



Board of Health Meeting

Tuesday, March 24, 2026

Agenda

Jagdish Bhati
Christopher Lewis, M.D.
Ken Patel

Mary Carol Burkhardt, M.D.
Santosh Menon, M.D.
Kiana Trabue

Jennifer Forrester, M.D.
Raynal Moore
Ashlee Young

6:00 pm – 6:05 pm Call to Order and Roll Call

Old Business

6:05 pm – 6:10 pm Review and Approval Minutes

- **Vote: Motion to Approve** the Minutes of February 24, 2026, Board of Health Meeting.

New Business

6:10 pm – 6:20 pm Finance Committee Update – Kiana Trabue

- **Vote: Motion to Approve** State of Ohio, Ohio Department of Development (ODO) 45x20609
- **Vote: Motion to Approve** Ohio Department of Health (ODH) 65x10852
- **Vote: Motion to Approve** People Working Cooperatively (PWC) 65x10853
- **Vote: Motion to Approve** American Heart Association 65x10855
- **Vote: Motion to Approve** Get Vaccinated Ohio Grant – Public Health Initiative 2024-2025 75x10851

6:20 pm – 6:30 pm Finance Update – Mr. Mark Menkhaus Jr.

- **Vote: Motion to Approve** LabCorp 65x10806

6:30 pm – 6:40 pm Personnel Actions – Dr. Grant Mussman

- **Vote: Motion to Approve** Personnel Actions dated March 24, 2026

6:40 pm – 6:50 pm Public Comments

7:00 pm Adjourn

Next Meeting April 28, 2026

Mission

To assure access to quality services and to improve community health and wellness.

CINCINNATI BOARD OF HEALTH
BOARD OF HEALTH MEETING
February 24, 2026

Ms. Ashlee Young, Chair of the Board of Health, called February 24, 2026, meeting of the Cincinnati Board of Health to order at 6:00 p.m.

I. ROLL CALL:

Board Members Attending: Mr. Jagdish Bhati, Dr. Mary Carol Burkhardt, Dr. Jennifer Forrester, Dr. Christopher Lewis, Ms. Raynal Moore, Mr. Ken Patel, Ms. Kiana Trabue, Ms. Ashlee Young

Absent: None

Others Present: Dr. Grant Mussman-Commissioner, Ms. Sa-Leemah Cunningham-Clerk, Dr. Maryse Amin, Mr. Ian Doig, Mr. Antonio Young, Mr. Mark Menkhaus Jr., Ms. Kim Wright, Dr. Camille Jones, Dr. Nick Taylor, Mr. John Kachuba, Mr. David Miller, Ms. Marla Fuller, Dr. Ashanti Salter, Dr. Michelle Daniels, Mr. Harry Barnes, Mr. Scott Besser

AGENDA PACKET → FEBRUARY-BOH-AGENDA-PACKET-2.24.26.PDF			
ITEM	TOPIC	RESPONSIBLE PARTY	ACTION/MOTION
Minutes	Motion that the Board of Health approves the minutes from January 27, 2026, Board of Health Meeting. <i>(Dr. Forrester and Dr. Lewis joined after this vote)</i>	Ms. Sa-Leemah Cunningham	Motion: Mr. Jagdish Bhati 2nd: Ms. Raynal Moore Action: 7-0 Passed
Old Business			
Introduction of New Board Member – Dr. Santosh Menon	Ms. Young welcomed new board member, Dr. Santosh Menon, to the Board. Ms. Young shared several background highlights about Dr. Menon. She noted that he was born in India and raised in New Jersey. She explained that he completed his Internal Medicine Residency at Robert Wood Johnson Medical School/St. Peter's Medical Center and later completed a Cardiology Fellowship at the University of Utah. Ms. Young also highlighted his advanced training in congestive heart failure and cardiac transplantation. She added that Dr. Menon currently serves as the Director of the Clinical Cardiology Service Line and Director of the Adult Cardiology Fellowship Program at The Christ Hospital. Dr. Menon thanked the Board for the opportunity to serve. He expressed his appreciation for being appointed and stated that he looks forward to	Ms. Ashlee Young	n/a

	contributing to the Board's work. Dr. Menon also shared his interest in expanding access to cardiovascular care and strengthening community-based prevention efforts.		
Commissioner's Report	Dr. Grant Mussman presented his commissioner's report to the Board. WIC Program Collaboration • Dr. Mussman explained that the Health Department has been working closely with Cincinnati Children's Hospital to improve several WIC program processes. • He noted that many aspects of the WIC program are mandated by the State of Ohio, which can make changes difficult; however, collaboration with partners has helped move improvements forward. Partnership with Cincinnati Children's Hospital • Dr. Mussman highlighted the work of Dr. Anig with Children's Hospital, who has been collaborating closely with the Health Department and the Ohio Department of Health. Through this partnership, considerable progress has been made in streamlining processes and making it easier and faster for individuals to submit information and register for WIC services. Technology Improvements in WIC Clinics • Dr. Mussman noted that one visible improvement resulting from this collaboration is the installation of public Wi-Fi in all WIC clinics. • He explained that Dr. Anig helped secure city alignment and funding to make Wi-Fi available to clients, allowing them to access and upload required documents more easily while at the clinics. Modernization of Application Processes • Dr. Mussman emphasized that the Wi-Fi implementation is just one part of the broader work being done by WIC staff and partners to modernize the application process and reduce barriers for participants. National Recognition • Dr. Mussman reported that an abstract highlighting these improvements has been accepted by the National WIC Association, and	Dr. Grant Mussman – Commissioner	n/a

	staff will be presenting the work during a 60-minute oral session at the national conference. The presentation will focus on the successes achieved in reducing bureaucratic barriers and improving access to WIC services. Closing Remarks and Staff Recognition • Dr. Mussman concluded by recognizing and commending the WIC staff for their dedication and innovation, noting that their efforts have made a meaningful impact in improving access for families in the community.		
COVID-19 Wastewater Sampling Study	Discussion Items: Presentation included in the agenda packet. Dr. Maryse Amin and Mr. Scott Bessler gave a presentation on COVID-19 Wastewater Sampling Study. Dr. Amin introduced Scott Bessler, Superintendent of the Compliance Services Division at MSD, and acknowledged his team's partnership in the study. Public Health Background & Study Overview (Dr. Amin) • During the COVID-19 pandemic, multiple surveillance methods were used: positivity rates, case counts, hospitalizations. • Ohio was able to implement wastewater surveillance statewide, enabling early detection of COVID-19 trends. • In Cincinnati, five treatment plants were monitored: Mill Creek treatment plant highlighted as covering ~600,000 people. • The study aimed to evaluate smaller populations (sub-sewersheds) to detect outbreaks before clinical cases appeared. Study Collaboration & Aims: • Partners: Metropolitan Sewer District (MSD), Ohio Department of Health (funding), CanDo (sampling technology), RJN and Limited Tech (collection). • Objectives: ○ Assess feasibility and effectiveness of monitoring in socially/economically diverse sub-sewersheds. ○ Compare traditional lab testing vs. real-time analysis (GeneXpert). Study Design:	Dr. Maryse Amin and Mr. Scott Bessler	n/a

- Four neighborhoods were studied, varying in vaccination rates and social vulnerability.
- Collection sites: 15 total; sampling conducted twice weekly.
- Time periods: April–June 2023 (low prevalence), October 2023–February 2024 (high prevalence).
- Sampling method: Devices placed in manholes to collect 24-hour wastewater samples.

Key Findings (Dr. Amin)

- Treatment plant-level detection occurred slightly earlier than sub-sewershed-level detection.
- Variation observed among individual collection sites within neighborhoods, indicating localized outbreak detection potential.
- Rapid PCR (GeneXpert) testing closely aligned with laboratory results and occasionally showed higher sensitivity.
- High prevalence months (fall/winter) showed higher concentrations in sub-sewersheds.
- No consistent correlation is found between social vulnerability and COVID-19 wastewater concentrations.
- Challenges: High costs of manual sample collection and analysis.
- Future applications: Surveillance of Norovirus, RSV, Influenza A/B, antimicrobial resistance, and illicit drug monitoring.

Questions from Board Members:

- Dr. Bhati asked whether higher detection peaks with GeneXpert were confirmed as more accurate; Dr. Amin indicated findings support this but offered to verify.

Water Quality Perspective (Mr. Scott Bessler)

- Introduced himself as a “sewer sleuth,” emphasizing how wastewater reflects human behavior, industrial activity, and weather patterns.
- Monitored 15 sites in two large treatment plant areas for water quality parameters: pH, oxidative-reductive potential (ORP), conductivity, and temperature.
- Detected an industrial discharge from a dye manufacturer exceeding permitted copper and molybdenum levels.

	• Video and images demonstrated the impact of acidic discharge on sewer infrastructure, including pitting and erosion over time. • Highlighted cost-benefit: Preventative action (pipe lining) is far less expensive than catastrophic sewer failures (~\$2M+). Key Takeaways: • Wastewater monitoring provides actionable data for both public health interventions and infrastructure protection. • Early identification of industrial discharges prevents infrastructure damage and costly repairs. Closing Remarks (Dr. Amin & Mr. Bessler) • Dr. Amin referenced the published article included in board materials and a short video demonstrating the technology and collection process. • Acknowledged the collaboration of multiple partners in completing the study.		
New Business			
Finance Committee	Discussion Items: Documents included in the agenda. Ms. Kiana Trabue presented the contracts that were discussed and presented at the Board of Health Finance Committee Meeting to the Board. Motion to Approve Hamilton County Public Health, 1st Amendment– Contract 55x10741. Motion to Approve Hamilton County Public Health (Dollars for Dentures Program)– Contract 65x10848. Motion to Approve Ohio Department of Health – Contract 65x10849. Motion to Approve Housing and Urban Development – Contract 65x10850.	Ms. Kiana Trabue	Vote: Contract 55x10741 Motion: Mr. Jagdish Bhati 2nd: Dr. Jennifer Forrester Action: 9-0 passed Vote: Contract 65x10848 Motion: Ms. Raynal Moore 2nd: Ms. Ashlee Young Action: 9-0 passed Vote: Contract 65x10849 Motion: Dr. Jennifer Forrester 2nd: Ms. Raynal Moore Action: 9-0 passed Vote: Contract 65x10850 Motion: Mr. Jagdish Bhati 2nd: Dr. Mary Carol Burkhardt Action: 9-0 passed
Finance Update	Discussion Items: Memo and materials were included in the agenda. Mr. Menkhaus gave an update on CHD Financials for January 2026 and Year over Year.	Mr. Mark Menkhaus Jr.	n/a

	Highlights - Revenue total was \$42,586,515.87; increased by 23.37%. - Private Pay Insurance increased by 19.91%. - Medicare increased by 17.61%. - Medicaid increased by 187.01%. - Medicaid managed care increased by 13.88%. - Self-Pay patients increased by 17.42%. - Board of Ed Svcs (School Nurse's Salary) decreased by 82.58%. - Grants/Federal decreased by 30.71%. - Expenses were \$38,595,188.55, increasing by 5.16%. - Property expenses increased by 205.72%. - Personnel expenses increased by 6.31%. - Contractual costs decreased by 5.99%. - Material costs decreased by 7.99%. - Fixed costs decreased by 7.02%. - Fringes increased by 3.89%. The available total is \$3,991,327.32 which increased by 28.79%.		
Personnel Actions	- Dr. Mussman directed the Board to the personnel actions included in the board packet. - Personnel actions included 2 Environmental Health Specialists-in-Training 1 Promotion to Senior Epidemiologist Motion to Approve the personnel actions dated February 24, 2026	Dr. Grant Mussman	Motion: Mr. Jagdish Bhati 2nd: Dr. Mary Carol Burkhardt Action: 9-0 passed
Additional New Business and Public Comments	Ms. Young announced that board clerk Sa-Leemah Cunningham is transitioning to a new role within the organization and that this meeting marks her last day clerking for the board. Ms. Young expressed gratitude for Shalima's contributions in organizing meetings and ensuring smooth operations. The board members all Wished her the best in her new role, noting that while the board is sad to see her leave her clerk position, they are pleased she will remain with the organization in a different capacity. Ms. Cunningham expressed her appreciation to the board and thanked the board. Public Comments There were no public comments.	Ms. Ashlee Young	n/a

7:08 p.m. adjourned.

Next meeting: Tuesday, March 24, 2026, at 6pm, via Zoom.

Meeting can be viewed at:

Minutes Approved by:

Sa-Leemah Cunningham
Cincinnati Board of Health Clerk

Ashlee Young
Chairperson, Board of Health

[illegible]

	Present	Yay	Nay	Absent	Didn't vote but present	Move	Second
X						M	2nd

[illegible]

Dr. Grant Mussman-Commissioner

Sa-Leemah Cunningham (clerk)

Antonio Young

Ian Doig

Mark Menkhaus Jr.

Dr. Camille Jones

Dr. Ashanti Salter

Dr. Michelle Daniels

Kim Wright

Dr. Maryse Amin

Mr. Scott Bessler - MSD

Harry Barnes

Dr. Nick Taylor

John Kachuba

Marla Fuller

Joyce Tate

City of Cincinnati Board of Health Finance Committee

Kiana Trabue, Chair of the Board of Health Finance Committee, called the Tuesday, March 17, 2026 Finance Committee meeting to order at 5:03 pm

Roll Call

Members present: Kiana Trabue, Jagdish Bhati, Dr. Camille Jones, John Kachuba, Mark Menkhaus Jr., Dr. Grant Mussman, and Joyce Tate

Topic	Discussion	Action/Motion
Approval of Minutes	The Chair asked Committee members if everyone had the opportunity to review the minutes from February 17, 2026. <u>Motion:</u> That the Board of Health (BOH) Finance Committee approves the minutes from February 17, 2026.	Motion: Mr. Kachuba Second: Ms. Tate Action: Passed
Review of Contracts for BOH Approval:	Ms. Trabue began reviewing contracts going to BOH for approval. State of Ohio, Ohio Department of Development (ODO) 45x20609 Dr. Amin presented on the Second Amendment contract with the Ohio Department of Development for lead abatement and safe housing. The contract includes an additional \$200,000 for community work to be completed by June. Motion: That the BOH Finance Committee recommends approval. Ohio Department of Health (ODH) 65x10852 Ms. Tate explained the \$15,000 grant from the Ohio Department of Health for smoking cessation services. Dr. Jones asked about participation in the required meetings and the submission of reports. Mr. Menkhaus clarified that the packet includes an information sheet noting that the grant ordinance was approved on February 11, 2026. Motion: That the BOH Finance Committee recommends approval. People Working Cooperatively (PWC) 65x10853 Dr. Amin outlined the grant agreement with HUD for the Lead-Safe Housing program, highlighting the role of People Working Cooperatively in supporting intake and inspection activities. The contract includes \$150,000 to be used over the life of the grant. Ms. Trabue asked whether there are specific deliverables tied to the funding or if the amount is primarily intended to cover staffing costs for People Working Cooperatively. Dr. Amin clarified that the main deliverables are related to intake, with a set payment tied to each completed application. She noted that HUD applications require extensive supporting documentation, and the partner	Motion: Mr. Bhati Second: Dr. Jones Action: Passed Motion: Mr. Bhati Second: Dr. Jones Action: Passed Motion: Mr. Bhati Second: Ms. Tate Action: Passed

	organization will help ensure those requirements are met. Each completed application will count as a deliverable. Dr. Amin added that People Working Cooperatively could also assist with inspections, such as conducting in-home risk assessments to identify lead hazards, if additional support is needed. Dr. Jones noted that this partnership has been in place for many years and has proven to be effective. Motion: That the BOH Finance Committee recommends approval. American Heart Association 65x10855 Ms. Tate presented a \$2,000 grant from the American Heart Association for cardiovascular health education. The grant has been a long-standing partnership, and resources from previous years are still being used. Motion: That the BOH Finance Committee recommends approval. Get Vaccinated Ohio Grant – Public Health Initiative 2024-2025 75x10851 Maryse Amin explains the \$285,000 grant from the Get Vaccinated Ohio Grant for public health initiatives. The grant supports educating providers, working in schools, and vaccinations. Motion: That the BOH Finance Committee recommends approval.	Motion: Mr. Bhati Second: Dr. Jones Action: Passed Motion: Mr. Bhati Second: Mr. Kachuba Action: Passed
Review of Contracts for BOH Information:	N/A	
Financial Update	Mr. Menkhaus provided an overview of the financial statement for the period ending in February 2026. Total Revenue at the end of February was \$47,104,900.32. Which is a 7.24% increase from February of 2026. Expenses as of February 2026 totaled \$43,665,170.08 which is a 3.13% increase from February 2026. Total net gain after the capital revenue transfer was \$5,382,730.24 Total Expenses: 7100 - Personnel increased by 5.3%. 7500-Fringes saw a corresponding increase of 3.17%. The increase is attributed to the increase in the employer contribution retirement rate (this increased from 19.79% to 23.83%). This is also attributable to the 5% COLA all AFSCME employees received at the end of September. AFSCME also received a one-time payment of \$1,500. This one-time payment totaled \$415,500 for the Health Department. 7200 - Contractual Services saw a decrease of 5.29% (5.99% decrease in January), and 7300 - Materials & Supplies decreased by 13.85% (7.99% increase in January). The differences are due to the timing of invoices paid. In FY26 we	

	paid temporary service vendors \$151,259.05 as of February, yet in FY25 we paid \$356,286.57 as of February. In FY26 we paid Cardinal Health \$1,312,934.68 (no change from January) as of February, yet in FY25 we paid Cardinal Health \$1,450,157.95 as of February. We also expensed \$500,000 to Greater Cincinnati Community Shares in FY26, this was not an expense in FY25. • 7400 - Fixed Costs increased by 11.71% (7.02% increase in January). The increase is the timing of invoices paid. In FY26 we paid Ochin \$1,490,657.38 as of February, yet in FY25 we paid Ochin \$1,239,054.50 (no change from January) as of February. We also expensed \$77,168 to Hamilton County in FY26, but in FY25 we expensed \$104,929. • 7600 - Property increased by 116.50% (205.72% increase in January). The increase is due to the renovation at the Price Hill Clinic and the sink hole at the Bobbie Sterne parking lot. Total Available: \$5,382,730.24	
New Business	N/A	
Public Comment	Mrs. Mitchell stated that as of 5 p.m. today, no questions or comments from the public were received.	

Meeting Adjourned: 5:28 pm

Next Meeting: **Tuesday, April 21, 2026, 5 p.m.**

Minutes prepared by Shurdina Mitchell

The meeting can be viewed and is incorporated in the minutes: <https://fb.watch/pD-N3kOzkN/>

Board of Health Finance Committee Roll Calls for March 17, 2026:

	Roll Call	Minutes	State of Ohio, Ohio Department of Development (ODoD) 45x20609	Ohio Department of Health (ODH) 65x10852	People Working Cooperatively (PWC) 65x10853	American Heart Association 65x10855	Get Vaccinated Ohio Grant – Public Health Initiative 2024-2025 75x10851
Mr. Jagdish Bhati	Y	Y	MY	MY	MY	MY	MY
Dr. Camille Jones	Y	Y	2Y	2Y	Y	2Y	Y
Mr. John Kachuba	Y	MY	Y	Y	Y	Y	2Y
Mr. Mark Menkhaus Jr.	Y	Y	Y	Y	Y	Y	Y
Dr. Grant Mussman	Y	Y	Y	Y	Y	Y	Y
Ms. Joyce Tate	Y	2Y	Y	Y	2Y	Y	Y
Ms. Kiana Trabue	Y	Y	Y	Y	Y	Y	Y

Y = Yes | N = No | A = Abstain | P = Present | R = Recuse | M = Moved | 2 = Second

Others present: Shurdina Mitchell (Clerk) Dr. Maryse Amin, and Dr. Ashanti Salter

Preparation Date March 11, 2026

CINCINNATI HEALTH DEPARTMENT CONTRACT AND GRANT INFORMATION SHEET

This information must be supplied to the Contract Liaison no less than one week prior to the Board of Health meeting.

Vendor	State of Ohio, Ohio Department of Development (ODoD)		
Contract #	45x20609 – 1st Amendment		
Person and Division responsible for administering contract/grant/lease:			
Initiator Person & Phone #	Maryse Amin, 513-357-7273		
Division Head & Phone #	Maryse Amin, 513-357-7273		
Division	Health (Lead)		
Type of Contract/Agreement	☐ Accounts Payable	☒ Accounts Receivable	
	☐ Service Contract (no \$)	☐ Lease	
Funding Source	☐ General Fund	☒ Grant Fund	☐ Other Funding
Action Required:	☒ Board Approval	☐ Board Information	

CONTRACT DOLLAR AMOUNT

Original Amount	<u>\$2,000,000</u>
1 st Amendment Amount	<u>-\$1,000,000</u>
2 nd Amendment Amount	<u>\$200,000</u>
Total Amount	<u>\$1,200,000</u>

TERM

Original Term	Start Date	<u>12/1/23</u>	End Date	<u>4/30/26</u>
1 st Amendment Term	Start Date	<u>12/1/23</u>	End Date	<u>4/30/26</u>
2 nd Amendment Term	Start Date	<u>12/1/23</u>	End Date	<u>8/31/26</u>

EXECUTIVE SUMMARY

The City of Cincinnati Health Department (CHD) has been Awarded \$2 million in grant funds through the State and Local Fiscal Recovery Funds (SLFRF) program. CHD wishes to enter into an agreement with the State of Ohio, Department of Development (ODD), to use the funding for lead-safe renovations, lead abatement and mitigation activities, and purchase of equipment such as XRF analyzers and HEPA-vacs.

The 1st amendment decreases the award amount by \$1,000,000.

The 2nd amendment increases the award amount by \$200,000 and extends the term by four (4) months.

Preparation Date February 19, 2026

CINCINNATI HEALTH DEPARTMENT CONTRACT AND GRANT INFORMATION SHEET

This information must be supplied to the Contract Liaison no less than one week prior to the Board of Health meeting.

Vendor **Ohio Department of Health (ODH)**

Contract # **65x10852**

Person and Division responsible for administering contract/grant/lease:

Initiator Person & Phone # **David Miller, 513-357-7357**

Division Head & Phone # **David Miller, 513-357-7357**

Division **Health**

Type of Contract/Agreement ☐ Accounts Payable ☒ Accounts Receivable

☐ Service Contract (no \$) ☐ Lease

Funding Source ☐ General Fund ☒ Grant Fund ☐ Other Funding

Action Required: ☒ Board Approval ☐ Board Information

CONTRACT DOLLAR AMOUNT

Original Amount **\$15,000**

TERM

Original Term Start Date **November 1, 2025** End Date **June 30, 2026**

EXECUTIVE SUMMARY

The Cincinnati Health Department (CHD) has been awarded a \$15,000 grant from the Ohio Department of Health (ODH) to participate in the ODH Tobacco Cessation Project (DOH57303 Addressing Nicotine Use in Community Health Centers).

This award is made contingent upon the following conditions being met:

	Expectation	Proof for Payment	Amount	Timeline
1	Participate in Initial Assessment with OACHC	Signed Letter of Commitment	\$1,000 (one-time)	12/30/25
2	Participate in Kick Off Meeting	1 Meeting	\$1,500 (one-time)	12/30/2025

3	Develop Implementation Plan with OACHC	1 Plan	\$2,000 (one time)	1/31/2026
4	Participate in Provider Trainings	2 Trainings	\$2,000 per training \$4,000 total	01/01/26 - 06/30/26
5	Participate in Monthly Calls with OACHC	6 meetings	\$250 per monthly call \$1,500 total	10/01/25-06/30/26
6	Submit Data Quarterly to OACHC	4 Data Reports	\$1,250 per report \$5,000 total	10/01/25-06/30/26
		Total:	\$15,000 per FQHC	November 1, 2025 - June 30, 2026

The term begins on November 1, 2025, and ends on June 30, 2026. Grant Ordinance No. 34-2026 was approved on February 11, 2026.

Preparation Date March 2,2026

CINCINNATI HEALTH DEPARTMENT CONTRACT AND GRANT INFORMATION SHEET

This information must be supplied to the Contract Liaison no less than one week prior to the Board of Health meeting.

Vendor People Working Cooperatively (PWC)

Contract # **65x10853**

Person and Division responsible for administering contract/grant/lease:

Initiator Person & Phone # **Gina Britton, 513-357-7368**

Division Head & Phone # **Maryse Amin, 513-357-7273**

Division **Health**

Type of Contract/Agreement	X	Accounts Payable	Accounts Receivable
----------------------------	----------	------------------	---------------------

Service Contract (no \$)	Lease
--------------------------	-------

Funding Source	General Fund	X	Grant Fund	Other Funding
----------------	--------------	---	------------	---------------

Action Required:	X Board Approval	Board Information
------------------	-------------------------	-------------------

CONTRACT DOLLAR AMOUNT

Original Amount	\$150,000
-----------------	-----------

TERM

Original Term	Start Date	3/2/2026	End Date	3/1/2030
---------------	------------	-----------------	----------	-----------------

EXECUTIVE SUMMARY

This agreement between People Working Cooperatively (PWC) and the Cincinnati Health Department (CHD) Childhood Lead Poisoning Prevention Program establishes the delivery of Lead Hazard Control (LHC) services, including intake, enrollment, lead inspections, and risk assessments. Funding for this agreement will be provided through CHD's Lead Hazard Control grant awarded by the Housing and Urban Development (HUD).

The contract becomes effective upon execution and ends on March 1, 2030.

Preparation Date March 10, 2026

CINCINNATI HEALTH DEPARTMENT CONTRACT AND GRANT INFORMATION SHEET

This information must be supplied to the Contract Liaison no less than one week prior to the Board of Health meeting.

Vendor **American Heart Association**

Contract # **65x10855**

Person and Division responsible for administering contract/grant/lease:

Initiator Person & Phone # **Joyce Tate, 513-357-7361**

Division Head & Phone # **Joyce Tate, 513-357-7361**

Division **Health**

Type of Contract/Agreement ☐ Accounts Payable ☒ Accounts Receivable

☐ Service Contract (no \$) ☐ Lease

Funding Source ☐ General Fund ☐ Grant Fund ☐ Other Funding

Action Required: ☒ Board Approval ☐ Board Information

CONTRACT DOLLAR AMOUNT

Original Amount **\$2,000**

TERM

Original Term Start Date **February 6, 2026** End Date **June 30, 2026**

EXECUTIVE SUMMARY

The Cincinnati Health Department has received a grant in the amount of \$2,000 from the American Heart Association. Outpace CVD, American Heart Association's Ambulatory Quality Improvement Program, is designed to input data, track results, and help provide evidence-based science to lower the risk of death and disability caused by cardiovascular disease, such as hypertension, diabetes, and cholesterol. The funds can support quality improvement and/or health interventions.

Preparation Date February 19, 2026

CINCINNATI HEALTH DEPARTMENT CONTRACT AND GRANT INFORMATION SHEET

This information must be supplied to the Contract Liaison no less than one week prior to the Board of Health meeting.

Vendor **Get Vaccinated Ohio Grant – Public Health Initiative 2024-2025**

Contract # **75x10851**

Person and Division responsible for administering contract/grant/lease:

Initiator Person & Phone # **Elizabeth Gay, 513-352-2901**

Division Head & Phone # **Maryse Amin, 513-357-7273**

Division **Community Health and Environmental Services**

Type of Contract/Agreement ☐ Accounts Payable ☒ Accounts Receivable

☐ Service Contract (no \$) ☐ Lease

Funding Source ☐ General Fund ☒ Grant Fund ☐ Other Funding

Action Required: ☒ Board Approval ☐ Board Information

CONTRACT DOLLAR AMOUNT

Original Amount **\$288,535**

TERM

Original Term Start Date **7/1/2026** End Date **6/30/2027**

EXECUTIVE SUMMARY

Get Vaccinated OHIO- Public Health Initiative (GV) Sub-grant 2026-2027

The Get Vaccinated Ohio Project is a state funded competitive grant designed to support activities that will improve and sustain immunization rates in children under two years of age, school aged children and adolescents. Grant activities will include immunization assessment, targeted reminder/recall, educational activities involving families and providers, assuring schools report vaccination rates, daycare/preschool and school immunization education, vaccine preventable disease outbreak planning, and developing and implementing a communication plan that raises awareness of the importance of pediatric and adolescent immunizations and increases community engagement. The Project's focus is on expanding education (peer-to-peer, family and community), assessment activities and reminder/recall. The Project provides peer-to-peer education utilizing the Maximizing Office Based Immunization (MOBI) program, Teen

Immunization Education Session (TIES) and immunization assessment services utilizing the CDC tool: Immunization Quality Improvement for Providers (IQIP) program within the local health department.

The outcome measure for this grant is to achieve and maintain the Centers for Disease Control (CDC) National Immunization Rate of 90% for **two-year-old children** and 80% for **adolescents**. In 2025, CHD health centers achieved 86-96% immunization rate for children by age two. This exceeds the 2023 Ohio rate of 71%. The CHD health centers achieved 89%-100% adolescent rates for **13-year-old** for the following vaccines: HPV #1, Meningococcal, and Tdap. The 2023 **Up-to-Date HPV** Ohio rate is 67.3% and CHD is 56%-88%. In 2025, of practices assessed in the public/private community, immunization rates for two-year-old children at individual offices were between 19%-100% with an HPV up to date range of 14%-56%. Through community outreach, education and assessment in the public and private sector, the GV team will work with community providers within the region to increase the community rates until 90% of children are immunized by age two and 80% for adolescents.



DATE: March 17, 2026

TO: City of Cincinnati Board of Health Finance Committee

FROM: Mark Menkhaus, Jr., CFO

SUBJECT: Fiscal Presentation 2026

FINANCIAL STATEMENTS REVIEW FOR THE FISCAL YEAR 2026 – FEBRUARY

2026 February Highlights:

- Revenue at the end of February was \$47,104,900.32. Which is a 7.24% increase from February of 2026. Expenses as of February 2026 totaled \$43,665,170.08 which is a 3.13% increase from February 2026. Total net gain after the capital revenue transfer was \$5,382,730.24.

Year over Year:

- As of February, we had \$95,801.08 in overtime compared to February of 2025's total of \$108,848.46. Neither year as of February had any disaster overtime.
- We received an additional capital revenue transfer in the amount of \$1,786,000 in the month of December. The FY26 total amount is \$1,943,000. In FY25 we received a total of \$2,187,000.
- 7100-Personnel increased by 5.3%. 7500-Fringes saw a corresponding increase of 3.17%. The increase is attributed to the increase in the employer contribution retirement rate (this increased from 19.79% to 23.83%). This is also attributable to the 5% COLA all AFSCME employees received at the end of September. AFSCME also received a one-time payment of \$1,500. This one-time payment totaled \$415,500 for the Health Department.
- 7200- Contractual Services saw a decrease of 5.29% (5.99% decrease in January), and 7300- Materials & Supplies decreased by 13.85% (7.99% increase in January). The differences are due to the timing of invoices paid. In FY26 we paid temporary service vendors \$151,259.05 as of February, yet in FY25 we paid \$356,286.57 as of February. In FY26 we paid Cardinal Health \$1,312,934.68 (no change from January) as of February, yet in FY25 we paid Cardinal Health \$1,450,157.95 as of February. We also expensed \$500,000 to Greater Cincinnati Community Shares in FY26, this was not an expense in FY25.
- 7400-Fixed Costs increased by 11.71% (7.02% increase in January). The increase is the timing of invoices paid. In FY26 we paid Ochins \$1,490,657.38 as of February, yet in FY25 we paid Ochins \$1,239,054.50 (no change from January) as of February. We also expensed \$77,168 to Hamilton County in FY26, but in FY25 we expensed \$104,929.
- 7600-Property increased by 116.50% (205.72% increase in January). The increase is due to the renovation at the Price Hill Clinic and the sink hole at the Bobbie Sterne parking lot.

Cincinnati Board of Health Financial Statement for the period of February

	FY26 Actual	FY25 Actual	Variance
Revenue			
8236-Pools/Spa	\$3,151.25	\$1,642.50	91.86%
8237-Household Sewage System	\$40,055.00	\$43,343.00	-7.59%
8239-Tatto/ Body, Environmental Waste License Fee	\$18,850.00	\$42,071.00	-55.19%
8241-Food Service (Mobile-Temporary)	\$56,882.00	\$54,467.44	4.43%
8242-Vending Machine Licenses	\$98.43	\$94.08	4.62%
8244-Food Establishments	\$56,053.50	\$121,060.25	-53.70%
8249-Food, NOC	\$55,947.25	\$37,028.95	51.09%
8432-Vending Machine Proceeds	\$0.00	\$0.00	0.00%
8536-Grants\State	\$1,529,664.35	\$754,330.83	102.78%
8556-Grants\Federal	\$5,607,597.81	\$7,895,843.61	-28.98%
8563-Bd of Ed Svc (School Nurses Sal.)	\$304,330.12	\$1,747,068.61	-82.58%
8564-Ham Co Service	\$102,533.32	\$88,959.51	15.26%
8571-Specific Purpose\Private Org.	\$6,000.00	\$151,097.86	-96.03%
8617-Non-Department Fringe Benefit Reimbursement	\$1,563.10	\$1,236.01	26.46%
8618-Overhead Charges Indirect Costs	\$60,700.00	\$61,340.00	-1.04%
8731-Birth & Death Certificates	\$358,492.56	\$356,255.50	0.63%
8732-Vital Stats - Other	\$5,523.33	\$6,342.27	-12.91%
8733-Self-Pay Patient	\$623,037.46	\$606,172.26	2.78%
8734-Medicare	\$4,042,952.79	\$3,402,903.52	18.81%
8736-Medicaid	\$10,458,355.77	\$8,526,711.72	22.65%
8737-Private Pay Insurance	\$885,123.06	\$781,043.02	13.33%
8738-Medicaid Managed Care	\$6,106,149.43	\$5,540,498.57	10.21%
8739-Misc. (Medical rec.\smoke free inv.)	\$606,374.73	\$1,274,011.32	-52.40%
8784-Private Lot Litter & Weed	\$0.00	\$0.00	0.00%
8811-Unclaimed Remains	\$5,572.00	\$0.00	0.00%
8914-Bond/Note Proceeds	\$1,786,000.00	\$0.00	0.00%
8917-Deferred Sewer Assessment Collections	\$0.00	\$226.60	-100.00%
8932-Prior Year Reimbursement	\$54,629.32	\$185,076.65	-70.48%
% That is attributable from 416	<u>\$14,329,263.74</u>	<u>\$12,247,883.58</u>	<u>16.99%</u>
Total Revenue	\$47,104,900.32	\$43,926,708.66	7.24%
Expenses			
71-Personnel	\$23,848,750.56	\$22,648,265.22	5.30%
72-Contractual	\$5,534,761.63	\$5,844,055.24	-5.29%
73-Material	\$2,641,568.33	\$3,066,344.05	-13.85%
74-Fixed Cost	\$1,576,964.88	\$1,411,708.59	11.71%
75-Fringes	\$9,393,313.36	\$9,104,809.91	3.17%
76-Property	<u>\$669,811.32</u>	<u>\$262,768.19</u>	<u>154.91%</u>
Total Expenses	\$43,665,170.08	\$42,337,951.20	3.13%
Net Gain (Losses)	\$3,439,730.24	\$1,588,757.46	116.50%
8936-Transfer	<u>\$1,943,000.00</u>	<u>\$2,187,000.00</u>	
Total Available	\$5,382,730.24	\$3,775,757.46	42.56%

Preparation Date March 10, 2026

CINCINNATI HEALTH DEPARTMENT CONTRACT AND GRANT INFORMATION SHEET

This information must be supplied to the Contract Liaison no less than one week prior to the Board of Health meeting.

Vendor **LabCorp**

Contract # **65x10806 – 1st Amendment**

Person and Division responsible for administering contract/grant/lease:

Initiator Person & Phone # **Yury Gonzales, 513-357-7281**

Division Head & Phone # **Grant Mussman, 513-357-7215**

Division **Health**

Type of Contract/Agreement ☒ Accounts Payable ☐ Accounts Receivable

☐ Service Contract (no \$) ☐ Lease

Funding Source ☐ General Fund ☐ Grant Fund ☒ Other Funding

Action Required: ☒ Board Approval ☐ Board Information

CONTRACT DOLLAR AMOUNT

Original Amount **\$1,612,500**

Amendment Amount **\$1,075,000**

Total Amount **\$2,687,500**

TERM

Original Term Start Date **Upon execution** End Date **March 30, 2026**

Amendment Term Start Date **Upon execution** End Date **September 30, 2026**

EXECUTIVE SUMMARY

This is an agreement between CHD and LabCorp to provide laboratory services to CHD patients. Clinical and anatomic laboratory testing includes but is not limited to analysis in the areas of clinical chemistry, hematology, serology, microbiology, cytogenetics, immunology, endocrinology, toxicology, histology, mycology, virology, cytology, and urinalysis.

An emergency purchase request was approved on 7/3/25. The specifications and supporting documents for a new RFP are currently being revised by CHD staff.

The 1st amendment extends the agreement by 6 months and adds \$1,075,000 to the original amount.



Date: 3/24/2026

To: MEMBERS of the BOARD of HEALTH

From: Grant Mussman, MD MHSA, Health Commissioner

Copies: Leadership Team, HR File

Subject: PERSONNEL ACTIONS for March 24, 2026 BOARD of HEALTH MEETING

NON-COMPETITIVE APPOINTMENT –pending EHS and/or background check

JANASIA DEPRIEST

DENTAL ASSISTANT

CCPC

(Promotional vacancy)

Salary Bi-Weekly Range:

\$2,154.85 - \$2,276.35

General Fund

Janasia DePriest graduated from a dental assistant program in 2019 from ATA College. She has worked at Aspen Dental for 6 year and has experience working in pediatrics and general dentistry. Ms. DePriest is a graduate of Oyler School and is familiar with the school-based dental program. She is the lead dental assistant at Aspen where she trains new assistants, orders supplies and ensures the office is running smoothly. She is eager and open to learning dental at an FQHC and we think she will be a great asset to the Cincinnati Health Department dental program.

JASMYN DURGAN

DENTAL ASSISTANT

CCPC

(Resignation vacancy)

Salary Bi-Weekly Range:

\$2,154.85 - \$2,276.35

Grant

Jasmyn Durgan graduated from a dental assistant program in 2020 from Fortis College. She has worked at several dental locations including Aspen Dental and PDS Health and has experience working in pediatrics and general dentistry. Ms. Durgan has experience utilizing EPIC wisdom, our electronic dental record and is also a Dental Assistant instructor, teaching dental assistant students. She is eager and open to learning dental at an FQHC and we think she will be a great asset to the Cincinnati Health Department dental program.

TAYLOR MORGAN

PHARMACY TECHNICIAN

CCPC

(Resignation)

Salary Bi-Weekly Range:

\$2,125.29 - \$2,231.39

General Fund

Taylor is a Registered Certified Pharmacy Technician. She joins us from our Temp Agency Rockglade, where she has served as a Certified Pharmacy Technician since January in various capacities. Her references highlight her strong customer service, excellent attendance, organizational abilities, and experience in clinical services. We are pleased to welcome her to the City's Pharmacy Program, where she will undoubtedly be an asset to our team.

PERSONNEL ACTIONS for March 24, 2026 , BOARD of HEALTH MEETING
Page 2 of 2

PROMOTIONS

ASHISH BUDEV SR. ENVIRONMENTAL HEALTH SPECIALIST CHES

(Promotional vacancy)

Salary Bi-Weekly Range: \$3,036.30 - \$3,142.55 General Fund

Ashish Budev is an experienced Environmental Health Specialist with more than 15 years of service in the Cincinnati Health Department, specializing in lead hazard investigations, Healthy Homes assessments, and public health compliance. Proven expertise in conducting inspections, writing technical reports, managing HUD-funded projects, performing PIRAs, and coordinating complex remediation work with property owners, contractors, and legal partners. He holds multiple ODH certifications, including Lead Risk Assessor and Lead Contractor/Supervisor. He is known for strong communication, problem-solving, and project-management skills, with a commitment to protecting community health and advancing environmental safety.

CHRISTINA DECK HEALTH CLINIC COORDINATOR CCPC

(Other)

Salary Bi-Weekly Range: \$2,706.55 - \$3,637.38 General Fund

The CCPC division wishes to promote Christina Deck to the position of Health Clinic Coordinator. Christina has been a Casework Associate with the department since June 2023. She has been responsible for many tasks including: participating in outreach and local health fairs, providing health insurance enrollment assistance to residents and developing training tools for new Casework Associates. Christina has also volunteered to assist with other CCPC projects. Her skills, knowledge, and commitment will be an asset to the CCPC Operations Team.

ALLISON FAY WIC PROGRAM COORDINATOR WIC PROGRAM

(Promotional vacancy)

Salary Bi-Weekly Range: \$2,706.55 - \$3,637.38 Grant Fund

Allison Fay has been selected for the vacant WIC Coordinator position. She brings with her experience from years of working at the State level of Kentucky WIC as well as currently being a site manager for Ohio WIC. She earned her IBCLC in lactation and breastfeeding support December 2025. She believes in the WIC program and the support that is provided to women, infants and children through nutritious foods, education, referrals and breastfeeding support.

DATE: March 17, 2026

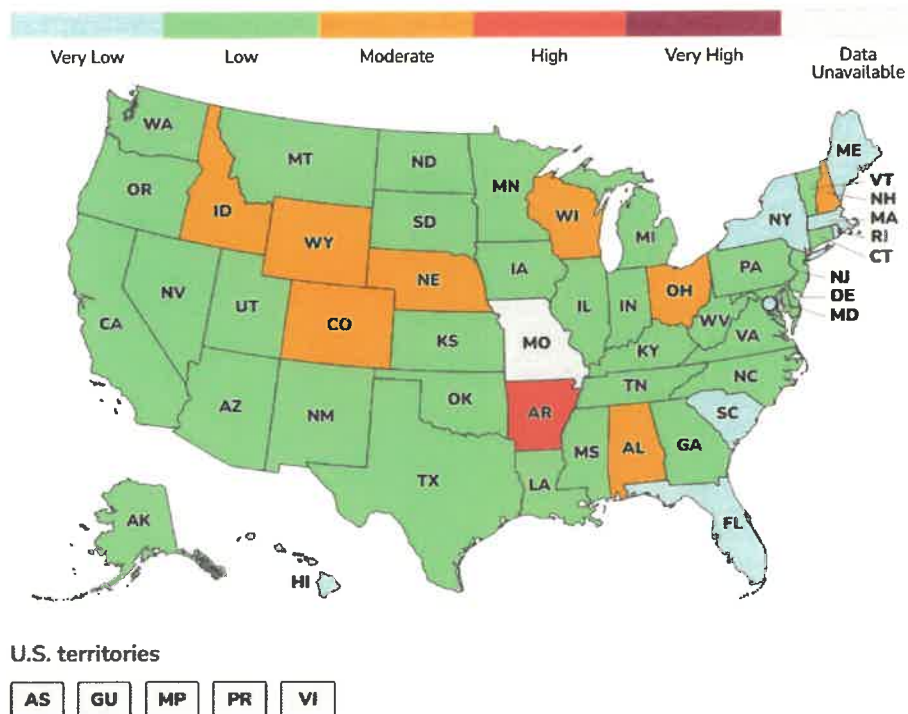
TO: Cincinnati Health Department Board of Health

FROM: Kim Wright, Supervising Epidemiologist Communicable Disease Prevention and Control - CHES

SUBJECT: March 2026 What's Bugging Us Report

Seasonal Respiratory Virus Activity Continues

Acute Respiratory Illness



National Activity

As of March 13, 2026, and reported on [CDC website](#):

- The amount of acute respiratory illness causing people to seek health care is low.
- RSV activity is elevated and increasing in some regions of the country.
- Overall seasonal influenza activity remains elevated nationally but is decreasing in most areas of the country. Influenza A activity continues to decrease while trends in influenza B activity vary by region.
- COVID-19 activity is decreasing nationally but elevated in some areas of the country.

- Influenza: Emergency department visits continue to decrease but remain highest among children 5-17 years old.
- Hospitalization trends continue to decrease overall but are highest among those 65 years and older.
- RSV: Emergency department visits for RSV are elevated among infants less than 1 and children 1-4 years old. Hospitalizations for RSV are highest among infants less than 1 year old.
- COVID-19: Emergency department visits for COVID-19 are elevated among infants less than 1 year old. Hospitalizations for COVID-19 are at low levels in all age groups.
- Deaths associated with COVID-19 (0.7%) and influenza (1.2%) are low. Deaths associated with RSV (0.0%) are very low.
- There has been a total of 90 (66) pediatric deaths associated with influenza reported nationwide. Among those eligible to be vaccinated, CDC is reporting approximately 85% (90%) of reported pediatric deaths so far this season have occurred in children who were not fully vaccinated.
- Burden of influenza this season: CDC estimates 26 million illnesses, 340,000 hospitalizations, and 21,000 deaths so far.
- CDC respiratory vaccine recommendations can be found [here](#).
- CDC influenza treatment recommendations can be found [here](#).

Ohio Activity

ODH is reporting statewide respiratory activity through 3/16/2026 on its [dashboard](#). Respiratory virus wastewater monitoring data is shown in the table below.

- Both Mill Creek and Little Miami have recorded only Influenza Type B since the 3/8/2026 sample collections.
- Both WWTPs are detecting low levels of Influenza and RSV, with Mill Creek still detecting moderate levels of COVID-19 and Little Miami detecting low levels of COVID-19.

Updated 3/16/2026

Respiratory Virus	US	Ohio	Greater Cincinnati	
			Mill Creek	Little Miami
COVID-19	Low	Moderate	Moderate	Low
Influenza	Very Low	Low	Low	Low
RSV	Moderate	Low	Low	Low

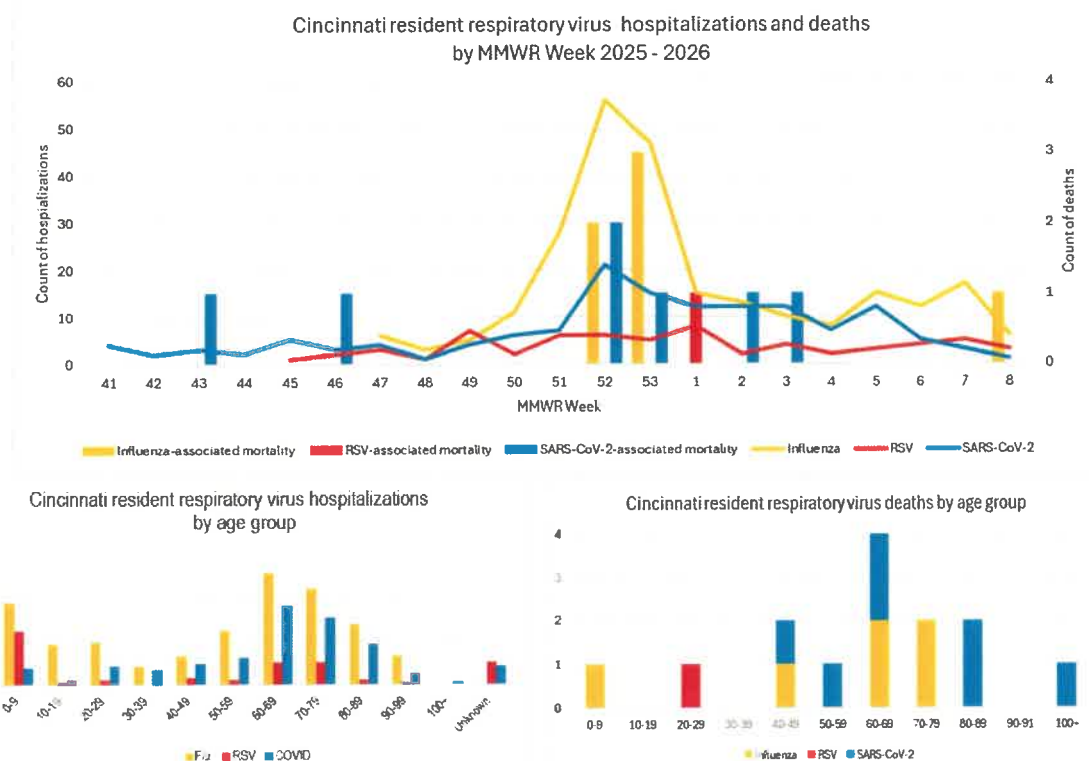
Sources: [NWSS Wastewater Monitoring in the U.S. | National Wastewater Surveillance System | CDC](#), [Monitoring Data | Ohio Department of Health](#)

Cincinnati Activity

Respiratory hospitalizations trends in Cincinnati residents are visualized by MMWR week in the graph below (lines colored by virus), as of 2/28/2026, according to data from the Ohio Disease Reporting System (ODRS) and statewide COVID and RSV associated hospital

surveillance. The mortalities that were reported are also visualized in the same graph (columns colored by virus).

- Influenza hospitalizations fluctuated in February. One pediatric mortality associated with influenza was reported during MMWR week 8. This was associated with Influenza Type B. The age range of the total 6 reported influenza-associated deaths was 4 – 77 years of age. An estimated 33% of the 252 people who were hospitalized had a record of seasonal influenza vaccination this season.
- COVID hospitalizations continued trending downward in February. A total of 141 people from all age groups have been hospitalized so far this season, with 7 being reported as deceased. Ages ranged from 40 – 125 years of age in those who died with 57% of those also reported as vaccinated. An estimated 39% of the hospitalized patients had a record of vaccination.
- RSV hospitalizations also fluctuated during February. There has been a total of 65 hospitalized patients reported so far this season with a little more than half of those being 60 years of age or older, and 1 RSV-associated mortality was reported in an adult. Only 17% of those hospitalized had a record of vaccination.



Immunization Rates and Measles Planning

Recently, ODH made school immunization level assessments available. This is self-reported data by schools in Ohio, who are required to report by October 15 of each school year. One of the limitations of the report is that it does not include home-schooled children. It is very useful for local health departments who are trying to address the potential for measles outbreaks in their jurisdictions. Immunization rates can be used to predict the impact of a measles outbreak in congregate settings, with or without public health interventions. Large measles outbreaks can result in temporary school closures, isolation and quarantine measures for those who are susceptible to measles (anyone who is not immunized, no matter the reason, especially infants <12 months of age). CDU continues to plan for and work with congregate settings in Cincinnati who are updating their measles plans.

Ohio

- The percentage of kindergarteners who met the MMR requirement in the current school year continued to decline, to 88.2% statewide. Conversely, the percentage of kindergarteners enrolled in school with a reason of conscience or religious objection continued to increase, to 5.4%, and the percentage of kindergarteners with a medical contraindication remained consistent at 0.2%.
- The percentage of seventh grade students meeting the MMR requirement in the current school year is 95.7%.

Kindergarten Students Meeting Requirement					
School Year	DTaP	Polio	MMR	Hep B	Varicella
2019-2020	92.3%	92.7%	92.5%	94.9%	91.9%
2020-2021	88.9%	89.4%	89.5%	94.0%	88.6%
2021-2022	88.5%	88.8%	88.2%	92.7%	87.8%
2022-2023	89.3%	89.7%	89.3%	93.0%	88.8%
2023-2024	89.3%	89.6%	89.2%	93.0%	88.5%
2024-2025	88.8%	88.6%	88.3%	92.3%	87.8%
2025-2026	88.5%	88.4%	88.2%	91.9%	87.8%

Total Reported Percent of Kindergarten Students Who Met All Requirements.	Total Reported Percent of Kindergarten Students with a Medical Contraindication.	Total Reported Percent of Kindergarten Students with a Reason of Conscience or Religious Objection.	Total Reported Percent of Kindergarten Students Missing At Least One Required Dose, With No Exemption on File (Incomplete Status).
89.9%	0.3%	2.6%	7.3%
86.5%	0.2%	2.3%	11.0%
85.6%	0.2%	2.8%	11.4%
86.5%	0.2%	3.6%	9.7%
86.2%	0.2%	4.0%	9.6%
85.4%	0.2%	4.5%	9.9%
85.4%	0.2%	5.4%	9.0%

- In the SW Ohio region, the range of kindergarteners having a reason of conscience or religious objection was from 3.5% - 7.5%. The total reported percentage of kindergarten students missing at least one required dose (of either vaccine requirement) and having no exemption on file ranged from 1.1% to 26.0%.
- All of which underscores the need to identify and “catch up” under immunized children, as measles outbreaks are increasingly popping up in states, including Ohio, where there are “pockets” of unvaccinated children and adults. The state medical director issued an announcement in January 2026 when the first outbreak of the year was reported: [ODH Director Dr. Bruce Vanderhoff Announces Measles Cases and Outbreak in Ohio | Ohio Department of Health.](#)
- As of 3/11/2026, according to the [Summary of Infectious Diseases in Ohio | DataOhio](#) there have been 3 confirmed cases of measles in Cuyahoga County and 6 confirmed cases of measles in Franklin County so far this year in Ohio.
- The largest outbreak currently active is in South Carolina, where, as of March 17, 2026, the South Carolina Department of Health is reporting 997 cases of measles centered around Spartanburg County: [2025 Measles Outbreak | South Carolina Department of Public Health.](#)

CDU Investigations and Outbreaks in February

CHD investigated 58 (65) communicable disease reports in February 2026. You can find the reports meeting confirmed and probable case definitions included in the February Monthly Infectious Disease Surveillance Summary in the board's packet. This data is also updated each month on the Communicable Disease Dashboard that is located on the website: [Communicable Disease Unit - Health](#).

Outbreak Response

CHD's Communicable Disease Control and Prevention Unit investigated 6 new outbreak reports (OB) in February:

- 5 Influenza OBs in school settings
- 1 COVID-19 OB in long-term healthcare settings

At the time of this report, one new possibly healthcare-associated cluster is under investigation in March:

- 1 Carbapenem-Resistant *Pseudomonas aeruginosa* (CRPA) Verona integron-encoded metallo- β -lactamase (VIM)

CITY OF CINCINNATI ENVIRONMENTAL HEALTH REPORT

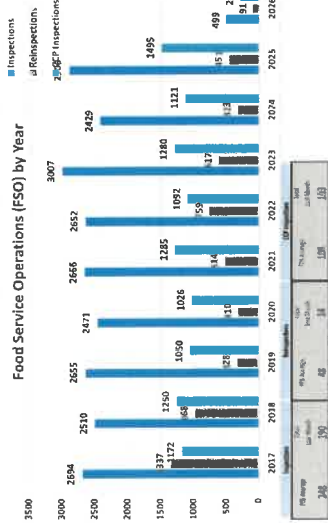
Environmental Health

The Environmental Health Division strives to provide quality community-based services to Cincinnati citizens through the enforcement of public health laws. Through five offices (including Licensing Administration), the Division issues licenses, investigates complaints, abates public health nuisances, and conducts inspections of Cincinnati's restaurants, food trucks, grocery stores, festivals, composting facilities, tattoo and body piercing parlors, infectious waste facilities, junk vehicles, solid waste open dumps, swimming pools and spray grounds, mosquitoes, rabies exposures, household sewage treatment systems, smoking in public places, mold, no heat, rat and mouse, surfacing sewage, roaches, defective plumbing, schools, unsanitary living conditions, hotels, and institutions, along with other programs. The Environmental Health Specialist focus on prevention, consultation, and educating our thinking community on health risks and maintaining a safe environment.

*Averages for each category are based on the last five years average for the same month.

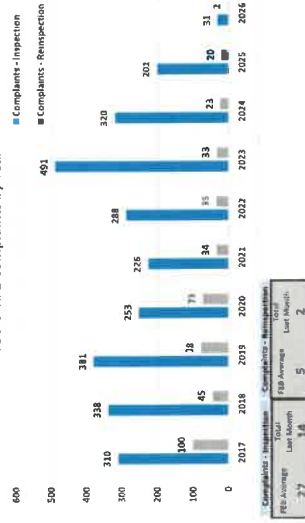
FOOD INSPECTION PROGRAM

The Food Safety Program had a staff meeting on 2/7/26 to discuss Food license renewals & Special Event OVERTIME policy. We completed all 2nd round inspections. We hired a new REHSIT, who started on 2/2/26.

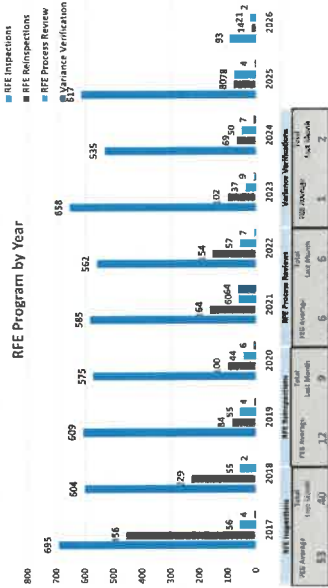
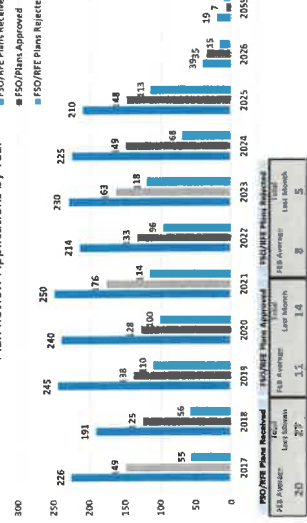


*Note: CDP = Critical Control Point Inspections.
*Note: FSO = Food Service Operations; RFE = Retail Food Establishment.

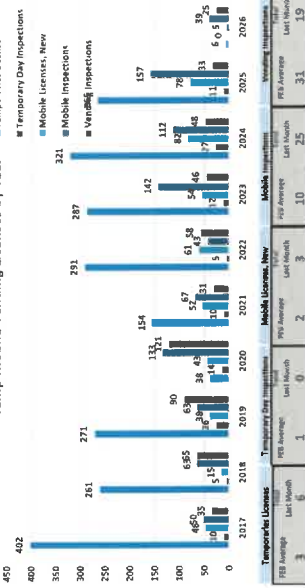
FSO & RFE Complaints by Year



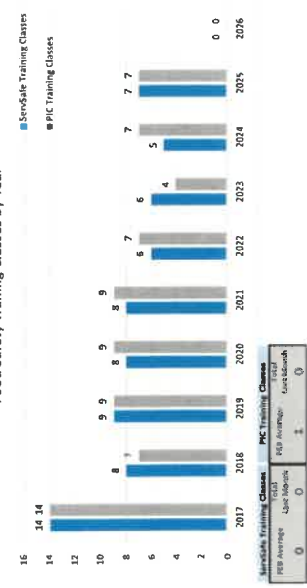
Plan Review Applications by Year



Temp Mobile Vending Licenses by Year



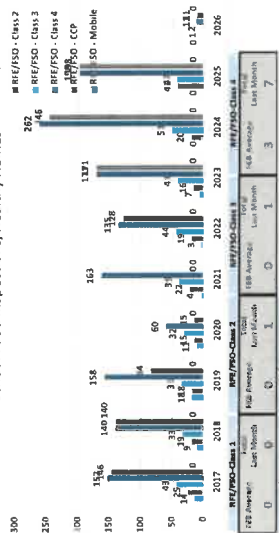
Food Safety Training Classes by Year



HEALTHY HOMES PROGRAM

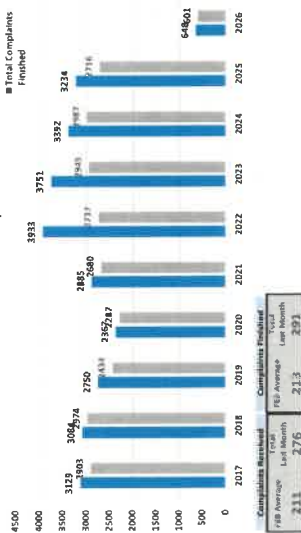
The Healthy Homes staff presented at a Lunch & Learn event sponsored by Children's Hospital and also at city hall for a high school outreach program.

School Food Inspections/Healthy Homes

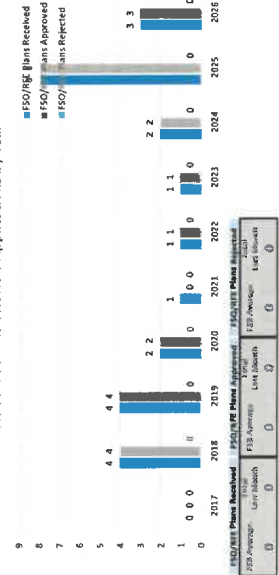


*Note: Class 1 based on food preparation risk and facilities site.

General Nuisance by Year

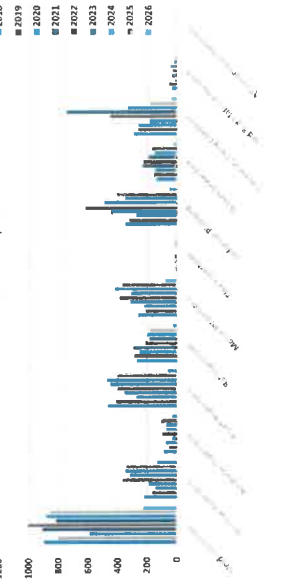


School Food Plan Review Applications by Year

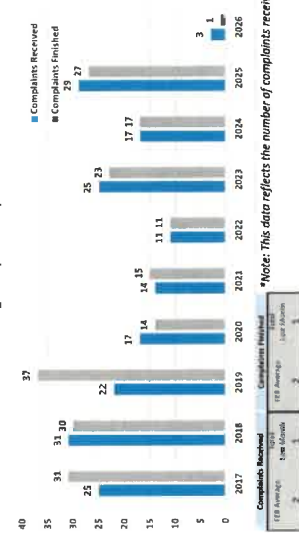


*Note: Plan Reviews are only completed when there is a new facility or renovation

General Nuisance Complaints



Smoking Complaints by Year

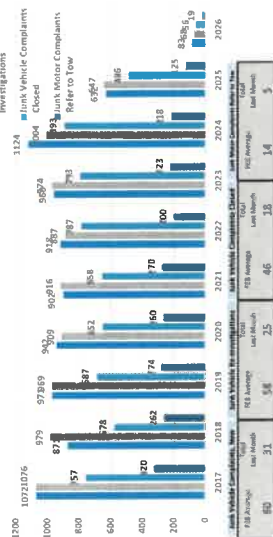


*Note: This data reflects the number of complaints received for the entire city

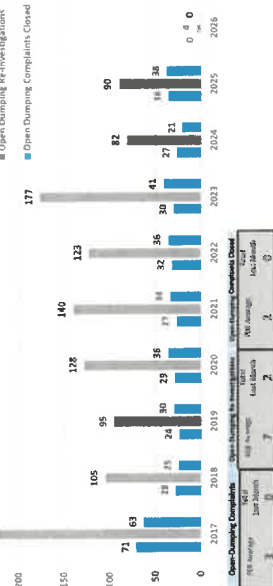
ENVIRONMENTAL WASTE PROGRAM

The Waste Unit conducted interviews for a vacant position and selected a candidate. Two temporary body art events were licensed and inspected this month. One at Rinegeist and the other at Lucas O. Blo.

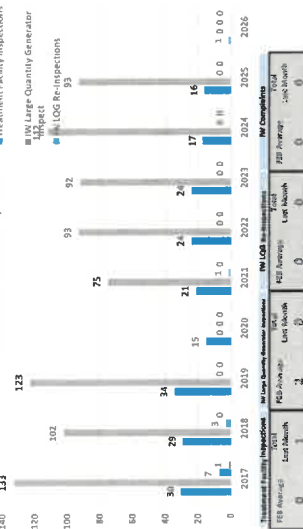
Junk Vehicles by Year



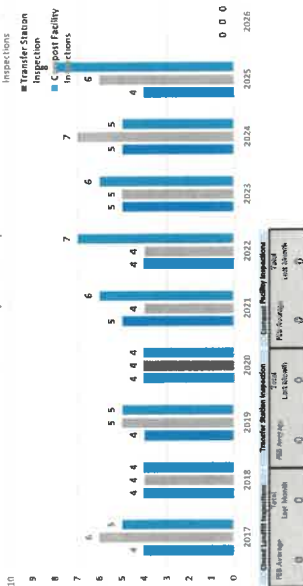
Open Dumping by Year



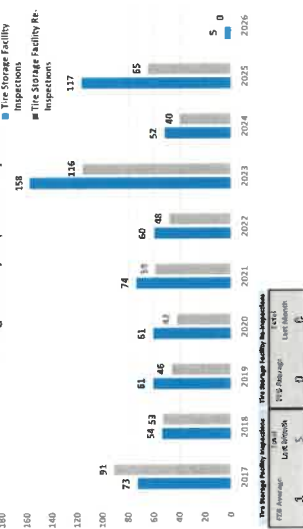
Infectious Disease by Year



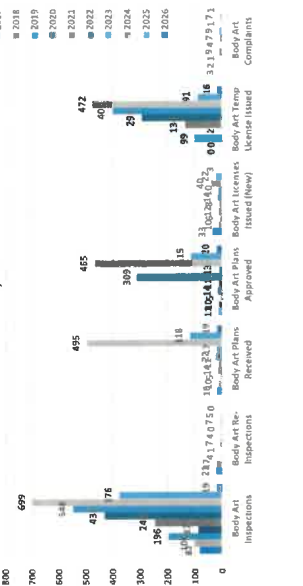
Landfill Inspections by Year



Tire Storage Facility Inspections by Year



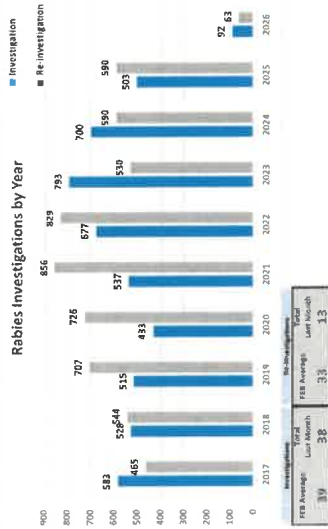
Body Art



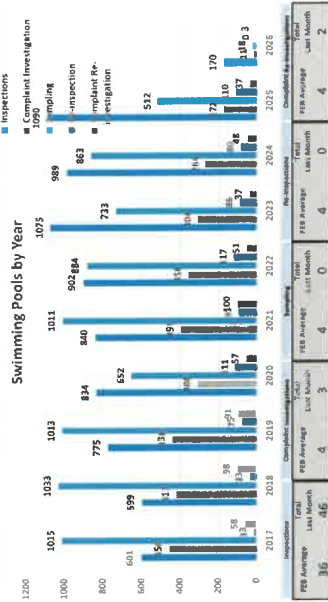
TECHNICAL ENVIRONMENTAL SERVICES (TES)

The Technical Unit worked with Stormwater Management to provide data for their WPDES report to DEPA. We also began contacting delinquent license holders for household sewage treatment systems to pay for their 2025 permits.

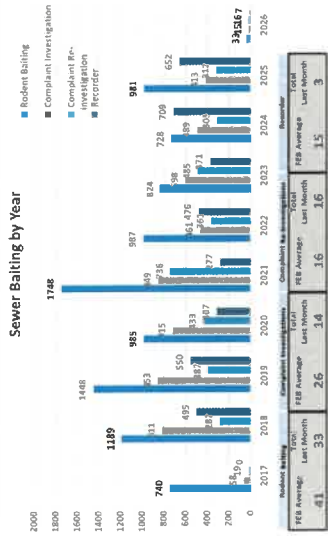
Rabies Investigations by Year



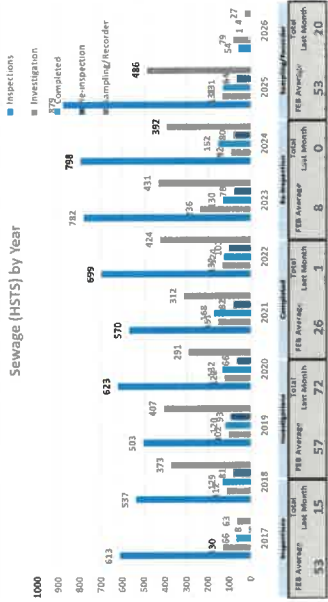
Swimming Pools by Year



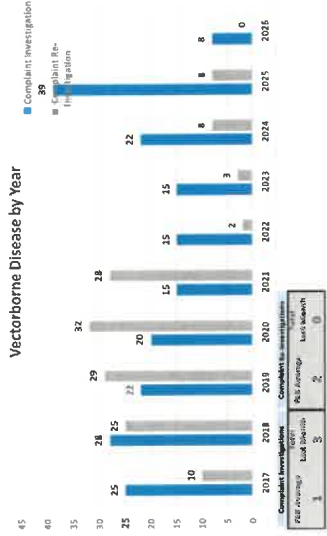
Sewer Baiting by Year



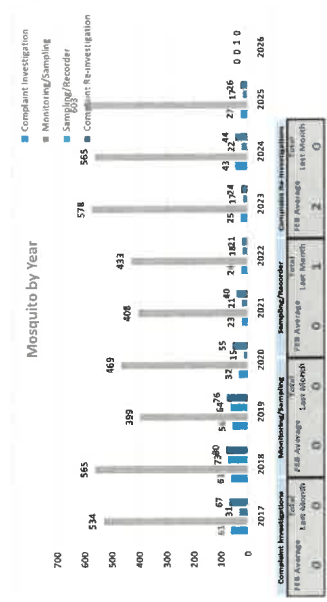
Sewage (HSTS) by Year



Vectorborne Disease by Year



Mosquito by Year



Monthly Infectious Disease Surveillance Summary^{1,2}, February 2026



Reportable Condition by Category ³	2026 February	2026 Year to Date (YTD)	2025 February	2025 YTD	2025 Rate	Cincinnati 5 Year Average Rate (2021-2025)	Ohio 5 Year Average Rate (2021-2025)
Food- or Waterborne	6	14	7	19	44.14	41.92	
Amebiasis					-	0.13	0.09
Botulism					-	0.06	0.04
Campylobacteriosis	2	4	4	6	9.21	9.40	20.57
Coccidiomycosis				1	.64	0.83	0.23
Cryptosporidiosis				1	3.18	3.81	4.55
Cyclosporiasis					0.32	0.25	3.68
<i>E. coli</i> , Shiga Toxin-Producing O157:H7					1.27	3.30	***21.71
Giardiasis		2			3.49	3.87	3.71
Hepatitis A (also vaccine-preventable)					.32	0.19	0.23
Hepatitis E					-	0.13	0.01
Legionellosis - Legionnaires' Disease			1	3	4.76	3.62	5.30
Listeriosis					.95	0.44	0.29
Salmonellosis	1	4		2	11.43	9.15	12.90
Salmonella Typhi (travel associated)					-	0.13	0.10
Shigellosis	1	2	1	3	6.67	5.33	3.05
Vibrios (not cholera)				1	1.59	0.64	***2.55
Yersiniosis	2	2	1	2	1.27	1.52	1.88
Vectorborne				1	2.22	3.24	
Chikungunya Virus Disease*					-	0.06	0.02
Dengue					-	0.19	0.11
Lyme disease					1.61	1.33	11.93
Malaria*				1	0.64	1.52	0.65
Spotted Fever Rickettsiosis					0.32	0.13	0.23
Vaccine-Preventable	90	210	216	310	227.36	104.73	
COVID-19-associated hospitalization	21	64			**21.91	-	-
<i>Hemophilus influenzae</i> , invasive disease			2	2	1.91	2.73	2.62
Influenza-associated hospitalization	49	108	205	280	163.22	74.37	***279.59
Mumps					-	0.25	0.19
Pertussis			5	14	13.65	5.73	7.07
Meningococcal disease - Neisseria meningitidis					0.64	0.19	0.11
RSV-associated hospitalization	15	31			**10.48	-	-
<i>S. pneumoniae</i> , invasive (abx susceptible/unknown)	3	4	4	10	10.80	10.10	7.85

<i>S. pneumoniae</i> , invasive (abx resistant)	1	1	1		3	3.18	2.16	2.31
Varicella (chickenpox)	1	2			1	1.27	2.48	1.84
<i>Viral Hepatitis</i>	30	61	37		89	136.23	149.37	
Hepatitis B, acute (<i>also vaccine-preventable</i>)					1	1.27	1.52	***5.58
Hepatitis B, chronic, newly identified (<i>also vaccine-preventable</i>)	7	16	7		19	29.53	26.61	***81.84
Hepatitis B, perinatal						-	0.06	***0.03
Hepatitis C, acute					1	1.27	1.52	***8.93
Hepatitis C, chronic, newly identified	23	45	29		67	103.84	119.14	***504.70
Hepatitis C, perinatal						0.32	0.51	(combined chronic and perinatal rate)
<i>Healthcare Associated Infections (HAIs)</i>¹⁴	5	8	5		18	28.58	36.96	
Carbapenemase-Producing Organisms (CPO)	2	3	3		4	13.02	9.40	8.21
CPO – Colonization Screening						-	0.13	0.73
Candida Auris	2	4	2		10	7.62	11.88	1.70
Candida Auris – Colonization Screening	1	1			4	7.94	15.56	2.37
<i>Other Conditions</i>	3	8	3		6	15.88	18.93	
Coccidioidomycosis		1				0.64	0.83	0.23
Creutzfeldt-Jakob Disease						-	0.06	0.19
Meningitis, bacterial (not <i>N. meningitidis</i>)						1.91	2.54	1.12
MPOX						0.64	1.78	0.84
<i>Staphylococcal aureus</i> - intermediate resistance to vancomycin (VISA)						-	0.06	0.03
Streptococcal, Group A, invasive	3	7	2		5	9.84	10.16	7.33
Streptococcal, Group B, newborn						0.64	0.95	0.52
Streptococcal toxic shock syndrome (STSS)						-	0.13	0.11
Tuberculosis ²					1	1.91	2.54	***6.49
<i>Sexually Transmitted Infection</i>²	355	818	420		932	1963.07	2045.57	
Chlamydia infection	235	520	269		594	1209.53	1226.30	***2465.52
Gonococcal infection	95	239	121		270	608.42	645.32	***1083.04
Human Immunodeficiency Virus (HIV)	9	20	8		24	44.09	47.31	***344.30
Syphilis - congenital			1		1	1.27	1.46	***2.27
Syphilis - early	6	9	7		11	17.47	27.12	-
Syphilis - primary	2	4	1		3	6.67	14.04	***67.56 (primary and secondary combined rate)
Syphilis - secondary	3	4	2		5	11.75	20.70	***158.91 (total syphilis rate)
Syphilis – stage unknown	3	9	5		6	18.10	23.18	
Syphilis – unknown duration or late	2	13	6		18	44.77	40.14	
TOTAL CONFIRMED AND PROBABLE CASES	489	1119	310		1375	2422.24	2406.30	
Outbreaks (Investigation Started)		2026 YTD	2025 February		2025 YTD	2025 Rate	Cincinnati 5 Year Average Rate (2020-2024)	
Dermatologic			1		1	1.59	7.39	

Article

High Household Transmission Among Asymptomatic Contacts Across Pandemic Waves in Cincinnati, Ohio

Katherine Bowers ^{1,2,*} , Stefanie Benoit ^{2,3}, James Rose ⁴, Andrew F. Beck ^{2,5}, Alonzo T. Folger ^{1,2} , Tara N. Calhoun ^{2,6}, Melissa E. Day ^{2,7} , Andrew Lovell ⁸ and Maryse Amin ⁸ 

- ¹ Division of Biostatistics and Epidemiology, Cincinnati Children's Hospital Medical Center, Cincinnati, OH 45229, USA
- ² Department of Pediatrics, College of Medicine, University of Cincinnati, Cincinnati, OH 45267, USA; tara.calhoun@cchmc.org (T.N.C.)
- ³ Division of Bone Marrow Transplantation & Immune Deficiency, Cincinnati Children's Hospital Medical Center, Cincinnati, OH 45229, USA
- ⁴ Division of Nephrology and Hypertension, Cincinnati Children's Hospital Medical Center, Cincinnati, OH 45229, USA
- ⁵ Division of General and Community Pediatrics, Cincinnati Children's Hospital Medical Center, Cincinnati, OH 45229, USA
- ⁶ Division of Hospital Medicine, Cincinnati Children's Hospital Medical Center, Cincinnati, OH 45229, USA
- ⁷ Division of Infectious Diseases, Cincinnati Children's Hospital Medical Center, Cincinnati, OH 45229, USA
- ⁸ Cincinnati Health Department, Cincinnati, OH 45229, USA
- * Correspondence: katherine.bowers@cchmc.org; Tel.: +1-513-803-9203

Abstract

Background/Objectives: COVID-19 and long COVID remain prevalent, with household transmission being an important mode of spread. To quantify household transmission of subclinical SARS-CoV-2 infection and identify sociodemographic risk factors that may explain disparities in transmission, we conducted a case-ascertained antibody surveillance study of households in Cincinnati, Ohio. **Methods:** A partnership was formed between the Cincinnati Health Department and Cincinnati Children's Hospital Medical Center. The Health Department identified cases of COVID-19. Infected individuals, along with their household contacts ($n = 245$), completed multiple questionnaires about symptoms, demographics, psychosocial (Adverse Childhood Experiences Scale and Everyday Discrimination Scale) and social risk factors, and conditions before and during the pandemic. In addition, they completed a non-fasting blood draw for IgG, IgM, IgA, and nucleocapsid protein serology testing. **Results:** Household contacts experienced few symptoms of COVID-19. However, according to the presence of the nucleocapsid protein, nearly 50% contracted the SARS-CoV-2 virus. This rate was similar by vaccination status but it was higher for household contacts who experienced high levels of early life adversity compared with those with lower levels. **Conclusions:** Our results confirm the high transmission of subclinical disease among household contacts, which may vary due to psychosocial factors. This reinforces the importance of isolating cases to prevent transmission, regardless of vaccination status.

Keywords: COVID-19; SARS-CoV-2; household contact; serology



Academic Editor: Hana Dobrovolny

Received: 17 October 2025

Revised: 21 November 2025

Accepted: 29 November 2025

Published: 12 December 2025

Citation: Bowers, K.; Benoit, S.; Rose, J.; Beck, A.F.; Folger, A.T.; Calhoun, T.N.; Day, M.E.; Lovell, A.; Amin, M. High Household Transmission Among Asymptomatic Contacts Across Pandemic Waves in Cincinnati, Ohio. *Epidemiologia* **2025**, *6*, 91. <https://doi.org/10.3390/epidemiologia6040091>

Copyright: © 2025 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (<https://creativecommons.org/licenses/by/4.0/>).

1. Introduction

In December 2019, an outbreak of coronavirus disease (COVID-19), caused by the Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2), emerged as a global

pandemic [1]. The first cases in the Greater Cincinnati region were identified by March of 2020. Even now, several years later, cases of acute disease as well as cases of long COVID continue to affect children and adults [2]. Reported cases of long COVID remain prevalent [3], and a comprehensive understanding of the household transmission of SARS-CoV-2, leading to recommendations for prevention, remains an important area of research.

Transmission characteristics vary by strain and are also likely to vary by household- and other individual- and community-level characteristics [4]. In addition, COVID-19 continues to disproportionately affect racial and ethnic minorities. A 2021 systematic review and meta-analysis found that COVID-19 positivity is highest in those identifying as Black/African American and those identifying as Hispanic, compared with those identifying as White, American Indian or Alaska Native, Asian American, Pacific Islander, and multiracial or another race/ethnicity.

Presentation and severity characteristics have also been shown to vary across sociodemographic factors. Intensive care unit admission was highest for Asian Americans [5]. Additionally, living in a deprived neighborhood (measured using a deprivation index) was associated with mortality in Asian American and Hispanic individuals. Decreased access to medical care was associated with COVID-19 positivity rates for both Hispanic and African American individuals [5]. Similar differences in disease severity have been observed in Cincinnati. From 2020 to 2024, the Black incidence rate was 5980.9 per 100,000 residents, while the rate was 4930.7 per 100,000 for White residents [6]. In addition, between 2020 and 2024, the Black hospitalization rate was 338.7 per 100,000 compared to 166.6 for White—a disparity ratio of 2.03.

However, less is known about how additional psychosocial factors, such as early life adversity and experiences with discrimination, may relate to COVID-19 transmission.

The objective of our study was to quantify the percentage of subclinical cases of COVID-19 among household contacts in Cincinnati, Ohio, and to determine whether rates of subclinical infection varied by race, ethnicity, as well as by sociodemographic and psychosocial characteristics. Since the vaccine was developed and widely distributed during the course of our study, we additionally employed serology of the nucleocapsid protein to distinguish between vaccine and viral response [7]. With the understanding that race is a sociopolitical construct, indicative of the experience of racism in our structures and systems, we hypothesized that self-reported race would be associated with higher transmission of SARS-CoV-2.

2. Materials and Methods

We conducted a case-ascertained antibody-surveillance study of households in Cincinnati, Ohio. To understand the transmission dynamics in Cincinnati, Ohio, a partnership was formed between Cincinnati Children's Hospital Medical Center (CCHMC) and the Cincinnati Health Department (CHD). We enrolled index cases and their household contacts for participation in the study. Beginning monthly in November of 2021, the CHD compiled a list of reported infections. Since COVID-19 cases were reportable events, the CHD had a comprehensive list of test-positive SARS-CoV-2 infections in the city.

We employed stratified randomization to the lists of reported infections to determine the order of recruitment. Randomization was stratified by race and ethnicity to increase the likelihood of enrolling non-Hispanic Black, non-Hispanic White, and Hispanic participants, the predominant racial and ethnic groups in the region. The research assistant at CHD would contact one potential participant from each race and ethnicity (non-Hispanic Black, non-Hispanic White, Hispanic) and then move on to the next racial category for recruitment. The first contact was with index cases unless the index case was a child, in which case a parent was contacted. At the time of study initiation, CHD was involved

with all contact tracing. CHD partners noted that contact tracing was able to contact 85% of individuals with whom tracing was attempted. From the list of close contacts, we assumed they were household contacts if a close contact had an identical address. The research assistant would call up to three times, leaving a voicemail followed by a single text message if the contact was unable to be reached. If a case agreed to participate in the study, their contact information was shared with research coordinators at CCHMC. All adult participants provided written informed consent utilizing an electronic consent (e-consent). Children ages 11–15 years provided verbal assent, and children 16–17 years provided written assent.

Inclusion criteria included index cases with past COVID-19 infection or household contact of an individual with a past infection. The date of infection must have occurred between one and three months prior to enrollment. An index case included the first positive in a household with a PCR- or antigen-test confirmed infection or a probable case with two or more symptoms and an epidemiologic link (at the time the study was initiated, probable cases were 3% of index cases). Index cases must have had household contacts and resided within the city of Cincinnati, Ohio, to be eligible. Household contacts included relatives or non-relatives living in the same house or apartment. Exclusion criteria included individuals living in congregate care facilities (e.g., nursing homes, group homes, shelters for the unhoused, prisons).

2.1. Study Visit

After providing written e-consent, participants completed several assessments electronically using REDCap's Survey function. The assessments included demographics, early life adversity, everyday discrimination (ages 13 and older with parental permission for minors), medical history, COVID-19 symptoms, and COVID-19 vaccination history (i.e., whether they were offered and/or had any COVID-19 vaccines). Early life adversity was measured using the adverse childhood experiences (ACE) scale (adult participants), a 10-item scale that captures various types of trauma experienced during childhood [8]. Discrimination was captured using the Everyday Discrimination Scale which measures the frequency of day-to-day experiences of discrimination using a scale ranging from 'almost every day' to 'never' [9]. For those answering 'a few times a year' or more frequently, they were then asked the main reason for the discrimination (race, age, gender, etc.). The internal consistency of both scales was high, with Cronbach's alpha of 0.88 for the ACE scale [8] and 0.88 [9] for the Everyday Discrimination Scale, based on prior validation studies. To better understand how each participant was affected by the pandemic, questions were asked about their experience before and during the pandemic. For example, participants were asked about food insecurity in the 12 months before the pandemic and their current experiences. When the study was initiated, the vaccine was not developed, and the study was modified once vaccines were available. In addition to remote assessments, study participation included a one-hour-long study visit to the Schubert Research Clinic at CCHMC with a non-fasted blood draw. If assessments were not completed remotely, they were administered at the study visit via iPad. In the event of technical difficulties, the assessments were administered via pen and paper. Participants were provided a monetary incentive for their time.

2.2. Laboratory Analyses

To evaluate the immunologic characteristics of index cases and to determine whether household contacts contracted the SARS-CoV-2 virus, serologic testing was conducted. This also enabled us to evaluate the antibody response to the virus. Specifically, to identify subclinical infection, we determined the presence of IgG, IgM, IgA, and the nucleocapsid

protein [10]. One 5 mL sample of whole blood was collected at the Schubert Research Clinic and then transferred to the CCHMC Nephrology Clinical Laboratory for processing and analyses. Samples were centrifuged, and plasma and/or serum were extracted and stored at -80 degrees Celsius until serologic assays were performed. Analyses included serology tests for SARS-CoV-2 IgG, IgM, and IgA, and nucleocapsid testing. IgG was measured via enzyme-linked immunosorbent assay [EUROIMMUN, Mountain Lakes, NJ, USA; (Cincinnati Children's Hospital Medical Center, Cincinnati, OH, USA, Lab Developed Test)] or chemiluminescent immunoassay (DIASORIN, Stillwater, MN, 311460), depending upon the time of specimen testing. IgM was measured via enzyme-linked immunosorbent assay (Cincinnati Children's Hospital Medical Center, Cincinnati, OH, USA, Lab Developed Test) or chemiluminescent immunoassay (DIASORIN, Stillwater, MN, USA, 311480), depending upon the time of specimen testing. IgA was measured via enzyme-linked immunosorbent assay (Cincinnati Children's Hospital Medical Center, Cincinnati, OH, USA, Lab Developed Test). Nucleocapsid testing was measured via enzyme-linked immunosorbent assay (EUROIMMUN, Mountain Lakes, NJ, USA, EI 2606-9601-2 G). Each participant was notified of SARS-COV-2 antibodies as well as present or absent nucleocapsid.

2.3. Statistical Analyses

Means with standard deviations and numbers with percentages were used to describe participant characteristics as well as COVID-19 symptoms and side effects for the full sample and separately for index cases and household contacts. Similarly, the percentage of participants with IgG, IgM, and IgA antibodies for COVID-19 as well as those specific to the nucleocapsid protein were described for index cases and close contacts. All testing was interpreted qualitatively as the presence of antibodies: yes/no. The presence of nucleocapsid protein among household contacts (secondary attack rate) was evaluated by demographic and sociodemographic characteristics including race, ethnicity, employment, and experience with adversity (ACEs) and discrimination. High ACEs were defined as having 4 or more, as the prior literature has described poor health outcomes in patients using this distinction [8], and this group of contacts was compared to contacts with 3 or fewer ACEs. Differences were tested for statistical significance using Fisher's exact test, due to small sample sizes for some comparisons. To determine whether antibody status varied by test type, we summarized the presence of antibodies among index cases by PCR, antigen, or missing data for test type. In addition, to determine whether infection and antibody characteristics varied by time (or pandemic wave) due to potential differences in immune response by variant, we stratified by dates including prior to 19 June 2021 (the first study visit was 3 December 2020), 20 June 2021 to 26 March 2022, and after 26 March 2022 (the last study visit was 17 March 2023). Dates were determined by epidemiologic curves provided by the CHD (Figure 1). We calculated the secondary attack rate (based on nucleocapsid positivity) for vaccinated and unvaccinated participants and by vaccine type. Finally, to determine differences in antibody status by additional factors, we stratified analyses by COVID-19 wave, type of test (antigen versus PCR), vaccination status, and time since infection. All analyses were available case analyses, and we did not impute data.

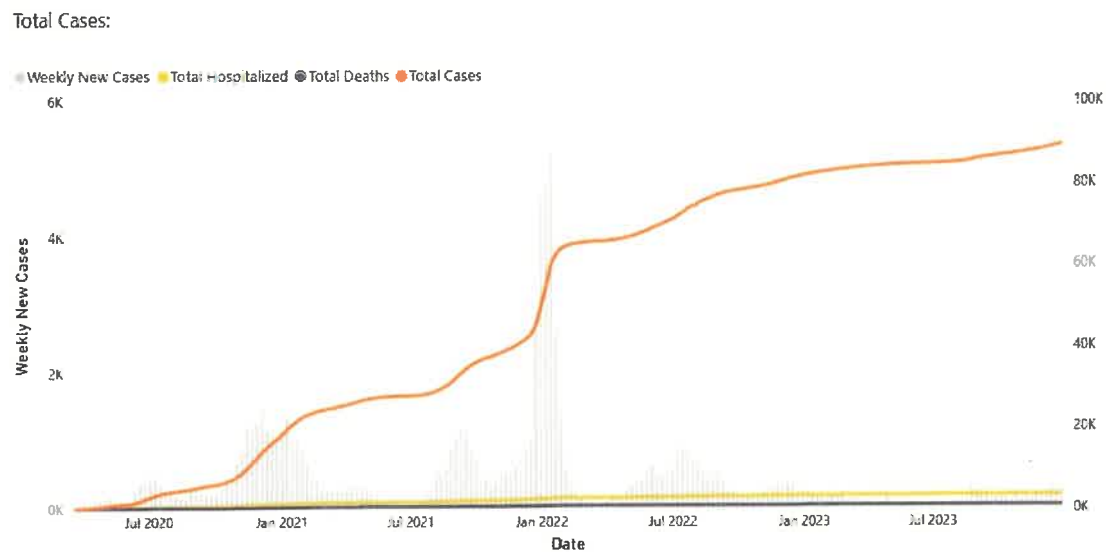


Figure 1. Cases, hospitalizations, and deaths from COVID-19 from July 2020 through early 2023.

3. Results

A total of 245 participants were enrolled in the study, including 146 index cases and 99 close contacts. This sample was composed of roughly 26% who identified as Black or African American and 3.4% as Hispanic adult participants (Table 1). Our sample underrepresented the Black population of Cincinnati, which is around 40%.

Table 1. Number and proportion of demographics and household characteristics of $n = 245$ participants.

Characteristics	N (%)
N	245
Adults	210 (85.7)
Adult age, yr	42.8 (14.8)
Adult Race	
White	141 (67.1)
Black	55 (26.2)
Asian	5 (2.4)
American Indian	1 (0.5)
More than one race	1 (1.0)
Other/unknown	6 (2.9)
Adult Hispanic Ethnicity	7 (3.4)
Smoking Status	
Current	19 (9.0)
Past	33 (15.6)
Never	160 (75.5)
Adverse Childhood Experience (ACE)	
$ACE \geq 4$	38 (18.2)

Table 1. *Cont.*

Characteristics	N (%)
Employed at study visit	165 (81.3)
Household Size	
1	78 (54.2)
2	41 (28.5)
3	17 (11.8)
4	6 (4.2)
5	2 (1.4)
Everyday Discrimination *	
Racial	41 (16.7)
Gender	44 (18.0)
Physical appearance	19 (7.8)
Case Status	
Index	146 (59.6)
Close contact	99 (40.0)

* If participants answered that they experienced any type of discrimination 3 times/year or more frequently, they completed questions about the type of discrimination.

A majority (93.2%) of the index cases were symptomatic. The most prevalent symptoms were subjective fever, chills, muscle aches, rhinorrhea, sore throat, cough, and headache, which were each experienced by more than 50% of index cases. About one-third of the index cases reported losing their senses of taste and smell. Only one case was hospitalized, and three had an abnormal chest x-ray. Few household contacts (24.2%) experienced COVID-19 symptoms, with rhinorrhea (13.1%) and headache (17.2%) being the most prevalent (Table 2).

Table 2. Numbers and proportions of symptoms and side effects of n = 146 index cases and close contacts n = 99.

	Index	Contacts	Total
N	146	99	245
<10 years	23	17	40
Symptoms			
Yes	136 (93.2)	24 (24.2)	160 (65.3)
Pneumonia	4 (2.7)	0	4 (1.6)
Respiratory distress	11 (7.5)	0	11 (4.5)
Fever	59 (40.4)	1 (1.0)	60 (24.5)
Subjective fever	75 (51.4)	4 (4.0)	79 (32.2)
Chills	89 (71.0)	5 (5.1)	94 (38.4)
Chills w/shaking	37 (25.3)	2 (2.0)	39 (15.9)
Muscle ache	96 (65.8)	6 (6.1)	102 (41.6)
Runny nose	95 (65.1)	13 (13.1)	108 (44.1)
Sore throat	83 (56.9)	3 (3.0)	86 (35.1)
Cough	102 (96.2)	4 (4.0)	106 (43.3)

Table 2. *Cont.*

	Index	Contacts	Total
Shortness of breath	49 (33.6)	4 (4.0)	53 (21.6)
Nausea	32 (21.9)	1 (1.0)	33 (13.5)
Headache	100 (68.5)	17 (17.2)	117 (47.8)
Abdominal pain	23 (15.8)	6 (6.1)	29 (11.8)
Diarrhea	32 (21.9)	4 (4.0)	36 (14.7)
Loss of taste	48 (32.9)	0 (0)	48 (19.6)
Loss of smell	48 (32.9)	1 (1.0)	49 (20.0)
Fatigue	6 (4.1)	1 (1.0)	7 (2.9)
Abnormal chest X-ray	3 (2.1)	0	3
Other	17 (11.6)	1 (1.0)	18 (7.4)
Hospitalization			
Yes	1 (0.7)	0	1
ICU, intubation, ECMO	0	0	0

Abbreviations: Intensive Care Unit (ICU), Extracorporeal Membrane Oxygenation (ECMO).

Most participants, including both index cases and household contacts, had IgG antibodies to COVID-19 (93.2% and 80.8%, respectively). In addition, most index cases had IgA antibodies (91.8%), while only 67.6% of household contacts had IgA antibodies. A similar proportion of index cases and household contacts had IgM antibodies (12.3% and 11.1%, respectively). The nucleocapsid results varied by case status. Among index cases, 65.8% were positive for nucleocapsid protein, while 44.4% of contacts were positive. The vaccine status was higher among cases compared with close contacts (78.8% versus 56.6%) (Table 3).

Table 3. Number and proportion of antibody, nucleocapsid, and vaccine status of index cases and close contacts among 216 participants.

	Index	Close Contacts	Total
Antibody status			
IgG Positive	136 (93.2)	80 (80.8)	216 (88.2)
IgA Positive	134 (91.8)	67 (67.6)	201 (82.0)
IgM Positive	18 (12.3)	11 (11.1)	29 (11.8)
Nucleocapsid			
Positive	96 (65.8)	44 (44.4)	140 (57.1)
Negative	31 (21.2)	46 (46.5)	46 (46.5)
Indeterminant	19 (13.0)	9 (9.1)	28 (11.4)
Vaccine Status			
Received Vaccine	115 (78.8)	56 (56.6)	171 (69.8)
Received Pfizer	69 (60.0)	39 (69.6)	108 (63.2)
Received Moderna	37 (32.1)	14 (25.0)	51 (29.8)
Other Vaccine	8 (7.0)	2 (3.6)	10 (5.9)
Type Unknown	1 (0.9)	1 (1.8)	2 (1.2)

The secondary attack rate (defined here as the percentage of close contacts who contracted SARS-CoV-2 indicated by positive test for the nucleocapsid protein) was compared by race, ethnicity, sociodemographic indicators, and psychosocial variables. While 45.5% of White

close contacts were positive for the nucleocapsid protein, 57.1% Black or African American contacts were positive ($p = 0.10$). The proportion was also higher for contacts who had experienced four or more ACEs compared with less than four (76.9% versus 36.1%, $p = 0.02$) and contacts who experienced everyday discrimination by race (66.7%, $p = 0.08$) (Table 4).

Table 4. Secondary attack rate (n (%)) by race, ethnicity, and other sociodemographic variables in close contacts with nucleocapsid protein by race or other sociodemographic characteristics. Differences across groups of $n = 72$ close contacts identified by Fisher's exact test.

	Nucleocapsid Status			<i>p</i> Value
	Positive	Negative	Indeterminant	
Close Contact Adults	31 (43.1)	33 (45.8)	8 (11.1)	
Adult Race				0.06
White	20 (45.5)	29 (53.7)	5 (9.3)	
Black	8 (57.1)	3 (21.4)	3 (21.4)	
Other	2 (100)			
Adult Hispanic Ethnicity	2 (40.0)	3 (9.4)	0 (0)	0.18
Smoking Status				0.59
Current	3 (50.0)	2 (33.3)	1 (16.7)	
Past	7 (58.3)	5 (41.7)	0 (0)	
Never	21 (38.2)	27 (49.1)	7 (12.7)	
Adverse Childhood Experience (ACE) $n = 211$				
ACE ≥ 4	10 (76.9)	2 (15.4)	1 (7.7)	0.02
ACE < 4	22 (36.1)	32 (52.5)	7 (11.5)	
Employed at Study Visit	23 (43.4)	25 (47.2)	5 (9.4)	0.56
Everyday Discrimination *				
Racial	8 (66.7)	2 (16.7)	2 (16.7)	0.05
Gender	8 (61.5)	4 (30.8)	1 (7.6)	0.37
Physical Appearance	3 (37.5)	5 (62.5)	0 (0)	0.65

* If participants answered that they experienced any type of discrimination three times/year or more frequently, they completed questions about the type of discrimination. Abbreviations: Adverse Childhood Experience (ACE).

Several stratified analyses were performed to explore additional factors influencing differences in antibody status, such as the vaccination status, COVID-19 wave (Table 5), type of test (antigen vs. PCR, Supplemental Table S1), and time since infection. We observed that the test sensitivity increased with each subsequent wave. Specifically, we found positivity rates of 52.6%, 61.5%, and 69.3% among index cases across the three pandemic waves. For index cases, we further stratified by the type of COVID-19 test used for diagnosis. The IgG and IgA status remained high regardless of the test type (or if the test type was missing). Among cases with antigen testing, 77.8% were nucleocapsid positive, while 66.3% of PCR-confirmed cases were nucleocapsid positive (Supplemental Table S1). There were no appreciable differences by vaccination status or type (Supplemental Table S2). However, among nucleocapsid negative cases, the median days from the SARS-CoV-2 test to visit were 149 days versus 76 days among those nucleocapsid.

Table 5. Number and proportion of antibody, nucleocapsid, and vaccine status of index cases (n = 146) and close contacts (n = 99) by COVID wave (total n = 245).

	3 December 2020–20 June 2021	20 June 2021–26 March 2022	26 March 2022–17 March 2023
Index	19 (13.0)	26 (17.8)	101 (69.2)
PCR confirmed	18 (94.7)	11 (42.3)	57 (57.4)
Antigen test confirmed	0 (0)	4 (15.4)	14 (13.9)
Missing	1 (5.3)	11 (42.3)	30 (29.7)
Contact	32 (33.3)	16 (16.2)	51 (51.5)
Antibody status—index			
IgG positive	16 (84.2)	25 (96.2)	95 (94.1)
IgA positive	15 (79.0)	24 (92.3)	95 (94.1)
IgM positive	5 (26.3)	3 (11.5)	10 (9.9)
Nucleocapsid			
Positive	10 (52.6)	16 (61.5)	70 (69.3)
Negative	7 (36.8)	5 (19.2)	19 (18.8)
Indeterminant	2 (10.5)	5 (19.2)	12 (11.9)
Vaccine status—index			
Received vaccine	8 (57.1)	22 (84.6)	91 (97.9)
Received Pfizer	6 (75.0)	14 (66.7)	49 (57.0)
Received Moderna	1 (12.5)	5 (23.8)	31 (36.1)
Other vaccine	1 (12.5)	2 (9.5)	5 (5.8)
Type unknown	0 (0)	0 (0)	1 (1.2)
Antibody status: contacts			
IgG positive	20 (62.5)	15 (93.8)	45 (88.2)
IgA positive	19 (59.4)	9 (56.3)	39 (76.5)
IgM positive	7 (21.9)	0 (0)	4 (7.8)
Nucleocapsid			
Positive	11 (34.4)	6 (37.5)	27 (52.9)
Negative	19 (59.4)	9 (56.3)	18 (35.3)
Indeterminant	2 (6.3)	1 (6.3)	6 (11.8)
Vaccine status: contacts			
Received vaccine	10 (50.0)	14 (87.5)	33 (97.1)
Received Pfizer	7 (70.0)	10 (76.9)	22 (66.7)
Received Moderna	2 (20.0)	2 (15.4)	10 (30.3)
Other vaccine	1 (10.0)	0 (0)	1 (3.0)
Type unknown	0 (0)	1 (7.7)	0 (0)

4. Discussion

In a diverse cohort of PCR- or antigen-testing confirmed cases and their close household contacts in Cincinnati, Ohio, we observed that a majority of close contacts experienced zero or few mild symptoms. However, 44% tested positive for the presence of the SARS-CoV-2 nucleocapsid protein, indicating the presence of the virus. In addition, the presence of SARS-CoV-2 was significantly higher among participants who were exposed to four or more ACEs. Though not reaching statistical significance, a similar pattern seemed to exist among Black participants and those who reported everyday racial discrimination.

The results from this study indicate that many individuals with COVID-19, as well as their household contacts, had antibodies to SARS-CoV-2 with a majority of cases being both IgG and IgA positive. There was a similarly high proportion of household contacts with IgG and IgA antibodies, though not as high as the cases. A low percentage of participants (similar between cases and contacts) were IgM positive (12.3% and 11.1%, respectively). Since the presence of these antibodies could represent an immune response to the vaccine (78.8% of cases and 56.6% of contacts received the vaccine), we additionally measured blood for the presence of the nucleocapsid protein. A positive result would be indicative of infection and not vaccination, as this protein is not a component of any of the vaccines. We found the presence of this protein in 44.4% of close contacts, a majority of whom did not experience any symptoms, representing subclinical disease. Interestingly, only 65.8% of cases were positive for the nucleocapsid protein, suggesting the test was not highly sensitive and, therefore, also suggesting that the 44.4% of asymptomatic contacts likely underrepresents the number with subclinical disease.

We conducted several sensitivity tests to understand the differences in antibody status, including stratifying analyses by COVID-19 wave, type of test (antigen versus PCR), vaccination status, and time since infection. Indeed, we identified 52.6%, 61.5%, and 69.3% positivity among index cases across the three assessed pandemic waves. This was higher among antigen test-positive cases and those with a shorter time between reported infection and their study visit. Assuming the test sensitivity is the same for cases and contacts, we do not expect any bias from test to visit differences, but we do believe nucleocapsid is underestimating the true prevalence of disease in close contacts. We found no difference by vaccination status or type.

A second study objective was to determine whether individuals who identified as being of Black race, Hispanic ethnicity, or with sociodemographic and/or psychosocial risk were more susceptible to contracting the SARS-CoV-2 virus from the index case. To examine this, we described the prevalence of the nucleocapsid protein in household contacts by race, ethnicity, smoking status, exposure to early adversity (as measured by the ACE scale), employment status, and experiences with discrimination (by quantity and type). We identified a higher proportion of individuals positive for the nucleocapsid protein who experienced high early adversity compared to those with lower adversity, and the differences were statistically significant. We also saw an indication of differences by race (57.1% of Black household contacts were nucleocapsid-positive compared with 45.5% among White contacts) and racial discrimination (66.7% among those reporting discrimination by rates 3 times per year or more frequently compared with 43.1% positivity among all close contacts); however, neither of these differences reached statistical significance. We do note that underrepresentation of Black participants may affect our findings. If Black household contacts were less likely to enroll and had higher transmission risk, our estimates of transmission for this group could be underestimated, limiting the interpretation of racial differences. As with other regions of the United States, Cincinnati experiences stark health disparities which can elevate the risk for disease transmission. Psychosocial factors, including early life adversity (ACEs) and discrimination may increase susceptibility to infection through multiple pathways. Chronic stress can lead to dysregulation of the hypothalamic–pituitary–adrenal (HPA) axis and immune modulation, including altered inflammatory responses and impaired antiviral immunity. These biological changes may increase vulnerability to infection or affect disease severity. In addition, individuals facing socioeconomic disadvantage, who also experience early life or ongoing psychosocial adversity also encounter barriers to healthcare access and reduced trust in health systems. Together, these mechanisms may affect transmission within households and communities.

While our findings are preliminary, they support the importance of addressing psychosocial stressors and structural inequities as part of comprehensive public health preparedness.

Our results are similar to a case-ascertained immunosurveillance study conducted by Bhatt and colleagues in Ontario, Canada, that identified a similar secondary attack rate (49.1%) [11]. Their study focused on a different set of risk factors to predict household transmission and identified increasing numbers of infected persons, high density households, adult-to-child transmission, and hospital admittance as risk factors for transmission [11]. Both our study and Bhatt et al.'s identified higher transmission rates than the combined effect of a 2019 metanalysis [12]. However, few studies used serology to identify subclinical cases, as our study did, along with the study by Bhatt et al. This approach was also clearly demonstrated in this large study that employed multiple methods to identify secondary cases [13].

There are several strengths to our study including the randomized recruitment of all reported cases in the City of Cincinnati and the use of serology to identify subclinical testing. That said, we do note several limitations. We experienced challenges in enrolling participants, both index cases and household contacts. While we did not have the opportunity to query reasons for non-participation, we recognize there were hesitations around leaving the house unnecessarily and, specifically, visiting a hospital where our study visit took place. We recognize that household contacts that did not participate may have had a different immunologic and symptom experience than those enrolled in the study. As a result of enrollment challenges, we had a relatively small sample across a long period of time and across multiple pandemic waves. However, this is also a strength as we observed characteristics preserved across different waves of the pandemic.

5. Conclusions

Our results confirm the high transmission of subclinical disease among household contacts and reinforce the importance of isolation of cases to prevent transmission regardless of vaccination status. Our results also suggest a relationship between transmission and psychosocial risk factors.

Supplementary Materials: The following supporting information can be downloaded at <https://www.mdpi.com/article/10.3390/epidemiologia6040091/s1>, Table S1: Number and proportion of antibody status of n = 146 index cases by test type; Table S2: The secondary attack rate (based on nucleocapsid positivity) of vaccinated versus unvaccinated contacts and comparison by vaccine type.

Author Contributions: Conceptualization, K.B., M.A. and S.B.; methodology, K.B., M.A., A.F.B., J.R. and S.B.; formal analysis, K.B.; investigation, K.B. and M.A.; data curation, A.L., A.T.F. and K.B.; writing—original draft preparation, K.B.; writing—review and editing, S.B., J.R., A.F.B., A.T.F., T.N.C., M.E.D., A.L. and M.A.; funding acquisition, K.B. and M.A. All authors have read and agreed to the published version of the manuscript.

Funding: This research received funding from the National Center for Advancing Translational Sciences of the National Institutes of Health, under Award Number 2UL1TR001425-05A1 and the U.S. Department of Justice. Award number 2020-VD-BX-1611 under the solicitation BJA FY 20 Coronavirus Emergency Supplemental Funding Program.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by the Institutional Review Board of Cincinnati Children's Hospital Medical Center Approval Code: 2020-0347 Approval Date: (30 April 2020); Cincinnati Health Department IRB Approval Code: IRB 2020-3; Approval Date: (1 November 2020).

Informed Consent Statement: Written informed consent was obtained from all subjects involved in the study.

Data Availability Statement: Data may be made available with permission from the authors.

Acknowledgments: We would like to acknowledge the Cincinnati Police Department who were awarded the funding from the U.S. Department of Justice.

Conflicts of Interest: The authors declare no conflicts of interest.

References

1. Zhu, N.; Zhang, D.; Wang, W.; Li, X.; Yang, B.; Song, J.; Zhao, X.; Huang, B.; Shi, W.; Lu, R. A novel coronavirus from patients with pneumonia in China, 2019. *N. Engl. J. Med.* **2020**, *382*, 727–733. [CrossRef] [PubMed]
2. Ford, N.D. Notes from the Field: Long COVID Prevalence Among Adults—United States, 2022. *MMWR. Morb. Mortal. Wkly. Rep.* **2024**, *73*, 135–136. [CrossRef] [PubMed]
3. Woodrow, M.; Carey, C.; Ziauddeen, N.; Thomas, R.; Akrami, A.; Lutje, V.; Greenwood, D.C.; Alwan, N.A. Systematic review of the prevalence of long COVID. *Open Forum Infect Dis.* **2023**, *10*, ofad233. [CrossRef] [PubMed]
4. Markov, P.V.; Ghafari, M.; Beer, M.; Lythgoe, K.; Simmonds, P.; Stilianakis, N.I.; Katzourakis, A. The evolution of SARS-CoV-2. *Nat. Rev. Microbiol.* **2023**, *21*, 361–379. [CrossRef] [PubMed]
5. Magesh, S.; John, D.; Li, W.T.; Li, Y.; Mattingly-App, A.; Jain, S.; Chang, E.Y.; Ongkeko, W.M. Disparities in COVID-19 outcomes by race, ethnicity, and socioeconomic status: A systematic review and meta-analysis. *JAMA Netw. Open* **2021**, *4*, e2134147. [CrossRef] [PubMed]
6. Department, C.H. COVID-19 Case Tracker. Available online: <https://www.cincinnati-oh.gov/health/public-health-hot-topics/covid-19/> (accessed on 1 October 2025).
7. Smits, V.A.; Hernández-Carralero, E.; Paz-Cabrera, M.C.; Cabrera, E.; Hernández-Reyes, Y.; Hernández-Fernaund, J.R.; Gillespie, D.A.; Salido, E.; Hernández-Porto, M.; Freire, R. The Nucleocapsid protein triggers the main humoral immune response in COVID-19 patients. *Biochem. Biophys. Res. Commun.* **2021**, *543*, 45–49. [CrossRef] [PubMed]
8. Felitti, V.J.; Anda, R.F.; Nordenberg, D.; Williamson, D.F.; Spitz, A.M.; Edwards, V.; Koss, M.P.; Marks, J.S. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *Am. J. Prev. Med.* **1998**, *14*, 245–258. [CrossRef] [PubMed]
9. Williams, D.R.; Yu, Y.; Jackson, J.S.; Anderson, N.B. Racial differences in physical and mental health: Socio-economic status, stress and discrimination. *J. Health Psychol.* **1997**, *2*, 335–351. [CrossRef] [PubMed]
10. Theel, E.S.; Slev, P.; Wheeler, S.; Couturier, M.R.; Wong, S.J.; Kadkhoda, K. The role of antibody testing for SARS-CoV-2: Is there one? *J. Clin. Microbiol.* **2020**, *58*, e00797–20. [CrossRef] [PubMed]
11. Bhatt, M.; Plint, A.C.; Tang, K.; Malley, R.; Huy, A.P.; McGahern, C.; Dawson, J.; Pelchat, M.; Dawson, L.; Varshney, T. Household transmission of SARS-CoV-2 from unvaccinated asymptomatic and symptomatic household members with confirmed SARS-CoV-2 infection: An antibody-surveillance study. *Can. Med. Assoc. Open Access J.* **2022**, *10*, E357–E366. [CrossRef] [PubMed]
12. Madewell, Z.J.; Yang, Y.; Longini, I.M.; Halloran, M.E.; Dean, N.E. Factors associated with household transmission of SARS-CoV-2: An updated systematic review and meta-analysis. *JAMA Netw. Open* **2021**, *4*, e2122240. [CrossRef] [PubMed]
13. Ng, O.T.; Marimuthu, K.; Koh, V.; Pang, J.; Linn, K.Z.; Sun, J.; De Wang, L.; Chia, W.N.; Tiu, C.; Chan, M. SARS-CoV-2 seroprevalence and transmission risk factors among high-risk close contacts: A retrospective cohort study. *Lancet Infect. Dis.* **2021**, *21*, 333–343. [CrossRef] [PubMed]

Disclaimer/Publisher’s Note: The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.

Community Health and Environmental Services (CHES) Updates for CHD BOH Meeting 3.24.2026

Community Health and Environmental Services (CHES) updates:

- The Cincinnati Health Department's Lead Program was awarded a \$4,440,000 Housing and Urban Development Lead Remediation Grant to continue the work of providing lead remediation for eligible Cincinnati residents with enrollment of applicants starting in April, 2026.
- Dr. Amin has worked on two recent publications as senior author regarding COVID-19 research. One manuscript in collaboration with Ohio Department of Health and Metropolitan Sewer District and another manuscript in collaboration with Cincinnati Children's Hospital Medical Center:
 - Servello, D.; Korach-Rechtman, H.; Bessler, S.M.; Partridge, D.; Turner, C.; White, M.; Bohrerova, Z.; Stiverson, J.; Chalasani, P.; Kellar, J.; Leasure, E.; Haubner, S.; Rehman, S.; Wright, K.; **Amin, M.** Effectiveness, Feasibility and Seasonality of Subsewershed Disease Surveillance in Socially and Economically Diverse Areas of Cincinnati, Ohio, in 2023 and 2024; Insights from Laboratory and Rapid Testing Analysis. *Water* **2026**, *18*, 158. doi: [10.3390/w18020158](https://doi.org/10.3390/w18020158)
 - High Household Transmission Among Asymptomatic Contacts Across Pandemic Waves in Cincinnati, Ohio. Katherine Bowers; Stefanie Benoit; James Rose; Andrew F. Beck; Alonzo T. Folger; Tara N. Calhoun; Melissa E. Day; Andrew Lovell; **Maryse Amin** *Epidemiologia* 2025, Volume 6, Issue 4, 91.
- Cincinnati Health Department is continuing the partnership with The Health Collaborative to conduct the Cardiovascular Collaborative with City of Cincinnati Leveraged Support Funding related to identifying next steps aimed at increasing life expectancy with cardiovascular disease.
- Cincinnati Health Department continues to meet with the Cincy CHIP action teams on the five priorities set for the next three years. 1) Access to Care, 2) Mental and Behavioral Health, 3) Nutrition and Food Access, 4) Infant Vitality, 5) Housing. More information in the Accreditation section.
- Alternative Response to Crisis (ARC) pilot diverting low acuity 911 calls to a behavioral health and EMT team is continuing in the Cincinnati community, more information can be found with the link below:

[Alternative Response to Crisis \(cincinnati-oh.gov\)](https://www.cincinnati-oh.gov/health/crisis-response/)

Epidemiology

Epidemiology Data Briefs and Educational Guides:

Data Briefs and Educational Guides can be found using the website below.

<https://www.cincinnati-oh.gov/health/community-health-data/epidemiology-data-briefs/>

2024 Annual Lead Report:

[2024-LEAD-ANNUAL-REPORT.pdf](#)

CCPC UPDATE

Community Health Centers

Figure 1. Number of Completed Patient Visits to All CCPC Community Health Center Sites

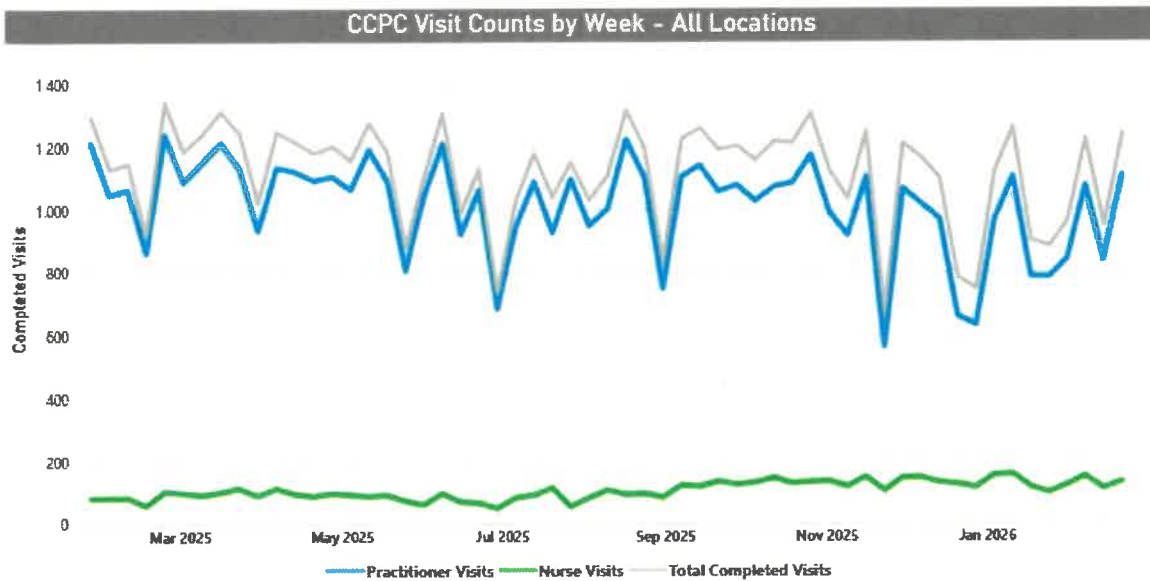


Figure 2. Number of Completed Patient Visits by Location for January 2026

February Visits by Health Center

● Monthly Visits Last Year ● Monthly Visits

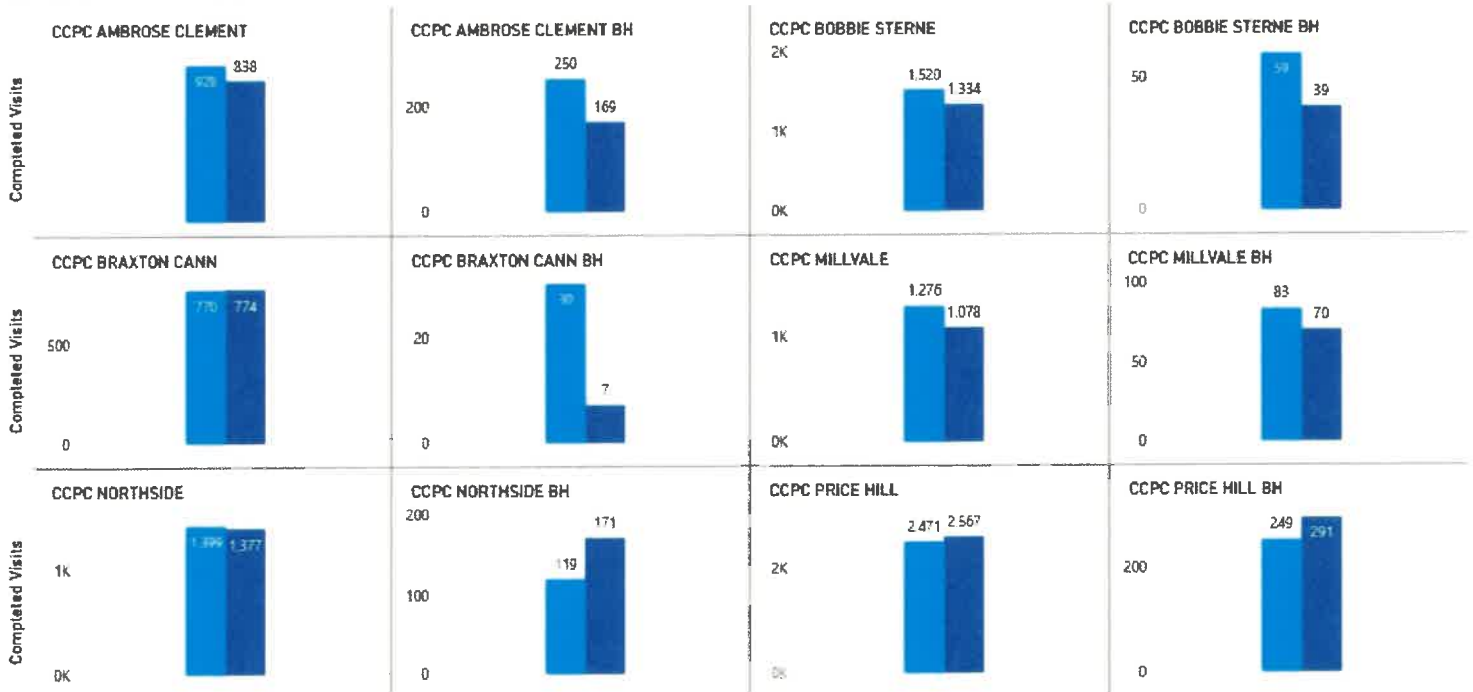


Figure 3. Number of Completed Patient Visits by Location for Fiscal Year to Date
FYTD Visits by Health Center

● FYTD Visits Last Year ● FYTD Monthly Visits

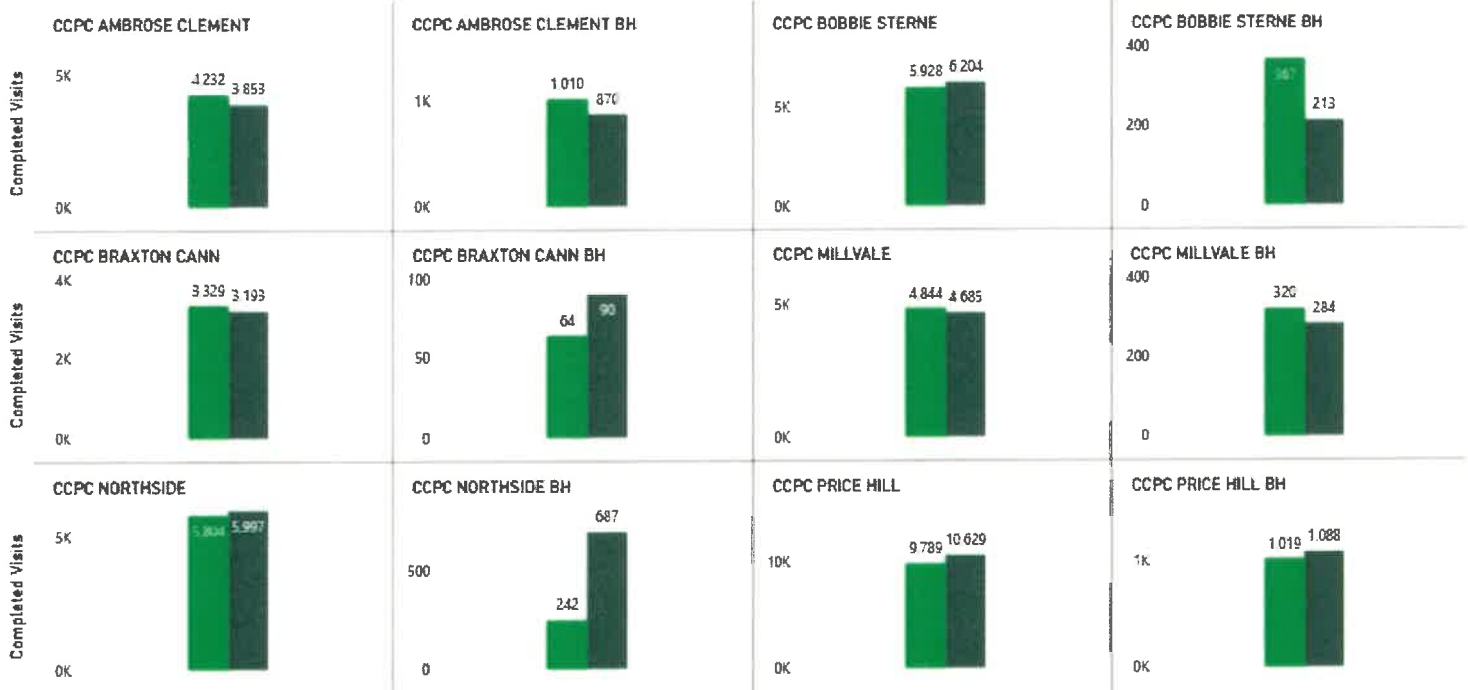
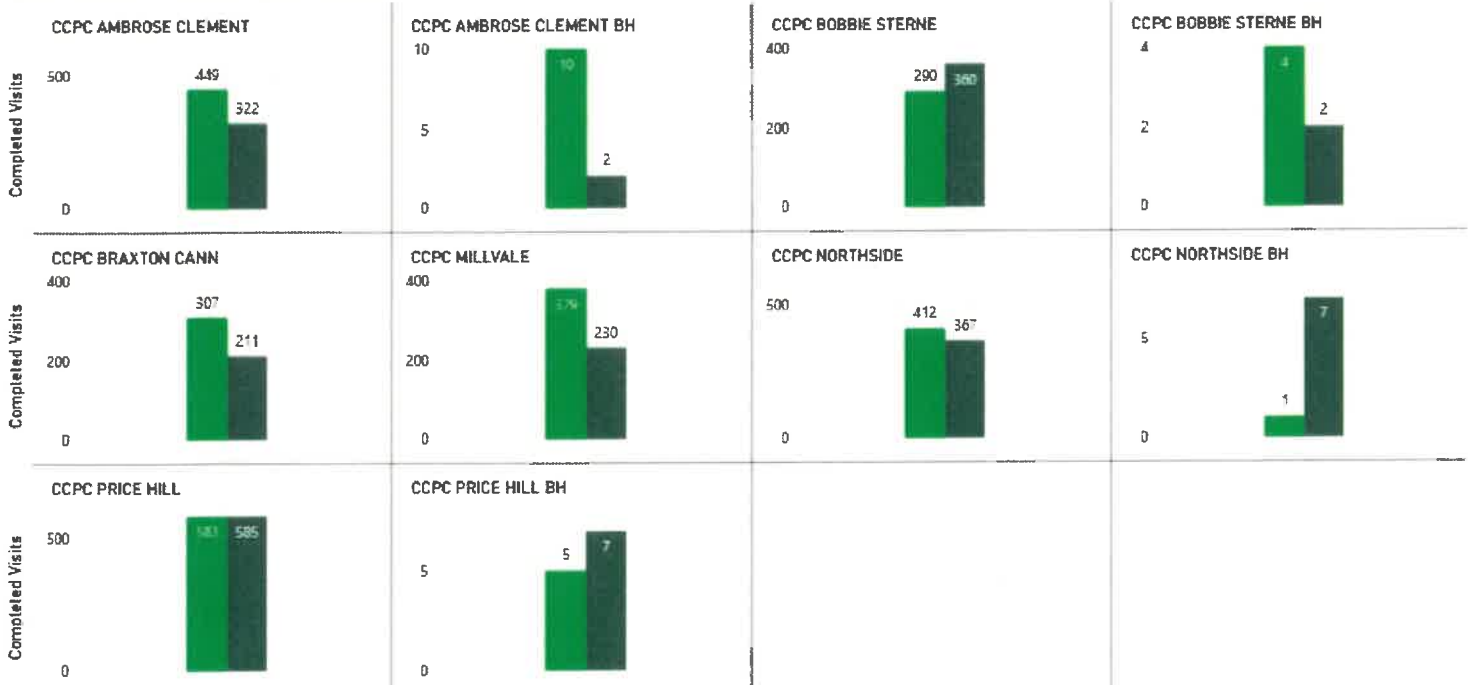


Figure 4. Number of New Patient Visits by Location for Fiscal Year to Date
FYTD New Patients by Health Center

● New Patients FYTD Last Year ● New Patients FYTD



Pharmacy

Figure 5. Number of Pharmacy Fills FYTD
FYTD Pharmacy Fills by Health Center

● Total Fills FYTD Last Year ● Total Fills FYTD

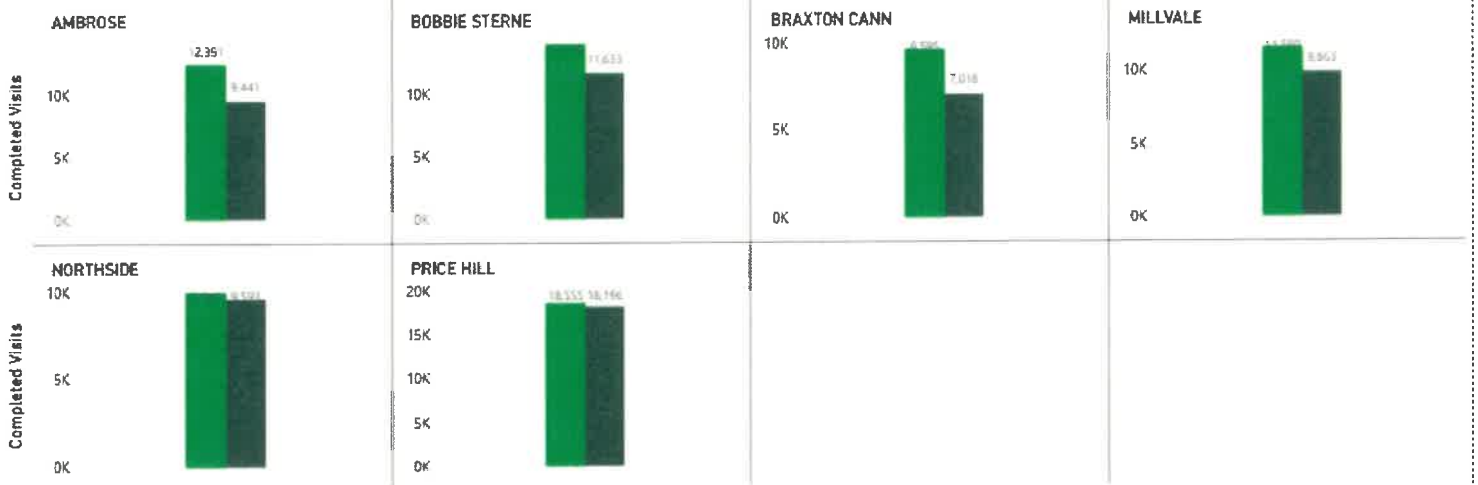
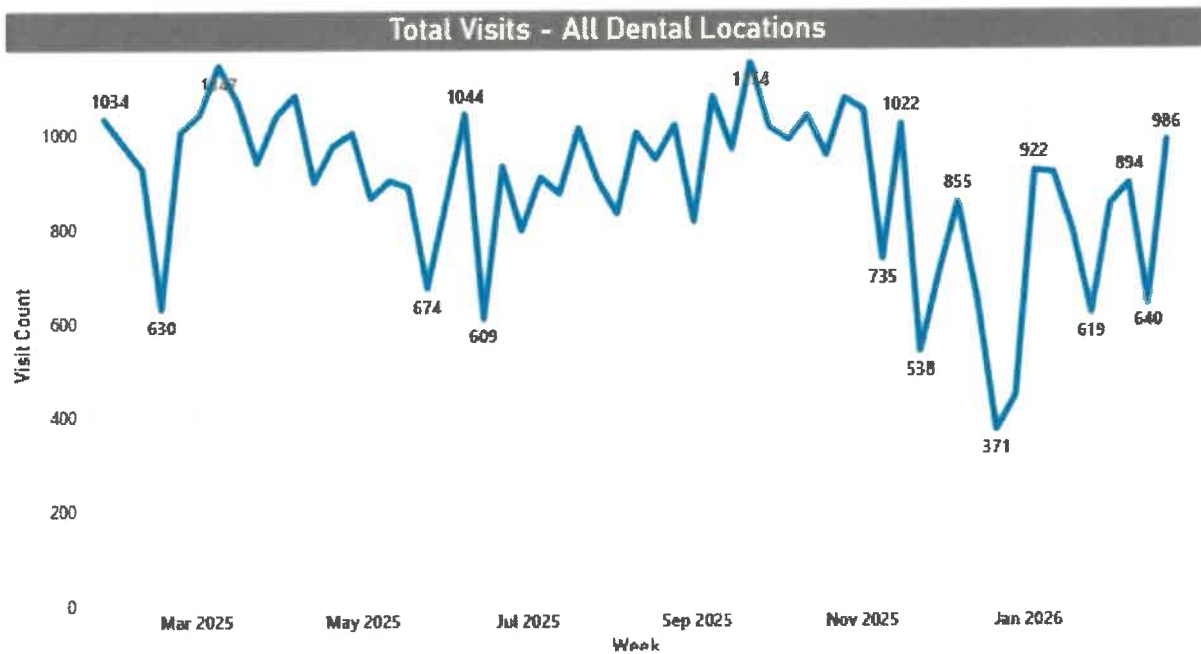
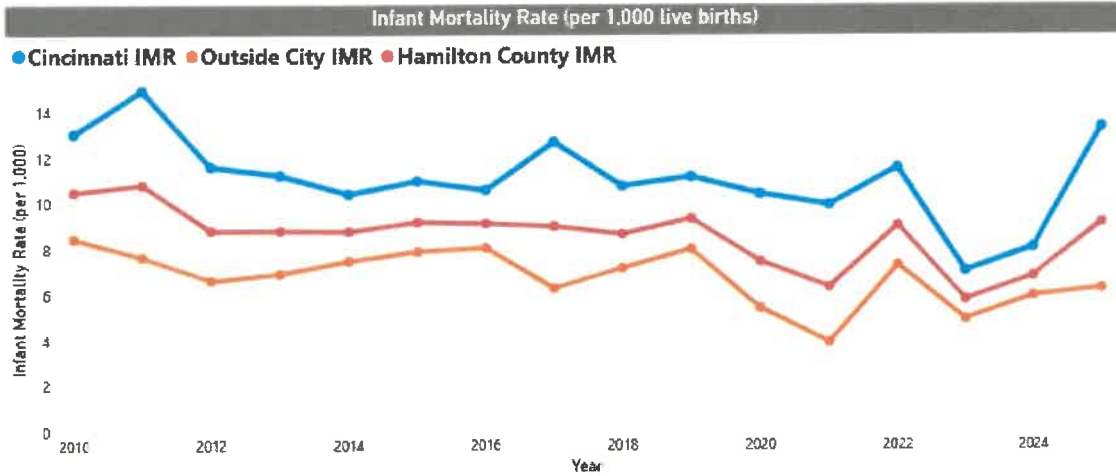


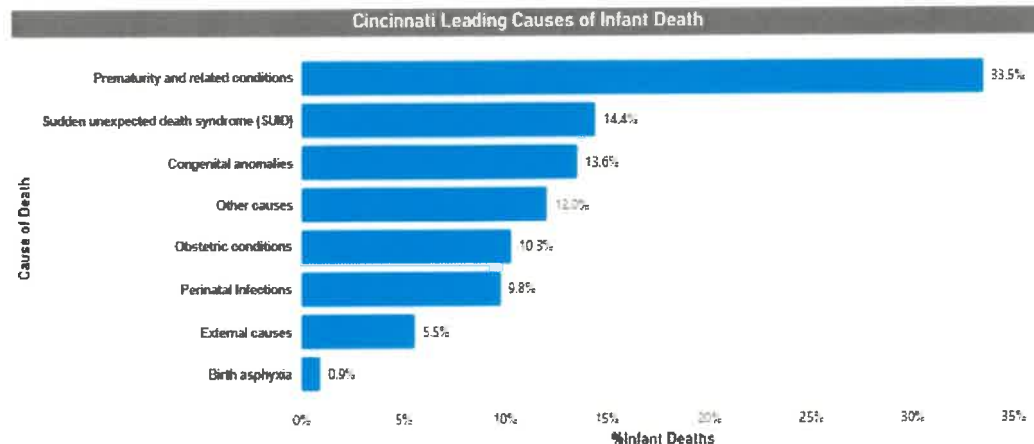
Figure 6. Number of Completed CCPC Dental Visits for All Locations



Infant Mortality Update



	City			Outside City			Hamilton County		
Cincinnati Year	Cincinnati Infant Deaths	Total Births	Infant Mortality Rate	Outside City Infant Deaths	Total Births	Infant Mortality Rate	Total Infant Deaths	Total Births	Infant Mortality Rate
2010	63	4,835	13.03	51	6,041	8.44	114	10,876	10.48
2011	72	4,821	14.93	48	6,287	7.63	120	11,108	10.80
2012	56	4,827	11.60	41	6,193	6.62	97	11,020	8.80
2013	53	4,719	11.23	42	6,077	6.91	95	10,796	8.80
2014	51	4,902	10.40	46	6,148	7.48	97	11,050	8.78
2015	50	4,554	10.98	50	6,336	7.89	100	10,890	9.18
2016	48	4,536	10.58	50	6,211	8.05	98	10,747	9.12
2017	58	4,571	12.69	39	6,209	6.28	97	10,780	9.00
2018	48	4,462	10.76	45	6,282	7.16	93	10,744	8.66
2019	50	4,481	11.16	49	6,127	8.00	99	10,608	9.33
2020	44	4,226	10.41	33	6,104	5.41	77	10,330	7.45
2021	41	4,129	9.93	24	6,136	3.91	65	10,265	6.33
2022	48	4,154	11.56	44	6,035	7.29	92	10,189	9.03
2023	29	4,127	7.03	29	5,907	4.91	58	10,034	5.78
2024	33	4,099	8.05	35	5,894	5.94	68	9,993	6.80
2025	53	3,976	13.33	36	5,756	6.25	89	9,732	9.15
Total	797	71,419	11.16	662	97,743	6.77	1,459	169,162	8.62



Reproductive Health and Wellness Program (RHWP) Data Report

Figure 1a. City of Cincinnati Primary Care Health Center Reproductive Health Visits by Gender and Month, Fiscal Year 2025 – 2026

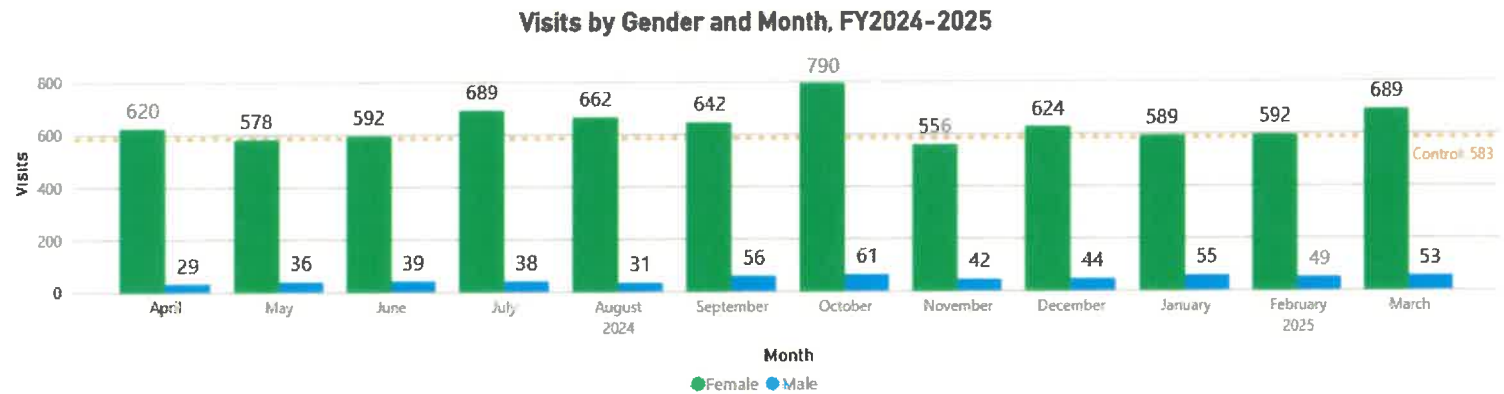
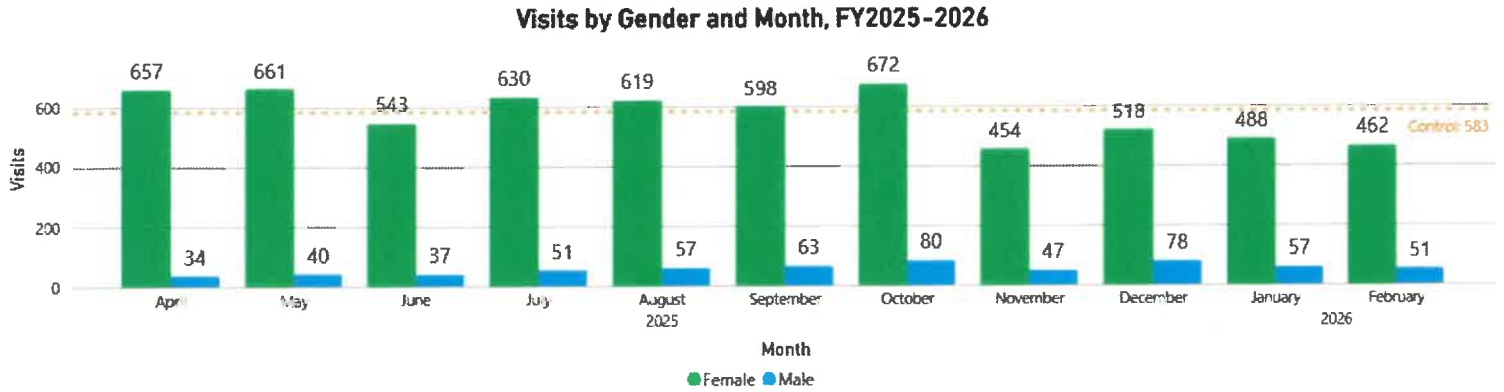


Figure 1b. City of Cincinnati Primary Care Health Center Reproductive Health Visits by Gender and Month, Fiscal Year 2024 – 2025

FY24/25 Visits with Men: 533 patients
 FY24/25 Visits with Women: 7,623 patients
 FY24/25 Visits Combined (men/women): 8,156 patients
 FY24/25 Control (Expected) Visits: 7,000 patients
 FY24/25 Visits as % of Control Total: 116.5%

Fiscal Year 2025 – 2026

FY25/26 Visits with Men: 595 patients
 FY25/26 Visits with Women: 6,302 patients
 FY25/26 Visits Combined (men/women): 6,897 patients
 FY25/26 Control (Expected) Visits: 6,413 patients
 FY25/26 Visits as % of Control Total: 107.5%

Figure 2a. Long-acting Reversible Contraception (LARC) (Intrauterine Devices) provision by Month and Insurance Type for patients seen at our City of Cincinnati Primary Care Health Centers, Fiscal Year 2025 – 2026

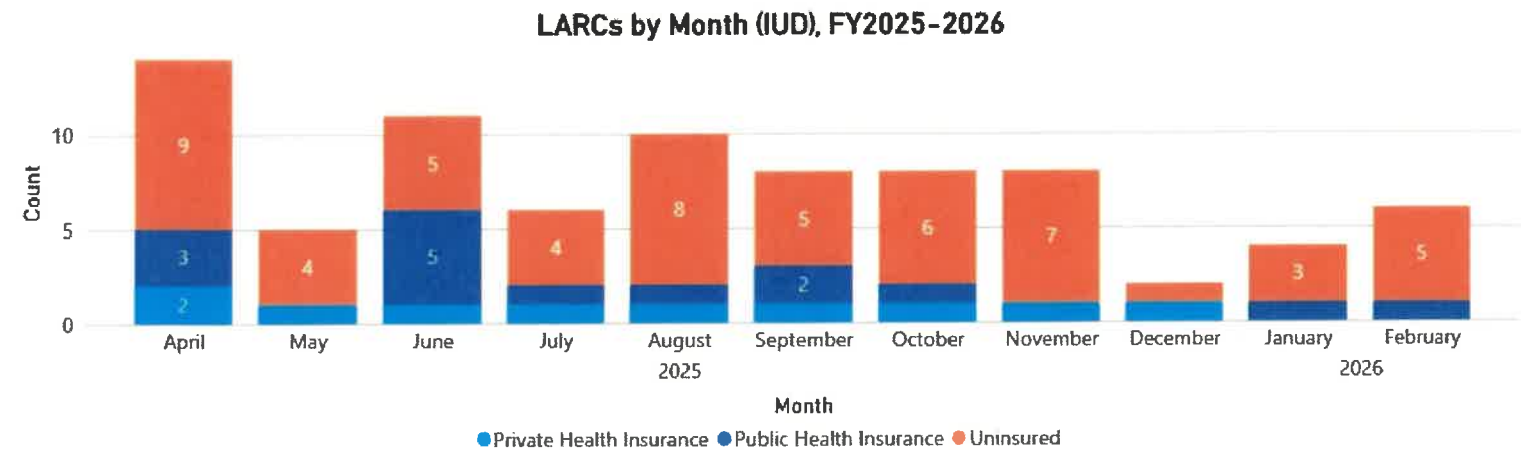


Figure 2b. Long-acting Reversible Contraception (LARC) (Intrauterine Devices) provision by Month and Insurance Type for patients seen at our City of Cincinnati Primary Care Health Centers, Fiscal Year 2024 – 2025

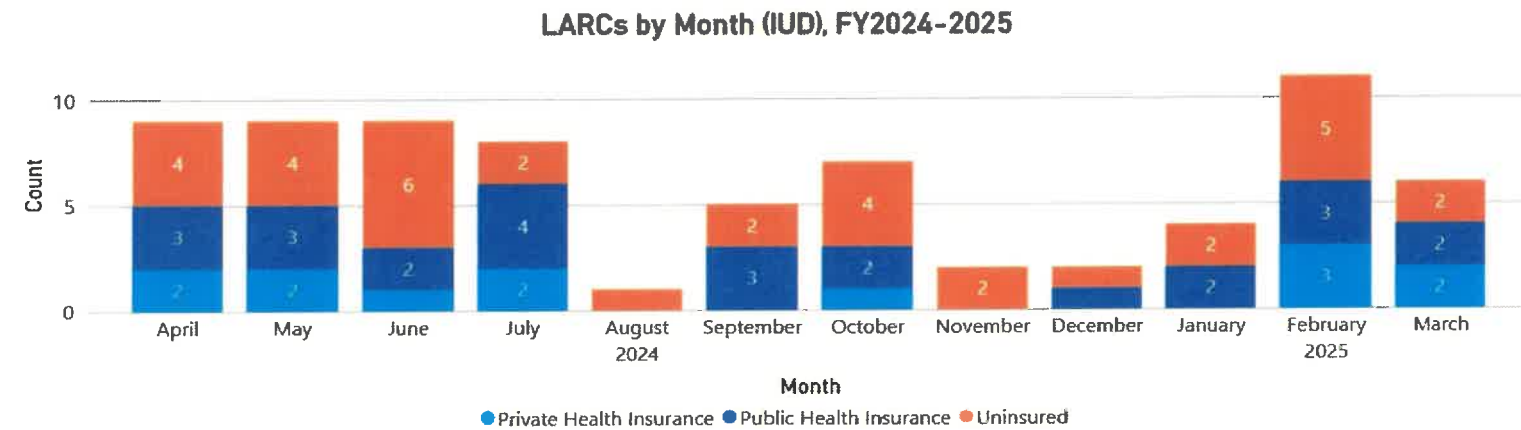


Figure 3a. Long-acting Reversible Contraception (LARC) (Implants) provision by Month and Insurance Type for patients seen at our City of Cincinnati Primary Care Health Centers, Fiscal Year 2025 – 2026

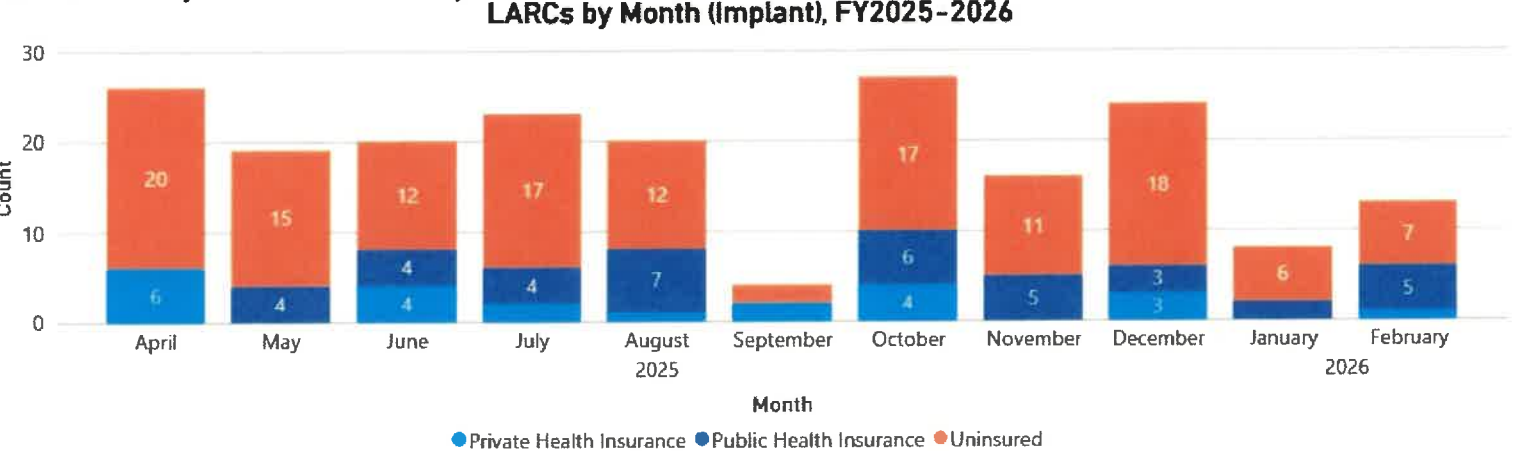


Figure 3b. Long-acting Reversible Contraception (LARC) (Implants) provision by Month and Insurance Type for patients seen at our City of Cincinnati Primary Care Health Centers, Fiscal Year 2024 – 2025

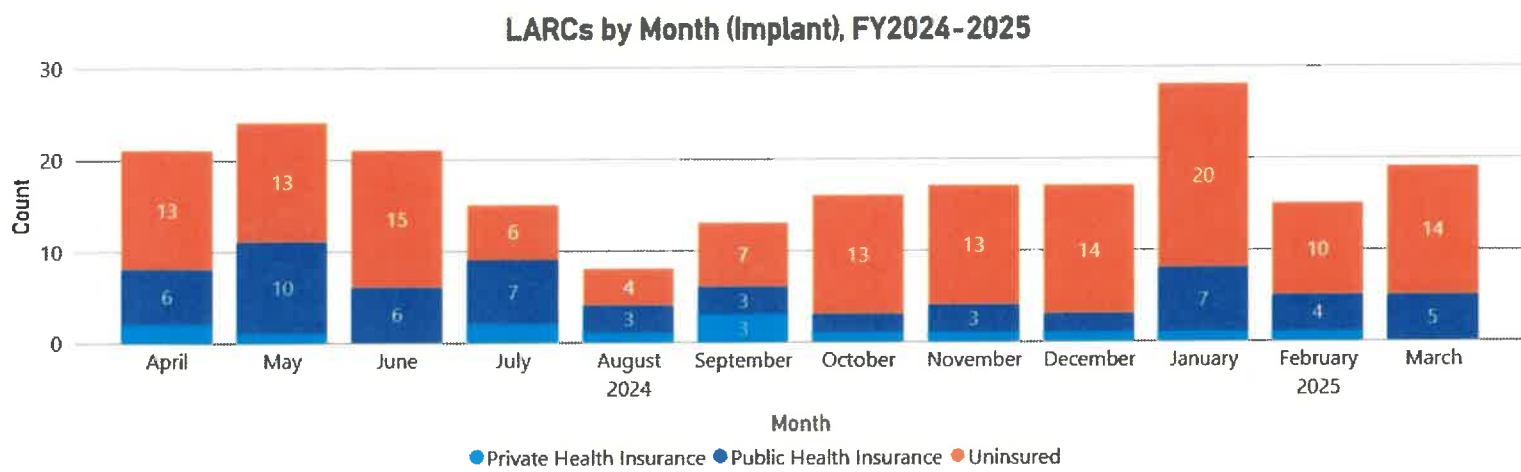


Table 1. Selected Demographic Characteristics of Unduplicated RHWP Patients, February 2026

	Female	% in col.	Male	% in col.	Total	% in col.
Race						
AI/AN	10	2.16%	0	0.00%	10	1.95%
Asian	12	2.60%	1	1.96%	13	2.53%
Black	180	38.96%	37	72.55%	217	42.30%
PI/HN	18	3.90%	0	0.00%	18	3.51%
Unknown	72	15.58%	5	9.80%	77	15.01%
White	169	36.58%	8	15.69%	177	34.50%
Ethnicity						
Hispanic	199	43.07%	3	5.88%	202	39.38%
Non-Hispanic	263	56.93%	48	94.12%	311	60.62%
Income						
<=100% FPL	391	43.07%	31	60.78%	422	82.26%
101-249% FPL	64	13.85%	13	25.49%	77	15.01%
>=250% FPL	7	1.52%	7	13.73%	14	2.73%
Insurance						
Private	41	8.87%	14	27.45%	55	10.72%
Public	165	35.71%	17	33.33%	182	35.48%
Uninsured	256	55.41%	20	39.22%	276	53.80%
Age (years)						
<15	2	0.43%	0	0.00%	2	0.39%
15-49	434	93.94%	39	76.47%	473	92.20%
>50	26	5.63%	12	23.53%	38	7.41%
Limited English						
No	247	53.46%	47	92.16%	294	57.31%
Yes	215	46.54%	4	7.84%	219	42.69%

Table 2. Unduplicated RHWP Patients by CCPC Health Center, January 2026

	Female	% in col.	Male	% in col.	Total	% in col.
Health Center						
Ambrose Clement	49	10.61%	36	70.59%	85	16.57%
Braxton Cann	32	6.93%	0	0.00%	32	6.24%
Bobbie Sterne	93	20.13%	7	13.73%	100	19.49%
Millvale	31	6.71%	1	1.96%	32	6.24%
Northside	102	22.08%	5	9.80%	107	20.86%
Price Hill	155	33.55%	2	3.92%	157	30.60%

* Reproductive health data is based on services as part of the Title X grant provided by our City of Cincinnati Primary Care (CCPC) Health Centers.

Accreditation

PHAB Update:

In the Fall of 2025, the Public Health Accreditation Board (PHAB) began seeking feedback from public health departments, site visitors, partners, and peer reviewers on suggested updates to the current Standard and Measures, version 2022. The public vetting period for those proposed changes closed on December 31, 2025. Based on feedback as well as informed data, PHAB will release its new Standard and Measures for Initial Accreditation, Pathways Recognition, and Reaccreditation in July 2026.

CHIP Action Team Update:

Cincy Community Health Improvement Plan (CHIP) partner progress and feedback surveys were sent out to all action team chairs in January. This feedback will be utilized to create clear, actionable steps to address any identified barriers to better ensure success from planning through implementation on our next CHIP cycle.

The Cincy CHIP focus areas for the upcoming Cincy CHIP cycle are as follows:

- Access to Care
- Behavior and Mental Health
- Infant Vitality
- Nutrition and Food Access
- Housing

Regional CHNA and CHIP Update:

The Regional CHNA lead by The Health Collaborative (THC) was released in February 2025. The Greater Cincinnati Tri-State regional priorities identified are:

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

The Greater Cincinnati Tri-State Region 2025-2027 Collective Health Agenda was released July 16, 2025. To access the full report, click the link below:

https://healthcollab.org/wp-content/uploads/2025/07/SWOHio_CollectiveHealthAgenda_Final.pdf

Quality Improvement/ Quality Assurance

The next Quality Improvement Steering Committee meeting will be held on March 25th at 1pm.

GET VACCINATED GRANT - MONTHLY DATA TABLE 2024-2025										
MONTH	RM 0-18 Years	RC 0-18 Years	IQIP Initial Site visit With office	IQIP 2 M Follow up	IQIP 6 M Follow up	IQIP 12 M Follow up	MOBI	TIES	PERI HEPB NEW CASES	PERI HEPB CLOSED CASES
July	785	872	0	2	2	0	4	1	0	0
August	868	922	0	0	4	0	1	1	2	3
September	950	1261	0	0	5	1	14	14	0	0
October	840	1621	6	0	1	4	3	2	1	0
November	961	1531	4	0	2	4	5	5	1	0
December	703	1339	1	7	0	0	3	3	2	1
January	787	1469	1	3	0	2	0	0	1	2
February	692	1408	1	1	0	3	2	2	1	1
March										
April										
May										
June										
TOTAL										

RM=reminders to families for immunizations now due

RC=recalls to families behind on immunizations

IQIP= Immunization Quality Improvement Process (CDC tool including audit) (2M/6M/12M=follow ups with practices involved in QI process)

MOBI=Maximizing Office Based Immunization education presentation for providers

TIES=Teenage Immunization Education Session -immunization education for providers regarding adolescents

Peri HEPB=Peri-natal Hepatitis

***JULY- MOBI, TIES, (7/17) and IQIP (7/324) required ODH training completed. ..training required PRIOR to initiating MOBI,TIES,IQIP outreach**

September- 41 in person school trainings

October- 56 in person school trainings

November- 17 in person school trainings

December- 27 in person school trainings

January- 35 in person trainings: 6 in person school validations

February 40 In person school trainings

Healthy Communities Program – Tiffany White

Live Work Play Cincinnati Coalition

A multi-sector coalition that works to improve health outcomes by addressing health-related social needs and social determinants of health at the community level.

Date of Meeting	Location & Presentations	Next Steps
March 4, 2025	The all-member March meeting was the inaugural Helping Hands themed meeting. Coalition members assisted UpSpring organization in putting together laundry kits & summer camp kits. Subcommittees shared out updates on Strategic Plan objectives and strategies. - February Newsletter - March Newsletter	Next in-person meeting is June 3rd, 10:15 AM – 12:15 PM Walnut Hills Library NEW meeting frequency: in-person all coalition meetings will be quarterly (March, June, September, and December) on the first Wednesday of each month. Subcommittees will be held virtually each month.

Creating Healthy Communities Grant

Implementation of strategies to improve healthy eating and active living in multiple Cincinnati neighborhoods.

Strategies include: 1 pedestrian infrastructure strategy in Carthage, 1 community garden strategy in the Beekman Corridor, 1 Safe Routes to School strategy across CPS.

# of Meetings	Location & Presentations	Next Steps
See Food Equity and Active Living Sections for more details.	Carthage – Planning work began for Millcreek trail improvements to connect Carthage business district to Caldwell Nature preserve. Safe Routes To School (SRTS) Plan Update – Co-submitted application with DOTE for 2026 SRTS ODOT funding for an infrastructure project. Beekman Corridor – Garden upgrades confirmed, supplies being purchased and delivered. Garden Together! dates set throughout Beekman Corridor.	Carthage – First official walk audit scheduled for 3/20/26. SRTS – Convene stakeholders to initiate 2026-2031 SRTS Plan. Beekman Corridor – Finalize orders, install all the upgrades. Partner with Keep Cincinnati Beautiful to finalize signage upgrades. Finalize education series for the summer.

Infant Vitality – Malina Harris

DCY- Cribs for Kids Subgrantee

The Ohio Department of Health (ODH), Bureau of Maternal, Child and Family Health is partnering with Cribs for Kids® and local organizations throughout Ohio to provide Cribettes® and safe sleep education to eligible families.

# of families served since last report	Project Partners and Status	3 Next Steps
--	-----------------------------	-----------------

95 families	Partners: All In Cincinnati, Bethany House Services, Cherished Hearts CPR Family, Community Action Agency, Cradle Cincinnati Connections (CCC), Crossroad Health Center, First Step Home, Greater Cincinnati Behavioral Health Services, Healthcare Access Now (HCAN), Healthy Homes: Block by Block (Community Matters), Healthy Moms & Babies, Helping Young Mothers Mentor, Inc., Home Health/CHD, Interfaith Hospitality Network of Greater Cincinnati (IHNGC), Mercy Health – Perinatal Outreach Program, Nurse Family Partnership/ECS-Pathways to Home, Rosemary's Babies Co., Santa Maria Community Service, Sigma Gamma Rho Sorority, Inc. Su Casa Hispanic Center, The Children's Hospital/ECS, The Children's Home of Cincinnati/ECS/Costars, The Christ Hospital, The Community Builders (TCB), TriHealth, The Salvation Army, University of Cincinnati Medical Center (UCMC)/Hoxworth/Women's Center, WIC, Women's Center of Ohio, TriHealth ----- Status: Active	Plan: Cribs for Kids and DCY contracts have been approved. Awaiting paperwork to be received to sign. Meeting frequency: ODH TA Meetings are Quarterly. Last meeting 3/2/26 Meetings are Quarterly Next Meeting TBD
--------------------	---	---

Sweet Cheeks Diaper Program

# distributed since last report	Project Partners and Status	Next Steps
300 diapers have been distributed since the last BOH report.	Partners: Sweet Cheeks Diaper Bank HCAN, Mercy Health, Health Vine, UC Women's Center, Hamilton County OEI, Cincinnati Health Department Home Health, WIC ----- Status: Active	Plan: Families have been referred to other agencies to receive diapers Agency is currently going through restructuring the program, so diaper ordering is currently on pause. Meeting frequency: Last Meeting: 1/21/26 Next Meeting: TBD

CAT- The Cincinnati-Hamilton County Community Action Team

The mission of the Cincinnati-Hamilton County Community Action Team is to optimize equitable health outcomes for women, infants, children, and families in Cincinnati-Hamilton County through collaboration, education, and action. This group meets monthly.

# of meetings since last report	Project Partners and Status	Next Steps
---------------------------------	-----------------------------	------------

2-Last Meeting: 2-26-26	Partners: Hamilton County Status: Active	Plan: Discuss the results of the Maternal & Child Health Survey. The work Group is being reconfigured and will meet on a quarterly basis. Meeting frequency: Quarterly Next Meeting: 4/23/26
OIPP/CIAG- Ohio Injury Prevention Partnership: Child Injury Action Group The function of the Child Injury Action Group (CIAG) is to identify priorities and strategies to reduce child injury in Ohio. The CIAG has identified focus areas to address in their five-year strategic plan including teen driving, traumatic brain injury, safe sleep, youth suicide and child passenger safety.		
# of meeting since last report	Project Partners and Status	Next Steps
3	Partners: Ohio Department of Health Status: Active	Plan: Strategic Plan Update Shared progress on the standardized data presentation the subcommittee members will be able to brand as their own and share within their respected communities. The presentation includes quantitative and qualitative data from multiple reporting sources (OPAS, CFR, etc.), representing all of Ohio. Presented on current work being done in the Infant Vitality Program. Meeting frequency: Quarterly Next Meeting TBD

Program supported projects/ meetings:

2/12/26- Human Milk Collective Impact Forum
 2/18/26- NACCHO Maternal Child Health Workgroup
 2/19/26- Baby Shower Brainstorming meeting with Buckeye Health Plan
 2/19/26- OHIO AAP 3s Introduction to Sleep, Space and Smoking
 2/19/26- Infant Vitality Program Meeting
 2/24/26- Black Maternal Health Week National Call
 2/24/26- Safe Sleep Workshop Meeting with Cradle Cincinnati
 2/24/26- Nicotine, Stress, and Mental Health Confirmation
 2/25/26- Healthy Communities Group Meeting
 2/25/26- Cincinnati Health Department QI Steering Committee
 2/26/26- Supporting Healthy Families Outcomes Webinar
 2/26/26- Hamilton County Public Health Meeting to discuss collaboration with maternal health team
 2/26/26- Hamilton County – Cincinnati Community Action Team
 3/3/26- Department of Children and Youth Quarterly TA Call
 3/4/26- Live Work Play Coalition Meeting
 3/6-3/10- Association of Maternal and Child Health Programs (AMCHP) Conference
 3/11/26- Cribs FOR Kids Grant writing meeting
 3/12/26- Human Milk Collective Impact Forum
 3/16/26- Cribs for Kids Training with Santa Maria

Food Equity (Healthy Eating)- Jasmine Robinson

Produce Perks- Community Supported Agriculture Distribution (Fruit and Vegetable Program)

Produce Perks and CHD partnered to increase access to healthy fresh fruits and vegetables in the Winton Hills neighborhood. The partnership has distributed over \$50,000 in healthy foods purchased directly from Mustard Seed Farms (a local, Cincinnati small-scale farm) strengthen healthy dietary habits and increase nutritional/cooking knowledge in hundreds of Winton Hills community members.

# of Meetings Since Last BOH Report	Project Partners and Status	Next Steps
0	Produce Perks, Winton Hills Community Church and Council, Mustard Seed Farm, and Last Mile Food Rescue. Status: Inactive (began 5/15/25- 21 families signed up)	Weekly produce distributions to enlisted families and other community members. Meeting frequency: as needed for planning Project expected to begin in May (aligns with harvesting season)

Cincy Freeze & Feed

The Cincinnati Health Department (CHD) Healthy Communities Program will partner with the Cincinnati Recreation Commission (CRC) Hirsch and Millvale locations to implement a pilot community freezer program.

# of Meetings Since Last BOH Report	Project Partners and Status	Next Steps
8	CRC, La Soupe, CareSource, Food for the Soul, and Hamilton County ReSource Status: Active (4 freezers installed)	Weekly freezer checks conducted to determine stock and cleaning needs. Meetings frequency: standing weekly meetings to discuss general project updates and workflow.

Systems to Achieve Food Equity (SAFE) Network

a sub-network of All Children Thrive made up of individuals and organizations committed to improving food security in Cincinnati to ensure that all children have the food that they need to grow, develop, learn, and thrive.

# of Meetings Since Last BOH Report	Project Partners and Status	Next Steps

2	CCHMC, Freestore Foodbank, Hamilton County ReSource, La Soupe, and more. Status: Active	Network planning for food distribution in the City of Cincinnati including non-instructional school day initiatives; communications team discussions' current project funding covers works in Avondale, East and Lower Price Hill (expansion into Roll Hill coming soon) Meeting frequency: 3rd Thursday of every month Stakeholder meeting to report on organizational updates, events, and needs working towards food equity in Cincinnati. Meeting frequency: 1st Thursday of every month
---	--	--

Food Equity Program Newsletter

Each month, the Food Equity Coordinator sends a newsletter that includes local food related events such as food/produce distribution sites, pop ups, cooking improv learning sessions and more.

# of Meetings Since Last BOH Report	Project Partners and Status	Next Steps
1	Newsletter sent to community members and partners by the end of the 2nd week of each month. Posted on FEC site routinely Status: Active (last sent on 11/14/25 to 291 individuals)	Continue to update newsletter content and layout to meet the reader's needs Meeting frequency: included in monthly program meeting with HCP program manager and health counselor supervisor as well as needed meetings scheduled with SAFE's SSF Communications team for discussion/ review

Department Engagement Champions

Engagement Champions play a crucial role in shaping the city's culture. Engagement Champions will be at the forefront of driving meaningful change within the city's engagement practices.

# of Meetings Since Last BOH Report	Project Partners and Status	Next Steps
0	Meet with other department champions, stay informed on city-wide engagement updates, and share resources with colleagues Status: Active (schedule conflict)	Complete the engagement tour series with CHD information; participate in internal CHD engagement discussions Meeting frequency: standing monthly meetings with full group and additional meetings as needed based on active projects or requests

	for October- next meeting on 11/20/25)	
Creating Healthy Communities Grant (Healthy Eating) Implementation of strategies to improve healthy eating and active living in multiple Cincinnati neighborhoods. Made possible with ODH grant funding. Strategies include: 1 food pantry strategy in Hartwell and Environmental assessments in the Beekman Corridor.		
# of Meetings Since Last BOH Report	Project Partners and Status	Next Steps
11	Food for the Soul (FFTS), Cincinnati Recreation Commission (CRC), Working in Neighborhoods (WIN), Civic Garden Center (CGC), and representatives from several Beekman corridor gardens.	Hartwell: Standing weekly meetings to discuss pantry needs and updates. Conduct consistent assessments to measure levels of effectiveness and community impact. Beekman Corridor: As needed garden improvement discussions to evaluate individual garden needs and to develop a garden workshop series to strengthen community education on maintenance practices.

Program supported projects/ meetings:

2/19/26: Baby Shower Brainstorming meeting with Buckeye Health Plan
 2/20/26: CRC: Millvale freezer cleaning and stock check
 2/20/26: CRC: Hirsch freezer cleaning and stock check
 2/20/26: CRC: Hartwell freezer/ pantry cleaning and stock check
 2/20/26: CRC: Winton freezer cleaning and stock check
 2/24/26: LWPC R.I.S.E Subcommittee Meeting
 2/25/26: Hartwell Pantry food distribution
 2/27/26: CRC: Millvale freezer cleaning and stock check
 2/27/26: CRC: Hirsch freezer cleaning and stock check
 2/27/26: CRC: Hartwell freezer/ pantry cleaning and stock check
 2/27/26: CRC: Winton freezer cleaning and stock check
 3/2/26: Last Mile Food Rescue collaboration discussion
 3/3/26: CPR renewal class
 3/4/26: Live Work Play Coalition Meeting
 3/6/26: CRC: Millvale freezer cleaning and stock check
 3/6/26: CRC: Hirsch freezer cleaning and stock check
 3/6/26: CRC: Hartwell freezer/ pantry cleaning and stock check
 3/6/26: CRC: Winton freezer cleaning and stock check
 3/10/26: LWPC R.I.S.E Subcommittee Meeting
 3/12/26: CRC: Millvale freezer cleaning and stock check
 3/12/26: CRC: Hirsch freezer cleaning and stock check
 3/12/26: Ohio Board of Nursing Advisory Group on Certified Community Health Workers meeting
 3/13/26: Path to Public Innovation Training
 3/17/26: Avondale Respite Center collaboration discussion
 3/18/26: YWCA Cultural Competency & Responsiveness Training

Tobacco Free Living (TFL) – Bemnet Melaku

Tobacco Education		
Date	Partners/Activity	Next Steps
2/19/2026	Community Health Subcommittee	Explore collaboration with harm reduction and tobacco
2/19/2026	Ohio AAP S Interconception Care Program to explore how to support new mothers in maintaining healthy environments for babies	Implement tools from program into education resources
2/23/2026	Connected with Fairview Elementary school to present to 4 th and 5 th graders	Presentation scheduled for 4/29/2026
2/27/2026	Meeting with UC Cancer Center Community Advisory Board (CAB) to explore opportunity for collaboration	Join board and attend next board meeting
3/17/2026	Patient Simulation for CTTS	Complete final case study and test
3/17/2026	CAB Meeting	Attend next board meeting
OACHC Tobacco Cessation Grant with ODH		
2/17/26	Meeting with The Voice of Your Customer to discuss potential collaboration on tobacco education	Reconnect if needing communication to community
3/11/2026	Submitted data to OACHC Tobacco Cessation Grant	Meet with team to discuss grant and continue to submit data

Program supported projects/ meetings:

3/20/26: Queen City Swish Presentation
 3/21/26: Black Family Wellness Expo
 3/24/26: R.I.S.E Subcommittee Meeting
 3/25/26: Healthy Communities QI Overview
 4/1/26: Tobacco Cessation Pilot Meeting

Tobacco 21/Tobacco Retail License (TRL) - Allyn Griffith

Tobacco Retail Licensing/T21		
License any retailer in the City of Cincinnati selling tobacco products. Conduct underage buy attempts and issue citations to enforce tobacco 21 laws.		
	Status	Next Steps
	252- Retailers Licensed 310- Identified retailers 116 2026 Underage Buy Attempts Completed, 66% Compliance	Plan: - Continue Inspections until further notice. - Continue Issuing Citations for Non-licensed Retailers after Education - Hire additional underage buyer(s) - Complete Tobacco Treatment Specialist Training

Worksite Wellness & Active Living – Scott Dean

ODH Creating Healthy Communities Grant (Carthage)
Supportive pedestrian infrastructure for Carthage. The goals being to increase the proportion of adults and adolescents that walk or bike to get to places and to reduce the proportion of adults, adolescents and children with obesity.

# of Meeting since last report	Project Partners and Status	Next Steps
3	Partners: Identified 36 partner agencies ----- Status: Active Working with community on neighborhood improvements. Finalized work for year 2 CHC grant.	- Continue pushing usage of the CAGIS Pedestrian Hazard map we created for the community to track issues and pushing utilization of neighborhood physical activity survey - Received update on desired playground equipment and working to see what is feasible for our grant to cover and how to proceed. - Working with community on creating plan to host and event to clean and clear Heritage Walk trail section that straddles Mill Creek - Walk Audit of Millcreek Greenway Trail scheduled for 3/20 - Additional traffic calming measures to be installed during year 2 of CHC Meeting frequency: Monthly with additional meetings as needed

Y.E.S on Bike & Pedestrian Safety and ODH Creating Healthy Communities grant

The aim of this education series is to increase youth knowledge around the responsibilities of pedestrians, cyclists, and drivers to create a culture of safe transportation in neighborhoods. The goals of the CHC grant are to increase the proportion of adults and adolescents that walk or bike to get to places and to reduce the proportion of adults, adolescents and children with obesity. We also are trying to increase the proportion of community members that engage in aerobic and muscle strengthening activity.

# of Meeting since last report	Project Partners and Status	Next Steps
3	Partners: Cincinnati Public School (CPS), Tri-State Trails, Green Umbrella: Green Schoolyards Team ----- Status: Active Year 2 CHC geared around Safe Routes to School Planning	- Continuing work with principal to secure bicycles from Ethel Taylor - Curriculum completed and working to secure a meeting time to present to the Gym Teacher at Roll Hill for use. - Starting to plan for possible professional development day surrounding Traffic Garden Curriculum so all traffic gardens in the district can be utilized - Continuing to work with DOTE and CPS on updating School Travel Safety Plan - Completed a project application in conjunction with DOTE utilizing the last

		year of the current SRTS plan. • Submitted grant application to AAP Put a lid on it, and was awarded 3 boxes of medium helmets for distribution Meeting frequency: Monthly
--	--	---

Program supported projects/ meetings:

2/12/26 – Green schoolyards network meeting
 2/19/26 – CHC Group Weekly Meeting
 2/20/26 – Toolbank Satellite Discussion
 2/23/26 – Carthage Commons Playground Discussion
 2/24/26 – CHC Group Weekly Meeting
 2/24/26 – Heart of Northside Tour and meeting
 2/25/26 – Healthy Communities Group meeting
 2/25/26 – Strategic Partnership for Greener Schools
 2/26/26 – Community WalkSheds Meeting
 2/26/26 – Healthy Communities and Adventure Crew meeting
 2/27/26 – Traffic Garden Curriculum wrap up
 2/27/26 – Millcreek Greenway Trail walk audit planning
 3/2/26 – CHC Group Weekly Meeting
 3/2/26 – PatientPoint Foundation Intro meeting
 3/2/26 – CHC Healthy Eating Networking Call
 3/4/26 – LWPC Coalition Meeting
 3/5/26 – Beekman corridor garden meeting
 3/10/26 – CHC Group Weekly Meeting
 3/10/26 – Carthage Millcreek Trail Discussion
 3/12/26 – Department Engagement Champions meeting
 3/12/26 – Freezer Checks
 3/13/26 – Path to Public Innovation Training

Behavioral Health and Recovery Services - Eric Washington

Men's Health – Eric Washington

Project/ Meeting Title: Open for ADDITIONAL MEETING		
# of Meetings Since Last BOH Meeting	Project Partners and Status	Next Steps:
1 Meetings	Partners: Recovery Ohio Drug Trends Monthly Meeting Status: Ongoing	Continue to utilize shared information to better serve communities through emerging trends, patterns, insights, and outcomes related to Ohio's drug epidemic. Plan: The meeting was created to provide decision makers across diverse public sectors with information sharing opportunities and actionable intelligence on emerging trends, patterns, insights, and outcomes related to Ohio's drug epidemic. Meeting frequency: Monthly x1
Project/ Meeting Title: Brother You're on My Mind and Youth Mentoring Program		
# of Events Since Last BOH Meeting	Project Partners and Status	Next Steps:
		Monthly safe and supportive space to address topics around: Mental, Spiritual, Physical Health, Chronic

		Disease, Child Support, Resources =
1 Meeting	Partners: Omega Psi Phi – Barbershop Talk Series and Youth Mentoring Status: Ongoing	Plan: Continue to provide a safe and supportive space for men to meet monthly to have open conversations and to provide mentorship to The Youth Mentorship Program Meeting frequency: Monthly x1
Project/Meeting Title: Harm Reduction Committee y		
# of Events Since Last BOH Meeting	Project Partners and Status	Next Steps:
1 Meeting	Partners: Monthly meeting with community partners Status: Ongoing	Plan: To continue to provide update on Harm Reduction in Hamilton County Meeting frequency: Monthly x1
Project/ Meeting Title: Recovery \Ohio Drug Trends Monthly Meeting		
# of Meetings Since Last Meeting	Project Partners and Status	Next Steps:
	Partners: State of Ohio Partners (200+) Department of Mental Health and Addictive Services: The Stepping Up Initiative is a national initiative targeted at reducing the number of people with mental illnesses in jails. Status: Ongoing	Plan: Monthly Drug Update - The ONIC consists of criminal intelligence analysts and computer forensic specialists providing investigative, analytical, and data management support to local law enforcement agencies and drug task forces throughout Ohio Meeting frequency: Monthly x1

*Distribution of Narcan - 6

Program supported projects/ meetings:

2/17/26 - OneOhio Recovery Foundation Statewide Meeting
2/18/26 - AAEW Meeting
2/19/26 - Community Health Subcommittee
2/20/26 - CHC Weekly Meetings - Year 2
2/26/26 - Cincinnati Healthy Communities Prostate Cancer Discussion
3/3/26 - 6th Quarterly Cribs for Kids TA Call
3/4/26 – LWPC Coalition Meeting
3/4/26 - Maximizing Client Interactions with Substance Using Populations
3/10/26 – Monthly Update Meeting – Men's Health Program
3/11/26 – Cincinnati Prostate Presentation Meeting
3/11/26 – Avondale Project Meeting
3/11/26 - Learning Opportunity for Black Males Planning Meeting

3/12/26 - Cancer Advisor Meeting
 1/15/26 – Wellness Recovery Action Plan (WRAP)
 1/15/26 –AAEW Large Group
 1/15/26 - Wellness Recovery Action Plan (WRAP) Day 2
 *In partnership with Hamilton County Public Health – Harm Reduction

Recovery Services/Community Outreach – Justin Berry

Project/ Meeting Title – BHRS Support		
Details/ description		
# of ...	Project Partners and Status	Next Steps
Meeting and Community Members reached)	Partners:	Plan: Meeting frequency: (Monthly and Bi-Monthly) The months to come I plan to continue providing things to the community that are needed. The warmer months are coming, and clients are asking about hygiene products. I will be making sure I am providing the supplies that the community are wanting.

Please add any meeting dates with partners

List Meetings by name:

2/5/26 -GCB

2/9- JFS

For QI Measures:

Number of Naloxone/Narcan Distributed – 12

Number of Referred -36

Number of individuals Engaged - 63

Supplies Distributed

UberHealth – 3

Bus Passes -0

Hats -38

Warmers- 27

First Aid (Band-Aids, Wraps, Etc.)- 17

2026 Month:	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Open Cases:	58	55										
3.5-9 µg/dL Case Mgt & Follow-up: *	8/10	19/8										
10+ µg/dL Case Mgt & Follow-up:	2	2										
Risk Assessments:	2	2										
Orders Issued:	2	1										
Clearances EBL:	2	1										
Clearances GRANT:	4	0										
Owner Meetings EBL:	1	0										
Owner Meetings GRANT:	0	1										
Compliance Checks EBL:	7	2										
Compliance Checks GRANT:	0	0										
Contractor Mtgs EBL:	1	0										
Contractor Meetings GRANT:	1	2										
Filed for Prosecution:	0	0										
LIRAs:	0	3										
Grant Apps Uploaded (ODH & ODD / HUD)	0	2/1										
Case Update w/ Lead Clinic:	8	6										
Affidavit of Fact	0	0										

Risk Assessment: If a child has a lead level of 10 ug/dL and above, a risk assessment of the property is conducted to determine the source of lead poisoning.

Orders Issued: If lead hazards are present on the property, orders are issued to the property owner to ensure compliance.

Clearances: These include soil and dust sample analysis for lead on EBL & HUD grant properties.

Owner Meetings: Meet with owners to discuss compliance with orders; meet with owners to discuss the HUD grant program.

Compliance checks: These are conducted to inspect the licensed lead abatement contractors and workers on the project sites for the EBL as well as the grant program.

Contractor Meetings: Meet with the licensed lead abatement contractor at the job site/property to discuss the orders/work specifications for the EBL/HUD grant program.

Filed for Prosecution: When non-compliance is achieved, the property owner is referred to the Law Department for enforcement action.

PIRA's: Paint Inspection/Risk Assessment of the house to evaluate lead hazards for lead remediation by the HUD grant.

Case Update with Lead Clinic: Collaboration with CCHMC Lead Clinic every Thursday.

Affidavit of Fact (AF): When all resources for compliance are exhausted, the AF is sent to the Auditor's Office to flag properties with lead hazards so new owners are aware of the BOH Lead orders on the property.

February 2026 BOH Report Emergency Preparedness/Safety

Meetings, Grants, and Employee Safety

Attended the CDC All STLT Update Call February 9.

Attended the Southwest Ohio Public Health Regions (SWOPHR) Regional Epidemiology Disease Investigation (REDI) work group virtual meeting February 10.

Attended the monthly Emergency Response Coordinator meeting February 13.

Attended a virtual meeting with the Hamilton County Mental Health and Recovery Services Board to discuss entering a Memorandum of Understanding between several agencies on February 20.

Attended the CDC All STLT Update Call February 23.

Attended the virtual TriState Disaster Preparedness Coalition meeting on February 27.

Training, Exercises and Improvement Plans

The Preparedness Team attended a 'Hot Wash' post exercise session for the Point of Dispensing Tabletop Game exercise conducted in January on February 13.

Attended a kickoff meeting with CHD Communicable Disease Unit and University of Cincinnati Student Health Office to discuss a future Tabletop Exercise on February 19.

The Preparedness Unit successfully passed the ODH Multi Agency Radio Communications System bi-annual radio check on February 24.

Response/Preparedness Activities

Nothing to report.

Cincinnati Vital Records and Statistics Program

Monthly Dashboard for February 2026

Vital Records received payment for 21 affidavits, where staff assisted customers with birth certificate corrections using the affidavit process.

Vital Records staff assisted 7 families with a paternity affidavit process to add the father to a birth certificate.

Vital Records received payments for 3 permits (burial, cremation, transport, or entombment).

Birth and Death Certificates requested from the kiosk, web system, and mail are shown in the chart that follows. The death certificates ordered through OVRs are not accounted for in this report. The new State of Ohio system Ohio Vital Records System takes orders directly from funeral homes.

December 2025	Kiosk	Web	Vitalchek.com	Mail
Birth Certificates	1457	1344	596	5
Death Certificates	132	353	88	5
Total Payments	\$35,618	\$39,099	\$15,488	\$245

