



Highland County  
Community Health Needs Assessment

**December 2025**

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## Acknowledgements

This Highland County Community Health Needs Assessment addresses community needs for the Greenfield, Ohio community and greater Highland County. This assessment is the work of a collaboration among local agencies, volunteers, and consultants, all dedicated to improving the health and quality of life of its community members. In addition, the support and engagement of the Highland County Healthcare Collaborative is interwoven into this assessment. Adena Health is a participating member of the health collaborative.

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## A note from Kathi Edrington, CEO of Adena Health

Dear community members and partners,

For more than 130 years, Adena Health has been honored to serve the residents of Highland County. Our deep-rooted commitment to this community extends well beyond delivering exceptional medical care — it encompasses truly understanding the people who call Highland County home and collaborating with local organizations, leaders, and residents to advance health and wellness across our region.

Health systems are often seen as places to go when illness strikes, but our role is far broader. To make a lasting difference, we must meet people where they are — in their homes, workplaces, and schools — and continually seek new opportunities to support prevention, wellness, and long-term well-being. This belief shapes our daily work and is woven throughout the strategies outlined in this Community Health Needs Assessment (CHNA).

The CHNA represents a comprehensive, community-wide effort to identify the most urgent health concerns and priorities facing Highland County. Grounded in health data, community feedback, and the experiences of local residents, health care providers, and public health partners, this assessment serves as a shared foundation for developing targeted, meaningful strategies to address current challenges, anticipate future needs, and strengthen the overall health of our county.

Every three years, this process helps us better understand the many factors that influence health outcomes — from access to care and preventive services to broader social determinants like education, employment, housing, and community resources. The CHNA highlights both the areas where we are making progress and the opportunities where deeper collaboration and innovation can lead to significant improvement. It is more than a report; it is a call to action for all who are invested in Highland County's vitality.

At Adena, we believe that creating a healthier Highland County is a shared responsibility. This CHNA is an essential step in that journey, allowing us to listen, learn, and respond thoughtfully to the needs of those we serve. We remain committed to using this knowledge to enhance community health, expand access to care, and support the safety and well-being of every resident.

To everyone who contributed time, insight, and expertise to this assessment — thank you. Your partnership strengthens our ability to build a healthier, stronger, and more resilient Highland County.

In partnership,



Katherine Edrington  
President and CEO  
Adena Health

# SECTION 1: Introduction to the 2025 Highland County CHNA

## Introduction

A Community Health Needs Assessment (CHNA) is a comprehensive, systematic process used to identify a community's most significant health needs and to guide coordinated strategies that improve population health and health equity. This assessment examines health outcomes, health behaviors, access to care, and the social, economic, and environmental conditions that influence health across the lifespan.

This Community Health Needs Assessment focuses on Highland County, a rural, Appalachian county in southern Ohio where geographic isolation, limited transportation infrastructure, workforce shortages, and economic conditions significantly influence health outcomes and access to care. Like many rural Appalachian communities, Highland County faces persistent challenges related to chronic disease burden, behavioral health needs, aging population trends, and social drivers of health such as income, housing stability, and access to services. This assessment is intended to support coordinated, cross-sector collaboration among healthcare providers, public health agencies, schools, behavioral health organizations, social service providers, and community partners as they work together to identify shared priorities and implement strategies that improve health and wellbeing across the county.

Poor health affects not only individuals and families, but also employers and the broader community by limiting economic stability, workforce participation, productivity, and quality of life. Improving health outcomes therefore requires addressing the broader drivers of health, including education, income, housing stability, transportation, access to resources, and health literacy—factors that strongly influence health behaviors, disease burden, and healthcare utilization.

In accordance with Internal Revenue Code §501(r) requirements, the Highland County Community Health Needs Assessment will be made publicly available through Adena Health and provided in print upon request.

## What is a community health needs assessment?

A Community Health Needs Assessment (CHNA) provides a structured, data-driven approach to identifying priority health needs and disparities within a defined community. Required under the Patient Protection and Affordable Care Act, the CHNA informs community health planning, resource allocation, and implementation strategies. Meaningful community input is central to

the process, ensuring that identified priorities reflect local experiences and support effective, equitable health improvement efforts.

Research consistently shows that communities experience the greatest health improvements when organizations, agencies, and residents work collaboratively—from identifying needs and setting priorities to implementing solutions and measuring progress. The Highland County Healthcare Collaborative, in partnership with Adena Health, completed the most recent community health assessment for Highland County in 2022. The 2025 assessment builds on that work by incorporating updated data sources and community input to understand current health needs, monitor trends over time, and support shared efforts to improve health and quality of life in Highland County.

## **Alignment with State and National Priorities**

This assessment aligns with state and national health and wellbeing priorities, including Healthy People 2030, a national initiative led by the U.S. Department of Health and Human Services to improve health and wellbeing, eliminate health disparities, and address the social and environmental conditions that influence health. Healthy People 2030 establishes five overarching goals:

1. Attain healthy, thriving lives and wellbeing free of preventable disease, disability, injury, and premature death.
2. Eliminate health disparities, achieve health equity, and attain health literacy to improve health and wellbeing for all.
3. Create social, physical, and economic environments that promote full health potential across populations.
4. Promote healthy development, healthy behaviors, and wellbeing across all life stages.
5. Engage leadership, key constituents, and the public across sectors to design and implement policies that improve health and wellbeing.

This CHNA also aligns with the Ohio State Health Improvement Plan (SHIP), which emphasizes health equity and addresses key drivers of health such as housing, education, economic stability, and trauma. Local community health improvement planning efforts in Highland County

are aligned with SHIP priorities, reinforcing a coordinated, statewide approach to improving health outcomes and reducing disparities.

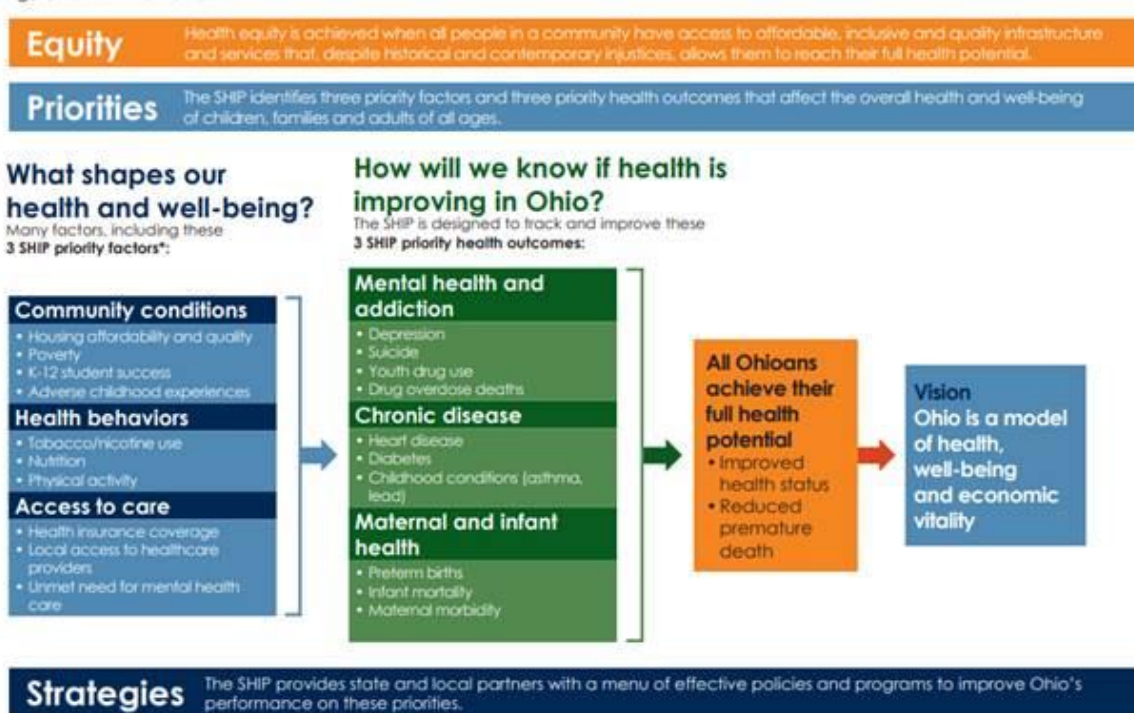


Figure 1: Ohio SHIP Priorities

## Community Profile and Demographics

Highland County is a rural, Appalachian county characterized by small towns, agricultural land use, and dispersed population centers. Demographic patterns in Highland County reflect those observed across the broader Adena Health service region and provide essential context for understanding current and future health needs.

Population trends in Highland County have remained relatively stable over the past decade, with modest decline driven primarily by out-migration of younger adults and an increasing proportion of older residents. The county has a higher percentage of adults age 65 and older and a higher prevalence of disability compared to Ohio overall, increasing demand for healthcare services, caregiving support, and transportation assistance.

Economic indicators show lower median household income and higher poverty rates than state benchmarks. Educational attainment lags Ohio averages, particularly for post-secondary education, which influences workforce participation, earning potential, and long-term health outcomes. Rural geography and limited transportation infrastructure further shape access to employment, education, healthcare, and social services. Together, these demographic and

socioeconomic characteristics establish the context for health disparities examined throughout this assessment and inform priority-setting and resource allocation.

### **Community Description: Highland County, Ohio (Population Context)**

Highland County is home to an estimated population of approximately 43,000 residents. While overall population levels have remained relatively stable, the county has experienced gradual demographic shifts marked by population aging and a declining share of younger adults. Compared to Ohio overall, Highland County has a higher proportion of older adults, a higher prevalence of disability, and lower median household income, all which influence healthcare demand and access patterns.

The county's geography includes small towns, villages, and extensive rural areas, resulting in dispersed population centers and limited public transportation infrastructure. These geographic conditions contribute to longer travel times for healthcare services, employment, education, and social supports, particularly for residents without reliable transportation.

Economic and educational challenges—including higher poverty rates and lower levels of post-secondary educational attainment—are closely linked to health-related drivers identified throughout this assessment, including access to care, chronic disease burden, and behavioral health needs.

### **Community Description: Greenfield, Ohio (Hospital-Centered Community)**

Greenfield, located in northern Highland County, is the county's second-largest municipality, with an estimated population of approximately 4,700 residents. Greenfield serves as a local service hub for surrounding rural townships and unincorporated areas, many of which rely on the city for healthcare, employment, education, and essential services.

Residents of Greenfield and nearby rural communities are more likely to experience economic stress, aging-related health needs, disability, and transportation barriers than residents of more urban areas. Household income levels in Greenfield are lower than state averages, and a significant share of households include older adults living alone, individuals with chronic illness, or residents with limited mobility.

Adena Greenfield Medical Center plays a central role in meeting healthcare needs within this community by providing 24/7 emergency services, inpatient care, outpatient diagnostics, and stabilization services close to home. For many residents—particularly older adults and individuals without reliable transportation—the presence of a Critical Access Hospital in Greenfield reduces the need for longer travel to Hillsboro or Chillicothe and helps mitigate delays in care.

Greenfield is located approximately 28–30 minutes by car from Hillsboro, the Highland County seat and location of Highland District Hospital, and approximately 30–35 minutes from Chillicothe, where higher-acuity and specialty services are available within the Adena Health system. These travel patterns reinforce the importance of maintaining hospital-based access in Greenfield for emergency stabilization, inpatient care, and outpatient diagnostics.

The community served by Adena Greenfield Medical Center includes residents who are more likely to experience transportation constraints and limited-service availability, particularly older adults, individuals with disability, and households experiencing economic stress. Hospital-based access in Greenfield is therefore a key structural asset for advancing access to timely care and supporting health equity in Highland County.

## Public Availability

This Community Health Needs Assessment fulfills the requirements of Internal Revenue Code §501(r)(3) and §501(r)(4) for nonprofit hospital organizations. Adena Health conducted this assessment in collaboration with community partners and will use the findings to inform implementation strategies and community benefit activities.

Printed copies of the report are available upon request at no cost. Requests may be made by contacting Adena Health.

This Community Health Needs Assessment fulfills the requirements of Internal Revenue Code §501(r)(3) and §501(r)(4) for nonprofit hospital organizations. Adena Health conducted this assessment in collaboration with community partners and will use the findings to inform implementation strategies and community benefit activities.



# SECTION 2: Summary and Overview of Findings

Economic, educational, and social conditions in Highland County continue to shape health outcomes for residents across the life course. Consistent with patterns observed throughout southern Appalachian Ohio, Highland County experiences poorer population health outcomes relative to most Ohio counties. While outcomes remain challenged, they are comparable to or modestly better than those observed in some neighboring Appalachian counties with similar rural, economic, and demographic characteristics.

## Use of County Health Rankings Data

Data from County Health Rankings & Roadmaps are used in this assessment as a comparative framework to understand Highland County’s relative position within Ohio. In recent reporting years, publicly available County Health Rankings files have shifted away from consistently publishing numeric ordinal ranks for all domains and instead emphasize relative standing using standardized Z-scores and grouped bands.

Accordingly, Highland County’s health outcomes and health factors are described using relative placement (e.g., lower-performing groupings statewide), which provides a stable and methodologically appropriate indicator of population health status across reporting years. Rankings and groupings are interpreted as directional indicators and are triangulated with local data sources and community input to inform the identification of significant health needs.

Table 1: 2019-2023 County Health Rankings for Highland County

County Health Rankings for Highland County									
2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Outcomes (ranking out of 88 counties)									
79	78	78	80	81	79	74	66	69	66
Factors (ranking out of 88 counties)									
77	82	81	82	73	70	67	76	82	77

Source: County Health Rankings & Roadmaps, Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute (2014–2023)

Beginning in 2024, County Health Rankings no longer assigns numeric county ranks for most domains. Counties are grouped into Health Groups based on standardized national Z-scores. In rank-based reporting years, Highland County’s Health Outcomes rank improved from 74th (2020) to 66th (2021), shifted to 69th (2022), and returned to 66th (2023), while Health Factors remained more challenged (67th in 2020; 76th in 2021; 82nd in 2022; 77th in 2023). Beginning in 2024, County Health Rankings transitioned to National Z-scores and grouped bands, and in

2025 adopted an updated model in which the closest comparable summaries are Population Health & Well-being and Community Conditions.

Table 2: Health Outcomes and Health Factor Drivers

Key Health Outcome and Health Factor Drivers – Highland County, Ohio (2023–2025)				
Driver Measure	2023	2024	2025 (Closest Comparable)	Trend Interpretation
<b>Life Expectancy (years)</b>	~74 years	~74 years	~74–75 years	— Largely stable; remains below Ohio average
<b>Premature Death (Years of Potential Life Lost)</b>	High (worse than OH)	High	High	— Persistent elevated mortality burden
<b>Poor Physical Health Days</b>	~4.5 days	~4.4 days	~4.4 days	— Minimal improvement
<b>Poor Mental Health Days</b>	~5.3 days	~5.4 days	~5.5 days	▲ Gradual worsening mental health burden
<b>Adult Smoking (%)</b>	~22–23%	~22%	~21–22%	▼ Slow improvement, still above Ohio
<b>Adult Obesity (%)</b>	~38–39%	~39%	~39–40%	▲ Slight upward pressure
<b>Unemployment (%)</b>	~4.5%	~4.2%	~4.0–4.2%	▼ Improving labor conditions
<b>Children in Poverty (%)</b>	~22–23%	~22%	~21–22%	— Persistently high
<b>Physical Inactivity (%)</b>	~30%	~30%	~29–30%	— No meaningful change
<b>Primary Care Provider Ratio</b>	Worse than OH avg	Worse than OH avg	Worse than OH avg	— Structural access constraint

Values for 2024–2025 reflect the closest comparable indicators available under updated County Health Rankings models. Approximate ranges are used to support trend interpretation rather than direct point-estimate comparison.

Source: County Health Rankings & Roadmaps, Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute; Ohio County Data Files (2023–2025). Prior Highland County CHNA (2022) trend comparisons.

Across the 2023–2025 assessment period, Highland County continues to experience persistent challenges in core health outcome and health factor drivers, including premature mortality, behavioral health burden, obesity, and child poverty. While modest improvements are observed in smoking prevalence and employment, these gains have not yet translated into measurable improvements in life expectancy or premature death. The consistency of these indicators across multiple assessment cycles underscores the need for sustained, upstream investment in prevention, access to care, behavioral health capacity, and social drivers of health.

## Public Input and Comment

Meaningful community input was central to the 2025 Highland County Community Health Needs Assessment. A countywide community health survey was administered to gather resident perspectives on health concerns, quality of life, barriers to care, and the social and environmental conditions influencing health. Surveys were distributed in both electronic and paper formats through healthcare settings, community agencies, libraries, food distribution sites, and community events to ensure participation from residents who may not engage through traditional public comment mechanisms.

Survey respondents were asked to identify the most important health issues facing Highland County, challenges to accessing care and services, and factors affecting overall quality of life. Several clear and recurring themes emerged, aligning closely with secondary data trends and stakeholder input.

Across all methods, community input consistently highlighted concerns related to mental health, substance use, chronic disease, access to care, transportation, housing stability, and food access. Participants emphasized that these issues are interconnected and disproportionately affect individuals living in rural areas, households experiencing economic instability, older adults, individuals with disabilities, and residents of higher social vulnerability areas.

Community perspectives closely aligned with trends observed in secondary data sources, including elevated premature mortality, behavioral health burden, and adverse social determinants of health. This alignment across data sources strengthens confidence in the assessment findings and supports the identification of priority health needs that are both data-driven and community-validated. Coordination of the Community Health Improvement Plan and

dissemination of public survey results will be led by the Highland County General Health District in collaboration with the Highland County Healthcare Collaborative and Adena Health.

## Health Outcomes

- Chronic conditions are common
- Mental health and substance use are prevalent
- Quality of life is affected by health concerns

## Health Trends

- Mental health concerns worsening
- Substance use is a concern
- Access to care concerns - wait times and provider shortages

## Social Factors

- Cost and insurance barriers
- Transportation challenges
- Economic concerns

## Health Education Needs

- Mental health and coping skills
- Substance use prevention
- Managing chronic disease
- Nutrition and healthy living guidance

*Figure 2: Community perspective on 2025 Highland County survey*

Survey findings indicate that Highland County residents experience persistent health challenges driven by mental health conditions, substance use, chronic disease, and structural barriers to care. These concerns mirror patterns observed in surrounding Appalachian counties, where social and economic conditions and limited access to services contribute to poorer health outcomes.

## **SECTION 3: Assessment Framework and Approach**

This section outlines the CHNA process utilized by the Adena Health and the Highland County Healthcare Collaborative to craft this document.

### **Highland County Healthcare Collaborative**

The Highland County Healthcare Collaborative is a community-based group, whose efforts are aimed at improving the quality of life for Highland County residents. The coalition, organized with a memorandum of understanding (MOU), is structured with a steering committee and subcommittees that are focused on specific health priorities, with representation from area health partners, schools, local government, service organizations and more. Adena Health is one participating member of the collaborative.

The Collaboratives' efforts are driven by a vision of a community, in which everyone has knowledge of and access to health and wellness resources. By keeping in mind, the values of respect, trust, inclusiveness, engagement, and communication, the Highland County Healthcare Collaborative and subsequently Adena Health, are mission-focused to raise awareness and to ultimately improve the health and wellness of Highland County residents through the ongoing cooperation of community leaders, local health care providers, community organizations, and citizen support. By addressing the socioeconomic conditions that influence health, the Collaborative seeks to support improved health and wellness outcomes for Highland County residents.

### **CHNA Process**

As with previous assessments, the Highland County Healthcare Collaborative utilized Mobilizing Action through Planning and Partnership (MAPP) for the 2025 assessment. The process is trusted evidence-based framework for CHNAs used by the National Association of County and City Health Officials (NACCHO) and the Centers for Disease Control (CDC).

MAPP is a three-phase process that guides the assessment of the community's health needs, as well as the development of a community health improvement plan (CHIP). The assessment portion of the process includes a four-part strategy focused on collecting qualitative and quantitative data from both primary and secondary sources to identify community themes and strengths, community health status, and forces of change in the community, as well as the assessment of the local public health system. The survey collected by the collaborative had more than 640 responses.

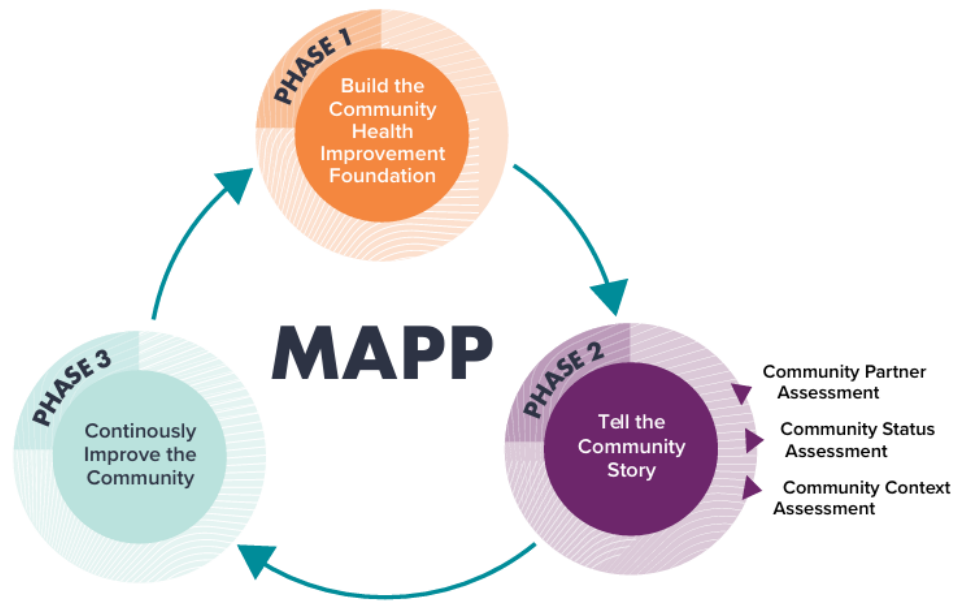


Figure 3: NACCHO MAPP Process

## Community Assessments

The 2025 CHNA was completed through a comprehensive process of data collection and evaluation using the MAPP framework. Both qualitative and quantitative data were collected from primary and secondary sources. Findings were organized across four MAPP assessment components: Community Themes and Strengths, Local Public Health System, Community Health Status, and Forces of Change. The information was compiled and evaluated by Adena Health and the Highland County General Health District, in collaboration with Highland County Healthcare Collaborative partners, to identify significant health needs and to inform CHIP priority selection.

## Data Sources

Primary and secondary data sources were used as part of the CHNA process and came from both local and publicly available sources. Primary data collection methods included a community resident survey, stakeholder interviews, and focus groups. Secondary data were drawn from established sources including, but not limited to:

- County Health Rankings & Roadmaps
- Ohio Department of Health (ODH)
- CDC PLACES (where applicable)
- U.S. Census Bureau / American Community Survey (ACS)
- Area Agency on Aging District 7 (AAA7)

- Local healthcare, education, and social service data (where available)

While data at the national and state levels is generally available for community health-related indicators, local data—from counties and cities—is less accessible and sometimes less reliable. Some data from publicly available sources are delayed by a minimum of two years, reflecting the time required for reported information to be collected, reviewed, approved, analyzed, and prepared for dissemination.

## **Community Input Methodology**

Multiple methods of community input were utilized to inform this Community Health Needs Assessment, recognizing that reliance on a single engagement strategy may not fully capture community perspectives in rural and Appalachian communities. Traditional public comment mechanisms alone may present participation challenges due to limited awareness of the assessment process or perceived relevance. To address this, a combination of quantitative and qualitative data collection methods was employed to ensure broad and inclusive community representation.

Primary data collection included a countywide public survey administered. Surveys were distributed using multiple outreach strategies, including electronic surveys promoted through social media and partner websites; paper surveys made available in medical offices, community agency locations, libraries, food distribution sites, and community events; and targeted distribution through community partners serving diverse populations. Survey findings will be summarized within this CHNA and may also be shared separately by the Highland County Healthcare Collaborative as part of community health improvement planning efforts. The finalized CHNA will be made publicly available on the Adena Health website.

## **Limitations**

As with all community health assessments, the findings presented in this report are subject to several limitations that should be considered when interpreting results. Much of the quantitative data used in this assessment is derived from publicly available state and federal sources that rely on multi-year estimates or lagged reporting cycles; as a result, some indicators may not fully reflect the most recent changes in community conditions. In addition, differences in data collection methods, definitions, and reporting periods across sources may limit direct comparability between measures.

Primary data collected through the community survey, focus groups, and stakeholder interviews represent voluntary participation and may be influenced by response bias. While multiple outreach methods were used to increase participation and accessibility, certain populations—particularly individuals with limited internet access, time constraints, language barriers, or

distrust of surveys—may be underrepresented. Subgroup analyses should therefore be interpreted with caution, as smaller sample sizes may increase the margin of error.

Finally, the identification and prioritization of health needs reflect conditions and community input available at the time of the assessment. Community health is dynamic, and emerging issues, policy changes, economic shifts, or public health emergencies may affect health needs during the implementation period. For these reasons, this CHNA is intended to serve as a guiding framework rather than an exhaustive inventory of all health concerns, and it will be supplemented through ongoing monitoring, community engagement, and future assessments.

Final determinations of significant health needs and the completed CHNA report are intended for review and adoption in accordance with applicable hospital policy and §501(r) governance requirements.



## SECTION 4: Community Context and Assets

Economic, educational, and social conditions in Highland County and the surrounding southern Ohio Appalachian region continue to exert a strong influence on health outcomes for residents. Southern Ohio counties, including Highland County, consistently experience poorer population health outcomes relative to many other Ohio counties, reflecting long-standing structural and systemic challenges rather than short-term variation.

The County Health Rankings & Roadmaps, produced annually by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, provide a comparative framework for assessing both current population health and the conditions that shape future health. In the 2025 County Health Rankings, Ohio continues to perform poorly relative to other states on key population health indicators. Within Ohio, all 88 counties are comparatively assessed based on health outcomes (length and quality of life) and health factors (health behaviors, clinical care, social and economic factors, and the physical environment).

In the most recent reporting periods, Highland County falls within the lower-performing groupings statewide for both health outcomes and health factors, indicating persistently poorer population health relative to many other Ohio counties. These patterns are driven primarily by premature mortality, injury deaths, mental distress, substance use, economic insecurity, tobacco use, physical inactivity, and chronic disease burden—areas in which Highland County continues to experience elevated risk.

### Trends in Health Outcomes and Health Factors

Highland County's health outcomes have remained persistently challenged over time, reflecting long-standing issues related to early death and reduced quality of life. Mortality associated with heart disease, cancer, chronic lower respiratory disease, injury, and substance-related causes remains elevated compared to state and national benchmarks. As emphasized in the County Health Rankings framework, these outcomes represent the cumulative effects of health behaviors, access to care, and social and economic conditions over many years and typically change gradually.

Health factors have also remained unfavorable for Highland County. Beginning in the post-pandemic period, methodological updates to the County Health Rankings model placed greater emphasis on social and economic conditions, mental health, substance use, workforce participation, housing instability, and social connectedness. These changes disproportionately affected rural and Appalachian counties, including Highland County, where economic stress, transportation barriers, workforce shortages, and limited housing options remain prevalent.

While modest improvements have occurred in select indicators, they have not been sufficient to offset broader structural pressures.

## **Clinical Care in Context**

Clinical care access and quality remain a structural challenge in Highland County. In the 2023 County Health Rankings—the most recent year in which Ohio county-level Clinical Care sub-domain rankings were published—Highland County ranked 80th of 88 counties statewide for Clinical Care, placing it in the bottom quartile relative to other Ohio counties.

This ranking reflects the combined influence of multiple access and quality indicators, including provider availability, preventive service utilization, and preventable hospital use. While selected measures such as insurance coverage perform comparatively better than some peer counties, significant constraints remain related to workforce shortages, long travel distances, transportation limitations, and limited specialty and behavioral health capacity. These access barriers are characteristic of rural Appalachian communities and contribute to delayed care and higher reliance on emergency services.

Beginning in 2024, County Health Rankings transitioned away from publishing numeric Ohio county sub-domain ranks for Clinical Care and instead emphasized grouped and standardized score reporting. Accordingly, the 2023 sub-domain rank is used in this assessment as the most recent directly comparable benchmark for evaluating clinical care access and quality in Highland County.

## **Interpretation and Use in the Assessment**

Despite relatively stronger clinical care performance, Highland County continues to experience poor overall health outcomes driven largely by social and economic conditions, health behaviors, injury risk, mental health, and substance use. These domains exert a greater influence on long-term outcomes such as premature death and quality of life than clinical care alone.

The data presented in this assessment build upon County Health Rankings findings to identify priority health needs for Highland County. Particular attention is given to factors contributing to early death and injury, mental and behavioral health, substance use, chronic disease, and social and economic conditions that limit opportunities for health. These findings, combined with community survey input and stakeholder engagement, guide the prioritization process and inform future planning efforts.

Table 3: Highland County Health Rankings

Highland County Health Rankings Summary			
Measure	Relative Standing	Most Recent Comparable Year(s)	Interpretation
Health Outcomes	Bottom quartile statewide	2023–2025	Driven by premature mortality and reduced quality of life
Health Factors	Bottom quartile statewide	2023–2025	Reflects persistent social, economic, and behavioral health challenges
Clinical Care	Bottom quartile statewide	2023	Limited access and workforce capacity despite presence of local hospitals

Source: County Health Rankings & Roadmaps (RWJF / University of Wisconsin Population Health Institute).

### ***Explanation of 2024–2025 Health Rankings Methodology and Quartile Reporting***

In recent releases of the County Health Rankings & Roadmaps, the methodology used to report county-level population health has evolved. Historically, annual rankings provided a numeric ordinal rank for each county within a state for both Health Outcomes and Health Factors (e.g., Xth of 88 counties). While these numeric rankings are available for earlier years, the most recent reporting cycles (2024 and 2025) emphasize relative standing and health group classifications rather than consistently publishing single numeric ranks for all domains for most counties.

Under the updated framework, counties are increasingly described using relative groupings (such as lower-performing quartiles or health group placement) derived from composite scores that summarize multiple indicators. This approach reflects guidance from the County Health Rankings program to reduce over-interpretation of small year-to-year rank changes that may result from minor score fluctuations, methodological refinements, or population size effects—particularly in rural counties.

As a result:

- Specific numeric ranks are not consistently published in publicly available Ohio summary files for 2024 and 2025, even though counties continue to be comparatively assessed statewide.
- Quartile-based or relative standing descriptors provide a stable and methodologically appropriate indicator of Highland County’s position relative to other Ohio counties.
- This approach aligns with broader efforts to focus attention on persistent health inequities and structural drivers of health rather than emphasizing small changes in ordinal position that may not represent meaningful differences in population health.

Accordingly, when numeric rankings are not available or are not directly comparable across years due to methodological updates, this assessment uses relative standing to characterize Highland County’s health outcomes and health factors, ensuring consistency across reporting periods.

Table 4: Core Population Health & County Health Rankings Metrics

Core Population Health & County Health Rankings Metrics – Highland County					
Indicator	Highland County	Ohio	U.S.	Data Year(s)	Interpretation
Health Outcomes (relative standing)	Lower-performing group	—	—	2023–2025	Bottom-tier statewide
Health Factors (relative standing)	Lower-performing group	—	—	2023–2025	Persistent structural disadvantage
Clinical Care	Mid-range	—	—	2023	Relative strength
Life Expectancy	~74 years	~76–77	~78–79	2020–2024	Below benchmarks
Premature Death (YPLL <75)	Elevated	Lower	Lower	2022–2024	Central driver of outcomes
Drug Overdose Death Rate	Elevated	Lower	Lower	2022–2024	Major contributor to injury deaths
Suicide Death Rate	Elevated	Lower	Lower	2022–2024	Persistent behavioral health concern
Adult Smoking	~22–23%	~18%	~13%	2023	Key chronic disease driver
Adult Obesity	~38–40%	~38%	~34%	2023	Sustains chronic disease burden
Physical Inactivity	~30%	~24%	~23%	2023	Linked to cardiovascular disease

## Core Population Health & County Health Rankings Metrics – Highland County

Indicator	Highland County	Ohio	U.S.	Data Year(s)	Interpretation
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**Data Interpretation Note:** Metrics reflect the most recent available estimates from County Health Rankings & Roadmaps, CDC PLACES, and Ohio Department of Health sources. Several indicators are based on multi-year rolling averages and are presented as ranges to reflect persistent trends rather than single-year fluctuations.

**Sources:**

- Ohio Department of Health, Ohio Public Health Data Warehouse
- County Health Rankings & Roadmaps (RWJF / UWPHI), Ohio County Rankings 2023–2025
- Centers for Disease Control and Prevention, CDC PLACES (2023–2024 estimates)
- Ohio Department of Health, Mortality and Injury Surveillance (2022–2024)

## Community Profile: Highland County, Ohio

Highland County (**Error! Reference source not found.**) is located in rural, south-central Ohio and is designated as one of Ohio’s 32 Appalachian counties. The county covers approximately 553 square miles, with land use patterns that reflect its rural and resource-based character. According to the Ohio Development Services Agency, only a small share of land is used for residential, commercial, or industrial purposes, while more than 32% of the county is forested and approximately 60% is farmland or pasture, contributing to dispersed settlement patterns and transportation-dependent access to services.

Highland County has an estimated population of approximately 43,000 residents, consistent with recent County Health Rankings & Roadmaps (CHR) reporting and decennial census benchmarks. The county seat and largest municipality is Hillsboro, which serves as the primary employment, healthcare, and service center for the county and surrounding rural townships.



Figure 4: Highland County, Ohio

The local economy is predominantly service-driven, with leading employment sectors including transportation, trade and utilities, education, healthcare and social assistance, leisure and hospitality, and public services. According to CHR-reported labor force indicators, Highland County's unemployment rate remains higher than state benchmarks, reflecting persistent workforce and economic challenges common across rural Appalachian communities.

CHR-reported socioeconomic indicators show that poverty remains a significant concern, particularly among children. Highland County's child poverty rate and overall poverty prevalence exceed Ohio averages, and a substantial share of households earn below \$50,000 annually. Educational attainment also lags state and national benchmarks, with CHR reporting a lower proportion of adults holding a four-year college degree, limiting economic mobility and long-term income growth.

These demographic and economic conditions are consistent with broader patterns observed across Appalachian Ohio and have important implications for health outcomes, access to care, workforce participation, and long-term economic stability. As reflected throughout this CHNA, these structural factors contribute directly to elevated rates of chronic disease, behavioral health burden, injury, and premature mortality observed in Highland County.

## **Community Assets**

As part of understanding the conditions that influence health and quality of life, Highland County assets are described using a community capitals framework. This approach recognizes that community health is shaped not only by medical care, but also by the natural, cultural, social, economic, and structural resources that support resilience, connection, and opportunity. The following sections summarize key community capitals as they relate to Highland County.

### **Natural Capital**

Highland County is part of Appalachian Ohio and is characterized by a predominantly rural landscape that supports outdoor recreation, environmental stewardship, and quality of life. A major natural asset is Rocky Fork State Park, a 2,000+ acre park located east of Hillsboro that provides residents and visitors access to hiking, boating, fishing, camping, and nature-based recreation.

The county also includes extensive forested and agricultural land, as well as proximity to Highland Nature Sanctuary and other protected natural areas within the Arc of Appalachia region. These assets support conservation, environmental education, and low-impact recreation. Collectively, Highland County's natural resources provide accessible opportunities for physical activity, stress reduction, and social connection—important protective factors for long-term physical and mental health.

## Cultural Capital

Highland County's cultural capital is rooted in its Appalachian heritage and strong community identity, reflected through local traditions, civic pride, and multigenerational ties to place. Community events serve as visible cultural strengths, including the Highland County Fair, which functions as a recurring gathering point for residents, families, youth programs, agricultural organizations, and local businesses.

The county also benefits from institutions that support lifelong learning and local identity, including the Highland County District Library, which provides educational programming, workforce resources, digital access, and community meeting space across multiple locations. Historic downtown areas, local arts initiatives, and school- and community-sponsored events further contribute to Highland County's cultural cohesion and sense of place.

## Human Capital

Highland County's human capital is strengthened by institutions that support workforce readiness, youth development, and adult learning. The Southern State Community College campus in Hillsboro provides postsecondary education, technical training, and credentialing aligned with regional workforce needs, including healthcare, manufacturing, and skilled trades.

Youth development capacity is further supported through Ohio State University Extension in Highland County, including 4-H youth development programming that builds leadership, agricultural literacy, life skills, and community engagement. Local school districts, career-technical education partnerships, and workforce programs also contribute to developing the county's future labor force.

## Social Capital

Highland County's social capital is supported by a strong network of community organizations, faith-based institutions, volunteer groups, and local service providers that offer connection and informal support—particularly important in rural communities where geographic distance can limit access to formal services.

Examples of community-serving assets include the Highland County YMCA, which provides opportunities for physical activity, youth programming, childcare, and community connection. Food pantries, senior centers, veteran service organizations, and civic clubs further strengthen informal support networks. Public health infrastructure contributes to community resilience through the Highland County General Health District, which delivers core public health services and serves as a trusted partner during community health planning and public health emergencies.

## **Political Capital**

Highland County benefits from local governance and civic leadership that support planning, coordination, and community responsiveness. County government is led by the Highland County Board of Commissioners, which provides oversight and coordination of county services, infrastructure, and policy priorities.

The county also has locally anchored partners focused on economic and community development, including the Highland County Chamber of Commerce and Highland County Economic Development, which support business retention and expansion, workforce initiatives, and community revitalization efforts. Collaboration among local government, schools, healthcare systems, and nonprofit organizations strengthens Highland County's capacity to respond to community needs.

## **Built Capital**

Highland County's built capital includes healthcare facilities, transportation infrastructure, educational institutions, and community service hubs that support access to essential services. The county is served by two Critical Access Hospitals—Highland District Hospital and Adena Greenfield Medical Center—which provide emergency services, inpatient care, outpatient diagnostics, and specialty clinics for residents across the county and surrounding rural areas.

Additional built assets include outpatient clinics, emergency medical services, schools, senior housing, public libraries, and community facilities such as the Highland County Fairgrounds. These sites function as trusted and accessible spaces for service delivery, outreach, education, and community engagement, particularly for residents with limited transportation options.

Overall, Highland County's community assets provide a strong foundation for health, resilience, and quality of life. The county's natural environment, Appalachian cultural identity, workforce and youth development resources, active civic and faith-based organizations, responsive local governance, and essential healthcare and community infrastructure collectively support physical and mental well-being across the lifespan. These assets enhance social connection, promote healthy behaviors, and strengthen the community's capacity to respond to challenges. Leveraging and aligning these existing strengths will be critical as Highland County moves from assessment to planning and implementation of strategies to address identified health needs and advance health equity. These community assets provide a critical foundation for identifying priority health needs and selecting feasible, evidence-informed strategies for the Community Health Improvement Plan (CHIP).

## Demographic Characteristics

A demographic profile of Highland County was developed using publicly available and verifiable data sources, including the U.S. Census Bureau Decennial Census, American Community Survey (ACS) 2019–2023 five-year estimates, County Health Rankings & Roadmaps, Ohio Department of Health administrative data, Ohio Healthy Youth Environment Survey (OHYES), and regional aging and veteran data. Together, these sources establish an objective baseline for understanding population trends, community context, and conditions that influence health outcomes.

Because health is shaped by the interaction of social, economic, environmental, and behavioral factors, quantitative indicators alone do not fully capture community needs. To support Community Health Needs Assessment (CHNA) planning and priority identification, these demographic data are interpreted alongside community input and stakeholder perspectives, which are presented in subsequent sections of this assessment.

The tables that follow summarize Highland County population characteristics—including population size, age structure, race and ethnicity, household composition, education, income, poverty, veteran status, and disability—to provide essential context for understanding health needs, disparities, and opportunities for improvement. This demographic overview utilizes the most recent U.S. Census Bureau Decennial Census (2020) and ACS 2019–2023 five-year estimates, consistent with IRS §501(r) guidance recommending reliable, publicly available data sources to describe community characteristics and social determinants of health.

## Population Size and Growth Trends

Highland County is a rural county in south-central Ohio with a population of approximately 43,000 residents, according to the 2020 U.S. Census and recent ACS estimates. Similar to many rural counties in southern Ohio, Highland County has experienced slow population growth and modest long-term decline, driven largely by out-migration of younger adults and an increasing proportion of older residents.

While population stability can support strong social ties and community cohesion, it also presents challenges related to workforce availability, tax base growth, service capacity, and long-term economic sustainability. These trends are particularly important when considered alongside an aging population, which influences healthcare utilization, transportation demand, caregiver availability, and the need for age-friendly community planning.

Table 5: Demographic Indicators — Highland County, Ohio

<b>Demographic Indicators — Highland County, Ohio</b>			
<b>Indicator</b>	<b>Highland County</b>	<b>Ohio</b>	<b>United States</b>
Total Population (2020 Census)	43,058	11,799,448	331,449,281
Population Change (2010–2020)	–1.8%	+2.3%	+7.4%
Median Age (years)	41.0	39.6	38.9
Population Under Age 18	22.0%	22.3%	22.1%
Population Age 65 and Older	18.9%	17.9%	16.9%
White (non-Hispanic)	95.4%	77.0%	58.7%
Median Household Income	\$53,100	\$69,680	\$77,719
Per Capita Income	\$31,900	\$38,531	\$41,261
Persons Below Poverty Level	17.8%	13.4%	12.6%
Children Below Poverty Level	22.4%	18.0%	16.3%
Bachelor’s Degree or Higher (25+)	15.3%	30.0%	35.0%

Source: U.S. Census Bureau, Decennial Census 2020; American Community Survey (ACS) 2019–2023 5-Year Estimates (DP05, DP03, S1701, S1501).

## Age Distribution and Aging Population

Highland County’s population is concentrated among working-age adults, but the county continues to experience population aging at a faster rate than Ohio overall. Adults age 65 and older represent a growing share of residents, consistent with patterns observed across Appalachian Ohio.

Regional aging data indicate that the number of adults over age 60 is increasing and is projected to peak during the current planning period, with particularly rapid growth among adults age 85 and older. An aging population has important implications for chronic disease prevalence, disability rates, transportation access, caregiving demand, and healthcare utilization—especially in rural areas where service availability may be limited. These trends increase the importance of

accessible primary care, behavioral health services, transportation supports, in-home services, and community-based aging supports.

See Table 6 for population change over time, which contextualizes workforce availability, service demand, and long-term economic sustainability.

Table 6: Population Trends - Highland County, Ohio

<b>Population Trends — Highland County, Ohio</b>			
<b>Year</b>	<b>Highland County</b>	<b>Ohio</b>	<b>United States</b>
2010	43,589	11,536,504	308,745,538
2015	43,641	11,617,527	320,635,163
2020	43,058	11,799,448	331,449,281
2023 (est.)	42,900	11,780,017	334,914,895
<b>Percent Change (2010–2023)</b>	<b>-1.6%</b>	<b>+2.1%</b>	<b>+8.5%</b>

Source: U.S. Census Bureau, Decennial Census (2010, 2020); ACS 2019–2023 5-Year Estimates.

See Table 7 for the age distribution trends that contribute to increased chronic disease prevalence, disability rates, transportation needs, and healthcare utilization in Highland County.

Table 7: Population by Age Group — Highland County Compared to Ohio and U.S.

<b>Population by Age Group — Highland County Compared to Ohio and U.S.</b>			
<b>Age Group</b>	<b>Highland County (%)</b>	<b>Ohio (%)</b>	<b>United States (%)</b>
Under 18 years	22.0	21.6	21.7
18–24 years	7.1	8.9	9.1
25–44 years	23.2	26.1	26.9
45–64 years	28.5	24.3	24.6
65 years and older	19.2	19.1	17.7

<b>Population by Age Group — Highland County Compared to Ohio and U.S.</b>			
<b>Age Group</b>	<b>Highland County (%)</b>	<b>Ohio (%)</b>	<b>United States (%)</b>
<b>Median Age (years)</b>	<b>41.0</b>	<b>39.9</b>	<b>39.2</b>

Source: U.S. Census Bureau, ACS 2019–2023 5-Year Estimates (DP05).

## Race, Ethnicity, and Gender

Highland County’s population is less racially and ethnically diverse than Ohio and the United States overall. Most residents identify as White, with smaller proportions identifying as Black or African American, Hispanic or Latino, or multiracial. Although these populations represent a smaller share of the total population, even small population groups may experience disproportionate health burdens, underscoring the importance of equity-focused planning and culturally responsive services.

Gender distribution in Highland County is similar to state and national patterns. Gender composition influences workforce participation, injury risk, caregiving roles, and health behaviors, particularly in rural communities where employment sectors and service access differ by gender.

Table 8: Population Characteristics by Sex, Race, Ethnicity, and Veteran Status

<b>Population Characteristics by Sex, Race, Ethnicity, and Veteran Status</b>			
<b>Indicator</b>	<b>Highland County</b>	<b>Ohio</b>	<b>United States</b>
Female	50.4%	50.7%	50.5%
Male	49.6%	49.3%	49.5%
White (non-Hispanic)	95.4%	78.1%	58.1%
Black or African American	1.4%	13.3%	12.1%
Hispanic or Latino (any race)	1.7%	4.5%	19.1%
Other Race / Multiracial	1.5%	8.6%	22.7%
<b>Veterans (Age 18+)</b>	<b>9.2%</b>	<b>7.6%</b>	<b>6.4%</b>

Source: U.S. Census Bureau, ACS 2019–2023 5-Year Estimates (DP05, S2101).

See Table 8 for demographic composition, which informs equity considerations and culturally responsive service planning.

### Veterans and Disability

Veterans represent a notable share of the adult population in Highland County, exceeding state and national averages. Veterans may have unique health needs related to physical injury, chronic disease, mental and behavioral health, and access to specialized services, making coordination with veteran-serving organizations and healthcare providers an important consideration for community health planning.

Disability prevalence in Highland County is substantially higher than Ohio and U.S. averages, affecting residents across age groups and disproportionately impacting older adults. Elevated disability prevalence reinforces the need for accessible healthcare, transportation, housing, workforce accommodations, and caregiver supports. These factors also contribute to increased healthcare utilization and underscore the importance of community-based services that support independent living and aging in place.

Table 9: Disability and Veteran Status — Highland County

Disability and Veteran Status — Highland County			
Indicator	Highland County	Ohio	United States
Persons with a Disability (Under 65)	11.4%	9.2%	8.6%
Persons with a Disability (All Ages)	16.9%	12.7%	12.9%
Veterans with a Disability	33.6%	29.7%	27.3%
Veterans with Service-Connected Disability	5.6%	4.6%	4.3%

Source: U.S. Census Bureau, ACS 2019–2023 5-Year Estimates (S1810, S2101).

### Households, Families, and Living Arrangements

Household characteristics in Highland County reflect both strengths and vulnerabilities common to rural Appalachian communities. Many households include children, older adults, or multigenerational family members, supporting informal caregiving and social connection. At the same time, a meaningful share of households includes older adults living alone and single-parent families, which are associated with increased risk of economic stress, social isolation, and transportation barriers.

Housing stability remains a mixed indicator. Homeownership rates are higher than state and national averages, reflecting long-term residence and community attachment. However, housing cost burden, housing quality, and limited broadband access present challenges for lower-income households, older adults, and families with children—particularly in more remote areas of the county.

Table 10: Households, Families, and Housing Characteristics

<b>Households, Families, and Housing Characteristics</b>			
<b>Indicator</b>	<b>Highland County</b>	<b>Ohio</b>	<b>United States</b>
Total Households	17,100	4,799,700	131,202,900
Average Household Size	2.47	2.45	2.53
Households with Children	28.3%	28.8%	29.0%
Single-Parent Households	11.2%	10.4%	10.2%
Owner-Occupied Housing Units	72.5%	65.3%	64.1%
Housing Cost-Burdened Households	27.1%	29.1%	30.6%
Households without Broadband	19.4%	13.0%	11.5%

Source: U.S. Census Bureau, ACS 2019–2023 5-Year Estimates (DP04, S2501).

## Income, Poverty, and Economic Conditions

Economic indicators show that median household and per capita income in Highland County remain below Ohio and U.S. benchmarks, while poverty rates—particularly child poverty—exceed state averages. Educational attainment also lags behind Ohio and national levels, with a smaller proportion of adults holding a bachelor’s degree or higher.

Table 11: Income — Highland County, Ohio, and United States

<b>Income — Highland County, Ohio, and United States</b>			
<b>Income Measure</b>	<b>Highland County</b>	<b>Ohio</b>	<b>United States</b>
<b>Per Capita Income</b>	\$31,900	\$39,455	\$43,289

Income — Highland County, Ohio, and United States			
Income Measure	Highland County	Ohio	United States
Median Family Income	\$69,800	\$90,288	\$96,922
Median Household Income	\$53,100	\$69,680	\$78,538

Source: U.S. Census Bureau, ACS 2019–2023 5-Year Estimates (DP03).

Table 12: Poverty — Highland County, Ohio

Poverty — Highland County, Ohio			
Poverty Indicator (FPL 100%)	Highland County	Ohio	United States
People Living Below Poverty Level	17.8%	13.2%	12.4%
Children Living Below Poverty Level	22.4%	18.0%	16.3%
Families Living Below Poverty Level	13.9%	9.2%	8.7%

Source: U.S. Census Bureau, ACS 2019–2023 5-Year Estimates (S1701).

These economic conditions influence access to healthcare, healthy food, stable housing, transportation, and educational opportunities. They also shape long-term health outcomes through cumulative exposure to financial stress and limited opportunity. Youth survey data from OHYES further indicate that economic stress, mental health concerns, and perceived lack of opportunity are salient issues among adolescents in Highland County, reinforcing the link between household conditions and health across the life course.

## Community Context Summary

Taken together, population trends, age distribution, household characteristics, veteran representation, disability prevalence, and economic conditions indicate that Highland County faces persistent structural challenges alongside meaningful community strengths. Rural geography, population aging, youth vulnerability, workforce and transportation limitations, and economic stress influence access to resources and exposure to health risks across the county.

These demographic and socioeconomic conditions provide essential context for interpreting the health indicators presented in the following sections. They help explain observed patterns in premature mortality, chronic disease, behavioral health challenges, and access to care, and they inform priority identification and strategy selection for the Community Health Improvement Plan (CHIP).

# SECTION 5: Social Determinants & Equity Context

## Social Vulnerability

The most widely used U.S. measure is the CDC/ATSDR Social Vulnerability Index (SVI), which ranks communities (counties and census tracts) using 16 ACS-based social factors grouped into 4 themes:

- Socioeconomic status,
- Household characteristics,
- Racial & ethnic minority status/language,
- Housing type & transportation.

Together, these themes summarize the extent to which the area is socially vulnerable to disaster. The higher the percentile rank, the more vulnerable a location is. Overall social vulnerability combines all the variables to provide a comprehensive assessment. Figure 5 shows the CDC/ATSDR Social Vulnerability Index (SVI).

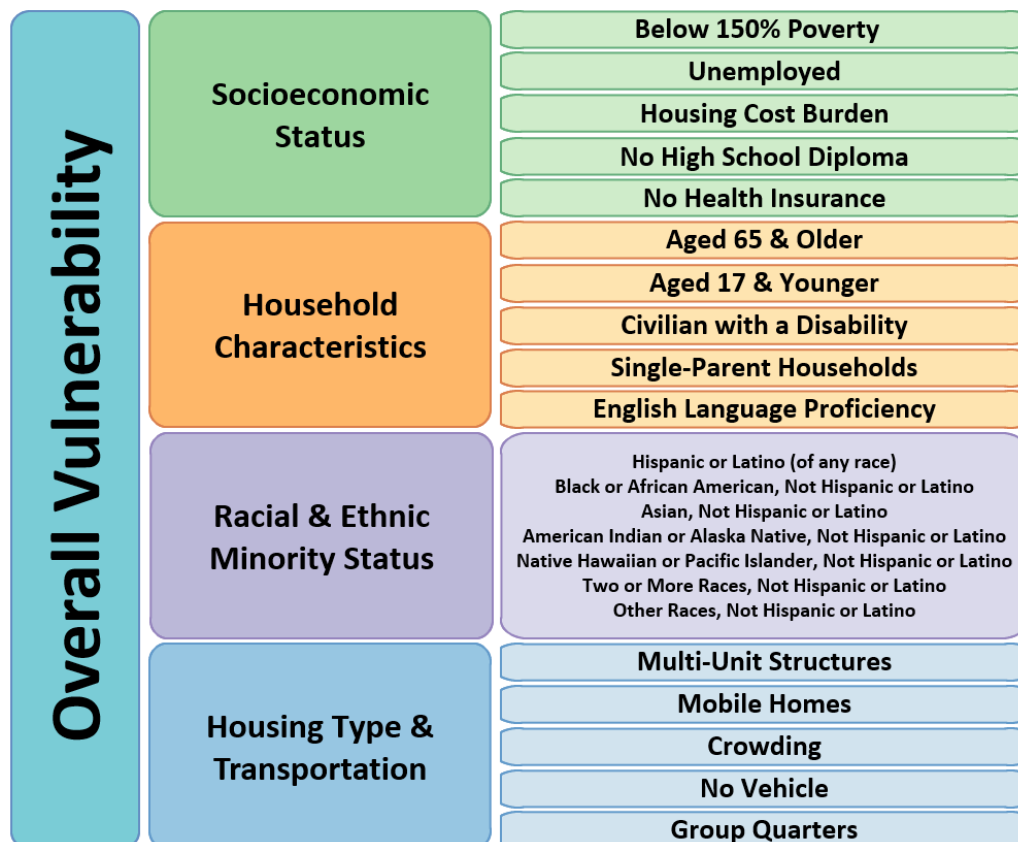


Figure 5: CDC/ATSDR Social Vulnerability Index (SVI) (Source: CDC)

Overall, Ohio’s social vulnerability profile is higher than the U.S. average, reflecting a greater concentration of communities experiencing socioeconomic and structural challenges. While Ohio includes areas of low vulnerability—particularly in some suburban counties—the state has a larger share of counties and census tracts with elevated SVI scores compared to national patterns.

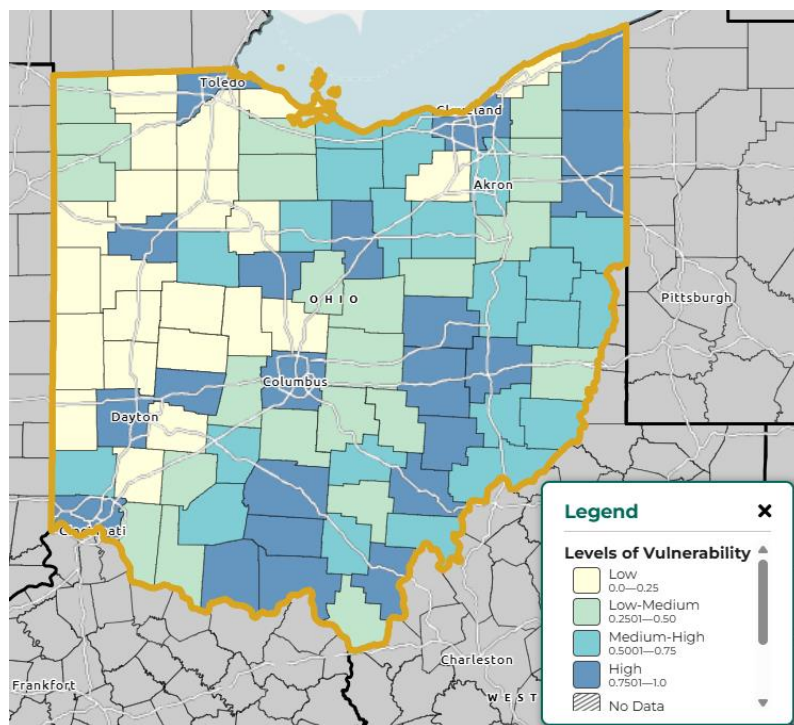
While Ohio’s overall SVI is higher than the U.S. average, the most important distinction is the geographic concentration of vulnerability. Ohio has:

- A greater number of high-SVI rural tracts than many states
- Persistent clusters of vulnerability that align with poorer health outcomes, higher chronic disease burden, and reduced access to care
- ODH: Ohio’s SVI profile supports continued use of Health Improvement Zones (HIZ) and place-based targeting.
- Elevated SVI relative to the U.S. strengthens the rationale for Health-Related Social Needs (HRSN) screening and social care investment, especially in rural areas.
- Comparing Ohio to the U.S. provides defensible context showing that community needs are shaped by structural and regional disadvantage, not isolated conditions.

Compared to the United States overall, Ohio experiences higher and more geographically concentrated social vulnerability, driven primarily by socioeconomic factors. This context supports targeted, equity-focused strategies in Ohio counties—particularly rural and Appalachian communities—where social conditions strongly influence health outcomes.

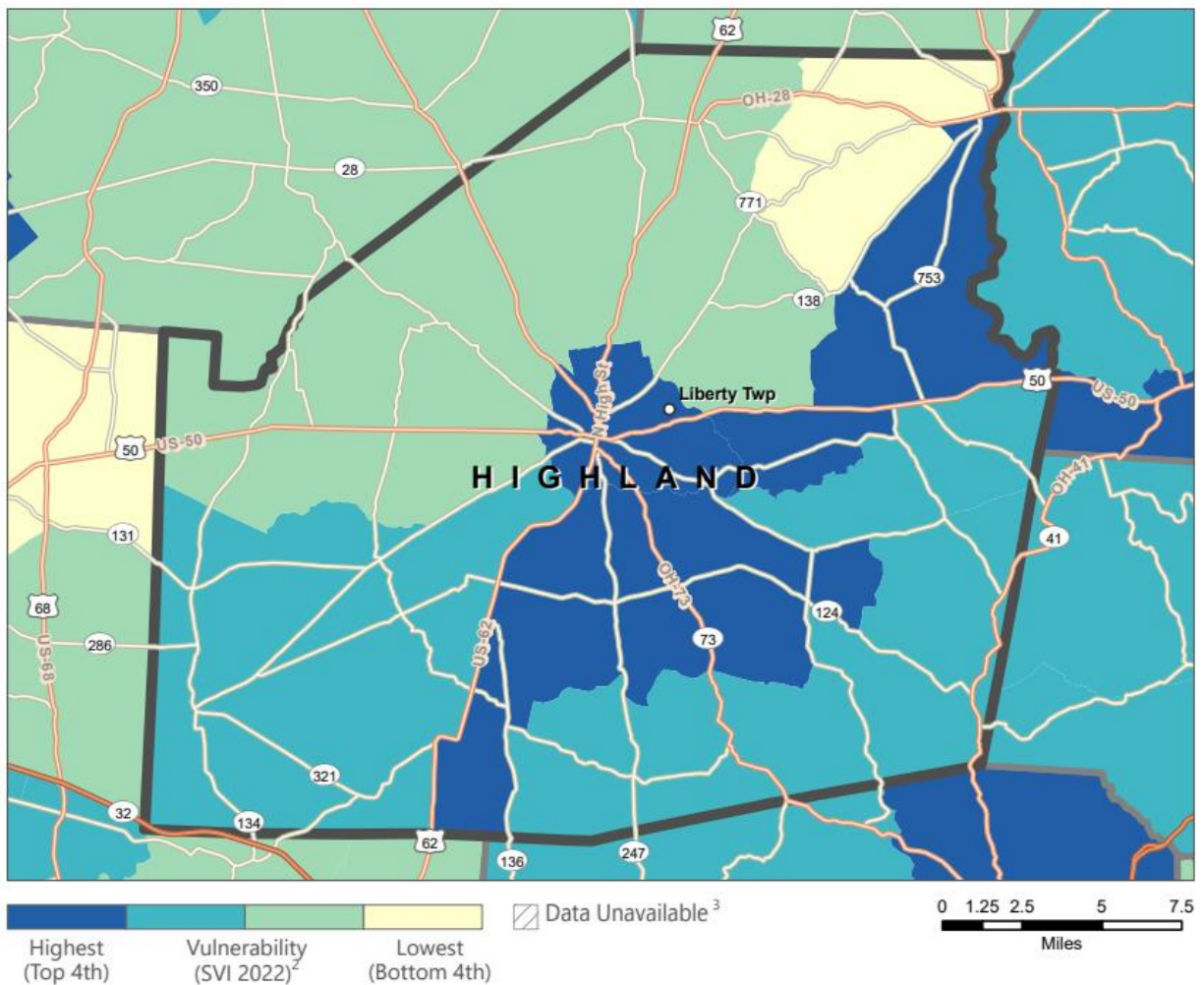
Highland County and several surrounding counties in southern Ohio exhibit elevated social vulnerability, reflecting a combination of rural geography, economic stress, aging population trends, and access barriers. As a transition county within Appalachian Ohio, Highland County includes communities that experience Appalachian-like vulnerability alongside areas that more closely resemble non-Appalachian rural Ohio. This mixed profile results in uneven distribution of risk across the county.

Figure 6: Ohio Social Vulnerability Map (Source: CDC)



Transportation limitations, housing affordability and quality, workforce constraints, and other economic barriers create challenges for many residents, particularly in more rural townships and census tracts with higher concentrations of older adults, low-income households, and individuals with disabilities. Figure 7 presents the Social Vulnerability Index (SVI) map for Highland County by census tract, illustrating how vulnerability varies geographically within the county. Darker shading indicates areas with higher relative social vulnerability, helping to identify neighborhoods where residents may face greater barriers to health, emergency preparedness, and access to services.

Figure 7: CDC Areas of Social Vulnerability for Highland County, Ohio



## Social Determinants – Driving Risks and Outcomes

Social determinants of health play a central role in shaping health outcomes in Highland County. Educational attainment remains lower than state and national averages, with a smaller share of adults holding a four-year college degree. Workforce participation is also lower than Ohio

benchmarks, reflecting a combination of limited local employment opportunities, higher rates of disability, and caregiving responsibilities—particularly among older adults.

Income levels in Highland County lag behind Ohio and U.S. benchmarks, and poverty—especially child poverty—remains elevated. Food insecurity affects a meaningful share of households, and housing cost burden is common among renters and lower-income households, limiting resources available for healthcare, transportation, and nutrition.

Transportation barriers, limited access to safe and convenient exercise opportunities, and lower broadband availability further influence access to care, health information, education, and healthy behaviors—particularly in rural townships and outlying areas of the county. At the same time, Highland County benefits from strong community networks, local institutions, and healthcare assets that help mitigate some barriers and support community resilience.

Table 13: Social Determinants of Health Indicators - Highland County

Social Determinants of Health Indicators — Highland County Compared to Ohio and U.S.					
Indicator	Highland County	Ohio	United States	Data Year(s)	Interpretation
Adults with Bachelor’s Degree or Higher (25+)	~17%	~30%	~35%	2019–2023 ACS	Lower educational attainment constrains workforce opportunity and income growth
Median Household Income	~\$53,100	~\$69,680	~\$78,538	2019–2023 ACS	Persistent income gap relative to state and national benchmarks
Per Capita Income	~\$31,900	~\$39,455	~\$43,289	2019–2023 ACS	Reflects lower earning potential and economic stress
People Living Below Poverty Level	~17.8%	~13.2%	~12.4%	2019–2023 ACS	Elevated poverty increases health risk and limits access to care
Children Living Below Poverty Level	~22.4%	~18.0%	~16.3%	2019–2023 ACS	Child poverty is a key driver of long-term health disparities

Social Determinants of Health Indicators — Highland County Compared to Ohio and U.S.					
Indicator	Highland County	Ohio	United States	Data Year(s)	Interpretation
Unemployment Rate	~4.5–5.0%	~4.0%	~3.8–4.0%	2023–2024 BLS	Workforce instability persists despite recent improvements
Housing Cost-Burdened Households	~27.1%	~29.1%	~30.6%	2019–2023 ACS	Housing costs limit resources for health, food, and transportation
Households Without Broadband	~19.4%	~13.0%	~11.5%	2019–2023 ACS	Digital divide affects telehealth, education, and employment access

**Sources:** U.S. Census Bureau, American Community Survey (ACS) 2019–2023 (DP03, S1501, S1701, DP04/S2501); U.S. Bureau of Labor Statistics (Local Area Unemployment Statistics); County Health Rankings & Roadmaps (contextual interpretation).

**Note:** ACS values are five-year pooled estimates; county figures are presented as approximate ranges where appropriate to reflect methodological uncertainty.

Environmental and built-environment conditions also influence health equity in Highland County. Rural land use patterns, aging housing stock in some communities, and limited infrastructure in more remote areas highlight the importance of environmental health monitoring, housing quality, and equitable access to basic services as part of comprehensive community health planning. Key built environment and access indicators present in Highland County are:

- Healthcare access: Presence of two critical access hospitals; limited specialty care availability; travel distance to higher-acuity services
- Transportation: Predominantly car-dependent travel; limited public transportation options; longer travel times for rural residents
- Broadband access: Higher share of households without broadband compared to Ohio and U.S. averages, affecting telehealth and education
- Food access: Rural and low-income areas with reduced proximity to full-service grocery stores
- Physical activity access: Parks, trails, and recreation areas present but unevenly accessible across the county

- Community hubs: Town centers (Hillsboro, Greenfield) function as service and employment nodes for surrounding rural areas

Areas with greater access constraints—driven by distance, transportation limitations, broadband gaps, and economic stress—are more likely to experience barriers to preventive care, chronic disease management, and emergency preparedness. These built environment conditions intersect with social vulnerability patterns and inform place-based strategies for transportation support, service coordination, and community health worker outreach.

When viewed alongside the Social Vulnerability Index (SVI), these built environment and access indicators help identify neighborhoods where structural barriers and social risk factors overlap, supporting targeted and equitable Community Health Improvement Plan (CHIP) strategies.

## **Health-Related Drivers of Health (HRDOH)**

The Ohio Department of Health (ODH) and the Centers for Medicare & Medicaid Services (CMS) emphasize the importance of assessing health-related drivers of health (HRDOH)—also referred to as social determinants of health (SDOH)—as a core component of a comprehensive Community Health Needs Assessment. These agencies direct health systems and communities to identify structural, economic, social, and environmental conditions that influence health outcomes, contribute to disparities, and affect access to care, particularly for Medicaid-eligible individuals, Medicare beneficiaries, rural populations, veterans, and individuals with disabilities.

In alignment with ODH’s State Health Improvement Plan and CMS’s Health Equity Strategy, this Community Health Needs Assessment evaluates the non-clinical social and environmental conditions that shape health risks, healthcare utilization, and health equity in Highland County. CMS defines HRDOH as the non-medical factors that affect health outcomes and recovery, while ODH identifies these same conditions as upstream drivers of inequities requiring population-level and community-based solutions.

Accordingly, this assessment examines key HRDOH domains including education and workforce readiness, economic stability, housing, food access and nutrition security, transportation, physical and environmental conditions, and social vulnerability. Evaluating these domains together illustrates how overlapping drivers contribute to preventable disease burden, barriers to care, and premature mortality in Highland County.

## **Education, Workforce Readiness, and Economic Opportunity**

Educational attainment and workforce readiness are foundational drivers of health in Highland County due to their strong downstream influence on income stability, insurance coverage, health literacy, and access to care. Compared to Ohio and the United States, a smaller

proportion of Highland County adults hold a bachelor’s degree or higher, limiting access to higher-wage employment opportunities.

Lower educational attainment contributes to greater reliance on lower-wage, service-sector, or physically demanding occupations, which are associated with higher injury risk, chronic disease burden, and reduced job flexibility. These conditions also affect residents’ ability to navigate healthcare systems, understand preventive care recommendations, and manage chronic conditions, increasing the likelihood of delayed care and poorer long-term outcomes.

Community input and stakeholder feedback highlight gaps in career exposure, credentialing pathways, and workforce training opportunities—particularly for young adults. These gaps function as upstream drivers of economic insecurity, stress, and unmet healthcare needs, elevating risk for behavioral health challenges and limiting economic mobility.

## **Employment, Income Stability, and Poverty**

Economic stability is a central HRDOH in Highland County. While unemployment rates may appear similar to state averages in some years, labor force participation remains lower, reflecting structural barriers such as disability, caregiving responsibilities, limited transportation, and constrained local job availability.

In addition to traditional poverty measures, Asset Limited, Income Constrained, Employed (ALICE) households represent a significant share of working families in Highland County. These households earn above the federal poverty level but struggle to afford necessities such as housing, food, transportation, healthcare, and childcare. ALICE households are more likely to delay medical care, experience food and housing insecurity, and struggle with chronic disease management due to cost barriers—patterns not fully captured by poverty rates alone.

Median household income in Highland County remains well below Ohio and U.S. benchmarks, and child poverty is particularly pronounced. These conditions increase risk for food insecurity, developmental challenges, behavioral health concerns, and long-term adverse health outcomes, reinforcing cycles of intergenerational disadvantage.

## **Transportation Access and the Built Environment**

Transportation access is a critical HRDOH in Highland County due to its role in connecting residents to healthcare, employment, education, food resources, and social services. Limited public transportation options and long travel distances disproportionately affect older adults, individuals with disabilities, veterans, and households with limited financial resources.

Transportation challenges contribute to missed or delayed appointments, difficulty accessing specialty and behavioral health services, and increased reliance on emergency care. They also

limit opportunities for physical activity and employment stability, compounding risks for chronic disease and poor self-reported health.

## **Housing Stability and Environmental Conditions**

Housing stability is a key HRDOH in Highland County due to its relationship to chronic stress, mental health outcomes, and healthcare utilization. While homeownership rates are relatively high, a substantial share of renters and lower-income households experience housing cost burden, reducing resources available for food, healthcare, and transportation.

Older housing stock increases exposure to safety hazards and maintenance challenges, disproportionately affecting children, older adults, and individuals with disabilities. Housing challenges were consistently identified through community input as barriers to workforce retention, family stability, and overall well-being.

## **Food Access and Nutrition Security**

Food insecurity remains a significant HRDOH in Highland County due to its strong association with chronic disease, mental health outcomes, child development, and healthcare utilization. Child food insecurity exceeds state and national averages, reflecting underlying economic stress and access limitations.

Limited proximity to full-service grocery stores in some rural areas increases reliance on convenience foods, contributing to obesity, diabetes, and cardiovascular disease. Food insecurity is also associated with higher emergency department use and avoidable healthcare costs due to delayed preventive care and poor chronic disease management.

## **Social Vulnerability and Health Equity**

The CDC/ATSDR Social Vulnerability Index (SVI) provides a census-tract–level measure of a community’s ability to prepare for, respond to, and recover from adverse events. The SVI incorporates 16 indicators across four domains: socioeconomic status; household characteristics; racial and ethnic minority status; and housing type and transportation.

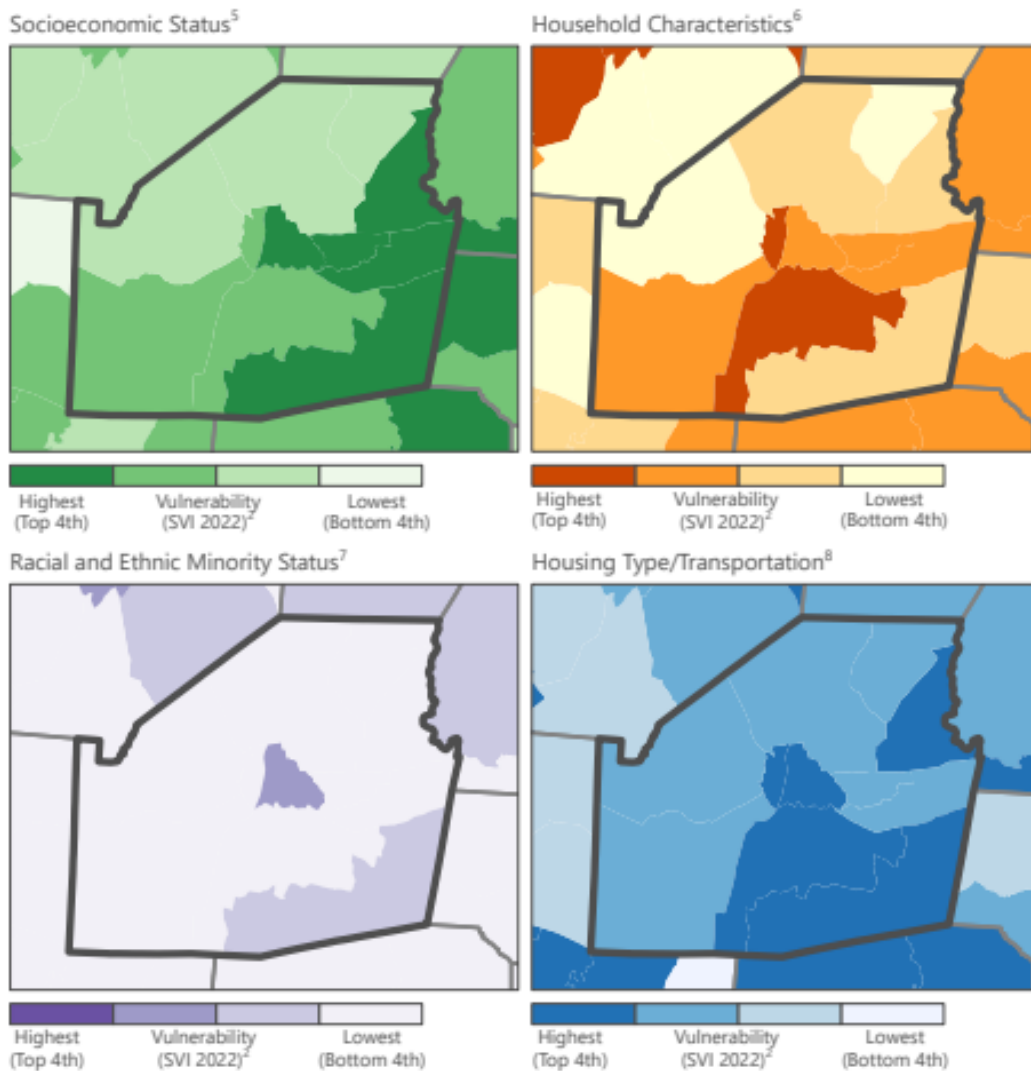
As a transition county within Appalachian Ohio, Highland County exhibits uneven patterns of social vulnerability across census tracts. Some areas demonstrate Appalachian-like vulnerability related to poverty, disability, aging populations, and transportation barriers, while others more closely resemble non-Appalachian rural Ohio. This variation results in concentrated pockets of vulnerability rather than uniform countywide risk.

SVI patterns align closely with other findings in this assessment, including economic instability, transportation barriers, housing cost burden, and elevated disability prevalence. These overlapping vulnerabilities increase the likelihood of delayed care, reduced access to preventive

services, and poorer health outcomes—particularly among older adults, low-income households, veterans, and individuals with chronic conditions.

Consistent with CMS and ODH guidance, census-tract–level vulnerability supports the use of place-based, equity-focused strategies that address multiple drivers of health simultaneously and inform targeted Community Health Improvement Plan (CHIP) interventions.

Figure 8: 2022 Highland County Social Vulnerability Index Themes



**Data Sources:** <sup>1</sup>CDC/ATSDR/GRASP, U.S. Census Bureau, ArcGIS StreetMap Premium.  
**Notes:** <sup>2</sup>Overall Social Vulnerability: All 16 variables. <sup>3</sup>One or more variables unavailable at census tract level. <sup>4</sup>The CDC/ATSDR SVI combines percentile rankings of U.S. Census American Community Survey (ACS) 2018–2022 variables, for the state, at the census tract level. <sup>5</sup>Socioeconomic Status: Below 150% Poverty, Unemployed, Housing Costs Burden, No High School Diploma, No Health Insurance. <sup>6</sup>Household Characteristics: Aged 65 and Older, Aged 17 and Younger, Civilian with a Disability, Single-Parent Household, English Language Proficiency. <sup>7</sup>Race/Ethnicity: Hispanic or Latino (of any race); Black and African American, Not Hispanic or Latino; American Indian and Alaska Native, Not Hispanic or Latino; Asian, Not Hispanic or Latino; Native Hawaiian and Other Pacific Islander, Not Hispanic or Latino; Two or More Races, Not Hispanic or Latino; Other Race, Not Hispanic or Latino. <sup>8</sup>Housing Type/Transportation: Multi-Unit Structures, Mobile Homes, Crowding, No Vehicle, Group Quarters.  
**Projection:** NAD 1983 StatePlane Ohio North FIPS 3401.  
**References:** Flanagan, S.E., et al., A Social Vulnerability Index for Disaster Management. *Journal of Homeland Security and Emergency Management*, 2011. 8(1).  
 CDC/ATSDR SVI web page: <https://www.atsdr.cdc.gov/placeandhealth/svi/index.html>.

## Integrated Implications for Priority Health Needs

Collectively, the health-related drivers of health in Highland County—educational and workforce readiness gaps, economic instability, transportation barriers, housing challenges, food insecurity, environmental conditions, and concentrated social vulnerability—interact to reinforce a set of interrelated priority health needs. These upstream conditions contribute directly to the county’s elevated burden of chronic disease, mental health and substance use disorders, preventable hospital utilization, and premature mortality.

Addressing these HRDOH through coordinated, multisector, place-based strategies is essential to improving health outcomes, advancing equity, and meeting ODH, CMS, and IRS Schedule H expectations for community benefit and population health improvement in Highland County.



## SECTION 6: Health Outcomes & Population Health

Highland County is an Appalachian-transition county where population health outcomes reflect the cumulative effects of demographic composition, health behaviors, access to care, and long-standing social and economic conditions. Compared to Ohio and national benchmarks, Highland County experiences elevated rates of premature mortality, chronic disease, injury, mental health burden, and substance-related harm, though outcomes are generally less severe than those observed in some neighboring Appalachian counties.

These outcomes are not attributable to a single factor, but rather to the interaction of economic insecurity, population aging, rural geography, behavioral health risk, and structural access barriers that accumulate over time. As a result, Highland County consistently performs in the lower-performing groupings statewide for population health outcomes, despite the presence of local healthcare assets and relatively stable insurance coverage.

### Population Health Across the Life Course

Highland County exhibits a distinct life-course pattern that shapes health needs across age groups. The county has a growing proportion of older adults aging in place, alongside children and adolescents experiencing economic stress, mental health challenges, and household instability.

Older adults face a higher burden of chronic disease, functional limitation, disability, and transportation barriers, increasing demand for primary care, chronic disease management, and aging-in-place supports. At the same time, youth and young adults experience elevated exposure to behavioral health risk, substance use within households and communities, and limited access to preventive and specialty services. Together, these parallel pressures strain healthcare, public health, education, and social service systems and contribute to persistent population health challenges across generations.

### Vital Statistics & Mortality Overview

Vital statistics provide critical insight into the overall health status of Highland County residents and help identify areas of preventable illness and early death. Measures such as life expectancy, years of potential life lost (YPLL), and leading causes of death reflect the cumulative impact of health behaviors, access to care, and broader social and economic conditions.

Life expectancy in Highland County remains below Ohio and U.S. averages, indicating a persistent gap in long-term health outcomes. Elevated premature mortality further underscores this challenge. Highland County experiences higher years of potential life lost before age 75

than state benchmarks, reflecting deaths that occur earlier in the lifespan and disproportionately affect working-age adults.

Leading causes of death in Highland County have remained consistent over time. Heart disease and cancer account for the largest share of deaths, followed by unintentional injury, chronic lower respiratory disease, stroke, and diabetes. Mortality rates for several of these causes exceed Ohio averages, highlighting the influence of preventable chronic disease, injury risk, tobacco exposure, and behavioral health factors.

Infant and child mortality rates are generally comparable to state benchmarks; however, excess mortality among adults—particularly from chronic disease, injury, and substance use—drives disparities in life expectancy and premature death.

Table 14: Vital Statistics and Mortality Review summary, Highland County, Ohio

Vital Statistics and Mortality Summary — Highland County Compared to Ohio and the United States				
Indicator	Highland County	Ohio	United States	CHNA Interpretation
Life Expectancy (years)	~74.0–74.5	~76.5–77.0	~78.5–79.0	Highland County residents live approximately 2–4 fewer years than Ohio and U.S. peers, reflecting cumulative impacts of chronic disease, injury, behavioral health conditions, and social determinants of health.
Years of Potential Life Lost (YPLL) before age 75 (per 100,000)	~11,500–12,500	~9,400–9,800	~8,200–8,600	Elevated YPLL indicates a persistent burden of premature mortality, particularly among working-age adults, and remains a central driver of poorer health outcomes.
Premature Mortality Rate (Deaths <75, per 100,000)	Higher than Ohio	Lower	Lowest	Elevated premature mortality highlights the preventable nature of many deaths in Highland County and the influence of upstream risk factors.
Leading Cause of Death #1	Heart Disease	Heart Disease	Heart Disease	Cardiovascular disease is the leading cause of death at all levels; rates are

Vital Statistics and Mortality Summary — Highland County Compared to Ohio and the United States				
Indicator	Highland County	Ohio	United States	CHNA Interpretation
				higher in Highland County due to chronic disease burden and risk factors.
Leading Cause of Death #2	Cancer	Cancer	Cancer	Cancer mortality exceeds benchmarks; lung cancer represents the largest share, consistent with smoking prevalence and occupational risk.
Leading Cause of Death #3	Unintentional Injury	Unintentional Injury	Unintentional Injury	Injury deaths—including drug overdose and motor vehicle crashes—contribute disproportionately to early death.
Leading Cause of Death #4	Chronic Lower Respiratory Disease (CLRD)	Stroke / CLRD	CLRD	Elevated smoking prevalence and respiratory disease burden contribute to higher CLRD mortality.
Leading Cause of Death #5	Stroke / Diabetes	Diabetes	Stroke	Chronic disease complexity and comorbidity increase mortality risk and healthcare utilization.

Sources: County Health Rankings & Roadmaps (RWJF / University of Wisconsin Population Health Institute), 2023–2025; Ohio Department of Health, Mortality & Injury Surveillance (DataOhio); CDC WONDER; U.S. Census Bureau.

Data Interpretation Note: Life expectancy and YPLL values reflect multi-year rolling averages used by CHR and ODH. Ranges are presented to support trend interpretation and cross-year comparability rather than point-estimate precision, consistent with IRS §501(r) and CHNA best-practice guidance.

## Cancer Burden and State Review Context

Cancer remains one of the leading causes of death in Highland County and contributes substantially to premature mortality, disability, and reduced quality of life. Mortality and utilization data indicate that the county’s cancer burden is driven primarily by cancers commonly associated with modifiable risk factors, delayed detection, and access to preventive services rather than a single environmental exposure.

The most frequently occurring and highest-mortality cancers affecting Highland County residents include lung and bronchus cancer, colorectal cancer, breast cancer, and prostate cancer. Lung cancer accounts for the largest share of cancer-related deaths, consistent with elevated tobacco use and chronic respiratory risk observed in the county. Colorectal, breast, and prostate cancers contribute significantly to morbidity and mortality and are strongly influenced by screening access, early detection, and continuity of care.

As part of statewide surveillance and response efforts, the Ohio Department of Health conducted a cancer study examining cancer incidence and mortality patterns in Highland County. Findings from this state-led analysis were reviewed as part of the 2025 Community Health Needs Assessment. The study did not identify statistically significant cancer clusters attributable to a single environmental exposure. ODH noted that cancer outcomes in Highland County are shaped by multiple interacting factors, including tobacco use, chronic disease risk, access to screening and early detection, socioeconomic conditions, and healthcare utilization patterns.

These findings reinforce the importance of evidence-based cancer prevention, tobacco cessation, screening, and early detection strategies. Cancer burden in Highland County was therefore considered within the broader chronic disease prevention and management framework of this assessment rather than as an exposure-driven environmental health priority.

## **Summary of Health Outcome Drivers**

Mortality and life expectancy patterns in Highland County indicate that a relatively small number of interconnected health issues account for a disproportionate share of poor outcomes. Premature death is driven primarily by chronic disease, injury, mental and behavioral health conditions, and substance use, with social and economic stressors and access barriers shaping risk across the life course. The sections that follow examine these outcome domains in greater detail to illustrate how these drivers affect different populations within Highland County.

## **Behavioral Health & Substance Use**

Behavioral health indicators in Highland County demonstrate both elevated prevalence and significant severity, making this a central concern for community health planning. A substantial share of adults report a history of depression, and many residents experience frequent poor mental health days, exceeding Ohio benchmarks. Despite gradual improvements in provider availability over time, population-level behavioral health outcomes remain poor, indicating ongoing access, utilization, and treatment-continuity challenges.

## Substance use and Suicide

Suicide contributes meaningfully to premature mortality in Highland County. Suicide death rates exceed Ohio and U.S. averages, with elevated risk among males and among adolescents, working-age adults, and older adults. These patterns are consistent with rural and Appalachian-transition trends and reflect the intersection of mental health needs, substance use, social isolation, chronic stress, and economic insecurity.

Unintentional drug overdose remains a significant contributor to injury-related death. Although overdose mortality rates in Highland County are generally lower than those observed in Pike County and some neighboring Appalachian counties, they remain elevated relative to state benchmarks. Opioids, including fentanyl, continue to be the primary driver of overdose mortality. Community prevention, treatment access, and harm-reduction efforts have mitigated some risk, but overdose-related harm remains an ongoing concern.

Table 15: Mental Health & Substance Use Indicators — Highland County Compared to Ohio and U.S.

Mental Health & Substance Use Indicators — Highland County Compared to Ohio and U.S.				
Indicator	Highland County	Ohio	United States	CHNA Interpretation
Adults Ever Diagnosed with Depression (%)	~27–28%	~24%	~21%	Elevated depression prevalence reflects cumulative economic stress, aging, and access barriers
Frequent Mental Distress (≥14 days/month)	~20–21%	~18%	~16%	Indicates high population-level mental health burden
Suicide Death Rate (per 100,000)	Elevated	Lower	Lower	Suicide is a significant contributor to premature mortality
Drug Overdose Death Rate (per 100,000)	Elevated	Lower	Lower	Lower than Pike County but remains above Ohio average
Excessive Drinking (%)	~17–18%	~18%	~19%	Comparable to state, but interacts with mental health risk

Sources: County Health Rankings & Roadmaps (2023–2025); CDC PLACES (2023–2024); Ohio Department of Health Mortality Data.

## Maternal & Child Health

Maternal and child health indicators in Highland County reflect a mixed pattern of strength and risk. While some birth outcomes—such as low birth weight—have shown stabilization or modest improvement, preterm birth rates remain elevated compared to state and national benchmarks.

Access to early prenatal care is lower than desired, and maternal smoking during pregnancy remains significantly higher than Ohio and U.S. averages. These factors increase the risk of adverse birth outcomes and contribute to long-term developmental and health challenges for children.

Children’s health data indicate elevated behavioral health need, particularly among Medicaid-participating students. School-based mental health staffing levels remain limited relative to need, contributing to unmet behavioral health demand during critical developmental periods. At the same time, Highland County demonstrates strengths in pediatric primary care and dental visit utilization, supporting early identification of physical health needs.

Table 16: Maternal & Infant Health Indicators — Highland County Compared to Ohio and U.S.

Maternal & Infant Health Indicators — Highland County Compared to Ohio and U.S.				
Indicator	Highland County	Ohio	United States	Interpretation
Preterm Birth (%)	~11–12%	~10%	~10%	Elevated risk for infant morbidity
Low Birth Weight (%)	~8%	~8%	~8%	Comparable but remains a concern
Mothers Smoking During Pregnancy (%)	~22–24%	~16%	~11%	Major modifiable risk factor
Adequate Prenatal Care (%)	Lower	Higher	Higher	Access and engagement gaps persist

Sources: Ohio Department of Health Natality Files; County Health Rankings & Roadmaps.

Table 17: Children & Adolescent Health Indicators — Highland County Compared to Ohio

<b>Children &amp; Adolescent Health Indicators — Highland County Compared to Ohio</b>			
<b>Indicator</b>	<b>Highland County</b>	<b>Ohio</b>	<b>Interpretation</b>
Children with Behavioral Health Conditions (%)	Higher	Lower	Elevated need, particularly among Medicaid-enrolled youth
Youth Reporting Persistent Feelings of Sadness (OHYES)	Elevated	Lower	Reinforces mental health priority
Well-Child Visit (past year)	Comparable	Comparable	Strength in preventive care access
Dental Visit (past year)	Comparable	Comparable	Supports early intervention

Sources: Ohio Healthy Youth Environments Survey (OHYES); Ohio Department of Education; County Health Rankings.

## Chronic Disease Burden

Chronic disease remains a dominant driver of morbidity and mortality in Highland County. Cardiovascular disease—including heart disease and stroke—continues to be the leading cause of death. Risk factors such as hypertension, obesity, physical inactivity, and tobacco use exceed Ohio and U.S. benchmarks, contributing to elevated mortality and disability.

Cancer incidence and mortality are also higher than state and national averages. Lung and bronchus cancer account for the largest share of cancer deaths, reflecting long-standing tobacco exposure and respiratory disease burden. Elevated rates of colorectal and other preventable cancers suggest gaps in screening uptake and risk-factor mitigation.

Diabetes prevalence and diabetes-related mortality remain elevated and frequently co-occur with cardiovascular disease and obesity, amplifying health risk and healthcare utilization. Chronic lower respiratory disease, including COPD, represents another substantial burden driven by tobacco exposure and occupational risk.

Despite relatively strong insurance coverage and routine care engagement, chronic disease outcomes remain poor, indicating that access alone has not been sufficient to offset the cumulative effects of long-standing behavioral risk, comorbidity, and social drivers of health.

Table 18: Chronic Disease Prevalence & Mortality — Highland County Compared to Ohio and U.S.

<b>Chronic Disease Prevalence &amp; Mortality — Highland County Compared to Ohio and U.S.</b>				
<b>Indicator</b>	<b>Highland County</b>	<b>Ohio</b>	<b>United States</b>	<b>Interpretation</b>
Adult Obesity (%)	~38–40%	~38%	~34%	Sustains chronic disease burden
Adult Smoking (%)	~22–23%	~18%	~13%	Central driver of cancer & CLRD
Hypertension (%)	Elevated	Lower	Lower	Increases cardiovascular risk
Diabetes (%)	~14–15%	~12%	~11%	Drives premature mortality
Heart Disease Mortality	Elevated	Lower	Lower	Leading cause of death

Sources: CDC PLACES; County Health Rankings; ODH Mortality Files.

## Public Health and Prevention

Public health surveillance and prevention activities provide insight into population-level risks influencing illness patterns and healthcare utilization in Highland County. Monitoring communicable disease trends, vaccination coverage, and prevention capacity helps contextualize preventable illness and preparedness needs.

## Communicable Disease and STI Trends

Communicable diseases remain an ongoing public health concern in Highland County, particularly sexually transmitted infections, hepatitis C, and respiratory illness. While overall case counts are lower than urban counties due to population size, incidence remains concentrated among younger adults and individuals facing barriers to routine preventive care, including transportation limitations and economic stress.

Hepatitis C remains elevated relative to Ohio benchmarks and is closely associated with substance use trends. Although recent years show some stabilization, hepatitis C continues to drive long-term liver disease risk and healthcare utilization. Vector-borne illnesses such as Lyme disease have increased in southern Ohio, including Highland County, reflecting land-use patterns

and environmental exposure. Influenza and pneumonia continue to contribute to hospitalization and mortality, particularly among older adults and individuals with chronic disease.

Table 19: Communicable Diseases of Public Health Significance — Highland County

Communicable Diseases of Public Health Significance — Highland County			
Condition	Recent Trend	Ohio Comparison	Interpretation
Hepatitis C	Elevated / stable	Higher	Linked to substance use; screening & linkage needed
Chlamydia	Moderate	Lower	Concentrated among young adults
Gonorrhea	Low	Lower	Continued surveillance needed
Influenza Hospitalizations	Seasonal spikes	Comparable	Older adults at highest risk
Lyme Disease	Increasing	Comparable	Environmental exposure risk

Sources: Ohio Department of Health ODRS; ODH Infectious Disease Reports.

## Vaccine Utilization

Vaccination uptake for influenza, COVID-19, and other adult preventive services remains below state benchmarks in Highland County. Lower vaccination coverage increases the risk of severe respiratory illness, hospitalization, and seasonal healthcare strain, particularly among older adults and those with chronic conditions.

Table 20: Vaccine-Preventable Disease Indicators — Highland County Compared to Ohio

Vaccine-Preventable Disease Indicators — Highland County Compared to Ohio			
Indicator	Highland County	Ohio	Interpretation
Influenza Vaccination (65+)	Lower	Higher	Increased hospitalization risk
COVID-19 Primary Series	Below average	—	Preventive engagement gap

Vaccine-Preventable Disease Indicators — Highland County Compared to Ohio			
Indicator	Highland County	Ohio	Interpretation
Pneumonia Hospitalizations (65+)	Elevated	Lower	Indicates prevention gaps

Sources: ODH; CDC PLACES; County Health Rankings.

## Prevention Gaps and Healthcare Impact

Prevention gaps in Highland County are closely linked to transportation barriers, limited routine care engagement, economic insecurity, and health-literacy challenges. These gaps contribute to avoidable emergency department use, preventable hospitalizations, and long-term complications associated with delayed diagnosis and treatment.

Table 21: Prevention Gaps & Healthcare Utilization — Highland County

Prevention Gaps & Healthcare Utilization — Highland County		
Prevention Gap	Pattern	Health System Impact
Limited routine primary care use	Persistent	ED reliance
Low adult vaccination	Ongoing	Respiratory admissions
Delayed STI screening	Youth & young adults	Higher complications
Untreated hepatitis C	Persistent	Liver disease burden
Transportation barriers	Rural tracts	Missed appointments

Sources: ODH; County Health Rankings; Highland County General Health District.

## Communicable Diseases Key Takeaways

Communicable diseases continue to contribute to preventable illness and healthcare utilization in Highland County, particularly among populations facing barriers to routine care and immunization access. Gaps in vaccination coverage and delayed detection increase the risk of disease transmission and place additional demand on healthcare and public health systems. These patterns reflect underlying access, utilization, and structural challenges and help contextualize communicable disease trends within Highland County’s broader population health profile.

## SECTION 7: Access to Care in Highland County

Access to comprehensive, affordable, and timely healthcare services is a key contextual driver of health outcomes in Highland County. As an Appalachian-transition county with a largely rural geography, transportation constraints and workforce distribution patterns shape how residents obtain care. Highland County benefits from essential local healthcare assets, including two Critical Access Hospitals that provide emergency and inpatient stabilization close to home—Highland District Hospital (Hillsboro) and Adena Greenfield Medical Center (Greenfield).

Even with these assets, residents continue to face persistent barriers to effective access—particularly for behavioral health, dentistry, and specialty care—related to provider availability, appointment wait times, travel distance, transportation reliability, and affordability (including cost-sharing and network adequacy). Insurance coverage is relatively stable at a population level; however, coverage alone does not ensure timely or effective access when the local workforce is constrained, providers do not accept all payer types, or residents must travel outside the county for specialty services. These system-level realities influence preventive care completion, chronic disease management, and behavioral health treatment engagement, and help explain patterns of avoidable emergency department use and preventable hospital stays.

### Health Care Delivery System and Care Options

Highland County’s care delivery system includes emergency and inpatient care through Highland District Hospital in Hillsboro and Adena Greenfield Medical Center in Greenfield. Outpatient access is supported through primary care and clinic services located in and around population centers (including Hillsboro and Greenfield). When specialty capacity is limited locally, residents often rely on regional referral networks for cardiology, oncology, neurology, orthopedics, endocrinology, higher-acuity behavioral health services, and advanced diagnostics. In a rural context, the need to travel for specialty care can delay diagnosis and treatment, increase caregiver burden, and contribute to missed appointments, particularly for older adults, households without reliable transportation, and individuals managing complex chronic conditions.

### Provider Access, Workforce Trends, and Clinical Care Capacity

Workforce availability remains a structural determinant of access in Highland County. County-level provider-to-population ratios indicate notable constraints in primary care, dental care, and behavioral health. In rural contexts, provider ratio metrics should be interpreted cautiously because they may include licensed providers who practice part-time, do not accept all payer types, or are not geographically accessible for residents in outlying areas—meaning that

“provider presence” may overestimate “timely access.” County Health Rankings & Roadmaps (CHR) provides standardized county measures used widely in CHNA reporting.

Table 22: Ratio of Highland County Residents to Licensed Health Care Providers

Ratio of Highland County Residents to Licensed Health Care Providers				
Provider Capacity Measure	Highland County	Ohio (County Median)	United States (County Median)	CHNA Interpretation
<b>Primary Care Physicians</b> (population-to-provider ratio)	3,610 : 1	1,330 : 1	1,330 : 1	Primary care capacity in Highland County is substantially more constrained than typical Ohio and U.S. County benchmarks, increasing the likelihood of appointment delays, reduced continuity of care, and greater reliance on emergency departments for conditions that could be managed in outpatient settings.
<b>Dentists</b> (population-to-provider ratio)	2,070 : 1	1,530 : 1	1,360 : 1	Dental workforce constraints contribute to delayed preventive and restorative care, unmet oral health needs, and avoidable oral disease burden, particularly for Medicaid-enrolled and low-income populations.
<b>Mental Health Providers</b> (population-to-provider ratio)	420 : 1	290 : 1	300 : 1	Behavioral health provider availability is more limited than state and national benchmarks; effective access may be lower than the ratio suggests due to part-time practice, payer participation, specialty availability, and geographic accessibility.

**Note:** Population-to-provider ratios represent licensed providers and do not fully reflect appointment availability, scope of practice, payer acceptance, or geographic access in rural counties.

**Source:** University of Wisconsin Population Health Institute. *County Health Rankings & Roadmaps*, 2025.

These ratios are presented for comparative context and are not intended to represent appointment availability or scope of services at the individual practice level.

## Primary and Specialty Care Access

Access to primary and specialty care shapes residents’ ability to prevent disease, manage chronic conditions, and avoid avoidable hospitalizations. Highland County benefits from two in-county Critical Access Hospitals—Highland District Hospital (Hillsboro) and Adena Greenfield Medical Center (Greenfield)—and a network of primary care and outpatient providers serving as essential access points for routine and acute care. However, provider presence alone does not fully capture residents’ ability to obtain timely and appropriate services across the continuum of care.

Primary care access is influenced by workforce distribution, appointment availability, transportation barriers, and payer participation. While many residents report a usual source of care, community input and utilization patterns indicate challenges in scheduling timely appointments—particularly for working adults, older adults, and individuals managing multiple chronic conditions. These barriers may contribute to delayed care-seeking and increased reliance on emergency departments.

Specialty care access presents a more pronounced challenge. Residents frequently travel outside the county for cardiology, oncology, neurology, endocrinology, orthopedics, and higher-acuity behavioral health services. Geographic distance, limited transportation options, and insurance network restrictions—especially within Medicaid and Medicare Advantage plans—can delay diagnosis, disrupt continuity of care, and increase caregiver burden.

Table 23: Specialty Care Access and Referral Considerations — Highland County

Specialty Care Access and Referral Considerations — Highland County			
Specialty / Service Type	Common Access Pattern for Highland County Residents	Typical Barriers	CHNA Interpretation
Cardiology / Endocrinology / Pulmonology	Often referred regionally for specialty visits/testing	Travel distance; transportation; appointment wait times	Impacts chronic disease control and avoidable hospital use.
Oncology	Regional referral networks for diagnosis/treatment	Travel burden; caregiver capacity; cost-sharing	Reinforces need for screening + navigation supports.

Specialty Care Access and Referral Considerations — Highland County			
Specialty / Service Type	Common Access Pattern for Highland County Residents	Typical Barriers	CHNA Interpretation
Neurology / Orthopedics	Regional access often required	Distance and limited local appointment availability	Delays can worsen disability and pain-related functional decline.
Psychiatry / Child & Adolescent BH	Limited specialty availability locally	Provider scarcity; network adequacy; long waits	Youth BH is a high-need access gap.
Dentistry (esp. Medicaid access)	Capacity constrained relative to need	Provider participation; scheduling	Drives delayed care and preventable oral health burden.

## Health Care Utilization and Preventable Hospitalizations

Patterns of utilization provide insight into access and coordination across outpatient, emergency, and inpatient settings. One widely used measure is Preventable Hospital Stays among Medicare enrollees (ambulatory care-sensitive conditions), which can reflect gaps in timely outpatient care, medication management, chronic disease control, and transitions of care. CHR reports this measure in county profiles and state datasets.

Table 24: Preventable Hospital Stays

Preventable Hospital Stays			
Utilization Measure	Highland County	Ohio county median	CHNA Interpretation
Preventable Hospital Stays (rate)	3,401	4,023	Highland County's rate is better than the Ohio county median, suggesting some strengths in outpatient management for Medicare beneficiaries; however, this measure does not

Preventable Hospital Stays			
Utilization Measure	Highland County	Ohio county median	CHNA Interpretation
			capture access barriers related to specialty care, behavioral health, dentistry, or transportation, which remain significant contributors to avoidable utilization.

Even when utilization measures suggest relative strengths, affordability and coverage type still shape whether care is sought early, completed, and sustained.

### Insurance Coverage, Medicare, and Network Adequacy

Public insurance programs play a central role in healthcare access in Highland County. Medicaid covers a substantial share of children and low-income adults, and Medicare accounts for a large portion of adult healthcare utilization due to the county’s aging population and chronic disease burden. These coverage patterns influence how residents interact with the healthcare system across the life course.

As Medicare Advantage enrollment continues to increase, network adequacy is an important access consideration for older adults. Limited in-network provider availability can restrict access to primary care, specialty services, dental care, and behavioral health treatment. Beneficiaries may experience longer wait times, increased travel outside the county, and delays related to prior authorization requirements and provider turnover. These constraints align with utilization patterns such as preventable hospitalizations and reliance on emergency care.

Uninsured rates help describe structural access, but insurance type, cost-sharing, and network adequacy determine whether coverage translates into timely services—especially for dental care, behavioral health, and specialty referrals. CHR provides county estimates for uninsured adults under age 65, which are commonly used in CHNAs and IRS §501(r) documentation.

Table 25: Insurance Coverage — Uninsured

Insurance Coverage — Uninsured			
Coverage Measure	Highland County	Ohio county median	CHNA Interpretation
Uninsured (% under age 65)	7.0%	7.1%	Highland is roughly comparable to the Ohio median; however, stable coverage does not eliminate barriers caused by limited local specialty capacity, transportation constraints, and cost-sharing.

Note: This measure reflects adults under age 65 and does not capture underinsurance, cost-sharing burden, or network adequacy, which are key determinants of effective access in rural counties.

Coverage measures should be interpreted alongside workforce and travel burden because effective access depends on service availability, network adequacy, and residents’ ability to complete referrals and preventive care.

## Behavioral Health Access, Capacity, and Utilization

Behavioral health access is a critical determinant of population health outcomes in Highland County and remains a significant health need despite the presence of local service capacity. Behavioral health conditions—including depression, anxiety, substance use disorders, and suicide risk—contribute substantially to premature mortality, reduced quality of life, and avoidable healthcare utilization.

Behavioral health services available in Highland County may include outpatient counseling, substance use disorder treatment and recovery supports, medication management where prescribers are available, care coordination and case management, peer supports, and crisis response and referral pathways. Practical access varies by age group, payer type, transportation reliability, and availability of specialty services. Community input and service utilization patterns indicate that demand exceeds effective access, with frequent barriers including appointment wait times, travel distance, limited specialty availability (including child and adolescent services), and payer network restrictions.

County Health Rankings data provide an estimate of the population-to-provider ratio for mental health professionals. This metric must be interpreted cautiously in a rural context. Ratios may include licensed providers who do not practice full time, do not accept all payer types, do not provide specialty services (e.g., child/adolescent psychiatry, addiction medicine), or are not geographically accessible for residents in outlying areas. As a result, numerical provider

availability does not fully reflect residents’ ability to obtain timely, appropriate behavioral health care.

Stakeholders and residents frequently report challenges related to appointment wait times, transportation barriers, limited availability of specialty services—including child and adolescent psychiatry and addiction medicine—and payer network restrictions, particularly for Medicaid and Medicare Advantage beneficiaries. Youth behavioral health access remains a notable gap, with high levels of identified need and limited school-based and specialty treatment capacity. Preventable hospitalizations and emergency department utilization related to behavioral health conditions further suggest gaps in timely outpatient care, continuity of treatment, and care coordination across settings.

Table 26: Behavioral Health Capacity in Highland County: Strengths and Gaps

<b>Behavioral Health Capacity in Highland County — Strengths and Gaps</b>			
<b>Domain</b>	<b>Existing Assets / Strengths</b>	<b>Persistent Gaps / Constraints</b>	<b>CHNA Interpretation</b>
Outpatient counseling & supports	Local providers and partners supporting counseling/case management	Scheduling delays; transportation barriers; payer limits	Navigation and care coordination remain essential.
Substance use disorder services	Prevention/treatment/recovery supports in the region	Limited specialty prescribers; travel for higher LOC	SUD contributes to injury-related harm and family instability.
Crisis response & stabilization	EDs provide stabilization; referral pathways exist	Inconsistent crisis-to-outpatient linkage capacity	Continuity reduces repeat crisis use and preventable admissions.
Youth behavioral health	Schools provide screening/referrals	Limited specialty youth providers; constrained school staffing	Youth need often exceeds capacity; prioritize school-linked solutions.

Source: CHR provider ratios; OHYES; Ohio Healthy Students Profiles / school staffing; local system resource lists (HCGHD / partners).

## Youth Access to Care

Children and adolescents in Highland County demonstrate mixed patterns of healthcare access. While many youth have contact with a primary care provider, completion of comprehensive well-child visits and recommended preventive services may lag benchmarks for some groups. Barriers include scheduling limitations, transportation constraints, caregiver availability, and limited access to pediatric specialty services or extended clinic hours.

Access challenges are particularly pronounced for children with behavioral health needs, developmental concerns, or complex medical conditions. School and survey-based indicators often show elevated behavioral health need, while school-based staffing levels for counselors, psychologists, and social workers may be limited relative to need. This mismatch contributes to delayed identification, fragmented referral pathways, and reduced continuity of care.

Caregiver capacity is an important contextual factor shaping youth access to care in Highland County. Households that include grandparents or other relatives as primary caregivers may face additional challenges navigating transportation, insurance, consent processes, and referral pathways—factors that can contribute to care fragmentation for vulnerable youth. These youth access challenges align with findings from the Ohio Healthy Students Profiles and reinforce the importance of school-linked, community-based, and family-centered access strategies.

## Preventive Care Access and Related Health Implications

Utilization of preventive care services in Highland County varies across populations and service types. While many residents have some contact with a healthcare provider engagement in recommended preventive services—including routine wellness visits, influenza vaccination, mammography, and age-appropriate screenings—lags Ohio benchmarks for certain populations. These patterns indicate that healthcare contact does not consistently translate into completion of preventive care.

Preventive care gaps increase the likelihood of late disease detection, poorer chronic disease control, avoidable complications, and higher downstream healthcare costs. Older adults, individuals with multiple chronic conditions, residents facing transportation or insurance-related barriers, and families with limited caregiver capacity are particularly affected.

## Public Health Capacity and Community Infrastructure

The Highland County General Health District plays a central role in communicable disease surveillance, immunization delivery, environmental health, health education, and emergency preparedness. Cross-sector collaboration among public health, hospitals/clinics, schools, and

community partners influences prevention capacity—especially where transportation and workforce constraints limit routine clinical access.

## Access to Care Takeaways

Access to care in Highland County is shaped by rural geography, workforce distribution, transportation constraints, payer network limitations, and caregiver capacity. The county benefits from in-county hospital access through Highland District Hospital (Hillsboro) and Adena Greenfield Medical Center (Greenfield), which serve as critical stabilization points and reduce travel burden for urgent and emergent needs.

At the same time, public data demonstrate that provider capacity is more constrained than typical Ohio county patterns for primary care, dental care, and behavioral health, and that preventive service utilization for selected measures remains below state benchmarks. Together, these factors indicate that effective access—not insurance coverage alone—remains a key driver of health outcomes. These findings meet IRS §501(r) requirements for identifying barriers to care and align with CMS and JCAHO emphasis on health equity, access, and continuity of care.



## SECTION 8: Community and Stakeholder Input

Public input collected for the 2025 Community Health Needs Assessment (CHNA) reaffirmed many of the core concerns identified in prior assessment cycles, while also providing greater clarity on the social, economic, and structural conditions shaping health outcomes in Highland County. Through the 2025 community survey and associated outreach efforts, residents consistently identified mental and behavioral health, substance use, housing affordability, economic opportunity, transportation, and access to affordable healthcare as the issues most affecting quality of life.

Although most respondents rated their overall health as good or excellent, a substantial proportion reported persistent stressors related to cost of living, mental health needs, and access to timely and affordable care. Respondents emphasized the need for expanded mental health counseling and support services, higher-paying employment opportunities, more affordable and stable housing options, improved transportation, and prevention-focused education related to substance use and youth mental health. Collectively, these themes reflect an increasing recognition of upstream social determinants of health as central drivers of community well-being in Highland County.

### Community Resident Input

Community resident input was collected through a countywide health survey to capture perceptions of health concerns, barriers to care, and the social and environmental conditions influencing health in Highland County. Resident input provides critical insight into lived experience at the household and community level and complements secondary data and utilization measures presented elsewhere in this assessment.

Consistent with best practice for rural and Appalachian communities, the resident survey was designed to reach individuals who may not participate in traditional public comment processes, including older adults, working families, and residents facing transportation or access barriers. Themes emerging from resident input align closely with quantitative findings related to behavioral health burden, chronic disease prevalence, access to care, and social determinants of health, strengthening confidence in the assessment findings.

### Survey Methodology

A countywide community health survey was administered to gather resident perspectives on health concerns, quality of life, barriers to care, and the social and environmental conditions influencing health in Highland County. Surveys were distributed in both electronic and paper formats through healthcare settings, community agencies, libraries, food distribution sites, and

community events to promote broad participation, including among residents who may not engage through traditional public comment processes.

Participation was voluntary and anonymous. As with all community surveys, results should be interpreted with recognition of potential response bias and subgroup limitations; however, the consistency of themes across responses provides meaningful qualitative insight into community priorities and lived experience. A total of 642 responses were included in the final analysis.

Table 25 summarizes the demographic characteristics of survey participants.

Table 27: Source: 2025 Highland County CHNA Survey

<b>Survey Respondent Demographics — Highland County</b>			
<b>Characteristic</b>	<b>Category</b>	<b>Count</b>	<b>Percent</b>
<b>Total Respondents</b>	—	642	100%
<b>Age</b>	25–34	66	10%
	35–44	129	20%
	45–54	135	21%
	55–64	118	18%
	65–74	121	19%
<b>Sex (at birth)</b>	Female	557	87%
	Male	82	13%
<b>Race</b>	White	618	96%
	Black or African American	4	1%
	American Indian / Alaska Native	5	1%
	Other / Prefer not to answer	15	2%
<b>Housing Status</b>	Own home	476	74%
	Rent	104	16%

Survey Respondent Demographics — Highland County			
Characteristic	Category	Count	Percent
	Other / unstable	62	10%

Source: 2025 Highland County CHNA Survey

Survey respondents skew older, female, White, and homeowners—patterns commonly observed in rural CHNA surveys. This demographic profile reinforces the importance of contextualizing survey findings using ALICE data and secondary indicators to ensure that the experiences of economically vulnerable households are fully reflected. Notably, nearly one-third of respondents rated their overall health as fair or poor, supporting the presence of underlying chronic and behavioral health burden despite generally positive self-ratings.

Table 28: Self-Reported Overall Health Status

Self-Reported Overall Health Status		
Health Status	Count	Percent
Excellent	16	2%
Very Good	116	18%
Good	310	48%
Fair	177	28%
Poor	23	4%

Source: 2025 Highland County CHNA Survey

## Public Survey Data Findings

To assess continuity, change, and progress over time, community input from the 2025 CHNA was reviewed in the context of prior assessment findings and regional trends. This approach allows for identification of health issues that have remained persistent, intensified, or emerged more prominently across assessment cycles. Examining themes across multiple data sources strengthens the validity of priority selection by demonstrating sustained community concern rather than isolated or short-term issues.

The sections that follow summarize key areas where community-identified priorities in 2025 align with, build upon, or expand concerns observed in prior assessments. Collectively, these findings provide a longitudinal view of community needs and confirm that many of Highland County’s most pressing health challenges—particularly those related to mental and behavioral health, substance use, housing stability, economic opportunity, access to care, and chronic disease—remain unresolved and continue to affect population health and health equity.

## **ALICE Households and Economic Context**

Interpretation of community survey results must consider the economic conditions of households that may be underrepresented in voluntary survey participation. According to United Way of Ohio’s ALICE (Asset Limited, Income Constrained, Employed) analysis, a substantial share of Highland County households are classified as ALICE, with an additional proportion living below the federal poverty level. Taken together, a significant portion of working households experience economic instability despite employment.

ALICE households are less likely to participate in traditional community surveys due to time constraints, limited access to technology, multiple job responsibilities, transportation barriers, or lack of awareness of the assessment process. As a result, survey respondents—who tend to be more likely female, older, and higher income—may not fully reflect the lived experiences of economically vulnerable working families.

When viewed alongside ALICE data, survey findings related to concerns about housing affordability, food access, transportation, childcare, healthcare costs, and economic opportunity are reinforced rather than contradicted. Incorporating ALICE data strengthens interpretation of community input by ensuring that priority health needs reflect both survey feedback and the underlying economic vulnerability faced by a substantial share of Highland County’s working households.

## **Mental and Behavioral Health**

Mental and behavioral health emerged as a leading concern in the 2025 assessment. Survey respondents frequently identified stress, anxiety, depression, and difficulty accessing mental health services as issues affecting individuals and families across the lifespan. Younger adults and lower-income households reported particularly high levels of mental health burden.

Community responses emphasized limited availability of counseling services, long wait times, transportation barriers, and affordability challenges. These findings align with secondary data showing elevated poor mental health days, suicide risk, and behavioral health-related utilization, indicating that mental and behavioral health needs remain a persistent and unresolved challenge in Highland County.

Table 29: Mental and Physical Health Burden

Mental and Physical Health Burden		
Indicator	Most Common Response	Percent
Poor Physical Health Days	≥1 day	51%
	≥6 days	22%
Poor Mental Health Days	≥1 day	66%
	≥6 days	35%

Source: 2025 Highland County CHNA Survey

## Substance Use and Prevention

Substance use was consistently identified as a major community concern. Survey respondents described the ongoing impact of substance use on families, workplaces, and community safety and emphasized the need for prevention, early intervention, treatment access, and recovery supports. Community-identified priorities included youth prevention education, expanded treatment options, and continued harm-reduction efforts.

These themes reinforce secondary data indicating elevated injury-related mortality and substance-related health impacts and highlight the continued importance of substance use prevention and treatment as a community health priority.

Table 30: Substance Use and Risk Indicators

Substance Use and Risk Indicators	
Indicator	Result
Ever used illicit drugs	27%
Currently uses tobacco (any form)	48%
Ever experienced an overdose	6%
Drug & alcohol use ranked as top community health problem	Highest frequency

Source: 2025 Highland County CHNA Survey

## Housing Affordability and Stability

Housing affordability and stability emerged as increasingly prominent concerns in 2025. Respondents identified housing costs, limited affordable housing options, housing quality, and utility expenses as stressors affecting household stability and overall health. While homeownership remains common in Highland County, cost burden and housing insecurity persist for renters, fixed-income households, and lower-wage workers.

Community input indicates that housing instability is closely linked to stress, mental health challenges, and difficulty maintaining consistent access to healthcare, employment, and education, reinforcing housing as a key social determinant of health.

## Economic Opportunity and Income Stability

Economic pressure was a recurring theme across community input. Respondents identified low wages, limited job advancement opportunities, and financial strain as barriers to health and quality of life. Income instability was frequently linked to challenges accessing healthcare, nutritious food, reliable transportation, and stable housing.

Table 31: Perceptions of Community Conditions

Perceptions of Community Conditions	
Statement	Agree / Strongly Agree
Highland County is a safe place to live	70%
Good place to raise children	58%
Good place to grow old	51%
Plenty of economic opportunity	22%
Good healthcare availability	45%

Source: 2025 Highland County CHNA Survey

These findings highlight community strengths related to safety and family life, while also underscoring persistent gaps in economic opportunity and healthcare access. Together, they reinforce the role of economic stability as a foundational determinant influencing multiple health domains.

## Chronic Disease and Preventative Health

Chronic disease burden—including obesity, diabetes, cardiovascular disease, respiratory conditions, and cancer—was frequently identified in survey responses. While many residents reported having contact with a primary care provider, persistent disease prevalence suggests ongoing gaps in prevention, lifestyle supports, and chronic disease self-management.

Respondents increasingly linked chronic disease to stress, nutrition, economic conditions, and access barriers, highlighting the need for integrated prevention strategies that address both clinical and social drivers of health.

Table 32: Self-Reported Chronic and Behavioral Health Conditions

Self-Reported Chronic and Behavioral Health Conditions	
Condition (ever diagnosed)	Percent
Overweight / Obesity	42%
High Blood Pressure	41%
Depression / Anxiety	38%
High Cholesterol	31%
Diabetes	21%
Asthma	14%
Cancer	10%

Source: 2025 Highland County CHNA Survey

Community-reported conditions mirror leading causes of death and utilization patterns, strengthening triangulation validity.

## Access to Care and Transportation

Access to healthcare services was a recurring concern across survey responses. Residents described challenges related to provider availability, appointment wait times, travel distance, cost of care, and insurance limitations—particularly for behavioral health, dental, and specialty services.

Table 33: Access to Care and Insurance Coverage

Access to Care and Insurance Coverage	
Access Indicator	Percent
Has health insurance	93%
Has dental insurance	78%
Has vision insurance	78%
Has a regular healthcare provider	88%
Has access to routine dental care	78%
Needed care but could not afford it (past year)	29%

Source: 2025 Highland County CHNA Survey

Transportation emerged as a cross-cutting issue affecting access not only to healthcare, but also to employment, food access, social services, and community participation. Older adults, individuals with disabilities, and lower-income households were identified as particularly affected by transportation limitations, reinforcing access and mobility as central equity considerations.

Table 34: Transportation Access and Barriers

Transportation Access and Barriers	
Transportation Indicator	Percent
Has reliable transportation	95%
Transportation prevented essential trips	14%

Source: 2025 Highland County CHNA Survey

## Health Information and Education Needs

Survey respondents identified mental health, substance use prevention, chronic disease management, and youth health education as priority topics for additional information and outreach. Respondents also shared preferred channels for receiving health information, underscoring the importance of using multiple communication methods to reach diverse populations across the county. These findings will inform future health communication and

education strategies and support more effective dissemination of prevention-focused information.

## **Stakeholder Input and System-Level Perspectives**

In addition to resident survey responses, the 2025 Highland County CHNA incorporated structured input from community partners representing healthcare, public health, behavioral health, education, social services, aging services, and community-based organizations. Stakeholder input provided system-level insight into service capacity, coordination challenges, and structural barriers influencing health outcomes.

Stakeholders consistently identified mental health and substance use, chronic disease burden, access to care and transportation, housing affordability, and economic instability as the most pressing community challenges. Workforce shortages, limited specialty capacity, transportation gaps, and fragmented care coordination were frequently cited as contributors to delayed care and avoidable utilization.

## **Youth, Families, and Community Well-Being**

Community survey responses reflected concern for youth mental health, substance use prevention, and family stability. Respondents emphasized the importance of safe environments, positive youth development opportunities, and access to school- and community-based supports. Respondents also identified leading health concerns such as lung disease, diabetes, heart disease, cancer, and access to care.

Findings from the Highland County Community Health Survey, stakeholder input, and the Ohio Healthy Youth Environments Survey (OHYES) demonstrate strong alignment across age groups and data sources. Youth-reported stress, anxiety, and access challenges mirror adult community concerns regarding behavioral health, substance use, transportation, and affordability. This convergence strengthens confidence in the assessment findings and underscores the importance of coordinated, prevention-focused strategies that address both immediate service gaps and the upstream social and economic conditions shaping health outcomes in Highland County.

## **Community and Stakeholder Input Summary**

Community and stakeholder input collected for the 2025 Community Health Needs Assessment provides a consistent, multi-perspective view of the factors shaping health and quality of life in Highland County. Across resident surveys, stakeholder input, and youth-reported data, respondents described health challenges as interconnected and rooted not only in individual behaviors, but also in economic conditions, access barriers, and structural constraints characteristic of a rural Appalachian-transition county.

Community residents consistently identified mental and behavioral health needs, substance use, chronic disease, housing affordability, economic opportunity, transportation, and access to healthcare as the most significant issues affecting well-being. While many respondents reported generally positive self-rated health, a substantial proportion also reported frequent poor physical and mental health days, unmet care needs, financial strain, and difficulty accessing timely services. These findings reinforce the importance of interpreting self-reported health alongside utilization patterns, workforce data, and social vulnerability indicators.

The inclusion of ALICE household data strengthens interpretation of community input by highlighting the economic vulnerability experienced by a significant share of working households who may be underrepresented in voluntary surveys. When viewed together, survey findings and ALICE analysis demonstrate that concerns related to housing costs, food access, transportation, childcare, healthcare affordability, and economic opportunity are not isolated issues, but reflect underlying structural conditions that shape health risks and access to care.

Stakeholder input further validated resident perspectives and provided system-level insight into service capacity and coordination challenges. Stakeholders consistently identified behavioral health and substance use, chronic disease burden, access to care and transportation barriers, housing affordability, and economic instability as the most pressing challenges facing Highland County. Workforce shortages, limited specialty capacity, transportation gaps, and fragmented care coordination were frequently cited as contributors to delayed care, avoidable emergency department use, and preventable hospitalizations.

Youth-reported data from the Ohio Healthy Youth Environments Survey (OHYES) closely aligned with adult community and stakeholder input, particularly regarding stress, anxiety, access barriers, and the need for prevention-focused supports. This alignment across age groups strengthens confidence in the assessment findings and underscores the importance of early intervention, school-linked supports, and family-centered strategies.

Community members and stakeholders expressed concern regarding cancer outcomes and access to screening and early detection services. While community perception included concern about environmental contributors, findings from the Ohio Department of Health cancer study helped contextualize these concerns by clarifying that cancer burden in Highland County reflects broader risk patterns rather than a localized exposure. This information supports transparent risk communication while reinforcing the importance of prevention, screening, and timely access to care.

Collectively, community resident input, stakeholder perspectives, youth data, and secondary indicators demonstrate strong convergence around a set of interconnected health challenges. Behavioral health and substance use, chronic disease, access to care and transportation

barriers, economic instability, and unmet social needs emerge as mutually reinforcing drivers of health outcomes and health equity in Highland County. These findings directly inform the identification of significant health needs and provide a clear, evidence-based foundation for prioritization and strategy development in the Community Health Improvement Plan presented in the sections that follow.



## SECTION 9: Significant Health Needs Determination

This section presents the formal determination of significant health needs for Highland County based on a comprehensive review of assessment findings. Building on the community and stakeholder input documented in Section 8 and the quantitative indicators presented in Sections 6 and 7, this determination identifies the health issues that rise to the level of significance due to their magnitude, severity, persistence, and disproportionate impact on vulnerable populations.

The purpose of this section is to transparently document how evidence from multiple data sources was synthesized to identify the most critical health needs affecting Highland County residents, in alignment with requirements outlined by the Internal Revenue Code §501(r), Ohio Department of Health (ODH) guidance, Centers for Medicare & Medicaid Services (CMS) health equity frameworks, and JCAHO community benefit expectations.

### Triangulation of Data Sources and Community Input

Significant health needs for Highland County were identified through a triangulated review of multiple data sources to ensure determinations reflect both lived community experience and objective indicators of population health. Community resident survey findings, stakeholder input, and secondary data—including population health indicators, utilization patterns, workforce capacity measures, and equity metrics—were reviewed together to identify areas of convergence and elevated risk. Secondary data sources were selected to reflect the most recent available multi-year trends (generally 2021–2025 where available), including County Health Rankings & Roadmaps, state and federal mortality and utilization indicators, and locally collected survey results.

This triangulated approach reduces reliance on any single data source and strengthens the validity of the assessment. Community and stakeholder input informed interpretation of quantitative data but did not independently determine significance.

### Interpretation and Use in Prioritization

To ensure that identified health needs reflect both objective data trends and lived experience, findings from multiple sources were systematically compared and validated. Quantitative secondary data, primary community survey responses, stakeholder perspectives, and youth-reported indicators were reviewed together to confirm consistency, identify disparities, and support determination of significant health needs.

Table 35 (Triangulation Summary of Priority Health Needs — Highland County) is intentionally placed here as the core decision-support tool. The table illustrates alignment across data

sources and documents the rationale for determining significance; it does not rank needs or assign implementation feasibility.

Table 35: Triangulation Summary of Priority Health Needs — Highland County

<b>Triangulation Summary of Priority Health Needs — Highland County</b>				
<b>Priority Health Need</b>	<b>Quantitative Data Evidence</b>	<b>Community Survey &amp; Stakeholder Input</b>	<b>Validation Across Sources</b>	<b>Conclusion</b>
Mental & Behavioral Health	Elevated poor mental health days; high prevalence of depression/anxiety; suicide risk above state benchmarks; behavioral health–related emergency utilization	Mental health identified as a top concern by residents and stakeholders; reported barriers include limited provider availability, long wait times, transportation challenges, and affordability	Strong alignment between secondary data, resident survey themes, stakeholder input, and OHYES youth-reported stress and anxiety	Validated as a significant and high-priority health need
Substance Use & Injury Prevention	Elevated injury-related mortality; substance-related hospitalizations and overdose risk indicators; tobacco and illicit drug use prevalence	Substance use repeatedly identified as a major community concern; residents emphasized prevention, youth education, treatment access, and recovery support	Consistent reinforcement across survey data, stakeholder perspectives, and mortality/utilization indicators	Validated as a significant and high-priority health need
Chronic Disease Prevention & Management	High prevalence of obesity, hypertension, diabetes, cardiovascular disease, cancer, and respiratory	Residents identified chronic disease as a major health concern; linked conditions to stress, nutrition, access	Community experience closely mirrors leading causes of death and utilization patterns	Validated as a significant and high-priority health need

Triangulation Summary of Priority Health Needs — Highland County				
Priority Health Need	Quantitative Data Evidence	Community Survey & Stakeholder Input	Validation Across Sources	Conclusion
	conditions; contributes to reduced life expectancy	barriers, and economic strain		
Access to Care & Transportation	Provider-to-population ratios worse than Ohio medians; specialty care often requires out-of-county travel; transportation vulnerability in rural census tracts	Residents and stakeholders cited difficulty accessing behavioral health, dental, and specialty care; transportation identified as a cross-cutting barrier	Alignment between workforce data, utilization patterns, survey findings, and stakeholder input	Validated as a significant health need affecting multiple outcomes
Health-Related Social Needs (HRSN)	Elevated ALICE households; housing cost burden; food insecurity; economic instability; social vulnerability concentrated in specific areas	Residents identified housing affordability, income stability, food access, childcare, and utility costs as major stressors	Strong concordance between ALICE analysis, community survey themes, and stakeholder observations	Validated as a cross-cutting driver of health inequities
Youth Mental Health & Family Stability	OHYES data show elevated youth stress, anxiety, and access challenges; school-based	Community and stakeholders emphasized youth mental health, prevention, and family stability;	Youth-reported data aligns with adult community input and system-level observations	Validated as a significant cross-cutting health need with youth and families as a priority

Triangulation Summary of Priority Health Needs — Highland County				
Priority Health Need	Quantitative Data Evidence	Community Survey & Stakeholder Input	Validation Across Sources	Conclusion
	behavioral health capacity limited	kinship caregiving noted		population focus

**Source:** Triangulation of 2025 Highland County Community Health Survey; County Health Rankings & Roadmaps; Ohio Healthy Youth Environments Survey (OHYES); ALICE Household Data; stakeholder interviews and partner input; utilization and mortality indicators.

## Integration of State Cancer Study Findings

Findings from the Ohio Department of Health cancer study were incorporated into the triangulation process used to determine significant health needs in Highland County. While the state analysis did not identify a discrete cancer cluster linked to a specific environmental exposure, it confirmed a sustained cancer burden consistent with regional and state trends.

Cancer outcomes—particularly lung, colorectal, breast, and prostate cancers—remain a significant contributor to premature mortality and reduced life expectancy in Highland County. Community input, utilization patterns, and secondary data indicate that cancer burden is closely linked to tobacco use, delayed screening, access barriers, and underlying social and economic conditions. As such, cancer prevention and control were addressed through the assessment’s chronic disease, behavioral health, access to care, and health-related social needs priority domains.

## Synthesis of Assessment Findings and Potential Impact

The triangulation process demonstrated strong alignment between quantitative data trends, community resident perspectives, stakeholder experience, and youth-reported data. Health issues identified through statistical analysis were consistently reinforced by lived experience and professional insight, strengthening confidence in the assessment findings.

Across data sources, Highland County’s most significant health challenges are interconnected, with behavioral health, substance use, chronic disease, access barriers, transportation limitations, and unmet social needs mutually reinforcing one another. These conditions contribute to reduced quality of life, preventable healthcare utilization, and persistent health inequities—particularly among older adults, low-income households, individuals with disabilities, and residents of high-SVI census tracts.

## **Integration of ALICE and Youth Survey Findings.**

ALICE household data and findings from the Ohio Healthy Youth Environments Survey (OHYES) further reinforce the determination of significant health needs in Highland County. Economic strain among working households increases vulnerability to delayed care, food and housing insecurity, transportation challenges, and unmanaged chronic disease. Youth-reported data highlight elevated stress, anxiety, and unmet mental health needs during critical developmental periods.

Together, these data demonstrate how economic instability and early-life behavioral health challenges interact across the life course, shaping long-term population health outcomes and reinforcing the need for equity-focused, prevention-oriented strategies.

## **Determination Framework and Criteria**

Health needs were determined to be significant based on the magnitude, severity, persistence, and equity impact observed across Highland County. A health issue was designated as significant when it met one or more of the following criteria:

- Affects a substantial portion of the population
- Contributes meaningfully to premature mortality, morbidity, or reduced quality of life
- Disproportionately impacts vulnerable populations or high-SVI geographies
- Is consistently identified across multiple data sources

Disparities by geography, income, disability status, age, and access to care were central to determining significance. This section reflects health need identification only and does not incorporate feasibility, resource availability, or implementation considerations, which are addressed separately in the Community Health Improvement Plan (CHIP).

## **Identified Significant Health Needs — Highland County**

Based on triangulated analysis of secondary data, community resident input, stakeholder perspectives, and equity considerations, the following were determined to represent significant health needs in Highland County:

- Mental and Behavioral Health
- Substance Use and Injury Prevention
- Chronic Disease Prevention and Management
- Access to Care and Transportation Barriers
- Health-Related Social Needs and Economic Stability
- Youth Mental Health and Family Well-Being

These needs affect a substantial portion of the population, contribute meaningfully to premature mortality or reduced quality of life, and disproportionately impact vulnerable groups.

## **Narrative Description of Significant Health Needs**

The following narrative sections describe the health needs determined to be significant for Highland County based on triangulated assessment findings. Each narrative summarizes the evidence supporting significance, including magnitude, severity, persistence, and disproportionate impact, and reflects convergence across community resident input, stakeholder perspectives, and secondary data indicators. These narratives are intended to document the rationale for determination and do not include implementation strategies or action planning, which are addressed separately in the Community Health Improvement Plan.

### **Mental and Behavioral Health**

Mental and behavioral health conditions were identified as significant health needs based on convergence across community resident survey responses, stakeholder input, youth-reported data, and secondary indicators. This need meets significance criteria based on its broad population impact, severity of associated health outcomes, persistence over time, and disproportionate impact on vulnerable populations. Residents and stakeholders described unmet mental health needs, limited provider availability, long wait times, transportation barriers, and affordability challenges. Secondary data demonstrate elevated poor mental health days, suicide risk, and behavioral health–related emergency department utilization, contributing substantially to premature mortality and reduced quality of life in Highland County.

### **Substance Use and Injury Prevention**

Substance use and injury-related harms were identified as significant health needs due to elevated injury mortality, overdose risk indicators, and sustained community impact. This need meets significance criteria based on its broad population impact, severity of outcomes—including preventable death—persistence over time, and disproportionate impact on vulnerable populations. Community members emphasized the effects of substance use on families, workplaces, and safety, while stakeholders cited ongoing system strain, treatment access gaps, and prevention needs. Mortality and utilization data reinforce these concerns, indicating continued preventable harm across multiple age groups.

### **Chronic Disease Prevention and Management**

Chronic disease was identified as a significant health need due to its contribution to mortality, disability, and healthcare utilization. This need meets significance criteria based on its broad population impact, severity of long-term health outcomes, persistence across assessment

cycles, and disproportionate burden among vulnerable populations. Residents identified heart disease, cancer, diabetes, obesity, and respiratory disease as leading concerns, while stakeholders emphasized delayed preventive care and limited self-management support. Secondary data confirm these conditions as leading causes of death and contributors to reduced life expectancy in Highland County.

Cancer contributes substantially to the chronic disease burden in Highland County and remains one of the leading causes of death. Lung cancer represents the largest share of cancer mortality, followed by colorectal, breast, and prostate cancers. These patterns align with known risk factors including tobacco use, physical inactivity, nutrition, and gaps in preventive screening.

This need meets significance criteria based on population impact, severity of outcomes, persistence over time, and disproportionate impact on vulnerable groups. Cancer burden is higher among older adults, low-income households, individuals with disabilities, and residents facing access barriers, reinforcing the need for prevention-focused, equity-oriented strategies.

### **Access to Care and Transportation Barriers**

Access to timely, affordable, and appropriate healthcare services was identified as a significant health need within the context of Highland County's rural geography. This need meets significance criteria based on its population-level impact, severity of downstream health consequences, persistence over time, and disproportionate effect on older adults, individuals with disabilities, and low-income households. Residents reported difficulty accessing behavioral health, dental, and specialty care due to provider shortages, travel distance, transportation reliability, and cost. Stakeholder input and utilization patterns reinforce access barriers as a system-level determinant affecting multiple health outcomes.

### **Health-Related Social Needs and Economic Stability**

Health-related social needs—including housing affordability, food insecurity, transportation, and economic strain—were identified as significant upstream drivers of health outcomes. This need meets significance criteria based on its broad population impact, severity of downstream health effects, persistence across assessment cycles, and disproportionate burden on economically vulnerable households and high-SVI communities. Community and stakeholder input consistently described these factors as complicating disease management, care engagement, and prevention. Secondary data demonstrate elevated ALICE households, disability prevalence, and concentrated social vulnerability across Highland County.

### **Youth Mental Health and Family Well-Being**

Youth mental health and family stability emerged as significant and cross-cutting health needs affecting long-term population health. This need meets significance criteria based on population

impact, severity of outcomes during critical developmental periods, persistence over time, and disproportionate impact on youth and families experiencing economic and access-related stressors. Youth-reported stress and anxiety from OHYES data align with adult community and stakeholder concerns regarding prevention, access, and family support. These findings indicate elevated risk during formative life stages and support early intervention and coordinated, family-centered strategies.

## Summary Determination

Based on comprehensive triangulation of data sources, Highland County's most significant health needs are behavioral health and substance use, chronic disease, access to care and transportation barriers, health-related social needs, and youth mental health and family well-being. These determinations establish the evidentiary foundation for the Highland County Community Health Improvement Plan and guide subsequent prioritization and action planning.



# SECTION 10: Community Health Improvement Plan (CHIP) Progress and Priority Alignment

## Background and Purpose

This Community Health Needs Assessment (CHNA) serves as the formal needs assessment foundation for the 2026–2028 Highland County Community Health Improvement Plan (CHIP), which will translate identified priorities into coordinated strategies, partnerships, and measurable outcomes. Highland County completed its most recent collaborative CHNA in 2022, and findings from that assessment informed the development of the 2023 Community Health Improvement Plan, which established shared priorities and aligned community-wide efforts to improve population health.

This section summarizes progress related to the 2023 CHIP and explains how existing CHIP priorities align with the significant health needs identified in the 2025 Highland County CHNA. This discussion is intended to document continuity, progress, and strategic focus and does not replace the formal determination of significant health needs presented in Section 9.

## CHIP Development and Collaborative Approach

The 2023 Highland County CHIP was developed collaboratively by partner agencies representing healthcare, public health, behavioral health, education, social services, aging services, and community-based organizations. Partners contributed to strategy development and implementation based on organizational capacity, expertise, and alignment with shared community goals.

The CHIP emphasizes coordinated, multisector action to address high-impact health issues and leverages existing programs, partnerships, and infrastructure to support measurable improvement during the implementation period.

## CHIP Priority Areas: Strategic Rationale

While the Community Health Needs Assessment identifies multiple significant health needs, the Community Health Improvement Plan is intentionally designed to focus on a limited number of priority areas where coordinated action can reasonably achieve measurable and sustainable improvement.

CHIP priorities for Highland County were selected because they:

1. Represent key drivers of premature mortality, morbidity, and reduced quality of life

2. Are consistently reinforced across community input, stakeholder perspectives, and secondary data
3. Are actionable through collaboration among existing community partners and systems

Collectively, these priorities address both immediate health outcomes and upstream drivers of health, positioning the CHIP to support population-level improvement rather than isolated programmatic change.

## Health Outcomes and Contributing Factors

Mortality and utilization data indicate that the leading causes of death in Highland County are driven by a combination of chronic disease burden, behavioral health risk, and preventable injury. Cancer and heart disease remain the primary causes of death, reflecting long-term exposure to modifiable risk factors such as tobacco use, poor nutrition, and limited physical activity. Chronic lower respiratory disease continues to contribute significantly to mortality, consistent with elevated tobacco use and respiratory risk in the county. Unintentional injury—including drug overdose and motor vehicle–related injury—represents a major contributor to premature death, particularly among working-age adults. Stroke and diabetes further reflect the cumulative impact of unmanaged chronic conditions and delayed or inconsistent access to preventive and primary care.

Together, these causes account for a substantial share of premature mortality in Highland County and are closely influenced by access to care, health behaviors, and underlying social and economic conditions.

Community input, secondary indicators, and healthcare utilization patterns further highlight a set of leading health issues that significantly affect residents' quality of life and long-term well-being. Substance use disorder, including opioid and polysubstance use, was consistently identified as a major concern affecting individuals, families, and community safety. Obesity and diabetes contribute to cardiovascular disease, disability, and reduced life expectancy, while depression and anxiety are associated with a high prevalence of poor mental health days and increased healthcare utilization. Respondents also emphasized concerns related to child and youth wellness and safety, particularly behavioral health and prevention needs, as well as ongoing challenges in managing mental health due to service availability, affordability, and transportation barriers. Access to care challenges—especially for dental, behavioral health, and specialty medical services—were frequently cited as limiting timely prevention, treatment, and follow-up care.

These health issues are persistent, interconnected, and disproportionately affect vulnerable populations, including low-income households, older adults, individuals with disabilities, and residents living in areas with higher social vulnerability.

Health behaviors play a central role in shaping these outcomes. Survey findings and secondary data indicate that alcohol and substance use, including tobacco and illicit drug use, remain prevalent and contribute directly to injury, chronic disease, and behavioral health burden. Insufficient physical activity and poor nutrition increase risk for obesity, diabetes, cardiovascular disease, and cancer, while food insecurity and economic stress further complicate healthy lifestyle choices. Delayed or limited healthcare utilization—particularly preventive and routine care—reduces opportunities for early detection and effective disease management. Teen pregnancy reflects gaps in prevention, education, and access to supportive services and has implications for maternal, infant, and long-term population health.

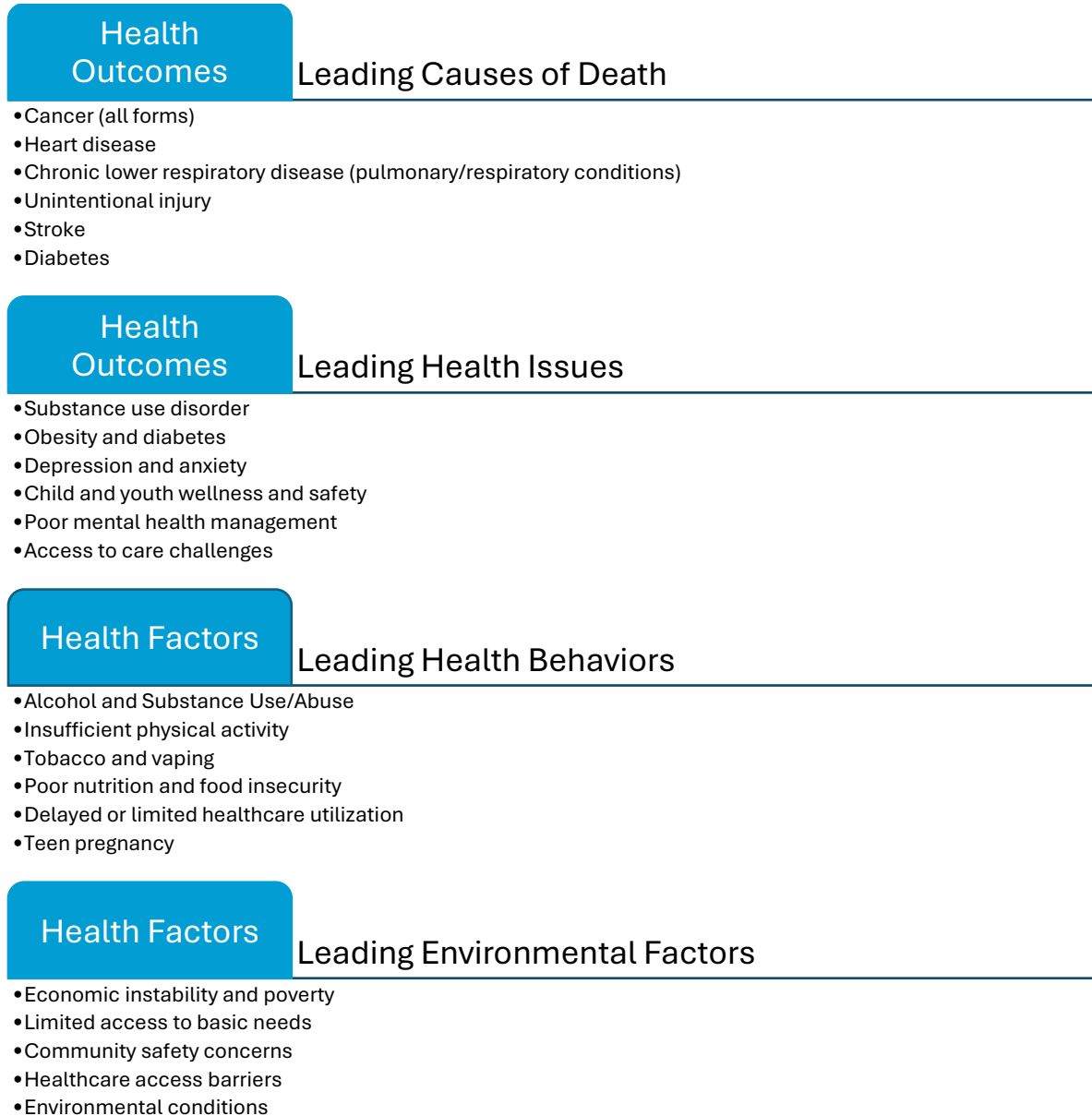
These behaviors are not isolated individual choices, but are shaped by access to care, education, economic conditions, transportation, and community infrastructure.

Upstream social, economic, and environmental conditions strongly influence both health behaviors and outcomes in Highland County. Economic instability and poverty—including a substantial proportion of ALICE households—limit access to healthcare, nutritious food, stable housing, and reliable transportation. Barriers to basic needs contribute to chronic stress, delayed care, and poorer health outcomes. Community safety concerns, including injury risk and interpersonal violence, further affect physical and mental well-being. Healthcare access barriers, particularly for preventive and specialty services, remain pronounced in a rural context where distance, workforce shortages, and transportation limitations intersect. Environmental conditions, including air quality and legacy environmental exposure concerns in specific areas, add to cumulative health risk.

Collectively, these social, economic, and environmental factors function as health-related social needs that drive delayed care, unmanaged chronic conditions, behavioral health strain, and preventable healthcare utilization. Addressing these upstream drivers is essential to improving health outcomes, reducing inequities, and supporting long-term community well-being in Highland County.

Figure 9 illustrates the relationship between health outcomes and the underlying health factors that shape them. While health outcomes reflect the end results experienced by individuals and communities, health factors—including behaviors, access to care, social and economic conditions, and the physical environment—represent upstream drivers that are more responsive to coordinated, community-level intervention. The CHIP prioritizes strategies that address health factors to influence long-term health outcomes.

Figure 9: 2025 CHNA Key Health Factors and Health Outcomes



## CHIP Priority Areas: Strategic Rationale

While the CHNA identifies multiple significant health needs affecting Highland County residents, the CHIP focuses on priority areas where multisector coordination can most effectively influence long-term population health outcomes. Priority selection was informed by magnitude and severity of health outcomes, convergence across data sources, and feasibility for collective action.

## **Mental and Behavioral Health**

Mental and behavioral health conditions were selected as CHIP priorities due to their severity, prevalence, and cross-cutting impact across the lifespan. These conditions contribute directly to suicide risk, substance use, family instability, workforce disruption, and increased healthcare utilization. Stakeholders identified access gaps, workforce limitations, and care coordination challenges as system-level barriers requiring community-wide solutions.

## **Chronic Disease Prevention and Management**

Chronic disease prevention and management were prioritized because chronic conditions account for the largest share of deaths, disability, and healthcare costs in Highland County. These outcomes are responsive to prevention, early detection, and community-based supports. CHIP strategies integrate clinical care, public health, nutrition, physical activity, tobacco cessation, and health education to reduce long-term disease burden.

## **Access to Care and Transportation Barriers**

Access to care, including transportation, was selected as a foundational CHIP priority because access barriers directly affect residents' ability to benefit from available health and social services. In a rural context, geographic distance, limited transportation options, and workforce shortages undermine prevention, treatment, and follow-up care. CHIP-level coordination supports improved navigation, alignment of resources, and service accessibility.

## **Health-Related Social Needs and Economic Stability**

Health-related social needs were prioritized because unmet basic needs consistently exacerbate medical and behavioral health conditions and undermine treatment effectiveness. Addressing food insecurity, housing instability, transportation, and economic strain strengthens outcomes across all priority areas and aligns with CMS and ODH expectations for addressing health-related drivers of health.

## **Youth Mental Health and Family Well-Being**

Youth mental health and family well-being were selected as CHIP priorities due to their high leverage for long-term population health impact. Stakeholders emphasized that unmet needs in childhood and adolescence often translate into adult behavioral health challenges, substance use, chronic disease risk, and economic instability. CHIP strategies emphasize prevention, early intervention, and school- and community-based supports.

## Other Health Needs Identified and Monitored

The CHNA identified additional health needs affecting Highland County residents. While all identified needs are important, the CHIP is intentionally structured to focus on a limited number of priorities. Other needs will continue to be monitored and addressed through existing programs, regulatory responsibilities, or as embedded components within selected priority areas. Non-prioritization does not indicate lack of importance.

### *Oral Health*

Oral health challenges were identified through community input and secondary data but were not elevated as a standalone CHIP priority due to existing provider networks, school-based programs, and public health initiatives. Oral health will continue to be addressed within broader access-to-care and preventive strategies.

### *Communicable Disease and Immunization*

Communicable disease prevention and immunization remain core public health responsibilities governed by regulatory requirements and existing infrastructure and were therefore not prioritized for CHIP action.

### *Injury Prevention and Community Safety*

Unintentional injury contributes to morbidity and mortality; however, prevention efforts are currently integrated across public health, emergency services, behavioral health, and safety initiatives and are addressed within other CHIP priorities.

### *Environmental Health and Exposure*

Environmental health concerns were reviewed and are primarily addressed through state and federal regulatory mechanisms. These issues will continue to be monitored and reflected within broader planning efforts.

### *Aging Services and Older Adult Supports*

Older adult needs overlap substantially with chronic disease, access to care, transportation, and social support and are therefore addressed through strategies embedded within selected CHIP priority areas.

## Why These Priorities Together

Taken together, the selected CHIP priorities:

- Address major drivers of premature death and reduced quality of life
- Reflect convergence across data, community input, and stakeholder perspectives
- Reinforce one another through integrated, upstream approaches
- Are actionable through multisector collaboration

- Align with state and federal health improvement priorities

Focusing the Highland County CHIP on these areas supports coordinated, equitable, and sustainable health improvement and provides a clear framework for implementation and evaluation.

## Reflection on Progress Related to the 2023 CHIP

The following section summarizes progress under the 2023 Highland County Community Health Improvement Plan and examines how prior priority areas align with the significant health needs identified in the 2025 CHNA. This reflection provides context for continuity across assessment cycles and supports evidence-based refinement of future CHIP priorities.

This review does not evaluate program effectiveness or attribute population-level outcomes to CHIP activities; rather, it situates implementation efforts within broader trend data and community input.

Table 36: Community Health Improvement Plan (CHIP) Priority Areas and Progress Summary — Highland County

<b>Community Health Improvement Plan (CHIP) Priority Areas and Progress Summary — Highland County</b>			
<b>CHIP Priority Area</b>	<b>CHIP Focus</b>	<b>Progress to Date (Implementation Activities &amp; System Alignment)</b>	<b>Ongoing Alignment with 2025 CHNA</b>
Mental Health & Substance Use	Improve access to behavioral health services, prevention, and recovery supports	Partners strengthened coordination among behavioral health, public health, and healthcare organizations, emphasizing referral pathways, system navigation, and awareness of prevention and recovery resources.	Behavioral health and substance use remain among the most significant needs in the 2025 CHNA, with continued elevation in depression, suicide risk, and substance-related indicators.
Chronic Disease Prevention & Management	Reduce chronic disease burden through prevention	Partners aligned education, screening, and lifestyle initiatives addressing cardiovascular disease,	Chronic disease continues to drive mortality, disability, and utilization, reinforcing

## Community Health Improvement Plan (CHIP) Priority Areas and Progress Summary — Highland County

CHIP Priority Area	CHIP Focus	Progress to Date (Implementation Activities & System Alignment)	Ongoing Alignment with 2025 CHNA
	and care coordination	diabetes, obesity, and respiratory conditions.	alignment with CHIP focus areas.
Access to Care & Transportation	Improve access through coordination and navigation	CHIP partners improved care navigation and coordination with existing transportation resources where feasible.	Access barriers remain significant contributors to delayed care and unmet needs, particularly in rural and high-vulnerability areas.
Health-Related Social Needs	Address food insecurity, housing instability, and economic strain	Partners integrated screening and referral for social needs into existing workflows and strengthened cross-sector linkages.	Social and economic conditions continue to underlie behavioral health, chronic disease, and access challenges.
Youth Mental Health & Family Well-Being	Strengthen prevention and early intervention	Efforts focused on coordination among schools, community organizations, and service providers to improve prevention and referral awareness.	Youth mental health and family stability remain significant and emerging needs identified in the 2025 CHNA.

Note: This table summarizes implementation activities and system-level alignment and does not evaluate program effectiveness or attribute outcomes, consistent with IRS §501(r) and ODH guidance.

### Summary and Transition to Implementation

Section 10 documents how Highland County’s Community Health Improvement Plan builds directly upon the findings of the 2025 Community Health Needs Assessment and reflects continuity, alignment, and strategic focus across assessment cycles. Review of CHIP progress demonstrates that priority areas established in the 2023 plan remain highly relevant, as the underlying drivers of poor health—behavioral health burden, chronic disease, access barriers,

unmet social needs, and youth mental health challenges—continue to affect a substantial portion of the population.

The alignment between identified significant health needs and CHIP priorities confirms that community partners have focused collective action on areas with the greatest potential to reduce premature mortality, improve quality of life, and advance health equity. At the same time, this review acknowledges that many health challenges are persistent and influenced by structural and social conditions that require sustained, coordinated, and upstream intervention.

The findings presented in this section provide a clear bridge between assessment and action. The subsequent Community Health Improvement Plan implementation framework will translate these aligned priorities into measurable strategies, defined roles, and shared accountability for the 2026–2028 implementation period, consistent with IRS §501(r), Ohio Department of Health guidance, CMS health equity priorities, and community benefit best practices.

# SECTION 11: Considerations for Community Health Improvement Planning

This section marks the transition from assessment to action. Building on the significant health needs formally identified in Section 9 and the CHIP alignment and progress review presented in Section 10, Section 11 outlines key considerations to inform development of the 2026–2028 Highland County Community Health Improvement Plan (CHIP). These considerations translate assessment findings, community and stakeholder input, and system-level analysis into a planning framework that supports coordinated, evidence-informed, and equity-focused implementation. This section does not prescribe specific interventions or commitments; rather, it establishes the contextual and strategic factors that should guide collaborative CHIP design, partner alignment, and prioritization.

## Purpose and Context

This Community Health Needs Assessment identifies significant health needs affecting Highland County residents and provides the evidentiary foundation for subsequent Community Health Improvement Plan (CHIP) development. Section 11 summarizes key considerations that should inform CHIP planning and implementation, drawing directly from assessment findings, community and stakeholder input, and observed system-level conditions.

These considerations are intended to support strategic focus, coordination, and alignment across partners, rather than define specific programs or assign implementation responsibility. The considerations reflect Highland County’s rural Appalachian context, demographic profile, existing community assets, and persistent structural challenges that influence health outcomes across the life course.

## Cross-Cutting System Considerations

Assessment findings consistently demonstrate that health outcomes in Highland County are shaped by interconnected system factors rather than isolated conditions. Behavioral health, substance use, chronic disease, access to care, transportation, and health-related social needs interact to influence when and how residents engage with services, adhere to treatment, and experience preventable illness or crisis.

Community input and utilization patterns indicate that coordination, navigation, and service reach are often as influential as service availability alone. CHIP strategies may therefore benefit from approaches that strengthen cross-sector alignment, reduce fragmentation, and improve residents’ ability to access existing resources in a timely and coordinated manner.

## Transportation and Geographic Access

Transportation constraints were consistently identified across community input, healthcare utilization patterns, and service delivery contexts in Highland County. Rural geography, travel distance, limited transportation options, and vehicle reliability influence access to primary care, specialty services, behavioral health treatment, preventive care, and social services—particularly for older adults, individuals with disabilities, and lower-income households.

Non-emergency medical transportation, senior transportation services, and travel demands for essential services represent ongoing system pressures. Transportation limitations also affect caregiver burden, appointment adherence, and continuity of care. As such, transportation should be considered a cross-cutting access factor influencing multiple CHIP priority areas, rather than a standalone health issue.

## Behavioral Health System Capacity and Coordination

Behavioral health and substance use disorders remain among the most significant health needs identified in Highland County. While local service capacity exists, effective access varies by age group, payer type, acuity, and geography. Community and stakeholder input highlighted workforce constraints, appointment wait times, limited specialty services (including youth and addiction services), and challenges in care coordination across settings.

CHIP planning considerations include strategies that emphasize system coordination, referral alignment, and continuity of care—particularly for individuals experiencing repeated crises or transitions between emergency, inpatient, outpatient, and community-based services. Youth behavioral health and family-centered supports warrant particular attention due to their long-term impact on population health trajectories.

## Chronic Disease and Preventive Care Gaps

Chronic disease continues to drive mortality, disability, and healthcare utilization in Highland County. Assessment findings indicate that delayed preventive care, limited self-management support, and access barriers contribute to avoidable complications and hospitalizations.

Future CHIP planning may benefit from approaches that integrate clinical care, public health, and community-based supports to strengthen prevention, early detection, and chronic disease management. Preventive care engagement—particularly among older adults, individuals with multiple chronic conditions, and residents facing transportation or affordability barriers—represents a key leverage point for reducing downstream system strain.

## **Health-Related Social Needs and Economic Stability**

Health-related social needs—including food insecurity, housing affordability, transportation access, and economic strain—were consistently identified as upstream drivers of poor health outcomes in Highland County. These factors complicate disease management, limit engagement in care, and disproportionately affect residents in high-vulnerability areas.

CHIP planning should consider strategies that strengthen linkages between healthcare, public health, and social service systems, recognizing that addressing social needs supports progress across all priority health areas. Alignment with state and federal health equity and health-related drivers of health frameworks may enhance sustainability and impact.

## **Older Adults, Caregiver Burden, and Protective Services**

Highland County’s aging population presents important considerations for health improvement planning. Increased chronic disease burden, transportation needs, service utilization, and caregiver demand underscore the importance of coordinated aging services and caregiver support.

Trends related to caregiver strain and Adult Protective Services involvement highlight the intersection of health, safety, social isolation, and access to supports. CHIP strategies addressing access, behavioral health, chronic disease management, and social support may also reduce risk factors associated with neglect, exploitation, and unmet needs among older adults.

## **Youth, Families, and Kinship Care Context**

Assessment findings and community input emphasize the importance of youth mental health, family stability, and prevention. Kinship caregiving arrangements—where children are cared for by grandparents or other relatives—represent an important contextual factor in Highland County.

While kinship care provides stability, caregivers may face financial strain, transportation barriers, and challenges navigating healthcare, education, and behavioral health systems. CHIP planning should account for caregiver capacity and recognize the value of school- and community-based supports, early intervention, and prevention-focused strategies.

## **Leveraging Community Assets and Partnerships**

Highland County benefits from established partnerships among healthcare providers, public health agencies, schools, social services, and community organizations. These relationships provide a strong foundation for coordinated action.

CHIP planning should build on existing collaborations, avoid duplication, and prioritize strategies that enhance alignment, shared accountability, and sustainability across sectors.

## **Summary Considerations for CHIP Development**

Informed by the 2025 Highland County CHNA, future Community Health Improvement Plan efforts should consider:

- Strengthening coordination and navigation across healthcare, behavioral health, and social services
- Addressing transportation as a cross-cutting access barrier
- Supporting prevention and early intervention for behavioral health and chronic disease
- Integrating health-related social needs into care and service planning
- Recognizing the needs of older adults, caregivers, youth, and kinship families
- Leveraging existing partnerships to achieve sustainable, community-wide impact

These considerations provide a structured framework for translating assessment findings into focused, collaborative CHIP strategies aligned with community priorities, system realities, and regulatory expectations in Highland County.

## Public Availability

This 2025 Highland County Community Health Needs Assessment (CHNA) is made publicly available in accordance with Internal Revenue Code §501(r). The report is available online at: <https://www.adena.org/community-health/overview>.

The CHNA was posted on December 31, 2025 and will remain publicly accessible until the next Community Health Needs Assessment is conducted. Printed copies of the report are available upon request at no cost by contacting Adena Health.

## CHNA Adoption and Approval

This 2025 Highland County Community Health Needs Assessment was adopted by board of Adena Greenfield Medical Center on February 19, 2026, following review of assessment findings, community input, and identified significant health needs.

Adoption of this assessment affirms that the CHNA fulfills the requirements of Internal Revenue Code §501(r) and reflects the health priorities of the Highland County community as identified through a comprehensive, data-driven, and community-engaged process.

## Implementation Strategy

An Implementation Strategy addressing the significant health needs identified in this Community Health Needs Assessment will be developed and adopted separately, in accordance with Internal Revenue Code §501(r). The Implementation Strategy will outline specific goals, strategies, responsible partners, and evaluation measures and will be adopted by Adena Health by within 12 months of CHNA adoption. The Implementation Strategies will be posted online and available for public review.

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<sup>1</sup> **Reference Note:** Data sources include the most recent publicly available estimates at the time of assessment. Where applicable, multi-year rolling averages were used to ensure stability in estimates for rural populations. Primary and secondary data were triangulated in accordance with IRS §501(r), ODH, CMS, and NACCHO guidance.

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# Appendix A: County Health Rankings Trend Analysis for Highland County (2022–2025)

This appendix summarizes recent trends in key health indicators for Highland County, Ohio, using data from County Health Rankings & Roadmaps (CHR&R). These indicators are derived from multiple federal and state data sources, including the Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), and the U.S. Census Bureau. The purpose of this appendix is to highlight changes in health outcomes and contributing factors over time and to support interpretation of findings presented throughout the Community Health Needs Assessment (CHNA).

## Key Health Trends in Highland County

Across the 2022–2025 reporting period, Highland County continues to demonstrate:

- Elevated rates of premature mortality relative to Ohio benchmarks
- Persistently high Years of Potential Life Lost (YPLL)
- Poorer performance on several health factor measures, particularly those related to health behaviors, access to care, and social and economic conditions

These trends reflect the cumulative impact of chronic disease, behavioral health conditions, substance use, injury, and health-related social needs.

## Premature Mortality & YPLL – Highland County

Premature death (defined as deaths occurring before age 75) remains a critical concern in Highland County.

- Premature death rate: Higher than the Ohio county median
- Years of Potential Life Lost (YPLL): Significantly elevated, indicating a high burden of early and preventable death

These indicators place Highland County below the Ohio median for health outcomes and reinforce the need for prevention-focused strategies addressing both clinical and non-clinical drivers of health.

## What These Trends Mean

Taken together, these trends indicate that Highland County experiences a persistent burden of preventable early mortality, driven by chronic disease, behavioral health conditions, substance

use, injury, and access barriers. These findings directly informed the determination of significant health needs presented in Section 9 and the priority alignment discussed in Section 10.

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Data Sources:

- County Health Rankings & Roadmaps, 2022–2025
- CDC National Center for Health Statistics (NVSS)
- Centers for Medicare & Medicaid Services
- U.S. Census Bureau, American Community Survey (ACS) 5-Year Estimates

# Appendix B: Highland County– Demographic Profile

This appendix provides a high-level demographic snapshot of Highland County, using the most recent U.S. Census Bureau Decennial Census and ACS 5-Year Estimates. These indicators provide context for understanding current and future health needs.

## Population & Growth

- **Total population:** Approximately 43,000 residents
- **Population changes since 2010:** Net decline

### Why this matters:

Population decline affects workforce availability, school enrollment, healthcare demand, and long-term community sustainability, particularly in rural Appalachian counties.

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## Age Profile

- **Adults age 65 and older:** Approximately 19% of the population
- **Working-age adults (25–64):** Majority of residents

### Why this matters:

An aging population increases demand for chronic disease management, transportation supports, caregiving services, and age-friendly healthcare and community infrastructure.

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## Race, Ethnicity & Gender

- Predominantly White population with smaller racial and ethnic minority groups
- Slightly higher proportion of females than males

### Why this matters:

While overall racial diversity is limited, equity-focused outreach remains important, as smaller populations may still experience disproportionate access barriers.

---

## Disability & Veterans

- **Disability prevalence:** Approximately 20% of residents, higher than Ohio and U.S. averages
- **Veteran population:** Approximately 8–9% of residents

### Why this matters:

Higher disability prevalence increases demand for accessible healthcare, transportation, supportive housing, and behavioral health services. Veterans may experience specialized behavioral health and chronic care needs.

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## Households & Families

- **Total households:** Approximately 17,000
- **Female-headed households with children:** Approximately 8%

### Why this matters:

Single-parent households face increased risk of economic instability, food insecurity, housing stress, and caregiver burden—factors closely linked to mental health and child well-being.

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## Key Takeaway

Highland County’s demographic profile—marked by population decline, aging trends, elevated disability prevalence, and household vulnerability—reinforces the importance of place-based, equity-focused strategies that address both health outcomes and health-related social needs.

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### Data Sources:

- U.S. Census Bureau. *Decennial Census (2010, 2020)*.
- U.S. Census Bureau. *American Community Survey (ACS) 5-Year Estimates*.
- U.S. Department of Veterans Affairs. *Veteran population estimates*.

### Notes:

- Population change reflects estimates since 2010.
- Disability prevalence includes individuals reporting one or more physical, cognitive, ambulatory, self-care, or independent living difficulties.
- Household and family characteristics are based on ACS estimates and may be subject to sampling variability in rural counties.

# Appendix C: Population Management and Improving Life Expectancy – Highland County

This appendix summarizes key opportunities for improving life expectancy and population health in Highland County based on findings from the Community Health Needs Assessment.

## Chronic Disease Prevention & Management

Chronic diseases account for a substantial share of mortality and disability in Highland County. Heart disease and cancer are the leading causes of death, with elevated prevalence of obesity, hypertension, diabetes, and tobacco use contributing to long-term disease burden.

**Priority focus:** Prevention, early detection, tobacco cessation, nutrition, physical activity, and chronic disease self-management.

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## Mental Health, Substance Use & Injury

Behavioral health conditions, substance use disorders, and injury contribute disproportionately to premature mortality. Elevated rates of depression, frequent poor mental health days, overdose risk, suicide, and unintentional injury highlight the need for coordinated behavioral health and prevention strategies.

**Priority focus:** Treatment access, recovery supports, crisis response, and injury prevention.

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## Maternal, Infant & Child Health

Early life health influences long-term outcomes. While some maternal and child health indicators align with state benchmarks, risk factors related to behavioral health, economic stress, and access barriers persist.

**Priority focus:** Prenatal care, early childhood development, and family-centered supports.

---

## Health Equity & Social Determinants

High levels of ALICE households, transportation barriers, disability prevalence, and social vulnerability influence life expectancy and health outcomes across the county.

**Priority focus:** Addressing health-related social needs through multisector collaboration.

- Household and family characteristics are based on ACS estimates and may be subject to sampling variability in rural counties.
- 

## Access to Care & Prevention

Provider shortages and preventable hospital utilization indicate ongoing access gaps.

**Priority focus:** Care coordination, workforce capacity, and transportation supports.

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Data Sources:

- Ohio Department of Health (ODH). *Ohio Public Health Information Warehouse*.
- County Health Rankings & Roadmaps. *Health Outcomes, Health Factors, and Mortality Indicators*.
- Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System (BRFSS)*.
- Centers for Medicare & Medicaid Services (CMS). *Health equity and utilization guidance*.

Notes:

- Priority action areas reflect triangulation of quantitative data, community survey results, and stakeholder input.
- Life expectancy and mortality indicators are influenced by both clinical and non-clinical factors, including economic stability, housing, transportation, and access to care.

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