/reduced-cost medications at discharge for patients with financial need. Mercy Health — Clermont Hospital is also a Dispensary of Hope partner, a charitable medication distributor providing donated medicines that can be provided to patients free of charge. In 2023, Mercy Health expanded the services provided by the Dispensary of Hope to support a small number of primary care practices in the Cincinnati Market that see a high number of uninsured patients. St. Vincent de Paul Charitable Pharmacy also provides free medications to Mercy Health patients throughout Greater Cincinnati. Over the 2023-2025 CHIP, Mercy Health — Cincinnati increased the number of unique prescriptions filled through the Dispensary of Hope. **2023**: Charitable Pharmacy: 7,992 prescriptions filled ($581,041 in value); 2,445 patients served Dispensary of Hope: 1,139 prescriptions filled ($124,994 in value); 412 patients served **2024**: Charitable Pharmacy: 7,889 prescriptions filled ($251,332 in value); 2,659 patients served Dispensary of Hope: 3,053 prescriptions filled ($213,290 in value); 1,025 patients served **2025 (through Q1)**: Charitable Pharmacy: 1,301 prescriptions filled ($51,261 in value); 417 patients served Dispensary of Hope: 845 prescriptions filled ($53,080 in value); 275 patients served

Appendix

- Appendix A: Full List of Resources
- Appendix B: Reference List

Appendix A

Full List of Resources

Health Care Facilities and Services:

- Mercy Health
- Christ Hospital
- Cincinnati Children's Hospital Medical Center
- Lindner Center of Hope
- Margaret Mary Health
- TriHealth
- UC Health

Health Departments:

- Butler County General Health District and Southwest Association of Ohio Health Commissioners
- Cincinnati Health Department
- Clermont County Public Health
- Hamilton County Public Health
- Warren County General Health District

General/Prevention:

- In5
- All-In Cincinnati
- Beech Acres Parenting Center
- Best Point Education & Behavioral Health
- BIPOC Mental and Behavioral Health Provider Directory
- Butler Behavioral Health
- Catholic Charities Southwestern Ohio
- Center for Healing the Hurt
- Centerpoint Health
- Central Clinic Behavioral Health
- Child Focus (Norwood, Eastgate, Mt. Orab)
- Child Mind Institute
- Envision Partnerships
- Federally Qualified Health Centers (FQHCs)
- FindHelpNowKY.org

- Greater Cincinnati Behavioral Health Services
- Greater Cincinnati Foundation
- Greenlight Fund
- Haile Foundation
- Hamilton County Addiction Response Coalition (ARC)
- Hamilton County African American Engagement Workgroup
- HealthSource of Ohio
- HEY! (Hopeful, Empowered, Youth) Cincinnati
- Hospitals and health systems
- Joe Burrow Foundation
- Lebanon Counseling Center
- Lighthouse Youth Services
- Mental Health America of Northern Kentucky and Southwest Ohio
- Mental Health and Addiction Advocacy Coalition (MHAC)
- Mental Health and Addiction Services Recovery Boards
- Middletown Counseling Center
- Millstone Fund
- MindPeace
- Modern Psychiatry and Wellness
- NAMI Southwest Ohio
- NeighborHub Health
- NewPath Child and Family Solutions
- Preston Brown Foundation
- PreventionFIRST!
- Public Health Departments
- State departments of mental and behavioral health
- Talbert House
- Tristate Trauma Network
- UMADOP of Cincinnati
- Urban League Greater Southwestern Ohio

Hotlines for General/Prevention:

- 2-1-1 resource hotline
- Central Line: (513) 558-8888
- Consumer Warmline: (513) 931-WARM
- Mental Health Hotline: (513) 281-CARE

Crisis Services:

- Central Clinic (Mental Health Access Point -MHAP)
- Charlie Health
- Freestanding Inpatient Psychiatric Units
- Georgetown Behavioral Hospital
- Mercy Health — Clermont Clinic
- Mobile Response and Stabilization Services (MRSS) Ohio
- Psychiatric Emergency Services (PES) at UC Health
- Suicide prevention coalitions
- Summit Behavioral Healthcare
- SUN Behavioral Health
- Women Helping Women

Crisis Hotlines:

- 9-8-8
- Mobile Crisis Team (Mental Health Crisis): (513) 574-5098
- Substance Abuse Crisis Response AIM: (513) 620-RING (7464)
- Veterans Hotline: (513) 281-VETS (8387)

Housing Stability:

- Adams County Economic and Community Development
- Brighton Center
- Caracole
- Cincinnati-Hamilton County Community Action Agency
- Community Development Corporations
- Community Matters
- Council on Aging
- County Departments of Job and Family Services
- Habitat for Humanity
- Housing Opportunities Made Equal (HOME)
- Independence Alliance
- Local Metropolitan Housing Authorities
- Northern Kentucky Community Action Commission (NKCAC)
- Ohio Valley Residential Services
- People Working Cooperatively
- Seven Hills Neighborhood Houses

- Shelterhouse
- Talbert House
- The Community Builders
- Warren County Community Services
- Women Helping Women
- Working In Neighborhoods

Homelessness Prevention:

- Adams County Shelter for the Homeless
- Bethany House
- Central Access Point (CAP) Helpline: (513-381-SAFE)
- City Gospel Mission
- Clermont County Community Services
- Emergency Shelter of Northern Kentucky
- Family Promise of Butler and Warren Counties
- Greater Cincinnati Homeless Coalition
- Healthcare for the Homeless
- Highland County Homeless Shelter
- Homeless Coalition of Southern Indiana
- County Departments of Job and Family Services
- New Life Mission
- Shelterhouse
- St. Vincent de Paul
- Strategies to End Homelessness
- Talbert House
- Tender Mercies
- Welcome House
- Wilmington Hope House
- Women Helping Women
- Working In Neighborhoods
- YWCA Greater Cincinnati
- Housing Opportunities Made Equal
- Strategies to End Homelessness

Shared Resources:

- 2-1-1 resource hotline
- Coalition on Homelessness and Housing in Ohio
- Federally Qualified Health Centers (FQHCs)
- Greater Cincinnati Foundation
- Hospitals and health systems
- Legal Aid
- LISC Greater Cincinnati
- Public Health Departments
- United Way of Greater Cincinnati

Regionally Based Heart & Cardiovascular Services:

- American Heart Association (AHA) Greater Cincinnati
- Christ Hospital Preventive Cardiology Program
- Federally Qualified Health Centers (FQHCs)
- HealthPath Foundation
- Heart to Heart Home Healthcare
- Hospice of Cincinnati Cardiac Care Program
- Mercy Health — The Heart Institute
- Premier Health HeartWorks
- ProjectADAM
- Public Health Departments
- St. Vincent DePaul Charitable Pharmacy
- The Center for Closing the Health Gap
- TriHealth Heart and Vascular Institute
- University of Cincinnati Heart, Lung and Vascular Institute
- WiseWoman
- Women's Heart Center at The Christ Hospital

State-Based Heart & Cardiovascular Services:

- American Heart Association chapters
- Cardi-OH
- State departments of health

Appendix B

Reference List

[1] Our Health, Our Opportunity. Cincinnati, OH: Interact for Health, September 2024. https://www.ourhealthouropportunity.org/; see also Behavioral Risk Factor Surveillance System, as compiled by County Health Rankings and Roadmaps, 2021.

[2] State of the Primary Care Workforce, 2024. Health Resources and Services Administration (HRSA), November 2024. https://bhw.hrsa.gov/sites/default/files/ bureau-health-workforce/state-of-theprimary-care-workforce-report-2024.pdf

[3] Analysis of Ohio Hospital Association Data Tables by the Health Collaborative, August 2024.

[4] U.S. Department of Agriculture, Food Environment Atlas, as compiled by County Health Rankings and Roadmaps, 2019.

[5] CDC WONDER and National Center for Health Statistics, as compiled by County Health Rankings and Roadmaps.

[6] United Way of Greater Cincinnati, 211 Dashboard. Accessed October 22, 2024.

[7] Behavioral Risk Factor Surveillance System, as compiled by County Health Rankings and Roadmaps.

[8] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, data provided by the Ohio Department of Health upon request.

[9] Health Policy Institute of Ohio. 2024 Health Value Dashboard.

[10] Centers for Disease Control and Prevention, Wide-ranging Online Data for Epidemiologic Research (WONDER).

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

[12] Our Health, Our Opportunity. Cincinnati, OH: Interact for Health, September 2024 https://www.ourhealthouropportunity. org/; see also Behavioral Risk Factor Surveillance System, as compiled by County Health Rankings and Roadmaps, 2021.

[13] National Center for Health Statistics, as compiled by County Health Rankings and Roadmaps, 2017-2021; see also "Healthy People 2030: Reduce the Suicide Rate." U.S. Department of Health and Human Services. https://odphp.health.gov/healthypeople/objectives-and-data/ browse-objectives/mental-health-andmental-disorders/reduce-suicide-ratemhmd-01

[14] "2021 CHNA focus group results." The Health Collaborative and Measurement Resources Company, 2021.

[15] Ibid.

[16] Our Health, Our Opportunity. Cincinnati, OH: Interact for Health, September 2024. https://www.ourhealthouropportunity. org/. Residents surveyed were in the region covered by Interact for Health, which serves 20 counties across Ohio, Kentucky, and Indiana.

[17] Our Health, Our Opportunity. Cincinnati, OH: Interact for Health, September 2024. https://www.ourhealthouropportunity. org/; see also Behavioral Risk Factor Surveillance System, as compiled by County Health Rankings and Roadmaps, 2021.

[18] A new approach to reduce infant mortality and achieve equity: Policy recommendations to improve housing. Columbus, OH: Ohio Legislative Service Commission, 2017. https://www.healthpolicyohio.org/wp-content/ uploads/2021/03/SDOIM_Final_ HousingExcerpt.pdf

[19] Healthy Moms and Babies: Housing and Health Integration: Research Findings and Recommendations for Policymakers. Columbus, OH: CelebrateOne, 2020. https://static1.squarespace.com/static/53206c76e4b0da7cd7fb97f6/t/606359f9eefc803e71f6dd6c/1617123839137/CO+Policy+Brief+v8.pdf

[20] "Healthy People 2030: Housing and Homes." U.S. Department of Health and Human Services. https://odphp.health. gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes

[21] HPIO analysis of data from the Cincinnati/ Hamilton County Continuum of Care (CoC) for the Homeless, 2023; see also State of Black Cincinnati: The Journey to Parity. Cincinnati, OH: Urban League of Greater Southwestern Ohio, 2024. https://www.ulgso.org/blackcincinnati; see HPIO analysis of data from the U.S. Census Bureau, American Community Survey 5-year estimates, as compiled by PolicyMap, 2018-2022.

[22] HPIO analysis of data from the Cincinnati/ Hamilton County Continuum of Care (CoC) for the Homeless, 2023; see also State of Black Cincinnati: The Journey to Parity. Cincinnati, OH: Urban League of Greater Southwestern Ohio, 2024. https:// www.ulgso.org/blackcincinnati

[23] State of Black Cincinnati: The Journey to Parity. Cincinnati, OH: Urban League of Greater Southwestern Ohio, 2024. https://www.ulgso.org/blackcincinnati

[24] United Way of Greater Cincinnati, 211 Dashboard. Accessed October 22, 2024.

[25] "Unhealthy Housing Can Lead to an Unhealthy Heart." American Heart Association, 2020. https://www.heart.org/en/news/2020/07/15/unhealthy-housing-can-lead-to-an-unhealthy-heart

[26] HPIO analysis of data from Centers for Disease Control and Prevention, Wideranging Online Data for Epidemiologic Research (WONDER), 2018-2022.

[27] Analysis of Ohio Hospital Association Data Tables by the Health Collaborative, August 2024.

[28] "Cerebrovascular Disease." Cleveland Clinic, Accessed December 19, 2024. https://my.clevelandclinic.org/health/ diseases/24205-cerebrovascular-disease

[29] "Community Health Status Survey." Interact for Health and the University of Cincinnati Institute for Policy Research, 2022.

Board Approval

The Mercy Health — Cincinnati 2025 Community Health Needs Assessment was approved by the Mercy Health — Cincinnati Board of Directors on September 30, 2025.

Board Signature 

Date: September 30, 2025

For further information or to obtain a hard copy of this Community Health Needs Assessment (CHNA), please contact Gina Hemenway at rahamenway@mercy.com.

Mercy Health CHNA Website: https://www.mercy.com/about-us/mission/giving-back/community-health-needs-assessment

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Mercy Health CHNA Short Link: Mercy Health CHNAs

MERCYHEALTH

CINBKT (9-25)