Carroll County Health & Safety Partnership

2026-2030

Community Health Improvement Plan

Community Health Improvement Plan (CHIP) 2026–2030

Carroll County

VISION STATEMENT	MISSION STATEMENT
"Carroll County will be recognized as one of the healthiest communities in Kentucky."	*"To create a healthy community, the Carroll County Health and Safety Partnership collaborates to improve the mental, spiritual, intellectual and physical health of Carroll County."*

Community Partners

Thank you to our community partners, for your public stewardship and investment in our community. A special thank you to those who have generously devoted their time and energy into completing our Community Health Assessments, participating in the planning process, and for their contributions to the Carroll County Health and Safety Partnership.

Agency	Name(s)
1N5	Mike Mizer
AGAPE Family Nurturing Center	Kim Skees
American Foundation for Suicide Prevention	Holly Dawson
Board of Health	Joe Gilbert
Cabot	Whitney Long
Carroll County Community Development Corporation	Bill Lewis
Carroll County Memorial Hospital	Emily Gosman Sedayah Welch
Carroll County Public Library	Elizabeth Mouzakitis Robin Kates
Carroll County Schools	Aayme Kindoll Brandi McIntyre Jeaneen Crutcher Kyndal Yager Mark Willhoite
Carroll County Senior Citizen Center	Frances Steurer Megan Herald
Carrollton Utilities	Terry Roach
Champions for a Drug Free Carroll County	Glenna Dallaquilla James Taylor

City Council	Linda Davis
Fairview Place Senior Living	Allie Wilson
Fiscal Court	Scott Nab
General Butler State Resort Park	Matthew Sabin Rylie St. Clair
iLEAD Academy	Mollie Shirley
ION Center	Erica Howard Shalayne Maxwell Summer Herrmann
Jefferson Community and Technical College	Heather Yocum
Judge Executive	David Willhoite
Kentucky Cancer Program	Mary Schneider
Mayor of Carrollton	Robb Adams
Molina Healthcare	Emma Breetz Lindsey Honaker
NKCAC	Sarah Quackenbush
NKY ASAP	Courtney New
North American Stainless	Angie Roberts
North Key	Jessica Ellis Michelle Murphy
SADD	Carol Lucio
St. Elizabeth Healthcare/Baby Steps	Lucy Rolfes
St. Elizabeth Healthcare/Mammogram Van	Madonna Vinicombe
Three Rivers District Health Department	Alicia Johnson – Clinic Supervisor Amy Marston – Specialty Nurse Consultant Arielle Rosenbaum – HANDS manager Danielle Tracy – Director of Nursing Jackie Vititoe – Harm Reduction Lindsey Tirey – District Director Meagan Meredith – Health Strategy Manager Rachel Massie – Community Health Strategist
Triad Health Systems	Kristen Gabbard Melody Stafford
UK Extension Office	Christy Eastwood
Welcome House	Jason McKinley
WellCare	Linda Bates

Executive Summary

Achieving health equity for all members of a community is the core foundation of public health. Addressing health inequities goes beyond the broad scope of public health, by requiring identification of the multiple social determinants that prevent a person from having the same access to resources, opportunities, and healthcare.

Addressing the social determinants of health inequity requires engaging multiple individuals who have knowledge about the social, economic, and physical barriers that affect a community. Community members of multiple sectors have profound insight in identifying these barriers, and as a group, they are able to analyze how to overcome those barriers *together*.

The Carroll County Health and Safety Partnership recognizes that there are multiple pillars that serve as a means to improve one's health. Those pillars include: Physical, Emotional, Social, Spiritual, Intellectual, Financial, and Environmental. These pillars also represent the core of the Community Wellness Coalition's mission and vision statement.

Methodology

Community partners representing a variety of organizations in Carroll County convened to collaborate on and complete a community health improvement planning process. The group utilized a process based on Mobilizing for Action through Planning and Partnerships (MAPP) framework. MAPP is a strategic planning process that helps communities prioritize public health issues, identify resources and brainstorm programming to address them. MAPP is an interactive, flexible framework that can be tailored by communities to fit their needs. The purpose of using this planning process is to provide the framework for identifying needs and planning for change and is intended to help guide communities through this process.

Typically, the Carroll County Health & Safety Partnership (CCH&SP) meets quarterly. However, during the MAPP process, the CCH&SP increased its meeting frequency to every other month to maintain progress and ensure the established timeline was met. The data from the MAPP Assessments were reviewed and discussed during the coalition meeting in May 2026.

The coalition's strategic issues were identified through discussion. Mapping the top five needs identified through the assessments into four categories. The top four strategic issues that were identified by coalition members are listed below as 'Health Priorities.' Those include:

- Health Priority #1: **Chronic Disease: Overweight and Physical Activity**
- Health Priority #2: **Cancer Education and Prevention**
- Health Priority #3: **Behavioral Health: Mental Health and Substance Abuse**
- Health Priority #4: **Healthy Aging**
- Health Priority #5: **Youth Health and Wellbeing**

Each priority gives a brief description of why this is an important issue to the community, as well as the goals, objectives, and interventions needed in order to address these issues. The purpose of the CHIP is to improve health outcomes for the three strategic issues identified as the CCH&SP's top priorities during the 2026-2030 period. This plan will be used to guide Carroll County community organizations and community stakeholders in their collaborative work together.

Health Priority #1: Chronic Disease: Overweight and Physical Activity

- Chronic diseases are among the most significant contributors to poor health and reduced quality of life, and many chronic conditions can be prevented or better managed through healthy lifestyle behaviors. Overweight and obesity, physical inactivity, poor nutrition, and diabetes are important areas of concern for Carroll County.
- Current data included in the Community Health Improvement Plan indicate that 40% of adults in Carroll County are obese, 30% report no leisure-time physical activity, and 18% of the population lack adequate access to food. Additionally, approximately 13% of adults have a diabetes diagnosis. These findings demonstrate the need for continued community efforts focused on physical activity, nutrition, diabetes prevention, and diabetes self-management.
- The Carroll County Health & Safety Partnership aims to improve chronic disease prevention and management by increasing opportunities for physical activity, promoting healthy eating, improving access to healthy food resources, and expanding diabetes prevention and self-management education. Community-wide events, nutrition education, Diabetes Self-Management Education and Support (DSMES), the National Diabetes Prevention Program, and partnerships with health care providers will be used to connect residents with resources that support healthier lifestyles and improved quality of life.

Health Priority #2: Cancer Education and Prevention

- Cancer continues to be an important health concern for Carroll County. Prevention, early detection, and access to recommended cancer screenings are key opportunities to improve cancer outcomes and reduce preventable illness and death. Current assessment data identify opportunities to increase participation in recommended screenings, including mammography, cervical cancer screening, and colorectal cancer screening.
- Baseline data indicate that mammography use among women ages 50–74 was 69.6%, cervical cancer screening among women ages 21–65 was 78.5%, and colorectal cancer screening among adults ages 50–75 was 63.7%. The current plan also identifies a cancer incidence rate of 80 cases as a baseline measure.
- The Carroll County Health & Safety Partnership aims to reduce the impact of cancer by increasing awareness of prevention strategies, improving access to recommended screenings, and connecting residents with preventive health services. Education, screening and wellness events, and partnerships with health care and community organizations will help residents better understand cancer risk factors and the importance of early detection. The Partnership will also continue to address tobacco use as an important modifiable cancer risk factor through cessation support, nicotine replacement therapy, education, and prevention efforts.

Health Priority #3: Behavioral Health: Mental Health and Substance Abuse

- Mental health and substance use are closely connected and have a significant impact on individuals, families, and the overall health and safety of Carroll County. Community members may experience barriers to behavioral health services, including stigma, limited awareness of available resources, and difficulty connecting with appropriate care and support.
- Current data indicate that 20% of adults report 14 or more days of poor mental health per month, while 25% report that they sometimes, rarely, or never receive the social and emotional support they need. Substance use also remains a significant concern, with 47 nonfatal drug-involved overdose-related hospital encounters and 9 fatal drug overdoses reported in 2024.
- The Carroll County Health & Safety Partnership aims to improve behavioral health outcomes by increasing awareness of mental health and substance use resources, reducing stigma, expanding prevention and crisis response education, and strengthening connections between residents and available services. Efforts will include naloxone distribution and education, 988 and crisis resource promotion, suicide prevention and crisis response training, Community Health Worker referrals, and continued collaboration among health care providers, community organizations, public safety, and other partners.

Health Priority #4: Healthy Aging

- Promoting healthy aging is an important component of improving the overall health and quality of life of Carroll County residents. Older adults may face increased risks related to falls, physical inactivity, chronic disease, social isolation, and difficulty accessing resources and supportive services. Creating opportunities for older adults to remain active, connected, and independent can help improve health outcomes and quality of life.
- The Carroll County Health & Safety Partnership aims to promote healthy aging, independence, and overall well-being by increasing participation in wellness and health promotion programs, supporting physical activity and fall prevention opportunities, and connecting older adults with safety resources and supportive services. Efforts will include senior center and community-based programming, exercise and balance activities, fall prevention education, home safety assessments, adaptive equipment, and the development of the Home Health Lite program.

Health Priority #5: Youth Health and Wellbeing

- Promoting youth health and wellbeing is an important component of building a healthy community and supporting lifelong health. Carroll County youth benefit from supportive relationships, a sense of belonging, positive school environments, healthy behaviors, adequate rest, and opportunities to be engaged in their community.
- The Carroll County Health & Safety Partnership aims to promote youth wellbeing and strengthen protective factors by increasing opportunities for youth connection, positive peer relationships, healthy behaviors, and community engagement. Efforts will include youth-focused education and activities, school and community partnerships, vaping prevention, wellness initiatives, and opportunities for youth to develop positive relationships and a strong sense of belonging.

Once the CHIP is implemented, it will be tracked and recorded throughout the life of the plan, and the coalition will report progress back to the community through media outlets, city council meetings, and fiscal court meetings in order to remain transparent with the CCH&SP's plans, activities, and accomplishments. The CHIP may be updated throughout the implementation cycle as projects are completed or as community stakeholders identify new projects to work on.

Community Health Status Assessment

The Community Health Survey was created for each county individually to address unique geographic details and made available online and by print, if requested. The survey consisted of multiple choice, yes/no and opinion questions and was offered in Spanish for participants with limited English proficiency. The Community Health Status Assessment identifies priority community health and quality of life issues. Questions answered include: "How healthy are our residents?" and "What does the health status of our community look like?". The survey availability was promoted through online social media platforms including Facebook, at local county MAPP community meetings, through promotions at local vendors with QR codes to take the survey, through flyers distributed at community events with promotion including the chance to win a $100 gift card.

The Carroll County Community Health Assessment (CHA) identifies the community's most significant health needs, existing strengths, and opportunities for improvement. Findings from community data, partner input, and the MAPP 2.0 process will guide the 2026–2030 Community Health Improvement Plan (CHIP).

Vision for a Healthy Community

- A community where all residents have access to the resources and services needed to live healthy, productive lives.
- Promote prevention, early intervention, and healthy behaviors across the lifespan.
- Support physical health, mental well-being, healthy aging, and social connection.
- Reduce barriers to health care and community resources.

- Strengthen partnerships that improve health and quality of life for all Carroll County residents.

Most Significant Health Needs

Rank	Health Priority Area	% Identifying Impact	Geographic Disparities & Context
1	Chronic Disease: Overweight & Inactivity	56.30%	Reaches 72.70% in Ghent and 58.50% in Carrollton. 40% baseline adult obesity rate.
2	Behavioral Health: Drug & Alcohol Abuse	44.80%	Major driver of non-fatal overdose hospital encounters (47 in 2024) and mortality.
3	Cancer Education & Prevention	31.40%	High cancer incidence rate; 22% adult smoking rate; delayed screening gaps.
4	Aging Problems / Healthy Aging	29.60%	Expanding older adult population needing fall prevention, isolation mitigation, and home safety.
5	Mental Health Problems	26.70%	20% of adults report 14+ days of poor mental health per month; 25% lack social/emotional support.

- **Chronic Disease: Overweight & Inactivity**
  - Increase opportunities for physical activity and healthy eating.
  - Promote healthy lifestyle education and prevention.
- **Drug and alcohol use**
  - Strengthen prevention, treatment, recovery, and harm-reduction efforts.
  - Increase awareness of available community resources.
- **Cancer**
  - Increase awareness and participation in recommended cancer screenings.
  - Promote prevention and early detection.
- **Aging-related health concerns**
  - Address falls, physical inactivity, social isolation, and maintaining independence.
  - Increase access to wellness and prevention programs.
- **Mental health**
  - Improve awareness and access to behavioral health resources.
  - Reduce stigma and promote early intervention.

Strengths of the Health Care System and Community

- Strong collaboration among health care, public health, emergency services, schools, government, and community organizations.
- Dedicated local health care and public health providers.
- Active community partnerships through the Carroll County Health and Safety Partnership.
- Strong network of community organizations and social service providers.
- Access to parks, recreational facilities, churches, schools, and other community resources.
- Community willingness to collaborate and address identified health needs.
- Existing programs focused on prevention, education, behavioral health, substance use, and chronic disease.

Opportunities for Improving the Health Care System

- Increase access to preventive services and recommended health screenings.
- Strengthen cancer screening outreach and early detection efforts.
- Expand physical activity, nutrition, and chronic disease prevention programs.
- Improve connections between residents and behavioral health and substance use services.
- Expand and promote Community Health Worker services and care coordination.
- Improve referrals and communication between health care and community-based organizations.
- Address transportation and other barriers that prevent residents from accessing care.
- Increase community awareness of available health and social services.
- Strengthen partnerships with health care providers, managed care organizations, public health, and community organizations.

Forces of Change Assessment

The Forces of Change Assessment identifies all the forces and associated opportunities and threats that can affect, either now or in the future, the health of a community. 'Forces' include trends, factors, or events.

- Trends are patterns over time, such as migration in and out of a community or employment opportunities.
- Factors are discrete elements, such as a large ethnic population or a rural community setting.
- Events are one-time occurrences, such as a natural disaster or the passage of new legislation.

Conducting this type of assessment answers, the following questions:

- What is occurring or might occur that affects the health of the community?
- What specific threats or opportunities are generated by these occurrences?

In November 2025, members of the Carroll County Health and Safety Partnership met to complete the Forces of Change Assessment. During these meetings, the top seven forces of change that are expected to most impact the health of Carroll County were identified. See the table below for a summary of these results.

Forces	Threats Posed	Opportunities Created
Economic Issues	Income/ Job availability Transportation; access and availability	Factories, Community Action Agency, Homeless Shelter, JCTC, Adult Ed, iLEAD, Chamber of Commerce, OC Public Transit partnership with CCMH, Empowered Living, TRDHD-CHW, Senior Center
Environmental	Access to care – Lack of providers Medicaid/Medicare Cuts Medical Marijuana Lack of Mental Health Services Natural Disasters (2025 Flood)	TRDHD-CHW, Specialty Nurse Consultant, Triad Empowered Living, NorthKey, Therapists in the School, 1N5, Flood Wall
Political	Changes in County Officials Government shutdown	Haven of Hope, Extension Services
Technology	Excessive use of social media	Parks and Rec, 1N5

2026–2030 Action Plan Framework

Priority 1: Chronic Disease – Overweight and Physical Activity

Program 1.1: Diabetes – Specialty Nurse Consultant
Description: Expands clinical and community diabetes self-management education (DSMES), prediabetes intervention (HALT/NDPP), and clinical referral networks.
Lead Partners & Community Assets: TRDHD Specialty Nurse, Carroll County Memorial Hospital (CCMH), Primary Care Clinics, Triad Health Systems.

Goal	Objective (Target Date: June 30, 2030)	Baseline Value	2030 Target / Measure
Develop Diabetes programming with Specialty Nurse Consultant	Obj 1.1: Decrease the percentage of adults aged 18 and above with diagnosed diabetes by 2% from 13% to 11% (CHR)	• 13% Adult Diabetes • 0 DSMES participants • 0 HALT/NDPP participants	• < 11.0% Adult Diabetes • 15 DSMES Participants • 25 HALT/NDPP Participants
Increase Access to Diabetes Self-Management education	Obj 1.2: Increase referrals to HALT, NDPP, and DSMES programs to at least 5 referrals per quarter.	• 0 practices contacted • 0 referral agreements • 0 referrals/QTR	• 10 practices contacted • 10 referral agreements • 5 Referrals/QTR

Program 1.2: Physical Activity Challenges and Events
Description: Increase community opportunities and participation in physical activity and healthy lifestyle activities to improve physical health and overall well-being.
Lead Partners & Community Assets: CC Parks & Recreation, General Butler State Park, CC Public Library (Zumba, Power Yoga, Pound), Chamber of Commerce.

Goal	Objective (Target Date: June 30, 2030)	Baseline Value	2030 Target / Measure
Improve physical health and overall well-being among community members by increasing opportunities for physical activity and engagement in healthy behaviors.	Obj 1.3: Decrease percentage of adults age 18 and over reporting no leisure-time physical activity by 3% from 30% to 27%. (CHR) Obj 1.4: Decrease percentage of adults reporting 14 or more days of poor physical health per month by 2% from 16% to 14%. (CHR)	• 30% physical activity • 16% poor physical health • 75 event participants • 10 partner orgs • 3 Events integrated/year	• 27% physical activity • 14% poor physical health • 150 event participants • 20 partner orgs • 4 Events integrated/year

Program 1.3: Eat Well, Live Well
Description: Nutrition education campaigns, cooking classes, expanding Senior/WIC Farmers' Market voucher redemptions, and food pantry coordination.
Lead Partners & Community Assets: UK Extension Office, Riverview Farmers Market, General Butler Farmers Market, TRDHD WIC, Local Food Pantries.

Goal	Objective (Target Date: June 30, 2030)	Baseline Value	2030 Target / Measure
Improve healthy eating behaviors and increase access to nutrition education and healthy food resources	Obj 1.5: Decrease the percentage of adults with obesity by 2% from 40% to 38%. (CHR) Obj 1.6: Decrease percentage of population who lack adequate access to food by 3% from 18% to 15%	• 40% Adult Obesity • 18% food Insecurity • 0 cooking classes/mo • 0 Nutrition campaigns/mo	• 38% Adult Obesity • 15% Food Insecurity • 2 Cooking classes/mo • 2 Campaigns/mo

Priority 2: Cancer Education and Prevention

Program 2.1: Cancer Education, Prevention, and Screening
Description: Promotes routine cancer screenings (Mammography, Cervical, Colorectal), expands mobile mammography visits, and drives commercial tobacco cessation.
Lead Partners & Community Assets: Kentucky Cancer Program (KCP), St. Elizabeth Mobile Mammography, Carroll County Memorial Hospital, CC Schools, TRDHD.

Goal	Objective (Target Date: June 30, 2030)	Baseline Value	2030 Target / Measure
Promote Early Detection & Prevention	Obj 2.1: Decrease annual cancer incidence rate from 80 to 70 cases. (cancer-rates.com/KY)	• 80 Incidence cases • __ Wellness events/QTR	• 70 Incidence cases • 1 Event/QTR
Increase Screening Compliance	Obj 2.2: Increase percentage of adults up to date on recommended screenings by 5%. (Screening Disparity Atlas)	• 69.6% Mammography • 78.5% Cervical screening • 63.7% Colorectal screening	• 74.6% Mammography • 83.5% Cervical screening • 68.7% Colorectal screening
Reduce Tobacco Use	Obj 2.3: Decrease the number of adult smokers who are current smokers by 2% from 22% to 20%	• 22% Adult smokers • __ NRT kits/ QTR	• 20% Adult smokers • 5 NRT Kits/ QTR • Secondhand Smoke outreach

Priority 3: Behavioral Health (Mental Health & Substance Abuse)

Program 3.1: Naloxone Distribution and Education

Description: Expands community naloxone access, maintains public naloxone emergency boxes, provides jail release kits, and offers harm reduction outreach.

Lead Partners & Community Assets: TRDHD Harm Reduction, CC Detention Center, Champions, Northern NKY Health, Emergency Medical Services (EMS).

Goal	Objective (Target Date: June 30, 2030)	Baseline Value	2030 Target / Measure
Increase Community Wide Awareness and Preparedness for Overdose Situations	Obj 3.1: Increase Naloxone distribution by 2% annually.	• Baseline kit volume • 9 Fatal Overdoses • 47 Nonfatal ER visits	• +2% Cumulative Kit Increase • < 5 Fatalities • 1 Outreach event/QTR • 1 Training/QTR

Program 3.2: Crisis Lines & Suicide Prevention Training

Description: Promotes 988 Suicide & Crisis Lifeline utilization, provides QPR/AFSP crisis intervention training, and expands school mental health support.

Lead Partners & Community Assets: NorthKey Community Care, AFSP, 1N5, Empowered Living, Carroll County Schools, Local First Responders.

Goal	Objective (Target Date: June 30, 2030)	Baseline Value	2030 Target / Measure
Improve community awareness, access, and utilization of crisis intervention resources and suicide prevention.	Obj 3.2: Decrease percentage of adults reporting 14 or more days of poor mental health per month by 2% from 20% to 18% (CHR) Obj 3.3 Decrease adults reporting that they sometimes, rarely, or never get the social and emotional support they need by 3% from 25% to 18% (CHR)	• 88% 988 Answer Rate • 20% Frequent Mental Distress • 25% Emotional Support • 2 Outreach/ QTR	• 95% 988 Answer Rate • 18% Mental Distress • 22% Emotional Support • 4 Outreach/ QTR • 2 Prevention trainings/yr

Program 3.3: Community Health Worker (CHW) Navigation

Description: Deploys CHWs to navigate underserved residents in rural precincts (Ghent, Worthville, Sanders) to healthcare, SUD care, housing, and social services.

Lead Partners & Community Assets: TRDHD CHWs, Welcome House Outreach, Haven of Hope, MCO Care Managers (WellCare, Passport, Aetna, Humana, Anthem).

Goal	Objective (Target Date: June 30, 2030)	Baseline Value	2030 Target / Measure
Increase awareness, access, and utilization of Community Health Worker services.	Obj 3.4: Increase CHW referrals by 5%	• Baseline Referrals/QTR • Baseline Provider contacts	• __ Referrals/QTR • 3 Practices contacted/QTR • 1 Outreach activity/QTR

Priority 4: Healthy Aging

Program 4.1: Healthy Aging and Prevention Initiative
Description: Promotes healthy aging, physical exercise, routine health checkups, and social connectedness among adults aged 65+.
Lead Partners & Community Assets: CC Senior Citizen Center, Fairview Place Senior Living, Northern Kentucky Area Development District (NKADD), TRDHD.

Goal	Objective (Target Date: June 30, 2030)	Baseline Value	2030 Target / Measure
Promote healthy aging, independence, and overall well-being among older adults.	Obj 4.1:	• __ Seniors in exercise/QTR • __ Checkup Rate	• 30 Seniors in exercise/QTR • __ Checkup Rate • 6 Senior programs supported/QTR • 2 Presentation/YR

Program 4.2: Fall Prevention and Home Safety ("Home Health Lite")
Description: Implements the "Home Health Lite" (HHL) program, conducting home hazard assessments and connecting seniors with adaptive equipment.
Lead Partners & Community Assets: CCMH Physical Therapy, TRDHD, CC Senior Citizen Center, NKADD, Emergency Medical Services (EMS).

Goal	Objective (Target Date: June 30, 2030)	Baseline Value	2030 Target / Measure
Develop Home Health Lite Program	Obj 4.2: By June 30, 2030 develop Home Health Lite program	• 0 Fall activities • 0 Home assessments • 0 HHL referrals	• 5 Fall activities/YR • 15 Home assessments/YR • 15 HHL program referrals/YR

Priority 5: Youth Health & Wellbeing

Program 5.1: The Youth Health & Wellbeing Initiative promotes healthy development among Carroll County youth by strengthening community belonging, positive peer relationships, healthy behaviors, and protective factors. The program uses education, youth engagement, and community partnerships to support youth wellbeing and prevent vaping.

Goal	Objective (Target Date: June 30, 2030)	Baseline Value	2030 Target / Measure
Improve the health and wellbeing of Carroll County youth by strengthening supportive environments, positive relationships, community connection, healthy behaviors, and protective factors.	Obj 5.1: Increase the percentage of Carroll County youth who report feeling a sense of belonging in their community from 65.6% in 2026 to 75% by 2030. Obj 5.2: Increase the percentage of Carroll County youth who agree that students at their school are nice to each other from 41.8% in 2026 to 50% by 2030. Obj 5.3: Increase the percentage of Carroll County youth who report waking up feeling fresh and rested all or most of the time from 42.2% in 2026 to 50% by 2030. Obj 5.4: Increase the percentage of Carroll County youth who report that none of their friends vape from 50% in 2026 to 60% by 2030.	• 65.6% Sense of Belonging • 41.8% Student are nice • 42.2% Feeling rested • 50% No friends vape	• 75% Sense of Belonging • 50% Student are nice • 50% Feeling rested • 60% No Friends Vape

Community Asset Matrix & Partner Directory

The 2026–2030 CHIP leverages an extensive network of local and regional partner organizations to execute improvement strategies efficiently:

Category	Key Community Assets & Partner Agencies
Primary & Specialty Care	Carroll County Memorial Hospital (CCMH), Triad Health Systems, NorthKey Primary Care Mobile Clinic, TRDHD Health Center Clinic, St. Elizabeth Healthcare (Baby Steps & Mammogram Van), Welcome House Medical RV.
Behavioral Health & SUD Care	NorthKey Community Care, Empowered Living, Champions, Triad Health Systems, 1N5, Addiction Recovery Care (ARC), Cleanse Clinic, Recovery Works, Haven of Hope, ION Center, AA Groups, TRDHD Harm Reduction.
Fitness, Recreation & Wellness	CC Parks and Recreation, General Butler State Park, Carroll County Public Library (Zumba, Power Yoga, Pound), Riverview Farmers Market, General Butler Farmers Market, Local Faith Community.
Youth & Family Services	Carroll County Schools, iLEAD Academy, CC Child Development Center (CCCDC), TRDHD HANDS & WIC programs, Agape Family Nurturing Center, Students Against Destructive Decisions (SADD).
Aging, Housing & Social Supports	Carroll County Senior Citizen Center, Fairview Place Senior Living, Northern Kentucky Area Development District (NKADD), Northern KY Community Action Commission (NKCAC), Welcome House Outreach Van, Medicaid MCO Care Managers (Aetna, Humana, Passport by Molina, WellCare).